

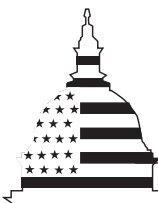
GAO

Report to the Chairman, Committee on
Health, Education, Labor, and
Pensions, U.S. Senate

May 2001

RETIREE HEALTH BENEFITS

Employer-Sponsored Benefits May Be Vulnerable to Further Erosion



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Abbreviations

ADEA	Age Discrimination in Employment Act
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPS	Current Population Survey
ERISA	Employee Retirement Income Security Act of 1974
FAS	Financial Accounting Standards
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
Kaiser/HRET	Kaiser Family Foundation and Health Research and Educational Trust
PPO	preferred provider organization
SPD	summary plan description



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Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

May 1, 2001

The Honorable James M. Jeffords
Chairman, Committee on Health,
Education, Labor, and Pensions
United States Senate

Dear Mr. Chairman:

In 1999, about 10 million retired people aged 55 and over relied on employer-sponsored health insurance as either their primary source of coverage or a supplement to their Medicare coverage.¹ For some of these individuals, however, concerns exist that the continued availability of employer-sponsored coverage may be uncertain. As we reported in 1998, the percentage of employers offering retiree coverage to early retirees—those aged 55 to 64—had dropped from about 70 percent in the 1980s to about 40 percent in 1997.²

Concerned about declining employer-sponsored health coverage for early retirees and Medicare-eligible (age 65 and over) retirees, you asked us to examine if this trend is continuing. In particular, you asked that we examine

- changes employers have made to the availability and terms of their health insurance plans with respect to retiree coverage;
- how factors such as economic conditions, Medicare changes, and demographic trends may influence employers' future provision of retiree health benefits; and
- the ability of retirees without employer-sponsored coverage to obtain alternative coverage.

To answer these questions, we reviewed available employer survey data; analyzed the March supplements of the 1995 to 2000 Current Population

¹In this report, "employer-sponsored" is used to refer to any employment-based group health coverage, including health plans offered under collectively bargained agreements and multiple employer associations.

²*Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year-Olds* (GAO/HEHS-98-133, June 1, 1998). A list of related GAO products is included at the end of this report.

Survey; reviewed applicable laws and court decisions pertaining to changes in employer-sponsored coverage; obtained individual insurance market premiums from insurers and health plans; and interviewed employee benefits consulting firms and several large employers. Appendix I provides additional information on our methodology. We conducted our work from June 2000 through February 2001 in accordance with generally accepted government auditing standards.

Results in Brief

Despite a sustained strong economy and several years of relatively low rates of increase in health insurance premiums, the decline in the availability of employer-sponsored retiree health benefits has not reversed since 1997—the last year for which we had reported previously—and several indicators suggest that there may be further erosion in these benefits. Employer benefit consultants we contacted generally indicated that retiree health benefits were continuing to decline. Two widely cited employer benefit surveys, however, provide conflicting data as to whether the proportion of employers sponsoring retiree health insurance remained stable or declined slightly from 1997 through 2000. In some cases, employers provide retiree health benefits to current retirees or long-term employees, but newly hired employees are not eligible. To date, however, the percentage of retirees with employer-sponsored coverage has remained relatively stable over the past several years, with about 37 percent of early retirees and 26 percent of Medicare-eligible retirees receiving retiree health coverage from a former employer. This stability may also be linked to employers' tendency to reduce coverage for future rather than current retirees. In some cases, employers that continue to offer retiree health benefits have reduced the terms of these benefits by increasing the share of premiums that retirees pay for health benefits, increasing copayments and deductibles, or capping the employers' expenditures for coverage.

Several current and developing market, legal, and demographic factors may contribute to a further decline in employer-sponsored retiree health benefits. These factors include

- a resumption of health insurance premiums rising at a rate faster than general inflation;
- a slowdown in economic growth and potential softening of the labor market;
- proposed changes in Medicare coverage, such as adding a new prescription drug benefit, that could affect the costs and design of employers' supplemental health benefits for Medicare-eligible retirees;

-
- a recent circuit court ruling allowing claims of violations of federal age discrimination law when employers make distinctions in health benefits they offer retirees on the basis of Medicare eligibility; and
 - the movement of the baby boom generation into retirement age, leading some employers to have a growing number of retirees relative to active workers.

Retirees whose former employers reduce or eliminate health benefits often face limited or unaffordable alternatives to obtaining coverage. Retirees may purchase coverage on their own—either individual insurance policies for those under 65 or Medicare supplemental plans for those 65 or older. However, despite federal laws that guarantee access to some individual insurance policies to certain individuals who lose group coverage, retirees’ ages and often poorer health status combine to make individually purchased health insurance expensive. For example, the majority of states do not restrict the price of premiums carriers may charge individuals who purchase individual insurance policies. Thus, carriers in these states may charge 60-year-old males a monthly premium close to 4 times higher than what they charge 30-year-old males, and there may be an even bigger difference if the older individual is not healthy. Similarly, the number of Medicare supplemental plans that federal law guarantees to retirees over 65 whose employers eliminate coverage is limited, and they do not include coverage for benefits such as prescription drugs. Thus, retirees seeking alternative coverage could receive less comprehensive coverage and pay more for it than they had previously.

Background

Since World War II, many employers have voluntarily sponsored health insurance as a benefit to employees for purposes of recruitment and retention, and some have also offered these benefits to their retirees. The federal tax code provides incentives for employers to subsidize health benefits because their contributions can be deducted as a business expense from their taxes, and these contributions are also not considered taxable income for employees. Employer-sponsored health benefits are regulated under the Employee Retirement Income Security Act of 1974 (ERISA),³ which gives employers considerable flexibility to manage the cost, design, and extent of health care benefits they provide. However, ERISA established certain requirements for employers, including that they provide health plan participants and beneficiaries with a summary plan

³29 U.S.C. 1001.

description (SPD) specifying the retirees' rights and circumstances under which the health plan can be modified or terminated.⁴

Concern over the costs associated with retiree health benefits was compounded in 1993 when the Financial Accounting Standards (FAS) Board adopted FAS 106, requiring employers to report annually on the liability represented by the promise to provide retiree health benefits to current and future retirees. While FAS 106 did not affect an employer's cash flow, there has been concern that listing this future liability could affect companies' stock prices because the reporting of projected retiree health care costs affects the overall statement of financial profitability. Some companies have said that FAS 106 requirements lead to reductions in reported income and shareholder equity and are a reason for reducing retiree health benefits. As a means of reducing their reported liability as well as controlling rising costs associated with retiree health benefits, some employers have passed a share of cost increases to their retirees in the form of higher premiums, deductibles, or copayments. Some other employers have reduced benefits or simply ceased to sponsor coverage.

In the absence of employer-sponsored retiree health benefits, retirees have certain coverage alternatives, but may find them to be expensive or even unaffordable. Individuals under 65 may rely on the individual insurance market or may, in limited instances, be eligible for continuation coverage from a former employer. For example, individuals whose jobs provided health benefits that ended at retirement may continue temporary coverage for up to 18 months under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).⁵ For eligible individuals who exhaust available COBRA coverage, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees access to the individual market, regardless of health status and without coverage exclusions, but

⁴Other requirements on employers include having a process for appealing claim denials, making available temporary continuation coverage for former employees and dependents, and meeting specific fiduciary obligations. For more information on ERISA's applicability to employer-sponsored health benefits see *Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA* (GAO/HEHS-95-167, July 25, 1995).

⁵29 U.S.C. 1161-1169 and 26 U.S.C. 4980B. COBRA coverage may entail substantial out-of-pocket costs because the employer is not required to pay any of the premium and may charge the enrollee up to 102 percent of the group rate. COBRA coverage can be extended an additional 11 months for most individuals who qualify for disability under the Social Security Act; however, they may be charged up to 150 percent of the group rate. COBRA coverage is not required for employers with fewer than 20 employees.

does not restrict the premiums that may be charged to older or less healthy individuals.⁶

For retirees 65 years or older, Medicare is typically the primary source of health insurance coverage. Under traditional Medicare, eligible individuals may apply for Part A, which helps pay for care in hospitals and some limited skilled nursing facility, hospice, and home health care, and may purchase Part B, which helps pay for doctors, outpatient hospital care, and other similar services. Medicare beneficiaries may rely on private retiree health coverage from a former employer or union or individually purchased Medicare supplemental insurance (known as Medigap) to cover some or all of the costs not covered by Medicare, such as copayments, coinsurance, deductibles, and most outpatient prescription drug costs.⁷ Depending on where they live, individuals may have the option of obtaining Medicare coverage on a fee-for-service basis or from a managed care or other private plan offered through the Medicare+Choice program since 1998.⁸ Many beneficiaries have been attracted to these plans because they typically have lower out-of-pocket costs than fee-for-service plans and offer services not covered by traditional Medicare, such as routine

⁶29 U.S.C. 1181-1191, 26 U.S.C. 9801-9803. HIPAA provides eligible individuals with group-to-individual portability; that is, eligible individuals losing group coverage have access to at least two individual insurance products. An eligible individual is one who has had at least 18 months of creditable coverage with no break of more than 63 consecutive days; has exhausted any COBRA or other continuation coverage available under a similar state program; is not eligible for any other group coverage, Medicare, or Medicaid; and did not lose group coverage because of nonpayment of premiums by the individual or fraud.

