

Retiree
Health
Benefits:
What Is the Promise?

AN EBRI-ERF POLICY FORUM



EMPLOYEE BENEFIT RESEARCH INSTITUTE

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Foreword

Until the early 1980s, many employers provided their retirees with health insurance coverage without giving much attention to costs. Retirees represented only a small proportion of the entire work force and were typically included in the active-worker health insurance plan, with no assessment of age-related costs. As well, many employers presumed they could end the benefit at any time.

The combination of escalating health care costs, growing numbers of retirees, and legal precedent establishing employee entitlement to retiree health insurance now confronts many employers, who face huge unfunded liabilities for these benefits. In addition, employers now face a rule proposed by the Financial Accounting Standards Board (FASB) that would require them to determine the cost and value of benefits promised to retirees and include the amounts on their corporate income statements (1992) and balance sheets (1997).

The costs involved are substantial. The Employee Benefit Research Institute (EBRI) estimates the present value of private employers' liability for retiree health insurance obligations to be between \$169 billion and \$250 billion, depending on the ultimate value of Medicare. To cope with these challenges, many employers are reconsidering the nature and implications of their retiree health care benefit commitments. They are restructuring plans, developing new strategies to manage costs, attempting to limit legal liabilities, and seeking appropriate prefunding vehicles.

In 1987, the Education and Research Fund of EBRI published a policy study, *Measuring and Funding Corporate Liabilities for Retiree Health Benefits*, which focused on how employers might deal with the issue through funding, and how much alternative approaches might cost. In October 1988, an EBRI policy forum comprehensively explored the issue, which provides the basis for this book. Participants in the day-long forum discussed employer initiatives under way and possible future strategies, as well as relevant legal and legislative issues. The forum brought together corporate executives, government officials, and representatives from labor and the legal profession, each of whom brought a unique perspective to the discussion.

Retiree Health Benefits: What Is the Promise? integrates the papers and proceedings of the policy forum with additional supplemental material, including the exposure draft of FASB's proposed standard, "Employers' Accounting for Postretirement Benefits Other Than Pensions." The book is organized into four parts, dealing with the benefit

“promise” and its cost, legal issues and accounting requirements, the response of employers and unions, and public policy concerns. EBRI’s intent in developing this volume is to give corporate planners, benefit experts, policymakers, the news media, and the public a fuller understanding of the importance and complexity of the retiree health benefit issue, and clarify the reasons for the increasing attention it is given. EBRI’s Education and Research Fund will publish a second major study on retiree health financing in late 1989 that builds upon this book.

On behalf of EBRI and its Education and Research Fund, I wish to thank the policy forum speakers and participants for their substantial contributions to this book. Special thanks are due to Laura Bos, Nancy Newman, and Shannon Braymen for planning the policy forum; to Deborah Holmes for compiling, editing, and producing this book; and to Christine Dolan for preparing the index.

The views expressed in this book are solely those of the authors and the forum participants. They should not be attributed to the officers, trustees, members of EBRI, its staff, or its Education and Research Fund.

DALLAS L. SALISBURY
President
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DAVID MOSSO

Mr. Mosso became assistant director of research and technical activities of the Financial Accounting Standards Board (FASB) in January of 1988. He joined FASB in 1978 as a member of the board. In 1986 he was appointed its vice chairman, serving in that position until the completion of his second five-year term. Before joining the board, Mr. Mosso was fiscal assistant secretary of the U.S. Department of the Treasury. He joined the Treasury Department in 1955 and served in various capacities, including commissioner of accounts.

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Mr. Nelson is an associate member with the Chicago office of Milliman & Robertson, Inc. A fellow of the Society of Actuaries and member of the American Academy of Actuaries, he has been active in each of these organizations, as well as in the Chicago Actuarial Association. He has served on the Academy's committees on health and on relations with accountants and on its task force on national health care issues. He is chairman of the committee on health and welfare plans. Nelson has written articles and made presentations on a number of topics related to group health care programs, such as postretirement benefits and the implications of recent legal and accounting actions.

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Mr. Schmidt is a partner in the Washington, DC, law firm of Arnold & Porter, specializing in tax and employee benefit matters, particularly as they affect multiemployer plans. He has written and spoken extensively in the benefits area, including papers and seminars for American Law Institute/American Bar Association, the Practicing Law Institute, New York University, the Institute on Labor, *New York Law Journal*, and Warren, Gorham & Lamont. He also writes a regular column on benefits litigation for EBRI's *Employee Benefit Notes*.

PART ONE

RELATING THE PROMISE TO THE COST

The security of retiree health benefits has become a prominent public policy issue affecting employers, policymakers, and labor unions and other organizations that represent millions of active and retired workers. Part One of *Retiree Health Benefits: What Is the Promise?* examines the legal nature and prevalence of this commitment and the relation of the expense involved to the larger issue of general health care cost inflation.

Our most important challenge, according to Alain C. Enthoven in chapter I, is not coping with the new Financial Accounting Standards Board (FASB) rule on the reporting of retiree medical benefits, but rather to come to terms with “the awesome total of health care costs for elders and the growing number of elders per working aged person.”

There is a need for fundamental, long-term efforts to slow the growth of health care spending and bring it roughly into line with the growth in the Gross National Product (GNP), according to Enthoven. He proposes that consumers be offered incentives to reward provider organizations for the delivery of high-quality, cost-effective health care. In addition, he says, there is a great need to increase savings to the extent that each generation saves enough during its working years to pay for its own retirement.

Enthoven supports tax-sheltered savings opportunities for all workers and not merely for long-service employees retiring from large corporations or for middle- and high-income retirees. He discusses the possibility of a system of compulsory saving and points to the need for universal health insurance.

In chapter II, Deborah J. Chollet describes the prevalence of retiree health insurance as an employee benefit and the prevalence and distribution of this benefit among early retirees (aged 55 to 64) and retirees aged 65 and older. She estimates the present value of private employers' liability for retiree health insurance obligations to be approximately \$169 billion, of which nearly \$101 billion is associated with current workers and slightly more than \$68 billion with current retirees.

Chollet reviews FASB documents that address the appropriate accounting practice for corporate-sponsored retiree health and life in-

insurance benefits, and describes various legislative proposals aimed at encouraging employers to advance-fund retiree health insurance obligations. The legislative debate will be a long one, she suggests, and the result may be measures that are less favorable to employers than comparable pension legislation has been.

In chapter III, participants reflect on a number of questions related to retiree health benefits and health care costs in general. They discuss whether individual saving is an appropriate answer to the problem of escalating health care costs, and whether some system of compulsory saving should be considered.

Participants also discuss the effectiveness of health maintenance organizations and similar group practices in managing costs, and explore policy issues surrounding the provision of tax-sheltered employer-provided health benefits. Looking ahead, they attempt to estimate future medical care inflation in terms of the GNP.

I. Retiree Health Benefits as a Public Policy Issue

PAPER BY ALAIN C. ENTHOVEN

Putting the Problem into Perspective

Start with the Grand Total—In 1982, the Financial Accounting Standards Board (FASB) proposed that the cost of retirees' health care be accrued during the service lives of employees who are expected to receive these benefits. The pay-as-you-go method of funding would no longer be acceptable in accrual basis financial statements. In 1986, the Department of Labor estimated that the present value of the liability of private-sector employers for postretirement health benefits was about \$100 billion in 1983 (U.S. Department of Labor, 1986). Subsequently, the Employee Benefit Research Institute (EBRI) has developed estimates for total unfunded employer liability, including the public sector, of about \$280 billion (Chollet, 1988). This figure includes the accumulated liability for workers who have not yet retired. The private sector's share is estimated to be about \$169 billion. The U.S. General Accounting Office (GAO) has recently estimated the private sector's liability at \$221 billion, not adjusted for this year's changes in Medicare (Klein, 1988). In July 1986, LTV Corporation filed for reorganization under bankruptcy and terminated the health benefits of 78,000 retirees. These events and others like them have attracted much attention. What is the problem? And how big is it?

Employers' liability is a piece of a much larger problem. To gain perspective, we should start with the total magnitude of the retiree health cost problem. I arbitrarily pick 40 as the age at which savings for retirement should begin. What is the present value of post-age-64 health care expenditures for all people now aged 40 and over? A precise calculation would take each annual cohort, factor in a life table, retirement rates, age-specific health care spending, and growth rates—all discounted to a present value. The task exceeds my resources, but there is a simple way to get a rough figure.

Personal health care expenditures for people aged 65 and over were estimated at \$4,202 per elderly individual in 1984 (Waldo and Lazenby, 1984). That would be approximately \$5,600 in 1988. There are about 60 million Americans aged 40 to 64 today. The average person reaching age 65 in the year 2000 will have a remaining life expectancy of 17.9

years (Wade, 1988). Real health care spending per capita has been growing about 4.6 percent per year in this decade. What is the real long-term interest rate? That is a very complex issue, but I believe that a reasonable answer would be in the range of 4 percent to 5 percent; for convenience, call it 4.6 percent. The present value of each of these people's post-age-64 health care costs is 17.9 times \$5,600 in 1988 dollars or around \$100,000. Of the 60 million, approximately 90 percent will reach age 65. Therefore, the present value of their post-age-64 health care costs is \$5.4 trillion. A similar calculation for people now aged 65 and over adds another \$1.3 trillion, for a total of \$6.7 trillion. This is about three times the national debt. This number is, of course, extremely sensitive to some very uncertain assumptions. In particular, it is difficult to believe that real health care spending per capita can continue to grow at anything like 4.6 percent per year.

Among other considerations, this calculation suggests that the "ice-berg" is the future cost for people still working; the costs for present retirees are the tip.

It is difficult to deal with such a huge number, so I will express the same problem another way.

The \$4,202 per elder in 1984 multiplied by 28.33 million elders equals \$119 billion, or 3.2 percent of Gross National Product (GNP). Let us extrapolate these figures to the year 2020. Real GNP per capita grew 1.8 percent per year in the 1980s, more than during the 1970s and about the same amount as during the 1960s. The 1.8 percent consisted of 0.8 percent growth in real GNP per worker, 0.8 percent in workers per working age population, and 0.2 percent working age population as a share of the total (U.S. President, 1988). By 1984, 79.3 percent of the working age population was in the work force, so there is not much room for further growth in that ratio. Assume this figure tops out at 90 percent in the year 2020. That is 0.35 percent per year growth. Working age population as a share of the total will be flat. Therefore, 1.15 percent per year growth in GNP per working age person looks like a reasonable baseline case. How fast will real costs per elder grow? As noted earlier, real expenditures per capita have been growing about 4.6 percent per year in this decade. However, a recent Health Care Financing Administration (HCFA) analysis projects that from 1986 to the year 2026, a changing age/sex structure alone will account for a 0.58 percent per year increase in real per capita expenditures.¹ Thus, an age-specific expenditure growth rate might be

¹See U.S. Department of Health and Human Services, Health Care Financing Admin-

closer to 4.0 percent. If we project the growth of a particular age group, it would be more accurate to use age-specific rates. However, there will be aging within the elder group. If we assume, respectively, that real health care expenditures per elder grow 4.0, 3.0, or 1.15 percent per year, elder care as a share of GNP will be 13.1, 9.2, or 4.8 percent. The higher numbers are staggering amounts. I believe that spending 13 percent of GNP on the health care of elders simply cannot happen. Some corrective forces are bound to come into play. Nevertheless, this calculation helps define a very serious problem.

The reaction of many people to the proposed FASB ruling, the hundreds of billions of dollars in employer liability for retiree medical benefits, and the LTV bankruptcy has been to focus attention on how bookkeepers are going to present this information, who will pay for employers' past promises, and how to secure retirees' rights to promised benefits. These questions are secondary; they are like arguing over deck-chair rights on the Titanic. The big problems are the awesome total of health care costs for elders and the growing number of elders per working aged person.

The Need for Fundamental Long-Term Solutions—It is important to get away from the musical chairs approach in which everyone tries to make someone else pay. As a nation, we must focus on fundamental long-term solutions. I see two broad avenues of approach.

First, we must slow the growth of health care spending, bringing it roughly into line with growth in GNP. This will not be easy. A number of industrialized democracies have done it by having their governments assume responsibility for health care financing and placing it under firm prospective global budgets. Obviously, this is not painless. In Great Britain and Sweden it has resulted in queues and rationing of care.

Some slowing of the growth in health care spending for elders might be achieved by a change in social priorities and medical ethics. Former governor of Colorado Richard Lamm and others have questioned the appropriateness of spending large amounts of money for costly medical technology to achieve small gains in the health status of frail elderly persons near the end of their lives. Others have questioned the medical appropriateness of much of the care they do receive (Winslow, Solomon, Chassin et al., 1988, and Winslow, Kosecoff, Chassin, 1988).

istration, Division of National Cost Estimates, "National Health Expenditures, 1986–2000," *Health Care Financing Review* (Summer 1987). Per capita expenditures are deflated by the GNP implicit deflator.

I have proposed that we try to get spending under control by a concerted strategy of managed competition in which sponsors—the large group purchasers—use cost-conscious consumer choice as a way of transforming our health care system into efficient delivery organizations. The idea is to manage the incentives consumers have to reward provider organizations for delivering high-quality, cost-effective care (Enthoven, 1988a and 1988b). It is a complicated strategy, which may be too complex for most employers to manage. However we do it, I cannot overemphasize the importance of getting this spending under control soon. Continued growth at even 3 percent per year would impose an enormous burden on taxpayers and elders.

Next, we must greatly increase savings. Each generation ought to save enough during its working years to pay for its own retirement, including health care. It seems unjust for each generation to impose these costs on the next. The custom of each generation relying on younger generations seemed reasonable in the past. But by the year 2020 there will be only 3.3 working aged people for each elder, or 2.1 workers per beneficiary in the Social Security system. The present generation of frail elderly can complain that they did not know how costly their care would be. But people now in their forties and fifties should be warned. Public policy should warn people and require savings. As each person reaches age 65, he or she or society should have saved about \$100,000 for his or her future health care costs (adjusted for cost growth and post-age-65 earnings on assets). This would be roughly \$50,000 net of Medicare. I am not now prepared to make specific recommendations, but we ought to be thinking in terms of strong medicine, such as compulsory individual medical accounts. I appreciate that the suggestion of compulsory savings will seem unpalatable in our free society. However, if elderly persons reach retirement age without adequate savings, the rest of society will be forced to pay for their care. As a society, we are simply not going to let them suffer and die without care.

To encourage adequate savings, we should reconsider normal retirement age, not to mention policies favoring early retirement. At present, many policies are biased in favor of early retirement. For example, Social Security beneficiaries in effect are taxed at 50 percent on their post-age-64 earnings.* It would be easier for people to save

*Editor's note: Currently, there is a Social Security earnings test limiting the amount that can be earned before Social Security benefits are partially or fully reduced. In 1989, a 65-year-old person with \$8,800 or less in earnings can continue to work and receive all of the Social Security benefits; those who retire early are permitted to

for their postretirement incomes and health care if they worked longer. Thus we need to reconsider the concept of retirement, to make it a process rather than an event. We need to change the incentives, to let people get the full actuarial benefit of working longer, and to restructure careers so that people can work full or part time after age 65. As we consider alternative policies for securing postretirement health benefits, we should avoid creating more incentives for early retirement.

Who Shall Pay?

Who should pay for these costs?

Medicare and Medicaid—HCFA actuaries estimated that in 1984 two-thirds of the personal health care costs of the elderly (or \$2,823 per elderly person) were paid by Medicare, Medicaid, or other government programs and, therefore, largely by working taxpayers (Waldo and Lazenby, 1984). Medicare's share will increase as a result of the passage of the Medicare Catastrophic Coverage Act of 1988, although the additional costs will be borne by beneficiaries.

How much should Medicare and Medicaid pay? We are caught in a bind. On the one hand, Medicare and Medicaid ought to assure every elderly person access to what we can tolerate as a decent minimum of health care. On the other hand, we must not transfer more of the burden from retirees to workers. In 1988 approximately 37 percent of federal outlays went to incomes and health care for the aged and disabled, about \$100 billion more than was spent for national defense. More increases will be produced as current programs interact with demographic trends. Reluctance to transfer more of the burden to workers was reflected in Congress' decision to fund Medicare catastrophic coverage with higher premiums and taxes on beneficiaries. More tax increases on workers to support health care for the elderly would probably result in higher marginal tax rates, a drag on economic growth, and incentives to avoid payment of taxes.

Of the \$6.7 trillion liability for postretirement benefits, approximately one-third, or \$2.2 trillion, is the liability of individuals and firms in the private sector. Apparently roughly \$170 billion to \$221 billion of that is the liability of private-sector employers (Chollet,

earn up to \$6,480 (these figures are adjusted annually). For every two dollars in earnings above the limit, Social Security will withhold one dollar of benefits. Beginning at age 70, however, there is no limit on the amount that can be earned without penalty. Beginning in 1990, one benefit dollar will be withheld for every three dollars in earnings above the limit for those 65 and older.

1988, and Klein, 1988). One way or another, most of the private sector's cost for postretirement health care will be borne by retirees.

What looks large to employers is a small part of the total problem.

Financial Accounting Standards Board

What issues are raised by the FASB proposal to require corporations to report the liabilities and accrued expenses of postretirement health care benefits on their financial statements? Contrary to what some company spokespersons appear to be saying, this requirement would not "raise their postretirement benefit costs by tens of millions of dollars" (Berton, 1988). It would merely require the accurate reporting (if such a term can be used in connection with such uncertain amounts) of costs and liabilities that already exist. It is simply a matter of truth in financial reporting. What justification could there be for concealing these liabilities from interested readers of financial statements? Would it not make sense for all public- and private-sector organizations to have to report such accruals in full? For one thing, this would force current recognition of benefit accruals in wage determination. Some public-sector officials and private-sector managers want to reconcile the conflicting pressures they experience by reporting a balanced budget or a profit while buying labor peace with promises that will not become due until later, on someone else's watch. Surely public policy should discourage this practice.

I have heard expressions of concern that the FASB standard will hurt stock prices, raise the cost of capital, put executives' options "under water," and increase the danger of unfriendly takeovers. I sympathize with the executives. I know what it feels like to have one's stock options deep under water. At first I was inclined not to believe that the FASB standard would affect stock prices. After all, reporting the accruals does not change cash flows. I believed that there was some truth in the view that the market processes and discounts all available information and that the growing costs of health care for retirees had received so much attention that by the late 1980s they could not come as a big surprise. Then I heard EBRI President Dallas Salisbury say that EBRI had questioned 25 securities analysts and found that none of them knew anything about the liability for postretirement health benefits. Apparently the analysts have not been doing their jobs and have missed liabilities by the billions. Booking these liabilities will change important debt-equity ratios that might affect indentures, loan agreements, and the like. On the other hand, analysts may have figured that what the United Automobile Workers

and United Steelworkers receive in health care they will not receive in wages, so it does not matter. In any case, the cat is out of the bag now. Surely it would be a Pyrrhic victory for management to win a big battle with FASB on this issue and not be required to report accrued costs and liabilities. The battle itself would call attention to the problem. Analysts will find out and factor these costs into their evaluations. The credibility of financial statements would not be helped by an attempt to cover up these liabilities.

The Roles of Employers, Stockholders, and Workers

Promises, Promises—Employers and stockholders obtained the services of some employees by promising them postretirement health benefits. It seems reasonable for the courts to take the view that they should have to fulfill these promises, although it may not be wise for the “creditors” to insist on full payment.

I am not aware that any stockholders are asking for taxpayers to relieve them of this obligation, but if they were, it would be difficult to see any justification for it. However, the new discovery of the burden of postretirement health benefits—much of which is for pre-Medicare retirees—may create some new converts to publicly financed universal health insurance.

There are some serious problems inherent in the way the issue of promises is being resolved. One is the dynamic aspect of health benefits and the consequent need for flexibility. This point is argued cogently by Willis Goldbeck, who points out that, in response to changing conditions in recent years, major socially responsible employers have made benefit design changes that improve retirees’ medical plans (U.S. Congress, 1986). These changes include the addition of hospice services, second surgical opinion, outpatient surgery, prescription drugs, prevention programs, outpatient mental health and substance abuse treatment, preadmission testing and certification, concurrent utilization review, home health care, case management, health maintenance organizations (HMOs), and organ transplants. It makes no sense to say that employers can add but they cannot subtract. Restructuring for cost containment is essential. We certainly would not want to force employers to say “we will pay only for technology that was available the year you retired,” or to force them to drop benefits altogether.

When one reflects on the rapid and continuing changes in the technology and organization of medicine, one must realize that it is unclear precisely what was promised to retirees. Certainly it cannot be

exactly the coverage and standard of care they had in their final years as active employees. Too many things change every year. Congress enacts catastrophic coverage. Employers replace indemnity coverage with HMOs and preferred provider organizations. It would not make sense for the courts to say that employers are obligated to continue the same indemnity coverage with the same deductibles. What about coverage for new drugs and procedures introduced years after retirement? I doubt that health care of retirees is good material for a long-term contract. For example, try to write down exactly what you are promising today's workers for their coverage in the year 2001. You will find that it is a nearly impossible task.

Congress changes Medicare every year: there are increased deductibles, changes in coverage and premiums, and changes in the payment system. This is accepted because the process is democratic and nobody gets hurt too badly. People think of the private sector as more flexible than government, but this may not be the case if the courts freeze retiree health care coverage. Perhaps a public social insurance model will prove to be a more adaptable way to finance retiree health care.

Death Spiral for Mature Employers?—One can imagine some grim scenarios for mature industrial companies and their retirees resulting from the burden of unfunded postretirement health benefits. What I say here is speculative, and I hope it is wrong. However, people should be thinking about this issue now while there is time to do something.

The health care cost per automobile for a mature American producer is likely to exceed by a significant amount that for a new manufacturer, for instance, a foreign company that produces automobiles in the United States. The mature American company will have an older work force, more health care costs for active employees and retirees, and more retirees per active worker. I doubt that the amount can be quantified on the basis of public information. But some available information can help give us a rough idea. The Ford Motor Co. reported 1987 outlays for postretirement health benefits for U.S. and Canadian employees of \$341 million (Ford Motor Company, 1987). Because there are a larger number of U.S. workers and Canada has universal publicly financed health insurance, I estimate that 95 percent of this cost is for U.S. workers. U.S. factory sales of cars, trucks, and tractors came to 3.7 million units year. This would amount to approximately \$88 per unit. GAO estimates that, on average, employers' 1988 accruals would be about

3.5 times current cash outlays for retiree health care (Klein, 1988). Thus, we may be seeing costs of \$300 or more per car. Of course, the foreign companies have postretirement benefit costs, too. I am assuming that their workers are younger, so they have a longer time during which to reserve funds for retirement. Also, their benefits may be less generous. It seems reasonable to guess that the difference might be at least \$100 per car now, and may possibly be several times that in a decade—enough to become a significant competitive factor. The same circumstances would apply to mature steel companies competing with new mini-mills and to other manufacturing companies, unless their managements succeed in reducing retiree benefits.

If the mature companies adjust their prices to cover these costs, one can imagine that this competitive disadvantage would cause them to lose market share to the younger companies. As they do, the problem would become worse. The ratio of retirees to active workers would rise, and eventually the companies would go into a “death spiral” and join LTV. They could not pay the high retiree health care and other costs and price their products competitively.

How serious are the consequences? Does this scenario require public intervention?

The bankruptcy of the mature steel and auto companies would not mean an end to steel and auto production in the United States. It would mean that the production of mature companies would be replaced by that of newer companies with lower costs. If the United States remains a good place to make these products, they will be made here.

What impact will this have on retirees? Those aged 65 and over would be eligible for Medicare and, if necessary, Medicaid. So their out-of-pocket costs for medical care would be limited, although possibly substantial. These people would remain protected by what our society considers to be an acceptable level of social insurance.

Retirees under age 65 and their dependents would present a different problem. They would not be covered by Medicare. They would have depended on our employment-based system of health insurance and been failed by it. They would join millions of other uncovered early retirees and others unprotected by our system. In fact, roughly 37 million Americans have no coverage at all. The plight of the retirees of bankrupt companies is especially poignant because they had reason to believe they had made prudent provision for their health care. But their problem is essentially the same as that of the rest of the 37

million. There is an urgent need for public policies that assure access to affordable health care coverage for everyone.

Some would argue that these workers bargained for overly generous compensation, at a level that could not be sustained. The rest of society is likely to resist accepting the burden of maintaining their high levels of benefits if their former employers cannot pay.

The main losers from this process would be the workers who did not get the benefits they were expecting and the stockholders and managements of these companies. This is essentially a private matter among them. What should they do? All these parties have an interest in the survival of their companies and would be better off making some concessions to preserve their viability. The following is one scenario they might consider.

The unions and management would negotiate a large reduction in benefits, especially in the area of health benefits for early retirees. Workers would accept reduced benefits and substantial employee contributions. Perhaps they would accept a health plan limited to efficient HMOs, where available. They would make concessions designed to give companies real leverage in controlling costs by directing employees and retirees to efficient providers. These "give backs" could cut the present value of the liability substantially. In exchange, management would prefund the obligation for past service on an agreed-upon schedule, with the funds going to a trust fund to pay future benefits. Future liabilities would be fully funded as accrued. Wage levels would be adjusted to keep the companies competitive. As a part of the scenario, unions might agree to defined contribution as opposed to defined benefit plans. All parties might agree to some form of worker/retiree participation in decisions about plan redesign intended to keep the plan viable under changing conditions as an alternative to an inflexible contractual arrangement.

One lesson for workers in this scenario is that promises of future benefits may be illusory if they are not fully funded in a secure trust fund. A lesson for employers is that they should be careful, definite, and precise about promises of future benefits and they should factor the present values of future costs into present decisions about wages. FASB is trying to help them do the right thing. Both management and labor leaders have been under powerful pressure to take a short-run view. Retiree health benefits were a bargaining prize that apparently could be won or granted with no

present sacrifice in wages or profits. Now the long-run consequences are becoming apparent.

Public Policy

What are the implications for public policy? Here are a few.

Encourage Savings, Discourage Borrowing from the Future—Public policy must encourage savings. The goal should be to encourage enough savings to enable each generation to support itself in retirement, including health care. It is difficult or impossible for individuals to save without tax-sheltered vehicles because of the interaction of inflation and taxes. Therefore, tax-sheltered arrangements must be designed. This must be done with care, however. For one thing, it can be costly to the U.S. Treasury. If corporations were allowed to deduct \$34 billion instead of \$10 billion a year, as suggested by the GAO numbers, the annual federal deficit would increase by about \$8 billion, not counting the revenue lost on untaxed interest. It is far from obvious that this is the most urgent use of \$8 billion.

Other important public policy objectives are also involved. One is “horizontal equity”: for example, tax-sheltered savings opportunities should be equally available to all, not only to those who happen to be long-service employees retiring from large companies. Another objective is “vertical equity.” Employer-provided postretirement health benefits are much more prevalent among middle- and high-income retirees than among those with low incomes (U.S. Senate, 1988). It does not make sense to spend scarce forgone tax revenues to help the most financially secure individuals to improve their positions while doing nothing to assist those who are less well off. In such circumstances, the latter suffer and some become a charge on public support. An additional public policy objective should be to encourage cost-consciousness and economic responsibility for choices. From this point of view, it is counterproductive to offer open-ended tax shelters for open-ended benefits. The well-to-do with employer-provided coverage are already receiving a substantial tax-free benefit as well as costing Medicare more than beneficiaries who have no private coverage. Public policy should also encourage job mobility, or at least avoid creating artificial barriers to it. For economic efficiency, workers should be able to move to jobs best suited to their skills. From this point of view, tax-favored savings plans should include instant full vesting and complete portability.

Large open-ended tax breaks for large employers to prefund health benefits for long-service employees would not score well according to any of these criteria.

In fact, a capped individual medical account (IMA) appears to meet these criteria much better. Let everyone shelter from taxes, say, 10 percent of earnings up to the wage base in an account that would be available for postretirement health benefits. There is much to recommend this in terms of equity, portability, and cost consciousness.

IMAs have some features that make them particularly interesting for financing long-term care. Long-term care financing is filled with conundrums. For one, for every disabled elderly person in a nursing home there are two living in the community with similar disabilities who are making do with help from family, friends, and hired help. If we create a social insurance program for nursing home care, with no provision for home help, we create a powerful incentive for families to give up the struggle and put their elders in nursing homes. We reward those who give up the struggle and do nothing for those who continue to support their elders at home. This creates a powerful argument for a home health aide benefit. Here the problem is that many of the services that can keep the disabled elderly out of nursing homes are indistinguishable from domestic help. Every elderly person would like to have a maid. It is very hard to define need and to manage such a benefit at a low cost. Another conundrum is the lack of reward for savings in the present Medicaid system. One elderly person works hard, saves her money, and is able to pay her nursing home bill for a year before spending down into poverty and receiving assistance from Medicaid. Her less frugal sister has no savings, goes to the same nursing home, and is immediately covered by Medicaid. So the frugal sister saves the taxpayers money and receives no reward for her frugality. That is a very counterproductive policy in a society that needs to save more.

If people entered their disabled elderly phase with a substantial fund of savings—their own money that they could spend or leave to their heirs—they would have an incentive to use it economically on home health aides. Or they could pay their own first year or two in a nursing home. Social insurance for nursing home care, with a large front-end deductible, could back this up.

But there are problems with the IMA. Individual retirement accounts (IRAs) were criticized for creating a tax break for the well-to-do without increasing their savings while not motivating much sav-

ings by people less well off. Alice Rivlin and Joshua Wiener have concluded that the IMA would not save taxpayers money (Rivlin and Wiener, 1988). The well-to-do who use it would not go on Medicaid anyway. People with modest incomes who might end up on Medicaid will not use it. However, IMAs could be structured differently from IRAs to reduce these problems.

Another problem is that one needs to tie into a sponsored group to be able to buy affordable health care coverage, or perhaps any coverage. This would not be the case for individuals eligible for Medicare, who could buy individual Medicare-supplemental coverage. But it would be a serious issue for those who retire early. Therefore, some compromises are needed.

In 1987, Rep. Rod Chandler (R-WA) proposed a voluntary retiree health plan (VRHP) which would enable employers to prefund retiree health care and long-term care benefits (Chandler, 1987). Contributions and interest would be tax deductible. Annual contributions would be capped. Employees would be vested on a schedule similar to that used for pensions. Once vested, the employee could take his or her account to a new employer who also funds a VRHP. At retirement, the employee and his or her spouse would receive coverage from the employer who currently maintains the employee's account. Beneficiaries would not be able to cash in the benefit, even in the case of death.

This concept encourages savings, ties savings to specific employees with some portability, and caps the benefit and spreads it widely. The reasons for tying this account to employers are to increase the likelihood the benefits will be funded and to tie the retiring employee into a sponsored group. Employers are now obligated to pay the postretirement benefits, so it is they who need the tax-sheltered vehicle.

One might consider extending Rep. Chandler's idea in various ways, such as faster vesting, portability to an insurance company if an employee with a VRHP account moves to an employer without postretirement health benefits, and permitting accumulations in IMAs in the case of employees or others who do not have employer-sponsored postretirement health benefits.

Another radical idea would be a compulsory savings scheme, requiring perhaps 10 percent of earnings to be deposited in a tax-sheltered fund up to a maximum annual contribution, adjusted annually for inflation. These accumulations might be used at retirement to buy postretirement coverage, with some funds available to indi-

viduals for noncovered health care goods and services. This would be a way of assuring that most people reach retirement with substantial savings to help cover health and long-term care expenses.

The savings issue and accrual accounting are related. Public policy ought to support full accrual accounting, disclosure, and funding of all employer-provided compensation and benefits for all employees, public sector and private. The present value of accruals for pensions and postretirement health benefits for all public employees should be disclosed. To the great extent we have not done this, we have created anti-savings incentives. We have reduced employees' incentives to save by promising them future benefits, but we have not required employers to make the offsetting savings.

Tax Treatment of Employer-Paid Benefits—The tax treatment of employer-paid postretirement health benefits is a public policy issue, as is the tax treatment of employer-paid health benefits in general. Aside from the size and growth of the drain on the budget, there are two key issues: efficiency and equity. If we want our decentralized market system of health insurance to seek efficiency, tax-induced cost-unconsciousness must be considered contrary to public policy. And it seems inequitable to use scarce tax dollars to subsidize more generous coverage for those who are already well protected by employer-paid plans while doing nothing for millions of others who lack coverage.

What would seem appropriate would be a cap on the annual value of tax-free employer-provided coverage and tax deductibility for individual purchases of coverage up to that level.

The Need for Universal Health Insurance—We have discussed the problem of early retirees left without coverage. They are only one example of the many ways that 37 million Americans are excluded from health care coverage by our employment-based system, and this problem is only one of several important shortcomings of this employment-based system. Another problem is the difficulty of writing a suitably flexible long-term contract for postretirement health benefits. Congress “breaks its promises” and restructures some aspect of Medicare almost every year. This is considered acceptable because Congress is constrained by the democratic process.

All of these considerations point to the need for a universal health insurance program with a socially acceptable process for modifying benefits as conditions require.

Chrysler-Type Bailout?—If, and as, mature industrial companies are driven toward bankruptcy, pressures for a bailout by the taxpayers will arise. People will confuse the prospective demise of large and famous companies with the demise of the whole industry. Will such

bailouts be appropriate public policy? In the case of Chrysler, bailout proponents argued that the company's troubles were temporary and that it could be returned to viability if the government would guarantee its loans.

A key feature of the Chrysler bailout was the principle that all who had a stake in the company would have to make concessions. The problem of retiree health care cannot be solved without major concessions by labor and stockholders. Any promises of bailouts would send the wrong message: that these people, who ought to be economically self-sufficient and managing for long-term economic viability, can be bailed out if they act irresponsibly.

Protectionism—Finally, some may suggest that protection against imports is needed to solve the problem of companies threatened with bankruptcy. But protectionism does not solve problems of competitiveness. Protection of steel, for example, would mean American manufacturers using steel in their products would become less competitive against, say, Korean manufacturers using Korean steel. In any case, the scenario I described was predicated on competition for the mature companies from other companies manufacturing in the United States.

In general, we should resist Band-Aids and the usual musical chairs approach. The real problem is not bookkeeping. The real problems are uncontrolled and rapid growth in the costs of health care for retirees, the fact that we have not been saving enough money to support ourselves in retirement at the standards to which we are accustomed, and the fact that roughly 37 million Americans lack any health care coverage.

References

- Berton, Lee. "FASB Plan Would Make Firms Deduct Billions for Potential Retiree Benefits." *Wall Street Journal*, 17 August 1988.
- Chandler, Rod. "Pursuing Funding for Retiree Benefits," *Business and Health* (December 1987): 21–25.
- Chollet, Deborah J. "Retiree Health Insurance Benefits: Trends and Issues." In *Retiree Health Benefits: What Is the Promise?* Washington, DC: Employee Benefit Research Institute, 1989.
- Enthoven, Alain C. "Managed Competition: An Agenda for Action." *Health Affairs* (Summer 1988a): 25–47.
- . *Theory and Practice of Managed Competition in Health Care Finance*. Amsterdam: North Holland Publishing Company, 1988b.
- Ford Motor Company. *1987 Annual Report*. Dearborn, MI: Ford Motor Company, 1987.

- Klein, Burma H. "Future Security of Retiree Health Benefits in Question." In *Retiree Health Benefits: What Is the Promise?* Washington, DC: Employee Benefit Research Institute, 1989.
- Rivlin, Alice, and Joshua M. Wiener. *Caring for the Disabled Elderly*. Washington, DC: Brookings Institution, 1988.
- U.S. Department of Labor. Pension and Welfare Benefits Administration. *Employer-Sponsored Retiree Health Insurance*. Washington, DC: U.S. Government Printing Office, 1986.
- U.S. Congress. Senate. Joint Committee on Taxation. *Overview of Present Law, Proposals, and Issues Relating to Employer-Provided Retiree Health Insurance*. Committee Print. Washington, DC: U.S. Government Printing Office, 1988.
- . Senate. Special Committee on Aging. "Retiree Medical Benefits, Issues and Trends." Testimony by Willis Goldbeck, 7 August 1986.
- U.S. President. Council of Economic Advisors. *Annual Report, 1988*. Washington, DC: U.S. Government Printing Office, 1988.
- Wade, Alice H. "Social Security Area Population Projections: 1987." *Social Security Bulletin* (February 1988): 3–30.
- Waldo, David R., and Helen C. Lazenby. "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977–1984." *Health Care Financing Review* (Fall 1984): 1–29.
- Winslow, Constance M., Jacqueline B. Kosecoff, Mark R. Chassin et al. "The Appropriateness of Performing Coronary Artery Bypass Surgery." *Journal of the American Medical Association* (July 22–29, 1988): 505–509.
- Winslow, Constance M., David H. Solomon, Mark R. Chassin et al. "The Appropriateness of Carotid Endarterectomy." *New England Journal of Medicine* (March 24, 1988): 721–727.

II. Retiree Health Insurance Benefits: Trends and Issues

PAPER BY DEBORAH J. CHOLLET*

Introduction

Retiree health insurance—its cost, funding, and future—has become a focus of concern and controversy among employers and public policymakers. An emerging history of court decisions upholding contractual retiree rights to continued benefits when employers have sought to terminate retiree plans or modify benefits has made employers cautious about the way they represent retiree rights to both workers and retirees.

New accounting rules from the independent Financial Accounting Standards Board (FASB) are expected to force employers to phase in recognition of unfunded liability for retiree health benefits promises as an offset to corporate income in 1992.¹ Employers may be required to fully recognize the present value of unfunded liability by 1997, for both current retirees and workers eligible to retire. Furthermore, FASB's forthcoming rules may not recognize employer funds held to offset liability if those funds are held in the tax-preferred trusts that, under current law, are the most likely avenues for funding health and/or retirement benefits (that is, 501(c)(9) trusts and 401(h) trusts), since the law does not prohibit other uses of funds held in these trusts.

In any case, employers with retiree health plans have generally claimed that funding these benefits during active workers' careers in order to assure benefits after retirement (the way that pensions are funded under current law) would pose a substantial expense both absolutely and in relation to current spending for health benefits.

*Editor's note: The tabulations of data from the Survey of Income and Program Participation (U.S. Department of Commerce, Bureau of the Census) in this chapter are preliminary and may change in future Employee Benefit Research Institute publications.

¹On February 14, 1989, FASB released an exposure draft of a proposed accounting standard that would require companies to recognize postretirement health care and insurance benefits as a form of deferred compensation and to report these obligations on their balance sheets. Selections from the exposure draft, *Proposed Statement of Financial Accounting Standards: Employers' Accounting for Postretirement Benefits Other Than Pensions*, are included in Appendix B.

Although Congress has been concerned that retirees who expect these benefits may have no real claim to benefits in the event of a plan termination or sponsor bankruptcy, the prospect of tax revenue losses will probably impede enactment of legislation allowing tax preferences to encourage employer funding.

This chapter describes the prevalence of retiree health insurance as an employee benefit and the prevalence and distribution of retiree health insurance benefits among early retirees (aged 55 to 64) and retirees aged 65 or older. The discussion generally distinguishes between retirees who receive benefits from a private employer plan and those who receive benefits from past employment in federal, state, or local government. It includes estimates of the current value of both private and public employer liability for retiree health insurance benefits, distinguishing between liability for benefits being provided to current retirees and expected liability for active workers.

Finally, the discussion summarizes the legislative environment of retiree health insurance benefits and reviews the implicit involvement of pension benefit guarantees as, in effect, an insurance system for retiree health benefits in cases of plan sponsor bankruptcy. Corporate funding ability and federal budget structures are likely to constrain the future of health insurance benefits for tomorrow's retirees, reducing the proportion of the elderly population with benefits from an employer plan and changing retirees' own cost for the benefit. Corporations' obligations to current retirees, however, are likely to pose an increasing financial burden on them. Their wish for legislative assistance providing greater tax preferences for retiree health benefits raises difficult public policy questions related to federal budget priorities and retirement policy.

Retiree Health Insurance as an Employee Benefit

Continuation of health insurance benefits after retirement is a common feature of both private and public employer plans. In 1986, three-quarters (75 percent) of full-time workers in medium-sized and large private-sector establishments participated in health insurance plans that continued coverage after early retirement (before age 65); more than two-thirds (68 percent) participated in plans that continued coverage after retirement at age 65 (U.S. Department of Labor, 1987).

Most plans that continue coverage after retirement also provide for an employer (or sponsor) contribution to the cost of coverage. In 1986, 64 percent of full-time workers under age 65 in medium-sized or large private-sector establishments had plans that continued coverage after

early retirement, with the plan sponsor paying all or part of the plan cost; 58 percent had plans with fully or partly sponsor-financed coverage after retirement at age 65 (table II.1). An estimated 41 percent of workers in larger private-sector establishments had health insurance plans for which the plan sponsor paid the full cost of coverage after either early or normal retirement.

Fully or partly employer-paid retiree coverage is less common among public-sector workers (state and local government employees) than among private-sector workers in larger establishments. In 1987, nearly one-half (47 percent) of full-time state or local government workers with employer-based health insurance had plans that would continue with an employer contribution after retirement; 44 percent had coverage that would continue with an employer contribution after retirement at age 65. About one-half of state and local employees who participated in plans to which the employer contributed had the full cost of coverage after retirement paid by the employer.

Employer plans that continue coverage typically continue benefits at the same level as that provided to workers before retirement; that is, the scope of services covered and retirees' cost-sharing under the plan are maintained at preretirement levels. However, retiree plans typically integrate Medicare coverage into plan benefits. That is, Medicare is first-payer for services covered by both Medicare and the retiree plan.² Because Medicare integration substantially reduces plan costs, it has probably encouraged the growth of health insurance as a retiree benefit.

Since 1981, the number of workers with health insurance plans that continue coverage after retirement has grown substantially. Between 1981 and 1985, the number of private-sector workers with plans that provide benefits after early retirement grew by more than 14 percent (table II.2); the number of private-sector workers with plans that continue after age 65 grew 18 percent. The most rapid growth of retiree benefits apparently occurred among workers in manufacturing establishments and those in very large establishments (establishments with 2,500 or more workers). The number of workers in medium-sized and large manufacturing establishments with plans that continue benefits after retirement at age 65 grew nearly 20 per-

²Alternative methods of Medicare integration are described in Deborah J. Chollet and Robert B. Friedland, "Employer-Paid Retiree Health Insurance: History and Prospects for Growth," in Frank B. McArdle, ed., *The Changing Health Care Market* (Washington, DC: Employee Benefit Research Institute, 1987).

TABLE II.1
Percentage of Private and Public Employer Health Insurance
Plan Participants with an Employer Contribution to Coverage
after Retirement, by Selected Benefit Provisions
and Age of Retiree, 1986–1987

Benefit Provision	Medium-Sized and Large Private Employer Plans ^a		State and Local Employer Plans ^b	
	Retirees under 65	Retirees 65 or older	Retirees under 65	Retirees 65 or older
With Retiree Coverage	64%	59%	47%	44%
Effect of Retirement on Benefit Level				
No change	50	46	45	41
Reduced coverage	12	10	3	3
Increased coverage	1	1	^c	^c
Retiree Share of Cost				
Partial cost	23	17	24	23
No cost	41	41	24	24
No Retiree Coverage ^d	32	38	48	52
Provision Not Determinable	2	2	2	2
Retiree Policy Not Established	1	1	^e	^e
Other ^f	1	1	^e	^e

Source: Estimated from U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1986* (Washington, DC: U.S. Government Printing Office, 1987), tables 29 and 30; and U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in State and Local Governments, 1987* (Washington, DC: U.S. Government Printing Office, 1988), tables 48 and 49.

Note: Data reflect benefits provided to full-time permanent employees. Detail may not add to totals because of rounding or because the specific provision was indeterminable.

^aData are for 1986. Estimates assume that specific benefit provisions are proportionately distributed among plans to which the employer contributes.

^bData are for 1987. Data on the number of participants with retiree plans to which the employer does not contribute are unavailable.

