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Report to the Chairman, Subcommittee on Regulation, Business Opportunities and Technology, Committee on Small Business, House of Representatives

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RETIREE HEALTH PLANS

Health Benefits Not Secure Under Employer-Based System

GAO/HRD-93-125

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Human Resources Division

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The Honorable Ron Wyden
Chairman, Subcommittee on Regulation,
Business Opportunities and Technology
Committee on Small Business
House of Representatives

Dear Mr. Chairman:

This report responds to your request for information on the trend among private sector employers to reduce retiree health benefits. Because of the importance of this issue relative to health care reform, you requested us to determine (1) the type of reductions in benefits that employers are making to retiree health plans; (2) the impact of Financial Accounting Standard (FAS) 106, which requires the accrual of health benefit liabilities, on the decisions of employers to change their health benefit plans; and (3) the basis on which federal courts have allowed employers to reduce retiree health benefits.

In conducting our review we relied on information from the Department of Labor's Bureau of Labor Statistics and from other sources, including health benefit consultants. We also reviewed the opinions and rulings of various U.S. courts of appeals and discussed FAS 106 with the Financial Accounting Standards Board. (See app. I for details on our scope and methodology.)

Background

In the United States, employer-based health care systems provide many active employees with health care benefits. Many employers, especially those that are medium and large, also provide health care benefits to retirees. The employer-based retiree health benefits came about mainly in the 1950s and 1960s. Because the costs were relatively small, employers were initially less concerned about them and many viewed retiree health benefits as a "throw-away" issue in the employee benefits bargaining process.

Since then, however, employer costs have increased sharply because, among other things, retirees are retiring earlier and living longer. Because early retirees (under age 65) are not yet eligible for Medicare, employers pay 3 to 4 times more for their health care than for retirees with Medicare. In addition, health care costs are escalating faster than the general rate of inflation and have been for the past two decades. The Bureau of Labor

Statistics reported that the medical cost inflation rate was 7.4 percent in 1992—4.4 percent above the general inflation rate of 3.0 percent. This differential has averaged just over 2 percent since about 1970. Since 1980, medical inflation has averaged just over 3 percent above the general rate of inflation.[1]

An additional pressure to control costs has come from a change in accounting standards. FAS 106, which was adopted in 1990 by the Financial Accounting Standards Board, requires employers to accrue and disclose billions of dollars for retiree health benefit liabilities in their financial records and statements. In 1989, we estimated the nation's FAS 106 liability as of 1988 to be $227 billion. For 1993, we estimate that the liability has grown to $412 billion. While this disclosure does not affect companies' cash flow, it initially reduces net income and shareholders' equity shown on financial statements.

In the face of these cost pressures, employers have moved to contain health care expenses.[2] Recent studies by employee benefit consultants and widely reported health benefit cuts by major corporations have highlighted the fact that employers are taking actions to reduce their liabilities for retiree health benefits or at least to control the growth in costs and liabilities.

Results in Brief

Based on our review of available data and health benefit consultant studies, retiree health benefits under an employer-based health care system are not secure because employers have been changing both their employee and retiree health benefit plans. The employer plan changes, in response to rapidly rising health benefit costs, have mostly involved cost shifts to participants. Such changes include increasing retiree contributions toward insurance premiums, increasing deductibles and copayments, setting limits on employers' contributions, or requiring retirees to pay the full cost of the premiums.

Only a small percentage of employers surveyed in the benefit consultant studies we reviewed had eliminated specific covered medical services for retirees. Precise numbers were not available because the responses of the employers to the survey question regarding the elimination of specific

[1]For an explanation of how these differences affect how much we, as a nation, spend on health care, see Employee Benefits: Companies' Retiree Health Liabilities Large, Advance Funding Costly (GAO/HRD-89-51, June 14, 1989).

[2]See Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, Sept. 22, 1992).

services were combined with responses to other questions. For example, some employers indicated that their response included changes in cost sharing or increases in deductibles. However, at least four employers had announced plans to entirely phase out their financial support for health benefit plans for both current and future retirees over the next few years. This phasing out by employers has significant implications for reform of the nation's employer-based health care system.

While modifications to retiree health benefit plans are primarily due to rapidly increasing costs, changes are also being spurred by the new accounting standard (FAS 106), which highlights the magnitude of the liabilities. In responding to benefit consultant surveys, many companies cited the fact that FAS 106 results in reductions in reported income and shareholder equity as a reason they modified retiree health benefits.