⁷The Medicare Current Beneficiary Survey found that in 1996 approximately 32 percent of traditional Medicare beneficiaries obtain their supplemental coverage as a retirement benefit from a former employer or union, 30 percent individually purchase Medigap coverage, and 4 percent have both an employer-sponsored and an individually purchased supplemental plan. Another 20 percent of traditional Medicare beneficiaries also qualify for Medicaid or other health coverage to supplement Medicare, and 13 percent have Medicare only.

⁸In the Balanced Budget Act of 1997 (P.L. 105-33, Aug. 5, 1997), Congress established the Medicare+Choice program to expand Medicare beneficiaries' health plan options and encourage wider availability of health maintenance organizations and other types of health plans, such as preferred provider organizations, as an alternative to traditional fee-for-service Medicare. Prior to 1998, Medicare managed care plans that were paid a fixed amount per enrollee were known as risk plans. Risk plans, along with new types of plans authorized by the Balanced Budget Act of 1997, are now known as Medicare+Choice plans. We previously reported that about 30 percent of Medicare beneficiaries—particularly those in rural areas—did not have a Medicare+Choice plan available in their location. See *Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings* (GAO/HEHS-00-183, Sept. 7, 2000).

physical exams and prescription drugs. Nearly 6 million people, or approximately 15 percent of Medicare's 39 million beneficiaries, were enrolled in a Medicare+Choice plan as of January 1, 2001, with recent plan withdrawals causing some beneficiaries to return to the traditional Medicare program.

The Decline in Employer Sponsorship of Retiree Health Benefits Has Not Reversed Since 1997

Despite a strong economy and relatively small premium increases during the latter part of the 1990s, available evidence from employer benefit surveys and employer benefit consultants we interviewed suggests the decline in employer-sponsored retiree health insurance has not reversed since 1997—the last year for which we had reported previously. Two widely cited employer benefit surveys estimate that just over one-third of large employers, and a smaller portion of small employers, offered health coverage to some of their retirees in 2000; however, one of these surveys shows the proportion of large employers offering coverage is the same as in 1997, whereas the other indicates a further small decline in coverage since 1997. Other data indicate that the percentage of retirees with employer-sponsored health insurance remained relatively stable during this time period. Still, many employers continuing to offer coverage have reduced the terms of coverage by tightening eligibility requirements, increasing the share of premiums retirees pay for health benefits, or increasing copayments and deductibles—thus, contributing to a gradual erosion of benefits.

Surveys Conflict as to Whether Employers' Offerings of Retiree Health Benefits Were the Same or Declined Slightly Since 1997

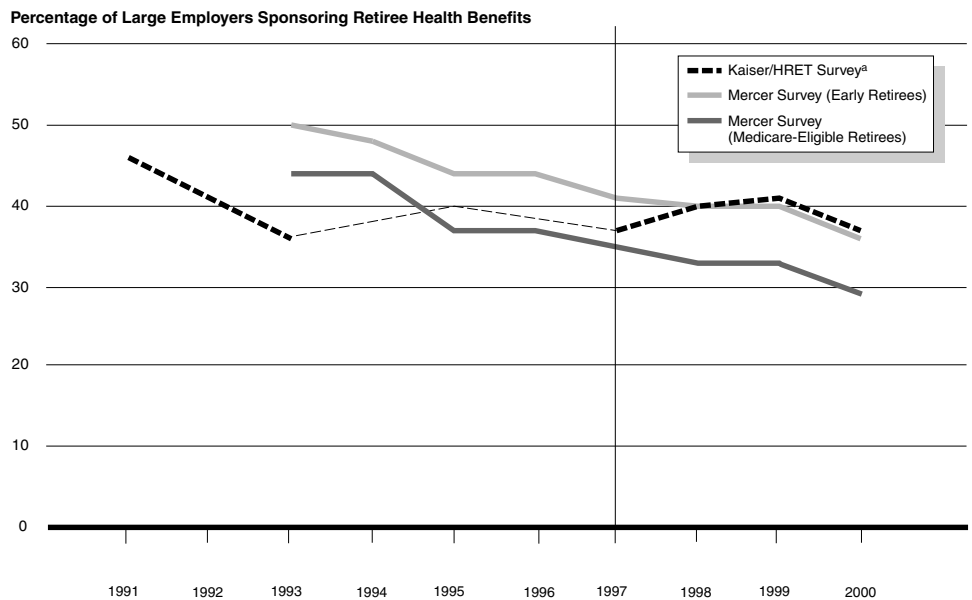
Employer sponsorship of retiree health benefits in 2000 was, at best, the same as in 1997 or, worse, continued to gradually erode according to two surveys. Surveys conducted by William M. Mercer, Incorporated, indicate that the portion of firms sponsoring health insurance for early retirees fell slightly from 41 percent in 1997 to 36 percent in 2000. Similarly, employer sponsorship of health benefits for Medicare-eligible retirees fell from 35 to 29 percent during this period. As shown in figure 1, this continues a gradual decline that began in the early 1990s. A second survey—conducted by the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET)—estimates that about 37 percent of large employers sponsored retiree health benefits in 2000⁹—the same percentage as in 1997, although with some year-to-year fluctuation. Like the Mercer survey,

⁹For those firms sponsoring retiree health benefits, 92 percent did so for early retirees, and 67 percent for Medicare-eligible retirees.

the Kaiser/HRET survey reflects a significant decline in coverage since 1991.

Year-to-year fluctuations or gradual changes in these surveys' results need to be interpreted with caution. These surveys are widely used and based on random samples designed to be representative of a broader employer population, but neither may have the precision needed to distinguish small changes in coverage from year to year because of the response rates and the number of firms surveyed. For example, only about 45 percent of the 1,887 firms in the Kaiser/HRET sample responded to the survey in 2000. Similarly, about 50 percent of the sampled firms responded to the Mercer

Figure 1: Surveys Report That Employer-Sponsored Retiree Health Benefits Have Remained the Same or Declined Slightly Since 1997 for Large Firms



^aThe narrow dashed lines between 1993 and 1997 for the Kaiser/HRET survey (at that time conducted by KPMG Peat Marwick) indicate that the survey did not report on employer sponsorship of retiree health benefits in 1994 and 1996.

Note: The Mercer data represent retiree health benefits offered by employers with at least 500 employees, whereas the Kaiser/HRET data represent employers with at least 200 employees. Until 1997, Foster Higgins, which merged at that time with William M. Mercer, Incorporated, conducted the Mercer survey.

The vertical line at 1997 indicates the year for which we had last reported.

Sources: William M. Mercer, Incorporated, and Foster Higgins employer benefit surveys from 1994 through 2000, and KPMG Peat Marwick and Kaiser/HRET employer benefit surveys from 1991 through 2000.

survey, which included 2,797 respondents. Thus, year-to-year differences may have resulted from differences in those employers that chose to respond to the surveys. Also, while neither Mercer nor Kaiser/HRET reported the size of these sampling errors, Kaiser/HRET's 1999 and 2000 reports indicated that 1-year differences in the percentage of large employers offering retiree health coverage since 1998 were not statistically significant.

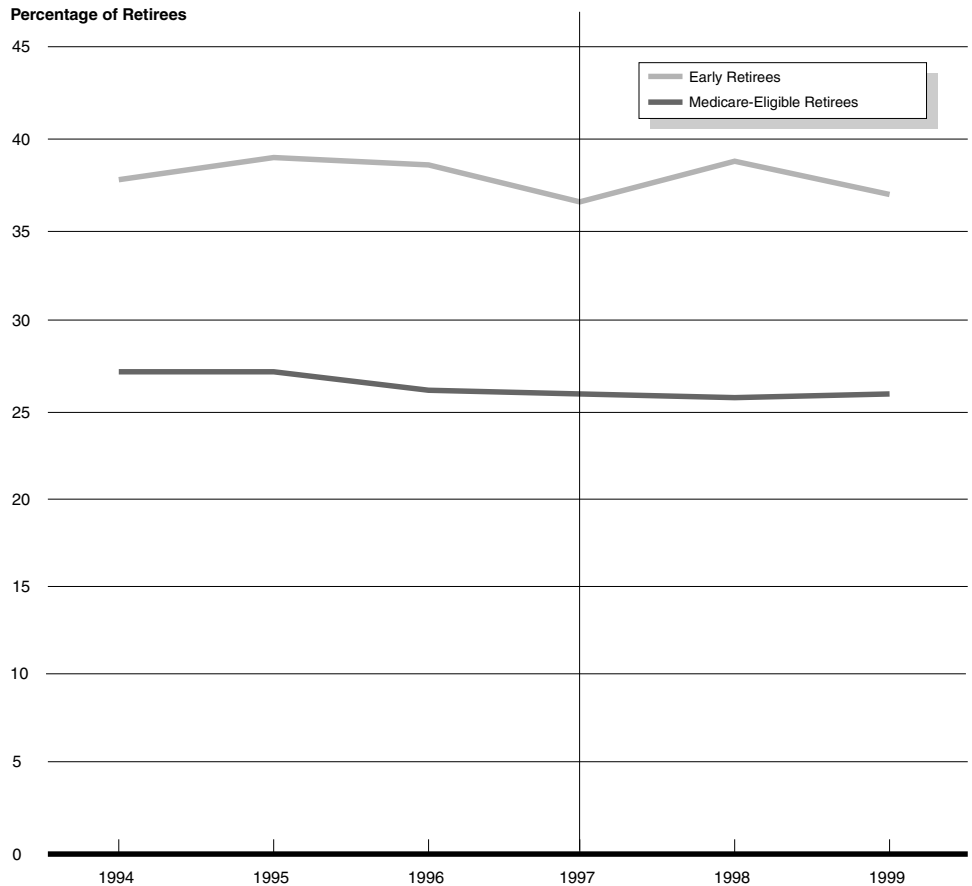
Large firms are more likely to sponsor health insurance for retirees than are smaller firms. For example, Kaiser/HRET reported that just over one-half of firms with 5,000 or more employees sponsored retiree health insurance in 2000, compared to only about 9 percent of firms with fewer than 200 employees. According to the Mercer data, the percentage of firms with 500 to 999 employees that sponsored retiree health insurance in 2000 was about 40 points lower than for those with 20,000 or more employees—about 30 percent or less compared to about 70 percent.

