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THE OUTLOOK OF RETIREE HEALTH BENEFITS

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It is almost impossible to pick up a newspaper or news magazine these days without seeing an article about employer-sponsored health benefit plans. Health inflation since 2000 has driven the cost of these benefits up much more rapidly than general inflation or wages. Employers have responded by modifying their plans, often raising premiums on those covered under them or raising deductible and coinsurance rates for those using their benefits. Retirees are one group that is particularly vulnerable to health plan changes. This article looks at what employers have done in regard to sponsoring these benefits generally and then looks at what employers in higher education are doing for retired faculty.

The opinions and conclusions drawn in this draft report are those of the author and should not be attributed to Watson Wyatt Worldwide or any of its other associates or to anyone who provided us input in developing the analysis.

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>>> EXECUTIVE SUMMARY

The outlook for continued employer sponsorship of retiree health benefits has not been very positive for some time. This discussion looks at what employers have done in regard to sponsoring these benefits generally and then looks at what employers in higher education are doing for retired faculty. Highlights of the article include:

Employers stumbled into offering these benefits in the 1950s and 1960s

- There were not many retirees so costs were relatively low
- The cost of health care generally was not all that significant
- The implementation of Medicare further reduced costs

In the mid-1980s, accounting and financing of these benefits became troublesome

- The Financial Accounting Standards Board (FASB) required that costs and liabilities be reported
- Federal legislation limited for-profit companies' ability to fund the benefits as they accrued
- The net result was large unfunded obligations leading many firms to curtail benefits

In higher education, parallel trends are now having an effect

- The Government Accounting Standards Board is applying to government entities rules that are similar to FASB rules
- The cost and implications of benefits will now be understood
- Pattern of curtailment of benefits has been less severe than in the private sector so far
- The reality of health cost pressures, tighter budgets and growing retiree populations will create new pressures to further restrict these benefits and shift costs to retirees
- The Medicare drug benefit may give many institutions of higher learning the cover to get out of the retiree health benefit business

>>> INTRODUCTION

Many employers in the United States today are grappling with what to do about the retiree health benefit plans they have been sponsoring. Partly, this matter has arisen because the character of these benefits and the regulatory environment in which they operate has raised concerns about the rationale for employer sponsorship of retiree health insurance. Cost inflation for health benefits generally, and particularly for prescription drug benefits that are a major part of retiree health benefit costs, has accentuated the concerns that some employers have about these programs. The demographic composition of the workforce and the prospect of burgeoning retiree populations are important considerations as well. Finally, the recent adoption of legislation expanding Medicare's coverage to include drug benefits for retirees raises questions about what employers sponsoring their own retiree health insurance programs ought to do relative to the new coverage.

>>> TRENDS IN RETIREE HEALTH BENEFIT PROVISION

Lawrence Atkins (p. 108) suggests that employer-provided health benefits for retirees evolved mostly

without "design or intent" as a result of collective bargaining over benefits during the 1950s and 1960s. Relatively few retirees were receiving benefits from these plans, and the low cost of providing the benefits on a pay-as-you-go basis made them virtually a "throw-away" in negotiations. By 1962, 21 percent of the post-65 population was enrolled in an employer-sponsored plan and another 31 percent purchased some level of coverage privately (Rice, p. 9).

The enactment of Medicare in 1965 produced savings for these employer-sponsored plans, because Medicare became the primary payer for retirees once they reached age 65. Employer-sponsored plans paid only for the costs not reimbursed by Medicare, and more employers began to offer these plans. Atkins argues that employers adopted these benefits "because they needed them to make their retirement packages work, because they helped in collective bargaining, because they were attractive to labor in competitive labor markets, and because the costs were rarely significant." He notes that there were so few retirees at the time that often they were simply kept on the active employee plan. The supplemental packages furnished by employers produced insurance coverage with very low out-of-pocket costs for retirees.

Retiree health benefits are different than health benefits that employers provide to active employees in that they are provided to people who no longer work for the entity providing them. In this regard, retiree health benefits are like a defined benefit pension, which raises a set of issues beyond the cost and incidence issues associated with health benefits provided to active workers. In the case of active workers' benefits, they are earned at the time the workers perform their duties for the employer. In the case of retirees' benefits, they are earned long before they are actually provided.