Regulation of retiree health benefits is under the purview of the federal government as a result of the Employee Retirement Income Security Act of 1974 (ERISA). Recent court decisions have permitted employers to modify or terminate retiree health benefits for current and future retirees if they reserved the right to do so in benefit plan documents or collectively bargained agreements.

Employers Acting to Control Retiree Health Benefit Costs

Employers are controlling rising retiree health benefit costs by changing their retiree health benefit plans in ways that shift costs to retirees. This pattern of change was first documented and reported by us in 1988[3] and has since been studied by many benefit consultants.

To obtain a general perspective on the extent to which employers are making changes and the type of changes being made, we reviewed recent studies by benefit consultants and others. While the studies are adequate for this purpose, their findings cannot be aggregated or generalized to the population because the samples were not statistically drawn (see app. II).

A large majority of employers in the samples had changed their retiree health benefit plans over the past few years or were planning or considering changes within the next few years. Five of the studies reported that from 42 percent to 93 percent of the employers surveyed had changed their retiree health benefit plans over the past few years, and three of these studies reported that from 33 to 100 percent of the

[3]See Employee Benefits: Company Actions to Limit Retiree Health Costs (GAO/HRD-89-31BR, Feb. 1, 1989).

employers were considering additional changes. Modification of employer-provided health benefits is an ongoing process. In other words, employers may change certain aspects of their retiree health plans in one year and in the following year make other changes.

As a result of these changes, retirees find they are paying more for health care. Few employers surveyed, however, have totally eliminated their retiree health benefit plans. Recent benefit consultant surveys reported that from 0 to 3 percent of employers surveyed terminated health benefit plans for their current retirees. Employers who have eliminated specific benefits, such as vision or dental services, from their plans have continued to provide for basic physician and hospital services.

The primary means by which employers shift costs of medical care from themselves to their employees and retirees are through increasing premium contributions, deductibles, and copayments and modifying eligibility requirements. Additionally, the risk of health care inflation is occasionally being shifted from employers to employees and retirees through the use of defined dollar or defined contribution plans. Under these plans, employers limit their payments or contributions to set amounts per employee. Health care costs that exceed the limits are paid by the employees or retirees.

The mechanisms that employers use to shift health care costs from themselves to retirees differ greatly in their effect on retirees. Increases in premiums or deductibles shift costs to retirees and may affect their access to medical services if the resulting costs for services are too high. On the other hand, the termination of retiree health plans may leave early retirees without access to health care insurance, especially if they have a preexisting condition, that is, they have a known illness or disability.

Employers reported that cost is the primary reason for changing, reducing, or terminating health benefits. When asked about the reasons for making plan changes, employers nearly always cited the need to reduce rising plan costs, future liabilities, or some combination of these factors.

Sampled employers were more likely to apply changes to future retirees than to current retirees, particularly those changes with the greatest adverse impact. For example, the studies we reviewed reported that from 0 percent of 1,386 employers to 3 percent of 150 employers surveyed terminated health benefit plans for their current retirees but that 3 to 5 percent of the employers terminated health plans for future retirees.

Focusing changes on future retirees delays the impact of severe benefit reductions and lessens the likelihood of litigation by current retirees.

The changes affecting retirees can severely impact early retirees because they are not eligible for Medicare until they reach the age of 65. However, the Consolidated Omnibus Budget Reconciliation Act of 1987 allows retirees to buy into their employers' health plan for 18 months. Thus, this act provides at least a partial bridge to Medicare for earlier retirees.

New Accounting Standard Highlights Employers' Financial Burden for Retiree Health Benefits

The Financial Accounting Standards Board[4] (FASB) requires employers to accrue health care liabilities in their financial records and disclose them in their financial statements for the next fiscal year beginning after December 1992. In December 1990, the board issued an accounting standard on this matter entitled "Employers' Accounting for Postretirement Benefits Other Than Pensions." The new standard, FAS 106, requires employers to estimate and record the cost of retiree health and other postretirement benefits during the working careers of active employees. It does not affect how much employers pay for the coverage provided in any year, nor does it require that they set aside funds to pay these future costs. However, FAS 106 has changed employers' perception of retiree health benefits by making them more aware of the magnitude of their liabilities, and it may be acting as a catalyst for reductions.

