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REGULATING EMPLOYEE HEALTH AND WELFARE PLANS POST-ERISA: HISTORY AND DIRECTIONS FOR CHANGE

Statement of

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Mr. Chairman, I am pleased to present this testimony on the regulation of employee health and welfare plans. In 1974, the Employee Retirement Income Security Act (ERISA) established participation, funding and termination standards for private pension plans. Few of ERISA's provisions, however, apply to health and welfare plans. Instead, federal regulation of health and welfare plans has evolved mainly as the result of legislation enacted for some purpose other than the protection of plan participants. Most recently, Congressional concern with federal tax revenues has guided new regulation of welfare plan funding practices and the establishment of nondiscrimination standards for some plans. The current patchwork of regulation lacks a national policy focus: it does not necessarily serve the interests of plan participants, nor does it represent clear national policy toward employee health and welfare plans.

This testimony describes the prevalence and importance of employee health and welfare benefits, as a part of employee compensation and as a source of income security for workers. ERISA regulation of welfare benefits is described, and other federal legislation that provides for the regulation of welfare plan participation, funding and termination is summarized. (State regulation of insured health and welfare plans is not presented.) Several

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areas of concern are discussed including: (1) the effects of ERISA preemption; (2) the effects of retiree health plan regulation; and (3) the lack of ERISA guidance in plan termination. Finally, several considerations that would advise caution in formulating new regulation of health and welfare plans are described.

I. Employer-Provided Health and Welfare Benefits

Employer contributions to group health and welfare benefits are a steadily growing component of total employee compensation. In 1983, employer contributions to health insurance, life insurance, and supplemental unemployment insurance equaled 4.5 percent of total compensation. Employer contributions to health insurance were the largest single benefit in this group, equaling 4.1 percent of total compensation--more than 90 percent of employer contributions all non-pension voluntary benefits, other than compensation for time not worked.[1]

The growth of health and welfare benefits as a share of compensation has resulted from (1) the growth of employee and retiree participation in health and welfare plans commensurate with the growth of total employment; and (2) the rising cost of providing, in particular, health benefits to plan participants.

A. Employer-Provided Health Benefits--Health insurance is probably the most common employee benefit provided to workers in the United States. In 1982, 84 million civilian nonagricultural workers reported coverage from an employer group health insurance plan; virtually all of these workers received

[1] By comparison, employer contributions to private and public employee pension plans represented 5.1 percent of total compensation in 1983.

an employer contribution to their coverage. Workers with employer group health coverage accounted for nearly 78 percent of the nation's total civilian nonagricultural workforce in 1982 (See Table 1).

Rates of employer group health insurance coverage are particularly high among workers who are employed full-time throughout the year--the largest segment of the workforce. In 1982, more than 90 percent of full-time full-year workers were covered by an employer group health plan.[2]

Most workers (60 percent) participate in a health insurance plan sponsored by their own employer. Rates of direct coverage are very high among full-time full-year workers (85 percent), and lower among workers with more fragmented work patterns. Many workers who are employed part-time or during only part of the year have coverage only as the dependent of another worker's plan. In 1982, 29.4 million part-time or part-year workers were covered by employer group health plans; 44 percent of these workers (13 million) were covered only as dependents of other workers who directly participated in an employer-sponsored health plan.

Employer group health insurance is possibly the most egalitarian employee benefit provided to workers in the United States. Employer health insurance plans Employer health plans include the spectrum of workers at all levels of earnings; rates of coverage among all workers except those at the very lowest annual earnings level--generally with fragmented work patterns--are high and roughly equal. Furthermore, the value of health insurance benefits shows no significant, systematic variation with workers'

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[2] By comparison, 56 percent of all workers, and 70 percent of the ERISA workforce, participated in an employer pension plan in 1983. Employee Benefit Research Institute, "New Survey Findings on Pension Coverage and Benefit Entitlement," EBRI Issue Brief, No. 33 (Washington, D.C.: Employee Benefit Research Institute, August 1984).

