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**Employer-Paid Retiree Health Insurance:
History and Prospects for Growth**

Employer-paid retiree health insurance is promised to more than half of the employees of medium or large establishments in the United States. As of this writing, however, the prospects for the continuation or growth of retiree health benefits are uncertain.

At least four factors could discourage establishment of new plans or restrict the benefits of existing plans. First, employers' unfunded liability for retiree benefits is potentially very large. The Financial Accounting and Standards Board (FASB) is still considering a requirement that employers disclose these liabilities. Second, the Deficit Reduction Act of 1984 (DEFRA) narrowed employer options for funding these liabilities on a tax-preferred basis. Third, recent and expected changes in Medicare are perceived as potentially raising the cost of employer-sponsored plans. Finally, recent litigation seems to indicate that employers may not be permitted to alter retiree health plans once benefit reciprocity has begun.

Estimates of the unfunded liability associated with employer-sponsored retiree health benefits suggest that unfunded liabilities of individual plans could be from 4 to 50 times the amount employers now pay annually for health insurance benefits.

DEFRA has discouraged prefunding of retiree plans by limiting deductible contributions to section 501(c)(9) trusts (called voluntary employee beneficiary associations, or VEBAs). These restrictions have focused attention on an alternative funding vehicle, 401(h) trusts. However, limits on contributions to 401(h) trusts and uncertainty about their legislative and regulatory status may impede their use.

This *Issue Brief* explores these factors and reviews the issues faced by employers and employees. Central to these issues are considerations of prudent financing for retiree health benefits, retirees' rights to promised benefits, and the private sector's role in assisting the elderly to finance catastrophic health expenses in retirement.

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Background

Employer-paid retiree health insurance is commonly promised to employees of medium or large establishments in the United States. Available national data from a survey of medium and large firms indicate that in 1984, 57 percent of all regular full-time workers participating in health insurance plans were promised retiree health insurance. No national data exist to indicate how commonly retiree health insurance is promised to workers in smaller establishments. Available evidence, however, suggests that retiree health insurance for workers in smaller firms is rare.¹

Because of the rapid increase in health care costs, particularly those of the elderly, employers have begun to focus on the long-term liability of their obligations to current and future retirees.

Employer-sponsored retiree health insurance appears to be predominantly a post-Medicare phenomenon. Although no data track the emergence of retiree health insurance as an employee benefit, anecdotal evidence suggests that only a few employers provided retiree health benefits in the 1950s. The Medicare debate in the early 1960s, however, brought to the attention of American workers the high cost of postretirement health care relative to the modest incomes of most retirees and probably encouraged demand among workers for retiree health insurance benefits. The advent of Medicare in 1966 dramatically reduced the cost to employers of offering retiree health insurance, since as primary payer Medicare would finance a large share of retirees' hospital and medical costs. Employer liability for retiree health care costs, although probably substantial, is secondary to Medicare's.

The acceleration of health care costs in the 1970s markedly raised employers' health insurance costs for active workers

and retirees alike. From 1965 through 1984, total spending for health care in the United States rose from \$43 billion to \$387.4 billion. The cost of hospital care rose three times faster than the cost of other consumer goods and services, increasing ninefold from 1965 through 1984. The cost of physician care also grew faster than other goods and services, more than tripling over that period. In 1984, 31.6 percent of all personal health care costs were financed by private insurance, principally by employer-sponsored group plans. By comparison, the federal government financed 28.9 percent, state and local governments financed 12.5 percent, and consumers directly paid 24.6 percent of personal health care costs.

Health care spending by and for the elderly has risen faster than spending for any other population group in the United States. From 1977 through 1984, the elderly's health care costs rose nearly twice as fast as those for all Americans.² In 1984, per capita health spending for people 65 years of age or over was, on average, two and two-thirds times the total population's per capita health spending.³

Because of the rapid increase in health care costs, particularly those of the elderly, employers have begun to focus on the long-term liability of their obligations to current and future retirees. Typically, employers have not distinguished between the cost of health insurance benefits for retirees and the cost for active employees. Instead, employers have usually measured health care costs in terms of current employees, as a proportion of payroll. Low ratios of retirees to active employees throughout the 1960s and the declining average age of the work force have masked the rising cost of retiree health benefits. Since neither law nor accepted accounting practice required employers to recognize accruing liability for nonpension retirement benefits, many employers did not address the mounting current and potential cost of providing health insurance for retirees.

