Retiree Health Benefits: Trends and Outlook

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Issue Brief

- This *Issue Brief* presents the changes to retiree health benefits employers have made as a result of Financial Accounting Statement No. 106 (FAS 106), and possible future changes they may make in response to continued increases in health benefit costs, recent court rulings, and potential federal legislation.

- FAS 106, approved by the Financial Accounting Standards Board in 1990, required most private companies to significantly alter the way they account for their retiree health benefits beginning with fiscal years after Dec. 15, 1992. FAS 106 dramatically impacts a company's calculation of its profits and losses and thereby creates a strong incentive for financial managers to limit expenses.

- As a result of FAS 106, and the increasing cost of providing retiree health benefits in general, many employers began a major overhaul of their retiree health benefit programs. Despite FAS 106, most 55–64-year-olds are covered by some form of health insurance. In 1999, 67 percent were covered by employment-based health benefits, nearly 9 percent purchased health insurance directly from an insurer, more than 16 percent were covered by some form of public health insurance, and 14.5 percent were uninsured.

- The percentage of persons ages 55–64 without health insurance generally has been increasing since 1994, when it was 13.9 percent. This increase has occurred for two reasons: (1) the percentage with public insurance coverage has been declining, and (2) the percentage purchasing insurance directly from an insurer has been declining. In fact, the percentage of persons ages 55–64 with employment-based health benefits generally increased, rising from 65 percent in 1994 to 67 percent in 1999.

- As a result of FAS 106, some employers placed caps on what they were willing to spend on retiree health benefits. Some added age and service requirements, while others moved to some type of "defined contribution" health benefit. Some completely dropped retiree health benefits for future retirees, while others dropped benefits for current retirees, although this has happened less frequently than the other changes.

- Federal age-discrimination laws and regulations, as most recently interpreted by federal courts in the *Erie County* case, may create new incentives for employers to review their retiree health benefits.

- While the changes employers have made to retiree health benefits do not appear to be having much impact on *current* retirees, they are likely to be felt most by *future* retirees who are not yet or may never become eligible for retiree health benefits because the courts have ruled that an employer has a right to terminate or amend retiree health benefits only if it has proved that such a right has been reserved or stated in specific language and on a widely known basis.

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Introduction

To understand the current state of retiree health benefits in the United States, it is necessary to understand how financial accounting dramatically changed for most American companies in December 1990. That's when the Financial Accounting Standards Board (FASB), a private-sector organization that establishes standards for financial accounting and reporting, approved Financial Accounting Statement No. 106 (FAS 106), "Employers' Accounting for Postretirement Benefits Other Than Pensions," which required most private companies to significantly alter the way they accounted for their retiree health benefits (Fronstin, 1996). FAS 106 required companies to record unfunded retiree health benefit liabilities on their financial statements in accordance with generally accepted accounting principles, beginning with fiscal years after Dec. 15, 1992.[1] FAS 106 requires employers to accrue and expense certain future claims' payments as well as actual paid claims. While FAS 106 did not require funds to be actually moved or reallocated, the recognition of these liabilities in financial statements dramatically impacts a company's calculation of its profits and losses and thereby creates a strong incentive for financial managers to limit expenses.

As a result of FAS 106, and the increasing cost of providing retiree health benefits in general, many employers began a major overhaul of their retiree health benefit programs. Some employers placed caps on what they were willing to spend on retiree health benefits. Some added age and service requirements, while others moved to some type of "defined contribution" health benefit. Some completely dropped retiree health benefits for future retirees, while others dropped benefits for current retirees, although this happened less frequently than the other changes. While these changes do not appear to be having much impact on *current* retirees, they are likely to be felt most by *future* retirees who are not yet or may never become eligible for retiree health benefits because the courts have ruled that an employer has a right to terminate or amend retiree health benefits only if it has proved that such a right has been reserved or stated in specific language and on a widely known basis (Davis, 1991).

In addition, federal age-discrimination laws and regulations, as most recently interpreted by federal courts, may create new incentives for employers to review their retiree health benefits. Another round of changes may take place in the near future, possibly further reducing or limiting the availability of retiree health benefits, as employers respond to the renewed surge in health benefit costs as well as recent court rulings and potential federal legislative initiatives. This *Issue Brief* presents recent changes to retiree health benefits and discusses various factors that may affect the outlook for them.

Coverage & Trends

Most 55–64-year-olds in the United States (the so-called "near-elderly") are covered by some form of health insurance. In 1999 (the latest year for which data are available), 67 percent were covered by employment-based health benefits, nearly 9 percent purchased health insurance directly from an insurer, more than 16 percent were covered by some form of public health insurance, and 14.5 percent were uninsured (table 1). In contrast, persons ages 35–54 were slightly less likely to have health insurance and thus more likely to be uninsured. In 1999, almost 74 percent of 35–54-year-olds were covered by employment-based health benefits, 5 percent purchased health insurance directly from an insurer, 9 percent were covered by some form of public health insurance, and 15.1 percent were

[1] State and local governments have similar accounting requirements under the Governmental Accounting Standards Board.

Table 1
Sources of Health Insurance Coverage, Population Ages 35–64, by Main Activity and Age, 1999

	Total	Workers	Retirees	Ill and Disabled	Other
			Ages 55–64		
Total Population (millions)	23.4	15.2	4.0	2.5	1.7
Percentage	100.0%	64.9%	16.9%	10.9%	7.3%
Distribution of Insurance	100.0	100.0	100.0	100.0	100.0
Employment-Based Health Benefits	67.0	78.3	56.8	25.3	52.0
Own name	49.9	64.2	36.3	13.1	9.3
Dependent coverage	17.0	14.1	20.5	12.2	42.7
Individually Purchased	8.5	6.8	13.7	8.8	11.3
Public	16.5	6.1	22.8	72.1	11.7
Medicare	8.7	1.3	14.3	47.4	3.4
Medicaid	6.3	1.6	4.9	38.1	4.2
Tricare/CHAMPVA[a]	4.3	3.6	6.6	4.6	4.9
No Health Insurance	14.5	12.4	17.2	12.8	29.7
			Ages 35–54		
Total Population (millions)	81.1	69.7	0.6	4.2	6.5
Percentage	100.0%	86.0%	0.8%	5.2%	8.0%
Distribution of Insurance	100.0	100.0	100.0	100.0	100.0
Employment-Based Health Benefits	73.7	78.8	46.0	19.3	56.2
Own name	53.9	61.5	26.7	7.1	5.2
Dependent coverage	19.8	17.3	19.3	12.2	51.0
Individually Purchased	5.1	4.8	16.5	5.2	7.7
Public	8.9	4.8	23.2	69.1	12.2
Medicare	2.4	0.4	14.5	36.9	1.2
Medicaid	5.0	2.3	6.6	45.5	7.4
Tricare/CHAMPVA[a]	2.6	2.3	5.6	4.8	4.3
No Health Insurance	15.1	13.9	26.6	16.6	26.6

Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplement 2000.
Note: Details may not add to totals because individuals may receive coverage from more than one source.
[a]Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans' Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

uninsured (table 1). Overall, persons ages 55–64 are less likely than those ages 35–54 to have employment-based health benefits and more likely to have public health insurance or insurance purchased directly from an insurer.

One of the main reasons that persons ages 55–64 are less likely to have employment-based health benefits and more likely to have public health insurance or insurance purchased directly from an insurer is that they are in the process of making a transition out of the labor force. Nearly 17 percent of individuals ages 55–64 consider themselves retirees,[2] and, in addition, nearly 11 percent are not working because they are ill or disabled. In contrast, less than 1 percent of individuals ages 35–54 are retired and 5 percent are ill or disabled.

The likelihood of persons having employment-based health benefits varies by age because older persons are more likely than younger workers to be out of the labor force. When examining workers only, the difference among them in the likelihood of having employment-based health benefits is virtually nonexistent. Specifically, 78.3 percent of workers ages 55–64 are covered by employment-based health benefits, compared with 78.8 percent of workers ages 35–54. Workers ages 55–64 are more likely either to purchase health insurance directly from an insurer or to be covered by a public program. As a result, 12.4 percent of workers ages 55–64 are uninsured, compared with 13.9 percent of workers ages 35–54.

In terms of demographics and job characteristics, the health insurance coverage of 55–64-year-olds tends to follow patterns similar to those in the entire population. For example:

[2] *Retirees are defined as those who are not working and report themselves as being retired.*

Table 2
Sources of Health Insurance Coverage, Population Ages 55-64, 1994–1999

	1994	1995	1996	1997	1998	1999
			(millions)			
Total	20.7	21.1	21.5	22.2	22.9	23.4
Employment-Based Health Benefits	13.5	14.1	14.0	14.5	15.2	15.7
Own name	10.0	10.6	10.6	10.8	11.4	11.7
Dependent coverage	3.5	3.5	3.5	3.6	3.8	4.0
Individually Purchased	2.2	2.0	2.2	2.3	2.0	2.0
Public	3.8	3.8	3.9	3.8	3.8	3.9
Medicare	1.5	1.7	1.8	1.8	2.0	2.0
Medicaid	1.3	1.4	1.6	1.5	1.4	1.5
Tricare/CHAMPVA[a]	1.5	1.2	1.0	1.1	1.1	1.0
No Health Insurance	2.9	2.8	3.0	3.2	3.4	3.4
			(percentage)			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Employment-Based Health Benefits	65.0	66.9	65.3	65.0	66.4	67.0
Own name	48.4	50.4	49.2	48.6	50.0	49.9
Dependent coverage	16.7	16.5	16.1	16.4	16.4	17.0
Individually Purchased	10.8	9.6	10.4	10.3	8.6	8.5
Public	18.5	18.0	18.2	16.9	16.8	16.5
Medicare	7.4	7.9	8.5	8.1	8.8	8.7
Medicaid	6.2	6.7	7.3	6.8	6.2	6.3
Tricare/CHAMPVA[a]	7.1	5.8	4.9	4.9	4.7	4.3
No Health Insurance	13.9	13.4	13.9	14.3	15.0	14.5

Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplements 1995 through 2000.
Note: Details may not add to totals because individuals may receive coverage from more than one source.
[a]Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans' Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

- Sixty-five percent of the uninsured ages 55–64 are in families with income of less than $40,000 per year.
- Sixty-one percent of the uninsured ages 55–64 are in families with income below 300 percent of the federal poverty level.
- Married individuals are more likely than unmarried individuals to have employment-based health benefits, and they are less likely to be uninsured.
- Whites are more likely than nonwhites to have employment-based health benefits, and they are less likely to be uninsured.
- Workers, regardless of hours and weeks worked, are less likely than nonworkers to be uninsured, and they are more likely to have employment-based health benefits.
- Public-sector workers and workers employed in manufacturing are more likely than other workers to have employment-based health benefits, and less likely to be uninsured.
- Nearly 70 percent of uninsured workers ages 55–64 are either self-employed or employed in firms with fewer than 100 employees.
- As earned income increases, the likelihood of being uninsured declines and the likelihood of having employment-based health benefits increases.