The implications of accruing obligations for employer-sponsored retirement plans and how to deal with them have been understood for decades. Steven Sass, who has written a history of employer pensions in the United States, describes the "science of reform" that swept the pension movement in this country in the 1920s. He says the scientific experts of the time understood the importance of eliminating the uncertainty of risk for both employee and plan sponsors. They concluded that the benefits paid under retirement plans had to be expensed "in conjunction with the employer's receipt of productive labor services." But the second condition for the soundness of a plan was that monies have to be laid aside to cover obligations as they are earned (Sass, p. 62).

Accounting and Paying for Retirement Benefits in the Corporate World

In 1984, the Financial Accounting Standards Board (FASB) issued Financial Accounting Standard 81 (FAS 81) requiring employers to report on their financial statements either the current cost of retiree welfare benefits or the unfunded liability if the amounts were distinguishable from the benefit costs for active employees. FAS 81 raised employer awareness about unfunded liabilities associated with their retiree health benefit plans and their magnitude was illuminated by a number of well-publicized studies. A number of studies documented that corporate unfunded health obligations were large and costly (Thompson, 1988; Investors Daily, 1989). By this time, many corporate employers were aware that unfunded retiree medical liabilities had the potential to be large relative to the value of assets in their companies or the market values of their stock.

With the subsequent promulgation of FAS 106, FASB required that employers estimate and report future obligations associated with retiree health benefit programs on their financial statements for fiscal years beginning after December 15, 1992. The rationale was that retiree medical benefits are a form of deferred compensation for current employees, and the future benefits should be reported as they are earned. The underlying theory was that if an employer is going to hold out these benefits to employees in trade for their work, the obligation of paying for them down the line has to be recognized at the time the work earning the benefit is done and the obligation incurred.

As the FASB moved to require accounting for retiree health obligations, they put in place the first principle underlying secure retirement benefits that Sass tells us has been well known since at least the 1920s. But while the accounting rules for retiree health plans were being tightened, the U.S. Congress enacted significant restrictions on employers' ability to fund welfare benefit plans. The Deficit Reduction Act of 1984 (DEFRA) prohibited employers from taking

medical cost inflation and utilization trends into account when funding retiree medical benefits, and limited funding to current retirees. At the time, health care inflation was nearly double the rate of general inflation and utilization rates were trending upwards. DEFRA limited the employer's deductible contribution, and imposed a 100 percent excise tax on any assets reverting to the employer from a funded welfare benefit plan. In 1989 and 1990, further limitations on funding of retiree health obligations were imposed on corporate sponsors of such benefits.

Benefits Squeezed in the Regulatory Vice

The first condition for securing retiree health benefits was put in place by FASB accounting regulations. However, the second condition—funding them as they were being earned—was trumped by legal restrictions on the funding of benefits as they were accrued. FAS 106 accounting for retiree medical benefits has provided better information to corporate investors and other interested parties concerning the extent of future obligations. It prompted corporate executives to closely examine the magnitude of their commitments in sponsoring retiree health benefit plans. For many employers, it became clear that the generous plan designs and premium subsidies offered in an earlier era were now producing unacceptable financial obligations. This was particularly true in view of the high rates of medical inflation in the 1980s and the funding limitations plans faced.

In a survey of medium and large firms in 1980, 85.6 percent of them reported that they provided some form of retiree health benefits. By 2000, the percentage reporting these benefits had dropped to 37.1 percent. For the most part, the larger employers continued to sponsor plans, but even there, substantial curtailments in what was offered were the general rule (McDevitt, Mulvey, and Schieber [MM&S], p. 14). There are a number of common ways that plans have been curtailed without being eliminated by larger employers in the for-profit sector. These include increasing periods of service under the plan in order to qualify for benefits at retirement age, implementing a sliding schedule of premium payments based on service under the plan, capping the dollar amount the employer will contribute for retiree health premiums, and shifting to a notional defined contribution plan where a balance is accumulated over the period of work for an employer and that balance can be used to pay part of the premium for retiree health insurance during retirement. All of these methods are being used extensively to curtail retiree health liabilities in the private sector today.

