ASSESSING RETIREE HEALTH LEGACY COSTS: IS AMERICA PREPARED FOR A HEALTHY RETIREMENT?

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 ASSESSING RETIREE HEALTH LEGACY COSTS:

IS AMERICA PREPARED FOR A HEALTHY RETIREMENT?

Thursday, May 16, 2002

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 10:30 a.m., in Room 2175, Rayburn House Office Building, Hon. Sam Johnson, Chairman of the Subcommittee, presiding.

Present: Representatives Johnson, DeMint, Tiberi, Wilson, Andrews, Kildee, Rivers, and Tierney.

Staff present: Kristin Fitzgerald, Professional Staff Member; David Connolly, Jr., Professional Staff Member; Dave Thomas, Legislative Assistant; Ed Gilroy, Director of Workforce Policy; Kevin Smith, Senior Communications Counselor; Heather Valentine, Press Secretary; Patrick Lyden, Professional Staff Member; and, Deborah L. Samantar, Committee Clerk/Intern Coordinator.

Camille Donald, Minority Counsel, Employer-Employee Relations; Michele Varnhagen, Minority Labor Counsel/Coordinator; and, Dan Rawlins, Minority Staff Assistant/Labor.

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

Good morning. The Subcommittee today is meeting to hear testimony on assessing retiree health legacy costs. I extend a warm welcome to all of you and thank you for being with us today. And I know your time is precious and some of you need to catch planes, so we will get on with it. I appreciate the ranking member, Mr. Andrews, and my other colleagues being with me today.

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

Today's hearing focuses on retiree health legacy costs and whether or not America is going to be prepared for a healthy retirement. This is our second hearing on retiree healthcare. In our first hearing, we heard testimony about how retirees are less likely to have access to employer-sponsored retiree healthcare. In fact, only 35 percent of employers still offer the benefit.

What does this mean? Well, clearly, many retirees are not going to be able to rely on an employer-provided plan. Instead, retirees must begin to prepare for their own healthy retirement, much as today's workers save their own money in a 401(k) account for future pensions.

Today's hearings can help determine why, I hope, employers are making changes to their retiree health benefits. We will hear a discussion of the retiree health obligations, known as legacy costs in some areas, and of a broad section of industries, as well as the factors that influence employers' decisions to reduce or eliminate retiree health benefits. We will also hear about the experience of Ford Motor Company and how they are able to balance the growing financial obligations of retiree health benefits with the needs of their employees during retirement.

Employers voluntarily provide healthcare for workers and for retirees. Unfortunately, the rising cost of coverage and the retirement of baby boomers make it difficult for employers to provide these benefits. Another obstacle employers face in providing healthcare is that, unlike the pension system, current law discourages employers' ability to pre-fund retiree healthcare. Increasingly, employers who offer retiree health benefits find themselves at a financial disadvantage with competitors who do not offer the benefit. And those companies that continue to offer retiree health benefits are adopting innovative changes to balance the cost of retiree health obligations with their desire to provide the benefit for employees.

As you know, the steel industry has an enormous retiree health legacy cost. However, retiree health legacy costs are spread across many industries. I would like to draw your attention to the chart we have displayed over there with the top 25 retiree health legacy costs of today's Fortune 500 companies. For example, SBC Communications anticipates $20.1 billion in legacy costs; Bell South $6.3 billion; Lockheed $3.1 billion. That is a lot of money even for Texas companies. Employees of all sectors are facing the inevitability that they will have to shoulder a larger amount of the cost of their healthcare and retirement. And rather than rifle-shot remedies for specific industries, we ought to focus on all industries.

At our next hearing in our retiree health series we hope to investigate ways that government policy can make it easier for employers of all industries to offer healthcare. In addition, the Subcommittee will continue to study how to better prepare workers for their role in ensuring their own healthy retirement. Retiree health is serious business, and our nation's retirees need our help in order to ensure that they will have the resources that they need when they retire.

I look forward to working with my colleagues on the Subcommittee as we examine the issue. And right now I would like to welcome all of our witnesses, and we look forward to your testimony and the guidance it will offer us as we address the critical issue in front of us.

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

Mr. Andrews, do you have a statement you would like to make before we get started?

Mr. Andrews. I do. Thank you, Mr. Chairman. I would like to welcome the witnesses to the Subcommittee. I look forward to hearing about this very serious and important problem. And I appreciate the panelists giving us their time to address it this morning.

OPENING STATEMENT OF RANKING MEMBER ROBERT ANDREWS, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

The title of the hearing is "Assessing Retiree Health Legacy Costs: Is America Prepared for a Healthy Retirement?" I would answer that question by saying no we are not. And the evidence is rather compelling. The number of employers offering healthcare benefits to retirees is decreasing. The amount of contributions that retirees themselves must make toward their healthcare costs is increasing rapidly. Coverage is being scaled back rather dramatically for people around the country.

I think these trends are going to be exacerbated by two larger trends that we are facing. One is globalization. Those large employers on that list, without exception, are competing against international competitors in a global market. Many of those international competitors do not offer retiree health benefits; they come from countries that have socialized or publicly subsidized health systems that give those competitors an enormous advantage against American companies, who are bearing most or all of that cost themselves.

The second trend is the graying of our population. The so-called age wave that will hit in the next few decades when the baby boomers, such as myself, reach an age where we will hit retirement years. The number of people in the workforce will be less. The number of people in the

retirement category will be more. Hopefully, people will live longer. The advances that we are making in nutrition and healthcare and medical science are going to give people the ability to live longer lives, and that is a blessing. But it is not an unmitigated blessing. There are some issues that are raised by it.

So I think the Chairman deserves credit for calling this very timely hearing. Some of the questions that I bring to the hearing that I would like to hear the panelists answer are the extent to which this is an accounting problem as opposed to a real economic problem. I think it is indisputable that the changes made in the accounting standards for years beginning after 1992 have had an impact on the way companies address the bearing of healthcare costs. I would be interested in hearing the panelists talk about the scope of that impact, whether they think any changes in that standard would be appropriate. And if there were changes in the standard, what benefit would it give us with respect to solving this problem.

Second, there is an option that we could pursue of publicly subsidizing more of retiree healthcare costs. The most obvious and dramatic increase in that subsidy would be the addition of a prescription drug benefit to the Medicare program since it would absorb a significant share of the cost that the remaining private plans are absorbing today.

Finally, I am interested in hearing the views of the panelists on various cost reduction and revenue increase strategies that employers have used. As many of you note in your written testimony, employers are asking employees, and/or requiring employees to contribute more. They are pursuing cost containment strategies that are designed to try to get more bang for the plan's buck. And it is important that we know the scope of the potential gain that could be had from pursuing these strategies as well as some of the very real human costs and human consequences of pursuing these strategies.

I'll say at the outset of this that although the questions that I raise are fraught with partisan pitfalls, I don't regard this at all as a partisan problem. I regard this as a public service problem, a governmental problem that we are going to have to solve together. It is of note that the hearing is sparsely attended when it comes to the news media this morning. I don't fault the news media at least for that, and that is because we are talking about a problem here that has some immediate significance, as General Motors and other companies can tell us when they look at the net profit that they are reporting. But this is really a problem that is going to come to full fruition in the next decade or two. And I hope this quiet hearing that we are having this morning will make a valuable contribution to developing legislative proposals and eventually laws that will help fix this problem.

So I thank the Chairman for convening the hearing. I look forward to hearing the testimony of the witnesses.

Chairman Johnson. Can you believe a baby boomer would say this is political?

[Laughter.]

Mr. Andrews. I am just glad to be called a baby.

Chairman Johnson. I hear you.

At this time, I would like to introduce our witnesses, and we appreciate all of you being here. Our first witness will be Mr. Syl Schieber, Vice President for Research and Information at Watson Wyatt Worldwide. Mr. Schieber has flown in from Berlin to be with us today, and I guess you have a plane to catch later today. We will try to get you out of here.

The second witness is Ms. Louise Novotny. Ms. Novotny is the Assistant Director of Research for the Communications Workers of America.

Our third witness is Mr. Fred Mittelstaedt. He is a professor at the University of Notre Dame. I know this is graduation there, and I thank you for being here.

Our fourth and final witness is Dr. Vincent Kerr. He is Director of Healthcare Management for the Ford Motor Company. Thank you, also.

Before the witnesses begin their testimony, I would like to remind Members that we will be asking questions of the witnesses after the entire panel has testified. In addition, Committee Rule 2 imposes a five-minute limit on all questions. We have timer lights out there, which you all will see, which will give you five minutes. We hope you will be able to complete your opening remarks within that length of time.

I also would ask unanimous consent for the hearing record to remain open 14 days to allow Member statements and other extraneous material referenced during the hearing to be submitted in the official hearing record. Without objection, so ordered.

Having said that, Mr. Schieber, please begin your testimony.

STATEMENT OF SYLVESTER J. SCHIEBER, Ph.D., VICE PRESIDENT FOR RESEARCH AND INFORMATION, WATSON WYATT WORLDWIDE, WASHINGTON, D.C.

Mr. Chairman and Members of the Committee, thank you very much for inviting me here today to talk about this extremely important issue. The testimony that I present is my own and my prepared remarks, which I have submitted for the record, are about 30 pages long so I will summarize those at a fairly high level.

To cut to the point, employer-sponsored retiree health benefits are gradually being eliminated in this country. Even where benefits will continue to be offered in the future, the relative size of the benefit in comparison to actual health needs will be significantly reduced from what has existed until this time.

The natural tendency might be to criticize business for the elimination of these benefits and to find fault with the profit structure on which most of our economy is based. That would ignore the range of factors contributing to the reality of the situation we face. The real forces at play here are well known. First, our health sector has been plagued for decades by very high rates of cost inflation. Second, employers have been forced to offer retiree health benefits in a schizophrenic policy environment that essentially forces them to operate their plans on a pay-as-you-go basis but to account for the obligations as they accrue. Third, business conditions in an open economy are not dictated by the efficiency of the employer down the street or the employer in the next state but by the conditions in a highly competitive world marketplace. Fourth, investors in American business, especially institutional investors, have become increasingly demanding about how businesses are run. Finally, the demographics of our society are driving up the cost of all of our retirement programs. As a practical matter, we all want to maintain our retirement system. We just do not want to pay its costs.

I believe that federal policy is a major contributor to the environment that has resulted in persistent health inflation in this country. Federal expenditures on research and development in the health sector have increased 168 percent over the past decade. In growth terms, Federal Government expenditures are growing 4.9 times faster than other R&D that the government finances and 3.4 times faster than all federal expenditures. R&D in the health sector is expanding, crowding out other R&D that we do.

Research into increasing health expenditures in the U.S. consistently shows that technology is the major cost driver of health expenditures and health costs. We spend massive amounts of money to add new toys to the medical bag but spend virtually none to understand which of these toys are particularly effective in advancing the health of our society and making sure that healthcare practitioners understand the relative efficiency of alternative treatment regimens.

In the regulatory arena, employers have to account for the obligations they accrue as employees earn their retiree health benefits. But federal tax policy effectively precludes plan sponsors from funding their employees' benefits when they are being earned.

Today, many of the retirees who are receiving health benefits from their prior employer earned those benefits during the 1950's, 1960's, 1970's, and 1980's. But it is the workers and stockholders of 2002 who are paying for those benefits. Of the 50 largest industrial companies on the Fortune list from 1972, only 21 of them are still organized and operating as freestanding companies. Even among these companies that do still exist, virtually none of the senior managers running them in 1972 is still at the helm. And no one in 1972 could have anticipated the long-term effects of ERISA in terms of creating the massive accumulation of labor ownership in the capital basis of our economy through funded retirement plans. No one could have anticipated the magnitude of the obligations for retiree health benefits that would arise with aging workforces, in maturing industries, in an increasingly competitive world marketplace. No one could have anticipated that the collective owners of capital would be so demanding that business managers run their operations providing higher returns. I have little doubt that the managers of U.S. business were committed to keeping their healthcare promises when they made them many years ago. But they could not foresee the future any more than we can today. They were making a promise they

could not keep.

It makes no economic sense for public policy to create an environment where employers create promises for workers to be paid in the distant future when those promises cannot be secured when they are earned. Making realistic retiree medical promises and keeping them requires the opportunity for employers and employees to secure retiree health benefits through pre-funding. One major motivation behind the adoption of ERISA in 1974 was to secure the retirement benefits that employers promised their employees through their defined benefit plans. Congress adopted ERISA to secure such benefits across time and across varying economic circumstances. From a public perspective, providing tax incentives for funding of retiree medical benefits is the best approach to preserve retiree medical benefits for the future.

Back in the early 1980's, policy-makers decided employers should not be allowed to fund retiree health benefits in the same way they pre-fund pensions, because policy-makers worried about the lost federal tax revenues. But if the promises made to people making steel in the 1980's were funded on the basis of their productivity at that time, we would not be sitting here today worrying about how these folks can survive the economic transition that is now under way in their industry. If the conclusion had been reached at that time that the cost of these benefits was too high for employers and their workers, the promises would not have been made, because people would not have been willing to fund them. But there would not have been the promise.

The policy I recommend makes sense for employers, their employees, and the government. I ask that you seriously consider it.

Thank you very much.

STATEMENT OF SYLVESTER J. SCHIEBER, Ph.D., VICE PRESIDENT FOR RESEARCH AND INFORMATION, WATSON WYATT WORLDWIDE, WASHINGTON, D.C. – SEE APPENDIX B

Chairman Johnson. Thank you, sir. Your entire testimony will be entered into the record.

Ms. Novotny, you may begin.

STATEMENT OF LOUISE NOVOTNY, ASSISTANT DIRECTOR OF RESEARCH, COMMUNICATIONS WORKERS OF AMERICA, WASHINGTON, D.C.

Thank you, Mr. Chairman and Members of the Subcommittee. I am pleased to be given the opportunity to speak with you this morning about our experience with retiree healthcare benefits. We have just concluded negotiations in the recent months with two of our major employers, one,

AT&T, and the other, Cincinnati Bell. And at both of those tables retiree benefits were a key issue and indeed a critical issue that held up negotiations in some instances and forced us into some important conclusions in others.

As you all may know, bargaining for retirees is a really tricky business. As a union, we can bargain for retirement benefits for active employees and our employers are obligated to bargain with us over that. It is a mandatory subject of bargaining. But bargaining for those who are already retired is permissive. So I actually want to applaud those employers that do provide those health benefits voluntarily because, again, we know how difficult it is to do that.

We have as a union made retiree health benefits a key point of our negotiations for many years. We first negotiated them in the 1960's. But we feel these benefits are important to all our retirees. For those age 65 and older, they tend to supplement Medicare and help with the serious cost-sharing requirements of the Medicare program. And, in addition, cover key benefits not covered by Medicare, prescription drugs being most notable.

But the benefit package is possibly more valuable still to those who are under age 65, and we are feeling this acutely now in recent years. In the telecommunications industries, there has been massive downsizing for all of our employers. Our members have been forced to take early retirements. If they were to go out in the individual health insurance market, they would find the cost of that coverage prohibitive. So, again, when we bargain, we consider retiree health as one of our most important obligations.

In 1989, I want to take us back a little bit, when we were bargaining, the companies came to us with a proposal to cap the amount of contributions they would make to retiree healthcare, and that was in response to the proposal by the Financial Accounting Standard Board, which came to be known as FAS 106. Under that rule, employers were to begin accruing for the projected cost of retiree benefits over the working lives of the employees, as Mr. Schieber has just mentioned. And at the time, our employers booked those costs only on a pay-as-you-go basis. At that time, to give an example of the magnitude of the new requirement, when we were bargaining with AT&T, they provided us with the information that showed that their total benefit obligation, if they were to adopt the FASB rule and cover our benefits as is, would have been a $9.5 billion new obligation on their books, with an annual expense of $1.7 billion.

We agreed then in negotiations. We recognized this problem that it was causing our companies. We agreed to cap the retiree health benefits, meaning that if the costs were to rise above those caps, then our retirees would be obligated to pay the difference. Recognizing that vulnerability, we negotiated several safeguards that we expected or hoped would provide additional protections. Those included grandfathering the already retired workers so that they would never be required to pay, setting the caps at high enough levels to preclude any retiree cost sharing for over a period of years, waiving the obligation for retirees to pay during a contract term. And that stipulation obviously had to be renegotiated year after year.

Another level of protection that we did not have before was to be able to link the level of retiree benefits to the level of benefits that were being provided to our active employees. In the past, when a worker retired, they carried the level of benefits they had at the time of retirement.

There were no improvements over time. And, finally, we agreed that we would negotiate over the scope and level of retiree benefits and the caps in the future so that permissive subject of bargaining became an agreed upon subject of bargaining.

We also bargained for trusts to pre-fund retiree health benefits, Voluntary Employee Benefit Accounts, or trust VEBAs, to help offset the company's liability. And these approaches helped us to stave off the costs for some years, but in subsequent years we continued to bargain, to come up with creative solutions to the problem, including at one point bargaining Medicare HMOs, which, as you know, soon left the market, so that did not become a solution.

In asking for recommendations, what we would hope to see is some kind of relief for the employers who have responsibly tried to provide these retiree health benefits, and that would include Medicare prescription drug costs to help relieve their cost burden.

Thank you.

STATEMENT OF LOUISE NOVOTNY, ASSISTANT DIRECTOR OF RESEARCH, COMMUNICATIONS WORKERS OF AMERICA, WASHINGTON, D.C. – SEE APPENDIX C

Chairman Johnson. Thank you, ma'am. I appreciate your statement.

Mr. Mittelstaedt, you may begin your testimony.

STATEMENT OF H. FRED MITTELSTAEDT, PROFESSOR, MENDOZA COLLEGE OF BUSINESS, UNIVERSITY OF NOTRE DAME, NOTRE DAME, IN

Thank you. Mr. Chairman and Members of the Committee. I am pleased to be here to share with you some of my research findings and thoughts on retiree health benefits. I hope that my remarks assist the Committee in its deliberations on this very important issue.

Many of these plans began in the 1950's when both healthcare costs and life expectancies were lower. The benefits were prevalent in large manufacturing firms, which at the time had high ratios of active employees to retirees. As longevity and healthcare costs increased, firms became more reluctant to offer these benefits. Consequently, today, retiree health benefit liabilities are primarily a problem for old, large, capital-intensive firms. These firms also often have numerous union employees.

Until the early 1990's, annual expense generally equaled the annual cash outlays for retiree health benefits. These are termed pay-as-you-go costs. Expenses were not accrued for the expected future payments associated with current employees or retirees. The pay-as-you-go costs were not even disclosed until mid-1980. In December of 1990, the FASB passed FAS 106, requiring firms

to change to an accrual basis of accounting.

Most retiree health plans were not pre-funded, in part due to the absence of tax incentives. In addition, because most firms had been accounting for the benefits on a cash basis, most of their retiree health benefit liabilities were not on their balance sheets. Consequently, upon adoption of FAS 106, most firms had large liabilities that had to be recognized. Firms could recognize this liability immediately or delay recognition by expensing it over a period not to exceed 20 years.

Numerous studies show that investors reduce share prices in proportion to the magnitude of retiree health benefit liabilities, both before and after adoption of FAS 106. The effects of FAS 106 vary greatly across industries, but the negative effects were most pronounced in capital-intensive manufacturing industries. Near the time that FAS 106 was passed, there was a noticeable increase in the number of firms reducing benefits.

One of my research projects examined the prevalence of the reductions and the motivations behind them. We found that about one-third of our sample firms reduced benefits. The most common types of changes were capping employer contributions and increasing co-payments. In the majority of instances, firms limited the effect on existing retirees.

With regard to motivation for the plan reductions, we found that 89 percent of healthcare benefit reductions were made within one year of FAS 106's adoption. Only 11 percent of the healthcare reductions were made prior to 1990, even though the U.S. medical inflation rate greatly exceeded the general inflation rate throughout the 1980's. In addition, firms with high FAS 106 liabilities and high existing debt were more likely to reduce benefits. Results also indicated that firms cutting healthcare benefits were financially weaker than no-cut firms but the results for increased healthcare costs were mixed.

These findings are consistent with managers attempting to reduce current or expected contracting costs associated with obtaining capital. An alternative explanation is that in complying with FAS 106, managers may have recognized that their firms could not afford the promised benefits. Under this reasoning, FAS 106 accelerated decisions that would have been made over a longer period of time as it became clear that the obligations could not be honored. We inferred from the findings that different debt or labor contracts would have been written if FAS 106 requirements had always been present.

Although we used data from the early 1990's, I believe that the studies findings are still relevant today. Firms with high retiree health benefit liabilities and high other debt obligations will experience the most pressure to reduce benefits. In addition, if firms experience cash flow or income shortfalls, they will be more likely to reduce retiree health benefits.

I have just a few concluding remarks. Private retiree health benefit plans represent an important source of wealth to millions of U.S. citizens. Old, large, capital-intensive firms primarily sponsor these plans. Firms with the largest liabilities are in industries, such as automobiles, telecommunications, aircraft, industrial equipment, steel, and air transport. However, some firms in almost every industry sponsor these types of plans. Because of the breadth of coverage, I believe that it would be difficult for the U.S. government to justify giving relief to just one

industry.

Over the past decade, firms sponsoring retiree health benefit plans have tried to reduce their exposure to rising medical costs by modifying plan agreements. I believe that the decisions of these firms to modify rather than end benefits suggest that managers wish to maintain good relations with labor and also provide some income security to their firms' retirees. However, firms do not wish to be at risk for rising healthcare costs and changes to Medicare over the next 50 years. Consequently, many younger employees at these firms will not have retiree medical benefits and many middle-age workers will have lower benefits than current retirees.

Congress may wish to slow the decline by offering additional incentives to business. If the decline continues, then Congress may wish to encourage more education on retirement planning. If workers do not plan early for potential medical costs during retirement, they may not be able to afford needed medical care or they may become destitute trying to pay for it.

Thank you.

STATEMENT OF H. FRED MITTELSTAEDT, PROFESSOR, MENDOZA COLLEGE OF BUSINESS, UNIVERSITY OF NOTRE DAME, NOTRE DAME, IN –SEE APPENDIX D

Chairman Johnson. Thank you, Mr. Mittelstaedt.

Dr. Kerr, you may begin your testimony.

STATEMENT OF VINCENT E. KERR, M.D., DIRECTOR OF HEALTHCARE MANAGEMENT, FORD MOTOR COMPANY, DEARBORN, MI

Good morning, Chairman Johnson, Ranking Member Andrews, and the rest of the Committee. It is a pleasure to be here before you this morning to discuss Ford Motor Company's retiree health coverage, in listening to Mr. Mittelstaedt, one of those old, large, capital-intensive companies. I feel older already.

I am the Director of healthcare management for Ford Motor Company. And in this position I am responsible for all of Ford's healthcare programs, including occupational health and safety, workers' compensation, and the healthcare benefits for employees, retirees, and their dependents.

I commend you for convening this Subcommittee, because this is a very important issue that we have before us. And in my statement today, I would like to discuss Ford's experience in providing healthcare benefits to our retirees and the challenges we face in continuing to provide this coverage. And I want to do this in order to assist Congress in its efforts to understand the state of employer-sponsored healthcare, particularly for retirees. We believe this is a critical issue.

In the U.S., Ford provides healthcare coverage for over 560,000 employees, retirees, and their dependents. We are located in all 50 states. And in 2001, our cost, including FAS 106 liability, was $2.5 billion. The 2001 costs represented a 25 percent increase over 2000. And of that $2.5 billion that we spend or that we have in cost, retiree healthcare accounted for $1.6 billion, a little over half, although in our population retirees are slightly less than half of the population.

One of the key factors driving our healthcare costs, particularly among our retirees, is prescription drugs. And several factors have contributed to this steady growth in prescription drug costs. I think you are familiar with them, utilization, primarily. Our retirees are taking more prescription drugs, like much of the population, and the costs of those drugs have increased. Pharmacy costs have been rising at an alarming rate, 14 percent in 2000, 15 percent in 2001, and we are projecting a 15 percent increase in 2000 compared to the recent CBO study which projected that spending would increase 10.1 percent per person every year for the next 10 years. When you look at our estimated $550 million spend in drugs, we will double that number by 2009 to over a billion.

Ford Motor Company provides comprehensive retiree health benefits. Eligibility is based on age and years of service. If you have been with the company for 30 years, you can retire at any age or at 55 with at least 10 years of service and receive these benefits. We offer a variety of healthcare options, including traditional or fee-for-service plans, PPO's, health maintenance organizations, to our population.

