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Report to the Honorable
Jerry Kleczka, House of Representatives

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RETIREE HEALTH INSURANCE

Erosion in Employer-Based Health Benefits for Early Retirees

GAO/HEHS-97-150

GAO

United States
General Accounting Office
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Health, Education, and
Human Services Division

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July 11, 1997

The Honorable Jerry Kleczka
House of Representatives

Dear Mr. Kleczka:

In August 1996, the Pabst Brewing Company notified about 750 retirees of its Milwaukee plant that it planned to terminate their health benefits within a month. Concerned about this abrupt cancellation, especially for early retirees—those who are not yet eligible for Medicare, you asked us to examine a number of issues related to the private sector's provision of health benefits to retirees:

- Has the number of private sector early retirees with health coverage declined since the late 1980s?
- How are retirees affected by an employer's decision to terminate health benefits?
- Do federal laws (1) prevent employers from reducing or terminating retirees' health benefits or (2) provide for continued group health coverage for retirees under age 65 years whose health plans are terminated?

Beyond the specific questions raised by Pabst's termination of retiree health benefits, you expressed concern about the fragility of the current system for providing retiree health coverage. Several factors suggest that retiree coverage is becoming an important national issue. These factors include the downward drift in employers' commitment to retiree coverage, the need to trim Medicare cost growth, and the dramatic near-term increase in the number of retirees as millions of baby-boomers approach retirement age.

To address your specific questions, we reviewed (1) available private sector and government surveys of changes in retiree access to and participation in employer-based health coverage; (2) the Pabst health benefit plan in effect during 1996; (3) data from health insurance carriers on the cost of alternative sources of coverage for early retirees in Wisconsin, where Pabst is located, and other selected states; (4) applicable federal and state laws and legal precedents; and (5) earlier GAO work. Appendix I contains a discussion of the sources of data on employer-sponsored coverage, the patchwork nature of the evidence on retiree health care trends, and a cautionary note on the strict

comparability of the data. We performed our work during April and May 1997 in accordance with generally accepted government auditing standards.

Results in Brief

The available data on employer-based retiree health benefits paints a limited but consistent picture of eroding coverage. The data, primarily from employer or retiree surveys, demonstrate a steady decline in the number of retirees with coverage through a former employer—both for early retirees and those who are Medicare eligible. Foster Higgins, a benefit consulting firm, reported in 1996 that only 40 percent of large employers with more than 500 employees offered health benefits to early retirees—a 6 percentage point decline since 1993. Even fewer small and medium-sized firms offered retiree coverage. Earlier employer survey data suggest that since 1988 the decline in the number of large employers who offer retiree coverage has been significant. It is important to point out that the decline in the availability of employer-based coverage has not resulted in as large an increase in early retirees without private health insurance. Among the reasons are that (1) the decision to retire is often predicated on the availability of health coverage and (2) access to other sources of private coverage appear to be filling a significant portion of the gap created by fewer employers offering retiree health benefits. For example, if employer-based coverage is not available, early retirees may purchase coverage themselves or obtain insurance through a working or retired spouse.

Retiree surveys provide another important perspective on the erosion in retiree health coverage. Comparing 1988 and 1994 data for all retirees aged 55 and older, the Labor Department reported that the number of individuals who continued to receive employer-based health benefits into retirement declined by 8 percentage points; in addition, the number still covered sometime after retirement dropped by 10 percentage points. There are several explanations for the erosion in coverage during retirement. First, some employers, much like Pabst, have ceased to offer retiree health benefits. Escalating health care costs have spurred employers to look for ways to control their benefit expenditures. Among the cost-control techniques adopted by employers are eliminating retiree coverage, increasing cost sharing, and requiring those covered to choose more cost-effective delivery systems. In addition, a new financial accounting standard developed in the late 1980s has changed employers' perceptions of retiree health benefits and may have acted as a catalyst for reductions in retiree coverage. The new rule makes employers much more

aware of the future liability inherent in retiree health benefits by requiring them to account for its estimated value as a cost against earnings. A second contributor to the erosion in employer-based health coverage during retirement is retirees' responses to changes in their coverage. According to the Labor Department, fewer retirees are choosing to participate in employer-based coverage when offered because firms are asking them to shoulder more of the costs. At the same time, retirees who decline employer-based benefits may have access to less expensive coverage through a working or retired spouse.

Losing access to employer-based coverage poses three major challenges for retirees: (1) higher costs in purchasing individual coverage on their own; (2) a related problem, the potential for less comprehensive coverage because of higher premiums; and (3) until recently, the possibility that coverage will be denied or restricted by a preexisting medical condition. The impact of the termination of health benefits on retirees varies from state to state, depending on the nature of state laws governing the purchase of insurance by individuals. The cost impact is starkly illustrated for affected Pabst early retirees by the nearly $8,200 annual cost of purchasing standard family coverage in the individual insurance market—an enormous increase given that the former Pabst plan required no contribution on the part of the retiree for most plan options. Beginning July 1, 1997, the implementation of the Health Insurance Portability and Accountability Act (HIPAA) will provide uniform federal standards to ensure that individuals leaving employer-based group plans can purchase insurance on their own if they can afford to do so.

