Trends In Retiree Health Benefits

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Trends In Retiree Health Benefits

Health benefits for retirees are eroding even in the best of times.

by Lauren A. McCormack, Jon R. Gabel, Heidi Whitmore, Wayne L. Anderson, and Jeremy Pickreign

ABSTRACT: Based on national surveys of employers from 1988 through 2001 and recent key-informant interviews, this paper examines trends in employer-based retiree health benefits. We assess trends in the availability of coverage to early and Medicare-eligible retirees, the cost of coverage, plan choice and enrollment, prescription drug coverage, and recent changes in plan design. During a period of low health care inflation and record prosperity, retiree coverage declined slightly, unlike the coverage of active workers. Indemnity enrollment remains strong among retirees, and employers are cautious about Medicare+Choice because of continuing plan withdrawals. Numerous indicators point to a further and accelerating decline in retiree coverage.

Retiree health benefits provide financial protection for four million retirees under age sixty-five and for twelve million Medicare-eligible retirees. Employer-based coverage is generally more comprehensive and affordable than is coverage purchased individually. In 1999 annual out-of-pocket costs for Medicare beneficiaries with Medigap coverage were approximately $3,400, versus $2,200 for those with employer-sponsored supplemental coverage. The availability of health insurance is often a critical factor in retirement decisions.

Retiree coverage for Medicare-eligible persons is closely intertwined with prescription drug coverage. Roughly 40–60 percent of all health care expenses incurred by employers for this population are for prescription drugs, and employer coverage is the source of drug coverage for 46 percent of Medicare beneficiaries with a single source of drug coverage. Retiree coverage generally provides better financial protection than do alternative forms of private insurance for drug expenses. In 1998 Medicare beneficiaries with retiree coverage from an employer paid just 26 percent of their prescription drug expenses out of pocket; beneficiaries who had drug coverage through Medigap and Medicare managed care paid 67 and 40 percent, respectively. Hence, any diminution of retiree coverage means that greater numbers of Medicare beneficiaries will be exposed to the financial risk associated with high prescription drug costs.

Rising costs have contributed to a declining percentage of firms offering retiree coverage. Many employers have already instituted an array of incremental cost-savings approaches over the years—increased cost sharing, reduced benefits, and financial incentives to select certain types of plans—so that they can continue offering coverage. Employers imple-
mented these measures during the 1990s, a pe-
period of low health care inflation and record
economic growth.

As a result of the economic downturn that
began in 2001 and double-digit insurance pre-
mium increases, employers are facing difficult
decisions about whether to continue offering
coverage and in what form. The factors that
motivate employers to offer coverage to retir-
ees may not be sufficient to withstand mount-
ing financial pressures. Employers may con-
sider alternative funding arrangements
including defined-contribution approaches,
but most have been reluctant to adopt these.7

In this paper we examine recent trends in
the percentage of firms offering health insur-
ance to retirees as well as those who have
dropped this coverage altogether. We report
the costs of coverage to both the employer and
the retiree, including differences between re-
tirees under and over age sixty-five. We dis-
cuss changes in plan choice and employers’ at-
titudes toward Medicare+Choice (M+C). Finally, we describe the changes employers
have made recently and are planning in the
near term.

Data And Methods

This study uses data from the Henry J. Kai-
s Family Foundation/Health Research and
Educational Trust (Kaiser/HRET) survey of
human resource and benefits managers in pub-
lic- and private-sector organizations.8 We pri-
marily use results from the 2000 and 2001 sur-
veys, which were completed from January
through May of each year. In some instances,
we report data from earlier years to illustrate
important longer-term trends that were trig-
gerated with implementation of the Financial
Accounting Standards (FAS) Board’s FAS 106,
which required employers to report their lia-
ibility for current and future retirees’ health
benefits on their balance sheets.9 We also con-
ducted twenty-five key-informant interviews
with public and private employers, unions,
benefits consultants, and one large insurer, to
complement our analysis of the survey data.