While FAS 106 may significantly impact the financial statements of companies that provide retiree health benefits, it does not appear to have a direct impact on the financial conditions of the companies because it does not affect their cash flow. Various studies by financial analysts and affected companies provided mixed opinions as to the likely effect of FAS 106. Overall, these studies suggest that possible financial impacts on affected companies will likely be negligible. However, even without FAS 106, many financial experts are concerned because these long-term liabilities erode equity positions and will become current obligations in future years.

Whether FAS 106 will have an impact on corporate credit ratings and borrowing capacity is also unclear. Credit ratings are based primarily on cash flow and financial flexibility and reflect the perception of the financial community of a company's credit worthiness. And, since neither will be directly affected by FAS 106, the rating agencies are generally

[4]FASB is responsible for setting standards for financial reporting. These standards are to ensure that investors and other interested parties have complete, accurate, and consistent information on companies and organizations.

inclined to view the new accounting standard as a "nonevent" at least as far as specific ratings go. In 1991, Standard & Poor's said that FAS 106 was not expected to have any widespread impact on credit ratings since cash flow would not be affected directly. Moody's stated that rating changes were not anticipated as a result of FAS 106 because it had already factored the liability into its ratings.

ERISA Allows Employers to Modify Health Benefits

The Employee Retirement Income Security Act (ERISA), enacted in 1974 by the Congress to reform employee pension and welfare benefits programs, allows employers to modify retiree health benefit programs. ERISA defined a welfare plan as any plan, fund, or program established or maintained by an employer or an employee organization to provide medical, surgical, or hospital benefits or benefits in the event of sickness, accident, disability, or death, among other "fringe benefits."

At the time ERISA was enacted, the Congress was concerned primarily with the reform of pension plans. Accordingly, ERISA established stricter requirements for pension plans than for the provision of health benefits. For example, ERISA requires employers to fund their pension plans and gives employees vested rights upon meeting certain service requirements. Health benefits were excluded from vesting and funding requirements. In general, employers may make changes in their plans as long as they have reserved the right to do so. According to the benefit consultants we contacted, virtually all employers have reserved their right, in some fashion, to change their health benefit plans.

Although the U.S. Supreme Court has not ruled directly on the question of whether ERISA permits the modification or termination of retirees' health benefits, a number of U.S. circuit courts of appeals generally have handed down consistent rulings involving this question. The Supreme Court, in declining to accept such cases for review, has let stand appeals court rulings that employers could alter health care coverage if they reserved the right to do so (see app. III).

Implications

Our review of available data and health benefit consultant studies showed that retiree health benefits are not secure under the present employer-based system because under certain circumstances they can be changed whenever and as employers deem necessary. This situation has implications for the ongoing health care reform effort. Although few retirees have lost health care coverage entirely, the retiree population is

finding itself paying increased amounts for health care. Under present law, retirees have a tenuous relationship with their former employers and some employers have ended their promises to active employees to provide health care benefits when they retire. Others have indicated they intend to do so. Thus, future retirees will have less health care coverage provided by their employers. Particularly vulnerable are retirees under age 65 who do not qualify for Medicare. As part of the ongoing reform of health care in the United States, particular attention should be paid to retirees, especially those under 65, who might otherwise lose health care coverage.

Agency Comments

We did not obtain agency comments as this report does not deal with the operations of a federal agency.

As arranged with your office, we will send copies of this report to interested parties. If you or your staff have any questions about this report, please call me at (202) 512-7215. Other major contributors are listed in appendix IV.

Sincerely yours,

Joseph F. Delfico

Joseph F. Delfico
Director, Income Security Issues

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Abbreviations

ERISA	Employee Retirement Income Security Act
FAS	Financial Accounting Standard
FASB	Financial Accounting Standards Board
HMO	health maintenance organization

Scope and Methodology

To determine the extent and nature of private sector employers' retiree health benefit reductions, we reviewed the literature and surveys/studies conducted by benefit consultants and others, and past GAO reports.[1] The surveys/studies we reviewed follow.