The healthcare coverage that we offer is the primary healthcare benefit for younger retirees who are not eligible for Medicare. And when they are Medicare-eligible, the transition is seamless in that we provide secondary coverage for the benefits that Medicare does not provide. Faced with the many challenges in maintaining the delivery of these healthcare benefits to our employees, retirees, and their dependents, Ford has undertaken a variety of initiatives to try to both improve the quality and help manage the cost of delivering these benefits.

We have focused on quality in the health plans that we offer through certification. A number of efforts by the company are in combination with GM, the UAW, and other entities to improve quality in terms of the selection of the healthcare that our members receive, through hospital profiling, which gives information on the quality of the services of individual providers, and by focusing on patient safety. Many of you are familiar with the recent IOM reports stating that the kind of care we receive in the U.S. perhaps is not justified based on the cost that we pay for it.

We have also undertaken a number of cost-sharing initiatives, increasing the contributions that our salaried retirees pay and on prescription drugs with tiered co-pays, using mail order drugs and discounts, and some direct to provider initiatives.

These alone I don't think are enough to stem the tide that we face, which Mr. Andrews referred to in terms of the deluge that will follow for us baby boomers as we enter retirement. So I would like to sum up with perhaps a few suggestions for your consideration.

One is Medicare reform, including prescription drug coverage. Medicare's current eligibility age should be maintained, since raising it will fail to address the underlying cost issues for the country as a whole and may have adverse impact in terms of employers' ability to sponsor healthcare coverage. Employers who voluntarily establish or maintain retiree coverage should not be discouraged from doing so through payroll taxes for example or other interventions or through mandates, which I believe would have this effect. We need to more aggressively encourage and allow the use of generic drugs, which are as effective and cheaper, and look carefully at the legislation that exists to encourage that.

As I said, reject benefit mandates, and promote safety and quality in the care that we receive.

Thank you for allowing me to testify today.

STATEMENT OF VINCENT E. KERR, M.D., DIRECTOR OF HEALTHCARE MANAGEMENT, FORD MOTOR COMPANY, DEARBORN, MI – SEE APPENDIX E

Chairman Johnson. Thank you, sir. I wonder if you could give me your opinion. If Medicare totally provided prescription drugs, would your company stop providing them for retirees?

Dr. Kerr. I think the option would probably be to look at a "wrap-around", similar to what we do with Medicare.

Chairman Johnson. What do you do with Medicare right now?

Dr. Kerr. Medicare is primary, and our insurance acts as secondary, so we reimburse employees for the Part B premium that they pay. And for what is not covered by Medicare, they have access to our insurance up to the limit it covers.

Chairman Johnson. In the bill that is being considered right now, there is a break in that coverage. I think it is $2,000 to $4,500. That is not firm yet. Would your company help the retiree with paying for that so it wouldn't come out of their pocket then?

Dr. Kerr. I suspect we would, and that there would be a plan that might involve some cost sharing with that percentage. But I doubt that we would abandon the coverage entirely.

Chairman Johnson. Okay, I am glad to hear that. Thank you.

I have a question here for Mr. Schieber. You mentioned "regulatory schizophrenia" has made it difficult for employers to secure retiree health benefits. If you had the opportunity to pre-fund, how would the health situation be different?

Mr. Schieber. Well, part of the problem here is that the rights to these benefits are earned in one period and the actual paying for them is going on in a different period. If a worker's productivity

can be partially tapped at the time they are working to help finance the benefit down the road, you can actually put an asset against the liability. And if that asset is there, it will make the benefit far more secure than when you are depending on the company at some point in the future having the ability to pay a promise that was earned many, many years ago. It simply would provide a security that does not now exist.

Now, in some cases it might actually lead to the elimination of benefits on a going-forward basis, because some employers with their employees might conclude that they couldn't afford to fund these benefits. But if you can't afford to fund a benefit sometime in the future, you really ought not to be promising it to people. At least that is my opinion.

Chairman Johnson. Maybe we ought to fix Social Security that way.

Mr. Andrews. We ought to do something with it. We should stop spending money on the budget.

Chairman Johnson. Yes, I know it.

Mr. Mittelstaedt, you mentioned that because of FAS 106 managers recognized that firms couldn't afford the present benefit levels. If the managers had understood the magnitude of liability for health benefits, do you think they would have changed the way the early labor contracts were negotiated or written?

Mr. Mittelstaedt. Yes, I do. When a lot of the promises were made, I don't think that the valuation techniques were there to actually even know what they were promising. And I am not sure that they could have foreseen how expensive costs would be 20 and 30 years later. So even if they had had to book a liability, I am not sure that the liability would have been high enough.

But following up with what Syl said, I think if firms would have had to expense something for the future benefits early on, they may not have promised the benefits originally. What they were doing is promising these benefits. They had to expense a very small portion of the promise. They only had to expense the amount actually paid to retirees in that year. So I think in some ways they promised things without really thinking about the ramifications later on.

Chairman Johnson. Thank you, sir. I won't ask any questions of the CWA, but I enjoy eating hamburgers with them in Plano.

I will recognize Mr. Andrews.

Mr. Andrews. Thank you, Mr. Chairman. Dr. Kerr, in your testimony, you talk about the company incurring $1.6 billion in healthcare costs for retirees. Did I read that number correct, $1.6 out of $2.5 billion?

Dr. Kerr. Yes.

Mr. Andrews. And the $550 million number that you refer to for pharmaceuticals is that just for retirees or is that for everybody?

Dr. Kerr. No, that is for everybody. Of that, retirees consume about $380 million.

Mr. Andrews. So if I understand this correctly, of the $1.6 billion the company spent last year on retiree healthcare costs, $380 million, or just below 25 percent of that, was on pharmaceuticals, prescriptions?

Dr. Kerr. That is correct.

Mr. Andrews. Okay. How much of a positive impact would it have on your company if we had a prescription drug benefit under Medicare? If that $380 million dropped to, say, $100 million a year in the "wrap-around" that you just described, how would you characterize the impact of that on your company's health plan?

Dr. Kerr. It would be huge in terms of a financial impact, not only the direct dollars that we pay out each year, but as a component of our FAS 106 liability drugs are an increasing portion.

Mr. Andrews. Now, one of the points that I want to make about this is there are a lot of proposals around here that are called Medicare prescription drug benefits, but not all of them would really do much to address the problem that we are talking about today. The President's proposal, for example, is rather severely means tested in a way that I would assume that most of the retirees who worked for companies that have retiree health benefits have incomes that would place them out of the program. If you have been fortunate enough to work for the companies that are on that list, you probably made enough money that you have a pension. And when that is added to your Social Security, you are out of the range that the President's plan would cover. So I think it is important to note for the record that if we are going to have a prescription drug benefit, it needs to be very broad in eligibility requirements.

If we had such a requirement, I would like to ask each of the panelists what impact you think it would have on the problem that we are talking about today? More precisely, do you think that a robust prescription drug benefit under Medicare would essentially solve the problem of the unfunded liabilities of retiree healthcare for employers? I would ask each of the panelists that.

Mr. Schieber. It would certainly have an effect on the recorded liabilities on the balance sheet of these companies. One of the things I think we need to keep in mind is that if we are going to start adding benefits through Medicare, that there is going to be a cost that is incurred in the provision of that benefit, and the people that have to pay for that cost are going to be the workers and the employers through increases ultimately in the payroll tax. We can talk about the reductions of costs or liabilities at one point, but it doesn't mean that there are not offsetting costs and liabilities created somewhere else.

Mr. Andrews. If I may, Mr. Schieber, one of the options would be an increase in the Medicare payroll tax. Another option is to subsidize the Medicare trust fund with other tax revenues from the

government from the income tax and other taxes. The Medicare trust fund is not constitutionally mandated.

Mr. Schieber. It is not constitutionally mandated, and I understand that. But a tax of any sort is going to impose a cost on the economy and the society. There is no zero-cost solution. I am not opposed to providing this kind of benefit. But as I said in my comments here before the Committee, we ought to want to maintain the benefits in our current retirement system. We are all trying to figure out how to get somebody else to pay the cost.

Mr. Andrews. Or some of us believe that a scaling back of the tax cut that was enacted in 2001 would provide that revenue.

Ms. Novotny, what would your answer be?

Ms. Novotny. I think I would provide some relief that our employers have been seeking. I guess I would say an alternative, if we don't have some relief like that, is that more retirees would be losing their benefits, because the cost would become intolerable. In the growth rate in our retiree health cost, 25 percent of that was due to prescription drugs. So we believe that that will have an immediate important impact and could help.

Mr. Andrews. Thank you. Mr. Mittelstaedt?

Mr. Mittelstaedt. I would agree that it would help. Anything Congress could do to slow down medical inflation would be helpful. But I think unless you add funding to that, it won't stop completely. All you are doing is reducing the liability. But I think you need to get some assets in there to provide more security to retirees.

Mr. Andrews. I appreciate that. And I think, Dr. Kerr, you have already answered the question in your written testimony that you would favor such a plan.

Dr. Kerr. We would.

Mr. Andrews. Thank you.

Chairman Johnson. For the record, I would just like to point out that prescription drugs are becoming more and more expensive. We find in the healthcare system that some of the doctors provide prescription drugs and sometimes they are the kind of drugs that a person has to take for life, which get to be pretty expensive. I suppose you have run into that at Ford already?

Dr. Kerr. Yes, in the retiree population if you look at drug usage, it is mostly in that area, cardiovascular, arthritis, drugs that you are going to take for chronic disease.

Chairman Johnson. And even generics are not that cheap anymore.

Dr. Kerr. They are cheaper than brand.

Chairman Johnson. I think the average cost is somewhere between 10 or 15 percent a year increase, and even from the government side we can't fund that kind of increase.

I recognize Mr. DeMint.

Mr. DeMint. Thank you, Mr. Chairman. I apologize for being late, and while I didn't hear a lot of the testimony, I have had a chance to review it, at least on paper.

I think the undercurrent I sense is that the future of defined benefit healthcare plans that are not pre-funded is kind of grim. And some of you may want to straighten me out if I didn't get that correctly from your testimony. The concept of employers pre-funding their plans is interesting, but also the idea of employees creating healthcare savings is also very appealing to me. This not only gives more security but it allows the employees themselves to shop and pay for their normal healthcare, at the same time allowing employers the opportunity to provide catastrophic coverage. The thought of employees arriving at retirement with some healthcare savings and giving Medicare an option to supplement those savings with another catastrophic overlay is interesting to me.

Dr. Kerr, I will direct my question to you as an employer but I would like some other opinions, too. What if you could offer a catastrophic level health plan for your active employees as well as retirees, and make pre-tax contributions to an employee health savings plan, or 401(k) for healthcare, and the employees themselves could roll over that money and accumulate it over a period of time? Has this type of plan been discussed where the employee would actually benefit from contributions from the employer as well as perhaps their own contributions to accumulate some healthcare savings that they could take to retirement? Has that been discussed, and is that of any interest to the Ford Company?

Dr. Kerr. It is early in the discussions of that type of plan. Some of the interest is in the form of questions that surface early on such as what would be the ultimate responsibility of the employee, what would the magnitude of that be, and how would it impact the current benefit coverage they have? These are issues that are very thorny but would need to be worked through to have that kind of plan accepted.

Mr. DeMint. Mr. Schieber, do you have some comments on that?

Mr. Schieber. Some employers are already beginning to create the equivalent of an individual account. It is more a notional account than a real account because of the funding issues that they face. But a theoretical contribution is made to this account for each year of service that the worker is employed, and then some additional interest is credited to that account. The account can then be used during retirement to help pay the premiums or the costs associated with utilizing healthcare. Some of it is going on already in spite of the hurdles that employers are facing. I think it is certainly a potential option that many more would look at if there were the possibility of creating real accounts and letting workers truly accumulate an asset.

Mr. DeMint. And I want to clarify that I am not talking about employers dropping insurance but perhaps raising the level and helping the employee to have the money necessary to do the

shopping.

Mr. Schieber. And I agree. I think that is vital.

Mr. DeMint. I believe another benefit of that type of plan, instead of mandating that employers cover every malady, whether it be mental health, diabetes, whatever, is that there would be money available for the employee to make choices based on their own need, again within the safety net coverage that could be provided while working as well as in retirement.

Any other comments on what I think are variations on a defined contribution plan? Dr. Kerr?

Dr. Kerr. We actually have begun to employ that for new salaried hires looking forward to their retirement. If you join Ford Motor Company after June 1, 2001 a year ago, the benefit that is provided currently is a window of time to begin to accumulate that asset. You know when you come in that that is an expectation; as opposed to having it imposed in short order before retirement. In retirement, the commitment for the employee and for the dependents that they may have is limited by percentage. That change in benefit is actually in place.

Mr. DeMint. That is good.

Yes, sir?

Mr. Mittelstaedt. I would just add that some things that I have read state that some employers would like to do more defined contributions style plans, but from what I understand it is unclear exactly how the employees would be taxed unless they are very careful with the design of that plan. So it should be made clearer about what happens.

The other thing that I would add is I think any program has to include more education for employees about retirement planning. And part of this goes back to what Mr. Andrews said earlier. People in the steel industry made a lot of money, cash wage. But now at the time when they are retiring, they don't have any money for retirement. Now I think with some education, they could have saved more on their own for the possibility that steel may not have had the money to pay.

Mr. DeMint. Thank you. I think I am out of time.

Chairman Johnson. The gentleman's time has expired.

I recognize the gentleman from Massachusetts, Mr. Tierney.

Mr. Tierney. Thank you, Mr. Chairman. Let me ask the members of the panel, first of all, when the Financial Accounting Standards Board concluded its statement for 106, one of its statements was that "post-retirement benefits are not gratuities but are part of an employee's compensation for services rendered. Since payment is deferred, the benefits are a type of deferred compensation."

Are we all in agreement on that?

Ms. Novotny. It is a real benefit.

Mr. Schieber. If you are going to operate this plan on an ongoing basis, certainly that is correct.

Mr. Tierney. Well, we have been doing it on an ongoing basis, have we not?

Mr. Schieber. Well, some companies haven't, because it is not a contractual obligation.

Mr. Tierney. Let me narrow it down. With respect to those companies that have, a great number of them have now decided that they are either going to reduce the coverage or eliminate the coverage for people. And my question to you is in those instances where this is in essence a form of deferred compensation, people have earned this, and now they retire and they find the landscape changing on them, why should that employee, or more likely if they can't do it, the taxpayer, start assuming the burden that the company had willingly obligated itself as a matter long ago?

Mr. Schieber. Your question is why should the taxpayers assume that obligation?

Mr. Tierney. Well, the employee but ultimately a lot of these employees can't, so they end up needing help.

Mr. Schieber. Well, the problem is the nature of the tax law.

Mr. Tierney. I am not even talking taxes here. I am talking a company has a deferred compensation here. They have agreed to pay these people in the form of deferred compensation by way of health benefits. Now, they want to break that promise. So now they are turning around, they are reducing their coverage or they are eliminating it, which means either that employee has to go out and get coverage or they have to go for some sort of government assistance. Explain to me if you would the legal or moral case in that matter?

Mr. Schieber. The economic reality is that it is not deferred compensation, because part of their compensation has not been laid away to be paid to them later.

Mr. Tierney. Well, that is the company's choice if they didn't do that, right?

Mr. Schieber. No, they are effectively precluded under the tax law from laying that away.

Mr. Tierney. The tax law says you cannot put money aside for a rainy day?

Mr. Schieber. If you put that money aside, you do not get a tax deduction and you pay a special business tax on what you accumulate.

Mr. Tierney. But this is the deal they made, isn't it?

Mr. Schieber. The problem is that the people that are now being called upon to fill that deal are not the same people that made the deal.

Mr. Tierney. Even though they are in the same company.

Mr. Schieber. No, they are not necessarily in the same company.

Mr. Tierney. Oh, a succeeding company, whatever.

Mr. Schieber. But let's look at the case of the steel industry, which is part of the reason this has all come to a head.

Mr. Tierney. Excuse me a second, I have only got a limited time here, so let me choose the examples we use. Let's not use the steel industry, let's use one of the other companies that have decided to eliminate their coverage, or that have changed the terms of it. The company plan not the steel industry but another company, like a Sears or somebody like that.

Mr. Schieber. Which has faced its own tremendous competitive pressures and its own reorganization requirements because of what has been imposed upon it in the marketplace.

Mr. Tierney. So the free market didn't work in their favor with respect to this and now they want to push it off onto others, is that what you are telling me?

Mr. Schieber. What I am saying is that you cannot expect someone today to make a commitment that a totally different group of people will necessarily fulfill 20 or 30 years down the road.

Mr. Tierney. Well, wait a minute; we are talking about corporations here. So technically we are talking about the same person. This corporation, this company had made a promise to these people, and nothing has changed.

Mr. Schieber. As I said in my testimony, if you look at the 1972 Fortune 50 list, there are only 21 left today as freestanding entities. All of the rest of them have either gone out of business, they have been assumed by some other entity, several of them have gone bankrupt. Some of them are right now in their second bankruptcy since 1972.

Mr. Tierney. With respect to companies that aren't in bankruptcy, companies that are still profitable, many of those companies are still reducing their retiree health coverage or eliminating it. What is the case morally or legally for them to be walking away from that obligation?

Mr. Schieber. It is an extremely regrettable circumstance.

Mr. Tierney. All right, let me move on. Does anybody else agree with the regrettable circumstances of companies that walk away from their moral obligation?

Mr. Mittelstaedt. May I answer that?

Mr. Tierney. Well, first Ms. Novotny, she was next.

Ms. Novotny. Thank you. I guess I am not quite tracking with your concern. What I see with the employers that we have negotiated with are employers that were playing by the rules when they made the promise and then the rules changed on them. And we negotiated under those same rules and struggled then to figure out how to maintain the promise in spite of the change of the rules. And I think that I have to commend both the unions and the companies with whom we bargain over trying to maintain this important benefit and recognizing the importance of it to the retirees on an individual basis.

Mr. Tierney. But, Ms. Novotny, there are some unions that weren't even allowed to negotiate for health benefits or have the legal authority to uphold, bargain for agreements for this. There are some court cases that allow the companies to walk away from their responsibilities, even though the union's case was that they had bargained for the continuation of these benefits in good faith. So not everybody is represented by the union and not everybody has been lucky enough to maintain them.

Ms. Novotny. Absolutely. But then I would say that is the help that is required. Once the rules changed about how companies could pay for it and the impact that payment would have on their balance statements, then we do need some help in figuring out a new landscape.

Mr. Tierney. Well, not just help for a landscape. These companies are looking to shift the burden, right?

Ms. Novotny. Well, is that the question then? There is the large question about the right to healthcare, I suppose, and some of us are saying that that is a right and we should help figure these burdens out, how to ease these burdens.

Mr. Tierney. Thank you.

Chairman Johnson. Mr. Mittelstaedt, do you want to respond to that question?

Mr. Mittelstaedt. Just briefly.

From a legal standpoint, most of the firms that are changing these plans had terms in their agreement that said that they had the right to modify. So this is a strange type of contract that says we can change it at any time.

Mr. Tierney. That is why I phrased it as both moral and legal. They have walked away and found the right to amend their contracts or to eliminate them. The problem is there are still a number of people who got deferred compensation promised to them that now aren't getting it. And the companies are saying we are not going to live up to that obligation. Take your choice, the employee, or if they can't afford it, the taxpayers. But it is another case of shifting responsibilities from corporations and companies onto individuals like we have with the 401(k) that I am fearful to hear my colleague suggesting that they want to do to healthcare benefits the same thing they did with retirement benefits, because all the research on that indicates that the 401(k) has not improved

people's retirement situation appreciably. And I think that is what you are going to find out in this instance.

Mr. Mittelstaedt. Well, I think from a moral standpoint, though, you have got these trade-offs between the current workers and retirees staying in business versus not staying in business. And if the choice is driving a firm into bankruptcy because you don't cut these benefits, then I am not sure that is the best solution, either.

Mr. Tierney. But when the choice is not that, when you have a profitable corporation that does this to move the bottom line that is where the moral question comes in.

Mr. Mittelstaedt. I think it is a continuum. It is not that easy, bankrupt, not bankrupt. It is do we stay on this track or we do go into bankruptcy.

Mr. Tierney. This is where it is pretty clear.

Chairman Johnson. I think we can all agree that employers who are offering retiree health benefits are doing the right thing and ought to be commended.

Mr. Tierney. What about the ones that are discontinuing, what would you say about them, Mr. Chairman?

Chairman Johnson. This hearing is intended to investigate the reasons why employers are finding it difficult to continue offering retiree health benefits.

Mr. Tierney. Always enlightening.

Chairman Johnson. I think our best approach, and you probably agree with me, Mr. Tierney, is to work together as a Committee to find ways to make it easier for employers to offer those benefits and make sure that employees have the resources they need after they retire.

Mr. Tierney. Well, I guess the question is, again, with respect to this, is it the taxpayers' resources that we are going to be going into, or are there other resources for people that are profitable?

Chairman Johnson. No, but there are tax benefits that can be given to companies that they are not now getting. Also some of the laws and regulations that are on the books are causing them problems, too. As far as health benefits are concerned, the President is trying to focus on those who have nothing so that we can take care of them first.

Sir?

Mr. Tierney. Compassionate as always.

Chairman Johnson. That is right.

Mr. Tierney. I got a new bridge to sell you.

Chairman Johnson. The Chair recognizes Mr. Tiberi.

Mr. Tiberi. Thank you, Mr. Chairman.

Mr. Schieber, you were beginning to answer Mr. Tierney's question regarding steel workers and you weren't able to finish part of that answer. I just was curious as to how you were going to answer that.

Mr. Schieber. Well, the fact of the matter is that these commitments were made at a point in time where the management in the steel firms could not have begun to understand the evolution of the economy and the environment they were going to be working in. I think they committed themselves to providing these benefits in good faith, but the environment has changed, and now they are facing the prospect in some cases that these liabilities, these obligations, actually do mean bankruptcy. And it is not clear to me that this straightforward moral case is so easily made. It is regrettable.

Now, when they made the promise and when people were actually accruing the benefit, if a portion of compensation had actually been put away, actually truly been deferred, there would be resources here to pay for these people's healthcare right now and these companies could go about doing their business in the very competitive environment they are in. And the obligations would not necessarily bankrupt them and put all their current workers out of a job.

Mr. Tiberi. In your written testimony, you suggest that giving consumers the ability to have some financial stake in their choices would stem the rapid growth of healthcare costs. Can you give some examples to that?

Mr. Schieber. Well, first of all, let me draw an analogy. Today when we go to the grocery store, if the price of steak is rising, at some juncture we start buying chicken instead of steak. Now, we have got a lot of options in our healthcare sector that people aren't provided with; the opportunity to look at buying chicken instead of buying steak. And what we have done in many cases is we have put a fee on getting into the grocery store. We have raised the premiums for these plans but not given people any sensitivity to what it is they are actually consuming.

I think if we went to more of a catastrophic health insurance program, where people paid for the first part of their consumption, then they would be making some price-sensitive decisions. And they probably would not buy some of the things they now buy.

I don't know if any of you watch the evening national news. But on all these stations, we are hearing one advertisement after another for the next new drug that is out. And in about half of these advertisements, they don't even tell us what the drug is for. You watch the Nexium commercials. They don't even tell us what it is for. You are supposed to go ask your doctor to prescribe Nexium.

Well, we have set up a situation where people are not at all sensitive about what it is they need and what these things cost. And I think we need to put some of that sensitivity into the system.

Mr. Tiberi. Dr. Kerr, you suggest that unfunded or unlimited liability, as well as mandating healthcare benefits, adversely impacts retirees' healthcare before anyone else's. Why is that?

Dr. Kerr. The comments were specifically addressed to retiree health. And to the extent that there are mandates and obligations, you deprive both the employees and the employer of the flexibility to adapt to a changing market and changing circumstances. And I say both because we have seen both in markets where Medicare plus choice has eroded or where employees want the choice of having a managed care plan and are willing to make concessions in terms of increased co-pays or contributions to maintain the plan to make it viable. If you mandate a prescriptive set of benefits, coverage, or even the financing mechanism you remove that flexibility.

Mr. Tiberi. Thank you.

Mr. Chairman, I yield back.

Chairman Johnson. The Chair recognizes Mr. Wilson from South Carolina.

Mr. Wilson. Thank you, Mr. Chairman. Professor Mittelstaedt, a comment was made a minute ago that 401(k)'s didn't seem to be very significant, but I was only elected in December so I have come here from the private sector, a medium-sized real estate law firm. And 401(k)'s were phenomenally important with persons that I associated with. From your background, what do you feel? I know it doesn't directly relate, but aren't 401(k)'s very significant to the American prospective retiree?

