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Testimony

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# RETIREE HEALTH INSURANCE

## Erosion in Retiree Health Benefits Offered by Large Employers

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# Retiree Health Insurance: Erosion in Retiree Health Benefits Offered by Large Employers

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Madam Chairman and Members of the Subcommittee:

We are pleased to be here today as you discuss issues related to pension benefits and retirement. As you know, forces in the U.S. labor market have been transforming the cash portion of retirement benefits, and these forces are impinging on retiree health benefits as well. Several factors suggest that retiree access to affordable health benefits is becoming an important national issue. These factors include the downward drift in employers' commitment to retiree coverage, the consideration of proposals to raise the Medicare eligibility age to 67, and the dramatic near-term increase in the number of retirees as millions of baby boomers approach retirement age.

You asked us to comment on the erosion in employer-based health benefits for retirees, especially early retirees who leave the workforce before age 65, when Americans typically become eligible for Medicare. My comments are based on a recent report we prepared at the request of Representative Jerry Kleczka.<sup>1</sup> His request was sparked by the Pabst Brewing Company's abrupt cancellation of health benefits for about 750 retirees of its Milwaukee plant in late 1996. My statement today will focus on three issues: (1) trends in access to employer-sponsored retiree health benefits, (2) the impact on retirees of an employer's decision to terminate health benefits, and (3) federal safeguards that protect the rights of retirees who have health benefits.

To address these questions, we reviewed surveys that track the availability of employer-based health coverage, data from health insurance carriers on the cost of alternative sources of coverage for individuals whose employers unexpectedly terminate retiree health benefits, applicable federal and state laws and legal precedents, and our earlier work. (See the list of related GAO products at the end of this statement.)

In summary, retiree access to and participation in private insurance through an employer has undergone a slow but persistent decline since the early 1990s. There are several explanations for this erosion in coverage. First, high and rising health care costs have spurred employers to look for ways to control their benefit expenditures, including eliminating retiree coverage and increasing cost-sharing. According to the Labor Department, increased cost-sharing by retirees has contributed to fewer electing coverage when it is offered. Second, a new financial accounting standard

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<sup>1</sup>Retiree Health Insurance: Erosion in Employer-Based Health Benefits for Early Retirees (GAO/HEHS-97-150, July 11, 1997).

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. By dropping retiree coverage, a company can immediately improve its balance sheet, making its stock more attractive to investors.

Losing access to employer-based coverage poses major challenges for retirees. The 1997 implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has eliminated one potential obstacle for retirees who lose group coverage through their former employer—the possibility that coverage in the individual market will be denied or restricted by a preexisting medical condition. HIPAA provides federal standards to ensure that eligible individuals leaving employer-based group plans can purchase insurance on their own if they can afford to do so. Because state laws governing the operation of the individual market differ, however, the premiums faced by early retirees vary substantially. Moreover, considering that large companies typically pay 70 to 80 percent of the premium, costs in the individual market may come as a rude awakening for early retirees. For example, had HIPAA been in effect in 1996, retirees trying to replace the benefits terminated by Pabst with comprehensive family coverage from a Wisconsin carrier would have faced an annual premium of almost \$8,200—a cost that they would have had to absorb on their own. And, using 1996 rates again, family coverage for a HIPAA-eligible early retiree would have been \$6,246 in Arizona but \$11,825 in New Jersey. While New Jersey restricts carriers' premium-rating practices and generally requires all carriers to set the same rate for all plan participants in a community, eligible retirees in Arizona and Wisconsin can be charged much more than the standard premium if they have a preexisting health condition. Early evidence from the implementation of HIPAA suggests that rates developed by insurance carriers for HIPAA guaranteed access products are substantially higher than the prices of standard products available in the individual market to those who are healthy. As a result, these 1996 rates may understate the cost of a HIPAA product purchased in 1998.

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. When an employer has terminated retiree health benefits, federal courts have turned to the nature of the written agreements and other pertinent evidence covering the provision of

retiree benefits to determine the legitimacy of the action. In essence, the issues before the court are often a matter of contract interpretation. If the employer explicitly reserved the right in plan documents to modify health benefits, the courts have generally upheld the termination of coverage. Individuals who are already retired when an employer terminates coverage are not eligible to temporarily continue that firm's health plan at their own expense.<sup>2</sup> COBRA coverage is only available to active employees who quit or retire or are fired or laid off. To address the potential gap in coverage when a former employer unexpectedly terminates health insurance, Members of the Congress as well as the President have proposed allowing affected retirees to purchase continuation coverage at a cost that reflects their higher utilization of services until they become eligible for Medicare.

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## Background

Because of the cost, retiree health benefits are a concern to both employers and older Americans. Employers recognize that these benefits help to retain an experienced workforce but must also consider the cost of providing coverage. Older Americans approaching or at retirement age consume a higher level of medical services, and as a result, their health care is commensurately more expensive. For workers 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.

