RETIREMENT SECURITY FOR THE AMERICAN WORKER: OPPORTUNITIES AND CHALLENGES

HEARING

BEFORE THE

SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

OF THE

COMMITTEE ON EDUCATION AND THE WORKFORCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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HEARING ON

"RETIREMENT SECURITY FOR THE AMERICAN WORKER:

OPPORTUNITIES AND CHALLENGES"

Thursday, November 1, 2001

Subcommittee on Employer-Employee Relations

Committee on Education and the Workforce

U.S. House of Representatives

Washington, D.C.

The Subcommittee met, pursuant to notice, at 2:30 p.m., in Room 2175, Rayburn House Office Building, Hon. Sam Johnson, Chairman of the Subcommittee, presiding.

Present: Representatives Johnson, Fletcher, McKeon, Kildee, Rivers, and Tierney.

Staff present: David Connolly, Jr., Professional Staff Member; Kristin Fitzgerald, Professional Staff Member; Dave Thomas, Legislative Assistant; Jo-Marie St. Martin, General Counsel; Heather Valentine, Press Secretary; Patrick Lyden, Professional Staff Member; Deborah L. Samantar, Committee Clerk/Internship Coordinator; Michele Varnhagen, Minority Labor Counsel/Coordinator; Camille Donald, Minority Legislative Associate/Labor; and, Brian Compagnone, Minority Staff Assistant/Labor.

Chairman Johnson. A quorum being present, the Subcommittee on Employer-Employee Relations will come to order.

OPENING STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

We're meeting today to hear testimony on retiree benefits, and how they are getting less and less and less. We are also meeting to hear testimony on retiree health proposals as part of the whole retiree problem, and how we can make sure that today people focus not just on retirement, but on their health benefits, as well. Health coverage is a central problem. Retiree health care affects nearly everyone both parents and children alike.

We want to educate our Subcommittee on the critical problems facing not only our employer-sponsored retiree health care systems, but also the entire health care delivery system. The baby boom generation is fast approaching retirement age, and we will have additional hearings in the coming months. We will examine such topics as the problems facing employers who are trying to provide health care coverage, current coverage by the Medicare system, and the future demands of the labor market.

We're also going to examine innovative approaches, and I look forward to listening to our witnesses' testimony today.

WRITTEN STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE – SEE APPENDIX A

Chairman Johnson. Because of the compressed time we have probably 20 or 25 minutes at the most until a vote is called on the floor of the House. I intend to allow Mr. Kildee to make comments if he wishes, and we'll let you all testify, time permitting, ask questions, and then close the hearing and send you written questions, which you can respond to in writing, if that's suitable.

Mr. Kildee, you're recognized at this time.

Mr. Kildee. Thank you, Mr. Chairman.

I join you in your remark that we're here to listen to the witnesses so I'll yield back the balance of my time, Mr. Chairman.

Chairman Johnson. Thank you.

Our first witness is William Scanlon, Director, Health Care Services, General Accounting Office.

Mr. Scanlon, I welcome you here, and you may begin your testimony at this time.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE SERVICES, GENERAL ACCOUNTING OFFICE, WASHINGTON, D.C.

I'm very pleased to be here today as you discuss the future financial security of retired Americans, particularly with respect to their access to health insurance coverage. Meeting the health care needs of an aging population is, indeed, a key element of the ongoing discussion on retirement security.

While there are reports that today's elderly and future elderly are going to be healthier than prior generations, the fact remains that the prevalence of disabilities and dependency will still increase with age, and that reality, combined with the sheer numbers of baby boomers who are currently starting to retire, means that the number of people needing extensive health and long-term care services will increase dramatically.

Unfortunately, work we have done at GAO indicates that many retirees may face significant costs and have a difficult time finding adequate coverage for their health care needs. Employer-sponsored health benefits have been an important contributor to health security for many retirees. In 1999, more than half of the 4 million retirees age 55 to 64 had some employer-sponsored health insurance. However, over the past decade the number of employers offering retiree health benefits have declined considerably.

As you may hear from Ms. Neuman and Mr. Kerby, surveys done by their organizations indicate that the number of large employers who are offering retiree health benefits has been significantly reduced over the last decade. Moreover, employers that continue to offer retiree benefits have often reduced their benefits. They have tightened eligibility requirements, increased cost sharing or retiree share of premiums. In fact, about 40 percent of large employers that offer benefits require retirees themselves, under 65, to pay the entire premium.

We may not have seen the end of the decline in employer coverage. The recent acceleration of health insurance premium increases, the weakening economy, and the large numbers of baby boom generation retirees, compared to the numbers of current workers, could lead to further erosion. Losing access to employer-sponsored coverage can be particularly problematic, as alternatives are often limited and costly, particularly for those in poor health.

Federal laws like COBRA's temporary coverage of continuation provisions and the Health Insurance Portability and Accountability Act's portability provisions guarantee some younger retirees access to coverage. HIPAA guarantees eligible retirees losing group coverage access to at least two individual plans, or an alternative such as a high-risk pool, regardless of their health. However, the premiums these retirees can face in the individual market are often far higher than the group rates available through an employer. Individual market rates are most often based on age and health.

We have found instances where a 60-year-old man was charged a premium nearly four times that charged a 30-year-old man. In most states, those in poor health would be charged even higher amounts. Even worse, unless guaranteed coverage by HIPAA, individuals with serious health conditions such as heart disease are generally unable to buy an individual health

insurance policy. Even those with non-life-threatening conditions, such as chronic back pain, may not have any luck obtaining coverage.

Retirees over 65 do have Medicare coverage, but this coverage still leaves them at risk for considerable out-of-pocket expenses, to either pay required cost sharing on Medicare-covered services or because some services such as prescription drugs are not covered. Most retirees over 65 consequently buy supplemental insurance to deal with these expenses. Nearly one-third of Medicare-eligible retirees are fortunate to have access to employer-sponsored supplemental coverage at group rates, but many others end up purchasing an individual medigap policy. Medigap coverage is not cheap. Policies cost on average $1,300 per year, and policies that include limited prescription drug coverage average more than $1,600 per year.

Also often overlooked is the costly risk for which the vast majority of retirees have no insurance at all, and that is long-term care. The cost of nursing home or other continuous care can be substantial. Today, nursing homes on average cost $55,000 per year. Since Medicare and private insurance most often do not cover much of these costs, individuals without long-term care insurance can face catastrophic costs or be forced to rely on Medicaid. Private long-term care insurance, a product that can provide some protection, still has a very small market. Few individuals purchase this insurance, and few employers offer it as a benefit. Even those employers that do usually do not pay any of the premiums. Questions of affordability, consumers' perceived need for, and the value of the policies make it difficult to predict what future role this type of insurance will play.

Let me close by underscoring that many retirees can encounter gaps in the availability of their health care coverage at the very time when their likelihood of illness and the risk of catastrophic health care costs are increasing. Those who do purchase insurance to fill some of these gaps can find it both costly and not comprehensive. A retired couple may spend nearly $6,000 a year to pay Medicare premiums and purchase an average medigap and long-term care insurance policy. They would pay even more if they were older, or in poor health, or buy more expensive or more generous coverage. Even then, they would still face significant out-of-pocket costs for prescription drugs and not have full protection for some catastrophic costs.

Gaps like these in coverage will become an even more significant concern if employer-sponsored health benefits continue to decline, and as the sheer numbers of the baby boom generation approach retirement age.

Thank you very much, Mr. Chairman. I'd be happy to answer any questions you have, or submit the answers in writing.

WRITTEN STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE SERVICES, GENERAL ACCOUNTING OFFICE, WASHINGTON, D.C. – SEE APPENDIX B

Chairman Johnson. Thank you for your testimony. It's getting harder and harder to get insurance, especially for long-term care, isn't it?

Mr. Scanlon. Yes sir.

Chairman Johnson. Our second witness is Patricia Neuman, Vice President, Henry J. Kaiser Family Foundation and the Director of the Foundation's Medicare Policy Project.

Thank you for being with us. You may begin your testimony now.

STATEMENT OF PATRICIA NEUMAN, VICE PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION AND DIRECTOR, MEDICARE POLICY PROJECT, WASHINGTON, D.C.

Thank you, Mr. Chairman. Employer-sponsored plans play a critical role in providing basic coverage for Americans who retire in their 50s and early 60s and in covering supplemental benefits for retirees on Medicare who are ages 65 and older. Employer plans provide needed coverage when retirees are most likely to face serious problems, and use medical services and prescriptions that can be prohibitively expensive without the financial protection offered by health insurance.

Since the early 1990s, the share of employers offering retiree health benefits has steadily declined. Initial declines were largely attributable to new accounting rules that required employers to account for their future liability. Declines in the past few years have been explained by rising costs. The recent downturn in the economy, coupled with double-digit increases in health care spending, threatens to hasten the erosion of needed retiree health benefits.

Early retirees who lose employer-sponsored benefits have difficulty finding comparable coverage on their own. They are often unable to find another job that offers health insurance, and until they turn 65, are unable to go on Medicare. With few alternatives, early retirees turn to the individual market, which has proven to be a less than reliable source of affordable coverage, particularly for those with medical problems or modest incomes.

Retirees age 65 and older confront a different set of challenges. Unlike early retirees, seniors are fortunate to have Medicare for basic health insurance, but often want and need additional coverage to pay for benefits such as prescription drugs that are not covered by Medicare. This is proving to be increasingly difficult with Medicare HMOs withdrawing from the Medicare Plus Choice program, and with Medigap premiums escalating. Even when retirees do find supplemental coverage, the benefits tend to come at a higher price, or are less generous than those typically offered by employer plans.

Without adequate insurance, retirees face substantial health risks. Americans without health insurance are far more likely to postpone or forgo needed health care, they are less likely

to get preventive services, and they are less likely to fill their prescription. And according to a new study just published in the New England Journal of Medicine, older adults without health insurance are more likely than those with health insurance to experience a major decline in health status.

Several policy options under discussion could address problems arising from the eroding retiree health benefits. Some would offer short-term targeted relief to retirees who lose employer benefits, while others would seek to help the broader group of retirees, or older adults who lack health insurance. A COBRA expansion is an example of a targeted approach to help early retirees. Current rules could be modified to make the termination of a retiree plan a qualifying event under COBRA. This would enable early retirees to purchase coverage under their former employer's plan. Extending the COBRA coverage period beyond the usual 18-month period would reduce the risk of subsequent gaps in coverage. Offering premium subsidies would help to make COBRA premiums a bit more affordable.

A proposal to help a broader group of older adults who lack health insurance would be to offer tax credits to help cover the cost of insurance. Under this type of approach, early retirees could look to purchase health insurance in the individual market and then apply for premium subsidies by filing their tax return. A concern, however, is that premiums in the individual market, as you just heard, tend to be quite expensive, particularly for those in their 50s or their 60s, and proposed tax credit amounts are often not enough to make such coverage affordable.

Even if tax credits were substantially increased, to cover a larger share of the premium, early retirees with chronic health conditions might find in impossible to find a policy at any price, given underwriting practices in this market.

Another option that has been proposed to help those who lose retiree health benefits, and others who lack coverage, would be to allow retirees to buy into Medicare before they turn 65, again with subsidies to make premiums relatively affordable. A strength of this approach is that it would guarantee retirees access to coverage, without regard to their medical history, unlike proposals that tend to rely on the individual market.

Policy options for seniors who lose retiree health benefits tend to be linked to discussions about Medicare and prescription drugs. The erosion of employer-sponsored benefits has become a key consideration in the ongoing debate about strategies to provide a drug benefit for seniors. It is also worth noting that a new Medicare drug benefit would have the indirect, yet significant effect of providing financial relief to employers that offer retiree medical benefits, potentially strengthening their capacity to continue to offer these benefits in the future.

Still another approach would offer employers financial incentives to retain retiree benefits, or impose penalties of employers that reduce benefits post retirement. A challenge raised by this option is, striking a balance between encouraging employers to maintain retiree medical coverage, while guarding against changes that could accelerate the erosion of these highly valued benefits, given the current economic climate.

Today, employer plans provide critically needed medical benefits for retirees, but the future of this coverage is anything but certain. If current trends continue, the current generation of workers will be far less likely than their parents' generation to receive retiree health benefits. The decline in retiree benefits underscores the need to provide affordable health insurance for early retirees who are uninsured, but too young for Medicare.

The erosion of retiree benefits for seniors confirms the urgency of making prescription drugs available to older retirees who lose access to such benefits. Employers, retirees, and workers have much at stake in the outcome of these discussions. I thank you.

WRITTEN STATEMENT OF PATRICIA NEUMAN, VICE [PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION AND DIRECTOR, MEDICARE POLICY PROJECT, WASHINGTON, D.C. – SEE
APPENDIX C

Chairman Johnson. Thank you, ma'am. I appreciate your testimony, and thank you for being here.

Our third and final witness for today is Chip Kerby. Mr. Kerby is an Attorney and Principal in the Washington Resource Group of William M. Mercer, Incorporated.

You may begin your testimony, sir.

STATEMENT OF CHARLES K. "CHIP" KERBY, III, ESQ., WASHINGTON RESOURCE GROUP, WILLIAM M. MERCER, INCORPORATED, WASHINGTON, D.C.

Thank you, Mr. Chairman. I'm going to abbreviate my remarks to keep us on schedule. I'd like to talk briefly about two different items. One is some of the recent retiree health plan trends. And the second is some of the challenges that are currently facing retiree health plan sponsors.

Each year, our company conducts a national survey of employer-sponsored health plans. This survey identifies health care costs, trends, and plan design information for both active and retired employees. And I'd like to share with you some of the key findings from the 1,924 large employers that responded to the retiree health portion of our 2000 survey. If you have a second to examine figures 1 and 2 in our written testimony, I think a couple of points can be drawn from this. While almost all employers offer health coverage to their active employees, far fewer employers offer coverage to their retired employees. And the prevalence of this benefit varies considerably, based on the size of the employer.

As you can see from figure 1, if we're talking about employers with 20,000 or more employees, then over 60 percent of those employers are likely to offer a retiree health benefit.

Conversely, for employers in the 500 to 1,000-employee range, the number is much lower. It drops to 26 percent for pre-Medicare coverage, and as low as 18 percent for Medicare-eligible coverage.

Now, the bad news is shown in figure 2, and these are the trends that Bill and Patricia have been describing. Our survey data is comparable for the last nine years, so this chart shows you what's been happening since 1993. And these are the averages of all large employers, meaning employers that employ at least 500 employees. This shows that for pre-Medicare retiree coverage, we've seen a decline from 46 percent to 31 percent since 1993. Similar drop for coverage offered for the Medicare-eligible retirees, from 40 percent down to 24 percent.

Let me talk briefly about some of the cost trends. Last year, the year 2000, the average cost increase for an employer plan covering pre-Medicare retirees increased by 10.6 percent, and the trend increase for coverage for Medicare-eligible retirees was 17 percent. These numbers are much higher than the cost increases for active employees, which last year was around 8 percent.

One of the principal reasons why these cost increases are so high is because of the double-digit inflation we've been seeing in prescription drug costs. Most of the cost for the employer coverage for Medicare-eligible retirees involves prescription drugs, and that tends to be the most significant driver in these cost increases.

Now let me identify some of the factors that are affecting employers, and their decision about whether to continue, or to cease offering retiree health benefits. The cost trends, obviously, are significant. Our actuaries think that the cost increases this year are going to be in the range for retirees between 12 and 18 percent. Labor market conditions, as you all know, vary considerably.

A year ago we had the lowest unemployment rates we've seen in 30 years. That's moved from 3.9 percent to 4.9 percent in only 12 months. When labor markets are tight, it's more difficult for employers to make changes in their benefits, and it's more difficult for them to shift cost increases to their retirees. Conversely, when labor is in greater supply, it's easier for employers to make those changes. One of the big constraints that prevent employers from shutting down this benefit is the lack of alternative sources of coverage. As Bill has pointed out, if you retire prior to being eligible for Medicare, your options are few and far between.

Another factor that's disruptive for employers is the decreasing availability of Medicare Plus Choice plans. These are the Medicare HMOs. We've seen the number of these plans drop from 346 in 1998 to 180 in October of this year. Most employers would welcome Medicare changes, especially any proposal under which the Federal Government would pick up all or a portion of the cost of prescription drugs.

Perhaps the most significant recent issue is a case that was decided last year by the third circuit court of appeals. This was the case of Erie County Retirees Association v. the County of Erie, in which the third circuit held that Medicare-based distinctions in retiree health plans presumptively violate the Age Discrimination in Employment Act. This case has caused great consternation among retiree health plan sponsors. They had never viewed their retiree health

plans as a source of potential ADEA liability. And although employers are heartened by the EEOC's recent decision to review ADEA policies for retiree health plans, the threat of litigation remains.

There are really a couple of policy issues that policymakers are going to have to address. One is, can we provide some alternative sources of coverage. The second is, how do we develop, or encourage, or provide incentives to encourage accumulations of funds to help pay for this coverage once people retire.

And with that, I think I'll cease my remarks, and respond to any written questions you might have.

WRITTEN STATEMENT OF CHARLES K. "CHIP" KERBY, III, ESQ., WASHINGTON RESOURCE GROUP, WILLIAM M. MERCER, INCORPORATED, WASHINGTON, D.C. – SEE APPENDIX D

Chairman Johnson. Thank you, sir. I appreciate that. Do you have charts for those who are in smaller employer-based groups? These are 500 plus.

Mr. Kerby. Yes. The prevalence among small employers, 500 or fewer employees, is that only 8 percent of those employers currently offer any kind of retiree health coverage.

Chairman Johnson. Okay. That was the number I had, so it agrees with yours.

You know, somehow we've got to get our population, especially the younger population, to understand that they've got to start thinking about health care earlier. A lot of them don't even want it. Exxon, in our area in Dallas, for example, offers a health care plan, and 22 percent of the people that work for them don't take it. They'd rather have the money in their paycheck, you know. They're bulletproof. And you and I both know that there's a time when you're not. So it gets harder and harder, I think.

I'm going to pass on any questions. Mr. Kildee, do you have any?

Mr. Kildee. No, I'd just like to thank all the witnesses today. It's a very important area of our national life, so I thank all of you for your testimony. It will be helpful as we deliberate here.

I'd like to particularly thank Mr. Scanlon, and extend our thanks to your colleagues at the GAO for sharing their offices with us during the recent crisis. I found out that Congress lives a lot better than GAO.

Chairman Johnson. I'll recognize Mr. Fletcher for questions.

Mr. Fletcher. Thank you, Mr. Chairman. And I want to thank each of you for coming and for your testimony. It's a great concern. With the events of 9/11 and the down turning of the

economy, a lot of layoffs are occurring. We're going to see compounded problems that we haven't yet realized.

Ms. Neuman, I read a New England Journal of Medicine article last month. There was a previous article in January of '97, I believe it was, that discussed the mortality rate of the uninsured as about three times that of a demographically matched insured. So it is a very serious problem particularly as the health care needs increase exponentially as we get older.

Let me ask you about three things. I have some concern about the Medicare buy-in. One is adverse selection. Two is what does that do without reform of Medicare that does not provide prescription drugs. Three is solvency. So if you could briefly answer, I've got a few other questions I'd like to ask in my allotted time.

Ms. Neuman. There is an issue with selection, depending upon what the premium would look like. There is a report that is coming out, that the Kaiser Family Foundation has funded the Urban Institute to do, which does discuss the potential selection problems. With the high premium, it's their view that people who are sicker will find it more necessary to get coverage. If they can't get coverage in the individual market, they may well look to Medicare as an important resource, but that might bring sicker people into the program.

With subsidies, however, people of all health needs and costs would be more likely to come into the program, and that would offset the concern of selection that you mention.

Mr. Fletcher. Would the subsidies cost more than the costs from adverse selection? Have you looked at that? Because with subsidies, you offset private money from healthy people that might be buying private plans.

Ms. Neuman. No, I understand the calculation. I think that's an interesting question that they might want to take a look at. I do think that subsidies would help to bring in a more mixed risk pool.

On the issue of prescription drugs, certainly early retirees would want prescription drugs, just like seniors on Medicare, and so many of these issues are interrelated. It would be important, in thinking about Medicare reform, to think more broadly about ways to provide affordable prescription drug coverage to retirees over 65, and those who are approaching the age of Medicare.

And finally, on the issue of solvency, that really depends on the level of subsidy.

Mr. Fletcher. So, clearly, the premiums for this buy-in would be much higher that what's required now under part B of Medicare?

Ms. Neuman. Well, premiums that have been proposed in the past for a self-funding program, meaning ones that wouldn't add to the federal budget, would be substantially higher than the part B premium. President Clinton proposed premiums that were, I think, on the order of $300 a

month, without adding cost to the federal program.

Mr. Fletcher. Let me just interrupt. I can't imagine that $300 a month on a selected high-risk pool, which you would end up, effectively, creating, would cover the cost. I mean of course a lot of it is projected on the adverse selection in that situation. That would be difficult.

There was a proposal we had that we passed out of the House on association health plans. I may ask the three of you to comment on it, and that will be my last question.

Small businesses rarely offer retiree plans, as you mentioned. A small percentage, I think, offer retiree health care plans. And yet, with association health plans they could come together like large companies, self-insure nationally, reduce the regulations, and increase the efficiency of delivering health care. Do you feel that would help us in our effort to make health care more available for retirees from small businesses?

Mr. Scanlon. We've done work on a related issue, which is the small business purchasing cooperatives that have been set up to try and do something on a more modest scale, that's similar to the association plans. And one of the things that we've discovered is the same issue that you've raised with respect to a Medicare buy-in, which is that adverse selection, or at least the prospect of adverse selection, causes difficulties for these cooperatives.

Businesses that have healthy employees are sometimes fearful of entering into them, and insurers are fearful of dealing with them. So we haven't found that they've been effective in terms of reducing the price of insurance, but they certainly have been effective in terms of offering a wider range of choices. And the association plans may be able to do that.

Mr. Fletcher. Thank you. Mr. Kerby, my time's up but could you comment on that?

Mr. Kerby. I think the point that Bill made is quite accurate. I think employers constantly assess if their risks are better if they self-insure their own risks, or are their risks and costs better if they move their populations into alternatives? So I think, as Bill just pointed out, the good news is association health plans at least offer some alternatives that do not exist in the present world. Whether employers will be encouraged to use them is a separate question.

Chairman Johnson. Thank you for your comments.

Mr. Tierney, I think you've got a bill like this. Would you care to question?

Mr. Tierney. Thank you, Mr. Chairman, for having these hearings on what is obviously an important issue. I do have a bill that deals with retiree self-insurance, as you know.

It seems to me that we can break this problem into several categories, one of which is people who negotiated either under a contract where they were represented or just as individuals, for a certain amount of pay and compensation with the belief that they were going to have retirement benefits when they retired. Now we have, in many instances, not small businesses but

sizeable, profitable corporations whether it's AT&T, IBM, or General Motors slamming them after they retire, and essentially taking away those benefits.

So that's one set of issues. How do we hold those businesses to their promise? Because that certainly was the deal that seniors believed they made, and we have to address that. The bill that I have does address that. These businesses are profitable, and to the extent that they might not be as profitable and need a loan, let's guarantee the loan and get it back in gear.