A key characteristic of America's voluntary, employer-based system of health insurance is an employer's freedom to modify the conditions of coverage or to terminate benefits. While federal law (the Employee Retirement Income Security Act of 1974 or ERISA) requires that the terms of an employee's health benefits be in writing, the intent was not to prevent an employer from changing or terminating those benefits for either active workers or retirees. In cases involving the termination of health benefits by an employer, federal courts have turned to the nature of the written agreements and extrinsic evidence covering the provision of retiree benefits. In essence, the issues before the court often come down to a matter of contract interpretation. If the employer has explicitly reserved the right in plan documents to modify health benefits, the courts have generally upheld the termination of coverage. On the other hand, if the contract leaves some doubt, courts will look to evidence such as collective bargaining agreements and other written and oral representations to

determine the rights and obligations of the parties. Today, most companies have reserved the right in plan documents to modify health benefits for current and future retirees. Finally, the right to purchase continuation coverage from an employer is only guaranteed to workers in certain circumstances, for example, if an employee is fired, laid off, quits, or retires. Individuals who are already retired when an employer terminates coverage are not eligible to continue that firm's health plan at their own expense.

Background

Although some Americans purchase health insurance individually for themselves or their dependents, most receive coverage as a benefit through their employer. The former is commonly referred to as individual coverage and the latter as employer-based group coverage. Complementing these two types of private insurance[1] are public programs including Medicaid for the poor and Medicare for the elderly and disabled.[2] With the exception of the long-term disabled, Medicare is only available to individuals aged 65 and older. The lack of affordable health insurance for older Americans—either employer based or purchased individually—was a key factor leading to the establishment of Medicare in 1965.[3]

The availability of employer-based health benefits is of particular concern to older Americans approaching or at retirement age—individuals who consume a higher level of medical services and whose health care costs are commensurately more expensive. For those under age 65 and not yet eligible for Medicare, the decision to retire may turn on the continuation of health benefits by an employer. For those 65 or older living on a fixed income, employer-based benefits may help fill coverage gaps in Medicare such as deductibles and copayments or the lack of a prescription drug benefit. (See app. II for a description of Medicare benefits and how they differ from employer-based coverage.) In 1994, about 75 percent of retirees were over age 65 and thus employer-based coverage supplemented Medicare benefits; the remaining 25 percent were ineligible for Medicare

[1]A significant portion of employer-based private insurance is provided by the public sector. The federal government covers civilian workers through its Federal Employees Health Benefit Program, while the Department of Defense operates a health care system for military personnel. Similarly, state and local governments also provide employee health benefits. About 17 percent of workers aged 18 to 64 have coverage provided though a public sector employer.

[2]Other public sources of health services include the Indian Health Service, the Department of Veterans Affairs, and public clinics and hospitals.

[3]Insurance coverage as part of a retirement benefit was the exception, not the rule, and private insurance companies had shown a reluctance to offer coverage to older persons even when these individuals could afford it. See Marilyn Moon, Medicare Now and in the Future (Washington, D.C.: Urban Institute Press, 1993), p. 25.

because they were between ages 55 and 65. For the latter group, employer-based benefits were a particularly critical source of coverage. Overall, about one-third of retirees 55 years and older received health benefits from a former employer. While Bureau of the Census data show that the number of retirees increased from 18.5 million to 23.4 million between 1988 and 1994, the first members of the baby boom generation are age 51 and poised to enter retirement, an event that will begin to dramatically increase the number of retirees.

Before 1980, most employers that provided retiree health coverage did so on a lifetime basis. The trend, especially for firms with labor unions, was to continue to improve retiree health benefits with each successive labor contract. Beginning in the 1980s, however, sharply rising medical costs, heightened foreign competition, corporate takeovers, the declining bargaining power of labor, and a change in accounting standards gave rise to attempts by some employers to modify or even eliminate retirees' health benefits. New accounting standards announced in 1990 changed employers' perception of retiree coverage by making them more aware of the magnitude of their liabilities.

ERISA established safeguards governing the creation, operation, and administration of most employer-based health benefits.[4] In addition, ERISA requires group health plans covering 20 or more workers to offer 18 to 36 months of continued health coverage in certain circumstances, such as when an employee is fired, laid off, or quits.[5] The mandate to offer such continuation coverage does not oblige employers to share in its cost. Finally, HIPAA has an impact on those who are seeking to transition from employer-based group benefits to individual coverage. Effective after June 30, 1997, the law provides uniform federal safeguards to ensure that individuals who lose group health benefits and can afford to purchase individual coverage have the right to do so.[6]

[4]P.L. 93-406, 29 U.S.C. 1001 et seq.

[5]This provision was added to ERISA by the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), 29 U.S.C. 1161 et seq. For this reason, continuation coverage is known by the acronym COBRA.

[6]P.L. 104-191.