Continued growth in the cost of employer health insurance plans, however, has led employers to focus closely on the causes of that growth. In 1983, employer payments for health insurance reached 4.6 percent of payroll, compared to 4.2 percent in 1982 and 3.6 percent in 1979 (table 1). For firms that offer retiree health insurance benefits, part of this growth is explained by an increase in the ratio of retirees to

¹ A 1977 Battelle survey, "Employment-Related Health Benefits in Private Nonfarm Business Establishments in the United States" (conducted under contract with the U.S. Department of Labor), provides the only available information on health insurance coverage offered by small establishments. Although the survey did not question respondents about retiree health insurance benefits in particular, responses to a question about continued coverage in any circumstance other than layoffs suggest that small establishments rarely continue coverage for retirees. See Deborah J. Chollet, *Employer-Provided Health Benefits: Coverage, Provisions and Policy Issues* (Washington, DC: Employee Benefit Research Institute, 1984), pp. 57-60.

² EBRI tabulations of data published in Daniel R. Waldo and Helen C. Lazenby, "Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-1984," *Health Care Financing Review* 6 (Fall 1984): 1-29, Table 10; and Robert M. Gibson, Katherine R. Levit, Helen C. Lazenby, and Daniel R. Waldo, "National Health Expenditures, 1983," *Health Care Financing Review* 6 (Winter 1984): 1-29, Table 1.

³ EBRI tabulations of data published in Waldo and Lazenby, Table 12, and U.S. Department of Health and Human Services press release, July 31, 1985.

active workers, a situation that was exacerbated as more workers were encouraged during the 1980–82 recession to retire early.⁴

◆ Sources of Health Care Financing Among the Elderly

With advanced age comes the increased probability of needing medical care. Poor health, in fact, is commonly associated with the decision to retire.⁵ Although Medicare is the primary source of health coverage for most retirees, it does not begin until age 65, is aimed at covering acute care, and requires substantial cost sharing. In 1984, 25.2 percent of the health care expenses of those age 65 and over were financed out-of-pocket. The Health Care Financing Administration estimates that the elderly's out-of-pocket expenses in 1984 were \$1,059⁶, or 21.4 percent of median income.⁷ Furthermore, this is expected to increase. By one projection, the average elderly household will pay \$2,583 for direct out-of-pocket payments in 1990.⁸

Retirees who are ineligible for Medicare—usually because they are under age 65—have limited options for obtaining health insurance if their employers do not continue coverage. Early retirees may be able to convert the employer-sponsored coverage into an individual policy. Twenty-six states require employers to offer conversion policies to employees that retire.⁹ However, because conversion policies do not exclude people with pre-existing conditions, they can be much more expensive than individual policies.¹⁰

⁴ See Employee Benefit Research Institute, "Complementing Social Security: Pensions, Earnings, Welfare, and Wealth," *EBRI Issue Brief 45* (August 1985).

⁵ Eardman B. Palmore, Gerda G. Fillenbaum, and Linda K. George, "Consequences of Retirement," *Journal of Gerontology* 39 (April 1984): 109–116. Also see Shelly Sherman, "Reported Reasons Retired Workers Left Their Last Job: Findings From the New Beneficiary Survey," *Social Security Bulletin* 48 (March 1985): 22–30.

⁶ Waldo and Lazenby, Table 12.

⁷ U.S., Congress, House, Select Committee on Aging, Fact Sheet, October 31, 1984.

⁸ U.S., Congress, House, Select Committee on Aging, *America's Elderly At Risk*, Committee Print, 99th Cong., 1st sess., July 1985, p. 20.

⁹ Blue Cross and Blue Shield Association memorandum, January 1985. It should be noted that self-funded health plans are exempt from state-mandated benefits.

¹⁰ A conversion policy for an individual age 60–64 can exceed \$2,600 per year; an individual policy for a person that does not have a pre-existing condition can cost \$1,680 per year. See U.S., Congress, Senate, Special Committee on Aging, *Funding Post-Retirement Health Benefits*, Committee Print, 99th Cong., 1st sess., July 1985.

Table 1
Employer Contributions to Health Insurance and as a Percent of Wages and Salaries, 1960–1983

Year	Health Insurance Contributions ^a (billions)	Health Insurance Contributions as a Percent of Wages and Salaries
1960	\$ 3.4	1.3%
1965	5.9	1.6
1966	6.4	1.6
1967	6.9	1.6
1968	8.4	1.8
1969	9.9	1.9
1970	12.1	2.2
1971	13.7	2.4
1972	16.2	2.6
1973	18.0	2.6
1974	20.7	2.7
1975	24.0	3.0
1976	28.8	3.2
1977	34.5	3.5
1978	39.3	3.6
1979	44.2	3.6
1980	49.8	3.7
1981	57.3	3.8
1982	65.7	4.2
1983	76.5	4.6

Source: U.S. Department of Commerce, Bureau of Economic Analysis, *Survey of Current Business* (Washington, DC: U.S. Government Printing Office, July 1981, July 1983, and July 1984).

^a Excludes employer contributions to Medicare.