Mr. Mittelstaedt. I think the concern with 401(k)'s is that not everyone participates in them, especially lower-paid workers, and so the concern is that you don't have the coverage that you would get under a traditional plan, either a defined benefit plan or a money purchase defined contribution plan. The other issue is that in a 401(k) plan the employee is bearing the investment risk instead of the firm. So I think those are the issues with the 401(k)'s.

Mr. Wilson. Well, they certainly aren't widely participated in and I believe they have trillions of dollars of assets?

Mr. Mittelstaedt. Yes, I would say that they aren't. I would say that they are decent retiree benefit plans or they are decent pension plans. They just aren't as good from an employee standpoint or may not be as good from an employee standpoint as a money purchase defined contribution plan or defined benefit plan. So, again, it is a kind of continuum thing; it is better than no retirement.

Mr. Wilson. But is it particularly helpful for small business?

Mr. Mittelstaedt. Yes.

Mr. Wilson. Mr. Kerr, you mentioned that the domestic auto industry is facing an extremely competitive international market. How do retiree medical costs impact American auto companies? And are your international competitors grappling with these issues as well?

Dr. Kerr. I will start with the second part of your question first, and the answer is international competitors are not grappling with those same issues by nature of the companies in which they operate and the retirement systems which their employees benefit from as a result. If you look at our retiree costs and try to append that to each automobile sold, it accounts for about $400 of the price in an automobile versus a competitor.

Mr. Wilson. In fact, in our state we have been very successful with BMW. And actually we were competitive with Germany because we did have a more flexible retirement system and healthcare system. And so I think we do all that we can to make it competitive so that we can continue to compete and bring phenomenal investments to our states.

I have no further questions, Mr. Chairman.

Chairman Johnson. Mr. Schieber, did you have a comment you wanted to make?

Mr. Schieber. I would like to respond to this issue on 401(k)'s.

Chairman Johnson. Okay, good.

Mr. Schieber. There are three professors, Steven Venti at Dartmouth, David Wise at Harvard, and James Poterba at MIT, who have recently written a paper that you can get from the National Bureau of Economic Research. It is on their website. They have looked at the evolution of the 401(k) system. Where these plans are offered, about 70 to 80 percent of workers take them up. The average contribution going into them today is between 8 and 9 percent of pay. Their projection, given the evolution of this system, is that by 2030 the 401(k) system will be paying out more in retirement benefits than our Social Security system as constructed under current law. By that time, our Social Security benefits will be costing between 15 and 16 percent of payroll.

So here will be a system at the half-life of Social Security that will be paying out as much as Social Security on a totally voluntary basis. Not one person has been coerced to put a dime in the 401(k) system. Now this contrived notion that these are not valuable retirement benefits is really a falsification of what is going on, and the public shouldn't stand for it.

Chairman Johnson. Yes, the only problem with 401(k)'s is the government cannot guarantee the stock market. You know that.

Mr. Schieber. There is no doubt about that. These are not absolutely perfect. But they are a dickens of a lot better than nothing.

Chairman Johnson. No kidding, you are right.

Mr. Andrews. I just wanted to ask the panelists if they would consider submitting a written answer to this question, because we need to get to the floor for welfare reform. I am interested in the views of the panelists on a proposal that would permit employers to take pre-funded healthcare costs for retirees, place them into an actual trust fund so the money would be dedicated to healthcare for retirees, could not be used for anything else and could be preserved from bankruptcy and what have you. And then making that fully tax deductible as compensation. I would be interested in what the panelists would think about that as an idea.

Mr. Schieber. That is what I support in my testimony.

Chairman Johnson. Yes, sir. This has really been an expert panel, and I thank you all for being here.

Mr. Wilson, you were finished, were you not?

Mr. Wilson. Yes, sir.

Chairman Johnson. Thank you.

Mr. Wilson. Thank you, Mr. Chairman.

Chairman Johnson. We appreciate you all being here, and I thank the witnesses for their valuable time and testimony and the Members for participating. And if there is no further business, then the Committee stands adjourned.

Whereupon, at 12:04 p.m., the Subcommittee was adjourned.

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

OPENING STATEMENT OF REP. SAM JOHNSON (R-TX), CHAIRMAN

SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS

May16, 2002

GOOD MORNING. LET ME EXTEND A WARM WELCOME TO ALL OF YOU, TO THE RANKING MEMBER, MR. ANDREWS, AND TO MY OTHER COLLEAGUES.

TODAY'S HEARING FOCUSES ON RETIREE HEALTH LEGACY COSTS AND WHETHER OR NOT AMERICA WILL BE PREPARED FOR A HEALTHY RETIREMENT.

THIS IS OUR SECOND HEARING ON RETIREE HEALTH CARE. IN OUR FIRST HEARING WE HEARD TESTIMONY ABOUT HOW RETIREES ARE LESS AND LESS LIKELY TO HAVE ACCESS TO EMPLOYER –SPONSORED RETIREE HEALTH CARE.

IN FACT, ONLY 35 PERCENT OF EMPLOYERS STILL OFFER THIS BENEFIT.

WHAT DOES THIS MEAN FOR RETIREES?

CLEARLY, MANY RETIREES WILL NOT BE ABLE TO RELY ON AN EMPLOYER-PROVIDED PLAN.

INSTEAD, RETIREES MUST BEGIN TO PREPARE FOR THEIR OWN HEALTHY RETIREMENT – MUCH AS TODAY'S WORKERS SAVE THEIR OWN MONEY IN A 401(K) ACCOUNT FOR THEIR FUTURE PENSION NEEDS.

TODAY'S HEARING WILL HELP DETERMINE WHY EMPLOYERS ARE MAKING CHANGES TO THEIR RETIREE HEALTH BENEFITS.

WE'LL HEAR A DISCUSSION OF THE RETIREE HEALTH OBLIGATIONS, ALSO KNOWN AS "LEGACY COSTS," OF A BROAD CROSS-SECTION OF INDUSTRIES, AS WELL AS THE FACTORS THAT INFLUENCE EMPLOYERS' DECISIONS TO REDUCE OR ELIMINATE RETIREE HEALTH BENEFITS.

WE'LL ALSO HEAR ABOUT THE EXPERIENCE OF FORD MOTOR

COMPANY AND HOW THEY ARE ABLE TO BALANCE THE GROWING FINANCIAL OBLIGATIONS OF RETIREE HEALTH BENEFITS WITH THE NEEDS OF THEIR EMPLOYEES DURING RETIREMENT.

EMPLOYERS VOLUNTARILY PROVIDE HEALTH CARE FOR WORKERS AND FOR RETIREES.

UNFORTUNATELY, THE RISING COST OF COVERAGE AND THE RETIREMENT OF BABY BOOMERS MAKE IT DIFFICULT FOR EMPLOYERS TO PROVIDE THESE BENEFITS.

ANOTHER OBSTACLE EMPLOYERS FACE IN PROVIDING HEALTH CARE FOR RETIREES IS THAT, UNLIKE THE PENSION SYSTEM, CURRENT LAW SEVERELY DISCOURAGES EMPLOYERS' ABILITY TO PRE-FUND RETIREE HEALTH CARE.

INCREASINGLY, EMPLOYERS WHO OFFER RETIREE HEALTH BENEFITS FIND THEMSELVES AT A FINANCIAL DISADVANTAGE WITH COMPETITORS WHO DO NOT OFFER THIS BENEFIT.

THOSE COMPANIES THAT CONTINUE TO OFFER RETIREE HEALTH BENEFITS ARE ADOPTING INNOVATIVE CHANGES TO BALANCE THE COST OF RETIREE HEALTH OBLIGATIONS WITH THEIR DESIRE TO PROVIDE THIS BENEFIT TO EMPLOYEES.

AS YOU KNOW, THE STEEL INDUSTRY HAS AN ENORMOUS RETIREE HEALTH LEGACY COST.

HOWEVER, RETIREE HEALTH LEGACY COSTS ARE SPREAD ACROSS MANY INDUSTRIES AND I WOULD LIKE TO DRAW YOUR ATTENTION TO THE CHART WE HAVE DISPLAYED WITH THE TOP TWENTY RETIREE HEALTH LEGACY COSTS OF TODAY'S FORTUNE 500 COMPANIES.

FOR EXAMPLE, SBC COMMUNICATIONS ANTICIPATES $20.1 BILLION IN LEGACY COSTS -- BELL SOUTH $ 6.3 BILLION, AND LOCKHEED $3.1 BILLION. THAT'S A LOT OF MONEY – EVEN FOR A BUNCH OF TEXANS.

EMPLOYEES OF ALL SECTORS ARE FACING THE GROWING INEVITABILITY THAT THEY WILL HAVE TO SHOULDER A LARGER AMOUNT OF THE COST OF THEIR HEALTH CARE IN RETIREMENT.

RATHER THAN RIFLE-SHOT REMEDIES FOR SPECIFIC INDUSTRIES, WE SHOULD FOCUS ON ALL INDUSTRIES.

THE NEXT HEARING IN OUR RETIREE HEALTH SERIES WILL INVESTIGATE WAYS THAT GOVERNMENT POLICY CAN MAKE IT

EASIER FOR EMPLOYERS OF ALL INDUSTRIES TO OFFER RETIREE HEALTH CARE.

IN ADDITION, THE SUBCOMMITTEE WILL CONTINUE TO STUDY HOW TO BETTER PREPARE WORKERS FOR THEIR ROLE IN ENSURING THEIR OWN HEALTHY RETIREMENT.

RETIREE HEALTH IS SERIOUS BUSINESS.

OUR NATION'S RETIREES NEED OUR HELP IN ORDER TO ENSURE THAT THEY WILL HAVE THE RESOURCES THEY NEED WHEN THEY RETIRE.

I LOOK FORWARD TO WORKING WITH MY COLLEAGUES ON THE SUBCOMMITTEE AS WE EXAMINE THIS ISSUE.

APPENDIX B - STATEMENT OF SYLVESTER J. SCHIEBER, Ph.D., VICE PRESIDENT FOR RESEARCH AND INFORMATION, WATSON WYATT WORLDWIDE, WASHINGTON, D.C.

Assessing Retiree Health Legacy Costs:

Is America Prepared for a Healthy Retirement?

Testimony by:

Sylvester J. Schieber, Ph.D.
Vice President
Watson Wyatt Worldwide

Before the:

Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
U.S. House of Representatives

May 16, 2002

The conclusions and opinions expressed in this testimony are the author's and should not be attributed to Watson Wyatt Worldwide or any of its other associates. Gordon Goodfellow, Roland McDevitt, and Janemarie Mulvey of Watson Wyatt Worldwide provided valuable input in preparing the analysis presented here.

Introduction

Mr. Chairman and members of the Subcommittee on Employer-Employee Relations, I am presenting testimony on the evolving state of employer-sponsored retiree health benefits in the United States. The testimony that I present here is my own. The opinions I state and the conclusions I draw should not be attributed to any other persons or organizations with whom I am associated.

Traditionally, employers have served as the primary source of health insurance coverage for early retirees, as well as playing an important role in supplementing Medicare benefits for eligible retirees. But in recent years many employers have been cutting back their retiree health benefit programs; some have eliminated them altogether. As we look to the future, there are strong indications that the trend away from employer-provided retiree health benefits will continue, leaving retirees and the government to divide up the increasingly expensive health care bill.

There are several factors behind employer cutbacks of retiree health benefits. For many employers, maintaining early levels of retiree health benefits has been more than they bargained for, given the combination of generous benefits, steadily increasing utilization rates, rapidly escalating costs of health services for retirees, growing retiree populations, and uncertain business growth and profitability. Employers still offering retiree health benefits today will face these same conditions and risks in the future, which will strongly influence the generosity of their programs and even whether they continue to offer them at all.

My assessment of the future evolution of retiree health benefits in this country is relatively dire. I believe the benefits provided to future retirees will be significantly less

generous than those current retirees receive today. Many employees will have to delay retirement and are likely to receive lower benefits as well. Given the extent to which retirees depend on employer-provided health benefits, I do not believe this evolutionary path will serve the interest of employees, employers or the public.

Employers Move to Provide Retiree Health Insurance

Employer-provided health benefits for retirees evolved mostly without "design or intent" as a result of collective bargaining over benefits during the 1950s and 1960s. Early on, relatively few retirees collected benefits from these plans, and the low cost of providing the benefits on a pay-as-you-go basis made them virtually a "throwaway" in negotiations.[1] By 1962, 21 percent of the post-65 population was enrolled in an employer-sponsored health benefit plan.[2]

The enactment of Medicare in 1965 saved these employer-sponsored plans money, because Medicare became the primary payer for retirees once they reached age 65, with employer-sponsored plans paying only those costs not reimbursed by Medicare. Lawrence Atkins argues that employers adopted these benefits "because they needed them to make their retirement packages work, because they helped in collective bargaining, because they were attractive to labor in competitive labor markets, and because the costs were rarely significant." He notes that there were so few retirees back

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[1] G. Lawrence Atkins, "The Employer Role in Financing Health Care for Retirees," in Judith F. Mazo, Anna M. Rappaport and Sylvester J. Schieber, eds., ***Providing Health Care Benefits in Retirement*** (Philadelphia: University of Pennsylvania Press and the Pension Research Council, 1994), p. 108.

[2] Dorothy P. Rice, "Health Insurance Coverage of the Aged and Their Hospital Utilization in 1962: Findings of the 1963 Survey of the Aged," ***Social Security Bulletin***, Vol. 27. No. 7, p. 9.

then that they were often simply kept on the active employee plan. The supplemental packages furnished by employers provided insurance coverage with very low out-of-pocket costs for retirees.

Subsequent legislation also played a role in the growing popularity of retiree medical benefits. First, the 1967 Age Discrimination in Employment Act and a series of other laws prohibited age discrimination against employees over age 40. Employers that dismissed older employees without showing cause did so at the risk of litigation. It was safer to encourage older employees to leave voluntarily by offering attractive retirement packages, including generous retiree medical benefits.

The second legislative development was the Employee Retirement Income Security Act (ERISA) of 1974, which effectively removed medium and large employer-sponsored health plans from the regulatory and taxing authority of states. Employers that elected to self-insure rather than purchase insurance could define their own benefits provisions without regard to state insurance regulations, which varied from state to state. Self-insured plans also avoided the premium taxes levied on commercial plans. Large employers increasingly opted to self-insure both their active and retired populations, and were able to realize considerable savings by doing so.

The period from the mid-1970s to the early 1980s was one of considerable economic reorientation, which included the loss of many jobs in old-line firms and industries. It was also when the baby boomers were entering the workforce in record numbers. These younger employees often were more highly educated than their older counterparts and were willing to work for much lower wages. These conditions prompted many employers to pursue policies aimed at retiring older employees. For companies

with established retirement plans, one means of the restructuring was the aggressive use of early retirement incentives, including retiree health benefits.[3] By the beginning of the 1980s, nearly 86 percent of medium and large employers were offering active employees some sort of retiree health benefit coverage.[4]

Increasing Retiree Health Costs and Changing Perspectives

When policymakers created the Medicare program in the mid-1960s there were two elements of thinking that prevailed. The first was that the rate of increase in health care costs per capita would grow at roughly the rate of growth of wages in the U.S. economy[5] and that there would be an ever-growing supply of workers that would support growing numbers of retirees in the future.[6] The same conventional wisdom that prevailed in the development of public policy also affected the thinking of managers in the employer sector of the economy. The reality proved to be otherwise.

The ratio of active employees to retirees in defined benefit plans declined from 4.7 in the mid-1970s to 2.5 in the mid-1980s.[7] Today, it is not uncommon among older more mature companies, especially in the manufacturing sector, that the number of

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

[4] Source: Watson Wyatt, *Group Benefits Survey* (1980).

[5] *1967 Annual Report of the Board of Trustees of the Hospital Insurance Trust Fund.*

[6] Paul Samuelson, "Social Security," *Newsweek* (February 12, 1967). Reprinted in *The Samuelson Sampler* (Glen Ridge, NJ: Thomas Horton, 1973) pp. 146-148.

[7] Private Pension Plan Bulletin, Abstract of 1993 Form 5500 Annual Reports, No. 6, winter 1987.

retirees exceeds the number of active workers still employed by the company. This falling ratio of employees to retirees was particularly significant for retiree medical plans, because these benefits were paid almost entirely on a pay-as-you-go basis, out of profits earned by current employees. More retirees drawing benefits meant that costs would rise relative to other current personnel costs — even if other factors were not exacerbating the phenomenon. But in fact other factors were exacerbating the cost of retiree benefits.

Figure 1 shows the annualized rates of growth in gross domestic product (GDP) per capita and medical expenditures per capita for the decades from 1960 through 2000. On a decade-by-decade basis, the growth in medical expenditures has consistently outpaced the growth in GDP over the last 40 years. Over the same period, total compensation costs have been a relatively constant share of GDP, which means they have grown at essentially the same rate over the years. The expectation that medical costs would grow at the same rate as wages has proven to be wrong.

Figure 1 decomposes the per-capita medical expenditure growth rates for each of the last four decades into three components: general price inflation, medical price inflation in excess of general inflation, and utilization/technology. General inflation and medical care inflation are calculated from the price indices published by the Bureau of Labor Statistics. The utilization/technology component is the residual that remains after removing the two elements of price inflation. It reflects the extent to which the total increase in health expenditures relates to the more intensive delivery of existing health services and the creation and delivery of new health goods and services.[8]

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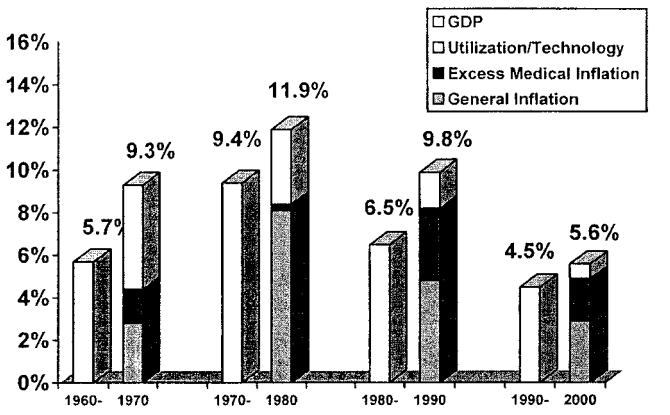
[8] This latter measure actually understates the role of technology because some portion of excess medical price inflation reflects technology enhancements to existing products and services provided in the health sector. While the Bureau of Labor Statistics attempts to measure the price

Figure 1: Compound Annual Growth Rates by Decade in Per Capita GDP and Medical Expenditures for the U.S. Population from 1960 to 2000



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

Price inflation, including general inflation and excess medical inflation, comprised approximately 50 to 90 percent of the medical expenditure growth rate for each decade. All decades experienced at least some medical price inflation in excess of general inflation, ranging from 3 percent of overall medical growth in the 1970s to over one-third in the 1980s and 1990s. The utilization/technology component of medical expenditure growth accounted for 10 to 50 percent of the total growth in expenditures during these decades.

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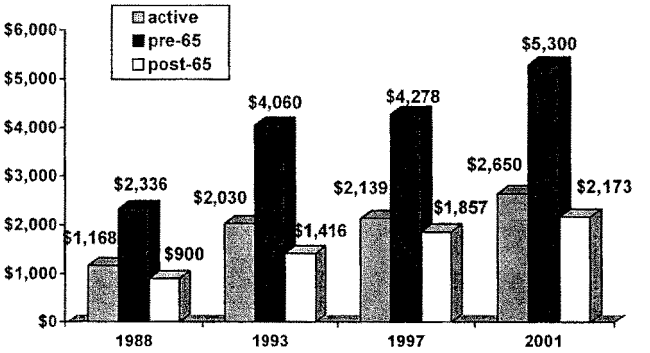
changes for a fixed market basket of goods over time, it is not uncommon for elements of the market basket to experience technological improvements, much as new automobiles are improved over time. To the extent that technology enhances the quality of a product so as to increase its price, the price increase reflects the imbedded improvement rather than price inflation.

In addition to overall medical cost increases, retiree medical plans face the higher costs of an aged population and the challenges of coordinating employer-sponsored benefits with Medicare. Figure 2 displays medical plan premiums for active employees and retirees for select years from 1988 to 2001, and shows that premiums for both active employees and retirees rose rapidly throughout this period. The average post-65 retiree premium of $900 in 1988 grew to $2,173 in 2001, while the average premium for active employees grew from $1,168 to $2,650 — premiums for both groups grew at an annual rate of about 7 percent. While growth rates for premiums increased at similar rates for the three groups, Figure 2 highlights another problem with employer-sponsored retiree health insurance. Since the base premium was so much higher for early retirees than for active employees in 1988, the same rate of growth more than doubled the absolute cost of health insurance for early retirees compared to those still employed.

By the late 1970s or early 1980s, employers were painfully aware that health costs were rising rapidly and resistant to control, and many believed the government was shifting health costs to employer-sponsored plans. By the early 1980s, employers began actively trying to rein in costs. For active employees, employers began offering flexible benefit options intended to encourage them and their dependents to become efficient consumers of care. Ultimately the path of health care cost control led to managed care, which does not appear to be the final stop in the evolution of the health financing and delivery system in this country. For retirees, changes to employer-sponsored benefits appeared to occur at a slower pace, although the perceived need for change was brought into more glaring view than for active employees.

Figure 2: Medical Plan Premiums for Single Employees and Retirees for Selected Years



Sources: The Wyatt Company, 1988 Group Benefits Survey: A Survey of Group Benefit Plans Covering Salaried Employees of U.S. Employers (1988); Health Insurance Association of America. Source Book of Health Insurance Data (1989); KPMG Peat Marwick. Health Benefits in 1993 (1993); KPMG Peat Marwick. *Retiree Health Benefits: The Uncertainty Continues* (1994); Watson Wyatt Data Services. *The ECS Survey Report on Employee Benefits 1998/99* (1998); and Watson Wyatt Data Services. *ECS Survey Report on Employee Benefits 2001/2002* (2001).

NOTE: Premiums for pre-65 retirees are actuarial estimates. The pre-65 retiree premiums reported in benefit surveys do not represent the true cost of these plans because some employers include these early retirees in their plans for active employees, and do not calculate a separate age-rated premium for the retirees. Consequently, benefit surveys obtain an unknown mix of premiums, with some representing the cost experience of retirees and others not. Watson Wyatt's actuarial estimates indicate that early retiree premiums cost more than those for single employee coverage by a factor of two.

Regulatory Schizophrenia Exacerbates Employers' Problems

For fiscal years beginning after December 15, 1992, the Financial Accounting Standards Board (FASB) required that employers estimate and report future obligations associated with retiree health benefit programs on their financial statements. The rationale was that retiree medical benefits are a form of deferred compensation for current employees. So if an employer is going to offer these benefits to employees in

trade for their work, the obligation of paying for them down the line has to be recognized at the time the worker hands over the goods.

FAS 106 played an important role in reducing employers' willingness to offer retiree health coverage to active employees, but it did not take employers by surprise, and much of its impact occurred before the final implementation. FASB put retiree health liabilities on its agenda in 1979.[9] In 1984, FAS 81 required employer's financial statements to report either the current cost of retiree welfare benefits or the unfunded liability if the amounts were distinguishable from the benefit costs for active employees.

FAS 81 raised employer awareness about unfunded liabilities, and their magnitude was illuminated by a number of well-publicized studies. In 1988, the Government Accounting Office (GAO) estimated that these liabilities represented 8 percent of the value of companies' stock.[10] Another study estimated that the annual costs of amortizing these retiree medical liabilities could run as high as 12 percent of payroll, or 10 times the current rate of pay-as-you-go spending.[11] By this time, most employers were aware that unfunded retiree medical liabilities would be quite large and could adversely affect stock prices.

The implications of accruing obligations for employer-sponsored retirement plans and how to deal with them has been understood for many decades. In a history of the evolution of employer pensions in the United States, Steven Sass wrote about the

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[9] Cited in Chollet, Deborah. 1989."Retiree Health Insurance Benefits: Trends and Issues," *Retiree Health Benefits: What is the Promise?* Employee Benefit Research Institute.

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

[11] "Retiree Health Benefits Total 12% of Payroll." *Investor's Daily*. February 2, 1988, p. 9.

"science of reform" that swept the pension movement in this country in the 1920s. He says the scientific experts of the time understood the importance of eliminating the uncertainty of risk for both employees and plan sponsors. They concluded that the benefits paid under retirement plans had to be expensed "in conjunction with the employer's receipt of productive labor services." But the second condition for the soundness of a plan was that money must be laid aside to cover obligations as they are earned.[12] As FASB moved to require accounting for retiree health obligations, it was enacting the first principle underlying secure retirement benefits, which Sass tells us has been well known since at least the 1920s.