>>>RETIREE HEALTH BENEFITS FOR FACULTY IN HIGHER EDUCATION

The accounting and funding rules that apply to corporate sponsors of retiree health benefits do not apply in the same way to most employers in the higher education sector. Virtually all the institutions of higher learning in the United States are either public sector or nonprofit entities. In the case of corporations, Securities and Exchange Commission disclosure requirements mean that any firm sponsoring a retiree health benefit program has to comply with the FAS 106 standard. Privately held for-profit organizations and private nonprofit entities are not subject to SEC disclosure but are required by ERISA to have an annual audit if they sponsor a defined benefit plan. Theoretically, this would not have to be done in accordance with the Generally Accepted Accounting Principles (GAAP) but it would likely be rare that any normal accountant would use an alternative standard. For this reason and others, it appears that most private institutions of higher learning are in compliance with at least the FASB's reduced disclosure requirements for nonpublic entities. These require the estimation of benefit obligations, value of plan assets, and funded status for retirement plans.

Public entities are covered by standards set by the Governmental Accounting Standards Board (GASB), which has not had the same requirements as FASB in this area historically. But in June 2004, GASB issued Statement No. 45, Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions, which includes accounting standards for retiree health benefits and other nonpension benefits. These new standards require that public employers recognize the cost of accruing benefits in periods when the related services are rendered by workers, that they calculate and report actuarial accrued liabilities for promised benefits associated

Table 1 Number of Institutions of Higher Learning in Survey Sample Providing Retiree Health Benefits to Retired Faculty by Indication of Coverage

	Private institutions			Public institutions		
	Current retirees	*Eligible to retire*	*New hires*	*Current retirees*	*Eligible to retire*	*New hires*
Pre-65 coverage						
Retiree	34	34	27	21	21	20
Spouse	34	34	27	21	21	19
Post-65 coverage						
Retiree	30	29	21	21	20	19
Spouse	30	29	21	21	20	19

Source: Watson Wyatt Worldwide.

with past service of workers and the extent to which such benefits have been funded, and that they indicate future cash flows required to meet these obligations. Largest employers (those with total annual revenues of $100 million or more) are required to implement these standards for periods beginning after December 15, 2006, while medium-sized employers (those with total annual revenues of $10 million or more but less than $100 million) have an additional year to implement the standards, and small-sized employers (those with total annual revenues of less than $10 million) have two additional years (GASB, 2004).

Even if institutions of higher learning are accounting for their retiree health benefits in a fashion similar to that required of corporate entities, the market pressures relative to continuing sponsorship of these benefits may be quite different. For a corporate sponsor, the retiree health accounting expenses drive down profits and potentially depress stock prices. The liabilities that affect the balance sheet can affect the perceived value of an organization and bring financial market pressure to significantly reduce or eliminate the liabilities. In the case of nonprofit institutions, donors may not often know about such obligations even though they have been calculated, and there is less of a sense of ownership. Nonprofits by their very essence are not driven by the same economic motivations as corporate entities. Thus, it is quite possible that characteristics of retiree health benefits in higher education are evolving along a different path than in the for-profit sector.

Since virtually all colleges and universities are nonprofit institutions, the funding limitations imposed on corporate employers sponsoring retiree health benefits did not apply so there would have been a greater opportunity to fund retiree health benefits with the accrual of liabilities during workers' careers. For most colleges and universities, the vagaries of market demand for specific goods and services that can lead to the rise and fall of corporate employers also are not applicable.

In order to see what academic institutions have done with retiree health benefits, Watson Wyatt undertook a survey in February 2004. The survey questionnaire was sent to 263 institutions and garnered complete responses from 67 of them. Among respondents, 18 percent reported they did not provide retiree health benefits. There were 46 private schools who responded to the survey, of which 12 did not have a plan. Among the latter, the average enrollment was approximately 2,300 undergraduate students. Among those reporting a health benefits plan for retired faculty, the average enrollment was around 4,300 undergraduate students. There were 22 public schools that responded to the survey and 21 reported providing health insurance to retired faculty. The average enrollment in the latter group of institutions was 19,300 undergraduates.

Table 2 Cost and Cost Sharing of Retiree Health Benefits Provided by Private and Public Colleges and Universities in 2004