Employer survey data. The Kaiser/
HRET survey draws its sample from Dun and
Bradstreet’s list of the nation’s private and pub-
lic employers. The sample is stratified by in-
dustry and number of workers. In 2000 the
sample included 1,887 firms with three or more
workers, and in 2001 the sample size was 1,907
firms. The response rate was 45 percent in

We used descriptive statistics to analyze
data from both years and employed t-tests or
Chi-square tests to determine statistical sig-
nificance. We make year-to-year statistical
comparisons as well as comparisons to 1997,
the first year in which significance tests could
be performed. Significance testing was per-
formed at the .05 alpha level. Because the sur-
veys employed complex sampling designs, we
used SUDAAN software so that standard er-
ers are corrected for the design effect and
stratification. All data are weighted to repre-
sent national estimates.

Key-informant interviews. We selected
twenty-five key informants based on the
breadth and depth of their knowledge and ex-
perience with employer-sponsored retiree
health benefits. Although the large majority of
the interviews were conducted with employ-
ers, findings from interviews with the other
types of organizations are also reflected in the
paper. To obtain diverse perspectives, we se-
lected employers from a range of industries,
firm sizes, and regions. We considered the
type of insurance the employers offered and
the length of time it was offered. Employer in-
terviews were conducted with human re-
source directors, benefit managers and staff,
and, in the case of smaller employers, company
presidents or other executives.

We discussed the following issues during
the interviews: factors that affect the likeli-
hood of offering retiree health benefits; the
type and evolution of retiree health benefits
offered, including Medicare managed care;
consequences of potential changes in
Medicare coverage policy; and recent and
planned changes to employers’ benefit pro-
grams. The interviews lasted from one to two
hours and were conducted primarily in sum-
Study Findings

■ Offer rates to retirees. The percentage of large firms (200 or more employees) offering retiree health benefits (to either early or Medicare-eligible retirees) appears to have declined over the past decade (Exhibit 1). Offer rates stood at 34 percent in 2001, down from 46 percent in 1991 and 37 percent in 1997, although there were no significant differences in offer rates by year for retirees since 1997. Small firms (3–199 employees) saw a statistically significant decline in offer rates to retirees over the past year, dropping from 9 percent in 2000 to 3 percent in 2001 (data not shown).

Offer rates to Medicare-eligible retirees (only), defined as those persons age sixty-five and older, have declined significantly in the past several years (Exhibit 2). There was a ten-percentage-point reduction in the number of large firms offering health benefits to Medicare-eligible retirees—down from 32 percent in 1997 to 22 percent in 2001. Offer rates for early retirees (only), defined as those under age sixty-five, were generally stable over the last half of the 1990s. Year-to-year differences in offer rates were statistically significant between 1997 and 2001, 1998 and 2001, and 1999 and 2001 for Medicare-eligible retirees. No year-to-year differences were statistically significant for early retirees.

■ Employers dropping retiree coverage. Some large and jumbo firms that once offered retiree benefits have recently dropped them. Of firms not offering retiree health benefits, 7 percent of large firms and 20 percent of jumbo firms (5,000 or more employees) reported that they formerly offered such coverage. Because a large proportion of people work for the largest employers, the impact of these firms’ dropping retiree health benefits is substantial. The continuing high cost of providing retiree health benefits is the single largest issue that makes employers want to cut back or eliminate them.

In our key-informant interviews, some employers told us that they no longer offer retiree health benefits to new employees or current employees who have yet to retire. The Kaiser/HRET survey showed that 4 percent of large firms reported that they had eliminated retiree health benefits for these two groups. A more troubling finding is that 9 percent of large firms reported that in the next two years they are very or somewhat likely to eliminate retiree health benefits for new employees or current employees who have not yet retired, and 6 percent are somewhat or very likely to eliminate

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**EXHIBIT 1**

Percentage Of Large Firms That Offer Retiree Health Benefits, Selected Years 1991–2001

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<tr>
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</tr>
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<tbody>
<tr>
<td>50</td>
<td>40</td>
<td>40</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
</tbody>
</table>


**NOTE:** Includes large firms (200 employees or more) that offer coverage to either early retirees or Medicare-eligible retirees, as well as to active employees.
Other employers are now applying more restrictive eligibility requirements such as longer periods of employment. The average number of years of employment required was 10.9 in 2001.