These data are presented in greater detail in the appendix tables.

Near-Elderly Coverage Trends

Since 1994, the percentage of persons ages 55–64 without health insurance generally has been increasing. In 1999, 14.5 percent of the population ages 55–64 were uninsured, up from 13.9 percent in 1994 (table 2). A comparison of these endpoints masks recent changes in coverage, however. For example, the percentage uninsured reached a high of 15 percent in 1998 before falling to its 1999 level of 14.5 percent. The percentage of persons ages 55–64 who are uninsured has been increasing for two reasons: (1) the percentage with public insurance coverage has been declining (mostly because of erosions in Medicaid and Tricare/CHAMPVA coverage),

Table 3
Sources of Health Insurance for Workers, Ages 55–64, 1994–1999

	1994	1995	1996	1997	1998	1999
			(millions)			
Total	13.1	13.4	13.9	14.4	14.9	15.2
Employment-Based Health Benefits	9.9	10.4	10.5	10.9	11.5	11.9
Own name	8.2	8.7	8.7	9.0	9.4	9.7
Dependent coverage	1.7	1.8	1.8	1.9	2.1	2.1
Individually Purchased	1.2	1.1	1.3	1.3	1.1	1.0
Public	1.1	1.0	1.1	0.9	0.9	0.9
Medicare	0.1	0.1	0.2	0.1	0.1	0.2
Medicaid	0.2	0.2	0.3	0.3	0.2	0.2
Tricare/CHAMPVA[a]	0.8	0.6	0.6	0.6	0.6	0.5
No Health Insurance	1.6	1.5	1.6	1.8	1.9	1.9
			(percentage)			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Employment-Based Health Benefits	76.5	78.4	76.0	76.1	77.4	78.5
Own name	63.2	65.2	63.1	62.8	63.5	64.4
Dependent coverage	13.3	13.2	12.9	13.3	13.9	14.0
Individually Purchased	8.8	8.0	9.7	9.1	7.4	6.8
Public	8.4	7.2	7.8	6.4	6.0	6.1
Medicare	0.9	1.0	1.3	1.0	1.0	1.2
Medicaid	1.6	1.8	2.4	1.7	1.3	1.5
Tricare/CHAMPVA[a]	6.2	4.8	4.4	4.0	3.9	3.6
No Health Insurance	12.0	11.4	11.4	12.3	13.0	12.3

Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplements 1995 through 2000.
Note: Details may not add to totals because individuals may receive coverage from more than one source.
[a]Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans' Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

and (2) the percentage purchasing insurance directly from an insurer has been declining.[3] In fact, the percentage of persons ages 55–64 with employment-based health benefits generally increased, rising from 65 percent in 1994 to 67 percent in 1999.

Coverage overall has been more stable for workers. The percentage of workers ages 55–64 with no health insurance increased slightly from 12 percent in 1994 to 12.3 percent in 1999 (table 3). However, this trend masks important variation in the source of health insurance: Overall, the percentage of workers ages 55–64 with employment-based health benefits has been increasing, while the percentage with insurance purchased directly from an insurer or public coverage has been declining. Specifically, the percentage of workers with employment-based health benefits increased from 76.5 percent in 1994 to 78.5 percent in 1999, while the percentage with insurance purchased directly from an insurer declined from 8.8 percent in 1994 to 6.8 percent in 1999, and the percentage with public coverage declined from 8.4 percent in 1994 to 6.1 percent in 1999.

Similar patterns can be seen in sources of coverage for retirees, but the trends are more pronounced. For example, the likelihood that a retiree age 55–64 is uninsured increased from 16.3 percent in 1994 to 17.2 percent in 1999 (table 4). In contrast, the percentage of retirees ages 55–64 with employment-based health benefits increased from 55.4 percent in 1994 to 56.8 percent in 1999. This increase in employment-based health benefits was mostly due to the fact that the percentage of retirees with health benefits through a spouse increased from 18.8 percent in 1994 to 20.5 percent in 1999, while the percentage with health benefits through a former employer or union remained unchanged. Despite the increase in the likelihood of being covered by employment-based health benefits, early retirees experienced an increase in the likelihood of being uninsured because the likelihood of purchasing health insurance directly from an insurer declined from 15.7 percent in 1994 to 13.7 percent in 1999, and the likelihood of having public coverage declined from 25.1 percent to 22.8 percent.

The experience of the ill and disabled (persons not working for health reasons) is much different from that of workers and retirees. In general, the likelihood of

[3] There are other reasons why public coverage and insurance purchased directly from an insurer have been declining. These dynamics are beyond the scope of the paper.

Table 4
Sources of Health Insurance for Retirees, Ages 55–64, 1994–1999

	1994	1995	1996	1997	1998	1999
			(millions)			
Total	3.6	3.6	3.6	3.8	3.8	4.0
Employment-Based Health Benefits	2.0	2.1	2.1	2.1	2.2	2.2
Own name	1.3	1.4	1.4	1.3	1.5	1.4
Dependent coverage	0.7	0.7	0.7	0.7	0.7	0.8
Individually Purchased	0.6	0.5	0.5	0.6	0.5	0.5
Public	0.9	0.9	0.8	0.9	0.9	0.9
Medicare	0.4	0.5	0.5	0.5	0.6	0.6
Medicaid	0.2	0.2	0.1	0.2	0.2	0.2
Tricare/CHAMPVA[a]	0.4	0.3	0.2	0.3	0.2	0.3
No Health Insurance	0.6	0.6	0.6	0.6	0.7	0.7
			(percentage)			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Employment-Based Health Benefits	55.4	58.0	58.1	55.5	57.5	56.8
Own name	36.6	38.2	37.8	35.7	38.5	36.3
Dependent coverage	18.8	19.8	20.3	19.8	19.0	20.5
Individually Purchased	15.7	14.1	14.0	14.8	12.1	13.7
Public	25.1	24.4	23.1	23.0	23.5	22.8
Medicare	12.3	12.5	14.8	13.5	15.1	14.3
Medicaid	5.0	5.6	4.1	5.0	5.4	4.9
Tricare/CHAMPVA[a]	10.7	8.4	6.0	6.9	6.4	6.6
No Health Insurance	16.3	15.8	16.7	16.7	17.5	17.2

Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplements 1995 through 2000.
Note: Details may not add to totals because individuals may receive coverage from more than one source.
[a]Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans' Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

an ill or disabled person being uninsured has been declining. In 1994, 15.2 percent of the ill and disabled were uninsured, compared with 12.8 percent in 1999 (table 5). The ill and disabled experienced an increase in the likelihood of being covered by either Medicare or Medicaid between 1994 and 1998. The variation in coverage from one year to the next for the ill and disabled is much greater than it is for workers and retirees. This may be due to actual changes taking place, such as moving from one health insurance status to another. It also may be due to the fact that this group is smaller than other groups.

For comparison purposes, trends in coverage for persons ages 55–64 who categorize themselves as homemakers, unemployed, or other are presented in table 6. Again, the year-to-year variations in these data are substantial and may be due to the small size of this group.

Retiree Health Benefits Trends

By law, employers are under no obligation to provide retiree health benefits, except to current retirees who can prove that they were previously promised a specific benefit. Between 1994 and 1999, retirees ages 55–64 experienced an increase in the likelihood of being uninsured, but, as mentioned above, the percentage of retirees covered by health benefits through a former employer or union was unchanged (although as is shown below, current retirees have seen increases in their share of health insurance premiums). In addition, the likelihood of an early retiree having health insurance through his or her own spouse increased. An erosion of public health insurance and health insurance purchased directly from an insurer accounts for the increase in the uninsured.

It is interesting to note that coverage from a former employer or union did not change between 1994 and 1999 despite FAS 106. It appears that the changes employers made to retiree health benefits during the mid-1990s in response to FAS 106 were more likely to affect *future* retirees than *current* retirees. The data suggest that future retirees are ones who will bear the brunt of the impact of FAS 106.

The remainder of this section discusses the changes that employers have made to retiree health benefits.

Table 5
Sources of Health Insurance for Ill and Disabled, Ages 55–64, 1994–1999

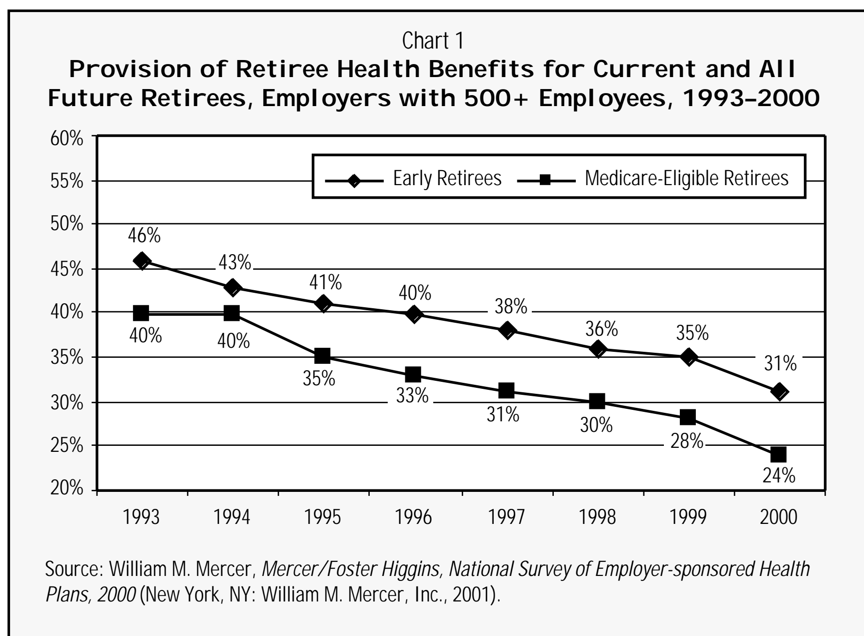
	1994	1995	1996	1997	1998	1999
			(millions)			
Total	2.2	2.3	2.3	2.4	2.5	2.5
Employment-Based Health Benefits	0.5	0.6	0.6	0.5	0.7	0.6
Own name	0.3	0.3	0.3	0.3	0.4	0.3
Dependent coverage	0.2	0.3	0.3	0.3	0.3	0.3
Individually Purchased	0.2	0.2	0.2	0.2	0.2	0.2
Public	1.5	1.6	1.7	1.7	1.8	1.8
Medicare	0.9	1.0	1.0	1.1	1.2	1.2
Medicaid	0.8	0.8	0.9	1.0	0.9	1.0
Tricare/CHAMPVA[a]	0.1	0.1	0.1	0.1	0.1	0.1
No Health Insurance	0.3	0.3	0.3	0.3	0.3	0.3
			(percentage)			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Employment-Based Health Benefits	24.1	26.3	25.3	23.1	27.5	25.3
Own name	13.8	14.8	13.6	12.2	15.4	13.1
Dependent coverage	10.4	11.6	11.7	10.9	12.0	12.2
Individually Purchased	9.2	8.1	8.8	9.2	8.8	8.8
Public	69.1	70.2	73.6	72.9	71.3	72.1
Medicare	42.5	44.6	44.9	46.1	48.5	47.4
Medicaid	35.3	35.7	40.8	41.1	36.1	38.1
Tricare/CHAMPVA[a]	5.6	6.1	4.4	5.5	5.3	4.6
No Health Insurance	15.2	13.4	12.2	12.4	11.9	12.8

Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplements 1995 through 2000.
Note: Details may not add to totals because individuals may receive coverage from more than one source.
[a]Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans' Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

Table 6
Sources of Health Insurance for Homemakers, Unemployed, and Others, Ages 55–64, 1994–1999

	1994	1995	1996	1997	1998	1999
			(millions)			
Total	1.9	1.8	1.7	1.7	1.7	1.7
Employment-Based Health Benefits	1.0	0.9	0.8	0.9	0.8	0.9
Own name	0.2	0.2	0.2	0.2	0.2	0.2
Dependent coverage	0.8	0.7	0.7	0.7	0.7	0.7
Individually Purchased	0.3	0.3	0.2	0.2	0.2	0.2
Public	0.3	0.3	0.3	0.3	0.2	0.2
Medicare	0.0	0.0	0.1	0.1	0.1	0.1
Medicaid	0.1	0.1	0.1	0.1	0.1	0.1
Tricare/CHAMPVA[a]	0.1	0.1	0.1	0.1	0.1	0.1
No Health Insurance	0.4	0.4	0.5	0.5	0.5	0.5
			(percentage)			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Employment-Based Health Benefits	54.0	52.8	49.3	51.5	49.5	52.0
Own name	11.3	12.0	11.1	10.6	10.7	9.3
Dependent coverage	42.8	40.8	38.2	40.9	38.8	42.7
Individually Purchased	16.2	14.1	10.7	12.2	10.1	11.3
Public	16.0	17.9	16.9	14.8	14.2	11.7
Medicare	2.4	2.5	3.8	3.0	4.0	3.4
Medicaid	6.9	8.4	8.4	5.7	5.7	4.2
Tricare/CHAMPVA[a]	7.7	8.1	6.9	7.0	6.2	4.9
No Health Insurance	19.4	21.9	29.3	27.4	31.1	29.7

Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplements 1995 through 2000.
Note: Details may not add to totals because individuals may receive coverage from more than one source.
[a]Tricare (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans' Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

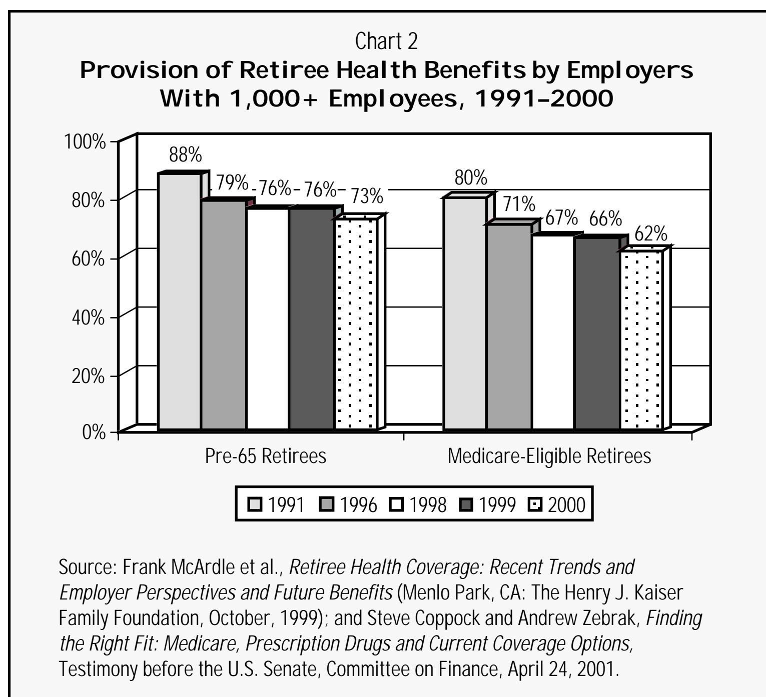


Source: William M. Mercer, *Mercer/Foster Higgins, National Survey of Employer-sponsored Health Plans, 2000* (New York, NY: William M. Mercer, Inc., 2001).

In general, the percentage of employers offering health benefits to future retirees seems to be declining. An annual survey of employers with 500 or more workers shows that those currently expecting to continue offering health benefits to future early retirees declined from 46 percent in 1993 to 31 percent 2000 (chart 1). The percentage of employers offering health benefits to Medicare-eligible retirees today and planning to offer them to future Medicare eligible retirees is also declining.

Another survey of larger employers (most with 1,000 or more employees) also showed that the percentage offering retiree health benefits has declined. The likelihood of these employers offering retiree health benefits to early retirees declined from 88 percent in 1991 to 73 percent in 2000 (chart 2).[4] The decline in the likelihood that an employer offered retiree health benefits shown in both charts 1 and 2 is mainly due to two factors:

- Some employers are terminating existing benefits.
- New organizations are choosing not to offer retiree health benefits at all.

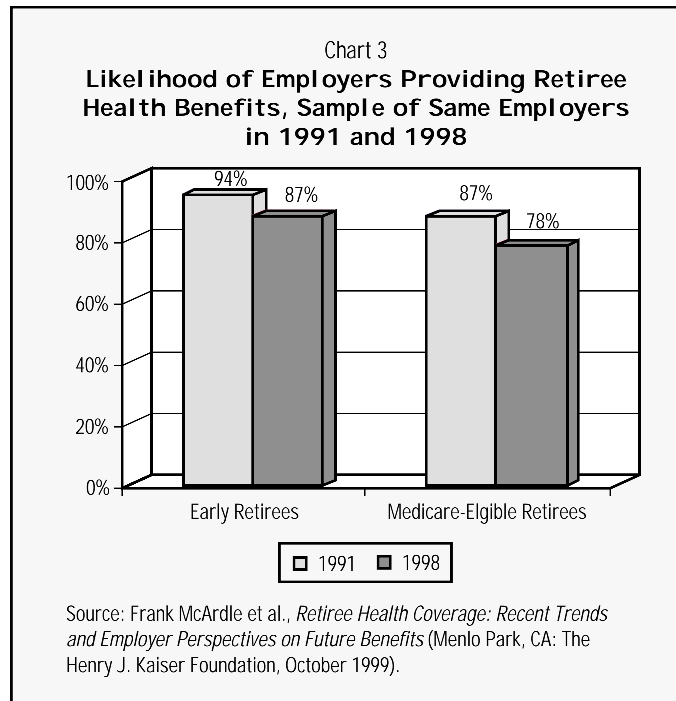


Source: Frank McArdle et al., *Retiree Health Coverage: Recent Trends and Employer Perspectives and Future Benefits* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, October, 1999); and Steve Coppock and Andrew Zebrak, *Finding the Right Fit: Medicare, Prescription Drugs and Current Coverage Options,* Testimony before the U.S. Senate, Committee on Finance, April 24, 2001.

To some degree, the data presented in charts 1 and 2 overstate the extent to which employers are *dropping* retiree health benefits. When broad cross sections of employers are studied over time, it appears that employers are dropping retiree health benefits. However, new large employers most likely never offered retiree health benefits. Thus, the cross sections that include these new employers are not examining employer behavior over time as much as they are providing snapshots of the current availability of retiree health benefits.

In order to understand how employers that offer retiree health benefits are changing their benefit packages, it is important to examine a constant sample of employers. McArdle et al. (1999) examined a constant sample of employers between

[4] The offer rates are much higher in chart 2 than in chart 1 because chart 1 includes employers with 500–999 employees, while chart 2 includes employers with mostly 1,000 or more employees.



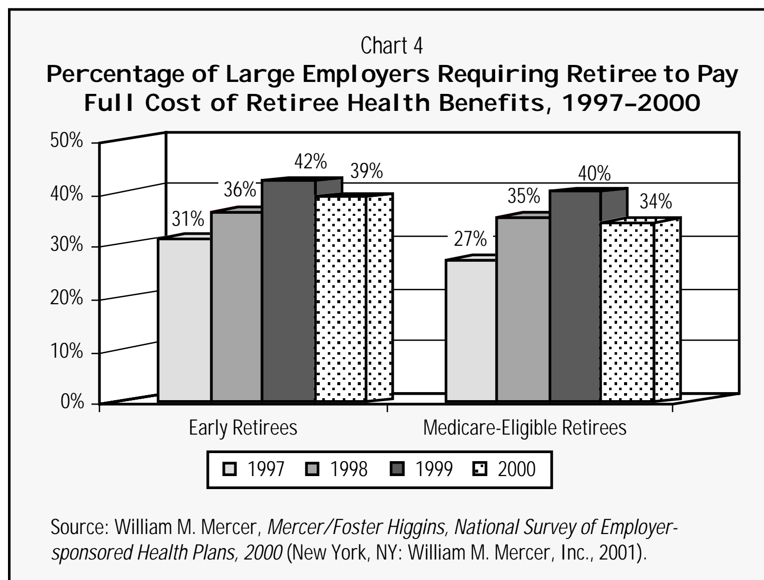
Source: Frank McArdle et al., *Retiree Health Coverage: Recent Trends and Employer Perspectives on Future Benefits* (Menlo Park, CA: The Henry J. Kaiser Foundation, October 1999).