	Current retirees				Now eligible to retire			
	Private schools		*Public schools*		*Private schools*		*Public schools*	
Pre-65 plan								
Total reporting	31		18		32		18	
	Percent of total	*Average spending*	*Percent of total*	*Average spending*	*Percent of total*	*Average spending*	*Percent of total*	*Average spending*
Retiree pays all	16.1	$5,030	27.8	$5,030	18.8	$4,890	27.8	$5,030
Share expenses	54.8		38.9		65.6		44.4	
Retiree share		$2,023		$950		$1,958		$1,432
Employer share		$2,717		$3,480		$2,574		$3,345
Employer pays all	29.0	$4,006	33.3	$4,134	15.6	$4,508	27.8	$4,274
Post-65 plan								
Total reporting	29		20		29		19	
	Percent of total	*Average spending*	*Percent of total*	*Average spending*	*Percent of total*	*Average spending*	*Percent of total*	*Average spending*
Retiree pays all	13.8	$3,725	20.0	$3,562	13.8	$3,725	21.1	$3,562
Share expenses	51.7		45.0		65.5		47.4	
Retiree share		$1,817		$679		$1,866		$679
Employer share		$1,781		$3,062		$1,735		$3,062
Employer pays all	34.5	$3,625	35.0	$3,513	20.7	$3,625	31.6	$3,644

Source: Watson Wyatt Worldwide.

Table 1 indicates the extent to which health insurance is being offered to retired faculty among the schools that were offering such coverage at the beginning of 2004. Among the 34 private institutions that offered retiree health benefits, all of them offered the benefits to retired faculty under the age of 65 who were already retired or eligible to retire. For new hires, however, only 27 offered the prospect of providing retiree health benefits in the future. A number of the private schools that provided retiree health benefits prior to age 65 did not continue to provide such benefits beyond age 65 when the retirees would typically qualify for Medicare. For new hires, only 62 percent of all the private institutions that offered some benefits currently would provide them beyond age 65 for faculty members now joining the staff. In the case of the public institutions, there is much less indication so far that the provision of coverage is being curtailed to the same extent as it is in the private schools.

The provision of retiree health insurance to retired faculty across the set of institutions reflected in Table 1 is important in that it gives a clear indication that the retired faculty members involved have access to continuing health insurance coverage. The value of what they have access to varies considerably from one institution to the next. Table 2 shows the extent of cost sharing of premiums between the retirees and the

Table 3 Utilization of Minimum Service Requirements to Qualify for Health Benefits Provided to Retired Faculty by Institutions of Higher Learning in 2004

	Private institutions			Public institutions		
Minimum service requirement	*Currently retired*	*Eligible to retire*	*New Hire*	*Currently retired*	*Eligible to retire*	*New Hire*
Number reporting	29	29	21	21	21	20
	Percent reporting service requirement of:					
None	4	3	5	5	5	5
5 years or less	7	3	5	33	29	30
10 years	48	48	48	38	29	30
More than 10 years	41	45	43	24	38	35

Source: Watson Wyatt Worldwide.

sponsoring institutions for the faculty members, but not necessarily their spouses, for those who are currently retired or eligible to retire.

The public schools are more likely to require that the retiree pay the full premium for the retiree health insurance coverage than are private schools. But the public schools are also more likely to pay the whole cost of the benefit than the private schools. Where premiums are shared, the private institutions generally share the cost on something approaching a 50-50 basis whereas the public employers typically pick up a significantly larger share of the total premium.

As noted earlier, a number of colleges and universities have adopted limitations on retiree health benefits similar to those being utilized in the corporate sector but the pattern of adoption of these methods is much less widespread by the academic employers, at least those in the public sector. In a 2001 survey of corporate sponsors of retiree health benefits, roughly 60 percent of the respondents indicated they had service requirements of 10 years to qualify for retiree health benefits plus another 30 percent required more than 10 years for future retirees (MM&s, p. 18).

In Table 3, the private academic employers in the current survey are showing around 90 percent indicating that they have implemented service requirements of 10 years or more for retiring faculty to qualify for retiree health benefits. For the public institutions, on the other hand, 35 percent or more still have service requirements of 5 years or less to qualify for benefits.

Among the responding academic institutions to the current survey, only 11 percent of the private and 19 percent of the public schools indicated they varied the share of premiums paid by current retirees based on service prior to retirement. For faculty members now eligible to retire but still working, 16 and 29 percent of the respondents respectively varied premiums based on service. For new hires still being offered benefits in the future, 18 and 29 percent of the respondents had such variable premium schedules. By comparison, 63 percent of private plan sponsors in 2001 reported that they would vary premiums based on service for pre-65 benefits and 72 percent reported they would do so for post-65 coverage (MM&S, p. 18).