For these retirees, health insurance coverage and out-of-pocket costs may be high relative to income. A Social Security Administration survey of new Social Security beneficiaries indicates that health insurance premiums for those age 62 to 64 averaged 56 percent of Social Security income in 1982. For couples with pension income in addition to Social Security, premiums averaged 35 percent of retirement income.¹¹

For retirees over age 65, Medicare is an important payer for health care, particularly for inpatient hospital care. (In 1984, 74.8 percent of Medicare expenditures were for hospital care.) Medicare in 1984 covered 48.8 percent of total personal health care expenditures for persons over age 65. Pri-

¹¹ Social Security data is from the New Beneficiary Survey. For more information see Emily S. Andrews, *The Changing Profile of Pensions in America* (Washington, DC: Employee Benefit Research Institute, 1985).

vate insurance, by comparison, covered 7.2 percent.¹² No available data indicate what percent of private insurance coverage was provided as a retirement benefit.

◆ Types of Employer-Paid Retiree Health Insurance

Employer-provided health insurance plans for retirees under age 65 are usually the same as those provided to active employees. For those over age 65, employer-provided health insurance plans for retirees are of three general types, defined by their relationship to Medicare.

The first type simply coordinates benefits with Medicare. These plans, called "coordination of benefits" (COB) plans, pay beneficiaries the lesser of (1) the plan benefit calculated without regard to the Medicare reimbursement amount or (2) the covered expenses under the plan, minus the Medicare payment.

The second type, the "exclusion" plan, subtracts Medicare payments before applying deductible and copayment provisions.

The third type, and probably the most common, are "carve-out" plans. Carve-out plans reduce plan reimbursement by the amount Medicare pays. In general, carve-out plans result in the lowest plan cost and the highest beneficiary cost of the three types.¹³

Finally, some plans offer retirees benefits not covered by the active employee plan but may also integrate Medicare cover-

age in any of the three ways described above. Regardless of their relation to Medicare, these plans commonly cover spouses of retired employees, although spousal coverage may be contributory. Some employers may also pay Medicare Part B (Supplementary Medical Insurance) premiums for retirees.¹⁴

Medicare costs are not directly affected by the type of plan offered. However, by minimizing beneficiary cost sharing, COB plans, in particular, may encourage higher utilization of Medicare-covered services. Conversely, carve-out plans preserve the cost-sharing incentives of employers' active-worker plans, although they reduce the cost sharing imposed by Medicare.

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EBRI tabulations of survey data collected by the Bureau of Labor Statistics indicate that the incidence of retiree health insurance coverage offered by medium and large establishments may be declining.

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◆ Trends in Employer-Paid Retiree Health Insurance

Although 56.6 percent of employees in medium and large establishments in 1984 were promised continuation of health insurance during retirement, EBRI tabulations of survey data collected by the Bureau of Labor Statistics indicate that the incidence of retiree health insurance coverage offered by medium and large establishments may be declining. In 1980, 59.6 percent of employees who participated in health insurance plans were promised continuation of employer-paid coverage during retirement.

The statistical significance of this difference is indeterminate. Nevertheless, several factors might explain the decline. Employers may simply have withdrawn the benefit. Collective bargaining may have traded retiree health insurance for higher wages, some other benefit, or reduced layoffs. Defined-benefit pension coverage, which is commonly the basis for continued health insurance coverage, has become less com-

¹⁴ William M. Mercer-Meidinger, Inc., "Understanding the Cost of Post-Retirement Medical Benefits," New York, May 1985. (Mimeographed.)

¹² Waldo and Lazenby, Table 13.

¹³ The following illustrates the differences among these methods in plan and beneficiary costs using this hypothetical claim: The medical expenses covered under the plan are \$1,100. Medicare pays \$600 of the \$1,100. The plan is comprehensive with a \$100 deductible and 20-percent copayment.

- The COB plan, absent Medicare, would pay \$800 (.8 × [\$1,100 - \$100]). However, since covered expenses less the Medicare payment are \$500 (\$1,100 - \$600), a smaller amount, the plan pays \$500. In this plan, the beneficiary pays nothing.
- The exclusion plan would pay 80 percent of covered medical expenses (that is, the amount not paid by Medicare: \$1,100 - \$600 = \$500), less the plan deductible. In this case, the plan payment would be \$320 (.8 × [\$500 - \$100]). The beneficiary would pay \$180 (\$1,100 - \$600 - \$320).
- The carve-out plan would pay \$800 (.8 × [\$1,100 - \$100]), but since Medicare pays \$600, the plan reduces the payment to \$200. The beneficiary pays \$300.

mon since 1980.¹⁵ Finally, a redistribution of the work force into jobs that do not offer continued coverage could contribute to a decline in coverage rates. However, the roles of these factors in explaining lower rates of retiree health coverage promised to current workers have not been investigated.