Decline in Access to and Participation in Employer-Based Retiree Coverage

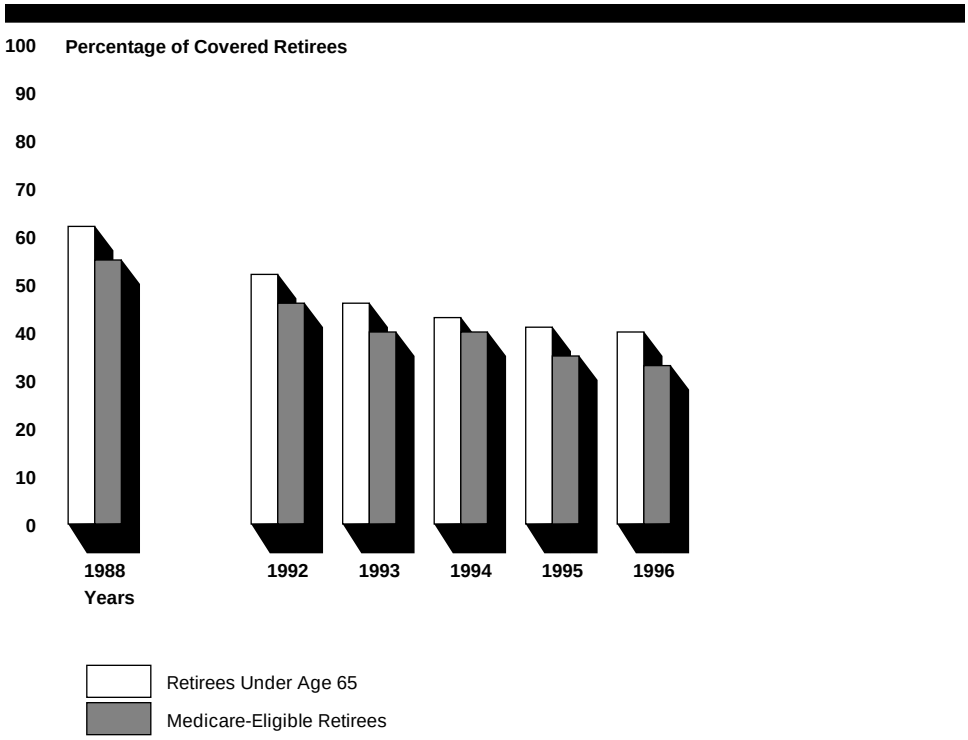
Since the late 1980s, retiree access to and participation in private insurance through an employer has declined. The drop in coverage—both for those who retire early (before they are eligible for Medicare) and to individuals who are Medicare eligible—has been reported in periodic surveys sponsored by benefit consulting firms and by the federal government. The erosion in coverage has been influenced not only by the discontinuation of employer-based health benefits but also by the trend to require greater retiree cost sharing—a factor contributing to lower participation rates. Survey data indicate that employers are more likely to offer coverage to early retirees than to those who are Medicare eligible.

Fewer Employers Offering Retiree Coverage

Data from an annual survey conducted by Foster Higgins suggest a significant decline between 1988 and 1996 in the availability of retiree coverage from large employers with over 500 workers.[7] The data appear to be consistent across the entire period, but the pre-1993 data should not be viewed as authoritative because of a change in the survey methodology, described in appendix I. The data distinguish between early retirees and those who are Medicare eligible. Since 1993, coverage for both groups has declined by 6 to 7 percentage points, a continuation of a trend evident since 1988. As shown by figure 1, early retirees at large firms are more likely than those who are Medicare eligible to be offered health benefits by a former employer. In 1996, for example, only 33 percent of Medicare-eligible retirees were offered health benefits compared with 40 percent of early retirees.

[7]National Survey of Employer Sponsored Health Plans 1996 (New York: Foster Higgins, 1997). The Foster Higgins survey included both public and private employers but only reported aggregated data on the two sectors.

Figure 1: Percentage of Large Employers Offering Retiree Medical Coverage, 1988 and 1992-96



Note: Data from 1988 and 1992 are not strictly comparable with data collected after 1992.

The two primary reasons cited for the decline in employer-based retiree health coverage are (1) new accounting standards, which highlight the magnitude of this liability over time; and (2) rapidly rising benefit costs. Since employers typically cover retiree health costs as they are incurred, the liability represented by a commitment to provide benefits to current and future retirees is largely unfunded. In 1990, the Financial Accounting Standards Board announced the introduction of a new rule, referred to as FAS 106, regarding these unfunded obligations. Beginning in 1993, employers were required to include the present value of future costs for retiree health benefits as a liability on their balance sheets. The new standard does not require that employers set aside funds to pay for these future costs and thus it does not affect their cash flow. However, many financial experts are concerned because these long-term liabilities erode equity positions and will become current obligations in future years.[8] On the other hand, by dropping retiree coverage, a company can immediately

[8]For additional information on the impact of FAS 106, see Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System (GAO/HRD-93-125, July 9, 1993).

improve its balance sheet. As shown in figure 1, a sharp drop in employer-based retiree coverage occurred between 1992 and 1993. It is difficult to determine the extent to which this 6 percent decline in a single year stems from the expected response to the FAS 106 rule or from the change in the survey methodology. 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 for modifying retiree health benefits, including the phasing out of such coverage.