For the schools responding to the survey in 2004, only 9 percent of the private institutions and 24 percent of the public ones indicated they had implemented employer contribution caps for health benefits provided to current retirees under age 65. For those already over the age of 65, 13 percent of private and 24 percent of the public institutions had adopted such caps. In the case of private employers in 2001, 26 percent had adopted caps for current retirees under age 65 and 24 percent had

them for retirees age 65 and over. For those now eligible to retire but still working, 12 percent of private and 24 percent of public schools had adopted premium caps for faculty retiring before age 65. For those retiring after age 65, 17 and 24 percent had such caps. The similar private sector rates in 2001 were 39 percent for both pre- and post-65 retirees (MM&S, p.20). Only a handful of the respondents to the current survey, across both the public and private institutions, had hit their premium caps already. By comparison, among the private firms surveyed in 2001, 42 percent had already hit their pre-65 caps and 50 percent had reached their caps for post-65 retirees (MM&S, p. 21).

One response that private employers have adopted to limit retiree health liabilities but to continue to provide some level of benefits for future retirees is the adoption of "retiree medical accounts" that accumulate during a worker's career and can be used to help pay health insurance premiums during retirement. Rather than paying a percentage of the premium for a defined insurance benefit, the employer makes a fixed contribution to an account, and the retiree is able to use the employer contribution in the account to purchase health insurance.

Like traditional retiree medical plans, retiree medical accounts are not taxable to the employee, they are not prefunded, and employees do not necessarily accrue a vested right to the benefit. Employers can retain the right to modify or eliminate the plan altogether as long as this is clearly communicated to employees and retirees. Employers may continue to offer a choice of one or more group-rated medical plans, but the retiree pays the full premium either from the retiree health account or directly.

Most of the employers reporting retiree medical accounts limit participation in these accounts to employees who have met age and service requirements, for example, age 40 and one year of service. This concentrates benefits on older employees and limits the cost of the benefits. Contribution formulas differ, but participants are typically credited a fixed dollar amount for each year of participation in the plan, and the account may earn interest both before and after retirement. Retiree health accounts are typically "notional accounts," meaning that funds are not deposited into these accounts as credits are earned. Rather, these accounts are simply a bookkeeping device that allows the employer and employee to keep track of the dollar amounts that will be made available for retiree medical benefits sometime in the future.

The retirement incentives associated with a retiree medical account are different from those of a traditional retiree medical plan. Where the traditional plan offers the highest present value to employees who retire early, the retiree health account continues to accumulate credits for each additional year of service. By working longer, the employee also reduces the number of costly pre-Medicare years for which retiree medical coverage must be funded. Finally, the traditional plan usually makes additional contributions for spousal coverage, but the retiree health account does not.

Although retiree medical accounts typically provide more limited employer contributions than those associated with traditional medical plans, they represent one way for employers to offer a benefit that is predictable, manageable, and consistent with prevailing strategies to attract and retain employees. Much like savings plans and cash balance plans designed to provide retirement income, retiree health accounts clearly communicate the dollar value of the benefit and encourage the employee to take on greater individual responsibility for retirement planning. In the 2001 survey of private employers, 13 percent had set up these accounts as a way to control retiree health liabilities but still maintain a plan. In the 2004 survey of academic institutions, only one private school had established such a plan.

Among the respondents to the current survey, 47 percent of the private institutions and 71 percent of the public ones indicated that they were at least partially funding retiree health obligations. These response rates were surprisingly high and we asked many follow-up questions of respondents to verify this information. We found a variety of things the schools were doing. For example, one university reported that they allow retiring employees to convert unused sick leave into an account at retirement to help pay the retiree's premiums, which they considered to be partial funding. In almost every case, we concluded there was very little funding taking place. At least in the case of public colleges and universities, our

conclusion is consistent with the GASB's assessment of how most public employers have been operating their retiree health benefit plans.

>>>FUTURE PROVISION OF HEALTH BENEFITS FOR RETIRED FACULTY

Despite the fact that employment patterns in higher education have evolved differently than those in many of the industries already troubled by the retiree health obligations they face, the same issues apply in this case as in the others. Retirement may come somewhat later in higher education than in other industries but the larger share of current workers that are now at advanced ages suggests that retiree dependency ratios among faculty could rise fairly quickly in future years. A disproportionate share of existing faculty are members of the baby boom generation or older. This generation of workers is now approaching the age at which they will begin to retire either because of health considerations or because of normal expectations to do so. Even if they are all replaced by young faculty members, the future ratio of retirees to active workers will increase in the vast majority of cases. The pressures on health costs that apply to other sponsors of health insurance will continue to apply to academic institutions although the burden may continue to be relatively less than in many other cases.