But while the accounting rules for retiree health plans were being tightened, Congress enacted significant restrictions on employers' ability to fund welfare benefit plans. The funding restrictions in the Deficit Reduction Act of 1984 (DEFRA) were prompted by concerns that funded plans could be used to shelter significant income. The legislative history also referenced discussion of potential abuses in the use of welfare plan assets, such as the acquisition of ski chalets or yachts.

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

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[12] Steven A. Sass, *The Promise of Private Pensions* (Cambridge: Harvard University Press, 1997), p. 62.

employer's deductible contribution, and imposed a 100 percent excise tax on any assets reverting to the employer from a funded welfare benefit plan.[13] The first condition of secure retiree health benefits was put in place by accounting regulations but the second condition was trumped by legal restrictions.

The Omnibus Budget and Reconciliation Act (OBRA) of 1989 further restricted retiree medical funding. Before OBRA, the IRS had allowed 401(h) contributions up to 25 percent of the pension plan's cost, including the normal or actuarial cost of providing pension benefits to participants.[14] OBRA 89 limited employer 401(h) contributions to 25 percent of all employer contributions to the pension plan. This meant that employers with well-funded pension plans could no longer contribute to the 401(h) account.

OBRA 90, section 420 permitted limited transfers of excess defined benefit plan assets into 401(h) accounts. The transferred assets could be used only to pay qualified current retiree health liabilities for the tax year of the transfer. The effect of these legal restrictions has been to eliminate any tax-preferred means of funding the health care liabilities of future retirees. The vehicles that do exist are largely for current retirees, they limit contributions, and they do not account for growing utilization and medical inflation.[15]

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

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

[15] In addition to the use of 401(h) accounts, there has been increased use of life insurance products such as Corporate Owned Life Insurance (COLI) and Trust Owned Life Insurance (TOLI). These informal funding vehicles allow firms to invest in cash-value life insurance on a relatively large group of active and

FAS 106 accounting for retiree medical benefits has provided better information to investors and other interested parties concerning future obligations. More importantly, it has prompted corporate executives to closely examine the magnitude of their commitments in sponsoring retiree health benefit plans. The FAS 106 liabilities reported on the most recent set of annual filings with the Security and Exchange Commission show these liabilities to be significant, actually exceeding the market or asset value of the plan sponsors in a surprising number of cases.

The New Realities of Retiree Health Insurance Financing

For many employers, it has become clear that the generous plan designs and premium subsidies offered in an earlier era now portend unacceptable financial obligations. Employers can modify or eliminate the promise of retiree health insurance for active employees or retirees. Current employees have no vested claim to future health benefits, and even benefits for current retirees can be dropped or modified as long as the employer has reserved these rights. The financial markets have put a great deal of pressure on employers to improve their balance sheets. The inability to create a segregated asset to offset the liability that is created in sponsoring a retiree health benefit program has resulted in tremendous pressure to cut retiree health benefits.

Forced to confront their retiree medical liabilities and fearful of unabated cost increases, many employers have restricted eligibility for retiree health benefit programs

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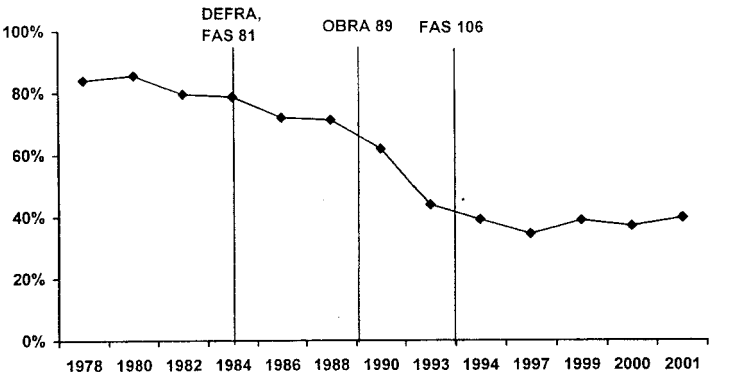
retired employees. The proceeds from these polices are used to pay post-retirement medical benefits. But because COLI is not held in a trust for the purpose of providing post-retirement medical benefits and the proceeds can be used for any purpose, it is not a plan asset for FAS 106 purposes and cannot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

and limited their accruing obligations. The new eligibility rules have not greatly affected the number of current retirees receiving benefits, but the amount retirees pay toward premiums has risen dramatically. Eligibility changes will have a greater effect in the future. Future retirees who are eligible will pay a steadily increasing share of premium expense under contribution formulas employers have already adopted. Finally, these new eligibility rules and contribution formulas have significantly reduced the retiree medical liabilities that employers are accruing for future retirees, as demonstrated by the reduced FAS 106 service costs that large employers now report.

In the final analysis, the most effective way for employers to eliminate the costs associated with their retiree health benefit programs is to shut them down. Figure 3 shows that the percentage of medium and large firms offering a retiree health plan to active employees declined sharply between 1988 and 1993, falling from 71 to 44 percent. The decline coincided with the cost escalation and the regulatory and legislative events discussed above. Many employers grandfathered benefits for current retirees and older employees, but the changes for future retirees are very significant. The 2001 Watson Wyatt *Retiree Health Survey* found that over 15 percent of firms sponsoring health benefits for current retirees have eliminated their retiree health plans for new employees. For those that continue to offer coverage to current and new workers, the subsidization of benefits by employers is being significantly scaled back. In addition, workers are now being subjected to more service requirements for earning full benefits than has been the case previously.

Figure 3: Percentage of Medium and Large Firms Offering a Retiree Health Plan to Active Employees



Source: Watson Wyatt Data Services—*ECS Survey Report on Employee Benefits* (1995-2002), *Employee Benefit Report* (1993), *Medical Benefits for Active and Retired Employees* (1990), Group Benefits Survey (1978-1988). These surveys were targeted at medium and large firms.

Although many employers dropped future retiree medical benefits for their active employees, most were reluctant to drop benefits for current retirees and for older employees near retirement. Some plans implemented before the mid-1980s expressly stated or implied that health benefits were guaranteed for life.[16] But even many employers that had not made such commitments to current retirees were still reluctant to eliminate their plans. Consequently, the prevalence of employer-sponsored medical

[16] Murray, Diana L. 1994. Commentary to "Is Retiree Health Insurance Crowding Out Retiree Cash Benefits," in Mazo, Judith F; Anna M. Rappaport, and Sylvester J. Schieber, (eds.), *Providing Health Care Benefits in Retirement*, (Philadelphia: University of Pennsylvania Press, 1994), pp. 53-58.

benefits has not changed greatly for current retirees. Changes are concentrated among younger retirees and even here the effects have been relatively muted, so far.

Policy Recommendations for Retiree Health Financing

The story that has unfolded to this point can be summarized succinctly. Employers initially committed to provide retiree health benefits without fully appreciating the magnitude of their commitments. Comprehensive health care insurance fostered extra price inflation in the health sector, greater health care utilization, and the development of new technologies. Retiree medical spending exploded as these factors combined with rapidly growing retiree populations. Just as employers were beginning to comprehend the magnitude of their retiree medical liabilities, they encountered a discrepancy between accounting rules that require accrual of retiree health obligations as they are earned and tax laws that essentially force plans to be funded on a pay-as-you-go basis. Employers now believe that the traditional model for providing retiree medical benefits is not an economically rational form of employee compensation, and many employers are retrenching in their commitments.

It is impossible to observe these trends and not conclude that the current model for providing these benefits is flawed, but the implications of the plan changes that are already in place will not be realized fully for many years into the future. Some people may conclude that we ought to significantly expand Medicare and be done with it. Indeed, policymakers considered such a proposal in 1994 and soundly defeated it. The problem with that option is that Medicare funding is badly out of balance itself, and eliminating the employer role would place even greater demands on Medicare.

The financial challenges facing employer-sponsored retiree medical plans resulted from the convergence of many forces, and it will take more than a single solution to secure the future of these benefits. First, we must attack the growth in per-capita medical expense by enlisting market forces, managing high cost cases, and identifying best practices in treatment and the use of technology. Second, we must restructure plans and employee expectations to deal with the demographic realities that will require employees to work longer and play a greater role in financing their own retiree medical care. Third, we must provide a tax environment that will encourage employers and employees to fund these future medical expenditures from today's productivity. If employers and retirees do not set aside the needed resources today, tomorrow's workers and taxpayers will bear much of the burden.

Structuring Plans to Control Costs

Consumer dissatisfaction with managed care restrictions and employer frustration with rising plan costs have given rise to demands for "consumer-driven health plans" where consumers have greater choice and responsibility for managing their own health care. By giving consumers more autonomy, better information and a financial stake in cost-effective care, advocates believe market forces can be brought to bear on health care costs. Part of the cost challenge for employers is to sensitize retirees to the relative prices of alternative health goods and services.

This is how our economy normally works. When the price of steak increases, consumers substitute chicken because of its lower price. Health insurance insulates health care consumers from costs, facilitating access to health care but largely removing cost considerations from the decision process. The approach we have taken is akin to

raising the cost of admission to the grocery store because the cost of steak has risen. Once in the grocery store, the consumer pays virtually the same price for chicken and steak. Given the low out-of-pocket costs that are typical of today's employer-sponsored plans, it is time to reconsider the use of market forces.

In the case of retiree medical plans, Watson Wyatt's research has documented dramatic increases in the share of premiums paid by retirees, although retiree medical plans still require relatively little cost sharing at the point of service. Since retirees pay only a small share of the costs of services covered by most employer-sponsored health plans, they do not consider the price or quantity of these services. Moreover, traditional models of managed care place much of the decision-making authority with the physician and the health plan, undermining the ability of consumers to influence purchasing and treatment decisions. By increasing the financial stake and decision-making role of consumers, we can anticipate that more of them will choose chicken rather than steak, and we may even find some who request smaller portions.[17]

Consumerism alone, however, will never be sufficient to stem the rapid growth in retiree medical costs because a relatively small percentage of high-cost claims drives much of the cost of retiree medical programs. These high-cost cases quickly surpass even substantial deductibles and they require comprehensive protection from catastrophic

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[17] Willard G Manning et al. "Health Insurance and the Demand for Medical Care: Evidence From a Randomized Experiment," ***American Economic Review*** (1987),Vol. 77, pp. 251-77. Shifting costs to the consumer can substantially reduce the demand for medical care. The RAND health insurance experiment found that overall medical expenses rose 37 percent when care was free of charge to the consumer, compared with a baseline plan where consumer cost sharing was set at 25 percent. The RAND researchers were not able to determine the reduction comes primarily from unnecessary or inappropriate services.

medical costs. For example, a straight 20 percent copayment could run into hundreds of thousands of dollars for some beneficiaries and undermine the basic goal of insurance.

In the context of retiree medical benefits, it is noteworthy that traditional Medicare has lagged private sector health plans in the use of such programs to manage the care of high cost and high risk beneficiaries. As the primary payer for post-65 retirees, this represents a missed opportunity for Medicare and a problem for employer-sponsored plans that pay a large portion of the medical expense not reimbursed by Medicare. Public policymakers could help to facilitate more efficient utilization of health services in this country by implementing this sort of program as an element of Medicare and Medicaid.

Identifying Efficacious Treatment Patterns

Judgements about medically necessary and appropriate care should be made in the context of good information about the outcomes of treatment alternatives. But there are huge variations in physician practice patterns that "appear to be determined largely by local medical opinion concerning the value of surgery or its alternatives."[18] Research by Wennberg and his colleagues indicates that because of these variations in practice patterns, Medicare spends more than twice as much per enrollee in Miami as it does in Minneapolis. The differences cannot be explained by population differences, and there is no evidence that patients in high cost areas enjoy longer lives or better quality of life.

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[18] John E. Wennberg, Elliott S. Fisher, and Jonathan S. Skinner, "Geography and the Debate over Medicare Reform," published at www.healthaffairs.org, February 13, 2002, pp.w98-w114.

Whether primary responsibility for control the growth in service use is placed with consumers, physicians or managed care organizations, we need far better information about the patient outcomes associated with various treatment alternatives. Unlike prescription drugs that undergo extensive clinical trials with randomized treatment groups, there is relatively little scientific basis for evaluating competing treatment procedures and protocols.

Driving these variations in treatment and the tremendous growth in service utilization is the proliferation of new technologies. The commitment of private and public investment in health research in the United States is unique in the world, even among developed nations. The National Institutes of Health (NIH) spent $7.9 billion on research and development (R&D) in 1992. A decade later, estimated NIH expenditures on R&D had risen to an estimated $21.3 billion, an increase of 168 percent. Over this same period, total federal government outlays for other R&D activities increased only 34 percent and total federal outlays on all activities grew only 49 percent.[19] In growth terms, federal government expenditures on health care R&D have grown 4.9 times faster than other R&D and 3.4 times faster than total expenditures.

Neumann and Sandberg estimate that total investment in R&D in the health sector has been growing much more rapidly than total health expenditures and investment in R&D activities in other sectors of the economy. They show that health R&D was 12.0 percent of total R&D expenditures in 1985 but had climbed to 20.3 percent by 1995.[20] If

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[19] *Historical Tables, Budget of the United States Government, Fiscal Year 2003* (Washington, DC: U.S. Government Printing Office, 2002), pp. 25-26 and 177-178.

[20] Peter Neumann and Eileen Sandberg, "Trends in Health Care R&D and Technology Innovation," *Health Affairs* (November/December 1998), vol. 17, no. 6, pp. 111-119.

new technology is the major cost driver of health expenditures and health costs must be brought under control, it is time to step back and review how we are spending our R&D money and how we finance the beneficial products and services that evolve from it.

Burton Weisbrod and Craig LaMay argue that the prevalence of health insurance and the process for inclusion of new services under health insurance arrangements converts many new technologies into higher costs. As new treatment regimens or health products evolve, they are introduced into the delivery chain. As their efficacy is determined, they come under the scope of services paid for by third-party insurance programs. Then the market for the treatment or product blooms. Fuchs and McClellan document explosive growth in the frequency of seven surgical procedures over the 1987-1995 period. The annualized rate of growth for these procedures ranged from 4 percent to 22 percent.[21] Those writing the checks to pay for these services, especially the employer sponsors of retiree health benefits, are sending signals that this kind of growth cannot be sustained. We have to find methods of controlling the cost of health service delivery that go beyond discounts and efficiency gains.

Weisbrod and LaMay call for a rethinking of R&D incentives. They point to efforts in other areas that are instructive of the potential that might be reaped in this pursuit. In 1993 the Whirlpool Corporation won a $30 million dollar prize offered by a consortium of twenty-five electric utility companies for the development of an energy-efficient refrigerator that would run on 25 percent less electricity than current models and

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[21] Victor R. Fuchs and Mark McClellan, "Medical Technology and Mortality in an Aging Society," cited as a NBER paper in progress in Victor R. Fuchs, "Health Care for the Elderly: How Much? Who Will Pay for It?" *Health Affairs* (January/February 1999) vol. 18, no. 1, pp. 11-20.

use no chlorofluorocarbons. Reaching further back in history they point to a prize awarded in 1714 by the British Royal Academy. It seemed that British shipping companies were losing cargo because of the inability of mariners to measure longitude. The Academy offered a prize for someone who would could devise the solution to this problem that had eluded Galileo and Isaac Newton. John Harrison solved the problem and was awarded a prize the equivalent of $24 million today.[22] Mankind has repeatedly shown tremendous ingenuity in solving life's problems when offered the appropriate rewards for doing so.

There are at least a couple of ways that policymakers could create incentives that would help to limit the growth in health care costs. One is to put the financing of certain technologies outside the realm of financing through tax-favored employer-sponsored health insurance plans. Another is to sponsor more structured research on efficient delivery regimens and best practices in health service delivery.

When a new drug broke onto the market several years ago that restored sexual potency for men, many insurance programs moved fairly quickly to cover prescriptions. While there is little doubt that this drug enhanced the quality of life of many people, it is hard to make a case that the problem it treated was a life threatening condition for its victims or even one that inhibited a relatively normal life. Yet there is little doubt that the coverage of this drug under health insurance programs significantly increased the demand for the product and total health costs covered under third-party payment arrangements.

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[22] Weisbrod and LaMay, Op cit., p. 124.

The coverage of questionable medical procedures or products is made all the more complicated by a legal and regulatory environment that encourages coverage of new technologies as they come on line. On the legislative front, there has been considerable support for a Patient's Bill of Rights that would provide an external appeals process for patients who are denied services they believe are necessary and appropriate. During the early experimentation with bone marrow transplantation for certain cancers, patients and their families have brought lawsuits against managed care plans that did not pay for treatments that the plans still considered experimental. In at least one case, following a multi-million dollar judgement against the health plan, subsequent medical research found that the effectiveness of the treatment was indeed highly questionable.

It is time that public policymakers redirect a portion of the money government currently spends on health R&D toward efforts to identify the treatment procedures, protocols and technologies that are most effective. With better information about treatment effectiveness, health plans, physicians, and consumers will be able to make more informed decisions about the use of available treatment options.

Implement Policies That Encourage People to Work Longer

The large retiree medical costs associated with early retirement are vastly reduced when an employee waits until age 65 to retire. Extending working careers will reduce the number of years over which retirees will need retiree medical care and increase the number of years for accumulating the necessary resources to cover retiree health costs. Many employees in the workforce today might not be happy with the prospect that they will have to work longer than their parents' generations, but the only alternative is that they save at much higher rates as a percent of earnings than most working people do

today. Public policy should facilitate people working longer and reward them for the extensions of their productive periods in the labor force.

The population in the United States will age rapidly over the next quarter century with significant implications for our retirement systems and our economy. For example, today there are roughly three people receiving Social Security benefits for every ten workers who are working and paying payroll taxes. This relationship between Social Security beneficiaries and payroll taxpayers has been virtually constant for about thirty years. Starting this decade, however, the number of retirees receiving Social Security relative to workers paying into the system will begin to climb. Initially, the increase will be gradual. By 2010, we expect there will be 32 beneficiaries for every 100 taxpayers. But then the increase will accelerate. By 2015, there will be 35 beneficiaries per 100 taxpayers; by 2020 it will be 40 to 100; and by 2035, it will be roughly 50 beneficiaries per 100 workers.[23]

The potential aging of American society has caused some policy analysts and policymakers to be concerned about the long-term costs of Social Security and Medicare. An alternative issue that has received much less attention is whether there will be sufficient numbers of workers in an aging society to support continuing expansion of our overall economy and continuing increases in the standards of living the members of our society enjoy.[24] Both sets of concerns point to the need to revisit the attitudes and

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[23] 2002 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, found at www.ssa.gov/OACT/TR/TR02/IV_LRest.html#178448, Table IV.B2.

[24] See Steven A. Nyce and Sylvester J. Schieber, "The Decade of the Employee: The Workforce Environment in the Coming Decade," *Benefits Quarterly* (First Quarter 2002), vol. 18, no. 1, pp. 60-79.

behaviors of both employers and employees about appropriate ages for retirement. The retirement system that evolved by the end of the twentieth century was a vestige of surplus labor that was available in the United States and other developed countries throughout the century. That system may no longer be appropriate or sustainable in the twenty-first century as the new demographic realities play out.

Employers have shown much more willingness to modify retirement programs to encourage people to extend their working lives than public policymakers have thus far. In large part, the story behind the shift to cash balance plans and other forms of hybrid pensions has been about eliminating some of the incentives in pensions that encourage early retirement.[25]

Policymakers have been encouraged to address the imbalances in our federal retirement system because of the demographics we face over the next couple of decades. The majority of members on the 1994-1996 Advisory Council on Social Security recommended that Congress increase the age of earliest entitlement for Social Security benefits. The Social Security Advisory Board issued a report solely devoted to the reasons why action should be taken sooner rather than later in reforming Social Security no matter what approach to reform is chosen. The Board's report concludes that, "The effect of delaying change is to deprive employees unnecessarily of important information upon which they can reasonably base their lifetime plans for retirement security."[26]

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[25] Robert L. Clark and Sylvester J. Schieber, "Taking the Subsidy Out of Early Retirement: The Story Behind the Conversion to Hybrid Pensions," in Olivia Mitchell, Zvi Bodie, Brett Hammond, and Steve Zeldes (eds.), *Innovations in Managing The Financial Risks of Retirement* (Philadelphia: University of Pennsylvania Press, 2002).

[26] Social Security Advisory Board, *Social Security: Why Action Should Be Taken Soon* (Washington, DC: Government Printing Office, 2001), p. 20.

So far public policymakers have not been willing to address either Social Security or Medicare financing issues related to the claims the baby boom generation will be making on these systems within the next ten years. The underlying arithmetic dictating change is clear. It is time that policymakers set about modifying our national retirement policies to recognize the realities of the twenty-first century.

Rationalizing the Financing of Retiree Medical Plans

Only 35 percent of Fortune 1000 companies have set aside assets to fund their future retiree health liabilities. These assets will only cover, on average, about one-third of their future liabilities.[27] Problems arise from accruing retirement benefits when they are not funded. This is often a difficult issue to confront with employers, employees, and even policymakers because it requires laying aside a portion of the compensation paid to employees during their active period of employment until they retire.

The viability of retirement programs that are not funded, often called pay-as-you- go systems, has been called into question even at the national level. [28] If national governments are at risk by relying on pay-as-you-go retirement systems, how much greater must the dangers be for such systems sponsored by organizations that do not enjoy the same ability to generate revenue to cover future liabilities through legislative

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[27] Watson Wyatt analysis of FAS disclosures of Fortune 1000 companies.

[28] In the early 1990s, the World Bank published a major study of the public retirement systems around the world and recommended that they should move to much greater reliance on funded retirement systems (Estelle James et al, *Averting the Old Age Crisis* (New York: Oxford University Press, 1994). Recently the Organization for Economic Cooperation and Development has released an analysis of aging populations in the developed world and concluded that the government of these countries should increase their utilization of "funded systems and private savings" in providing for the needs of retirees (Ignazio, Visco, "Paying for Pensions: How Important is Economic Growth," *BNL Quarterly Review* (March 2001), no. 216, p.99.)

fiat? Employers in private enterprise cannot avoid the pressures from private financial markets to minimize unfunded liabilities on their books. At the plan sponsor level, the gradual disappearance of retiree health benefits should not come as a particular surprise if one considers the nature of the commitment implied by a retiree health insurance program.

The earlier discussion about things employers have done to control their retiree health liabilities suggests that even where employers are still sponsoring retiree health benefit programs the level of benefits today often depends on years of service under the plan prior to retirement. It is not uncommon under these plans that an employee would have to work thirty or more years to earn a relatively "full" benefit, one that may still require the retiree to pay more than half the cost of health care consumption during retirement.

To put the viability of an unfunded retirement benefit promised to such an employee in perspective, we went back to the 1972 Fortune 500 list of industrial companies in the United States. Of the 50 largest companies on that list, 21 of them remain intact and operating under the same corporate structure as they did 30 years ago. Another 21 of them have been purchased or subsumed into some other corporate organization, four have been split into multiple parts, and four have gone through at least one bankruptcy but are still operating. At least three of the 21 that were acquired by another entity have also undergone bankruptcy in the 30 years since being on the Fortune top 50 list in 1972. No matter how well intentioned the management of a company might be in committing to provide future retirees with health insurance, it is impossible to

guarantee that benefit over a normal working career and retirement on a pay-as-you-go basis.

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

One of the major reasons that employer-sponsored retirement health benefits are being eliminated is that employers have been forced to operate their retiree health benefit programs largely on a pay-as-you-go basis. The Deficit Reduction Act of 1984 does not allow employers to fund retiree health benefits as they are accruing by taking into account anticipated medical inflation. There is no area of activity in our economy where ignoring the effects of inflation over a long period of time would pose a greater risk. Not only can employers not fund accruing retiree health obligations on a realistic basis, any

excess contributions to their retiree health plans are subjected to unrelated business taxes. If a plan sponsor tries to reclaim excess contributions in order to pay regular corporate taxes on them, they are subjected to a 100 percent excise tax on any reclaimed assets.

The cost of retiree health benefits and the underlying demographics of the workforce are important in explaining the curtailment of retiree health benefits but even if these matters could be resolved, it would not likely lead to an increased willingness of employers to provide retiree health benefits. The underlying principles of the accounting rules to which employers are held treat retiree medical benefits and other retirement benefits as an element of compensation. Employees earn these benefits in return for supplying their labor on a fair and equitable basis. The problem is that the actual payment of that compensation is deferred. When the deferred compensation actually comes due, the managers tasked with delivering on the previous promise may be completely different than those that "negotiated" the employment conditions under which employees accrued their retirement benefits.