Percentage of Retirees With Employer-Sponsored Coverage Has Remained Relatively Steady

The percentage of retirees obtaining health benefits through a former employer has remained relatively stable since 1997. According to our analysis of the Census Bureau's Current Population Survey (CPS), in 1999, about 37 percent of retirees aged 55 to 64 had employer-sponsored coverage in their own names from former employers, as did about 26 percent of elderly retirees in 1999 (see figure 2).¹⁰ Since 1994, these figures varied by only 1 or 2 percentage points for early retirees and even less for elderly retirees. Year-to-year differences are too small to be statistically significant. This stability in coverage may exist in part because employers tend to reduce coverage for future rather than current retirees.

¹⁰These percentages include only those retirees that had employer-sponsored health coverage "in their own names." Nearly 20 percent of early retirees and about 7 percent of Medicare-eligible retirees also had employer-sponsored coverage through spouses or other related individuals who may be either active workers or retired.

Figure 2: Percentage of Retirees With Employer-Sponsored Health Benefits Has Remained Relatively Stable



Source: GAO analysis of Current Population Survey, March Supplements 1995 through 2000.

Employers Are Restricting Eligibility, Reducing Benefits, and Increasing Employee Costs

Employers have adopted several strategies to limit their liability for retiree health costs other than terminating benefits, and these mechanisms contribute to an erosion in health benefits available to retirees. Some employers have restricted eligibility for retiree health insurance to certain employees, such as those hired before a certain date, thus reducing their future liability for these benefits without causing a large disruption in health coverage for those who are currently or soon-to-be retiring. According to Mercer's data, about 5 percent of large employers sponsored

retiree health insurance in 2000 for only selected employees, typically excluding employees hired more recently.¹¹

Employers have also attempted to better manage or control their health care expenditures by increasing the share of health care costs for which the retiree is responsible. This approach encompasses a range of activities and includes employer efforts to increase the retirees' deductibles, copayments, and premium share; cap the employer's overall expenditures; or pay a fixed amount per retiree for health care.¹² For example, more than 10 percent of employers reported having recently increased retirees' potential out-of-pocket costs for deductibles, coinsurance, and copayments. Kaiser/HRET and Mercer, respectively, report that 16 to 25 percent of employers increased the retiree's share of their premium contribution during the last 2 years. According to Mercer data, about 40 percent of large firms that offer early retiree health benefits now require these retirees to pay the entire premium—an increase of 8 or more percentage points since 1997. Likewise, the percentage of firms requiring Medicare-eligible retirees to pay the entire premium has increased 7 or more points during this time period.

In other cases, employers have established caps on their overall expenditures for future retiree health benefits. The 1999 Kaiser/HRET survey estimated that about 35 percent of all large firms had recently capped their total projected contribution for retiree health benefits. How employers will ensure spending does not exceed the caps and how coverage will be affected are not clear. Benefit consultants we interviewed stated that employers typically set caps prospectively at a level higher than current spending. In some cases, employers that find they are approaching the cap for retiree health spending will raise it.

Some employers are considering—but not yet widely implementing—a more fundamental change by shifting to a defined contribution plan, under

¹¹Less than one-third of large employers offered retiree health benefits to most retirees in 2000—an 8 percentage point drop since 1997. According to Mercer officials, the percentage of firms offering benefits to most retirees represents firms making these benefits available to employees who were retiring at the time of the survey.

¹²Although these strategies are consistent with those used to control costs for active employees, employers typically pay a much higher portion of premiums for their active workers than for their retirees. According to Mercer's 2000 annual survey, on average, employers paid about two-thirds or more of the premium for active workers compared to about one-third of the premium for retirees.

which an employer directly provides each retiree with a fixed amount of money to purchase coverage, either in the individual market or through a choice of plans offered by the employer. The individual is then responsible for the difference between the employer's contribution and the selected plan's total premium. In addition to the potential cost savings, employers report that a defined contribution plan (1) could be administratively simpler (if the employer simply provided a payment retirees could use to purchase individual coverage) or (2) could allow them to offer retirees a wider choice (if the employer provided multiple plan offerings and retirees could purchase individual coverage as well). Thus far, few employers have adopted a defined contribution approach.¹³

Benefit consultants we interviewed said that many employers would prefer to move toward a defined contribution approach, but noted several issues that would need to be addressed before making such a fundamental change. For example, a recent study by PricewaterhouseCoopers stated that employers are uncertain about (1) the availability of insurance products that would meet their objectives for employee choice with a defined contribution approach, (2) retirees' readiness to assume the responsibility for managing their health benefits, and (3) the potential loss of the existing tax exclusion for the employee if the employer shifts to a defined contribution.¹⁴ Contractual bargaining agreements with union plans and concerns among employees and retirees about major changes in their health benefits have also limited employers' ability to shift to such an approach. Employer consultants also indicated that a defined contribution approach would highlight differences in health benefit costs among employees. Differences in how much an employer pays for an employee's health benefits are not readily apparent with defined benefit plans because

¹³Limited data are available regarding the use of defined contributions by employers for active workers or retirees. A recent Hay Group survey shows that only 8 percent of employers with at least 100 employees pay a fixed amount per employee for retiree health benefits, but this may not in all cases reflect a defined contribution plan unless the employer also allows retirees flexibility in selecting their health plan or allows them to use the employer contribution to purchase an individual insurance policy. See Hay Group, *Benefits Report*, 1999. Another survey, by the Center for Studying Health System Change, found that only 8 percent of employees are paid a fixed employer contribution amount and have a choice of health plans.

¹⁴Some defined contribution strategies may retain the preferential tax treatment afforded to employer-sponsored health insurance. For example, employers could maintain these tax advantages by adopting defined contribution strategies that comply with Section 125 of the Internal Revenue Code, which allows contributions of pretax dollars for health care spending accounts, or in which the employer sponsors a choice of plans.

each employee is offered the same set of benefits at the same premiums. Such differences, however, could become apparent and potentially contentious under a defined contribution approach. For example, if each employee were given the same fixed amount for health insurance, those who were older, less healthy, in need of family coverage, or living in a more expensive area could pay significantly more than other employees to purchase comparable coverage. Alternatively, if employees were given a risk-adjusted fixed amount, those who were older or otherwise more costly would receive a larger payment than would others.

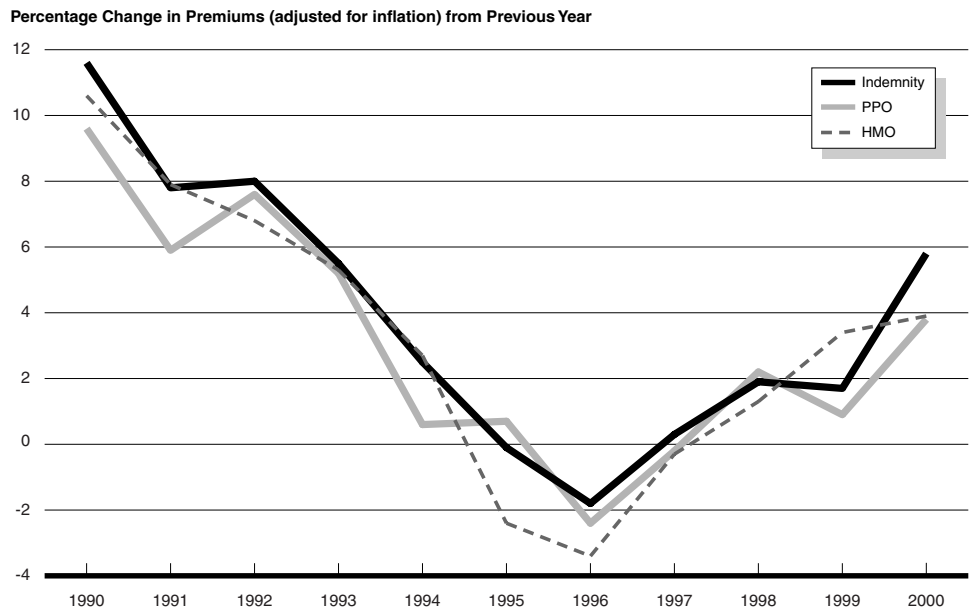
Increasing Cost Pressures and Other Factors May Further Erode Employer-Sponsored Health Coverage

Various factors suggest that an erosion in employer-sponsored retiree health insurance may continue. Most immediately, employers are experiencing the resurgence of inflation in their premium costs and thus could look for ways to further control costs to remain competitive, especially if the slowing of the economy continues. Moreover, if the Medicare program establishes an outpatient prescription drug benefit, some employers may reexamine their need to offer retiree health coverage. In addition, a recent court case validating a claim of age discrimination under federal law could have significant implications for employer-sponsored retiree health coverage. In the longer term, as the number of retirees relative to active workers increases with the aging of the baby boom generation, concerns over employers' retiree health costs are likely to grow.