^cLess than 0.05 percent.

^dIncludes participants in plans that continue access to coverage after retirement other than that required by federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985), but to which the employer does not contribute. These workers represent 11 percent of all plan participants.

^eNo plan participants in this category.

^fIncludes employees who participate only in the employer's dental insurance plan and for whom health insurance coverage and provisions are unknown.

cent between 1981 and 1985. The number of workers in very large establishments with this type of benefit increased 41 percent.³

Retirees with Employer-Sponsored Coverage

Employer-sponsored plans are an important source of health insurance among retirees. In 1984 (the most recent year for which data are available), at least 11.3 million retirees aged 55 or older had health insurance from an employer-sponsored plan (table II.3). Of these, 7.6 million were aged 65 or older. In 1984, at least 29 percent of all elderly persons reported having health insurance coverage from a past employer.

The evolution of retiree coverage as a feature of employer health plans is reflected in higher rates of retiree coverage among recent retirees. In 1984, nearly one-third of the elderly aged 65–69 (33 percent) reported having insurance coverage from a past employer, compared with just over one-quarter (26 percent) of elderly persons aged 75 or older.

Employer-sponsored retiree health insurance plans represent a substantial share of the elderly's Medigap insurance (table II.4). Among all people aged 65 or older with private insurance to supplement Medicare (62 percent of the elderly in 1984), about one-half—47 percent—had all or part of that coverage provided by an employer-sponsored retiree health insurance plan. Nearly 60 percent of elderly workers and retirees with private coverage to supplement Medicare derived all or part of that coverage from an employer plan.

Most retirees who report having health insurance from a past employer live in low- and middle-income families. Consequently, health insurance benefits represent an important real income supplement for most of the retirees who have them. In 1984, more than one-half of the elderly with retiree health insurance (56 percent) had family income of less than \$20,000; 79 percent had family income of less than \$30,000 (table II.5). Retirees under age 65 with health insurance from a past employer report slightly higher, but generally comparable, levels of family income. In 1984, 47 percent of early retirees with employer-sponsored health insurance reported family income of less than \$20,000; 76 percent reported family income of less than \$30,000.

Available data do not directly indicate whether the health insurance benefits that retirees are now receiving are sponsored by a private or

³These data from the Bureau of Labor Statistics are not strictly reliable in firm-size and industry disaggregation. Nevertheless, the tabulations presented here probably provide reasonable estimates of general magnitudes.

TABLE II.2
Number and Percentage of Workers in Health Insurance Plans
with an Employer Contribution to Coverage after Retirement:
Medium-Sized and Large Private Establishments,
by Establishment Size and Industry Group, 1981-1985

Establishment Size/ Industry Group	1981		1985		Percentage Increase 1981-1985
	Number (in millions)	Percent- age	Number (in millions)	Percent- age	
early retirement ^a					
Participants with Employer Contribution	11.2	61.1%	12.8	63.9%	14.3%
Establishment size					
100-249	0.8	39.3	1.1	46.2	37.5
250-499	1.6	45.7	1.6	40.6	^b
500-999	2.4	61.3	2.2	63.4	-8.3
1,000-2,499	2.4	64.8	2.8	72.5	16.7
2,500+	3.7	80.4	5.0	80.7	35.1
Industry group					
manufacturing	6.3	59.7	7.3	64.4	15.9
nonmanufacturing	4.8	63.2	5.4	63.3	12.5
retirement at age 65 ^c					
Participants with Employer Contribution	10.0	55.0	11.8	58.9	18.0
Establishment size					
100-249	0.8	39.3	1.0	42.6	12.5
250-499	1.3	37.1	1.5	36.4	15.4
500-999	2.2	55.5	1.9	54.2	-13.6
1,000-2,499	2.2	58.7	2.6	67.3	18.2
2,500+	3.4	72.9	4.8	76.8	41.2
Industry group					
manufacturing	5.6	52.4	6.7	59.1	19.6
nonmanufacturing	4.5	58.6	5.0	58.6	11.1

Source: Michael A. Morrissey and Gail A. Jensen, "Employer-Sponsored Post-Retirement Health Benefits: The State of Knowledge and Some Unresolved Issues," Working Paper, Birmingham, AL: University of Alabama (September 1988); and Gail A. Jensen, unpublished tabulations of the U.S. Department of Labor Employee Benefit Survey, 1981 and 1985.

Note: Detail may not add to totals because of rounding. Data are not strictly reliable in firm size and industry disaggregation.

^aData include workers with coverage that continues at least until age 65; workers with some other limited period of continuation are not included.

^bNo measurable change.

^cData include only workers with coverage that continues indefinitely; workers with a limited period of continuation are not included.

TABLE II.3
Number and Percentage of People Aged 55 or Older
with Retiree Health Insurance, by Age, 1984

Retiree Age	Number* (in millions)	Percentage within Age Group	Percentage of All People Reporting Retiree Health Insurance
Total	11.3	23.6%	100.0%
55-59	1.2	10.2	10.2
60-64	2.6	24.4	23.1
65-69	2.9	32.9	25.2
70-74	2.1	30.0	18.8
75+	2.6	26.3	22.6
Summary			
Under 65	3.8	17.1	33.4
65 or older	7.6	29.6	66.6

Source: Preliminary Employee Benefit Research Institute tabulations of the Survey of Income and Program Participation, matched waves 2 through 5 (U.S. Department of Commerce, Bureau of the Census).

Note: Data omit individuals living in households that were not interviewed at any time during the calendar year. Items may not add to totals because of rounding.

*Includes primary-insured retirees and people with dependents' coverage.

public employer. Nevertheless, most retirees' health plan sponsors can be inferred from available data about their pension plan sponsors. From these data, we estimate that at least one-half of all retirees with health insurance from a past employer receive coverage from a private employer plan; that is, the retiree also receives income from a private pension plan (table II.6). While 20 percent of retirees with health insurance from a past employer report no current pension income, most of these individuals probably receive their health insurance benefits from a private plan sponsor. At least 30 percent of retirees now receiving health insurance from a past employer have coverage as retirees from public employment—federal, state, or local government.

The relatively high rate of private employer-sponsored coverage reported among recent retirees corroborates industry survey data showing that private employer plans that provide retiree benefits have become increasingly common. Similarly, the relatively low proportion of retirees of any age with public plan benefits indicates that retiree coverage as a feature of public plans matured relatively early. Among covered retirees aged 75 or older in 1984, 44 percent had

TABLE II.4
Percentage of People Aged 65 or Older with Private Health
Insurance from Selected Sources, by Age, 1984

Source of Coverage	Total, Age 65+	Age 65-69	Age 70-74	Age 75+
Active Worker Coverage				
from a Current Employer	8.5%	16.4%	7.2%	2.5%
Direct ^b	5.6	10.4	5.1	a
Dependents' coverage ^c	2.9	6.0	2.1	a
Retiree Coverage from a Past Employer	29.6	32.9	30.0	26.3
Direct ^b	23.7	24.7	23.6	22.9
Dependents' coverage ^c	5.9	8.2	6.4	3.4
Other Private Insurance	54.8	48.6	58.2	57.9
No Private Insurance	38.1	31.7	36.3	45.1

Source: Preliminary Employee Benefit Research Institute tabulations of the Survey of Income and Program Participation, matched waves 2 through 5 (U.S. Department of Commerce, Bureau of the Census).

Note: Data omit individuals living in households that were not interviewed at any time during the calendar year. Items may not add to totals because of rounding.

^aStatistically insignificant.

^bIncludes people with survivors' coverage and those who report both direct and dependents' coverage of the same type.

^cExcludes people with both direct and dependents' coverage of the same type.

coverage sponsored by a private employer, and 31 percent had coverage from a public employer plan. By comparison, among younger retirees (aged 65-69) with coverage from a past employer, at least 55 percent were covered by a private employer plan and 28 percent had public plan coverage.

While most retirees receive some contribution to the cost of their plan (a characteristic of private and public plans that is clear from the Department of Labor data on active workers' plans described earlier), a significant minority report that they pay the full cost of coverage themselves, with no sponsor contribution. In 1984, nearly 22 percent of all retirees paid the full cost of the coverage without a sponsor contribution; among retirees aged 65 or older, 23 percent paid the full cost of coverage (table II.7). Conversely, for nearly 39 percent of retirees with health insurance from a past employer, the employer paid the full cost of coverage.

TABLE II.5
Number and Distribution of People with Retiree Health Insurance,
by Family Income and Age, 1984

Family Income	Recipients under Age 65		Recipients Aged 65 or Older	
	Total* (in millions)	Cumulative Percentage of Beneficiaries	Total* (in millions)	Cumulative Percentage of Beneficiaries
Less than \$10,000	0.5	11.7%	1.2	14.8%
\$10,000–\$14,999	0.7	29.2	1.5	35.2
\$15,000–\$19,999	0.7	46.7	1.6	55.8
\$20,000–\$24,999	0.4	63.8	1.2	70.2
\$25,000–\$29,999	0.5	76.2	0.7	79.4
\$30,000–\$39,999	0.5	88.3	0.8	89.7
\$40,000 or more	0.5	100.0	0.8	100.0

Source: Preliminary Employee Benefit Research Institute tabulations of the Survey of Income and Program Participation, matched waves 2 through 5 (U.S. Department of Commerce, Bureau of the Census).

Note: Data omit individuals living in households that were not interviewed at any time during the calendar year. Items may not add to totals because of rounding.

*Includes only retirees aged 55–64.

The likelihood that the plan sponsor contributes all or part of the cost of coverage is substantially higher among retirees with coverage from a private plan than among those with public plan coverage, an observation also consistent with the reported features of active worker plans. Among both early retirees (aged 55 to 64) and retirees aged 65 or older with private plan coverage, approximately one-half (49 percent and 51 percent, respectively) had their coverage fully paid by the plan sponsor.⁴ By comparison, about one-quarter of retirees with coverage from a public employer (23 percent) had the full cost of coverage paid by the plan sponsor.

Employer Liability for Retiree Benefits

Since 1979, the Financial Accounting Standards Board (FASB) has issued a series of documents that address appropriate accounting practice for corporate-sponsored retiree health and life insurance ben-

⁴Because retirees in plans whose sponsor was indeterminable are excluded, the percentage of retirees in private plans with coverage fully paid by the plan sponsor may be slightly biased upward.

TABLE II.6
Number and Percentage of People Aged 55 or Older
with Retiree Health Insurance, by Type of Pension Plan Sponsor^a
and Recipient Age, 1984

Recipient Age	Total with Retiree Health Coverage (in millions)	Percentage with Pension Income			Percentage with No Pension Income
		Total ^b	Private pension	Public pension ^c	
Total	11.3	79.8%	50.2%	29.7%	20.2%
55-59	1.2	78.7	44.7	34.1	21.3
60-64	2.6	82.3	54.5	27.8	17.7
65-69	2.9	82.1	54.0	28.1	17.9
70-74	2.1	79.2	49.6	29.6	20.8
75+	2.6	75.8	44.4	31.4	24.2
Summary					
55-64	3.8	81.2	51.4	29.7	18.8
65+	7.6	79.1	49.5	29.6	20.9

Source: Preliminary Employee Benefit Research Institute tabulations of the Survey of Income and Program Participation, matched waves 2 through 5 (U.S. Department of Commerce, Bureau of the Census).

Note: Data omit individuals living in households that were not interviewed at any time during the calendar year. Items may not add to totals because of rounding.

^aFor people with only dependents' coverage from a spouse's plan, the spouse's pension plan sponsor is reported.

^bAlso includes military pensions and other pensions from unspecified sources.

^cFederal, state, or local government employee plan. Category excludes military pensions.

efits.⁵ In 1984 these documents culminated with FASB Statement No. 81, which required employers to disclose either the current cost of retiree welfare benefits or the accrued unfunded liability for them as a footnote to the corporation's balance sheet, if the amounts were

⁵The following FASB publications are concerned with retiree welfare benefits: *Disclosure of Pension and Other Post-retirement Benefit Information* (July 12, 1979); *Employers' Accounting for Pensions and Other Postemployment Benefits*, discussion memorandum (February 19, 1981); *Preliminary Views on Major Issues Related to Employers' Accounting for Pensions and Other Postemployment Benefits* (November 1982); *Employers' Accounting for Pensions and Other Postemployment Benefits*, discussion memorandum (April 19, 1983); *Disclosure of Post-retirement Health Care and Life Insurance Benefits*, exposure draft (July 3, 1984); and Statement No. 81, *Disclosure of Post-retirement Health Care and Life Insurance Benefits* (November 1984).

TABLE II.7
People Aged 55 or Older with Retiree Health Insurance
by Level of Retiree Contribution to Coverage,
Type of Pension Plan Sponsor, and Retiree Age, 1984

Retiree Age and Pension Sponsor	Number of Retirees with Benefit (in millions)	Share of Plan Cost Paid by Retiree		
		All (percentage of participants)	Part	None
All Retirees	11.3	21.9%	39.3%	38.8%
Age 55-64				
Total	3.8	19.3	42.2	38.5
Pension sponsor				
private	2.0	14.3	36.4	49.3
public	1.1	19.1	60.2	20.7
not reported	0.8	33.4	29.6	37.1
Age 65+				
Total	7.6	23.2	37.9	38.9
Pension sponsor				
private	3.9	14.8	34.0	51.2
public	2.2	22.4	54.4	23.3
not reported	1.7	44.3	23.8	31.9

Source: Preliminary Employee Benefit Research Institute tabulations of the Survey of Income and Program Participation, matched waves 2 through 5 (U.S. Department of Commerce, Bureau of the Census).

Note: Data omit individuals living in households that were not interviewed at any time during the calendar year. Items may not add to totals because of rounding.

distinguishable from benefits costs for active workers. Although most corporations apparently now disclose the current cost or unfunded liability for retiree welfare benefits, many do not.⁶ Statement No. 81 offers no guidance on how employers should measure or amortize

⁶A survey of 100 corporate annual reports for 1987 indicates that nearly 90 percent of corporations with retiree benefits disclose costs. Of these, 8 percent reported costs to be immaterial, 18 percent did not distinguish between costs for retirees and active employees, and 74 percent provided separate cost figures for retirees. See Charles D. Spencer and Associates, Inc., "What Retiree Health Coverage and Life Insurance Cost 100 Major Firms Revealed in Spencer Survey," news release, 17 June 1988 (Chicago, IL: Charles D. Spencer and Associates).

TABLE II.8
Private and Public Employer Liability for Retiree Health
Insurance Benefits: Preliminary Intermediate Estimate,
Discounted Present Value, 1988

Worker/Retiree Status	Private Employers	Public Employers	Total
	(in billions)		
Current Retirees	\$ 68.2	\$ 23.0	\$ 91.2
Current Workers	100.5	87.7	188.2
Total, retirees and current workers	168.7	110.7	279.4

Source: Deborah J. Chollet, *Financing the Elderly's Health Care* (Washington, DC: Employee Benefit Research Institute, forthcoming).

Note: Estimates include reductions in plan cost as a result of recent legislation expanding Medicare benefits. On average, corporate and public employer liabilities are estimated to decline by approximately 30 percent as a result of new Medicare benefits.

accrued unfunded liability, and it specifically does not apply to multi-employer plans.

Subsequent to issuing Statement No. 81, FASB has been considering appropriate standards for mandatory measurement and disclosure of accrued unfunded liability for retiree welfare benefits. Anticipating new accounting rules for retiree health benefits, employers have begun to focus on the amount of unfunded liability that they will be required to disclose as an offset to corporate income, directly reducing reported profit.

Table II.8 provides estimates of both private and public employer liability for retiree health insurance benefits. Although private employer and public employer estimates are reported together, they are of public policy interest for different reasons. Specifically, the new FASB rules would apply only to private employers. Amounts of unfunded liability for retiree health benefits are probably distributed very unevenly among employers that sponsor retiree plans. If, as seems likely, equity markets have not fully anticipated individual corporations' unfunded liability for retiree health benefits, disclosure of the liability will probably produce an adjustment in the relative value of corporate stocks.

The issues associated with public employer liability for retiree health insurance are different. Public employer liabilities represent a claim against future tax dollars. The current cost of state and local government

obligations for retiree health benefits directly affects their operating budgets and poses an increasing strain on fiscal management. Most states and municipalities are required to balance their budgets annually.

We estimate the present value of private employers' liability for retiree health insurance obligations to be approximately \$169 billion. Most of this liability, nearly \$101 billion, is associated with current workers. The present value of corporate liability for current retirees is slightly more than \$68 billion. These estimates are low compared with those recently reported by the General Accounting Office (U.S. Congress, 1988), in part because they include a downward adjustment for recent legislation expanding Medicare benefits.

The value of the new Medicare benefits to plan sponsors can vary radically from plan to plan, depending on the plan provisions and the Medicare assignment rate among physicians in the areas where retirees live. The new Medicare benefits, phased in over a five-year period, are likely to greatly reduce liability for many employers for benefits provided to retirees aged 65 and over. Much of this saving is likely to occur as a consequence of Medicare's coverage of prescription drugs during the last two years of the phase-in period. The estimates presented here assume that the new Medicare coverage will reduce employer plan costs by 10 percent in 1990, 40 percent in 1991, 45 percent in 1992, and 50 percent in subsequent years. This assumption, applied to both private and public plans, reduces estimated liability by approximately 30 percent. Without this adjustment, the current value of private, corporate liability for retiree health benefits would be \$247 billion: \$98 billion for current retirees and \$149 billion for current workers.

A second major assumption implicit in these estimates is the projected rate of inflation in health care services. The estimates assume that health care cost inflation will continue to exceed general inflation, but that the difference between the rates will decline incrementally over the next 25 years. The rates of inflation are assumed to converge (at 3.5 percent) in the year 2013, when aggregate spending for health care services reaches 22 percent of Gross National Product (GNP); real per capita GNP is assumed to grow at a rate of 1.5 percent per year, resulting in assumed annual per capita health care spending increases of 5 percent after the year 2013.⁷

⁷These economic assumptions are also used by Phyllis A. Doran, Kenneth D. MacBain, and William A. Reimert in *Measuring and Funding Corporate Liabilities for Retiree Health Benefits* (Washington, DC: Employee Benefit Research Institute, 1987).

Employers' annual cost to amortize these obligations is likely to be substantial. Based on a survey of 76 retiree medical plans conducted by one benefits consulting firm, the annual cost of retiree health insurance benefits would total about 12 percent of payroll (about 10 times more than the current pay-as-you go system) if it were calculated on a basis comparable to that used for pension plans (*Investor's Daily*, 1988).

Legislative Activity and Proposals

The loss of health insurance by retirees when a plan sponsor declares bankruptcy has captured congressional attention and generated legislation to protect retirees. The LTV Corporation's Chapter 11 bankruptcy reorganization in 1986, in particular, became a catalyst for congressional action. The Omnibus Budget Reconciliation Act of 1986 made a firm's initiation of Chapter 11 bankruptcy reorganization a qualifying event under the coverage continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA requires employers to offer continued health insurance benefits to workers and/or their dependents in various circumstances that might otherwise lead to benefit termination. Under COBRA's amended continuation provisions, retirees may purchase continued postretirement medical benefits from the plan until they die or obtain coverage from another source. The retiree's surviving spouse can purchase continued coverage for an additional 36 months. As with other continuation provisions in COBRA, the plan may require retirees to pay premiums of as much as 102 percent of the plan's average (per participant) cost.

In 1986, Congress also issued House Joint Resolution 738, requiring any company paying postretirement medical benefits as of October 2, 1986, that had not had reorganization plans confirmed by a bankruptcy court, as well as companies filing for Chapter 11 reorganization after that date, to continue paying benefits until May 15, 1987.

Subsequently, Congress passed, and President Reagan signed into law, the Retiree Benefits Bankruptcy Protection Act of 1988 (P.L. 100-334). This law prevents an employer from unilaterally canceling retiree coverages on filing for Chapter 11 protection in bankruptcy; it also prevents the plan sponsor or administrator from attempting to collect from individual retirees repayment of plan expenses incurred before the filing. P.L. 100-334 allows retirees to claim creditor status in Chapter 11 bankruptcy proceedings and to be represented by a court-designated representative or committee. The law requires the

plan sponsor to continue retiree benefits pending agreement to modification by the retirees' representative or a decision by the bankruptcy court to modify or terminate benefits. As a formal creditor in bankruptcy proceedings, retirees may increasingly compete with the Pension Benefit Guaranty Corporation (PBGC) as a principal claimant to employer assets. If PBGC is able to recover less of its insurance loss because of unfunded retiree health claims against employer assets, it in effect becomes an insurer of retiree health benefits. Lower recoveries by PBGC would presumably force higher employer premiums to ensure defined benefit pension obligations.⁸

Various legislative proposals have been forwarded to encourage employers to fund retiree health insurance obligations by allowing them to use excess pension assets to fund retiree health benefits and/or allowing tax-free contributions to a designated trust fund. One proposal (H.R. 5309) sponsored by Rep. Rod Chandler (R-WA) in the 100th Congress would allow employers with defined benefit or defined contribution pension plans to make tax-deductible contributions toward future retiree health care and long-term care expenses. The bill would allow employers to deduct funding for plans that provide annual retiree health benefits worth \$2,500 per retiree and, additionally, long-term care plans that provide average annual benefits worth \$2,500. Annual contribution limits would be set at \$825 for retiree health benefits and an equal amount for long-term care benefits; both contributions would count against the pension contribution limits now imposed under section 415 of the tax code. Plan investment earnings would be tax exempt. H.R. 5309 would also allow employers to transfer excess pension assets (above 125 percent of plan liability) to a separate trust for the purpose of funding retiree health benefits or long-term care benefits.

A similar proposal, circulated in 1988 by the Senate Special Committee on Aging as a draft bill, would authorize tax-deductible employer contributions to retiree health insurance but limit the value of a qualified plan to \$1,200 per retiree per year. Tax-deductible employer contributions would not be counted against section 415 limits, but the proposal would apply pension vesting, funding, and participation standards to the retiree health insurance plan. In addition, the proposal would require employers to provide health ben-

⁸In May 1988, PBGC filed an objection in the U.S. Bankruptcy Court of the District of Colorado related to the Kaiser Steel Corporation bankruptcy reorganization proceedings (*In re Kaiser Steel Corporation et al.*, May 27, 1988), protesting the way that retiree health insurance liabilities (estimated at \$400 million) were calculated in the firm's disclosure statement. PBGC has since settled its claims in this case.

efits to spouses of deceased employees, if the deceased employee had been eligible for benefits. This proposal was not introduced.

The Prospect for Retiree Health Benefits

The history of retiree health insurance benefits is probably a poor predictor of the future. The relatively low current cost of retiree health benefits and their usefulness as an early retirement incentive contributed to the expansion of these benefits even during the 1980s, when it has been clear that the courts would strictly enforce employers' implied or stated promises to retirees and that a ruling from FASB on accounting standards for retiree health benefits was virtually inevitable. Possibly the best explanations for such short-sighted corporate behavior include the 1982 economic recession, which put great pressure on employers to reduce their work forces through early retirement rather than layoffs, and pressure from older workers and senior management who anticipated retirement with high and fast-growing out-of-pocket health care costs under Medicare.

While the Employee Retirement Income Security Act of 1974 (ERISA) establishes vesting and funding rules for private pension plans, there is no current law governing vesting and funding for retiree health benefits. Employers have generally regarded retiree health benefits as a year-to-year promise, and have financed benefits as part of the same health plan provided to active workers. Very few employers have funded future retiree health benefit obligations at all, and none have funded them fully.

The legislative proposals that are likely to emerge in the 101st Congress will present employers with some difficult choices. No legislation is likely to come without a "price": a benefits-related provision in the legislation that would make new tax incentives budget-neutral and perhaps also include funding and vesting rules for retiree health benefits. Employers are likely to find reaching a consensus on a benefits "sacrifice" difficult but necessary, given the prospect of reporting unfunded liability and the possibility that FASB will not recognize funds held in current-law tax-advantaged trusts as an offset to liability. As a result, employers may badly need new legislation establishing tax-advantaged trusts exclusively for retiree health benefits, but the price may discourage further expansion of retiree health benefit promises and lead employers to terminate plans for future retirees.

A microsimulation analysis of the effect of vesting rules on future benefit reciprocity offers some idea of the impact such rules might

have on employer costs.⁹ Currently, workers who terminate employment before they are eligible to retire generally retain no right to retiree health benefits when they do retire. That is, retiree health insurance plans generally do not allow benefit deferral, even if the terminating employee is vested in the employer's pension plan.

If, however, employers were required to vest employees in their health plans, using the employer's 1985 pension vesting standard (before tax reform), benefit receipt among future retirees would rise significantly. Among the cohort of workers projected to retire between the years 2000 and 2009, the projected rate of reciprocity would rise 44 percent: from about 25 percent of workers retiring with benefits to more than 36 percent. Among workers projected to retire between 2010 and 2019, the rate of reciprocity would rise 58 percent: from 25 percent to 39 percent.

If employers were required to vest employees using the five-year pension vesting standard effective in 1989 under the Tax Reform Act of 1986, benefit reciprocity among future cohorts of retirees would rise even more dramatically. Assuming a five-year vesting standard, but no benefit deferral, benefit reciprocity among workers projected to retire between the years 2000 and 2009 would rise 55 percent: 39 percent of workers in this cohort would retire with benefits. Among workers projected to retire between the years 2010 and 2019, benefit reciprocity would rise 72 percent, with 42 percent of workers retiring with benefits.

These results suggest that the coming legislative debate over retiree benefits will be particularly difficult. As in past benefits debates, the U.S. Department of the Treasury may want vesting rules to ensure that retirees ultimately benefit from current tax expenditures. However, by raising benefit reciprocity rates among future retirees, vesting rules will raise both employer costs and the federal revenue cost of tax incentives to fund benefit promises. This conundrum is likely to delay legislation, maximizing incentives for employers to terminate their retiree health plans for future retirees or to substantially modify the benefit.

Employers are now widely discussing conversion of their benefits for future retirees to a "defined contribution" benefit, instead of the service benefit that is now virtually universal. Such a benefit would transfer much or all of the risk of continuing health care

⁹These results are based on a rebenchmarked, enhanced version of the pension and retirement income simulation model (PRISM). A description of the model and complete results are reported in Deborah J. Chollet, *Financing the Elderly's Health Care* (Washington, DC: Employee Benefit Research Institute, forthcoming).

cost inflation and rising benefits costs to the future retiree and enable employers to graduate the value of the benefit for longer-service workers.

In summary, it seems unlikely that future retirees will enjoy the kind of health benefits that we see among today's retirees. Confronting huge financial liabilities for retiree benefits, many employers are likely either to terminate their health plans or substantially alter the benefit promise to reduce projected corporate cost. The budget and philosophical constraints on legislation that would assist employers in funding benefit obligations suggest that the legislative debate will be a long one, and that the ultimate legislation may be less favorable to employers than comparable pension legislation has been.

Unlike pensions, retiree health insurance benefits may not be a congressional priority. Congress recently expanded Medicare benefits and will probably be asked to consider controls on physician charges in the next session. That these controls will include price regulation seems inevitable; they may also include mandatory Medicare assignment. A Congress that completes such an agenda may perceive supplemental coverage—including corporate-sponsored retiree benefits—to be largely unnecessary, particularly since Medicaid is already required to pay Part B premiums and Medicare cost-sharing for most elderly in poverty. Having addressed the acute health care financing needs of the elderly, Congress may be willing to take further revenue losses only for health care issues related to other needs or populations: specifically, financing care for the uninsured and financing long-term care. Employers may gain more tax concessions related to these issues than concessions to their standing obligations to finance acute health care benefits for retirees.

References

- "Retiree Health Benefits Total 12% of Payroll." *Investor's Daily*. 2 February 1988, p. 9.
- U.S. Department of Labor. Bureau of Labor Statistics. *Employee Benefits in Medium and Large Firms, 1986*. Washington, DC: U.S. Government Printing Office, 1987, tables 29 and 30.
- U.S. Congress. House. Committee on Ways and Means. Subcommittee on Oversight. Statement of Lawrence H. Thompson, U.S. General Accounting Office, 15 September 1988.

III. Part One Discussion

An Institutional or an Individual Responsibility?

MR. PAUL: One of the issues that has surfaced in this discussion is that of institutional versus individual solutions. We now have an expanded Medicare program that includes catastrophic coverage and that, according to Deborah Chollet's figures, provides slightly larger benefits for eligible persons—those over age 65, in general. Mr. Enthoven, you argue that savings through an employer for additional health care for retirees is not the best public policy. On the other hand, you urge that there be some kind of individual portable accounts. In your judgment, should they be tax sheltered during the accumulation period? And how do you encourage people to use these accounts if they are totally voluntary?

MR. ENTHOVEN: Your questions are a good ones. I am going to say something that will sound absolutely wild and off the wall, but it is something I think we have to think about. A student of mine from Singapore said to me after class one day, "I want to explain to you the social insurance system in Singapore." According to his description, for every \$100 that an employer pays an employee, they each must contribute \$25 to a compulsory savings fund. That fund is available for retirement and also for ordinary medical expenses incurred by the employee and his or her immediate family members. People with conditions that would involve catastrophic medical expenses are treated free of charge in teaching hospitals. Thus, savings are high in Singapore, he said, and national income per capita has increased very rapidly.

I know that compulsory savings brings to mind Big Brother, but I think we need to think about it. We have other forms of compulsion in this society, including a kind of moral compulsion. If a person is badly injured in an automobile accident, my whole life, upbringing, and cultural conditioning tell me that I have no choice as a decent human being but to see that he or she is given care. We do not let people die because they cannot pay for medical care. Once we realize that we are tied together by a fabric of mutual responsibility and moral obligations, we say that everyone should have to provide for their old age, because if they do not and they are poor, the rest of us will be imposed on to provide for them. Therefore, I have no problem

with the idea that we ought to think about some requirement to ensure adequate savings.

The Question of Savings

MR. BALL: I liked so many points in Mr. Enthoven's paper, in fact, almost all of them, that it seems all the more important to pick up on one omission. We do have a compulsory savings system. The Social Security program is currently producing annual excesses of approximately \$40 billion. In 1990, that will be approximately \$100 billion a year. To make that a major contribution to an increase in national savings requires bringing the non-Social Security budget of the government much more into balance. When that is done, we will have a real opportunity. Three Brookings Institution analysts have estimated that if the Social Security surpluses already legislated are saved, national income will rise about as much as retirement benefits will go up because of the population bulge.* I do not want you to overlook that. Your idea is already there.

MR. ENTHOVEN: I certainly agree that we ought to bring the rest of the government budget into balance. Your point is a good one.

MS. YOUNG: I do not know much about Singapore, but in most of the world outside the United States the governments take care of other major expenses, such as university education, in addition to medical expenses. They are very different societies. You talk about starting to put money away. Most people over age 40 who are in a position to do so are paying universities for the education of their children. I do not know how you can get around that point.

Another point concerns the 37 million people who are uninsured and do not have any means of paying for their health care. Are you going to tell the middle class—who are perhaps struggling to get by since the government is not providing catastrophic health care or education for their children or many other services—that they are going to be compelled to save more and that they must also pay for the 37 million uninsured who cannot afford health care? What is your solution to this problem?

MR. ENTHOVEN: On the first point that you raised, since three of my six children are in private colleges today, the other three having

* Editor's note: See Henry J. Aaron, Barry P. Bosworth, and Gary Burtless, *Can America Afford to Grow Old? Paying for Social Security* (Washington, DC: The Brookings Institution, 1989).

completed Harvard and Stanford, I am aware of the problem parents face. I am not saying that I have an easy solution. I am merely trying to pose the problem and saying that I think we have a major problem of undersavings in our society, and that we must move toward the ideal that each generation must save for its own needs.

I think a lot of middle-class struggling is competitive—keeping up with the Joneses. If these people put 6 percent or 8 percent of their income into a retirement account, they would probably still be struggling about as much, but they would have savings. I am not saying there is an easy solution. I think Robert Ball's point is very well taken.

In fact, if I could come back to his question about institutional versus individual solutions, I think that a lot of this does have to be accomplished through collective institutions. As a way of motivating people to save, I think that if some of the savings were more clearly tied to individual benefits, that might increase the incentive.

MS. YOUNG: How do you view the people who basically cannot afford to save?

MR. ENTHOVEN: You have to make some judgment about the point at which people are too poor to save.

Payment System Reform

MR. WELLER: Your reference to the Titanic hit a very important point. I think what I heard you say is that talking about financing and accounting issues is like rearranging the deck chairs. Isn't the real issue how we change the Titanic's direction? A central part of changing the direction is the payment system. How do we pay doctors and hospitals for medical care? Obviously, the future scenario is gloomy for those of us on the Titanic who will need to have health benefits in the future, if we do not change the direction. My question is, how far have we come toward that fundamental change in the payment system for doctors and hospitals, and is there still a significant opportunity that might, indeed, change the direction?

MR. ENTHOVEN: That is a very good question. I feel quite pessimistic and quite disappointed about what has been accomplished so far. There is a great flurry of creation of service organizations, such as individual practice associations (IPAs) and preferred provider insurance plans, that fly under the banner of health maintenance organizations (HMOs). Ten years ago, I felt some optimism that these organizations would function as transition mechanisms and that they

would become more cohesive and more cost-effective organized medical care systems.

What we see today is that prepaid group practices, such as the Harvard Community Health Plan, Kaiser-Permanente, and similar organizations, continue to exceed the rest of the system in terms of efficiency and cost effectiveness, and they demonstrate that cost-effective quality health care is possible. Many individual practice associations (IPAs) that started in the 1970s as physician groups or doctors in individual practice used the organization as a vehicle with which to compete against Kaiser Permanente and the Harvard Community Health Plan while at the same time offering their patients cost-contained, high-quality care. Many IPAs have been bought by insurance companies, or for one reason or another have become separated from local control and from the commitment of the doctors, who now perceive them as "just one more damned insurance company that is trying to rip us off."

One thing that makes Harvard Community Health Plan and Kaiser Permanente Plan different is that they can control the number of doctors by specialty in relation to the number of patients. I think that is fundamental, because busy doctors are a key to economy and quality in health care. In other situations there are too many doctors, and they are looking for new ways to make themselves useful, driving up costs.

We really have not come very far in payment system reform. We have not accomplished much in the last 10 years. Preferred provider insurance is helping by providing discounts. But again the fee-for-service doctors have figured out how to beat that, and so we are seeing health care costs go up faster than ever.

Should Health Care Benefits Be Tax Sheltered?

MR. JACKSON: I would like to comment on the need to mandate savings and why Americans may be saving too little. When you have inflation, why should you prefund anything? For example, after World War I the French totally lost faith in stocks and bonds, which had become worthless paper, and adopted a system for their long-range promises that was not based on investment. I was surprised to read a reference to this event in an article concerned with placing more confidence in trust funds. When the stock market took a little blip in October 1987, everyone was upset. The market could well go down to 10 cents on the dollar, if history is any example, and then I wonder what will happen to all the wonderful programs like the Teachers

Insurance and Annuity Association-College Retirement Equities Fund (TIAA/CREF) program.*

I read recently that 60 percent of the increase in corporate profit during the period from 1986 to 1987 was due to lower pension costs. That was done by adopting the Financial Accounting Standards Board (FASB) standard no. 87 and using projected unit credit with higher interest to lower the cost, combined with the rise in the market. It was sort of a one-time occurrence, and with FASB waiting in the wings in 1992 to require the reporting of retiree health benefit liabilities, you wonder what happens to a market that is largely grounded on earnings.

Another thing mentioned in the debate over pension legislation that concerns me is the reference to the big tax break that occurs when an employer purchases a health plan and workers do not pay income tax on it. That is the reason usually given for the creation of some huge governmental program that government benefits design experts conclude that everyone ought to have. For my part, I would prefer to drop the tax break entirely. Let the individual citizen spend his or her own money. Let employers pay their employees and let the employees do as they wish with their money. It seems to me that we now have employers buying health insurance with the employees' money, and then, because of the loss of tax revenues resulting from this tax-free benefit, we say that the government ought to take more of the employees' earnings and make them save that. My answer is, why not drop both of them and go back to ground zero?

MR. ENTHOVEN: I have been proposing for a long time that we limit the tax break both for reasons of fairness and as an incentive for economy. The federal budget loses between \$40 billion and \$50 billion a year because of the nontaxation of employer-provided health benefits, and most of that money goes to upper-income people, giving them an incentive to buy a more costly, rather than less costly, health plan. I have a certain sympathy with what you are saying: if we eliminated employer-provided health benefits and gave employees the money, they would probably spend it more carefully, and be motivated to ask their doctors whether certain tests were really necessary.

*Editor's note: TIAA is a nonprofit, legal reserve life insurance and annuity company that was established for the benefit of educational institutions and their faculty and staff. CREF is a separate, nonprofit corporation companion to TIAA that was established to provide a common-stock-based annuity component for the TIAA-CREF retirement system.

I think one reason for not going all the way, though, is that it is not possible to have a workable market for health insurance at the individual level. It simply does not work. The market gets torn apart by a process of adverse risk selection and "free riders." That is why there are 37 million uninsured Americans and why it is impossible for many people to buy health insurance. The insurers fear that the unhealthy people want to buy insurance, but the healthy do not want to buy it because they do not need it. And so a spiral of adverse selection takes place that increases premiums.

This process has, in fact, destroyed most of the nongroup market for health insurance. Therefore, I am afraid we do need some kind of collective compulsory arrangement that finances everyone's serious medical expenses.

Another reason we need a compulsory arrangement is the one I commented on earlier, which is the moral imperative to care for the sick. If you did not save enough money to afford a car in retirement and I saw you walking around, I would not feel a moral imperative to do anything about that. But if you are sitting on the doorstep in pain and suffering for lack of medical care, I would feel that that is intolerable and I must do something about it. And I think you should not be able to take a free ride on me. You have to have some kind of health care coverage, and so we need some kind of collective arrangement, and tax subsidies for group health insurance are just such an arrangement. It is a way of socializing health care expenses by giving even the healthy a powerful incentive to participate in health insurance. So I would go part way with you, but definitely not all the way.

Government's Role

MR. FLATLEY: Mr. Enthoven, I agree with your general thrust that each generation ought to fund its own retirement, but I would urge a word of caution as you look outside the United States for role models. The central provident fund in Singapore that you mentioned has run into some significant funding problems over the past 10 years because, like most government-provided social welfare programs, it is not prefunded but is a current transfer scheme. It has run into severe liquidity problems, as did our own social welfare programs in the late 1970s.

I am concerned when massive amounts of capital are accumulated under government auspices. I question whether it will be there beyond the next budgetary year. I think that is a real concern with compulsory programs under government auspices. The government's

ability to save that money until the bills come due is a problem for many countries, including the United States. So it is important to be careful as you talk about compulsory government-sponsored schemes funded by employees and employers under a government-controlled payout. I do not know of any system that has been able to defuse the demographic time bomb, including Singapore's current transfer scheme or any other government-provided programs.

MR. ENTHOVEN: I am not advocating compulsory savings, I am merely throwing it out for consideration. The idea was that workers would have to put 10 percent of their pay into accounts with their names on them and it would be their money to use in retirement. One argument for trying to do this on an individual basis is that the money is in the employees' names, and congressmen are not free to take it and spend it.

When I spoke of Singapore, what I had in mind was that *kind of* system. I did not realize that there was a large element of current transfers. I grant you that the problem with the kind of arrangement that Robert Ball was talking about is that we are all afraid that when Congress sees that money they are going to think of all kinds of good projects in their districts that ought to be funded with it.

Group Medical Practices

MR. KILLEEN: I agree that the record fairly strongly indicates that the old prepaid group practices and other HMOs of that model represent the one part of the health care system that has maintained quality and is cost effective. I am a member of the board of directors of Michigan's Health Alliance Plan, which is the seventh largest HMO in the country and is based on a prepaid group practice model. I would take issue with the point made about cutting benefits, reducing benefit packages, or putting individuals more at risk. It seems that where there are system controls and certain financial arrangements are instituted to make a medical care system function appropriately, prepaid group practices are not only working efficiently but tend to offer the broadest benefits with the least amount of out-of-pocket cost sharing.

MR. ENTHOVEN: Prepaid group practices have generally done best in those situations in which the employee is cost conscious, such as the Federal Employees Health Benefits Program or Stanford University's health care plan. In the latter, the employer makes a fixed dollar contribution that is less than the premium of any of the plans; the

employee chooses between the prepaid group practice and a much more expensive fee-for-service arrangement, keeping the savings if he or she joins the more cost-effective health care plan.

For many years the United Auto Workers and the auto companies have agreed on a formula that pays for coverage up to the cost of Blue Cross and Blue Shield and an HMO. In California one year the auto companies paid approximately \$80 a month for employees who joined Kaiser Permanente and \$110 a month for those who joined Blue Cross and Blue Shield. In other words, the workers were making the auto companies subsidize fee-for-service medical practice against prepaid group practice. That is very perverse economics and I cannot understand why such an irrational, counterproductive arrangement would be tolerated. The answer is that union officials like to get reelected, too.

Horizontal and Vertical Equity

MR. KILLEEN: I agree with Mr. Enthoven's analysis of horizontal and vertical equity. However, our society seems to approach problems one part at a time. In collective bargaining we build up benefit programs a piece at a time, starting with active workers and then including retirees to broaden the package. The government has also tended to take one piece at a time, with the exception of Medicare, which was one big program it created in a single step. As a practical matter, the step-by-step approach is the way our society seems to solve problems. What is wrong with addressing retiree health benefits at this time if, for whatever reason, FASB has decided that this is the time to consider the problem?

MR. ENTHOVEN: Why not solve this problem now and work on the others later? That is probably the way we will end up doing it, because the people who are going to benefit from tax-sheltered prefunding of health care benefits are articulate and relatively well organized. I am just speaking up for the poor and downtrodden and saying we have a \$165 billion annual deficit and are short on funds. The \$8 billion or \$10 billion a year we would add to the deficit if tax-sheltered prefunding were allowed is real money. Before we spend a nickel of that on making health benefits better for those who are already well protected, we ought to get serious about the 37 million Americans who do not have health insurance and cut them in on the same kind of tax subsidies that we employed people receive.

Why not now? Because we are short on money, and the situation of the uninsured represents a pressing need.

MR. MCMAHON: I would like to take exception to your comment that there is no horizontal equity. I think medical benefits are the most egalitarian benefit corporate America provides. When you and others go to Congress and say what you have said—that there is no horizontal equity—we wind up with section 89.* Now section 89 is probably going to give you the other thing you want, taxation of the medical benefits of almost 80 percent of the people in this room.

Let me go through the entire scenario. Corporate America gets taxed for its benefits, so Paul Jackson's theory says, "Well, let us give everyone a benefit. Let us give them the income, not just the top level people like myself who can afford the \$5,000 it costs me as an individual in California, but also the keypunch operators, so that they will receive another \$5,000 in income. State and local taxes in California will cost them \$1,250. They will not be able to get the same medical benefits for \$3,750, and they will not buy the insurance. Providing them that benefit is forced savings. If they have the money in their pockets, they will not use it for the intended purpose. You will see not 37 million people uncovered but probably 50 million or 60 million as a result of that kind of approach.

That, coupled with the FASB standard that is coming, is going to make it much easier to give people income than to go through the section 89 tests. There will be more tax revenue, but there will also be more people who are not covered.

MR. ENTHOVEN: I am not saying that there is no horizontal equity in the system. I certainly have not favored section 89, which seems to me was an answer to a nonexistent problem. I grant you that, generally speaking, among most large employers health benefits are provided fairly equitably. I was merely raising the question of horizontal equity here with respect to the question of retiree health benefits. If we add \$8 billion to the deficit by allowing tax-sheltered prefunding by employers who provide retiree benefits, then we are helping those employees and those companies while doing nothing for the larger number of people who are not long-service employees and who do not receive these benefits. Many of the latter are worse off than the former and are more likely to end up on Medicaid if we do not help them to help themselves.