The future of postretirement health coverage is uncertain. At least four major factors may discourage employers from either establishing health coverage for future retirees or expanding existing coverage. These factors are:

- the prospect of action by FASB to require that unfunded liability for postemployment health and welfare benefits be disclosed;
- current tax law;
- recent and expected changes in Medicare coverage; and
- recent litigation addressing the rights of retirees to promised health insurance benefits.

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Concurrent with employers' emerging recognition of retiree health plan liability, changes in tax law made the prospect of funding accrued liability unattractive.

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Disclosure

The Employee Retirement Income Security Act of 1974 (ERISA) requires that accrued liability in qualified pension plans be funded. Employers receive tax deductions for contributions to qualified pension-trust funds; investment income earned by the trusts receives favorable tax treatment. In contrast, ERISA does not require that tax-qualified retiree health and welfare plans be funded. Rather, employer payments for retiree health coverage are treated as operating expenses for the year in which the benefits are paid.

¹⁵ Between 1979 and 1983 the coverage rate for workers meeting ERISA standards fell four percentage points. This finding may, in part, be from statistical quirks, but could also be from a decline in the growth of coverage and from job loss associated with the 1980-82 recession. For more information see Employee Benefit Research Institute, "New Survey Findings on Pension Coverage and Benefit Entitlement," *EBRI Issue Brief* 33 (August 1984).

In a statement issued in November 1984, FASB established employers' responsibility to provide information about post-employment health and welfare benefits as a footnote to their financial statements. In itself, this is not a significant change in accounting practice, since the current costs of these benefits are indicated and included in calculating net income. Nevertheless, FASB's position is important in that it requires employers to recognize the current cost of retiree benefits separately from the cost of plan benefits for active workers.

Ultimately more significant may be the issue still under consideration by FASB—requiring that employers recognize accruing unfunded liability for retiree health and welfare benefits, similar to the way unfunded pension liabilities must be recognized. By most estimates, unfunded liability for retiree health and welfare benefits is large.

Based on a nonrepresentative selection of employer plans, the National Association of Accountants estimates that unfunded liabilities for retiree health plans could range from 4 to 50 times the amount that employers are now paying annually as current plan expense. Actuaries who have calculated these costs for clients concur that liabilities can range from 30 to 50 times the current expense level.

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Section 401(h) plans are receiving more attention from employers seeking to fund liabilities for retiree health benefits.

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Tax Law

Concurrent with employers' emerging recognition of retiree health plan liability, changes in tax law made the prospect of funding accrued liability unattractive. Prior to DEFRA's enactment in 1984, the tax code defined two tax-favored vehicles for prefunding retiree health benefits: section 501(c)(9) trusts (VEBAs) and section 401(h) trusts.¹⁶ Although no existing national data document the use of these vehicles, consulting actuaries indicate that very few firms used either

¹⁶ Technically, the tax-preferred status of VEBAs was not allowed for retiree health benefits, unless the VEBA financed the costs of health benefits for active and retired employees alike.

vehicle to fund accruing liability for retiree health benefits. Reportedly, those that did fund these liabilities most often used VEBAs; virtually no employers used 401(h) trusts.

DEFRA discourages the use of VEBAs to fund liability for retiree health benefits in four ways:

- DEFRA establishes limits for deductible contributions to VEBAs. Actuarial assumptions must be based on the current medical plan and cannot include any adjustment for inflation.¹⁷ Under DEFRA, qualified contributions are limited to the sum of (1) benefits paid during the year; (2) reasonable expenses; and (3) a permissible addition to reserves. Without actuarial certification, the safe-harbor limit on the permissible addition is limited to 35 percent of the qualified direct cost for one year.
- DEFRA subjects all investment earnings on reserves held in VEBAs for postretirement medical benefits to the tax on unrelated business income.¹⁸
- DEFRA imposes a 100-percent penalty tax on any disqualified benefits paid from the funds. Disqualified benefits include any assets reverting to the benefit of employers sponsoring the welfare benefit funds. This means that any excess of funds greater than necessary to cover current-year retiree benefits cannot be recaptured by an employer.
- DEFRA imposes nondiscrimination rules for qualified contributions to VEBAs. In addition, limits on employer contributions to qualified pension and profit-sharing plans for highly compensated employees (section 415 limits) include contributions for postretirement health benefits.

Many benefit experts consider DEFRA's restrictions on using VEBAs to fund retiree health liabilities prohibitive, given the competing uses of funds—many of which receive preferential tax treatment—within firms. Chart 1 illustrates allowable funding for postretirement health benefits prior to and after DEFRA's enactment.

Section 401(h) of the tax code defines an alternative for funding retiree health insurance liabilities. Section 401(h)

¹⁷ The new deduction limits imposed by DEFRA apply to contributions paid or accrued after December 31, 1985, in taxable years ending after this date. There is, however, a special transition rule that may be applied for the first four years.