Table 1

DISTRIBUTION OF WORKERS COVERED BY AN EMPLOYER GROUP HEALTH INSURANCE PLAN BY LEVEL OF WORKFORCE ACTIVITY, 1982[a]

Workforce Activity	Employer Coverage			No Employer Coverage
	Total	Direct Coverage[b]	Indirect Coverage[b]	
		(Persons in millions)		
All workers	83.7	65.3	18.4	24.2
Full-time workers	65.1	58.3	6.8	11.8
Full-year	49.4	46.1	3.3	5.3
Part-year	15.8	12.3	3.5	6.5
Part-time workers	13.6	4.1	9.5	8.1
Full-year	5.1	2.1	3.0	2.5
Part-year	8.5	1.9	6.5	5.6
Self-employed	5.0	2.9	2.1	4.3
		(Percents)		
All workers	77.6	60.5	17.1	22.5
Full-time workers	84.7	75.8	8.9	15.3
Full-year	90.4	84.3	6.1	9.6
Part-year	70.7	55.0	15.7	29.3
Part-time workers	62.3	18.8	43.8	37.4
Full-year	66.7	27.9	38.8	33.3
Part-year	60.3	13.8	46.5	39.7
Self-employed	53.6	30.8	22.8	46.4

SOURCE: EBRI tabulations of the March 1983 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).
Note: Items may not add to totals because of rounding.

[a]Includes civilian nonagricultural workers, except those living in families in which the greatest earner is a member of the Armed Forces or an agricultural worker.

[b]Direct coverage is defined as coverage provided by the worker's own employer plan at any time during 1982; indirect coverage is coverage received as the dependent of another worker in 1982.

earnings.[3] As a result, employer-provided health insurance is a particularly valuable benefit for low- and middle-income workers: for these workers, employer contributions to coverage represent a proportionately larger income supplement than they do for higher-income workers.

Similar to the distribution of all workers in the United States, most workers covered by an employer group health plan are low- and middle-income workers. In 1982, more than 80 percent of all workers covered by an employer group health insurance plan earned less than $30,000; about half (53 percent) earned less than $15,000 (see Table 2). Only 5 percent of all workers covered by an employer group health insurance plan in 1982 earned more than $40,000.

In addition to coverage of active employees, many employer group health insurance plans--particularly those offered by larger employers--continue health insurance coverage to retirees. In 1982, more than 60 percent of all plan participants employed in medium-size or large establishments had coverage that would continue after early or normal retirement.[4] In general, plans which provide retiree coverage either "carve out" Medicare benefits (that is, integrate Medicare coverage as first-payer for the same coverage offered to active workers), or provide supplemental coverage for services not covered by their active workers' health plan.

Eligibility for retiree health insurance benefits is often determined differently than eligibility for active employee coverage. For

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[3] Gail R. Wilensky and Amy K. Taylor, "Tax Expenditures and Health Insurance: Limiting Employer-Paid Premiums," Public Health Reports (July/August 1982), table 2.

[4] EBRI tabulation of the 1983 Level of Benefits Survey, U.S. Department of Labor, Bureau of Labor Statistics.

Table 2

DISTRIBUTION OF WORKERS
COVERED BY AN EMPLOYER GROUP HEALTH INSURANCE PLAN
BY PERSONAL EARNINGS, 1982[a]

Personal Earnings	Workers with Employer Coverage[b] (in millions)	Percent of Workers within Earnings Group	Percent of All Workers with Employer Coverage
Loss	0.4	43.4	0.5
$ 1-$ 4,999	15.2	56.2	18.2
5,000- 7,499	6.6	65.9	7.9
7,500- 9,999	6.6	74.8	7.9
10,000- 14,999	15.8	85.1	18.9
15,000- 19,999	12.7	90.4	15.2
20,000- 24,999	9.6	92.8	11.4
25,000- 29,999	6.3	93.9	7.6
30,000- 34,999	3.9	93.3	4.6
35,000- 39,999	2.1	93.6	2.5
40,000- 49,999	2.1	91.7	2.5
50,000- 59,999	1.0	92.3	1.2
60,000- 74,999	0.6	89.4	0.7
75,000 or more	0.7	86.9	0.9
Total, All Workers[c]	83.7	77.6	100.0
Summary:			
Loss-$14,999	44.7	68.2	53.4
$15,000- 24,999	28.6	91.9	34.2
25,000- 39,999	6.0	93.4	7.2
40,000 or more	4.4	90.7	5.3

SOURCE: EBRI tabulations of the March 1983 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

[a]Includes nonagricultural civilian workers who reported employer group health insurance coverage at any time during 1982; excludes workers in families in which the greatest earner is a member of the Armed Forces or an agricultural worker.

