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EMPLOYER-PAID RETIREE HEALTH INSURANCE:
HISTORY AND CURRENT ISSUES

Statement of

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Employer-paid retiree health insurance is a common benefit promised to employees of medium-size or large establishments in the United States. In 1984, 57 percent of all regular full-time workers in medium-size and large establishments participating in a health insurance plan were promised retiree health insurance. The cost of coverage promised these workers will be at least partly paid by the employer, usually on a current basis. That is, employers who offer retiree benefits seldom contribute against their accruing liability during the employee's working career.

No data exist that 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 establishments is rare.¹

History

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 few employers provided retiree health benefits in the 1950's. The Medicare debate in the early 1960's, however, brought to the attention of American workers the high

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cost of post-retirement health care relative to the modest incomes of most retirees, probably raising the demand for retiree health insurance as a benefit. The advent of Medicare benefits in 1966, furthermore, dramatically reduced the cost to employers of offering retiree health insurance, since Medicare would pay a large share of retirees' hospital and medical bills. Employer liability for retiree health care costs, although probably substantial, is secondary to Medicare.

The acceleration of health care costs in the 1970's markedly raised employers' health insurance costs for both active workers and retirees. Between 1965 and 1983, total spending for health care in the United States rose from \$43 billion to \$355 billion. The cost of hospital care rose three times faster than the cost of other consumer goods and services, increasing six-fold between 1965 and 1983. The cost of physician care also grew faster than other goods and services, more than tripling over that period. In 1983, 14.1 percent of these costs were financed by private insurance, principally by employer group plans. By comparison, the federal government financed 17.3 percent of personal health care spending in 1983.

Health care spending by and for the elderly has risen faster than spending for any other population group in the United States. In 1984, per capita personal health care spending for persons age 65 and older was, on average, 2.66 times the level of per capita personal health care spending for the population as a whole.

Despite the rapid increase in health care costs, particularly for the elderly, many employers did not focus on the rising cost of their obligations to current and future retirees. Reasons for this are many. Typically, employers do not distinguish between the cost of health insurance benefits for

retirees and the cost for active employees. Employers usually measure health care costs only in terms of current employees (or equivalently, as a percent of payroll). Low ratios of retirees to active employees throughout the 1960's, and the declining average age of the workforce, served to mask the rising cost of retiree health benefits. Since neither law or accepted accounting practice requires employers to recognize accruing liability for nonpension retirement benefits, employers were able to ignore the mounting current and future cost of health insurance for retirees.

Continued growth in the cost of employer plans, coupled with slowing inflation and reduced profits, has led employers to focus closely on sources of cost increases. In 1983, employer payments for health insurance reached 4.6 percent of payroll, compared to only 3.6 percent in 1979 (see 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 active workers as more workers were encouraged to take early retirement during the recession.

Types of Employer-Paid Retiree Health Insurance

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" or COB plans, pay beneficiaries the lesser of either (1) the plan benefit calculated without regard to the Medicare reimbursement, or (2) the covered expenses under the plan less the Medicare payment. A second type, "exclusion" plans, subtract Medicare payments before applying the plan's deductible and copayment provisions. The third type, and probably the most common, are "carve-out" plans. Carve-out plans reduce plan reimbursement by

Table 1

Employer Contributions to Health Insurance^a,
and as a Percent of Wages and Salaries, 1960-1983

Year	Health Insurance Contributions (amount in 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 (1981, 1983, 1984).

^aExcludes employer contributions to Medicare.

the amount Medicare pays. In general, carve-out plans result in the lowest plan cost, and the highest beneficiary cost of the three types.²

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

Trends in Employer-Paid Retiree Health Insurance

EBRI tabulations of survey data collected by the Bureau of Labor Statistics indicate that the prevalence of retiree health insurance benefits in medium-size and large establishments may be declining. In 1980, 59.6 percent of employees in medium-size or large establishments who participated in a health insurance plan were promised continuation of employer-paid coverage after retirement. In 1984, 56.6 percent of these employees were promised health insurance after retirement.

The decline in retiree health insurance promised to workers may result from (1) employers simply withdrawing the benefit, or collective bargaining that trades retiree health insurance for higher wages, some other benefit or reduced layoffs; (2) the erosion of defined-benefit pension coverage which is commonly the basis for continued health insurance coverage; or (3) a redistribution of the workforce into employment that does not offer continued coverage. The significance of each of these factors in explaining lower rates of retiree health coverage promised to current workers has not been investigated.