¹⁸ VEBAs used for benefits other than retiree health insurance face a tax on unrelated business income for reserves that exceed the limits specified for that particular benefit fund. The new rules regarding unrelated business income taxes do not apply to income on reserves set aside as of the close of the last plan year ending prior to July 18, 1984.

authorizes (1) tax-exempt employer contributions to health insurance benefits for retirees, their spouses, and dependents and (2) tax-deferred contributions to retiree death and disability benefits.

No existing data indicate the use of 401(h) trusts. Actuaries report, however, that few firms use them for retiree health benefits. Those that do may limit plan benefits to payment of Medicare Part B premiums.

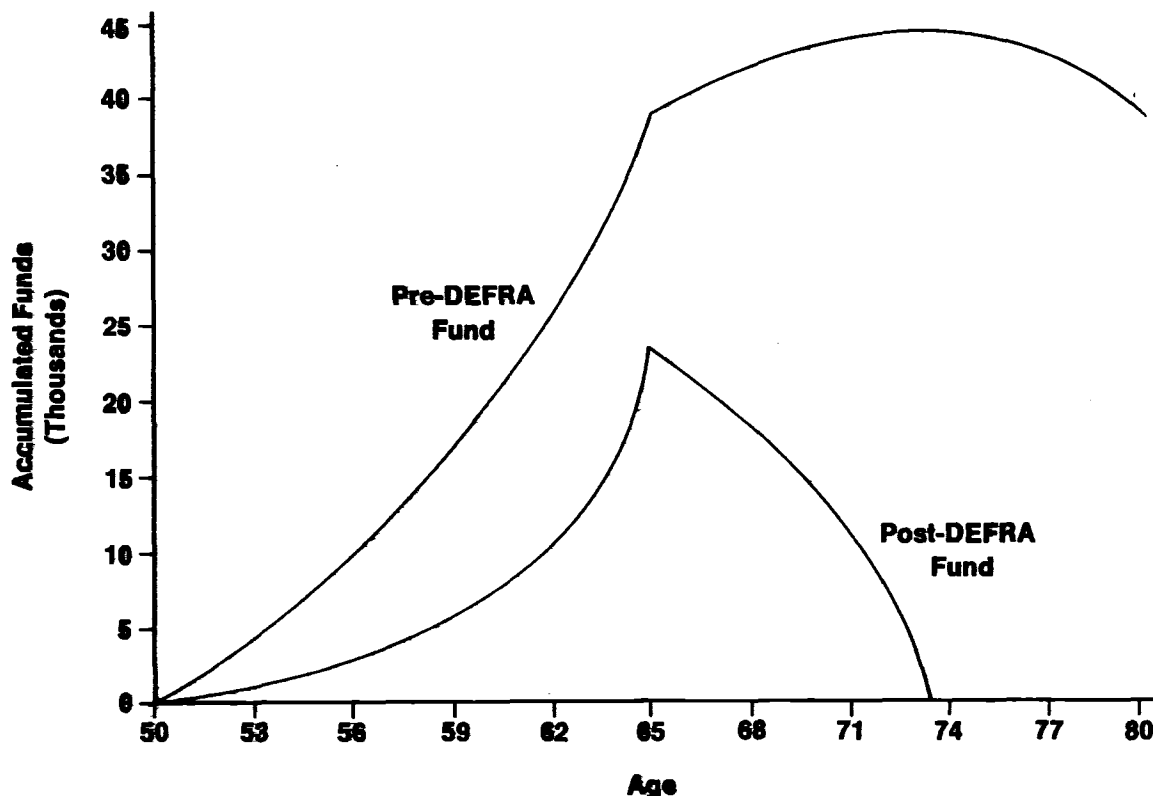
Changes in Medicare coverage and reimbursement that shift costs to beneficiaries in turn shift costs to employer-sponsored retiree health plans.

Prior to DEFRA, employers may have avoided establishing section 401(h) trusts for several reasons:

- The Internal Revenue Code limits employer contributions to section 401(h) trusts, requiring that the benefits paid by these accounts be "subordinate" or incidental to the retirement benefits paid by the employer pension plan. This limit is interpreted as constraining employer contributions to the trust to 25 percent of annual total contributions to retiree benefits, including pension benefits. For most employers, the limit on contributions to 401(h) trusts is too low to adequately fund accruing liabilities for retiree health, death, and disability benefits.
- Funds contributed to a 401(h) are separate from the rest of the pension plan. This means that excess funds contributed to a 401(h) cannot be used to fund other costs in the pension plan.
- The nondiscrimination rules applicable to the pension plan are applied to 401(h) trusts. Because prior to DEFRA the use of VEBAs was not governed by nondiscrimination rules, 401(h) trusts may have been a relatively unattractive means to fund retiree health liabilities.
- Benefit consultants may have had relatively little experience with 401(h) trusts and been uncertain about technical aspects.