[b]Includes coverage from the worker's own employer group plan or from the plan of another worker.

[c]Items may not add to totals because of rounding.

example, employers may require ten to fifteen years of service for retiree benefit eligibility; active employees, by comparison, are typically eligible for coverage immediately or within three months of service. In addition, most employers require that the retiree be eligible for pension benefits to qualify for retiree health benefits. Employees who terminate employment before retirement, even though they are vested in the pension plan, may also be ineligible for retiree health insurance benefits.

These restrictions on employee eligibility for retiree health coverage may exclude many workers from eventually receiving post-retirement health benefits, even though they currently participate in a plan that offers that coverage. Currently, no survey data exist that document the prevalence of employer-based health insurance coverage among retirees.

B. Employer-Provided Disability and Life Insurance Benefits--Employer group disability and life insurance plans provide income replacement for workers and their dependents in the event of the worker's total disability or death. Although no population survey data exist to document the prevalence and distribution of disability and life insurance benefits among workers, published data from a national survey of medium-size and large establishments suggest that, among full-time full-year workers in these establishments, disability protection and life insurance are about as widely held as health insurance.[5]

(i) Disability Benefits. Long-term disability benefits provide earnings replacement for workers who become permanently and totally disabled.

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[5] Data on disability and life insurance plan coverage are taken from published tabulations of the Level of Benefits Survey, conducted annually by the U.S. Department of Labor, Bureau of Labor Statistics. See: U.S. Department of Labor, Employee Benefits in Medium and Large Firms, 1983, Bulletin 2213 (Washington, D.C.: U.S. Government Printing Office, 1984).

This protection can be provided through an insurance arrangement or through the worker's pension plan. In 1982, about 43 percent of full-time permanent workers in medium-size and large establishments participated in an employer group disability plan; 49 percent participated in a pension plan that would provide immediate retirement benefits if the worker became disabled (See Table 3). In total, about 92 percent of all full-time workers have disability coverage provided by a disability or pension plan.

Employer group disability plans usually require an employee contribution. Since earnings replacement is goal of disability coverage, the contribution amounts--and the amount of plan benefits--vary by employee earnings. In 1982, two-thirds of full-time permanent workers in medium-size and large establishments with group disability coverage contributed to the plan. Employee contributions, however, were low--usually less than one percent of employee earnings. By comparison, private pension plans are seldom contributory.

(ii) Employer-Provided Life Insurance. Nearly all full-time permanent employees in medium-size and large establishments (96 percent) participate in an employer-sponsored basic life insurance plan. Like disability insurance, basic life insurance benefits are generally intended to provide income to replace lost earnings. The amount of basic coverage provided by employer plans, therefore, is usually a multiple of the worker's earnings. In 1982, about two-thirds of plan participants in medium-size and large establishments belonged to plans that paid 100 percent or 200 percent of the deceased worker's annual earnings. One third of plan participants belonged to plans that paid a flat dollar amount, usually between $2,000 and $15,000.

Table 3

PERCENT OF FULL-TIME EMPLOYEES PARTICIPATING IN EMPLOYER HEALTH, LONG-TERM DISABILITY, AND LIFE INSURANCE PLANS, MEDIUM-SIZE AND LARGE ESTABLISHMENTS, 1982[a]

Employee Benefit Plan	Participants as a Percent of All Full-Time Employees
Health Insurance for Employee[b]	97
Noncontributory[c]	71
Health Insurance for Dependents[b]	93
Noncontributory	44
Long-Term Disability Insurance	43
Noncontributory	33
Retirement pension with immediate disability retirement provision	49
Noncontributory	d
Life Insurance	96
Noncontributory	82

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics, Employee Benefits in Medium and Large Firms, 1982, Bulletin 2176 (August 1983), pp. 6 and 16.

[a]Participation is defined as coverage by a time off, insurance, or pension plan to which the employer contributes. Employees subject to a minimum service requirement before they are eligible for a benefit are counted as participants even if they have not met the requirement at the time of the survey. In contributory plans, only employees who elect and contribute to coverage are counted as participants. Benefits to which the employer does not contribute are outside the scope of the survey. Only current employees are counted as participants; retirees who participate in the benefit program are excluded.