I'd like to hear your comments on that, starting with Ms. Neuman. How are we going to hold those people responsible for what they entice people into?

Ms. Neuman. I think you're absolutely right to think about the situation in terms of different groups of employers, because they do have different situations. And I think where there is a legal and contractual obligation, that's an issue that should be arguable in the courts.

Mr. Tierney. Well, it hasn't. Unfortunately, we only have a short time, so I don't mean to be rude, but obviously the courts have dropped the ball on this one. They've made some horrendous decisions, and they haven't upheld the contracts, and the people's enforceable rights. So we're stuck with a situation where the only remedy is going to be through legislation.

Another group of people, obviously, are those that may not fall into that situation. Smaller businesses, or businesses like steel which now have a tremendous retiree problem, or some other failed corporations like Polaroid, where they just didn't have the funds set aside. Doesn't that point us into a couple of directions?

One direction is to find some way to control costs if you're going to supplement the premiums, or do something of that nature. Even then you're still going to have to be worried about those premiums skyrocketing whether it be the insurance premiums, or whether it be the provider's costs, like prescription drugs.

I think, Mr. Kerby, you mentioned some cumulative pile of funds from which to provide insurance. I think we're talking about universal health care. We're talking about whether you call it a tax or you call it a premium, but you're talking about who's going to pay the bill for a substantial form of health care, for which we can get prescription drugs, and other benefits that people need.

How are we going to save costs? Hopefully by having private delivery of medicine, and all the benefits that you need, yet somehow reducing the administrative costs and the overhead. And I think we're talking about very private but very universal types of health care, and coming together to understand that we can't let these prescription drug companies run rampant while they pass on ridiculous costs, and make outrageous profits when they've been supplemented by the government for research monies, and given patents on these products.

So there certainly is a monopoly. It's not as competitive as they would have us believe. Doesn't it mean that we have to get a little more active in those areas? I'll just leave that with the

three of you to answer one at a time in any particular order.

Mr. Scanlon. I would agree completely, but the underlying problem that we face here is the unpredictability and lack of control over costs. It's not just a problem for private insurance; it's a problem for the Medicare program and the Medicaid program. The solutions have been elusive. We have certainly tried a variety of different mechanisms, and I think we still need to be diligent in terms of trying some of those with increased vigor, as well as new mechanisms. But this has been a problem that for the last 25 years, we have not been able to get our hands around.

Mr. Tierney. Medicare Plus Choice is an example of that. In my district, they just went up $107 in their premiums. They're claiming they didn't get enough money from the government, but GAO tells us they got more per person than fee for service would get. And the fact of the matter is that they can't commit a promise when the promise is to give you more for less. It doesn't work.

Ms. Neuman. No, I would agree with Mr. Scanlon. And when you look at the issue of prescription drugs, with costs going up by 15 to16 percent in various places, there obviously needs to be a broad strategy to think of ways to make prescription drugs, as well as other health care services, but this is the one that, in particular, seems to be driving costs of late.

There needs to be a broad strategy, and there are different philosophical views about what's the best way to achieve that, but obviously employers and other payers, both public and private, are dealing with the same kinds of concerns. And if the goal is to deliver affordable prescriptions for seniors or younger populations, some solution needs to be found.

Mr. Tierney. Can any of you find a reason why we should let profitable corporations who promise retirees health plans off the hook? Thank you.

Chairman Johnson. You may answer that in writing if you wish. At this point, I would request that the witnesses would respond to questions from both the majority and the minority, submitted in the official hearing record. And with that, I ask unanimous consent that the hearing record remain open for 14 days to allow Members' statements, questions and other extraneous material referenced during the hearing be submitted in the official hearing record. Hearing no objection, so ordered.

I want to thank the witnesses for their valuable time and testimony, and Members for their participation. If there's no further business, the Committee stands adjourned. Thank you very much.

Whereupon, at 3:05 p.m., the Subcommittee was adjourned.

APPENDIX A - WRITTEN STATEMENT OF CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

STATEMENT OF THE HONORABLE SAM JOHNSON
CHAIRMAN
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

November 1, 2001

Hearing On:
"Retirement Security for the American Worker: Opportunities and Challenges"

Good afternoon everyone and welcome to the first in a series of hearings that the subcommittee will be holding on retirement security issues for present and future generations of Americans. Since September 11th, Americans have taken a serious look at our national security, as well as their personal security. One aspect that comes to mind is financial security. People are concerned for themselves, their parents, and other elderly Americans. In short, even as we face a war, Americans still want to know they'll be okay once they no longer have to show up for work everyday—and that means retiree health benefits.

Today's hearing focuses on the extent to which the national population is directly effected by the need for retiree health coverage. However we must keep in mind this central principal: retiree health problems are problems for all Americans. Retiree healthcare affects the children who have to care for elderly parents or the worker fresh out of school on her first job whose payroll taxes pay for retiree health care. This hearing is designed to help educate the members of the subcommittee as we examine the critical problems facing not only the country's employer sponsored retiree health care system but the entire health care delivery system that is in place throughout America.

Let me remind my colleagues and, our guests, that the baby boom generation is rapidly approaching retirement age and many fear that our public/private institutions are not adequately prepared to care for them. I anticipate additional hearings in the coming months to examine such topics as the problems facing employers who are trying to provide health care coverage for their employees, current coverage by the

Medicare system, and the future demands of the labor market. We will also look at innovative approaches to retiree health coverage that some employers are using to provide for their retirees' health needs and ideas for government policies which will address this silent but looming problem. Even in this time of national trial, it is important that we develop an effective national policy towards our retiree population. If we do not work with, and hear from, all involved professionals to understand the nature of the problem and possible solutions, we will be judged by future generations as a Congress that failed to adequately address one of the major national problems before it.

This hearing will focus on the demographic and cost trends for retirees who retire both before and after the Medicare eligibility age of 65 ("early retirees" and "retirees"). Recent studies by both the GAO and other respected research institutes have shown that while the number of retirees has increased, there has been a decline in the number of retired employees covered by their employers' health insurance plans. These studies also point to other contributing factors such as including a change in the rules governing the financial statements of corporations, the increased cost in retiree health coverage, and court decisions which are interpreting the rights of older workers. I look forward to the witnesses' discussion of the developing trends in the demographic and statistical data on the growth of the retiree population and the costs of health care that is provided to this portion of the population.

Additionally, any data on the problems that employers are having with providing coverage to their retirees under the Employee Retirement Income Security Act (ERISA) will be of great interest and benefit to the subcommittee. Our witnesses may also suggest changes to Federal policies that would improve retiree employee health coverage without putting the underlying coverage at risk. As all the members know and understand, retiree health coverage provided by employers under ERISA is a voluntary undertaking by employers.

We should not do anything that would cause this coverage to be withdrawn due to higher costs or complicated Federal governmental policy. Thus any policy changes must be considered with care. I look forward to working with the members of the subcommittee, and I am eager to have these witnesses help us start our journey which will guarantee the retirement security of our senior citizens who have given so much of themselves to help make America great.

APPENDIX B - WRITTEN STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE SERVICES, GENERAL ACCOUNTING OFFICE, WASHINGTON, D.C.

Testimony of Mr. William J. Scanlon

Director of Health Care Services, GAO

November 1, 2001

I am pleased to be here today as you consider the future financial security of retired Americans, particularly the availability of employer-sponsored health benefits and other sources of insurance coverage to meet the increasing health care and long-term care needs of an aging population. Many retired Americans—about 10 million aged 55 or over—relied on employer-sponsored health benefits in 1999 to provide health coverage until they became eligible for Medicare or as supplemental coverage to pay for out-of-pocket costs not covered by Medicare. However, the number of employers offering these benefits has declined considerably over the past decade. This decline, coupled with the sheer numbers of the aging baby boom population, has raised concerns about whether individuals will continue to have access to employer-sponsored health benefits when they retire and, if not, whether alternative sources of coverage may assist in meeting retirees' health care needs.

In view of these concerns, you asked us to provide information on trends in employer-sponsored retiree health benefits and implications for retirees who may seek alternative sources of coverage. Accordingly, my remarks today will focus on recent changes employers have made to the availability and terms of their retiree health benefits and whether these trends are likely to continue, and the availability of alternative sources of coverage for retirees whose health care and long-term care needs typically increase as they age.

My comments are based largely on our previously issued reports on trends in employer-sponsored retiree health benefits, and in Medicare, Medicare supplemental insurance (also known as Medigap), and long-term care financing.

In summary, some retirees face gaps in coverage to meet their health care and long-term care needs because the availability of employer-

sponsored retiree health benefits is declining and alternative sources of coverage are costly or limited. Despite several years of a sustained strong economy and relatively low increases in health insurance premiums during the late 1990s, the availability of employer-sponsored retiree health benefits has eroded. Two widely cited surveys found that coverage has declined such that about one-third of large employers and less than 10 percent of small employers offer retiree health benefits. Nonetheless, the percentage of retirees with employer-sponsored coverage remained relatively stable between 1994 and 1999, covering about 57 percent of retirees aged 55 to 64 and providing Medicare supplemental coverage to about 32 percent of retirees 65 or older. To some extent, these differing trends may reflect employers' tendency to eliminate coverage for future rather than current retirees. Some employers that continue to offer retiree health benefits, however, have reduced these benefits by increasing the share of premiums that retirees pay, increasing co-payments and deductibles, or limiting future commitments for what they will spend for retiree coverage. For example, an increasing share of large employers that offer retiree health benefits—about 40 percent in 2000, about 8 percentage points higher than in 1997—require retirees younger than 65 to pay the entire premium. Increasing cost pressures on employers, such as rising premiums and a weakening economy, suggest that erosion in retiree health benefits may continue.

With the declining availability of employer-sponsored retiree health benefits, alternative sources of health coverage for retirees may be costly, more limited, or unavailable. Retirees not yet 65 may be eligible for coverage from a spouse's employer or from their former employer under the provisions enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). While these provisions allow an individual to purchase temporary continuation coverage from a former employer, such coverage can be quite expensive as the retiree may be required to pay the entire premium. Other retirees in this age group may seek coverage in the individual insurance market, but individual policies can be expensive or offer more limited coverage, especially for those with existing health problems. Although Medicare covers virtually all retirees 65 or older, most Medicare beneficiaries also obtain supplemental insurance to cover Medicare's cost-sharing requirements and some gaps in Medicare's coverage, such as prescription drugs. Nearly one-third of Medicare-eligible retirees have employer-sponsored supplemental coverage, but many others purchase

individual private supplemental coverage known as "Medigap." While Medigap coverage is widely available to retirees when they initially enroll in Medicare at 65, it costs an average of $1,300 per year and even more for policies that include prescription drug coverage. Finally, neither Medicare nor private insurance covers a significant share of long-term care services. The potentially catastrophic costs of long-term care are currently paid primarily by Medicaid, the joint federal-state health financing program for certain low-income individuals, and by individuals out-of-pocket. Private long-term care insurance plays a small role in financing long-term care services.

Since World War II, many employers have voluntarily sponsored health insurance as a benefit to employees for purposes of recruitment and retention, and many have also extended these benefits to their retirees. The federal tax code gives employers incentives to subsidize health benefits because their contributions can be deducted as a business expense, and these contributions are also not considered taxable income for employees. Employer-sponsored health benefits are regulated under the Employee Retirement Income Security Act of 1974 (ERISA), which gives employers considerable flexibility to manage the cost, design, and extent of health care benefits they provide.

Working adults and retirees aged 55 to 64 rely on employer-sponsored coverage as their primary source of health insurance. In 1999, according to the Bureau of the Census' Current Population Survey, employers provided coverage to 78 percent of all working adults aged 55 to 64 and to 57 percent of the 4 million retirees aged 55 to 64. Other retirees in this age group purchased individual (nongroup) health insurance or relied on Medicaid or other public insurance, and a significant portion—17 percent—were uninsured.

Retirees aged 65 or older typically rely on Medicare as their primary source of coverage. However, Medicare, which helps pay for hospital and physician expenses for acute care, has gaps in coverage that leave Medicare beneficiaries facing significant out-of-pocket costs. For example, Medicare does not cover most outpatient prescription drugs nor does it cover potentially catastrophic expenses associated with long-term stays in hospitals or skilled nursing facilities. As a result, most Medicare beneficiaries obtain supplemental insurance to cover some of these out-of-pocket costs. In 1999, according to the Current Population Survey, nearly one-third of the 23 million retirees aged 65 or older had

Medicare with employer-sponsored supplemental coverage. Slightly more than one-third had Medicare with other sources of supplemental coverage. Most often, these beneficiaries had individually purchased supplemental coverage, known as Medigap, but some received assistance from Medicaid. The remaining portion of retirees had Medicare without supplemental coverage. However, many of these are enrolled in Medicare+Choice plans, which provide beneficiaries an alternative to traditional fee-for-service Medicare and typically have nominal cost-sharing requirements and often cover additional services, such as prescription drugs. Data from the 1998 Medicare Current Beneficiary Survey indicate that half of Medicare beneficiaries with Medicare-only coverage were enrolled in a Medicare+Choice plan.

The health care needs and costs of retired Americans are likely to grow significantly as the baby boom generation nears retirement age. As shown in figure 2, the number of individuals aged 55 to 64 will increase by 75 percent by 2020, and the number of people aged 65 or older will double by 2030. The sheer numbers of baby boomers and greater numbers of people reaching age 85 and beyond are expected to have a dramatic effect on the number of people needing long-term and other health care services because the prevalence of disabilities and dependency increases with age. Projections of the number of disabled elderly individuals who will need such care range from 2 to 4 times the current number.

Insurance coverage, and access to effective preventive, acute, and long-term care, is particularly important for maintaining the health of older adults. For those individuals needing nursing home or other extensive continuing care, the costs can be substantial. On average, nursing home care costs an individual about $55,000 annually. Individuals needing care and their families pay a significant portion of long-term care costs out-of-pocket.

Employer sponsorship of retiree health benefits continues to erode, with about one-third of large employers and few small employers currently offering health benefits to their retirees. Even when employers continue to offer insurance, many have reduced coverage by tightening eligibility requirements, increasing the share of premiums retirees pay for health benefits, or increasing copayments and deductibles. Increasing cost pressures on employers, such as rising premiums and a weakening economy, suggest that erosion in retiree health benefits may continue.

The availability of employer-sponsored retiree health benefits has declined during the last decade. Two widely cited surveys—by William M. Mercer, Incorporated, and the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET)—indicated that nearly half of large employers offered retiree health benefits in the early 1990s, but their most recent surveys reported that this proportion has declined to about one-third of large employers. (See fig. 3.) The decline in large employers offering retiree health benefits has continued in recent years, despite several years during the latter part of the 1990s experiencing a strong economy and relatively small premium increases. Large employers are less likely to offer these benefits to Medicare-eligible retirees than to retirees under age 65. These surveys also found that large employers are more likely to sponsor health insurance for retirees than are small firms, with fewer than 10 percent of the latter doing so.

While fewer employers sponsor retiree health benefits now, the percentage of retirees obtaining health benefits through an employer has remained relatively stable in recent years. According to our analysis of the Current Population Survey, over half of retirees aged 55 to 64 and about one-third of retirees 65 or older had employer-sponsored coverage in 1999. (See fig. 4.) Since 1994, the percentage of both retirees aged 55 to 64 and those 65 or older with employer-sponsored coverage has varied from year to year by only 1 or 2 percentage points. This stability in coverage may exist in part because employers tend to reduce coverage for future rather than current retirees.

Some employers that continue to offer retiree health coverage have adopted several strategies to limit their liability for these costs. These strategies include the following:

Restricting eligibility. According to Mercer's data, among the 36 percent of large employers sponsoring health benefits for retirees younger than 65 in 2000, about 5 percent did so for only selected employees. The remaining 31 percent offered retiree health benefits to most retirees.

Increasing retirees' share of premiums. The Mercer survey found that as many as one-fourth of employers increased retirees' share of premium contributions within the past 2 years. About 40 percent of large employers that offer health benefits to retirees younger than 65 require

those retirees to pay the entire premium—an increase of about 8 percentage points since 1997.

Increasing retirees' out-of-pocket costs. Both the Mercer and Kaiser/HRET surveys found that more than 10 percent of employers recently increased retirees' potential out-of-pocket costs for deductibles, coinsurance, and copayments. In particular, the Kaiser/HRET survey reported that one-third of employers have increased the amount that retirees pay for prescription drugs within the past 2 years.

Limiting future commitments. The 1999 Kaiser/HRET survey found that in the previous 2 years 35 percent of large firms offering retiree health benefits limited their future financial commitment by implementing a cap on projected contributions for these benefits. Benefit consultants we interviewed stated that employers typically set their cap prospectively at a level higher than current spending, and if spending approaches the cap, they can either reduce benefits to stay within the cap or raise the cap.

Some employers are considering, but few have implemented, a more fundamental change that would shift retiree health benefits to a defined contribution plan. Under a defined contribution plan, an employer directly provides each retiree with a fixed amount of money to purchase insurance coverage, either in the individual market or through a choice of plans offered by the employer. The individual is then responsible for the difference between the employer's contribution and the selected plan's total premium. Benefit consultants have reported that many employers would prefer to move toward a defined contribution approach. However, several issues, such as retirees' readiness to assume responsibility for managing their own health benefits and contractual bargaining agreements with union plans, could limit employers' ability to make such a fundamental change.

Increasing economic pressures and evolving demographic trends could lead employers to reevaluate their provision of retiree health benefits and could result in further erosion of benefits. The following are contributing factors:

Health insurance premium increases, which were less than the general inflation rate from 1995 to 1997, began to rise faster than general inflation in 1998 and were about 6 or 8 percentage points above the

general inflation rate in 2001.

The weakening economy may lead employers to reevaluate employee salary and benefit levels. Specifically, the nation's gross domestic product increased at an annual rate of 2.4 percent in the second quarter of 2001, slower than the 4.2 percent and 5.0 percent growth in 1999 and 2000. Also, the nation's unemployment rate has gradually but steadily increased to 4.9 percent as of September 2001 after reaching a historic low of 3.9 percent 1 year earlier. Many economists expect a further weakening of the economy, at least in the short term, as a result of the September 11 terrorist attacks.

The aging of the baby boom generation will increase the proportion and number of Americans of retirement age, leading some employers to have a larger number of retirees for whom they provide coverage but comparatively fewer active workers to subsidize these benefits.

Other factors have increased employers' uncertainty about their future role in providing retiree health benefits, but their implications are less clear. For example, if a proposed outpatient prescription drug benefit was added to Medicare, some employers could redesign their coverage to supplement the Medicare benefit, while others could choose to reduce or eliminate drug coverage. General workforce trends could also affect the availability of retiree health benefits. While some anecdotal information suggests increasing mobility of the workforce with fewer long-term job attachments, the data on this trend are mixed. Nonetheless, the percentage of workers with 20 or more years with a current employer has declined in recent decades and could indicate that fewer employees are likely to be eligible for retiree benefits that are often based on longevity with an employer.

In addition, a March 2001 ruling in the Third U.S. Circuit Court of Appeals found an employer—Erie County, Pennsylvania—in violation of the Age Discrimination in Employment Act (ADEA) because it offered a benefit for Medicare-eligible retirees that the District Court found to be inferior to the benefit offered retirees not yet eligible for Medicare. To what extent the decision will lead to limitations on employers' flexibility in designing their retiree health benefits, and therefore discourage employers from offering such benefits, remains uncertain. This will depend, in part, on whether other circuit courts adopt similar interpretations of ADEA and which differences in benefits

employers provide to non-Medicare-eligible and Medicare-eligible retirees are regarded as potential age-discrimination violations. The Equal Employment Opportunity Commission (EEOC) had initially said it would consider employers' reducing or eliminating retiree health benefits on the basis of a person's age or Medicare eligibility an ADEA violation. However, recognizing concerns raised by employers and unions that this decision could have adverse consequences on the availability of retiree health benefits, EEOC rescinded this policy statement on August 17, 2001. It is considering alternative policies to ensure that health benefits provided to Medicare-eligible retirees are consistent with ADEA without adversely affecting employers' sponsorship of retiree health benefits.

At an age when their health care needs are likely to grow, retirees who lose access to employer-sponsored coverage may face limited coverage alternatives, and those who are unable to obtain coverage may do without or begin to rely on public programs. Some federal laws guarantee access to alternative sources of coverage to both retirees under 65 and those eligible for Medicare; but these options may be costly or limited, particularly for individuals in poor health. A problem apart from whether employer-provided retiree health coverage is available is the potential financial burden of long-term care. Medicare and the private insurance available to most retirees do not typically cover costs of long-term care services that are increasingly needed as the prevalence of disability grows with advancing age. Thus, paying for these services may present a significant and growing financial burden for many individuals and for public health care programs.

Employers have been the predominant source of health coverage for most working adults. Although more than half of retirees report that they intend to continue working, the jobs they take are often part-time, or they are self-employed, and neither situation is likely to offer health benefits. Some individuals retire because of declining health—more than one-fifth of retirees aged 55 to 64 report being in fair or poor health—which further highlights their need for health insurance coverage. Therefore, even in retirement, over half of those aged 55 to 64 in 1999 continued to rely on health insurance either from their former employer or their spouse's employer. However, retirees without access to employer-sponsored coverage either seek an alternative source of health insurance or become uninsured.

Individuals whose jobs provided health benefits that ended at retirement may continue temporary coverage through their employer for up to 18 months under provisions enacted as part of COBRA. But COBRA coverage may be an expensive alternative because the employer is not required to pay any portion of the premium and may charge the enrollee up to 102 percent of the group rate.

The individual insurance market may be an option for some retirees until they become eligible for Medicare, but this alternative can be costly as well. Unlike the employer-sponsored market, where the price for coverage is based on risk characteristics of the entire group, premium prices in the individual insurance market in most states are based on the characteristics of each applicant, such as age, gender, geographic area, tobacco use, and health status. For example, premiums charged a 60-year-old man may be 2-1/2 times to nearly 4 times higher than those charged a 30-year-old man. For eligible individuals leaving group coverage, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees access to at least two individual insurance policies or an alternative such as a state high-risk pool, regardless of health status and without exclusions. Nevertheless, the premiums faced by retirees eligible for HIPAA protections, as well as by other retirees who must rely on the individual insurance market for coverage, may be substantially higher than those charged to healthier or younger individuals and may be cost-prohibitive. This is because retirees are more likely than working adults of the same age to be in fair or poor health. Unless they are guaranteed coverage by HIPAA, individuals with serious health conditions such as heart disease are virtually always denied coverage, and those with other, non-life-threatening conditions such as chronic back pain also may be excluded from coverage. Under a group plan, these individuals cannot be denied coverage, nor can they be required to pay a higher premium than others in the plan, and specific conditions can only be temporarily excluded from coverage.

Although Medicare is the primary source of coverage for retirees 65 years or older, gaps in Medicare coverage mean this population may have high out-of-pocket costs for health care. For example, Medicare does not typically cover outpatient prescription drugs, and it primarily covers acute care but not long-term hospital and skilled nursing facility stays. Most Medicare-eligible retirees obtain supplemental coverage to pay some of the costs not covered by Medicare. Nearly one-third of

Medicare-eligible retirees obtain this supplemental coverage from an employer, and most other Medicare beneficiaries seek other sources of supplemental coverage, such as Medigap or Medicaid, or participate in Medicare+Choice plans, which typically have low cost-sharing requirements and cover services such as prescription drugs that traditional Medicare does not cover.