Overall, about one-third of retirees 55 and older received health benefits from a former employer in 1994. About 75 percent were over age 65, and any employer-based coverage available to them supplemented their Medicare benefits; the remaining 25 percent of retirees were generally ineligible for Medicare because they were between ages 55 and 65. For the latter group, employer-based benefits were the primary source of coverage.

Bureau of the Census data show that the number of retirees increased from 18.5 million to 23.4 million between 1988 and 1994. However, the first members of the baby boom generation are now aged 52 and poised to enter retirement, an event that will begin to dramatically increase the number of retirees.

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<sup>2</sup>Continuation coverage was mandated 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.

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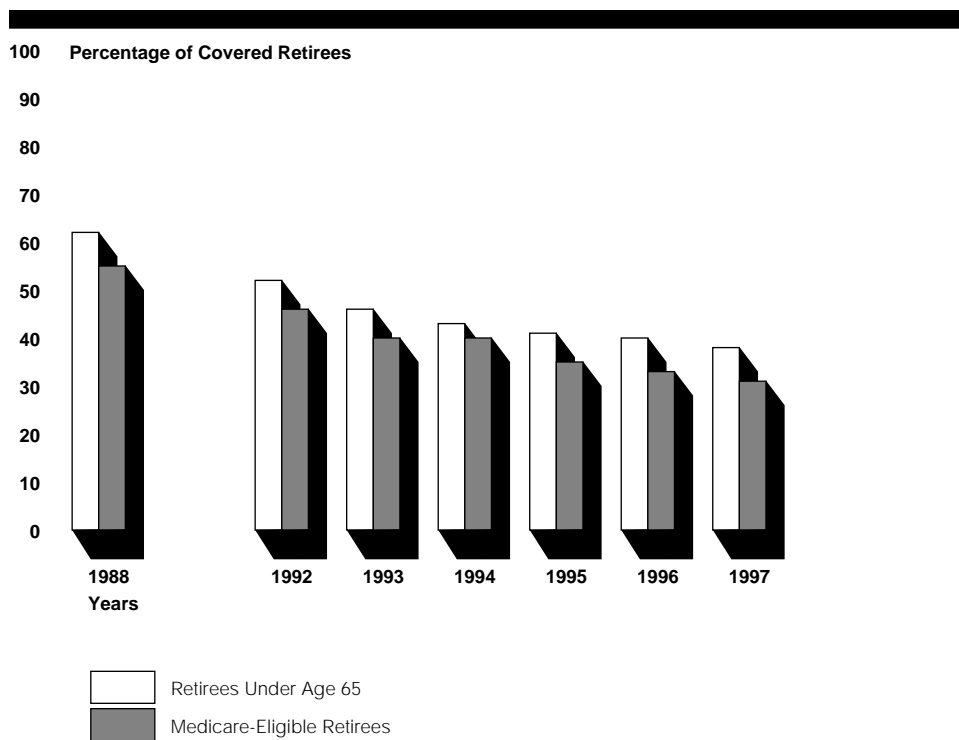
## **Decline in Access to and Participation in Employer-Based Retiree Coverage**

Data from an annual survey conducted by Foster Higgins, a benefit consulting firm, suggest a significant decline between 1988 and 1996 in the availability of retiree coverage from large employers with over 500 workers. Because of a change in the survey methodology, the pre-1993 data should not be viewed as authoritative.<sup>3</sup> However, the data from these two periods appear to be consistent. The data distinguish between early retirees and those who are Medicare-eligible. Since 1993, coverage for both groups has declined by 8 to 9 percentage points, a continuation of a trend evident since 1988. As shown by figure 1, early retirees are more likely than those who are Medicare-eligible to be offered health benefits by a former employer. In 1997, for example, only 31 percent of Medicare-eligible retirees were offered health benefits compared with 38 percent of early retirees.

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<sup>3</sup>National Survey of Employer Sponsored Health Plans 1996 (New York: Foster Higgins, 1997). 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.

**Figure 1: Percentage of Large Employers Offering Retiree Medical Coverage, 1988 and 1992-97**



Note: 1988 and 1992 data are not strictly comparable with data collected in 1993 and later. Large firms are those that employ more than 500 workers.

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. Many financial experts are concerned because these long-term liabilities erode equity positions and will become current obligations in future years.<sup>4</sup> The new standard does not require that employers set aside funds to pay for these

<sup>4</sup>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).

future costs, and thus it does not affect their cash flow. However, by dropping retiree coverage, a company can immediately improve its balance sheet, making its stock more attractive to potential investors. In responding to benefit consultant surveys, many companies cited FAS 106 as a reason for modifying retiree health benefits, including the phasing out of such coverage.