The late 1980s was also a period of double-digit health care inflation. Although the growth in premiums has slowed dramatically in the past few years, the percentage of large firms offering retiree health benefits has continued to drop. The decline between 1994 and 1996 was especially sharp for Medicare-eligible retirees. Among the reasons cited by Foster Higgins for the slowdown in the growth of employers' health care costs are that more workers moved into managed care plans—including retirees—and the fact that some employers dropped retiree coverage. The Medicare program is also facing cost pressures. In 1997, the Congress and the President reached a tentative agreement to cut about $115 billion from the program over a 5-year period in order to reduce the program's rate of growth. The effect on those eligible for the program will become clearer as legislation is debated and signed into law. Although higher beneficiary premiums have been discussed, they may be balanced by a wider variety of managed care plans and increased preventive care benefits.

There are several potential explanations for higher levels of employer coverage among early retirees. First, individuals are not as likely to seek early retirement unless they are able to continue employer-based health benefits. A RAND study of the effect of access to post-retirement health insurance found that the offer of continued coverage had a positive effect on the likelihood of retirement for men aged 55 to 62.[9] Second, those who retired early through buyouts may have been guaranteed health benefits as an enticement to do so. Third, COBRA provides 18 months of coverage, allowing individuals to retire at age 63-1/2 and continue with employer-based group coverage until Medicare eligibility kicks in at age 65. Fourth, because of higher managed care enrollment among early retirees, cost may be a less important factor in an employer's decision to offer or withdraw health benefits to this group. While just over one-half of early retirees are enrolled in a managed care plan, the corresponding figure for Medicare-eligible retirees is only 29 percent. Finally, employers

[9]Lynn Karoly and Jeannette Rugowski, The Effect of Access to Post-Retirement Health Insurance on the Decision to Retire Early, RAND Reprints: 94-13E (Santa Monica, Calif.: 1995).

know that coverage is available to retirees aged 65 and older through Medicare, an option not open to younger retirees.

Other sources of private insurance appear to be filling a significant portion of the gap created by the fact that fewer employers offer retiree health benefits. If employer-based coverage is not available, early retirees may purchase coverage themselves or obtain insurance through a working spouse. Thus, between 1989 and 1995, the percentage of early retirees with private coverage fell by only 7 percentage points compared with a much larger drop in the number of employers offering retiree coverage.[10]

Coverage Influenced by Factors Other Than Availability

While Foster Higgins surveys employers about the health benefits they offer, CPS data emanate from interviews with individuals, in this instance, retired workers. As with the Foster Higgins survey, CPS data include both the private and public sectors. Analysis of CPS data by the Labor Department's Pension and Welfare Benefits Administration revealed a significant erosion between 1988 and 1994 in the number of individuals who retain employer-based health coverage upon retirement.[11] As shown in table 1, only 42 percent of retirees aged 55 and older continued such coverage into retirement in 1994, a decline of 8 percentage points since 1988. Moreover, the percentage of individuals with employer-based coverage continued to decrease throughout retirement. Only 34 percent still retained coverage several years after retirement, and an even smaller percentage believed that their employer-based health benefits would be available until they die. Although a smaller percentage of retirees from the private sector have employer-based benefits at or sometime after retirement, the decline in coverage between 1988 and 1994 can be seen in both the public and private sectors in a roughly proportional manner. Appendix III replicates the data in tables 1 and 2 for the private sector only.

[10]GAO estimate based on Current Population Survey (CPS) data from the Bureau of the Census. See Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures (GAO/HEHS-97-122, July 1997).

[11]U.S. Department of Labor, Pension and Welfare Benefits Administration, Retirement Benefits of American Workers: New Findings from the September 1994 Current Population Survey (Washington, D.C.: Department of Labor, Sept. 1995), p. 25.

Table 1: Percentage of Retirees With Employer-Based Coverage, 1988 and 1994

	All retirees (aged 55 and older)	
	1988	1994
Active employees with coverage at time of retirement	69%	65%
Workers who continued coverage into retirement	50	42
Retirees currently covered by employer's plan	44	34
Retirees who believed their employer-based coverage could be continued for life	32	30

Source: Department of Labor, Pension and Welfare Benefits Administration.

Factors other than the actual availability of coverage are responsible for an undetermined portion of the decline in retirees with employer-based health benefits. According to the Labor Department, the propensity for retirees to enroll in employer-based plans when they are offered has dropped because of the increased costs retirees are being asked to shoulder by employers. In both the 1988 and 1994 surveys, individuals who declined employer-based coverage at retirement were asked to articulate the reasons for their decision. Of the approximately 5.3 million retirees who discontinued employer-based benefits in 1994, 27 percent cited the expense as a factor—an increase from 21 percent in the earlier survey. Moreover, there was a 6 percentage point increase over the same time period in the number of such retirees who indicated that they still had health insurance through a plan other than that of their former employer. For example, a retiree may have access to health benefits through a working or retired spouse.

Table 2 summarizes changes in employer/employee cost sharing for retiree coverage. Compared with 1988, in 1994, more employers were requiring retirees to share in the cost of coverage, a fact reflected in (1) the drop in the percentage of firms paying the entire premium and (2) the increase in those sharing some of the premium costs. Overall, the employee's contribution to premiums rose about 10 percent faster than the inflation rate over that 6-year period. While this amount reflects the cost increase for both single and family coverage, there was considerable variation between the two. The inflation-adjusted employee share for family coverage increased by almost 23 percent, while the share for single coverage decreased by about 9 percent. Employers appear to be encouraging retired employees to sign up for single coverage while hoping that spouses will choose alternative sources of coverage if they are available, for example, single coverage from their own former employer.