1991 and 1998 and found a decline in the availability of retiree health benefits, but not as large as that portrayed in chart 2. Chart 3 shows the trend for the constant sample of employers and indicates that there was a 7 percentage point drop in the likelihood that employers offered retiree health benefits to early retirees and a 9 percentage point drop for Medicare-eligible retirees.

Most employers that are continuing to offer retiree health benefits have made changes in the benefit package. Modifications to cost-sharing provisions are a common change, with employers asking retirees to pick up a greater share of the cost of coverage. In 2000, 39 percent of employers with 500 or more workers that offered retiree health benefits required retirees to pay 100 percent of the premium for coverage, up from 31 percent of employers in 1997 (chart 4).[5]

Employers do not have to change the benefits package to control spending on retiree health benefits. Instead, they can tighten eligibility requirements, for instance, by requiring workers to attain a certain age and/or tenure with the company before they become eligible to receive any retiree health benefits. Overall, the percentage of employers with an age requirement of 55 and a service requirement of 10 years increased from 30 percent in 1996 to 38 percent in 2000 (table 7). Also, some employers instituted a requirement of age 55 and 20 years service or age 60 and 10 years service for the first time. In addition, employers have imposed caps on the total amount of money they are willing to spend on retiree health benefits.[6] In 1993, 72 percent of employers with 1,000 or more employees did not have any type of cap on their total contributions, compared with 55 percent in 2000 (table 8). Only 4 percent of those with a defined dollar cap on the employer subsidy have indexed it for inflation.[7]

Employers are continuing to consider more changes to retiree health benefits. More than 50 percent



Source: William M. Mercer, *Mercer/Foster Higgins, National Survey of Employer-sponsored Health Plans, 2000* (New York, NY: William M. Mercer, Inc., 2001).

[5] *The apparent decline between 1999 and 2000 in the percentage of employers requiring retirees to pay the full cost of retiree health benefits is not statistically significant. In addition, the survey used in this chart includes public-sector employers and nonprofit-sector employers, which are more likely than private-sector for-profit employers to require retirees to pay the full cost of retiree health benefits.*

[6] *Caps could work on a total aggregate spending basis or on a per-retiree basis.*

[7] *This table also shows that only 10 percent of employers required their retirees to pay 100 percent of the cost of retiree health benefits in 2000. This compares with roughly 40 percent in chart 4. The difference in the estimates may be due to two reasons. First, chart 4 includes employers with 500 or more employees, while table 8 includes employers with 1,000 or more employees. Second, the sample used in chart 4 includes plans provided by the public and nonprofit sectors. The sample used in table 8 is mostly private-sector employers, and includes very few nonprofit organizations.*

of firms with 5,000 or more workers are likely to increase the amount retirees are asked to pay, while 25 percent are likely to impose a cap on their contributions (chart 5).

Another change some employers have made to retiree health benefits is to reduce benefits for workers hired (or retiring) after a specific date. Some employers have reduced the subsidy for workers hired after a certain date, while others have eliminated benefits altogether for workers hired after a certain date. According to William M. Mercer,[8] about 16 percent of employers with 500 or more employees that offer retiree health benefits only offer them to current retirees or those hired before a specific year.

It will be a few more years before

[8] *Calculated from U.S. General Accounting Office (2001) and William M. Mercer (2001).*

Table 7
Eligibility Requirements for Retiree Health Benefits, 1996 and 2000

	1996	2000
Age 50 + 10 years service	1%	2%
Age 50 + 15 years service	1	1
Age 55 + 5 years service	9	10
Age 55 + 10 years service	30	38
Age 55 + 15 years service	5	8
Age 55 + 20 years service	0	2
Age 60 + 10 years service	0	1
Based on age/service points	1	5
Based on age and/or service plus age/service points	6	3
Two or more alternatives	35	19
Other (e.g., age only or service only)	11	11

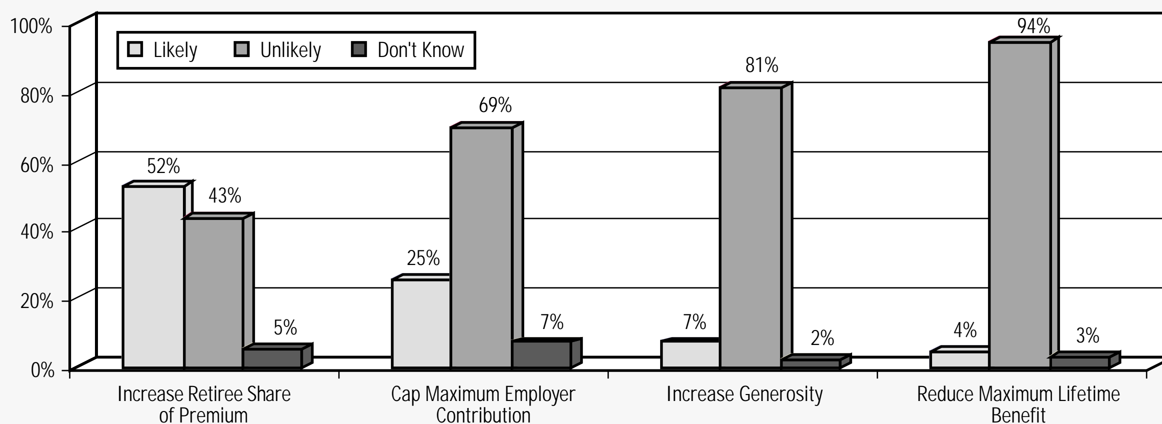
Source: Frank McArdle et al., *Retiree Health Coverage: Recent Trends and Employer Perspectives and Future Benefits* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, October, 1999); and Hewitt Associates LLC, *Salaried Employee Benefits Provided by Major U.S. Employers, 2000–2001* (Lincolnshire, IL, 2000).

Table 8
Use of Defined Dollar Approach to Cap Employer Contribution Toward Retiree Health Benefits, Employers With 1,000 or More Employees, 1993 and 2000

	1993	2000
Defined dollar approach that is limiting current employer cost	15	29
Defined dollar approach with cap set at some future time	5	6
No defined dollar cap to employer subsidy	72	55
Retiree pays 100% of cost	8	10

Source: Hewitt Associates LLC, *Salaried Employee Benefits Provided by Major U.S. Employers in 1993 and Salaried Employee Benefits Provided by Major U.S. Employers, 2000–2001* (Lincolnshire, IL: Hewitt Associates LLC, 1993 and 2000).

Chart 5
Likelihood of Making Various Changes to Retiree Health Benefits in the Next Two Years, Among Firms Offering Retiree Health in 2000



Source: Larry Levit, et al., *Employer Health Benefits: 2000 Annual Survey* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, and Chicago, IL: Health Research and Eductional Trust, 2000).

sufficient data are available to determine how workers and retirees will be affected by cutbacks in retiree health benefits. Many workers may never qualify for retiree health benefits because their employers offer them only to workers hired before a specific date or because they may never reach the age and/or service requirements needed to qualify for benefits.

Outlook

Recent court rulings and federal legislative initiatives may continue to cause employers to reduce or limit their retiree health benefits. This section discusses how employers may respond to these public policy changes.

Erie County and the ADEA

Like most employers, Erie County, PA, a municipal public employer, classified its retirees into two groups: early retirees (those under age 65 and not yet eligible for Medicare) and Medicare-eligible retirees (those age 65 and older and eligible for Medicare benefits). Prior to 1998, all the county's retirees were covered by a traditional indemnity health plan.

Beginning February 1998, Erie County required Medicare-eligible retirees to enroll in a Medicare HMO sponsored by Highmark Blue Cross Blue Shield (BCBS). The Medicare HMO generally paid 100 percent of covered health care services of network health care providers. In addition, the Medicare HMO covered vision care, dental care, hearing aids, and prescription drugs. Medicare-eligible retirees were required to pay the Medicare Part B premium ($43.70 per month per enrollee in 1998 and $50 per month per enrollee in 1999). Pre-Medicare eligible retirees continued to participate in the traditional indemnity plan. They were charged a monthly premium of $12 per enrollee per month.

Starting in October 1998, retirees not yet eligible for Medicare were provided a point-of-service (POS) plan sponsored by Highmark BCBS. The POS plan allowed retirees to choose between network providers under the HMO and out-of-network providers under an indemnity arrangement similar to the plan they participated in previously. Under this new arrangement, pre-Medicare retirees paid no monthly premium (as opposed to the $12 per month per enrollee previously paid). Medicare-eligible retirees were disqualified from enrolling in the POS because of underwriting criteria set by Highmark BCBS.

In 1998, the Erie County Retirees Association sued Erie County in federal district court claiming that the retiree health benefits program violated the federal Age Discrimination in Employment Act (ADEA), claiming that (older) Medicare-eligible retirees were treated less favorably than (younger) early retirees, inasmuch as age determined eligibility for less valuable retiree health benefits.

The federal district court ruled that ADEA did not apply. The Retirees Association appealed, and the Third Circuit Court reversed the district court's decision, saying that the plaintiffs had established a claim under ADEA—unless one of two prongs of the ADEA "safe harbor" provision applies. The case was sent back to the district court to determine if either the "equal benefit" or "equal cost" safe harbor test could be met. If not, the Medicare-eligible retiree plan was discriminatory based on age and therefore illegal under ADEA. In taking these tests into account, the Circuit Court also ruled that the county could take Medicare *benefits* into account when applying the equal *benefit* test, but it could not take Medicare *costs* into account when applying the equal *cost* test.

In the case sent back to district court, the county conceded it could not meet the "equal cost" test. In applying the "equal benefit" test, the court looked to two separate periods: (1) between February 1998 and September 1998, when the early retirees were in the pre-February 1998 traditional indemnity plan, while the Medicare-eligible retirees were in the new Medicare

Recent court rulings and federal legislative initiatives may continue to cause employers to reduce or limit their retiree health benefits.

HMO plan; and (2) after October 1998, when the early retirees were in the new POS plan and the Medicare-eligible retirees were still in the Medicare HMO plan.

The district court found that the county violated ADEA between February 1998 and September 1998, because Medicare-eligible retirees were required to pay the Medicare Part B premium, while early retirees were required to pay only a $12 per month per enrollee premium toward the cost of the indemnity plan.[9] The court also ruled that differences in provider and drug choice between the younger and older retirees (indemnity plan and HMO plan) did not violate the ADEA.

