



Broken Promises: Retiree Health Care

A report by
the Alliance for
Retired Americans
Educational Fund
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Alliance
for Retired
Americans

Educational Fund

This report is dedicated to *Bert Seidman*

who served for more than a decade as expert advisor on Social Security, pension, health and housing issues for the Alliance for Retired Americans and the National Council of Senior Citizens. He was a resolute activist dedicated to improving the lives of workers, retirees and their families. Millions of Americans have a better life today because he applied his incisive mind, compassionate heart, and unlimited energy to labor and social justice causes. Bert Seidman, who was deeply committed to the principles in which he believed, devoted his entire life to service for others.

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Summary

Retiree health plans in America today for retirees over and under age 65 are not keeping pace with the needs of the nation's seniors. Since retirees are likely to require more care, but have less health care coverage than ever, this problem will only get worse if left unchecked.

Most early retirees, those retiring before age 65, are without insurance coverage. Only a little more than a third (37 percent) of early retirees in 2001 had medical insurance based on their prior employment. However, this percentage is expected to decline sharply in the years ahead. Faced with increasing numbers of retirees and rising costs, employers are expected to further cut benefits, leaving fewer and fewer retirees with health care coverage. With the graying of the baby-boomers, the number of older adults (ages 55 to 64) and seniors (ages 65 and over) will grow from one-fifth of the population today, to one-fourth in the year 2011. There were 35.6 million Americans over age 65 in 2002; and that number is projected to grow to 70 million by 2030.

Retiree health care benefits do not have the same protection that defined benefit pension plans have under the Pension Benefit Guaranty Corporation (PBGC). Accounting rules, however, require companies to record retiree health benefit liabilities annually on their financial statements, highlighting the growing cost of retiree health benefits. Many firms have reacted by shifting costs to retirees, capping their future obligations, and for some, by dropping their plans entirely.

Corporate bankruptcies have also become a growing threat to retiree health care. Retiree health benefits have recently been the basis of age discrimination cases before the courts.

Retirees under age 65 have some help from a variety of programs that allow continued coverage for a limited period, restrict private health insurance from limiting coverage for preexisting conditions, and provide a refundable income tax credit to cover health insurance costs for certain trade displaced workers and retirees receiving payments from the PBGC. Medical and health savings accounts, and individual coverage, are beyond the financial means of most early retirees. Medicaid is the public safety net for low-income individuals and families, and those in need of long-term care.

For those over age 65, Medicare is typically the primary source of health insurance coverage. It covers little more than half of the costs (53 percent) of health care, excluding long-term care. Non-covered services, such as dental care, eyeglasses, and hearing aids, Medicare cost sharing, deductibles, and premiums generally amount to 45 to 47 percent of total retiree health care expenditures. Many people without employer coverage purchase Medigap insurance coverage to pay co-insurance, deductibles, and

other costs not paid for by Medicare. However, under the new Medicare law, Medigap plans will no longer be able to offer prescription drug coverage.

The new Medicare law includes subsidies for employers to continue retiree coverage. Nevertheless, employers are taking the subsidies, but continue to increase retiree cost sharing.

There are a number of proposals that would address the erosion of retiree health care directly or indirectly. They include:

- Allow early-retirees to buy into Medicare;**
- Overhaul the 2003 prescription drug law;**
- Provide tax credits;**
- Extend health care protections through state programs;**
- Protect existing benefits;**
- Amend the bankruptcy code;**
- Encourage employer innovations;**
- Elevate health costs consciousness;**
- Change plan type and access;**
- Provide for long-term care; and**
- Implement universal health care.**

Whatever solution or solutions are devised and implemented, the increase in health costs and cost-sharing accompanied by an overall decline in retiree health care coverage indicates that immediate action is necessary.

Costs of prescription drugs, other health care, and long-term care are increasing. None of the positive public policies to help retirees meet their skyrocketing health care costs will take place unless more seniors and the general public vote for candidates dedicated to improving the lot of retirees. Representatives in the nation's capital and its state houses need to be reminded of the plight of aging Americans brought on by the continuing rising cost of health care, and the decline in employer coverage. The crisis for retirees is growing. The nation needs leadership that will address the health care crisis of retirees and all Americans.

Introduction

“I retired from Dyncorp in September 2000 at age 62. Dyncorp paid my insurance until I reached age 65 and went on Medicare. Then, I started to pay for my medicine, which runs \$4,300 per year, supplemental insurance, which costs approximately \$1,400, and Medicare premiums, which are over \$700. This means that I am now paying approximately \$6,000-\$7,000 more per year than I was before I was on Medicare. A \$7,000 cut in your retirement per year is devastating.”

Lawrence Thomas Denton, Ozark, AL

When planning for retirement, many people focus only on whether they will have enough retirement income, such as Social Security payments, pensions, and savings, to cover their day-to-day living expenses. They may not realize that the spiraling cost of health care for retirees is likely to add to those expenses considerably. This prospect could put the dream of “a comfortable retirement” out of reach for many Americans.

Simply put, retiree health plans in America today for retirees over and under age 65 are not keeping pace with the needs of the nation’s seniors. Since retirees are likely to require more care, but have less health care coverage than ever, this problem will only get worse if left unchecked.

The purpose of this report is to assess current public and private approaches to retiree health care costs. The report addresses approaches for retirees under and over age 65, as well as those who are insured and uninsured. The report makes policy recommendations that could help current and future retirees meet their health care expenses in this new century.

In amending Medicare in 2003, Congress passed, and President Bush signed into law, a complicated, inadequate drug plan. The new law also undermines the overall Medicare program. Additionally, the law fails to curtail rising drug and health care costs.

Medical costs are out of control. They continue to escalate much faster than the overall inflation rate. In 2003, the cost of health care for retirees rose 13.7 percent (the third consecutive year of double digit inflation), while the overall cost of living rose 2.5 percent.¹ The outlook is for still more double digit increases in medical costs in the years ahead. Health care costs are projected to increase by an average of 18 percent from 2003 to 2004. In looking five years ahead, business groups project health care costs to increase by 17 percent each year.²

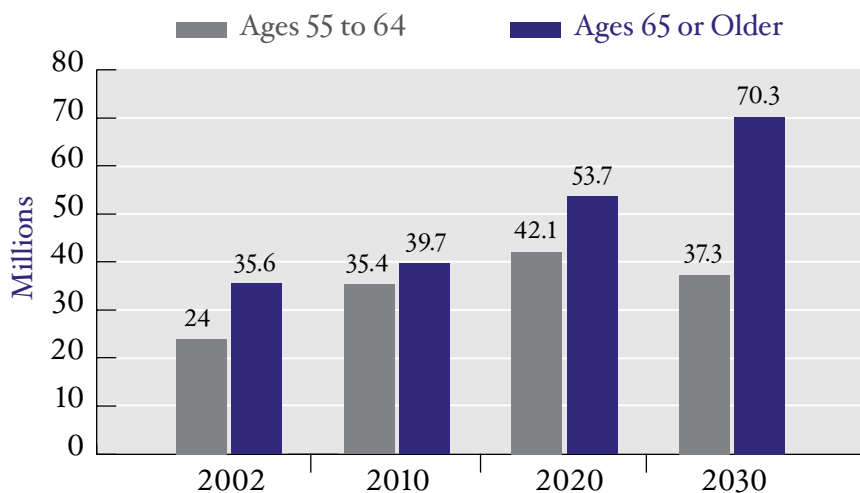
Most early retirees, those retiring before age 65, are without insurance coverage. In 2001, only a little more than a third (37 percent) of early retirees had medical insurance based on their prior employment. However, this percentage is expected to decline sharply in the years ahead, as employers downsize existing health care plans. Increasingly, new hires are being denied retiree health care, existing retirees are losing protection, and more and more of the rising health care costs are being shifted to retirees. While someone with no retiree health insurance may have a few governmental protections in extending health insurance or purchasing private insurance, all of the choices are costly and some are of only limited duration.