Given DEFRA's restrictions on the use of VEBAs, section 401(h) plans are now receiving more attention from employers seeking to fund liabilities for retiree health benefits. However, limits on contributions to these plans and uncertainty

Chart 1
**Comparison of Allowable Funding for Postretirement
 Medical Benefits for Employee Age 50**



Source: Buck Consultants.

Note: This hypothetical example considers a 50-year-old employee with current annual postretirement health costs of \$600. It is assumed that these costs increase annually by 10 percent and that the fund into which contributions are deposited earns 10 percent annually. In this example, if prefunding had occurred without the limits imposed by DEFRA, sufficient funds would accumulate by retirement at age 65. If prefunding had occurred within DEFRA contribution limits, funds for this worker would be exhausted by age 74.

about the legislative and regulatory status of any plan established under section 401 may be important factors impeding their use.

Medicare

Recent and expected changes in Medicare are a critical factor in the development of retiree health insurance benefits. Changes in Medicare coverage and reimbursement that shift costs to beneficiaries in turn shift costs to employer-sponsored retiree health plans. Observing the financial status of the Part A (Hospital Insurance) trust fund and the rising public cost of Part B coverage, employers anticipate that Congress will

impose additional cost sharing on Medicare beneficiaries. In addition, employers are concerned that Medicare will expand its position as secondary payer, reducing Medicare obligations for employer-covered retirees in the same way that Medicare has reduced its obligations for workers over age 65 who are covered by employer plans.

Finally, employers are concerned that the Medicare prospective payment system may increase the cost of retiree health benefits by reducing the length of hospital stays, possibly increasing the number of physician visits or use of outpatient services that are covered by employer plans. While Medicare

covers the full cost of inpatient services after the deductible for the first 60 days of illness (called a benefit period), Medicare coverage for physician care entails much greater cost sharing. The cost sharing for physician care imposed by Medicare is a major expense for employer-sponsored retiree health plans.

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Retirees' rights to health insurance benefits—in particular those not funded during their working careers—have been the subject of numerous court decisions at the federal level.

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Recent Litigation

Retirees' rights to health insurance benefits—in particular those not funded during their working careers—have been the subject of numerous court decisions at the federal level. The decisions are based in contract law and generally define retirees' rights to benefits.

Court rulings have addressed the rights of new retirees to health insurance and other nonpension benefits, as well as the rights of current retirees to continued benefits in various instances of plan termination. Recent decisions have affirmed retirees' rights to the benefits promised them, generating some concern among employers that vesting standards for unfunded retiree health and welfare benefits are being defined in common law.

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Vesting for retiree health and welfare benefits may not be implicitly defined "outside the contract" in the context of vesting for other retiree benefits, such as pensions.

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Early court decisions regarding retirees' rights to nonpension benefits, brought under contract law, interpreted the rights conservatively: retirees may be entitled to benefits only while the contract promising benefits is in force and the employer

remains in business.¹⁹ The employer may be obligated to provide lifetime benefits to retirees beyond plan termination only if that obligation is clearly assumed in the contract. Furthermore, vesting for retiree health and welfare benefits may not be implicitly defined "outside the contract" in the context of vesting for other retiree benefits, such as pensions.²⁰

The precedent established by these decisions placed the burden of proving a continuing right to benefits largely on retirees. Retirees whose benefits were terminated were responsible for proving that the employer breached a bargaining agreement clearly obligating the employer to continue benefits, or at least implying intent to do so.

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At least one court decision specifically rejected a lower court's presumption that retiree health and life insurance benefits are lifetime benefits, absent express contract language limiting their duration.

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However, given stated or implied intent to provide benefits to retirees, several decisions interpreted the right to retirement benefits broadly. These decisions have defined vesting for retiree health and welfare benefits as implicit in retirement status, unless otherwise defined in the labor agreement.

¹⁹ *Oddie v. Ross Gear & Tool Co.*, 305 F. 2d 143 (6th Cir.) cert. denied, 371 U.S. 941 (1962); *UAW v. Robertshaw Controls Co.*, 405 F. 2d 29 (2nd Cir. 1968); *Burgess v. Kawneer Co.*, Memorandum Opinion No. K77-487 CA8 (W.D. Mich. 1977); *Turner v. Teamsters, Local 302*, 604 F. 2d 1219 (9th Cir. 1979); *UAW v. Houdaiville Industries, Inc.*, Case No. 5-70742, (E.D. Mich.) undated slip op.; *Metal Polishers Local No. 11 v. Kurz-Kasch, Inc.*, 538 F. Supp. 368, 110 LRRM 3319 (S.D. Ohio 1982); *UAW v. New Castle Foundry*, 4EBC 2455 (S.D. Ind. 1983); *UAW v. Roblin Industries, Inc.*, 561 F. Supp. 288 (W.D. Mich 1983); *Policy v. Powell Press Steel Co.*, Case No. C82-24024, slip op. (N.D. Ohio 1984); *Bomhold v. Pabst Brewing Co.*, (No. 83-1327, July 6, 1984).