I think we could devise a way to provide medical benefits that would not involve anything like section 89 but that would make the

* Editor's note: Section 89 refers to the section of the Internal Revenue Code created by the Tax Reform Act of 1986 that requires employers to subject their employee welfare benefit plans to qualification and nondiscrimination tests.

money available for that tax break, or subsidy, on a more equitable basis and would include all income groups and both short- and long-service employees. Why should we have a policy that gives this benefit to long-service employees but not to workers who happen to move from one job to another or do not work for a large employer? The people who are best off in our society tend to be long-service employees of large employers. We ought to understand that most of the people who are hurting are ones who are not in that category.

I do not agree that this would wipe out health insurance. I am not talking about just giving them the money. I think that any subsidies that are made available should be in a form usable only as a premium contribution to a group health insurance scheme.

Social Responsibility and Public Policy

MS. YOUNG: I want to challenge one of your basic premises—that our society and our worries have not changed and that we would not leave someone who needs medical care on the street. What is happening is the opposite. People without health insurance, most of which is employer provided, do not get treated at hospitals. Many of the people discussed in the Employee Benefit Research Institute data on the uninsured are children whose parents probably have coverage, but who are not covered because their parents have not paid the little extra amount to cover them. Child abuse statistics indicate that we have a lot of children at risk. We did not force the system to cover them. We have many people in this country who have no way of providing for themselves, and they are children under the age of 18.

MR. ENTHOVEN: I am personally in favor of a public policy that is, in effect, universal, based on mandatory health insurance. I have written on that and am a well-known advocate of universal health insurance. So if there is any doubt about that, let me make it clear. I think we ought to support universal coverage, and I think it takes public policies to do it: tax subsidies, incentives. It has to be compulsory. You have to pay for it whether you take it or not.

With respect to the other point, I will grant you that we are all sinners in this world, in this country, and that we often depart from our moral standards and that at times we find circumlocutions and ways of looking the other way. But I do think that the moral standards shared by most people in our society are such that it is considered wrong to let people suffer and die for lack of medical care because they cannot pay for it. That sort of thing happens in hospitals that dump and transfer patients; then Congress passes laws against this

practice and we read editorials condemning it. I am referring to a standard of behavior that I think is accepted by the great majority of American people. I realize we do not live up to that standard every day, but at least we acknowledge that is the way we ought to live. I believe we ought to create a health care financing system that is consistent with our American values of fairness and compassion.

MS. YOUNG: I guess my response to that is that there are a lot of children who, instead of being treated for strep throat, would wind up with rheumatic fever or scarlet fever when finally treated.

Health Care Cost Inflation

MR. DUVA: Ms. Chollet, is the 15 or 25 percent increase in health care costs that you mentioned an annual increase? Would it be on top of the costs that we have today?

MS. CHOLLET: The costs would increase the average corporate budget by about 23 percent a year.

MR. DUVA: One thing that is very important is the freedom to redesign the retiree medical programs. They have been poorly structured over the years: the plan for active workers was passed on to the retirees. I think that the ability to change these plans to meet a new environment would go a long way to help solve the problem. I think some of the current legal constraints make it very difficult.

MS. CHOLLET: I agree. I think that there is going to be a lot of pressure on corporations to decide how they would like those legal impediments removed and on Congress and the administration to figure out how they can afford to remove them.

MR. WYMAN: I have the impression from your paper that the difference between the General Accounting Office estimate and yours may well be that you applied that discount for prescriptions to the cost of the postretirement coverage for people who are under age 65. Is that possible?

MS. CHOLLET: No. Only for those aged 65 or over.

MR. WYMAN: Perfect technique.

MS. CHOLLET: The reduction in cost that we expect from Medicare prescription drug coverage is huge. I produced these estimates with Phyllis Doran of Milliman & Robertson. The staff at Milliman & Robertson have evaluated quite a few retiree health insurance plans

over the last year or so. I had the opportunity to look at a range of cost reductions associated with the Medicare Catastrophic Coverage Act of 1988. Their estimates of cost reductions associated with the new Medicare coverage varied across the board. They ranged from trivial amounts to huge reductions. Two major factors were involved in the magnitude of the adjustment. One, obviously, was the coverage the employer already offered. If the employer was covering only limited physician care but a lot of catastrophic hospital care and prescription drugs, the new Medicare coverage basically supplanted almost all the coverage provided by those plans and produced a huge decrease in employer liability.

The other critical variable was whether or not the retirees were in a market area where physicians largely accepted Medicare assignment. If they were in markets where Medicare assignment was prevalent, the employer liability was relatively small and the fact that the new Medicare benefits do not pick up physician services made no difference in terms of impact on employer plan cost. For example, in many of the western states, where the rate of physician assignment is relatively low, the fact that the new Medicare legislation did not address physician care made physician cost and plan cost very stable. In those plans, most cost is associated with physician care, and the Medicare legislation had little effect on plan cost. Basically, in order to come up with reasonable assumptions about the average impact of Medicare, we aimed for the middle of the range of cost impacts estimated for actual plans. In the out-years, we assumed that the new Medicare coverage will reduce employer cost by 50 percent for Medicare beneficiaries.

We do know that employer plans are very volatile with respect to Medicare benefits. Changes in Medicare benefits and administration can change employer costs a lot. Employers have generally claimed that small changes in Medicare benefits generate disproportionately large changes in their plan cost.

MR. MIKKELSEN: In calculating the liabilities, how did you account for the so-called maintenance-of-effort rule under the catastrophic bill?

MS. CHOLLET: We assumed that during the first year employer costs did not change and during the second year they were reduced 10 percent. It was not until the out-years, when prescription drug benefits begin, that we projected real drops. We assumed that the maintenance-of-effort rules held employer liability approximately constant.

MR. PETERTIL: You indicated that there will be 20 percent to 30 percent increases in employee benefit health care costs on an annual basis. To what extent was that type of inflation trend put into your long-term projections? Another way of putting this is, in your long-term projection what percentage of Gross National Product (GNP) did you see ultimately going to health care?

MS. CHOLLET: That is the major difference among the estimates that have been made: what is assumed about inflation in the long-term. What is a realistic economic distribution between health care and all other goods and services produced in the economy? The estimates that I presented in my paper assumed a declining margin between general inflation and health care cost inflation. When the total cost of health care services reached 22 percent of GNP, we inflated health care costs at the rate of general inflation and maintained health care services spending at 22 percent of GNP. That happened in about 12 years. But the assumed rate of health service cost growth is the primary reason that the estimates vary—that and whether the discount rate you use to produce a present value figure is eventually allowed to exceed the rate of assumed growth in health care services prices. Our estimates did allow that. Other analysts are more reluctant to allow the discount rate to exceed assumed inflation. My position is, that is a relatively unorthodox thing to do. I have never seen a present value calculation that forced the discount rate and inflation rate somehow to relate to one another in that way. But one can produce extremely large estimates if one never allows the discount rates to exceed the rate of inflation.

MR. WELLER: Ms. Young's and Mr. Enthoven's comments about efficient delivery systems underscored my preexisting bias concerning the central significance of payment system reform. It has been estimated by a number of people that the waste and ineffectiveness—in terms of services that do not improve outcomes or have marginal impact on them—account for approximately 20 percent of health care costs, or \$100 billion. Assuming we are smart enough and have the political will to change that payment system (which I liken to drinking wine out of leaden chalices in the sense that it is wasting the wine of our health benefits), what would health care spending and unfunded liability look like? It is obviously a very unorthodox approach, but I think it might be an interesting number.

MS. CHOLLET: It would be, but it would be virtually impossible to estimate. That may be why we have policies that effect marginal change: we are not very good at estimating nonmarginal effects. I

cannot tell you what the effect of comprehensive payment reform would be. Certainly there is an entire provider group that would like to see it make absolutely no difference at all. And they might be successful.

MR. KILLEEN: The point that you made about estimating future medical care inflation is really the key one. We were involved in this as early as 1982 in the White Motor bankruptcy. It was a real problem. It was going to determine how much money we received to provide a medical program for people. We had an excellent dialogue with Dan McCarthy of Milliman & Robertson, who said that health care costs could not continue to increase. Society would not tolerate it. But we have 30 years of data to show that that happened. While I admit that it could not consume 100 percent of GNP, because people still need clothing, food, and housing, there is no magic reason to say that it is going to stop at 12 percent or 15 percent.

MS. CHOLLET: I agree. I personally have a lot of hope that it would stop at 22 percent.

PART TWO

LEGAL ISSUES AND ACCOUNTING REQUIREMENTS

In chapter IV, K. Peter Schmidt views retiree health benefits from a legal perspective. He points out that the Employee Retirement Income Security Act of 1974 (ERISA) established few substantive benchmarks with regard to welfare benefit plans as distinct from pension plans. Because ERISA contains no vesting or other rules for these plans, difficult legal questions arise concerning the nature of current workers' and retirees' entitlement to future benefits.

The courts have responded by creating a body of federal law, largely through the adoption of generally applicable contract principles. Schmidt describes how the courts have used contract law to provide a general framework for resolving retiree entitlement questions.

In chapter V, David Mosso gives the history of the Financial Accounting Standards Board's (FASB) retiree health accounting project from the time these benefits were first addressed in 1979 to the present. He reviews FASB's decision on the vexing question of whether these benefits should be accrued over an employee's entire working life or only to the point at which he or she becomes fully eligible for them. Mosso also discusses the board's deliberations concerning how employers should account for already-accrued liability at the time they adopt FASB's accounting change.

In chapter VI, Thomas G. Nelson points out that a lack of information prevented many employers from realizing the extent of the liability they were incurring when they formulated their retiree health benefit plans. Long-term projections of employers' retiree health insurance costs are consistently larger than expected, regardless of plan design. The accounting profession, through its standards-setting process, has been instrumental in pointing out the existence and extent of this problem, he maintains. Employers may soon be faced with requirements to begin accrual accounting and to establish vesting, funding, and participation provisions for their plans, according to Nelson, who believes employers will need sound management, legal, and financial information if they are to formulate cost-effective strategies.

In chapter VII, participants continue to explore the legal issues involved in the interpretation of retiree medical plan documents as

put forth by K. Peter Schmidt. They also ask David Mosso to clarify FASB's position on the amortization of liability for retiree health benefits. Participants discuss the nature of the transition obligation and possible funding vehicles, such as 501(c)(9) trusts. They also exchange ideas on whether plan assets should be placed into irrevocable trusts, raise questions about FASB guidance in estimating the inflation rate, and debate the issue of vesting.

IV. Retiree Health Benefits: An Illusory Promise?

PAPER BY K. PETER SCHMIDT

Introduction

Life, health, and other coverage for retired workers and their families are sometimes among the benefits promised by employers. For a variety of reasons, including tax and legal considerations,¹ a funded trust arrangement is generally not involved, and such retiree benefits are therefore dependent on a continuing stream of employer contributions or payments. Where the employer encounters financial difficulty or, for other reasons, wishes to curtail benefit payments, a thorny legal question arises as to its right to do so.

Statutory Framework

ERISA—The Employee Retirement Income Security Act of 1974 (*ERISA*) was meant by Congress as a “comprehensive and reticulated statute”² governing employee benefit plans. It established disclosure and reporting requirements, trust and fiduciary responsibility requirements, and enforcement rights in participants, administrative agencies, and fiduciaries. It established the Pension Benefit Guaranty Corporation and its pension insurance program, and, with respect to most *pension* benefit plans, minimum participation, vesting, and funding standards. With respect to welfare benefit plans, however,

¹The Employee Retirement Income Security Act of 1974 (*ERISA*) and the Internal Revenue Code (*IRC*) require the prefunding of pension, but not welfare, benefits. Moreover, contributions for such pension prefunding are tax deductible, whereas contributions to prefund retiree health benefits are generally deductible only to the extent of the amount necessary to fund nondiscriminatory medical benefits (determined on the basis of current medical costs) on a level basis over the working lives of covered employees. Compare *IRC* section 404 with *IRC* section 419A. Retiree medical benefits prefunded in this fashion must be provided, in the case of “key employees” (certain owners and officers), through separate accounts, contributions to which reduce the maximum contributions that may be made to a pension plan (*IRC* section 419A(d)). In addition, a welfare benefit trust may be subject to tax on its income to the extent of amounts set aside to prefund retiree medical benefits (*IRC* section 512(a)(3)(E)).

²*Nachman Corp. v. Pension Benefit Guaranty Corporation*, 446 U.S. 359, 361 (1980).

particularly retiree welfare benefit plans, ERISA established few substantive benchmarks.

Lack of Substantive Welfare Plan Standards—The U.S. Supreme Court recently contrasted ERISA’s treatment of pension plans with that of welfare plans, as follows:

ERISA imposes on pension plans a variety of substantive requirements relating to participation, funding, and vesting. . . . It does not regulate the substantive content of welfare-benefit plans.³

Because of these substantive requirements relating to vesting, funding, and benefit guarantees, the entitlement/curtailment issue described above with respect to retiree welfare benefits does not arise in the pension context. ERISA section 203 and section 411 of the Internal Revenue Code (IRC) require that, on attainment of specified minimum levels of service, pension benefits become “vested,” i.e., nonforfeitable. Moreover, through its funding and pension insurance provisions, ERISA helps assure not only that workers will have a legal right to their pensions but also that the resources with which to pay such pensions will actually exist when they retire. These vesting and funding requirements are established by statute and are thus independent of the contractual undertakings and respective intents of the employer, the workers, and their collective bargaining representative.

If ERISA contained vesting requirements for welfare as well as pension benefits, there would be no difficult legal question concerning entitlement thereto. ERISA specifically provides, however, that its minimum standards provisions, including those relating to vesting, apply only to plans “other than an employee welfare benefit plan.”⁴ Similarly, the regulations under IRC section 411(d)(6), which prohibits retroactive reductions of a participant’s accrued benefit, state that ancillary life insurance protection and accident or health insurance benefits are not among the benefits so protected.⁵

ERISA Preemption—Notwithstanding its failure to provide substantive vesting or other rules regarding retiree welfare benefits, the sweeping preemptive effect of ERISA section 514 dictates that principles of federal law are the only ones applicable in this area:

ERISA’s broad preemption provision makes it clear that Congress intended to establish employee benefit plan regulation as an exclusive

³*Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 732 (1985).

⁴ERISA section 201(1).

⁵Treasury Regulation sections 1.411(d)–4(d)(1), (2) (1986).

federal concern, with federal law to apply exclusively, even where ERISA itself furnishes no answer.⁶

Thus, courts faced with this issue have had to create a body of federal common law. As described below, this has been done to date largely through the adoption of generally applicable contract principles.

Judicial Contract Law Analysis

Freedom to Contract under ERISA—The courts have generally agreed that, while ERISA does not require vesting of retiree welfare benefit rights, neither does it forbid it:

The exemption from ERISA's vesting requirements does not prohibit an employer from extending benefits beyond the expiration of the collective bargaining agreement. Rather, the exemption allows the parties to determine the duration of the welfare benefits. Thus, the issue is "simply one of contract interpretation."⁷

Yard-Man—The most frequently cited retiree benefits entitlement decision is the Sixth Circuit's landmark, *International Union, United Automobile, Aerospace and Agricultural Implement Workers of America v. Yard-Man*.⁸ In adopting a contract law analysis, the court noted that contracts are controlled by the intent of the parties and went on to catalog a variety of relevant contract interpretation principles:

Many of the basic principles of contractual interpretation are fully appropriate for discerning the parties' intent in collective bargaining agreements. For example, the court should first look to the explicit language of the collective bargaining agreement for clear manifestations of intent. The intended meaning of even the most explicit language can, of course, only be understood in light of the context which gave rise to its inclusion. The court should also interpret each provision in question as part of the integrated whole. If possible, each provision should be construed consistently with the entire document and the relative positions and purposes of the parties. As in all contracts, the collective bargaining agreement's terms must be construed so as to render none nugatory and avoid illusory promises.⁹

⁶*In re White Farm Equipment Co.*, 788 F.2d 1186, 1191 (6th Cir. 1986); see also *Metropolitan Life*, *supra*.

⁷*Anderson v. Alpha Portland Industries, Inc.*, 836 F.2d 1512, 1516 (8th Cir. 1988); see also *DeGeare v. Alpha Portland Industries, Inc.*, 837 F.2d 812 (8th Cir. 1988) (related case involving salaried, nonunion workers); *in re White Farm*, *supra*; *International Union, United Automobile, Aerospace and Agricultural Implement Workers of America v. Yard-Man*, 716 F.2d 1476 (6th Cir. 1983), *cert. denied*, 465 U.S. 1007 (1984).

⁸716 F.2d 1476 (1983), *cert. denied* 465 U.S. 1007 (1984).

⁹716 F.2d at 1479–80 (citations omitted).

Unambiguous Contract Terms—As in any question of contract interpretation, and as stated by the *Yard-Man* panel to be appropriate here, the courts begin their analysis with the terms of the contract itself. If retirees are or were covered by collective bargaining agreement, that agreement is thus the starting point for analysis. Where, however, the employees in question have not been so covered, there may be no written plan or other agreement, and the very “contract” to be analyzed must first be implied or derived. In these contexts, courts have had to consider such evidence as summary booklets and testimony regarding oral statements or promises. (As discussed later, similar evidence is adduced where there is a written contract, but its terms are regarded as ambiguous.)

Occasionally this starting point, the terms of the relevant agreement, does in fact end the analysis. In *Policy v. Powell Pressed Steel Co.*,¹⁰ for example, the court interpreted “the collective bargaining agreement to unambiguously grant lifetime health insurance benefits to certain retirees. . . .” No additional analysis was required. Similarly, albeit with opposite result, the court in *Moore vs. Metropolitan Life Insurance Company*,¹¹ held that the employer had unambiguously reserved the right to amend (or terminate) the program at issue there.

The *Moore* decision rejected the participants’ argument that the “contract” had to be derived from the totality of the employer’s communications to the employees. The participants and their representatives had introduced evidence of communications that were allegedly less than complete, or even misleading, since they did not describe the possibility that this benefit might be modified in the future. The participants argued that the totality of these communications had to be looked to as the relevant contract, which would then be interpreted to determine the employer’s obligation.

In the court’s view, however, Congress intended that official plan documents and summary plan descriptions exclusively govern an employer’s obligations under ERISA plans. It held that these documents contained, in the case before it, the unambiguous reservation described above.

¹⁰770 F.2d 609, 611 (6th Cir. 1985), *cert. denied*, 475 U.S. 1017 (1986) (“Despite anything to the contrary herein contained, present pensioners who have, prior to August 31, 1976, elected and maintained hospitalization and surgical coverage, and those who retire subsequent to that date will, *subject to the conditions hereinafter set forth*, receive Medicare complementary coverage on their hospitalization and surgical benefits for the pensioner and his spouse, if any, *during the life of the pensioner* at no cost to the pensioner.”) (Emphasis supplied by the court.)

¹¹856 F.2d 488 (2d Cir. 1988).

Thus, courts have regarded some benefit contracts as unambiguous, but have then gone on to decide the cases in both directions.

Interpreting Ambiguous Language—More often, however, the controlling terms of the contract (whether there is a written agreement or not) are seen as ambiguous, and the courts look to inferences drawn from other contract terms and from extrinsic evidence of the parties' intent. The *Yard-Man* court summarized this approach as follows:

Where ambiguities exist, the court may look to other words and phrases in the collective bargaining agreement for guidance. Variations in language used in other durational provisions of the agreement may, for example, provide inferences of intent useful in clarifying a provision whose intended duration is ambiguous.¹²

Courts examining extrinsic evidences of intent have looked to the following: summary plan descriptions, other benefit summary booklets, or personnel material;¹³ oral statements to employees from personnel managers or others, *e.g.*, in application or exit interviews;¹⁴ specific durational clauses in other parts of the contract, *e.g.*, where the contract specifically provides for termination of the insurance benefits of active employees but has no such limitation with respect to retirees;¹⁵ and the conduct of the parties, *e.g.*, continuation of benefits past the expiration of the collective bargaining agreement (implying that continued entitlement is not a function of current agreements) or prior curtailment of retiree benefits without complaint from the retirees (implying that retirees did not have vested rights).¹⁶ As might be expected, the parties often disagree fundamentally on the basic facts and draw widely differing inferences from the facts on which they do agree, leading to judicial resolutions that are not wholly predictable.

Shortcomings of Contract Law Analysis—Applying contract law analysis to these questions has drawn criticism on several fronts. One commentator, for example, argues that past behavior and employment agreements have generally been premised on the later-shown-to-be-inaccurate assumption that the business would continue in-

¹²716 F.2d at 1480.

¹³*Bower v. Bunker Hill Co.*, 725 F.2d 1221, 1224 (9th Cir. 1984); *Eardman v. Bethlehem Steel Corp. Employee Wel. Ben.*, 607 F. Supp. 196, 209 (E.D.N.Y. 1984).

¹⁴*International Union, UAW v. Cadillac Malleable Iron*, 728 F.2d 807, 809 (6th Cir. 1984); *Eardman*, *supra* at 199–200.

¹⁵*Yard-Man*, *supra*, at 1481.

¹⁶*Local Union No. 150-A United Food v. Dubuque Packing*, 756 F.2d 66, 69 (8th Cir. 1985); *Cadillac Malleable*, *supra* at 808–09.

definitely. In these circumstances, neither the terms of such agreements nor the prior conduct of the parties are particularly relevant to the parties' expectation. This commentator cites with approval the following language from a 1973 arbitration decision:

The difficulty here is that the parties had no intent one way or the other on the specific issue when they negotiated the agreement, or any of those which preceded it. No one at any time even broached the question of what would happen if the Company went out of business. There is no evidence that such a possibility even crossed either party's mind It is not surprising, therefore, that the words of the Agreement provide no clear guide; if they seemed to, it would only be an illusion, an unintended result When confronted by such a problem of interpretation, little is gained by dissecting the words of the contract or searching for intent on a matter which no one considered. Whatever intent is found will not be one which was in the mind of the parties but one which was constructed by the interpretation.¹⁷

Another commentator has criticized the lack of certainty, and the resulting costs and delay, inherent in applying a contractual analysis in this context.¹⁸ (This commentator also believes that social policy considerations militate against the creation of minimum standards.)

To date, however, neither the courts nor Congress has established any generally applicable, substantive rules in this area.

Judicial Attempts at Further Guidance—Theoretically at least, the role of courts is not to make substantive law. As noted previously, however, the sweeping effect of ERISA preemption has required courts to create a body of federal common law in this area, since ERISA itself provides no answer. With one notable exception, the courts' response has been the contract law analysis previously described. The exception itself was short-lived, as it involved a district court opinion that was subsequently reversed.

● *White Farm. In Re White Farm Equipment Co.*¹⁹ is a Sixth Circuit decision involving a manufacturer that ceased operations and filed a bankruptcy petition in 1980. The manufacturing operations were then purchased by another entity, which soon had its own financial problems. As a result, retirees covered by a noncollectively bargained insurance plan were notified that the plan would be discontinued.

¹⁷Donald T. Weckstein, "The Problematic Provision and Protection of Health and Welfare Benefits for Retirees," *San Diego Law Review* 101 (1987): 123–124.

¹⁸John T. McNeil, "The Failure of Free Contract in the Context of Employer-Sponsored Retiree Welfare Benefits: Moving Towards a Solution," *Harvard Journal on Legislation* 213 (1988).

¹⁹788 F.2d 1186 (1986).

Their response was to sue their former employer for recovery of lost benefits and reinstatement of the plan.

Initially the bankruptcy court entered summary judgment for the employer, relying on its view that “the plain language of the various insurance coverage description booklets . . . does not admit of a construction other than that [the employer] retained the unqualified power to terminate or amend” the plan.²⁰ However, the bankruptcy court was reversed by the district court, which in turn entered summary judgment for retirees.

The district court felt required to fashion a federal common law principle applicable to the case before it, and therefore looked to analogous state law decisions. The court first noted “[a]n older line of cases” that permitted amendment or termination, pursuant to a reserved power. The court went on, however, to adopt what it characterized as the “modern view,” namely vesting at retirement:

During the past 30 years, however, more and more courts have accepted “the modern view that the promise of a pension constitutes an offer which, upon performance of the required service by the employee[,] becomes a binding obligation.”²¹

The court saw *dicta* from *Yard-Man* as “an important further endorsement of the modern view that welfare benefits vest upon retirement.”²²

Applying this view, the district court held that the retirees must prevail whether or not the employer had otherwise properly reserved termination rights:

Assuming *arguendo* that the undisputed facts prove the existence of a termination clause in the formal documents . . . , at the time the retirees completed their employment with White Farm they nonetheless acquired a vested contractual right to continued coverage²³

The Sixth Circuit, however, rejected establishment of a common law, vesting-at-retirement principle and reversed this aspect of the district court’s opinion:

In the absence of clear precedent, we find that the statutory scheme of ERISA, though silent on this issue, counsels against the imposition by

²⁰*In re White Farm Equipment Co.*, 42 B.R. 1005, 1010–11 (N.D. Ohio 1984), *rev’d*, 788 F.2d 1186 (6th Cir. 1986).

²¹42 B.R. at 1017.

²²42 B.R. at 1018.

²³42 B.R. at 1019.

this court of an absolute rule effectively requiring mandatory vesting at retirement We conclude, moreover, that the parties may themselves set out by agreement or by private design, as set out in plan documents, whether retiree welfare benefits vest, or whether they may be terminated.²⁴

Although it reversed on the point discussed above, the Sixth Circuit underscored its agreement with the lower court “that no leap of logic transforms Congress’ exclusion of welfare benefit plans from various ERISA requirements into an express endorsement of unfettered unilateral termination of such plans.”²⁵ In other words, neither ERISA itself nor common law developed thereunder provides a universally applicable answer, and relevant contract principles must be applied on a case-by-case basis.

● **Status Benefit Inference.** Several courts have, however, added an important gloss to contract law analysis of these issues. In examining the context in which benefits were negotiated, and the nature of the benefits themselves, the *Yard-Man* court saw a lifetime benefit “inference” that could be thought to exist in every case of this kind:

If [workers] forego [sic] wages now in expectation of retiree benefits, they would want assurance that once they retire they will continue to receive such benefits regardless of the bargain reached in subsequent agreements. . . . Further, retiree benefits are in a sense “status” benefits which, as such, carry with them an inference that they continue so long as the prerequisite status is maintained. Thus, when the parties contract for benefits which accrue upon achievement of retiree status, there is an inference that the parties likely intended those benefits to continue as long as the beneficiary remains a retiree.²⁶

The court indicated that this “inference” was not controlling but rather was one of the factors to be taken into account with all other indications of the parties’ intent.

In a subsequent decision, *International Union, UAW v. Cadillac Malleable Iron*,²⁷ the Sixth Circuit made clear that this inference was not a “presumption,” that is, it did not shift the burden of proof to the employer to prove that the benefits were not meant to last the retiree’s lifetime. The *Cadillac* district court had found for the retirees,

²⁴788 F.2d at 1192-93.

²⁵*Id.* at 1192. Ultimately the case was remanded for further proceedings in the bankruptcy court, since the Sixth Circuit also agreed that the allegedly unrestricted reservation of termination rights was in fact ambiguous, precluding entry of summary judgment for the employer on that basis.

²⁶716 F.2d at 1482.

²⁷728 F.2d 807 (1984).

based on a contract law analysis of the factors outlined previously. It had, however, gone on to find that “ ‘the inherent duration of the retirement status beyond any particular contract’ supported its conclusion. . . .”²⁸ The Sixth Circuit made the following comments in upholding the lower court decision:

While we agree with [the employer] that there is no legal presumption based on the status of retired employees, we do not believe that this leads to a conclusion that the district court erred in its determination.²⁹

In *Anderson v. Alpha Portland Industries, Inc.*, *supra*, however, the Eighth Circuit took an entirely different tack:

[W]e disagree with *Yard-Man* to the extent that it recognizes an inference of intent to vest. Congress explicitly exempted welfare benefits from ERISA’s vesting requirements. It, therefore, seems illogical to infer an intent to vest welfare benefits in every situation where an employee is eligible to receive them on the day he retires. The Court in *Yard-Man* recognized that no federal labor policy presumptively favors vesting. Because Congress has taken a neutral position on this issue “traditional rules for contractual interpretation are applied as long as their application is consistent with federal labor policies.” . . . We believe that it is not at all inconsistent with labor policy to require plaintiffs to prove their case without the aid of gratuitous inferences.³⁰

The existence or nonexistence of this inference may prove an important factor in the outcome of these cases. Given the leeway possible in drawing inferences from the factors that all courts see as relevant, however, it may be that this point is actually of little moment.

Bankruptcy Interaction—Attempts at benefit curtailment by employers who have filed for bankruptcy pose a separate set of issues. On one level, at least, the analysis described above may not be affected. The initial question likely remains one of contract analysis: has the employer contractually committed itself to continue the program? If the answer is no, that is, the employer has effectively re-

²⁸*Id.* at 808.

²⁹*Id.*; *cf. Policy v. Powell Pressed Steel Co.*, *supra* at 613 (“the *Yard-Man* court recognized that ‘retiree benefits are in a sense “status” benefits which, as such, carry with them an inference that they continue so long as the prerequisite status is maintained.’”).

³⁰836 F.2d at 1517; the court went on to explain the consistency of its holding with its own prior decision, *Local Union No. 150-A United Food v. Dubuque Packing*, 756 F.2d 66, 70 (1985), which had seemed to adopt the *Yard-Man* view on this point. (“The right to receive health and welfare benefits arises from the retiree’s status as a past employee. It is not dependent on a continued or current relationship with the Company. The status of a retiree cannot be affected by future negotiations or agreements between the Company and the Union; neither can act on behalf of retirees.”)

served the right to make the contemplated change, the analysis presumably stops there.³¹ Assuming, however, that the court does find an ongoing contractual obligation—an obligation that would determine the issue in nonbankruptcy contexts—bankruptcy situations may require further analysis.

In general, the federal Bankruptcy Code permits an employer that has filed a bankruptcy petition to reject an executory contract under which it would otherwise be obligated.³² If retiree benefits are seen as nothing more than executory contract obligations, this aspect of the Bankruptcy Code might be regarded as authorizing curtailment by an employer that would not be so permitted in the absence of a bankruptcy petition filing.

In response to this possibility, and to the reality of the LTV bankruptcy and LTV's attempts to terminate its retiree benefit programs, Congress enacted in 1986 a stopgap measure requiring continuation of retiree health and other coverages in certain instances, "[n]otwithstanding any provision of [the Bankruptcy Code]."³³ The legislation precluded, until May 15, 1987, curtailment of such programs by employers that either commenced bankruptcy cases after October 2, 1986, or were still paying benefits on such date, notwithstanding prior commencement of a bankruptcy proceeding. The Retiree Benefits Bankruptcy Protection Act of 1988 extended this legislation through the enactment of such act, and precluded retiree benefit curtailment thereafter except where procedures similar to those now required for rejection of a collective bargaining agreement have been followed.³⁴

³¹The Retiree Benefits Bankruptcy Protection Act of 1988 and its predecessor (discussed in this chapter) do not appear intended to change this result. As Sen. Howard Metzenbaum (D-OH), the legislation's principal sponsor, stated on the floor of the Senate:

"This measure sends a strong and powerful message to companies which make promises to their workers—you cannot expect to use the bankruptcy courts as a way of renegeing on retiree promises." *Congressional Record* 26 May 1988, pp. S. 6824–6825 (emphasis added).

Thus, the legislation seems clearly aimed at preventing the use of the bankruptcy laws to curtail retiree benefit programs that could not otherwise be curtailed. Nonetheless, the literal language of such legislation could be read to preclude unilateral curtailment by bankrupt employers even where a clear contractual right to do so exists quite apart from bankruptcy. Even if the law were so interpreted, it would presumably have no effect on an employer's exercise of such right on the eve of bankruptcy.

³²11 U.S.C. section 365(a) (1982).

³³Continuing Appropriations for Fiscal Year 1987, P.L. No. 99-591, 100 Stat. 3341–74 (1986).

³⁴Retiree Benefits Bankruptcy Protection Act of 1988, P.L. No. 100-334, 102 Stat. 613 (1988).

Bankruptcy situations present a further twist where the benefits in question are provided pursuant to collective bargaining. In its *Bildisco*³⁵ decision in 1984, the U.S. Supreme Court held that the contract rejection right described above extended freely to collective bargaining agreements and an employer's obligations thereunder. Congress responded with an amendment to the Bankruptcy Code providing that collective bargaining agreements can be rejected only with the approval of the bankruptcy court and only after a specified showing has been made and specified procedures followed.³⁶

Since then, at least one employer has argued unsuccessfully that this Bankruptcy Code amendment and its required proceedings do not apply to those provisions of a collective bargaining agreement that pertain to retirees, or, alternatively, that they apply only to those situations covered by the "stopgap" anticurtailment legislation discussed earlier.³⁷

Conclusion

As evidenced by the foregoing discussion, entitlement to retiree benefits is an issue at the intersection of a number of different, and sometimes conflicting, policies—policies relating, for example, to taxation,³⁸ retirement, bankruptcy, financial accounting, and labor

³⁵*NLRB v. Bildisco & Bildisco*, 465 U.S. 513.

³⁶11 U.S.C. section 1113 (1982).

³⁷*In re Unimet Corp.*, 842 F.2d 879 (6th Cir. 1988); cf. *In re Century Brass Products, Inc.*, 795 F.2d 265 (2d Cir. 1986), cert. denied, 476 U.S. ___, 107 S. Ct. 433 (1986) (rejection procedures required by Bankruptcy Code amendment contemplate additional bargaining over retiree benefits, but union may, because of conflict-of-interest, not be the appropriate retiree representative).

³⁸Among the issues yet to be sorted out under the Internal Revenue Code (IRC) is how retiree health benefits will be taken into account under IRC section 89. To avoid being considered a "discriminatory employee benefit plan" thereunder, with resultant adverse tax consequences for any "highly compensated employees," the plan must meet either three eligibility tests and a benefits test or a coverage test and nondiscriminatory eligibility test. These tests are designed to prevent discrimination in favor of "highly compensated employees." Although the tests are stated in terms of "employees," and retirees are no longer employees, the statute does not appear meant to exclude retirees from these tests. Section 89(j)(3) provides as follows: "Except to the extent provided in regulations, this section shall be applied separately to former employees under requirements similar to the requirements that apply to employees." What exceptions the regulations might provide, and what "similar to" means in this context, is yet to be elucidated.

The legislative history, however, directs the Treasury to provide in such regulations as follows:

Employers may generally restrict the class of former employees to be tested to those who have retired on or after a reasonable retirement age, or to those who have separated from

law. Moreover, the demographics of our society suggest that the issue will not go away and is only likely to grow in importance over the coming years.

Theoretically, the courts alone could fully resolve the conflicting legal principles. Indeed, they have already been forced to provide a general framework (contract law) for resolving retiree entitlement questions. The more important social questions, however, will have to be resolved by the legislative branch. Hopefully, this will not continue in a "stopgap" or narrowly focused fashion but will be part of a comprehensive examination of all relevant policies.

service due to disability. In addition, employers may generally limit the class further to employees who have, for example, retired within a certain number of years. Finally, in testing whatever class of employees is chosen, employers may make reasonable assumptions regarding mortality, so that they do not have to determine those former employees who are still alive.

U.S. Congress, House, *Report of the Committee on Ways and Means, House of Representatives, on the Tax Reform Act of 1986*, H.R. Rept. 426, 99th Cong., 1st sess., 1985; *Conference Report on Tax Reform Act of 1986*, H.R. Rept. 841, 99th Cong., 2nd sess., 1986; U.S. Congress, Senate, *Report of the Committee on Finance U.S. Senate, on the Tax Reform Act of 1986*, S. Rept. 313, 99th Cong., 2nd sess., 1986; see also U.S. Congress, Staff of Joint Committee on Taxation, *General Explanation of the Tax Reform Act of 1986*, Committee Print (Washington, DC: U.S. Government Printing Office, 1987).

This ability to test retirees separately from other employees is important. It will allow employers to maintain, on a tax-favored basis, retiree-only plans that meet the nondiscrimination requirements when only retirees are considered but fail those requirements when *all* former employees, including those who left the company at a relatively early age, are considered.

In addition, the ability to further limit the class tested to employees who have retired within a certain number of years will apparently make it easier for an employer to meet the nondiscrimination tests with respect to a health plan under which an employer begins to offer retiree benefits but does not reach back to cover all prior retirees. This language may also be interpreted to make it easier to meet these tests with respect to a health plan under which an employer that has explicitly stopped promising retiree benefits to new employees continues to provide for the current or future payment of benefits to employees who have already retired or to whom such benefits have already been promised.

These and other retiree health benefit issues which, as of this writing, have not been clarified, will likely be addressed in regulations under IRC section 89. Provisions included in both the House and Senate versions of the pending technical corrections would require the Treasury to issue, by October 1, 1988, rules on which employers may rely. This initial guidance is to focus primarily on issues not addressed by the statute or legislative history and needed immediately for compliance. Both versions also provide that, if the required regulations are not issued by October 1, an employer's compliance with its good faith interpretation of section 89, based on the statute and its legislative history, will constitute compliance with the statute. [Editor's note: The Internal Revenue Service issued proposed regulations on March 2, 1989.]

V. Retiree Health Benefits: The FASB Decision Process

REMARKS OF DAVID MOSSO

Introduction

Professor Alain Enthoven of Stanford University has said that fussing with the accounting and legal issues surrounding retiree health benefits is akin to rearranging the deck chairs on the Titanic. I would use that analogy a little differently: If you want to avoid hitting an iceberg, it is good to know that there is an iceberg in the vicinity, and one might describe the Financial Accounting Standards Board (FASB) retiree health accounting project as an attempt to put a telescope on every deck chair.

Let me give you a brief history of the project and then some tentative conclusions on the major issues.

History

FASB put retiree health care and other benefits on the agenda in 1979. At that time we had an active pension accounting project; retiree health benefits seemed to be similar, so we incorporated them into the pension project.

In 1982 we came out with a preliminary document that said retiree health care benefits should be accrued over the working lives of employees. We found that we could not readily follow up on that conclusion, however, because pension issues tended to dominate the board's thinking at that point. So in 1984 we separated health care benefits from pensions and basically set them aside for a couple of years. But we did issue Statement No. 81, which required disclosure of a description of the retiree health plan and the cost recognized in the income statement.

In 1986 we went back to work on the retiree health care project and have been working on it since then. An exposure draft should be issued in February 1989.* Following that, there will be six months

*Editor's note: On February 14, 1989, FASB released an exposure draft of a proposed accounting standard that would require companies to recognize postretirement health care and insurance benefits as a form of deferred compensation and to report these obligations on their balance sheets. Sections of the exposure draft, *Proposed Statement of Financial Accounting Standards: Employers' Accounting for Postretirement Benefits Other Than Pensions*, are included in Appendix B.

for comments on the exposure draft. Then in October 1989 we will hold public hearings at which anybody will be free to offer testimony. Sometime in 1990, probably in the first half of the year, we will issue a final statement.

The Liability Issue

The key conclusion that the board has reached is on the basic issue of whether employers have a liability, in the accounting sense, for retiree health benefits. Of course, we really reached that conclusion in 1982 and said, yes, there is a liability and it should be accrued. But we reexamined that question in great depth when we resumed work on the project in 1986. Again we concluded that, yes, it is a liability, and that postretirement health care benefits are a part of the employee compensation package.

Compensation for some current work is paid in cash, some is paid in kind; some is paid now, some is paid later during retirement. We did not see health care benefits as being any different from any other kind of compensation in that regard.

Whether or not the promise to provide retiree health benefits is legally binding is not our bailiwick, and is not really the key issue for us. If the promise is legally binding, there is no question whatsoever that an accounting liability exists. We basically operate on the presumption that a promise made in a plan document is a promise that is intended to be kept, and the obligation for that promise should be accounted for until there is some indication that the promise will not be kept.

Benefit Accrual

On the issue of how to accrue the benefits, the board has concluded that, basically, they should be accrued like pensions—that is, by estimating the future benefits that are earned during the current accounting period and then calculating the present value of those future benefits. The result is the current period cost and the increment to the liability.

A major issue in our deliberations was whether the benefits should be accrued over the entire working life of an employee or over the working life to the point at which the employee becomes fully eligible for the benefits—in other words, when the employee could retire and get the benefits, whether or not the employee chooses to retire then. The board decided to require accrual to the eligibility date rather

than to the retirement date. Any funding would be offset against the liability and any income on fund assets would be offset against expense.

Transition Liability

Another major issue is what to do about the liability that has already accrued at the time a company first adopts an accounting change such as the one proposed. There has been much discussion of the magnitude of the liability and its impact on corporate equity. The board decided that the amount had to be spread over some period, and the decision was to amortize it—to [require employers to] disclose the liability immediately on adoption of the statement but not to book it on the balance sheet. Rather, it would be amortized into income and onto the balance sheet over the average remaining service life of active employees or, if that service life was relatively short, over a 15-year period.

Despite its conclusion that the transition liability should be amortized onto the balance sheet gradually, the board debated whether or not it wanted to have at least a minimum liability booked at some time prior to the time the transition obligation was fully accrued. The board decided to require that a minimum liability be booked, and that it would be the amount of the benefits that had been earned by existing retirees and those active employees who were then eligible to receive benefits.

This requirement was mitigated somewhat by the effective date provision. Basically, the accrual of current expense and current liability increments would begin for calendar year 1992. For small business and for foreign plans of U.S. companies, the accrual would be effective for calendar year 1994. The minimum liability, however, would not have to be recorded until 1997, so there would be, in effect, eight years before the minimum liability would have to be recorded on the balance sheet.

VI. FASB Accounting and Funding Issues

PAPER BY THOMAS G. NELSON

Introduction

By now most of us are aware that a large majority, approximately 80 percent, of large and medium-sized employers continue to pay for retiree life and/or health benefits for former employees. Many of us know first-hand that the cost of providing these benefits can be overwhelming. Compounding the financial difficulty is the fact that the accounting and legal requirements for retiree plans continue to change.

Many employers who pay the current retiree costs as they occur have not yet experienced the full force of the financial consequences of these plans. The relative proportion of the hidden retiree costs varies by employer, but in general these plans have two common characteristics: they are deceptive and promise to become very expensive. Take the case of one very large employer that had a long-standing plan and a mature work force. Actuarial estimations indicated that the cost of its existing plan could more than quadruple in the next 15 years, with a present value obligation totaling several billion dollars.

Another company, recently considering the adoption of a retiree health plan, benefited from our collective progress in advancing along the retiree medical learning curve. The company was aware of the rumblings regarding retiree medical plans, and wisely decided to develop financial estimates before acting. This particular employer's work force was relatively young, with very few current retirees.

The company's benefits manager had made an estimate of the next year's (modest) costs. However, an actuarial analysis that projected retirements and costs much further into the future provided quite a different picture. The estimated hidden costs—those for future years when the bulk of the retirements would be anticipated—were enormous compared with the initial costs expected by the employer. In fact, while both analyses agreed that the costs would begin modestly, the actuarial analysis projected a tenfold increase by the year 2000. The present value of all anticipated benefits was more than 100 times the initial year's expected outlay.

Long-term projections such as these demonstrate that, regardless of the group, the plan design, or any reasonable assumptions about

the future, we are headed for some very expensive times that were previously unforeseen. As is usually the case, learning about the extent of the problem is a painful but essential first step in forming strategies that will enable employers to gain added control of their future benefit programs and business expenses.

Overview of the Issues

In 1974, the Employee Retirement Income Security Act (ERISA) set funding, participation, and vesting standards for retirement income plans. However, even before 1974, pension accounting and actuarial values were determined on an accrual basis.

For nonpension coverages, accounting standards are not as advanced. They are being studied by the Financial Accounting Standards Board (FASB), as are possible funding, participation, and vesting standards by the federal government. Additionally, retiree coverage has been the focal point of a number of judicial disputes that tilt toward requiring a more certain employer responsibility for retiree benefits.