In any case, post-retirement health coverage faces an uncertain future. At least four major factors may discourage employers from either establishing health coverage for future retirees or expanding existing coverage. These factors include:

- o the prospect of action by the Financial Accounting Standards Board (FASB) to require that unfunded liability for post-employment health and welfare benefits be disclosed;
- o current tax law;
- o recent and expected changes in Medicare coverage; and
- o recent litigation over the rights of retirees to promised health insurance benefits.

(1) Disclosure. Federal law requires that qualified pension plans under ERISA be funded. Employers receive tax deductions for contributions to a qualified pension trust fund, and investment income to the trust receives favorable tax treatment. In contrast, retiree health and welfare benefits do not have to be funded, and generally are not funded. Instead, employer payments for retiree health coverage are treated as operating expenses in the year in which the benefits are paid.

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

Ultimately more significant, however, 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, the 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. Various actuaries who have calculated these costs for clients concur that liabilities can range from 30 to 50 times the current expense level.

One report, involving a relatively new manufacturing company with 5,000 active employees and 80 retirees (40 of whom are eligible for Medicare) measures unfunded liability at 20 times current plan expense.³ The current cost of retiree health benefits in this firm is \$60,000 a year. Using the actuarial rules under consideration by FASB, funding the accrued liability for the health care costs of current and future retirees would require employer contributions of \$1.2 million per year.

(2) Tax law. Concurrent with employers' growing recognition of accruing retiree health liabilities, changes in tax law made the prospect of funding these liabilities less attractive. Prior to the Deficit Reduction Act of 1984 (DEFRA), the tax code defined two tax-favored vehicles for pre-funding retiree health benefits: Section 501(c)(9) trusts, called Voluntary Employee Beneficiary Associations or VEBAs; and Section 401(h) trusts. Although no data exist documenting the use of these vehicles, apparently very few firms used either vehicle to fund accruing liability for retiree health benefits. Those that did fund these liabilities, reportedly, most often used a VEBA; virtually no employers use a 401(h) trust.

DEFRA discouraged use of VEBA to fund liability for retiree health benefits in four ways:

- o DEFRA imposed nondiscrimination rules for qualified contributions to a VEBA. Contributions for health benefits now are applied against the limits to qualified pension and profit sharing plans to highly compensated employees (Section 415 limits).
- o DEFRA established limits for deductible contributions to VEBAs. Under DEFRA, qualified contributions are limited to the sum of benefits paid during the year, reasonable expenses, and a permissible addition to reserves. Without actuarial certification, the safe harbor limit on the permissible addition is 35 percent of the qualified direct cost. The actuarial assumptions must be based on the current medical plan and cannot include any adjustment for inflation.
- o DEFRA imposed a 100-percent penalty tax on any disqualified benefit paid from the fund. Disqualified benefits include any assets reverting to the benefit of the employer sponsoring the welfare benefit fund. This means that any excess of funds greater than necessary to cover retiree benefits cannot be recaptured by the employer.
- o DEFRA made all reserves held in VEBAs subject to the tax on unrelated business income.

Many benefit experts consider DEFRA's restrictions on using VEBAs to fund retiree health liabilities prohibitive, given competing uses for funds within a firm--many of which receive preferential tax treatment.

Section 401(h) of the tax code defines a potentially important alternative to VEBAs for funding retiree health insurance liabilities. Section 401(h) authorizes tax-exempt employer contributions to health insurance benefits for retirees, their spouses and dependents, and tax-deferred contributions to retiree death and disability benefits.

Data indicating the use of 401(h) trusts do not exist. Actuaries claim, however, that few firms use 401(h) trusts for retiree health benefits. Those that do may limit plan benefits to payment of Medicare Part B premiums.

Employers may avoid Section 401(h) trusts for several reasons:

- o The tax 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 only 25 percent of total contributions to retiree benefits, including pension benefits. For many employers, the limit on contributions to a 401(h) trust is too low to adequately fund accruing liabilities for retiree health, death and disability benefits.
- o Funds contributed to a 401(h) are entirely 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.
- o The nondiscrimination rules applicable to the pension plan are applied to use of 401(h) trusts. Since, 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.
- o Since this type of plan is seldom used, employers have no experience with the plans and are uncertain about the technical aspects of 401(h) trusts.

Given DEFRA's restrictions on the use of VEBAs, Section 401(h) plans may receive much more attention from employers seeking to fund liabilities for retiree health benefits. Limits on contributions to these plans and uncertainty about the legislative and regulatory status of any plan established under Section 401, however, may be important factors impeding their use.

(3) Medicare. Recent and expected changes in Medicare are a critical element 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 (Supplementary Medical Insurance) 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 payor, reducing Medicare obligations for employer-covered retirees in the same way that Medicare has reduced its obligations for workers over age 65 covered by an employer plan.