Retirees can purchase private individual Medigap coverage, but this coverage may cost more or be less comprehensive than typical employer-sponsored health coverage. Medigap policies are widely available to 65-year-old Medicare beneficiaries during an initial 6-month open-enrollment period guaranteed by federal law. Beneficiaries can select from among 10 standard policy types. Most purchasers buy mid-level policies that cover Medicare's cost-sharing requirements and selected other benefits, but not prescriptions. Relatively few Medigap purchasers (8 percent of those with a standardized Medigap policy) have bought the standardized plans that include prescription drug coverage. Whether they include prescription drug coverage or not, Medigap policies can be expensive—the average annual Medigap premium per covered life was more than $1,300 in 1999—and still leave retirees with significant out-of-pocket costs. Medigap policies that provide prescription drug coverage average more than $1,600 compared with about $1,150 for standardized plans without prescription drug coverage. However, even the standardized coverage for prescription drugs pays less than half of beneficiaries' drug costs, and catastrophic prescription drug expenses are not covered.

Access to Medigap policies may be more limited for beneficiaries who are not in the initial open-enrollment period or otherwise eligible for federally guaranteed access under certain other circumstances. For example, federal law provides certain guarantees to ensure an individual has access to Medigap insurance if an employer eliminates or reduces coverage. In these cases, the individuals are guaranteed access to 4 of the 10 standardized Medigap policies, regardless of their health status, but none of these 4 guaranteed plans includes prescription drug coverage.

Although long-term care is a growing need for the retiree population, Medicare and private insurance (through employers or purchased individually) play a small role in financing this care. Public programs, primarily Medicaid, and individuals' out-of-pocket payments are the

primary funding sources for nursing home and home and community-based care for those needing long-term care. In 1999, spending for nursing home and home health care was about $134 billion. Medicaid, which is generally only available after individuals have become nearly impoverished by spending down their assets, paid the largest share of these costs—nearly 44 percent. Individuals needing care and their families paid for almost 25 percent of these expenditures out-of-pocket. Medicare has traditionally primarily covered acute care, but during the 1990s it increasingly covered some long-term home health care services. In 1999, Medicare paid nearly 14 percent of nursing home and home health care.

While private long-term care insurance is viewed as a possible way to reduce catastrophic financial risk for the elderly and relieve some of the financing burden now shouldered by public programs, private insurance (through both long-term care insurance and traditional health insurance) accounted for a small share—10 percent in 1999—of long-term care spending. Most long-term care insurance is purchased individually, with premiums depending on the beneficiary's age at purchase. Premiums for a 65-year-old are typically about $1,000 per year and may be much higher for more generous coverage or older buyers.

The private long-term care insurance market remains small, and few employers offer this insurance as a benefit to employees. Less than 10 percent of individuals 65 or older and an even lower percentage of those younger than 65 have purchased long-term care insurance. Most private long-term care insurance is bought by individuals, but some employers offer employees a voluntary group policy option for long-term care insurance. Only about one-fourth of long-term care insurance policies sold as of 2000 were group offerings, according to the American Council of Life Insurers. Even when employers offer long-term care insurance, they usually do not subsidize any of the costs. In 2000, the Congress passed legislation to offer optional group long-term care insurance to federal employees, retirees, and their relatives beginning by fiscal year 2003, with eligible individuals paying the full premium for the insurance. This initiative will likely establish the largest group offering of long-term care insurance and could encourage further expansion of this market.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Subcommittee may

have.

For more information regarding this testimony, please contact Kathryn G. Allen at (202) 512-7118 or John Dicken at (202) 512-7043. Susan Anthony and Carmen Rivera-Lowitt also made key contributions to this statement.

APPENDIX C - WRITTEN STATEMENT OF PATRICIA NEUMAN, VICE PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION AND DIRECTOR, MEDICARE POLICY PROJECT, WASHINGTON, D.C.

Testimony of Patricia Neuman, Sc.D.

Vice President of the Henry J. Kaiser Family Foundation

November 1, 2001

Thank you, Mr. Chairman and Members of this Subcommittee. I am pleased to be here to testify on retiree health issues and the health challenges facing aging Americans. I am Patricia Neuman, a Vice President of the Henry J. Kaiser Family Foundation and Director of the Foundation's Medicare Policy Project. I am also an associate faculty member at the Johns Hopkins University School of Public Health in the Department of Health Policy and Management.

Employer-sponsored health plans play a critical role in providing health insurance for retirees. Retiree health benefits bridge a potentially risky gap in coverage for many who retire in their late fifties or early sixties—years before they are eligible for Medicare. Health coverage offered by employers provides needed health insurance for early retirees at a time in their lives when they face increasing health problems and might otherwise find health insurance difficult to obtain. For those ages 65 and older, employer-sponsored health plans are a vital source of insurance that supplements Medicare by assisting with cost-sharing requirements and paying for critically needed benefits that are not covered by Medicare, especially prescription drugs.

Over the past decade, however, there has been a steady erosion of retiree health insurance benefits that threatens to increase the number of early retirees who are uninsured and to diminish needed supplemental coverage for seniors on Medicare. In addition, there is concern that the recent downturn in the economy, coupled with double-digit increases in health-care costs, will hasten the decline of retiree health benefits. Within just the past few weeks, two large national firms (Polaroid and Bethlehem Steel) filed for Chapter 11 bankruptcy protection and, as part of that process, signaled their intent to substantially reduce their retiree health obligations. These events underscore the vulnerability of retirees to changes that could significantly impact their health and financial security.

Health Needs of Aging Adults

Health insurance matters to Americans of all ages but is especially important to retirees as they grow older and tend to experience more acute and chronic health problems. Mid-life and older adults are far more likely than younger adults to report being in fair or poor health (Exhibit 1). They are also more likely to be living with chronic health conditions such as heart disease, arthritis, and diabetes (Exhibit 2).

As a result, older adults tend to have a greater need for medical services that can be prohibitively expensive without the financial protection offered by health insurance. The average number of physician contacts per person increases with age, as does the share of adults reporting one or more hospital episodes per year (Exhibit 3). Prescription drug use also increases with age, with adults between the ages of 45 and 64 filling more than twice as many prescriptions—and those ages 65 and older filling four times as many—as do younger adults (Exhibit 4).

Insurance Challenges Facing Early Retirees

Today, the majority of 55- to 64-year-olds (865 percent) have ve some form of health insurance (Exhibit 5). Two-thirds (66 percent) have health insurance from an employer (as workers, retirees, or dependents); another 123 percent have coverage under public programs (mainly Medicaid and Medicare); and 7 percent purchase coverage in the private, individual market. Adults ages 55 to 64 are less likely than 35- to 54- year- old younger adults to have job-based insurance, but are more likely to rely on individually purchased policies and public coverage under Medicare and Medicaid. These public programs offer a vital safety net for people with permanent physical or mental disabilities, but are limited to those who meet eligibility requirements, including the income and asset tests for Medicaid.

There are more than three million About 15 percent of 55- to 64-year-old Americans who are uninsured today. While Rates of uninsured are roughly the same across the 35-to-564 year-olds are just as likely to be age group uninsured as are those ages 55 to 64—with 14 percent of adults in each of these age groups (3 million people) are uninsured—slightly less than the 18 percent average for the entire non-elderly population. While rates of uninsurance are virtually the same across but uninsured—lacking health insurance poses more more serious risks for

people in this older group because they tend to have more health problems than do younger, uninsured adults. More than a quarter (26 percent) of uninsured adults between the ages of 55 and 64 report being in fair or poor health, compared with 16 percent of uninsured adults between the ages of 35 and 54, and 7 percent of uninsured adults under age 35 (Exhibit 6). Lack of insurance disproportionately impacts women, racial and ethnic minorities, non-workers, and adults with low incomes in this age group (Exhibit 7).

More than half of uninsured adults between the ages of 55 and 64 have incomes below 200 percent of the federal poverty level. For a widow in her early sixties, this is an annual income of roughly $17,000. These low-income, uninsured early retirees are especially vulnerable because they lack the financial resources either to purchase health insurance in the private market or to pay directly for their medical care out-of-pocket. They may be further disadvantaged by poor health, since low incomes and health problems are highly correlated.

There is now a significant body of evidence documenting the problems faced by Americans who lack health insurance, including uninsured, early retirees. The uninsured are far more likely than those with health insurance to postpone or forgo needed health care (Exhibit 8). They are also less likely to get preventive services such as pap smears, mammograms, and prostate exams. Without insurance, many cannot afford to get the care they need. Nearly a third of uninsured adults report not having filled a prescription in the past year and more than a third went without a recommended medical test or treatment, citing costs as the reason. A study published earlier this month in the *New England Journal of Medicine* presented new evidence that uninsured adults between the ages of 51 and 61 are more likely than insured adults in this age group to experience a major decline in health status (Exhibit 9).

Despite the incontrovertible need for health insurance, it can be difficult or in some cases impossible for older adults to find affordable, comprehensive health insurance on their own. If workers retire before age 65 and their employer terminates retiree health coverage, they do not currently have a right under COBRA to purchase health coverage under a plan offered by their former employer to active workers. At this stage in their lives, they may be unable to find another job that offers health insurance. And, until they reach age 65, they do not qualify for

Medicare. Many in this age group look to purchase non-group policies in the individual market, but these policies have proven to be a less than reliable source of affordable coverage—particularly for those with a history of medical problems and those with modest incomes.

Premiums in the individual market can be prohibitively expensive for early retirees, presenting a considerable financial hurdle for those living on fixed incomes. For example, a new report prepared by the Urban Institute found that a 60-year old man who is a non-smoker with one health problem could expect to pay nearly $7,000 in insurance premiums. Clearly, few retirees have the resources to pay such premiums. For the majority of uninsured adults ages 55 to 64 who live on incomes below 200 percent of the poverty level, this premium would consume about 40 percent of their income. Among older adults with chronic diseases such as hypertension or depression, premiums would be considerably higher, potentially posing an even greater financial burden for those with substantial health-care needs.

Many early retirees are unable to buy insurance in this market at any price. According to a 1998 report prepared for the Kaiser Family Foundation, one by Karen Pollitz and colleagues from Georgetown University, and the other by Deborah Chollet and Adele Kirk of the Alpha Center, insurers in the individual market tend to underwrite aggressively—screening applicants for pre-existing conditions, excluding coverage for the very services that people with specific health conditions need, or denying coverage altogether. In states where insurers are not required to guarantee issue, for example, insurers may deny coverage for such common conditions as rheumatoid arthritis, chronic headaches, angina, kidney stones, heart attacks, and stroke.

Given the limitations of the individual market for older adults, and the limited access to alternative sources of coverage, employer-sponsored retiree health benefits provide a critical safety net for many workers who retire before they are eligible for Medicare.

Insurance Challenges Facing Retirees 65+

Retirees ages 65 and older confront a different set of insurance challenges when they lose employer-sponsored retiree health benefits. Unlike than do early retirees, seniors By contrast, they are fortunate to have Medicare as a safety-net insurer and their primary source of basic

health insurance protection. For 65+ retirees seniors, the challenge is finding supplemental insurance to assist with Medicare's high cost-sharing requirements and with paying for services and items that are excluded from Medicare's benefit package, particularly prescription drugs. Given the limitations of Medicare's benefit package relative to plans typically offered to workers, supplemental coverage is particularly important. Beneficiaries who lack supplemental coverage are substantially more likely than those with private coverage such as employer-sponsored retiree health benefits to experience serious access problems and to delay getting needed care due to costs (Exhibit 10).

Today, more than a third of all seniors—almost 14 million people on Medicare—have supplemental coverage from an employer plan (Exhibit 11). Others get coverage from a variety of sources, including Medicare HMOs, Medigap, and Medicaid. Unfortunately, the supplemental insurance market has become increasingly unstable in the past few years, jeopardizing retirees' access to needed coverage. Medicare HMOs HMOs, once considered a promising and affordable source of supplemental benefits part of the Medicare+Choice program, have also experienced turbulent times, with more than 173 HMO plans pulling out of the Medicare+Choice program since 11998, disrupting coverage for more than one million beneficiaries and limiting the ability of seniors to get help with their prescription drug expenses. In addition, Medigap premiums have become increasingly unaffordable; premiums for policies that cover some prescription drugs have risen by more than 30 percent since 1999.

Given this instability, This instability helps to explain why employer-sponsored retiree plans are an especially important source of supplemental coverage for millions of older Americans. Retiree coverage assists seniors in many ways, often helping with Medicare's cost-sharing requirements and covering the costs of services not included in the basic Medicare benefit package, such as prescription drugs and, in some cases, dental care. benefits are so valued by retirees.

Virtually all employer-sponsored retiree health plans provide prescription drug benefits today. In fact,

employer-sponsored health plans are the primary source of prescription drug coverage for seniors, providing drug benefits to one-third of all people on Medicare. Drug benefits offered under retiree health plans

tend to be more generous than the three standard Medigap policies that include prescription drug coverage and most Medicare+Choice plans. These benefits are therefore especially valuable for retirees, given recent and fairly dramatic increases in prescription drug spending and the absence of alternative, reliable, affordable sources of drug coverage for people on Medicare.

The Role of Retiree Health Benefits

Given the limitations of the individual market for older adults, and the limited access to alternative sources of coverage, employer-sponsored retiree health benefits provide a critical safety net for many workers who retire before they are eligible for Medicare. Health benefits offered to early retirees are generally comparable to the benefits offered to active workers, and far more comprehensive and affordable than policies typically sold in the individual market. As a result, retirees often rely on this source of coverage during the years that bridge retirement age and Medicare eligibility.

Employer-sponsored health plans are critical to Medicare-eligible retirees as well. They serve as the primary source of prescription drug coverage for this population, providing drug benefits to one-third of all beneficiaries. This coverage is especially valuable given recent and fairly dramatic increases in prescription drug spending among seniors and the instability of alternative sources of drug coverage.

Retiree health benefits tend to be substantially more generous than other forms of private supplemental coverage for Medicare-eligible retirees—particularly in the area of prescription drugs. To date, for example, drug benefits included in retiree health plans tend to be unlimited (i.e., without a cap), in contrast to both the three standard Medigap policies that include prescription drug coverage and most Medicare+Choice plans. As a result, Medicare beneficiaries with supplemental retiree health benefits typically have lower average out-of-pocket drug costs than do those with Medigap ($313 versus $546), according to a recently published analysis of the 1998 Medicare Current Beneficiary Survey. The absence of this coverage would clearly signal a rise in out-of-pocket prescription drug costs for a large share of seniors on Medicare.

The Erosion of Retiree Health Benefits

The prevalence of retiree heath coverage has declined over the past decade. Among large employers—who are far more likely than small or mid-sized employers to offer retiree health benefits—the share offering coverage to pre-65 retirees decreased from 88 percent in 1991 to 76 percent in 1999 (Hewitt Associates, 2000). During this same period, the share of large employers offering retiree health benefits to retirees ages 65+ dropped from 80 percent in 1991 to 66 percent in 1999 (Exhibit 12). Since 1999, the share of firms offering health benefits to retirees ages 65 and older has fallen by 10 percentage points, according to a recent survey of employers in mid-size to large firms (Kaiser/Commonwealth/Health Research and Educational Trust, forthcoming). This decline is a function of the rising number of employers terminating coverage as well as fewer new companies offering retiree health benefits. Typically, but not always, terminations affect future retirees, eroding the promise of retiree coverage for younger workers, while "grand fathering" current retirees and those close to retirement.

The decline in retiree health benefits observed in the early- and mid-1990s has been attributed to new accounting rules issued by the Financial Accounting Standards Board (FASB) that required employers to account for their future liability for retiree health benefits on their balance sheets. More recent declines, however, have been attributed to the recent rise in health-care spending. Health-care premiums for job-based insurance grew at a higher rate than in previous years, increasing by 11 percent between 2000 and 2001 (Kaiser/Health Research and Educational Trust, 2001).

Confronted with a fiscal downturn, employers may look to cut costs by reducing their retiree health obligations in an effort to keep their margins up. Retiree health is a voluntary benefit and, where it is not negotiated with unions or provided under other contractual arrangements, employers may choose to terminate coverage on a prospective basis under the assumption that providing benefits to active workers is more important to maintaining business performance than is providing benefits for retirees.

Among firms that continue to offer retiree health coverage, there is mounting pressure to control the growth in spending for these benefits. Many employers impose stringent eligibility rules to cut costs, including both minimum eligibility age requirements (e.g., ages 55 and

older) and minimum-years-of-service rules (e.g., 10 to 15 years) as conditions for receiving retiree health benefits. These rules reward workers who make a long-term commitment to firms offering retiree health benefits, but make it difficult for many workers to qualify for these benefits when they are ready to retire.

In addition, a growing share of large employers are raising premiums and cost-sharing requirements, making retirees cover a greater share of their own health-care costs. In particular, employers are continuing to bear down on prescription drug costs that are projected to represent as much as 80 percent of health-care costs for Medicare-eligible retirees in 2003 (Hewitt Associates, 2000). These changes will ultimately erode the value of retiree benefits for seniors, exposing them to higher out-of-pocket spending.

Looking to the future, there is ample reason to suspect that the trend of declining retiree health benefits will continue, if not accelerate. In a 1999 survey of large employers, many said they would seriously consider major changes in their benefits, including increasing premiums and cost-sharing for retirees ages 65 and older (83 percent), shifting to a defined contribution approach to cap their own liability (51 percent), cutting back on prescription drug coverage for 65+ retirees (36 percent), and terminating coverage prospectively for elderly retirees (29 percent) (Hewitt Associates, 1999) (Exhibit 13) (Hewitt Associates, 1999). It is important to note that these findings are from 1999—a time when the economy was considerably stronger, the labor market was tighter, and health-care costs were growing far more slowly than they are today. In the current climate, the outlook for retirees could be substantially worse.

Policy Options

There are a variety of policy options that could help address problems that arise from eroding employer-sponsored retiree health benefits. Some aim to provide health insurance coverage to retirees who were adversely affected by the decisions of employers to terminate health benefits. These range from more comprehensive approaches (which are not currently under discussion) to more incremental approaches. Others seek to reinforce the role of employers, by encouraging them to maintain commitments to their retirees. , ranging from comprehensive approaches (which are not currently receiving serious consideration) to

more incremental strategies.

Among the more incremental proposals to assist early retirees, For pre-65 retirees whose option would be to modify existing COBRA rules to make the termination of retiree health benefits a qualifying event and give early retirees the right to purchase health insurance coverage under a plan offered by that their former employer to its active workers. To minimize the risk of subsequent gaps in coverage, These COBRA protections—generally limited to 18 months—could be extended to cover retirees until they reach the age of Medicare eligibility, to minimize the risk of subsequent gaps in coverage.

A COBRA This approach would give many early retirees access to relatively generous health insurance benefits under group health plans coverage. However, COBRA premiums are relatively high, because those who buy into a plan are typically required to pay both the employer and employee share of the premium plus a 2 percent administrative fee. As a result, the COBRA option, by itself, may be unaffordable for many who need coverage. Premium subsidies, while adding costs to the federal government, would clearly help to lower the costs borne by retirees, potentially increasing the number of people who would opt for coverage under this approach. s concern that premium costs would be too high to help many of those in need. Under COBRA, those who buy into a plan typically pay both the employer and employee share of the premium plus a 2 percent administrative fee. An additional concern is that many early retirees would not qualify for these new protections because COBRA rules do not apply to employers with fewer than 20 workers.

Another option under discussion would be to provide tax credits to help early retirees (and others) purchase health insurance on their own. Under this general approach, retirees would turn to the individual insurance market, choose a health plan, and people would choose their own health plan and apply for premium subsidies by filing a tax return. This idea has been raised by many as a strategy to help the uninsured of all ages. Proponents suggest that tax credits would ease the financial burden on consumers by making health insurance premiums more affordable than it is today, without expanding the role of public programs such as Medicare or Medicaid.

Others observe, however, that most tax credit proposals cwould be of

minimal help because premiums in the individual market tend to be expensive, particularly for people in this age group, and proposed tax credit amounts (typically $1,000 for an individual and $2,000 for a family) please check $) are unlikely to be high enough to make this coverage affordable. Furthermore, even if the tax credits were substantially increased to cover not offer credits at a high enough level to offset a larger share of the high the premium cost, many early retirees could face of health insurance premiums for individuals in this age group, especially for those living on modest incomes. A tax credit approach, by itself, would not address barriers to coverage as a result of related to underwriting and rating practices in the non-group market.

A third option to provide coverage —and one that was proposed by President Clinton and others—would permit early retirees to buy into the Medicare program before they turn 65. The success of this approach would depend on its design and the generosity of the premium subsidy offered to retirees. If designed to be cost-neutral and financed fully by individual premiums, then a Medicare buy-in would expand access to coverage, but would again be unlikely to help those with modest incomes. If adequately subsidized, however, a Medicare buy-in could be a relatively direct way to provide affordable coverage to early retirees, including those with modest incomes and those with medical problems, bridging the gap between retirement and Medicare eligibility (Johnson, et al., 2001).

For seniors who lose Policy options to assist seniors ages 65 and older that lose their retiree health benefits but who, unlike early retirees, are fortunate to have basic coverage under Medicare, the policy options under discussion tend to focus more broadly on strategies to enhance Medicare benefits. These options are integrally related to ongoing discussions about Medicare reform. The erosion of coverage for retirees ages 65 and older underscores the problems facing seniors today who lack access to affordable supplemental coverage—particularly those who lack access to prescription drug benefits. There are now a variety of options under discussion that would address this concern. Some would modify the current program, by adding prescription drugs to the basic Medicare benefit package. Others would offer access to new benefits as part of more fundamental changes to the structure of the program.

It is also worth noting that a new Medicare prescription drug benefit—

while designed to achieve the specific objective of increasing access to prescription medications for those on Medicare—could also have the indirect effect of strengthening the capacity of employers to continue to offer retiree health benefits. This is because a Medicare drug benefit could offer employers significant financial relief forom the cost of retirees' prescription drugs. In fact, the majority of large employers surveyed in 2000 said they would continue to offer retiree health benefits as wrap-around coverage, if a Medicare drug benefit were enacted (Exhibit 14) (Hewitt Associates, 2000).

Another strategy for addressing the predicted decline in retiree health benefits would encourage employers to be to target employers by encouraging them to maintain their health commitments to their retirees. Some would offer financial incentives, while others would impose penalties on plans that reduced retiree health benefits post-retirement.

As these policies are considered, it will be important to strike a balance between .... encourages employers to retain retiree health benefits by... and by providing civil monetary penalties on employers... encouraging employers to maintain medical coverage for retirees, while guarding against changes that could accelerate the erosion of these highly valued benefits. This could prove to be especially challenging given the current economic outlook.

It is also worth noting that a new Medicare prescription drug benefit—while designed to achieve the specific objective of increasing access to prescription medications for those on Medicare—could have the indirect effect of slowing the rising costs of retiree coverage and of thus allowing employers to continue offering retiree health benefits more easily as wrap-around coverage (Exhibit 14) (Hewitt Associates, 2000)..