[b]The employee or dependents may be covered by a working spouse's plan instead of, or in addition to, participation in the surveyed employer plan.

[c]All coverage in the benefit program is provided at no cost to the employee. Supplemental life insurance plans, not tabulated here, may be contributory.

[d]Published tabulation not available.

Some basic life insurance plans also provide a form of disability protection by continuing coverage or paying immediate benefits to workers who become disabled. Life insurance plans may pay disability benefits in two ways. First, some plans provide a lump-sum or periodic distribution of the policy's face value to workers who become disabled. Second, some plans pay the face value, or a multiple of the face value, of the policy for accidental death or dismemberment; in these cases, permanent disability is presumed. In 1982, nearly all full-time permanent workers (99 percent) who participated in an employer-sponsored basic life insurance plan were entitled to extended coverage or distribution of the policy's face value if they became disabled. Nearly three-quarters (72 percent) had coverage that provided accidental death or dismemberment benefits.

In addition to current life insurance coverage, some employers offer life insurance benefits that provide insurance protection after the worker retirees. Employers can provide and fund this coverage in a variety of ways; two general types of plans, however, are prevalent: (1) retired lives reserve plans; and (2) plans which simply group workers and retirees and pay claims on a current basis.

A retired lives reserve plan is a group life insurance plan that funds post-retirement life insurance benefits for employees prior to their retirement. That is, the employer reserves against post-retirement life insurance costs during the employee's working career. Funds are withdrawn from the plan to purchase term life coverage for workers only after they retire, or in some cases, when the worker becomes disabled. The tax advantages associated with these plans and other similar kinds of advance-funded plans have encouraged their popularity in recent years.

Plans which simply group current employees and retirees and pay claims on a current basis may be the more prevalent form of retiree life insurance plan. Employers do not contribute to these plans to cover accruing liabilities. Rather, claims that arise are simply paid against current assets.

National survey data do not distinguish between worker participation in Retired Lives Reserve plans and other forms of retiree life insurance plans. In 1982, 66 percent of workers in medium-size and large establishments who participated in an employer-provided basic life insurance plan had coverage that continued after retirement. In nearly all cases, retiree coverage is continued for life, generally with at least one reduction in the value of insurance coverage during the retirement period.

II. Regulation of Employee Health and Welfare Plans

The 1974 Employee Retirement Income Security Act (ERISA) and its subsequent amendments establish participation, funding and termination standards for private pensions and other retirement income plans. The general goal of ERISA legislation has been to protect the interests of pension plan participants; few of ERISA's protections apply to health and welfare plans. Instead, most regulation of employee health and welfare plans is authorized by legislation directed toward some other goal--generally, nondiscriminatory compensation for older workers or federal revenue enhancement.

A. ERISA Regulation--Possibly the most important provision of ERISA affecting employee health and welfare plans has been ERISA's preemption of state insurance laws and regulation with respect to self-insured or self-funded plans. Although ERISA defines nondiscrimination rules for, in particular, self-funded health plans, ERISA's uneven treatment of self-funded and insured plans been a significant incentive for employers to self-fund, in

particular, their health benefits.

This incentive arises in several ways. First, by self-funding health benefits, employers are able to avoid the burden of state excise taxes on insurance premiums. As health care costs and, consequently, health insurance premiums have risen, avoiding state taxes on insurance premiums has become an increasingly important consideration in employers' decisions to self-insure.

Second, some states (now approximately eight states) have established catastrophic health insurance pools which, on an assigned-risk basis, underwrite health insurance coverage for persons without proof of insurability. The underwriting losses borne by insurers who participate in these pools are shared by insured plans in the form of higher average premium levels. Because ERISA preempts state regulation of self-funded employee health plans, self-funded plans do not participate in state catastrophic health insurance pools and, therefore, do not share the underwriting losses associated with these pools. In states where a large proportion of employee health insurance is provided on a self-funded basis, the cost of a state assigned-risk pool for catastrophic coverage can represent a significant increment in insured plan premiums. The incentive to self-fund employee health benefits in these states, therefore, may be substantial, even for relatively small employers.