Rising Health Insurance Premiums and General Economic Factors Could Influence Employers' Offering of Retiree Health Benefits

The resumption of large health insurance premium increases and a general economic slowing could exacerbate the decline in employer-sponsored health insurance for retirees. Survey data suggest that health insurance premiums for employer-sponsored coverage are beginning to rise at an increasing rate, and these increases will likely be reflected in larger future reported liabilities. As shown in figure 3, premium increases were higher than the general inflation rate from 1990 through 1994, but increased less than general inflation from 1995 through 1997. Because the actual level of premium inflation was lower than what had been anticipated for this latter period, some firms reduced their projected FAS 106 liabilities, with some even showing increasing profits as a result of their adjusted liabilities for retiree health benefits. Beginning in 1998, however, premiums began again to rise faster than general inflation and were about 5 percentage points above general inflation in 2000. Premium increases have occurred among all major insurance types, including health maintenance organizations (HMO), preferred provider organizations (PPO), and traditional indemnity plans.

Figure 3: Health Insurance Premium Increases Resume After a Decline in the Mid-1990s



Note: Premium increases were adjusted for general inflation. Trend lines showing the adjusted premium rates below zero indicate that unadjusted premium increases were lower than the general inflation rate.

Source: GAO calculations based on data from KPMG Peat Marwick and Kaiser/HRET employer benefit surveys and the Bureau of Labor Statistics' Consumer Price Index.

The strength of the overall economy may also affect whether employers provide retiree health benefits. Employment remains at near-historic high levels, which could make employers hesitant to reduce employee benefits that potentially could harm their recruitment and retention in a tight labor market. However, if economic growth and employment levels decline, as economic indicators are starting to show, employers may be more willing to reevaluate salary and benefits to determine the combination that is most effective in recruiting and retaining employees.

The strong stock market during the 1990s also provided some employers with high rates of return on pension and other assets that could be used to cover some retiree health benefit costs. ERISA requires employers to prefund their future pension benefit liabilities for retirees, but not their retiree health benefits. Thus, employers are unlikely to have significant investment income to fund retiree health benefits directly. However, some employers have transferred some of the excess pension assets generated by investment earnings to finance their retiree health benefits. This option

to finance retiree health benefits could be curtailed as the rising stock market seen in the 1990s levels off. Further, recently proposed Internal Revenue Service regulations that clarify employers' ability to transfer surplus assets from a defined benefit pension plan to a retiree health benefit plan would prevent an employer that does so from subsequently significantly reducing the number of retirees covered or the cost of such coverage.¹⁵

Medicare Changes Are Likely to Influence Employer-Sponsored Retiree Health Coverage

Recent and proposed changes to Medicare are also leading employers to reexamine their design of retiree benefits that supplement Medicare. Notable developments include withdrawals of health plans participating in the Medicare+Choice program and proposals to add prescription drug coverage to Medicare. A Medicare prescription drug benefit could significantly lower the cost of providing retiree health coverage, but may affect employers' interest in doing so. Prescription drugs are typically the largest component of costs for employer-sponsored retiree health benefits for Medicare-eligible enrollees.

The recent withdrawals of some health plans participating in Medicare+Choice could affect some employers that had anticipated savings in their retiree health benefit costs and had encouraged employees to join these plans. Medicare+Choice plans typically offer health benefits that are not available through traditional Medicare but are generally included in employer-sponsored Medicare supplemental coverage, such as prescription drugs and reduced cost sharing. Furthermore, many Medicare+Choice plans have historically charged enrollees small or no premiums. The 2000 Mercer survey indicates that 43 percent of large employers that provide retiree health coverage offer a Medicare+Choice HMO, and that 11 percent of Medicare-eligible retirees are enrolled in one of these plans.¹⁶ Some employers encouraged employees to enroll in Medicare+Choice plans by lowering their premium contributions or enhancing benefits. However, benefit consultants we interviewed report that some employers are concerned about recent Medicare+Choice plan premium increases and withdrawals. Mathematica Policy Research, Inc., reports that Medicare+Choice premiums more than doubled from an

¹⁵These proposed regulations were published in the *Federal Register* on Jan. 5, 2001, 66 FR 1066.

¹⁶For comparison, the Mercer survey reports that for large employers, 19 percent of pre-Medicare-eligible retirees and 34 percent of active workers are enrolled in HMOs.

average of \$6 per enrollee per month in 1999 to \$14 in 2000 and are expected to increase further in 2001.¹⁷ Since 1999, more than 200 plans have fully terminated their Medicare+Choice contracts, reduced their service areas, or announced plans to reduce their participation in 2001.¹⁸ As Medicare+Choice plans drop out of the market, some employers are left to find alternative coverage for retirees for whom they had promised benefits.¹⁹

The effects of a Medicare prescription drug benefit, if enacted, are less certain but potentially significant. More than 40 percent of Medicare beneficiaries had prescription drug coverage from a private supplemental plan in 1996, and three-quarters of them received this prescription drug coverage from employer-sponsored plans. According to benefit consultants' reports and some employers we interviewed, prescription drugs typically represent 40 to 60 percent of employers' retiree health costs for Medicare-eligible enrollees and have been the fastest-growing element of health costs, increasing by 17 percent or more during the last year. Thus, adding a prescription drug benefit to Medicare could lower or make more predictable employers' costs, encouraging some employers to retain retiree health benefits. Conversely, the enhanced Medicare benefit could reduce the value employees place on employer-sponsored retiree health benefits, making it easier for employers to reduce or eliminate coverage.

Benefit consultants and recent studies indicate that employers' responses to Medicare coverage of prescription drugs could vary depending on the

¹⁷Amanda Cassidy and Marsha Gold, *Medicare+Choice in 2000: Will Enrollees Spend More and Receive Less?* (Mathematica Policy Research, Inc., July 2000, p. 9). For 2001, initial plan submissions to the Health Care Financing Administration (HCFA) indicate a further increase in Medicare+Choice premiums to an average \$25 per enrollee per month. However, these 2001 initial premiums could be reduced when HCFA releases revised premiums and benefit designs as resubmitted by plans to reflect changes required by H.R. 5661, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

¹⁸*Medicare+Choice: Plan Withdrawals Indicate Difficulty of Providing Choice While Achieving Savings* (GAO/HEHS-00-183, Sept. 7, 2000).

¹⁹For example, one large employer we interviewed indicated it had encouraged eligible retirees to enroll in Medicare+Choice plans by providing outreach and educational information informing them of the potential benefits of these plans. This employer had as many as 19 percent of its Medicare-eligible retirees enrolled in Medicare+Choice plans, but recent plan withdrawals have reduced the share of retirees participating in these plans to less than 10 percent.

prescription drug benefit design implemented, for example, the coverage limits that are included and beneficiary cost sharing that would be required. One study evaluating two general proposals estimated that employers would have significant cost savings and likely would retain supplemental prescription drug coverage for retirees to complement an outpatient prescription drug benefit.²⁰ However, any savings that might actually be realized are dependent on the design features that Congress ultimately enacts and employers' and beneficiaries' responses.

Recent Court Decision May Prompt Employers to Reevaluate Their Retiree Health Benefits

According to employer benefit consultants, an August 2000 court ruling raises concern among some employers and could potentially accelerate the decline of retiree health benefits, although its actual effect is uncertain at present. The Third Circuit Court of Appeals, which has jurisdiction for Pennsylvania, New Jersey, Delaware, and the Virgin Islands, held that Medicare-eligible retirees have a valid claim of age discrimination under the Age Discrimination in Employment Act (ADEA)²¹ when their employers provide them with health insurance coverage inferior to that provided to retirees not yet eligible for Medicare. In this case, Erie County, Pennsylvania, had offered Medicare-eligible retirees an HMO under contract with Medicare that had several features that were more restrictive than the point-of-service plan available to those retirees not yet Medicare-eligible, including a more limited choice of physicians and required primary care physician authorization for medical services. The Third Circuit decided that Medicare-eligible retirees were treated differently because of age but Erie County might not be in violation of the ADEA if the health plans provided to Medicare-eligible retirees are equal in either benefits or costs to the plans offered to retirees under age 65.²² The Third Circuit has sent the case back to the District Court for it to determine whether the county's treatment of pre- and post-age 65 retirees, under their respective plans, meets either the equal cost or equal benefit requirement under ADEA.

²⁰See Hewitt Associates, LLC, *The Implications of Medicare Prescription Drug Proposals for Employers and Retirees*, Kaiser Family Foundation, July 2000, pp. 4-8.

²¹29 USC 621-633a. ADEA prohibits employers from discriminating against individuals age 40 or older with respect to compensation, terms, conditions, or privileges of employment.

²²*Erie County Retirees Association v. County of Erie*, 220 F.3d 193 (3d Cir. 2000) cert. denied, 69 U.S.L.W. 3409 (U.S. Mar. 5, 2001) (No. 00-906).

The implications of the Erie County decision for other employers remain uncertain. While only about 12 percent of employers offering retiree health coverage enroll Medicare-eligible enrollees in an HMO—the issue raised in the *Erie* decision—many other employers make further distinctions between the health benefits provided to their retirees based on their eligibility for Medicare. Also, some employers provide retiree health benefits only for early retirees and not for Medicare-eligible retirees. Some benefit consultants have said that this decision, if adopted by other federal courts, could lead some employers to make changes to their retiree health benefits so that benefits for Medicare-eligible retirees are no more restrictive than those offered other retirees, in some cases further eroding the level of employer-sponsored retiree health benefits. These changes could include eliminating retiree health benefits; reducing benefits to the lowest common level for all retirees; offering a Medicare supplemental plan that, combined with the traditional Medicare program, is at least as generous as benefits provided to pre-Medicare-eligible retirees; or paying retirees the same defined contribution to purchase retiree health coverage whether or not they are Medicare-eligible.

