NRLN
NATIONAL RETIREE
LEGISLATIVE NETWORK

Retiree Health Maintenance of Cost Protection (MCP)

Congress Should Enact a Business Tax Credit to Encourage Companies to Maintain Contributions to Retiree Health Coverage

Executive Summary

The ongoing cancellation or reduction of employer-sponsored retiree health care benefits has had a devastating impact on the lives and financial security of millions of America's retirees. During the decades when today's retirees earned these benefits, they were a bargained-for promise that more than two-thirds of the workforce counted on when calculating what it would take to retire. With repeated assurances after 20 or 30 or 40 years of service that their health, disability and death benefits would be there when needed, few workers ever suspected or prepared for the possibility that courts would agree that a "reservation of rights" clause buried in the fine print of plan documents that had never been disclosed would trump years of promises.

In an October 2005 investigative report entitled "The Broken Promise," *TIME* magazine reported that Congress had passed bankruptcy reforms and other measures "encouraging companies to repudiate lifetime benefit agreements. Businesses in one industry after another are revoking longstanding commitments to their workers. It's the equivalent of your bank telling you it needs the money you put into your savings account more than you do – and then keeping it."

The share of large firms (200 or more employees) that offer any retiree health coverage has dropped dramatically over the past two decades – from 66 percent in 1988, to 40 percent in 1999, to 29 percent in 2009. Only 5 percent of employers with fewer than 200 workers offer retiree coverage. Even among the large firms still offering coverage, while nearly all offer benefits to early retirees, since 2003 the share maintaining supplemental coverage for Medicare-eligible retirees has tumbled from 81 to 68 percent. Most of that decline came soon after the Equal Employment Opportunity Commission's 2007 ruling allowing companies to cancel coverage for Medicare-eligible retirees 65 and older, while maintaining coverage for early retirees.

During the 2009 historic health care debate, the legislation enacted by the U.S. House included a provision (Section 110) prohibiting employers from reducing an individual retiree's health care benefits after he or she retires. The provision would have superseded any "reservation of rights" clause in plan documents, which many companies have used to cancel or reduce promised health and welfare benefits. Benefits as of the date of retirement would have been protected *unless* the reduction was also made with respect to active workers under the group health plan (a counter-productive loophole the NRLN opposed), *or* if the company received an "undue hardship" waiver from the Department of Labor. The House bill would not have required the restoration of previously reduced benefits. Unfortunately, the failure to include any part of Section 110 in the final legislation has left retirees vulnerable to further cutbacks in employer-paid coverage. The number of companies offering retiree health benefits will undoubtedly now fall further considering the impact of the economic downturn on the auto sector and other industries that

traditionally provide such benefits, as well as the pressures of global competition. This has a particularly negative impact on the health status of near-elderly adults who took early retirement, but who are not yet eligible for Medicare. In 2006, roughly 16 percent of adults age 55 to 64 relied on employer-provided retiree health insurance – while 18.6 percent of active employees worked for employers still offering coverage to retirees under 65. While these numbers have certainly declined somewhat during the current downturn, it should be a policy priority to encourage the continuation of employer-based coverage for as many in this group as possible.

The Retiree Reinsurance Trust Fund included in the final health reform bill is a positive step in this direction, as it reimburses employers for a substantial share of catastrophic claims paid on behalf of retirees aged 55 to 64. However, because it excludes Medicare-eligible retirees and is inadequately funded, the Trust Fund should be replaced or at least enhanced with a broader and longer-term tax subsidy along the lines of the Maintenance of Cost Protection proposed here.

The MCP proposal described here would offer companies a tax credit to partially offset the cost of maintaining retiree health coverage in return for an obligation that plan sponsors will not reduce their contribution to the cost. The MCP credit is analogous to the 28 percent subsidy paid under Medicare's Part D to companies that agree to maintain prescription drug coverage for retirees. Although it only reimburses firms for 28 percent of their drug benefit costs, the Part D subsidy has proven effective in maintaining superior employer plans, with no 'doughnut hole,' for roughly 30 percent of Medicare-eligible retirees. This has benefited millions of retired Americans while reducing Medicare costs.

Key features of the MCP include:

- Plan sponsors (including VEBAs) would be eligible for a tax credit equal to 50% of actual expenditures on retiree health (not including retiree payments). Retiree payments would remain non-deductible except over 7.5% of AGI.

- An employer (or VEBA) electing the subsidy would be obligated to maintain their current nominal level of contribution (as maintenance of effort is defined in the tax code with respect to Section 420 transfers).

- Employers could claim the credit for retirees 55 and older. The firm's minimum required contribution (MCP) in each year would be equal to its nominal contribution to the cost of an individual retiree's health benefit at the date of enactment, or at the date of retirement (for future retirees), whichever is later. **The firm's MCP remains fixed in subsequent years, gradually reducing the cost to employers and the government in real terms each year.**

- As early retirees enroll in Medicare, they would be entitled to a reduced MCP sufficient to purchase supplemental insurance in an amount that would maintain parity with their coverage in effect on the date of enactment, or date of retirement, whichever is later.

- Employers could elect to contribute the Maintenance Cost Protection toward the cost of full or supplemental coverage under a plan purchased through a state health care Exchange, or selected by the retiree from another provider, with retirees paying the difference. The firm's eligibility for a federal subsidy based on its actual MCP contribution would continue.

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Revised: January 2013

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I. Introduction and Background

> *Businesses in one industry after another are revoking longstanding [retiree benefit] commitments to their workers. It's the equivalent of your bank telling you it needs the money you put into your savings account more than you do – and then keeping it. Result: A wholesale downsizing of the American Dream.*
>
> – "The Broken Promise," *TIME Magazine* (October 2005 cover story)[1]

The ongoing cancellation or reduction of employer-sponsored retiree health care benefits has had a devastating impact on the lives and financial security of millions of America's retirees. During the decades when today's retirees earned these benefits, they represented deferred compensation – a bargained-for promise that more than two-thirds of the workforce counted on when calculating what it would take to retire. With repeated assurances after 20 or 30 or 40 years of loyal service that their health, disability and death benefits would be there when needed, few workers ever suspected or prepared for the possibility that courts would agree that a "reservation of rights" clause buried in the fine print of plan documents that had never been disclosed would trump years of promises. Yet the courts have repeatedly allowed firms to use this loophole to shirk their promises, sometimes canceling coverage or, more commonly, pushing a greater and greater share of the costs onto retirees with fixed incomes and onto taxpayers when retirees resort to public programs.