Implications

While millions of retirees enjoy the financial protections offered by employer-sponsored retiree health benefits, it is clear that fewer workers will be able to rely on such coverage when they retire. A combination of factors—the -steady decline of employers offering retiree health coverage, the implementation of strict eligibility requirements imposed as a condition for receiving benefits, and predictions that benefits will continue to erode in the future—all

suggest that the current generation of workers will be far less likely than their parents' generation to receive employer-sponsored retiree health benefits.

current environment suggests the continued decline of retiree health benefits—a trend that may accelerate with the downturn in the economy and one that will impact both pre-65 and Medicare-eligible future retirees and, consequently, the present generation of workers.

The erosion of retiree health benefits poses serious risks for adults who retire before they are eligible for Medicare. Those who retire in their late 50s or early 60s—for health concerns, because they worked for a firm that downsized, or other reasons—have greater difficulties than younger workers finding new jobs, and are thus less likely to obtain insurance from another employer. Early retirees—particularly those with health problems or modest incomes—face major challenges finding affordable health insurance in the private individual market. Without insurance, they are less likely to get needed care, are more likely to experience a decline in health outcomes, and are highly vulnerable to large medical bills that could wipe out their life savings. and are at greater risk of going without needed care and medications.

For the Medicare population seniors on Medicare, the erosion of retiree health benefits could is likely to expose millions of seniors beneficiaries to rising out-of-pocket costs for health benefits that are not covered by Medicare. Today, employer plans provide drug coverage to one-third of all beneficiaries. If employers cut back on these benefits—as many say they are seriously considering—a growing number of elderly people will be left without prescription drug coverage. There is ample evidence that seniors without drug coverage are more likely than those with coverage to go without needed medications, and in so doing, risk serious medical complications and preventable health problems. Clearly, the predicted decline of retiree health benefits will only add to the growing pressure for improvements in the Medicare program

The decline in retiree benefits underscores both the need to provide affordable health insurance for early retirees older adults who are uninsured but too young for Medicare and also the urgency of making prescription drug coverage available to older retirees covered by Medicare who lose access to such benefits under an employer plan. who lack access to such benefits under an employer plan. Employers,

workers, and retirees have much at stake in the outcome of these decisions.

APPENDIX D - WRITTEN STATEMENT OF CHARLES K. "CHIP" KERBY, III, ESQ., WASHINGTON RESOURCE GROUP, WILLIAM M. MERCER, INCORPORATED, WASHINGTON, D.C.

COMMITTEE ON EDUCATION AND THE WORKFORCE
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS
THE UNITED STATES HOUSE OF REPRESENTATIVES

HEARING:

RETIREMENT SECURITY FOR THE AMERICAN WORKER: OPPORTUNITIES AND CHALLENGES

Testimony of:

Charles K. "Chip" Kerby, III, Esq.
Washington Resource Group
William M. Mercer, Incorporated

November 1, 2001

Introduction

Chairman Johnson, Ranking Member Andrews, and Members of the Committee, thank you for the opportunity to testify on the current environment for employer-sponsored retiree health plans. I am Chip Kerby, a consulting attorney and principal with the Washington Resource Group of William M. Mercer, Incorporated. Mercer is a global consulting firm that helps organizations in all aspects of strategic and operational human resource consulting. Our special areas of emphasis include employee benefits, compensation, communication, and actuarial services.

Mercer works primarily with large employers, many of whom sponsor retiree health plans. For years, these employers voluntarily offered retiree health coverage to their retirees. But the pressures on retiree health plan sponsors are significant and growing. Escalating retiree health costs, rapidly aging workforces, the volatility of the Medicare+Choice system, the possibility of a Medicare prescription drug benefit, and accounting, funding and litigation constraints are causing many employers to reevaluate their retiree health programs.

As Congress begins to tackle the complex issues facing retiring workers, this Committee is to be commended for its efforts to understand how retiree health plans fit into this equation. My testimony today will address recent retiree health plan trends, the challenges facing retiree health plan sponsors, and the policy consequences associated with these developments.

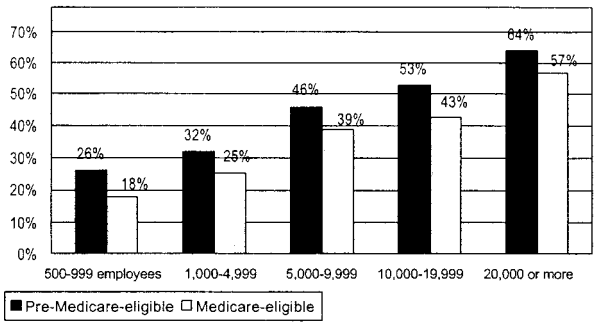
Retiree Health Trends

Each year, our company conducts a national survey of employer-sponsored health plans. The survey was established in 1986 by Foster Higgins (now merged with William M. Mercer), and since 1993 the survey has used a stratified random sample that produces comparable results from year to year. The survey identifies health care costs, trends and plan design information for both active and retired employees. The data that I'll be sharing with you today reflects responses from 1,924 large employers (500 or more employees) who responded to the 2000 survey, and is projectable to all large U.S. employers.

Employers sponsoring retiree health coverage. Most employers offer health coverage to active employees. But many employers do not offer health coverage to retirees. The larger the employer, the more likely it is to offer retiree health coverage. Among large employers, the prevalence of retiree health coverage for pre-Medicare retirees ranges from 26% of those with 500 to 999 employees to 64% of those with 20,000 or more employees. The prevalence of retiree health coverage for Medicare-eligible retirees is slightly lower, ranging from 18% of those with 500 to 999 employees to 57% of those with 20,000 or more employees (Figure 1). Among small employers (fewer than 500 employees) only 8% offer coverage to any retirees.

Figure 1

RETIREE HEALTH COVERAGE OFFERED BY EMPLOYERS WITH 500 + EMPLOYEES, BY EMPLOYER SIZE

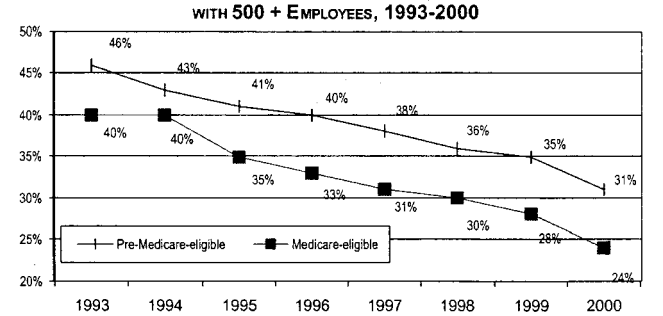


Source: William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans* (New York, NY; William M. Mercer, 2001)

But the percentage of large employers offering retiree health coverage has been slowly eroding over the last eight years, and the decline accelerated in 2000. From 1999 to 2000, the percentage of large employers offering coverage to pre-Medicare retirees dropped from 35% to 31%, while the percentage offering coverage to Medicare-eligible retirees dropped from 28% to 24% (Figure 2). These numbers

Figure 2

RETIREE HEALTH COVERAGE OFFERED BY EMPLOYERS WITH 500 + EMPLOYEES, 1993-2000



Source: William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans* (New York, NY; William M. Mercer, 2001)

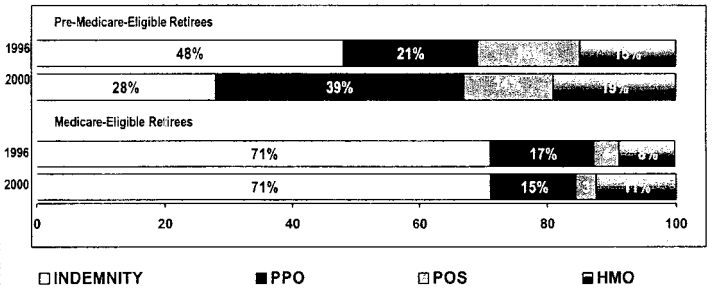
refer only to plans that cover current and future retirees. An additional 5% of large employers sponsor plans covering only employees who were hired or retired before specified dates.

Type of plan. Over the last five years, the percentage of pre-Medicare retirees participating in traditional indemnity plans has been shrinking, while the percentage participating in preferred provider organizations has been growing. In 2000, 28% of pre-Medicare retirees participated in indemnity plans, 39% participated in preferred provider organization (PPO) plans, 14% participated in point-of-service (POS) plans and 19% participated in health maintenance organization (HMO) plans.

The great majority of Medicare-eligible retirees continue to participate in traditional indemnity plans. In 2000, 71% of Medicare retirees participated in indemnity plans, 15% participated in PPO plans, 3% participated in POS plans and 11% participated in HMOs. Although 43% of retiree health plan sponsors offered a Medicare + Choice (M+C) HMO in 2000, there was very little movement into these plans. This is consistent with the slowing enrollment in M+C plans observed nationwide (Figure 3).

Figure 3

RETIREE ENROLLMENT BY TYPE OF HEALTH PLAN



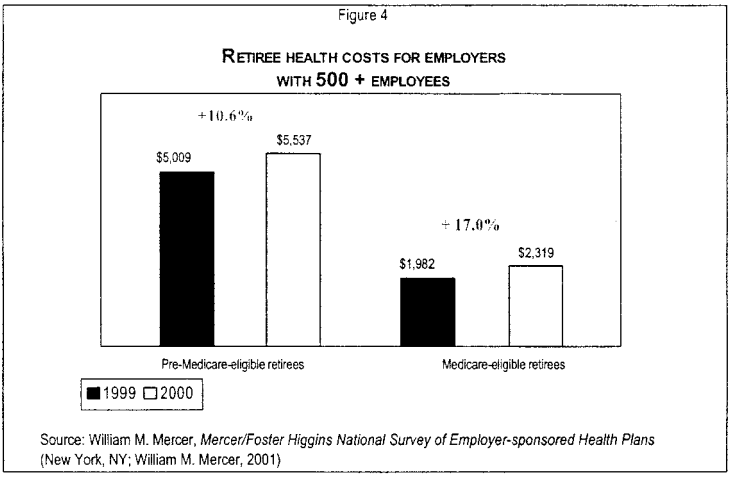
Source: William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans* (New York, NY; William M. Mercer, 2001)

Defined contribution plans. Despite the significant media attention focused on defined contribution health plans, few employers currently offer such programs to retirees. Only 1% of employers provide retirees with a subsidy to purchase coverage on their own. Most employers are reluctant to consider defined contribution approaches, because they don't believe retirees could obtain coverage (based on preexisting conditions, chronic illness or affordability). Nevertheless, our recent consulting experience suggests there is considerable interest in account-based retiree health programs designed to assist retirees in accumulating sufficient funds to purchase health insurance coverage.

Cost trends. The average per-capita cost of retiree health benefits increased dramatically in 2000 – producing a 10.6% trend for pre-Medicare retirees and a 17.0% trend for Medicare-eligible employees (Figure 4). In comparison, the health care cost trend for active employees was 6.6% in 2000. The

increase for Medicare-eligible employees is significantly affected by increases in prescription drug costs. Medicare doesn't cover prescription drugs but most retiree health plans do. As a result, drug costs drive the total trend because they often exceed 50% of the employer's total cost.

Figure 4



Source: William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans* (New York, NY; William M. Mercer, 2001)

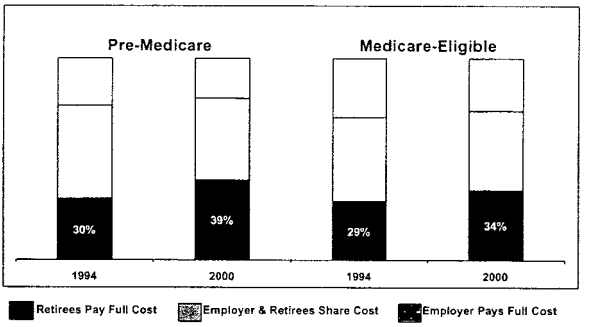
Retiree contributions. Many employers share the cost of retiree health programs with retirees. For pre-Medicare retirees, a fifth of employers pay the full cost of individual coverage, two-fifths require the retiree to pay the full cost and two-fifths share the cost. Where costs are shared, the average contribution for pre-Medicare retirees is 34% of premium. For Medicare-eligible retirees, approximately one-fourth of employers pay the full cost of individual coverage, one-third require the retiree to pay the full cost, and the remainder share the cost. Where costs are shared, the average contribution for Medicare-eligible retirees is 33% of premium. Some retiree health plan sponsors adjust the contribution amount on the basis of age or years of service or both. Such adjustments are made by 29% of sponsors for pre-Medicare retirees, and by 36% of sponsors for Medicare-eligible retirees. Although contribution strategies changed little from 1999 to 2000, they have changed considerably since 1994 (Figure 5).

Prescription drugs and other benefits. Although virtually all health plans for active employees cover prescription drugs, only 84% of retiree health plan sponsors offer this coverage. Drug benefit exclusions are more common among smaller employers – while 97% of employers with 20,000 or more employees cover prescription drugs, only 79% of employers with 500 to 999 employees cover prescription drugs. A few employers limit their liability with an annual or lifetime prescription drug maximum (3% of employers covering pre-Medicare retirees, and 6% of employers covering Medicare-eligible retirees include these limits).

More employers offer dental and vision coverage to pre-Medicare retirees than to Medicare-eligible

Figure 5

RETIREE HEALTH CONTRIBUTIONS AMONG EMPLOYERS WITH 500 + EMPLOYEES



Source: William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans* (New York, NY; William M. Mercer, 2001)

retirees. For pre-Medicare retirees, about 52% of retiree health plan sponsors offer dental coverage and 30% offer vision coverage. For Medicare-eligible retirees, about 42% of retiree health plan sponsors offer dental coverage and 22% offer vision coverage.

Challenges Facing Retiree Health Plan Sponsors

Several factors will influence the extent to which employers continue to voluntarily offer retiree health coverage. These include cost trends, labor market conditions, lack of alternative sources of coverage, M+C plan availability, Medicare changes, accounting requirements, funding constraints, and the recent age discrimination decision in *Erie County Retirees Association v. County of Erie*.

Cost trends. Our actuaries believe that retiree health plan costs will continue to increase faster than the overall consumer price index (CPI) and the medical portion of the consumer price index (MCPI). Employers are predicting an average 11.0% increase in health benefit costs for active employees in 2001, and expect even greater increases for their retiree health plans. Recent trends in prescription drug costs are also expected to increase at double-digit rates. This last development is especially disturbing, given the relative impact prescription drug costs have on the total cost of retiree health coverage for Medicare-eligible retirees. As a result, many employers are already indicating that they intend to pass some portion of these cost increases on to both pre-Medicare and Medicare-eligible retirees.

Labor market conditions. Employers offer health benefits to help attract and retain a high-quality workforce. But the relative generosity of these benefits may vary depending on the availability of human capital. When labor is in short supply, employers are less willing to modify health benefits or shift health benefit cost increases to plan participants. This was certainly true a year ago, when the unemployment

rate reached a 30-year low of 3.9% in October 2000. But the unemployment rate has increased to 4.9% in September 2001, and employers may now be more willing to change their health benefits and shift health benefit costs.

Retiree health benefits are part of this equation. Some employers have discovered that offering retiree health coverage improves their ability to "rightsize" their workforce. Employees with access to a retiree health plan are more willing to accept early retirement packages. But employees without a retiree health plan wait longer to retire – the median retirement age is 61 among employers that sponsor retiree health plans and 64 among employers that don't. Other employers find that a lack of retiree health coverage may interfere with their ability to hire experienced, mid-career employees.

Lack of Alternative Sources of Coverage. Employees retiring at or after age 65 have access to generous healthcare coverage under Medicare. But employees retiring at younger ages have limited access to health insurance coverage. In the absence of employer-sponsored retiree health coverage, these early retirees must rely on a patchwork quilt of health insurance options:

- Early retirees may be able to continue their employer-provided coverage for 18 months under COBRA

- Early retirees who elect and exhaust COBRA coverage are guaranteed the right to purchase individual health insurance products under insurance reforms enacted as part of the Health Insurance Portability and Accountability Act (HIPAA), but there's no guarantee that these products will be affordable

- Early retirees who don't qualify for these HIPAA "guaranteed issue" products may still be able to purchase individual health insurance, assuming they are in reasonably good health

Other possible coverage options include access to health insurance coverage through (1) a spouse's employer, (2) entitlement to veterans' benefits, (3) state high risk pools, or (4) Medicaid. Without full access to coverage, it's no surprise that employees who don't have employer-provided retiree health coverage tend to retire later.

M+C plan availability. When employers began offering M+C plans to their retirees in the 1990s, they did so for two reasons – managed care provided a convenient way to save money, and pre-Medicare retirees wanted to continue with HMOs after they reached 65. Congress added additional flexibility to the M+C program in the Balanced Budget Act of 1997, and many employers expected the availability of M+C plans to increase. Unfortunately, the legislation produced the opposite effect, principally because government reimbursement rates have not kept up with inflation. The number of M+C plans available to retirees dropped precipitously (from 346 in December 1998, to 180 in October 2001), and the number of M+C plan enrollees also declined (from 6.06 million in December 1998, to 5.56 million in October 2001). Some retiree health plan sponsors were "burned" when M+C plans withdrew, leaving thousands of retirees with no HMO choices. As a result, some employers lost faith in the ability of the M+C market to service their retiree groups. While legislation enacted in December 2000 may help stabilize the M+C market, employers remain less than enthusiastic about the long-term prospects for M+C plans.

Medicare changes. Various legislative proposals have been introduced to reform the Medicare program. Several of these proposals would make prescription drugs a covered Medicare benefit. The impact of a Medicare prescription drug benefit on retiree health plan sponsors would vary, depending on the availability of the benefit, the level of benefits, the premium cost, any required cost-sharing, and the availability of an employer subsidy.

Depending on the design of a Medicare drug benefit, employers might choose one of several courses of action. One approach might be to continue offering Medicare-eligible retirees a prescription drug benefit, and coordinate with the new Medicare benefit. Another approach might be to cease offering a prescription drug benefit to Medicare-eligible retirees, and instead offer to pay any additional premiums for the new Medicare benefit. But predicting employer responses to a potential Medicare drug benefit is difficult in the absence of design specifics.

Employers recognize that a Medicare drug benefit is a two-edged sword. On the one hand, costs for employer-sponsored *retiree* health plans are likely to drop if the federal government picks up a portion of the cost of prescription drugs for Medicare-eligible retirees. On the other hand, costs for employer-sponsored *employee* health plans might actually increase. If the federal government demands discounts for drugs sold to the Medicare market, pharmaceutical companies may raise drug prices for other purchasers. Employers are likely to withhold judgment on a Medicare drug benefit until additional details are known.

Accounting requirements. Under Financial Accounting Statement (FAS) 106, employers are required to accrue and expense future retiree health claims and disclose unfunded retiree health liabilities on their financial statements. When employers adopted FAS 106 in the early 1990s, many opted to impose "caps" on their retiree health programs. A typical cap limits the employer's annual financial commitment to a specified dollar amount, usually a higher amount for pre-Medicare retirees and a lower amount for Medicare-eligible retirees. Recent increases in health care cost inflation are causing some employers to bump into these caps, leading them to re-evaluate their retiree health plan designs. Employers in this situation are considering a number of options – raising the caps, passing future cost increases to retirees, indexing the caps to some inflationary measure, shifting to a defined contribution design, terminating the retiree health plan or some combination of these measures.

The Government Accounting Standards Board (GASB) is developing an accounting statement similar to FAS 106 that will apply to governmental employers that sponsor retiree health plans. This statement is likely to impose accrual accounting and greater disclosure requirements on governmental retiree health plan liabilities, and is likely to have an impact similar to FAS 106. Many governmental employers are already studying their estimated retiree health liabilities in anticipation of this new statement, and some can be expected to reduce their retiree health plan commitments. GASB expects to issue an exposure draft of the new statement in late 2001 or early 2002.

Funding constraints. ERISA requires employers to fund pension plans, and provides favorable tax treatment for these arrangements. Thus, when employers contribute to a "tax-qualified" retirement plan, the employer gets a current deduction and the trust assets grow tax-free. But ERISA does not require

employers to fund retiree health plans, and less favorable tax treatment is available for employers that do so.

Under current law, two types of retiree health funding arrangements receive limited tax-favored treatment. One arrangement is a 401(h) account attached to a pension plan. Employer contributions to a 401(h) account are deductible, the assets grow tax-free, and retirees receive tax-free health benefits. But contributions to a 401(h) account are severely limited and, in many cases, employers are precluded from making any contributions to a 401(h) account. Another arrangement is a voluntary employees' beneficiary association (VEBA). But VEBAs used to fund retiree health costs are subject to two significant limitations – employer contributions typically are not fully deductible, and earnings on retiree health reserves are generally taxable.

Erie County litigation. Last year, the Third Circuit Court of Appeals (covering Delaware, Pennsylvania, New Jersey and the Virgin Islands) held that Medicare-based distinctions in retiree health plans presumptively violate the Age Discrimination in Employment Act (ADEA). In *Erie County Retirees Association v. County of Erie*, the court concluded that this presumption may be overcome only if a retiree health plan satisfies ADEA's so-called "equal benefits/equal cost" test, under which benefits or costs for Medicare-eligible retirees must be equal to benefits or costs for younger retirees. This decision came as a surprise to many employers who assumed, based on ADEA's legislative history, it was permissible to offer different benefits to Medicare-eligible retirees.

On remand, the District Court for the Western District of Pennsylvania considered whether Erie County's retiree health plan satisfied the equal benefits or equal cost test. The County conceded that it didn't satisfy the equal cost test, because it paid less to provide coverage for Medicare-eligible retirees than for pre-Medicare retirees. The District Court concluded that the County didn't satisfy the equal benefit test because: (i) pre-Medicare retirees paid less for their coverage than Medicare-eligible retirees (*taking into account Medicare Part B premiums paid to the federal government*); (ii) the County offered a choice of indemnity and HMO plans to pre-Medicare retirees but offered only an HMO plan for Medicare-eligible retirees; and (iii) the County offered a more generous prescription drug benefit for pre-Medicare retirees than for Medicare-eligible retirees.

The *Erie County* case has caused great consternation among retiree health plan sponsors, who never viewed their retiree health plans as a potential source of ADEA liability. Especially troubling is the District Court's novel interpretation that Medicare Part B premiums must be taken into account in determining whether Medicare-eligible retirees receive lesser benefits than pre-Medicare retirees. This interpretation appears to be inconsistent both with ADEA's legislative history and with EEOC guidance regarding retiree health plans that coordinate with Medicare. The EEOC is aware of these employer concerns, and is studying ADEA's application to retiree health plans. Nevertheless, employers with retiree health plans remain vulnerable to additional ADEA lawsuits.

Employers with limited contacts in the Third Circuit are taking a "wait and see" approach pending additional judicial developments. Other employers are considering various ways to "fix" possible ADEA problems. One possibility might be to offer the same health plan options to all retirees. But in many locations the same managed care option won't be available for both Medicare-eligible and pre-Medicare retirees. A second possibility might be to equalize benefits and retiree contributions. But it may not

be possible to provide equal benefits and/or require equal or proportionate retiree contributions without reducing subsidies for some retirees and increasing subsidies for others. A third possibility might be to eliminate health coverage for all retirees. But such a decision may trigger additional litigation and adverse employee and retiree relations.