In the case of pensions, the legal requirements that benefits be "funded" when the work earning them is done ties an employee's compensation directly to his or her own productivity. The legal funding and vesting regulations behind pensions translate an employer's commitment on such benefits into a contractual obligation. In the case of retiree health benefits, the financing of the deferred compensation on a pay-as-you-go basis ties an employee's deferred compensation to the willingness of future managers and employees to uphold agreements that they themselves were generally not party to forming in the first place.

The net result of public policy and skyrocketing medical costs has been to render retiree health benefits economically irrational for many employers. Thus, there have been declining insurance coverage rates among the retiree population and calls to allow retirees below the age of 65 to buy health insurance coverage through Medicare. But many retirees, especially those with lower incomes who do not have employer coverage, would not be able to buy their way into Medicare under such a policy because of the relatively steep cost of doing so. This dilemma cannot be reasonably addressed without revisiting the treatment of retiree health funding under the U.S. tax laws. If the concern is consistent tax treatment with retirement benefits provided in the form of cash, this can be achieved through more than one mechanism.

Making realistic retiree medical promises and keeping them requires the opportunity for employers and employees to secure retiree health benefits through pre-funding. If retiree medical benefits constitute compensation for current labor, employers should be putting aside some of the fruits of that labor to ensure that the benefits will be there when needed. One major motivation behind the adoption of ERISA in 1974 was to secure the retirement benefits that employers promised their employees through their defined benefit plans. Before ERISA, plan sponsors were not legally required to fund benefits as they were earned and many did not. Some plan sponsors ultimately found that they were unable to meet their pension benefit obligations when they came due. Congress adopted ERISA to secure such benefits across time and varying economic circumstances. It seems particularly inconsistent that lawmakers worried about securing a retirement benefit provided in the form of cash, but did not show a similar concern about securing an in-kind benefit provided in the form of health insurance.

From a public policy perspective, providing tax incentives for funding of retiree medical benefits is the best approach to preserve retiree medical benefits for future retirees. Some policy analysts will claim that this approach will simply create a tax leakage that is not worth the cost over the longer term. But let us review the results of history to understand why I have reached the conclusion I have. Back in the early 1980s policymakers decided that employers should not be allowed to fund retiree health benefits in the same way they fund pensions. If retiree health benefits had been treated the same as pensions instead of differently, then we would likely be looking at a very different situation in the case of the steel industry than we are today.

There is no doubt that the extension of tax preferences to retiree health benefit funding at this time would create some fiscal costs for the government. On the other hand, such an approach would keep more employer money in the game and increase active employee contributions to retiree health financing, thereby reducing the demand by future retirees for expansions in government financing of health insurance. If employers are offered the opportunity to begin funding retiree health benefits on a tax-preferred basis, few of them would revert to employer-pay-all retiree health plans that were prevalent back in the 1970s and 1980s. But I believe the erosion of current benefits could be substantially stemmed as virtually all employers still sponsoring plans changed to a financing approach that is much more sustainable than the current one. In addition, employers that have moved completely away from offering a retiree health plan or that have never offered one would be likely to give opportunities to employees to save additionally to secure their own retiree health benefits if they were allowed to do so.

Largest 100 Retiree Medical Liabilities from Fortune 500 List for FY 2001*

Company	Fiscal year ending date	Medical liabilities as percentage of market values	Medical liabilities as percentage of corporate assets	Medical Liabilities in thousands
General Motors Corporation	12/31/2001	193.2	16.2	$52,489,000
Ford Motor Company	12/31/2001	89.4	9.2	25,433,000
SBC Communications, Inc.	12/31/2001	15.3	20.9	20,140,000
Verizon Communications, Inc	12/31/2001	11.1	8.4	14,310,000
Lucent Technologies	09/30/2001	48.0	27.9	9,398,000
Boeing Company	12/31/2001	22.0	14.1	6,800,000
General Electric Company	12/31/2001	1.7	1.4	6,796,000
BellSouth Corporation	12/31/2001	8.8	12.1	6,315,000
International Business Machines Corporation	12/31/2001	2.9	7.0	6,148,000
E.I. du Pont de Nemours and Company	12/31/2001	13.7	14.5	5,832,000
Delphi Automotive Systems Corporation	12/31/2001	71.0	29.2	5,435,000
American Telephone and Telegraph Company	12/31/2001	8.3	3.2	5,316,000
Qwest Communications	12/31/2001	20.0	6.4	4,700,000
Caterpillar Inc.	12/31/2001	25.2	14.7	4,514,000
Philip Morris Companies Inc.	12/31/2001	4.0	4.7	3,966,000
Aluminum Company of America	12/31/2001	10.5	11.2	3,177,000
Exxon Mobil Corporation	12/31/2001	1.2	2.2	3,131,000
Lockheed Martin Corporation	12/31/2001	15.2	11.3	3,125,000
Deere & Company	10/31/2001	35.5	13.7	3,114,000
Eastman Kodak Company	12/31/2001	35.6	22.8	3,046,000
Bethlehem Steel Corporation	12/31/2001	5146.3	71.4	3,031,000
AMR Corporation	12/31/2001	80.1	8.4	2,759,000
Visteon Corporation	12/31/2001	138.5	24.4	2,707,000
ChevronTexaco Corporation	12/31/2001	2.6	3.3	2,526,000
Goodyear Tire and Rubber Company	12/31/2001	61.4	17.6	2,383,700
UAL Corporation	12/31/2001	317.8	9.4	2,359,000
Exelon Corporation	12/31/2001	15.2	6.7	2,331,000
Honeywell International Inc.	12/30/2001	7.8	8.9	2,149,000
Delta Air Lines, Inc.	12/31/2001	58.2	8.9	2,100,000
Prudential Insurance Company of America	12/31/2001			2,096,000
Edison International	12/31/2001	41.7	5.6	2,053,000
Dow Chemical Company	12/31/2001	6.7	5.7	2,035,000
Northrop Grumman Corporation	12/31/2001	16.6	8.7	1,813,000
United Parcel Service	12/31/2001	2.9	7.1	1,759,000
AK Steel Holding Corporation	12/31/2001	136.4	32.0	1,672,400
Metlife, Inc.	12/31/2001	7.4	0.6	1,669,000
American Electric Power Company, Inc.	12/31/2001	11.8	3.5	1,655,000
FirstEnergy Corp	12/31/2001	15.2	4.2	1,581,600
Raytheon Company	12/31/2001	12.0	5.8	1,547,000
TRW Inc.	12/31/2001	31.4	10.2	1,473,000
US Airways Group Inc	12/31/2001	336.5	18.0	1,442,000
Dana Corporation	12/31/2001	68.6	13.9	1,415,000
Consolidated Edison, Inc.	12/31/2001	15.8	7.9	1,351,100
Minnesota Mining and Manufacturing Compan	12/31/2001	2.8	8.9	1,304,000
Wyeth	12/31/2001	1.6	5.5	1,270,085
Southern Company	12/31/2001	7.0	4.2	1,239,000

Viacom, Inc.	12/31/2001	1.5	1.3	1,190,100
Merck and Co., Inc.	12/31/2001	0.9	2.6	1,154,600
DTE Energy Company	12/31/2001	16.7	5.9	1,127,000
PG&E Corporation	12/31/2001	15.2	3.0	1,065,000
J.P. Morgan Chase & Co.	12/31/2001	1.5	0.2	1,056,000
United Technologies Corporation	12/31/2001	3.4	3.9	1,040,000
CitiGroup	12/31/2001	0.4	0.1	1,018,000
Dominion Resources	12/31/2001	6.3	2.9	996,000
General Dynamics	12/31/2001	6.2	8.9	984,000
Keyspan Corporation	12/31/2001	20.1	8.2	969,692
Abbott Laboratories	12/31/2001	1.1	4.1	963,411
CMS Energy Corporation	12/31/2001			956,000
Allstate Corporation	12/31/2001	3.9	0.9	945,000
Bank of America Corporation	12/31/2001	1.0	0.2	944,000
Eli Lilly and Company	12/31/2001	1.1	5.6	928,200
TXU Corporation	12/31/2001	7.3	2.2	914,000
PepsiCo, Inc.	12/29/2001	1.1	4.2	911,000
Sears, Roebuck and Co.	12/29/2001	5.9	2.0	905,000
Wachovia Corporation	12/31/2001	2.1	0.3	899,000
Kellogg Company	12/31/2001	7.3	8.6	895,200
Eaton Corporation	12/31/2001	17.3	11.7	894,000
Sprint Corporation	12/31/2001	4.7	3.6	878,000
International Paper	12/31/2001	4.4	2.3	856,000
PPG Industries, Inc.	12/31/2001	9.4	9.7	823,000
Georgia Pacific Corporation	12/29/2001	12.7	3.1	807,000
Pfizer Inc.	12/31/2001	0.3	2.0	785,000
Johnson & Johnson	12/31/2001	0.4	2.0	782,000
Eastman Chemical Company	12/31/2001	25.9	12.8	779,000
RJ Reynolds Tobacco Holdings, Inc	12/31/2001	13.9	4.9	740,000
Duke Energy Company	12/31/2001	2.3	1.5	712,000
Ameren Corporation	12/31/2001	12.0	6.7	701,000
Cummins, Inc.	12/31/2001	47.0	16.1	697,000
Kimberly-Clark Corporation	12/31/2001	2.2	4.6	696,500
Pharmacia Corporation	12/31/2001	1.2	3.1	690,000
Xcel Energy, Inc.	12/31/2001	7.2	2.4	687,455
Crown Cork & Seal Company, Inc.	12/31/2001	212.0	7.0	677,000
Public Service Enterprise Group Inc.	12/31/2001	7.8	2.7	673,800
Northwest Airlines	12/31/2001	48.4	5.0	647,000
Bristol-Myers Squibb Company	12/31/2001	0.6	2.4	639,000
Textron Inc.	12/29/2001	10.8	3.9	632,000
Corning Incorporated	12/31/2001	7.7	4.9	631,000
Motorola, Inc.	12/31/2001	1.8	1.8	605,000
Entergy Corporation	12/31/2001	6.8	2.3	590,731
Marathon Oil Corporation	12/31/2001	6.4	3.7	590,000
Sempra Energy	12/31/2001	11.8	3.9	590,000
Walt Disney Company	09/30/2001	1.6	1.3	585,000
Union Pacific Corporation	12/31/2001	4.1	1.8	580,000
Levi Srauss & Co.	11/25/2001		18.8	561,227
El Paso Corporation	12/31/2001	2.4	1.2	560,000
Wells Fargo & Company	12/31/2001	0.7	0.2	546,000
Coca-Cola Company	12/31/2001	0.5	2.4	530,000
Whirlpool Corporation	12/31/2001	10.7	7.5	525,000

Avaya Inc.	09/30/2001	18.1	11.0	513,000
CIGNA Corporation	12/31/2001	3.9	0.6	506,000

* Medical liabilities from 10-Ks filed with SEC for FY 2001
Market values and assets from Standard and Poor's Compustat database

APPENDIX C - STATEMENT OF LOUISE NOVOTNY, ASSISTANT DIRECTOR OF RESEARCH, COMMUNICATIONS WORKERS OF AMERICA, WASHINGTON, D.C.

Testimony of Ms. Louise Novotny
Assistant Director of Research, Communications Workers of America

May 16, 2002

Thank you Mr. Chairman and Members of the Subcommittee. I am pleased to be given the opportunity to speak with you this morning about our experience with retiree health care benefits. My name is Louise Novotny. I am the Assistant Director of Research for the Communications Workers of America. CWA has just concluded negotiations with two of our major employers, AT&T and Cincinnati Bell, and retiree health care benefits were a major issue at both those bargaining tables. I have been asked to describe how our union has negotiated for these benefits, at these and other employers, the typical retiree health benefits package, how accounting standards have impacted our ability to bargain for retiree health benefits, and to offer any recommendations for securing access to health care for retirees.

As you all may know, bargaining for retirees is a tricky business. The National Labor Relations Board (NLRB) defines retirement benefits for active workers as a mandatory subject of bargaining. But bargaining for retirees, that is individuals already retired, is a permissive subject of bargaining. Nevertheless, CWA has consistently made retiree benefits, including health care, a key demand in our negotiations with major employers in the telecommunications industry.

For our older retirees, age 65 and older, the benefits we have negotiated supplements to Medicare, which cover the substantial cost sharing requirements and pay for benefits not covered by Medicare, notably prescription drugs. Our benefit packages may be even more valuable to retirees under age 65. In recent years, many of our members in the telecommunications industry have been forced to take early retirements as a result of downsizing to avoid layoffs. The early retirees are too young to qualify for Medicare, but they are at that vulnerable age when health care needs are increasing. If they had to purchase coverage in the individual market, they would find it prohibitively expensive.

Our retiree health benefits, therefore, offer an important source of retirement security, protecting retirement income from erosion due to rising health costs, as well as assuring access to necessary health care services.

CWA first won health coverage for retirees in the 1960s. The benefits were designed for workers age 65 and older and supplemented coverage provided under the newly enacted Medicare program. Over the years as benefits for active workers were improved through bargaining, we were also able to improve the level of benefits for workers who retired over the term of the contracts but because bargaining for retirees is permissive, we could not demand. A contract, for example,

for a worker who retired in 1984 was covered by the benefits package we negotiated in 1983, but could not access preventive coverage negotiated in 1986. As a result, the benefit package for retirees was different depending on when they retired.

In 1989, bargaining in the telecommunications industry reached new heights of contentiousness around our health care benefits. In those days CWA bargained with AT&T and the so-called "Baby Bells" at the same time. AT&T's contract expired in May and the seven Regional Bell Operating Companies expired in August. That year all eight of the companies drew a line in the sand demanding major cost shifting to workers. They wanted premium sharing, severe cuts in coinsurance levels, removal of out of pocket limits that protect workers, and finally, they wanted to cap the amount of money paid toward retiree health coverage.

The retiree health proposals were in response to the Financial Accounting Standards Board which had just issued a proposal for a new rule which would require employers to account for their retiree health costs as an ongoing liability. Employers were to begin accruing for the projected costs of retiree benefits over the working lives of the eligible employees. At the time, companies booked these costs only when benefits were actually paid to retirees, because any accrual wouldn't be tax deductible, as are reserves for future pension costs. The rule came to be known as FAS 106, but at the time we were bargaining, the rule was still a proposal. However, there was every expectation that it would be implemented. The concept was simple and straightforward. If firms are making promises to pay retiree health benefits into the future, then honest accounting would treat that obligation as a liability, not a short term expense. As an example, when we bargained with AT&T that year, the company estimated that when applied to the FASB rule would impose a new, ongoing annual expense of about $1.7 billion and a total benefit obligation of $9.5 billion.

The agreements we reached in that round of bargaining followed a general pattern, though there are differences at each company. CWA agreed to cap the employer contribution to retiree health coverage. The intent of our agreements was to help the companies deal with the problem that the FASB rule imposed. We set company contribution limits for retirees based on age over or under 65 and based on single or family coverage. If costs were to rise above the caps, then retirees would be required to pay the excess. At the same time, we also included several safeguards that we hoped would provide extra levels of protection for retirees to limit their exposure to rising health costs. The safeguards included:

> grandfathering the already retired workers so that they would never be required to pay;
>
> setting the caps at generous levels, high enough to preclude any retiree cost sharing at least during the course of the contract.
>
> waiving the requirement for retiree cost sharing during the

term of the contract;

linking the scope and level of retiree benefits to those negotiated for active workers;

and negotiating an agreement to bargain for retiree health benefits into the future.

We also bargained the establishment of separate VEBA trusts to prefund retiree health benefits. This new asset would help offset the companies liability.

To greater or lesser degrees, those were the elements that became the model for bargaining health benefits in the telecommunications industry. In the ensuing years different trends in health delivery and economic conditions have offered a variety of opportunities and challenges to our continuing goal of preserving retiree living standards and access to health care.

While it is true that the FASB rule made has changed the way employers - the way they implement.

When the FASB rule kicked in in 1993, AT&T took an after-tax charge of more than $7 billion to cover the reserve for future retiree health benefits. Companies could take the catch up charge all at once, or spread it out over up to 20 years. AT&T took it all at once in order to stem the impact on earnings in future years.

When AT&T and Cincinnati Bell calculated their respective retiree health liabilities, the companies assumed the negotiated caps would never be changed, that the company would never pay more than the contribution limits negotiated in 1989. This is in spite of the fact that the collective bargaining agreements committed the companies to bargain over the contribution limits in the future.

Other companies took a different approach. Some of the regional Bell Operating Companies calculated their liabilities using an assumption that the company's contribution limit would continue to increase over time. For example, when the company then called Bell Atlantic calculated its liability, it used an assumption that the company and retirees subject to the contribution cap will share in the future cost increases in medical benefits. These different approaches have crated different dynamics at the bargaining table - less margin to explore alternatives that will impact access and cost goals. Other factors also influence telephone companies in regulated

These different approaches have created different dynamics at the bargaining table. The first locks employers and unions into an unrealistic framework which forces fights over cost shifting. The second provides an opportunity for the parties to explore alternatives that will meet mutual access and affordability goals.

In subsequent rounds of bargaining, we have struggled to come up with new and

effective measures to continue to protect retirees from health care payments on the union side, while recognizing the companies sensitivity to increasing the annual expense. In the words of one company, the union's goal has been to keep the caps from biting. This has not always been easy. Because of the strict accounting rules, it is difficult to increase the negotiated caps without the company incurring huge new expense. There are two basic strategies: revising the plan design to come up with less expensive, more efficient health plans or providing alternative funding sources to ease the company's expense burden. Under the heading of plan design changes, in some cases we were able to lift the caps by including different benefits, such as dental benefits, under the cap. In other cases we were able to reduce the actual cost of retiree health care in some years by shifting more retirees into our point of service managed care networks negotiated for active workers.

In one of our most labor intensive and frustrating efforts to modify plan design in order to reap cost savings, we bargained retiree HMOs. At Qwest (then U.S. WEST), Verizon in the mid-Atlantic region (then Bell Atlantic) and AT&T we bargained participation in Medicare HMOs. We were able to negotiate a processing to assure that under the plans, our retirees would have access to benefits equal to or a better than the benefits they enjoyed as active workers. At the same time the plans promised to hold down costs giving both management and the union some confidence that our negotiated caps would hold for many years. But no sooner did we begin to implement the program, then HMOs began dropping out of Medicare droves. The squeeze on Medicare reimbursements and the revision of Medicare HMO rate setting sent scores of the plans HMOs scurrying from the market.

Under the strategy heading of alternative funding sources, we were able to relieve the employers' expense burden in some years by negotiating pension asset transfers. We felt this was a responsible, if short term, solution. For many years the investments of the pension funds at our major employers had been earning income at rates far exceeding the increase in pension plan liabilities. Thus, employers were able to pay for retiree health costs in a year without incurring an expense. For example, AT&T implemented its first asset transfer in 1991. The pension plan was $1.75 billion overfunded. To cover 1990 health benefits for retirees covered by the plan, AT&T transfered $245 million to the 401(h) retiree health account established within the plan.

However, the attractiveness of this funding option changes with the economic situation. This year in bargaining with AT&T and Cincinnati Bell the companies resisted transferring any funds out of the pension plans. They complained mightily of the rising cost of retiree health care and expressed great concern about labor costs in general. But they were unwilling to transfer assets because the pension funds play another important role for corporations than merely funding benefits. Another FASB accounting standard allows companies to include investment gains by their pension funds in their operating earnings. Thus, a company's bottom line can look much rosier than it really is. The two companies we negotiated with this year were concerned that transferring funds out of the pension fund would reduce their operating earnings and could negatively impact earnings per share. This would

happen for two reasons. First, the actual transfer would reduce the amount of pension assets. But also, under the 401(h) transfer rules, all plan participants must be vested at the time of the transfer. At both of these companies we have negotiated cash balance accounts. Vesting participants with less than five years of service could add an immediate and substantial liability in the form of lump sum payouts. Particularly in situations where management is anticipating downsizing in response to workforce reductions due to economic conditions.

Just to let you where we ended our negotiations, at AT&T we settled an 18 month labor contract which included the establishment of a new retiree benefit, a health care spending account. It is hoped that this new spending account will offset any cost sharing retirees may be required to pay when and if the costs exceed the company contribution caps during that short period. In the interim , we have a joint committee at Cincinnati Bell and we agreed to continue talks for one year in order to come up with acceptable options for funding and design of retiree health benefits. In other words, in this round of bargaining, we agreed we couldn't find a solution.

We have been asked to make some recommendations for legislative action that would help both the union and the employers meet their goals of continuing to assure our retirees access to necessary care through cost effective, employer sponsored health benefits.

Of course, CWA has long supported the concept of a national health insurance plan that would assure all of us, regardless of age, access to all medically necessary health care. And frankly, we believe that current health cost trends will persuade more and more people, organizations and employers to call for some comprehensive legislative action to assure universal coverage.

In the meantime, we are supportive of measures that encourage responsible employers like the ones with which we negotiate, who currently offer health coverage for both their employees and retirees to continue to do so. It is inequitable and shortsighted to penalize employers who have been responsible and not ask employers who have failed to provide such benefits to make a contribution to the goal of expanded access to necessary health care benefits.

Perhaps the most immediate relief could be gained from implementation of a new Medicare prescription drug benefit. Not only will it achieve the essential goal of increasing access to necessary medication for retirees on Medicare, the new benefit would also provide employers who currently offer prescription drug coverage some cost relief. If designed effectively, a Medicare drug benefit could slow the rising cost of retiree coverage, reducing the pressure to cut benefits. However, funding the drug benefit amount by cuts in Medicare provider reimbursements is robbing Peter to pay Paul.

APPENDIX D - STATEMENT OF H. FRED MITTELSTAEDT, PROFESSOR, MENDOZA COLLEGE OF BUSINESS, UNIVERSITY OF NOTRE DAME, NOTRE DAME, IN

United States House of Representatives

Committee on Education and the Workforce

Assessing Retiree Health Legacy Costs: Is America Prepared for a Healthy Retirement?

May 16, 2002
10:30 a.m.

Written Testimony

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Mr. Chairman and Members of the Committee:

I am pleased to be here to share with you some of my research findings and thoughts on retiree health benefits. I hope that my remarks assist the committee in its deliberations on the very important issue of retiree healthcare.

My comments are organized as follows. In the first section, I give some background regarding retiree health plans and the evolution of accounting for these plans. Also in this section, I outline the prevalence of coverage and magnitude of the liabilities that existed in the 1990s. In the second section, I describe how plans have been modified to reduce benefits. I also explain research that investigated motivations for reducing health care benefits. In the final section, I offer my conclusions and recommendations.

Background

Prevalence of Retiree Health Benefit Coverage

The General Accounting Office (GAO 2001, 8) estimates that in 1999 approximately 37% of the retirees between the ages of 55 and 64 and approximately 26% of the retirees 65 and older received employer-sponsored retiree health benefits. The report also indicates that large firms were more likely to provide coverage than were smaller firms. More than 50% of the firms with more than 5,000 employees provided retiree healthcare benefits, whereas only 9% of the firms with under 200 employees sponsored such plans (GAO 2001, 8). In 1999, approximately 10 million retirees relied on these plans, making them an important source of medical care funding.

Many of these plans began in the 1950s when both health care costs and life expectancies were lower. The benefits were prevalent in large manufacturing firms, which at the time, had high ratios of active employees to retirees. As longevity and health care costs increased, firms became more reluctant to offer these benefits. Consequently, today retiree health benefit liabilities are primarily a problem for old, large, capital-intensive firms. These firms also often have numerous union employees.

The statements in the above paragraph are supported by results in Exhibits 1 and 2 of Warshawsky, Mittelstaedt, and Cristea (1993, 191-192). These exhibits are reproduced in tables 1 and 2 of this testimony. Table 1 compares industry membership of firms that sponsor and firms that do not sponsor retiree health benefit plans.[1] The table shows that retiree benefit plans are offered by firms in almost every industry. The highest degree of sponsorship occurs in capital intensive industries, such as petroleum refining, glass, cement, and ceramics, metal works, industrial equipment, and utilities.

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[1]The comparisons of sponsors and non-sponsors are based on 1988 information collected from the May 1990 edition of *Corporate Text*. To my knowledge, comparisons using more recent data have not been published.