The court reasoned that requiring the older Medicare-eligible retirees to pay a greater portion of the total cost of their health insurance costs (through premiums) than younger retirees (under the traditional indemnity plan) is expressly prohibited as a disproportionate contribution share under the ADEA regulations.[10] Although the indemnity plan was more expensive to the county than the HMO plan, the county still charged the early retirees a significantly lower monthly premium than it charged the older retirees.

On the issue of provider and drug choice to younger retirees under the indemnity plan and older retirees under the HMO plan, the court stated, "While [Medicare-eligible retirees] may prefer the traditional indemnity plan for its greater choice of service providers, other retirees are likely to prefer [the HMO] for its low co-payments or other unique attributes such as coverage for eye examinations and dental visits. ……we find that absent the demonstration of some objective diminishment, i.e., a lower quality of health care, [Medicare-eligible retirees'] preference for the traditional indemnity plan's mechanism of insuring medical services is a subjective preference outside the scope of the [ADEA]."[11]

The court also found that after October 1998, Erie County violated the equal benefit test of the ADEA in three ways. First, Medicare-eligible retirees were required to pay the Medicare Part B premium, while early retirees were not. The court cites ADEA regulations concerning noncontributory ("employer-pay-all") plans: "Where younger employees are not required to contribute any portion of the total premium cost, older employees may not be required to contribute any portion."[12]

Second, early retirees were able to choose between an HMO and an indemnity benefit (the POS plan), while Medicare eligible retirees were able to get coverage only under the HMO. Third, Medicare-eligible retirees were subject to a drug formulary and paid higher co-payments for covered drugs, while early retirees were not subject to a formulary and paid lower co-payments for drugs. The court reasons, "The ability to [use a point-of-service plan and to] obtain coverage for a greater number of prescription drugs at a lower cost under [the POS plan] renders the plan a greater benefit than [the HMO plan]."[13]

The district court's ruling has raised a number of questions, including the likelihood of the ruling being overturned on appeal and its implications for retiree health benefit programs if upheld. For example, instead of ruling on a comparison of the entire retiree health benefits package offered to early retirees and Medicare-eligible retirees (a test of actuarial value), the court ruled on several specific factors. The court did not take into account the possibility that some aspects of a benefits

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[9] *While it may seem that a difference in Medicare Part B premiums would fall under the equal-cost test and the Third Circuit Court ruled that Medicare costs should not be taken into account when applying the equal-cost test, the district court said that contribution requirements from retirees must be taken into account in determining whether Medicare-eligible retirees received "lesser benefits" than early retirees.*

[10] *See 29 C.F.R. Sec. 1625.10(d)(4)(ii).*

[11] Erie County Retirees Association v. Erie County Employees' Retirement Board, *140 F. Supp. 2d 466, 474 (April 16, 2001).*

[12] *See 29 C.F.R. Sec. 1625.10(d)(4)(ii)(B).*

[13] Erie County Retirees Association v. Erie County Employees' Retirement Board, *140 F. Supp. 2d 466, 477 (April 16, 2001).*

Because the Erie County decision increases the uncertainty about their future liability, some employers may decide to review some features of their retiree health plan.

program may be better for Medicare-eligible retirees than for early retirees. The ruling also did not consider what determines whether a benefit is objectively better or subjectively better. This point alone may lead more retirees to bring suits against employers.

Employers could respond to the ruling in a number of ways. The ruling only applies to employers located in the Third Circuit, which covers Pennsylvania, New Jersey, and Delaware (and the Virgin Islands). The Equal Employment Opportunity Commission (EEOC) has not signed on to this opinion, and is choosing not to enforce it. Employers in other circuits may take a wait-and-see approach before making any changes to their benefit programs.

Because the Erie County decision increases the uncertainty about their future liability, some employers may decide to review some features of their retiree health plan. For employers, answering "yes" to the questions below will require further review of their plan:

- Are pre- and post-Medicare-eligible retirees charged a premium proportionate to the cost of providing coverage?
- Do pre-Medicare-eligible retirees pay no premium while post-Medicare-eligible retirees pay a premium?
- Do pre-Medicare-eligible retirees receive a higher quality of health care than Medicare-eligible retirees?
- Do pre-Medicare-eligible retirees objectively receive a greater benefit than post-Medicare-eligible retirees?

With health care costs currently increasing sharply and some employers already dropping retiree health benefits or making it harder for retirees to qualify for health benefits, it is unlikely that employers will increase the level of health benefits for Medicare-eligible retirees. Instead, because of the legal and cost concerns raised by the Erie County decision, they are likely to cut back on benefits for early retirees until the program meets the "equal cost" or "equal benefit" safe harbor of ADEA. Furthermore, the Erie County ruling may result in more employers eliminating retiree health benefits altogether. Some employers may consider using a defined contribution approach (discussed below) to provide retiree health insurance, essentially offering current employees a promise for future monies available to purchase retiree health insurance either on their own or with the employer's or union's assistance.

H.R. 1322

The proposed Emergency Retiree Health Benefits Protection Act of 2001 (H.R. 1322 in the 107th Congress) would also affect the future availability of retiree health benefits, although like any bill introduced in Congress, it faces an uphill battle for passage. This bill would prohibit (after the date of the bill's enactment) employers from making any changes to retiree health benefits once an employee retires and is covered by these benefits. The bill would prohibit employers from dropping retiree health benefits or increasing retirees' out-of-pocket premiums. The bill would not mandate that employers provide retiree health benefits, nor would it prohibit employers from changing retiree health benefits that current employees could expect during retirement.

Under the bill, retirees would need to know what to reasonably expect at retirement in terms of retiree health benefits, as the bill would disallow plan sponsors from reducing these benefits once a person is retired. However, plan sponsors would be allowed to make changes to their benefits plan if it could be shown that continuation of the retiree health benefits program would create a substantial hardship for the business. The bill includes a provision that would require excess pension benefits to be used to keep retiree health benefits intact before a waiver would be granted allowing changes to retiree health benefits. The bill would apply to all group health plans that include at least 100 retirees (not counting dependents), and would exempt collectively bargained arrangements. In addition,

retirees who specifically consent to a benefit cutback or elimination would not be covered under the bill.

The most controversial provision of the bill would require plan sponsors to restore retiree health benefits for retirees whose benefits were reduced before enactment of the bill. In order to qualify for restoration of benefits, a retiree must have been covered under the retiree health plan as of the date of enactment of the bill. For example, a retiree would be allowed to request restoration of benefits even if benefits were reduced several years prior to enactment of the bill. The bill does not appear to allow retirees who have experienced a reduction in benefits to apply for restoration of benefits if they are no longer covered by the plan.

An emergency loan program would be created under the bill to assist plan sponsors in restoring benefits. Before being eligible for a loan, plan sponsors would probably be required to use any excess pension assets to continue providing retiree health benefits. An oversight board, composed of the secretaries of Labor, Commerce, Treasury, Health and Human Services, and the chairman of the Council of Economic Advisers, would be created to manage the loan program. At any time, $5 billion would be available for loans, with no more than $5 million going to any individual plan sponsor. In order for a plan sponsor to qualify for a loan, the board would have to take into account the availability of such loans generally, the prospective earning power of the plan sponsor, and whether or not the loan would meet the plan sponsor's obligation to continue providing retiree health benefits. The board would not be able to make any loans after 2006.

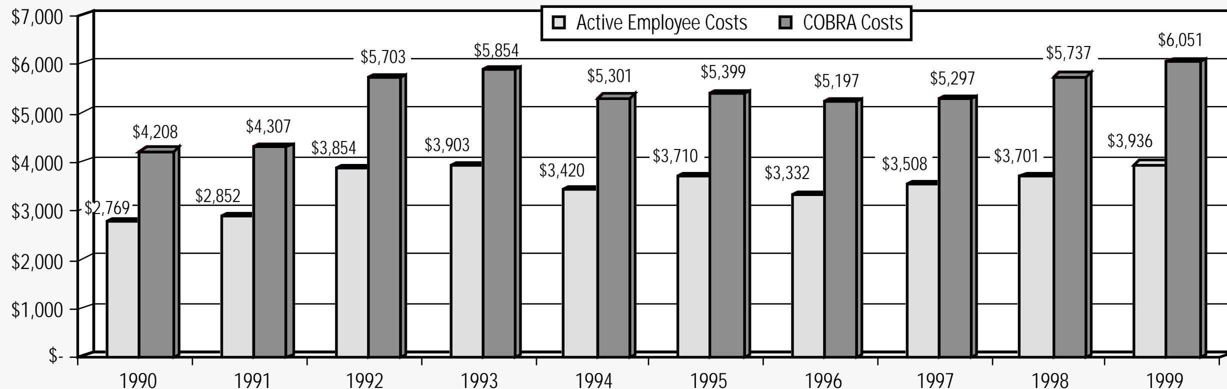
If enacted, this bill may result in sudden changes to retiree health benefits for active workers. If employers are concerned that they will not be able to make changes to retiree health benefits once a person is retired, they may respond by protecting themselves against potentially significant costs by making it harder for active workers to qualify for retiree health benefits.

H.R. 1255/S. 623 and H.R. 1078

A group of bills would extend availability of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to current retirees (ages 55–64) whose health benefits were reduced or terminated during retirement (COBRA allows ex-workers to purchase health insurance through their former employers at their own cost for a set period of time). The Medicare Early Access and Tax Credit Act (H.R. 1255/S. 623) would require companies that have discontinued or substantially cut a company retiree health plan for current retirees, but continue to provide coverage for active employees, to provide retirees access to the company health plan. Retirees would be required to pay 125 percent of the cost of health benefits. COBRA coverage could continue until the retiree becomes eligible for Medicare. The bill also would provide a 50 percent tax credit to help retirees pay for COBRA, meaning they would get a tax credit for half the cost of their COBRA premium.

This bill also would permit a Medicare buy-in. Individuals ages 62–64 without health insurance, who have earned enough quarters of coverage to be eligible for Medicare at 65, would be able to purchase Medicare coverage, whether or not they have exhausted any employer COBRA eligibility. They would pay a base premium of approximately $326 monthly, adjusted for inflation and varying according to geographic differences in the cost of health care. An additional premium of about $4 monthly would be taken from the covered person's Social Security check after retirement for a 20-year period during which the individual would be covered under Medicare. The coverage could continue even if the individual later becomes eligible for an employer group health plan or public plan. Individuals ages 55–61 and their uninsured spouses would be able to purchase the full range of Medicare benefits if they have earned enough quarters of coverage to be eligible for Medicare at age 65; are eligible for

Chart 6
Average Health Care Costs for Active Workers and COBRA-Covered Beneficiaries, Plan Years 1990–1999



Stephen A. Huth, "COBRA Costs Continue to Be High, Erratic," *Employee Benefit Plan Review* (September 1997): 36–44, and "High COBRA Costs Continue, but Fewer Employees Become Eligible," *Employee Benefit Plan Review* (September 2000): 22–26.

unemployment insurance; had a year-plus of employment-based health insurance coverage prior to being laid off; and are not eligible for COBRA or other coverage as a result of unemployment. Such coverage would cost approximately $460 monthly, adjusted for inflation. There would be no additional premium at age 65 because the base cost would be set to include the likely enrollment of sicker-than-average people.