Although ERISA's preemption is generally presumed to be a strong factor in the increasing number of self-funded employee health plans, economic factors independent of ERISA have also encouraged the growth of self-funded plans. Two factors, in particular, have encouraged greater rates of self-funded benefits for both health and welfare plans. First, persistent

high interest rates have raised the value to employers of retaining the reserves against unreported claims that are imbedded in insurance premiums. Some insurers have responded to the self-insurance incentives implicit in high interest rates by offering employers delayed premium arrangements. By delaying premium payments for as long as 90 or 120 days, insurers allow employers to retain and accrue interest on reserves. There are no data, however, that indicate the prevalence of these arrangements or their ultimate effect on employers' decisions to self-fund benefits.

A second factor in the growing rate of self-funded health and welfare plans has been the emergence of a market offering support services for self-funded plans. These services include "administrative services only" (ASO) contracts and stop-loss coverage offered by commercial insurers and Blue Cross and Blue Shield plans. ASO contracts provide claims handling and other administrative services for self-funded plans. Stop-loss coverage limits employer liability for individual and aggregate claims in excess of a specific level. By facilitating plan administration and limiting employer liability for large or catastrophic claims, these arrangements may make self-funding feasible for even relatively small employee groups.

The importance of ERISA preemption relative to other factors as an incentive for plans to self-fund employee health and welfare benefits has not been established. Further, despite ERISA's preemption of state mandatory benefits laws, it is not clear that self-funded benefits, as regulated under ERISA and other legislation, are in any way contrary to the interests of plan participants. In 1983, 24 percent of all covered workers in medium-size and large establishments had major medical benefits provided by a self-funded plan, rather than an insured plan; another 16 percent had basic hospital benefits provided by a self-funded plan. In total, as many as 40 percent of

all workers in these establishments had all or some of their health insurance benefits provided by a self-funded plan.

B. Other Regulation Affecting Health and Welfare Plans--Most regulation of employee health and welfare plans occurs outside of ERISA. Two sources of regulation have been particularly important: (1) regulation authorized by the Age Discrimination in Employment Act (ADEA); and (2) regulation under various provisions of the tax code that define tax-qualified plans and funding arrangements.

(i) The Age Discrimination in Employment Act (ADEA). Responding to charges of widespread discrimination based on age, Congress legislated ADEA in 1967. As amended in 1978, ADEA prohibits any employee benefit practices that would discriminate against workers on the basis of age. ADEA protections apply, in particular, to workers aged 40 to 69. As interpreted in Department of Labor regulations, ADEA requires that employee benefit plans observe several general principles:

- Benefit cutbacks in welfare plans that are unjustified by cost increases for older employee are impermissable. In particular, this principle implies that complete removal of coverage on the basis of either entry age or attained age is impermissable.

- Older employees may not be required, as a condition of employment, to make greater contributions to a benefit plan than a younger employee. In plans that are not mandatory, however, older employees may be required to contribute more, but not more than is justified by age-related cost differences.

- With important exceptions, ADEA's nondiscrimination tests must be met for each benefit individually. That is, employers may not justify discrimination with respect to one benefit in terms of a nondiscriminatory total package of benefits.[6]

[6]The "benefit package" approach can be used, however, if (1) pension benefits are not included; (2) health benefits are not affected; (3) it "is not used to reduce costs to the employer;" and (4) the favorability of overall benefits to older employees is not reduced.

In general, ADEA has probably been effective in equalizing employee benefits among workers of all ages. With respect to health insurance benefits, ADEA does not recognize any reduction in total health benefits for older workers without sound and specific cost data justifying the reduction. This provision supplements ERISA's (earnings-related) nondiscrimination rules for self-funded health insurance plans by discouraging age-discriminatory benefit provision in insured health plans. Similarly, for insured welfare plans generally, ADEA may be an important factor in the apparently widespread, nondiscriminatory participation and benefits among older workers.

(ii) Tax-Related Regulation of Health and Welfare Plans. The regulation of employee health and welfare plans authorized by the tax code pertains, variously, to both insured and self-funded plans. Various parts of the tax code define nondiscrimination, funding and plan termination rules by which statutory benefits qualify for tax preferences. Recent legislation has contributed importantly to the level of regulation associated with tax-qualification, particularly for self-insured plans. The discussion that follows is intended to illustrate the nature of regulation associated with the tax qualification of statutory employee benefit plans; it by no means intended to be an exhaustive listing of tax-related regulation.