Appendix IV summarizes changes from 1988 to 1994 in costs paid by retirees for both single and family coverage from a former employer.

Table 2: Costs Paid by Retirees for Employer-Based Coverage, 1988 and 1994 (Includes Both Single and Family Coverage)

	1988	1994
Employee pays nothing	42%	37%
Employee pays some costs	33%	42%
Employee pays all costs	21%	19%
Don't know/no response	4%	2%
Median annual cost to retirees (1994 dollars adjusted for inflation)	$874	$960

Source: Department of Labor, Pension and Welfare Benefits Administration.

CPS data also contain insights on the characteristics of individuals more and less likely to have employer-based coverage. Those characteristics are summarized in table 3.

Table 3: Characteristics of Retirees More and Less Likely to Have Employer-Based Health Benefits

MORE likely to have coverage	LESS likely to have coverage
Work for larger firms	Work for smaller firms
Have higher preretirement earnings	Have lower preretirement earnings
Belong to union	Are nonunion
Work in manufacturing or communications/public utilities	Work in retail sector or service industries
Work for public sector	Work for private sector
Are men	Are women
Are white	Are black or other race

Source: Department of Labor, Pension and Welfare Benefits Administration.

Employers' Decisions to Terminate Coverage Subjects Retirees to New Costs and Risks

If available, employer-based group health insurance provides two important advantages to retirees: (1) more affordable health benefits and (2) access to benefits for those retirees whose health status might otherwise impinge on their ability to obtain coverage in the individual insurance market. Such insurance is affordable because many employers continue to finance all or a significant amount of their retirees' health insurance costs, even though over the last decade retirees have been required to pay an increasing share of these costs. In addition, the overall premiums for employer-based health plans are generally lower than those in the individual insurance market because the premiums charged to

employers are based on risks spread over an entire group of workers. In contrast, premiums in the individual insurance market reflect the risk characteristics of each applicant. These characteristics include not only age and coverage type but also gender, health status, and geographic differences in health care costs.[12] Unless there is a state law prohibiting price differences by age, most carriers charge higher premiums to older applicants.

Consequently, retirees no longer covered by their former employer's group health plan are likely to encounter higher premiums to obtain similar coverage in the individual insurance market. For example, before its 1996 decision to terminate health benefits to retired employees at its Milwaukee plant, Pabst financed the total cost of practically all of the health plans it offered to its retired workers. With the elimination of these benefits, affected Pabst retirees who want to obtain health coverage must now absorb its full cost, which can be a significant amount of money. Individual retirees may be affected differently by the varying methods insurance companies use to determine price and eligibility. Table 4 provides an example of the premiums Pabst retirees might face if they purchase comprehensive coverage from a Wisconsin carrier to replace the benefits terminated by Pabst.

Table 4: Comparison of Costs to Retiree Under Age 65 Before and After Pabst's Termination of Health Benefits in 1996

	Annual cost to retiree for Pabst health benefits[a]	Potential annual cost to retiree for individual coverage
Family coverage (retiree and spouse)	$0-$1,444	$8,186.96[b]
Single (male applicant)	$0	$4,502.76

[a]Pabst offered its workers eight different plans and paid their full cost with the exception of one of four plans that provided family coverage. Few employees selected the family option requiring cost sharing. The workers who did only had to pay the difference between what Pabst paid for the other family plans and the cost of this particular plan. This difference was about $1,444 a year.

[b]Premium rate charged by one carrier in Milwaukee, Wisconsin, for a standard plan for a nonsmoker with a $250 deductible. Covering an additional dependent would bring the cost to about $9,300. A retiree who smokes and also covers a spouse would pay about $11,000 for coverage.

Premiums in other states could be higher or lower given the high geographic variability of health insurance rates in the individual market. For example, in 1996, a major carrier in New Jersey offered family

[12]For details on the individual health insurance market, including its structure, premium prices, the effect of demographic characteristics, and health plans offered, see Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs (GAO/HEHS-97-8, Nov. 25, 1996).

coverage with a $250 deductible at an annual price of $11,825.[13] The price of similar family coverage in Maricopa County, Arizona, was only $6,264 in 1996. However, retirees in Arizona with preexisting conditions can be denied coverage altogether, be charged a premium much higher than the standard, or have a condition excluded from coverage.

Before the July 1, 1997, implementation of HIPAA, consumers, including retirees entering the individual insurance market, often discovered that they were not eligible for insurance or that their coverage was conditioned upon the permanent exclusion of an existing health problem. Many with specific health problems found coverage only at prohibitive prices. For example, health insurance carriers often declined coverage for Acquired Immune Deficiency Syndrome (AIDS) and diabetes; offered coverage but excluded conditions such as asthma, ulcers, and glaucoma; and charged higher premiums for plans that covered problems like anemia and arteriosclerosis.[14] Although HIPAA does not address the cost of health insurance, it will help guarantee access to the individual market by those with qualifying coverage from a former employer—regardless of their health status—and will provide for the renewability of individual coverage. Although HIPAA offers no protection to Pabst retirees whose health benefits were terminated in 1996 or to any retiree who lost employer-based health benefits before July 1, 1997, it will protect future retirees. Wisconsin law requires insurers to accept individual applicants who previously had employer-based insurance if such insurance is not self-funded,[15] but it does not apply to Pabst retirees because the firm self-funded its health benefits.