²⁰ In *UAW v. Houdaiville*, the court found that the continuation of some benefits for which retirees were vested did not implicitly obligate the employer to continue health and life insurance benefits for retirees beyond the termination of the labor agreement. *UAW v. Houdaiville Industries, Inc.*, Case No. 5-70742, (E.D. Mich.) undated slip op.

As early as 1960, *Cantor v. Berkshire Life Insurance Company*²¹ established that the employer may not withdraw or terminate the retirement program after the employee has complied with all conditions entitling him or her to retirement rights. Subsequent court rulings have affirmed that opinion.

Other court rulings concerning the continuation of benefits also construed ambiguity in contract language in favor of retirees when evidence of intent was present. In a series of cases since 1967, the courts have obligated employers who promised retiree benefits to continue those benefits throughout the retirees' lifetimes. Generally, these findings have been based on the absence of contract language to the contrary and on evidence of intent. The circumstances of these cases included, variously, contract expiration and corporate takeover or merger.

The inference of intent in these rulings was in each instance drawn from the particulars of the case. Commonly the courts considered both failure of the labor contract to address the issue of lifetime benefits for retirees (or ambiguity in contract language) and management's representations that the benefit would continue for life—including oral statements to that effect.

Reconciling these decisions with more conservative legal precedent, at least one court decision specifically rejected a

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Common law has established a general vesting rule for these plans: former employees who properly retire gain a vested right to welfare benefit plans at retirement.

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lower court's presumption that retiree health and life insurance benefits are lifetime benefits, absent express contract language limiting their duration.²² Similarly, another decision included the following remarks:

. . . retiree insurance benefits are [not] necessarily interminable by their nature. [No] federal labor policy identi-

²¹ *Cantor v. Berkshire Life Insurance Co.*, 171 Ohio St. 405, 171 N.E. 2d 518 (1960).

²² *UAW v. Cadillac Malleable Iron*, 728 F. 2d 807 (6th Cir. 1984).

fied to this court presumptively favor[s] the finding of interminable rights to retiree insurance benefits when the collective bargaining agreement is silent.²³

Two recent court decisions upholding retirees' rights to continued health insurance benefits have gained particular attention. These cases were brought under ERISA, which governs the funding, vesting, and fiduciary practices of private pension plans. In that these cases were brought under ERISA,

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Ambiguous plan language regarding the employer's right to terminate or alter the plan may be interpreted broadly in favor of retirees.

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*Eardman v. Bethlehem Steel*²⁴ and *Hansen v. White Farm Equipment Company*²⁵ are departures from the precedent established earlier under contract law. *Hansen v. White Farm*, furthermore, cited ERISA's failure to define the rights of retirees to nonpension benefits as the basis for common law, defining the respective rights of retirees and employers in modifying or terminating retiree health benefits.

In *Eardman v. Bethlehem Steel*, Bethlehem Steel was constrained from modifying its retiree health insurance plans to parallel the benefits offered to active employees under a collective bargaining agreement. Similar to earlier cases where contract language was ambiguous, the court ruling requiring Bethlehem Steel to reinstate benefits strongly took into consideration implied intent. The decision was appealed, and in a later settlement Bethlehem Steel was allowed to establish a substitute "permanent health program" not subject to later modification or termination.

The plaintiff in *Hansen v. White Farm* contested the termination of a noncontributory retiree health plan after a bankruptcy reorganization. The bankruptcy court authorized

²³ *UAW v. Yard-Man, Inc.*, 716 F. 2d 1476 (6th Cir. 1983), cert. denied, 104 S. Ct. 1002 (1984).

²⁴ *Eardman v. Bethlehem Steel Corp.*, No. 84-274E, slip op. (W.D. NY Sept. 17, 1984).

²⁵ *Hansen v. White Farm Equipment Co.*, No. C82-3209 (N.D. Ohio Sept. 20, 1984).

replacement of the plan with a group plan arrangement financed entirely by participant premiums. Reversing the bankruptcy court decision, the federal district court held that, in excluding welfare benefit plans from the minimum vesting requirements of ERISA, Congress did not intend to permit the unrestricted termination of these plans by employers. Furthermore, the court stated,

. . . the modern view concerning benefit plans, under which an employer may not invoke a termination clause to cut off the benefits of a former employee who has properly retired pursuant to the employer's requirements, should be adopted as a rule of common law under ERISA.²⁶

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***Hansen v. White Farm* invites legislative clarification of ERISA's provisions regarding health and welfare plans.**

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In the absence of legislation clarifying ERISA's protections for health and welfare plan participants, the precedent set by *Hansen v. White Farm* and earlier cases governs the organization and administration of retiree health insurance plans. In particular, common law has established a general vesting rule for these plans: former employees who properly retire gain a vested right to welfare benefit plans at retirement. An employer may not terminate the plan or alter its provisions unless the employer has reserved the right to do so and has clearly communicated that right to employees. Ambiguous plan language regarding the employer's right to terminate or alter the plan may be interpreted broadly in favor of retirees.