As NRLN President Bill Kadereit testified before the House Committee on Education and Labor in 2008, most retirees, even retired managers, "were unaware . . . that retiree health benefit plans contained statements that reserved to the company the right to reduce or cancel health care benefits. Retiree exit interviews ended with a handshake and the passing of an envelope stuffed with benefit promises."[2] One reason that many of the retiree associations in the NRLN were organized by former HR executives is that "retired senior managers are sickened by what is happening more than any other segment of our membership," Kadereit explained.

Sandy Anderson, a retired IBM senior manager and co-founder of an association of retired IBM employees, put it this way: "I feel I misled a lot of [retiring workers], that I've lied to people. It does not sit well with me at all."[3]

Anderson worked as a manager in IBM's semiconductor division for 32 years. To retain senior workers, he said, IBM encouraged him to assure his staff that even if they could get a higher salary elsewhere, IBM's promise of benefits for life more than made up for it. Instead, soon after retirement, he saw his own retiree health premiums triple in 2004 after the Financial Accounting Standards Board adopted FASB 106 – requiring companies to recognize the present value of all future retiree health promises as a current liability – and IBM took a $2.3 billion charge to earnings as a result. IBM continued coverage, but capped its costs per retiree, shifting future health cost inflation onto retirees in the years since.

The House Health Reform Provision on Post-Retirement Cutbacks

Of course, retiree advocates and many members of Congress have tried for years to find a way to stop the erosion of promised retiree health care coverage. The health reform legislation enacted by the U.S. House of Representatives in November, 2009 (H.R. 3962) included a provision (Section 110) that would have prohibited employers from reducing an individual retiree's health care benefits after he or she retires.[4] The provision would have superseded any "reservation of rights" clause in plan documents, which many companies have used as the excuse to cancel or reduce promised health and welfare benefits that retirees on fixed incomes had earned and relied on. Benefits as of the date of retirement would have been protected *unless* the reduction is also made with respect to active workers under the group health plan (a counter-productive loophole the NRLN opposed), *or* if the company receives an "undue hardship" waiver from the Department of Labor. The House bill would not have required retroactive restoration of previously reduced benefits. Employers could also maintain existing caps on the aggregate amount they pay toward a retiree's health costs – and continue to increase the share of premiums paid by retirees – provided that the actuarial value of an individual's benefit paid by the company is not reduced post-retirement.

Unfortunately, because the Senate bill did not include even a modified form of the House provision protecting retiree health coverage, the health reform legislation that President Obama signed into law leaves millions of retirees vulnerable to further cutbacks in employer-paid coverage. The number of companies offering retiree health benefits will undoubtedly now fall further considering the impact of the economic downturn on the auto sector and other industries that traditionally provide retiree health benefits. This will have a particularly negative impact on the health status of near-elderly adults who took early retirement, but who are not yet eligible for Medicare.

Roughly 16 percent of adults age 55 to 64 relied on employer-provided retiree health insurance as of 2006 – while 18.6 percent of active employees worked for employers still offering coverage to retirees under 65. **Overall, more than 7 million retirees and their beneficiaries rely on private sector retiree health plans.** While these numbers have certainly declined somewhat during the current downturn, **it should be a policy priority to encourage the continuation of employer-based coverage for as many in this group as possible**.

Retiree Hardship Testimonies: Earned Benefits, Broken Promises, Retirement Insecurity

The following excerpts are just a few of the dozens of personal stories that were collected from members of NRLN retiree associations and individual members last year. Each is typical of the situation faced by retirees at the companies mentioned – and many others as well:

Diana B. Smith – Ft. Myers, FL
Delphi Retiree

As a salaried retiree from Delphi Corp., I was notified mid-February (2009) that my health care, dental, vision and life insurance were cancelled effective April 1. I was unable to find any kind of replacement insurance and was forced to go into a health savings account with very high deductibles. My health care costs went from $37 a month to about $750 a month. I am nearly 64 and have on-going health issues. I have a blood clot with resulting bilateral pulmonary emboli. I work full time … [but] I can't pay for my health care, can barely keep the utilities paid, and am now getting behind on everything else.

Alan Campbell – Gold River, CA
GM Retiree

I am 77 years of age and a salaried retiree from GM's Oldsmobile Division with 33 years of service. When I retired in 1986, I was informed in writing that GM would provide health insurance including dental, vision, life and prescription insurance for me and my wife for the rest of our lives. There was no GM disclaimer that they could alter or eliminate this coverage. Beginning in 1993, GM began reducing the coverage piece by piece until effective Jan. 1, 2009, all health insurance was cancelled and life insurance reduced to $10,000. Compensation was made by GM in the amount of $300 per month to cover my wife and me. This amount is taxable as income. We have been forced to purchase separate health insurance policies … and cannot afford either dental or vision insurance. We have both enrolled in Medicare Part D … [but] a number of prescriptions put us in the 'donut hole.'

Mark A. Johnson – Yorkville, IL
Caterpillar Retiree

Caterpillar, my employer for 35 years, promised us benefits in place of pay increases over the years. Little did we know they would take it all away when we retired. They have announced … that effective with our 65th birthday Caterpillar will be dropping all insurance since Medicare will provide it. They are saying they will put $3,000 per year into an account that we can use for supplemental insurance. Our dental, eyeglass, medical and prescription drug insurance will all be gone effective on our 65th birthday.