Any discussion of retiree health benefits should include the following considerations.

- Our legal system has been trying to determine the extent to which retirees are entitled to benefits that are construed to have been earned during their active working lives. Despite what appears to be a legal trend toward entitlement for retirees, Congress chose, in the Deficit Reduction Act of 1984 (DEFRA), to emasculate available funding mechanisms through severe taxation of retiree plan reserves and contributions. In addition, federal budget constraints have affected governmental health programs such as Medicare, putting increasing pressure on the private sector to finance benefits for the elderly.
- The accounting standards-setters went beyond merely recognizing an important contingency-accounting omission—i.e., exclusions regarding group insurance obligations—that has existed in FASB Statement No. 5. They examined the materiality and measurability of the value of retiree health benefits as well as the apparent extent of employers' obligations to former employees. Their findings indicated a need to account for the value of such benefits over employees' working lifetimes instead of using today's nearly universal norm, cash (or pay-as-you-go) accounting. Definitive proposals by FASB on accounting standards were issued in February.*

* Editor's note: On February 14, 1989, FASB released an exposure draft of a proposed accounting standard that would require companies to recognize postretirement health

- Not only are accounting and legal issues pressuring retiree benefits, but the aging of the work force and ongoing medical inflation are causing the surprising cost increases that are being estimated for many postretirement medical benefits programs. No one knows the true aggregate cost of these plans, but the U.S. House of Representatives' Select Committee on Aging has been given estimates indicating that the liability for future retiree health benefits for the Fortune 500 companies is approximately 150 percent of total assets. This may or may not be true, but it is clear that the pay-as-you-go accounting and funding approaches generally used—along with the unavailability of more accurate data—have masked the exponential increases in retiree costs and hampered our ability to plan intelligently for our businesses' futures.
- Where the legal status of benefits is such that funding, reserving, and accrual accounting for plans are deemed appropriate, actuarial estimations of future costs are needed, using mathematical models that combine economic, demographic, and probabilistic assumptions over the next several decades.

Accounting Influences

The accounting profession, through its standards-setting process, has been instrumental in pointing out the existence and extent of the "problem." In early 1984, FASB split its long-running study of the accounting for pension and nonpension postemployment benefits into separate projects.

The pension study resulted in FASB Statement No. 87, *Employers' Accounting for Pensions*, and FASB Statement No. 88, *Employers' Accounting for Settlements and Curtailments of Defined Benefit Pension Plans and for Termination Benefits*. FASB then turned to nonpension benefits (primarily group life, health, and disability coverages).

FASB's Emerging Issues Task Force studied a number of issues related to retiree medical benefits, including materiality, measurability, the extent of employers' obligation to former employees, and accounting for these benefits in circumstances involving mergers and acquisitions. FASB staff and representatives of the American Academy of Actuaries worked closely to combine the pertinent accounting and actuarial principles to ensure that the accounting standards would be based on an appropriate conceptual foundation.

Based on FASB's study to-date, the following can be noted.

care and insurance benefits as a form of deferred compensation and to report these obligations on their balance sheets. Selections from the exposure draft, *Proposed Statement of Financial Accounting Standards: Employers' Accounting for Postretirement Benefits Other Than Pensions*, are included in Appendix B.

- From an accounting perspective, retiree health care benefits are considered deferred compensation earned during service.
- In the next few years, accrual methods will supersede pay-as-you-go as the acceptable accounting method.
- Actuarial projections of unfunded benefits will be used to measure costs and liabilities. Assumptions used in the projections will not be pegged; rather, explicit “best-estimate” assumptions should be employed.
- For most typical plans, expected benefits will be allocated ratably over the employee’s working period from date of hire to date of eligibility for benefits.
- Minimum liabilities, to be reflected on the balance sheet, will be required for values associated with current retirees and those eligible to retire and receive benefits.
- Transition obligations will be required on the unfunded present values of benefits to be paid to current retirees, with a proportionate amount also required for active workers. The transition amount would start as a footnote to the balance sheet and be recognized over the average remaining service periods of active workers, or 15 years if longer.
- Gains and losses could be recognized either immediately or on a delayed basis.
- Accounting disclosures would be similar to those for pensions (FASB Statement No. 87), supplemented by a statement of the assumed health care trend rate and the effect of a one percentage point change in that rate on the obligation and periodic cost.
- Final standards would generally be effective for fiscal years beginning after December 15, 1991, with up to five years longer to recognize a minimum liability.

Funding

Highly publicized court cases have brought to public and congressional attention the almost total lack of prefunding for today’s retiree health plans. A second general area of legal activity involving retiree benefits deals with the taxation of funded retiree plans. The passage of ERISA affected health plans in a number of ways but did not establish pension-like standards for their funding, vesting, or participation—nor has any other federal law done so since that time. DEFRA crippled available employer funding mechanisms and mandated further governmental study of funding. The inclusion of funding limitations in this legislation was a philosophically puzzling move, coming at a time when the federal government had consistently asked the private sector to shoulder a greater share of employee welfare costs. Under DEFRA, actuarial funding over employees’ working life-

times is technically allowed for in health plans but specifically may not provide for medical inflation, a critical component. Moreover, tax advantages were stripped from the holding of advance-funded retiree reserves. These provisions severely restrict employers who might wish to prefund retiree benefits as they are earned.

It may be possible for retiree health plans to regain legislatively the kind of favorable tax treatment that is accorded to pension plans. However, if this does occur, the *quid pro quo* would likely be a requirement for the sponsor to operate within specific funding, vesting, and participation rules. Thus, employers who wished to continue their plans in order to assist former employees with the financial risks associated with their health would be required to fund on a more accelerated basis than pay-as-you-go. The direction of such a potential funding/taxing change would then coincide with, rather than contradict (as do the provisions of DEFRA), the direction of expected future accounting changes.

Conclusion

In past years, plan sponsors have unknowingly granted health benefits to retirees and disabled persons worth literally billions of dollars. To a certain extent, employers were blind-sided on this retiree issue because sufficient information was generally not available to help them formulate these plans. As it turns out, the reported pay-as-you-go costs are a small portion of the total cost. Most employers did not ask for, and no one offered, better data. Even with better data and projections, however, it would have been difficult to predict the advent of the tough legal restrictions that have been established. Thus, employees have found themselves in a reactive position facing a number of tough issues.

Employers' increased interest in the financial risks associated with their retiree health plans is understandable because they may soon be faced with requirements to begin accrual accounting; to guarantee coverage for former employees in certain instances; and to establish formal vesting, funding, and participation provisions for their plans. Employers' future strategies will vary greatly, and the development of these strategies will depend on the availability of sound management, legal, and financial advice.

Employers who have not yet studied their plans' costs, or who are involved in mergers or acquisitions with companies that have not examined retiree costs, are certain to benefit greatly by studying cost projections for their plans. This information will enable them to begin

an informed planning process to manage the risk involved with these benefits. The knowledge derived from a long-term projection of its retiree benefits will assist the employer in determining the amount of risk to be accepted. The employer's stance on risk will then lead either to changes in, or to an affirmation of, existing policy. Once the employer's philosophy and plan for retiree benefits are in place, periodic updates of legal, accounting, and actuarial developments will help to keep the entire retiree medical program on course.

VII. Part Two Discussion

Legal Issues

MS. IGNAGNI: I am with AFL-CIO. I would like to begin by stating that I am still confused about some of the issues that Mr. Schmidt discussed. The documents of most of the plans that we have negotiated do not mention the issues of cost management or cost sharing. I have read some conflicting things by legal theoreticians and others who would make one argument or another, so I would like to ask you your views on the rights of a retiree versus those of a current employee in situations where the plan documents do not explicitly cover the issues of cost management and cost sharing. Are they treated differently in your mind? Should they be? What are the rights here? I am not familiar with these principles, and I do not believe anybody else is.

MR. SCHMIDT: I do not think anyone is, including the courts. I think the basic mode of analysis that I described is what would be adopted in that circumstance, which is to say, courts would try to fathom the underlying intent of the parties with respect to cost sharing, etc. You might say we did not think about it. That may be the reality of the situation and the court may believe that itself, but I think it will, nonetheless, go through that kind of an analysis. Relevant factors would be, for example: If cost sharing has been in the program for some time, has it increased? Did people claim that it was a violation of the contract when that happened? If there was no cost sharing for a while and then it was instituted, is that what started the complaint? If not, the court may say that it is not a violation of the contract. The parties did not seem to think it was a problem.

The court may be able to find other factors that shed light on this phantom intent of the parties. It is a facts-and-circumstances analysis, and parties disagree about the facts and the inferences properly drawn from the facts. I do not think you can predict, even with a stipulated set of facts sometimes, how one court or another will decide.

MS. IGNAGNI: There is a question of utilization and management, recertification—even triple options type arrangements. We have made very little progress in obtaining information on these initiatives in the area of retiree health. We think that the initiatives should go

forward, but what would your opinion be on the rights of the two parties in that situation in relation to cost sharing?

MR. SCHMIDT: Part of the problem is that you do not always have only two parties. Sometimes it is thought of as three parties, and in that case, does the collective bargaining representative represent retirees? If you pass that one for a minute and assume that they do, then it is a basic contract principle that, between themselves, two parties to a contract can do whatever they want. They can amend, modify, change it, so that if there is agreement between the union and the employer about how to implement the contract, you should not have a problem. But this raises a sticky point: Are you representing, and in effect standing in the shoes of, the retiree, and is that proper?

Modifying Contracts

MR. NELSON: A followup to that. You talked about collective bargaining. In my experience in dealing with employers, there has been a dearth of written information about the retiree portion of the contract: whether it is an insured case or a self-insured arrangement. How far are you seeing these kinds of contractual arrangements taken, for instance, in terms of cost sharing or even administration? The way the program is administered—whether it is based on coordination of benefits or a carve-out program—can mean a big difference to the retiree and to the employer in terms of how much each is responsible for. How far are you seeing that go in new contracts? Are these types of references being included in restructured plans?

MR. SCHMIDT: You are talking about people agreeing to modifications, so it is not a question of law or—

MR. NELSON: How about where an employer determines that this is going to be the program from here on, trying unilaterally to implement changes?

MR. SCHMIDT: I think when an employer is trying to implement changes and he faces a complaint from people covered by the program—and not much of anything is written—that past conduct will be an extremely important factor. In the Second Circuit decision, I believe the plan was initially not contributory. Then a contribution was made on the order of a couple hundred dollars a year, and later it went to \$400 and subsequently to approximately \$800. At that point the people covered first started a lawsuit. That is a little late to take a position, because there is this inference about the prior changes.

MR. NELSON: As employers attempt to modify the retiree contracts that are in effect, what level of detail is being implemented in the promises that are being made to future retirees? Are the details of cost sharing and administration being included? Have you seen any trend?

MR. SCHMIDT: I do not do labor bargaining and I cannot say what is happening at the bargaining table.

MR. RAPS: Mr. Schmidt, do you think it would carry any weight with the federal courts if an employer wanted to modify a postretirement benefit program that was found to be discriminatory by reducing the benefits to make it nondiscriminatory?

MR. SCHMIDT: I have not seen a case like that. I think one obvious response is to raise benefits to make it nondiscriminatory. The problem with that starts with the premise that there is a fixed pool and the reduction is only to make it nondiscriminatory with the limited assets available.

I work with multiemployer plans a lot and the fixed-pool issue is a reality in that context. Yet we still sometimes have a hard time selling it. My guess is that a court would not be moved very far by that notion.

MR. MARINACCI: To the extent that courts have held employers' feet to the fire on the benefits promise, has it always been on behalf of a current retiree group? Have there ever been cases where the plaintiffs were present employees, i.e., future retirees, who want to hold the employer's feet to the fire on the implied promise?

MR. SCHMIDT: Where you draw the line is certainly an issue: what the promise is, what it takes to have it sealed into a contract. For example, if the idea is that it is an offer from the employer, once an employee has worked the required time and become entitled, then it is a contract.

If it is a question of the contract providing that if you have 10 years of coverage under the plan with the employer you are entitled to lifetime benefits at normal retirement age—and the benefit has been provided to people who leave the company after 10 years and then return—I think that would be a good case for people that have not reached normal retirement age. But I cannot cite any specific case law on that.

New Financial Accounting Standards Board Rule

MS. CHOLLET: I want to make sure that I understand what Mr. Mosso said. Am I right in saying that amortization of liability for retiree health benefits would involve estimating the present value of current benefits provided to current retirees, and estimating the present value, again, if it is promised, to active workers?

Amortizing for the first group would be over the 15-year period, as you do with Financial Accounting Standards Board Statement No. 87. For the second, rather than the working life, when workers become eligible, that year-to-year amortization payment goes in current liabilities. Am I right about that?

MR. MOSSO: The liability that exists at the transition date has already been earned, and any unrecognized amount would be amortized over the longer of the remaining service life of active employees or 15 years. The accrual for a current employee's service would begin with the date of hire and would be accrued up to the date that the employee becomes eligible for benefits.*

MS. CHOLLET: Whatever that number is in both categories, some goes in the current liability section of the balance sheet and would increase expenses, essentially, to the employer.

MR. MOSSO: That is correct. To the extent that the prior service obligation is amortized, it would go into liabilities.

MS. CHOLLET: Would you explain the minimum liability again?

MR. MOSSO: The transition obligation, which is the total amount that is owed as of the date the standard is adopted, breaks down into three pieces: the piece that has been earned by existing retirees, the piece that has been earned by active employees who are eligible [for retirement], and the piece that has been earned by active employees who are not yet eligible. All of these pieces would be part of the transition obligation that would be disclosed but not immediately recognized in the financial statements. Beginning in 1997, however, the unfunded obligation for retirees and eligible active workers would be required to be reported on the balance sheet.**

*Editor's note: This represents a reversal of an earlier FASB decision that would have measured the obligation to provide retiree health benefits based on the portion of expected total service rendered, that is, service to the expected retirement date.

**Editor's note: This represents a reversal of earlier FASB decisions that would have defined the minimum liability as the unfunded liability for current retirees only and would have set the effective date for recognizing the minimum liability at 1994.

MS. CHOLLET: When you say that by 1997 it would have to go on the balance sheet, am I to assume that it would go in a footnote until then?

MR. MOSSO: Yes.

Funding Vehicles

MR. LAURENT: I would like Mr. Nelson to comment on one of the key points of this discussion: What are employers going to do? I agree that the first reaction will be to try to reduce liability. The big question in my mind is, what is going to happen on the asset side? In your opinion, will there be any nontrivial level of funding before there are tax advantages greater than we have now? And if there is—if you believe people will start to fund—which of the available funding vehicles do you think are most likely to be used?

MR. NELSON: I have not seen any meaningful trend in the way employers fund retiree health care liabilities. I would be interested to know if other forum participants have a comment on that.

If not too many people are funding, I am not sure which of the vehicles are preferable. Certainly there are advantages to 401(h) in the sense that there are some standards associated with it, but it is limited. Essentially, 401(h) cannot do all that you would like to do. The voluntary employee beneficiary association approach is so emasculated that I do not see any activity in that direction. If there were reversions from pension plans, that might create some assets that would be helpful.

MR. LAURENT: Mr. Mosso, one of the FASB handouts defined plan assets that could be used to reduce liability as assets that are segregated and legally restricted. What level of restriction is required? Many people may start to fund with trust funds that may not be irrevocable. Would this kind of asset accumulation be available to offset the liability?

MR. MOSSO: I do not know for sure what you were given. It may, in fact, be the language that is likely to go into the exposure draft. We have not addressed revocability. I am not sure what the term “legally restricted” means. I do not think it goes so far as to mean that the assets have to be in an irrevocable trust, but it probably would go far enough to mean that you could not tap into them willy nilly for other corporate purposes.

MR. LAURENT: If it is not irrevocable, then it could be attacked willy nilly.

MR. MOSSO: Without being totally irrevocable, there might be conditions that would have to be met—a requirement that would protect the beneficiaries to some extent.

MR. LAURENT: So you feel that there probably would have to be some restriction on availability of the funds for them to qualify as plan assets?

MR. MOSSO: Yes.

MR. NELSON: Some of the informal discussions that I have had on this have focused on the fact that 501(c)(9) trusts typically are not segregated and dedicated to the use of the retiree program. However, my understanding is that FASB would require some kind of definite segregation in order for assets to be recognized as funding for those liabilities.

MR. LAURENT: But again, even if you set up a 501(c)(9) trust, it is my understanding that that is probably nonreversionary once the money goes in.

MR. NELSON: The 501(c)(9) trusts that I am familiar with are not specifically for the retiree segment of the population. I think that, in their initial discussions, FASB was indicating that they would need that type of trust in order to have assets recognized for the retiree evaluation.

FASB Guidance

MR. EASLEY: When FASB Statement No. 87 was issued, there was guidance on interest rates used. We have discussed the importance of the rate of medical care inflation in relation to general inflation. What type of guidance does FASB have in mind?

MR. MOSSO: It will be very general. It will not be as specific as that given for pensions, because the pension rates lean heavily on the availability of purchased annuities and use those rates as a guide. There do not seem to be similar kinds of arrangements available now, and so the guidance at this point leans more to an asset rate. If there is funding, the guidance would be related to the kinds of assets in the fund. Other than that, it would probably be related to the kinds of assets you would use otherwise. In other words, it will be very broad guidance, at least in the exposure draft.

The interest rate and the extent to which a trust would be restricted will be addressed during the public comment and public hearing process. It is very likely that they will be refined a good bit before the final statement comes out.

MR. EASLEY: I was not referring so much to the interest rate as I was to the inflation rate.

MR. MOSSO: We will give very broad guidance on that. I think about the only thing we are saying is that it should be the employer's best estimate, based on specific assumptions and the best estimate of all of the factors that go into that rate.

MR. NELSON: The discussion that I have heard to date on this point has indicated that, in terms of the explicit best-estimate assumption for medical trends, there is no prescribed relationship between the discount rate, which Mr. Mosso talked about, and the medical trend rate, which you are asking about. There is no prescription as to the levels of these rates. And in these calculations the key is the relationship between these two numbers. In addition, it was indicated that footnotes would contain information about the effect of varying the trend rate by one percentage point from whatever was assumed. Will there be some financial information for the reader in the statement also?

MR. MOSSO: That will be a proposed disclosure. I would observe, however, that we proposed that in the pension exposure draft and later dropped it. However, the board still opted to require it here, principally, I think, because the health care estimate is bound to be even softer than a pension estimate, and so the sensitivity type of disclosure would be helpful to users.

The Accrual Period

MR. EASLEY: I would like to ask a question about the early retirement provision. Why is it that many of these plans are focused heavily on early retirement? When you said that accrual would be made to the earliest eligibility date, does that also mean that the benefit available at that eligibility date would be the one used in the calculation?

What weight would be given to the fact that benefits could continue to accrue beyond that date?

MR. MOSSO: The accrual would be of the liability that exists at the retirement date, but that accrual would be made to the eligibility date. In other words, what is being accrued to the eligibility date is

the final liability as it would exist on the retirement date, so that the lag between eligibility and retirement would be a factor in the calculations.

MR. EASLEY: You still use an assumed retirement that might deviate from the eligibility date?

MR. MOSSO: Yes.

MR. NELSON: The benefits are really expected benefits. If they are increased beyond the eligibility date, the present value of those additional benefits would have to be spread over an attribution period as well.

MR. FERRUGGIA: Along with many of the employers that I have been working with, I have gradually come to accept that some form of accrual-based accounting is proper recognition of these costs, albeit a pretty painful recognition. But I think most of the violent opposition that I have heard is [regarding the issue of] accruals up to the date of first eligibility.

I would like to know more about the task force's thinking. In practice, if you have liberal early retirement provisions, accrual can cease as early as age 55. Now, through the lifting of mandatory retirement, we can have employees working more than 15 years beyond first eligibility, rendering an economic benefit to the employer, yet attributing no cost to that period, and front loading the entire cost.

MR. MOSSO: FASB's basic rationale is that accounting is for contracts. Looking at the plan as a contract, if an employee is eligible as of a given date for full benefits, then the accounting would follow the contract and accrue benefits to that date. That is really the same as pension accounting, except that pension accounting does not usually run into the problem of service rendered beyond the date of full eligibility.

MR. FERRUGGIA: Nonservice related benefits?

MR. MOSSO: Right.

MR. FERRUGGIA: I am not an accountant, but I thought that one of the fundamental principles was proper income matching. These older employees generate income for the corporation, yet there is no charge to income for their benefits because they have already been charged off previously. Are you saying that they have earned everything early in their careers and are not earning anything more beyond first eligibility?

MR. MOSSO: That is correct. Matching does not override the need to accrue the cost of the benefits over the contract period in which the benefits are earned. Incidentally, the figures that we have seen—and the figures from a number of corporations—indicate that accruing to the eligibility date does not make a great deal of difference in the amount of liability or in the current period cost. What makes a greater difference, however, is in the amortization of the transition obligation. I suspect that at least some of the board members felt that they should do the accruing according to the contract terms, and, if there was going to be any amelioration of the transition impact, it would be through a slower amortization of the transition obligation.

MR. NELSON: Your point was well taken about the dates on the attribution period. I think if there is a probability that people are going to retire beyond that eligibility date, why not recognize that? But that is apparently not the way the board has decided.

MR. MOSSO: It was a very controversial issue for the board, too.

Is the Retiree Medical Benefit Vested?

MR. MCMAHON: There is a difference between a liability and a vested liability. Every employer here has worked very diligently to vest those benefits [as of] the day people retire. And in the stroke of a pen, you have vested them at early retirement.

I guarantee you that we will fight you on that. It is not a vested benefit. In America, 99 percent of the plans do not give employees a retiree medical benefit until the day they retire. The consequence, if this goes through, is that you can retire early and get your pension, but you have not earned a retiree medical benefit until the day you retire [at normal retirement age]. And therefore, from age 55 to age 65 these people are going to be on their own. That is going to be the bottom line. There is a difference between a vested pension benefit and a vested retiree medical benefit. And you will hear it louder and louder. They do not earn it until the day they retire.

MR. MOSSO: That is the question. The board is not defining or even suggesting that this benefit is legally vested. However, for accounting purposes the board has defined the eligibility date as the date the employee has earned the benefit and does not have to work any longer to get it.

MR. MCMAHON: We will wind up with the Securities and Exchange Commission telling us what accounting is. Because if you vest those

benefits, we will take a qualified statement before we will put that into effect. Because you will not vest our medical benefits.

MR. MOSSO: We are not vesting anything. But the contract defines when an employee attains eligibility for benefits. It is the contract that governs, and we are accounting for the contract.

MR. MCMAHON: What contract? I told our employees that the day they retire they get a benefit. If they worked for 35 years and they die, their spouse, by law, gets one-half of their pension benefit, zero medical coverage, zero retiree medical coverage. That is the contract. There is no vesting, and that represents 99 percent of the contracts.

MR. MOSSO: Then there should be no problem. Accrual to the eligibility date would be only for expected cash payments and, in the case you described, nothing would be accrued for an employee expected to die before receiving the benefits. Such factors are considered in the actuarial measurement.

MR. FLATLEY: You have indicated that there will be some difference in the effective dates for certain types of plans, specifically foreign plans. Some of the more meddlesome issues are associated with accounting in the foreign plans. Was there much discussion in the task force or at the board level about certain unique features that are typically found in foreign plans, and are there any special provisions, other than the lag in the effective dates, for these plans?

MR. MOSSO: There was not a lot of discussion, and we do not have a large body of information about foreign plans. There are no other provisions other than the lag in application, which was modeled after FASB Statement No. 87. I do not know about the unique features.

MR. FLATLEY: Did I hear you say that you had just issued pronouncements over what you do not know much about? Is that, in fact, the case?

MR. MOSSO: It was not done without discussion with the task force and others. I do not mean to say that we did it blindly. But if there is a problem, it will come out in the comment period and it will be resolved.

MR. FLATLEY: You can count on it.

Estimating Health Cost Inflation

MR. KILLEEN: I would like to return to medical care inflation. We have all agreed that this is the most difficult item to estimate. FASB

shows an awareness of this difficulty by wanting to build the sensitivity test into the footnote. But you are allowing a lot of latitude for employer judgment. It seems that there is a lot of room for the employer to arbitrarily determine the bottom line. Is the actuarial profession going to step in and develop more explicit guidelines so that employers have more specific rules under which to operate?

MR. MOSSO: I think, from the accounting point of view, it will be more a matter for the actuarial profession. They are the experts in that kind of estimation. We would expect that, as time goes on, the estimates will get better and the range will probably decrease. But even with pension estimates, the range is fairly wide.

MR. NELSON: The Actuarial Standards Board is preparing a draft of evaluation standards for these items.* It will not be prescriptive in the sense of saying "use 7 percent or 19 percent" but will be more concerned with considerations that should be taken into account in making reasonable or acceptable assumptions.

*Editor's note: This standard, *Recommendations for Measuring and Allocating Actuarial Present Values of Retiree Health Care and Death Benefits*, was released in October 1988.

PART THREE

THE RESPONSE OF EMPLOYERS AND UNIONS

Employers and unions have for some time been concerned with the escalating costs of active-worker and retiree health care benefits. The proposed new accounting standard of the Financial Accounting Standards Board (FASB) has added a new dimension to the issue. FASB's rule would require employers to carry the cost of these benefits as a liability on their balance sheets. Part Three reviews how employers are responding to these challenges.

In chapter VIII, Joseph W. Duva describes Allied-Signal, Inc.'s growing awareness of the need to stabilize its active worker and retiree health plan costs and liabilities. In 1987 it became evident that the cost management strategies that had proven successful in the early 1980s had ceased to be effective. It was decided that the company could no longer afford to continue as a passive payer of medical costs, and that a new initiative was needed. Duva describes Allied-Signal's plan of action: a managed health care program for active employees and better management of current and future retiree health care arrangements.

The approach taken by a company with a predominantly young work force will necessarily differ from that taken by a company with a large proportion of older workers, says Kevin B. Flatley of American Express in Chapter IX. With an average employee age of 33 and few retirees, it is relatively easy for American Express to deal with retiree medical benefit costs. Notwithstanding these current advantages, American Express is preparing for the time when it will need to attract more middle-aged workers. It began offering a long-term care plan to employees, retirees, and their families in 1988, and has become active in the area of elder care. To combat escalating health care costs, American Express is considering instituting service-related contributions, reducing spousal coverage, and advancing the retirement age.

Flatley believes that the provision of postemployment health care benefits is an important management tool, and cautions employers against cutting back too far in response to increasing costs or to FASB's accounting requirement. If the discrepancy between health

care coverage for active workers and that for retired workers is too great, people will delay retirement, he concludes.

In Chapter X, Patrick F. Killeen of the United Automobile Workers pictures employers and unions being as caught in a triple squeeze: economic restructuring, the FASB requirement, and limitations on tax-free prefunding due to the present tax code and federal budget deficits.

Killeen perceives a number of problems with the FASB rule. Many businesses do not have the cash to prefund, or desperately need this money for other purposes, he maintains. Furthermore, he contends that it is much more difficult to develop cost estimates of the liability for future health care benefits than it is to make comparable estimates for pensions.

Labor union members have been forewarned that "a crisis is coming," Killeen says, adding that union representatives have specific options and strategies under internal review.

In the discussion that follows the Part Three chapters, forum participants ask questions about specific aspects of Allied-Signal's new health care benefit plans. They debate the pros and cons of early retirement policies in terms of particular industries, question how much flexibility retirement plans should have, and discuss the use of "excess" pension assets to fund retiree health benefits. Exploring the nature of the benefit promise, they exchange opinions on whether it is the appropriate role of Congress or the courts to define employers' obligations.

VIII. Allied-Signal's Response to Rising Health Care Costs

REMARKS OF JOSEPH W. DUVA

Introduction

In 1987, we became aware that, because of the implications of the forthcoming Financial Accounting Standards Board (FASB) rule, we would have a problem with retiree medical costs and liabilities. After studying all the facts, we concluded that the major problem was health care costs; that the controls put in plans primarily for active employees in the early 1980s were no longer working; and that the retiree medical plans were not properly designed and needed to be changed in response to current business conditions and the implications of the proposed FASB rule.

Until the last few years, most companies paid little attention to the cost of continuing medical benefits after retirement. Companies began by offering postretirement medical coverage as a supplement to Medicare, then started to provide coverage to employees who retired before age 65 in order to make early retirement options more attractive. In addition, the early retiree rolls have grown substantially as a result of corporate restructuring and early retirement incentive plans.

I will review a case study of how Allied-Signal has planned to attack both problems. We decided we could not wait any longer to stabilize our active and retiree health plan costs and liabilities—we had to act immediately. As background for the discussion, table VIII.1 provides information about the structure of Allied Signal, Inc.

Inflation Projections

A comparison of Allied-Signal's overall health care cost with the consumer price index (CPI) shows that our costs for medical care increased approximately 28 percent in 1981 and approximately 15 percent in 1982 (chart VIII.1).

Allied-Signal was one of the first companies to take action to slow the significant medical care cost increases. These changes first became evident in 1984 when, for the first time, our health care cost

TABLE VIII.1
Allied-Signal, Inc.

	1986	1987
Sales	\$9.9 billion	\$12 billion
Employees	137,000	114,300
Retirees		50,000
Major Businesses (Sales, in billions)		
Aerospace		\$5
Automotive (auto parts)		4
Engineered materials (chemicals)		3

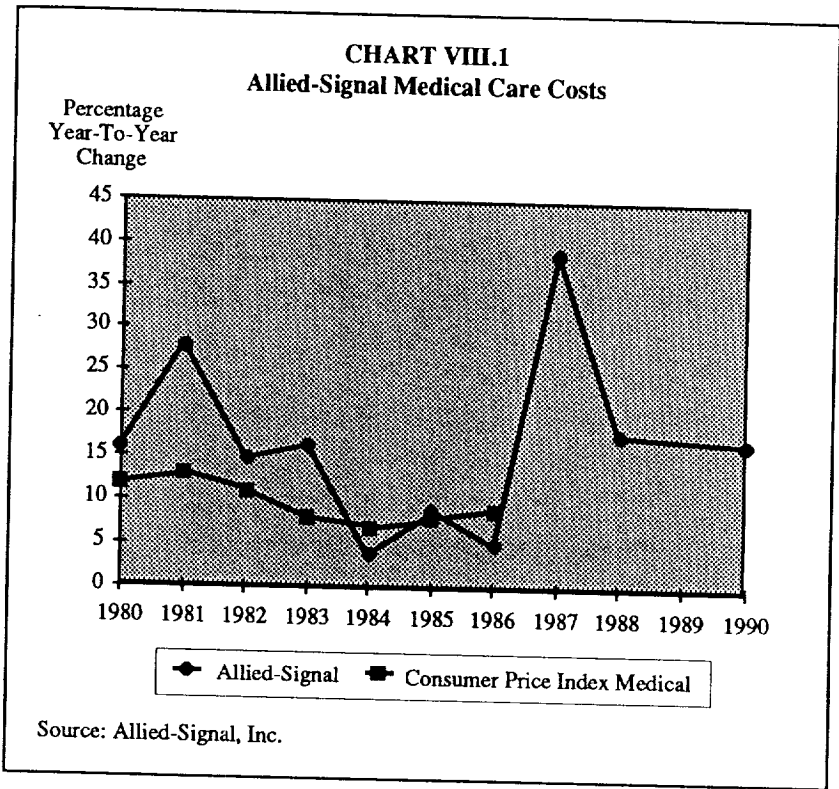
Source: Allied-Signal, Inc.

increase of 3 percent was less than the 6.1 percent CPI medical care increase.

Since 1984, our medical care cost increases have been either at the CPI level for medical care or below, indicating that the actions taken were successful in controlling Allied-Signal's health care costs for that period.

Allied-Signal's stabilization of health care costs ran out of steam in 1987, when an increase of 39 percent occurred. Chart VIII.1 includes an estimated trend increase of 18 percent for 1988 and 17 percent for 1989 and 1990. These trends were estimated in 1987. Currently, many carriers are using trends as high as 22 percent to 25 percent. Our projections for 1988, 1989, and 1990 assume no changes in our health care plans.

To gain a better understanding of the individual business impact, we projected health care increases by sectors (table VIII.2). This table shows the 1987 health care costs by sector and projects the costs for 1988, 1989, and 1990, using the health care cost trend factors mentioned earlier. If we made no changes in the current health care plans, health care costs in the aerospace sector would increase from \$204 million in 1987 to \$316 million in 1990; in the automotive sector, from \$58 million in 1987 to \$98 million in 1990; in the engineered materials sector, from \$44 million in 1987 to \$74 million in 1990; and in the corporate and technology sector from \$27 million to \$43 million in 1990. Our overall health care costs would increase from \$355 million in 1987 to \$564 million in 1990. If we used a trend factor of 20 percent for the next three years, our health care costs in 1990 would be \$614 million.



I believe the battle to control health care costs will be even more difficult after 1990. We are now facing health care cost escalation higher than that which occurred during the early 1980s in spite of the actions taken since 1983 to control cost increases. In effect, actions taken by Allied-Signal and other companies worked for a short period. However, the providers of medical care have adjusted to the changes, and another round of significant health care escalation is upon us. We will not only have to deal with the issues of the early 1980s but with newer ones as well. Some of the problems of the early 1980s that we are familiar with are inflation, utilization, and cost shifting.

Escalating Costs—Health care costs continue to rise despite changes in the delivery system and cost-cutting measures. For more than 20 years, the rate of inflation in health care has been substantially higher than the overall CPI. The medical care component of the CPI increased at an average annual rate of between 7 percent and 8 percent in 1986

TABLE VIII.2
Actual and Projected Health Care Costs,
Active and Retired Employees, by Industry^a
(dollars in millions)

Industry	Year			
	1987	1988 ^b	1989 ^b	1990 ^b
Aerospace	\$204	\$231	\$270	\$316
Automotive	58	72	84	98
Engineered Materials	44	54	63	74
Corporate and Technology	27	31	36	43
Closed, Divested Unit Retirees	21	24	29	33
Total	\$355	\$412	\$482	\$564

Source: Allied-Signal, Inc.

^aIf present plans were continued.

^bProjected.

and 1987. This increase is higher than the 6.2 percent increase for 1985 and, again, is approaching the medical care inflation rate of the early 1980s.

New technology in health care is a cost escalator rather than a means of reducing cost. Each new piece of equipment pushes the cost of health care units higher as "quality" gets better. Also, the health care system is overbuilt. There are too many hospital beds, doctors, nurses, etc.

We are currently operating at a collective capacity rate of about 60 percent. The cost of that overcapacity is higher unit costs. Lastly, and unfortunately, the cost of malpractice insurance, which is passed along to the consumer, seems to have no ceiling.

Utilization—One way to control health care costs is to control the number of units used. Health care is used for many reasons. Unfortunately, many are inappropriate. The demand is driven by the industry. A hospital with low occupancy has an incentive to stimulate revenue. A physician worried about malpractice will overtreat. A hospital worried about the millions spent on a new CAT scanner will use the machine on as many patients as possible. Finally, and unavoidably, we are an aging population, and we will use more services as we grow old.

Cost Shifting—Cost shifting has been a problem for years. The government shifts costs to employers by mandating a prescribed level of benefits, by requiring employers to offer programs, and by reducing Medicare payments. In some states, employers pay a substantial amount for care used by those who have no insurance. Cost shifting will continue in the years ahead as both federal and state governments try to pass on to employers increasing responsibility for health care costs.

These three areas have been, and continue to be, very important in controlling overall health care costs.

New Challenges

There are new, and even more difficult, issues impacting on health care costs that provide a formidable challenge to U.S. employers. Companies that meet the challenge to better control these health costs for the future will have a competitive advantage. The challenges that face Allied-Signal include the following:

- The company has 50,000 retirees.
- The 1987 cost for retiree health benefits was approximately \$66 million and, although one-third of the company's retirees are under age 65, they incur two-thirds of the cost.
- The plans were poorly designed (they were not based on service).
- Health care costs for retirees under age 65 are four times higher than those for active workers.
- The implications of the forthcoming FASB standard need to be addressed.

HMO Financing—Another factor that affects a corporation's health care costs is the use of health maintenance organizations (HMOs).

The existence of HMOs and the way they are financially managed within a company can no longer be ignored. Because of their number and size and the type of risk they involve, they are an important factor in our overall health care costs, and we need to know their impact on our purchasing power and leverage. Our studies indicated that the methods we were following (based on our interpretation of the federal HMO law) resulted in Allied-Signal overpaying HMOs for the risk they were assuming. Basically, they were attracting younger and healthier employees, and our indemnity plans were left with older employees who incurred more and larger claims.

Special Medical Conditions—Conditions such as mental and nervous disorders, substance abuse, and acquired immune deficiency syndrome (AIDS) are another source of significant cost. In addition, employers are seeking ways to control the staggering costs of psychiatric care. Their approaches range from severely restricting benefits to adopting managed care programs. Our information indicates that major companies pay as much as 15 percent to 20 percent of their overall claims for these special medical conditions. Included in this group are claims for alcoholism, substance abuse, and other claims that should be in this category but are not because—to protect the employee—the physician's diagnosis does not properly reflect his or her condition. Until lately, companies have not been aggressive in attempting to control these costs because of the sensitive nature of the claims and the lack of good data. However, many companies have determined that they cannot wait any longer.

There is agreement between both public- and private-sector experts that drug abuse may be the most common health hazard in the American workplace today.

Another frightening and costly area is the AIDS epidemic. An AIDS patient is expected to incur an average of between \$100,000 and \$120,000 in medical bills between the time he or she is diagnosed with the illness and his or her death, which usually comes within two years of diagnosis. When disability and group life insurance benefits are added, corporate costs for employees with AIDS soar even higher. As a result of the cost of caring for employees with AIDS, alternative forms of health care must be considered to hold down the treatment costs.

Allied-Signal's Action Plan for Health Care

In summary, Allied-Signal decided to change health care programs and the manner in which they are provided for the following reasons.

- As a company, we cannot afford the kinds of health care cost increases that we would be facing over the next three years.
- Prior cost containment efforts worked for the short term, but are not the answer to longer-term problems and issues.
- Cost shifting to traditional indemnity plans is increasing.
- Health care plans with managed care features are experiencing lower increases—in many cases, one-half of the increase of indemnity plans.
- Attractive opportunities currently exist to stabilize costs over the short term.

- Companies that take decisive action on health care costs will be ahead of their competition.
- Health care must be managed like a business because of its significant expense and the impact on the bottom line.

We decided that we could no longer continue to provide medical benefits, as we had in the past, as a passive payer of the cost. This decision was based on the conclusion that the approaches of the early 1980s—such as increasing deductibles and employee contributions, requiring a second opinion for surgery, and precertification programs—work for a short period of time but are not the long-term solution. Therefore, we developed a health care strategy that would: emphasize changes for active employees, on the assumption that what is done today for these employees will produce savings tomorrow for retirees; try to reduce cost of retiree medical coverage immediately; limit costs by encouraging use of alternative delivery systems; share costs with employees and retirees through deductibles, coinsurance, and premium sharing; and include the design and implementation of a retiree medical plan for workers retiring after January 1, 1989.

Managed Care Program for Current Employees—For current employees we introduced a managed care program. The new Health Care Connection program uses the existing CIGNA health plan networks throughout the United States. At present, there are 30 health care networks available to Allied-Signal. They do not cover all our locations. Accordingly, we have developed a phased-in approach for implementing the program. As of March 1, 1988, 37,000 Allied-Signal employees became eligible for the plan, or 67 percent of those ultimately eligible. Initially, the CIGNA network covers employees in southern California; Arizona; northern New Jersey; the Baltimore-Washington, DC, area; Kansas City, Mo.; Ft. Lauderdale, Fla.; Chicago; and Baton Rouge, La. As of January 1, 1989, 16,000 additional employees will become eligible, resulting in a total of 53,000 employees covered under the managed care program, out of 60,000 employees who ultimately will become eligible.

With the addition of dependents as of January 1, 1989, we will be covering 120,000 people. It is our objective to have a health care network available to all eligible employees over the next three to four years.

Under the Health Care Connection, an employee has the option at the point of medical service to opt out of the managed care program by selecting a non-network provider. He or she would then be covered for benefits under the revised indemnity plan, which has a higher

TABLE VIII.3
Allied-Signal's Health Care Connection

	Network Benefits	Indemnity Benefits
Deductible	None	1 percent of salary (family, 3 percent)
Coinsurance	None	80 percent
Out-of-Pocket Maximum	None	4 percent of salary (family, 12 percent)
Hospitalization	In full	80 percent after deductible
Surgery	In full	80 percent after deductible
Lab, X-Ray	In full	80 percent after deductible
Nursing Care	In full	80 percent after deductible
Prescription Drugs	\$5 copayment	80 percent after deductible
Office Visits	\$10 copayment	80 percent after deductible
Preventive Well-baby care	In full	Not covered
Emergency Room (appropriate use)	n/a	\$25 Copayment
Restrictions	Must access via primary care physician	Preadmission certification/ concurrent stay review, mandatory second opinion

Source: Allied-Signal, Inc.

deductible and is more expensive than the managed care program. The program has been designed to encourage employees to use the managed care network.

In addition, our businesses revised the indemnity plan benefit levels in areas where networks were not presently available until they become available.

Table VIII.3 shows how the Health Care Connection is structured. When the network is available at a location, all eligible employees select a network primary care physician. At the point of medical service, the employee or dependent can elect to go outside the network and be covered under the indemnity plan. The plan is designed so that when an employee goes out of the network, it costs him or her

TABLE VIII.4
Allied-Signal's Action Plan for Retiree Health Care Benefits

Retiree Changes 1/1/89 (deferred from 7/1/88)
Increase contributions—retiree 10 percent and dependent 15 percent
Preadmission certification
Increase prescription drug deductible from \$3 to \$5
Deferred to Later Date (1/1/90 or 7/1/90)
Medicare carve-out
Extend Health Care Connection plan to existing retirees under age 65
Future Retirees (1/1/90 or 7/1/90)
Defined dollar plan
<ul style="list-style-type: none"> ● limit buildup of retiree medical liabilities ● reduce charge to earnings
Plan to be developed by 7/1/89

Source: Allied-Signal, Inc.

more. The Health Care Connection has one overall financial arrangement with CIGNA for three years.

Retiree Medical Plan—Table VIII.4 shows our action plan to better manage the retiree medical plans now and in the future. As I mentioned earlier, in 1987 and 1988 employers for the first time looked seriously at retiree medical program design and financing and determined exactly what they should be doing in the future. We believe the actions that Allied-Signal is taking will permit us to provide this important protection to our retirees on a better-managed and cost-effective basis.

Conclusion

Allied-Signal is seeking an innovative solution with the adoption of its Health Care Connection program, which has a managed health care option added to a revised indemnity plan for its active employees. This new program provides us with an opportunity to stabilize our health costs for the short term (three years) and a better long-term opportunity than if we had not taken this aggressive action. We concluded that aggressive action is required in an attempt to find a more cost-effective approach to provide employees and dependents with quality care at a more affordable cost to the company and its employees.

With regard to retiree medical benefits, we believe the program we have adopted will manage these benefits more effectively for the future and provide Allied-Signal with plans that are affordable for both the company and retirees, while preserving valuable protection.

IX. Health Care Benefits for a Changing Work Force

REMARKS OF KEVIN P. FLATLEY

Introduction

I think that American Express is unique in some ways and this uniqueness makes me somewhat of a contrarian with regard to some of the things that I have heard at this forum.

During the last few years, American Express has been committed to a decentralized philosophy of management. We have four main operating subsidiaries: our travel-related services business, which is our card, check, and travel division; Shearson, Lehman, Hutton, our brokerage and investment banking operation; IDS, which deals with financial planning and investments; and American Express Bank, which is principally located outside the United States and is involved in international banking.

As a result of these separate operating subsidiaries and decentralized philosophy, we have different benefit plans in each of these operations. They are in different industries, even though they are under a general umbrella of financial and travel services, and they have different work forces. We have found over time that to develop an American Express position in benefit matters is a challenge because each of these industries needs a different approach.