Policy Consequences

Retiree health plan sponsors are reacting to these challenges. But they are doing so in ways that concern us, and may concern policymakers as well. Our survey data reveals a disturbing trend – employers are slowly, but consistently, terminating their retiree health plans for future retirees. The trend is slower among large employers, but still universal. While recent consulting activity suggests that some employers are considering defined contribution plans for future retirees, these plans are still in their infancy.

Despite the evident decline in employer-sponsored retiree health plans, there hasn't been a similar decline in the number of retirees with health insurance. A recent analysis of the March 2000 Current Population Survey by the Employee Benefit Research Institute (EBRI) shows virtually no change in the number of pre-Medicare retirees with health insurance coverage from 1994 through 1999. Does this mean we shouldn't worry? To the contrary, the EBRI analysis suggests that the day of reckoning is still to come. According to EBRI, "many current employees will never qualify for retiree health benefits because their employers offer them only to workers hired before a specific date." See "Employment-Based Health Benefits: Trends and Outlook," Paul Fronstin, *EBRI Issue Brief Number 233*, May 2001.

Which leads us to the age-old question – what should policymakers do?

There are two key issues – one is access to health insurance coverage, and the other is funding the cost of the coverage. On the access issue, should pre-Medicare retirees continue to have access to an employer-sponsored plan? Should we allow younger retirees to "buy-in" to the Medicare program? Should we encourage the insurance industry to create sources of group coverage for pre-Medicare retirees other than employer-based coverage? On the funding issue, should we encourage or require employers and employees to pre-fund the cost of retiree health coverage? Should we establish federal or state subsidies for pre-Medicare retirees? Should we do both?

A related question is whether employers should continue to be involved. In large measure, the employment-based health system is a historical accident, having developed during World War II when employers were able to avoid wage and price controls by offering health benefits to attract workers. If the access and funding issues can be addressed through mechanisms that don't involve employers, then policymakers may need to consider non-employment-based alternatives. Indeed, the interest in defined contribution plans is a signal that employers are looking for a solution with less employer involvement. To facilitate change from the current system, one possibility is a "dual-track" strategy – keeping employers involved in the short-term, but building mechanisms that facilitate greater individual and market involvement in the long-term.

When tackling these issues, it's critically important to think "outside the box." Too often, there is a tendency to focus on solutions within the particular confines of the existing order – we limit our thinking

to the silos with which we are most familiar. Instead of focusing narrowly on employers and their benefit plans, or insurance carriers and their products, or government subsidies and entitlement programs, why not focus on what the customer – the retiree – needs? A retiree doesn't view Medicare, Social Security and employer-provided benefits in isolation, but rather in combination. From this perspective, a retiree needs two things – cash and access to health coverage.

There are many different ways to approach the access and funding issues. We describe below some suggested policy options, with no comment on their political feasibility. Each of these options will influence employer, individual, insurance carrier and government behaviors, and each will come with different costs.

Expanding access for retirees. There are several approaches that could be considered to expand access to health care for retirees.

First, employers could be required to offer continued coverage rights to employees who terminate at or after age 55. In effect, this would create "super-COBRA" rights for pre-Medicare retirees. But employers are not likely to support this approach, even if they could charge the full age-rated value of the coverage.

Second, the federal government could establish federal regulation for group and individual insurance products sold to individuals over age 55. This would not be a federally financed program like Medicare, but would provide federal rules (with state enforcement) to regulate insurance carriers who create over-55 products. This is similar to the approach currently used to regulate Medigap plans.

Third, the federal government could establish a subsidy program to provide refundable tax credits for individuals over age 55 who don't have another source of group coverage. This is the approach taken in S. 590, although a more targeted approach may be necessary to address the higher health insurance costs of retirees.

Fourth, various existing federal programs (such as the Federal Employees Health Benefits Program or Medicare) could be opened to individuals over age 55 who don't have another source of group coverage. To enhance budget neutrality, eligible individuals would be required to pay the full premium cost. This option may not be feasible for Medicare, given the problems currently facing that program.

Finally, employers could be penalized for terminating existing retiree health plans. This is the approach adopted in H.R. 1322. But this approach is antithetical to the voluntary employment-based system endorsed and preserved by ERISA. Employers would strongly object to any proposal obligating them to continue offering a retiree health plan.

Encouraging funding of retiree health costs. There are also several alternatives that could be considered to provide incentives for employers and individuals to fund retiree health costs.

First, federal tax law could encourage employers to fund retiree health costs by making the existing rules governing 401(h) accounts and VEBAs more flexible. With minor changes, these vehicles could provide the same favorable tax treatment for retiree health funding that is available for retirement plans. The rules

governing 401(k) plans, 403(b) annuities and 457 plans could also be modified to encourage similar retiree health funding opportunities within those plans as well.

Second, federal tax law could allow employers and individuals to establish tax-favored Retiree Medical Savings Accounts ("Retiree MSAs") to accumulate funds to pay for retiree health coverage. Retiree MSAs might receive the same tax treatment as Roth IRAs, with contributions being made on an after-tax basis and assets growing tax-free.

Third, by combining the previous approaches, employers could be given a current tax deduction for contributions to fund retiree health costs through *any* dedicated retiree health funding vehicle (e.g., Taft-Hartley trusts, 401(h) accounts and equivalent arrangements in defined contribution plans, VEBAs, or Retiree MSAs). Similarly, employees might be permitted to make pre-tax contributions to one or more of these dedicated retiree health funding vehicles.

Fourth, employers could be given greater flexibility to use existing asset accumulations to pay for retiree health benefits. For example, the federal tax laws might expand and extend section 420 to encourage employers to use excess pension assets and/or other accumulated benefits (such as vacation or sick pay) to pay for retiree health costs.

Finally, employees could be given greater flexibility to use existing asset accumulations to pay for retiree health benefits. For example, the cafeteria plan rules could allow employees to use accumulated pension and 401(k) assets to pay for retiree health costs on a pre-tax basis. Similarly, it might also be possible to let employees use other accumulations (such as IRAs, U.S. Savings Bonds, life insurance cash values and equity in a personal residence) to pay for retiree health costs on a pre-tax basis.

Conclusion

The erosion of employer-sponsored retiree health benefit plans is not a trivial concern. Although the full impact of this development has not yet been felt, many current employees will not have access to employer-sponsored health coverage when they retire. When this happens, and 80 million individuals will reach age 55 over the next 20 years, there are sure to be societal repercussions.

Is it possible to reverse this trend? Some employers have already concluded that they don't need to offer retiree health benefits to remain competitive in the global economy. But other employers believe they must provide retiree health benefits to attract and retain a high-quality workforce. If we do nothing, the pattern of erosion is likely to continue.

There is still time to develop policy options that may slow this trend. The options should be holistic – we should stand in the shoes of retirees and contemplate how to provide an integrated and seamless solution to the issues of access and funding. The options should be flexible – flexible enough to encourage employers and insurance carriers to offer health coverage to retirees; flexible enough to encourage employers and employees to accumulate assets, or use previously accumulated assets, to pay for retiree health costs; and flexible enough to encourage the establishment of non-employer-based mechanisms to enable individuals to obtain and purchase coverage when they retire.

Committee on Education and the Workforce

Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)

Your Name: Charles K. Kerby III		
1. Will you be representing a federal, State, or local government entity? (If the answer is yes please contact the Committee).	Yes	No X
2. Please list any federal grants or contracts (including subgrants or subcontracts) which you have received since October 1, 1998: N/A		
3. Will you be representing an entity other than a government entity?	Yes	No X
4. Other than yourself, please list what entity or entities you will be representing: None		
5. Please list any offices or elected positions held and/or briefly describe your representational capacity with each of the entities you listed in response to question 4: N/A		
6. Please list any federal grants or contracts (including subgrants or subcontracts) received by the entities you listed in response to question 4 since October 1, 1998, including the source and amount of each grant or contract: N/A		
7. Are there parent organizations, subsidiaries, or partnerships to the entities you disclosed in response to question number 4 that you will not be representing? If so, please list:	Yes	No X

Signature: Charles K. Kerby III Date: 31 OCT 01

Please attach this sheet to your written testimony.

CHARLES K. "CHIP" KERBY, III

Chip Kerby is an attorney and a Principal in the Washington Resource Group of William M. Mercer, Incorporated. Chip has over 20 years of experience with ERISA and other federal and state laws affecting the design and administration of employer-sponsored benefit plans, and specializes in issues affecting health and welfare plans.

Chip assists employers in understanding legislative and regulatory developments affecting their employee benefit programs and business operations. He is in regular contact with congressional staff, government agencies, and Washington-based interest groups to monitor congressional and agency policies and actions. Chip also consults on a national basis with Mercer professionals and their clients to discuss client-specific implications of legislative and regulatory developments.

Over the last several years, Chip has focused much of his attention on several key issues: (i) the tax and legal issues associated with the developing consumer-driven health care system; (ii) retiree health plan design and funding alternatives; (iii) the erosion of ERISA preemption and potential health plan liability; (iv) tax and ERISA compliance responsibilities for health and group benefit plans; and (v) Federal and state initiatives to reform the nation's health care system. He actively monitors health care reform initiatives, and is familiar with recent legislation reforming the Medicare program. Chip serves as a member of several Mercer task forces and work groups designed to assist Mercer's clients in developing strategic business responses to retiree health plan issues, tax and ERISA compliance responsibilities, and enacted and anticipated health care reform legislation.

Prior to joining Mercer, Chip worked for three years as a Senior Manager with the Employee Benefits Services group at Price Waterhouse. Chip's experience also includes two and one-half years as an associate with the tax and employee benefits practice at Miller and Chevalier, and four and one-half years as an Assistant Branch Chief and attorney-advisor in the Chief Counsel's office of the Internal Revenue Service. While at the IRS, he participated in the development of legislation and regulations affecting health plans and deferred compensation plans.

Chip is a graduate of the University of Delaware (B.A., magna cum laude). He holds a law degree from the Washington and Lee University Law School (J.D., cum laude), and a masters in law from the Georgetown University Law Center (L.L.M. in taxation). He is a member of the National Health Lawyers Association and the Employee Benefits Committee of the Tax Section of the American Bar Association, and speaks and writes frequently on federal and state health care developments and other employee benefit issues.

APPENDIX E – SUBMITTED FOR THE RECORD, LETTER FROM SAM JOHNSON, CHAIRMAN SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, TO WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE SERVICES, GENERAL ACCOUNTING OFFICE, NOVEMBER 8, 2001

COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
2181 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

MAJORITY–(202) 225-4527
(TTY)–(202) 226-3372
MINORITY–(202) 225-3725
(TTY)–(202) 226-3116

November 8, 2001

Mr. William J. Scanlon
Director, Health Care Services
General Accounting Office
441 G Street, Northwest
Washington, DC 20548

Dear Mr. Scanlon:

On behalf of the members of the Subcommittee and myself, I want to thank you for testifying at the November 1, 2001 hearing on "Retirement Security for the American Worker: Opportunities and Challenges" held by the Subcommittee on Employer-Employee Relations of the Education and the Workforce Committee. Your testimony was very informative and will be of great benefit to us as we explore this issue during the 107th Congress.

Due to our busy voting schedule on the floor of the House of Representatives, most of the members of the Subcommittee were unable to ask you questions regarding your testimony during the hearing. Having said that, I have included a number of prepared questions that we would like you to answer to the best of your ability. Your answers will be extremely helpful to the members of the Subcommittee and will be included in the record. The questions are as follows:

1. Your testimony references many factors that contribute to the decline in employer-sponsored retiree health coverage. In your estimation, how will the economic conditions that our country is experiencing further impact this situation?

2. In your testimony, you speak of the growth in the retiree population in percentages. Can you translate those percentages into numbers? How will the influx of retirees when the baby boom generation retires impact active workers?

3. What is the current number of seniors with disabilities and dependencies? What will that number be in 20 years?

4. What are the leading cost pressures on employer sponsored health coverage? Are there any means to relieve these pressures?

5. What is the rate of increase in long care cost coverage? Is that more or less than general medical inflation?

6. Do present long-term care insurance policies solve the long-term care costs of those insured?

7. You mention that the Erie County decision – holding employers in violation of the Age Discrimination in Employment Act for offering differing benefits to early and later retirees -- may lead to limitations on employers' flexibility in offering retiree benefits. Why is this flexibility so important?

Your answers should be returned to my staff by November 14, 2001. They can be faxed to the attention of Dave Thomas at (202) 225-2454. If you have any questions, please feel free to contact David Connolly, Kristin Fitzgerald, or Dave Thomas at (202) 225-7101. Again, thank you for your valuable contribution. I hope that you will continue to work with us on this and other matters of mutual concern.

Sincerely,

SAM JOHNSON
Chairman
Subcommittee on Employer-Employee Relations

Enclosures
Questions

APPENDIX F – SUBMITTED FOR THE RECORD, LETTER FROM WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE, TO CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, NOVEMBER 16, 2001

United States General Accounting Office
Washington, DC 20548

November 16, 2001

The Honorable Sam Johnson
Chairman
Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
House of Representatives

Dear Mr. Chairman:

In response to your November 8, 2001 letter to GAO, we are providing answers to questions you submitted to us following the November 1, 2001 hearing entitled "Retirement Security for the American Worker: Opportunities and Challenges". The questions and answers can be found on the attached enclosure.

We trust that you will find this information helpful. Please call me at (202) 512-7114 if we can be of further assistance.

Sincerely yours,

William J. Scanlon
Director, Health Care Issues

Enclosure

cc: The Honorable Robert E. Andrews
Ranking Minority Member

RESPONSE TO SUBCOMMITTEE QUESTIONS
ON NOVEMBER 1, 2001 GAO TESTIMONY
RETIREE HEALTH INSURANCE:
GAPS IN COVERAGE AND AVAILABILITY

1. **Your testimony references many factors that contribute to the decline in employer-sponsored retiree health coverage. In your estimation, how will the economic conditions that our country is experiencing further impact this situation?**

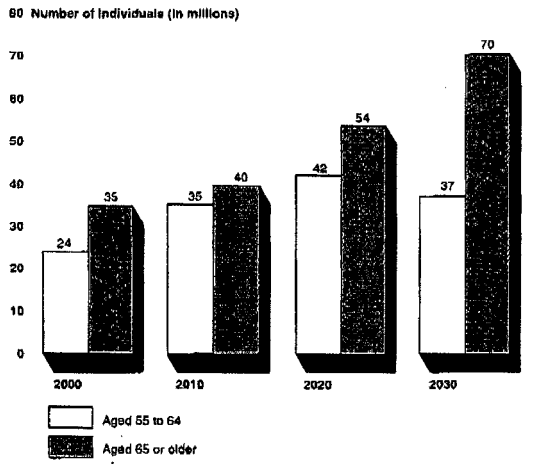
As the economy further weakens—with unemployment reaching 5.4 percent in October 2001 and the real GDP decreasing at an annual rate of 0.4 percent in the third quarter of 2001— retiree health benefits may be vulnerable to further erosion. The timing and extent, however, is uncertain. According to a number of employee benefit consultants and researchers, a slowing economy and rising health care costs could lead many employers to reconsider their continued provision of these benefits. In fact, one expert suggested that employers had been delaying making reductions in retiree benefits when the labor market was tight and speculated that if the economy were to go into recession retirees would be the first to feel the negative effects. Recent bankruptcy filings by two companies may prove his point. For example, after filing for Chapter 11 bankruptcy protection last month, Bethlehem Steel changed the terms under which retiree health benefits are provided—in some cases, nearly doubling retiree copayments. Similarly, Polaroid, which also filed for Chapter 11 bankruptcy protection last month, eliminated outright health benefits to thousands of retirees. Whether and when other employers will take action to reduce health benefits depends on multiple factors, including the severity and longevity of the current economic downturn, the effectiveness of policies implemented to stimulate the economy, and employers' financial position.

2. **In your testimony, you speak of the growth in the retiree population in percentages. Can you translate those percentages into numbers? How will the influx of retirees when the baby boom generation retires impact active workers?**

Over the next 30 years, both the number and proportion of individuals potentially affected by a decline in employer-sponsored retiree health insurance will increase. As shown in figure 1, from 2000 to 2030, the number of individuals ages 55 to 64 will increase by 75 percent--from 24 million to 37 million. About 17 percent of individuals this age were retired in 1999. Even larger growth will be occurring among individuals ages 65 and older. Their numbers will double during this period--from 35 to 70 million. In contrast, the number of working-aged persons under 55 is estimated to increase by only about 10 percent from 2000 to 2030.

Unlike pension plans, employer-sponsored health benefits for retirees and active workers are not typically prefunded; instead, employers usually rely on current funding sources to pay for health care costs. As the number of retirees grows considerably over the next couple of decades, employers will have a larger number of retirees for whom to potentially provide health coverage, but comparatively fewer active workers to generate revenue and subsidize these benefits. As a result, many employers may face difficulty in continuing to fund retiree health benefits.

Figure 1: Baby Boom Generation Will Greatly Increase the Elderly and Near-Elderly Population



Source: Bureau of the Census, Projections of the Total Resident Population by 5-Year Age Groups and Sex With Special Age Categories: Middle Series, selected years 2000 to 2030 (Washington, D.C.: Jan. 2000).

3. What is the current number of seniors with disabilities and dependencies? What will that number be in 20 years?

Although a chronic physical or mental disability may occur at any age, the older an individual, the more likely a disabling condition will develop or worsen. In a May 1999 study, we estimated that approximately 2.3 million adults living in the community had severe disabilities and required considerable help from another person to perform multiple activities of daily living (ADL) or instrumental activities of daily living (IADL).[1] Roughly 1.3 million of these adults were age 65 or older. Similarly, the Lewin Group estimated that 1.8 million persons age 65 or older had at least two ADL limitations in the period 1996-2000.[2]

Projecting the number of individuals who will develop disabilities and dependencies in the future is complicated. With baby boomers expected to live longer and greater numbers reaching age 85 and older, this generation is expected to have a dramatic effect on the number of people needing long-term care services as the prevalence of disabilities and dependencies increases with age. But researchers disagree about the effects of better health care and healthier lifestyles on the baby boomers' future health. Some contend that medical advances have increased life expectancy but have not changed the age of onset of illness and that therefore the need for long-term care may have increased. Others contend that better treatment and prevention could decrease the time period at the end of life when long-term care is needed. For example, Lewin ICF estimates that the number of persons age 65 and older with at least two ADL limitations will increase from 1.8 to 2.4 million over the period of 1996-2000 to 2020-2024, and other estimates suggest that the number of disabled baby boomers who will need long-term care could more than double.

[1] *See Adults with Severe Disabilities: Federal and State Approaches for Personal Care and Other Services* (GAO/HEHS-99-101, May 14, 1999)

[2] The differences in these estimates can be attributed in part to differing definitions of disabled individuals. The 2.3 million we identified represents individuals who had (1) two ADLs and four or more IADLs or (2) three or more ADLs with a high difficulty level. Lewin's 1.8 million includes individuals age 65 or older with at least two ADL limitations.

4. **What are the leading cost pressures on employer-sponsored health coverage? Are there any means to relieve these pressures?**

The resumption of large health insurance premium increases fueled at least in part by rising health care costs is a major financial concern for employers offering retiree health benefits, particularly in a weakened economy. Hospital and prescription drug spending accounted for nearly three-quarters of the increase in health care spending between 1999 and 2000, according to data from the Center for Studying Health System Change. Specifically, hospital spending accounted for 43 percent of the increase in health care spending. Prescription drug spending, which accounted for 29 percent of the increase in health care spending, had the fastest rate of increase of any component of total health care spending.

Some employers that continue to offer retiree health coverage have adopted several strategies to limit their liability for retiree health costs. For example:

- Some employers have increased retirees' share of premium contributions. William M. Mercer, Incorporated's survey found that about one-fourth of employers increased retirees' share of premium contributions within the past 2 years. About 40 percent of large employers that offer health benefits to retirees younger than 65 require those retirees to pay the entire premium—an increase from 32 percent in1997.
- Some employers are also increasing retirees' cost sharing requirements. Both the Mercer and the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET) surveys found that more than 10 percent of employers recently increased retirees' potential out-of-pocket costs for deductibles, coinsurance, and copayments.
- Employers are particularly focusing on benefit changes to control prescription drug spending because this is their largest cost for health benefits for Medicare-eligible retirees—representing 40 to 60 percent of many employers' costs for these benefits. The Kaiser/HRET survey found that among employers offering retiree health benefits, 33 percent increased the amount retirees pay for prescription drugs in the past two years. Also, 13 percent introduced three-tiered cost sharing for drugs, which is intended to encourage retirees to choose less expensive drugs by having lower cost-sharing for generic drugs or brand-name drugs on a preferred list of drugs (i.e., a formulary).

While such steps help employers limit their share of retiree health costs, finding means to gain better control of the underlying problem—rising health care costs—has been extremely challenging. That challenge is one faced not just by employers offering retiree coverage, but all purchasers of health care. Unfortunately, no solutions have yet resolved the fundamental increase in health care costs.

5. **What is the rate of increase in long-term care cost coverage? Is that more or less than general medical inflation?**

Unfortunately, limited data are available on average rates of premium increases for long-term care insurance, and premium increases can vary widely by insurer and policy. The long-term care insurance market remains relatively small despite its emergence a few decades ago. The market has continued to evolve, as some insurers have reduced premiums over time as they set initial premiums relatively high and have since developed better actuarial projections of costs for purchasers. In contrast, other insurers initially set premiums too low and have had sharp premium increases. For example, a class action lawsuit settled in 1999 involved long-term care policyholders in North Dakota who had substantial premium increases—some more than 700 percent—even though they had thought that their premiums would not increase while they held their policies. In August 2000, the NAIC amended its model acts and regulations to encourage insurers to set initial rates at levels unlikely to require further increases.

A further difficulty in examining average premium trends is that premiums are strongly related to the age at which long-term care insurance policies are initially purchased, and insurers have increasingly marketed these policies to working-aged adults as well as the elderly. Average premiums may decline if the average age at purchase is declining, but this may not accurately represent the trend in premiums for policies at a given age.

Better information exists on the costs associated with long-term care. The Health Care Financing Administration's National Health Expenditures data show that spending for home health and nursing home services grew from $80.5 billion in 1992 to $123.1 billion in 1999, a 53 percent increase. During this same time, other health care expenditures increased from $648.5 billion to $934.6 billion, a 44 percent increase. These expenditures for nursing home and home care, however, likely understate the true costs of long-term care since family members or other unpaid caregivers provide much of this care. An estimated 60 percent of the disabled elderly living in communities rely exclusively on their families and other unpaid sources for their care.

6. Do present long-term care insurance policies solve the long-term care costs of those insured?

Private long-term care insurance is viewed as a possible way to reduce catastrophic financial risk for the elderly needing long-term care and to relieve some of the financing burden now shouldered by public long-term care programs. However, although the number of individuals purchasing long-term care insurance increased during the 1990s, less than 10 percent of elderly individuals and even fewer near-elderly individuals (those aged 55 to 64) have purchased long-term care insurance. Several recent Congressional initiatives, such as the availability of group long-term care insurance for federal employees, retirees, and their dependents and proposals to provide additional tax subsidies to individuals purchasing long-term care insurance, aim to increase the use of private insurance in financing long-term care.