Joe Cannon – Alma, AR
Lucent Technologies (Alcatel Lucent) Retiree

I worked for Western Electric and Lucent for 38 years and for the most part my health insurance was covered. But soon after I was laid-off at 58 years old my health care premiums went up each year to the point I can no longer afford. Here are the premiums I've paid since retirement:

2001 - $ 17.07 Monthly	2007 - $862.80
2003 - $140.83	2009 - $944.86
2005 - $551.87	

…Retiree stories continued (see page 13)…

Retiree Health at Risk

The maintenance of promised employer-based coverage is particularly critical among retirees under age 65, who are not yet eligible for basic Medicare coverage and who face both high rejection rates and unaffordable premiums in the non-group market for individual insurance coverage. Nearly one in five Americans age 55 to 64 relies on retiree health benefits from their former employer (14%), or their spouse's former employer (5%).[5] While a majority of workers who voluntarily retire before age 65 continue to receive employer-based coverage, the share of employers offering early retirement benefits has fallen dramatically over the past two decades, while the share of costs shifted onto the retiree has risen dramatically.

Even if national health reform expands coverage through state-based insurance Exchanges that prohibit denials of coverage or excessively high rates based on pre-existing medical conditions, the availability of this option and of subsidies based on household income will induce a substantial share of employers to drop early retiree coverage in particular. This will both increase costs to taxpayers and to retirees, who would in most cases pay more for the same or lesser coverage if they lost employer coverage.

The other, larger group at risk comprises retirees 65 and older who are typically living on fixed incomes and who retired with the reasonable expectation that they had earned lifelong Medigap coverage that would not be canceled or reduced. Older retirees rely on continuing employer coverage as a protection against catastrophic medical costs in particular. Medicare has no limit on out-of-pocket costs for costly chronic disease treatment, or for major medical incidents, or for nursing home care. Although it will gradually narrow, for years to come Medicare's Part D drug benefit will still have a "doughnut hole" in its coverage that the 30 percent of retirees with employer-based drug coverage typically avoid. Many retirees also rely on earned ancillary benefits, including disability, vision, dental and death benefit payments to surviving spouses. The risk of losing these earned benefits is eroding retirement security for millions who are either too old or unhealthy to compensate for their loss or serious reduction many years after their retirement.

The "Maintenance of Cost Protection" (MCP) proposal that the NRLN describes here would address this problem by recognizing that American business needs positive incentives and assistance in shouldering these legacy benefit obligations. The NRLN proposes that Congress offer employers offering retiree health care the option of a 50 percent tax credit to partially offset the cost. In exchange, plan sponsors would assume an obligation to maintain their current nominal dollar contribution to the cost of each individual retiree's health insurance and any related ancillary retiree benefits (disability, dental, vision, life insurance) based on the plan sponsor's share of the cost at enactment, or at the date of retirement, whichever is later. Employers could maintain existing per retiree caps or modify their group plan – but to receive a tax credit they must agree not reduce their nominal dollar contribution **(the MCP)** to each eligible retiree's overall cost of coverage.

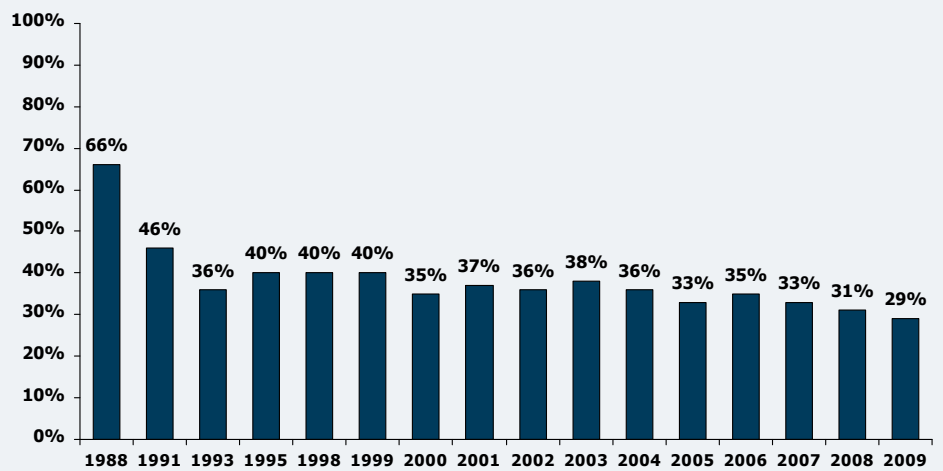
The MCP tax credit is analogous to the 28 percent subsidy paid under Medicare's Part D to companies that agree to maintain prescription drug coverage for retirees that is actuarially equivalent or superior to Part D coverage. Although it only reimburses firms for 28 percent of their drug benefit costs, the Part D subsidy has proven effective in maintaining superior employer plans, with no 'doughnut hole,' for roughly 30 percent of Medicare-eligible retirees.

This has benefited millions of retired Americans while also reducing Medicare costs. We believe that like the Part D subsidy, a MCP credit is a fiscally responsible means by which the government can encourage companies to continue keeping their end of the bargain with retirees who will otherwise face the devastating loss of coverage.

II. Broken Promises: The Steady Erosion of Retiree Health Security

The share of large firms (200 or more employees) that offer any retiree health coverage has dropped dramatically over the past two decades – from 66 percent in 1988, to 40 percent in 1999, to 29 percent in 2009, according to the Kaiser Family Foundation's annual survey (see chart below).[6] The Mercer survey of employer-sponsored health plans charts a similarly steep drop off, from 46 percent in 1993 to 27 percent and falling in 2008.[7] Among firms with fewer than 200 employees, only 4 percent offer retiree health coverage.[8]

Among All Large Firms (200 or More Workers) Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, 1988-2009*



*Tests found no statistical difference from estimate for the previous year shown (p<.05). No statistical tests are conducted for years prior to 1999.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009; KPMG Survey of Employer-Sponsored Health Benefits, 1991, 1993, 1995, 1998; The Health Insurance Association of America (HIAA), 1988.