Medicare, enacted in 1965, starts at age 65 for most retirees, but has significant gaps and high out-of-pocket health care expenses. It pays a large part of short-term hospital costs and provides doctor's coverage after payment of a premium and various co-pays. There are ceilings and exclusions. These various gaps include exclusions of long-term care, most dental and vision care, and—prior to passage of the Medicare prescription drug law in 2003 that provides a drug benefit beginning in 2006—drug coverage. Many retirees have depended upon their union- or employer-based retiree health care plans to close many of these gaps. To save for these contingencies, workers would have needed to set aside huge sums, beyond what most people could afford.

As one looks into the future, retiree health care costs are expected to balloon. Faced with increasing numbers of retirees and rising costs, employers are expected to further cut benefits, leaving fewer and fewer retirees with health care coverage. With the graying of the baby-boomers, the number of older adults (ages 55 to 64) and seniors (ages 65 and over) will grow from one-fifth of the population today, to one-fourth in the year 2011.³ There were 35.6 million Americans over age 65 in 2002; and that number is projected to grow to 70 million by 2030 (Figure 1).⁴

Figure 1

Baby Boom Generation Will Inflate 55-64 and 65 + Population
 Projected number of Individuals Ages 55 to 64 and 65 or Older



Source: U.S. Census Bureau, "Projections of the Total Resident Population by 5-Year Age Groups and Sex With Special Age Categories: Middle Series," selected years 2000 to 2030, January 2000 and "The Older Population in the United States: March 2002."

Background

“Retired Teamsters who are receiving insurance through United Parcel Service just had their health insurance premiums jump again. In 2002, the premium was \$150 per quarter for the retiree and spouse. In January 2003, that premium tripled to \$450 per quarter. In January 2004, we were notified that it is now \$750 a quarter, or \$3,000 a year in premiums. We will have to drop it by the end of this year.”

Sue Riguette, Howell, MI

Private Sector

Since World War II, most employees receive health care through union-negotiated contracts or as an employer-provided fringe benefit. Many unions first negotiated the benefit when they were limited in their ability to negotiate wage increases during the war. However, they also wanted to apply group insurance principles to mitigate health care costs. Non-union employers often adopted similar benefit plans. Legislation to exempt the cost of employer-paid health insurance from federal taxable income also helped spread the popularity of such programs. Soon, union contracts began extending health care benefits to retirees, and non-union employers again copied this trend. With the 1965 enactment of Medicare, more employers offered supplemental retiree medical coverage, as much of the cost was shifted away from the employer and onto the Medicare system.

According to a study by the Kaiser Family Foundation, retiree health care coverage began dropping in the late 1980s, from a high of 66 percent of large firms (with 200 or more employees) providing such benefits in 1988, to just 38 percent in 2003.⁵ For those in smaller firms, only 10 percent provided retiree medical care.

Another 2003 survey of about 3,000 employers by the Mercer Human Resource Consulting firm painted a more dismal picture. For the firms in its survey, it found that only 28 percent still offer medical coverage to early retirees, down from 46 percent ten years earlier. Similarly, coverage for Medicare age retirees dropped to 21 percent from 40 percent.⁶

Most large firms that provide retirees with medical coverage extend it to early retirees (93 percent), and Medicare age retirees (78 percent).⁷ The large employers generally cover health benefits for the spouses of retirees and other dependents. Firms with a union are nearly twice as likely to provide retirees with medical benefits as firms without a union (56 percent to 29 percent).⁸

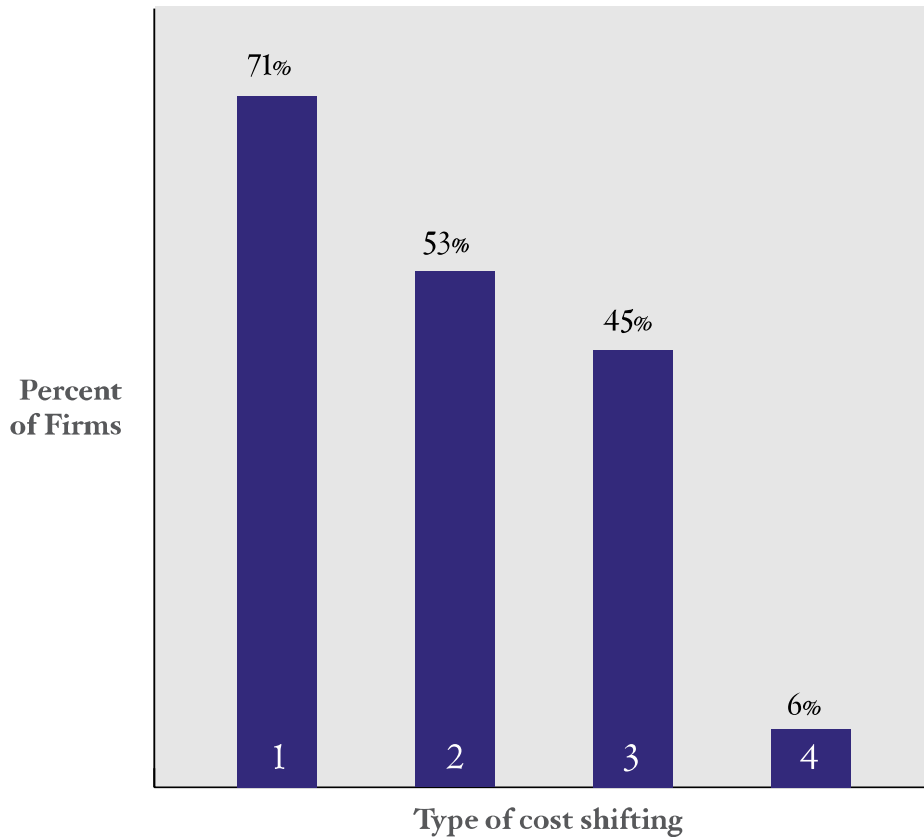
Worker qualifications for retiree health benefits have been tightening, with 90 percent of large companies with plans in 1984 offering such benefits to workers over 65, who had at least 5 years of service. By 2002, all but 25 percent of such large firms had lengthened the service requirements for eligibility.⁹

A new Kaiser study provided a thin ray of good news, with 12 percent of large employers adding health benefits or improving coverage for retirees in 2003. However, this same survey shows much more cost shifting to retirees. Seventy-one percent of the large firms increased retiree contributions for premiums, and 53 percent required more cost sharing. Forty-five percent of the firms raised contributions for dependent

benefits and 6 percent shifted to a defined contribution plan with no guaranteed benefit. Employers at 10 percent of the firms have eliminated all employer-financed health coverage for future retirees (Figure 2).¹⁰

Figure 2

Employers Shift Health Care Costs to Retirees in 2003*



- 1. Increased premiums
 - 2. Required more cost sharing
 - 3. Raised dependent contributions
 - 4. Shifted to a defined contributions plan
- * Large firms with 200 or more employees

Source: Kaiser Family Foundation. “Retiree Health Benefits Now and in the Future: Findings from the Kaiser/Hewitt 2003 Survey on Retiree Health Benefits” (January 2004)

In 2003, retirees paid on average 39 percent of the total health care insurance premium at large firms. At 8 percent of the large firms, early retirees pay none of the premium, and at 22 percent of the firms, they pay all of the premium costs. Medicare eligible retirees pay none of the premium at 11 percent of the large firms, but pay all of the premium at 21 percent of the firms. Nearly half of large firms surveyed by the Kaiser Family Foundation have placed “caps” (pre-determined limits) on their future financial retiree health obligations, leading to more cost shifting to retirees.¹¹