Facing FAS 106: Where Employers Stand, Towers-Perrin Company, 1992

FASB Retiree Health Accounting, Hewitt Associates, December 1991; October 1992

Hay/Huggins Benefits Report, Hay/Huggins Company Inc., 1991; 1992

Health Care Benefit Survey, Report 4, Retiree Health Care, A. Foster-Higgins & Co. Inc., 1989 and 1991

Health Care Benefit Survey, Report 1, Medical Plans, A. Foster-Higgins & Co. Inc., 1992

Making Sense of the Health Care Dollar, Environmental Analysis, Blue Cross/Blue Shield Association, 1992

Postretirement Nonpension Benefit Design: A Delicate Balance, Buck Consultants Inc., March 1991; February 1993

Retiree Health Benefits in the 1990s, William H. Mercer Inc., 1991

Retiree Health Benefits, 1991, Health Insurance Association of America, Preliminary Report, June 1992

Retiree Health Benefits Survey, William H. Mercer Inc., July 1992

Wyatt Comparison, The Wyatt Company, February 1992

We obtained information from the Department of Labor's Bureau of Labor Statistics and the nongovernmental organizations, including the Employee Benefit Research Institute, the Blue Cross/Blue Shield Association, the Bureau of National Affairs, Coopers & Lybrand, and the Financial Executives Research Foundation. We also discussed FAS 106 with the

[1]See Employee Benefits: Companies' Retiree Health Liabilities Large, Advance Funding Costly (GAO/HRD-89-51, June 14, 1989), Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, Sept. 22, 1992), Employee Benefits: Effect of Bankruptcy on Retiree Health Benefits (GAO/HRD-91-115, Aug. 30, 1991), and Employee Benefits: Extent of Companies' Retiree Health Coverage (GAO/HRD-90-92, Mar. 28, 1990).

Financial Accounting Standards Board and obtained information from the board.

Although differences in survey designs make comparisons of findings difficult, we identified the types of benefit reductions made most often by employers, determined their frequencies, and compared findings across studies. The findings of these surveys cannot be generalized beyond their respective samples because the samples were not statistically drawn. In addition, the findings cannot be aggregated because the studies varied in terms of the number of employers surveyed, the time periods covered, and the manner in which questions were asked and answered. The number of employers surveyed ranged from 72 to 1,386 and the time periods reported ranged from 1987 through 1992. In addition, the responses of employers are not weighted by their number of retirees or active workers. As a result, the responses of an employer with 50 retirees is given equal weight to one with 5,000 retirees. Nevertheless, these surveys include companies in a wide range of sizes and industries; we believe the diverse nature of companies in these studies make them appropriate for our purposes. We also conducted an extensive search of the literature on retiree health benefits.

To learn the legal history related to retiree health benefits, we examined the literature and reviewed the opinions and rulings of the various U.S. courts of appeals involving the rights of employers to modify or terminate their health benefit plans.

We did our review from August 1992 through June 1993 in accordance with generally accepted government auditing standards.

Employers Reducing Their Role in Providing Retiree Health Care Benefits

In this appendix we provide details of our review of studies by benefit consultants and the Health Insurance Association of America describing the reduced role of employers in providing retiree health care benefits.

In response to rapidly rising health benefit costs, employers have continued to change both their employee and retiree health benefit plans. Most plan changes involved cost shifts from employers to participants. Such changes include increasing retiree contributions toward insurance premiums, increasing deductibles and copayments, setting limits on the employer's contribution, or requiring retirees to pay all costs. Only a small percentage of surveyed employers had eliminated specific medical services from their plans, totally eliminated their retiree plans, or changed to requiring retirees to pay all costs.

Employers Modifying Health Benefits by Shifting Some Costs to Retirees

A large majority of employers in the benefit consultant samples had changed their retiree health benefit plans over the past few years or were planning or considering changes within the next few years. The studies we reviewed all reported that the majority of employers in their respective samples had done so. Five of the studies reported that from 42 percent to 93 percent of the employers surveyed had changed their retiree health benefit plans over the past few years, and three of these studies reported that 33, 35, and 100 percent of the employers were considering changes. This shows that modification to employer-provided health benefits is an on-going process. Employers may change certain aspects of their retiree health plans in one year and in subsequent years make additional changes.

When asked about the reasons for changing, reducing, or terminating health benefits, employers nearly always cited the need to reduce rising plan costs, future liabilities, or some combination of these factors. One benefit consultant study reported in 1991 that one-third of 1,386 employers changed their plans primarily because of cost, while another third did so to control future liabilities. Another consultant study reported that 53 percent of 164 employers changed their plans because of cost and future liability, while 22 percent did so to address cost only and 25 percent changed to address future liability only.