Even among large firms still offering retiree coverage, while nearly all offer benefits to early retirees, the share maintaining supplemental coverage for Medicare-eligible retirees has tumbled from 81 to 68 percent since 2003 (see chart below). Most of that decline came immediately after the EEOC's 2007 ruling that it is not age discriminatory for companies to cancel coverage for Medicare-eligible retirees 65 and older, while maintaining coverage for younger retirees.
The initial sharp drop in retiree health coverage occurred in the early 1990s and is largely attributed to an accounting rule change (FASB 106) adopted in 1990 that required firms to show the full future cost of promised retiree health benefits as liabilities on their balance sheets.[9] Large firms with legacy benefit promises had to take an immediate charge to earnings. Although

this was a one-time adjustment, executives found that under FASB 106, any time they reduced the future cost of promised benefits, the improvement ran through the income statement as a credit to reported earnings – a metric tied to increasingly "performance-based" pay for the executives themselves. Nell Minow, the widely-quoted editor of the Corporate Library, a corporate governance watchdog group, explained that executives' self-interest in generating accounting income credits by reducing benefits is

> . . . a dirty little secret. Certainly benefits are getting very expensive, but we are aware of the juxtaposition between cuts in benefits and [compensation] increases for top executives. They cut benefits to make the balance sheet look stronger. The executives then reap the benefit of the stronger balance sheet by paying themselves better.

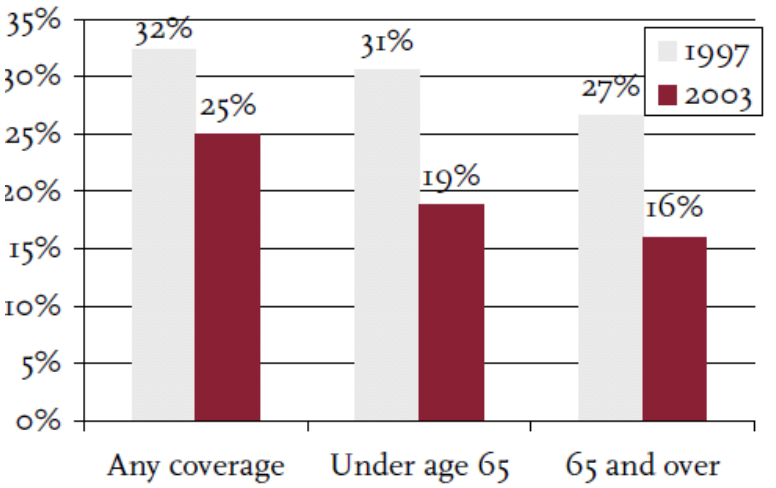
NRLN President Kadereit noted in his 2008 testimony before the House Education and Labor Committee that during the 1990s FASB 106 provided a rationale for major companies – including IBM, Sears and International Paper – that imposed nominal caps on their retiree health expenditures, which shifts future cost increases entirely onto retirees. "IBM implemented caps in 1999 that affected 190,000 retirees," Kadereit testified. "It took three years for retiree health care costs to reach the $625 cap, but in 2002 retiree premiums increased nearly 67% and another 29% in 2003."[10]

Retiree health cost-shifting can trigger additional savings for companies by causing retirees who can least afford the unexpected cost increases to drop their coverage entirely. As out-of-pocket costs steadily rise, many of the healthier retirees drop the company coverage, some to purchase less expensive (and less comprehensive) coverage elsewhere, others to rely on Medicare alone. But their departure burdens the remaining pool with sicker participants, on average, and as premium costs rise even faster to compensate, more dropouts follow. A company in this situation, with its own expenses capped, also has little incentive to stop the death spiral, or even to negotiate the lowest possible prices with medical providers.[11] An example is Sears Roebuck & Co. After Sears imposed caps in the late 1990s, the number of retirees participating in its health plan fell by 18% over the next decade.

Many employers have exacerbated this downward spiral by segregating retirees into separate risk pools. As the *New York Times* reported, "in dropping their subsidies, many companies push reirees into insurance pools that are separate from those of younger, healthier workers, executives said. That lowers the company's costs for insuring its current workers, while raising the premiums charged to retirees even further."[12]

This cost-shifting of health costs to retirees was accompanied by a near elimination of the annual Cost of Living Adjustments (COLAs) designed to prevent the steady erosion of the purchasing power of defined-benefit pension payments due to inflation. Data collected by the NRLN shows that the erosion of purchasing power caused by the diversion of retiree pension income to pay for rising health care premiums, deductibles and co-pays has reduced the typical retiree's disposable pension income by 15-to-20% over the past decade alone.[13]

PERCENT OF PRIVATE SECTOR WORKERS AT FIRMS OFFERING RETIREE HEALTH BENEFITS BY COVERED AGE GROUP: 1997, 2003



Source: Center for Retirement Research (2007)[14]

Pulling the Rug Out from Retirees on Fixed Incomes

Retired workers who gave loyal service to America's premier companies for decades are now being squeezed by broken promises. A typical example among NRLN association members is John Devitto, who worked for 39 years at Lucent Technologies (and its predecessor companies) and retired just shy of age 60 with a promise of a fixed monthly pension and full health benefits for himself and his family. Ten years later, at age 70 and unable to return to regular employment, Lucent was requiring Devitto to contribute $700 per month from his pension income for health insurance co-premiums – and another $200 per month to replace the retiree life-insurance policy that Lucent stopped covering.

"I'm paying $1,000 a month more than I expected," Devitto says. "I'm not on welfare. But my wife has gone back to work, I've given up my golf membership and we don't go away on vacations."

After Hanesbrands first reduced and then eliminated company payments for retiree health insurance premiums in 2007, retirees who had been paying $60 per month were shocked to find they would need to pay $750 per month to continue their coverage (and as much as $1200 to cover a spouse). "Now I'm going to have to come up with $617 a month [to maintain coverage]," said Frances Flinchum, who retired in 1999 after 35 years service. "I don't know how I will pay this huge amount. I have a part-time job, but I also have a huge home-equity loan. I think they are doing me an injustice since I worked for them 35 years."[15]

Another type of post-retirement reduction was imposed on General Motors retirees. As of January 1, 2009, over-age-65 salaried retirees lost their fully-paid retiree health coverage. The benefit was replaced by a flat $300 monthly pension increase, which is roughly $400 less than it will cost a retiree, on top of Medicare, to replace the company-paid Medigap insurance –

including catastrophic coverage, dental, vision, and hearing coverage – the company previously provided.