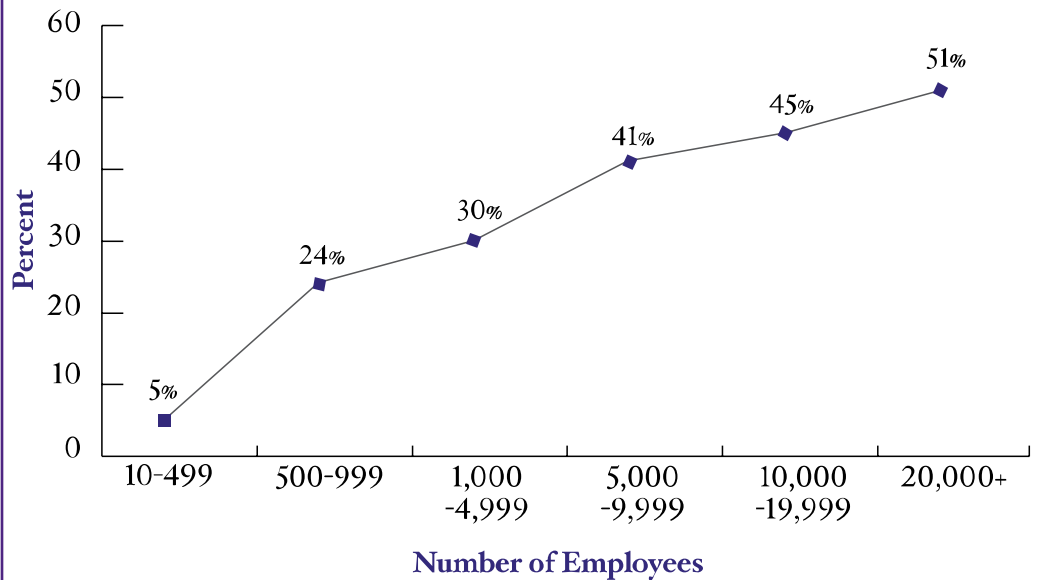
The future looks even bleaker, with some firms no longer promising health care in retirement to new employees, and most firms shifting more of the cost to retirees. Many workers are already facing the triple burden of higher premiums, increased cost sharing, and reduced benefits. Low-income workers and low-income retirees are particularly vulnerable. Even now, 22 percent of large companies plan to drop coverage for future retirees during the next three years. Another 26 percent plan to only provide retirees access to health plans, but no financial support, and 22 percent will shift to a defined contribution plan (see Glossary).¹²

“Twenty years from now, no company will offer retiree health care.”

Uwe Reinhardt, Health Economist, Princeton University

Figure 3

Percent of Employers Promising Retiree Health Benefits to Current Employees by Number of Employees: 2003



Source: Mercer National Survey of Employer-Sponsored Health Plans, 2003.

Public Sector

The picture for state and local government employees is generally much brighter than that for private employees. Every state makes health benefits available to early retirees, and all but one offers health benefits to Medicare eligible retirees. Some of the state plans cover those who worked for state universities and colleges, but only in some cases those who worked as public school teachers and local government employees. Rising health costs have led nearly every state to make changes in their plans: cutting administrative costs, requiring higher cost sharing by retirees, reducing benefits, or some other kind of limiting action. However, no state anticipates eliminating

coverage, as some private sector employers have done.¹³ Local government plans, however, are under greater stress than state plans.

Federal government retirees, including postal workers, and their surviving spouses can carry their active duty health insurance into retirement, provided they have had five years of service (with some exceptions). They retain their eligibility in the Federal Employees Health Benefit Program (FEHBP) at the same cost as current employees. For most retirees, the federal government picks up approximately 75 percent of the total premiums. The retiree, like the active employee, can choose from a broad range of health plan options, including a number offered by several unions.

In some cases, veterans may be eligible for health care under specific programs designed for those who served in the Armed Services. Veterans need to check on their rights for health care for service and non-service related illnesses. Military retirees are also covered by their own special program called TRICARE.

Safeguarding Health Care Benefits

The 1974 Employee Retirement and Income Security Act (ERISA) does not require that funds for retiree health care be put aside into separate accounts that would pay for future benefits. Actuarial accounts must be setup for defined benefit pension funds only—health benefit costs depend on a “pay-as-you-go” (see Glossary) principle.

While pension funds are insured by the federal government through the Pension Benefit Guaranty Corporation (PBGC), no such protection is provided to retiree medical benefits. The pension guarantee raises funds from existing pension plans in order to provide an insurance backup in case of fund failures. This is not so for health care. ERISA and tax rules set explicit standards for funding of future pension liabilities. While health benefits for retirees have no such pre-funding requirements, some firms have transferred some of the excess pension assets generated by investment earnings to finance their retiree health benefits.¹⁴

Accounting rules, however, require companies to record retiree health benefit liabilities annually on their financial statements. They must report on the liability represented by the promise to provide retiree health benefits for current and future retirees. These rules were established by the Financial Accounting Standards Board (FASB, see Glossary) in 1982, and revised in 1990. They require private sector employers to accrue and expense certain future claims, as well as actual paid claims.¹⁵ While the rules do not affect an employer’s cash flow, it affects the overall statement of financial profitability by listing these projected retiree health costs as liabilities. For example, at General Motors, the noted liabilities for retiree health benefits averaged 20 percent of operating cash flow over the past five years; at Navistar, that figure was 57 percent; and at Xerox, that figure was 20 percent during those same years.¹⁶

The FASB rules highlight the growing costs of retiree health benefits, and many firms have reacted to them by trying to shift costs to retirees, and by capping their future obligations, and some, by entirely dropping their plans. When a firm cuts or caps their benefits, it creates instant income for the firm. It reduces its future liability and generates an immediate accounting gain. Also, when a firm changes its assumptions about interest rates or health care inflation, it also gets to adjust its liability. The accounting gains can be used in the current year or spread out over a number of years.¹⁷

Firms with drug benefit plans for retirees under Medicare have begun to restate their financial reports as a result of the new Medicare prescription drug law, even though the benefit does not take effect until 2006. In February 2004, the FASB stated that companies should “book the amount of federal subsidy they expect to receive... as a reduction of future benefit costs—instead of a stream of income from continuing operations.”¹⁸ More details on this effect are provided later in this report.

State and local government employees face a possible new rule that governments must include in their financial statements their future obligation to pay for retirees' health costs, and how they plan to pay for these obligations. The proposal comes from the Governmental Accounting Standards Board (GASB, see Glossary), and could have a major impact on state government finances and retiree health benefits.¹⁹

Courts have generally provided the greatest protection to union retirees, because of union contracts defining retiree health care benefits. The Sixth Circuit court in the *UAW v. YardMan, Inc.* case held that retiree benefits were a "form of compensation or reward for past services."²⁰ Some courts have held that those benefits end at the expiration of the agreements. Other cases have held that the benefits continue beyond the life of the contract.²¹

However, unions are restricted in their bargaining for retirees, because retiree benefits are considered permissive and not mandatory subjects of collective bargaining. A series of federal court decisions in the mid-1990s held that employees needed a specific *written* promise of future health care in retirement, in order to bring suit against an employer for breach of such a promise. No matter how explicit, verbal promises would not be sufficient. In addition to union contracts, such promises of retiree health care may be in letters, brochures, medical plan booklets, employee handbooks, or other written material, or in records of meetings where an employer promised retiree health benefits. If the promise is not explicit, but couched in language allowing employer's discretion to change, suspend, revoke, or terminate health plans for existing and retired employees, retirees are at the mercy of the employer.

International Paper Co. Gains, Retirees Lose

Since the early 1990s, International Paper has reaped accounting gains when they cut retirees' health care benefits.