Mechanisms Used to Shift Costs

The primary mechanisms through which employers shift health costs from themselves to retirees are raising premium contributions, deductibles, and copayments and tightening eligibility requirements. In some cases, the risk of health care inflation is being shifted from employers to retirees through

the use of defined dollar or defined contribution plans under which employers set dollar limits on their contributions to the accounts of participants. In these plans, costs exceeding the limits are paid by the retirees.

The most common way employers shift costs to retirees is to increase the contributions retirees must pay toward health insurance premiums. The benefit consultant studies we reviewed showed that from 14 percent of 372 employers to 48 percent of 780 employers have increased retiree premium contributions over the last several years.

Employers also frequently shift costs to retirees by increasing or establishing deductibles or copayments. Increased or newly established deductibles require retirees to pay more of their health care charges before the plan starts to pay. Increased copayments require retirees to pay a larger flat rate each time they use specific medical benefits, such as office visits or prescription drugs. Two benefit consultant studies, one in 1991 and another in 1992, reported that 41 percent of 173 employers and 44 percent of 780 employers had increased or decided to increase retiree deductibles.

Tightening eligibility requirements, such as age and service time, is another common method of shifting health care costs. For example, an employer might provide full retiree medical benefits only to retirees who completed 30 years of service. Retirees with fewer years would receive a pro rata portion of the full benefit. Six benefit consultant studies found that from 11 percent of 1,386 employers to 29 percent of 780 employers had tightened eligibility rules over the past several years. Employers considering more restrictive rules ranged from 11 percent of 377 employers to 21 percent of 173 employers.

Medical Services Not Being Eliminated

Although employers are making numerous changes in their plans that shift costs to retirees, employers have not been eliminating basic physician and hospital services. A small number of employers have, however, eliminated such benefits as dental, vision, or hearing services.

Nevertheless, some employers have terminated their retiree health benefit plans or required retirees to pay the entire cost. In 1990 we estimated that less than 1 percent of 2.5 million employers had terminated retiree benefit

plans since 1984.[1] Three recent studies by benefit consultants found that from 0 percent of 1,386 employers to 3 percent of 150 employers had terminated health plans for current retirees. In addition to terminations, three benefit consultant studies also found that from 1 percent of 377 employers to 6 percent of 173 employers required retirees to pay all health care costs at the company's group rate.

Requiring retirees to pay all of their health care costs at the company's group rate reduces benefit values to retirees but allows them to maintain access to health insurance at a cost lower than individual plans. In contrast, companies that terminate retiree plans reduce benefit values to zero and require retirees to obtain insurance at the higher individual rates. Some retirees are not able to purchase individual health insurance because of preexisting conditions. Clearly, such reductions affect early retirees (under age 65) particularly severely because they are not eligible for Medicare. However, the Consolidated Omnibus Budget Reconciliation Act of 1987 allows retirees to buy into their employers' health plan for 18 months and thus provides at least a partial bridge to Medicare.

Changes Mostly Applied to Future Retirees

Employers are more likely to apply changes to future than current retirees. A 1991 study reported that 59 percent of 173 employers making changes had grandfathered all current retirees. Another study reported that employers seldom make eligibility changes applicable to current retirees or those near retirement. Grandfathering current retirees delays the impact of severe benefit reductions because they will be applied only in the future and may also lessen the likelihood of litigation by current retirees.

We found that employers' focus on future retirees is particularly true for those changes with the greatest adverse impact. Two studies comparing future and current retirees reported higher proportions of employers terminating plans for future retirees. One of the studies also showed that more employers implemented retiree-pay-all plans for future retirees than for current retirees.

Mechanisms Used to Shift Health Cost Inflation

Employers shift the burden of health care inflation by changing from defined benefit to defined dollar plans. Doing so ends their open-ended commitment to pay all claims for specific medical services. Employers

[1]See Employee Benefits: Extent of Companies' Retiree Health Coverage (GAO/HRD-90-92, Mar. 28, 1990).

offering defined dollar plans to retirees pay a fixed dollar amount per retiree toward their cost of health care coverage. Retirees are responsible for charges or premiums in excess of the employers' contributions.