Table 2 compares financial characteristics of firms with retiree health benefit plans to firms without such plans. The first four rows contain various measures of firm size: market value of common stock, total assets, sales and number of employees. All four measures indicate that firms with retiree health plans are statistically larger than firms that do not sponsor retiree health plans. The table also shows that firms sponsoring plans have statistically larger debt and after-tax earnings, as a percentage of total assets, than do firms not sponsoring plans. The higher debt ratios may be indicative of firms that were more profitable in past years when the retiree benefits were first promised but are now financing more of their operations with debt, which includes obligations to retirees.

Retiree Health Care Benefit Accounting

Until the early 1990s, annual expense generally equaled the annual cash outlays for retiree health benefits (hereafter, pay-as-you-go costs). Expenses were not accrued for the expected future payments associated with current employees or retirees. There are several reasons for the lack of accrual accounting during this time period. First, there was debate as to whether these programs represented contractual commitments or gratuities that could be ended at any time. Second, when these programs first became prevalent (in the 1950s and 1960s), due to reliability concerns, the accounting profession was reluctant to record expense and liabilities using present value techniques and actuarial assumptions. Third, initially, accountants believed that the costs were relatively immaterial, and therefore, income would not be materially distorted using cash basis accounting.

During the 1970s, as retiree health benefit costs grew and it became clearer that the benefit programs represented enforceable contracts, accountants began to question cash basis accounting. After a series of documents and hearings in the late 1970s and early 1980s, the Financial Accounting Standards Board (FASB) issued *Statement of Financial Accounting Standards No. 81 - Disclosure of Postretirement Health Care and Life Insurance Benefits* (SFAS No. 81). This statement required employers to disclose, in their annual financial statements, information about the benefits provided, employee groups covered, accounting and funding policies, and annual cost recognized. Until this time pay-as-you-go costs were disclosed only on a voluntary basis. This pronouncement was viewed as an interim measure so that the FASB and other interested parties could ascertain the magnitude of retiree benefits other than pensions.

In December 1990, the FASB passed *Statement of Financial Accounting Standards No. 106 - Employers' Accounting for Postretirement Benefits Other than Pensions* (SFAS No. 106). SFAS No. 106 required firms to change to an accrual basis of accounting that parallels *Statement of Financial Accounting Standards No. 87 - Employers' Accounting for Pensions* (SFAS No. 87). The pronouncement's method for calculating retiree health benefit liabilities required assumptions about interest rates, medical inflation, life expectancy, and job tenure. These assumptions also affect the calculation of annual expense. The annual expense comprised 1) service cost (the cash equivalent of benefits earned during the period), 2) interest on the retiree health benefit liability, 3) amortization of actuarial losses (gains) and/or prior service costs

(benefits), and 4) expected return on plan assets.[2] The expected return reduces annual expense, but because most firms had few, if any, plan assets in the early 1990s, expected return had little effect on annual expense. The amortization of actuarial gains or prior service benefits also reduces expense recognized under SFAS No. 106. As with pensions, SFAS No. 106 requires these expense components to be disclosed in financial statement footnotes.

Whereas most pension plans were overfunded upon adoption of SFAS No. 87, most retiree health plans were not prefunded, in part, due to the absence of tax incentives. In addition, because most firms had been accounting for the benefits on a cash basis, most of their retiree health benefit liabilities were not on their balance sheets. Consequently, upon adoption of SFAS No. 106, most firms had large liabilities that had to be recognized. Firms could recognize this liability (transition liability) immediately as a cumulative effect of an accounting change or delay recognition by expensing it over a period not to exceed 20 years.[3] In either case, the total liability was disclosed in financial statement notes.

Because of the complexity of the new calculations and because compliance with SFAS No. 106 may have caused some firms to violate their debt covenants, mandatory adoption was delayed to fiscal years beginning after December 15, 1992. However, Securities and Exchange Commission (SEC) Staff Accounting Bulletin No. 74 (SAB No. 74) required firms to discuss the impact of SFAS No. 106 in the Management Discussion and Analysis section of their 10-Ks each year prior to adoption. Few liability estimates were provided in 1990 financial statements, but most firms gave point or range estimates in 1991. Mittelstaedt, Nichols, and Regier (1995, 538) indicate that 60% of their sample firms adopted SFAS No. 106 prior to 1993, with most of the early adoptions coming in 1992. Most of the early adopters also elected immediate recognition of the transition obligation.

Effects of SFAS No. 106

Warshawsky, Mittelstaedt, and Cristea (1993) used methods developed in Warshawsky (1992) to estimate the effects of SFAS No. 106 before the SFAS No. 106 liability amounts were disclosed in financial statements. The method in that study obtained estimates of SFAS No. 106 liabilities by multiplying disclosed pay-as-you-go costs by specific multiples according to the firm employee growth rate. Warshawsky, Mittelstaedt, and Cristea (1993, 195) estimated that

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[2]Actuarial gains and losses occur when actual plan experience is different from prior expectations. For example, increased longevity would cause an actuarial loss in that benefits would have to be paid for more years than originally expected. Prior service costs arise when workers or retirees are granted additional benefits for work already performed. Prior service benefits arise when amendments reduce benefits.

[3]A cumulative effect of an accounting change is shown on the income statement below income from continuing operations and above net income. It represents the total difference in income between the new accounting method and the old accounting method for all prior years. Stock analysts would not expect cumulative effects to affect income statements in future years.

the median retiree health care liability per firm (net-of-tax) was $46 million or approximately 6% of the market value of common equity.[4] They also estimated that SFAS No. 106 would decrease income in the years after adoption by approximately 5% if the transition liability is recognized immediately and by approximately 8% if it is amortized.

The authors also examine the potential effect of SFAS No. 106 by industry. The results of the industry analysis appear in the authors' Exhibit 5, which is reproduced in this testimony's table 3. The effect of SFAS No. 106 varied greatly across industries. The effect on the steel industry was expected to be the highest with a median increase to the debt asset ratio of 27% and a median decrease to ongoing earnings of 15%. Large negative effects were also prevalent in other capital intensive industries with two-digit SIC codes between 28 and 39.

Data from one of my current research projects indicate that some of the largest retiree health liabilities are still concentrated in these industries. According to 1999 data, General Motors and Ford (SIC code 3711) have liabilities of $44.6 billion and $19.9 billion, respectively. Other companies with liabilities in excess of $2 billion in these industries include Lucent Technologies (SIC code 3661), Boeing (SIC code 3721), Caterpillar (SIC code 3531), Lockheed Martin (SIC code 3760), Deere (SIC code 3523), Bethlehem Steel (SIC code 3312), USX - US Steel Group (SIC code 3312), and Eastman Kodak (SIC code 3861). In addition, several telecommunications companies (SIC code 4813) also have liabilities in excess of $2 billion, and several airlines (SIC code 4512) have liabilities in excess of $1.5 billion. We are still in the process of collecting data, but our current information indicates a total liability of $145 billion for just the 30 firms with the largest obligations. The liability for our entire 166-firm sample is $183 billion.

A number of studies have shown that these liabilities are considered by investors in setting stock prices. Amir (1993) and Mittelstaedt and Warshawsky (1993) suggest that the market was estimating the liabilities from pay-as-you-go costs prior to the disclosure of SFAS No. 106 liabilities. Consequently, there were not huge declines in market values as firms adopted SFAS No. 106. However, the studies suggested that the market did not appear to reduce share prices for the estimated liabilities dollar-for-dollar, thereby suggesting greater uncertainty about the costs or an expectation that the firms or the government would reduce the firms' obligations. Subsequent studies by Choi, Collins, and Johnson (1997) and Davis-Friday et al. (1999) using SFAS No. 106 liability disclosures also showed that the market reduced share prices for retiree health liabilities. However, Davis-Friday et al. (1999) suggest that amounts recognized on the balance sheet upon adoption of SFAS No. 106 were weighed more heavily by the market than were liabilities disclosed prior to adoption under SAB No. 74 requirements. Davis-Friday, Liu, and Mittelstaedt (2002) suggest that the underpricing may be due to market participants perceiving the disclosed amounts as less reliable.

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[4]Later studies using SFAS No. 106 liability amounts subsequently disclosed by firms obtain effects similar in magnitude (see, for example, Choi, Collins, and Johnson 1997, 365; Davis-Friday et al. 1999, 412).

In summary of this section, the results of prior studies and ongoing research indicate that retiree health obligations represent significant liabilities for firms in numerous industries. The liabilities are concentrated in large, old, capital-intensive firms. Although the liabilities have grown since the 1950s, they were not recorded on employers' balance sheets until the early 1990s. Numerous studies show that investors reduce share prices in proportion to the magnitude of these liabilities.

Reductions in Retiree Health Benefits

Near the time that SFAS No. 106 was passed, there was a noticeable increase in the number of firms modifying plans to reduce benefits. Explanations for the plan reductions included the passage of SFAS No. 106, financial weakness of the plan sponsor, and increases in healthcare costs. Mittelstaedt, Nichols, and Regier (1995) (MNR) examine the prevalence of the reductions and whether the above factors influence the decision. Most of this section of the testimony draws heavily from that study.

MNR examined a sample of 71 firms that reduced healthcare benefits and 131 firms that had not announced benefit reductions by the end of 1992.[5,6] They examined financial statements to obtain SFAS No. 106 liabilities and pay-as-you-go costs and to ascertain whether firms reduced benefits.

The authors noted five types of benefit reductions. Their descriptions of the reduction types (MNR, 542) are reproduced below.

(1) *Cap employer contributions.* Firms that place fixed dollar caps on employers' total future contributions for retiree health care. The cap is often set at the level of contributions made by the firm in a prior year or that will be made in a predetermined future year, such as 1996.

(2) *Increase copayment amounts.* Firms that increase copayment requirements for benefits such as prescription drugs, dental, vision, or other medical-related benefits. Firms which switch from the coordination of benefits method or the Medigap coverage method to the carve-out method in coordinating Medicare benefits are also classified in this category.

(3) *Tie benefits to years of service.* Firms that amend plans to tie medical benefits to

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[5]Firms in utility or finance industries were not included in the sample of firms.

[6]The sample included firms from a variety of industry groupings and there was little industry clustering. Of the 24 industry groups, only eight groups represented more than 5 percent of the sample and no group represented more than 8 percent of the sample. The proportion of benefit-reducing firms within an industry grouping equaled or exceeded 50 percent in the publishing, electronic components, computers, automobiles, and air transport industry groupings.

years of service. For example, plans may stipulate that retirees receive a certain percentage of medical credit for each year of service, starting at age 40 up to a maximum of 20 years for 100 percent coverage.

(4) *Change to a defined contribution plan.* Firms that change from defined benefit to defined contribution plans. In defined contribution plans firms fund individual accounts that can be used to pay for health care upon retirement. Health benefits depend on the amounts contributed, investment return, and forfeitures from participants leaving the firm. There is no guaranteed health benefit upon retirement.

(5) *Eliminate benefits.* Firms that eliminate health care benefits for certain classes of employees.

MNR (545) report that for their sample, 16 firms limited employer contributions, 15 firms increased retiree copayments, five firms based benefits on years of service, two firms switched to defined contribution plans, and eight firms eliminated health care benefits for various classes of existing employees.[7] In addition, 25 firms stated that benefits were reduced, but did not specify the method. The reductions could affect four different employee groups: new hires, partially eligible active plan participants, fully eligible active plan participants, and retirees. For the 35 firms that disclosed the group affected by the reduction, 43% related to all participants, 51% related to all active participants and new hires, and 6% related to partially eligible active participants and new hires.

Thirty-four firms reported the dollar amount of the reductions. The reductions, as a percentage of the postretirement benefit liability, ranged from 0.2% to 80.0% with a median (mean) of 22.0% (25.7%). There was not a clear relation between type of modification and severity of benefit reduction.

With regard to motivation for the plan reductions, the study found that 89% of health care benefit reductions were made within one year of SFAS No. 106 adoption. Only 10.5% of the healthcare reductions were made prior to 1990, even though the U.S. medical inflation rate greatly exceeded the general inflation rate throughout the 1980s. In addition, firms with high SFAS No. 106 liabilities and high existing debt were more likely to reduce benefits. The effect of SFAS No. 106 on benefit reductions held after controlling for industry membership, financial condition, and firm-specific health care costs. The authors suggested that this finding is consistent with managers attempting to reduce current or expected contracting costs associated with obtaining capital (MNR, 555). However, they also note that in complying with SFAS No. 106, managers may have recognized that their firms could not afford the promised benefits. Under this reasoning, SFAS No. 106 accelerated decisions that would have been made over a

[7]Seven firms that reduced benefits for existing employees also eliminated benefits for new hires.

longer period of time as it became clearer that the obligations could not be honored. The authors infer from their findings that different debt or labor contracts would have been written if SFAS No. 106 requirements had always been present (MNR, 536).

The authors also conclude that financial weakness is related to benefit reductions. Firms that reduce benefits have significantly higher debt to total assets ratios up to three years before the year of the reduction. The firms also had lower cash flows from operations and income from operations in the year of the reduction. These results hold with and without industry adjustment. The cash flow and income results also suggest that the industries of the cut firms may have been declining during the three years prior to the cuts. When the authors control for the SFAS No. 106 effect and firm-specific health care costs, industry-adjusted results indicate that cut-firms have higher debt to asset ratios and larger decreases in cash flow near the time of the plan reductions (MNR, 553).

The results for the firm-specific retiree health care costs are mixed. Unadjusted and industry-adjusted median values of pay-as-you-go costs to sales revenue are significantly higher for the benefit-cut firms in the year of the cut and the three years preceding the cut-year. However, the cut firms do not experience significantly higher increases in costs. When the authors control for the SFAS No. 106 effect and financial weakness, none of the health cost variables are significant. Additional tests indicate that the reason for the weak result is that the pay-as-you-go cost measures are correlated with the SFAS No. 106 effect measure, thereby suggesting that firms with large SFAS No. 106 liabilities and other balance sheet debt also had higher pay-as-you-go costs.

Although MNR was based on data from the early 1990s, I believe that the study's findings are still relevant today. Firms with high retiree health benefit liabilities and high other debt obligations will experience the most pressure to reduce benefits. In addition, if firms experience cash flow or income shortfalls, they will be more likely to reduce retiree health benefits. In a new research project, I am continuing to see firms amending their plans in attempts to reduce their exposure to rising medical costs.

Conclusions and Recommendations

Private retiree health benefit plans represent an important source of wealth to millions of U.S. citizens. These plans are primarily sponsored by old, large, capital-intensive firms. Firms with the largest liabilities are in industries such as automobiles, telecommunications, aircraft, industrial equipment, steel, and air transport. However, some firms in almost every industry sponsor these types of plans. Because of the breadth of coverage, I believe that it would be difficult for the U.S. government to justify giving relief to just one industry.

Over the past decade, firms sponsoring retiree health benefit plans have tried to reduce their exposure to rising medical costs by modifying plan agreements. I believe that firms' decisions to modify rather than end benefits suggests that managers wish to maintain good

relations with labor and also provide some income security to their firms' retirees. However, firms do not wish to be at risk for rising healthcare costs and changes to Medicare over the next 50 years. Consequently, many younger employees at these firms will not have retiree medical benefits, and many middle age workers will have lower benefits than current retirees. I also believe that few firms are establishing new retiree health benefit plans.

The decline in retiree benefit coverage raises difficult policy issues. If Congress wishes to slow the decline, it could encourage coverage by providing additional tax incentives for prefunding. Prefunding would also provide more protection for plan participants in the case of sponsor bankruptcy. However, tax incentives would reduce government revenue. Congress could also encourage these plans by liberalizing Medicare or somehow decreasing medical inflation. Again, liberalizing Medicare would require additional revenue or reductions in other government programs. In any event, Congress should consider these plans in any deliberations aimed at reducing healthcare costs or altering Medicare.

If retiree health plan coverage continues to decline, then Congress may wish to encourage more education on retirement planning or provide tax favored vehicles for individuals to save for their medical care during retirement. If workers do not plan early for potential medical costs during retirement, they may not be able to afford needed medical care or they may become destitute trying to pay for it. I do not believe that either outcome is desirable.

This concludes my statement. I would be happy to answer any questions you may have.

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Table 1. Sample by Industry
Source: Warshawsky, Mittelstaedt, and Cristea (1993, 191, Exhibit 1)

Industry	2 and/or 3 Digit SIC	Firms with Retiree Health Plans	Firms without Retiree Health Plans
Agriculture	01-08	1	4
Mining	10-12,14	11	13
Oil & Gas Exploration	13,353	10	59
Construction	09,15-17,24,25	8	39
Food and Tobacco	20,21	26	32
Textiles and Apparel	22,23	9	40
Paper	26	16	14
Publishing	27	10	26
Chemicals	280-282	17	11
Pharmaceuticals	283	11	23
Specialty Chemicals	284-289	17	20
Petroleum Refining	29	21	7
Rubber, plastic, leather	30-31	6	35
Glass, cement, ceramic	32	15	2
Steel	331-332	14	14
Metalworks	333-336	11	2
Metal parts	339,34	15	32
Industrial Equipment	351,352,354	21	9
Small Industrial Mach.	355,356,358,359	15	35
Electrical Machinery	360-364,369	9	29
Telecomm. Equipment	365-366	4	25
Electronic Components	367	4	34
Computers	357,368	9	32
Automobiles	371,375	17	17
Aircraft	372,376	19	7
Misc. Manufacturing	38,39	22	76

Table 1 (CONTINUED). Sample by Industry
Source: Warshawsky, Mittelstaedt, and Cristea (1993, 191, Exhibit 1)

Industry	2 and/or 3 Digit SIC	Firms with Retiree Health Plans	Firms without Retiree Health Plans
Commercial Transport	373,374,379,40, 42,44,46	13	18
Air Transport	45,47	10	10
Telecommunications	48	18	21
Electric Utilities	491	47	8
Natural Gas	492	37	12
Other Utilities	493-499	49	18
Wholesalers	50-51	10	79
Building Mat'l - Retail	52	0	6
Department Stores	53	5	18
Specialty Stores	55-59, except 591	4	73
Grocers	54,591	6	15
Financial Services	60-62	52	123
Insurance	63	17	38
Investors	64-67	3	152
Personal Services	70,72,739,76-80, 82-83	2	86
Business Services	73(except 739),75, 87,89	9	69
Total		620	1383

Table 2. Descriptive Statistics
Source: Warshawsky, Mittelstaedt, and Cristea (1993, 192, Exhibit 2)

	Firms with Retiree Health Plans		Firms without Retiree Health Plans	
Characteristic	Mean Median Std. Dev.	Minimum Maximum	Mean Median Std. Dev.	Minimum Maximum
Market Value of Common Stock (in millions)	2555.8 955.2 5402.6	2.8 71874	430.7 86.5 1275	0.595 23536
Total Assets (in millions)	7894.8 1971.4 19132.5	16.5 207666	1336.3 170.8 5289.0	2.073 97455
Sales (in millions)	4188.5 1493.3 9340.9	31.6 121816	600.4 140.3 1623.5	0.012 25864
Employees (in thousands)	25.5 8.38 54.7	0.12 766	5.77 1.38 18.7	.011 330
Debt / Total Assets	0.655 0.623 0.208	0.135 2.151	0.586 0.571 0.281	0.003 3.417
After-tax Income from Continuing Operations / Total Assets	0.040 0.046 0.103	-1.635 0.473	0.034 0.035 0.213	-2.749 4.708
Pretax pay-as-you-go Reported Retiree Health Cost (in millions)[a]	14.7 2.5 62.9	0.01 1130.0	NA	NA
Number of Observations	620		1383	

[a]Reported pay-as-you-go statistics are based on the 476 firms that report the amount of pay-as-you-go costs and were not accruing expected retiree health costs for active workers during 1988.

Table 3. Statement No. 106 Effects by Industry
Source: Warshawsky, Mittelstaedt, and Cristea (1993, 197, Exhibit 5)

		Income Statement Effect						Balance Sheet Effect	
		Delayed Recognition		Immediate Recognition				Immediate Recognition	
Industry	2 and/or 3 Digit SIC	Percentage Change in After-tax Earnings		Percentage Change in After-tax Earnings (ongoing expense)		Percentage Change in After-tax Earnings (additional charge in adoption year)		Percentage change in Debt / Total Assets	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median
Mining (8)[a]	10-12,14	-65.2	-8.3	-33.9	-5.7	-650.2	-53.2	21.8	15.6
Oil & Gas Exploration (7)	13,353	-25.1	-16.1	-17.0	-10.9	-217.9	-222.9	5.8	4.8
Construction (6)	9,15-17, 24,25	-19.5	-11.2	-10.1	-5.6	-255.3	-147.1	17.9	4.6
Food and Tobacco (18)	20,21	-18.3	-3.5	-10.6	-1.8	-152.5	-35.2	11.8	5.1
Textiles and Apparel (7)	22,23	-35.6	-22.3	-22.3	-15.2	-265.3	-142.7	15.2	9.7
Paper (11)	26	-5.4	-3.5	-3.3	-1.8	-42.2	-28.3	5.8	4.5
Publishing (7)	27	-4.6	-4.6	-2.8	-2.8	-34.7	-31.9	5.6	5.3
Chemicals (14)	280-282	-17.7	-12.1	-11.4	-7.3	-126.9	-104.3	17.4	10.1
Pharmaceuticals (8)	283	-5.8	-4.6	-3.7	-2.6	-41.2	-30.9	9.7	8.5
Specialty Chemicals (11)	284-289	-22.8	-8.5	-13.5	-4.5	-186.7	-64.4	10.4	6.8
Petroleum Refining (17)	29	-44.3	-8.2	-24.0	-5.3	-418.2	-57.6	5.3	5.4
Rubber, plastic, leather (6)	30-31	-12.9	-9.6	-7.7	-6.2	-138.0	-75.7	11.8	11.7
Glass, cement, ceramic (11)	32	-25.4	-11.5	-14.3	-7.4	-258.4	-114.8	12.2	11.3
Steel (12)	331-332	-54.8	-29.3	-34.5	-15.3	-423.4	-236.8	35.2	26.9
Metalworks (8)	333-336	-327.9	-8.5	-213.4	-5.6	-2291.1	-61.6	10.8	8.6
Metal parts (11)	339,34	-6.9	-6.5	-4.0	-3.6	-74.9	-57.9	9.3	7.5
Industrial Equipment (21)	351,352, 354	-230.4	-21.4	-118.9	-11.1	-2287.5	-198.0	23.7	11.7
Small Industrial Mach. (13)	355,356, 358, 359	-26.3	-27.9	-16.2	-14.7	-231.9	-213.8	14.0	10.2

Table 3. Statement No. 106 Effects by Industry
Source: Warshawsky, Mittelstaedt, and Cristea (1993, 197, Exhibit 5)

		Income Statement Effect						Balance Sheet Effect	
		Delayed Recognition		Immediate Recognition				Immediate Recognition	
Industry	2 and/or 3 - Digit SIC	Percentage Change in After-tax Earnings		Percentage Change in After-tax Earnings (ongoing expense)		Percentage Change in After-tax Earnings (additional charge in adoption year)		Percentage change in Debt / Total Assets	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median
Electrical Machinery (6)	360-364,369	-7.9	-7.9	-4.5	-4.5	-69.7	-61.2	13.5	13.8
Electronic Components (4)	367	-139.1	-48.4	-91.6	-27.2	-1000.0	-524.7	15.6	13.1
Computers (7)	357,368	-90.1	-3.2	-45.7	-1.7	-917.2	-29.9	16.1	4.6
Automobiles (16)	371,375	-34.3	-23.7	-19.5	-12.5	-321.1	-243.7	15.0	10.8
Aircraft (16)	372,376	-18.2	-16.9	-10.4	-8.5	-182.2	-167.8	10.8	9.9
Misc. Manufacturing (17)	38,39	-16.4	-12.8	-10.1	-8.3	-173.6	-132.4	12.1	10.6
Commercial Transport (10)	373,374, 379, 40,42, 44,46	-33.5	-4.1	-22.2	-2.2	-304.6	-103.1	3.2	2.5
Air Transport (7)	45,47	-10.8	-11.8	-6.9	-7.7	-134.4	-85.7	4.2	4.2
Telecommunications (16)	48	-15.9	-13.8	-10.0	-9.1	-143.3	-120.2	9.8	6.8
Electric Utilities (33)	491	-10.2	-4.0	-6.5	-2.6	-90.6	-30.5	3.3	2.1
Natural Gas (30)	492	-19.0	-12.8	-11.6	-8.0	-160.9	-113.4	7.2	5.0
Other Utilities (36)	493-499	-13.6	-5.7	-8.6	-3.4	-106.0	-41.7	5.8	2.8
Wholesalers (4)	50-51	-24.6	-17.9	-16.5	-11.8	-160.9	-121.4	15.9	10.7
Department Stores (4)	53	-30.3	-21.5	-18.9	-11.3	-227.9	-203.8	4.4	4.6
Financial Services (46)	60-62	-4.0	-2.1	-2.6	-1.3	-50.9	-17.2	0.2	0.2
Insurance (16)	63	-4.6	-2.8	-2.4	-1.4	-56.2	-26.1	0.6	0.4

[a]The number of firms in each industry sponsoring retiree health plans and meeting data requirements appears in parentheses. Only industries with four or more firms are included in the analysis.