Since faculty members tend to work somewhat later into life than many workers in the for-profit sector, especially workers in the for-profit sector covered by defined benefit plans, many will be eligible for Medicare by the time they receive their employer-sponsored retiree health insurance. The cost of supplementing Medicare is virtually always less than the cost of providing full coverage. With the recent changes adopted in Medicare, this may be even more the case in the future. Still, the prospect of a growing retiree population suggests these costs may become more expensive for institutions still sponsoring the benefits in the future.

Of course, there is always the prospect that the higher education sector will continue to grow more rapidly than the remainder of the economy and that the added employment will allow employers in this sector to continue to escape the age dependency problems that have plagued other sectors. Much of the growth in the education sector over the past 40 years has been demand driven and it is not clear that the fundamental market factors that have persisted over this history will continue in coming decades. The baby boom generation and even its echo with subsequent birth cohorts have been accentuated with increasing demand for a college education. This growing demand has been supported by public and private funds that may be constrained by alternative claims in the future. The baby boomer generation's retirement will likely place an unprecedented claim on public budgets unless there are remarkable changes to public pensions and medical programs. To the extent there is retrenching on these programs, it may be concentrated on the middle and upper middle classes, including older workers and retirees who have been major contributors to higher education in the past.

In the case of public institutions of higher learning, the new GASB accounting standard is going to introduce some of the same sorts of pressures on retiree health benefits that they have introduced in the private sector. Given that changes that will be adopted to respond to these pressures will be undertaken in a public policy environment, the changes may not be as rapid as those taken in the private sector or as radical. But even in the public sector, the recognition of costs associated with retirement plans often leads to changes. If nothing else, the recognition of costs associated with these sorts of programs can lead to reallocation of budgets within organizations and may ultimately result in actual reallocation of resources.

For institutions of higher learning in both the private and public sectors, it appears that most of them have not funded retiree health benefit obligations as they have accrued historically. This raises the prospect that future management of institutions that continue to sponsor these benefits will become hamstrung with obligations that are not properly anticipated and that have the potential to become so large that they pose a threat to the long-term viability of the institutions. Whether an academic institution is in the public or the private sector there are fundamental cross-generational issues that the provision of these benefits raise. The basic principles on which GASB is basing its new standard for accounting for retiree health benefits are

the same as those that Steven Sass, the pension historian, has told us plan sponsors learned more than 80 years ago. To secure a retiree benefit over time, the obligation it poses must be accrued as it is being earned and must be funded at the time it is accrued.

It is likely that full accounting and a shift toward funding of retiree health benefits will lead many academic sponsors to reconsider the benefits that they have provided up until the present time. It is clear that some of this reassessment is now underway and that the net result is that benefits are being curtailed or costs shifted to retirees. The implementation of the prescription drug benefit recently adopted under Medicare may allow some sponsors to go further in terms of reducing retiree health obligations than they would have gone in the past. This opportunity arises for several reasons.

First, a typical employer-sponsored plan covering retirees also eligible for Medicare now spends something approaching two-thirds of its outlays on prescription drugs. The lack of drug coverage in Medicare has been its major inadequacy as a stand-alone insurance plan. Second, for a substantial number of plans documented in this analysis, 14 percent of the private school plans and 20 percent of the public plans, retirees are already paying the full premiums for their retiree health insurance and the Medicare coverage may be no more costly than the existing coverage and may be nearly as comprehensive as current plans up to and including the catastrophic coverage levels. Third, in many cases, the employer cost of the current benefits is roughly as expensive as the Medicare coverage will be up to and including the catastrophic coverage levels. If employers want to continue to provide this level of benefits on a defined benefit basis, they would be better off establishing an actual defined benefit pension plan to provide future retirees a stream of income to cover their Medicare costs for prescription coverage. For the remaining employers that are in a cost sharing relationship with their retirees the financial picture may not be as clear but the logic that applies to cashing out current health obligations for the other employers applies here as well. Defining a limited commitment and funding it as it is accrued will be a much sounder guarantee over the long term than what is being provided today.

It is clear that many current employers in this sector have a strong aversion to defined benefit pensions. Yet, in sponsoring retiree health benefits it is clear these same institutions have committed themselves to an alternative form of defined benefit plan where they have virtually no control over the escalation of costs over time, where inflation has historically been extremely high and persistent, and where there is little precedent for funding the obligations as they accrue. This is not a logical situation for either the sponsoring organizations or the potential beneficiaries of current plans to sustain.

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