The late 1980s was 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. 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.

As shown in figure 1, employers are less likely to offer coverage to Medicare-eligible retirees than to early retirees. There are several potential explanations for this disparity. First, individuals are not as likely to seek early retirement if they cannot continue employer-based health benefits. A RAND study on the effect of access to postretirement health insurance found that the offer of continued coverage made it more likely that men aged 55 to 62 would retire.<sup>5</sup> Second, those who retired early through buyouts may have been guaranteed health benefits as an enticement to do so. Third, federally mandated COBRA coverage allows some individuals to retire at age 63-1/2 and continue with employer-based group coverage until they become Medicare-eligible at age 65. Finally, employers know that coverage is available to retirees aged 65 and older through Medicare, an option not open to younger retirees.

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### Coverage Influenced by Factors Other Than Availability

The decline in the number of large employers that offer retiree coverage is corroborated by an analysis conducted by the Labor Department's Pension and Welfare Benefits Administration. The study, which examined Current Population Survey (CPS) data, revealed a significant erosion between 1988 and 1994 in the number of individuals who retained employer-based health coverage upon retirement.<sup>6</sup> Only 42 percent of retirees aged 55 and older continued employer-based coverage into retirement in 1994, a decline of

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<sup>5</sup>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.: RAND, 1995).

<sup>6</sup>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.



8 percentage points since 1988. Moreover, the percentage of individuals with employer-based coverage continued to decrease throughout retirement. Thus, only 34 percent still retained coverage several years after retirement.

In addition to the availability of coverage, the Labor Department study suggests that cost is another factor contributing to the decline in retirees with employer-based insurance. Thus, the propensity for retirees to enroll in employer-based plans when they are offered has also 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 the reasons for their decisions. Of the approximately 5.3 million retirees who discontinued employer-based benefits in 1994, an estimated 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. Thus, some retirees who find coverage from their own employer too expensive may have switched to plans with lower cost-sharing available through a working or retired spouse.

Other sources of private insurance do appear to be filling a significant portion of the gap created by the fact that fewer employers offer retiree health benefits. We estimated that 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.<sup>7</sup> If employer-based coverage is not available, early retirees may postpone retirement, purchase coverage themselves, or obtain insurance through a working spouse.

CPS data also contain insights on the characteristics of retirees more likely or less likely to have employer-based coverage. The characteristics for these two groups of retirees are summarized in table 1.

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<sup>7</sup>Our estimate is based on 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 24, 1997).

**Table 1: Characteristics of Retirees More and Less Likely to Have Employer-Based Health Benefits**

<b>MORE likely to have coverage</b>	<b>LESS likely to have coverage</b>
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, analysis of CPS data.

## **Employers' Decisions to Terminate Coverage Expose 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 premiums, 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 that insurers charge 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 but also gender, health status, geographic differences in health care costs, and family size.<sup>8</sup> Unless there is a state law prohibiting price differences by age, most carriers charge higher premiums to older applicants.

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 from the policy 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 immunodeficiency syndrome (AIDS) and diabetes; offered coverage but excluded conditions such as asthma, ulcers, and

<sup>8</sup>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).

glaucoma; and charged higher premiums for plans that covered conditions like anemia and arteriosclerosis.<sup>9</sup> HIPAA guarantees access to the individual market by eligible individuals with qualifying coverage from a former employer—regardless of their health status—and also provides for the renewability of individual coverage.<sup>10</sup> This guaranteed access is often referred to as “portability.” However, 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 its July 1, 1997, implementation date.<sup>11</sup>

Although HIPAA guarantees access to the individual market, it does not address the cost of coverage. Retirees no longer covered by their former employer’s group health plan are likely to pay higher premiums for similar coverage in the individual insurance market. And with the loss of employer-based coverage, affected retirees who want to purchase health insurance must now absorb its full cost, which can be significant. Thus, had HIPAA been in effect in 1996, a Milwaukee retiree who wanted to replace the benefits terminated by Pabst would have paid \$8,187 for a standard family plan with a \$250 deductible.<sup>12</sup> Since Wisconsin does not restrict the underwriting practices of carriers, a carrier may choose to charge an unhealthy individual more. Before its 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 retired workers. Given the substantial geographic variability of health insurance rates in the individual market, HIPAA-eligible retirees will be affected differently. For example, in 1996, a major carrier in New Jersey offered family coverage with a \$250 deductible at an annual price of \$11,825.<sup>13</sup> The price of similar family coverage in Maricopa County, Arizona, was only \$6,264 in 1996. However, as in Wisconsin, HIPAA-eligible retirees in Arizona with preexisting conditions can be charged a premium much higher than the standard.

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<sup>9</sup>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.