One misconception is that once retirees hit age 65 – and become eligible for Medicare – that the loss of their employer-based benefits is of marginal concern. Medicare does cover basic care, including care in hospitals, physician services, diagnostic tests, preventive services and, under Part D, a substantial portion of outpatient prescription drug costs. However, Medicare's gaps in coverage and high out-of-pocket costs make a "medigap" plan essential for retirement security – and a rising cost that retirees who earned lifelong coverage did not expect to purchase on their own. Medicare does not have an annual cap on out-of-pocket spending, the catastrophic coverage that makes medigap coverage most essential; nor does it cover long-term care, nor dental, vision or hearing services, nor the full cost of prescription drugs – all of which become unexpected costs when employers cancel or greatly reduce their share of the cost of coverage.

"It's scary to be retired and find out your former employer has pulled the plug on your retirement benefits," said Michelle Strollo, co-author of a 2006 Kaiser Family Foundation study that found only 35% of companies with more than 200 employees continued to offer retiree health benefits, down from 66% in 1988. "We have also found, among companies that still offer benefits, that they have been reducing their generosity. This comes in the form of higher co-pays at the point of service, increases in deductibles, and, most strikingly, between 2004 and 2005 seven companies out of 10 increased the amount retirees must contribute to the insurance premiums."[16]

"It is frightening," explained Geraldine Picha, 64, whose former employer has raised her medical insurance bill steadily since she retired. At $560 per month, her out-of-pocket cost for retiree health benefits now exceed the $514 monthly pension check she receives for 15 years service at AT&T and its spin-off, Lucent Technologies. Picha remembers a time when retiring from a big company meant you could count on certain earned benefits for the rest of your life – but like millions of other older Americans she discovered too late that those days are ending.

Losing expected health and/or disability coverage after retirement often has a far more devastating impact on people with fixed incomes. Elizabeth Warren, a Harvard Law Professor and chair of the Congressional Oversight Panel to investigate the TARP bank bailouts, found in a study of consumer bankruptcies that people 65 and older were more than twice as likely to file and that the filing rate among those 75 and older had more than quadrupled. "Older Americans are hit by a one-two punch of jobs and medical problems and the two are often intertwined," Warren observed in her Consumer Bankruptcy Project's report on the study.

Unfortunately, the erosion in retiree health coverage – and the capping of contributions by a majority of firms maintaining coverage – has continued its gradual descent as health costs climb and companies find it difficult to pay for promises that competitors have shirked or never made. A recent report by the Center for Retirement Research at Boston University concluded:

> Although millions of older Americans still rely on retiree health benefits from former employers to help pay their medical expenses, coverage appears to be slowly disappearing, possibly jeopardizing retirement security for future generations. As health care costs rise, the workforce ages, and global competition intensifies, many employers seem to be concluding that they can no longer afford to offer subsidized health insurance to retirees.[17]

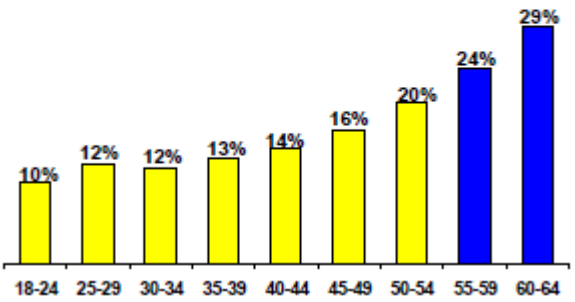
Pre-Medicare Retirees are Particularly Vulnerable

Retirees who are not yet 65 and eligible for Medicare are particularly vulnerable to losing employer-based health coverage, since the alternative is the non-group market for individual insurance. Today nearly one in five Americans in this age cohort relies on retiree health benefits from their former employer (14%), or their spouse's former employer (5%), for coverage as of 2004.[18] Early retiree coverage by employers is what keeps the rates of health insurance coverage among the near-elderly from plunging below the levels for workers generally. While the overall uninsured rate for Americans age 55 to 64 is relatively low (13 percent), it would worsen significantly if there is a renewed wave of firms dropping health coverage for early retirees.

The dependence of the pre-Medicare population on employer-based group coverage takes on added significance because of the large share of older workers who report being pushed involuntarily into retirement (or part-time work) far sooner than they had planned. While it is easy to say that today's older workers should plan to remain employed full time until at least age 65, the reality is that a substantial number are involuntarily retired or reduced to part-time or contingent work. According to the latest (2009) *Retirement Confidence Survey* conducted each year by the Employee Benefit Research Institute, there is a huge disparity between the planned and actual retirement age of older workers.[19] While only 26 percent of older workers in EBRI's Survey said they planned to retire from full-time work before age 65, in fact 72 percent actually retired before age 65 (35 percent before age 60). Without access to affordable group coverage, at least until they are eligible for Medicare, early retirees must rely on the discriminatory and over-priced market for individual insurance coverage.

The non-group market is particularly problematic for workers and early retirees over 55 because in most states insurance companies can refuse to provide coverage to individuals with chronic and other pre-existing medical conditions, or can charge premium rates far higher than employers pay in group markets. According to the insurance industry's own survey, denial rates in 2006 were three times greater for those 60 to 64 years old (29%) than for those age 35 to 39 (10%).[20] As the chart just below indicates, denial rates by age worsen dramatically over age 50, with more than one-fourth of all 55-to-65 year olds who seek coverage denied access.[21] Many who are not outright denied coverage must purchase insurance subject to an "elimination rider" that requires them to pay all of the costs for pre-existing conditions (such as diabetes or high blood pressure) out of pocket. America's Health Insurance Plans (AHIP) reports that 10 percent of non-group plans offered to adults 55 and over were subject to such a rider.

Denial Rates for Non-Group Coverage by Age Group, 2008



Source: Kaiser Family Foundation (2009), based on survey data from America's Health Insurance Plans (AHIP)[22]

As the Senate Finance Committee stated in its 2009 paper outlining options to expand health coverage, the market for individual health coverage has failed to meet the special and growing needs of the vulnerable older adult population:

> In the individual market, many people who have health problems are denied coverage or are offered policies that exclude coverage for preexisting conditions. Because older people are sicker, people ages 55 to 64 tend to have greater difficulty obtaining insurance in the individual market than their younger counterparts do.