In our key-informant interviews, some employers reported not dropping benefits out of concern for the welfare of their former employees. In some cases, employers were afraid of bad publicity, while others indicated that they would not terminate benefits because Medicare does not have a prescription drug benefit. Many employers know that individual policies are expensive because of the lack of a viable market for individual health insurance and therefore continue providing coverage.

A 2001 circuit court ruling about an employer’s decision to offer retiree benefits caught the attention of several benefits consultants we interviewed. In *Erie County Retirees Association v. County of Erie*, the Third Circuit Court held that a retiree medical program violates the Age Discrimination in Employment Act (ADEA) if it provides lesser benefits to Medicare-eligible retirees than to early retirees. If widely enforced, it would prevent employers from providing benefits to early retirees that are not offered to Medicare-eligible retirees. Key employer informants indicated that they might drop retiree health benefits altogether rather than incurring the additional costs of compliance. The Equal Employment Opportunity Commission recently announced a proposed rule of its intent to allow employers to offer Medicare-eligible retirees a different level of benefits than those offered to early retirees; however, the proposed rule is still undergoing review.

### Cost of coverage
Total monthly premiums for Medicare-eligible retirees with single coverage (in the plan with the firm’s largest Medicare-eligible retiree enrollment) averaged $193 in 2001 (Exhibit 3). This represents an annual average rate of increase in the total monthly premium of 5.4 percent between 1988 and 2001 (from $100 to $193). Differences in total monthly premiums and retiree contributions were not statistically significant between 2000 and 2001. Total monthly premiums for early retirees averaged $246 for single coverage in 2001. Although total monthly premiums for early retirees are somewhat higher than those for Medicare-eligible retirees, the latter’s total monthly premium pays largely for supplemental coverage not provided through Medicare, while the former’s premium pays for the full cost of coverage. Medicare-eligible retirees pay more for their health coverage than active employees pay, in terms of both absolute dollars ($30 more per month) and percentage.
(14 percent more per month), but just slightly more than early retirees pay. This is the case because employers pay a higher percentage of the total premium for early retirees than for Medicare-eligible retirees.

Changes in plan choice and enrollment. The typical Medicare-eligible retiree could choose from an average of seven health plans in 2001. Medicare-eligible retirees worked disproportionately for the largest firms that offer more plan choices to their workers than smaller firms offer (average of two plans). Hence, many retirees have considerable plan choice. Although the large majority (68 percent) of Medicare-eligible retirees saw no change in the number of health plans offered from one year ago, nearly one-third (28 percent) had a decrease in choice. Only 4 percent of retirees had an increase in plan choice. This decrease in choice surpasses that experienced by active workers, where just 5 percent of covered workers had less choice in 2001 than in 2000. The Kaiser/HRET data do not permit an analysis of retiree choice beyond changes from one year ago.

In contrast to active workers, indemnity plans generally enroll a plurality of a firm’s retirees, but this declined sharply in the past year. In 2001, 40 percent of Medicare-eligible retirees obtained their benefits through firms in which the largest retiree plan was a conventional plan, versus 34 percent for preferred provider organizations (PPOs) and 19 percent for Medicare health maintenance organizations (HMOs) or M+C plans (Exhibit 4). These enrollment patterns reveal a marked change from one year ago. In 2000 just 11 percent of Medicare-eligible retirees received health benefits through firms where the largest retiree plan was a PPO, a statistically significant increase.