1991: IP records a \$405 million balance-sheet liability at year's end for then current program of health coverage for retirees.

1992: IP caps what the company will pay per retiree per year in the future. This reduces obligation and creates a \$133 million pool of accounting gains that will trickle into income over time. IP adds \$18 million of this to 1992 income.

1993-1999: IP adds \$17.7 million from this pool of gains to earnings each year, exhausting the pool.

2000-2002: IP makes various benefit changes, including imposing caps for plans at newly acquired companies, thus reducing liability again and replenishing pool of accounting gains.

2000-2003: IP adds \$65 million to earnings from the new pool.

Source: Wall Street Journal. "How Cuts in Retiree Benefits Fatten Companies' Bottom Lines." (March 16, 2004)

Bankruptcies Threaten Health Care Coverage

Corporate bankruptcies have lately become a growing threat to retiree health care. In a bankruptcy, retirees with a claim on health care benefits must stand in line with all other unsecured creditors, which means they have slim chances of salvaging anything. Buyers in bankruptcy want to shed pensions and retiree health benefits. When a firm goes bankrupt, retiree health benefits are left at the discretion of the bankruptcy court, since there is no separate fund for retiree health care.

Many retirees, and active workers, have lost health benefits through bankruptcies. Particularly hard hit in the past few years have been workers in the steel, airline, communications, textile, and retail industries.

Bethlehem Steel

On March 21, 2003, Bethlehem Steel, in Chapter 11 bankruptcy, terminated the health and life insurance benefits of more than 95,000 retirees and surviving spouses. These retirees had already suffered the involuntary takeover of their pension by the PBGC, and the subsequent reduction in pension payments.

This involuntary termination has also:

- Denied steelworkers at Bethlehem the \$400 a month pension supplements they would have received under the special shutdown provisions in their existing contracts.
- Reduced the pensions that might have been negotiated should Bethlehem successfully restructure through the bankruptcy process.
- Undermined progress toward steel industry consolidation, by preventing the union from negotiating more favorable pension benefits.

Bethlehem retirees aged 55 to 64 and not on Medicare, will be eligible for a Health Coverage Tax Credit (HCTC) under the 2002 amendments to the Trade Adjustment Assistance Act (known as the TAA Reform Act), in those states that have a qualifying state based plan. Examples of such qualifying coverage include private-state arrangements with carriers like Blue Cross Blue Shield, state high-risk pools, and state public employee health plans. By summer 2003, there were 17 states with qualified plans.

In order to be protected from exclusions for pre-existing conditions and other protections under the Health Insurance Portability and Accountability Act (HIPAA) it may be necessary for retirees to have three months of prior health coverage without a break of 63 days prior to joining a state program. Eligible retirees are able to receive a 65 percent refundable, advanceable tax credit. The credit can apply to COBRA, spousal coverage, and state-based coverage, as well as individual policies in some cases. The retiree is responsible for the remaining 35 percent of the insurance premiums.

The hardships are exemplified by a Bethlehem retiree who said that he and his wife both have cancer. His pension is \$600 per month. Now they will have to pay \$507 per month to continue their health benefits.

Improvements in the TAARA program sought by the Steelworkers include:

- Lowering the qualifying age to 50.
- Providing all qualifying individuals who previously had health care the four federal consumer protections (guaranteed issue; no exclusions for preexisting conditions; and nondiscrimination in premiums and benefits) when entering state health plans.
- Ensuring that the non-Medicare eligible spouses and dependents of individuals on Medicare receive the tax credit.

Until recently, the courts have generally not focused on age discrimination in employer provision of retiree health benefits. In August 2000, a federal appeals court ruled that Medicare eligible retirees had to be provided with benefits and/or costs that were equal to the plans offered to retirees under age 65.²² In that case, the health maintenance organization (HMO, see Glossary) plan for Medicare-eligible retirees was more restrictive than the point-of-service plan available to those retirees not yet eligible for Medicare.

Subsequently, on April 22, 2004, the Equal Employment Opportunity Commission (EEOC) approved a rule that would permit employers to exempt Medicare-eligible retirees from retiree health plans. In approving the proposal, the EEOC emphasized an estimate from the General Accounting Office that 10 million retired individuals aged 55 and over count on employer-sponsored health plans as either their primary source of health coverage or as a supplement to Medicare, and such benefits are provided on a voluntary basis at the discretion of each employer. The Commission stated that it acted to preserve benefits for these retirees.²³ The rule is currently under inter-agency review but it is not expected to be released until after the November 2004 elections.

In another age discrimination case, the employer, General Dynamics Land Systems, had entered into a collective bargaining agreement that provided retiree medical benefits only to workers who were age 50 or older by a certain date. The suit was brought by a group of workers who were ages 40 to 49 and therefore did not qualify for the benefits. The U.S. District Court dismissed the case but the U.S. Court of Appeals reversed the decision, ruling that the language of the Age Discrimination in Employment Act (ADEA) prohibits employers from discriminating against any employee age 40 or over based on that person's age. The AFL-CIO in its brief to the Supreme Court opposing the federal appeals court ruling argued that the union at the plants sought "to protect the workers closest to retirement and least able to make financial adjustments to compensate for higher medical costs, while protecting the jobs of younger workers." The Supreme Court, on February 24, 2004, overturned the appeals court decision and held that designing more generous benefit packages for older workers doesn't violate federal age discrimination law.²⁴

Age Bias and Retiree Benefits

Options for Older Adults Under Age 65

“I retired from AT&T with full medical benefits. I worked for them for 34 years, but two years after retirement AT&T told me that I am going to have to pick up the full \$311 a month for my medical coverage—plus they cut some benefits. We made sacrifices for years on our union contracts to keep our medical coverage, and now we are being denied what I think is ours.”

Tommy Johnson, Adamsville, AL

Those who retire before age 65 and lose their employer-based health insurance, or those who were never covered at work, face daunting alternatives in obtaining affordable coverage. Costs skyrocket, coverage restrictions are extracted, and retirees are often in poorer health, and most are in need of health coverage. Over the years, Congress tried to offer some small help through a variety of programs that will be explored in more detail below, but are known more by these acronyms – COBRA, HIPAA, TAARA, and Medicaid. These programs cover active workers as well as retirees.

COBRA

In 1985, Congress passed COBRA (Consolidated Omnibus Budget Reconciliation Act) that allowed workers leaving the employ of a company to continue their coverage for up to 18 months following separation or retirement. This may entail substantial out-of-pocket costs, because the employer is not required to pay any of the premium. Actually, an enrollee can be charged up to 102% of the group rate. Those who qualify for disability under Social Security may be charged up to 150 percent of the group rate. COBRA only requires firms with 20 or more employees to provide this option. COBRA premiums for individuals and families combined averaged about \$400 a month in 2000. As a result of the high costs, only about 7 percent of all unemployed workers were covered by COBRA in 1999.²⁵

Many states have adopted state continuation laws for those under smaller group plans. However, if an employer discontinues a health plan or switches to a health access only plan there may be no health plan available for the retiree.

HIPAA

In 1996, Congress passed HIPAA (Health Insurance Portability and Accountability Act) that restricts private health insurance from limiting coverage for preexisting conditions and prevents insurers from denying coverage because of past or present conditions. However, it does not restrict the premiums that may be charged to older or less healthy individuals. To be eligible, an individual must have had at least 18 months of creditable group insurance coverage with no break of more than 63 consecutive days, and must have exhausted COBRA or similar plans.