Even when access is not denied, non-group coverage is unaffordable for far too many older individuals and families. According to AHIP's annual survey, the average annual premium for an individual 55 to 64 ($4,800 in 2007) is more than double the cost of the same coverage purchased by an adult under age 55 ($2,600).[23] This is not likely to change even when health reform is implemented and uninsured older adults can purchase through the Exchanges, since the new health reform law permits an age-based disparity in premium charges of up to 3-to-1. On top of high premiums, the higher deductibles and other out-of-pocket costs associated with non-group plans take a far higher and often unsustainable percentage of family income for older adults than for any other group. Average out-of-pocket spending on health care is more than twice as high among older Americans buying coverage in the individual market compared to those with employer coverage.

A lack of access to affordable health insurance is a particularly serious problem for the early retiree population because the risk of serious and costly illness increases dramatically over the age of 55. According to a John Hopkins University study, 70 percent of 50- to 64-year-olds have been diagnosed with one or more chronic health conditions, with *more than half suffering from two or more chronic conditions*. Average total health spending for an adult with two chronic conditions is more than three-and-half times as high as for an adult with none. Twenty percent of pre-Medicare adults over age 50 also report limitations in one or more activities of daily living, which is also strongly associated with higher health costs and risk.[24]

Retiree Hardship Testimonies (continued): Broken Promises, Retirement Insecurity

Jack Schleef – Dataw Island, SC

IBM Retiree

I retired from IBM in 1988 after 35 years. In all those years all of my health benefits were on a non-contributory basis (doctor, dentist, psychologist, hospital, vision, etc.). Here's what happened when I retired early for IBM's convenience …. The first thing they did was cancel my life insurance after building it up for 35 years. I am now 81 years of age and no company will insure me … unless I can handle a premium 20 times what I currently pay. The next thing IBM did was to start charging me for health insurance… Each year the premiums went up, straining my retirement funds. Can you imagine the degree of lost sleep when I contemplate job-hunting at age 81 with medical problems requiring medications and afternoon naps!!

Edward J. Sowinski – Ray, MI

Chrysler Retiree

I am 81 and a retired salary Chrysler employee who retired in 1980. I was promised health care benefits for myself and spouse along with a life insurance policy. Five years ago I was informed by Daimler-Chrysler they would no longer carry my supplemental health insurance that provided medical, dental and vision. [The] monthly stipend to purchase supplemental insurance that does not have the same coverage and forced me into Medicare Part D. [The] premiums keep rising every year, but I'm living on a fixed income. … [M]y monthly income barely meets the bare essentials to survive. My wife and I both … both fall into the 'donut hole.' … Two years ago, Daimler-Chrysler eliminated my life insurance … Where is an 80-year-old man with congestive heart failure going to find life insurance?

Jim Lamar - Spicewood, TX

Lucent Technologies (Alcatel Lucent) Retiree

I retired from what is now Alcatel Lucent in July 1999, after over 31 years. . . . sometimes we complained that we weren't as highly compensated as some of our competitors and were told that might be true but our benefits were better. I retired on a fixed pension. My medical insurance cost (including prescription and dental for self and wife) was ZERO through 2000. In 2001, we began having to make contributions to the cost [that have escalated from $205 in 2001 to $11,338 in 2009].

Henry A. Baker – Fernandina Beach, FL

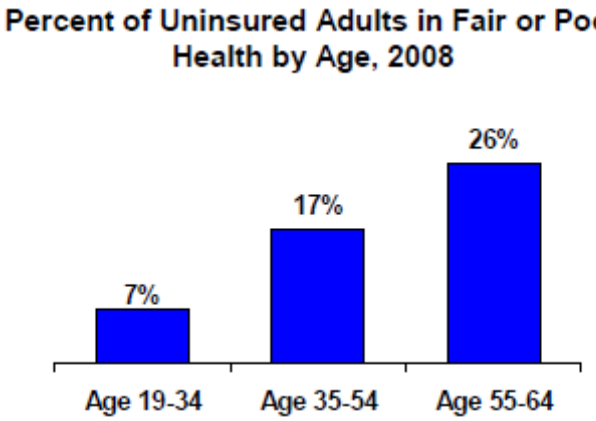
GM Retiree

I am a GM retiree since 1992. I am 73 years old and my spouse is 72. My spouse is a breast cancer survivor (2005) and has diabetes since 2004. We have been on a "fixed" income since 1992, except for the annual cost-of-living adjustment on Social Security. Since 1/1/09, when we lost ALL our medical coverage, except Medicare, we have experienced about $8,000 increase in our annual cost for health and prescription drug insurance. I have no prescription drug coverage for myself. We have no dental insurance coverage. We have no vision coverage. I lost all my Extended Health Care coverage. My life insurance policy is going from $68,000 down to $10,000. Do not let anything happen to my GM pension!

Robert Stacy – Livingston, TX

US West/Qwest Retiree

I am 64 years old. I retired from US West/Qwest in 1998 with over 30 years service to the Bell System. My wife and I planned our retirement based on, in part, my life insurance, a benefit promised to me. My life insurance has now been reduced from over $60,000 to a flat $10,000 to save money for Qwest. Now, at my age and with a pension of $900 a month, I can't afford to buy life insurance.



Source: Kaiser Family Foundation (2009); data from KCMU/Urban Institute analysis of 2008 ASEC Supplement to Current Population Survey.

Unsurprisingly, the uninsured among older adults report the worst health status and outcomes. Uninsured adults age 55 to 64 are more than twice as likely to be in poor or fair health than their peers with continuous employer-based or other private group-plan coverage.[25] About four in ten uninsured older adults have not seen a doctor in the past 12 months and more than one in four receive no preventive care.[26] Nationally representative surveys show that uninsured adults over age 55 are at much greater risk of premature death compared to their insured peers.[27] One major national survey by Harvard Medical School professors, published in *Health Affairs*, concluded that the number of premature deaths among older adults attributable to a lack of health insurance coverage may exceed 30,000 *per year* by 2015.[28]

Of course, many of the worst features of the current non-group insurance market will be mitigated when the new health care reform legislation is fully implemented – and older, uninsured adults can purchase coverage through state insurance Exchanges without fear of rejection, rescission, or being discriminated against due to pre-existing medical conditions. However, the Exchanges and the impact of these reforms are not expected to help most older Americans until 2014 at the earliest – and retirees need help now. Moreover, the Exchanges may make it even more likely that employers cancel promised early retiree health coverage, saving money at taxpayer (and retiree) expense by rationalizing that now their early retirees can rely on guaranteed coverage through the state insurance Exchanges. This makes the situation even more akin to the rationale for the government's 28 percent Part D subsidy, which was effective in helping employers to maintain group coverage and not shift their retirees to the public program.