Seven studies indicated that from 1 percent of 372 employers to 13 percent of 780 employers surveyed had changed to defined dollar or defined contribution plans.[2] Three studies showed that the use of these plans by employers was increasing. One benefit consultant stated that such plans were nearly nonexistent 5 years ago.

One study found that employers were also beginning to index retiree premiums, deductibles, and out-of-pocket limits. Indexed premiums, deductibles, and out-of-pocket limits will increase each year on the basis of changes in consumer prices. The study, which surveyed 200 employers, reported in 1993 that 6 percent, 6 percent, and 4 percent of them had indexed, or decided to index premiums, deductibles, or out-of-pocket limitations, respectively, within the past 3 years. Another 13 percent had tied retiree premium contributions to fixed percentages of cost.

Employers Shift to Managed Care and Flexible Benefit Plans

Two approaches that employers are using to restructure their retiree health benefit plans are managed care and flexible benefits. Managed care programs, such as health maintenance organizations (HMO), attempt to reduce health care costs through more efficient delivery of medical services. With flexible benefit plans, employers fix the amount of their contribution and allow the retirees to determine how the funds will be spent.

Despite increasing adoption of managed care programs, retiree enrollment in HMOs remains low. Two studies found that 24 percent of 150 employers and 38 percent of 780 employers offered managed care to current or future retirees or both. One study reported that the proportion of employers offering HMOs to both active workers and retirees grew from 50 percent of 1,112 employers in 1989 to 66 percent of 1,386 employers in 1991. Despite this increase, retiree enrollment remained at the 1989 level of 12 percent.

With flexible benefit plans, employers control their costs by providing a fixed amount of dollars or credits to the participants, who then decide how the benefit dollars or credits are to be allocated. The participants can choose between taxable benefits, such as cash, and nontaxable benefits,

[2]Defined dollar plans are used to cover current retirees so that employers only pay a certain amount for health care. Defined contribution plans apply to future retirees. Employers contribute amounts to the accounts of employees that will be available to pay for their health care when they retire.

such as health insurance. Additionally, participants may choose from among health care plans with various cost, coverage, and provider options. Three of the studies we reviewed reported that from 4 percent of 200 employers to 8 percent of 150 employers had offered or decided to offer flexible benefit plans to their retirees.

Medicare Integration

Benefit consultants said that employers can reduce retiree health care costs by changing the way they integrate benefits with Medicare, particularly in managed care plans. The method of integration is significant because Medicare typically only pays for about two-thirds of each claim. The remaining one-third is shared by employer and retiree.

Three of the studies we reviewed showed that from 8 percent of 828 employers to 19 percent of 780 employers changed or planned to change their method of integrating with Medicare. According to one of these studies, employers are moving from "coordination of benefits," the method most generous toward retirees, to the "carve-out" method, which results in the greatest cost for retirees. Under the coordination of benefits method, Medicare payments are applied first to the claim and are used to cover any retiree deductible or coinsurance. Any remaining Medicare amounts are applied to the employer's obligation. In the carve-out method, plan benefits are determined without regard to Medicare payments, which are first applied to reduce benefits payable by the employer.[3] Although coordination of benefits was once the most frequently used method, the study found that only 12 percent of the employers surveyed were now using this approach, while half were using the carve-out method.

[3]For example, assume a $2,000 claim, a Medicare payment of $1,200 (that is, the employer and retiree share the remaining $800), a $200 deductible, and 20-percent coinsurance. Under coordination of benefits, the Medicare payment would be first applied to the retiree's obligation of $560, and the balance would reduce the employer's obligation to $800. Under the carve-out method, the Medicare payment would first be applied to the employer's obligation of $1,440, reducing it to $240, and the retiree would remain obligated for the deductible and coinsurance ($560).

Federal Law and Court Decisions Allow Employers to Modify Health Benefits

Current law and recent court decisions allow employers to modify or terminate retiree health benefits for current and future retirees if they reserved the right to do so in benefit plan documents or collectively bargained agreements. According to the benefit consultants we contacted, virtually all employers have reserved their right, in some fashion, to change their health benefit plans.