The Broken Promises Retiree Health Coverage Act (H.R. 1078) also would extend availability of COBRA coverage to retirees who experience a reduction or termination of retiree health benefits during retirement. Retirees would be required to pay 110 percent of the applicable premium. This bill does not include the tax credit provisions contained in H.R. 1255/S. 623.

Extending COBRA coverage to retirees (along with current COBRA coverage requirements, for that matter) is of concern to employers because COBRA beneficiaries typically cost employers more to insure than active workers—roughly 50 percent more. For example, average employer claim costs for COBRA beneficiaries amounted to $6,051, compared with $3,936 for active employees in 1999 (chart 6). The difference in claim experience occurs because persons at high risk of needing health care services are more likely to pay for COBRA benefits than those in average health. As a result, COBRA programs suffer from adverse selection, meaning that they tend to attract high-risk and high-cost enrollees.

The issue of adverse selection is exacerbated by the fact that retirees, being older, on average, than active employees, have much higher morbidity. Even before considering the effects of adverse selection, average health costs for 55–64-year-olds are more than double those of 18–54-year-olds.[14]

Adverse selection is a concern for employers because they are currently able to require COBRA beneficiaries to pay only 102 percent of the premium.[15] If the employers' plan is self-insured, then the employer is, in effect, subsidizing the cost of COBRA coverage for former employees. Fully insured employers may indirectly subsidize the cost of COBRA coverage if continuing to cover former employees drives up the average cost of providing health benefits over time. By requiring retirees to pay 110–125 percent of the premium, these bills recognize that employment-based health plans experience adverse selection under COBRA.

While COBRA in general raises employers' costs for providing health benefits, these proposed bills may or may not result in additional costs to employers. As mentioned above, employers subsidize COBRA beneficiaries on average because their claims experience are roughly 50 percent higher than the claims experience of active workers, yet employers are able to collect only 2 percent more than the premium for health benefits. So, on one hand, requiring a retiree to pay 125 percent of the premium would still expose employers to some added cost; on the other hand, the tax credit provision might have the effect of reducing adverse selection. A 50 percent tax credit might induce healthier retirees who otherwise might not purchase COBRA coverage to do

[14] *According to author estimates from the 1996 Medical Expenditure Panel Survey, health care costs averaged $1,512 for 18–54-year-olds and $3,492 for 55–64-year-olds.*

[15] *The additional 2 percent is designed to compensate plan sponsors for additional administrative costs associated with maintaining health insurance benefits for COBRA beneficiaries. It was not meant to accommodate expected higher claim costs due to adverse selection.*

so—although the tax credit might also attract more unhealthy retirees who otherwise could not afford to purchase health insurance on their own.

The Medicare buy-in provisions of H.R. 1255/ S. 623 would provide individuals ages 55–64 with a means of obtaining insurance not otherwise available to them because of age and health status. As provided for in the bill, allowing early retirees to offset future Social Security entitlements by amounts actuarially required to provide Medicare benefits during early retirement could cover some of this cost.

Medicare and Prescription Drugs

Congress and the Bush administration currently have proposals to add a prescription drug benefit to Medicare. There is strong support for adding a prescription drug benefit, even if it may mean an increase in Medicare premiums or taxes. According to the 1999 Health Confidence Survey, more than 71 percent of Americans age 21 and older favor expanding Medicare to cover prescription drugs.

A Medicare prescription drug benefit, depending on how it is structured, could substantially change the role that employers play in providing supplementary coverage for Medicare-eligible retirees. Employers offering retiree health benefits to Medicare-eligible retirees would be able to integrate their programs with the prescription drug benefits offered through the Medicare program. This benefit would provide a significant source of savings to employers offering retiree health benefits. One study found employer cost savings in the range of 5–8 percent if employers "wrapped around" various Medicare prescription drug benefits (McArdle et al., 2000). The financial savings could slow the erosion in retiree health benefits, although in the long run Medicare-eligible retirees might not place value in supplemental retiree health benefits if Medicare prescription drugs were a substitute for private employer plans.

DC Health Benefits

Currently, some employers are interested in the concept of defined contribution (DC) health benefits as an alternative to the defined benefit health benefits system. This type of approach to health benefits is also being considered as an alternative way to provide health benefits to retirees. There are numerous issues involved with providing DC health benefits to active workers for current health insurance needs, and the concept has potential benefits and drawbacks for workers (Fronstin, 2001). Many of the issues that employers and employees must address in order to switch to a DC health benefits system are not applicable or easily addressed in a DC health benefits system for retiree health benefits, and there also are other issues to consider. The remainder of this section describes how DC health benefits for retirees could work in practice, as well as some issues specific to retiree health benefits.

Some employers already have established DC health-type benefits for retirees. These benefits are more similar to DC retirement benefits, such as 401(k) plans, than DC health benefits would be for active employees. Like a DC retirement plan, active employees under a DC health plan for retiree health benefits would typically accumulate funds in an account to pre-fund retiree health benefits during their working life. After workers retire, the funds in the account could be used to purchase health insurance from their former employer or union, or directly from an insurer.

While working, each employee would have an account. The account might be funded or unfunded. Both employer and employees could contribute to the value of account balances. Employer contributions to the value of the account could be unfunded, meaning that the value of the account could be made available to pay for retiree health benefits. If only employer contributions were made to the account, the employer could set up the account on paper, and could amend, modify, or even terminate the plan at any time for current and/or future retirees. If employee contributions were made to the

Research already shows a strong link between a worker's decision to retire and the availability of retiree health benefits.

account, an actual account would have to be established, as the employees would "own" their contributions (i.e., such amounts would be fully funded), although they would not own the employer contributions.

Another issue to consider when deciding who could contribute to the account is the tax treatment of contribution sources. Employer contributions to the account could be designed so as not to be treated as taxable income to the employee, either during working years or during retirement on payout of insurance benefits. Active employee contributions, however, could not be treated as pre-tax income like the contributions employees make toward health benefits (through Internal Revenue Service Sec. 125 plans) during their working years.

Yet another issue to consider in designing a plan is how to treat new employees who are older than the plan's entry age when they join the employer. A "lump-sum" or opening balance could be provided to employees who join the plan if they commence participation after entry age into the plan has passed. The opening balance could also be tied to age and/or years of service.

Employers might require that employees meet an age and/or service requirement before being allowed to use the funds in the account to buy insurance in retirement. Employers might also vary their contribution to the account based on age and/or service requirements. Age requirements are common in defined benefit pension plans, where an employee would not qualify for retirement benefits until he or she reaches a minimum age. Age requirements are also increasingly common for qualifying for retiree health benefits. It is likely that employers with both a defined benefit pension plan and retiree health benefits would consider standardizing the age qualifications across the benefit plans.

After retirement, retirees could use the funds accumulated in the account to buy health insurance. The insurance could be provided by the employer—meaning, the employer would continue to decide what benefits to offer and at what price—or the employer could allow retirees to buy insurance on their own and pay an insurer of the retirees' choice directly.

Employers are interested in these accounts for retiree health benefits for a number of reasons. Pre-funding an account could reduce future employer costs for retiree health benefits. By pre-funding an account, an employer would decide how much to contribute to retiree health benefits while a person is working. Contributions to the account might accumulate interest, and the value of the contribution could grow over time or could vary with age or years of service; however, it is possible that the value of the account would not grow as fast as the anticipated cost of providing retiree health benefits. Essentially, in this type of model employees bear the risk of unpredictable health benefit cost inflation.

Employers must also decide how the account could be used once an employee retires. As mentioned above, employers could continue to provide the health benefit. This means retirees would be purchasing health insurance from their former employer using funds accumulated in the account. In contrast, employers might allow retirees to use the funds to purchase any health insurance, including policies sold directly by insurers. Account balances also could be used to pay out-of-pocket expenses, such as deductibles, co-payments, and health care services not covered by the benefit plan.

Whether or not retirees are allowed to use the funds accumulated in the account to purchase insurance on their own or as a spending account, retirees run the risk of depleting the assets in the account while money is still needed to purchase insurance. As a result, employers run the risk of losing a tool to manage the retirement process. If employees think that their account balance is not large enough to pay for retiree health benefits, they might postpone their retirement date until they are closer to being eligible for Medicare. Research already shows a strong link between a worker's decision to retire and the availability of retiree health benefits (Fronstin, 1999).

It will be an important exercise for retirees to

predict how much it will cost them to purchase health insurance during retirement, and whether there will be enough assets accumulated in their accounts for this purpose. If a shortfall is expected, they might want to start saving additional funds for later years. They also might want to use some of their own money up front, rather than the funds in the account, if they expect the cost of insurance to increase faster than the gains on the assets accumulated in the account, or because health care cost inflation is typically higher than overall inflation and may be higher than the amount of money the account may earn over time. The decision to use personal assets, rather than the assets accumulated in an unfunded account, is highly complex, and involves predicting the cost of health insurance, the composition of the benefits package, the rate of return on personal assets, the rate of return on the assets in the paper account, life expectancy, future income, other budget needs, and the ability of the plan sponsor to make good on its promise to fund the liability.

Because the DC health account could be depleted before the death of a retiree, employers could consider allowing retirees to convert their account balance to an annuity. While the annuity might not provide enough funds to cover the full cost of health insurance, retirees would be guaranteed a stream of funds until their (or their spouse's) death. The annuity also could allow for different payouts before and after age 65, when retirees become eligible for Medicare and the cost of their health insurance falls substantially. Annuities, however, may be taxable upon payout if the retiree has a choice between receiving money or health insurance.

It is important to understand the basic difference in how DC health benefits would work in practice for active workers and for retirees. For active workers, a DC health benefit would be used to fund their current health insurance. While DC health benefits could be provided under a number of different scenarios, in all cases employers would generally provide a fixed contribution that employees would then use to buy health insurance. In contrast, DC health benefits for retirees are a pre-funding mechanism that would be used to accumulate assets to purchase health insurance on retirement. While the risk of health care cost inflation is transferred to employees under both types of DC arrangements, the risk for retirees may be greater because of the longer time frame between the accumulation of assets to pay for health insurance and the actual purchase of insurance and the increased possibility that the assets will be insufficient to keep up with the cost of health insurance.