Many states, including Wisconsin, offer a high-risk program, or "pool," for people who have been denied coverage or have one of a number of specified health conditions. However, this safety net option often has very limited coverage and lower lifetime limits. The cost of a high-risk pool can be 50 percent more than the average or standard rate charged in the individual insurance market for a comparable plan. The annual premium for a single male aged 55 to 59 in Wisconsin's high-risk pool averaged $5,122 in 1996—over $500 more than the cost in the individual insurance

[13]This amount is for nonsmokers aged 55 to 59 with one child. Moreover, New Jersey restricts carriers' premium rating practices and generally requires all carriers to set the same rate for all plan participants within a community.

[14]See GAO/HEHS-97-8, Nov. 25, 1996, for a discussion of the evaluation process that health insurance companies have used in providing access to the individual insurance market.

[15]Self-funded plans are those in which employers bear much of the financial risk for health claims. Employers that self-fund are not subject to state insurance regulation. See Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance (GAO/HEHS-96-161, Aug. 19, 1996).

market, as shown in table 4. Wisconsin offers subsidies to families with incomes of less than $20,000.

Limited Federal Protection of Employer-Based Retiree Health Benefits

ERISA covers both the pension and health benefits of most private sector workers. The voluntary nature of these employer-based benefits as well as the manner in which coverage is funded have important regulatory implications. Consistent with the lack of any mandate to provide health benefits, nothing in federal law requires an employer to offer coverage or prevents cutting or eliminating those benefits. In fact, an employer's freedom to modify the conditions of coverage or to terminate benefits is a defining characteristic of America's voluntary, employer-based system of health insurance.[16] Moreover, employer-based health benefits are funded on a pay-as-you-go basis. In contrast, the sheer magnitude of accumulated employer-employee contributions to retirement funds necessitates a greater degree of regulation of pension benefits. Thus, ERISA not only requires employers to fund their pension plans but gives employees vested rights upon meeting certain service requirements. Health benefits, on the other hand, were excluded from such funding and vesting requirements.[17]

Although ERISA was passed in response to concerns about the solvency and security of pension plans, some of its provisions, including federal preemption of state regulations, also apply to employer-sponsored health coverage. The preemption effectively blocks states from directly regulating most employer-based health plans, while allowing states to oversee the operation of health insurers.[18] ERISA, however, does impose some federal requirements on employer-based health plans. For example, employers must

[16]The demise of traditional fee-for-service indemnity coverage and the growth in managed care enrollment exemplifies the ability of employers to modify their health benefit programs. Between 1987 and 1996, employer-based managed care enrollment rose from 27 percent to 74 percent as employers (1) altered the type and mix of health plans offered, sometimes eliminating the traditional fee-for-service indemnity option; (2) changed employee financial incentives; and (3) used the information provided to employees to influence their selection of health plans. See Health Insurance: Management Strategies Used by Large Employers to Control Costs (GAO/HEHS-97-71, May 6, 1997) for a discussion of the flexibility of large employers as well as the constraints they face in modifying their health benefit purchasing strategies.

[17]GAO/HRD-93-125, July 9, 1993.

[18]Federal preemption is valued by employers who self-fund their health benefit plans because they can avoid taxes, are exempt from mandated state benefits, and can offer a uniform benefit plan to company employees located in different states. Because of the sometimes obscure distinction between prohibiting states from directly regulating employer health coverage but allowing them to set rules for health insurers, the courts have had to determine many of the actual implications of ERISA preemption. See Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA (GAO/HEHS-95-167, July 25, 1995).

- file annual Summary Plan Descriptions (SPD) with the Department of Labor,
- provide participants and beneficiaries access to information about the plans,
- have a process for appealing claim denials,
- make available temporary continuation coverage for former employees and dependents, and
- meet specific fiduciary obligations.

While ERISA protected the pension benefits of retired workers at the Pabst Brewing Company, it offered only limited federal safeguards to retirees participating in the firm's health benefit plan. ERISA requires companies such as Pabst to make an SPD available to health plan participants within 90 days of enrolling. For retirees, the SPD that was in effect at the time of retirement is the controlling document. The SPD must clearly set out employee 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, the agency responsible for enforcing ERISA. According to Labor, unless employers have made a clear promise of specific health benefits for a definite period of time or for life and have not reserved the right to change those benefits, they are free to cut or terminate health care coverage. Appendix V contains an excerpt from a Labor brochure outlining employer responsibilities/employee protections under ERISA.

Because of the federal preemption of state regulation, the rights of active and retired employees under ERISA are determined in federal courts. In reviewing cases involving changes to health benefit plans by employers, several federal courts have focused on the actual language used in plan documents and, if applicable, in collective bargaining agreements. Virtually all employers have reserved the right to modify health benefits for current and future retirees in such documents. However, if the language leaves some doubt as to the nature or duration of benefits, or if there are conflicts in the plan documents, the courts have examined significant written and oral representations made to employees to determine whether the employer has the right to modify retiree health benefits.