The majority (67 percent) of Medicare-eligible retirees were offered some type of M+C plan or Medicare HMO in 2001, although only 11 percent of retirees in small firms (3–199 employees) had this option, a statistically significant difference (not shown). Ongoing Medicare M+C withdrawals have created a climate of uncertainty that has made many employers reluctant to offer them, and benefits consultants are discouraging employers from adding this type of coverage, given the potential disruption to retirees’ coverage. Several employers expressed concern about rising premiums and the lack of flexibility in the administration of the M+C program. Most employers indicated that they need to see a more stable market before offering M+C plans to their retirees. However, those that are already offering them are continuing to do so and taking a “wait-and-see” approach. As evidenced in Exhibit 4, a Medicare HMO or M+C plan was still the plan type with the largest Medicare-eligible retiree enrollment for nearly one-fifth of firms in 2001.

Prescription drug coverage. Nearly all

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### Exhibit 3


<table>
<thead>
<tr>
<th>Year</th>
<th>Monthly premium</th>
<th>Monthly retiree contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>$100</td>
<td>$15 15%</td>
</tr>
<tr>
<td>1992</td>
<td>124</td>
<td>34 47%</td>
</tr>
<tr>
<td>2000</td>
<td>178</td>
<td>45 25%</td>
</tr>
<tr>
<td>2001</td>
<td>193</td>
<td>55 28%</td>
</tr>
</tbody>
</table>


**Notes:** Includes firms of all sizes that offer coverage to Medicare-eligible retirees as well as to active employees. The monthly premium includes both the employer and the retiree contribution.
(99 percent) Medicare-eligible retirees in the firm’s plan with the largest retiree enrollment had prescription drug coverage in 2001. Of such retirees, 29 percent received coverage from firms in which the largest retiree plan had a three-tier cost-sharing formula for prescription drugs, and 31 percent had a two-tier formula. With tiered drug coverage, retirees pay less for generics than for preferred and non-preferred drugs.15

Prescription drug copayments continued to be more commonplace than coinsurance in 2001, regardless of the type of drug (generic, preferred, or nonpreferred), roughly 65 percent of Medicare-eligible retirees faced copayments across the three classes of drugs.16 Most Medicare-eligible retirees faced financial incentives to choose generic drugs. Copay amounts averaged $8 for generics, $14 for preferred drugs, and $17 for nonpreferred drugs. Copays for nonpreferred drugs increased 21 percent from 2000, when they were $14 ($p = .06). During the past few years many large firms in particular have made changes to increase cost sharing for retirees or provide financial incentives to choose less expensive drugs. For example, 19 percent of large firms introduced a three-tier cost-sharing formula for prescription drugs, 32 percent increased retirees’ cost-sharing requirements, and 53 percent increased retirees’ share of the premium (Exhibit 5).

In the next two years many other firms are planning to adopt similar strategies. Thirty-two percent of large firms are very or somewhat likely to introduce a three-tier cost-sharing formula for prescription drugs in the next two years; 51 percent expect to increase retirees’ cost-sharing requirements for purchasing prescription drugs; and 48 percent expect to increase retirees’ share of the premium. Again, small firms were generally less likely to report these planned changes (significantly so only for increasing the retirees’ share of the premium).

Discussion And Policy Implications

This paper presents a number of clear-cut reasons for pessimism about the future of retiree health benefits. Unlike coverage for active workers, the prolonged economic expansion of the 1990s and record-low health care inflation from 1994 to 1998 did not boost coverage for retirees.17 Instead, the percentage of employers offering health benefits to Medicare-eligible retirees decreased from 32 percent to 22 percent among firms with 200 or more employees from 1997 to 2001.

### Impact on retirees from the largest firms

More than 65 percent of retirees obtain their coverage from the nation’s largest firms (5,000 or more employees), and these firms were the most likely to have dropped retiree coverage. Among these firms, one in five of those not offering retiree health benefits in 2001 had offered them previously. Thus, despite promises made to employees about life-
time health insurance coverage, employers are dropping retiree benefits, which is permitted as long as the employer reserved the right to modify, revoke, suspend, terminate, or change the benefit plan in its Summary Plan Description.18

Impact on Medicare spending. By reducing beneficiaries’ out-of-pocket expenses, retiree coverage not only reduces financial barriers to care but also raises the demand for medical services. Other factors held constant, Medicare spending is 23 percent higher for beneficiaries with retiree coverage than for those with no Medicare supplemental coverage and 15 percent higher than for those with Medigap coverage; however, these estimates do not account for potential adverse selection.29 Should retiree coverage erode further, it would inadvertently ease pressure on the Medicare Trust Fund and the remaining federal budget. This would come at the expense of retirees, who would be required to pay even more for their health care or possibly have to forgo needed health care services.