We are a young company, notwithstanding the fact that we are over 100 years old. The average age of our employees is about 33. That varies a little, but in no event is it over age 40. The average length of service is less than five years. We have 95,000 employees around the world, the majority of whom are in the United States, and we have less than 3,000 retirees. This small number of retirees makes dealing with retiree medical benefits easier for us than it is for companies like Bethlehem Steel.

Our turnover tends to be a bit higher than average. In some of our operations, particularly back office operations, nonexempt turnover can be as high as 40 percent to 50 percent per year. One of the things that differentiates American Express from our competition is that we deliver a quality level of services. We are fanatics about delivering that quality, so we are very concerned with the effect that benefit

changes, and particularly benefit cutbacks, might have on our ability to attract and keep the kind of workers we need.

What we do now in regard to retiree funding is probably not different from what everyone else does. Generally, we cover retirees as active employees until they reach age 65. We have a mix of Medicare supplement and carve-out coordination.

Currently, given the Financial Accounting Standards Board's (FASB) initiative on retiree medical benefits, we do fully accrue the benefit to age 55, which is our early retirement date. Employees earn the right to the benefit at that age, with varying levels of service. We fund the benefit on a pay-as-you-go basis, although last year we established a voluntary employee beneficiary association to handle run-off claims for the prior year. So we have some form of prefunding infrastructure in place, although we are not now taking advantage of it.

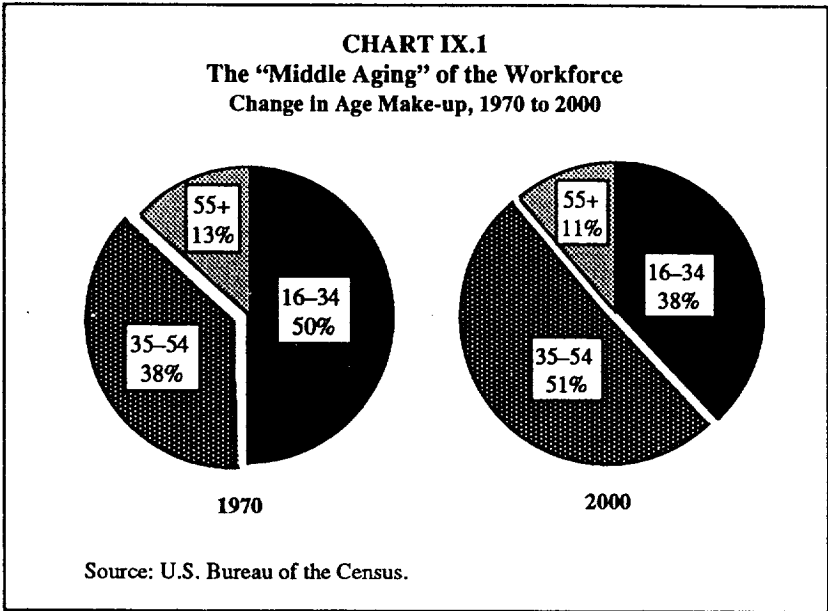
We have been concerned about the impact of the new FASB standard. According to our most recent statistics, which are based on 1988 data, our annual expense for the retiree medical portion of our benefits will be about \$40 million. This compares with about \$6 million for the portion paid on a pay-as-you-go basis and about \$100 million for the portion covering active employees.

Our projected liability for our current work force is just over \$300 million. Our accrued liability—the obligation we expect FASB will require us to report—amounts to \$152 million. We have never believed that they would allow accrual all the way to the expected retirement date; that is why we retained our earliest possible retirement date.

One thing that makes us a bit contrarian is that the projected \$306 million liability represents about one-quarter of American Express' net earnings, and the annual expense represents about seven working days' worth of net income for the company.

We told this to management and they said, "And then what?" The point is that when you have the luxury of having the kind of work force that we have, retiree medical benefits are not the problem that they might be in other kinds of industries. A much bigger concern to our management is the overall cost of health care.

We are more concerned with getting the right kind of people to work for us. One major strategic issue that we keep facing is the so-called "middle aging" of the work force. We have counted on an ever-increasing, ever-available source of youthful labor to operate our business. This has been possible because one-half of the work force is



under age 34. As we look to the future, that is going to flip, and one-half of the work force will be middle aged (chart IX.I).

Nontraditional Policies: Long-Term Care and Elder Care

We will need to attract and keep middle-aged people in the years ahead. We are trying to direct the focus of our benefits into somewhat nontraditional areas. For example, in addition to our typical benefit plans, we have become active in the field of long-term care. In 1988, we became one of the first companies to provide a long-term care plan for employees, retirees, and their families. The plan is currently fully paid by the employees, and we have had a phenomenal enrollment. The people in the travel-related service business became the prime movers behind the project when they learned that an enormous number of employees were caught between caring for young children and caring for aging parents.

It is interesting that, with a work force as young as ours, almost 8 percent of our employees signed up for long-term care for themselves.

We clearly struck a chord. And if this particular kind of coverage were not so expensive, we think even more would have signed up.

Another somewhat nontraditional area that we are involved in is elder care, which we consider an essential element of retiree or aging health care. We are trying to direct attention from catastrophic illness to chronic health problems. We have supported a number of initiatives in the New York City and New York state area, working with city and state government and other private employers to provide education, referral, and other resources to acquaint people with elder care providers. The American Express Foundation has provided seed money to various organizations around the country that are active in this area.

Concerning health benefit plans, the changes we expect to make will vary by unit. Because of our different work forces, some units will be more active than others. The two most popular approaches that we are considering are service-related contributions and a reduction in spousal coverage.

We are concerned with the backward nature of retiree medical benefits, which results in employees with shorter service receiving higher benefits than those with longer service. We considered providing a service-related benefit but were not able to determine how to structure it, so we may end up with a service-related contribution instead. We think that over the long term there will be a way to address this problem.

We are considering a defined contribution approach, which has the advantage of helping to redefine some costs; service-related benefits; and an increase in retirement age.

The New Accounting Standard

In talking to American Express management and others, I have become aware that there is a danger that the benefits industry will respond in a knee-jerk way to the FASB requirement for increased current provision for retiree medical benefits. Such a response could lead to the question, "Why do we have this kind of program at all?" There is a danger that we will go a bit too far in this direction. This leads me to the somewhat heretical notion that postemployment medical benefits are good for you.

The cost of the retiree health benefits program that was promised to employees will not change because FASB requires it to be recognized on the balance sheet. If an employer considered it affordable when the commitment was made, I do not know why it would be

unaffordable now. The costs themselves have not changed. Some people have argued that the FASB rule would actually reduce the cost, because it would require some advance funding. I guess that it is a question of whether you think you can make more money investing inside or outside your business. We happen to think we can probably do pretty well if we keep it inhouse.

As employers consider the effect of the FASB rule, I think they must ask themselves why they are providing postemployment medical benefits. If they think it is a good thing to do, then I think they have to be careful not to cut back too far. It is helpful to me to imagine what would happen if it was not provided: no one would retire because they could not afford to. Presumably employers will continue to provide health care benefits to active employees. If there is a great discrepancy between the coverage for active and retired workers, people will not retire.

Attracting Older Workers

I think that there will be no older worker mobility. At American Express we will need to hire people in the older age group and to recycle retirees back into our work force. However, people are not going to work for you if it means that they forfeit postemployment coverage from another employer and you do not provide adequate coverage.

The point is that there is a place for postemployment health benefits. They are an important management tool. I think we need to guard against short-term thinking with regard to current expense.

Having said that and admitting to being a contrarian, I freely admit that the nature of our work force at American Express gives us the ability to think in these terms. I am not sure that, were I representing some other employer, I would have similar thoughts on this issue.

I would like to sound a note of caution for employers: As you cut back more and more, you may be raising a political issue that will exacerbate the problem of the 37 million Americans who are uncovered. And as business abrogates what is being seen as its responsibility to provide health care coverage to active workers and retirees, there is a risk that these benefits will become less voluntary and flexible.

X. The Retiree Health Benefits Quandary

PAPER BY PATRICK F. KILLEEN

Introduction

Labor unions began bargaining for retiree health care benefits in the late 1950s and early 1960s, when health care costs were relatively low by today's standards. Furthermore, it was quite clear at that time that the anticipated advent of Medicare would largely solve the problem of retiree health care protection.

What Has Happened?

What has happened? There are several factors. Medical care costs have soared as a result of price increases, marketplace failure, inappropriate utilization, proliferation of advanced technology, and for a number of other reasons. Moreover, for over 20 years we experienced a steady erosion of Medicare protection that is only now somewhat offset by the enactment of Medicare catastrophic coverage. In addition, there has been a notable increase in the ratio of retired employees to active employees as a result of the trend toward early retirement; the overall maturing of the population; and the restructuring of certain industries, particularly in the manufacturing sector. With the drastic decline of jobs in industries such as steel, auto manufacturing, and agricultural implements—caused to a considerable extent by Reagan-Bush trade policies—we have had to look for places to put people, and one place was into retirement.

All United Automobile Workers (UAW) benefits and other compensation are costed on a cents-per-hour worked basis. Greater retiree health insurance costs are spread over fewer workers and fewer hours worked, thereby resulting in increased labor costs.

More recently, the Financial Accounting Standards Board (FASB) intends to require businesses to show as a liability on the balance sheet the present value of the future cost of lifetime retiree health coverage.

Finally, the courts, pursuant to litigation brought by UAW and others, have tended to determine that health care benefits for retirees represent a lifetime promise by employers, unless there is substantial, specific evidence to the contrary. The lifetime promise, and the pres-

ent value of its projected costs, have been a major factor in a growing number of bankruptcy settlements.

The question of the lifetime promise also has arisen as a result of some corporate takeovers and plant sales. The new owners often do not feel a sense of loyalty to newly acquired employees. Also, new owners may not have been aware of the promise and the liability at the time of purchase.

Where Are We Now?

The costs of retiree health care protection in collective bargaining have risen exponentially as a result of the foregoing factors. These costs are not faced by foreign competitors in many industries such as steel, auto, and farm implements. Employers cannot terminate or materially reduce the coverage due to legal, moral, and/or collective bargaining constraints.

FASB is going to require that the present value of the lifetime cost of such benefits be carried as a liability on the balance sheet. To offset the balance sheet liability, some are proposing prefunding to create a corresponding asset. There are at least four problems with this.

- Many businesses simply do not have the cash to prefund or desperately need it for other business purposes.
- Employers who consider prefunding may want to count the cost against current collective bargaining settlements, this despite the fact that the promise and obligation were made under earlier collective bargaining settlements and workers traded off other economic objectives at that time.
- Inadequate mechanisms exist under current tax law to allow for adequate funding with pretax dollars. Prefunding is not recognized by the tax code as a legitimate business expense.
- It is far more difficult to develop cost estimates of the liability for future health care benefits than it is for pensions. Projecting medical care inflation and the extent of Medicare coverage 50 or 70 years into the future is tricky business. The UAW Social Security department actuaries have been developing such estimates since the White Motor bankruptcy in 1982, and we are all too aware of the uncertainties involved. Therefore, how do you know how much to prefund?

Legislation has been proposed to require prefunding and to make appropriate tax code vehicles available. There are two main problems with this.

- Congress will be very reluctant to make changes that will result in a reduction in federal revenues. This is another legacy of the Reagan-Bush tax cut of 1981.
- Those who propose mandatory prefunding typically talk about phasing it in over time in order to mitigate the financial consequences of compliance for employers with large liabilities. They point out, quite appropriately, that in the long run, the costs of pay-as-you-go and prefunding are exactly the same, which is mathematically correct. They say the problem is merely one of transition. The trouble is that many of the companies and industries with the greatest liabilities are also struggling with several other transitions at the same time: restructuring and downsizing of the work force; growing retiree-to-active-worker ratios; loss of market share to foreign competitors that do not have a retiree health cost problem; new pension funding standards under the Employee Retirement Income Security Act of 1974; increased Pension Benefit Guaranty Corporation premiums; and new pension accounting rules.

How many such transitions can these businesses and their employees survive at one time?

In short, employers and unions are caught in a triple squeeze: economic restructuring, the FASB requirement, and limitations on prefunding due to present tax code and federal budget deficits.

I recently participated in the production of an AFL-CIO educational video on these issues. Dramatizations, formal presentations, and panel discussions presented the problems clearly but offered no specific solutions. Frankly, neither the AFL-CIO nor any of its major affiliate unions have officially adopted a formal policy on these issues. We wanted to avoid making policy by video, but we had to alert labor union people around the country that a crisis is brewing. The name of the program is "Danger Ahead."

Where Do We Go?

Where do we go? I have written two endings to this paper. The first is to say that anyone who is familiar with UAW knows that we must have several specific options and strategies under internal review and under quiet discussion with other unions and that we are just awaiting the right moment to announce our definitive and comprehensive response.

The other ending is to suggest that an acceptable solution can only be found in some social insurance type of approach: expansion of Medicare, national health insurance, and/or socialization of the risk for lifetime health insurance, so that this liability effectively is recognized on a pay-as-you-go basis only. Is that sufficiently vague?

Possible approaches currently are being discussed in some business and labor circles in a very tentative way.

It would be ironic if the next major step toward universal health insurance protection were to owe much of its impetus to the staid Financial Accounting Standards Board.

XI. Part Three Discussion

Allied Signal's Innovations

MR. GARRETT: Mr. Duva, you spoke of bringing the retiree contributions up to 10 percent, and commented that that obviously was an increase for some. I wonder if that would be the first time some people had to contribute. Either way, were your plan documents ambiguous or unambiguous on that point, or are you waiting for the first lawsuit?

MR. DUVA: Our attorneys reviewed all the language in the documents that employees were given—both the plan and booklets—and they told us to proceed.

MR. GARRETT: Did you make some contributions for the first time on retirees?

MR. DUVA: I think in almost all cases the payments were already in. There may have been an isolated case where it was not.

MR. MARINACCI: You mentioned that several companies have already done major surgery on their retiree health care plans. I was aware of the Pillsbury Company. What other companies have gone beyond the study stage and are actually doing it?

MR. DUVA: I have problems with "major surgery." I think when you manage a business, you have to take changing times and situations into consideration. I do not think what has been done in terms of defined dollars is major surgery. Some companies are setting their contribution at the current level of health care costs, so that anyone retiring in the near future has monies for health care coverage. Companies are projecting the future cost of these programs and are concluding that retirees should share more of the cost. To me this is a good business approach in handling a needed benefit whose costs will be considerable in the future. TRW is one company now using the defined dollar approach for retiree medical.

MR. PAUL: CMD Corporation put in a dollar-per-year-of-service medical savings account allowance for future retirees, effective about 15 months ago. It was described in *Investor* magazine recently.

MR. DUVA: We are trying to preserve health care coverage for our retirees. I think we have to find a way to do it. I do not think anyone is considering eliminating it. We are merely trying to provide these benefits on a more affordable basis.

MR. FERRUGGIA: The defined dollar concept that Mr. Duva mentioned obviously gives an employer a lot more control, in terms of being able to predict costs accurately, by removing the inflation component. And obviously, by removing the inflation component, we are talking about taking a major ax to the liability. I do not think anyone is naive enough to believe that there will not be regular ad hoc increases needed in these dollar amounts. How do you feel that these increases might be reflected in terms of accounting practices?

MR. DUVA: I have a problem with that. I share the view that the problem we have is one of health care costs. Unless we attempt to control that, it all becomes academic. My feeling is that we have to provide cost-effective plans for retirees. We have to change the way we provide benefit programs to a more cost-effective way.

Concerning ad hoc increases, when you start a plan you would like to know what your liability is, so that it does not escalate before you even start the program. Then it is up to you to make a determination of whether you want to make an increase or not.

MR. FERRUGGIA: But if you do not make regular ad hoc increases, you effectively eliminate the program, unless you control inflation.

MR. DUVA: We face the same problem in our plan for active employees. They said, "Why don't you just increase our contributions and not make a change to managed care?" We replied, "If we constantly passed on to you the 39 percent or 40 percent increases, you will be very unhappy. . . ." So we went to what we believe is a more cost-effective program. I think the jury is still out on whether managed care is cost effective in the long term.

MR. FLATLEY: If the question is whether the accountant is going to force you to recognize ad hoc increases in advance, so that you end up in the same place or nearly the same place, I suggest that you look at the pension model, which has a longer track record. Observe the difference between career average and final average pay plans. The pension model works fairly well, and I have not heard anyone suggest in a career average plan any absence of actual approved updates in the past service base requiring advance recognition of the fact that you might have them. So I think it is highly unlikely, at least in the short run, that the accounting field would require advance recognition of future possible ad hoc increases.

MR. MIKKELSEN: Mr. Duva, I think most of us regard you as a very creative pioneer. Unfortunately, pioneers have a tendency to wind up

with arrows in their backs. Has there been any employee relations fallout?

MR. DUVA: I think that any time you are an innovator or you start something on a nationwide basis, especially in health care, there is fallout. In our situation, the program has operated for seven months, and the problems we have center on claims and administration. It took us a couple of months to overcome an initial employee perception that if you go to a network you are not going to get quality care.

We have many problems in the United States that result from the belief that the more you pay, the better the quality is. We are finding that as you move through the program, in five, six, or seven months you learn that no one can judge quality. Employees who are using the network are finding that their medical services are just as good as they were before in terms of quality.

I would say that companies can learn a lot from our experience, but none of the things that we have encountered to date have been unmanageable.

We felt when we designed the indemnity plan that we would give participants an incentive to use the managed care networks because of the 1 percent of pay and 3 percent of pay deductibles. But many companies are now making these kinds of changes to their indemnity plans without a network because of the significant rate increases in health care costs. With our indemnity plan, the only people that the deductible increases affects are the higher paid people, because we had in our prior plans a 1 percent deductible for up to \$50,000 and we removed the cap so now the 1 percent deductible is on all base compensation.

I think the results are very interesting: after seven months, over 74 percent of our employees are using the network 95 percent to 100 percent. In some locations, we have network usage of over 90 percent.

I think that is very interesting considering the importance that Americans assign to their relationship with their physicians. The most fortunate people in the program were those whose doctors were also in the network.

MR. ENTHOVEN: Mr. Duva, I either read or heard that CIGNA was not planning to undertake any other arrangements similar to the one you described. Do you have any comment on that?

MR. DUVA: We met with the CIGNA people recently and I think they have had trouble digesting 120,000 people in a very short time—March 1988 through January 1989. There are a lot of administrative requirements. CIGNA has assured us that they are interested in of-

fering products similar to ours in each of the areas in which we have our employees in their networks.

I can say this, every one of CIGNA's networks is better today than it was before we became a part of it.

Universal Health Insurance

MR. ENTHOVEN: Mr. Killeen, you ended by saying that perhaps FASB will provide the impetus for universal publicly financed health insurance. I think this is a two-edged sword. In our democracy, incrementalism is one of the first laws of behavior, and it is a means that public policies use to avoid creating large windfalls, gains, or losses for any parties as they go into effect. I think that one of the problems related to universal health insurance is that it would require the taxpayers to relieve the automobile companies of tens of millions of dollars of liabilities unless there were some transition rule.

MR. KILLEEN: The social insurance approach that I talked about does not necessarily have to be the type of program that we considered 20 years ago—a completely tax-supported, government-administered program. There are different concepts now, such as the Massachusetts initiative.* There might be some type of mechanism that would enable the retirees of a bankrupt company to move automatically into some kind of pool. And perhaps FASB would not require that liability to be shown on the books. I cannot tell FASB what to require and what not to require. They make the rules, but that is the type of mechanism that some people are considering.

MR. MOSER: How do companies that are considering a defined dollar contribution plan present the issue? Their retirement planning was supposed to provide employees a level of income that would sustain a standard of living comparable to what they had before retiring. If employers cap the dollar spent under the medical plan, won't retirees ask for an increase in their pension benefit to offset what they are losing in medical benefits? How is that going to turn out? It seems to me that you are trading one kind of dollar for another, or you are lowering the standards for what people will have in retirement.

* Editor's note: On April 21, 1988 Gov. Michael Dukakis signed a universal health care bill for the state of Massachusetts that would expand health coverage to the uninsured population, primarily by requiring employers to cover their employees.

MR. DUVA: What I have seen so far in companies that are either changing to defined dollar contribution plans or considering them is that they are grandfathering certain groups of employees. In other words, they are redefining their promise for the future, but for certain groups of people to whom they feel they have made a commitment, they are grandfathering the benefits.

MR. MOSER: In effect, are you saying that the percentage of final income that you are going to provide to future retirees is going to be less?

MR. DUVA: No, however, the coverage will be provided in a different way or method for a portion of new retirees.

MR. MOSER: Through a medical plan adjustment you have altered your pension plan considerably, too.

MR. DUVA: You could broaden this and say that every time we paid for an increase in health care, we should recognize that as part of the total retirement income, too. It is a total employee benefit package. You can make the case that you are making, but I think a broader case could be made.

MR. FLATLEY: We are doing some modeling to study potential future changes requiring a percentage of postretirement net income to be contributed toward medical care as a way of a cost sharing. We are looking at various levels, from 13 percent to 15 percent of postretirement income, as a retiree contribution. This would allow for various income-related levels but would preserve a constant standard of living that could be predefined. It does not totally answer the problem, because the amount would still be frozen at retirement.

MR. DUVA: Obviously, you must work on making the health care plans more cost effective.

MR. MOSER: My point is that I hope that that kind of response or solution does not diminish industry's attention to what the real problem is.

MR. DUVA: I agree, and I think that the first responses that I have seen do not address that problem. They merely provide one program, an indemnity program, which in effect will increase the amount of money a retiree needs to buy insurance, because the actual health care costs have not been contained. I think we must come up with more cost-effective options for retirees to solve the problem.

MS. YOUNG: I am curious about how the Allied-Signal program works for your active workers, not just your retirees. What happens to workers who have an ongoing illness, such as cancer, that requires treatment for a long time? Do they have to change their doctors in midstream, or do you have special provisions for them?

MR. DUVA: We have special transition situations. Each one is handled individually, so that would not happen. Fortunately for us, the carrier that was selected was also the incumbent carrier for most of our employees, so the transition was a lot easier. In some cases where employees and/or dependents had serious illnesses they were permitted to continue with their physicians until they adequately recovered. We had hardly any transition problems.

MR. WELLER: Mr. Duva, could you define more specifically what you mean by "managed care network," for example, at one of your sites? What percentage of the hospital do you include? What percentage of the physicians?

MR. DUVA: We need to define managed care. It is operated by doctors or hospitals? Is it an individual practice association or a staff model? Is the financial model a discount fee-for-service or capitation? The variations are unbelievable. After working through this for two years, you get a feeling of what the best financial arrangement is in the long-term.

What we bought was CIGNA's health plan network, and they had the doctors and hospitals under contract or other arrangements. Every network that we had in the first wave was one that already existed with CIGNA, except in northern New Jersey, where a new network was set up for our corporate office.

MR. WELLER: How big is the panel?

MR. DUVA: It is quite large now. It includes over 350 primary care physicians and more than 500 specialties.

MR. WELLER: What percentage of the hospitals and doctors in northern New Jersey were included in the managed care plan?

MR. DUVA: I do not have those numbers, but we started off not having the right number of doctors and the right hospitals in the right geographical locations, in the opinion of our employees. That is no longer the case. We have heard from a number of doctors who would not join the network in the beginning but have indicated that when it hurts them enough financially not to be in the network, they will reconsider. More and more doctors are now writing and calling

us, wanting to be network physicians. Others have indicated that as more companies follow our example, they will have to reevaluate their position. So it is really a question of money, leverage, and time.

We have found that when a primary care physician makes enough money on a capitated basis, he or she is very anxious to work in the program. When only a few people have selected him or her, and there is not enough money coming in, there will be less interest.

MR. PETERTIL: I was glad to hear a number of people say that the defined dollar plan will work only in conjunction with strong managed care. The modeling we have done showed that even a defined dollar plan would have some ad hoc increases in the future which would result in cost shifting to employees and mean that a substantial number of retirees would devote all of their pension money to contributions for health care.

Mr. Duva, you mentioned that your company was deferring the carve-out in a number of plans and you made the point that efficient short-term cost savings can be realized by moving to a carve-out from coordination of benefits. Is your deferral related to the legal questions that were mentioned earlier?

MR. DUVA: Yes. About 80 percent or 85 percent of our retirees are in plans with carve-outs now, and we saw that as not an important issue at the moment. But we agree that this is the proper plan design.

MR. PETERTIL: Then you are not too concerned about the legal question of having gotten somebody into a plan administered that way?

MR. DUVA: I think we may have some concern about that and that is why we deferred it.

Section 89

MR. MCMAHON: Mr. Killeen, a number of your members have very good salaries and medical care. When section 89 goes into effect and some of the retirees' benefits are taxed, what will the American Federation of Labor's (AFL) position be?

MR. KILLEEN: I cannot speak for the whole AFL. I only represent the United Automobile Workers. And we are still, like everyone else, trying to sort out exactly what section 89 means. I suggest that that is probably one area in which labor and management may work together for the first time to get an exemption. Perhaps, working together, we can beat this. I do not think that we want to throw the

baby out with the bathwater in the matter of antidiscrimination, but section 89 certainly needs to be altered. I am not sure that most of our members, or many of our members, are in such high income brackets that they are going to be affected by it. We do not have it all sorted out yet because of the complexities.

Reconsidering Early Retirement

MS. IGNAGNI: Mr. Flatley, you said that the retiree medical obligation was less of an issue at American Express because your work force was younger than most. Given the cost of offering and providing retiree health insurance benefits for retirees under age 65, do you foresee a change in your attitude toward early retirement and of your policy to encourage it?

MR. FLATLEY: Absolutely. We now have a series of proposals that will substantially modify our position. In hindsight, we think that we applied a long-term solution to a short-term problem in managing the work force. Like most American industries, we felt that, as a way of covering up poor performance-based appraisals, we would offer humane ways of easing superannuated employees off the payroll. Unfortunately, that proved to be a bad idea because no one thought of the long-term implications in terms of changing work force demographics.

We are thinking of substantially curtailing subsidized early retirement and pension plans, increasing the normal retirement age, and requiring a longer career. Again, it is a lot easier to make these changes in a company with a large number of 35-year-old employees. I do not propose our company as a model, but we are probably going to make these changes.

MR. KILLEEN: In some industries, like automobiles, this is a critical issue. We negotiated last year with General Motors (GM) and Ford, and GM was initially talking about limiting early retirement. We took a serious look at the issue. In the end, as the negotiations progressed, we realized that we had about 350,000 people to fit into about 275,000 future jobs and we did not know where to put them. One place was early retirement. We did not put any limitations on early retirement, and we actually opened up a window for a short period for people who were even younger and had less experience to retire, knowing that this was going to raise the pension costs and therefore the labor costs.

MR. DUVA: I suppose each company has a different perspective on what the real bottom line pressures are. Different industries have

different kinds of needs. The aerospace industry could be completely different from the automotive industry. The first challenge we had was to be competitive worldwide, and that meant restructuring and becoming lean and mean. Once you get there, other kinds of real-world things take place. Should you continue to do it? I think that is now where we are.

MS. IGNAGNI: I would say becoming lean and mean has a cost that is not recognized.

MR. FLATLEY: I think if people had recognized some of the retirement costs and had been aware of the fact that the regulatory environment was going to institutionalize and in some sense ossify the status quo, they might have had a different feeling about using pension plans as opposed to window programs, which I think will clearly be the direction of the future. This is unfortunate hindsight.

Flexible Retirement Plans

VOICE FROM THE AUDIENCE: I have heard it said that we need to maintain the ability to adjust retirement plans and make them flexible. Indeed, the trend in plan documents is to incorporate provisions that allow them to be changed at any time. There is talk about using this kind of thing to encourage early retirement. I am puzzled by this need for employers to maintain maximum flexibility. Workers will retire thinking they have something, when, in fact, what they have can be changed at will by the employers.

As a retiree, I would want some certainty about what I was going to receive. If the plan document said that the benefit could be adjusted at the employers' discretion, it would not give me much comfort.

MR. KILLEEN: You used the term "maximum flexibility." I do not think you can have maximum flexibility. If an employee retires with an expectation of receiving a certain level of health care benefits, the employer should maintain, in general terms, that level of benefit protection. But this does eliminate all flexibility. That would be irrational; I hope we do not have court decisions that take away all flexibility.

We have never had a major collective bargaining agreement in which we did not make adjustments in retiree health coverage, and I am not merely talking about improvements such as adding dental care or vision care. We have raised the prescription drug copayment. That could be considered a benefit reduction, but we have done it in a package of other adjustments.

We think that you can provide a certain basic level of health care protection through managed care alternatives without breaking the promise to people. You can put in cost containment programs, managed care, predetermined hospital stays, and other administrative provisions. What I oppose would be sudden substantial increases in deductibles or in the retiree contribution to premiums.

MR. DUVA: Our approach is to try to provide a variety of cost-effective programs that retirees can join. These programs would have to be evaluated from time to time and possibly revised, but the idea is to make health care more cost effective, rather than continue to pay the 25-percent- or 30-percent-a-year increases associated with indemnity plan increases. The cost of a typical managed care program that provides full benefits and includes some copayments is now increasing at a slower rate than that for indemnity plans. The managed care trends are not as low as we would like them to be, but still they are lower than the indemnity plans. We need the flexibility to adopt arrangements that are more cost effective.

Funding Health Benefits with Pension Assets

MS. COLLAZO: Could the speakers comment on the use of excess pension assets to fund these benefits?

MR. FLATLEY: American Express used excess pension assets. We terminated a defined benefit pension plan, reestablished it in accordance with agency guidelines, and used the money for several different corporate purposes, not specifically for the pension program.

You have to answer a fundamental question concerning whose money it is before you ask what you will do with it. People who claim ownership of pension assets might want input into that decision. My opinion, which I suspect represents the American Express philosophy, is that it is the company's and the shareholders' money because they assumed the risk involved in providing a defined benefit.

To the extent that a corporation wants to deploy assets in a different manner, to secure different liabilities as they promised, I think it ought to have the ability to do that. If you are talking about taking the money out on a tax-efficient basis, rather than paying a tax collector, that is a political question. That depends on what party is in power.

Ultimately, I think the corporation should have the ability to re-deploy its assets, and to the extent that the government wants to impose a toll on the privilege of doing that, that is a political decision.

The Nature of the Benefit Promise

MR. JACKSON: I would like to challenge Mr. Killeen's statement that the promise and obligation made by employers was made under earlier collective bargaining settlements, and workers traded off other economic objectives at that time.

Group insurance has operated on a one-year term insurance basis. In the past, retirees were handled on a year-to-year basis. The bargaining agreements operated on a three-year-and-out basis. At the end of three years there was a new agreement. No one promised anything to retirees beyond a current continuation of a benefit. It is very easy to criticize employers for promising too much. It is easy to blame unions for demanding too much, but the problem is Congress and the courts, which have repromised everything that was originally promised, with a tremendous emphasis on security.

I submit that the situation with regard to Congress and the courts is totally uncontrolled. There is nothing to prevent a judge from simply saying, "This meant something else and some more benefits ought to be paid."

Thirty-five years ago, when I was with the Aetna Life Insurance Company, the cost of continuing coverage medical and life insurance was known, and there was no promise to continue these benefits for life. Reading that into the promise has caused the problem we are discussing today. The problem was not caused by employers or by unions. It was caused by Congress and the courts.

MR. KILLEEN: I tend to disagree with that. I think that the expectation of most workers who retired 20 years ago was that retirement benefits would continue for life. They were told, "Here are the terms under which you get a pension," and that health care came with it.

At that time, I do not think the question of the duration of these benefits was even raised. Not only was the economy expanding, but the major sectors of the economy were expanding. The period during the late 1950s and early 1960s was very optimistic, economically. I think the retirees who retired at that time, or those who negotiated benefits, clearly thought they were negotiating something for life. Retirement benefits only became an issue later when plant closings and industrial contractions occurred. Then employers ended up in court trying to reinterpret the contract language, the language of the brochures given to employees, and what they were told in exit interviews as they retired. I do not particularly blame the courts, but I think they have had a difficult time sorting out what was agreed upon and not agreed upon.

MR. JACKSON: I sat in on bargaining sessions and I am aware that union demands for pension benefits were defined in terms of the price and the cents-per-hour cost. The determinations were based on a projected, funded pension cost.

The cost for medical and similar benefits was based on the cost in the next two or three contract years. In bargaining, the unions never gave up enough in earnings to cover a lifetime of medical coverage or life insurance coverage for the retirees. They did give up enough to cover a lifetime pension. There was no promise to continue medical benefits for life.

MR. KILLEEN: The costs in those days were so small compared with what we are faced with today, that, again, I think no one thought about it. If we had known then what we know now about what these costs would be, I think we would have funded them.

Long before the Employee Retirement Income Security Act (ERISA) was in existence, UAW went on strike to get funded pension plans. We struck Chrysler in the early 1950s. They wanted to give us a pay-as-you-go pension plan. We educated our membership about that kind of funding and said, "There is no security there."

We worked to get the standards in ERISA. Before ERISA was created, we got standards into our own negotiated agreements. I think that if we had known that the medical care costs were going to be so high, we would have tried to fund them, too, for retirees. But that is with the vision of hindsight. Logically, I would want to do it that way. Today we are asking ourselves to unscramble the omelet.

MR. KAHN: Congress has not required anything in this area. If anything, it went the other way a few years ago when it backed off on voluntary employee beneficiary associations. The courts have acted, but I think that the FASB rule changes clearly show that FASB is trying to recognize what they think is reality and that reality is a promise.

You can say that companies ought to be able to pull out any time they want, and they surely can, but the courts are saying that they want to stop them from doing that. But I do not think that the government, whether in the form of the courts or in the form of Congress, is pointing the finger.

FASB is a private-sector entity. It says to the private sector, "This [promise to provide retiree health benefits] is an obligation. It is something you have been living with all these years and ignoring." FASB's proposed change in the status of retiree medical benefits is quite different from a move by Congress and courts to impose something on employers.

PART FOUR PUBLIC POLICY CONCERNS

With the security of some retiree health benefits now in question, Congress is faced with deciding whether and to what extent the federal government should become more involved.

In Chapter XII, Gary Hendricks places the issue of retiree health benefits in the larger context of health policy. He describes five approaches to funding health care benefits and explains why none of them will be effective as long as medical costs are not brought under control.

A lack of consensus on how public policy should approach this issue makes congressional action uncertain, he says.

In Chapter XIII, Charles N. Kahn reviews possible congressional responses to this issue, the most likely of which, he believes, may be an initiative resembling the Employee Retirement Income Security Act of 1974. Such an approach would be voluntary and would include vesting, portability, and caps on the amount that could be contributed tax free.

Kahn believes that the 101st Congress may consider the retiree health care benefit issue within a larger framework that would include long-term care and the uninsured. Ultimately, he says, the issue must be seen in terms of the long-term implications of health care inflation.

In Chapter XIV, Burma H. Klein reviews the results of a study undertaken by the U.S. General Accounting Office (GAO) to help Congress address the issue of retiree health care benefits. The study estimated companies' liabilities for current and future retirees' health care benefits, assuming that they continue to provide current benefits; estimated the annual amounts needed to advance fund these liabilities and compared them with companies' pay-as-you-go expenses; obtained companies' views on their flexibility to change their health plans to accommodate rising costs; and described how companies are using this flexibility to make changes.

According to Klein, GAO believes that Congress should consider the desirability of legislation to preserve retiree health care benefits, especially for retirees under age 65, who are not covered by Medicare. She discusses possible policy approaches and points out their advantages and drawbacks.

In the Part Four discussion, questions are raised about the assumptions GAO made concerning the real growth rate in per capita spending for health benefits and the real interest rates that produced the \$227 billion that GAO estimates to be the present value of future retiree health benefits. The chapter concludes with a five-point summary of the forum's presentations and discussions.

XII. Public Policy and Retiree Health Benefits-

REMARKS OF GARY HENDRICKS

Introduction

I think that it is fair to say that the issue of employer-sponsored retiree health benefits is clearly on the back-burner as far as the Executive Branch and Congress are concerned. There are several reasons for this.

First, the issue has been overtaken by other, much larger, health concerns that were not on the table when these benefits were first discussed in 1985 and 1986. There are 37 million uninsured persons in the United States, and Sen. Edward Kennedy (D-MA) introduced a proposal* in the 100th Congress to have the private sector insure at least 24 million of them. That is a much larger issue. It is difficult to argue, when there are so many uncovered workers, that we should spend tax dollars and our time and energy on retiree health benefits. That does not mean that there will not be congressional activity on the issue, but I do not think any significant action will be taken.

Congressional Priorities

I think the 101st Congress will pay more attention to long-term care, because it has a higher priority in the minds of many senators and congressmen. Retiree health benefits is an example of an issue that has received little or no coverage.

One thing that makes moving this particular issue of retiree health benefits on the Hill very difficult is that there is no agreement on how public policy should address it. It is much easier to act once there is a consensus, but there seems to be very little agreement on this issue except with regard to prefunding. If special tax preferences are to be instituted for this type of benefit, it is generally agreed that there must be standards. That would involve the Employee Retirement Income Security Act (ERISA) in any initiative that involves prefunding. However, those in the business community who might most strongly support prefunding do not like ERISA.

*Editor's note: The Minimum Health Benefits for All Workers Act (S.1265) was approved by the Senate Labor and Human Resources Committee but was not brought to a vote in the Senate during the last Congress.

Tax Considerations

Any tax-favored prefunding must be considered in the context of the budget. Where do we get the money? We could tax other benefits, but I think the deficit problem is so great that Congress will consider taxing other benefits and giving nothing in return to the community. Taxing benefits itself is highly controversial, and there is little consensus there. If we do tax employee benefits or find some money elsewhere, I think Congress will decide to spend that money on some other area of health.

Managing Health Care Costs

One thing that bothers me most about the issue of retiree health benefits is that it is part of a more fundamental problem, which is the problem of health care costs in general. These costs are rising so quickly that it is difficult to get a handle on them. Management utilization seemed to work for Allied-Signal for about two or three years, and then it ceased to work. This seems to happen again and again. You think you are managing costs, and then you lose control.

It seems to me that any solution we might arrive at would be unworkable if we have no handle on health care costs. I think that Congress and the Executive Branch would be loath to work on the problems associated with "ERISA-fication," establishing standards, finding tax dollars, and justifying and selling a solution when it is not clear that employers could afford the solution eight or ten years from now, and the employers that you would want to prefund probably cannot afford to do so.

We have to do something about Bethlehem Steel, about the automobile companies. What do you do when more than 50 percent of the people covered by their health plans are retirees? How do you start them out with prefunding? Would it happen fast enough when, for instance, General Motors has 350,000 workers to fill 270,000 jobs in the next few years?

As public policymakers, we are concerned about who is at risk and who is likely to lose retiree health benefits.

There are five fundamental approaches to funding retiree health care benefits, and I say nothing will work if you cannot manage health care costs. You can establish an individual health account approach, but that will not work because you do not know how much money to put in it. You do not know what amount would be sufficient to allow retirees to continue to pay their premiums.

The defined contribution approach, on the employer's side, involves the same problem, as does the defined dollar approach. If an employer contributes a certain amount of money to each retiree each year, a retiree who lives to be 90 or 95 could end up using his or her entire pension income to cover the remaining portion of health costs.

The defined benefit approach we have now offers a set of benefits; it has been mentioned repeatedly that employers must have flexibility in these benefits. Why do they need this flexibility? Why will they not lock in? Because of costs.

Is National Health Insurance the Answer?

We could take a public approach and adopt national health insurance. I think the problem there would be exactly the same. We cannot manage health care costs. No matter what strategy we take, we may end up in a situation similar to that of the United Kingdom, where they charge little or nothing for medical care but patients over age 55 cannot get kidney dialysis. The national health system will not pay for it. That is the way the British control costs and keep them from consuming 35 percent their Gross National Product.

I also think that the pressure from the Financial Accounting Standards Board (FASB) will dissipate. The new FASB rule will take effect slowly. It will be 1997 before employers are required to report the first large liability on the balance sheet. By then labor markets are projected to be much tighter. If older workers are going to become more valuable and employers are going to want to keep them around, policies will change and there will be less pressure for public policy solutions that specifically address retiree health benefits as opposed to including this group in the broader context of health policy.

Is Government Action Necessary?

A question I have to ask is, what is the public good? Alain Enthoven has suggested that we do not like to have people die in the streets. The people whose retiree health benefits we are discussing are largely middle-class, blue-collar workers. I do not think they are necessarily the class of people we are going to see dying in the streets.

If the employers cut off the benefits, workers will not retire, so that would mitigate the problem somewhat. I do not know why I, as a public policymaker, should worry. We all value income security in retirement, and that is one of the reasons I think this issue reached the Hill in the first place. We do not like insecure contracts. We want things to be more secure.

These are high-risk contracts. And our society does not favor the kind of contract that would allow both parties to agree that benefits can be stopped. Perhaps these contracts should not be permitted. There should be prefunding.

I have difficulty finding the public good here. I would like to hear arguments that would persuade me to put this issue high on my priority list and take it to an assistant secretary for pensions and welfare benefits at the Department of Labor and say, "We have to worry about this one."

XIII. A Congressional Perspective

REMARKS OF CHARLES N. KAHN*

Introduction

Retiree health benefits are clearly not at the top of the U.S. congressional agenda now, but the House Ways and Means Committee has started considering the issue. In the next couple of years, I believe heightened attention will be paid to retiree health benefits, as the implications of the Financial Accounting Standards Board's (FASB's) new accounting standards become clearer, and as companies reevaluate their retiree benefit "promise."

There are two factors to keep in mind when considering how Congress views retiree benefits. One, because we are dealing with the federal budget, this is a zero sum game. If Congress provides a tax incentive to prefund retiree health benefits, money must be found to make up the difference. Companies must ask themselves, then, what are they willing to trade off? Second, I expect that in return for tax breaks to prefund retiree health benefits, there would be some kind of policy *quid pro quo* to ensure the security of the benefit. Mandating the benefit is unlikely, but some type of "ERISA-fication"—that is, vesting, portability, and benefit caps—may be required.

Defined contribution arrangements may be a good way to deal with the benefits. However, there will be a tremendous amount of cost shifting likely in the out years because health care costs—if they continue as in the past—will increase. Retirees will be unhappy about this, and probably quite vocal about it.

Regardless of what Congress does or does not do, many companies must contend with FASB's new accounting requirements, higher health care costs, and a growing retiree-to-active-worker ratio. Someone has to pay and no one wants to. Pressures are building. Spiraling health care costs are driving all health care issues today, and we must deal with this factor sooner or later.

*The views expressed in these remarks are the author's own and do not represent the views of the House Committee on Ways and Means, its health subcommittee, or its members.

Health Care Priorities of the 101st Congress

If there is any action in the retiree health area, it may be within the broader context of health care issues, such as long-term care, the uninsured, and Medicare.

Long-Term Care—It is unlikely that Congress will take action on long-term care in 1989 because of the large expense associated with it. The more modest entitlement plans being discussed cost between \$18 billion and \$20 billion, with the high price-tag, full coverage plans costing \$50 billion to \$60 billion. It can be argued that a comprehensive long-term care program for nursing home and home health care might reduce the federal contribution to Medicaid, but with a \$140 billion to \$150 billion deficit that must be reduced by at least \$40 billion to \$50 billion, it will be difficult to justify a tax increase to pay for the program. Raising the money, whether through estate or payroll taxes, would not be popular.

The Uninsured—The 101st Congress is likely to examine the issue of the 37 million Americans uninsured for health care. Proposals to mandate employer-sponsored coverage will be back, as will risk pool proposals. While the costs for covering the uninsured may be high, proposals thus far try to push that cost on to employers and avoid new federal expenditures. And, while the issue does not have the kind of vocal constituency that long-term care has from the elderly and elderly groups, Congress may find it hard to ignore a problem that so many find socially unacceptable.