Finally, employers are concerned that the Medicare Prospective Payment System may increase the cost of retiree health benefits, if reduced hospital lengths of stay result in more physician visits or outpatient services covered by the employer plan. While Medicare covers the full cost of inpatient services after the deductible (\$400) for the first 60 days of a spell 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 source of cost for employer-sponsored retiree health plans.

(4) Recent litigation. The rights of retirees to health insurance benefits--in particular those that were not funded during retirees' working careers--have been the subject of numerous court decisions at the federal level. The decisions are based in contract law and generally define the property rights of retirees to plan 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. These vesting standards may imply significant employer costs, in some cases exceeding employer costs for pension benefits.

Early court decisions regarding retirees' rights to nonpension benefits,

brought under contract law, interpreted those rights conservatively: retirees may be entitled to benefits only while the contract promising benefits is in force and the employer remains in business.⁴ 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 a pension.⁵

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.

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. As early as 1960, Cantor v. Berkshire Life Insurance Company⁶ 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 obligated employers who promised retiree benefits to continue those benefits throughout the retirees' lifetimes. Generally, these findings were 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 lower court's presumption that retiree health and life insurance benefits are lifetime benefits, absent express contract language limiting their duration.⁷ Similarly, another decision included the following remarks:

"...retiree insurance benefits are [not] necessarily interminable by their nature. [No] federal labor policy identified to this court presumptively favor[s] the finding of interminable rights to retiree insurance benefits when the collective bargaining agreement is silent."⁸

Two recent court decisions upholding retirees' rights to continued health insurance benefits have gained particular attention. These cases were brought under the Employee Retirement Income Security Act of 1974 (ERISA) which governs the funding, vesting, and fiduciary practices of private pension plans. In that these cases were brought under ERISA, Eardman v. Bethlehem Steel⁹ and Hansen v. White Farm Equipment Company¹⁰ 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 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 considered 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.

Hansen v. White Farm Equipment Company contested the termination of a noncontributory retiree health plan after a bankruptcy reorganization. The bankruptcy court authorized 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."¹¹

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.

Issues in the Coming Debate

Besides limiting the use of VEBAs for funding retiree health insurance liability, DEFRA mandated Treasury 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 like health insurance, since the cost of providing service benefits is much less predictable than the cost of providing a cash benefit

like, for example, defined-benefit pension payments.

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 that a pension plan can reduce annual benefits when retirees elect joint and survivors benefits. As a result, survivors benefits can represent a significant net addition to plan costs, and an added source of uncertainty in forecasting those costs. 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 an additional source of uncertainty in forecasting plan costs.

Preliminary estimates from the U.S. Department of Labor's Office of Pension and Welfare Benefits 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.¹² Estimates of additional employer spending per year required to meet that liability in 20 years are \$10 billion to \$15 billion, 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.

The coming debate over appropriate rules, however, should also consider the current and potential role of employer-sponsored coverage in financing health care for the elderly, and 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.

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 dedicated 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 an greater private insurance coverage among retirees. Possible reductions in the fiscal burden of Medicare and Medicaid spending for the elderly, however, are 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.

ENDNOTES

1 The 1977 Battelle survey of Employment Related Health Benefits in Private Nonfarm Business Establishments in the United States (conducted under contract to the U.S. Department of Labor) provides the only available information on the 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.

2 The following hypothetical claim and plan illustrate the differences among these methods in plan and beneficiary cost:

- o the medical expenses covered under the plan are \$1,100;
- o Medicare pays \$600 of the \$1,100;
- o the plan is comprehensive with a \$100 deductible and 80 percent coinsurance.

The COB plan, absent Medicare, would pay \$800 (.8 x (\$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 would payment would be \$320 (.8 x (\$500 - \$100)). The beneficiary would pay \$180 (\$1,100 - \$600 - \$320).

The carve-out plan would pay \$800 (.8 x (\$1,100 - \$100)), but since Medicare pays \$600, the plan will pay \$200. The beneficiary pays \$300.

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

4 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 CAB (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); Struble v. Welfare Trust Fund, F. 2d, 116 LRRM 2980 (3rd Cir. 1984); Bomhold v. Pabst Brewing Co., (No. 83-1327, July 6, 1984).

5 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.

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

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

8 UAW v. Yard-Man, Inc., 716 F. 2d 1476 (6th Cir. 1983), cert. denied, 104 S. Ct. 100 2 (1984).

9 Eardman v. Bethlehem Steel Corp., F. Supp., 5 EBC 1985 (W.D. N.Y. 1984).

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

11 Ibid.

12 Julie Kosterlitz, "'Disaster' Stories May Spur Congress to Protect Health Benefits for Retirees," National Journal (July 27, 1985), pp. 1743-1746.