Uncertain but interdependent future. Consequently, retiree coverage, prescription drug coverage, Medicare program outlays, and the M+C program all face an uncertain but interdependent future. Should Congress add prescription drug benefits to the Medicare benefit package, the cost of providing retiree benefits for the Medicare population will decline, thereby encouraging employers to retain retiree coverage. This is true because employers are likely to wrap retiree prescription drug benefits around Medicare benefits as a supplement.30 A revitalized M+C program will similarly reduce the cost to employers of providing retiree benefits. If employer-based retiree coverage is retained, about one-third of the Medicare population will have greater financial protection against the cost of prescription drugs and other services. Nonetheless, without congressional changes in prescription drug coverage and the M+C program, an accelerated decline in retiree coverage, and thus, in drug coverage, seems inevitable.

### EXHIBIT 5
Percentage Of Large Firms That Have Made Or Are Planning To Make Changes In Retiree Health Benefits, 2001

<table>
<thead>
<tr>
<th>Change</th>
<th>Made change in past two years</th>
<th>Very or somewhat likely to make change in next two years</th>
<th>Very or somewhat unlikely to make change in next two years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce three-tier cost-sharing arrangement for prescription drugs</td>
<td>19%</td>
<td>32%</td>
<td>61%</td>
</tr>
<tr>
<td>Increase retirees’ cost-sharing requirements when purchasing prescription drugs</td>
<td>32</td>
<td>51</td>
<td>41</td>
</tr>
<tr>
<td>Increase retirees’ share of premium</td>
<td>53</td>
<td>48</td>
<td>35</td>
</tr>
<tr>
<td>Eliminate retiree health benefits for new employees or for existing employees who have not yet retired</td>
<td>4</td>
<td>9</td>
<td>76</td>
</tr>
<tr>
<td>Eliminate retiree health benefits entirely</td>
<td>-20</td>
<td>6</td>
<td>79</td>
</tr>
<tr>
<td>Offer a Medicare HMO</td>
<td>-20</td>
<td>15</td>
<td>68</td>
</tr>
</tbody>
</table>


**NOTES:** Includes large firms (200 employees or more) that offer health benefits to early and Medicare-eligible retirees, as well as to active employees. HMO is health maintenance organization.

*Not available.*
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NOTES


5. Briesacher et al., Drug Coverage.


8. HRET is a nonprofit 501(c)3 research organization affiliated with the American Hospital Association.

9. Prior to 1999, the survey was sponsored by KPMG Peat Marwick and the Health Insurance Association of America.

10. A firm is regarded as offering retiree health bene-

11. These figures likely underestimate the extent of change, since a response of “not likely” includes firms that have already embraced these measures.


13. Medicare eligibles pay an average of $55 per month in premiums, which is 28 percent of the total premium, whereas active employees pay $25 per month, which is 14 percent of the total premium. Early retirees pay an average of $66 per month in premiums.

14. Data in Exhibit 4 refer to the proportion of retirees who obtain their benefits through firms in which a particular plan type had the largest retiree enrollment during the respective year. The data do not reflect the distribution of enrollment across the four plan types. The HMO/M+C category includes Medicare HMOs that are and are not part of the M+C program.

15. Under two-tier cost-sharing formulas, retirees face one level of copayments (or coinsurance) when using generic drugs and a higher level when using brand-name drugs. With three-tier cost sharing, retirees face one level of cost sharing when using generic drugs, a higher level when using a brand-name drug when no generic drug is available, and a still higher copayment level when using a brand-name drug for which a generic form is available.

16. Coinsurance is a percentage and a copayment is a specific dollar amount associated with purchase of a medical service or product.