In the past, retiree benefit litigation has not focused on age discrimination, but on employers' ability to modify or terminate retiree health benefits. Since ERISA provides employers considerable flexibility to manage the cost, design, and extent of health care benefits they provide, federal courts have generally ruled in favor of the employer when challenged over termination of the plan or changes in retiree health benefits if the employer had included the right to change benefits in plan documents or collective bargaining agreements. Nearly all companies reserve the right in plan documents to modify health benefits for current and future retirees. See appendix II for an overview of the case law history regarding retiree health benefits.

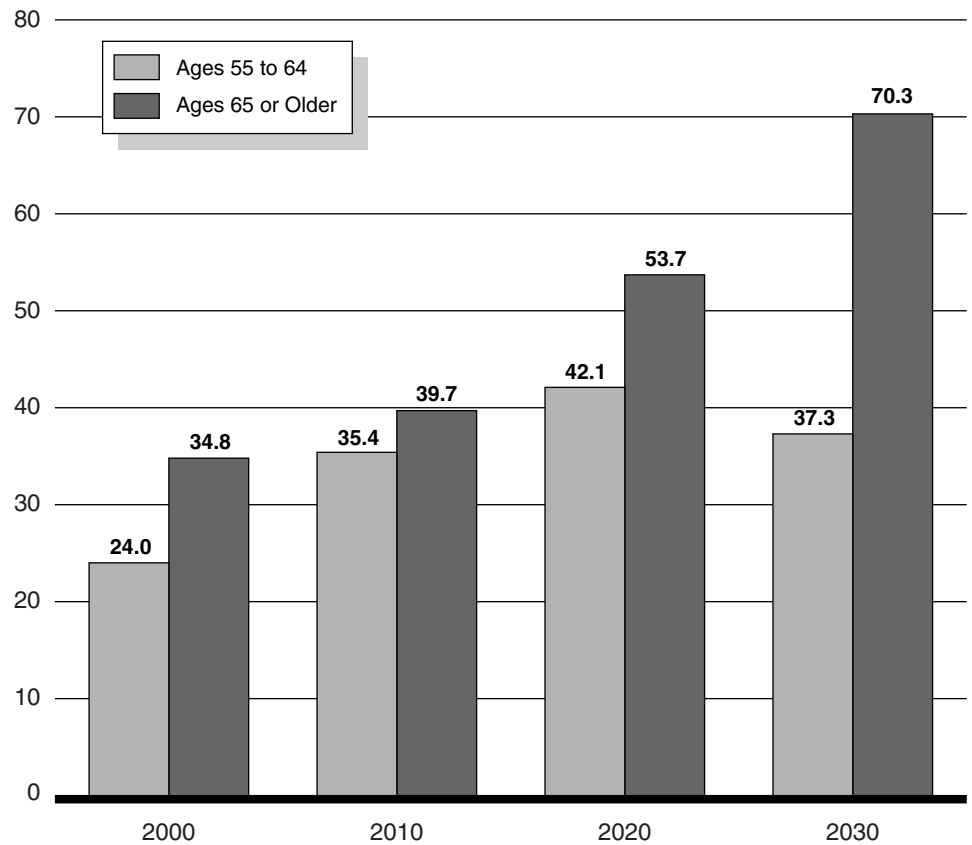
Aging of Baby Boom Generation Could Further Pressure Employers to Reduce Retiree Health Benefits

Over the next 30 years, both the number and proportion of Americans potentially affected by a decline in employer-sponsored retiree health insurance will increase, whether or not additional employers drop this coverage. Elderly and near-elderly individuals together will represent more than one-fourth of the population of the United States in the year 2011—the year when the first of the baby boomers will turn 65 years old—compared to one-fifth of the current population. As shown in figure 4, the number of near-elderly individuals will increase by 75 percent by 2020, and the number of elderly will double by 2030. Thus, employers will not only have a larger number of retirees for which to potentially provide health coverage, but comparatively fewer active workers to subsidize these

benefits. This declining base of productive workers to support more retirees could make it more difficult for many employers to maintain retiree health benefits.

Figure 4: Baby Boom Generation Will Greatly Increase the Elderly and Near-Elderly Population

Number of Individuals Ages 55 to 64 and 65 or Older (in Millions)



Source: U.S. Census Bureau, "Projections of the Total Resident Population by 5-Year Age Groups and Sex With Special Age Categories: Middle Series," selected years 2000 to 2030, January 2000.

Loss of Employer Coverage Can Have Significant Implications for Certain Retirees

Federal laws guarantee access to coverage to certain individuals who lose group coverage. However, the coverage options available to retirees whose former employers reduce, eliminate, or did not offer health coverage may be limited. Affected retirees may seek to purchase coverage on their own as individuals—either an individual insurance market product for those under 65 or a Medicare supplemental plan for those 65 or older. However, depending on their demographic characteristics and health status, retirees may encounter difficulty obtaining or affording comprehensive plans.

Federal Laws Provide Some Protections to Retirees But Their Impact May Be Limited

Although federal laws, such as COBRA and HIPAA, guarantee some individuals leaving employer-sponsored group health plans access to continued coverage or to a product in the individual market, these laws may offer only limited protections to many retirees that lack access to employer-sponsored health benefits. Individuals whose jobs provided health benefits that ended at retirement may continue temporary coverage for up to 18 months under COBRA, but COBRA may be an expensive alternative because the employer is not required to pay any portion of the premium. Also, COBRA coverage is generally not available to individuals whose employers terminate health insurance after they retire.

Likewise, HIPAA's group-to-individual portability provision guarantees access to at least two individual insurance policies, regardless of health status and without exclusions, to eligible individuals leaving group coverage. States comply with this provision by using either the federal rules—which require carriers to guarantee access to certain insurance policies to eligible individuals—or an alternative mechanism. Under an alternative mechanism, states may, within broad federal parameters, design other approaches, such as a state high-risk pool, to provide eligible individuals with a choice of coverage.²³ Depending on the approach taken by states to comply with HIPAA and the extent to which a state restricts premium rate variation in the individual market, the premiums these individuals face may be substantially higher than prices charged to healthy or younger individuals, and may be cost prohibitive to many retirees.

²³In *Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards* (GAO/HEHS-99-100, May 12, 1999), we reported that 12 states were operating under the federal rules and 38 were using an alternative mechanism. Of the 38 using an alternative mechanism, 22 were using a high-risk pool to provide coverage to these eligible individuals. Also see *Implementation of HIPAA: State-Designed Mechanisms for Group-to-Individual Portability* (GAO/HEHS-98-161R, May 20, 1998).

Although these laws are limited in the protections they afford individuals without access to employer-sponsored health benefits, they may facilitate the transition of some retirees from employer-based coverage to coverage in the individual market.

Alternative Coverage May Be Limited, Unavailable, or Unaffordable to Retirees Whose Employers Eliminated Health Benefits

Although federal law provides some retirees with guaranteed access to certain coverage, others may encounter difficulty obtaining or affording coverage, especially since health insurance carriers often consider a retiree’s health status in making coverage decisions, and many retirees report poorer health. Near-elderly and elderly individuals are the most likely to report fair or poor health of any age group. The CPS indicates that more than one-fifth of near-elderly and one-third of elderly individuals reported fair or poor health in 1999, compared to about 14 percent of 45- to 54-year-olds. Moreover, as shown in table 1, the retired among these populations were more likely to report poorer health status than those who were employed.

Table 1: Percentage of Elderly and Near-Elderly Individuals Reporting Fair or Poor Health Status by Employment Status, 1999

Age	Percentage reporting fair or poor health	
	Employed	Retired
55-64	11.3	21.7
55-61	10.6	19.7
62-64	14.5	23.7
65+	17.7	35.3
65-74	17.0	30.0
75+	20.0	40.2

Source: GAO Analysis of March 2000 Current Population Survey.

For retirees under 65, the individual insurance market, on which about 7 percent of the near-elderly population relied for their primary source of coverage in 1999, may be an option for some individuals until they reach Medicare eligibility. However, in most states, access to the individual market is not guaranteed, and individuals may encounter difficulty obtaining comprehensive plans at affordable prices, or any plans at all. The problems in purchasing plans may be exacerbated because retirees who lose employer-sponsored coverage and individually purchase private health insurance become responsible for the entire premium rather than the share they paid for employer-sponsored coverage. Further, except for some self-employed persons and certain individuals with medical expenses exceeding 7.5 percent of adjusted gross income, the federal tax

code offers no subsidies for the individual purchase of private health insurance.²⁴

Unlike the employer-sponsored market, where the price for coverage is based on the risk characteristics of the entire group, premium prices in the individual markets of most states are based on characteristics of each applicant, such as age, gender, geographic area, tobacco use, and health status. Even for persons with similar health, premium prices can vary significantly. For example, carriers anticipate that the likelihood of requiring medical care increases with age. Consequently, individuals between 55 and 64 in the individual market of most states pay considerably more than a 30-year-old for the same coverage. For group policies, older individuals usually pay the same amount as younger members of the group. Table 2 demonstrates the difference in premiums charged by carriers we contacted to applicants based solely on age for the same comprehensive health plan.