(a) Nondiscrimination. Various amendments to the tax code have established nondiscrimination standards for self-funded or insured health and welfare plans. ERISA, for example, established tax-qualification standards for self-funded health insurance plans aimed at eliminating plans which serve only "highly compensated" individuals. The 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) established similar nondiscrimination rules for employee life insurance plans, aimed at eliminating special treatment for "key employees." In addition TEFRA amended ADEA to make employer health plans, at the employee's election, first payer for health care services covered by the regular employee plan when the employee is otherwise covered by Medicare.

Most recently, the 1984 Deficit Reduction Act (DEFRA) established nondiscrimination standards for health, disability, life insurance, legal services, dependents care and other benefits if they are financed through a tax-exempt trust. DEFRA established maximum levels for reserves held in trusts or contributed to an experience-rated insurance plan for disability, severance pay and supplemental unemployment benefits. These limits are based on employee earnings, or for some benefits, the maximum that would be allowed under a defined benefit pension plan. DEFRA also affects employer contributions to post-retirement health and life insurance plans for key employees.

(b) Funding. Under DEFRA, deductable employer contributions to funded welfare benefit plans are limited. DEFRA established safe harbor rules for funding short-term disability, medical plans, severance pay or supplemental unemployment benefit plans and long-term disability and death benefits. In addition, DEFRA redefines all earnings on employer contributions to a funded retiree health plan as taxable unrelated business income; earnings on excess reserves held in a funded retiree life insurance plan are also taxable as unrelated business income.

(c) Plan Termination. General rules for terminating funded health and welfare benefit plans are specified in the tax code governing voluntary employee benefit associations (called 501(c)(9) plans or VEBAs). In general, plan assets must be distributed in the interest of participation employees. No such rules exist for unfunded health and welfare benefit plans, including those which offer continued coverage to retirees.

III. Directions for Change

The various regulations affecting employee health and welfare benefit plans raise several issues that require further consideration by the public policy community.

First, ERISA preemption of state insurance laws may be a strong incentive for employers to self-insure benefits, particularly health insurance benefits. Commercial insurers and Blue Cross and Blue Shield plans claim that ERISA's incentive for self-insurance poses an unfair burden by impairing their ability to compete. ERISA's preemption may also impose an unfair burden on

small employers by shifting state excise taxes and the cost of state catastrophic assigned risk pools to employers for whom self-insurance is unfeasible. This additional cost for small employers may contribute to the lower rate of health insurance coverage observed among workers in small establishments.

Second, DEFRA's limits on funded retiree health insurance plans come at a time when employers are increasingly aware of accruing liabilities for retiree health benefits. Under rules proposed by the Financial Standards Accounting Board (FASB), firms would be required to list unfunded retiree health insurance benefits as a corporate liability. The prospect of Medicare reform that might reduce the value of Medicare benefits for some retirees would also raise corporate liability for retiree health benefits. DEFRA's incentives to provide unfunded retiree health insurance benefits should be reevaluated in terms of responsible public policy toward retiree health care costs, not simply as revenue enhancement. Furthermore, some have argued that DEFRA's tax treatment of funded retiree health plans may be appropriate, since restrictions on eligibility for these benefits may effectively exclude rank and file employees; research is needed to evaluate this argument.

Finally, clearer specification of plan termination rules for unfunded plans--particularly, unfunded retiree health plans--is needed. Workers' rights to a retiree benefit is unclear when the benefit is financed as a current labor cost. Some have suggested that this problem might be addressed by establishing reasonable funding rules for retiree health benefits, or simply by forbidding employers from asserting termination rights that are not disclosed under ERISA reporting requirements. Defining funding standards or vesting rules for retiree health insurance plans, however, raises

many cost and administrative problems that have not been explored.

With respect to changes in rules affecting employee health insurance benefits, several cautions are in order. Employer liability for retiree health benefits have begun to accrue at an accelerated rate as the work force ages and health care cost inflation continues. The age distribution of workers by industry, however, is quite uneven. The average age of workers in manufacturing firms, for example, is significantly greater than the average age of workers in most other industries. The proportion of manufacturing workers covered by health plans that offer retiree benefits is also greater than in most other industries. The uneven distribution of both older employees and retiree health insurance plans among industries suggests that public policy toward these benefits may have strong sectoral effects. Any public policy initiative toward retiree health or welfare benefits should anticipate these effects, providing for gradual implementation and ample transition periods to discourage plan terminations.