Furthermore, by extending retirees' rights as a proposed common law principle under ERISA, *Hansen v. White Farm* invites legislative clarification of ERISA's provisions regarding health and welfare plans. The *Hansen v. White Farm* decision may be construed as preventing employers from invoking a termination clause in welfare benefit plans for retirees, regardless of how clearly the rights of the employer are worded or communicated to employees, since this right is not otherwise recognized in ERISA's provisions governing pension

plans. The precedent established by *Hansen v. White Farm* differs markedly from earlier precedent under contract law and may be an important factor in employer decisions to offer retiree health insurance benefits. Moreover, by rescinding, in effect, employers' ability to terminate benefits, *Hansen v. White Farm* may be an important impetus to funding accruing liability for retiree health and welfare benefits.

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Funding and vesting are difficult concepts as applied to service benefits such as health insurance, since the cost of providing service benefits is much less predictable than the cost of providing cash benefits such as pensions.

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◆ **Issues in the Coming Debate**

In addition to limiting the use of VEBA's for funding retiree health insurance liability, DEFRA mandated the Treasury Department to study possible funding and vesting rules for retiree health plans, similar to the rules now governing pensions under ERISA. Funding and vesting, however, are difficult concepts as applied to service benefits such as health insurance, since the cost of providing service benefits is much less predictable than the cost of providing cash benefits such as pensions.

As with cash benefits, accruing liability for service benefits (measured as the discounted present value of forecasted plan costs) depends on the probability of employees' ultimately qualifying for benefits and on the expected lifespan of retirees. Unlike cash benefits, however, future health insurance costs also depend on the long-term rate of health-care cost inflation, changes in the delivery of health care, and changes in medical technology. Moreover, survivorship rights under a retiree health plan cannot be factored into the benefit payout in the same way a pension plan can reduce annual benefits when retirees elect joint and survivors' benefits. As a result, survivors' benefits can add significantly to net plan costs and make forecasting those costs even more uncertain. Finally, the possibility of vesting in more than one retiree health insurance plan represents a practical problem in coordinating benefits from multiple plans, as well as Medicare, and constitutes an additional source of uncertainty in forecasting plan costs.

²⁶ Ibid.

Preliminary estimates from the U.S. Department of Labor's Office of Pension and Welfare Benefit Programs (OPWBP) indicate that aggregate unfunded liability for retiree health insurance benefits may have reached \$125 billion in 1983 and may continue to grow by \$5 billion each year.²⁷ OPWBP estimates that employers must spend an additional \$10–15 billion to meet that liability in 20 years, equivalent to a 13- to 20-percent increase in the average amount spent by employers for health benefits in 1983.

The emerging policy debate centers on the appropriate and prudent financing of retiree health and other nonpension benefits, as well as the rights of retirees to receive these benefits. While federal rules governing the administration of qualified plans may place funding and reporting burdens on employers—potentially discouraging employers from providing retiree health benefits—such rules may also safeguard promised benefits to workers.

If a larger private system of health insurance for the elderly is to be encouraged, several related issues must be addressed. These include the relative merits of an employer-based system of coverage versus a more individualized system, such as the proposed individual retirement accounts (sometimes called "medical IRAs") specifically earmarked for the purchase of health care or health insurance in retirement. They also include the willingness of Congress and the administration to sustain the near-term revenue loss implied by tax policy to encourage greater private insurance coverage among retirees. Possible reduction in the fiscal burden of Medicare and Medicaid spending for the elderly, however, is an important offsetting consideration. Possible long-term reductions in public spending enabled by private coverage should be weighed carefully against the near-term cost of aggressive tax policy to encourage private health insurance coverage among retirees.

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In the coming debate over appropriate rules, however, the current and potential role of employer-sponsored coverage in financing health care for the elderly should also be considered, along with the potential advantages and disadvantages of a larger private system of health insurance for the elderly versus a growing public system. Employer plans may be important in protecting early retirees from the high cost of major illness and in ensuring access to health care. For retirees covered by Medicare, especially those with chronic health problems, employer-sponsored health coverage helps finance substantial out-of-pocket expenses and represents an important supplement to pension income—one that may exceed the value of many retirees' pension plans.

²⁷ Julie Kosterlitz, "'Disaster' Stories May Spur Congress To Protect Health Benefits For Retirees," *National Journal*, July 27, 1985, pp. 1743–1746.

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