While long-term care insurance can provide financial protection for those who purchase it and incur long-term care expenses, these policies may not fully cover their long-term care costs for several reasons. First, policies typically pay a maximum rate, such as a per day rate for nursing homes or a per visit rate for home care. While a $100 per day nursing home payment may cover some nursing home expenses, it may not fully cover the daily rate for many nursing home residents. Further, not all long-term care insurance policies have inflation protection, meaning that a benefit such as a $100 per day nursing home benefit that seems sufficient to cover most anticipated long-term care costs at the time of purchase may erode as policyholders may hold their policies for decades before using benefits. Finally, policies typically cover costs for a limited period of time, such as 24 or 36 months. Thus, individuals who reside in a nursing home longer than their private insurance will pay become personally responsible for the costs or may need to spend down to become Medicaid eligible.

7. **You mention that the Erie County decision—holding employers in violation of the Age Discrimination in Employment Act for offering differing benefits to early and later retirees—may lead to limitations on employers' flexibility in offering retiree benefits. Why is this flexibility so important?**

What impact the Erie County decision will have on the latitude employers have to design and modify their retiree benefit packages is not yet clear. The Third Circuit Court of Appeals determined that the equal benefits or equal cost provision of ADEA applies to retiree benefits as it has to benefits of active employees. Thus, even within the jurisdiction of the Third Circuit, employers will retain some flexibility regarding retiree benefits as long as they meet the equal benefits or equal cost standard.

Flexibility can be important because employers know that they can make adjustments to their health insurance benefits as future circumstances change. With the potential for future health care cost inflation to exceed reasonable estimates, employers could be very concerned about being locked into a certain set of benefits. Without flexibility to modify benefits, uncertainty about future costs could lead some employers to not offer benefits in the first place. At the same time, flexibility provided employers creates some uncertainty and risk for retirees. When employers curtail benefits, retirees may be ill equipped to fill the gap.

APPENDIX G – SUBMITTED FOR THE RECORD, LETTER FROM SAM JOHNSON, CHAIRMAN SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, TO CHIP KERBY, PRINCIPAL, WASHINGTON RESOURCE GROUP, WILLIAM M. MERCER, INCORPORATED, NOVEMBER 8, 2001

COMMITTEE ON EDUCATION
AND THE WORKFORCE
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November 8, 2001

Mr. Chip Kerby
Principal
Washington Resource Group
William M. Mercer, Incorporated
1255 23rd Street, NW Suite 250
Washington, D.C. 20037

Dear Mr. Kerby:

On behalf of the members of the Subcommittee and myself, I want to thank you for testifying at the November 1, 2001 hearing on "Retirement Security for the American Worker: Opportunities and Challenges" held by the Subcommittee on Employer-Employee Relations of the Education and the Workforce Committee. Your testimony was very informative and will be of great benefit to us as we explore this issue during the 107th Congress.

Due to our busy voting schedule on the floor of the House of Representatives, most of the members of the Subcommittee were unable to ask you questions regarding your testimony during the hearing. Having said that, I have included a number of prepared questions that we would like you to answer to the best of your ability. Your answers will be extremely helpful to the members of the Subcommittee and will be included in the record. The questions are as follows:

1. Many employees remember a day when upon retirement one received a pension plan, a health care plan and a gold watch commemorating 30 years of service to a particular company. Now employees are likely to have many employers in the course of their career. How does the changing nature of the workforce impact the availability of employer sponsored retiree health coverage?

2. Many have suggested that moving to a defined contribution system – where employers give employees a defined dollar amount instead of access to a health plan – might relieve some of the pressures of the employer-based health care system. In your view, why are only a few employers offering this option? What do you perceive to be the benefits of the employer-based health care system vs. a defined contribution approach?

3. Your testimony illuminates the fact that workers are less likely to have employer sponsored retiree health coverage when they retire. This trend parallels the fact that retirees are also less likely to have a defined pension benefit. Most employees have prepared for their retirement by saving in a 401K. Why has there not been a similar savings trend to prepare for retiree health coverage?

4. You mention in your testimony that larger employers are more likely than smaller employers to offer health insurance to retirees. Why is this? Do you have any recommendations for increasing small business retiree health care coverage?

5. As you referenced in your testimony, health care costs increased dramatically in the year 2000, 6.6 % for active employees, 10.6 % for pre-Medicare retirees, and 17 % for Medicare-eligible employees. Why is retiree coverage so much more expensive than coverage for active employees? Will you expand upon why the cost of coverage for Medicare-eligible employees is increasing so much faster than for younger retirees?

6. You mention that retirees often share the cost burden for retiree coverage with their employers. Are these after tax dollars for employees? How about employers?

7. How are employers adjusting or varying retiree health coverage to accommodate both workers who spent the majority of their career in their employ and others that may have a much shorter tenure?

8. In your view, should employers continue to be involved in providing retiree health coverage? What do you think are the greatest benefits of the employer based system for employees?

9. In order to provide actuarially sound coverage, how much would the average defined contribution retiree health account have to contain on a person's early retirement? Regular retirement? What would be the investment vehicle for such a defined contribution plan? Stocks? Bonds?

10. You mention that retiree health plan costs will continue to increase faster than the overall consumer price index (CPI). Do you have any projections for the increase in health care costs in the next ten years? Twenty years? In addition to prescription drugs, what other factors increase health plan costs?

11. How big an effect will the GASB rule have on the cost of governments providing retiree health coverage to employees?

Your answers should be returned to my staff by November 14, 2001. They can be faxed to the attention of Dave Thomas at (202) 225-2454. If you have any questions, please feel free to contact David Connolly, Kristin Fitzgerald, or Dave Thomas at (202) 225-7101. Again, thank you for your valuable contribution. I hope that you will continue to work with us on this and other matters of mutual concern.

Sincerely,

SAM JOHNSON
Chairman
Subcommittee on Employer-Employee Relations

Enclosures
Questions

APPENDIX H – SUBMITTED FOR THE RECORD, LETTER FROM CHARLES K. "CHIP" KERBY III, WILLIAM M. MERCER, INCORPORATED, TO CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, NOVEMBER 26, 2001

WILLIAM M.
MERCER

November 26, 2001

The Honorable Sam Johnson
Chairman, Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
U.S. House of Representatives
2181 Rayburn House Office Building
Washington, DC 20515-6100

Subject: Responses to Committee Questions

Dear Mr. Chairman:

Thank you for the opportunity to testify at the November 1, 2001 hearing on "Retirement Security for the American Worker: Opportunities and Challenges" held by the Subcommittee on Employer-Employee Relations of the Education and Workforce Committee. I'm pleased to offer the following responses to the questions raised in your letter of November 8, 2001:

1. *Many employees remember a day when upon retirement one received a pension plan, a health care plan and a gold watch commemorating 30 years of service to a particular company. Now employees are likely to have many employers in the course of their career. How does the changing nature of the workforce impact the availability of employer-sponsored retiree health coverage?*

I certainly agree that the workforce is changing. Employees work more jobs during their careers, are more likely to work on a part-time or temporary basis, and are more likely to leave their jobs gradually through "phased" retirement. As a result, some believe that the "social contract" between employers and employees has changed, leading employers to offer fewer benefits to retirees.

But I am not aware of any empirical evidence suggesting that these workforce changes have affected the availability of employer-sponsored retiree health coverage. To the contrary, the better evidence is that rising health costs and competitive economic pressures are affecting the availability of this benefit.

2. *Many have suggested that moving to a defined contribution system – where employers give employees a defined dollar amount instead of access to a health plan – might relieve some of the pressures of the employer-based health care system. In your view,*

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why are only a few employers offering this option? What do you perceive to be the benefits of the employer-based health care system vs. a defined contribution approach?

The idea of delivering a defined dollar amount to enable retirees to purchase health coverage is certainly not new. This concept has been the subject of discussion both before and after employers adopted FAS 106. But employers have been reluctant to implement these "pure" defined dollar designs for several reasons:

- Defined dollar designs can impose greater cash flow obligations than traditional designs. Rather than paying claims only for those who are sick, defined dollar designs obligate employers to provide credits or contributions for all eligible individuals.

- Defined dollar designs require employers to make difficult decisions about "how much" money to contribute per individual. Should an employer contribute the same amount for each individual? Or should different amounts be contributed based on family size, geographic location and health status?

- Defined dollar designs do not provide retirees with any guarantee that they will have a source of health insurance coverage. As my written testimony indicates, the opportunities for retirees to find health insurance coverage prior to Medicare eligibility are limited. Because of this access problem, most of the defined dollar designs that have been implemented continue to provide retirees with access to their employer-sponsored health plan.

Defined contribution approaches and the employer-based health care system are not mutually exclusive. Over the next several years, many employers will begin offering defined contribution health plans – also known as consumer-driven health plans – to both active employees and retirees. I expect most of these early adopters will define a fixed level of financial commitment for active employees and retirees, and at the same time continue to offer access to coverage under an employer-sponsored health plan. Defined contribution approaches offer employers greater predictability over their financial commitment, but don't necessarily provide retirees with an independent source of coverage.

WILLIAM M. MERCER

The employer-based health care system also provides an efficient mechanism for pooling and distributing risk. Employees and retirees come in all ages, genders and health status, allowing employers and insurance carriers to spread the risk of providing health coverage among groups with diverse characteristics. Defined contribution approaches are simply a financing tool, and don't by themselves offer an alternative method of risk-distribution.

3. *Your testimony illuminates the fact that workers are less likely to have employer-sponsored retiree health coverage when they retire. This trend parallels the fact that retirees are also less likely to have a defined pension benefit. Most employees have prepared for their retirement by saving in a 401K. Why has there not been a similar savings trend to prepare for retiree health coverage?*

A 401(k) plan is a highly tax-efficient savings vehicle. Employees contribute on a pre-tax basis, and contributions grow tax free. In addition, employees receive constant messages from their employers, the financial industry and the government about the importance of saving for retirement.

But from the retiree health perspective, things are very different. There are no retiree health savings vehicles with the same level of tax efficiency as a 401(k) plan. Employees can't make pre-tax contributions to save for retiree health coverage. And employees don't receive messages encouraging them to save for retiree health coverage.

As my written testimony suggests, there are many ways to encourage a similar savings trend for retiree health coverage. For example, policymakers could create new tax-efficient savings vehicles for retiree health coverage, and/or broaden the rules governing existing tax-efficient savings vehicles (including 401(k) plans) to permit accumulations for both retirement and retiree health purposes.

4. *You mention in your testimony that larger employers are more likely than smaller employers to offer health insurance to retirees. Why is this? Do you have any recommendations for increasing small business retiree health coverage?*

Large employers tend to have greater financial and operational resources to manage risk than small employers. This tendency makes it easier for large employers to self-insure their health plans, and spread the risk of large health claims over diverse risk pools. In contrast, most small employers don't self insure because they can't handle the risk of large

health claims. Even when small employers purchase health insurance, state laws generally allow insurance carriers to quote premiums based on the risks associated with each small employer's group. In addition, small employers generally don't need to offer retiree health coverage to attract and retain employees, and tend to have fewer retirees.

The primary health coverage issue facing small employers is how to offer coverage to active employees. If this challenge can be met, then it seems logical that this success will spillover and encourage small employers to also provide coverage for their retirees. As you are aware, current laws discourage small employers from managing their health risks in the same manner as large employers. Multiple employer health plans are subject to state rather than federal law, and states can dictate both the form and operation of these plans. Isn't it a bit of an anachronism that we encourage free trade among nations, yet continue to tolerate state-by-state regulation of a health insurance industry that has not served small employers well?

As a first step, small employers should be allowed to pool their risks and self insure their health plans *exactly like large employers*. These multiple-employer plans should operate independent of state insurance licensing requirements, state premium taxes and state benefit mandates. If there is concern about the management and financial solvency of these plans, then operational and financial requirements should be established at the federal level with either federal or state oversight. The proposal for association health plans included in the House-passed version of the Bipartisan Patient Protection Act (HR 2563) is a good first step.

5. *As you referenced in your testimony, health care costs increased dramatically in the year 2000, 6.6% for active employees, 10.6% for pre-Medicare retirees, and 17% for Medicare-eligible retirees. Why is retiree coverage so much more expensive than coverage for active employees? Will you expand upon why the cost of coverage for Medicare-eligible employees is increasing so much faster than for younger retirees?*

Although our survey data doesn't identify the specific reasons why retiree health care costs are higher than for active employees, Mercer actuaries typically identify two key factors that are responsible. One factor is age – most retirees aren't eligible for employer-sponsored retiree health plans until they attain age 55, and health costs tend to increase with age. The second factor is prescription drugs – because Medicare doesn't cover prescription drugs, drug costs often exceed 50 percent of an employer's total retire health costs for Medicare-eligible retirees. Thus, recent drug cost increases have tended to disproportionately increase retiree health care cost trends for Medicare-eligible retirees.

6. *You mention that retirees often share the cost burden for retiree coverage with their employers. Are these after tax dollars for employees? How about employers?*

Unfortunately, when retirees pay for retiree health coverage their contributions are paid on an after-tax basis. Active employees may pay for health coverage on a pre-tax basis under a Code section 125 cafeteria plan, but the IRS doesn't extend similar pre-tax treatment to retirees. Employer contributions for retiree health coverage are always pre-tax based on Code section 106.

7. *How are employers adjusting or varying retiree health coverage to accommodate both workers who spent the majority of their career in their employ and others that may have a much shorter tenure?*

Employers generally do not vary retiree health *benefits* based on an employee's length of service – all employees eligible for retiree coverage typically receive the same package of benefits. But some employers adjust *contribution amounts* based on length of service. For 2000, our survey results indicate that 12 percent of employers adjust contributions based on length of service for pre-Medicare eligible retirees, and 15 percent of employers adjust contributions based on length of service for Medicare-eligible retirees. Other employers adjust contributions based on age only, or based on age and years of service. But most employers still don't adjust contributions – according to the survey, 71 percent of employers don't adjust contribution amounts for pre-Medicare eligible retirees, and 64 percent of employers don't adjust contribution amounts for Medicare-eligible retirees.

8. *In your view, should employers continue to be involved in providing retiree health coverage? What do you think are the greatest benefits of the employer-based health system for employees?*

WILLIAM M. MERCER

There are several reasons why employers should continue to be involved in providing retiree health coverage. First, employers offer the most convenient source of health coverage for retirees. The risk-distribution advantages of employer-provided coverage aren't readily available elsewhere. Until alternative sources of group coverage can be developed, we should encourage employers to remain active in providing this benefit. Second, employers bring natural "prudent buyer" skills to the table when purchasing health coverage. Employers tend to purchase goods and services more efficiently than either individuals or government, and retiree health coverage is no exception. Third, employers are generally willing to experiment creatively with new approaches. We're likely to learn more from employer-initiated experiments with consumer-driven health care programs than we would if employers weren't involved.

9. *In order to provide actuarially sound coverage, how much would the average defined contribution retiree health account have to contain on a person's early retirement? Regular retirement? What would be the investment vehicle for such a defined contribution plan? Stocks? Bonds?*

Unfortunately, I'm not in a position to provide a specific answer to this question. To calculate an "adequate" value for a retiree health account, we'd need to make a wide variety of assumptions. For example, we'd need to identify (i) the relative generosity of the benefit package (both covered benefits and cost-sharing) to be financed by the account, (ii) the age or ages at which the benefit will commence, (iii) the level of participation among retirees (the more universal the participation, the less adverse selection comes into play), (iv) the extent to which the account provides coverage for single and/or married individuals, (v) whether the account will reimburse medical claims or insurance premiums, (vi) geographic information, (vii) medical trend rates, (viii) the period of time over which assets will be accumulated, and (ix) rates of investment return. Obviously, it is possible to construct answers to these questions using economic modeling tools. But the answers are highly sensitive to assumptions, and small changes in the assumptions would produce a range of answers.

WILLIAM M. MERCER

With respect to choice of investment vehicles, the most appropriate thinking might be to emulate the investment choices permitted by federal law for similar accumulation vehicles. For example, ERISA permits employer-sponsored benefit plans to invest in most types of investment vehicles, subject to restrictions regarding prudence, diversification, liquidity and prohibited transactions. Similarly, the tax rules applicable to individual retirement accounts and Archer medical savings accounts permit most types of investments consistent with the common law of trusts. At the same time, the tax law prohibits both vehicles from investing in life insurance contracts, and prohibits IRAs from investing in collectibles.

10. You mention that retiree health plan costs will continue to increase faster than the overall consumer price index (CPI). Do you have any projections for the increase in health care costs in the next ten years? Twenty years? In addition to prescription drugs, what other factors increase health plan costs?

We don't have projections for the increase in health care costs over the next ten to twenty years. Our sources for this information tend to be the same as those available to the Congress, including the Congressional Budget Office and the Centers for Medicare and Medicaid Services. Other factors responsible for increasing health plan costs include intensive R&D investment in new medical equipment and procedures, rapid dissemination of these new technologies and procedures to the marketplace, increasing utilization of high-cost services, and an aging population.

11. How big an effect will the GASB rule have on the cost of governments providing retiree health coverage to employees?

At this point, it's speculative to predict the extent to which government employers will be affected by the GASB rule for post-retirement benefits other than pensions. The rule is still under development, and we're not likely to see an exposure draft until the Spring of 2002. At the same time, I expect the GASB rule could have an impact similar to FAS 106. The full consequences of the GASB rule will depend on the extent to which the rule requires a government employer to disclose the true costs of its post-retirement health plan obligations, the employer's ability to adopt changes to manage these obligations, and the financial viability of the employer.

WILLIAM M. MERCER

For example, if we assume that the GASB rule will require government employers to disclose the true costs of their post-retirement medical obligations, employers might respond by implementing strategies designed to (i) reduce or mitigate costs through plan design changes, (ii) shift a portion of the costs to retirees, (iii) adopt state-of-the-art management practices to lessen costs, (iv) prefund retiree medical obligations, and (v) raise taxes. At a minimum, the GASB rule will motivate government employers to protect their bond ratings through better management of their post-retirement medical obligations.

* * *

Mr. Chairman, I trust that these answers are responsive to your questions. If you have additional questions, or if we can provide further assistance, please don't hesitate to call me at 202-263-3921.

Sincerely,

Chip Kerby

Charles K. "Chip" Kerby III

APPENDIX I – SUBMITTED FOR THE RECORD, LETTER FROM CONGRESSMAN JOHN F. TIERNEY, 6TH DISTRICT OF MASSACHUSETTS, U.S. HOUSE OF REPRESENTATIVES, TO CHAIRMAN JOHN BOEHNER AND RANKING MEMBER GEORGE MILLER, COMMITTEE ON EDUCATION AND THE WORKFORCE, NOVEMBER 15, 2001

Congress
of the
United States
House of Representatives

JOHN F. TIERNEY
MASSACHUSETTS
SIXTH DISTRICT

November 15, 2001

The Honorable John Boehner
Chairman
House Committee on Education & the Workforce
2181 Rayburn House Office Building
Washington, DC 20515

The Honorable George Miller
Ranking Member
House Committee on Education & the Workforce
2101 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Boehner and Ranking Member Miller:

Pursuant to the Chairman's directive at the November 1, 2001 hearing on Retiree Health Insurance, the enclosed questions are filed for (a) inclusion in the record and (b) forwarding by the Committee through the Majority staff for the respective witness seeking their prompt written response to the Committee for the record. Kindly notify this office first of the date upon responses will be required, and then eventually of the receipt of the responses once submitted.

Additionally, I ask that the Committee schedule further hearings on the topic of Retiree Health Benefits and specifically H.R. 1322, together with further hearings on the connections between safeguards for retirees (as in H.R. 1322) and in improving retiree health benefit coverage. Unless improved safeguards are connected to improve coverage, health benefits for retirees are in jeopardy: there will be no improvised coverage that will enjoy public confidence, and the only alternative will be to turn to expanded Medicare system or a similar program where no question of retiree safeguards will arise.

Again, I respectfully press the Committee, through its Chairman, to schedule and conduct hearings specifically to the pros and cons of H.R. 1322. I should think that those most committed to a private retiree health system have the most to gain by agreeing to such a hearing.

COMMITTEES
EDUCATION & THE WORKFORCE
SUBC ON 21ST CENTURY COMPETITIVENESS
SUBC ON EMPLOYER-EMPLOYEE RELATIONS
GOVERNMENT REFORM
SUBC ON NATIONAL SECURITY, VETERANS AFFAIRS AND INTERNATIONAL RELATIONS
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Thank you for your attention to these matters. I shall anticipate your reply to the hearing request, as well as the eventual witness response.

Sincerely,

John F. Tierney
Member of Congress

JFT:em

APPENDIX J – SUBMITTED FOR THE RECORD, LETTER FROM SAM JOHNSON, CHAIRMAN, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, TO WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE SERVICES, GENERAL ACCOUNTING OFFICE, DECEMBER 3, 2001

COMMITTEE ON EDUCATION
AND THE WORKFORCE
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December 3, 2001

Mr. William J. Scanlon
Director, Health Care Services
General Accounting Office
441 G Street, Northwest
Washington, DC 20548

Dear Mr. Scanlon:

On behalf of Congressman John Tierney, a member of the Subcommittee, I have included a number of prepared questions that Mr. Tierney would like you to answer to the best of your ability in regards to your testimony at the November 1, 2001 hearing on "Retirement Security for the American Worker: Opportunities and Challenges" held by the Subcommittee on Employer-Employee Relations of the Education and the Workforce Committee. Mr. Tierney would like you to answer the questions that are directed to you as well as any of the other questions included below. Your answers to these questions will be included in the hearing record. The questions are as follows:

Questions re: Neuman Testimony

1. Neuman opines that employers "terminating" retiree health insurance plans "typically" only do so for "future retirees" but grandfather "current retirees and those close to retirement". Neuman Testimony at 5. What is the empirical source for this observation? Even assuming the observation is true, isn't it also true that most companies, without terminating their plans, have made post-retirement cutbacks in retiree health benefits without grand fathering those who already retired? Shouldn't this also be regarded as a form of retiree health benefit erosion which requires just as much legislative attention, if not more, than those who retire without insurance? In the latter case the employer has made no promises so, theoretically, an employee can seek alternative employment where retiree health insurance is available. In the former case, the employee has retired with a health insurance commitment that is then broken. In Neuman's view, which is the worst?

2. Neuman points out that retiree health benefits were eroding rapidly during a period when the economy was considerably stronger than it is today, and when retiree health costs were not rising

as much as they are now. She fears that retiree health coverage will now fall to even a greater degree with the slowdown in the nation's economy. Neuman Testimony at 6. This may be an accurate description of what has happened and what may happen, but how does Neuman account for the fact that retiree health benefits slumped so badly during a period when the economy was so robust and corporate profits were at an unprecedented high? Could it be that corporate financial gimmicks to artificially hype corporate profitability (and avoid coming to terms with FASB 106) were the decisive factors? Could it be that the net result of this financial reporting manipulation was to shift corporate resources that were previously dedicated to retiree health to shareholders, especially corporate insiders with highly beneficial stock option or stock bonus plans? If so, would this change Neuman's views as to the legislative priorities that need to be addressed in connection with improving retiree health insurance coverage? How, for example, would Neuman recommend preventing a recurrence of this type of anti-retiree financial manipulation if Congress provided incentives to expand retiree health insurance coverage?