Table 2: Examples of Differences in Premiums for a 30-Year-Old and a 60-Year-Old Male

	Deductible (plan type)	Monthly premium, 30-year-old	Monthly premium, 60-year-old
Carrier A (Arizona)	\$250 (indemnity)	\$162	\$512
Carrier B (Illinois)	\$500 (PPO)	\$116	\$439
Carrier C (Colorado)	\$0 (HMO)	\$132	\$324

Note: Although the range in prices listed represents differences attributable to age only, each of these carriers varies its rates for other characteristics as well. In addition to adjustments for differences in age, Carrier A also varies rates for gender, geographic area, and family size; Carrier B for gender, geographic area, tobacco use, and family size; and Carrier C for family size.

Source: GAO review of premiums from selected carriers.

About 20 states have passed legislation that limits the amount individual market carriers can vary premium rates or the characteristics they may use to vary these rates, but substantial variation exists among these states. For example, Minnesota allows individual market carriers to vary premiums for differences in individual characteristics such as occupation, age, and geographic area; New Hampshire allows carriers to modify premium rates only for differences in age; and New Jersey does not allow

²⁴The federal tax code also does not provide subsidies to individuals who purchase COBRA continuation coverage.

carriers to vary rates on the basis of any individual characteristics.²⁵ In states where no restrictions apply, a carrier may also engage in medical underwriting, whereby it evaluates the health status of applicants to determine whether it will charge a higher premium rate, exclude an existing health condition from coverage, or deny coverage altogether. For example, individuals with serious health conditions such as heart disease are almost always denied coverage. Other, non-life-threatening conditions, such as chronic back pain, may also be excluded from coverage. In contrast, under a group plan, individuals with these conditions could not be denied coverage nor be required to pay a higher premium than others in the plan, and specific conditions could only temporarily be excluded from coverage. Table 3 provides examples of how several large individual market carriers treat non-HIPAA-eligible individuals with certain health conditions in states that do not prohibit medical underwriting.

Table 3: Examples of Specific Health Conditions for Which Carriers May Decline Coverage or Exclude From Coverage

Conditions for which an applicant may be denied coverage altogether	Conditions that may be explicitly excluded from an applicant's coverage
Alzheimer's disease	Asthma
Diabetes	Glaucoma
Hypertension	Impotence
Migraine headaches	Parkinson's disease
Rheumatoid arthritis	Ulcers

Source: GAO review of selected carriers' medical underwriting practices.

Federal law provides certain guarantees to ensure that retirees over 65 have access to Medicare supplemental policies in the event that an employer eliminates or reduces coverage; however, the coverage alternatives available to these individuals may be limited, less

²⁵See *Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year-Olds* (GAO/HEHS-98-133, June 1, 1998) and *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs* (GAO/HEHS-97-8, Nov. 25, 1996).

comprehensive, or more expensive.²⁶ For example, a retiree over 65 receiving supplemental coverage through a typical private, employer-sponsored plan may receive coverage for a number of benefits, including prescription drugs. If the employer eliminated this coverage, the affected retiree could seek to purchase alternative coverage on his or her own through the Medigap market. However, under federal law, these individuals would be guaranteed access without medical underwriting to only 4 of the 10 standardized Medigap policies available in most states.²⁷ None of these four plans includes prescription drug coverage. Access to other Medigap plans, including those with limited prescription drug coverage, could depend on the retiree's health and the carrier's willingness to offer coverage.²⁸ Thus, retirees could end up with less comprehensive coverage than they received from their former employers.

Further, in cases where the employer had contributed to the majority or all of the cost of the Medicare-eligible retiree's health plan, the retiree will be responsible for the full premium price. Retirees who had obtained employer-sponsored coverage through a Medicare+Choice plan could potentially face similar challenges in terms of limited choice and coverage and higher costs in the event that health plans were no longer available, such as when a Medicare+Choice plan withdraws from the market. Regardless of how they lose their employer-sponsored coverage,

²⁶Federal Medigap protections include "guaranteed issue" rights, which provide certain individuals access to a limited number of Medigap products at a time other than when they are first eligible for Medicare. For example, individuals are eligible for at least four Medigap plans if their employer eliminates retiree benefits, or if their managed care plan or traditional Medicare plan provider leaves the program or stops serving their area, provided they apply for coverage no later than 63 days after their health coverage ends. Depending on the state and the health status of the applicant, carriers may choose to offer more than these four plans to qualified individuals. In addition to these federal protections, 21 states provide for additional Medigap protections, according to HCFA's *2000 Guide to Health Insurance for People with Medicare*.

²⁷The standardized plans, called A through J, differ in the benefits they provide. For example, plan A provides basic (core) benefits, whereas plans H, I, and J provide more comprehensive benefits, including limited prescription drug coverage. (See appendix III for a description of the Medigap benefits included in some standardized plans.) Massachusetts, Minnesota, and Wisconsin are exempt from providing the standard plans because they standardized their Medigap policies prior to the establishment of the federal standardized plans A through J.

²⁸Moreover, Medigap prescription drug coverage is limited. For example, after an individual pays a \$250 deductible, plans H and I cover 50 percent of prescription drug costs up to a maximum of \$1,250 per year. Plan J offers a somewhat more extensive prescription drug benefit; after an enrollee pays the \$250 deductible, the plan covers 50 percent of prescription drug costs up to a maximum of \$3,000 per year.

purchasing Medigap coverage may be a costly alternative for many retirees. Table 4 shows examples of premiums for several popular Medigap plans in selected states.²⁹

Table 4: Sample Monthly Premiums for a 65-Year-Old for Three Medigap Plans in Four Areas

	Plan C	Plan F	Plan H
Chicago, Illinois	\$85	\$94	Not offered
Tampa, Florida	\$117	\$129	\$170
North Carolina (statewide)	\$112	\$100	\$152
Denver, Colorado	\$129	\$135	\$175

Note: The cost of Medigap policies varies considerably among carriers, although the benefits are identical. We obtained premium prices for Medigap policies from one of the largest Medigap carriers in each state, according to state insurance department representatives. The cited rates were applicable in 2000 for all places but Tampa, Florida, where the rates were effective as of December 1999.

Plan F is the most popular Medigap plan. According to data from the National Association Insurance Commissioners, plans C and F together represent over 60 percent of all Medigap sales. Plan H is one of the three standardized plans that include a limited prescription drug benefit. Under the federal Medigap special enrollment rules, eligible individuals have guaranteed access to four plans, including plans C and F. In contrast, access to plan H may be subject to medical underwriting.

Source: GAO review of Medigap premiums obtained from state insurance departments.

Concluding Observations

Premium increases and forecasts for a potential economic slowdown could pose concerns for many employers and may make employer-sponsored benefits vulnerable to further erosion. In the longer term, these factors, coupled with the potential for Medicare reforms and an increasing number of aging baby boomers, may produce even more uncertainty and cost pressures for employers. Consequently, as the number of retirees without employer-based coverage increases, retirees, particularly those in poorer health, may encounter difficulty finding affordable alternative health coverage.

Agency Comments

We provided a draft of this report to the Department of Labor and several expert reviewers for comments. The reviewers provided technical comments that we incorporated as appropriate.

²⁹A HCFA official said that Medicare requires all carriers participating in the Medigap market to offer plan A. In addition to plan A, carriers can opt to provide any combination of the remaining nine supplemental policies. For nationwide examples of Medigap premiums, see *Medigap: Premiums for Standardized Plans That Cover Prescription Drugs* (GAO/HEHS-00-70R, Mar. 1, 2000).

As agreed with your office, unless you announce the report's contents earlier, we plan no further distribution of it until 30 days after its issue date. We will then send copies to the Honorable Elaine Chao, Secretary of Labor; the Honorable Michael McMullan, Acting Administrator of the Health Care Financing Administration; and other interested congressional committees and members and agency officials. We will also make copies available to others on request.

Please call me at (202) 512-7118 if you have any questions. Another contact and major contributors are listed in appendix IV.

Sincerely yours,



Kathryn G. Allen
Director, Health Care— Medicaid
and Private Health Insurance Issues

Appendix I: Methodology

In conducting our study, we reviewed available employer survey data, analyzed the March supplements of the Census Bureau's 1995 to 2000 Current Population Survey, reviewed applicable laws and court decisions pertaining to changes in employer-sponsored coverage, obtained individual insurance market premiums from carriers, and interviewed employee benefit consulting firms and several large employers. We conducted our work from June 2000 through February 2001 in accordance with generally accepted government auditing standards.

Surveys on Employer-Sponsored Retiree Health Insurance

For information on the extent to which employers offer health coverage to retirees as well as the conditions under which coverage is made available, we relied on private employer benefit surveys, specifically those of (1) the Health Research and Educational Trust (HRET) sponsored by the Kaiser Family Foundation (and formerly produced by KPMG Peat Marwick) and (2) William M. Mercer, Incorporated (which were formerly produced by Foster Higgins). These surveys have more current or comprehensive information on retiree health benefits than do existing surveys conducted by the federal government. Also, these surveys are distinguished from a number of other private ones not only by their content but also by their large random samples, which allow their results to be generalized to a larger population of employers. Neither survey, however, reports sufficient information about its sampling errors to determine the precision of its estimates, although the Kaiser/HRET survey notes that year-to-year changes in the percentage of employers offering retiree health benefits have not been significant since 1998.