Medicare Catastrophic—We have probably not heard the last of the Medicare Catastrophic Coverage Act of 1988. Cards and letters sent to senators and congressmen indicate that many elderly people are not happy with Medicare catastrophic coverage—at least the 40 percent who are going to pay for 66 percent of it.

The Congressional Budget Office has determined that if the new benefits and premiums were in place in 1988 and some assumptions are made about how much is spent on Medigap policies, about 30 percent of the elderly are, on average, approximately \$278 a year worse off than they were before the Medicare legislation was passed. And the premium will increase every year.

One could argue that this makes sense. The logic behind the legislation was that the premiums would be income related, on the assumption that those who could pay more should pay more. However, I do not think that the elderly realize that they made that deal.

Conclusion

Health care costs have been an intractable issue that Congress has only focused on directly once during the last eight years—when it wanted to reduce the government’s cost for Medicare. It will be difficult for Congress to continue to avoid the issue of rising health care costs in the economy as a whole and merely look at what is paid through the entitlement programs.

It is not clear to me whether we will return to the types of cost containment proposals that were made during the late 1970s, but in the next decade Congress will have to focus on the long-term implications of health care inflation for our society. The issue cannot be avoided much longer, because it has broad and inescapable economic ramifications. The American people may want to have it all, but sooner or later they may not be satisfied with the implications of spending 15 or 20 percent of Gross National Product on health care, with that portion growing yearly.

XIV. Future Security of Retiree Health Benefits in Question*

PAPER BY BURMA H. KLEIN

Introduction

The private sector plays an important role in providing retirees access to affordable health care coverage. Not only is the cost of medical care under group plans generally less expensive than that purchased by retirees individually but companies often pay some or all of the costs. The benefits provided through company plans are especially important to retirees under the age of 65 because most are not covered by Medicare. In 1988, retirees under age 65 comprised one-third of all retirees covered by company health plans, but they received about two-thirds of the benefits.

Faced with significantly increasing costs, some companies are taking action to control their current costs and limit their obligations for retiree health care benefits. Retirees now receiving these benefits and active workers who expect to receive retiree benefits have limited protection from benefit modification or termination. For example, when the LTV Corporation, one of the largest companies in the United States, filed for bankruptcy in July 1986, it attempted to terminate the health benefits of more than 78,000 retirees. Only congressional action maintained these benefits.

Because the security of some retiree health benefits is in question, Congress is faced with deciding whether and to what extent the federal government should become more involved.

To help them address this issue, the U.S. General Accounting Office (GAO) was asked to: (1) estimate companies' liabilities for current and future retirees' health benefits, assuming that companies continue to provide health care as they currently do; (2) estimate the annual amounts needed to advance fund these liabilities and compare them with companies' pay-as-you-go expenses; (3) obtain companies' views on their flexibility to change their health plans to accommodate

*Editor's note: This paper was presented as testimony before the Subcommittee on Oversight, House Committee on Ways and Means, by the Assistant Comptroller General, Lawrence H. Thompson, on September 15, 1988.

rising costs; and (4) describe how companies are using this flexibility to make changes.

Liabilities and Annual Contributions to Advance Funding

About seven million retirees are receiving health benefits through company plans, and about \$10 billion will be paid by companies in 1988 for these benefits, according to our estimates. Assuming coverage and benefit provisions do not change, in the year 2008 these companies will pay \$25 billion in today's dollars for nine million retirees.

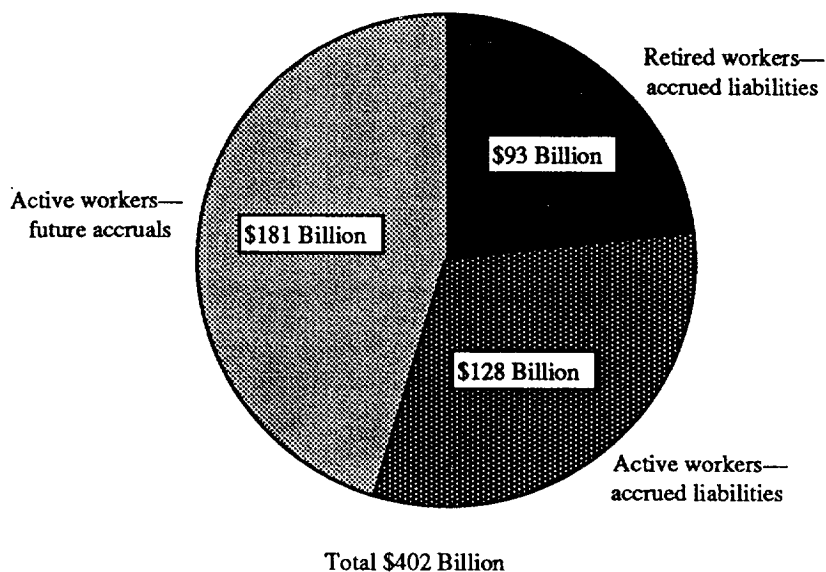
GAO estimates that the present value of future retiree health benefits accrued to date is \$227 billion. This amount is about one-twelfth of the value of the stocks of American corporations (\$2.6 trillion) in 1986. This estimate includes accrued liabilities of \$100 billion for retirees and \$127 billion attributable to the past service of active workers (chart XIV.1). The remaining \$175 billion is for benefits that workers will earn from now until they retire. The amount the nation's private employers would need for investment today to pay future health benefits for retirees and for all covered workers during their retirement is \$402 billion.

We did not consider employers' savings resulting from the passage of the Medicare Catastrophic Coverage Act of 1988 in our estimates. Sufficient information was not available to us to determine how overall employer costs might be affected.

It has been the practice of the Financial Accounting Standards Board (FASB) to require material costs to be disclosed on a company's accounting statements to help ensure that the statements accurately represent the company's financial condition. Since 1979 disclosure of postemployment benefit costs, such as those for company health care, has been on FASB's agenda. As an interim step, FASB required current retiree health costs to be reported on companies' financial statements beginning with accounting periods after 1984. FASB has announced its intention to issue an exposure draft that will detail its rules for recognizing and disclosing retiree health liabilities.

Most companies do not advance fund their retiree health benefits but rather pay them on a pay-as-you-go basis. Companies and others have expressed concern that the disclosure of unfunded retiree health liabilities could adversely affect their operations, including their ability to obtain capital financing. This could prompt some companies to reduce or terminate their health benefits, require retirees to pay more of the plans' cost, or start advance funding the benefits.

CHART XIV.1
Private Companies' Estimated Retiree Health Liabilities, 1988

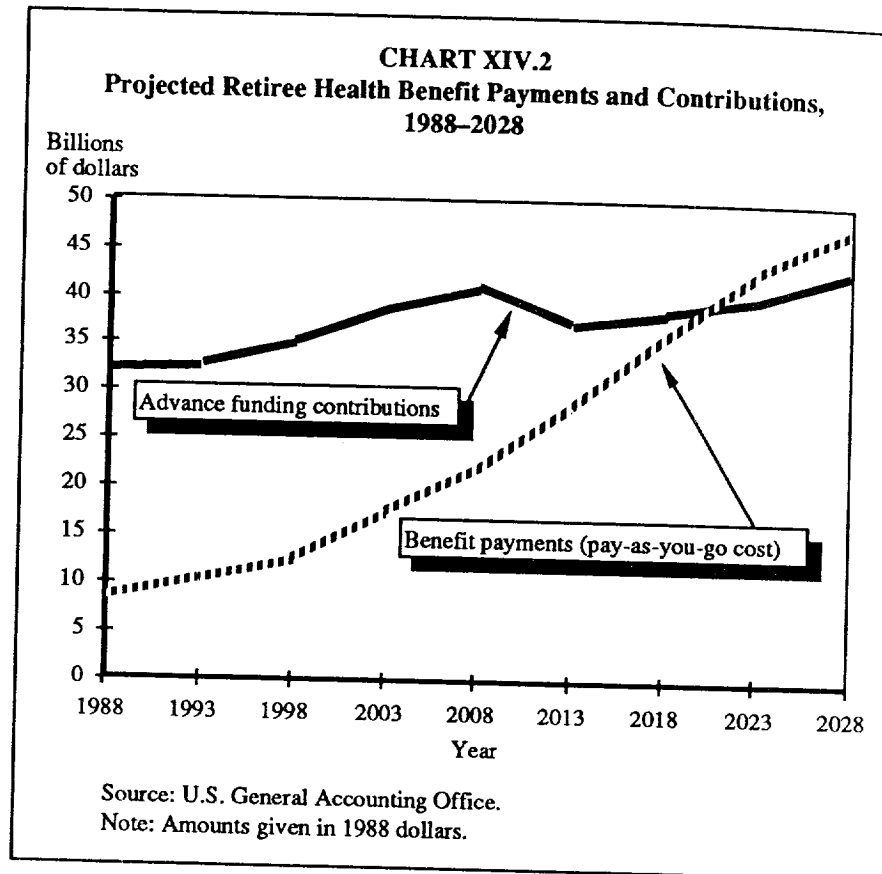


Source: U.S. General Accounting Office.

Advance funding of retiree health liabilities would stabilize companies' annual expenditures. Moreover, the accumulation of assets would result in added security for retired workers. However, this would be very costly.

If employers were to start advance funding their retiree health liabilities the way they fund pensions, they would contribute \$32 billion in 1988 under current coverage and benefit provisions and under our methods and assumptions.¹ This is about three and one-half times their current pay-as-you-go costs of \$9 billion and one-eighth of the estimated 1988 pretax profits of American corporations.

¹GAO used different values for selected variables in the model to determine low and high estimates of first-year contributions and accrued liabilities. First-year contributions could range from \$26 billion to \$47 billion to fund accrued liabilities as low as \$174 billion or as high as \$295 billion, respectively.



GAO projected contributions and benefit payments assuming current retiree health coverage and benefit provisions to not change. As shown in chart XIV.2, annual contributions would continue to be higher than pay-as-you-go costs (in today's dollars) until the year 2018. Thereafter, pay-as-you-go costs would exceed annual contributions. If companies wait to begin advance funding, first-year contributions will be even greater relative to pay-as-you-go costs.

Companies' Changes to Manage Their Health Costs

Recognizing that companies may change or terminate their retiree health plans, GAO asked company officials about their flexibility to

change health plans to cope with rising costs and how they are using this flexibility to make changes. We looked at the retiree health plans of 29 companies in the Chicago area. We selected a sample of companies that had plans in 1984 to determine whether they had reduced or terminated benefits since then. We also interviewed company officials to obtain their views and concerns about the security of these benefits.

Short of terminating benefits, companies can control their costs by changing health plan provisions and cost-sharing arrangements to: (1) limit the services covered; (2) restrict eligibility for coverage and the period of coverage; and (3) require plan participants to share more of the costs. A comparison of two of the companies GAO surveyed shows the range of possibilities. One company allowed access to group plan coverage but did not share the costs. In 1987, this company charged retirees and their families enough in monthly contributions to fully cover plan costs. In contrast, another company, which did not require contributions, paid almost \$4,000 per retiree.

Company actions to modify or terminate retiree health coverage have been challenged in court. In some cases, the courts have ruled that companies may not terminate the benefits being provided persons who are already retired. In other cases, the courts have upheld the companies' right to modify or terminate the benefits if the companies have previously taken explicit actions to reserve this right.

Officials at all 29 of the companies we surveyed told us they believe their companies have the right to modify or terminate health benefits for active workers and retirees; 27 of the 29 include explicit language to that effect in their health plans. This is not a new development: 25 companies already had plans with this language at least four years ago. Since then, one company has clarified the wording, and two others have added new language to this effect.

According to company officials, concerns about rising medical costs have led 24 of the companies in our survey to modify their health benefits since 1984. The modifications consisted of (1) implementing cost containment measures to help ensure that the health services are medically necessary and economical, (2) increasing deductibles and coinsurance payments, and (3) raising monthly contributions. These changes were directed at both active workers and retirees.

Officials at 26 of the 29 companies told us that they are committed to providing health benefits to their retirees but are uncertain about their companies' continued ability to pay for these benefits. Officials at 16 companies specifically said they were concerned about the ef-

fects of the proposed FASB disclosure requirement on their companies' reported financial condition.

Officials at 21 companies said they were considering additional changes to their retiree health plan structures. The current and future costs of providing retiree health insurance may be more than they can afford, and future court rulings could reduce their ability to modify plans. Some provisions being considered are much different from those already in place and would result in new benefit structures. These include offering: (1) health benefits that vary with length of employment, (2) defined dollar benefits that would cap annual medical payments based on years of employment, or (3) flexible compensation packages that would allow workers to choose from among a variety of pension and welfare benefits.

Company officials said they were planning to wait for FASB to publish its proposed guidelines and for other possible legislative and regulatory actions before deciding what additional changes are needed. They indicated that an expanded tax preference would provide a major incentive for advance funding their benefit payments.

Issues for Consideration by Congress

The private sector has played an important role in providing retirees with access to company-sponsored health benefits and helping to pay for their costs. However, this role may be changing. Current and future retirees have limited protection against company actions to reduce or stop providing health benefits. In fact, to control their current and future costs, some companies are already taking action to require retirees to pay more for their medical care. Projected future costs and requirements to disclose unfunded liabilities on financial statements may increase such actions and erode retiree benefits.

GAO believes that Congress should consider the desirability of legislation to preserve retiree health benefits, especially for retirees under age 65, who are not covered by Medicare. In considering the type of action it might take, the Congress should be aware of some likely consequences. For example, any broadening of tax preferences will obviously create tax losses for the federal treasury at a time when reducing the budget deficit is both extremely difficult and very important. Even with tax advantages, employers' higher annual contributions under advance funding could affect companies' willingness to offer retiree health benefits.

If Congress decides it should take steps to increase benefit security, it can consider actions ranging from applying pension policies to

retiree health benefits to requiring companies with health plans to allow their pre-age-65 retirees to purchase coverage at group rates similar to the coverage now provided terminated employees.

To apply pension-type policies to retiree health benefits, Congress, among other things, will need to define vested benefits, expand tax preferences for advance funding, develop funding standards, and consider establishing an insurance program similar to the one administered by the Pension Benefit Guaranty Corporation. This approach would provide more secure health benefits for some retirees but may cause some companies to discontinue retiree benefits for others. In addition, the federal government may have to establish additional organizational structures to administer the system.

Another option would be to give companies the choice of maintaining their retiree health plans on a pay-as-you-go basis or advance funding their liabilities within a pension-type framework. Companies that wished to advance fund could take advantage of expanded tax preferences but would become subject to regulations and restrictions similar to those covering pension plans. Companies that did not want to be subject to pension-type regulations could maintain their pay-as-you-go plans if they desired. Under this option, the benefits of some current and future retirees would be more secure than others.

A less comprehensive approach would be for Congress to provide more incentives for companies to advance fund their retiree health liabilities on a voluntary basis but not to impose the full pension regulations. Standards for advance funding and for the distribution of plan assets in events such as plan termination would need to be established. This approach lessens burdens on companies, but it also does less to promote the security of these benefits. Under this approach, more companies may be willing to increase benefit security through advance funding, but the absence of vesting rules and other protections lowers the level of security provided to individual retirees.

Under any of the above approaches, Congress could also consider adopting current legislative proposals to let companies use excess pension assets to help advance fund retiree health plans.

To avoid some of the adverse effects of requiring advance funding, Congress might take a less ambitious tack. For example, one approach not requiring advance funding would be to require all health plans to extend coverage to retirees at group rates. Under this approach, retirees would bear all of the cost of their health benefits, although payments would be at group rates which are usually lower than in-

dividual rates. An advantage is that this approach might well expand the availability of retiree health coverage.

Objectives, Scope, and Methodology

To prepare our estimates of companies' total and accrued liabilities, we updated and expanded an economic model used by the Department of Labor in a 1986 report on employer-sponsored retiree health insurance. Total liabilities—the present value of future benefits—represent the amount of money one would need to have available for investment to provide currently covered workers and retirees with retiree health benefits. If these benefits were advance funded and assumed to be earned over workers' careers, the accrued liabilities would be the portion of total liabilities assigned to workers' and retirees' past years of employment.

To make our calculations, we made several simplifying assumptions. For example, we based our model on our own and others' estimates of average national retiree health costs and of the number of current and future workers covered by employer-provided retiree health plans. We assumed current levels of coverage and benefit provisions would continue, even though companies can modify or cancel their plans. We treated the 1988 accrued liabilities as unfunded, even though we know a few firms are currently funding these liabilities in advance. Finally, we used a projected unit credit funding method with accruals for service after age 40 and no terminations other than death.

For specific model parameters, we analyzed data on numbers of active workers and retirees with retiree health benefit coverage, health care costs, rates of retirement, life expectancy and interest rates, and we reviewed available studies of retiree health costs. Because precise, up-to-date information does not exist for many of the factors affecting companies' total liabilities and annual contributions, we performed sensitivity analyses of our liability estimates by varying our coverage, retirement, mortality, and inflation assumptions.

To estimate the contributions companies would have to make to start advance funding their liabilities in 1988, we used a closed group of workers and retirees. Our estimates of benefit payout and advance funding contributions in the year 2008 were based on an open group valuation allowing for new entrants through the year 2032. Annual contributions include an amount to cover accruals for active workers as well as a 25-year amortization payment on initial (unfunded) accrued liabilities.

To assess companies' flexibility to modify retiree health plans and examine recent changes that companies have made in these plans,

we surveyed 29 medium-sized and large companies with retiree health plans in the Chicago area. These companies had from 186 to more than 50,000 active workers; the number of retirees ranged from 12 to 39,000. We also met with company officials and other experts and reviewed recent public- and private-sector studies and court decisions to better understand the kinds of changes that companies were making. Our findings on specific changes cannot be generalized beyond the 29 plans we surveyed.

XV. Part Four Discussion

State Pools

MR. WELLER: Mr. Kahn, what do you think about requiring states to set up risk pools?

MR. KAHN: I do not see any meaningful risk pool legislation passing in isolation, but it could be attached to a larger piece of legislation.

MR. WELLER: Such as the tax bills, where Congress originally had it in 1987?

MR. KAHN: No. I mean it could pass as a component of a big mandated benefits bill, but not in isolation. The Senate has objected consistently to the way the idea has been proposed, and I do not know why, because it would not affect that many people. The amount of money that would have to be raised to pay for it would not be large. I am still confused about why business is so up in arms about it. I understand it would set precedent. But I think it is much ado about nothing; it would be a marginal program to help the dramatically uninsured. If it is not mandated either through a tax penalty or a clear mandate from the federal government, I do not know what there is to be upset about.

The Cost of Prefunding

MR. ENTHOVEN: Ms. Klein, would you please tell us the assumptions that were made, and a little about the alternative assumptions, with respect to the real growth rate in spending per capita for health benefits and the real interest rates that produced the \$227 billion that you say the General Accounting Office (GAO) estimates to be the present value of future retiree health benefits? And does the \$32 billion needed to begin advance funding include the current \$9 billion pay-as-you-go costs? Are you saying that if a company switched over to full prefunding and continued payment of its obligations for current retirees, its total cost would be \$32 billion a year? Or is that \$32 billion, plus \$9 billion?

MS. KLEIN: I will answer the second question first. The \$9 billion is to be subtracted from the \$32 billion. Obviously, we are not talking about all companies advance funding this year, but if they all did, it would be \$32 billion to start advance funding.

MR. ENTHOVEN: That would be their contributions to the unfunded obligations and the currently accrued obligations, and it would also cover the out-of-pocket payment for the current retiree expenses?

MS. KLEIN: Yes.

MR. ENTHOVEN: It is not \$32 billion-plus, then?

MS. KLEIN: That is correct. It is the past liability and the amortization. Concerning the assumptions, Donald Snyder, the economist who did the estimates, will give us a quick rundown.

GAO's Methodology

MR. SNYDER: When I started out, I built on the work that the U.S. Department of Labor had done in its estimates of 1983 liabilities. Many of our assumptions are the same as theirs, because we can change the discount rate, with the same medical inflation assumption, and change the size of the liabilities. We used a discount rate of 7 percent. It is not the exact interest rate and discount rate that matter so much; it is the differential between the consumer price index (CPI) and medical care cost increases that is really the issue.

You can start with a 7 percent discount rate. If you have 10 percent inflation of medical care, you have a 3 percent differential. In that regard, our medical inflation differential is 1.5 percent for 14 years, three-fourths of 1 percent for 14 years, and then it caps out at 14.7 percent of Gross National Product (GNP). We have a very *de minimus* assumption about the future of health care inflation. We should all get on our knees and pray that GAO is correct in that. Were there other assumptions you were concerned about?

MR. ENTHOVEN: Yes. What is the real interest rate you used to get the present values?

MR. SNYDER: Two percent.

MR. ENTHOVEN: Two percent for how many years?

MR. SNYDER: The real interest rate? It is 2 percent for all time.

MR. ENTHOVEN: What about for the automobile industry?

MR. SNYDER: We assume a 5 percent inflation rate and a 2 percent real rate of interest for a 7 percent discount rate. Two percent is an historically derived figure with which reasonable people could disagree. Maybe 1½ percent or 2½ percent would be appropriate.

MR. ENTHOVEN: Then you use the excess of the medical CPI over the CPI of 2 percent? In other words, are you saying that the medical inflation is equal to the real interest rate, or the real growth in medical spending is below the real interest rate?

MR. SYNDER: It comes down to that in 30 years. The medical rate starts at 3.5 percent over the CPI, falls to 2.75 percent over it, and is always 2 percent higher than the CPI thereafter. However, we do not maintain that medical inflation is equivalent to the CPI-Medical Component.

MR. MAHONEY: What was the percentage of GNP?

MR. SNYDER: It would grow to 14.7 percent in 30 years. We should be clear about the share of GNP. The best data we have, and the easiest data to use, are from the *Economic Report of the President* and the consumer price index for medical care. That is what I used and what most people use because we do not have better information. A particular company with a very generous plan might have much higher price experience. This is an aggregate estimate. If you apply this differential between the CPI and medical care components and the real growth of the economy, and take the share of GNP that goes to health care expenditures, then you get 14.7 percent in our model with our assumptions.

MR. MAHONEY: Is GAO low, medium, or high on that assumption?

MR. SNYDER: I consider it to be low; "conservative" is probably an understatement.

MR. LAURENT: Is this a public document? If so, what is the document number?

MS. KLEIN: If you are interested in the testimony that we gave September 15, 1988, before the Oversight Subcommittee of the Ways and Means Committee, it is GAO T-HRD88-30. There will be a technical appendix that will describe the assumptions and all the details. This document does not go into that kind of detail.

MR. LAURENT: Would the reinvestment rate you used assume that the proceeds were taxable or not taxable?

MS. KLEIN: We assumed they were not taxable.

MR. LAURENT: Chart XIV.2 shows your premium curves. Usually under premium scenarios, the area above the curve in the early part equals the area under the curve in the later part. If you add the areas

under these curves, obviously prefunding is a lot higher than cumulative costs. Is that because you did not just carry it out far enough? Presumably after 2028 the pay-as-you-go method keeps going up.

Ms. KLEIN: That is correct.

Wrap-Up

MR. GARBER: I have summarized five points from our discussion that I think start in one place and end back at the same place. First, I think there is general agreement that the FASB action is correct in principle, if not necessarily in all of its details. Recognizing retiree health care costs on a current basis rather than on a pay-as-you-go basis is an appropriate accounting action and an appropriate way for companies to measure their financial situation.

The second point would be that this is a difficult problem, principally because the cost of health care is out of control, creating a risk that employers cannot accept. Therefore, the fundamental problem is to come to terms with health care costs, which must be done in any event, regardless of what is done about retiree health.

The third point is that action at the federal level to permit funding is probably not likely for the reasons you have heard. These reasons are basically on the revenue side; we would end in a zero sum game in which there would be questionable tradeoffs. Moreover, if there were advance funding, ERISA-type provisions would be required, and I think ultimately this probably would not be helpful to industry because what they would gain by receiving the ability to fund might not be worth what they would lose.

Fourth, there are the legal limitations on what employers can do with respect to the retired and near-retired employees, because of the obligations that are already in place. They can change policies at the margin but not in a fundamental way. For active workers, however, employers can take actions to offset long-term costs, although these actions will not offset current costs.

Which leads me back to FASB, my fifth point. FASB has started a process and employers have until 1992 to complete the first installment. It seems to me that companies will begin by fine tuning their numbers. They will begin to adjust and adopt plans to affect their longer-term liabilities, which are related to active employees. Thus the process of bringing these long-term costs up to date and into current income statements or balance sheets will, in the long term, ensure the elimination of a large part of these costs.

Appendix A. Retiree Health Benefits: Given the Tax Incentives, Corporations Can Solve the Problem

PAPER BY A. HERBERT NEHRLING

A. Herbert Nehrling, assistant treasurer of E.I. du Pont de Nemours & Company, delivered the following address at the Sixth National Conference of Americans for Generational Equity, July 29, 1988.

Let me briefly summarize the retiree health care dilemma faced by U.S. companies.

U.S. industry's aggregate unfunded future cost for retiree health care is estimated at between \$100 billion and \$2 trillion. In the 1992 to 1994 time frame, the Financial Accounting Standards Board (FASB) will require accrual accounting for retiree health care, which will have severely adverse consequences for corporations' balance sheets and income statements. Mainly as a result of revenue considerations, Congress will not permit tax-favored funding for retiree health care, which would offset some of these consequences. At the same time, Congress worries that companies cannot keep their promises to retirees. The dilemma for industry is: How can we reduce future FASB income statement charges and balance sheet liabilities and at the same time make our health care promises to retirees more secure?

I have been asked to say a few words on the premise that "given the tax incentives, corporations can solve the retiree health benefits problem." Let me say, to begin, that I cannot honestly say that this premise is true. However, I can say with certainty that, absent such tax incentives, there is no way that corporations can solve the problem, and that with such incentives, there is a chance that we can indeed solve the problem—a good chance, I believe.

What incentives do we need? I would like to suggest a three-step legislative program. The first step would be to permit companies to pay their current retiree health benefits directly from excess pension assets. The second step would be to permit companies to transfer a portion of their excess pension assets to a separate fund that would pay retiree health benefits for current and future retirees. The third step would be to establish the same type of ongoing tax-favored funding for retiree health care as we already have for pensions.

Before briefly discussing each of these steps, I would point out that the key question is: Would business use the vehicles provided by such legislation?

I recognize that individual companies would make decisions in terms of their own situations with regard to cash flow, earnings, and alternative investments. However, there is a new, powerful motivator which will affect every company. The FASB rules, which will be effective between 1992 and 1994, will have such a severely adverse impact on corporate earnings and liabilities that companies will be faced with a choice of either finding a way to fully or partially offset the liability or reducing or eliminating their retiree health care benefits. The only way I know to offset the liability is to set assets aside to cover it—either the assets we have already set aside for pensions that are in excess of the need for that purpose or new assets purchased through an advance tax-favored funding vehicle.

This leads us back to our proposed three-step legislative program. First, let us permit companies to pay their current retiree health benefits directly from excess pension assets in their pension funds rather than from general corporate funds.

This provision could be in effect for a limited period of time—for example, from two to five years—and it would move us in the direction of permitting transfers of excess pension assets into a separate retiree health care fund and eventually permitting full advance funding of retiree health benefits. Meanwhile, the proposal would increase tax revenues by \$500 million to \$1 billion annually. This would occur because payments of retiree health benefits from excess pension assets would not be tax deductible, whereas current payments on a pay-as-you-go basis from general corporate funds are tax deductible. Moreover, the proposal would make retiree health care promises more secure for retirees without jeopardizing the security of their pension promises. Excess pension assets are now estimated at more than \$200 billion, while the annual corporate payout for retiree health care is only \$5 billion. Thus, a cushion could easily be retained in pension plans to provide further protection for pension promises.

Our second proposed legislative step would be to allow employers whose pension plans are overfunded to transfer a portion of the excess assets to a separate fund that would pay retiree health benefits for current and future retirees. This would be another move in the direction of eventually permitting full advance funding of retiree health benefits. This second step would also increase tax revenues. Payments from a retiree health care fund would not be tax deductible, while current payments on a pay-as-you-go basis from general corporate

funds are tax deductible. Finally, this step would also make retiree health care promises more secure for retirees without jeopardizing the security of their pension promises, because the rules should leave a cushion in the pension fund.

As stated earlier, excess pension assets are now estimated at more than \$200 billion. An aggregate of funds in this amount should go a long way toward solving the problem, thus minimizing corporate actions to reduce or eliminate retiree health care benefits. In return, employers should be willing to accept a prohibition on reversions of pension assets for any other purpose.

While we firmly believe that pension plan benefits, not pension assets, represent the substance of the employer's pension promise to employees, we should be willing to agree to a restriction on reversions but only if the *quid pro quo* is the permitted transfer of excess pension fund assets just described and the ongoing ability to prefund postretirement medical benefits on a tax-favored basis.

This brings us to our third and final proposed legislative step, which would be the establishment of the same type of ongoing funding vehicle for retiree health care as we already have for pensions. That is, the ability to prefund postretirement medical benefits on a tax-favored basis. In return, employers should be prepared to accept a "retiree health care ERISA." That is, if a company elects to provide retiree health care, it would have to advance fund for the benefit and, further, it would have to meet vesting and participation standards in return for a tax deduction for the contributions and for tax-free accumulation of earnings on the funds contributed.

However, even with ERISA-type rules, the country's budget deficit situation would seem to preclude tax-favored funding in the foreseeable future, because such funding would reduce tax revenues. Therefore, if we are to have a funding vehicle—and we must ultimately have one if we are to solve the problem—business must be willing to put some revenue raisers on the table. Such items could be in or outside of the benefits area. I am not speaking here either for my company or for the business community. Furthermore, I am not going to advocate specific give-ups. I am merely pointing out, as one knowledgeable professional in the field, that the retiree health care problem is symptomatic of the fact that business, labor, and government have not sorted out their priorities in the employee benefits area, in particular, regarding health care. We all need to decide how much our society can afford and who should pay for what. If employer-sponsored retiree health care is deemed by all parties to have a high priority, a tax-favored funding vehicle will give business a good chance

to solve the problem, and the terms and conditions of such a solution must result from statesmanlike compromises by all parties.

Perhaps the debate on retiree health care will focus attention on the urgent need for developing a comprehensive national retirement income and retiree health care policy. We, in the benefits community, at one time believed that this policy should be developed independently of revenue considerations. However, in today's world, this is not realistic. Revenue issues must be considered for the foreseeable future.

In this connection, I would especially like to commend the legislation proposed by Rep. Rod Chandler (R-WA)* as a statesmanlike effort to begin crafting a comprehensive national retirement income and retiree health care policy, taking into account the practical revenue realities. I urge your serious consideration of Rep. Chandler's major proposals.

To summarize, the FASB rules will have such an adverse impact on corporate earnings and liabilities that companies will be faced with a choice of either finding a way to fully or partially offset their retiree health benefits liability or reducing or eliminating the retiree health care benefit. The only way I know to offset the liability is to set aside assets to cover it, either assets already set aside for pensions that are in excess of what is needed for that purpose or new assets purchased through an advance-funding vehicle. As Rep. Chandler has said, "It's time we recognized that the need for adequate retirement income *and* financing retiree health care are part of the same fabric." Accordingly, if assets set aside for pensions are excessive for that purpose, they should be used to satisfy retiree health needs. And, if retirement *income* warrants tax-favored funding, then retiree *health care* should receive the same treatment.

*Editor's note: The Retiree Health Benefits and Pension Preservation Act (H.R. 5309) was introduced in the 100th Congress on September 18, 1988. It would have permitted defined benefit plan sponsors to prefund a retiree's medical or long-term care premiums in amounts of up to \$2,500 per year. Funds from defined contribution plans would also have been allowed to be used to pay for the premiums.

Appendix B

Proposed Statement of Financial Accounting Standards: Employers' Accounting for Postretirement Benefits Other Than Pensions*

FEBRUARY 14, 1989

Summary

This proposed Statement would establish accounting standards for employers' accounting for postretirement benefits other than pensions (hereinafter referred to as postretirement benefits). Although it would apply to all forms of postretirement benefits, this proposed Statement focuses principally on postretirement health care benefits. It would significantly change the prevalent current practice of accounting for postretirement benefits on a pay-as-you-go (cash) basis by requiring accrual, during the years that the employee renders the necessary service, of the expected cost of providing those benefits to an employee and the employee's beneficiaries and covered dependents.

The Board's conclusions in this proposed Statement result from the view that a defined postretirement benefit plan sets forth the terms of an exchange between the employer and the employee. In exchange for services provided by the employee, the employer promises to provide, in addition to current wages and other benefits, health and other welfare benefits during the employee's retirement period. It follows from that view that postretirement benefits are not gratuities but are part of an employee's compensation for services rendered. Since payment is deferred, the benefits are a type of deferred compensation. The employer's obligation for that compensation is incurred as employees render the services necessary to earn their postretirement benefits.

The ability to measure the obligation for postretirement health care benefits and the recognition of that obligation have been the subject of controversy. The Board believes that measurement of the obliga-

*Editor's note: Included in this appendix are selected sections of the Financial Accounting Standards Board exposure draft document. For more detail, refer to the actual document.

tion and accrual of the cost based on best estimates are superior to implying, by a failure to accrue, that no obligation exists prior to the payment of benefits. The Board believes that failure to recognize any obligation prior to its payment impairs the usefulness and integrity of the employer's financial statements.

The Board's objectives in issuing this proposed Statement are to improve employers' financial reporting for postretirement benefits in the following manner:

- a. To enhance the relevance and representational faithfulness of the employer's reported results of operations by recognizing net periodic postretirement benefit cost as employees render the services necessary to earn their postretirement benefits, pursuant to the terms of the plan
- b. To enhance the relevance and representational faithfulness of the employer's statement of financial position by including a measure of the obligation to provide postretirement benefits based on the terms of the underlying plan
- c. To enhance the ability of users of the employer's financial statements to understand the extent and effects of the employer's undertaking to provide postretirement benefits to its employees
- d. To improve the understandability and comparability of amounts reported by requiring employers with similar plans to use the same method to measure their accumulated postretirement benefit obligation and the related cost of the postretirement benefits.

Similarity to Pension Accounting

The provisions of this proposed Statement are similar, in many respects, to those in FASB Statements No. 87, *Employers' Accounting for Pensions*, and No. 88, *Employers' Accounting for Settlements and Curtailments of Defined Benefit Pension Plans and for Termination Benefits*. To the extent the promise to provide pension benefits and the promise to provide postretirement benefits are similar, the provisions of this proposed Statement would be the same as or similar to those prescribed by Statements 87 and 88; different accounting treatment would be prescribed only when the Board has concluded that there is a compelling reason for different treatment. Appendix B [of full FASB document] identifies the major similarities and differences between this proposed Statement and employers' accounting for pensions.

Basic Tenets

This proposed Statement relies on a basic premise of generally accepted accounting principles that accrual accounting provides more relevant and useful information than does cash basis accounting. The importance of information about cash flows or the funding of the postretirement benefit plan is not ignored. Amounts funded or paid are given accounting recognition as uses of cash, but the Board believes that information about cash flows alone is insufficient. Accrual accounting goes beyond cash transactions and attempts to recognize the financial effects of noncash transactions and events as they occur. Recognition and measurement of the accrued obligation to provide postretirement benefits will provide users of financial statements with the opportunity to assess the financial consequences of employers' compensation decisions.

Accrual accounting is concerned with expected future cash receipts and disbursements as a result of transactions and events that have already occurred and recognizes assets, liabilities, and earnings on that basis. The Board believes that for postretirement benefits, as in other areas, the resulting accounting information is more representationally faithful and more relevant to financial statement users than accounting information prepared solely on the basis of cash transactions.

In applying accrual accounting to postretirement benefits, this proposed Statement would adopt three fundamental aspects of pension accounting: delayed recognition of certain events, reporting net cost, and offsetting liabilities and related assets.

Delayed recognition means that certain changes in the obligation for postretirement benefits, including those changes arising as a result of a plan initiation or amendment, and certain changes in the value of plan assets set aside to meet that obligation would not be recognized as they occur. Rather, those changes would be recognized systematically over future periods. All changes in the obligation and plan assets would ultimately be recognized unless they are first reduced by other changes. The changes that have been identified and quantified but not yet recognized in the employer's financial statements as components of net periodic postretirement benefit cost and as a liability or asset would be disclosed.

Net cost means that the recognized consequences of events and transactions affecting a postretirement benefit plan would be reported as a single amount in the employer's financial statements. That single amount would include at least three types of events or

transactions that might otherwise be reported separately. Those events or transactions—exchanging a promise of deferred compensation in the form of postretirement benefits for employee service, the interest cost arising from the passage of time until those benefits are paid, and the returns from the investment of plan assets—would be disclosed separately as components of net periodic postretirement benefit cost.

Offsetting means that plan assets restricted for the payment of postretirement benefits would offset the accumulated postretirement benefit obligation in determining amounts recognized in the employer's statement of financial position and that the return on those plan assets would offset postretirement benefit cost in the employer's statement of income. That offsetting would be reflected even though the obligation has not been settled, the investment of the plan assets may be largely controlled by the employer, and substantial risks and rewards associated with both the obligation and the plan assets are borne by the employer.

Recognition and Measurement

The Board is sensitive to concerns about the reliability of measurements of the postretirement health care benefit obligation. The Board recognizes that limited historical data about per capita claims cost are available and that actuarial practice in this area is still developing. The Board has taken those factors into consideration in its decisions to delay the effective date for the proposed standard and to emphasize disclosure while phasing in recognition of the transition obligation in an employer's statement of financial position. However, the Board believes that those factors are insufficient reason not to utilize accrual accounting for postretirement benefits in financial reporting. With increased experience, the reliability of measures of the obligation and cost should improve.

This proposed Statement would require that an employer's obligation for postretirement benefits expected to be provided to or for an employee be fully accrued by the date that employee attains full eligibility for the benefits expected to be received by that employee, any beneficiaries, and covered dependents (the full eligibility date), even if the employee is expected to render additional service beyond that date. That accounting reflects the fact that at the full eligibility date the employee has provided all service necessary to retire and receive all of the benefits that employee is expected to earn under the plan.

The beginning of the attribution (accrual) period is the employee's date of hire unless the plan only grants credit for service from a later date, in which case benefits are generally attributed from the beginning of that credited service period. An equal amount of the expected postretirement benefit obligation is attributed to each year of service in the attribution period unless the plan otherwise specifies the benefits earned for specific periods of service. The Board concluded that, like accounting for other deferred compensation agreements, accounting for postretirement benefits should reflect the explicit or implicit contract between the employer and its employees.

Single Method

The Board believes that understandability, comparability, and usefulness of financial information are improved by narrowing the use of alternative accounting methods that do not reflect different facts and circumstances. The Board has been unable to identify circumstances that would make it appropriate for different employers to use fundamentally different accounting methods or measurement techniques for similar postretirement benefit plans or for a single employer to use fundamentally different methods or measurement techniques for different plans. As a result, a single method would be prescribed for measuring and recognizing an employer's accumulated postretirement benefit obligation.

Minimum Liability

Certain aspects of the delayed recognition features of this proposed Statement cause the liability that is recognized in the employer's statement of financial position to differ from the best available current measurement of the unfunded accumulated postretirement benefit obligation. This proposed Statement would require recognition of a minimum liability to limit the extent to which delayed recognition of the transition obligation, changes in the plan, and loss recognition would otherwise understate the employer's recognized obligation. That minimum liability would be measured as the unfunded accumulated postretirement benefit obligation for retirees and other fully eligible plan participants.

Transition

Unlike the effects of most other accounting changes, a transition obligation for postretirement benefits generally reflects, to a consid-

erable extent, the failure to accrue the accumulated postretirement benefit obligation in earlier periods as it arose rather than the effects of a change from one acceptable accrual method of accounting to another. The Board believes that accounting for transition from one method to another is a practical matter and that a major objective of that accounting is to minimize the cost and mitigate the disruption to the extent possible without unduly compromising the ability of financial statements to provide useful information.

This proposed Statement measures the transition obligation as the unfunded and unrecognized accumulated postretirement benefit obligation for all plan participants. The initial emphasis of this proposed Statement is on disclosure of that transition obligation, with recognition of the effect of that obligation in the statement of financial position and in the statement of income being phased in over future periods. However, that delayed recognition would not be permitted to result in less rapid recognition than accounting for the transition obligation on a pay-as-you-go basis.

Effective Date

This proposed Statement generally would be effective for fiscal years beginning after December 15, 1991, except that the application of this proposed Statement to non-U.S. plans and certain small, non-public employers would be delayed to fiscal years beginning after December 15, 1993. The provisions requiring recognition of a minimum liability would be delayed for all employers to fiscal years beginning after December 15, 1996.

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Introduction

1. This Statement establishes standards of financial accounting and reporting for an employer that offers **postretirement benefits other than pensions**¹ (hereinafter referred to as **postretirement benefits**) to its employees.² The Board added a project on postemployment **benefits** other than pensions to its agenda in 1979 as part of its project on accounting for pensions and other postemployment benefits. In 1984, the subject of accounting for postemployment benefits other than pensions was identified as a separate project. As interim measures, in November 1984, the Board issued FASB Statement No. 81, *Disclosure of Postretirement Health Care and Life Insurance Benefits*, and in April 1987, issued FASB Technical Bulletin No. 87-1, *Accounting for a Change in Method of Accounting for Certain Postretirement Benefits*.
2. Most employers have accounted for postretirement benefits on a pay-as-you-go (cash) basis. As the prevalence and magnitude of employers' promises to provide those benefits have increased, there has been increased concern about the failure of financial reporting to identify the financial effects of those promises.
3. The Board views a **postretirement benefit plan** as a deferred compensation arrangement whereby an employer promises to exchange future benefits for employees' current services. Since the obligation to provide benefits arises as employees render the services necessary to earn the benefits pursuant to the terms of the **plan**, the Board believes that the cost of providing the benefits should be recognized over those employee service periods.
4. This Statement addresses, for the first time, the fundamental accounting issues related to measuring and recognizing the exchange that takes place between an employer that promises to provide postretirement benefits and the employees who render services in exchange for those benefits. The Board believes the accounting recognition required by this Statement should result in more useful and repre-

¹Words that appear in the glossary are set in **boldface type** the first time they appear.

²The Board will consider the accounting for benefits paid after employment but before retirement (for example, layoff benefits) in a separate phase of its project on accounting for postemployment benefits other than pensions. The fact that this Statement does not apply to those benefits should not be construed as discouraging the use of accrual accounting for those benefits.

sentationally faithful financial statements. However, this Statement is not likely to be the final step in the evolution of more useful accounting for postretirement benefit arrangements.

5. The Board's objectives in issuing this Statement are to improve employers' financial reporting for postretirement benefits in the following manner:

- a. To enhance the relevance and representational faithfulness of the employer's reported results of operations by recognizing **net periodic postretirement benefit cost**³ as employees render the services necessary to earn their postretirement benefits, pursuant to the terms of the plan
- b. To enhance the relevance and representational faithfulness of the employer's statement of financial position by including a measure of the obligation to provide postretirement benefits based on the terms of the underlying plan
- c. To enhance the ability of users of the employer's financial statements to understand the extent and effects of the employer's undertaking to provide postretirement benefits to its employees
- d. To improve the understandability and comparability of amounts reported by requiring employers with similar plans to use the same method to measure their **accumulated postretirement benefit obligation** and the related cost of the postretirement benefits.

Standards of Financial Accounting and Reporting

Scope

6. This Statement is applicable to all postretirement benefits expected to be provided by an employer to current and future **retirees** (including those employees deemed to be on a disability retirement), their beneficiaries, and covered dependents, pursuant to the terms of an employer's undertaking to provide those benefits. Postretirement benefits include, but are not limited to, postretirement health care, which is thought to be the most significant in terms of cost and prevalence; life insurance provided to retirees outside a pension plan; and other welfare benefits such as tuition assistance, day care, legal

³This Statement uses the term *net periodic postretirement benefit cost* rather than *net postretirement benefit expense* because part of the cost recognized in a period may be capitalized along with other costs as part of an asset such as inventory.

services, and housing subsidies provided after retirement. Often those benefits are in the form of a reimbursement or direct payment to providers for the cost of specified services as the need for those services arises, but they may also include benefits payable as a lump sum, such as death benefits.