3. Neuman also points out that adding prescription drug coverage to Medicare would "strengthen the capacity" of employers to offer retiree health insurance, including, presumably, some form of supplemental drug coverage to Medicare. See Neuman Testimony at 7. However, if one of the objectives of shifting the principal responsibility for prescription drug coverage to Medicare is to facilitate the retention of retiree health insurance sponsorship by employers, doesn't it also follow that in return for being able to shed the ultimate responsibility for prescription drugs, employers must keep the retiree health commitments they make and not be able to renege on providing these benefits after an employee has retired and has been receiving such benefits? Also, what would Neuman recommend with respect to maintaining prescription drug benefits for non-Medicare-eligible retirees? Wouldn't the same loss of coverage now affecting Medicare-eligible retirees be experienced by non-Medicare eligible retirees unless they could get such coverage under Medicare? If a subsidized Medicare-buy-in program was authorized for early retirees, wouldn't that be the death knell for corporate retiree health insurance plans, especially if the Medicare buy-in program adequately covered prescription drug needs? Assuming adequate protections for retirees were enacted, wouldn't it be just as justified, if not more justified, to advocate some reasonable subsidization of employer retiree health insurance initiatives that included prescription drug coverage?

Questions re: Scanlon (GAO) Testimony

1. Scanlon fails to discuss that portion of the GAO report that outlined the ERISA legal problems relating to post-retirement reductions in retiree health benefits and his remarks on the erosion of retiree health benefits are ambiguous in that they do not clearly distinguish between employer cost-cutting measures aimed at future retirees (e.g., increasing retiree premiums, deductibles, coinsurance, co-payments, etc.), and similar measures aimed at those who have already retired and are living on fixed incomes. See Scanlon Testimony, 8-9. Does GAO know what percentage of retirees affected by these cost-cutting measures are already retired employees as opposed to prospective retirees? Has GAO reviewed H.R. 1322 and does it have an opinion on the bill? If GAO disagrees with H.R. 1322, or has reservations about the bill, does it nonetheless think that the problem of post-retirement cost-cutting measures deserves legislative consideration? Would GAO rank the problem of post-retirement cutbacks more important, equally important, or less important than dropping or reducing health benefits from future retirees? Describe the rationale for the answer.

2. Scanlon states that 35% of large employers limited their exposure to retiree health benefits by setting a financial cap "on projected contributions for benefits" and reducing "benefits to stay within the cap" or raising the cap. Scanlon Testimony at 9. Our experience has been that many more employers limit their exposure by setting financial limits on the amount of health benefits they will provide over the retiree's "lifetime", or annually, or both. Does GAO have any data on the extent of this practice and how it correlates with the practice of setting financial caps on employer contributions? Our experience also indicates that many large employers have made post-retirement cutbacks in retiree health benefits regardless of whether "lifetime" and/or "annual" limitations on such benefits have been exceeded. Does GAO have any data indicating the pervasiveness of this phenomenon or any comments concerning its significance in terms of proposals to strengthen retiree health insurance benefits?

Questions re: Kerby Testimony

1. Kerby is the only expert who specifically refers to H.R. 1322 and does so in a negative way that is based on a completely erroneous interpretation of the bill. Kerby says at page 10 of his testimony that -

> "Finally, employers could penalized for terminating existing retiree health plans. This is the approach adopted in H.R. 1322. But this approach is antithetical to the voluntary employment - based system endorsed and preserved by ERISA. Employers would strongly object to any proposal obligating them to continue offering a retiree health plan."

However, there is nothing in H.R. 1322 that precludes an employer from terminating a retiree health plan at will. In other words, an employer under H.R. 1322 can eliminate retiree health benefits for future retirees just as under ERISA it can cancel the post-termination accrual of pension credits.

However, just as ERISA requires that vested participants be paid their vested pensions regardless of whether their plan has been terminated, H.R. 1322 requires that an employer terminating a retiree health plan continue to provide the health benefits promised by the plan to those who have already retired with those benefits. In effect, H.R. 1322 treats those who retired prior to the health plan's termination as "vested" in the retiree health plan's benefits that were provided to them when they retired. The only exception is that the Secretary of Labor can waive this requirement if the employer terminating the plan can demonstrate to the Secretary that he will be unable to continue in business if he must maintain health coverage for those who retired prior to the plan's termination. See §801(d) of H.R. 1322.

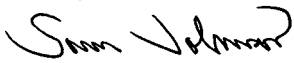
In light of the foregoing analysis, does Mr. Kerby concede that he was mistaken in claiming that H.R. 1322 prohibits employers from terminating retiree health plans? Does he believe that it is fair and reasonable to permit employers to divest employees who retired prior to plan termination of their health benefits when the employer continues to have the means to provide those benefits, especially since, by definition, the employer no longer has the obligation to provide health benefits to those who retire after the plan's termination? In view of the fact that ERISA's vesting requirements in pension plans did not result in the abandonment of these plans by employers, does Mr. Kerby continue to believe that Section 801(d) of H.R. 1322, as explained above, would significantly discourage employers from offering retiree health plans? If so, what changes would

he recommend to Section 801(d) that would help avoid discouraging employers while at the same time provide some form of "vesting" protection to retirees comparable to the protection they get in their pension plans. Or does Mr. Kerby believe that any form of vesting in retiree health plans, no matter how circumscribed, would threaten the continuation of a voluntary employer-sponsored retiree health system?

2. Mr. Kerby recommends that consideration be given to encouraging the funding of retiree health costs, and mentions various tax incentives that could be used in this connection. See Kerby Testimony at 10-11. Insofar as employer-sponsored retiree health plans are concerned, why should further tax incentives be given serious consideration unless they are combined with adequate safeguards for retirees so they don't lose the benefits that Congress has given tax incentives to provide? What is the point of giving more favorable tax treatment for funding if an employer retains unlimited discretion to withdraw these health benefits after an employee has retired and has become dependent on receiving these benefits? Isn't this sort of one-sided tax incentive approach directly contrary to ERISA's treatment of funding in pension plans where the tax deductions provided are tied to eligibility, vesting and plan termination protections for participants?

Your answers should be returned to my staff by December 10, 2001. They can be faxed to the attention of Dave Thomas at (202) 225-2454. If you have any questions, please feel free to contact David Connolly, Kristin Fitzgerald, or Dave Thomas at (202) 225-7101. Again, thank you for your time in answering these questions.

Sincerely,



SAM JOHNSON
Chairman
Subcommittee on Employer-Employee Relations

APPENDIX K – SUBMITTED FOR THE RECORD, LETTER FROM WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE ISSUES, GENERAL ACCOUNTING OFFICE, TO CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, DECEMBER 10, 2001

GAO
Accountability • Integrity • Reliability
United States General Accounting Office
Washington, DC 20548

December 10, 2001

The Honorable Sam Johnson
Chairman
Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
House of Representatives

Dear Mr. Chairman:

In response to your December 3, 2001 letter to GAO, we are providing answers to questions Representative Tierney submitted to us following the Subcommittee's November 1, 2001 hearing entitled "Retirement Security for the American Worker: Opportunities and Challenges." The questions and answers can be found in the attached enclosure.

We trust that you will find this information helpful. Please call me at (202) 512-7114 if we can be of further assistance.

Sincerely yours,

William J. Scanlon

William J. Scanlon
Director, Health Care Issues

Enclosure

cc: The Honorable Robert E. Andrews
Ranking Minority Member
The Honorable John Tierney

RESPONSE TO QUESTIONS FROM REP. TIERNEY
ON NOVEMBER 1, 2001 GAO TESTIMONY
RETIREE HEALTH INSURANCE:
GAPS IN COVERAGE AND AVAILABILITY

1. **Scanlon fails to discuss that portion of the GAO report that outlined the ERISA legal problems relating to post-retirement reductions in retiree health benefits and his remarks on the erosion of retiree health benefits are ambiguous in that they do not clearly distinguish between employer cost-cutting measures aimed at future retirees (e.g., increasing retiree premiums, deductibles, coinsurance, co-payments, etc.), and similar measures aimed at those who have already retired and are living on fixed incomes. See Scanlon Testimony, 8-9. Does GAO know what percentage of retirees affected by these cost-cutting measures are already retired employees as opposed to prospective retirees? Has GAO reviewed H.R. 1322 and does it have an opinion on the bill? If GAO disagrees with H.R. 1322, or has reservations about the bill, does it nonetheless think that the problem of post-retirement cost-cutting measures deserves legislative consideration? Would GAO rank the problem of post-retirement cutbacks more important, equally important, or less important than dropping or reducing health benefits from future retirees? Describe the rationale for the answer.**

The data available from employer benefit surveys do not specifically quantify the effects of changes for current and future retirees. However, some changes that these surveys identify are more likely to affect either future or current retirees.[1] For example, some employers restrict eligibility for retiree health benefits to employees hired after a certain date, which is more likely to affect future retirees. Other changes, though, will directly affect current retirees. For example, many large employers have increasingly required retirees to pay a higher or the entire share of the premium for health benefits, and some employers have increased cost-sharing requirements, particularly for prescription drug coverage. Provided that employers have reserved the right to modify or terminate benefits in health benefit documents or collective bargaining agreements, they generally maintain flexibility to reduce these benefits for retirees as well as active employees.

H.R. 1322, "The Emergency Retiree Health Benefits Protection Act of 2001," would restrict employers' ability to reduce retiree health benefits after retirement unless the Secretary of Labor determines that the employer would be unable to continue in business if required to maintain this coverage. While this legislation is intended to help retirees maintain health benefits without reductions, concerns exist that in a voluntary employer-based system, employers who face uncertainty about future cost increases or changes in financial well-being may forego offering retiree health benefits altogether if they are unable to revise benefits in changing financial circumstances after an individual retires. The adverse impact of health care inflation

[1]For further information on changes employers are making to retiree health benefits, see *Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion*, (GAO-01-374, May 1, 2001).

exceeding cost increases in other sectors is shared by consumers, employers, and public programs.

The erosion of retiree health benefits post-retirement deserves consideration. It can have serious implications for retirees because rising out-of-pocket costs can be problematic for persons on fixed incomes and those losing coverage may have limited alternative sources of health insurance. Retirees with post-retirement cutbacks do have some options, such as purchasing coverage in the individual insurance market or Medicare supplemental insurance, known as Medigap. However, these alternative sources may be expensive or provide more limited benefits than employer-sponsored coverage. In particular, retirees not yet eligible for Medicare, in poor health, or not meeting the criteria for guarantees to purchasing Medigap may have difficulty finding affordable health insurance. The lack of attractive alternative sources of insurance coverage may be particularly problematic for those who lost their employer-sponsored coverage.

2. **Scanlon states that 35% of large employers limited their exposure to retiree health benefits by setting a financial cap "on projected contributions for benefits" and reducing "benefits to stay within the cap" or raising the cap. Scanlon Testimony at 9. Our experience has been that many more employers limit their exposure by setting financial limits on the amount of health benefits they will provide over the retiree's "lifetime", annually, or both. Does GAO have any data on the extent of this practice and how it correlates with the practice of setting financial caps on employer contributions? Our experience also indicates that many large employers have made post-retirement cutbacks in retiree health benefits regardless of whether "lifetime" and/or "annual" limitations on such benefits have been exceeded. Does GAO have any data indicating the pervasiveness of this phenomenon or any comments concerning its significance in terms of proposals to strengthen retiree health insurance benefits?**

These are two distinct types of caps. Many employer-sponsored health plans include annual or lifetime limits on the amount of claims that they will pay for an individual beneficiary. While survey data are not available showing the prevalence of these limits for retiree health benefits, data for health plans for active workers show the prevalence of lifetime limits and the relatively few plan participants who meet these limits. For example, the 2000 employer health benefit survey conducted by the Kaiser Family Foundation and the Health Research and Educational Trust found that about 70 percent of employer-sponsored conventional and preferred-provider organization plans for active employees had a lifetime maximum benefit, typically $1 million or more.[2] However, very few individuals actually have catastrophic health care costs that exhaust their annual or lifetime limits. For example, a 1995 analysis

[2]Neither the Kaiser/HRET nor the Mercer surveys we summarized report separately on annual or lifetime benefit limits for retiree health plans.

by Price Waterhouse LLP estimated that only about 1,500 people in 1995 and 2,500 people in 2000 exhausted lifetime benefits of $1 million.

The type of cap referred to in GAO's written statement involves caps employers place on their projected contributions for retiree health benefits for all eligible participants, not just the few with catastrophic expenses. One benefit consultant's report we reviewed provided an example of an employer setting its financial cap on contributions to retiree health benefits at twice the current average annual cost of retirees. Thus, even though participants had not approached the annual or lifetime limits on their expenses, employers often limit their potential financial liability if their retiree health costs should increase significantly.

APPENDIX L – SUBMITTED FOR THE RECORD, LETTER FROM SAM JOHNSON, CHAIRMAN, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, TO PATRICIA NEUMAN, VICE PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION, DECEMBER 3, 2001

COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
2181 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

MAJORITY–(202) 225-4527
(TTY)–(202) 226-3372
MINORITY–(202) 225-3725
(TTY)–(202) 226-3116

December 3, 2001

Ms. Patricia Neuman
Vice President
Henry J. Kaiser Family Foundation
1450 G Street, NW
Suite 250
Washington, D.C. 20005

Dear Ms. Neuman:

On behalf of Congressman John Tierney, a member of the Subcommittee, I have included a number of prepared questions that Mr. Tierney would like you to answer to the best of your ability in regards to your testimony at the November 1, 2001 hearing on "Retirement Security for the American Worker: Opportunities and Challenges" held by the Subcommittee on Employer-Employee Relations of the Education and the Workforce Committee. Mr. Tierney would like you to answer the questions that are directed to you as well as any of the other questions included below. Your answers to these questions will be included in the hearing record. The questions are as follows:

Questions re: Neuman Testimony

1. Neuman opines that employers "terminating" retiree health insurance plans "typically" only do so for "future retirees" but grandfather "current retirees and those close to retirement". Neuman Testimony at 5. What is the empirical source for this observation? Even assuming the observation is true, isn't it also true that most companies, without terminating their plans, have made post-retirement cutbacks in retiree health benefits without grand fathering those who already retired? Shouldn't this also be regarded as a form of retiree health benefit erosion which requires just as much legislative attention, if not more, than those who retire without insurance? In the latter case the employer has made no promises so, theoretically, an employee can seek alternative employment where retiree health insurance is available. In the former case, the employee has retired with a health insurance commitment that is then broken. In Neuman's view, which is the worst?

2. Neuman points out that retiree health benefits were eroding rapidly during a period when the economy was considerably stronger than it is today, and when retiree health costs were not rising as much as they are now. She fears that retiree health coverage will now fall to even a greater degree with the slowdown in the nation's economy. Neuman Testimony at 6. This may be an accurate description of what has happened and what may happen, but how does Neuman account for the fact that retiree health benefits slumped so badly during a period when the economy was so robust and corporate profits were at an unprecedented high? Could it be that corporate financial gimmicks to artificially hype corporate profitability (and avoid coming to terms with FASB 106) were the decisive factors? Could it be that the net result of this financial reporting manipulation was to shift corporate resources that were previously dedicated to retiree health to shareholders, especially corporate insiders with highly beneficial stock option or stock bonus plans? If so, would this change Neuman's views as to the legislative priorities that need to be addressed in connection with improving retiree health insurance coverage? How, for example, would Neuman recommend preventing a recurrence of this type of anti-retiree financial manipulation if Congress provided incentives to expand retiree health insurance coverage?

3. Neuman also points out that adding prescription drug coverage to Medicare would "strengthen the capacity" of employers to offer retiree health insurance, including, presumably, some form of supplemental drug coverage to Medicare. See Neuman Testimony at 7. However, if one of the objectives of shifting the principal responsibility for prescription drug coverage to Medicare is to facilitate the retention of retiree health insurance sponsorship by employers, doesn't it also follow that in return for being able to shed the ultimate responsibility for prescription drugs, employers must keep the retiree health commitments they make and not be able to renege on providing these benefits after an employee has retired and has been receiving such benefits? Also, what would Neuman recommend with respect to maintaining prescription drug benefits for non-Medicare-eligible retirees? Wouldn't the same loss of coverage now affecting Medicare-eligible retirees be experienced by non-Medicare eligible retirees unless they could get such coverage under Medicare? If a subsidized Medicare-buy-in program was authorized for early retirees, wouldn't that be the death knell for corporate retiree health insurance plans, especially if the Medicare buy-in program adequately covered prescription drug needs? Assuming adequate protections for retirees were enacted, wouldn't it be just as justified, if not more justified, to advocate some reasonable subsidization of employer retiree health insurance initiatives that included prescription drug coverage?

Questions re: Scanlon (GAO) Testimony

1. Scanlon fails to discuss that portion of the GAO report that outlined the ERISA legal problems relating to post-retirement reductions in retiree health benefits and his remarks on the erosion of retiree health benefits are ambiguous in that they do not clearly distinguish between employer cost-cutting measures aimed at future retirees (e.g., increasing retiree premiums, deductibles, coinsurance, co-payments, etc.), and similar measures aimed at those who have already retired and are living on fixed incomes. See Scanlon Testimony, 8-9. Does GAO know what percentage of retirees affected by these cost-cutting measures are already retired employees as opposed to prospective retirees? Has GAO reviewed H.R. 1322 and does it have an opinion on the bill? If GAO disagrees with H.R. 1322, or has reservations about the bill, does it nonetheless think that the problem of post-retirement cost-cutting measures deserves legislative consideration? Would GAO rank the problem of post-retirement cutbacks more important,

equally important, or less important than dropping or reducing health benefits from future retirees? Describe the rationale for the answer.

2. Scanlon states that 35% of large employers limited their exposure to retiree health benefits by setting a financial cap "on projected contributions for benefits" and reducing "benefits to stay within the cap" or raising the cap. Scanlon Testimony at 9. Our experience has been that many more employers limit their exposure by setting financial limits on the amount of health benefits they will provide over the retiree's "lifetime", or annually, or both. Does GAO have any data on the extent of this practice and how it correlates with the practice of setting financial caps on employer contributions? Our experience also indicates that many large employers have made post-retirement cutbacks in retiree health benefits regardless of whether "lifetime" and/or "annual" limitations on such benefits have been exceeded. Does GAO have any data indicating the pervasiveness of this phenomenon or any comments concerning its significance in terms of proposals to strengthen retiree health insurance benefits?

Questions re: Kerby Testimony

1. Kerby is the only expert who specifically refers to H.R. 1322 and does so in a negative way that is based on a completely erroneous interpretation of the bill. Kerby says at page 10 of his testimony that -

> "Finally, employers could penalized for terminating existing retiree health plans. This is the approach adopted in H.R. 1322. But this approach is antithetical to the voluntary employment - based system endorsed and preserved by ERISA. Employers would strongly object to any proposal obligating them to continue offering a retiree health plan."

However, there is nothing in H.R. 1322 that precludes an employer from terminating a retiree health plan at will. In other words, an employer under H.R. 1322 can eliminate retiree health benefits for future retirees just as under ERISA it can cancel the post-termination accrual of pension credits.

However, just as ERISA requires that vested participants be paid their vested pensions regardless of whether their plan has been terminated, H.R. 1322 requires that an employer terminating a retiree health plan continue to provide the health benefits promised by the plan to those who have already retired with those benefits. In effect, H.R. 1322 treats those who retired prior to the health plan's termination as "vested" in the retiree health plan's benefits that were provided to them when they retired. The only exception is that the Secretary of Labor can waive this requirement if the employer terminating the plan can demonstrate to the Secretary that he will be unable to continue in business if he must maintain health coverage for those who retired prior to the plan's termination. See §801(d) of H.R. 1322.

In light of the foregoing analysis, does Mr. Kerby concede that he was mistaken in claiming that H.R. 1322 prohibits employers from terminating retiree health plans? Does he believe that it is fair and reasonable to permit employers to divest employees who retired prior to plan termination of their health benefits when the employer continues to have the means to provide those benefits, especially since, by definition, the employer no longer has the obligation to provide health benefits to those who retire after the plan's termination? In view of the fact that ERISA's vesting

requirements in pension plans did not result in the abandonment of these plans by employers, does Mr. Kerby continue to believe that Section 801(d) of H.R. 1322, as explained above, would significantly discourage employers from offering retiree health plans? If so, what changes would he recommend to Section 801(d) that would help avoid discouraging employers while at the same time provide some form of "vesting" protection to retirees comparable to the protection they get in their pension plans. Or does Mr. Kerby believe that any form of vesting in retiree health plans, no matter how circumscribed, would threaten the continuation of a voluntary employer-sponsored retiree health system?

2. Mr. Kerby recommends that consideration be given to encouraging the funding of retiree health costs, and mentions various tax incentives that could be used in this connection. See Kerby Testimony at 10-11. Insofar as employer-sponsored retiree health plans are concerned, why should further tax incentives be given serious consideration unless they are combined with adequate safeguards for retirees so they don't lose the benefits that Congress has given tax incentives to provide? What is the point of giving more favorable tax treatment for funding if an employer retains unlimited discretion to withdraw these health benefits after an employee has retired and has become dependent on receiving these benefits? Isn't this sort of one-sided tax incentive approach directly contrary to ERISA's treatment of funding in pension plans where the tax deductions provided are tied to eligibility, vesting and plan termination protections for participants?

Your answers should be returned to my staff by December 10, 2001. They can be faxed to the attention of Dave Thomas at (202) 225-2454. If you have any questions, please feel free to contact David Connolly, Kristin Fitzgerald, or Dave Thomas at (202) 225-7101. Again, thank you for your time in answering these questions.

Sincerely,

SAM JOHNSON
Chairman
Subcommittee on Employer-Employee Relations

APPENDIX M – SUBMITTED FOR THE RECORD, LETTER FROM PATRICIA NEUMAN, Sc.D., VICE PRESIDENT AND DIRECTOR, MEDICARE POLICY PROJECT, THE HENRY J. KAISER FAMILY FOUNDATION, TO CHAIRMAN SAM JOHNSON, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, DECEMBER 11, 2001

December 11, 2001

Hon. Sam Johnson
Chairman
Subcommittee on Employer-Employee Relations
of the Education and the Workforce Committee
United States House of Representatives
Room B-346, Rayburn House Office Building
Washington, DC 20510-6100

Dear Chairman Johnson:

Thank you again for the opportunity to testify before the Subcommittee on Employer-Employee Relations of the Education and the Workforce Committee on November 1, 2001, regarding Retirement Security for the American Worker. I received the Committee's follow-up questions and am submitting the following information for the record.

Question #1

A large share of firms that offer retiree health benefits have made post-retirement cutbacks in health coverage by raising premiums and altering their benefits packages. However, research from both Hewitt Associates LLC[1] and the Kaiser Family Foundation/Health Research and Educational Trust Survey[2] suggests that in the vast majority of cases where large employers have terminated retiree health coverage, they have done so on a prospective basis affecting future retirees, "grandfathering" their current retirees and those close to retirement so that they remain eligible for retiree health benefits. When employers that currently offer retiree health benefits were asked about their plans for the future, few reported plans to eliminate benefits entirely. According to the 2001 survey by KFF/HRET, four percent of companies that are now offering retiree coverage said they are likely to eliminate that coverage entirely in the next two years. Seven percent of firms said it is likely that they will eliminate retiree benefits for new employees or for existing workers who have not yet retired.