The law requires access to at least two individual insurance policies or an alternative, such as a state high-risk pool. Insurance premiums for people ages 55 to 64 are nearly twice as high as rates for people ages 35 to 54. Unless they are guaranteed coverage by HIPAA, individuals with serious health conditions, such as heart disease, are nearly always denied coverage, and those with other non-life threatening conditions, such as chronic back pain, may have related medical problems excluded from coverage.²⁶

TAARA

In 2002, Congress expanded the country's system of TAA (Trade Adjustment Assistance) beyond cash aid and job training to include modest health coverage for trade displaced workers. The Trade Adjustment Assistance Reform Act (TAARA) provides a fully refundable, advanceable federal income tax credit to cover health insurance costs for certain trade displaced workers and retirees receiving payments from the PBGC. The law provides states with funds to help them extend health coverage to tax-credit beneficiaries and to establish and operate high-risk pools.

To be eligible, workers must fall into one of three categories:

1. Workers who are certified by the Labor Department as losing their jobs because of foreign competition, and are receiving Trade Adjustment Allowances or Unemployment Insurance.
2. Workers age 50 or older who lost their job because of foreign trade and then begin a different line of work at lower pay would be able to receive Alternative Trade Adjustment Assistance, making up part of their reduced income.
3. Retirees ages 55 to 64 who receive monthly payments from PBGC, which assists retirees of certain firms that no longer pay promised pensions.²⁷

The program restrictions limit coverage to only 135,000 workers in the first and third groups, and even fewer workers are provided benefits in the second group. Congress appropriated only \$40 million to cover the Act's health assistance programs in 2002 and 2003 combined.

The tax credit for health insurance premiums amounts to 65 percent of covered health insurance premiums. Workers may buy a continuation of their prior insurance through COBRA or use insurance offered by a spouse's employer, or buy insurance through their state high-risk pool or through plans applying to state government employees.²⁸ The new group plans designated by states average about \$417 a month for an individual, or \$680 a month in a high-risk pool plan. Even with the tax credit, this would still require a monthly premium of \$146 or \$238. According to a February 2004 report, only 8,000 eligible individuals are signed up and participating in the advanceable credit. The government is spending almost \$5,000 per person to administer this program through Accenture, a private contractor.²⁹

Medicaid- The Frayed Safety Net

Medicaid, a jointly-funded federal-state program administered by the states, provides health care for low-income individuals and families, and those in need of long-term care. Eligibility depends upon the income and the assets that an individual has accumulated in savings and

other goods. Unfortunately, some who meet the threshold levels do so because of a catastrophic medical episode that has consumed most of their savings. Often, people faced with the high costs of long-term care in hospitals, nursing homes, and assisted living facilities have no other place to turn, except Medicaid.

Medicaid benefits are also wrapped around the Medicare plan, helping to pay Medicare out-of-pocket costs not covered by Medicare. The federal-state program is available to people with limited assets and income (generally below the federal poverty level – about \$12,490 for a couple in 2004). In terms of assets, the limit is tied to the Supplemental Security Income (SSI) standard that in 2004 is \$2,000 for individuals and \$3,000 for couples. Certain items, such as a car or a person's primary home, are excluded from the test. Some Medicaid benefits are paid by states for persons whose income is up to 35 percent above the federal poverty level or whose assets do not exceed twice the SSI level. But these programs, known as Qualified Medicare Beneficiary (QMB), Special Low-Income Medicare Beneficiary (SLMB), and Qualified Individual-1 (QI-1), vary from state to state.

While, in theory, the Medicaid program provides those eligible with a comprehensive health plan and very little cost sharing, the budget cuts made by states over the past few years have fallen heavily on Medicaid and other programs designed to help the poor.

President Bush, in his budget proposal for 2005, calls for a reduction in Medicaid funding by nearly \$1 billion and by nearly \$16 billion over the next 10 years. The President's budget also fails to include an extension of the 2004 temporary increase in the Federal Medical Assistance Percentage (FMAP), the percentage at which the federal government matches the state Medicaid agencies for Medicaid services. The budget reaffirms the Administration's goal of block-granting Medicaid, thus making it non-responsive to the needs of the poor and elderly. The block grant proposal would result in state-by-state block granting without waiting for legislative authority.³⁰ This would ultimately eliminate Medicaid's open-ended financing and legal entitlement structure that has allowed the program to absorb a large number of uninsured individuals, and to respond to recessions, epidemics/disasters, and dramatic medical treatment innovations. Congress, however, did not adopt the President's reduced budget and block grant proposal for Medicaid this year.

Medical/Health Savings Accounts, and Individual Coverage
Employers are increasingly setting up retiree medical accounts, to which they contribute a fixed amount based on years of service, typically from \$750 to \$2,500 a year. This maneuver is similar to that of employers who switch defined pension benefits to defined contribution plans. These medical accounts, or glorified savings accounts, allow retirees to buy

insurance coverage until the account is depleted. Then the retirees are on their own.

Since the late 1990s Medical Savings Accounts (MSAs) have been available for individuals to put aside money for health care, with few takers. Under current law, contributions, earnings on account assets, and withdrawals used to pay un-reimbursed medical expenses are not taxed.

The 2003 Medicare law established Health Savings Accounts (HSAs). These accounts, which are an expanded and less restrictive form of MSAs, allow individuals covered only by high-deductible health insurance policies (i.e., at least \$1,000 annual deductible for individuals, \$2,000 for families), to pay medical expenses with tax-sheltered dollars. President Bush, in his 2005 budget, proposes to further expand these HSAs. These programs that favor wealthier and healthier people also undermine traditional employer-provided health plans, because they create an incentive to shift the burden of health care to working families.³¹

As of 2002, a 65-year-old person needed to have saved \$194,000 to pay for the basic gaps in his or her Medicare coverage over the next 15 years. Now, double that amount for a couple. This estimate, made prior to the 2003 Medicare Prescription Drug law, is based on the costs of the Medicare Part B premiums, the insurance cost of a Medigap (see Glossary) plan, and average out-of-pocket expenses. It also takes into account the current life expectancy, which is 15.8 additional years for a 65-year-old male and 19 additional years for a 65-year-old female. If someone were to live to age 90, the required savings jump to \$558,000. Someone wanting to retire at age 55 would need to add another \$286,000 to these totals. These estimates by the Employee Benefit Research Institute assume an annual health care inflation rate of 10 percent, and a return on the invested savings of 4 percent.³² These figures do not include the funds needed for long-term care.

The high costs and difficulty in obtaining individual coverage have limited the medical insurance of older adults (ages 55 to 64). Only about 7 percent relied on individual insurance as their primary source of coverage in 1999.³³ According to a 2001 Commonwealth Fund study of premium costs, individual insurance coverage is substantially more expensive than employer group insurance for all but young, healthy males. Furthermore, covered benefits are less generous and patient cost sharing is greater in individual plans than in employer plans.

The individual insurance market is state regulated, and plan offerings, underwriting restrictions, and rate levels vary greatly from state to state. However, in most states, access to the individual market is not guaranteed, and individuals may have difficulty obtaining coverage under comprehensive plans at affordable prices, or any plans at all.

In states that allow medical underwriting, insurers may use an individual's health status to determine expected claim rates and to charge a premium that reflects an individual's risk.

Since medical care needs generally increase with age, premiums for older adults (ages 55 to 64) are often 3 to 4 times as much as those paid by a 30 year old. For example, according to a study by the General Accounting Office, the premium for a \$250 deductible indemnity plan in Arizona was \$162 a month for a 30-year-old, and \$512 a month for a 60-year-old (with rates varying by gender, geographic area, and family size). In 2003, Kaiser Permanente in Maryland was quoting individual rates of \$167 a month at age 30, and more than doubling to \$381 a month at age 60. Similarly for a family of two, the rate at age 30 was \$335 a month; and at age 60, it had risen to \$764 a month.³⁴ This is typical of health insurance plans.