APPENDIX E - STATEMENT OF VINCENT E. KERR, M.D., DIRECTOR OF HEALTHCARE MANAGEMENT, FORD MOTOR COMPANY, DEARBORN, MI

Testimony of Dr. Vincent E. Kerr, MD
Director of Healthcare Management, Ford Motor Company

May 16, 2002

Introduction

Good morning, Chairman Johnson, Ranking Member Andrews, and Members of the Committee. It is my pleasure to be here today to discuss Ford Motor Company's retiree health care coverage – I am Dr. Vincent Kerr, Director of Healthcare Management for Ford Motor Company. In this position, I am responsible for all aspects of Ford's health care programs, including occupational health & safety, worker's compensation, and health care benefits for employees, retirees, and their dependents around the world.

First of all, I commend the chairman and the members of this Subcommittee for addressing this very important subject. In my statement before you today, I'd like to discuss Ford's experience in providing health care benefits to our retirees and the challenges we face in continuing to provide this coverage, in order to assist Congress to better understand the state of employer sponsored retiree health care benefits and why we believe this is such an important issue.

Ford Health Care Costs

In the United States alone, Ford provides health care coverage for over 560,000 employees, retirees and their dependents, located in all 50 states. In 2001 Ford's total cost, including the FAS 106 liability, was $2.5 billion. The 2001 cost represents a 25% increase over 2000. Of the $2.5 billion cost, retiree health care was $1.6 billion. These numbers reflect the spin-off of our Visteon automotive supply division. Although the UAW Visteon workers remain Ford employees and Ford procures their health care, their costs are paid by Visteon and are not reported in Ford's financial results. Therefore, for our purposes today, Ford UAW employees at Visteon Corporation will not be included in our discussion.

At Ford, the retirees and their dependents account for approximately 246,000 people. Although the retiree population represents less than half of the total population (44%), their health care cost accounted for 66% of the total cost in 2001.

One of the key factors driving Ford health care costs, particularly among our retirees, is prescription drugs. Several factors have contributed to this steady growth in our pharmacy costs:

- First, the utilization of prescription drugs has increased. Our retirees

are taking more prescription drugs, and often for chronic conditions, which require the medication for life.

• Second, the cost of prescription drugs has increased. Drugs that are new to the market are typically more expensive, and quickly replace older, less expensive drugs. Some new drugs have proved to have substantial benefits, while others have offered little improvement over the existing prescription drugs in the same category currently in the market place, and have only served to increase costs.

Pharmacy costs have been rising at an alarming rate with a 14% increase in 2000, a 15% increase in 2001 and a projected 15% increase in 2002. The 2002 forecast for pharmacy cash costs in Ford's traditional medical plans is $358 million, $310 million of that forecasted for our retirees, both salaried and hourly. This figure does not include the drug cost included in premiums paid for managed care plans (71% of active and 25% of retirees subscribe to such plans). Therefore, including costs of drugs paid by managed care plans, one can project that Ford will spend approximately $550 million on prescription drugs this year. The relatively small increase (15%) compared to the national average reported in the news media (18 to 20% increase) is due to a change in benefits for salaried employees and retirees, which I will describe in a moment.

One additional thought on pharmacy costs -- A recent CBO study projected that drug spending per person would increase 10.1% every year for the next ten years. That is a truly sobering prospect. If this occurs, Ford's pharmacy costs of $550 million would double by 2009.

Ford Retiree Coverage

Ford Motor Company presently provides comprehensive retiree health care benefits. Eligibility is based on age and years of service. Our present health care plans generally provide that an employee who retires under our pension plans with 30 years of service at any age, or at 55 years of age with 10 years of service, receives retiree health care benefits. There are some exceptions to these guidelines, such as retirement based on total and permanent disability. Spouses and other eligible dependents of retirees are also eligible to receive health care coverage.

Ford offers retirees a variety of health care options, including traditional (fee-for-service) plans, Preferred Provider Organizations (PPOs), and Health Maintenance Organizations (HMOs). Ford Motor Company self-insures our traditional plans and those plans are administered by Blue Cross Blue Shield and UNICARE.

Ford health care coverage is the primary coverage for our younger retirees who are not eligible for Medicare. The health care benefits are comprehensive, and include a prescription drug benefit, with no annual cap. For the most part, the health care transition from active employment to retirement is seamless, with no difference in health care coverage. When our retirees reach Medicare eligibility, Ford's coverage

becomes secondary. We reimburse the Part B premium for our retirees, and cover certain benefits not included in Medicare, such as prescription drugs, again with no annual cap. In certain areas of the country where we have approved Medicare+Choice plans, some of our retirees began to enroll in these plans in 1999, but the penetration into our population has been limited.

Ford Initiatives

Faced with many challenges in the delivery of health care benefits to our employees, retirees, and their dependents, Ford has undertaken a variety of initiatives to both improve quality and control costs. I would like to emphasize that we are equally concerned about quality improvement and managing costs.

We use several methods to evaluate the quality of care provided by individual providers, hospitals, and health plans, including requiring all Ford offered HMOs to be certified by the National Committee for Quality Assurance (NCQA), and all PPOs to be accredited by the NCQA or the Utilization Review Accreditation Commission (URAC).

We also are significantly increasing our efforts in measuring and reporting the quality of services by comparing patient satisfaction among individual hospitals and health plans, and by comparing hospital performance in terms of quality and cost for specific diseases. For example:

- ***Hospital Profiles*** – in partnership with the UAW, GM, Daimler-Chrysler, and other businesses, we evaluate the quality of hospitals in six major metropolitan areas in the U.S.

- ***Patient Safety*** – we are a key member of the Leapfrog Group, which is an organization of leading Fortune 500 companies created to reduce preventable medical errors by requiring hospitals to report information on their specified safety metrics.

In addition, we continuously communicate our expectations to our major health care suppliers, through conferences and individual meetings. We have met with the senior leadership of virtually all of Ford's health care suppliers and major providers (hospitals and physicians) to convey the urgency of improving efficiency and safety.

We are equally dedicated to providing health care education to employees and retirees. We provide an online benefit comparison guide with educational information, which includes quality ratings of health plans, prescription drug information and links to important health care information websites. The quality ratings result from a health plan report card that was developed in partnership with DaimlerChrysler, General Motors, the State of Michigan and other employers. Ford also has provided an online tool that allows employees to evaluate their own health risks, and record and track their individual and family health improvement efforts.

In addition to our e-health efforts, we have developed educational campaigns that focus on subjects of importance to the Ford population. We have used electronic, print media and face-to face seminars to educate employees, retirees and their families on the use of generic drugs, breast cancer detection and treatment, encouraging organ donation, Hepatitis C awareness and other subjects.

Now I'd like to discuss specific initiatives we have undertaken to manage the cost increases:

Cost Sharing

We recently announced the following changes to the salaried retiree health care benefits:

- Salaried employees and present retirees hired before June 1, 2001 are required to make monthly contributions for their health care coverage throughout retirement. Early retirees not yet enrolled in Medicare make contributions approximately equal to the contributions paid by active employees – up to $150 per month depending on the size of family covered. The premiums will be approximately 20% less for those enrolled in Medicare.

- For salaried employees hired after June 1, 2001, the Company intends to make monthly contributions for the cost of health care coverage that will cover about 75% of the cost for an eligible retired employee and 50% of the cost for their eligible spouse and dependent child(ren) under the Ford Medical Plan (FMP). We also are in the process of establishing an employee pay-all VEBA Trust so that eligible employees may contribute, and invest, after-tax dollars to be used for retiree medical premiums and other qualified medical expenditures as defined under the IRS code.

Prescription Drug

Within my Healthcare Management Department, we have a pharmacy team headed by a medical doctor charged with managing our pharmacy programs in terms of quality assurance and cost management. Some of the programs implemented by the team include the following:

- Effective June 1, 2001, we changed the tiered co-pay for prescription drugs, in an effort to more strongly encourage the use of generic drugs for salaried employees and retirees.

- We also encourage the use of mail-order prescription drugs by employees and retirees which allows them to receive up to 90-day supply and waiving one of three co-pays associated with 90-day supply.

- We have implemented a dosage optimization program where we communicate to health care providers of the opportunity to simplify dosage regimen (one pill instead of two per day, for example).

- To reinforce these and other quality assurance programs, we are undertaking a pilot program called Academic Detailing Report Physician Prescription pilot, in conjunction with Blue Cross-Blue Shield of Michigan, where physicians at participating hospitals are provided financial incentives for promoting dose optimization, use of generic drugs, and appropriate use of antibiotics.

Closing

I hope this helps you better understand the challenges that employers face in providing health care coverage to retirees. The domestic automotive industry is facing an intensively competitive international market, exacerbated by a weak yen. In partnership with the UAW, it is encumbent on us together, to come up with a viable business model that ensures competitive success while simultaneously continuing to provide a cost-effective, quality health care to all of our employees and retirees. I'd like to once again thank you for the invitation to share our experiences with you and commend you for examining this very critical issue.

At this point time, we do not have any specific recommendations as to how to address the issue of accounting for retiree health care obligations; however, we believe it is in all stakeholders' interest -- our employees and retirees, the investor community, dealers, and the consumer -- to ensure that there is full and fair disclosure of any liabilities facing the Company, including our health care obligations to retirees.

Finally, while I understand some of them may fall under jurisdictions of other committees, I'd like to leave you with a few suggestions on how Congress could assist employers in managing the financial burden of offering retiree health care benefits:

- ***Medicare Reform, including prescription drug coverage:***

  - Medicare's current eligibility age should be maintained since raising it fails to address underlying cost drivers.

- Employers who voluntarily establish or maintain retiree health coverage should not be discouraged from doing so (through increased pay-roll taxes, for example).

- Broad-based financing for Medicare reforms should be adopted, instead of "quick-fix" solutions.

- Prescription drug coverage must go hand-in-hand with the modernization of Medicare. Furthermore, it should be universal; meaningful and affordable to both beneficiaries and taxpayers; must be oriented to achieve positive medical outcomes and value; and should provide incentives for employers who are already offering the coverage to continue to do so (by allowing them to wrap-around the benefit, for example).

• ***Promote the use of generic drugs:*** Congress should carefully examine the existing patent process for prescription drugs and close any "loopholes" which may prevent generics from reaching the market. Our analysis indicates that Ford Motor Company saves $1.7 million for every one percentage point increase in the use of generic drugs. Any legislative action in this area, however, should avoid discouraging research and development for future innovation.

• ***Reject benefit mandates:*** Legislation that discourages employers from offering health benefits to their employees and retirees should be rejected. Legislation that imposes mandates on employer sponsored health care or that creates unlimited liability for routine coverage and administrative decisions will ultimately reduce the availability of health coverage and is likely to adversely affect retiree health first.

• ***Promote health care education:*** Finally, we believe that the government must re-double its efforts to promote evidence-based health care delivery. We are in the middle of an explosion of knowledge and technology in the field of health care. Ultimately, we can only succeed in our roles as health care sponsors and purchasers by being even smarter about what works best and by putting our research and coverage dollars behind proven practices.

APPENDIX F – SUBMITTED FOR THE RECORD, LETTER FROM VINCENT E. KERR, M.D., DIRECTOR, HEALTHCARE MANAGEMENT, FORD MOTOR COMPANY, TO CHAIRMAN SAM JOHNSON AND RANKING MEMBER ROBERT ANDREWS, SUBCOMMITTEE ON EMPLOYER-EMOLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE, JUNE 10, 2002

Ford Motor Company

June 10, 2002

The Honorable Sam Johnson
U.S. House of Representatives
1030 Longworth House Office Bldg.
Washington, DC 20515

The Honorable Robert E. Andrews
U.S. House of Representatives
2439 Rayburn House Office Bldg.
Washington, DC 20515

Dear Chairman Johnson and Ranking Member Andrews:

I am writing in response to the Ranking Member Andrews's request, made at the May 16, 2002 Subcommittee hearing on Retiree Health Legacy Cost, for suggestions that would allow employers tax-efficient pre-funding of retiree health care benefits.

Our Understanding of Available Tax-Efficient Vehicles that Allow pre-Funding of Retiree Health Care Benefits Within the Existing Tax Code:

- The present tax law permits limited pre-funding of retiree health care costs: code sections 419 and 419A allow tax-efficient pre-funding for certain unionized employees by establishing VEBAs (voluntary employees' beneficiary associations); and code section 401(h) allows certain pension contributions to be used for retiree health care expenses. Code section 401(h) is of limited use if the pension plan is over-funded.
- For very over-funded plans, code section 420 allows transfer of certain excess pension assets to a 401(h) account if the surplus exceeds the 125% threshold and the "five year cost maintenance period" requirements are met. This provision expires at the end of 2005.

Options:

- Relax code sections 419 and 419A rules to allow for tax-efficient non-collectively bargained VEBAs. The new rules should be crafted, however, to allow maximum flexibility to the employers in terms of the amount and timing/frequency of contribution such that their financial burden would not become too onerous.
- Relax the threshold and "five year cost maintenance period" requirements imposed by code section 420 for 401(h) account transfer.
- Allow pension plans to increase pension payouts, specifically directed to pay for retiree health care premiums, with the increased payments being tax-free to retirees (thereby the net effect to retirees would be zero).
- Allow retirees to participate in "cafeteria plan" arrangements, with the pre-tax elections reducing their pension or other deferred compensation.

Thank you once again for the opportunity to comment on this very important subject.

Sincerely,

/s/

Vincent E. Kerr, M.D.
Director, Healthcare Management
Ford Motor Company

APPENDIX G – SUBMITTED FOR THE RECORD, "RESPONSE TO QUESTION REGARDING TAX DEDUCTIONS FOR PREFUNDING RETIREE HEALTHCARE", H. FRED MITTELSTAEDT, MAY 23, 2002

Response to Question Regarding Tax Deductions for Prefunding Retiree Healthcare

H. Fred Mittelstaedt
May 23, 2002

As stated in my written testimony on page 8, I believe providing additional tax incentives for prefunding would encourage employer-sponsored retiree health benefit plan coverage. I also believe that prefunding would provide more security for workers. As we have seen in recent months with LTV and Bethlehem Steel, when firms go bankrupt, both workers and retirees lose their healthcare benefits.

The government could pay for the tax incentives by taxing retiree health benefits as they are received or as plans are prefunded. In addition, the government could reexamine the taxation of current health benefits for active workers. At the present time, workers are not taxed for the employer's share of group healthcare coverage. I believe taxation of healthcare benefits was considered several years ago, in part, to make healthcare costs more salient to workers.

The decline in retiree healthcare coverage is part of a larger problem related to the U.S. medical care system. We have problems with rising medical costs and with providing adequate healthcare to the poor, working poor, and retirees. Attempts to control Medicare costs have prompted some doctors to stop seeing Medicare patients or to leave the profession. Such changes also can increase the cost of employer Medigap retiree health plans, thereby making them less attractive. I do not know how to solve all of these problems. My main point is that the decline in employer-sponsored retiree health coverage cannot be addressed in isolation. Instead, it must be addressed within the larger context of providing healthcare to an aging population for the next 50 years.

APPENDIX H – SUBMITTED FOR THE RECORD, STATEMENT FROM MICHAEL S. GORDON, GENERAL COUNSEL, ON BEHALF OF THE NATIONAL RETIREE LEGISLATIVE NETWORK (NRLN), WASHINGTON, D.C., MAY 28, 2002

NRLN
NATIONAL RETIREE LEGISLATIVE NETWORK, INC

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Roland Chernek
Fred Churchill
William Jones
Kevin Mahar
Bill Murfy
Ron Orr
Nelson Phelps

Member Organizations:
Association of BellTell Retirees
Association of US WEST Retirees
Boeing (Engineering Society Retirees)
GE Retirees
GM Retirees
IBM Retirees
Johns Manville Retirees
National Association of Prudential Retirees
Portland General Electric-Enron
Raytheon Retirees
SNET Retirees
Western Union Retirees

May 28, 2002

The Honorable Sam Johnson
Chairman
Employer-Employee Relations Subcommittee
Committee on Education and the Workforce
Room 1030
Longworth House Office Building
U.S. House of Representatives
Washington, D.C. 20515

-and-

The Honorable Robert E. Andrews
Ranking Member
Employer-Employee Relations Subcommittee
Committee on Education and the Workforce
Room 2439
Rayburn House Office Building
U.S. House of Representatives
Washington, D.C. 20515

Re: **Submission of Written Statement on Behalf of The National Retiree Legislative Network (NRLN) In Connection With Hearing Before The Subcommittee On Employer-Employee Relations, Committee On Education And The Workplace, U.S. House of Representatives, May 16, 2002, On "Assessing Retiree Health Legacy Costs: Is America Prepared For A Healthy Retirement?"**

Dear Mr. Chairman and Mr. Ranking Member:

On behalf of the National Retiree Legislative Network (NRLN), I respectfully request that the attached written statement reflecting NRLN's views on the subject-matter of the above-referenced hearing be included in the written record of the hearing in accordance with the applicable procedures established by the Subcommittee on Employer-Employee Relations.

Please do not hesitate to contact the undersigned if you have any inquiry in this regard. Your attention to this matter is appreciated greatly.

Sincerely,

Michael S. Gordon

Michael S. Gordon
General Counsel.

Assessing Retiree Health Legacy Costs: Is America Prepared for a Healthy Retirement?

Written Statement Submitted on Behalf Of the National Retiree Legislative Network (NRLN)

Michael S. Gordon
General Counsel, NRLN

In Connection with:

Hearing before the Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce, U.S. House of Representatives, May 16, 2002

INTRODUCTION

This written statement is being submitted for inclusion in the record of the Subcommittee on Employer-Employee Relation's hearing of May 16, 2002 on retiree health benefit cost issues. It is being submitted on behalf of the National Retiree Legislative Network (NRLN), a Washington, D.C. based grassroots retiree organization that was formed in April 2001 to deal specifically with the problem of post-retirement health benefit loss under private-sector company-sponsored plans.

All the retiree groups that belong to NRLN - many from major companies like Verizon, General Motors and General Electric - have members who have had first-hand experience over the past two decades with significant, adverse post-retirement reductions in, or revocations of, their company-provided health benefits. In most instances, retirees have not succeeded in getting these cutbacks reversed, either in the courts 1/ or otherwise.

So far, the testimony received by the Subcommittee on this subject has been provided by those who personally have not experienced post-retirement health benefit cutbacks, but rather are company or collective bargaining representatives, consultants or academics. They have explained this problem in the same way that meteorologists might explain the occurrence of an extended period of especially bad weather. Standing by itself, this testimony, however valuable its insights, does not move us very far in terms of being able to formulate a durable solution to what is, after all, not a meteorological problem but a human institutional one, and one that apparently is peculiar to the United States.

What is missing from this Subcommittee's review is the experience of the retirees themselves. One of the expert witnesses who testified before this Subcommittee on May 16 characterized the rules governing the accounting and financing of retiree health benefits as "regulatory schizophrenia". 2/ He may be right but what about the "legislative schizophrenia" that arises from a Congressional review of retiree health that fails to provide ample opportunity for the beneficiaries, the consumers of the retiree health plan product, to inform the Subcommittee of their perspective?

NRLN urges the Subcommittee to schedule further hearings on the retiree health crisis in company-sponsored plans with a view toward obtaining detailed testimony on the subject from retirees and their representatives, and particularly on HR 1322, the Emergency Retiree Health Benefits Protection Act, authored by Representative John F. Tierney (D. Mass.) and cosponsored by 90 members of the House. Make no mistake about it, if legislation ultimately emerges on this subject that is satisfactory only to plan sponsors, the decline in private-sector retiree health coverage and benefits will continue unabated and, indeed, may be exacerbated.

In the meantime, NRLN wishes to take this opportunity to discuss briefly some key aspects of the retiree health controversy which may be contrasted with the testimony that was presented on May 16. These are: (1) the role of ERISA, (2) FASB 106, (3) retiree health benefit funding, (4) the implications of adding prescription drug coverage to Medicare and (5) the relation of retiree health benefit loss to retirement income security.

ERISA and Retiree Health Benefits

ERISA requires private employment-based pension plans to adhere to vesting, funding, termination insurance, fiduciary and disclosure requirements. By comparison, ERISA requires employment-based health plans to comply only with fiduciary and disclosure requirements. In addition, whereas ERISA outlawed pay-as-you go funding in defined-benefit pension plans, it permits it in defined-benefit health plans, including retiree health plans.

ERISA's limited regulation of health plans, compared to its more comprehensive regulation of pension plans, has mystified a great many commentators. Even now, at testimony presented at this Subcommittee's May 16 hearing, one expert witness seemed baffled by ERISA's failure to regulate retiree health plan funding as strenuously as pension plan funding, stating that "[i]t seems particularly inconsistent that lawmakers worried about securing a retirement benefit provided in the form of cash, but did not show a similar concern about securing an in-kind benefit provided in the form of health insurance." 3/

But when ERISA's background is examined, the mystery of limited health plan regulation quickly vanishes. ERISA was enacted in 1974 and there was no inflationary health cost crisis in the 1970s. Health plan beneficiaries were not complaining about loss of their benefits as were pension plan beneficiaries in great numbers. Moreover, high-tech medicine had not appeared on the scene. The mortality rates of retirees still conformed to the standard actuarial projections, and there was no evidence of post-retirement cutbacks in retiree health benefits that might warrant legislative intervention. 4/

Moreover, there was no indication that pay-as-you go funding of retiree health benefits was unsatisfactory and required replacement by procedures that resembled those being mandated for pension plans. Whatever the theoretical inconsistencies or puzzles created by the differential regulation of health and pension plan funding, there was no practical health plan funding problem that compelled legislative attention.

Of course, the situation dramatically changed in the 1980s with the arrival of double-digit medical cost inflation, a development that had the most adverse implications for retirees since they were the ones that tended to need medical attention more frequently and were more prone to develop chronic illnesses. It is precisely at this point in time that companies initiated programs of post-retirement cutbacks in retiree health benefits, a course of action unknown to, and unforseen by, the ERISA legislators.

Thus, the issue presented to this Subcommittee is not what ERISA did or didn't do, but what should be done now in the face of dramatically altered conditions. This Subcommittee, and its counterpart in the Senate, confront a legislative task as great, if not greater, than the one faced by those who gave birth to ERISA. The damage being done to retirees by the inordinate post-retirement withdrawal of their health benefits is as great, if not greater, a cause for alarm than the

pre-ERISA failure of pension plan participants to obtain the retirement benefits they had counted on getting when they retired. Millions of retirees nationwide are looking to Congress for meaningful leadership on this issue just as millions of workers looked to Congress in the 1970s for leadership on protecting their pensions. These retirees will be greatly disappointed and disillusioned if such leadership is not forthcoming.

FASB 106

FASB 106 has been viewed by many employers and their advisors as a prime force behind the explosion in post-retirement health cutbacks and the general decline in retiree health plan coverage. This criticism is not without merit but it is important to bear in mind that FASB 106 is not directly responsible for the upsurge in retiree health benefit costs; that is a result of the economics of medicine and not how retiree health liabilities are disclosed.

Nonetheless, the role of FASB 106, or, more accurately, the role of the Financial Accounting Standards Board, requires careful examination in connection with any potential overhaul of ERISA's regulatory treatment of retiree health benefits. A quick review of the basic concepts behind FASB 106 will demonstrate why this is the case.

Prior to FASB 106, an employer that provided retiree health benefits had to disclose in a footnote to the company's annual statement, the annual pay-as-you-go cost of providing such benefits for retirees. No accrued liability for post retirement benefits "earned" by employees during their years of service was reported. This method of reporting corresponded quite well to the legal reality surrounding employer-provided health insurance for retirees. As has been observed previously, ERISA did not ban pay-as-you-go funding of retiree health benefits, and did not mandate any form of vesting in this regard, thus making the concept of "accrued" or "earned" retiree health benefits inapposite unless there was an enforceable contractual obligation of the employer to provide such benefits.