Although the U.S. Supreme Court has not ruled on the question of modification or termination of retirees' health benefits, a number of U.S. circuit courts of appeals have handed down rulings. The Supreme Court has declined to accept for review several such cases. Most recently, on November 9, 1992, it declined to review a case involving an employer's change to its health benefit plan. The Supreme Court thereby left in place a 5th Circuit Court of Appeals ruling that companies can alter or amend their health care coverage. The court decisions have been based, in part, upon Employee Retirement Income Security Act (ERISA) provisions.

In 1974, the Congress sought to reform employee welfare benefits programs when it passed ERISA. ERISA defined a welfare plan as any plan, fund, or program established or maintained by an employer or an employee organization for the purpose of providing medical, surgical, or hospital benefits, as well as other "fringe benefits," through insurance or otherwise.

However, the Congress was concerned primarily with the reform of pension plans. Accordingly, ERISA established requirements for pension activities to a much greater extent than over health benefits. ERISA requires employers to fund their pension plans and gave employees vested rights upon meeting certain service requirements. Health benefits were excluded from vesting and funding requirements.

Regarding retiree health benefits, ERISA holds employers who provide welfare benefits to (1) reporting and disclosure standards, (2) fiduciary responsibility, and (3) continuation of benefits in certain situations. ERISA requires employers to provide their employee-participants with a document clearly setting out their rights, including "...information concerning the provisions of the plan which govern the circumstances under which the plan may be terminated." Employers must file these documents with the Department of Labor.

In addition, the Consolidated Omnibus Budget Reconciliation Act of 1987, which amended ERISA, requires employers to continue health benefits in

certain situations. Employers must provide coverage for 18 to 36 months following "qualifying events" such as layoff, retirement, termination, death of the employee, or divorce of a spouse and the covered employee. The basic period of continuation coverage is 18 months when an employee is terminated or the employee's hours are reduced. However, up to 36 months of continuation coverage is available for spouses and dependents when coverage is lost due to any other qualifying event.

ERISA covers all employee benefit plans established or maintained by an employer engaged in or affecting interstate commerce. With the passage of ERISA, the federal government preempted regulation by the states of all employee welfare benefits plans. Accordingly, the rights of employers and retirees are being settled under federal law, often in U.S. bankruptcy courts.

U.S. bankruptcy courts handle cases involving matters of bankruptcy, subject to review by U.S. district and circuit courts. In 1988 the Congress passed the Retiree Benefits Bankruptcy Protection Act of 1988 in response to a number of chapter 11 reorganization cases. The act gave a higher priority to retiree health benefits, making them equal to administrative expenses, which have priority status. The act added a section to the bankruptcy code under which retiree health benefits could not be changed without the agreement of a committee representing retirees or unless so ordered by the court. However, in an August 1991 report,[1] we concluded that the added section has not made much of a difference or given retirees much protection.

Recent Court Decisions Rely on Plan Documents

In reviewing disputes involving changes to health benefit plans, the approaches adopted by the U.S. courts of appeals essentially have been that (1) the right to change depends on the language in plan documents;[2] (2) primary consideration is given to the language in plan documents, but extrinsic evidence may be considered if the plan language is ambiguous; and (3) if plan documents are ambiguous, retiree health benefits may be found to vest upon retirement "status" and cannot be changed as long as the retiree's status is unchanged.

[1]See Employee Benefits: Effect of Bankruptcy on Retiree Health Benefits (GAO/HRD-91-115, Aug. 30, 1991).

[2]ERISA requires that health benefit plans be in writing. Thus, courts have been reluctant to allow documents outside the plans or collective bargaining agreements to be used to modify the plans as to the intent regarding duration of benefits.

For example, in one of the first cases involving retiree health benefits, the 6th Circuit Court of Appeals[3] held that retiree health benefits rights are "status" rights, and as long as one retained the status (retired), he or she retained the right to retiree health benefits despite a collective bargaining agreement "generally" limiting the duration of benefits to the term of the agreement. The court held that the agreement was ambiguous and did not expressly limit retiree health benefits nor did it limit them specifically as to retirees.

Regarding the right of vesting, the 6th Circuit[4] reversed a district court decision that once an employee complied with all the conditions of participation, his or her rights became vested. The district court had found that the company, in oral statements and brochures to early retirees (those under age 65), had said that retiree health benefits would not change. The district court said that the company could not reduce the benefits despite express reservation in the plan of its right to change or terminate the plan. The 6th Circuit Court, in reversing the decision, held that the reservation clause in the plan was clear and unambiguous and entitled the employer to modify or terminate these benefits at its discretion.