The temporary availability of health care coverage guaranteed by COBRA to an individual who is fired, laid off, or leaves a job is not available to retirees whose employer terminates their health care coverage. However, COBRA does allow covered individuals, upon retirement, to continue

employer-based coverage for 18 months if their company does not offer health benefits to retirees. Those eligible for COBRA coverage may have to pay the entire premium plus an additional 2 percent. For many individuals, the cost of COBRA coverage represents a rude awakening, considering that under employer-based coverage large companies typically pay 70 to 80 percent of the premium.

Retirees whose former employers terminate coverage are ineligible for COBRA and they also may be too late to purchase a supplemental Medigap policy to replace any lost employer coverage. In 1994 and again in 1996, we brought this "catch 22" situation to the attention of the Congress. An individual turning 65 has a 6-month open-enrollment window in which to buy supplemental Medigap insurance to cover Medicare deductibles and coinsurance and certain uncovered services. (See app. II for a description of Medicare benefits.) Medicare enrollees who seek a Medigap policy after this 6-month period may be denied coverage because of a preexisting condition. For example, a diabetic might not be able to buy supplemental prescription drug coverage, a benefit not available under Medicare. Similarly, if termination of employer coverage occurs after the open-enrollment period, a retiree may be unable to obtain alternative Medigap coverage. We suggested that the Congress may wish to consider amending the law to provide a mechanism for retirees to obtain Medigap insurance under these circumstances.[19]

Agency Comments

We sought comments on a draft of this report from private sector experts and the Department of Labor's Pension and Welfare Benefits Administration. The reviewers generally agreed with our presentation of the information but provided technical suggestions that we included where appropriate.

As agreed with your office, we will make no further distribution of this report until 30 days after the date of this letter. At that time, we will make copies of this report available to interested parties who request them.

[19]Health Insurance for the Elderly: Owning Duplicate Policies Is Costly and Unnecessary (GAO/HEHS-94-185, Aug. 3, 1994). See also Medigap Insurance: Alternatives for Medicare Beneficiaries to Avoid Medical Underwriting (GAO/HEHS-96-180, Sept. 10, 1996).

Please call either Michael Gutowski, Assistant Director, at (202) 512-7128 or me at (202) 512-7029 if you or your staff have any questions concerning this report. Major contributors to this report included John Dicken, Carmen Rivera-Lowitt, and Walter Ochinko.

Sincerely yours,

Jonathan Ratner
Associate Director, Health Financing and
Systems Issues

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1986
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
SPD	Summary Plan Description

Limited but Consistent Data on Trends in Employer-Based Retiree Health Care Coverage

Despite the existence of a number of public and private surveys that touch on the issue of employer-based retiree health coverage, only limited trend data are available. Two surveys that include data from the late 1980s through the mid-1990s both demonstrate a downward trend in such coverage, but the evidence was collected from different vantage points and the survey methodologies were not consistent across the entire time period. The results are not strictly comparable since one survey focused on employers, while the other was based on retiree responses. The former asks employers if they offer coverage to retirees; the latter focuses on the decisions of individual retirees, who may choose not to participate even when employer-based insurance is available because of cost or the availability of alternative coverage. In addition, changes in the methodologies used to conduct the surveys suggest that individual numbers should be used cautiously even though the trends appear to be consistent.

Employer Survey by Foster Higgins. Although the Foster Higgins survey dates from 1986, the survey methodology was changed in 1993 so that the results could be representative of all U.S. employers rather than just those who responded. In addition, the survey was expanded to include smaller employers with between 10 and 500 employees, an important group that provides health insurance to about one-third of Americans with employer-based coverage and a group on which there were little or no credible data. As a result of the revamped methodology, pre- and post-1993 data are not strictly comparable even though the resulting trend line appears to be consistent. According to a Foster Higgins official, the earlier data are not as "authoritative" as that collected after 1992. Foster Higgins focuses on large public and private sector employers, that is, those with more than 500 workers. Such large employers are more likely than smaller firms to offer health benefits. While Foster Higgins reports separately with respect to early retirees versus those who are Medicare eligible, it does not (1) provide an overall estimate of the extent to which large employers provide retiree coverage or (2) differentiate between the extent to which public versus private sector employers provide benefits. Finally, the Foster Higgins data are considered proprietary, and only the data it chooses to release in summary form are generally available.

Retiree Survey Analyzed by Department of Labor. In contrast to the annual Foster Higgins surveys, data from public sources are more sporadic and not as up to date. In 1995, the Pension and Welfare Benefits Administration in the Department of Labor released a comparison of 1988 and 1994 Current Population Survey (CPS) data on retirees. The report is based on

special supplements, sponsored by the Labor Department, to the August 1988 and September 1994 CPS surveys. These supplements focused on retiree health benefits. The resulting data only provide a limited picture of employer trends because (1) they are based on interviews with retired workers and (2) they do not always clearly distinguish between the availability of coverage and a worker's decision not to participate in employer-based retiree coverage. In addition, no 1988 to 1994 trend data were reported on an important subset of workers—early retirees. Finally, questions about reasons for discontinuing coverage were expanded in the 1994 survey, making a precise comparison across the period difficult.