In essence, FASB 106 required employers to disclose their retiree health benefit liabilities as if their liabilities were enforceable legal obligations and if these liabilities were required to be funded like ERISA defined-benefit plan pension liabilities. FASB 106 eliminated footnote disclosure of retiree health liabilities by requiring such liabilities to be recorded in the main body of the company's financial statement, and it canceled the pay-as-you-go practice of accounting for such liabilities by instituting an accrual accounting methodology which basically required the employer to account for retiree health benefits as they were "earned" or "accrued" by employees rather than wait until claims were incurred or insurance payments made. In addition, FASB 106 required employers to assign and record on their financial statements their existing obligations to provide retiree health benefits based on their employees' years of past service, and, among other things, to take into account health cost inflation in calculating the extent of these liabilities.

Predictably, the adverse effect of the switch to accounting for retiree health under FASB 106 was enormous since suddenly billions of dollars in liabilities were transferred to corporate

balance sheets, upsetting debt-equity ratios and terrorizing unsophisticated investors who were unable to distinguish between real liabilities and artificially-imposed "accounting" liabilities. Moreover, Congress never enacted any form of funding-tax relief to complement FASB 106, so that, independent of rising retiree health care costs, there now came into being a consequential disincentive to establish or continue company retiree health programs. Indeed, some employers have specifically cited FASB 106 as the reason for terminating their retiree health plans. 5/

It may be that there was justifiable concern over the possible underreporting of growing retiree health liabilities prior to FASB 106, but the formal rationale given by the Financial Accounting Standards Board in support of FASB 106 was that retiree health benefits were a form of deferred wage, not a gratuity, and, therefore, accrual, as opposed to pay-as-you-go, accounting was required. Unfortunately, this rationale is inconsistent with the usual legal treatment given to retiree health benefits as well as with the legal treatment accorded to pensions prior to ERISA where pensions were also regarded as a form of deferred wage but not required to be vested unless the pension plan or contract so required.

It is true that the Congressional sponsors of ERISA often used the deferred wage theory to justify their contention that federal law should require employers to provide reasonable pension vesting privileges to their employees, and the same theory can be used to justify an ERISA amendment that would require reasonable vesting protections in retiree health plans. But that does not give the Financial Standards Accounting Board the right to enact accounting standards as if they were charged with enacting social legislation.

The point is that if Congress does enact some form of vesting protection for retiree health benefits, as it should, the Financial Accounting Standards Board must be prevented from acting like a super-Congress and, under the guise of exercising its professional autonomy, inflict greater burdens on employers than can be justified under the standards enacted by Congress itself. This responsibility is just one more on the list of things for Congress to do in connection with the post-Enron scrutiny of the accounting profession.

Retiree Health Benefit Funding

Despite the fact that FASB 106 made the absence of tax-privileged funding for retiree health benefits a public policy anomaly, for reasons described in testimony before this Subcommittee on May 16 -- mainly the perception of a potentially open-ended burden on the fisc -- no serious effort has been made to look into an appropriate retiree health funding methodology that could earn Congressional approval. It cannot be emphasized too strongly, however, that this problem has been complicated by the unwillingness of retiree health plan sponsors to embrace openly ERISA reforms that would provide reasonable protection to retirees against post-retirement cutbacks in their health benefits.

It should have been clear to all concerned quite some time ago that it would be irresponsible for Congress to authorize tax-privileged funding of retiree health benefits on

something other than a pay-as-you-go basis if employers insisted on retaining the unchecked prerogative to make post-retirement cutbacks in benefits they received a tax subsidy for funding. While there is nothing in the testimony provided to this Subcommittee on May 16 which explicitly rejects the idea of basing tax-privileged funding relief on post-retirement protections for retirees, neither is there any explicit affirmation of this principle, or anything resembling a public recognition of its validity by the plan sponsor community.

There is no way to escape from the morass created by FASB 106 without first acknowledging the urgent necessity of providing post-retirement protections to retiree health benefits. Once that is done, it is inevitable that funding reforms will follow.

The nature of the funding relief that could be provided remains to be determined. FASB 106 derives in large measure from the ERISA defined-benefit plan pension model but retiree health liabilities (really future retiree health benefit claims) are much less quantifiable than actuarially-determined future defined-benefit pension liabilities. This is not just a matter of the unpredictability of medical cost inflation but also the rapid turnover in medical technologies which can modify the characteristics of future retiree health insurance claims in ways unforseen to those who must make current funding decisions.

All this means, however, is that the ERISA pension funding model need not be slavishly followed in order to produce a sound formula for constructing a tax-favored funding procedure for retiree health. It does not mean that attempts to devise an appropriate retiree health funding approach should be abandoned or that retirees would fail to support such an effort once they are assured that they will be protected adequately against continuing post-retirement health cutbacks which have devastated so many of them.

The Implications of Adding Prescription Drug Coverage To Medicare

NRLN supports adding a prescription drug benefit to Medicare. Such an action is long overdue. However, in some quarters it is erroneously presumed that employers will no longer feel compelled to make post-retirement reductions in retiree health benefits, or such reductions will be far less frequent or painful, if Medicare covers prescription drugs. Unfortunately, such is not the case; the Medicare prescription drug scenario is not a silver bullet.

In the first place, adding a prescription drug benefit to Medicare does nothing for retirees who are not Medicare-eligible, which means virtually everyone who took early retirement from their company. The early retirees are totally dependent on their company's health plan and, in most instances, would not have agreed to take early retirement had they not been promised the continuation of their health benefit coverage, including coverage for prescription drugs. Obviously, post-retirement cutbacks in health benefits hits this group the hardest since until they become Medicare-eligible they have nowhere else to turn unless they are independently wealthy and/or exceptionally healthy.

It has been suggested that this problem could be solved if, in addition to authorizing a prescription drug add-on to Medicare, Congress also authorized a Medicare buy-in program for those who are not Medicare-eligible. It is not possible for NRLN to address the merits of such an approach in the absence of a specific proposal. However, even if a Medicare buy-in program were in the picture, the crux of the retirees' post-retirement dilemma would persist in one form or another.

Why should the early retiree have to use his or her funds to buy prescription drugs from Medicare if the employer promised the early retiree prescription drug coverage as part of a package to induce early retirement? Moreover, even if the employer agrees to subsidize Medicare prescription drug buy-in privileges for the early retiree, why should the employer be permitted to revoke at will a more generous form of prescription drug coverage that was a factor in the employee electing early retirement?

Even with a Medicare prescription drug buy-in program in place, those who retired before such a program became effective ought to be grandfathered from efforts to substitute the buy-in program for their employer-provided prescription drug insurance unless such retirees wish to waive such existing coverage in favor of the Medicare buy-in alternative. In other words, employers should be free to change their prescription drug arrangements for those who have not yet retired but should be restricted from imposing such changes on those who have already retired and made their financial plans for retirement on the basis of the benefits provided when they retired.

It should be also recognized that while shifting the burden of providing prescription drug coverage to Medicare could reduce future company costs for providing retiree health insurance, it still leaves open the question of whether employers should remain free to make post-retirement cutbacks in non-prescription drug retiree health benefits. What good is having greater access to reasonable prescription drug coverage if the retiree is cut-off from obtaining the medical assistance which is the predicate for obtaining the appropriate prescription drug treatment?

If prescription drug costs counts for the lion's share of the medical cost inflation experienced in retiree health plans, then shifting such costs to Medicare should reduce, if not eliminate, any need for post-retirement cutbacks in non-prescription drug retiree health benefits. In short, employers cannot have it both ways: they cannot advocate relieving themselves of their self-imposed burden of providing retiree prescription drug coverage and, at the same time, insist they should continue to have the right to make post-retirement cutbacks in other retiree health benefits whenever they wish to do so.

The Relation of Retiree Health Benefit Loss to Retirement Income Security

It is an open secret that the value of the pension benefits provided to retirees under ERISA pension plans are being watered down at a significant rate. This is not only a product of the

failure of many large employers with long-established defined-benefit pension plans to continue their historic practice of providing ad hoc cost-of-living increases to their retirees; it is also the result of the same employers generating wave after wave of post-retirement health cutbacks which force their retirees to cannibalize pension income in order to keep their employer-provided health insurance coverage intact and maintain access to the medical services they need.

This widespread shifting of increased retiree health costs to the retires themselves - generally, the most vulnerable part of the ERISA participant universe - is especially repugnant in light of the fact that many of the same plan sponsors that stopped providing retiree cost-of-living increases, while also mandating further post-retirement cutbacks in retiree health insurance, were sitting on huge, historically unprecedented surpluses in their defined benefit pension plans. It is no coincidence that the elimination or reduction of retiree health liabilities, coupled with the rejection of any further retiree cost-of-living charges on pension plan surpluses, enabled employers to show on their financial statements superficially high corporate profits that lured investors into thinking that these companies were more productive than they really were.

This is something that ought to be of concern to every member of this Subcommittee and every American who is counting on a secure retirement because of a belief that the pensions earned from employer plans will be sufficient to meet their retirement income needs. If an ever increasing share of the retirement benefits distributed by private pension plans is shifted into covering retiree medical costs without any compensating increase in the level of pension benefits provided by these programs, it will undermine the ability of employees to make adequate preparations for their retirement and hinder greatly the ability of employers to use their retirement programs to make needed workforce changes. Needless to say, the negative implications for future productivity and growth are quite serious.

In conclusion, NRLN believes it is in the interest of retiree health plan sponsors, as well as their retiree health plan beneficiaries, to pursue legislative changes to ERISA that will enable retiree health plans to function on a more dependable basis - one that will restore retiree confidence in the integrity of the plan sponsor's retiree health commitments and one that will promote the delivery of benefits covered by such commitments in a sound and stable way. Because so many retirees have had their lives and their health adversely affected by the lack of reasonable protections for their health benefits, in NRLN's view it is imperative that the Subcommittee give the utmost priority to this subject.

Endnotes

1/ The leading case in non-collectively bargained situations authorizing plan sponsors to make post-retirement changes to retiree health benefits that are adverse to retirees already receiving such benefits is *Sprague v. General Motors Corp.*, 133 F. 3d 388 (6th Cir.) (en banc), *cert. denied*, 118 S. Ct. 2312 (1998). In collectively-bargained situations, the federal courts of appeal are split over whether an employer can cancel unilaterally retiree health benefits that derive from a collective bargaining agreement that has expired. See discussion in *United Auto Workers Local 1697 v. Skinner Engine Co.*, 188 F. 3d (3d Cir. 1999). For a discussion of the pre-*Sprague* court decisions on retiree health, see Michael S. Gordon, "The Postretirement Health Care Imbroglio and the Interests of the Retirees", *Corporate Book Reserving For Post Retirement Health Care Benefits*, (Pension Research Council, Wharton School, University of Pennsylvania: Irwin, 1991), p.22

2/ See Testimony by Sylvester J. Schieber, Ph.D., Vice President, Watson Wyatt Worldwide, before the Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce, U.S. House of Representatives, May 16, 2002, p.8.

3/ *Ibid.* at p. 29.

4/ For further background on ERISA's limited regulation of private-sector health plans, see Michael S. Gordon, "Introduction to the Second Edition", *Employee Benefits Law*, (Employee Benefits Committee, Section of Labor and Employment Law, American Bar Association: The Bureau of National Affairs, Inc.; Washington, D.C., 2002), pps. lxvii - lxix.

5/ See e.g., *United Auto Workers Local 1697 v. Skinner Engine Co.*, n.1, *supra*.

APPENDIX I – SUBMITTED FOR THE RECORD, STATEMENT FROM CHRISTINE OWNES, DIRECTOR, PUBLIC POLICY DEPARTMENT, AFL-CIO, WASHINGTON, D.C., MAY 28, 2002

STATEMENT OF CHRISTINE OWENS
DIRECTOR, PUBLIC POLICY DEPARTMENT,
AMERICAN FEDERATION OF LABOR AND
CONGRESS OF INDUSTRIAL ORGANIZATIONS,
TO THE
SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS
OF THE
COMMITTEE ON EDUCATION AND THE WORKFORCE,
U.S. HOUSE OF REPRESENTATIVES
ON
RETIREE HEALTH CARE COVERAGE

May 16, 2002

Thank you for the opportunity to present the views of the AFL-CIO, a federation of 66 national and international unions, on retiree health plan coverage. This issue is a top priority for our 13 million active and 3.2 million retired members.

The union movement is greatly concerned about the erosion of employer provided retiree health coverage, particularly in light of gaps in the Medicare program. Our concerns are related to the broader trend of increasing fragility across-the-board in employment-based health care coverage.

Unions' Commitment to Employment-Based Retiree Benefits

Employment-based coverage is the backbone of our country's health care system, providing benefits to 153 million active U.S. workers and their dependents and 19 million retirees (including over 5 million early retirees). Today, unions negotiate health benefits for 40 million covered lives, including active workers, retirees and their family members. As purchasers, employers

and unions that sponsor health plans exercise group purchasing power to obtain cost-effective, quality care. By bringing employees into risk pools, they are able to provide adequate, uniform coverage to all employees regardless of income or health status.

Historically, unions have played a central role in the development of the employment-based health care system as a collective approach to providing health care. The Granite Cutters Union created one of the country's first national sick benefit programs in 1877. The International Ladies Garment Workers Union established the first union medical services program in 1913, incorporated the first union health center four years later and established the first multiemployer welfare fund to provide benefits to workers who change jobs frequently or lose benefits due to company failures. During and after World War II, unions played a key role in the dramatic growth in health insurance coverage among working families, successfully bargaining for employer-provided benefits.

Unions have long recognized that health security is an essential component of retirement security and negotiated health insurance coverage for many union retirees. Union retirees are more than twice as likely as non-union retirees to be covered by a post-retirement health plan.

This retiree coverage is critical because coverage in the individual market for anyone in less than perfect health—and especially for retirement-age individuals—is either unavailable or prohibitively expensive. Employment-based coverage may be the only safeguard against financial disaster for workers who retire in their fifties and early sixties, before they become eligible for Medicare at

age 65. A great many union members retire at this point in their lives after working full careers in physically demanding jobs.

Even among Medicare-eligible retirees, the absence of adequate prescription drug coverage exacts an enormous toll on the finances and health of those who require costly pharmaceutical treatment. Currently, over a third of Medicare beneficiaries have no drug coverage; rural and older beneficiaries fare worse (50 percent and 45 percent respectively have no drug coverage.)[1] Seniors often face high prices for the medications they need most. For example, of the 50 drugs used most by seniors, the average annual cost *per prescription* last year was $956 and the average price of these drugs increased at more than twice the rate of inflation between 2000 and 2001.[2] As a result, many seniors face large out-of-pocket pharmaceutical bills. In some cases, a senior's out-of-pocket drug costs may eat up a large part of her monthly Social Security check.

Unfortunately, Medicare managed care plans are becoming a less reliable source for drug coverage. Since 1999, the number of HMO plans contracting with Medicare has declined by over 40 percent, from 309 to 178. More than 900,000 Medicare beneficiaries were dropped from their HMOs in 2000 alone. At the same time, the share of Medicare HMOs that offer drug benefits has fallen from 84 percent to 70 percent since 1999, while the share of Medicare HMOs with prescription drug coverage that cap the amount of drugs costs they will cover in a year at $750 or less has increased from 21 percent to 39 percent.

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[1] M. Laschober, et al, Health Affairs, February 27, 2002.
[2] Families USA

Erosion of Retiree Coverage

Retiree health coverage disintegrated greatly in the nineties. Between 1991 and 1998, the share of large companies (with more than 1,000 employees) that provide health coverage to retirees 65 and older dropped 13 percentage points (from 80 percent to 67 percent) and early retiree coverage dropped 12 percentage points (from 88 percent to 76 percent). Although coverage of these two groups may have stabilized, or at worst, declined only slightly in recent years,[3] experts predict a further decline in retiree coverage as premiums rise, the labor market softens and the baby boomers enter retirement.

Even though many large employers have retained some retiree coverage, they have cut benefits substantially since the mid-1990s. The most common way employers have cut benefits is by requiring retirees to pay a share of the plan premium. In 1991, 73 percent of Medicare-eligible retirees in large firms contributed to the premium costs, as compared with 92 percent in 1998. Today, retirees are asked to contribute more toward the cost of coverage than active employees. Medicare-eligible retirees with coverage now pay 26 percent of the total premium cost on average—twice as much as actives in the same firms.[4]

Some employers have placed tighter restrictions on eligibility for benefits, requiring more years of work and/or higher ages to qualify for benefits under the plan. By 1998, 49 percent of large employers had imposed strict age and service requirements, compared to just 30 percent in 1991.

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[3] *Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,* Government Accounting Office, May 2001.
[4] Id.

Perhaps the most dramatic change has been the adoption of financial contribution caps to shield employers from rising health care costs and shift them on to workers. Under a contribution cap, an employer stops paying for additional health care costs after the premium costs reach a specific point, for example, 200 percent of the cost of retiree benefits in 1993. While no employers capped retiree benefits in 1991, 40 percent were using caps by 1998. Many employers have already reached the cap, thanks largely to double-digit health care inflation. As a result, retirees at those companies will have to pay for every additional dollar of health insurance cost.

The experiences of unions also make clear that pressures to cut back retiree benefits have grown over the last decade. At the bargaining table, all unions are facing employer demands to reduce coverage and shift costs and responsibilities on to retirees. In the direst cases, some unions representing low-wage workers have been forced to accept severe reductions, and in some instances, complete elimination of all medical and prescription drug coverage for retirees.

Forces Contributing to the Erosion of Employment-based Retiree Health Coverage

FAS 106: The adoption of Statement of Financial Accounting Standards No. 106 (FAS 106) by the Financial Accounting Standards Board in 1990 put enormous pressure on retiree health plans. FAS 106 requires employers to treat post-retirement medical and life insurance benefits as a form of deferred compensation and to accrue the costs over the period of employment in which

the benefits are earned. Prior to FAS 106, which was adopted by most companies in 1993, companies did not have to account for retiree health expenditures until they were actually paid out.

FAS 106 resulted in an increase in reported costs, particularly for employers sponsoring defined benefit postretirement plans. Suddenly, employers were posting health care liabilities that nearly equaled, or in some cases, exceeded their net worth. Among the Big Three automakers, for example, General Motors announced a one-time FAS 106 charge of $20.8 billion in 1992. Ford reported a one-time charge of $7.5 billion, and Chrysler reported a one-time charge of $4.7 billion.[5]

The effects of FAS 106 remain powerful. Future liabilities continue to rise to unanticipated levels. Ford just announced that it subtracted 24% more from pretax income for expected retiree medical costs in 2001 than in the previous year, as well as benefit cutbacks.[6]

Court Rulings: Even among retired union members, retiree health insurance coverage has proven to be the most vulnerable piece of the employment-based system. A series of federal court decisions in the mid-1990's gave employers the right to cut or eliminate health benefits for retirees, including those already receiving benefits, and provided very limited protections for union retirees.[7] Retirees' weaker link to their former employers has made employers more willing to take advantage of the opening provided by these court rulings.

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[5] Testimony by Bill Hoffman, UAW, before House Committee on Ways and Means October 28, 1993.
[6] New York Times, May 10, 2002.
[7] See, for example, *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995)

Rising Health Care Costs: Today, employers are facing double digit increases in health plan premium costs for the second year in a row (12.7 percent projected for 2002)—due in large part to double digit prescription drug costs increases, which we have seen for the last three years. Experts predict two more years of double-digit increases in health plan premiums.

Retirees are the most vulnerable to such cost pressures. Coverage for early retirees is already more expensive than it is for active workers. In 1998, the average cost of covering an early retiree was $4,984, compared with $4,037 for actives.

Prescription drugs typically represent of 40-60 percent of employers' retiree health costs for Medicare-eligible enrollees and have been the fastest growing cost component (17 percent increase between 2000 and 2001).[8] Since retiree coverage costs now closely track prescription drug costs, employers may be more likely to drop retiree health benefits completely as prescription drug costs soar.

Some employers have responded by excluding prescription drug coverage from the retiree benefits they provide. In 1998, 24 percent of retiree plans did not offer drug coverage to early retirees and 28 percent did not offer it to Medicare-eligible retirees.

Union Cost Containment Initiatives

Unions employ a range of approaches to maintain benefits for retired and active workers in the face of rising costs. Many unions that negotiate for

[8] New York Times, May 10, 2002.

coverage from single-employer plans are working with employers to reduce health care costs. Unions that administer health and welfare funds jointly with employers (Taft-Hartley funds) have a unique opportunity to affect plan operations and implement cost containment mechanisms. Over the years, employers and unions, often working in tandem, have developed an array of techniques to boost the quality and cost effectiveness of their health plans.

Initiatives that Improve Quality of Care and Member Health: Programs that measure and control quality of care, reduce errors and promote disease management and wellness can reduce costs. Unions employing these approaches have found that the front-end investment costs reap savings in the long run, both in terms of overall program costs and quality of life for active and retired members and their families.

To ensure that quality measures adequately represent their members' health care needs, some unions have developed new measurement tools on their own or in conjunction with local or national efforts such as the National Committee on Quality Assurance, and the Foundation for Accountability.

In addition, a number of unions and employers are working together in labor-management committees to jointly select providers based on agreed upon quality measures. For example, the United Auto Workers (UAW) and automakers have worked together through joint health care committees since the early 1980s to engage in a wide range of joint activities. These include Medicare education and an improved claims handling process for retirees, increasing patient involvement in treatment decisions, member education about quality, working

with insurance carriers to develop programs for assessing quality of care, identifying appropriate medical practices and implementing safe medication programs.

The UAW Center for Community Health Care Initiatives aims to achieve greater quality, cost-effectiveness and accessibility of local delivery systems. Activities include resource-needs assessment for the community, setting health priorities, developing appropriate standards of care and wellness programs.

The International Association of Machinists (IAM), which, like the UAW, negotiates for health benefits under single-employer plans, has undertaken a number of quality initiatives, including the introduction of hospital safety measures that reduce medical errors. IAM and Boeing became the first union and company team to sign on to the Leapfrog patient safety group. In addition, IAM and Boeing are meeting with plans and providers to implement the three top patient safety principles adopted by Leapfrog. Several other unions also are participating in Leapfrog.

Disease management and wellness programs are widely used among multiemployer, union-sponsored plans, too. The 1199 National Benefit Fund of the Service Employees International Union, based in New York City, cost-effectively addresses the health needs of members through health screenings for hypertension, disease management programs for asthma and diabetes that include counseling on nutrition and medication compliance, and case management of mental health treatment when multiple providers are involved.

Pooled Purchasing Power: Union funds have formed purchasing cooperatives in several areas in the country. Some initially were formed to provide ancillary benefits such as prescription drugs, dental and vision care. Their ability to purchase collectively allows them to negotiate larger discounts from providers.

The Labor Health Alliance (LHA), a non-profit health care purchasing cooperative comprised of 40 New York area union health and welfare funds that collectively serve more than 500,000 union members and another 100,000 retired members, provides an opportunity to purchase quality, cost-effective health care services through an independent, not for-profit cooperative. By collectively purchasing Medicare HMO contracts, the Alliance is able to secure enhanced benefits and services. Another important role for the Alliance is helping retired members navigate the Medicare+Choice system by providing education and advocacy services.

Prescription Drug Benefits: Health and welfare funds that continue to provide prescription drug coverage for retirees have implemented various mechanisms to control costs. For example, some funds require the substitution of generic drugs for name-brand drugs (when available) or the use of mail order suppliers for maintenance drugs in order to achieve savings. There are a limited number of tools available to rein in drug costs, however, while maintaining coverage.

CONCLUSION

Even with innovative cost containment strategies, employer-based health coverage remains seriously at risk. In the long term, responsible employers, union negotiators and cost containment experts will be no match for runaway health care costs.

Employers that try to fulfill their health care responsibilities to retired workers should not be left to manage today's health care cost crisis on their own. Only Congress can provide meaningful assistance. Medicare must be modernized to include a prescription drug benefit. Many illnesses that were only treatable in a hospital 35 years ago when Medicare was created can be effectively treated today with prescription drugs. Adding a drug benefit not only makes the program current with health care today, it will provide immediate and urgently needed relief to employers providing retirees with prescription drug coverage through retiree benefits.

However, this benefit should be paired with aggressive action to stem the escalating prices of prescription drugs. Such initiatives will not only make a Medicare prescription drug benefit more viable, they will provide relief to all consumers and to employers struggling with unmanageable cost increases. Among initiatives now under consideration, Congress could take meaningful actions to reform patent laws that block generic competition and to establish fairer prices for drugs purchased by U.S. customers vis-à-vis prices in other developed countries.

Finally, as long as retiree coverage continues its decline, many more early retirees will find themselves without health coverage. For these retirees, Congress should establish an option to buy into the Medicare program.

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