About 20 states have passed legislation that limits the amount by which insurance carriers can vary their premiums, or other standards applying to medical insurance. For people without HIPAA protections, insurance companies often deny insurance to people suffering such diseases as Alzheimer's disease, diabetes, hypertension, migraine headaches, or rheumatoid arthritis. If the insurance company does sell an individual a policy, that policy may exclude an existing health condition or set specific conditions on illnesses such as asthma, glaucoma, and ulcers.

The fall back for some early retirees may actually be the insurance coverage of a spouse who receives the benefit from a current or former employer. This coverage may not always be available if there has been no history of prior coverage.

The Uninsured

The previous sections of this report dealt with the types of health care coverage that early retirees may access. While not insuring saves the early retiree the premium expense, it exposes the individual or family to the possibility of catastrophic claims. Few individuals can accumulate enough personal savings against the risks of a serious accident or major illness. Over three million older adults ages 55 to 64 lack health coverage, which is 13 percent of all uninsured adults.

According to reports by the Institute of Medicine, a section of the National Academy of Sciences:

- Uninsured Americans get about half the medical care of people with insurance, which tends to leave them sicker and more likely to die younger.

- About 18,000 Americans die unnecessarily, because they lack health insurance. When even one family member is uninsured, the whole family is at increased risk for financial catastrophe, because of the expense of an illness or injury.
- The nation loses \$65 billion to \$130 billion a year because of the poor health and premature death of uninsured Americans.³⁵

Options for Those Over 65 or Disabled

For those over age 65, Medicare is typically the primary source of health insurance coverage. Most older retirees can count on Medicare to provide a little more than half of the costs (53 percent) of health care, excluding long-term care. Medicare Part A pays part of the hospital costs for up to 150 days, as well as limited skilled nursing, home health care, and hospice care costs. Most individuals also opt to purchase a Part B coverage that pays for some doctor visits and outpatient hospital care. Non-covered services, such as dental care, hearing aids, and eyeglasses, Medicare cost sharing, and the Medicare premium itself, account for the remaining costs amounting to 45 to 47 percent of total retiree health care expenditures and constitute 22 percent of beneficiaries' average income.³⁶ (This does not include long-term care.) Thus, while Medicare provides a basic level of coverage, there are still significant additional health care costs. The need for continued employer-provided health care extends into the period of Medicare coverage.

Medicare comes in a variety of flavors. For the overwhelming majority of beneficiaries, it is a fee-for-service plan, but some have a managed care or other private program offered through the Medicare + Choice program. (See page 21 for details.)

Medigap

Many people without employer coverage purchase Medigap insurance coverage to pay co-insurance deductibles and other costs not paid for by Medicare. Because of the proliferation of overlapping and confusing policies sold by insurance companies, Congress established 10 standardized Medigap or Medicare Supplemental Insurance Policies (A through J) that insurance companies could offer. In all states, except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of the 10 uniform policies, so that they can be easily compared. These three states are exempt, because they had standardized their Medigap policies prior to the establishment of the federal plans. Additionally, any standardized policy may be sold as a "Medicare Select" policy that requires use of specific hospitals or doctors to get full reimbursement. These policies are usually less expensive than the basic Medigap plans. Whereas Medigap policies are available in all 50 states, Medicare Select policies are only available in 15 states.³⁷

In order to assure full eligibility in a Medigap program, retirees should sign up within six months of their 65th birthday, within 63 days of being dropped by an HMO plan, or if their employer eliminates retiree benefits. If a Medicare beneficiary doesn't buy a Medigap policy during the open enrollment period, then the beneficiary may not be able to buy the better policies, or could be charged more for the policy. Medigap policies vary substantially depending upon the area and insurance carrier. For

example, in 2000, Plan C cost a 65-year-old \$85 a month in Chicago, and \$129 a month in Denver.³⁸

The 2003 Medicare law prohibits the sale of Medigap insurance coverage to fill the gaps in the new pharmaceutical drug program. The current Medigap plans that include drug coverage (H-J) can no longer offer new plans after January 1, 2006.

Medicare + Choice (Medicare Advantage)

Medicare + Choice provides alternatives to the basic Medicare plan. It includes certain health maintenance organizations (HMOs), preferred provider organizations (PPOs), Medicare specialty plans, or Medicare private fee-for-service plans. These plans, however, have not drawn much support, particularly since a number of HMOs have dropped their coverage of seniors during the past few years, forcing many members to scramble for new doctors and health care. Some older HMOs are still continuing their service to seniors and non-seniors.

The new Medicare law replaces Medicare + Choice with the Medicare Advantage program. It will provide larger federal payments and require regional networks to be established. In 2010, a six-year experiment would be designed to examine the efficiency of the private plans in the Medicare program versus traditional Medicare. The experiment would take place in six metropolitan areas in which at least two private plans enroll at least 25 percent of Medicare beneficiaries. The subsidized private plans would be vetted against the existing program operating without a subsidy, in an attempt to undermine traditional Medicare. Many believe that this skewed experiment with subsidized private plans will lead to future efforts to destroy the traditional Medicare program.

Long-Term Care Insurance

Medicare does not cover long-term hospital stays, nursing home care, or assisted living care. Some insurance policies cover these costs, generally with a set dollar amount and for a specified period. These plans are often expensive and so many people rely on their savings. But when those are exhausted, they turn to Medicaid, which is often the program of last resort for people facing large costs for long-term care.

The new Medicare Prescription Drug legislation provides for a drug discount card in 2004 and 2005 that Medicare beneficiaries can purchase. Proponents of the card claim it will save 10 percent or more off the cost of drugs.

But there are no price controls on these drugs. In fact, the Secretary of Health and Human Services is prohibited from using the purchasing power of the federal government to negotiate lower prices. The law maintains a ban on importing prescription drugs from Canada or other foreign countries, although a study of the safety of importation is required.

In 2006, Medicare beneficiaries will be able to sign up for a stand-alone drug plan or join a private health plan that offers drug coverage. There would be an estimated premium of \$35 a month or \$420 a year. After meeting a \$250 deductible, insurance would pay 75 percent of drug costs up to \$2,250. Then, there would be a gap, the infamous “doughnut hole,” where no insurance payment would be made, until drug costs exceeded \$5,100. After this point, insurance would cover 95 percent of costs. The Congressional Budget Office estimates that nearly half of Medicare beneficiaries will fall into the doughnut hole in 2006.³⁹

Annual increases in the premium, as well as the deductible and the coverage gap, will occur in future years. Annually, these costs will increase at the rate of prescription drug inflation, not the much lower overall inflation rate. According to the Congressional Budget Office,

Medicare Prescription Drug Legislation

“They [who supported the legislation] have callously used a much-needed and long-awaited prescription drug benefit as an excuse to privatize Medicare and keep drug prices excessively high. They profess to be looking out for older Americans, but when it’s known who truly stands to profit from this shameful legislation, those who betrayed seniors will be exposed for their hollow political victory.”

Edward F. Coyle, executive director of the Alliance for Retired Americans

Figure 4

Beneficiary Rx Costs Under Medicare Law 2006 and 2013

	2006	2013	Percentage Increase
Annual Premiums	\$420	\$696	66%
Annual Deductible	\$250	\$445	78%
Width of Doughnut Hole	\$2,850	\$5,066	78%
Beneficiary Out of Pocket Costs at Catastrophic Limit	\$3,600	\$6,400	78%

Source: Letter to Senator Don Nickles from Congressional Budget Office Director Douglas Holtz-Eakin (November 20, 2003)

the premiums are projected to increase 66 percent by 2013. They would reach \$58 a month with a \$445 deductible, and individuals with the largest drug bills would be entirely responsible for more than \$5,000 in drug costs.⁴⁰

The bill passed by Congress was projected to cost the government \$395 billion over 10 years, over and above the premiums and co-payments of those who enroll in the program. However, the President's budget for 2005 projects the costs to be \$534 billion, because the Administration forecasts that more people will enroll, drug costs will be higher, and enrollment in managed care plans will be higher than previously projected. The Administration knew about these costs well before passage of the legislation, but it muzzled the Health and Human Services (HHS) actuary from reporting these costs to the Congress.