Comparison of Medicare Benefits and Employer-Based Group Coverage by Large Firms

Medicare benefits are more convoluted and contain more gaps than those generally offered by large employers. For example, standard (fee-for-service) Medicare has separate benefits for hospitalization (part A) and physician/outpatient services (part B), with different copayments and deductibles. Those eligible for Medicare are automatically enrolled in part A but must pay a premium to elect part B coverage. Part A has a relatively high deductible for each hospitalization and requires copayments for stays longer than 60 days;[20] part B has a separate deductible, requires 20 percent coinsurance for physicians' bills, and does not cover prescription drugs. Neither part A nor part B has a limit on out-of-pocket costs. In order to cover some of the gaps in Medicare coverage, beneficiaries may purchase so-called Medigap supplementary insurance or may enroll in a health maintenance organization (HMO) offered through Medicare if one is available in their area. In contrast to Medigap, some HMOs do not even charge a premium for the benefits otherwise not covered by Medicare, but generally require beneficiaries to use plan doctors and hospitals. Large employer coverage, on the other hand, generally offers a single, comprehensive benefit with an associated deductible and copayment. Normally, annual out-of-pocket costs are capped, and health services beyond that point are reimbursed at 100 percent. In addition, benefits provided by large employers typically include prescription drugs.

[20]The current deductible is $760. The copayment of $190 per day for more than 60 but fewer than 91 days of hospitalization rises to $380 per day for the 91st though the 150th days.

CPS Data on Private Sector Retiree Coverage and Cost Sharing

Table III.1: Percentage of Private Sector Retirees With Employer-Based Coverage, 1988 and 1994

	All retirees (55 and older)	
	1988	**1994**
Active employees with coverage at time of retirement	65%	60%
Workers who continued coverage into retirement	42	35
Retirees currently covered by employer's plan	37	27
Retirees who believed their employer-based coverage could be continued for life	27	24

Source: Department of Labor, Pension and Welfare Benefits Administration.

Table III.2: Costs Paid by Retirees for Private Sector Employer-Based Coverage, 1988 and 1994 (Includes Both Single and Family Coverage)

	1988	**1994**
Employee pays nothing	50%	42%
Employee pays some costs	28%	36%
Employee pays all costs	22%	21%
Don't know/no response	0%	1%
Median annual cost to retirees (1994 dollars adjusted for inflation)	$778	$840

Source: Department of Labor, Pension and Welfare Benefits Administration.

CPS Data on Costs to Retirees for Single and Family Coverage Through a Former Employer

Table IV.1: Single Coverage—Costs to Retirees for Employer-Based Health Benefits, 1988 and 1994

	1988	1994
Employee pays nothing	42%	34%
Employee pays some costs	37%	39%
Employee pays all costs	27%	25%
Don't know/no response	4%	2%
Median annual cost to retirees (1994 dollars adjusted for inflation)	$753	$684

Source: Department of Labor, Pension and Welfare Benefits Administration.

Table IV.2: Family Coverage—Costs to Retirees for Employer-Based Health Benefits, 1988 and 1994

	1988	1994
Employee pays nothing	42%	40%
Employee pays some costs	38%	44%
Employee pays all costs	17%	14%
Don't know/no response	3%	2%
Median annual cost to retirees (1994 dollars adjusted for inflation)	$979	$1,200

Source: Department of Labor, Pension and Welfare Benefits Administration.

Excerpt From Department of Labor Brochure on Employer Responsibilities Under ERISA

"Can the Retiree Health Benefits Provided by Your Employer Be Cut?

"You should know—coverage can change.

"If your employer has reserved the right in the SPD and controlling plan document to change the terms of the plan, you may lose coverage at any time during your retirement. If your employer made a clear promise that you will have specific health care benefits for a definite period of time or for life, and did not reserve the right to change the plan, you should be covered.

[Text omitted.]

"—Do the SPD or other plan documents promise that health benefits after retirement will continue at a specified level for a certain period of time?

"—If there is no specific language describing retiree health benefits in your plan documents, it is unlikely that you have coverage.

"—If there is such language, how specific is it?

"Sometimes language covering retiree health benefits is included in the documents, but it is too vague to stand up to a test in the courts. Conversely, there is language on employee health benefits that has held up in court. Here is an example:

" '*Basic health care coverage will be provided at the company's expense for your lifetime.*'

"—Even if a specific promise is made, is there also language that gives your former employer the right to change or terminate that specific promise or to amend or terminate the entire plan?

"Typical language giving the employer that right might read:

" '*The company reserves the right to modify, revoke, suspend, terminate, or change the program, in whole or in part, at any time.*'

"This is an actual example, but other similar language may be found anywhere in the plan documents.

"If you are an employee reviewing the current plan, it is important to remember that it can change in the future. The documents in effect when you retire are the ones that will determine your health benefits, if any, in your retirement."[21]

[21]U.S. Department of Labor, Pension and Welfare Benefits Administration, Division of Technical Assistance and Inquiries.

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