Under both arrangements, individuals may have to use some of their own money to buy insurance, but the issues of how much money and when it is used differ. For example, under a DC health benefits arrangement for active workers, employers may provide a fixed contribution that covers only 90 percent of the cost of health insurance. In order to buy insurance, employees would then have to pay the difference each month. Under a DC health benefits arrangement for retirees, retirees are likely to have accumulated enough assets in the account to buy health insurance without having to use their own funds for at least a few years, or they could apportion their funds so that all of the accounts' accumulated assets are not used at once. However, as mentioned above, once the assets in the fund are depleted, the retiree would then need to purchase health insurance with his or her own funds.

Conclusion

FAS 106 triggered substantial changes to retiree health benefits starting a decade ago. Some employers capped their spending on retiree health benefits. Some required employees to meet age and service requirements before becoming eligible for retiree health benefits. Others moved to defined contribution health benefits, or completely dropped retiree health benefits.

However, the changes that employers have made

to retiree health benefits have not yet had a huge impact on *current* retirees. Between 1994 and 1999, the percentage of retirees ages 55–64 with retiree health benefits was unchanged, at roughly 37 percent, although it is likely that many current retirees are paying more to maintain retiree health benefits. The finding that current retirees have not experienced a decline in coverage may be explained by the fact that the courts have ruled that an employer has a right to terminate or amend retiree health benefits only if it has proved that such a right has been reserved or stated in specific language and on a widely known basis (Davis, 1991).

The changes that employers have made to retiree health benefits will likely have a greater impact on *future* retirees. These changes may not have noticeable effects on trends in insurance coverage until a few years after the post-World War II baby boom generation starts to retire. Retirement behavior patterns may also change as employees nearing retirement age postpone their decision to retire on learning that, without a job, they may not be able to obtain health insurance coverage.

Public policymakers face the difficult task of trying to provide policy solutions for a system that is largely voluntary. By law, employers are under no obligation to provide retiree health benefits, except to current retirees who can prove that they were promised a specific benefit. In the meantime, it is likely that employers will continue to make changes to retiree health benefits in response to predicted future medical inflation, court rulings involving the ADEA, and potential federal legislative initiatives. While these changes in retirement health benefits are not being widely felt by today's retirees, the coming wave of baby boom retirees may find themselves unpleasantly surprised.

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Appendix

Table A1
Sources of Health Insurance Coverage, Population Ages 55–64, by Family Income, 1999

Family Income	Total	Employment-Based Health Benefits: Total	Employment-Based Health Benefits: Own name	Employment-Based Health Benefits: Dependent	Individually Purchased	Public: Total	Public: Medicaid	Uninsured
				(millions)				
Total	23.4	15.7	11.7	4.0	2.0	3.9	1.5	3.4
Under $5,000	0.8	0.2	0.2	0.0	0.1	0.2	0.1	0.3
$5,000–$9,999	1.2	0.2	0.2	0.0	0.1	0.7	0.5	0.3
$10,000–$14,999	1.4	0.4	0.4	0.1	0.2	0.5	0.3	0.3
$15,000–$19,999	1.3	0.6	0.5	0.1	0.2	0.4	0.1	0.3
$20,000–$29,999	2.6	1.5	1.1	0.4	0.4	0.5	0.2	0.5
$30,000–$39,999	2.6	1.8	1.4	0.4	0.2	0.4	0.1	0.5
$40,000–$49,999	2.4	1.8	1.3	0.5	0.2	0.3	0.0	0.3
$50,000 and over	11.0	9.2	6.7	2.5	0.6	0.9	0.1	0.9
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under $5,000	3.6	1.5	1.7	1.2	6.2	4.6	8.0	9.8
$5,000–$9,999	5.3	1.3	1.5	0.9	5.8	18.3	35.0	8.1
$10,000–$14,999	5.8	2.7	3.0	1.7	8.7	13.2	18.7	10.0
$15,000–$19,999	5.8	3.9	4.1	3.4	8.3	9.9	9.1	8.9
$20,000–$29,999	11.2	9.4	9.6	9.1	18.0	13.6	11.1	14.6
$30,000–$39,999	11.3	11.4	11.6	10.6	11.1	9.2	7.5	13.4
$40,000–$49,999	10.2	11.3	11.1	11.7	9.8	6.9	3.2	9.2
$50,000 and over	46.9	58.5	57.4	61.5	32.3	24.3	7.5	25.9
				(percentage within family income categories)				
Total	100.0%	67.0%	49.9%	17.0%	8.5%	16.5%	6.3%	14.5%
Under $5,000	100.0	28.9	23.2	5.7	14.8	21.2	14.1	39.9
$5,000–$9,999	100.0	17.2	14.4	2.8	9.3	57.5	41.9	22.4
$10,000–$14,999	100.0	30.8	25.8	5.0	12.7	37.3	20.2	24.9
$15,000–$19,999	100.0	45.3	35.4	10.0	12.2	28.5	9.9	22.5
$20,000–$29,999	100.0	56.5	42.7	13.8	13.7	20.1	6.2	19.0
$30,000–$39,999	100.0	67.4	51.5	15.9	8.4	13.5	4.2	17.2
$40,000–$49,999	100.0	74.2	54.5	19.7	8.2	11.3	2.0	13.2
$50,000 and over	100.0	83.4	61.1	22.3	5.9	8.6	1.0	8.0

Note: Details may not add to totals because individuals may receive coverage from more than one source.
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplement 2000.

Table A2
Sources of Health Insurance Coverage, Population Ages 55–64, by Family Income as a Percentage of the Federal Poverty Level, 1999

		Employment-Based Health Benefits				Public		
Poverty Status	Total	Total	Own name	Dependent	Individually Purchased	Total	Medicaid	Uninsured
				(millions)				
Total	23.4	15.7	11.7	4.0	2.0	3.9	1.5	3.4
0–99%	2.2	0.5	0.4	0.1	0.2	0.9	0.7	0.7
100%–124%	0.8	0.2	0.2	0.0	0.1	0.3	0.2	0.2
125%–149%	0.9	0.3	0.2	0.1	0.1	0.3	0.1	0.2
150%–199%	1.5	0.7	0.5	0.2	0.2	0.4	0.1	0.4
200%–299%	3.2	1.9	1.4	0.5	0.4	0.5	0.1	0.6
300%–399%	3.1	2.3	1.7	0.6	0.2	0.4	0.1	0.4
400% or more	11.7	9.8	7.3	2.5	0.7	1.0	0.1	0.9
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
0–99%	9.5	3.2	3.4	2.7	12.2	23.8	45.5	19.3
100%–124%	3.4	1.3	1.4	1.2	4.5	8.3	12.4	6.8
125%–149%	3.7	2.0	2.1	1.6	5.7	7.6	9.9	6.0
150%–199%	6.5	4.3	4.3	4.2	9.1	10.9	9.3	10.7
200%–299%	13.5	12.1	11.8	13.0	19.5	13.3	10.1	18.5
300%–399%	13.4	14.6	14.7	14.5	11.7	10.4	6.6	12.4
400% or more	50.0	62.4	62.3	62.8	37.2	25.6	6.2	26.2
				(percentage within poverty categories)				
Total	100.0%	67.0%	49.9%	17.0%	8.5%	16.5%	6.3%	14.5%
0–99%	100.0	23.0	18.1	4.8	11.0	41.6	30.3	29.6
100%–124%	100.0	26.1	20.4	5.7	11.2	40.3	22.9	29.0
125%–149%	100.0	36.0	28.3	7.6	13.2	34.5	17.0	23.6
150%–199%	100.0	44.5	33.4	11.1	12.0	27.8	9.0	24.0
200%–299%	100.0	59.7	43.4	16.3	12.3	16.2	4.7	19.9
300%–399%	100.0	73.0	54.6	18.5	7.4	12.9	3.1	13.5
400% or more	100.0	83.6	62.2	21.4	6.3	8.5	0.8	7.6

Note: Details may not add to totals because individuals may receive coverage from more than one source.
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplement 2000.

Table A3
Sources of Health Insurance Coverage, Population Ages 55–64, by Gender and Marital Status, 1999

Gender and Marital Status	Total	Employment-Based Health Benefits			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
				(millions)				
Total	23.4	15.7	11.7	4.0	2.0	3.9	1.5	3.4
Male married	8.6	6.6	5.3	1.2	0.6	1.1	0.2	0.9
Male not married	2.5	1.3	1.3	0.0	0.2	0.6	0.3	0.5
Female married	8.1	5.6	2.9	2.7	0.8	1.1	0.3	1.2
Female not married	4.2	2.1	2.1	0.0	0.5	1.0	0.6	0.8
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Male married	36.8	41.9	45.7	30.8	28.8	29.0	16.5	27.0
Male not married	10.8	8.6	11.4	0.4	10.1	16.4	22.3	15.2
Female married	34.6	35.7	24.7	68.0	37.8	28.6	20.3	35.0
Female not married	17.8	13.7	18.2	0.8	23.3	26.0	40.9	22.8
				(percentage within gender and marital status categories)				
Total	100.0%	67.0%	49.9%	17.0%	8.5%	16.5%	6.3%	14.5%
Male married	100.0	76.2	61.9	14.3	6.7	13.0	2.8	10.7
Male not married	100.0	53.6	53.0	0.6	8.0	25.1	13.1	20.4
Female married	100.0	69.2	35.7	33.5	9.3	13.7	3.7	14.7
Female not married	100.0	51.5	50.8	0.7	11.1	24.1	14.4	18.5

Note: Details may not add to totals because individuals may receive coverage from more than one source.
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplement 2000.