III. The NRLN's Maintenance of Cost Protection Proposal

During last year's health care debate, the bill first adopted by the U.S. House included a provision (Section 110) that would have prohibited employers from canceling or reducing a retiree's health care benefits after he or she retires. The provision would have superseded any "reservation of rights" clause in plan documents, which many companies have used to cancel or cut promised health and welfare benefits post-retirement. Health benefits as of the date of retirement would be protected *unless* the reduction is also made with respect to active workers

under the group health plan, *or* if the company receives an "undue hardship" waiver from the Department of Labor. The House bill would not have required the restoration of previously reduced benefits.

Unfortunately, the failure to include Section 110 in the final legislation has left retirees vulnerable to further cutbacks in employer-paid coverage. The number of companies offering retiree health benefits will undoubtedly now fall further considering the impact of the economic downturn on the auto sector and other industries that traditionally provide such benefits, as well as the ongoing pressures of global competition. The Retiree Reinsurance Trust Fund included in the final health reform bill is a positive step toward encouraging employers to continue coverage for at least early retirees, as it reimburses employers for a substantial share of catastrophic claims paid on behalf of retirees ages of 55 to 64. However, because it excludes Medicare-eligible retirees and is inadequately funded, the Trust Fund should be replaced or at least enhanced with a broader and longer-term tax subsidy along the lines of the Maintenance of Cost Protection proposed here.

Although the NRLN continues to support an outright ban on post-retirement health benefit reductions, our associations recognize that health cost inflation are putting pressure on even the most responsible firms. We therefore propose an approach that combines a business tax incentive with a maintenance of contribution obligation. The NRLN believes Congress should offer companies a tax credit to partially offset the cost of maintaining retiree health coverage in return for an obligation that plan sponsors will not reduce their contribution to the cost. This Maintenance of Cost Protection (MCP) would be voluntary for plan sponsors, yet with an adequate incentive should avert the cancellation or reduction of promised health and welfare benefits for most retirees. In addition to being voluntary, the maintenance of contribution itself would remain fixed in nominal dollars, as many company caps are currently, thereby providing a stable and (in real dollars) declining burden for both companies and taxpayers over time.

Key features of the MCP include:

- ***Business Tax Credit:*** Plan sponsors (including VEBAs) would be eligible for a tax credit equal to 50% of actual expenditures on retiree health-related benefits (but not including the retirees' share of payments). Retiree payments would remain non-deductible except over 7.5% of AGI.

- ***Maintenance of Effort:*** An employer (or VEBA) electing the subsidy would be obligated to maintain their current nominal level of contribution (as maintenance of effort is defined in the tax code with respect to Section 420 transfers). The fixed maintenance of effort payment should be based on the plan sponsor's actual cost for all of a retiree's health-related and disability benefits at the time of enactment or date of retirement, whichever is later.

- ***Stable Employer Contribution:*** Employers could claim the credit for retirees 55 and older. The firm's minimum required contribution (MCP) in each year would be equal to its nominal contribution to the cost of an individual retiree's health benefit at the date of enactment, or at the date of retirement (for future retirees), whichever is later. *The firm's MCP remains fixed in subsequent years, gradually reducing the cost to employers and the government in real terms each year.*

- ***Reduced Contribution for Medicare Eligible Retirees:*** As early retirees enroll in Medicare, they would be entitled to a reduced MCP sufficient to purchase supplemental insurance in an amount that would maintain parity with their coverage in effect on the date of enactment, or date of retirement, whichever is later.

- ***Choice to Continue Coverage or Contribute:*** Employers could elect to contribute the Maintenance Cost Protection toward the cost of full or supplemental coverage under a plan purchased through a state health care Exchange, or selected by the retiree from another provider, with retirees paying the difference. The firm's eligibility for a federal subsidy based on its actual MCP contribution would continue.

The administration of the business tax credit could either piggyback on process being established for reimbursements from the Retiree Reinsurance Trust Fund, and/or it could be added to the list of tax credits processed through the normal corporate income tax. Both the plan sponsor's MCP and the corresponding tax credit would be fixed in nominal terms – and so the per participant cost would decline in real terms each year. The overall cost of the tax credit would also presumably decline steadily as the number of current retirees eligible for the subsidy diminishes, as it is expected that current trends will continue and few currently active workers will be eligible in the future for retiree health benefits. Indeed, for fiscal reasons the legislation could limit the program to individuals retired as of the date enactment, or some future date that provides notice to those nearing retirement.

Precedents Suggest a Public-Private Incentive Can Work Best

There is ample precedent for an approach offering plan sponsors a partial subsidy in exchange for the broad social benefit of maintaining their retiree health and welfare plans. Indeed, our nation's entire employer-based health and pension benefit system is premised on the implicit subsidy of either tax exemption (health care) or tax deferral (retirement saving), tax expenditures that have successfully encouraged at least larger employers to voluntarily maintain a social benefit system operated by the private sector in the service of both business and worker needs.

The MCP business tax credit proposed here is most analogous to the 28 percent subsidy paid under Medicare's Part D to companies that agree to maintain prescription drug coverage for retirees. Although it only reimburses firms for 28 percent of their drug benefit costs, the Part D subsidy has proven effective in maintaining superior employer plans, with no 'doughnut hole,' for roughly 30 percent of Medicare-eligible retirees. This has benefited millions of retired Americans while reducing Medicare costs. The subsidy for employers that maintain their drug benefits also substantially reduces Medicare Part D expenditures, compared to what they would be if employers dumped millions more retirees into the more heavily-subsidized Part D program.