7. This Statement also applies to **settlement** of all or part of an employer's accumulated postretirement benefit obligation or **curtailment** of a postretirement benefit plan and to an employer that provides postretirement benefits as part of a special termination benefits offer.

8. An employer's promise to provide postretirement benefits may take a variety of forms and may or may not be funded. This Statement applies to any arrangement that is in substance a postretirement benefit plan, regardless of its form, or the means or timing of its funding. This Statement applies both to written plans and to plans whose existence may be implied from a well-defined, although perhaps unwritten, practice of paying postretirement benefits. For the purposes of this Statement, a postretirement benefit plan is an arrangement whereby an employer undertakes to provide its employees with benefits during their retirement in exchange for their services over a specified period of time, upon attaining a specified age while in service, or both. Benefits may commence immediately upon termination of service or may be deferred for payment upon attaining a specified age.

9. An employer's practice of providing postretirement benefits to selected employees under individual contracts with specific terms determined on an individual-by-individual basis does not constitute a postretirement benefit plan under this Statement. Those contracts shall be accrued individually, following the terms of the contract. If the contract does not define the specific years of service to be rendered in exchange for the benefits, the contract should be accrued in accordance with paragraphs 34–36. This Statement does apply to deferred compensation contracts with individual employees if those contracts, taken together, are equivalent to a postretirement benefit plan.

10. A postretirement benefit plan may be part of a larger plan or arrangement that provides benefits currently to active employees as well as to retirees. In those circumstances, the promise to provide benefits to present and future retirees under the plan shall be seg-

regated from benefits provided currently to active employees and shall be accounted for in accordance with the provisions of this Statement.

11. This Statement does not apply to pension or life insurance benefits provided through a pension plan. The accounting for those benefits is set forth in FASB Statements No. 87, *Employers' Accounting for Pensions*, and No. 88, *Employers' Accounting for Settlements and Curtailments of Defined Benefit Pension Plans and for Termination Benefits*.⁴ This Statement also does not apply to temporary benefits that are provided only to certain employees after their employment and are not provided to employees who retire.

12. This Statement supersedes FASB Statement No. 81, *Disclosure of Postretirement Health Care and Life Insurance Benefits*. Paragraphs 13 and 84 of this Statement amend APB Opinions No. 12, *Omnibus Opinion—1967*, and No. 16, *Business Combinations*, respectively. Paragraph 108 rescinds FASB Technical Bulletin No. 87-1, *Accounting for a Change in Method of Accounting for Certain Postretirement Benefits*.

Amendment to Opinion 12

13. The following sentences replace the first four sentences of paragraph 6 of Opinion 12:

FASB Statements No. 87, *Employers' Accounting for Pensions*, and No. XXX, *Employers' Accounting for Postretirement Benefits Other Than Pensions* (this Statement), apply to deferred compensation contracts with individual employees if those contracts, taken together, are equivalent to a postretirement income or health or welfare benefit plan. Other deferred compensation contracts with specific terms determined on an individual-by-individual basis should be accounted for individually on an accrual basis in accordance with the terms of the underlying

⁴Two Special Reports prepared by the FASB staff, *A Guide to Implementation of Statement 87 on Employers' Accounting for Pensions* and *A Guide to Implementation of Statement 88 on Employers' Accounting for Settlements and Curtailments of Defined Benefit Pension Plans and for Termination Benefits*, provide accounting guidance on implementation questions raised in connection with Statements 87 and 88. Many of the provisions in this Statement are the same as or are similar to the provisions of Statements 87 and 88. Consequently, the guidance provided in those Special Reports should be useful in understanding and implementing many of the provisions of this Statement.

contract. If the contract does not define the specific years of service to be rendered in exchange for the future payments, the amounts expected to be paid should be accrued in a systematic and rational manner over the period of active employment from the date the contract is entered into to the date the employee attains full eligibility (as defined in Statement XXX) for the benefits expected to be received by that employee, any beneficiaries, and covered dependents.

Use of Reasonable Approximations

14. This Statement is intended to specify accounting objectives and results rather than specific computational means of obtaining those results. If estimates, averages, or computational shortcuts can reduce the cost of applying this Statement, their use is appropriate, provided the results are reasonably expected not to be materially different from the results of a detailed application.

Single-Employer Defined Benefit Postretirement Plans

15. This Statement primarily focuses on an employer's accounting for a **single-employer plan** that defines the postretirement benefits to be provided to retirees. For purposes of this Statement, a **defined benefit postretirement plan** is one that defines the postretirement benefits in terms of (a) monetary amounts (for example, \$100,000 of life insurance) or (b) benefit coverage (for example, up to \$200 per day for hospitalization, 80 percent of the cost of specified surgical procedures, and so forth) to be provided. (Specified monetary amounts and benefit coverage are hereinafter collectively referred to as benefits.) **Full eligibility** for postretirement benefits may be defined in terms of compensation levels, years of service, attained age while in service, or a combination of those factors and may or may not coincide with full eligibility for pension benefits.

16. A postretirement benefit is part of the compensation paid to an employee for services rendered. In a defined benefit plan, the employer promises to provide, in addition to current wages and benefits, future benefits during retirement. Generally, the amount of those benefits depends on the **benefit formula** (which includes factors such as the number of years of service rendered or the employee's compensation before retirement or termination) and how long the retiree and any beneficiaries and covered dependents live and the incidence

of events requiring benefit payments (for example, illnesses affecting the amount of health care required). In most cases, services are rendered over a number of years before an employee retires and begins to receive benefits or is entitled to receive benefits as a need arises. Even though the services rendered by the employee are complete and the employee has retired, the total amount of benefits the employer has promised and the cost to the employer of the services rendered are not precisely determinable but can be estimated using the plan's benefit formula and estimates of the effects of relevant future events.

Basic Elements of Accounting for Postretirement Benefits

17. Any method of accounting that recognizes the cost of postretirement benefits over employee service periods (before the payment of benefits to retirees) must deal with two factors that stem from the nature of the arrangement. First, estimates or **assumptions** must be made concerning the future events that will determine the amount and timing of the benefit payments. Second, an **attribution** approach that assigns benefits and the cost of those benefits to individual years of service must be selected. The basic elements of accounting for postretirement benefits are described in paragraphs 18–20.

18. The **expected postretirement benefit obligation** for an employee is the **actuarial present value** as of a date of the postretirement benefits expected to be paid to or for the employee, the employee's beneficiaries, and any covered dependents pursuant to the terms of the plan. Measurement of the expected postretirement benefit obligation is based on the expected amount and timing of future benefits, taking into consideration future costs and the extent to which the benefit promise encompasses cost increases. An employee's future compensation is considered in that measurement if the benefit formula is based on compensation. Plans that base benefits on compensation may be referred to as **pay-related plans**. Plans that do not base benefits on compensation may be referred to as **non-pay related plans**.

19. Net periodic postretirement benefit cost comprises several components that reflect different aspects of the employer's financial arrangements. The **service cost** component of net periodic postretirement benefit cost is the actuarial present value of benefits attributed to services rendered by employees during the period (the proportion of the expected postretirement benefit obligation attributed to service in the period). The service cost component is the same for an unfunded

plan, a plan with minimal funding, and a well-funded plan. The other components of net periodic postretirement benefit cost are **interest cost**⁵ (interest on the accumulated postretirement benefit obligation, which is a discounted amount), **actual return on plan assets**, **amortization of unrecognized prior service cost**, amortization of the **transition obligation or asset**, and the **gain or loss component**.

20. The accumulated postretirement benefit obligation as of a particular date is the actuarial present value of all future benefits attributed to employees' service rendered to that date pursuant to paragraphs 34–37, assuming the plan continues in effect and that all assumptions about future events are fulfilled. Prior to the date on which an employee attains full eligibility for the benefits that employee is expected to earn under the terms of the postretirement benefit plan (the **full eligibility date**),⁶ the accumulated postretirement benefit obligation for an employee is a portion of the expected postretirement benefit obligation. On and after the full eligibility date, the accumulated postretirement benefit obligation and the expected postretirement benefit obligation for an employee are the same. Determination of the full eligibility date is not affected by measurement assumptions such as when the benefit payments will commence, **dependency status**, salary progression, and so forth.

Measurement of Cost and Obligations

21. The Board believes that measuring the net periodic postretirement benefit cost and accumulated postretirement benefit obligation based on best estimates is superior to implying, by a failure to accrue, that no cost or obligation exists prior to the payment of benefits. This Statement requires the use of **explicit assumptions**, each of which individually represents the best estimate of a particular future event, to measure the expected postretirement benefit obligation. A portion of that expected postretirement benefit obligation is attributed to

⁵The interest cost component of postretirement benefit cost shall not be considered interest for purposes of applying FASB Statement No. 34, *Capitalization of Interest Cost*.

⁶For example, for a plan that provides 100 percent benefit coverage to employees who render at least 10 years of service and attain age 55 while in service, the full eligibility date is the date at which an employee first meets both of those conditions. For a plan that provides 50 percent benefit coverage to employees who render 20 years of service and 3 percent benefit coverage for each year of service thereafter, up to a maximum of 80 percent benefit coverage, the full eligibility date is the earlier of the date at which an employee has rendered 30 years of service or retires (terminates) with at least 20 years of service.

each period of an employee's service associated with earning the postretirement benefits, and that amount is accrued as service cost for that period. The accumulated postretirement benefit obligation is the aggregation of the expected postretirement benefit obligation attributed to **plan participants'** prior service periods associated with earning the postretirement benefits together with interest thereon less benefits paid.

22. The **vested postretirement benefit obligation** provides information about the amount of benefits expected to be paid to or for retirees, former employees, and active employees assuming they terminated immediately, including benefits expected to be paid to or for beneficiaries and any covered dependents. The vested postretirement benefit obligation for active employees measures the obligation for postretirement benefits for which employees' rights to receive those benefits are not contingent on remaining in the service of the employer; it may exceed the employer's accumulated postretirement benefit obligation for those employees.⁷ The vested postretirement benefit obligation for former employees, including retirees, is the same as the accumulated postretirement benefit obligation for those employees.

Assumptions

23. The service cost component of postretirement benefit cost, any **prior service cost**, and the accumulated postretirement benefit obligation are measured using actuarial assumptions and present value techniques to calculate the actuarial present value of the expected future benefits attributed to periods of employee service. Each assumption used shall reflect the best estimate solely with respect to that individual assumption. All assumptions shall presume that the plan will continue in effect in the absence of evidence that it will not continue. Principal actuarial assumptions include the time value of money (**discount rates**); the amount and timing of future benefit pay-

⁷For example, for a plan that provides 100 percent benefit coverage commencing upon retirement (termination of service) to employees who render at least 10 years of service and attain age 55 while in service, the accumulated postretirement benefit obligation for a 55-year-old employee who has rendered at least 10 years of service and is expected to retire at age 62 would be measured as the actuarial present value of the benefits expected to be paid to or for that employee commencing upon retirement at age 62. The vested postretirement benefit obligation would be measured as the actuarial present value of the benefits that would be paid to or for that employee assuming benefits commenced immediately (as though the employee retired immediately).

ments, which for **postretirement health care benefits** consider past and present **per capita claims cost by age, health care cost trend rates, Medicare reimbursement rates**, and so forth; salary progression (for pay-related plans);⁸ and the probability of payment (turnover, retirement age, dependency status, mortality, and so forth).

24. Assumed discount rates shall reflect the interest rates inherent in the amount at which the postretirement benefit obligation could be effectively settled (that is, the interest rates that determine the single amount that, together with returns on that amount equal to the discount rates, would provide the cash flows necessary to provide the benefits, assuming no future experience **gains or losses**). In making that assumption, employers may also look to rates of return on high-quality fixed-income investments currently available and expected to be available during the period until the benefits are expected to be paid. Assumed discount rates are used in measurements of the expected, accumulated, and vested postretirement benefit obligations and the service cost and interest cost components of net periodic postretirement benefit cost.

25. The **expected long-term rate of return on plan assets** shall reflect the average rate of earnings expected on the existing assets that qualify as **plan assets** and contributions to the plan expected to be made during the period. In estimating that rate, appropriate consideration should be given to the returns being earned by the plan assets currently invested and the rates of return expected to be available for reinvestment. If the return on plan assets is taxable to the plan, the expected long-term rate of return shall be reduced to reflect the expected income tax accrual rate under existing law determined in accordance with FASB Statement No. 96, *Accounting for Income Taxes*. If the return on plan assets is taxable to the employer, the expected long-term rate of return shall not reflect the effect of taxes. The expected long-term rate of return on plan assets is used (with the **market-related value of plan assets**) to compute the **expected return on**

⁸Unlike Statement 87, this Statement includes salary progression in the measurement of the accumulated postretirement benefit obligation of a pay-related plan. Statement 87 refers to the measurement that excludes salary progression as the accumulated benefit obligation and the measurement that includes salary progression as the projected benefit obligation. In both this Statement and Statement 87, the accumulated benefit obligation is disclosed and, as discussed in footnote 30, either all (Statement 87) or a portion (this Statement) of the unfunded accumulated benefit obligation is used to measure the **minimum liability**.

plan assets. (Refer to paragraph 50.) There is no assumption of an expected long-term rate of return on plan assets for plans that are unfunded or that have no assets that qualify as plan assets pursuant to this Statement.

26. The service cost components of net periodic postretirement benefit cost and the expected and accumulated postretirement benefit obligations shall reflect future compensation levels to the extent the postretirement benefit formula defines the benefits wholly or partially as a function of future compensation levels.⁹ Future increases in benefits for which a present commitment exists as described in paragraph 37 shall be similarly reflected. Assumed compensation levels shall reflect the employer's best estimate of the actual future compensation levels of the individual employees involved, including future changes attributed to general price levels, productivity, seniority, promotion, and other factors. All assumptions shall be consistent to the extent that each reflects expectations of the same future economic conditions, such as future rates of inflation. Measuring service cost and the expected and accumulated postretirement benefit obligations based on estimated future compensation levels entails considering any indirect effects, such as benefit limitations, that would affect benefits provided by the plan.¹⁰

27. Automatic benefit increases¹¹ specified by the plan that are expected to occur shall be included in measurements of the expected,

⁹For pay-related plans, salary progression is included in measuring the expected postretirement benefit obligation. For example, a postretirement health care plan may define the deductible amount or copayment, or a postretirement life insurance plan may define the amount of death benefit, based on the employee's average or final level of annual compensation. Refer to the discussion in footnote 8 regarding inclusion of the salary progression assumption in measurement of the accumulated postretirement benefit obligation.

¹⁰For example, a plan may define the maximum benefit to be provided under the plan (an unadjustable cap). In measuring the expected postretirement benefit obligation under that plan, the projected benefit payments would be limited to that cap. For a plan that adjusts the maximum benefit to be provided under the plan for the effects of inflation (an adjustable cap), the expected postretirement benefit obligation would be measured based on adjustments to that cap consistent with the assumed inflation rate reflected in other inflation-related assumptions.

¹¹For purposes of this Statement, a plan that promises to provide retirees a benefit in kind, such as health care benefits, rather than a defined dollar amount of benefit, is considered to be a plan that specifies automatic benefit increases. (The assumed increase in the future cost of providing health care benefits, the assumed health care cost trend rate, is discussed in paragraph 31.) A benefit in kind includes the direct rendering of services, the payment directly to others who provide the services, or the reimbursement of the retiree's payment for those services.

accumulated, and vested postretirement benefit obligations and the service cost component of net periodic postretirement benefit cost. Also, retroactive **plan amendments** shall be included in the computation of the expected and accumulated postretirement benefit obligations once they have been contractually agreed to, even if some provisions take effect only in future periods. For example, if a plan amendment grants a different benefit level for employees retiring after a future date, that increased or reduced benefit level shall be included in current-period measurements for employees expected to retire after that date.

Assumptions Unique to Postretirement Health Care Benefit Measurements

28. Measurements of the expected, accumulated, and vested postretirement benefit obligations, the service cost component of net periodic postretirement benefit cost, and determination of prior service cost for postretirement health care benefits require the use of several assumptions in addition to those addressed in paragraphs 23–27. Most significantly, they include assumptions about the amount and timing of future benefits, which require consideration of historical per capita claims cost by age, health care cost trend rates (for plans that provide a benefit in kind), and medical coverage by governmental authorities and other providers of health care benefits.

29. The **assumed per capita claims cost by age** is the future per capita cost, after the **measurement date**, of providing the postretirement health care benefits at each age from the earliest ages at which plan participants could begin to receive benefits under the plan through their remaining life expectancy or the covered period, if shorter. To determine the assumed per capita claims cost by age, the per capita claims cost by age based on historical claims costs is adjusted for assumed health care cost trend rates and the effects of coverage by Medicare and other providers of health care benefits. The resulting assumed per capita claims cost by age reflects expected future costs and is applied with the plan **demographics** to determine the amount and timing of expected future benefits.

30. Past and present claims data shall be used in developing an employer's assumed per capita claims cost by age to the extent that those data are considered to be representative of the employer's expected future experience. That assumption also may be based on or

may consider a historical pattern of claims by age (claims curve) and claims experience of other employers with similar participant demographics. The latter information may be developed by insurance companies, actuarial firms, or employee benefit consulting firms from information in data banks. The per capita claims cost by age developed on those bases shall be adjusted to best reflect the employer's circumstances. For example, the information should be adjusted, as necessary, for differing demographics, such as health care utilization patterns by men and women at various ages, the expected geographical location of retirees and their dependents, the age and sex of plan participants, and the plan's terms to the extent that different benefits are provided.

31. The health care cost trend rates assumption represents the expected annual changes in the incurred claims cost of health care benefits currently provided by the postretirement benefit plan due to factors other than changes in the demographics of the plan participants. That assumption shall consider estimates of health care inflation, changes in health care utilization or delivery patterns, technological advances, and changes in the health status of plan participants.¹² Differing services, such as hospital care and dental care, may require the use of different health care cost trend rates. It is appropriate to reflect in that assumption the fact that health care cost trend rates change over time.

32. Assumed discount rates include an inflationary element that reflects the expected general rate of inflation. Assumed compensation levels include consideration of future changes attributable to general price levels. Similarly, assumed health care cost trend rates include an element that reflects expected general rates of inflation for the economy overall and for health care costs in particular. To the extent that those assumptions consider similar inflationary effects, the assumptions about those effects shall be consistent.

33. Certain medical claims may be covered by governmental programs under existing law¹³ or by other providers of health care ben-

¹²An assumption about changes in the health status of plan participants considers, for example, the probability that certain claims costs will be incurred based on expectations of future events, such as the likelihood that some retirees will incur claims requiring technology currently being developed or that historical claims experience for certain medical needs may be reduced as a result of participation in a wellness program.

¹³For example, under existing U.S. law, certain health care benefits are provided by the Health Care Financing Administration through Medicare.

efits.¹⁴ Benefit coverage by those providers shall be assumed to continue at the level provided by the present law or plan, absent evidence to the contrary. Enacted changes in the law or amendments of plans of other health care providers that will affect the future level of their benefit coverage shall be considered in current-period measurements for benefits expected to be provided in future periods. Future changes in the law or future amendments of benefits provided by others shall not be anticipated.

Attribution

34. For purposes of this Statement, except as described in paragraphs 35–37, the expected postretirement benefit obligation for a plan participant ordinarily shall be attributed to periods of employee service to the full eligibility date based on the plan's benefit formula to the extent that the formula states or implies how that obligation should be attributed. An equal amount of benefits will not necessarily be attributed to each period of employee service to the full eligibility date.

- a. The beginning of the **attribution period** shall be the date of hire¹⁵ unless the plan's benefit formula grants credit only for service from a later date, in which case benefits shall be attributed from the beginning of that **credited service period**.¹⁶
- b. An equal amount of the expected postretirement benefit obligation shall be attributed to each year of service in the attribution pe-

¹⁴For example, a retiree's spouse also may be covered by the spouse's present (or former) employer's health care plan. In that case, the spouse's employer (or former employer) may provide primary or secondary postretirement health care benefits to the retiree's spouse or dependents.

¹⁵For example, for a plan that provides benefit coverage to employees who render 30 or more years of service or who render at least 10 years of service and attain age 55 while in service, without specifying when the credited service period begins, the expected postretirement benefit obligation is attributed to service from the date of hire to the earlier of the date at which a plan participant has rendered 30 years of service or has rendered 10 years of service and attained age 55 while in service.

¹⁶For example, for a plan that provides benefit coverage to employees who render at least 20 years of service after age 35, the expected postretirement benefit obligation is attributed to a plan participant's first 20 years of service after attaining age 35 or after the date of hire, if later than age 35.

riod¹⁷ (a benefit/years-of-service approach)¹⁸ *unless the plan's benefit formula specifies the benefits earned for specific periods of service*,¹⁹ in which case benefits shall be attributed in accordance with the plan's benefit formula.²⁰

35. Some plans may have benefit formulas that define benefits in terms of specific periods of service to be rendered in exchange for those benefits but attribute all or a disproportionate share of the expected postretirement benefit obligation to employees' later years of service.²¹ For those plans, the expected postretirement benefit obligation shall be attributed to employee service as described in paragraph 36. A plan benefit formula is considered to attribute all or a

¹⁷For example, for a plan that provides health care benefits of up to \$800 per year in incurred claims for life to employees whose attained age plus years of service equals at least 80 when they retire, an equal amount of the expected postretirement benefit obligation is attributed to each year of service from the date of hire to the date at which a plan participant's age plus years of service equals 80. For an active plan participant who is expected to have rendered 20 years of service upon attaining age 60, the amount of the benefit attributed to each of the first 20 years of that plan participant's service is \$40 multiplied by the number of years of life expectancy after retirement (assuming that the plan participant is expected to receive the maximum benefit of \$800 in each of those years); the service cost attributable to each of those years of service is the actuarial present value of that benefit. Stated another way, because this plan does not specify different benefits for different years of service, each year prior to the plan participant's full eligibility date, one twentieth of the expected postretirement benefit obligation for that plan participant is recognized as service cost.

¹⁸Except as noted in footnote 19, that method is the same as the projected unit credit or unit credit with service prorate actuarial cost method for pay-related plans. For non-pay related plans, it is the same as the unit credit actuarial cost method.

¹⁹Some plans have benefit formulas that define different benefits for different years of service. For example, a step-rate plan might provide a benefit of 1 percent of final pay for each year of service up to 20 years and 1.5 percent of final pay for years of service in excess of 20. Another plan benefit formula might define the benefit as 1 percent of final pay for each year of service but limit the total annual benefit to no more than 20 percent of final pay. For plans that define different benefits for different years of service, the attribution called for by this Statement will not assign the same amount of benefits to each year of service and is not the same as the actuarial cost methods identified in footnote 18.

²⁰For example, for a plan that provides 50 percent benefit coverage to employees who render 20 years of service and 3 percent benefit coverage for each year of service thereafter, the actuarial present value of the cost of providing 2.5 percent benefit coverage is attributed to service in years 1–20, and the actuarial present value of the cost of providing 3 percent benefit coverage is attributed to each year of service thereafter.

²¹For example, a plan with a benefit formula that defines no benefits for the first 19 years of service after age 35 and benefits of \$10,000 for the 20th year of service after age 35 is substantively the same as a plan with a benefit formula that defines benefits of \$500 for each of the first 20 years of service after age 35, with employees only eligible for the benefits upon completion of the 20th year of service after age 35.

disproportionate share of the expected postretirement benefit obligation to later years of service if (a) a disproportionate share of the expected postretirement benefit obligation is attributed to later years of service in the credited service period or (b) an employee is fully eligible for benefits upon completion of the credited service period and the years of service in the credited service period are nominal relative to the total years of service prior to the full eligibility date.

36. For plans with a benefit formula that attributes all or a disproportionate share of benefits to employees' later years of service, the expected postretirement benefit obligation shall be attributed as follows:

- a. For plans with a benefit formula that attributes all or a disproportionate share of the benefits to employees' later years of service in the credited service period, an equal amount of a plan participant's expected postretirement benefit obligation shall be attributed to each year of that plan participant's service in the credited service period.²²
- b. For plans with a benefit formula that attributes the benefits to a credited service period that is nominal in relation to employees' total years of service prior to their full eligibility date, an equal amount of a plan participant's expected postretirement benefit obligation shall be attributed to each year of that plan participant's service prior to full eligibility for benefits.²³
- c. For plans with a benefit formula (1) that attributes all or a disproportionate share of the benefits to later years of service in the credited service period and (2) that defines a credited service period that is nominal in relation to employees' total years of service prior to their full eligibility date, an equal amount of a plan par-

²²For example, a plan that attributes 1 percent benefit coverage to each of the first 19 years of service after age 35 and 61 percent benefit coverage to service in the 20th year of service after age 35 attributes a disproportionate share of the benefit to later years of service in the credited service period (service after age 35). For plan participants expected to render at least 20 years of service after age 35 under that plan, the service cost recognized each year during their credited service period is an equal portion (1/20) of the expected postretirement benefit obligation.

²³For example, a plan with a benefit formula that defines 100 percent benefit coverage for service in the year employees attain age 60 has a 1-year credited service period. If plan participants are expected to have rendered an average of 20 years of service at age 60, the credited service period is nominal in relation to their total years of service prior to their full eligibility date. In that case, the service cost recognized each year of a plan participant's service to age 60 is an equal portion of the expected postretirement benefit obligation.

participant's expected postretirement benefit obligation shall be attributed to each year of that plan participant's service prior to full eligibility for benefits.²⁴

37. In some situations a history of regular increases in benefits and other evidence may indicate that an employer has a present commitment to make future improvements to the plan and that the plan will provide benefits attributable to prior service that are greater than the benefits defined by the written terms of the plan. In those situations the commitment shall be the basis for the accounting, and the existence and nature of the commitment to make future amendments shall be disclosed.

Recognition of Net Periodic Postretirement Benefit Cost

38. As with other forms of deferred compensation, the cost of providing postretirement benefits shall be attributed to the periods of employee service rendered in exchange for those future benefits pursuant to the terms of the plan. That cost notionally represents the change in the **unfunded accumulated postretirement benefit obligation** for the period, ignoring employer contributions to the plan, plan settlements, and payments made by the employer directly to retirees. However, changes in that unfunded obligation arising from experience gains and losses and the effects of changes in assumptions may be recognized on a delayed basis. In addition, the effects of a plan initiation or amendment are generally recognized on a delayed basis.

39. The following components shall be included in the net postretirement benefit cost recognized for a period by an employer sponsoring a defined benefit postretirement plan:

- a. Service cost
- b. Interest cost

²⁴For example, a plan with a benefit formula that defines 5 percent benefit coverage for service in years 20–24 and 80 percent coverage for service in year 25 attributes a disproportionate share of benefits to later years of service in the credited service period (service in years 20–25), and the credited service period is nominal in relation to employees' total years of service prior to their full eligibility date. For a plan participant expected to render 25 or more years of service, the service cost recognized in each of that plan participant's first 25 years of service is an equal portion (1/25) of the expected postretirement benefit obligation.

- c. Actual return on plan assets, if any
- d. Amortization of unrecognized prior service cost, if any
- e. Gain or loss (including the effects of change in assumptions) to the extent recognized (paragraphs 52–54)
- f. Amortization of the unrecognized obligation or asset existing at the date of initial application of this Statement (hereinafter referred to as the **unamortized transition obligation**²⁵ or **unamortized transition asset**). (Refer to paragraphs 105 and 106.)

Service Cost

40. The service cost component recognized in a period shall be determined as the actuarial present value of the expected postretirement benefit obligation attributed to employee service during that period. The measurement of the service cost component requires use of assumptions and an attribution method, which are discussed in paragraphs 21–37 of this Statement.

Interest Cost

41. The interest cost component recognized in a period shall be determined as the increase in the accumulated postretirement benefit obligation to recognize the effects of the passage of time. Measuring the accumulated postretirement benefit obligation as a present value requires accrual of an interest cost at rates equal to the assumed discount rates.

Actual Return on Plan Assets

42. For a funded plan, the actual return on plan assets shall be determined based on the **fair value** of plan assets (refer to paragraphs

²⁵The term *unamortized* is used rather than *unrecognized* because in recognizing an additional liability pursuant to paragraph 56, the amount recognized as an intangible asset may at least partially represent a previously unrecognized transition obligation. However, for purposes of (a) recognition of the effects of a negative plan amendment pursuant to paragraph 48; (b) the constraint on immediate recognition of a net gain or loss pursuant to paragraph 53; (c) settlement accounting pursuant to paragraphs 87 and 88; (d) **plan curtailment** accounting pursuant to paragraphs 92–94; and (e) the constraint on delayed recognition of the unrecognized transition obligation pursuant to paragraph 106, the amount of the transition obligation or asset referred to is the amount that has not been recognized in the income statement (as opposed to the amount that has not been recognized in the statement of financial position). The term *unamortized* has been used to distinguish that unrecognized amount.

61 and 62) at the beginning and end of the period, adjusted for contributions and benefit payments. If the plan is a taxable entity, the actual return on plan assets shall reflect the tax expense or benefit for the period determined in accordance with Statement 96. If the return on plan assets is taxable to the employer, no provision for taxes shall be included in the actual return on plan assets.

Prior Service Cost

43. Plan amendments (including initiation of a plan) may include provisions that attribute the increase or reduction in benefits to employee service rendered in prior periods (**retroactive benefits**).²⁶ Similarly, plan amendments may include provisions that attribute the increase or reduction in benefits only to employee service to be rendered in future periods (**prospective benefits**).²⁷ In other cases, plan amendments may not specify how the increase or reduction in benefits is attributed to employee service periods. In the absence of plan provisions defining the specific period of service to which the plan amendment applies, the plan amendment shall be viewed as retroactive.²⁸ That is, for purposes of measuring the accumulated postretirement benefit obligation, the effect of the plan amendment on a plan participant's expected postretirement benefit obligation shall be attributed to each year of service in that plan participant's attribution period, including years of service already rendered by that plan participant, in accordance with the attribution discussed in paragraphs 34–36.

44. Plan amendments are granted with the exception that the employer will realize economic benefits in future periods. Consequently, this Statement does not require the cost of providing retroactive benefits (that is, prior service cost) to be included in net periodic postretirement benefit cost entirely in the year of the amendment. Rather, paragraph 45 of this Statement provides for recognition of prior service cost arising from benefit increases during the remaining years

²⁶For example, if a plan amendment increases the benefits of **fully eligible plan participants**, the additional benefits are implicitly retroactive (attributable to employee service rendered in prior periods).

²⁷For example, if a plan amendment increases benefits by \$25 annually for each year of service rendered after the date the plan is amended, any additional benefits are earned prospectively (attributable only to employee service rendered in future periods).

²⁸For example, if a plan amendment increases benefit coverage provided to all plan participants who render at least 20 years of service, the plan amendment is viewed as retroactive.

of service prior to full eligibility for benefits of those plan participants active at the date of the plan amendment. (Refer to paragraph 48 for plan amendments that reduce benefits.)

45. The cost of retroactive benefit improvements (including improved benefits that are granted to fully eligible plan participants) is the increase in the accumulated postretirement benefit obligation as a result of the plan amendment, measured at the date of the amendment. Except as specified in the next sentence and in paragraphs 46 and 47, that prior service cost shall be amortized by assigning an equal amount to each remaining year of service to full eligibility for benefits of each plan participant active at the date of the amendment (who was not yet fully eligible for benefits at that date). If all or almost all of a plan's participants are fully eligible for benefits, the cost of retroactive plan amendments shall be amortized based on the remaining life expectancy of those plan participants rather than on the remaining years of service prior to full eligibility of the **active plan participants**.

46. To reduce the complexity and detail of the computations required, consistent use of an alternative amortization approach that more rapidly reduces the unrecognized cost of retroactive amendments is permitted. For example, a straight-line amortization of the cost over the average remaining years of service to full eligibility for benefits of the active plan participants is acceptable.

47. In some situations, a history of regular plan amendments and other evidence may indicate that the period during which the employer expects to realize economic benefits from an amendment granting increased benefits retroactively is shorter than the remaining years of service to full eligibility for benefits of the active plan participants. Identification of those situations requires an assessment of the individual circumstances and the substance of the particular plan situation. In those circumstances, the amortization of prior service cost shall be accelerated to reflect the more rapid expiration of the employer's economic benefits and to recognize the cost in the periods benefited.

48. A plan amendment can reduce, rather than increase, the accumulated postretirement benefit obligation. A reduction in that obligation shall be used first to reduce any existing unrecognized prior service cost, then any remaining unamortized transition obligation.

The excess, if any, shall be amortized on the same basis as specified in paragraph 45 for prior service cost. Immediate recognition of the excess is not permitted.

Gains and Losses

49. Gains and losses are changes in the amount of either the accumulated postretirement benefit obligation or plan assets resulting from experience different from that assumed or from changes in assumptions. This Statement does not distinguish between those sources of gains and losses. Gains and losses include amounts that have been realized, for example, by the sale of a security, as well as amounts that are unrealized. Because gains and losses may reflect refinements in estimates as well as real changes in economic values and because some gains in one period may be offset by losses in another or vice versa, this Statement does not require recognition of gains and losses as components of net postretirement benefit cost in the period in which they arise. (Gain and loss recognition in accounting for settlements and curtailments is addressed in paragraphs 85–94).

50. The expected return on plan assets shall be determined based on the expected long-term rate of return on plan assets (refer to paragraph 25) and the market-related value of plan assets. The market-related value of plan assets shall be either fair value or a calculated value that recognizes changes in fair value in a systematic and rational manner over not more than five years. Different methods of calculating market-related value may be used for different classes of assets (for example, an employer might use fair value for bonds and a five-year-moving-average value for equities), but the manner of determining market-related value shall be applied consistently from year to year for each class of plan assets.

51. Plan asset gains and losses are differences between the actual return on plan assets during a period and the expected return on plan assets for that period. Plan asset gains and losses include both (a) changes reflected in the market-related value of plan assets and (b) changes not yet reflected in the market-related value of plan assets (that is, the difference between the fair value and the market-related value of plan assets). Plan asset gains and losses not yet reflected in market-related value are not required to be amortized under paragraphs 52 and 53.

52. As a minimum, amortization of an **unrecognized net gain or loss** (excluding plan asset gains and losses not yet reflected in market-related value) shall be included as a component of net postretirement benefit cost for a year if, as of the beginning of the year, that unrecognized net gain or loss exceeds 10 percent of the greater of the accumulated postretirement benefit obligation or the market-related value of plan assets. If amortization is required, the minimum amortization²⁹ shall be that excess divided by the average remaining service period of active plan participants. If all or almost all of a plan's participants are inactive, the average remaining life expectancy of the inactive participants shall be used instead of the average remaining service period.

53. Any systematic method of amortization of unrecognized gains and losses may be used in place of the minimum amortization specified in paragraph 52 provided that (a) the minimum is used in any period in which the minimum amortization is greater (reduces the unrecognized amount by more), (b) the method is applied consistently, (c) the method is applied similarly to both gains and losses, and (d) the method used is disclosed. If an enterprise uses a method of consistently recognizing gains and losses immediately, any gain that does not offset a loss previously recognized in income pursuant to this paragraph shall first offset any unamortized transition obligation; any loss that does not offset a gain previously recognized in income pursuant to this paragraph shall first offset any unamortized transition asset.

54. The gain or loss component of net periodic postretirement benefit cost shall consist of (a) the difference between the actual return on plan assets and the expected return on plan assets and (b) the amortization of the unrecognized net gain or loss from previous periods.

Recognition of Liabilities and Assets

55. This Statement requires that an employer's statement of financial position report a liability for postretirement benefits that is the greater of (a) the **accrued postretirement benefit cost** or (b) the accumulated postretirement benefit obligation for fully eligible plan participants

²⁹The amortization must always reduce the beginning-of-the-year balance. Amortization of an unrecognized net gain results in a decrease in net periodic postretirement benefit cost; amortization of an unrecognized net loss results in an increase in net periodic postretirement benefit cost.

in excess of the fair value of the plan assets (minimum-liability).³⁰ That requirement is intended to limit the extent to which the delayed recognition of any transition obligation, prior service cost, and losses can result in omission of a liability for those participants' benefits from an employer's statement of financial position.

56. If an employer's measure of the accumulated postretirement benefit obligation for plan participants fully eligible for benefits exceeds the fair value of the plan assets, an additional liability may be required to be recognized. The amount of that additional liability is determined as follows:

- a. If an employer has recognized net periodic postretirement benefit cost in excess of amounts the employer has contributed to the plan³¹ (accrued postretirement benefit cost), an additional liability shall be recognized equal to the amount, if any, by which the employer's minimum liability *exceeds* that accrued postretirement benefit cost.
- b. If an employer has recognized an asset for amounts contributed to the plan in excess of net periodic postretirement benefit cost (**prepaid postretirement benefit cost**),³² an additional liability shall be recognized equal to the employer's minimum liability for that plan *plus* the amount of prepaid postretirement benefit cost.
- c. If an employer has not recognized either accrued or prepaid postretirement benefit cost, an additional liability shall be recognized equal to the employer's minimum liability for that plan.

57. The offset to any additional liability recognized pursuant to paragraph 56 shall be recognized as an intangible asset, provided that the asset recognized shall not exceed the amount of any unrecognized prior service cost.³³ If the additional liability required to be recog-

³⁰Measurement of the minimum liability to be recognized pursuant to this Statement differs from that required to be recognized by Statement 87 because the unfunded accumulated benefit obligation is defined differently (refer to footnote 8) and because the Statement 87 minimum liability includes the unfunded accumulated benefit obligation for all active plan participants, not just those plan participants who have attained full eligibility for benefits.

³¹Benefit payments made directly by the employer to or on behalf of participants in an unfunded plan are considered to be amounts contributed to the plan.

³²Refer to paragraph 106 regarding limitations on recognition of prepaid postretirement benefit cost.

³³For purposes of this paragraph, any unamortized transition obligation (paragraph 105) shall be treated as unrecognized prior service cost.

nized exceeds unrecognized prior service cost, the excess (which would represent a net loss not yet recognized as net periodic postretirement benefit cost) shall be reported as a separate component (that is, a reduction) of equity, with that component of equity reported net of any tax benefits that result from considering such a loss as a temporary difference for purposes of applying the provisions of Statement 96. The additional liability is unaffected by those tax considerations.

58. Each year-end (refer to paragraph 63) an employer shall determine the amount of additional liability to be recognized pursuant to paragraph 56. Any previously recognized additional liability and offsetting intangible asset and component of equity shall be adjusted as necessary to recognize the amount of any additional liability currently required to be recognized pursuant to paragraphs 56 and 57.

Measurement of Plan Assets

59. Plan assets are assets—usually stocks, bonds, and other investments (except certain insurance contracts as noted in paragraph 75)—that have been segregated and restricted (usually in a trust) to be used for postretirement benefits. The amount of plan assets includes amounts contributed by the employer (and by plan participants for a **contributory plan**) and amounts earned from investing the contributions, less benefits, taxes, and other expenses incurred. Plan assets ordinarily cannot be withdrawn by the employer except under certain circumstances when a plan has assets in excess of obligations and the employer has taken certain steps to satisfy existing obligations. Securities of the employer held by the plan are includable in plan assets provided they are transferable.

60. Assets not segregated in a trust, or otherwise effectively restricted, so that they cannot be used by the employer for other purposes are not plan assets for purposes of this Statement, even though the employer may intend that those assets be used to provide postretirement benefits. Those assets shall be accounted for in the same manner as other employer assets of a similar nature and with similar restrictions. Amounts accrued by the employer but not yet paid to the plan are not plan assets for purposes of this Statement.

61. For purposes of measuring the minimum liability required by paragraph 56 and for purposes of the disclosures required by paragraph 66, plan investments, whether equity or debt securities, real

estate, or other, shall be measured at their fair value as of the measurement date. The fair value of an investment is the amount that the plan could reasonably expect to receive for it in a current sale between a willing buyer and a willing seller, that is, other than in a forced or liquidation sale. Fair value shall be measured by the market price if an active market exists for the investment. If no active market exists for an investment but an active market exists for similar investments, selling prices in that market may be helpful in estimating fair value. If a market price is not available, a forecast of expected cash flows may aid in estimating fair value, provided the expected cash flows are discounted at a current rate commensurate with the risk involved.³⁴ (Refer to paragraph 75.)

62. Plan assets used in plan operations (for example, buildings, equipment, furniture and fixtures, and leasehold improvements) shall be measured at cost less accumulated depreciation or amortization for all purposes.

Measurement Date

63. The measurements of plan assets and obligations required by this Statement shall be as of the date of the financial statements or, if used consistently from year to year, as of a date not more than three months prior to that date. Even though the postretirement benefit measurements are required as of a particular date, all procedures are not required to be performed after that date. As with other financial statement items requiring estimates, much of the information can be prepared as of an earlier date and projected forward to account for subsequent events (for example, employee service).

64. The additional liability reported in interim financial statements ordinarily will be based on the additional liability (paragraph 56) recognized in the previous year-end statement of financial position to reflect the minimum liability, adjusted for subsequent accruals and contributions.³⁵ However, if measures of both the obligation and

³⁴For an indication of factors to be considered in determining the discount rate, refer to paragraphs 13 and 14 of APB Opinion No. 21, *Interest on Receivables and Payables*. If significant, the fair value of an investment shall reflect the brokerage commissions and other costs normally incurred in a sale.

³⁵This determination of the reported additional liability applies to the first interim period of the first fiscal year for which paragraph 56 is effective even though no such liability was "recognized" in the previous year-end financial statements.

the plan assets are available as of a more current date or a significant event occurs, such as a plan amendment, settlement, or curtailment, that ordinarily would result in new measurements, those more recent measurements shall be used.

65. Measurements of net periodic postretirement benefit cost for both interim and annual financial statements shall be based on the assumptions at the beginning of the year (assumptions used for the previous year-end measurements) unless more recent measurements of both plan assets and the accumulated postretirement benefit obligation are available or a significant event occurs, such as those noted in paragraph 64, that ordinarily would call for remeasurement of net periodic postretirement benefit cost from the date of the event to the year-end measurement date.

Disclosures

66. This Statement requires disclosures about an employer's obligation to provide postretirement benefits and the cost of providing those benefits that are intended to enhance the usefulness of the financial statements to investors, creditors, and other users of financial information. An employer sponsoring one or more defined benefit postretirement plans (refer to paragraph 70) shall disclose separately, if applicable, the following for those plans that provide primarily postretirement health care benefits and those plans that provide primarily other postretirement welfare benefits:

- a. A description of the plan(s) including employee groups covered, types of benefits provided, benefit formula, **funding policy**, types of assets held and significant nonbenefit liabilities, and the nature and effect of significant matters affecting the comparability of information for all periods presented
- b. The amount of net periodic postretirement benefit cost for the period showing separately the service cost component, the interest cost component, the actual return on plan assets for the period, amortization of the unamortized transition obligation or transition asset, and the net total of other components³⁶

³⁶The net total of other components is the net effect during the period of certain delayed recognition provisions of this Statement. That net total includes:

- a. The net asset gain or loss during the period deferred for later recognition (in effect, an offset or a supplement to the actual return on plan assets)
- b. Amortization of the net gain or loss from earlier periods
- c. Amortization of unrecognized prior service cost.