Table A4

Sources of Health Insurance Coverage, Population Ages 55–64, by Race, 1999

Race	Total	Employment-Based Health Benefits: Total	Own name	Dependent	Individually Purchased	Public: Total	Medicaid	Uninsured
				(millions)				
Total	23.4	15.7	11.7	4.0	2.0	3.9	1.5	3.4
White	18.5	13.0	9.6	3.4	1.7	2.7	0.9	2.2
Black	2.3	1.3	1.1	0.3	0.1	0.6	0.3	0.4
Hispanic	1.7	0.8	0.6	0.2	0.1	0.4	0.2	0.5
Other	0.9	0.5	0.4	0.1	0.1	0.2	0.1	0.2
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
White	79.0	83.3	82.6	85.4	85.2	70.0	59.6	65.4
Black	9.7	8.3	9.0	6.4	5.8	16.3	21.0	12.1
Hispanic	7.5	4.9	5.0	4.7	6.2	9.4	15.3	16.2
Other	3.8	3.4	3.4	3.5	2.8	4.2	4.1	6.4
				(percentage within race categories)				
Total	100.0%	67.0%	49.9%	17.0%	8.5%	16.5%	6.3%	14.5%
White	100.0	70.6	52.2	18.4	9.2	14.7	4.8	12.0
Black	100.0	57.6	46.4	11.2	5.1	27.8	13.7	18.1
Hispanic	100.0	44.4	33.6	10.8	7.1	20.9	13.0	31.4
Other	100.0	59.6	44.0	15.6	6.2	18.3	6.7	24.4

Note: Details may not add to totals because individuals may receive coverage from more than one source.
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplement 2000.

Table A5

Sources of Health Insurance Coverage, Population Ages 55–64, by Work Status, 1999

Work Status	Total	Employment-Based Health Benefits: Total	Own name	Dependent	Individually Purchased	Public: Total	Medicaid	Uninsured
				(millions)				
Total	23.4	15.7	11.7	4.0	2.0	3.9	1.5	3.4
Full-year, full-time worker	11.1	8.7	7.8	0.9	0.8	0.7	0.2	1.4
Part-time or part-year worker	4.1	3.2	1.9	1.3	0.3	0.3	0.1	0.5
Nonworker	8.2	3.8	1.9	1.8	1.0	2.9	1.2	1.5
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Full-year, full-time worker	47.4	55.4	66.9	21.5	38.5	17.0	12.4	40.2
Part-time or part-year worker	17.5	20.5	16.5	32.1	13.5	6.9	3.6	15.2
Nonworker	35.1	24.1	16.5	46.4	48.1	76.0	84.0	44.6
				(percentage within work status categories)				
Total	100.0%	67.0%	49.9%	17.0%	8.5%	16.5%	6.3%	14.5%
Full-year, full-time worker	100.0	78.3	70.6	7.7	6.9	5.9	1.7	12.3
Part-time or part-year worker	100.0	78.4	47.1	31.2	6.5	6.6	1.3	12.6
Nonworker	100.0	46.0	23.5	22.5	11.7	35.8	15.1	18.4

Note: Details may not add to totals because individuals may receive coverage from more than one source.
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplement 2000.

Table A6

Sources of Health Insurance Coverage, Working Population Ages 55–64, by Industry, 1999

Industry	Total	Employment-Based Health Benefits			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
					(millions)			
Total	15.2	11.9	9.7	2.1	1.0	0.9	0.2	1.9
Agriculture, forestry, fishing, mining, and construction	1.3	0.8	0.6	0.2	0.2	0.1	0.0	0.3
Manufacturing	3.3	2.8	2.6	0.3	0.1	0.2	0.0	0.3
Wholesale and retail trade	4.2	3.0	2.3	0.7	0.4	0.3	0.1	0.6
Personal services	3.5	2.6	2.0	0.6	0.3	0.2	0.1	0.5
Public sector	2.8	2.6	2.3	0.3	0.1	0.2	0.0	0.2
					(percentage within coverage category)			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Agriculture, forestry, fishing, mining, and construction	8.8	7.0	6.1	11.4	17.7	8.6	9.9	14.5
Manufacturing	21.5	23.7	26.2	11.9	9.7	16.3	15.7	16.2
Wholesale and retail trade	27.8	25.2	23.5	33.2	40.8	32.9	37.0	34.1
Personal services	23.2	22.3	20.5	30.3	25.8	23.4	25.2	27.0
Public sector	18.7	21.8	23.7	13.3	6.0	18.8	12.3	8.2
					(percentage within industry categories)			
Total	100.0%	78.3%	64.2%	14.1%	6.8%	6.1%	1.6%	12.4%
Agriculture, forestry, fishing, mining, and construction	100.0	62.4	44.3	18.2	13.7	6.0	1.7	20.4
Manufacturing	100.0	86.0	78.2	7.8	3.1	4.6	1.1	9.3
Wholesale and retail trade	100.0	71.2	54.4	16.8	10.0	7.2	2.1	15.2
Personal services	100.0	75.2	56.9	18.4	7.6	6.2	1.7	14.4
Public sector	100.0	91.2	81.2	10.0	2.2	6.1	1.0	5.5

Note: Details may not add to totals because individuals may receive coverage from more than one source.
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplement 2000.

Table A7

Sources of Health Insurance Coverage, Working Population Ages 55–64, by Firm Size, 1999

Firm Size	Total	Employment-Based Health Benefits			Individually Purchased	Public		Uninsured
		Total	Own name	Dependent		Total	Medicaid	
					(millions)			
Total	15.2	11.9	9.7	2.1	1.0	0.9	0.2	1.9
Self-Employed	2.3	1.3	0.8	0.5	0.5	0.1	0.0	0.5
Total Wage and Salary Workers	12.9	10.6	9.0	1.6	0.6	0.8	0.2	1.4
Public sector	2.8	2.6	2.3	0.3	0.1	0.2	0.0	0.2
Private sector	10.0	8.0	6.7	1.3	0.5	0.6	0.2	1.3
fewer than 10	1.6	0.9	0.6	0.4	0.2	0.1	0.0	0.4
10–24	1.0	0.7	0.5	0.2	0.1	0.1	0.0	0.2
25–99	1.4	1.1	0.9	0.2	0.0	0.1	0.0	0.2
100–499	1.6	1.4	1.2	0.2	0.1	0.1	0.0	0.2
500–999	0.6	0.5	0.5	0.0	0.0	0.0	0.0	0.0
1,000 or more	3.7	3.3	3.0	0.4	0.1	0.2	0.1	0.2
					(percentage within coverage category)			
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Self-Employed	15.2	11.0	7.8	25.6	46.1	13.3	11.1	24.9
Total Wage and Salary Workers	84.8	89.0	92.2	74.4	53.9	86.7	88.9	75.1
Public sector	18.7	21.8	23.7	13.3	6.0	18.8	12.3	8.2
Private sector	66.0	67.2	68.5	61.1	47.8	67.9	76.5	66.8
fewer than 10	10.9	7.9	5.8	17.4	19.1	12.9	17.6	23.2
10–24	6.7	6.1	5.3	9.7	7.3	6.7	5.7	10.3
25–99	8.9	9.0	9.3	7.7	3.7	10.8	11.1	10.7
100–499	10.8	11.7	12.6	7.5	5.6	11.5	14.7	8.2
500–999	4.0	4.6	5.1	2.0	1.2	3.3	3.1	2.3
1,000 or more	24.7	28.0	30.5	16.7	10.9	22.7	24.4	12.2
					(percentage within firm size categories)			
Total	100.0%	78.3%	64.2%	14.1%	6.8%	6.1%	1.6%	12.4%
Self-Employed	100.0	56.4	32.7	23.6	20.6	5.3	1.1	20.3
Total Wage and Salary Workers	100.0	82.3	69.9	12.4	4.3	6.2	1.6	11.0
Public sector	100.0	91.2	81.2	10.0	2.2	6.1	1.0	5.5
Private sector	100.0	79.7	66.7	13.0	4.9	6.3	1.8	12.5
fewer than 10	100.0	56.8	34.3	22.5	12.0	7.2	2.5	26.4
10–24	100.0	70.8	50.5	20.4	7.4	6.0	1.3	19.0
25–99	100.0	78.8	66.6	12.2	2.8	7.4	1.9	14.8
100–499	100.0	84.5	74.8	9.7	3.5	6.5	2.1	9.4
500–999	100.0	89.4	82.2	7.2	2.0	5.0	1.2	7.2
1,000 or more	100.0	88.9	79.4	9.5	3.0	5.6	1.5	6.1

Note: Details may not add to totals because individuals may receive coverage from more than one source.
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplement 2000.

Table A8
Sources of Health Insurance Coverage, Working Population Ages 55-64, by Annual Earnings, 1999

		Employment-Based Health Benefits				Public		
Earned Income	Total	Total	Own name	Dependent	Individually Purchased	Total	Medicaid	Uninsured
				(millions)				
Total	15.2	11.9	9.7	2.1	1.0	0.9	0.2	1.9
Under $10,000	2.7	1.5	0.9	0.6	0.3	0.4	0.1	0.7
$10,000–$19,999	2.7	1.8	1.4	0.5	0.2	0.2	0.1	0.5
$20,000–$29,999	2.7	2.2	1.8	0.4	0.1	0.1	0.0	0.3
$30,000–$39,999	2.1	1.9	1.6	0.2	0.1	0.1	0.0	0.1
$40,000–$49,999	1.5	1.3	1.2	0.1	0.1	0.0	0.0	0.1
$50,000 or more	3.6	3.2	2.9	0.3	0.2	0.1	0.1	0.2
				(percentage within coverage category)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Under $10,000	17.8	12.6	9.0	29.0	33.8	37.9	53.1	34.6
$10,000–$19,999	17.8	15.5	13.9	22.6	22.1	20.6	25.6	29.1
$20,000–$29,999	17.5	18.6	18.5	18.7	11.6	13.1	10.9	15.5
$30,000–$39,999	13.7	15.6	16.9	10.0	8.4	9.4	4.7	6.4
$40,000–$49,999	9.6	11.0	12.2	5.3	6.1	4.8	4.7	4.9
$50,000 or more	23.5	26.8	29.5	14.5	18.1	14.2	21.4	9.6
				(percentage within earnings categories)				
Total	100.0%	78.3%	64.2%	14.1%	6.8%	6.1%	1.6%	12.4%
Under $10,000	100.0	55.3	32.4	22.9	13.0	13.0	4.6	24.1
$10,000–$19,999	100.0	68.1	50.2	17.9	8.5	7.1	2.2	20.3
$20,000–$29,999	100.0	83.0	68.0	15.0	4.5	4.6	1.0	11.0
$30,000–$39,999	100.0	89.2	79.0	10.2	4.2	4.2	0.5	5.7
$40,000–$49,999	100.0	89.1	81.4	7.7	4.3	3.0	0.8	6.3
$50,000 or more	100.0	89.2	80.5	8.6	5.2	3.7	1.4	5.1

Note: Details may not add to totals because individuals may receive coverage from more than one source.
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March Supplement 2000.

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