Similar results have been reached by the other U.S. circuit courts. The 7th Circuit Court[5] upheld a district court's reading of a retiree health benefit plan and collective bargaining agreement allowing the company to terminate benefits, saying that the plan reserved the right to terminate and ERISA explicitly exempted welfare benefits from vesting. The 8th Circuit Court[6] held that express language in the collective bargaining agreement and insurance documents limiting the duration of coverage and reserving termination rights established conclusively that retirees did not have lifetime entitlements. Recent decisions in the 7th Circuit Court have limited the use of evidence in collectively bargained retiree health cases and have generally supported the authority of an employer to modify or terminate retiree health benefits at the expiration of a contract.[7]

[3]International Union UAW v. Yard-Man Inc., 716 F. 2d 1476 (6th Cir. 1983), cert. denied, 465 U.S. 1007, 104 S. Ct. 1002 (1984).

[4]Musto v. American General Corporation, 861 F. 2d 897 (6th Cir. 1988), cert. denied, 490 U.S. 1020, 109 S. Ct. 1745 (1986).

[5]Ryan v. Chromalloy American Corp., 877 F. 2d 598 (7th Cir. 1989).

[6]Howe v. Varity Corp., 896 F. 2d 1107 (8th Cir. 1989).

[7]Senn v. United Dominion Industries, Inc., 951 F. 2d 806 (7th Cir. 1992); Bidlack v. Wheelabrator Corp., 993 F. 2d 603 (7th Cir. 1993).

The 5th Circuit Court has reached a similar decision. The 5th Circuit Court[8] held that ERISA did not bar reduction in an employee's health benefits, and an employer may cut insurance coverage for employees in accordance with its health benefit plan documents. The court held that the level of health care benefits provided under an employer's plan was not a vested right under ERISA.

Self-Insurance, State Regulation, and ERISA

To reduce costs and avoid state taxes and regulations, more companies are self-insuring their health benefit plans. According to an October 1992 Congressional Budget Office study, Economic Implications of Rising Health Care Costs, key benefits of self-insurance are the avoidance of state-mandated coverage—although such coverage is that commonly provided anyway—and the avoidance of taxes. The states now tax commercial insurers about 2 to 3 percent of their gross premiums. If, for example, a company with a self-insured plan had health care expenses of $100 million, it would avoid state taxes of $2 to $3 million a year.

A benefit consultant survey of 2,160 small, medium, and large employers reported in 1992 that 67 percent had self-insured plans. The percentage was 46 percent in 1986. Large firms generally were already self-insured. The biggest movement toward self-insurance was among small- to medium-sized firms. In its 1991 and 1992 surveys, the benefit consultant reported that, among smaller employers (under 1,000 employees), self-funded plans grew from 44 percent in 1990 to 48 percent in 1991 and, among employers with between 500 and 1,000 employees, self-funding grew to 63 percent in 1992. Among medium-sized employers (1,000 to 2,499 employees), self-funding rose from 69 percent in 1990 to 75 percent in 1992.

A number of states have attempted to "reform" their health care systems, in part, by trying to tax and regulate the retiree health benefit efforts of self-insured employers by asserting that employers are subject to the states' regulatory power over insurance companies. Such claims by the states have not been successful, however, because of the ERISA preemption.

[8]Greenberg v. H & H Music Co., 946 F. 2d 401 (5th Cir. 1991), cert. denied, —U.S. —, 113 S. Ct. 482 (1992).

A 5th Circuit Court[9] decision held that a self-insured employer was not subject to state regulation under the state's power to regulate insurance companies. One district court in the 9th Circuit[10] has noted that an attempt by the state to impose a requirement on an employer's health benefit plan was an attempt to modify an employer's health benefit plan and as such was not permissible in view of ERISA. The court noted that the Congress enacted ERISA as a comprehensive legislative means by which to govern employee benefit plans and that its primary goal was to establish uniformity and stability in the law. In order to maintain such uniformity, the Congress included a broad preemption clause providing that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan."

[9]Greenberg v. H & H Music Co., 946 F. 2d 401 (5th Cir. 1991), cert. denied, —U.S. —, 113 S. Ct. 482 (1992).

[10]Aloha Airlines v. Ahue, 807 F. Supp. 1501 (D. Hawaii 1992).

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