- c. A schedule reconciling the funded status of the plan(s) with amounts reported in the employer's statement of financial position, showing separately:
 - (1) The fair value of plan assets
 - (2) The accumulated postretirement benefit obligation
 - (3) The amount of unrecognized prior service cost
 - (4) The amount of unrecognized net gain or loss (including plan asset gains and losses not yet reflected in market-related value)
 - (5) The amount of any remaining unamortized transition obligation or transition asset
 - (6) The amount of any additional liability recognized pursuant to paragraph 56
 - (7) The amount of net postretirement benefit asset or liability recognized in the statement of financial position, which is the net result of combining the preceding six items
- d. The vested postretirement benefit obligation
- e. The weighted-average assumed discount rate, rate of compensation increase, and health care cost trend rate used to measure the accumulated postretirement benefit obligation and the weighted-average expected long-term rate of return on plan assets and, for taxable plans, the estimated income tax rate included in that rate of return
- f. The effect of a one-percentage-point increase (or decrease) in the weighted-average assumed health care cost trend rate on the net periodic postretirement health care benefit cost and the accumulated postretirement benefit obligation for postretirement health care benefits
- g. The amounts and types of securities of the employer and related parties included in plan assets, and the approximate amount of future annual benefits of plan participants covered by **insurance contracts** issued by the employer and related parties
- h. Any alternative amortization method used pursuant to paragraphs 46 and 53 and the existence and nature of any commitment as discussed in paragraph 37
- i. The amount of gain or loss recognized during the period for a settlement or curtailment and a description of the nature of the event(s) (Refer to paragraphs 85–94.)
- j. The cost of providing special or contractual **termination benefits** recognized during the period and a description of the nature of the event(s). (Refer to paragraphs 96 and 97.)

Employers with Two or More Plans

67. Postretirement benefits offered by an employer may vary in nature and may be provided to different groups of employees. As discussed in paragraph 68, in some cases an employer may aggregate data from unfunded plans for measurement purposes in lieu of performing separate measurements for each unfunded plan (including plans whose designated assets are not appropriately segregated and restricted and thus have no plan assets as that term is used in this Statement).

68. The data from all unfunded postretirement health care plans may be aggregated for measurement purposes if (a) those plans provide different benefits to the same group of employees or (b) those plans provide the same benefits to different groups of employees. Data from other unfunded postretirement welfare benefit plans may be aggregated for measurement purposes in similar circumstances. However, a plan that has plan assets (as defined herein) shall not be aggregated with other plans but shall be measured separately.

69. Net periodic postretirement benefit cost, liabilities, and assets shall be determined for each separately measured plan or aggregation of plans by applying the provisions of this Statement to each such plan or aggregation of plans. In particular, unless an employer clearly has a right to use the assets of one plan to pay benefits of another, a liability required to be recognized pursuant to paragraph 56 for one plan shall not be reduced or eliminated because another plan has assets in excess of its accumulated postretirement benefit obligation or because the employer has prepaid postretirement benefit cost related to another plan.

70. Except as noted in paragraph 66 and below, disclosures required by this Statement may be aggregated for all of an employer's single-employer defined benefit plans, or plans may be disaggregated in groups to provide more useful information. For purposes of the disclosures required by paragraph 66(c), plans with plan assets in excess of the accumulated postretirement benefit obligation shall not be aggregated with plans that have accumulated postretirement benefit obligations that exceed plan assets. Disclosures for plans outside the United States shall not be combined with those for plans in the United States unless those plans use similar economic assumptions.

Insurance Contracts

71. For purposes of this Statement, an insurance contract is defined as a contract in which an insurance company unconditionally undertakes a legal obligation to provide specified benefits to specific individuals in return for a fixed consideration or premium. The insurance contract must be irrevocable and must transfer significant risk from the employer to the insurance company.

72. Some insurance contracts (**participating insurance contracts**) provide that the purchaser (either the plan or the employer) may participate in the experience of the insurance company. Under those contracts, the insurance company ordinarily pays dividends to the purchaser, the effect of which is to reduce the cost of the plan. If the participating insurance contract³⁷ causes the employer to remain subject to all or most of the risks and rewards associated with the benefit obligation covered or the assets transferred to the insurance company, that contract is not an insurance contract for purposes of this statement, and the purchase of that contract does not constitute a settlement pursuant to paragraphs 85–90.

73. The purchase price of a participating insurance contract ordinarily is higher than the price of an equivalent contract without a **participation right**. The difference is the cost of the participation right. The cost of the participation right shall be recognized at the date of purchase as an asset. In subsequent periods, the participation right shall be measured at its fair value if the contract is such that fair value is reasonably estimable. Otherwise the participation right shall be measured at its amortized cost (not in excess of its net realizable value), and the cost shall be amortized systematically over the expected dividend period under the contract.

74. To the extent that **nonparticipating insurance contracts**³⁸ are purchased during the period to cover postretirement benefits attributed

³⁷If the insurance company is controlled by the employer or if there is any reasonable doubt that the insurance company will meet its obligations under the contract, the purchase of the contract does not constitute a settlement for purposes of paragraphs 85–90 of this Statement.

³⁸If the insurance company providing the contract does business primarily with the employer and related parties (a **captive insurer**) or if there is any reasonable doubt that the insurance company will meet its obligations under the contract, the contract is not an insurance contract for purposes of paragraphs 74 and 75 of this Statement.

to service in the current period (such as life insurance benefits), the cost of those benefits shall be the cost of purchasing the coverage under the contracts. If all the postretirement benefits attributed to service in the current period are covered by nonparticipating insurance contracts purchased during that period, the cost of the contracts determines the service cost component of net postretirement benefit cost for that period. Benefits attributed to current service in excess of benefits provided by nonparticipating insurance contracts purchased during the current period shall be accounted for according to the provisions of this Statement applicable to plans not involving insurance contracts.

75. Benefits covered by insurance contracts shall be excluded from the accumulated postretirement benefit obligation. Insurance contracts shall be excluded from plan assets. Other contracts with insurance companies shall be accounted for as investments and measured at fair value. For some contracts, the best available evidence of fair value may be contract value. If a contract has a determinable cash surrender value or conversion value, that is presumed to be its fair value.

Multiemployer Plans

76. For purposes of this Statement, a **multiemployer plan** is a postretirement benefit plan to which two or more unrelated employers contribute, usually pursuant to one or more collective-bargaining agreements. A characteristic of multiemployer plans is that assets contributed by one participating employer may be used to provide benefits to employees of other participating employers since assets contributed by an employer are not segregated in a separate account or restricted to provide benefits only to employees of that employer. A multiemployer plan usually is administered by a board of trustees composed of management and labor representatives and may also be referred to as a "joint trust" or "union plan." Generally, many employers participate in a multiemployer plan, and an employer may participate in more than one plan. The employers participating in multiemployer plans usually have a common industry bond, but for some plans the employers are in different industries, and the labor union may be their only common bond. Some multiemployer plans do not involve a union. For example, local chapters of a not-for-profit organization may participate in a plan established by the related national organization.

77. An employer participating in a multiemployer plan shall recognize as net postretirement benefit cost the required contribution for the period and shall recognize as a liability any contributions due and unpaid.

78. An employer that participates in one or more multiemployer plans shall disclose the following separately from disclosures for a single-employer plan:

- a. A description of the multiemployer plan(s) including the employee groups covered, the type of benefits provided (defined benefit or defined contribution), and the nature and effects of significant matters affecting comparability of information for all periods presented
- b. The amount of cost recognized during the period.

79. In some situations, withdrawal from a multiemployer plan may result in an employer's having an obligation to the plan for a portion of its unfunded accumulated postretirement benefit obligation. If withdrawal under circumstances that would give rise to an obligation is either probable or reasonably possible, the provisions of FASB Statement No. 5, *Accounting for Contingencies*, shall apply.

Multiple-Employer Plans

80. Some postretirement benefit plans to which two or more unrelated employers contribute are not multiemployer plans. Rather, those **multiple-employer plans** are in substance aggregations of single-employer plans, combined to allow participating employers to pool plan assets for investment purposes and to reduce the costs of plan administration. Those plans ordinarily do not involve collective-bargaining agreements. They also may have features that allow participating employers to have different benefit formulas, with the employer's contributions to the plan based on the benefit formula selected by the employer. Those plans shall be considered single-employer plans rather than multiemployer plans for purposes of this Statement, and each employer's accounting shall be based on its respective interest in the plan.

Non-U.S. Postretirement Benefit Plans

81. Except for its effective date (paragraph 103), this Statement includes no special provisions applicable to postretirement benefit ar-

arrangements outside the United States. To the extent those arrangements are in substance similar to postretirement benefit plans in the United States, they are subject to the provisions of this Statement for purposes of preparing financial statements in accordance with accounting principles generally accepted in the United States. The substance of an arrangement is determined by the nature of the obligation and by the terms or conditions that define the amount of benefits to be paid, not by whether (or how) a plan is funded, whether benefits are payable at intervals or as a single amount, or whether the benefits are required by law or custom or are provided under a plan the employer has elected to sponsor.

Business Combinations

82. When an employer is acquired in a business combination that is accounted for by the purchase method under Opinion 16 and that employer sponsors a single-employer defined benefit postretirement plan, the assignment of the purchase price to individual assets acquired and liabilities assumed shall include a liability for the accumulated postretirement benefit obligation in excess of the fair value of the plan assets or an asset for the fair value of the plan assets in excess of the accumulated postretirement benefit obligation. The accumulated postretirement benefit obligation assumed shall be measured based on the benefits attributed by the acquired entity to employee service prior to the date the business combination is consummated, adjusted to reflect any changes in assumptions based on the purchaser's assessment of relevant future events (as discussed in paragraphs 23–33). If it is expected that the plan will be terminated or curtailed, the effects of those actions shall be considered in measuring the accumulated postretirement benefit obligation. Otherwise, no future changes to the plan shall be anticipated.

83. As a result of applying the provisions of paragraph 82, any previously existing unrecognized net gain or loss, unrecognized prior service cost, or unamortized transition obligation or transition asset is eliminated for the acquired employer's plan. Subsequently, to the extent that the net obligation assumed or net assets acquired are considered in determining the amounts of contributions to the plan, differences between the purchaser's net postretirement benefit cost and amounts it contributes will reduce the liability or asset recognized at the date of the combination.

Amendment to Opinion 16

84. The following footnote is added to the end of the last sentence of paragraph 88 of Opinion 16:

*Paragraphs 82 and 83 of FASB Statement No. XXX, *Employers' Accounting for Postretirement Benefits Other Than Pensions* (this Statement), specify how the general guidelines of this paragraph shall be applied to assets and liabilities related to postretirement benefit plans.

Accounting for Settlement of a Postretirement Benefit Obligation

85. For purpose of this Statement, a settlement is defined as a transaction that (a) is an irrevocable action, (b) relieves the employer (or the plan) of primary responsibility for a postretirement benefit obligation, and (c) eliminates significant risk related to the obligation and the assets used to effect the settlement. Examples of transactions that constitute a settlement include making lump-sum cash payments to plan participants in exchange for their rights to receive specified postretirement benefits and purchasing long-term nonparticipating insurance contracts for the accumulated postretirement benefit obligation for some or all of the plan participants.

86. A transaction that does not meet the three criteria of paragraph 85 does not constitute a settlement for purposes of this Statement. For example, investing in a portfolio of high-quality fixed-income securities with principal and interest payment dates similar to the estimated payment dates of benefits may avoid or minimize certain risks. However, that investment decision does not constitute a settlement because that decision can be reversed and investing in that portfolio does not relieve the employer (or the plan) of primary responsibility for a postretirement benefit obligation nor does it eliminate significant risks related to that obligation.

87. For purposes of this Statement, the maximum gain or loss subject to recognition in earnings when a postretirement benefit obligation is settled is the unrecognized net gain or loss defined in paragraphs 49-53 plus any remaining unamortized transition asset.³⁹ That max-

³⁹As discussed in paragraph 106, in measuring the gain or loss subject to recognition in earnings when a postretirement benefit obligation is settled, it shall first be determined whether recognition of an additional amount of any unamortized transition obligation is required.

imum gain or loss includes any gain or loss resulting from remeasurements of plan assets and the accumulated postretirement benefit obligation at the time of settlement.

88. If the entire accumulated postretirement benefit obligation is settled and the maximum amount subject to recognition is a gain, the settlement gain shall first reduce any remaining unamortized transition obligation; any excess gain shall be recognized in earnings. If the entire accumulated postretirement benefit obligation is settled and the maximum amount subject to recognition is a loss, the maximum settlement loss shall be recognized in earnings. If only part of the accumulated postretirement benefit obligation is settled, the employer shall recognize, in a similar manner, a pro rata portion of the maximum settlement gain or loss equal to the percentage reduction in the accumulated postretirement benefit obligation.

89. If the purchase of a participating insurance contract constitutes a settlement (refer to paragraph 72), the maximum gain (but not the maximum loss) shall be reduced by the cost of the participation right before determining the amount to be recognized in earnings.

90. If the cost of all settlements⁴⁰ in a year is less than or equal to the sum of the service cost and interest cost components of net periodic postretirement benefit cost for the plan for the year, gain or loss recognition is permitted but not required for those settlements. However, the accounting policy adopted shall be applied consistently from year to year.

Accounting for a Plan Curtailment

91. For purposes of this Statement, a curtailment is an event that significantly reduces the expected years of future service of active plan participants or eliminates the accrual of defined benefits for some or all of the future services of a significant number of active plan participants. Curtailments include:

⁴⁰For the following types of settlements, the cost of the settlement is:

- a. For a cash settlement, the amount of cash paid to plan participants
- b. For a settlement using nonparticipating insurance contracts, the cost of the contracts
- c. For a settlement using participating insurance contracts, the cost of the contracts less the amount attributed to participation rights. (Refer to paragraph 72.)

- a. Termination of employees' services earlier than expected, which may or may not involve closing a facility or discontinuing a segment of a business
- b. Termination or suspension of a plan so that employees do not earn additional benefits for future service. In the latter situation, future service may be counted toward eligibility for benefits accumulated based on past service.

92. The unrecognized prior service cost associated with the future years of service that are no longer expected to be rendered as the result of a curtailment is a loss. For purposes of measuring the effect of a curtailment, unrecognized prior service cost includes the cost of retroactive plan amendments and any remaining unamortized transition obligation. For example, a curtailment may result from the termination of a significant number of employees who were plan participants at the date of a prior plan amendment.⁴¹ The loss associated with that curtailment is (a) the portion of the remaining unrecognized prior service cost related to that (and any prior) plan amendment that is attributable to the remaining years of service in the attribution period that had been expected to be rendered by those employees who were terminated and (b) the portion of the remaining unamortized transition obligation that is attributable to the remaining expected future years of service of the terminated employees who were plan participants at the date of transition.

93. The accumulated postretirement benefit obligation may be decreased (a gain) or increased (a loss) by a curtailment.⁴²

- a. To the extent that gain exceeds any unrecognized net loss (or the entire gain, if an unrecognized net gain exists), it is a curtailment gain.
- b. To the extent that loss exceeds any unrecognized net gain (or the entire loss, if an unrecognized net loss exists), it is a curtailment loss.

⁴¹A curtailment also may result from terminating the accrual of additional benefits for the future services of a significant number of employees. The loss in that situation is (a) the portion of the remaining unrecognized prior service cost attributable to the remaining years of service in the attribution period of those employees who were plan participants at the date of the plan amendment and whose future accrual of benefits has been terminated and (b) the portion of the remaining unamortized transition obligation that is attributable to those same employees.

⁴²Increases in the accumulated postretirement benefit obligation that reflect termination benefits are excluded from the scope of this paragraph. (Refer to paragraphs 96 and 97.)

For purposes of applying the provisions of this paragraph, any remaining unamortized transition asset shall be treated as an unrecognized net gain and shall be combined with unrecognized net gain or loss arising subsequent to transition to this Statement.

94. If the sum of the effects identified in paragraphs 92 and 93 is a net loss, it shall be recognized in earnings when it is probable that a curtailment will occur and the net effect is reasonably estimable. If the sum of those effects is a net gain, it shall be recognized in earnings when the related employees terminate or the plan suspension or amendment is adopted.

Relationship of Settlements and Curtailments to Other Events

95. A settlement and a curtailment may occur separately or together. If benefits expected to be paid in future periods are eliminated for some plan participants (for example, because a significant portion of the work force is dismissed or a plant is closed) but the plan remains in existence and continues to pay benefits, to invest assets, and to receive contributions, a curtailment has occurred but not a settlement. If an employer purchases nonparticipating insurance contracts for the accumulated postretirement benefit obligation and continues to provide defined benefits for future service, either in the same plan or in a successor plan, a settlement has occurred but not a curtailment. If a **plan termination** occurs (that is, the obligation is settled and the plan ceases to exist) and the plan is not replaced by a successor defined benefit plan, both a settlement and a curtailment have occurred (whether or not the employees continue to work for the employer).

Measurement of the Effects of Termination Benefits

96. Postretirement benefits offered as special or contractual termination benefits shall be recognized in accordance with paragraph 15 of Statement 88. That is, an employer that offers special termination benefits to employees shall recognize a liability and a loss when the employees accept the offer and the amount can be reasonably estimated. An employer that provides contractual termination benefits shall recognize a liability and a loss when it is probable that employees will be entitled to benefits and the amount can be reasonably estimated. A situation involving special or contractual termination benefits may also result in a curtailment to be accounted for under paragraphs 91–94 of this Statement.

97. The liability and loss recognized for employees who accept an offer of special termination benefits to be provided by a postretirement benefit plan shall be the difference between (a) the accumulated postretirement benefit obligation for those employees assuming that those employees (active plan participants) not yet fully eligible for benefits would terminate at their full eligibility date and that fully eligible plan participants would retire immediately, without considering any special termination benefits, and (b) the accumulated postretirement benefit obligation as measured in (a) adjusted to reflect the special termination benefits.

Disposal of a Segment

98. If the gain or loss measured in accordance with paragraphs 87–89, 92–94, or 96 and 97 is directly related to disposal of a segment of a business or a portion of a line of business, it shall be included in determining the gain or loss associated with that event. The net gain or loss attributable to the disposal shall be recognized pursuant to the requirements of APB Opinion No. 30, *Reporting the Results of Operations—Reporting the Effects of Disposal of a Segment of a Business, and Extraordinary, Unusual and Infrequently Occurring Events and Transactions*.

Defined Contribution Plans

99. For purposes of this Statement, a **defined contribution postretirement plan** is a plan that provides postretirement benefits in return for services rendered, provides an individual account for each plan participant, and has terms that specify how contributions to the individual's account are to be determined rather than the amount of postretirement benefits the individual is to receive. Under a defined contribution plan, the postretirement benefits a plan participant will receive are limited to the amount contributed to the plan participant's account, the returns earned on investments of those contributions, and forfeitures of other plan participants' benefits that may be allocated to the plan participant's account.

100. To the extent a plan's defined contributions to an individual's account are to be made for periods in which that individual renders services, the net postretirement benefit cost for a period shall be the contribution called for in that period. If a plan calls for contributions for periods after an individual retires or terminates, the estimated cost shall be accrued during the employee's service period.

101. An employer that sponsors one or more defined contribution plans shall disclose the following separately from its defined benefit plan disclosures:

- a. A description of the plan(s) including employee groups covered, the basis for determining contributions, and the nature and effect of significant matters affecting comparability of information for all periods presented
- b. The amount of cost recognized during the period.

102. A postretirement benefit plan having characteristics of both a defined benefit plan and a defined contribution plan requires careful analysis. If the *substance* of the plan is to provide a defined benefit, as may be the case with some “target benefit” plans, the accounting and disclosure requirements shall be determined in accordance with the provisions of this Statement applicable to a defined benefit plan.

Effective Dates and Transition

103. Except as noted in the following sentences of this paragraph and in paragraph 108, this Statement shall be effective for fiscal years beginning after December 15, 1991. For plans outside the United States and for defined benefit plans of employers that (a) are **non-public enterprises** and (b) sponsor no defined benefit postretirement plan with more than 100 plan participants, this Statement shall be effective for fiscal years beginning after December 15, 1993. For all plans, the provisions of paragraphs 56 and 57 shall be effective for fiscal years beginning after December 15, 1996. In all cases, earlier application is encouraged. Restatement of previously issued annual financial statements is not permitted. If a decision is made in other than the first interim period of an employer’s fiscal year to apply this Statement early, previous interim periods of that year shall be restated.

104. If at the transition date an employer has excluded assets in a **postretirement benefit fund** from its statement of financial position and some or all of the assets in that fund do not qualify as plan assets as defined herein, the employer shall recognize in the statement of financial position the fair value of those nonqualifying assets as the employer’s assets (not prepaid postretirement benefit cost) and an equal amount as an accrued postretirement benefit obligation pursuant to the transition to this Statement and before applying para-

graph 105. Thereafter, those assets shall be accounted for in accordance with generally accepted accounting principles applicable to those types of assets, including their presentation in the employer's statement of financial position based on any restrictions on their use. The fair value of those assets at the transition date shall be used as their cost.

105. For a defined benefit plan, an employer shall determine as of the measurement date (paragraph 63) for the beginning of the fiscal year in which this Statement is first applied (the transition date), the amounts of (a) the accumulated postretirement benefit obligation and (b) the fair value of plan assets plus any recognized accrued postretirement benefit cost or less any recognized prepaid postretirement benefit cost. Except as required by paragraph 106, the difference between those two amounts, whether it represents an unrecognized transition obligation or an unrecognized transition asset, shall be amortized on a straight-line basis over the average remaining service period of active plan participants, except that (1) if the average remaining service period is less than 15 years, the employer may elect to use a 15-year period, and (2) if all or almost all of the plan participants are inactive, the employer shall use the average remaining life expectancy period of those plan participants. Any unrecognized transition obligation related to a defined contribution plan shall be amortized in the same manner.

106. Amortization of the transition obligation shall be more rapid than otherwise required by paragraph 105 in the following situations:

- a. Cumulative benefit payments subsequent to the transition date to fully eligible plan participants at the transition date exceed the sum of (1) the cumulative amortization of the entire transition obligation and (2) the cumulative interest on the **unpaid transition obligation**.
- b. Cumulative benefit payments subsequent to the transition date to all plan participants exceed the cumulative accrued postretirement benefit cost recognized subsequent to the transition date (including amounts required to be recognized pursuant to subparagraph (a) above).

An additional amount of the unamortized transition obligation shall be recognized equal to the excess cumulative benefit payments in one or both of those situations. For purposes of applying this paragraph,

cumulative benefit payments shall be reduced by any plan assets or any recognized accrued postretirement benefit obligation at the transition date. Payments made pursuant to a settlement, as discussed in paragraphs 85–89, shall be included in the determination of cumulative benefit payments made subsequent to the transition date.

107. If at the measurement date for the beginning of an employer's fiscal year it is expected that additional recognition of any remaining unamortized transition obligation will be required pursuant to paragraph 106, amortization of the transition obligation for interim reporting purposes shall be based on the amount expected to be amortized for the year, except for the effects of applying paragraph 106 for any settlement required to be accounted for pursuant to paragraphs 85–89. Those effects shall be recognized when the related settlement is recognized. The effects of changes during the year in the initial assessment of whether additional recognition of the unamortized transition obligation will be required for the year shall be recognized over the remainder of the year. The amount of the unamortized transition obligation to be recognized for a year shall be finally determined at the measurement date for the end of the year based on the constraints on delayed recognition discussed in paragraph 106; any difference between the amortization of the transition obligation recognized during interim periods and the amount required to be recognized for the year shall be recognized immediately.

Rescission of Technical Bulletin 87-1

108. Effective with the issuance of this Statement, FASB Technical Bulletin No. 87-1, *Accounting for a Change in Method of Accounting for Certain Postretirement Benefits*, is rescinded. If a change in method of accounting for postretirement benefits is adopted subsequent to the issuance of this Statement, the new method shall comply with the provisions of this Statement.

**The provisions of this Statement need
not be applied to immaterial items.**

Glossary

476. This appendix contains definitions of certain terms used in accounting for postretirement benefits.

Accrued postretirement benefit cost

Cumulative net postretirement benefit cost accrued in excess of the employer's cumulative contribution or, in the case of an unfunded plan, of cumulative benefits paid by the employer.

Accumulated postretirement benefit obligation

The actuarial present value of benefits attributed to employee service rendered to a specific date. Prior to an employee's full eligibility date, the accumulated postretirement benefit obligation as of a specified date for an employee is the portion of the expected postretirement benefit obligation attributed to that employee's service rendered to that date; on and after the full eligibility date, the accumulated and expected postretirement benefit obligations for an employee are the same.

Active plan participant

Any active employee who has rendered service during the credited service period and is expected to receive benefits, including benefits to or for any beneficiaries and covered dependents, under the postretirement benefit plan. Also refer to **Plan participant**.

Actual return on plan assets (component of net periodic postretirement benefit cost)

The change in the fair value of the plan's assets for a period including the decrease due to expenses incurred during the period (such as income tax expense incurred by the plan, if applicable), adjusted for contributions and benefit payments during the period.

Actuarial present value

The value, as of a specified date, of an amount or series of amounts payable or receivable thereafter, with each amount adjusted to reflect (a) the time value of money (through discounts for interest) and (b) the probability of payment (for example, by means of decrements for events such as death, disability, withdrawal, or retirement) between the specified date and the expected date of payment.

Amortization

Usually refers to the process of reducing a recognized liability systematically by recognizing revenues or of reducing a recog-

nized asset systematically by recognizing expenses or costs. In accounting for postretirement benefits, amortization is also used to refer to the systematic recognition in net periodic postretirement benefit cost over several periods of previously *unrecognized* amounts, including unrecognized prior service cost, unrecognized net gain or loss, and any unamortized transition obligation or asset.

Assumed per capita claims cost by age

The future per capita cost of providing postretirement health care benefits, after the measurement date, at each age from the earliest ages at which plan participants could begin to receive benefits under the plan through their remaining life expectancy or the covered period, if shorter. To determine the assumed per capita claims cost by age, the per capita claims cost by age based on historical claims costs is adjusted for assumed health care cost trend rates and the effects of coverage by Medicare and other providers of health care benefits. The resulting assumed per capita claims cost by age reflects expected future costs and is applied with the plan demographics to determine the amount and timing of future benefits. Also refer to **Per capita claims cost by age**.

Assumptions

Estimates of the occurrence of future events affecting postretirement benefit cost, such as turnover, retirement age, mortality, dependency status, per capita claims costs by age, health care cost trend rates, levels of Medicare and other health care providers' reimbursements, and discount rates to reflect the time value of money.

Attribution

The process of assigning postretirement benefits or cost to periods of employee service.

Attribution period

The period of an employee's service to which the expected postretirement benefit obligation for that employee is assigned. The beginning of the attribution period is the employee's date of hire unless the plan's benefit formula grants credit only for service from a later date, in which case the beginning of the attribution period is generally the beginning of that credited service period.

The end of the attribution period is the full eligibility date. Within the attribution period, an equal amount of the expected postretirement benefit obligation is attributed to each year of service unless the plan's benefit formula specifies the benefits earned for specific periods of service. In that case, benefits are attributed in accordance with the plan's benefit formula.

Benefit formula

The basis for determining benefits to which participants may be entitled under a postretirement benefit plan. A plan's benefit formula specifies the years of service to be rendered, age to be attained while in service, or a combination of both that must be met for an employee to be eligible to receive benefits under the plan. A plan's benefit formula may also define the beginning of the credited service period and the benefits earned for specific periods of service.

Benefits

The benefits or benefit coverage to which participants may be entitled under a postretirement benefit plan, including health care benefits, life insurance not provided through a pension plan, and legal, educational, and advisory services.

Captive insurer

An insurance company that does business primarily with related entities.

Contributory plan

A plan under which employees contribute part of the cost. In some contributory plans, employees wishing to be covered must contribute; in other contributory plans, employee contributions result in increased benefits.

Credited service period

Employee service period for which benefits are earned pursuant to the terms of the plan. The beginning of the credited service period may be the date of hire or a later date. For example, a plan may provide benefits only for service rendered after a specified age. Service beyond the end of the credited service period does not earn any additional benefits under the plan. Also refer to **Attribution period**.

Curtailment

Refer to **Plan curtailment**.

Defined benefit postretirement plan

A plan that defines postretirement benefits in terms of monetary amounts (for example, \$100,000 of life insurance) or benefit coverage (for example, up to \$200 per day for hospitalization, 80 percent of the cost of specified surgical procedures, and so forth) to be provided. Any postretirement benefit plan that is not a defined contribution postretirement plan is, for purposes of this Statement, a defined benefit postretirement plan.

Defined contribution postretirement plan

A plan that provides postretirement benefits in return for services rendered, provides an individual account for each plan participant, and specifies how contributions to the individual's account are to be determined rather than specifies the amount of benefits the individual is to receive. Under a defined contribution postretirement plan, the benefits a plan participant will receive depend solely on the amount contributed to the plan participant's account, the returns earned on investments of those contributions, and the forfeitures of other plan participants' benefits that may be allocated to that plan participant's account.

Demographics

The characteristics of the plan population including geographical distribution, age, sex, and marital status.

Dependency status

The status of a current or former employee having dependents (for example, a spouse or other relatives) who are expected to receive benefits under a postretirement benefit plan that provides dependent coverage.

Discount rates

The interest rates inherent in the amount at which the postretirement benefit obligation could be effectively settled (that is, the interest rates that determine the single amount that, together with returns on that amount equal to the discount rates, would provide the cash flow necessary to provide the benefits, assuming no future experience gains or losses). Discount rates are used to reflect the time value of money. Also refer to **Actuarial present value**.

Expected long-term rate of return on plan assets

An assumption about the rate of return on plan assets reflecting the average rate of earnings expected on existing plan assets and contributions to the plan expected to be made during the period.

Expected postretirement benefit obligation

The actuarial present value as of a date of the benefits expected to be paid to or for an employee, the employee's beneficiaries, and any covered dependents pursuant to the terms of the postretirement benefit plan. The expected postretirement benefit obligation for an employee is measured using assumptions about the employee's expected retirement date and the employee's future compensation (if the benefit formula is based on future compensation levels).

Expected return on plan assets

An amount calculated as a basis for determining the extent of delayed recognition of the effects of changes in the fair value of plan assets. The expected return on plan assets is determined based on the expected long-term rate of return on plan assets and the market-related value of plan assets.

Explicit (approach to) assumptions

An approach under which each significant assumption used reflects the best estimate of the plan's future experience solely with respect to that assumption.

Fair value

The amount that a plan could reasonably expect to receive for an investment in a current sale between a willing buyer and a willing seller, that is, other than in a forced or liquidation sale.

Full eligibility (for benefits)

The status of an employee having rendered all the service necessary to have earned the right to receive all of the benefits that are expected to be received by that employee (including any beneficiaries and covered dependents) under a postretirement benefit plan upon the occurrence of a specified event or as the need for those benefits arises during the retirement period. Full eligibility for benefits is earned by meeting specified age, service, or age and service requirements of the postretirement benefit plan.

Full eligibility date

The date at which an employee attains full eligibility for the benefits that employee is expected to earn under the terms of a postretirement benefit plan. Determination of the full eligibility date is not affected by measurement assumptions such as when benefit payments commence, dependency status, salary progression, and so forth.

Fully eligible plan participants

Collectively, that group of former employees (including retirees) and active employees who have rendered service to or beyond their full eligibility date and who are expected to receive benefits under the plan, including benefits to their beneficiaries and covered dependents.

Funding policy

The program regarding the amounts and timing of contributions by the employer(s), plan participants, and any other sources to provide the benefits a postretirement benefit plan specifies.

Gain or loss

A change in the value of either the accumulated postretirement benefit obligation or the plan assets resulting from experience different from that assumed or from a change in an actuarial assumption. Also refer to **Unrecognized net gain or loss**.

Gain or loss component (of net periodic postretirement benefit cost)

The sum of (a) the difference between the actual return on plan assets and the expected return on plan assets and (b) the amortization of the unrecognized net gain or loss from previous periods. The gain or loss component is the net effect of delayed recognition of gains and losses (the net change in the unrecognized net gain or loss) except that it does not include changes in the accumulated postretirement benefit obligation occurring during the period and deferred for later recognition.

Health care cost trend rates

An assumption about the rates of annual changes in the per capita claims cost of benefits currently provided by the postretirement benefit plan due to factors other than changes in the composition of the plan population by age and dependency sta-

tus. The health care cost trend rates consider estimates of health care inflation, changes in health care utilization or delivery patterns, technological advances, and changes in the health status of the plan participants. Differing types of services, such as hospital care and dental care, may have different trend rates.

Insurance contract

A contract in which an insurance company unconditionally undertakes a legal obligation to provide specified benefits to specific individuals in return for a fixed consideration or premium. An insurance contract is irrevocable and involves the transfer of significant risk from the employer (or the plan) to the insurance company.

Interest cost (component of net periodic postretirement benefit cost)

The accrual of interest on the accumulated postretirement benefit obligation due to the passage of time.

Market-related value of plan assets

A balance used to calculate the expected return on plan assets. Market-related value can be either fair value or a calculated value that recognizes changes in fair value in a systematic and rational manner over not more than five years. Different methods of calculating market-related value may be used for different classes of plan assets, but the manner of determining market-related value shall be applied consistently from year to year for each class of plan asset.

Measurement date

The date of the financial statements or, if used consistently from year to year, a date not more than three months prior to that date, as of which plan assets and obligations are measured.

Medicare reimbursement rates

The health care cost reimbursements expected to be received by retirees through Medicare as mandated by enacted legislation. Medicare reimbursement rates vary by the type of benefits provided.

Minimum liability

The accumulated postretirement benefit obligation for retirees and other fully eligible plan participants in excess of the fair value of plan assets.

Multiemployer plan

A postretirement benefit plan to which two or more unrelated employers contribute, usually pursuant to one or more collective-bargaining agreements. A characteristic of multiemployer plans is that assets contributed by one participating employer may be used to provide benefits to employees of other participating employers since assets contributed by an employer are not segregated in a separate account or restricted to provide benefits only to employees of that employer. A multiemployer plan is usually administered by a board of trustees composed of management and labor representatives and may also be referred to as a "joint trust" or "union plan." Generally, many employers participate in a multiemployer plan and an employer may participate in more than one plan. The employers participating in multiemployer plans usually have a common industry bond, but for some plans the employers are in different industries and the labor union may be their only common bond.

Multiple-employer plan

A postretirement benefit plan maintained by more than one employer but not treated as a multiemployer plan. Multiple-employer plans are generally not collectively bargained and are intended to allow participating employers, commonly in the same industry, to pool their plan assets for investment purposes and to reduce the cost of plan administration. A multiple-employer plan maintains separate accounts for each employer so that contributions provide benefits only for employees of the contributing employer. Multiple-employer plans may have features that allow participating employers to have different benefit formulas, with the employer's contributions to the plan based on the benefit formula selected by the employer.

Net periodic postretirement benefit cost

The amount recognized in an employer's financial statements as the cost of a postretirement benefit plan for a period. Components of net periodic postretirement benefit cost include service cost, interest cost, actual return on plan assets, gain or loss, amortization of unrecognized prior service cost, and amortization of the unrecognized transition obligation or asset.

Nonparticipating insurance contract

An insurance contract that does not provide for the purchaser to participate in the investment performance or in other experience of the insurance company.

Non-pay-related plan

A plan that has a benefit formula that does not base benefits or benefit coverage on compensation.

Nonpublic enterprise

An enterprise other than one (a) whose debt or equity securities are traded in a public market, either on a stock exchange or in the over-the-counter market (including securities quoted only locally or regionally), or (b) whose financial statements are filed with a regulatory agency in preparation for the sale of any class of securities.

Participating insurance contract

An insurance contract that provides for the purchaser to participate in the investment performance and possibly other experience (for example, morbidity experience) of the insurance company.

Participation right

A purchaser's right under a participating contract to receive future dividends or retroactive rate credits from the insurance company.

Pay-related plan

A plan that has a benefit formula that bases benefits or benefit coverage on compensation, such as a final-pay or career-average-pay plan.

Per capita claims cost by age

The amount required to be paid to provide postretirement health care benefits for one year at each age from the youngest age to the oldest age at which plan participants are expected to receive benefits under the plan.

Plan

An arrangement whereby an employer undertakes to provide its employees with benefits during their retirement period in ex-

change for their services over a specified period of time, upon attaining a specified age while in service, or a combination of both. A plan may be written or it may be implied from a well-defined, although perhaps unwritten, practice of paying postretirement benefits.

Plan amendment

A change in the terms of an existing plan. A plan amendment may increase or decrease benefits, including those attributed to years of service already rendered. Also refer to **Retroactive benefits**.

Plan assets

Assets—usually stocks, bonds, and other investments—that have been segregated and restricted (usually in a trust) to provide for postretirement benefits. The amount of plan assets includes amounts contributed by the employer (and by employees for a contributory plan) and amounts earned from investing the contributions, less benefits, income taxes, and other expenses incurred. Plan assets ordinarily cannot be withdrawn by the employer except under certain circumstances when a plan has assets in excess of obligations and the employer has taken certain steps to satisfy existing obligations. Assets not segregated in a trust or otherwise effectively restricted so that they cannot be used by the employer for other purposes are not plan assets even though it may be intended that those assets be used to provide postretirement benefits. Amounts accrued by the employer as net periodic postretirement benefit cost but not yet paid to the plan are not plan assets. Securities of the employer held by the plan are includable in plan assets provided they are transferable. If a plan has liabilities other than for benefits, those nonbenefit obligations are considered as reductions of plan assets.

Plan curtailment

An event that significantly reduces the expected years of future service of active plan participants or eliminates the accrual of defined benefits for some or all of the future services of a significant number of active plan participants.

Plan participant

Any employee or former employee who has rendered service in the credited service period and is expected to receive benefits

under the postretirement benefit plan, including benefits to or for any beneficiaries and covered dependents. Also refer to **Active plan participant**.

Plan termination

An event in which the postretirement benefit plan ceases to exist and all benefits are settled by the purchase of insurance contracts or by other means. The plan may or may not be replaced by another plan. A plan termination with a replacement plan may or may not be in substance a plan termination for accounting purposes.

Postretirement benefit fund

Assets accumulated in the hands of a funding agency for the sole purpose of paying postretirement benefits when the claims are incurred or benefits are due. Those assets may or may not qualify as plan assets. Also refer to **Plan assets**.

Postretirement benefit plan

Refer to **Plan**.

Postretirement benefits

All forms of benefits, other than retirement income, provided by an employer to retirees. Those benefits may be defined in terms of specified benefits, such as health care, tuition assistance, or legal services, that are provided to retirees as the need for those benefits arises, such as certain health care benefits, or they may be defined in terms of monetary amounts that become payable on the occurrence of a specified event, such as life insurance benefits.

Postretirement benefits other than pensions

Refer to **Postretirement benefits**.

Postretirement health care benefits

A form of postretirement benefit provided by an employer to retirees for defined health care services or coverage of defined health care costs, such as hospital and medical coverage, dental benefits, and eye care.

Prepaid postretirement benefit cost

Cumulative employer contributions in excess of cumulative accrued net periodic postretirement benefit cost.

Prior service cost

The cost of retroactive benefits granted in a plan amendment (or initiation). Also refer to **Unrecognized prior service cost**.

Prospective benefits

Benefits granted in a plan amendment (or initiation) specifically in exchange for employees' future service only. That is, only future service of the employee counts towards eligibility for the benefits. The cost of those benefits is included in the service cost component of net periodic postretirement benefit cost during the periods that that future service is rendered.

Retirees

Collectively, that group of plan participants that includes retired employees, their beneficiaries, and covered dependents.

Retroactive benefits

Benefits granted in a plan amendment (or initiation) that are attributed to prior years of service by the plan benefit formula. In the absence of a benefit formula that defines the specific years of service to be rendered in exchange for the benefits, they are the benefits that are allocated based on the provisions of this Statement to employee services rendered in periods prior to the plan amendment (or initiation). The cost of the retroactive benefits is referred to as prior service cost. Also refer to **Plan amendment**.

Service cost (component of net periodic postretirement benefit cost)

The portion of the expected postretirement benefit obligation attributed to employee service during a period.

Settlement

An irrevocable action that relieves the employer (or the plan) of primary responsibility for a postretirement benefit obligation and eliminates significant risks related to the obligation and the assets used to effect the settlement. Examples of transactions that constitute a settlement include (a) making lump-sum cash payments to plan participants in exchange for their rights to receive specified postretirement benefits and (b) purchasing nonparticipating insurance contracts for the accumulated postretirement benefit obligation for some or all of the plan participants.

Single-employer plan

A postretirement benefit plan that is maintained by one employer. The term also may be used to describe a plan that is maintained by related parties such as a parent and its subsidiaries.

Termination benefits

Benefits provided by an employer to employees in connection with their termination of employment. They may be either special termination benefits offered only for a short period of time or contractual benefits required by the terms of a plan only if a specified event, such as a plant closing, occurs.

Transition asset

The unrecognized amount, as of the date this Statement is initially applied, of (a) the fair value of plan assets plus any recognized accrued postretirement benefit cost or less any recognized prepaid postretirement benefit cost in excess of (b) the accumulated postretirement benefit obligation.

Transition obligation

The unrecognized amount, as of the date this Statement is initially applied, of (a) the accumulated postretirement benefit obligation in excess of (b) the fair value of plan assets plus any recognized accrued postretirement benefit cost or less any recognized prepaid postretirement benefit cost.

Unamortized transition asset

The portion of the transition asset that has not been recognized as a part of net periodic postretirement benefit cost, as an offset to certain losses, or as a part of accounting for the effects of a settlement or a curtailment.

Unamortized transition obligation

The portion of the transition obligation that has not been recognized as a part of net periodic postretirement benefit cost, as an offset to certain gains, or as a part of accounting for the effects of a settlement or a curtailment.

Unfunded accumulated postretirement benefit obligation

The accumulated postretirement benefit obligation in excess of the fair value of plan assets.

Unpaid transition obligation

The transition obligation (a) reduced for subsequent benefit payments to plan participants who were fully eligible for benefits at the date of transition and (b) increased for subsequent interest at the discount rates used at the date of transition. The unpaid transition obligation is used in determining the constraint on delayed recognition of the transition obligation pursuant to paragraph 106(a)

Unrecognized net gain or loss

The cumulative net gain or loss that has not been recognized as a part of net periodic postretirement benefit cost or as a part of the accounting for the effects of a settlement or a curtailment. Also refer to **Gain or loss**.

Unrecognized prior service cost

The portion of prior service cost that has not been recognized as a part of net periodic postretirement benefit cost, as a reduction of the effects of a negative plan amendment, or as a part of the accounting for the effects of a curtailment.

Vested postretirement benefit obligation

The actuarial present value as of a date of the benefits expected to be paid to or for retirees, former employees, and active employees assuming they terminated immediately, including benefits expected to be paid to or for beneficiaries and any covered dependents of those plan participants.

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"Better benefits will attract and retain the best and most satisfied employees; satisfied employees will increase productivity; and increased productivity will help pay for the support of a growing pool of children. Benefits packages that do not evolve quickly enough to stay relevant will find disfavor with the best employees first. Among the most attractive benefits will be those associated with child care and elder care."—Ronald Pilenzo, president, American Society of Personnel Administration

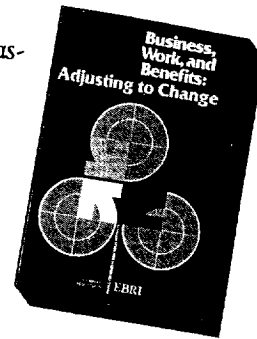
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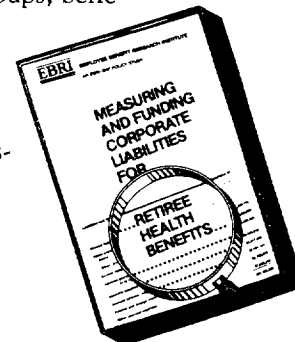
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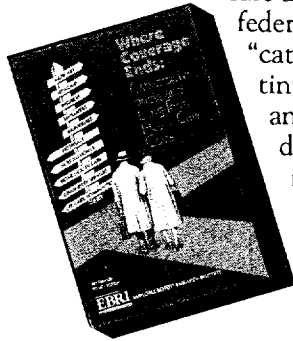
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