Beginning in June 2004 and through December 2005, Medicare beneficiaries will be offered an interim drug discount card. For seniors with annual incomes below 135 percent of the federal poverty line (\$12,569 for an individual and \$16,862 for a couple in 2004), and whose assets total less than \$6,000 (\$9,000 for a couple) excluding their own house, the federal government will pay the card's annual fee, and the card will include a credit of \$600 to help pay for drugs. It is estimated that the asset test will disqualify 1.8 million very low-income seniors for assistance.⁴¹

Many employers supported passage of the recent legislation for Medicare drug benefits, and the bill would give \$86 billion in payments and tax advantages over 10 years to the nation's employers if they maintain drug coverage for retirees. The new subsidy is intended to discourage companies from dropping such plans.⁴²

Subsidy payments to employers will equal 28 percent of a retiree's gross covered retiree plan related to prescription drug costs over the \$250 deductible, but not over \$5,000. The payments would be made on behalf of an individual covered under the retiree plan who is entitled to enroll in the new drug program, but elects not to. The employer subsidy will be based both on what the employer spends for prescription drugs and what the retiree spends. So, if an employer and a retiree each pay \$1,000 toward the retiree's prescriptions costs, the employer's subsidy is calculated on the full \$2,000. The company would receive a payment of \$490, and still deduct the \$1,000 from income, for an after tax cost of \$650 if the corporation is paying a 35 percent corporate income tax. The net cost to the employer would be just \$160. Some firms have already included their anticipated government payments in their 2003 financial statements.⁴³

Large companies save billions of dollars from Medicare prescription drug bill.

Due to the expected employer subsidy, 18 companies estimated their cost savings from benefit obligations in 2003 as follows:

Alcoa: \$180 million

AMR: \$415 million

BellSouth: \$572 million

Consolidated Edison: \$256 million

Delphi: \$454 million

Dominion Resources: \$70 million

Equifax: \$2 million

Ford Motor: \$1.8 billion

General Motors: \$4.1 billion

Norfolk Southern: \$45 million

New York Times: \$33 million

Pepsico: \$50 million

SBC Communications: \$1.6 billion

TXU: \$142 million

Union Pacific: \$47 million

UAL: \$280 million

U.S. Steel: \$450 million

Verizon: \$1.25 billion

Source: Dow Jones Newswires
(March 22, 2004)

Employer-sponsored health plans are the primary source of drug coverage for people on Medicare.⁴⁴ About one-third of those covered by such employer plans, or between 2.7 million and 3.8 million retirees, are projected to lose their employer drug benefit under the new bill or have it reduced.⁴⁵ In general, the new Medicare provisions are inferior to most of the existing employment-based plans. The deductibles and co-payments are lower under existing plans, and the new law's monthly premiums for drugs are higher than those paid by most retirees who have such benefits. Also, none of the employer plans have the doughnut hole that is in the new legislation, where benefits are suspended for drug costs between \$2,250 and \$5,100. The law only requires the plan to provide drug coverage that is "at least actuarially equivalent to the standard prescription plan," which means that many companies could, and probably will, reduce current coverage. The average senior spends an estimated \$2,500 on annual drug expenditures. Those with employer insurance pay about \$500 out of their own pocket, whereas under the Medicare plan, these costs could rise to \$1,000.⁴⁶

Retired United Auto Workers at General Motors are guaranteed maintenance of their drug benefits under the recently signed four-year agreement. Under the new law, it is anticipated that GM will receive a subsidy of \$200 million a year, or \$2 billion over the next decade.⁴⁷ However, GM has already sharply cut retiree benefits for workers hired after 1992.⁴⁸

Here is how *BusinessWeek* described the result of the new legislation: "With a better overall bill, this mess might well have been avoided. But a deeply divided Congress created a patchwork plan that mixes public and private insurance. So, \$86 billion [the amount allocated to encourage private plans participation] is the price of the bailing wire and bubble gum lawmakers needed to hold together the shaky health-care system for seniors."⁴⁹

Also losing in the new drug bill are the poorest of elderly Americans. Retirees under Medicaid, whose drug costs have been paid for by Medicaid, will no longer get them cost-free. Instead they will be subject to co-payments of \$1 to \$5 per prescription. Also pharmaceutical benefit management companies that will run the new program will have greater latitude to substitute generics for brand name prescriptions.⁵⁰

There are a number of proposals that would address the erosion of retiree health care directly or indirectly. They include:

- Allow early-retirees to buy into Medicare;**
- Overhaul the 2003 prescription drug law;**
- Provide tax credits;**
- Extend health care protections through state programs;**
- Protect existing benefits;**
- Amend the bankruptcy code;**
- Encourage employer innovations;**
- Elevate health costs consciousness;**
- Change plan type and access;**
- Provide for long-term care; and**
- Implement universal health care.**

Proposed Solutions

Buy-Into Medicare

A proposal has been put forth in Congress by Representatives Sherrod Brown (D-OH) and Pete Stark (D-CA) that would allow individuals ages 55 to 64 to buy into Medicare (H.R. 4357). Premiums would be set by the Centers for Medicare & Medicaid Services, and adjusted annually. Participants would receive a 75 percent refundable, advanceable tax credit to offset premium costs.

Overhaul the 2003 Prescription Drug Law

Senator Edward Kennedy (D-MA) introduced a bill (S. 1992) that would rewrite the 2003 prescription drug provisions “to reduce the role of private health plans, to increase drug benefits, and to authorize the government to negotiate drug prices.” The bill would allow Americans to import prescription drugs from Canada and eliminate the doughnut hole, thus closing the gap in coverage. It would also abolish the demonstration project that requires Medicare to compete with subsidized private plans beginning in 2010. Another provision would repeal the program of Health Savings Accounts that help the healthy, the wealthy, and the insurance companies. The measure would eliminate the way the true out-of-pocket costs are calculated for the treatment of employer subsidies.

Senator Kennedy has also introduced legislation (S. 2300) that would repeal the premium support demonstration program, cut additional payments to private plans, and strengthen the federal fallback program. The lawmaker cited the recent report by Medicare Trustees, which found that the Medicare Part A trust fund will be financially insolvent in 2019, seven years earlier than projected a year ago, as an indication that the new law was damaging the long-term solvency of the program.

Tax Credits

In his fiscal year 2005 budget, President Bush proposed providing a refundable tax credit for individuals and families who do not have employer or public program coverage and purchase health insurance. However, the budget proposal does not provide new resources for the tax credit, rather it offsets the costs through cuts in other programs, including reductions in Medicare and Medicaid. While the tax credit appears to be a possible means of covering people who lose insurance coverage, it could lead some employers to discontinue providing coverage for their employees. Additionally, individual health insurance is expensive and would be unaffordable for many low- and middle-income families.⁵¹ Ultimately, expanded coverage of the uninsured is unlikely through this proposal.

“My former employer for years used the cost of health care as a crutch for keeping wage increases to a minimum. This was at a time when health care premiums, especially group rates, were not a very costly item. When this benefit did become a costly item, we were required to offer up our share—and did! These companies shouldn’t be allowed to have it both ways now. Quit protecting insurance companies and their overpaid executives and bring on national health care.”

David L. Riggle, Mather, RA

State Plans

In Hawaii, employers have long been required to provide workers with health insurance, and this requirement has helped many retirees achieve coverage.