Even more recently Congress has enacted two other temporary health-related tax credits aimed at mitigating the loss of health care coverage for early retirees. One is the health Coverage Tax Credit (HCTC) initially enacted as part of the Trade Act of 2002. In recent years the HCTC has paid 65 percent of health insurance premiums for thousands of trade-displaced workers and early retirees receiving payments from the Pension Benefit Guarantee Corporation. The other is the $5 billion Retiree Reinsurance Trust Fund incorporated in this year's health reform legislation,

which reimburses employers for a substantial share of catastrophic claims paid on behalf of early retirees 55 to 64 years old. However, it excludes Medicare-eligible retirees.[29]

While each of these three recent efforts to mitigate the adverse impact of eroding retiree health coverage is well-intended, they also add up to an inadequate patchwork that fails to address the larger downward spiral. We believe that the same basic logic of the Medicare Part D business credit and of the Retiree Reinsurance Trust Fund's partial reimbursement for catastrophic claims should be applied more broadly to encourage companies to maintain promised health coverage for *all* retirees. The MCP mechanism outlined above would do precisely that by combining a voluntary business tax credit and a maintenance of effort obligation on plan sponsors that extends beyond the current tax year – thereby offering a greater measure of protection and security to current retirees.

ENDNOTES

[1] Donald L. Bartlett and James B Steele, "The Broken Promise," *TIME Magazine*, Oct. 31, 2005 (cover story).
[2] Testimony of Bill Kadereit, "Safeguarding Retiree Health Benefits," U.S. House Committee on Education and Labor, September 25, 2008.
[3] *Ibid.*
[4] H.R. 3962, "Affordable Health Care for America Act," 111th Congress, passed the House 220-215 on Nov. 7, 2009.
[5] Richard W. Johnson, "What happens to health Benefits After Retirement?", Center for Retirement Research, Issue Brief, February 2007, at p. 2.
[6] Kaiser Family Foundation and Health Research Educational Trust, *Employer Health Benefits 2009 Annual Survey* (2009), available at http://ehbs.kff.org/?page=charts&id=2&sn=26&ch=1154.
[7] Mercer National Survey of Employer-Sponsored Health Plans (2008).
[8] *Ibid.*
[9] This refers to Financial Accounting Standard (FAS) Rule 106. See Government Office, "Retiree Health Insurance: Erosion in Retiree health Benefits Offered by Large Employers," U.S. Government Printing Office (1998).
[10] Testimony of Bill Kadereit, *supra* note 2.
[11] *See* NRLN, "Safeguarding Retiree Health Care Benefits: Protecting Retirees from Fixed-Income Erosion," submitted with testimony of Bill Kadereit, U.S. House Committee on Education and Labor, September 25, 2008, at pp. 72-73.
[12] Milt Feudenheim, "Companies Limit health Coverage of many Retirees," *The New York Times*, Feb. 3, 2004.
[13] NRLN, "Safeguarding Retiree Health Care Benefits," *supra* note 11, at pp. 14-19.
[14] Richard W. Johnson, Center for Retirement Research, *supra note 1*, at p. 5, based on data from Buchmeuller, T.C., Johnson, R.W., and LoSasso, T.C., "Trends in Retiree Health Insurance: 1993 to 2007," *Health Affairs* 25(6), at pp. 1507-16.
[15] NRLN, "Safeguarding Retiree Health Care Benefits," *supra* note 11, at p. 41.
[16] Kaiser Family Foundation and Health Research Educational Trust, *Employer Health Benefits 2009 Annual Survey* (2006).
[17] *Ibid.* at p. 6.
[18] Richard W. Johnson, Center for Retirement Research, *supra note 1*, at p. 2.
[19] R. Helman, C. Copeland and J. VenDerhei, "The 2009 Retirement Confidence Survey: Economy Drives Confidence to Record Lows as Many Look to Work Longer," Employee Benefit Research Institute, Issue Brief No. 328, April 2009, at p. 15.

[20] America's Health Insurance Plans (AHIP), *Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability and Benefits* (2007).
[21] Jacobsen, Schwartz and Neuman, Kaiser Family Foundation, *supra note* 4, at p. 7.
[22] America's Health Insurance Plans (AHIP), *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability and Benefits* (2009).
[23] AHIP, *Comprehensive Survey of Premiums, Availability and Benefits (2007)*, *supra note* 27.
[24] AARP Public Policy Institute, "Health Care Reform: What's at Stake for 50-to-64-Year-Olds?" (March 2009), at p. 3, summarizing John Hopkins University analysis of 2005 Medical Expenditure Panel Survey data.
[25] G. Jacobsen, K. Schwartz and T. Neuman, "Health insurance Coverage for Older Adults: Implications of a Medicare Buy-In," Kaiser Family Foundation, Focus on Health Reform series (December 2009), at p. 3.
[26] *Ibid,* at p.6.
[27] *See, e.g.,* J.M. McWilliams, J.M., Zaslavsky, J.M., Meara E. and Ayanian, J.Z., "Health Insurance Coverage and Mortality Among the Near Elderly," *Health Affairs*, Vol. 23, No. 1 (July/August 2004); P. Franks,C.M.Clancy, and M.R. Gold, "Health Insurance andMortality: Evidence from a National Cohort," *Journal of the AmericanMedical Association* 270, no. 6 (1993):737–741; and P.D. Sorlie et al., "Mortality in the Uninsured Compared with That in Persons with Public and Private Health Insurance," *Archives of Internal Medicine* 154, no. 21 (1994):2409–2416.
[28] M. McWilliams, J.M., Zaslavsky, J.M., Meara E. and Ayanian, J.Z., "Health Insurance Coverage and Mortality Among the Near Elderly," *Health Affairs*, Vol. 23, No. 1 (July/August 2004), at p. 229.
[29] The program reimburses participating employment-based plans for 80 percent of the cost of benefits provided per enrollee in excess of $15,000 and below $90,000. The plans are required to use the funds to lower costs borne directly by participants and beneficiaries, and the program incentivizes plans to implement programs and procedures to better manage chronic conditions. The act appropriates $5 billion for this fund and funds are available until expended.