Lack of health insurance coverage both for those directly affected by employer cutbacks or for those who retire without the promise of health insurance poses substantial challenges to the health and financial security of aging Americans. Early retirees are often unable to find another job that offers health insurance. In fact, many choose retirement because of health conditions that make it difficult for them to continue working. For those already on Medicare, supplemental coverage to help fill in Medicare's gaps is increasingly difficult to get due to rising Medigap premiums and the instability of the Medicare+Choice program. Given the increasing lack of viable alternatives for affordable, meaningful insurance, employer-sponsored retiree health plans are an

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essential source of coverage for millions of retirees. Without it, many retirees could face major medical bills or risk going without needed medical care.

Question #2

The gradual decline in the share of employers offering retiree health benefits over the last decade occurred at a time when the economy was considerably stronger than it appears to be today. During that period, employers maintained benefits to the extent necessary to fulfill contracts and retain workers, but continued to cut back on retiree health spending. The retrenchment in retiree health benefits is most likely due to the rising cost of such benefits, financial concerns of employers, changed accounting rules, and employers' desire to put a cap on what otherwise might be viewed as an open-ended future obligation for retiree health care. Where resources are limited, perhaps greater priority is assigned to the health benefit needs and costs of active workers. Employers have a greater incentive to provide health benefits to active workers than to retirees because active workers are essential to business performance and profitability, and employers tend to have weaker ties to retirees. For these reasons and because retiree health benefits are often provided by employers on a voluntary non-mandated basis, a growing number of retirees are experiencing a decline in health benefits that warrants attention by policymakers.

Question #3

Expanding Medicare to offer a prescription drug benefit would help to alleviate much of the financial burden experienced by employers who offer retiree health benefits, as described in my testimony. While designed with the specific objective of increasing access to prescription medications for those on Medicare, a Medicare drug benefit could have the indirect effect of strengthening the capacity of employers to continue to offer retiree health benefits other than prescription drugs. A study by Hewitt for the Kaiser Family Foundation found that employers might be more likely to honor their retiree health commitments rather than terminating benefits altogether if Medicare were expanded to include a prescription drug benefit.[3]

As you note, prescription drug benefits are also important for non-Medicare eligible retirees. Permitting early retirees to buy into the Medicare program before they turn 65 could be a promising approach if Medicare covered prescription drugs. With an adequately subsidized premium, a Medicare buy-in offers a means of providing affordable coverage to early retirees, especially for those with modest incomes and/or health problems.[4] A Medicare buy-in may enable employers to continue offering wrap-around coverage to early retirees, just as they do for the 65+ population. Employers could fill in cost-sharing obligations, offer stop-loss protection, and provide other highly-valued benefits to retirees to wrap around the Medicare benefit package.

Subsidizing employers that offer retiree health benefits that include prescription drug coverage is another approach that could be considered as part of the broader policy discussion over how to provide older Americans access to affordable prescription medications. Such an approach could encourage employers to maintain benefits, but

would target federal dollars only to the one-third of Medicare beneficiaries with retiree health benefits. The remaining two-thirds who lack employer-sponsored retiree health coverage would gain no direct benefit from an approach that subsidizes employers.

I hope that this information is useful to the Subcommittee as it considers options for protecting retiree health coverage for future generations of retirees. Please do not hesitate to contact me if you need any additional information. Thank you very much.

Sincerely,

Patricia Neuman

Patricia Neuman, Sc.D.

Vice President and Director, Medicare Policy Project
The Henry J. Kaiser Family Foundation

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[1] Testimony of Steve Coppock and Andrew Zebrak. Hewitt Associates LLC before the United States Senate Committee on Finance, "Finding the Right Fit: Medicare, Prescription Drugs, and Current Coverage Options." April 24, 2001.

[2] Kaiser Family Foundation/Health Education Research Trust Survey of Employer-Sponsored Health Benefits, 2001.

[3] Hewitt Associates LLC, "The Implications of Medicare Prescription Drug Proposals for Employers and Retirees." Prepared for the Kaiser Family Foundation, July 2000.

[4] Urban Institute, "A Medicare Buy-In for the Near-Elderly: Design Issues and Potential Effects on Coverage." Prepared for the Kaiser Family Foundation, Forthcoming 2001.

APPENDIX N – SUBMITTED FOR THE RECORD, LETTER FROM SAM JOHNSON, CHAIRMAN, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, TO CHIP KERBY, PRINCIPAL, WASHINGTON RESOURCE GROUP, WILLIAM M. MERCER, INCORPORATED, DECEMBER 3, 2001

December 3, 2001

Mr. Chip Kerby
Principal
Washington Resource Group
William M. Mercer, Incorporated
1255 23rd Street, NW Suite 250
Washington, D.C. 20037

Dear Mr. Kerby:

On behalf of Congressman John Tierney, a member of the Subcommittee, I have included a number of prepared questions that Mr. Tierney would like you to answer to the best of your ability in regards to your testimony at the November 1, 2001 hearing on "Retirement Security for the American Worker: Opportunities and Challenges" held by the Subcommittee on Employer-Employee Relations of the Education and the Workforce Committee. Mr. Tierney would like you to answer the questions that are directed to you as well as any of the other questions included below. Your answers to these questions will be included in the hearing record. The questions are as follows:

Questions re: Neuman Testimony

1. Neuman opines that employers "terminating" retiree health insurance plans "typically" only do so for "future retirees" but grandfather "current retirees and those close to retirement". Neuman Testimony at 5. What is the empirical source for this observation? Even assuming the observation is true, isn't it also true that most companies, without terminating their plans, have made post-retirement cutbacks in retiree health benefits without grand fathering those who already retired? Shouldn't this also be regarded as a form of retiree health benefit erosion which requires just as much legislative attention, if not more, than those who retire without insurance? In the latter case the employer has made no promises so, theoretically, an employee can seek alternative employment where retiree health insurance is available. In the former case, the employee has retired with a health insurance commitment that is then broken. In Neuman's view, which is the worst?

2. Neuman points out that retiree health benefits were eroding rapidly during a period when the economy was considerably stronger than it is today, and when retiree health costs were not rising as much as they are now. She fears that retiree health coverage will now fall to even a greater degree with the slowdown in the nation's economy. Neuman Testimony at 6. This may be an accurate description of what has happened and what may happen, but how does Neuman account for the fact that retiree health benefits slumped so badly during a period when the economy was so robust and corporate profits were at an unprecedented high? Could it be that corporate financial gimmicks to artificially hype corporate profitability (and avoid coming to terms with FASB 106) were the decisive factors? Could it be that the net result of this financial reporting manipulation was to shift corporate resources that were previously dedicated to retiree health to shareholders, especially corporate insiders with highly beneficial stock option or stock bonus plans? If so, would this change Neuman's views as to the legislative priorities that need to be addressed in connection with improving retiree health insurance coverage? How, for example, would Neuman recommend preventing a recurrence of this type of anti-retiree financial manipulation if Congress provided incentives to expand retiree health insurance coverage?

3. Neuman also points out that adding prescription drug coverage to Medicare would "strengthen the capacity" of employers to offer retiree health insurance, including, presumably, some form of supplemental drug coverage to Medicare. See Neuman Testimony at 7. However, if one of the objectives of shifting the principal responsibility for prescription drug coverage to Medicare is to facilitate the retention of retiree health insurance sponsorship by employers, doesn't it also follow that in return for being able to shed the ultimate responsibility for prescription drugs, employers must keep the retiree health commitments they make and not be able to renege on providing these benefits after an employee has retired and has been receiving such benefits? Also, what would Neuman recommend with respect to maintaining prescription drug benefits for non-Medicare-eligible retirees? Wouldn't the same loss of coverage now affecting Medicare-eligible retirees be experienced by non-Medicare eligible retirees unless they could get such coverage under Medicare? If a subsidized Medicare-buy-in program was authorized for early retirees, wouldn't that be the death knell for corporate retiree health insurance plans, especially if the Medicare buy-in program adequately covered prescription drug needs? Assuming adequate protections for retirees were enacted, wouldn't it be just as justified, if not more justified, to advocate some reasonable subsidization of employer retiree health insurance initiatives that included prescription drug coverage?

Questions re: Scanlon (GAO) Testimony

1. Scanlon fails to discuss that portion of the GAO report that outlined the ERISA legal problems relating to post-retirement reductions in retiree health benefits and his remarks on the erosion of retiree health benefits are ambiguous in that they do not clearly distinguish between employer cost-cutting measures aimed at future retirees (e.g., increasing retiree premiums, deductibles, coinsurance, co-payments, etc.), and similar measures aimed at those who have already retired and are living on fixed incomes. See Scanlon Testimony, 8-9. Does GAO know what percentage of retirees affected by these cost-cutting measures are already retired employees as opposed to prospective retirees? Has GAO reviewed H.R. 1322 and does it have an opinion on the bill? If GAO disagrees with H.R. 1322, or has reservations about the bill, does it nonetheless think that the problem of post-retirement cost-cutting measures deserves legislative consideration? Would GAO rank the problem of post-retirement cutbacks more important,

equally important, or less important than dropping or reducing health benefits from future retirees? Describe the rationale for the answer.

2. Scanlon states that 35% of large employers limited their exposure to retiree health benefits by setting a financial cap "on projected contributions for benefits" and reducing "benefits to stay within the cap" or raising the cap. Scanlon Testimony at 9. Our experience has been that many more employers limit their exposure by setting financial limits on the amount of health benefits they will provide over the retiree's "lifetime", or annually, or both. Does GAO have any data on the extent of this practice and how it correlates with the practice of setting financial caps on employer contributions? Our experience also indicates that many large employers have made post-retirement cutbacks in retiree health benefits regardless of whether "lifetime" and/or "annual" limitations on such benefits have been exceeded. Does GAO have any data indicating the pervasiveness of this phenomenon or any comments concerning its significance in terms of proposals to strengthen retiree health insurance benefits?

Questions re: Kerby Testimony

1. Kerby is the only expert who specifically refers to H.R. 1322 and does so in a negative way that is based on a completely erroneous interpretation of the bill. Kerby says at page 10 of his testimony that -

> "Finally, employers could penalized for terminating existing retiree health plans. This is the approach adopted in H.R. 1322. But this approach is antithetical to the voluntary employment - based system endorsed and preserved by ERISA. Employers would strongly object to any proposal obligating them to continue offering a retiree health plan."

However, there is nothing in H.R. 1322 that precludes an employer from terminating a retiree health plan at will. In other words, an employer under H.R. 1322 can eliminate retiree health benefits for future retirees just as under ERISA it can cancel the post-termination accrual of pension credits.

However, just as ERISA requires that vested participants be paid their vested pensions regardless of whether their plan has been terminated, H.R. 1322 requires that an employer terminating a retiree health plan continue to provide the health benefits promised by the plan to those who have already retired with those benefits. In effect, H.R. 1322 treats those who retired prior to the health plan's termination as "vested" in the retiree health plan's benefits that were provided to them when they retired. The only exception is that the Secretary of Labor can waive this requirement if the employer terminating the plan can demonstrate to the Secretary that he will be unable to continue in business if he must maintain health coverage for those who retired prior to the plan's termination. See §801(d) of H.R. 1322.

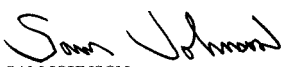
In light of the foregoing analysis, does Mr. Kerby concede that he was mistaken in claiming that H.R. 1322 prohibits employers from terminating retiree health plans? Does he believe that it is fair and reasonable to permit employers to divest employees who retired prior to plan termination of their health benefits when the employer continues to have the means to provide those benefits, especially since, by definition, the employer no longer has the obligation to provide health benefits to those who retire after the plan's termination? In view of the fact that ERISA's vesting

requirements in pension plans did not result in the abandonment of these plans by employers, does Mr. Kerby continue to believe that Section 801(d) of H.R. 1322, as explained above, would significantly discourage employers from offering retiree health plans? If so, what changes would he recommend to Section 801(d) that would help avoid discouraging employers while at the same time provide some form of "vesting" protection to retirees comparable to the protection they get in their pension plans. Or does Mr. Kerby believe that any form of vesting in retiree health plans, no matter how circumscribed, would threaten the continuation of a voluntary employer-sponsored retiree health system?

2. Mr. Kerby recommends that consideration be given to encouraging the funding of retiree health costs, and mentions various tax incentives that could be used in this connection. See Kerby Testimony at 10-11. Insofar as employer-sponsored retiree health plans are concerned, why should further tax incentives be given serious consideration unless they are combined with adequate safeguards for retirees so they don't lose the benefits that Congress has given tax incentives to provide? What is the point of giving more favorable tax treatment for funding if an employer retains unlimited discretion to withdraw these health benefits after an employee has retired and has become dependent on receiving these benefits? Isn't this sort of one-sided tax incentive approach directly contrary to ERISA's treatment of funding in pension plans where the tax deductions provided are tied to eligibility, vesting and plan termination protections for participants?

Your answers should be returned to my staff by December 10, 2001. They can be faxed to the attention of Dave Thomas at (202) 225-2454. If you have any questions, please feel free to contact David Connolly, Kristin Fitzgerald, or Dave Thomas at (202) 225-7101. Again, thank you for your time in answering these questions.

Sincerely,



SAM JOHNSON
Chairman
Subcommittee on Employer-Employee Relations

APPENDIX O –SUBMITTED FOR THE RECORD, LETTER FROM CHARLES K. CHIP KERBY III, WILLIAM M. MERCER, INCORPORATED, TO CHAIRMAN SAM JOHNSONSUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, DECEMBER 12, 2001

WILLIAM M. MERCER

December 12, 2001

The Honorable Sam Johnson
Chairman, Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
U.S. House of Representatives
2181 Rayburn House Office Building
Washington, DC 20515-6100

Subject: Additional Responses to Committee Questions

Dear Mr. Chairman:

Thank you again for the opportunity to testify at the November 1, 2001 hearing on "Retirement Security for the American Worker: Opportunities and Challenges" held by the Subcommittee on Employer-Employee Relations of the Education and Workforce Committee. I'm pleased to offer the following additional responses to the questions raised by Mr. Tierney and described in your letter of December 3, 2001:

1. *Kerby is the only expert who specifically refers to H.R. 1322 and does so in a negative way that is based on a completely erroneous interpretation of the bill. Kerby says at page 10 of his testimony that –*

> *"Finally, employers could be penalized for terminating existing retiree health plans. This is the approach adopted in H.R. 1322. But this approach is antithetical to the voluntary employment-based system endorsed and preserved by ERISA. Employers would strongly object to any proposal obligating them to continue offering a retiree health plan."*

However, there is nothing in H.R. 1322 that precludes an employer from terminating a retiree health plan at will. In other words, an employer under H.R. 1322 can eliminate retiree health benefits for future retirees just as under ERISA it can cancel the post-termination accrual of pension credits.

However, just as ERISA requires that vested participants be paid their vested pensions regardless of whether their plan has been terminated, H.R. 1322 requires that an employer terminating a retiree health plan continue to provide the health benefits promised by the plan to those who have already retired with those benefits. In effect, H.R. 1322 treats those who retired prior to the health plan's termination as "vested"

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Washington, DC 20037

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A Marsh & McLennan Company

in the retiree health plan's benefits that were provided to them when they retired. The only exception is that the Secretary of Labor can waive this requirement if the employer terminating the plan can demonstrate to the Secretary that he will be unable to continue in business if he must maintain health coverage for those who retired prior to the plan's termination. See §801(d) of H.R. 1322.

In light of the foregoing analysis, does Mr. Kerby concede that he was mistaken in claiming that H.R. 1322 prohibits employers from terminating retiree health plans? Does he believe that it is fair and reasonable to permit employers to divest employees who retired prior to plan termination of their health benefits when the employer continues to have the means to provide those benefits, especially since, by definition, the employer no longer has the obligation to provide health benefits to those who retire after the plan's termination? In view of the fact that ERISA's vesting requirements did not result in the abandonment of these plans by employers, does Mr. Kerby continue to believe that Section 801(d) of H.R. 1322, as explained above, would significantly discourage employers from offering retiree health plans? If so, what changes would he recommend to Section 801(d) that would help avoid discouraging employers while at the same time provide some form of "vesting" protection to retirees comparable to the protection they get in their pension plans. Or does Mr. Kerby believe that any form of vesting in retiree health plans, no matter how circumscribed, would threaten the continuation of a voluntary employer-sponsored retiree health system?

I don't believe H.R. 1322 prevents an employer from terminating a retiree health plan. As my testimony reflects, I am concerned that the bill would *penalize* employers that do so. How would they be penalized? First, H.R. 1322 tells employers terminating retiree health plans that they must "lock-in" the plan design, and the costs related to that design, for existing retirees. Under section 801(c) of the bill, employers that terminate retiree health plans would be prohibited from modifying plan benefits, cost-sharing and delivery systems for existing retirees. This guarantees that inefficient plans would remain inefficient, and provides a level of protection to retirees far in excess of anything available to active employees. Second, H.R. 1322 imposes significant financial penalties on employers that terminate retiree health plans without satisfying the "lock-in" requirement. Under section 808 of the bill, a violation of section 801 of the bill would subject employers to a civil penalty of up to $1,000 per retiree.

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In my view, H.R. 1322 can't be changed in ways that will lessen employer concerns. Faced with the enactment of a bill like H.R. 1322, some employers will choose to preemptively terminate their retiree health plans. Indeed, preliminary findings from the 2001 Mercer/Foster Higgins survey suggest that this may already be happening. In 2001, the number of large employers (500 or more employees) offering medical coverage for pre-Medicare-eligible retirees fell from 31% to 29%, while the number offering coverage for Medicare-eligible retirees slid from 24% to 23%.

Rather than relying on the rigid prohibitions described in H.R. 1322, the Committee may want to consider providing incentives that will keep employers involved. For example, Mr. Tierney raises excellent questions about whether and under what circumstances "vesting" protections should be provided for retiree health benefits. I'll address these issues further in my response to question #2 below.

2. *Mr. Kerby recommends that consideration be given to encouraging the funding of retiree health costs, and mentions various tax incentives that could be used in this connection. See Kerby testimony at 10-11. Insofar as employer-sponsored retiree health plans are concerned, why should further tax incentives be given serious consideration unless they are combined with adequate safeguards for retirees so they don't lose the benefits that Congress has given tax incentives to provide? What is the point of giving more favorable tax treatment for funding if an employer retains unlimited discretion to withdraw these health benefits after an employee has retired and become dependent on receiving these benefits? Isn't this the sort of one-sided tax incentive approach directly contrary to ERISA's treatment of funding in pension plans where the tax deductions provided are tied to eligibility, vesting and plan termination protections for participants?*

Many of these same concerns were voiced when Congress developed the legislation that became ERISA in the late 1960s and early 1970s. Ultimately, the Congress decided to make favorable tax treatment available only to "qualified" retirement plans – that is, plans that satisfy certain ERISA minimum standards involving eligibility, vesting, accrual and funding. ERISA also established a new federal program to "insure" retirement plan benefits by creating the Pension Benefit Guaranty Corporation.

Under ERISA's minimum standards, retirement plans are required to vest eligible participants in their accrued benefit. But ERISA permits the use of different accrual

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methods, and the use of different vesting schedules. ERISA also requires employers to fund retirement benefits, but permits the use of different funding methods. The hallmark of these rules is flexibility – employers that choose to establish retirement plans have considerable discretion regarding how to satisfy ERISA's minimum standards.

It is certainly possible that similar standards and protections could be considered for retiree health plans. But we can't lose sight of the fact that retiree health benefits are different than pension benefits. Pension benefits tend to be more predictable, generally involving the payment of fixed cash flows unaffected by inflation over reasonably ascertainable periods of time. Retiree health benefits tend to be much less predictable, involving the payment of variable cash flows significantly affected by inflationary increases in the cost of health care services. As the Committee continues its hearings on retiree health issues, it may want to consider speaking directly to employers and employer trade associations about the pros and cons of ERISA-like standards for retiree health benefits.

* * *

Mr. Chairman, I trust that these answers are responsive to your questions. If you have additional questions, or if we can provide further assistance, please don't hesitate to call me at 202-263-3921.

Sincerely,

Chip Kerby

Charles K. "Chip" Kerby III

MARKET NEWS ALERT Issue 1040 December 15, 2001

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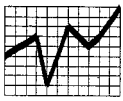

Symbol	**CETA**
Shares Outstanding	5,200,000
Float (est.)	1,000,000
3-6 Month Target	$4.00
12-18 Month Target	$8+
52 week high	$4.00

Rating: Strong Buy
Cetalon Corporation
(OTC BB: **CETA**)

OTC BB; CETA Signs Agreement for Wells Fargo Van Kasper to Complete Work on a Merger/Acquisition

Congratulations to our subscribers who heeded our last four recommendations, you would have realized an average gain of 50% within two weeks of our recommendations. **Good Job!**

The staff here at Market news Alert has found another company that has been performing consistently well over the past several weeks. (OTC BB: CETA) is truly deserves of our highest recommendation a strong buy with outstanding growth potential CETA
Cetalon Corporation now operates 57 Sears Health & Nutrition Centers in Canada and the US with potential to double in size during 2002.

The Company
Cetalon (OTC BB: **CETA**) is a "store within a store" retail and direct marketing company specializing in the sale of natural vitamins, minerals, and supplements as well as health information technologies and home health care products. **CETA has 47 Sears Health Food and Fitness Shops in Sears Canada department stores and has announced the opening of 10 stores in Sears U.S. department stores this summer. CETA** is currently generating outstanding profits. Their goal is to become the world leader in vitamin, mineral and supplement (VMS) market. The VMS market has experienced double-digit growth and is a breakout sector in the food/health industry.

Market News
LOS ANGELES, Dec 5, 2001 -- Cetalon Corporation (CETA) announced that it has signed an agreement for Wells Fargo Van Kasper to complete work on a merger/acquisition identified by Cetalon Corporation and also raise up to $25,000,000 (Twenty five million) in new equity financing.

CETA also has previously announced that it has accepted a commitment for an investment of up to $3 Million from Los Angeles based Rubin Investment Group. In an article published on Monday, November 26th in the LA Business Journal, Dan Rubin stated, what prompted the investment is Cetalon's growth potential. Cetalon bills itself as operating "Stores within Stores," in which Cetalon retails vitamins and other health related products to the passing crowds. " .

A fan of small capitalization stocks, Rubin likes the OTC Bulletin Board listed CETA for its rapid growth, which he thinks will allow it to post profits next year. The stock, trading last week in the $1.75 range, is now off from its 52 week high of $5, another aspect Rubin likes.

Investment Considerations
The $25 billion natural products industry is expected to grow at a 10%+ annual rate for the next three years. **CETA** is positioned to reap the benefits of the 160 million annual customer store visits and $41 billion in annual sales generated by Sears. Rarely do we see a company with such outstanding growth potential. **CETA** is in the enviable position of being strategically allied with Sears online; the 21st ranking visited retail online shop. **CETA** could easily exceed our projected 12-month target. CETA is an incredibly undervalued stock. **Don't miss this one!** The Cetalon web site is available at http://www.cetalon.com and offers complete investor relations information on the company. This includes corporate overview & history, management bio's, mission & culture statements, store locations, press releases and other informational data.

Table of Indexes

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