A 2003 California law requires employers to provide health care beginning in 2006. Employer groups have sought to repeal the health law with a referendum. A vote will be held with the November 2004 elections.⁵² Under the California law, large employers with 200 or more employees would be required to provide coverage for employees and their dependents starting in 2006. The following year, employers with 50 to 199 employees would provide coverage for only their employees. In 2007, employers with 20 to 49 employees would provide coverage for their employees, only if the legislature approves a tax credit to further subsidize the costs of coverage.

Other programs are being considered by states to extend health coverage to their citizens. The Maine Rx Plus, for example, uses state purchasing power to negotiate lower drug prices. In 2003, the state passed the Dirigo Health Program that offers lower-cost health plans to self-employed individuals and to employees of small businesses. More state experiments may also be a route to better retiree health care mechanisms.

Another approach is state expansion of Medicaid services to seniors and people with disabilities, by extending Medicaid to all people whose income is less than 100 percent of the federal poverty level, and by providing Medicaid to all people receiving SSI benefits.

Protection of Existing Benefits

Representative John Tierney (D-MA) has introduced a bill (S. 1322) that would prohibit employers from making post-retirement cancellations or reductions of health benefits that retirees were entitled to when they

retired. The bill would also obligate employers to restore benefits taken away after retirement unless the employer can demonstrate substantial business hardship if compelled to restore the benefits.

Amend the Bankruptcy Code

Senator John D. Rockefeller (D-WV) has introduced legislation (S. 1970) that would require bankrupt companies to pay a minimum level of compensation to retirees. Under this bill, retirees would be entitled to a payment equal to the cost of purchasing comparable health insurance for a period of 18 months. The retirees would continue to be entitled to a claim for the value of the benefits lost in excess of the one-time payment. Another provision would provide bankruptcy courts with the authority to recover company assets in cases where company executives paid excessive compensation to some employees just before declaring bankruptcy in order to recover more assets for retirees and employees.

Employer Innovations

Employers can introduce innovative initiatives that will reduce costs without shifting them to retirees. Some employers have adopted the following long-term approaches⁵³:

- Improve quality of care as strategy to control costs. For example, one employer is creating decision-support tools for employees, including access to nurse coaches to help employees navigate the health care delivery system;
- Introduce disease management and wellness programs after analysis of their own claims data; and
- Develop a long-term relationship with a single insurance carrier gaining more leverage in premium negotiations, facilitated customer service and lower administrative costs.

Employee Health Costs Education

Employers could provide life-planning programs for workers of all ages addressing not only preparation for adequate retirement income but also the likely increase in health care expenditures as one ages. Presumably consumer education for quality of life beyond work could lead to savings.

Change Plan Type and Access to Health Plans

Some employers have limited their retiree benefits to providing access-only health plans to retirees. This only softens the blow of losing employer-provided coverage. Under this arrangement, retirees would be able to buy insurance at group rather than individuals rates. However, they would have to pay 100 percent of the costs. Resembling the trend in pensions, a significant number of employers have indicated that they are likely to shift their health plans from a defined benefit to a defined contribution approach.⁵⁴ Modeled on the financing mechanism

of pension plans, a defined benefit health plan provides a guarantee of certain benefits by a sponsor. Under a defined contribution plan, the health benefits would be based on an employer's specific contribution on behalf of each individual, without guaranteeing the benefit. The employer may also set caps on the contributions and the annual allowed expenditures. The individual pays the costs above the cap, which would increase with health care inflation while the employer's share remains fixed. This approach may be in lieu of terminating a plan altogether but is another means of shifting rising costs to retirees.

Long-Term Care

Legislation is needed to establish a long-term care system that is affordable and is based on health and physical needs, not income levels. Similar to Medicare, it should protect an individual's right to choice of provider and care environment. Older Americans, as well as those with disabilities, need access to affordable home and community-based, long-term care, and rehabilitative and nursing home services. A small first step would be to increase the federal Medicaid matching rate.

Universal Health Care

Another solution to retiree health care problems is the same as that for all Americans—a universal health care system that covers all people. This system could be based on a sound financing model similar to the Medicare program. The United States is the only developed country without a national health insurance program. The result is that 45 million Americans have no insurance coverage to pay for their medical needs.

Whatever solution or solutions are devised and implemented, the increase in health costs and cost-sharing accompanied by an overall decline in retiree health care coverage indicates that immediate action is necessary.

Costs of prescription drugs, other health care, and long-term care are increasing. None of the positive public policies to help retirees meet their skyrocketing health care costs will take place unless more seniors and the general public vote for candidates dedicated to improving the lot of retirees. Representatives in the nation's capital and its state houses need to be reminded of the plight of aging Americans brought on by the continuing rising cost of health care, and the decline in employer coverage. The crisis for retirees is growing. The nation needs leadership that will address the health care crisis of retirees and all Americans.

Conclusion

Glossary

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Refers to a provision in this legislation which requires that certain employers allow terminated employees to remain on the employee health plan for up to 18 months, provided the former employee pays the full cost of the premium.

Defined benefit plan. Funding mechanisms for pension plans that can also be applied to health benefits with a guarantee of certain benefits by a sponsor.

Defined contribution plan. Funding mechanism for pension plans that can also be applied to health benefits based on a sponsor's specific dollar contribution on behalf of each covered individual, without defining the services to be provided. The individual pays costs above the defined amount.

Federal Medical Assistance Percentage (FMAP). The percentage at which the federal government matches the state Medicaid agencies for Medicaid services. This can be no less than 50 percent and no greater than 83 percent.

Financial Accounting Standards Board (FASB). A private entity that writes rules for the accounting profession.

Governmental Accounting Standards Board (GASB). An entity similar to FASB above, but for state and local governments.

Health Insurance Portability and Accountability Act (HIPAA). A federal law that helps workers maintain coverage when they change jobs, and limits the ability of insurers to deny coverage for pre-existing conditions.

Health Maintenance Organization (HMO). Managed care plan primarily owned and operated by insurers that acts as both the insurer and the provider of health care services to an enrolled population.

Health Savings Accounts (HSAs). Authorized by the 2003 Medicare law, an HSA is a savings or investment account that is permitted for an employee who also has a high-deductible medical insurance plan.

Medicaid. A jointly funded, federal-state program that provides health coverage for low-income individuals who meet income, assistance, and categorical eligibility criteria.

Medigap Plans. Private supplemental insurance plans designed to cover gaps in the Medicare program. There are 10 standardized policies labeled Plan A through Plan J. Only Plans H through J offer a prescription drug benefit; but they will not be available after January 1, 2006.

Pay-As-You-Go. Pertains to contributions paid to a system, such as Social Security, which are in turn distributed to current beneficiaries.

Trade Adjustment Assistance Reform Act (TAARA). Provides a fully refundable, advanceable federal income tax credit to cover health insurance costs for certain trade displaced workers and retirees receiving payments from the Pension Benefit Guarantee Corporation (PBGC).

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About the Alliance for Retired Americans Educational Fund

This report is a publication of the Alliance for Retired Americans Educational Fund (ARAEF), the research and educational branch of the Alliance for Retired Americans. The ARAEF is a 501 (c) (3) organization that focuses primarily on retiree issues in three program areas:

- Research and development of written materials on public policy issues;
- Building grassroots via education on public policy issues; and
- Coalition activities with other not-for-profit organizations.

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About the Alliance for Retired Americans

The mission of the Alliance for Retired Americans is to ensure social and economic justice and full civil rights for all citizens so they may enjoy lives of dignity, personal and family fulfillment and security. The Alliance believes that all older and retired persons have a responsibility to strive to create a society that incorporates these goals and rights; and that retirement provides them with opportunities to pursue new and expanded activities with their unions, civic organizations and their communities. The Alliance's public policy and legislative goals will be achieved through mobilization of members in an extensive grassroots network in every region, state and district in the country.

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