The Kaiser/HRET surveys are based on samples of employers with three or more employees selected from a Dun and Bradstreet list of private and public employers. For some retiree health benefit questions, the Kaiser/HRET survey limits its reported data to employers with 200 or more employees. The Kaiser/HRET surveys' sample size was about 1,800 in 1993 and 1,887 in 2000, with response rates of 55 percent and 45 percent, respectively (see table 5 for additional information on the Kaiser/HRET sample by firm size).

Table 5: 2000 Kaiser/HRET Sample by Firm Size

Firm size	Sample size
Fewer than 200 employees	843
200 to 999 employees	363
1,000 to 4,999 employees	367
5,000 or more employees	314

Source: Kaiser/HRET Employer Health Benefits, 2000 Annual Survey.

The Mercer/Foster Higgins surveys are based on samples of employers with 10 or more employees selected from the Dun and Bradstreet database for private firms and the Census of Governments for government agencies. For some retiree health benefit questions, the Mercer survey limits its reported data to employers with 500 or more employees. The Mercer survey’s sample size was about 3,676 in 1993, with a response rate of 78 percent. In 2000, Mercer’s database contained 2,797 responses from its random sample—a response rate of about 50 percent.

Current Population Survey

We relied on the Census Bureau’s March supplement of the Current Population Survey (CPS) for information on the demographic characteristics of retirees and their access to insurance. The survey is based on a sample designed to represent a cross-section of the nation’s civilian noninstitutional population. In March 2000, about 60,000 households were sampled for the survey, and about 47,000 of them, containing approximately 94,000 persons 15 years of age or older, were interviewed. The total response rate for the 2000 CPS March supplement was about 86 percent.

Because the CPS is based on a sample, any estimates derived from the survey are subject to sampling errors. A sampling error indicates how closely the results from a particular sample would be reproduced if a complete count of the population were taken with the same measurement methods. To minimize the chances of citing differences that could be attributable to sampling errors, we highlight only those differences that are statistically significant at the 95 percent confidence level.

The following provides more detail on how some of the CPS questions are phrased and how the responses are categorized, including some clarifications and limitations.

Insurance Status

The CPS asks whether a respondent was covered by employer/union-sponsored, Medicare, Medicaid, private individual, or certain other types of health insurance in the last year. Thus, the 2000 CPS asked what coverage an individual might have had in 1999. Until recently, individuals were not asked directly whether they were uninsured, but were deemed to be so if they denied having any of the above sources of coverage. As a result, the CPS is believed to have slightly overestimated the number of people who are uninsured. Beginning in 2000, the CPS insurance questions are being revised so that individuals who report no health insurance are specifically asked if they are uninsured; however, the Census Bureau has not yet reported the responses to this question.

Another limitation to the CPS insurance questions is that they do not ask how long an individual had each source of insurance or whether the individual was covered through any source(s) at the time of the interview. Thus, the CPS considers a person to be insured even if he or she was covered for only 1 day in the past year, and regardless of whether the person was insured on the day of the interview. However, some individuals may respond with their current insurance status rather than their coverage for the past year.

Because some people may receive coverage from several sources, we prioritized the source of insurance individuals reported to avoid double counting. That is, if individuals reported having coverage from two or more kinds of insurance, we assigned them to one type based on a hierarchy. Specifically, employer-sponsored coverage was considered primary to other sources of coverage for individuals less than 65 years of age, and respondents were classified as having employer-sponsored coverage even if they also had other types of coverage. The other types of health insurance were prioritized in the following order: Medicare, Medicaid, military/veterans, and individual insurance. For people 65 years of age or older, we first determined whether an individual had Medicare and then prioritized any remaining coverage in the following order: employer-sponsored, Medicaid, military/veterans, and individual insurance.

The CPS also asks whether employer-sponsored insurance is provided “in their own name” or as a dependent of another policyholder. We primarily focused on whether retired individuals had employer-sponsored health insurance coverage in their own names because this coverage can most directly be considered retiree health coverage from a former employer.

Employment Status

The CPS questions that we used for employment status are similar to those on insurance status. Respondents are considered employed if they worked at all in the past year and not employed only if they did not work at all during the past 12 months.

Legal Review

We reviewed applicable laws and court decisions pertaining to changes in employer-sponsored coverage. Appendix II presents additional information on the results of this review.

Insurance Premiums

We contacted health insurance carriers in certain states with limited rating restrictions to obtain premiums for individual market policies available to applicants who were 30 and 60 years old. Similarly, we contacted several state insurance departments to obtain premium prices of Medigap policies available to eligible individuals. From carriers, we also obtained information on the kinds of health conditions that may be excluded from coverage or for which an applicant may be denied coverage altogether.

**Interviews With
Employee Benefit
Consulting Firms and
Employers**

For additional information on current and prospective changes to employer-sponsored retiree health benefits, we interviewed and obtained documents from several global employee benefits consulting firms. In addition, we contacted selected large employers for information on the kinds of changes they had made to their retiree health benefits as well as the factors that had led to these changes.

Appendix II: Case Law Review of Changes to Employer-Sponsored Retiree Health Benefits

Although employers often provide health benefits to retirees, they are not required to do so. However, employers that provide retiree health benefits are responsible for acting consistent with certain administrative and fiduciary requirements established by the Employee Retirement Income Security Act of 1974 (ERISA). In most retiree health benefit litigation, retirees have sought to restore health benefits that have been reduced or eliminated by alleging that the employer breached representations made about the quality, extent, and duration of retiree health benefits. Courts generally have ruled that an employer can modify or terminate health care benefits provided to retirees if the employer specifically had reserved that right in health benefit documents or collective bargaining agreements. A recent Third Circuit Court decision, which focused on whether differences in health benefits provided to Medicare-eligible retirees and retirees not yet eligible for Medicare violated the Age Discrimination in Employment Act (ADEA), could influence employer decisions on whether to continue retiree health benefits.

ERISA Standards Applicable to Retiree Health Plans

Employer-sponsored retiree health benefits are considered welfare benefits under Title I of ERISA.¹ To ensure a uniform federal law governing employee benefit plans,² ERISA generally preempts all state law as it may pertain to employee benefit plans covered under its jurisdiction.³

Under ERISA, private employers who choose to provide retiree health benefit plans must give plan participants and beneficiaries a summary plan description (SPD) describing their rights and obligations, and are responsible for acting consistently with certain administrative and fiduciary requirements. The SPD, which must be written in a manner intended to be understood by the average plan participant, specifies retirees' rights and the circumstances under which the health plan can be modified or terminated. In addition, ERISA establishes fiduciary standards to protect employee benefit plan participants and beneficiaries from plan mismanagement. Generally, these standards require fiduciaries to act with the care, skill, and diligence of a prudent person in protecting plan participants and beneficiaries.

¹29 U.S.C. 1001-1191c.

²Under ERISA, employee benefit plans can be pension plans or welfare plans. Welfare plans are specifically exempt from vesting requirements to which pension plans are subject. 29 U.S.C. 1051(1).

³29 U.S.C. 1144.

Employers' Rights to Modify or Terminate Health Benefits

Federal courts generally have ruled that an employer can modify or terminate retiree health care benefits based on the fact that the employer specifically had reserved that right in health benefit documents or collective bargaining agreements.⁴ Challenges to maintain or restore these benefits largely have been unsuccessful.⁵

Generally, retirees cannot rely on oral communications or representations that benefits would be maintained for life or without reduction.⁶ ERISA requires that every plan be established and maintained under a written instrument.⁷ Thus, courts look to plan documents including the terms of the SPD to determine if the plan precludes an employer from modifying or terminating benefits. Courts, however, are divided on whether the reservation clause must be contained in the SPD. Several courts have held that, inasmuch as the SPD is an employee's primary source of information regarding employment benefits, employees are entitled to rely on the descriptions in the summary.⁸ However, at least one appellate court has ruled that an employer reserved the right to amend or terminate health

⁴See, e.g., *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (Employers "are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.")

⁵Some courts, however, have recognized exceptions for fraud or misrepresentation. Challenges to salaried retiree health benefits modifications are brought exclusively under section 502(a)(1)(B) of ERISA, 29 U.S.C. 1132(a)(1)(B).

⁶In *re Unisys Corp. Retiree Medical Benefits ERISA Litigation*, 58 F.3d 896, 902 (3d Cir. 1995) ("the written terms of the plan documents control and cannot be modified or superseded by the employer's oral undertakings"), *cert. denied sub nom Unisys Corp. v. Pickering*, 517 U.S. 1103 (1996).

⁷29 U.S.C. 1102(a)(1); *Musto v. American General Corp.*, 861 F.2d 897, 910 (6th Cir. 1988) ("we are quite certain that Congress, in passing ERISA, did not intend that participants in employee benefit plans should be left to the uncertainties of oral communications in finding out precisely what rights they were given under their plan"), *cert. denied*, 490 U.S. 1020 (1989).

⁸*Barker v. Ceridian Corp.*, 193 F.3d 976, 983 (8th Cir. 1999) ("Where the formal plan and summary plan description conflict, the employer is bound by the summary plan description."), *cert. denied*, 120 S. Ct. 1963 (2000); *Helwig v. Kelsner-Hayes Co.*, 93 F.3d 243 (6th Cir. 1996); *cert. denied*, 519 U.S. 1059 (1997); *Pierce v. Security Trust Life Ins. Co.*, 979 F.2d 23, 27 (4th Cir. 1992).

benefits if the reservation clause is in other plan documents, even if it is not mentioned in the SPD.⁹

Retirees receiving health benefits under collective bargaining agreements have fared only slightly better than salaried retirees in litigation.¹⁰ Absent a finding that the parties intended that the health benefits were to be maintained for the retiree's life or some period beyond the expiration of the agreements, courts generally view these benefits as ending at the expiration of the agreements.