<sup>10</sup>HIPAA only guarantees access to the individual market to eligible individuals leaving group coverage. Thus, someone living in Arizona who wanted to purchase individual coverage but did not qualify under HIPAA could still be denied an individual policy because of a preexisting health condition.

<sup>11</sup>Wisconsin law requires insurers to accept individual applicants who previously had employer-based insurance if such insurance is not self-funded, but it does not apply to Pabst retirees because the firm self-funded its health benefits. 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.

<sup>12</sup>Family coverage is for a retiree and spouse. The rate is for an individual who does not smoke. A retiree who smokes would pay about \$11,000 for family coverage.

<sup>13</sup>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.

These 1996 rates may understate the actual cost of a HIPAA guaranteed access product purchased today. Thus, in September 1997 correspondence to the Chairman of the Senate Labor and Human Resources Committee on early HIPAA implementation concerns, we reported that (1) premiums for some HIPAA products may be substantially higher than for standard products available to healthy individuals and (2) the way many carriers will determine future premium rates for portability products may lead to even higher rates. Some carriers permit HIPAA eligibles to apply for both a HIPAA product and a lower-cost standard product. Since healthy individuals are likely to enroll in the less expensive option, only unhealthy individuals would be enrolled in the HIPAA product—a practice that could result in an increasing spiral of poorer risks and higher premiums.

States were allowed to choose a number of approaches to meet HIPAA's portability requirements. Thus, 22 states elected to use their high-risk pools to provide guaranteed access to the individual market for qualified individuals leaving group coverage. Prior to the enactment of HIPAA, many states had high-risk pools for those who had been denied coverage or had 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. For example, the annual premium for a single male aged 50 to 55 in Wisconsin's high-risk pool averaged \$5,122 in 1996—over \$500 more than the cost in the individual insurance market. Wisconsin offers subsidies to families with incomes of less than \$20,000.

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## Limited Federal Protection of Employer-Based Retiree Health Benefits

The Employee Retirement and Income Security Act (ERISA) protects both the pension and health benefits of workers. It does not, however, mandate that employers offer such benefits. ERISA requires employers to fund their pension plans and gives employees vested rights upon meeting certain service requirements; health benefits, on the other hand, were excluded from such funding and vesting requirements. In fact, employer-based health benefits for both active and retired workers are commonly funded on a pay-as-you-go basis.

Nothing in federal law prevents an employer from cutting or eliminating health benefits. In fact, an employer's freedom to modify the conditions of coverage or to terminate health coverage is a defining characteristic of

America's voluntary, employer-based system of health insurance.<sup>14</sup> While ERISA protects the pension benefits of retired workers, it offers only limited federal safeguards to retirees participating in a firm's health benefit plan. ERISA requires companies to make a summary plan description (SPD) available to health plan participants within 90 days of enrolling. For retirees, the SPD that is 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.

Because federal law preempts state regulation of pension and health benefits, 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.

One ERISA protection—the right to elect COBRA coverage from a former employer if a worker is fired, laid off, or leaves a job—is available to some but not all retirees. Thus, COBRA allows covered individuals, upon retirement, to continue employer-based coverage for 18 months if their company does not offer health benefits to retirees.<sup>15</sup> Those eligible for COBRA coverage may have to pay the entire premium plus an additional

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<sup>14</sup>The decline 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.

<sup>15</sup>COBRA only covers firms with 20 or more employees who offer health benefits to active workers.

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2 percent. For many individuals, the high cost of COBRA coverage is a shock because under employer-based coverage, large companies typically pay 70 to 80 percent of the premium. COBRA is not available, however, to retirees whose employer unexpectedly terminates their health care coverage at some point after retirement. To address the coverage gap for such retirees, Members of the Congress as well as the President have proposed allowing affected retirees to purchase continuation coverage at a cost that reflects their higher utilization of services until they become eligible for Medicare.

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Madam Chairman, this concludes my statement. I will be happy to answer your questions.

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# Related GAO Products

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Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators ([GAO/HEHS-98-67](#), Feb. 25, 1998).

The Health Insurance Portability and Accountability Act of 1996: Early Implementation Concerns ([GAO/HEHS-97-200R](#), Sept. 2, 1997).

Private Health Insurance: Continued Erosion in Coverage Linked to Cost Pressures ([GAO/HEHS-97-122](#), July 24, 1997).

Retiree Health Insurance: Erosion in Employer-Based Health Benefits for Early Retirees ([GAO/HEHS-97-150](#), July 11, 1997).

Health Insurance: Management Strategies Used by Large Employers to Control Costs ([GAO/HEHS-97-71](#), May 6, 1997).

Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs ([GAO/HEHS-97-8](#), Nov. 25, 1996).

Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA ([GAO/HEHS-95-167](#), July 25, 1995).

Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System ([GAO/HRD-93-125](#), July 9, 1993).

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