In one of the earliest collectively bargained contract cases, *UAW v. Yard-Man, Inc.*,¹¹ the court noted that any right to lifetime benefits must be based on the contract. The contract contained the promise that the company will provide insurance to retired employees, which reasonably could be construed either as a reference to the nature of retiree benefits or as creating a benefit continuing beyond the life of the agreement. The court resolved the ambiguity by looking to other provisions of the collective bargaining agreement for evidence of intent and an interpretation in accord with the entire document. From that examination, the court concluded that the parties had intended to create insurance benefits that continued beyond the life of the collective bargaining agreement.¹²

The court noted that retiree benefits were permissive not mandatory subjects of collective bargaining, and that "it is unlikely that such benefits, which are typically understood as a form of delayed compensation or reward for past services, would be left to the contingencies of future negotiations." The court characterized retiree health benefits as "status"

⁹*Sprague v. General Motors Corp.* 133 F.3d 388, 400 (6th Cir. 1998) ("Not all of the summaries clearly stated that GM could amend or terminate the plan. But the failure to allude to this power in some of the booklets did not prejudice GM's right, clearly stated in the plan itself, to change the plan's terms"), *cert. denied*, 524 U.S. 923 (1998).

¹⁰Typically, litigation by former union employees receiving retirement health benefits has been filed under section 301 of the Labor Management Relations Act, 29 U.S.C. 185, and section 502(a)(1)(B) of Title I of ERISA, 29 U.S.C. 1132(a)(1)(B).

¹¹716 F.2d 1476 (6th Cir. 1983), *cert. denied*, 465 U.S. 1007 (1984).

¹²*Id.* At 1479-81.

benefits carrying with them “an inference that they continue so long as the prerequisite status is maintained.”¹³

The Yard-Man case served to spur some, but not all, courts into concluding that collective bargaining agreement language that appeared to require the continuation of retiree health benefits should require employers to provide those benefits.¹⁴ The First, Fourth, Sixth, and Eleventh Circuits have followed the “inference” standard first articulated in Yard-Man.¹⁵ The Fifth Circuit has questioned the inference.¹⁶ The Eighth Circuit has rejected the inference that employees engaged in collective bargaining are forgoing wages in consideration for retiree health benefits.¹⁷ The Seventh Circuit has also rejected the inference altogether, observing that the courts in this circuit do not distinguish between collective bargaining agreements and ERISA plans for this purpose.¹⁸

Claims of some retirees that modification or termination of their retiree health benefits constitutes a breach of fiduciary duty have, by and large, been denied.¹⁹ However, the Supreme Court articulated a standard for fiduciary liability in certain limited instances, finding that an employer

¹³*Id.* At 1482.

¹⁴*United Steelworkers of America v. Connors Steel Co.*, 855 F.2d 1499 (11th Cir. 1988), *cert. denied*, 489 U.S. 1096 (1988); *Policy v. Power Pressed Steel Co.*, 770 F.2d 609 (6th Cir. 1985), *cert. denied*, 475 U.S. 1017 (1986).

¹⁵See *United Steelworkers v. Textron, Inc.*, 836 F.2d 6 (1st Cir. 1987; *Keffer v. H.K. Porter Co.*, 872 F.2d 60 (4th Cir. 1989); *Golden v. Kelsey-Hayes Co.*, 73 F.3d 648 (6th Cir. 1996); *Smith v. ABS Industries, Inc.*, 890 F.2d 841 (6th Cir. 1989); *United Steelworkers of America v. Connors Steel*, 855 F.2d 1499 (11th Cir. 1988)).

¹⁶*United Paperworkers International Union v. Champion International Corp.*, 908 F.2d 1252, 1261 n. 12 (5th Cir. 1990) (“we find no basis in logic or federal labor policy for such a broad inference.”) See also *International Association of Machinists v. Masonite Corp.*, 122 F.3d 228, 231 (5th Cir. 1997).

¹⁷In *Anderson v. Alpha Portland Industries, Inc.*, the court concluded that retiree health and life insurance benefits were not vested for the lifetime of the retiree, but were intended to last only for the duration of the collective bargaining agreement. 836 F.2d 1512, 1517 (8th Cir. 1988), (“We believe that it is not at all inconsistent with labor policy to require plaintiffs to prove their case without the aid of gratuitous inferences.”) *cert. denied* sub nom, *Anderson v. Slattery Group, Inc.*, 489 U.S. 1051 (1989).

¹⁸*Rosetto v. Pabst Brewing Company, Inc.*, 217 F3d 539, 544 (7th Cir. 2000).

¹⁹See, e.g., *id.* at 817-818; *Musto v. American General Corp.*, 861 F.2d 897, 912 (6th Cir. 1988) (“when an employer decides to establish, amend, or terminate a benefits plan, . . . its actions are not to be judged by fiduciary standards.”)

acted as a fiduciary when it intentionally misled employees about the future and security of benefits.²⁰ The Third Circuit has detailed four elements retirees must demonstrate to succeed in a breach of fiduciary duty claim: proof of fiduciary status, misrepresentations by the company, company knowledge of the confusion created, and resulting harm to the employees.²¹

Recent Decision Raises Age Discrimination Issues Regarding Retiree Health Benefits

The decision in *Erie County Retirees Association v. County of Erie*²² raises a new issue in evaluating retiree health benefits and could affect an employer's continued provision of these benefits. Erie County selected a health plan for Medicare-eligible retirees that limited choice of a primary care physician and reimbursed for services, except emergencies, only if authorized by the primary care physician. However, unlike a traditional indemnity plan, there were no deductibles and few or no copayments. For former employees not yet Medicare-eligible, the county selected a hybrid point-of-service plan under which a retiree could choose an HMO option (and accept its benefits and limitations) or a traditional indemnity option. The Medicare-eligible retirees filed suit against Erie County, contending that the health coverage offered to them was inferior to that offered to retirees under 65, and therefore they were discriminated against based on section 4(a) of the Age Discrimination in Employment Act (ADEA).²³

The Third Circuit ruled that Erie County treated its Medicare-eligible retirees differently from other retirees with respect to their compensation, terms, condition, or privileges of employment because of age, establishing a claim under the ADEA. The court also ruled that, under the act,²⁴ the

²⁰*Variety v. Howe*, 516 U.S. 489 (1996).

²¹*In Re Unisys Corp. Retiree Medical Benefits ERISA Litigation*, 957 F. Supp. 628 (E.D. Pa. 1997), citing *In Re Unisys Corp. Retiree Medical Benefits ERISA Litigation*, 57 F.3d 1255, 1265 (3d Cir. 1995), *cert. denied sub nom Unisys Corp. v. Pickering*, 517 U.S. 1103 (1996).

²²220 F.3d 193 (3d Cir. 2000), *cert. denied*, 69 U.S.L.W. 3409 (U.S. Mar. 5, 2001) (No. 00-906).

²³29 U.S.C. 623(a) ("It shall be unlawful for an employer . . . to . . . discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of . . . age.")

²⁴29 U.S.C. 623(f)(2)(B)(i) provides an exception for what would otherwise be a violation of the ADEA where "the actual amount of payment made or cost incurred on behalf of an older worker is no less than that made or incurred on behalf of a younger worker." The implementing regulation, 29 C.F.R. 1625.10, established what is known as the "equal benefit or equal cost" rule.

employer could provide different benefits to Medicare-eligible retirees only if (1) they provided equal benefits to those provided to retirees not yet eligible for Medicare or (2) the employer's costs for Medicare-eligible retirees and retirees not yet eligible for Medicare were equal. The case was sent back to the trial court for a determination on the county's compliance with this "equal benefit or equal cost" rule.

Appendix III: Benefit Summaries for Selected Medigap Policies

The 10 standardized Medigap policies, called plans A through J, differ by the benefits they provide. However, all 10 plans include the same “basic benefits,” including Part A hospitalization coinsurance (days 61 to 90), lifetime reserve coinsurance (days 91 to 150), 365 extra days of hospital care, the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year that Medicare Parts A and B do not cover, and Part B coinsurance (20 percent).

Individuals can purchase a Medigap plan with additional benefits, although the extent to which the 10 plans offer these various benefits differs. (Table 6 illustrates benefit differences among the three plans for which we obtained premium rates.) Plan F is the most popular Medigap plan. According to a HCFA official, plans C and F together represent over one half of all Medigap sales. Plan H is one of the three standardized plans that include a limited prescription drug benefit. Under Medigap’s special enrollment rules, eligible individuals have guaranteed access to four plans, including plans C and F. In contrast, access to plan H may be subject to medical underwriting.

Table 6: Additional Medigap Benefits for Plans C, F, and H

	Plan C	Plan F	Plan H
Additional benefits	X	X	X
Skilled nursing facility coinsurance (days 21-100)	X	X	X
Part A deductible	X	X	X
Part B deductible	X	X	
Part B excess charges		X ^a	
Foreign travel emergency	X	X	
At-home recovery			
Prescription drugs			X
Preventive medical care			

^aPlan F covers 100 percent of excess charges, which is the difference between the doctor’s charge and Medicare’s approved amount.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

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Related GAO Products

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