

Erie County decision means, among other things, that an employer who voluntarily provides its pre-age 65 retirees with a bridge to Medicare (with the intent to terminate all employer-sponsored retiree coverage at that time) can do so without ADEA implications only if the benefits provided by the bridge coverage are either the same as or less generous than those provided by Medicare. Stated otherwise, in every instance where employer-provided bridge coverage exceeds Medicare coverage, the employer would be prevented by the ADEA from ending its coverage when retirees become eligible for Medicare. The Commission is concerned that many employers will respond to this outcome, given the dramatic cost increases for retiree health benefits, not by incurring additional costs for retiree benefits that supplement Medicare, but rather by reducing or eliminating health coverage for retirees who are not yet eligible for Medicare.

In fact, this is ultimately what happened in *Erie County*. In an attempt to comply with the court's ruling, the county transferred younger retirees from the hybrid point of service plan—where each retiree had the ability to select between HMO or traditional indemnity plan coverage on an as-needed basis—to an HMO plan similar to that available to retirees over age 65 that did not provide such an option. *Erie County Retirees Ass'n v. County of Erie*, 192 F. Supp.2d 369, 372 (W.D. Pa. 2002). The county also required employees not yet eligible for Medicare to pay a monthly amount for such coverage equal to the monthly amount of Medicare Part B premiums that retirees over age 65 paid. *Id.* The result, therefore, is a decrease in health benefits for retirees generally; older retirees receive no better health benefits, while younger retirees must pay more for health benefits that offer fewer choices.

Alternative Proposals

In considering the proper regulatory approach, EEOC closely examined whether it would be possible to apply the equal benefit/equal cost test in its regulations to the practice of coordinating employer-sponsored retiree health benefits with Medicare or a State-sponsored retiree health benefits program. The Commission evaluated various proposals that would have allowed employers to take the cost of Medicare into account when assessing

whether they satisfied the equal cost test. The Commission also considered the feasibility of implementing regulations under the ADEA that would require employers to adopt or maintain benefits programs that supplement Medicare in order to satisfy the equal benefits test.

After extensive study, however, it does not appear that retiree health costs or benefits can be reasonably quantified in a regulation. Unlike valuation of costs associated with life insurance or long-term disability benefits, calculating retiree health costs is complex due to the multitude of variables, including types of plans, levels and types of coverage, deductibles, and geographical areas covered. In addition, the subjective nature of some health benefits, such as a greater choice in providers, makes any such valuation more complicated.

Even allowing an employer to take into account the "cost" of Medicare is problematic because the government's cost to provide Medicare services does not reflect what similar benefits would cost an employer in the marketplace. Nor can an employer's Medicare tax obligation, pursuant to the Federal Insurance Contributions Act, 26 U.S.C. 3101 *et seq.* (FICA), be considered the "cost" of any specific retiree's Medicare benefits inasmuch as most retirees have been employed by multiple employers over the course of their careers and employer FICA contributions are paid into a general Medicare fund that is not employee-specific. Additionally, the fact that employees themselves pay for a portion of the cost of Medicare further complicates cost valuation.

The Commission therefore believes that quantifying the cost to employers of post-Medicare retiree health benefits under any formulation of the equal cost test would not be practicable. This is particularly true for employers who maintain multiple plans for different categories of employees. Even for employers with only one plan, the variability in health claims data from year to year can be great. As a result, calculating retiree health benefit expenses would be cost prohibitive for many employers. Thus, even if it were possible to capture the myriad of complexities involved in a retiree health cost analysis in a regulation, the likelihood is that far too many employers might simply reduce or eliminate existing retiree health benefit plans instead of attempting to comply with such a regulation.

Further complicating compliance with many of the alternative proposals considered by the Commission is the fact that employers do not have the

same flexibility in designing retiree health benefit programs as they do when designing other types of retirement benefit programs, such as cash-based retirement incentives. For example, providing supplemental health benefits to retirees who are eligible for Medicare may require that the employer obtain and administer a separate policy just for that coverage. Many employers are unable or unwilling to bear such a burden. Instead, if faced with such a choice, employers are more likely to simply eliminate retiree health coverage altogether—for retirees under and over age 65. Furthermore, future changes in the private health insurance market or in Medicare likely would necessitate further regulatory action were the Commission to adopt many of the alternative proposals considered. The Commission does not believe that it is possible to apply the equal benefit/equal cost test, or a variant of that rule, to the rapidly changing landscape of retiree health care.

The Commission therefore believes that application of the equal cost/equal benefit rule, or a variant of that rule, to the practice of coordinating retiree health benefits with Medicare or a State-sponsored retiree health benefits program would not allow employers to readily and cost-efficiently determine which practices are, and are not, permissible and therefore would not fully alleviate employers' concerns about offering retiree health benefits. It is clear that small and medium-sized employers, and those unable to hire sophisticated employee benefit professionals, would be most affected by a complicated rule. In light of the other factors affecting an employer's decision to provide retiree health benefits, the Commission believes that the current regulatory framework of the ADEA does not provide a sufficient safe harbor to protect and preserve the important employer practice of providing health coverage for retirees.

This lack of regulatory protection may cause a class of people—retirees not yet 65—to be left without any health insurance. It also may contribute to the loss of valuable employer-sponsored coverage that supplements Medicare for retirees age 65 and over. Because almost 60% of retirees between the ages of 55 to 64 rely on employer-sponsored health coverage as their primary source of health coverage,²⁸ and about one-third

²⁸ Hearing Before the House Comm. on Education and the Workforce, 107th Cong. (2001) (statement of William J. Scanlon, Director of Health Care Services, GAO). Of the 56.8% of retirees covered by employer-sponsored health coverage in 1999, 36.3% were covered in their own name and 20.5% received health benefits through a spouse. Paul

Institute Aug. 2001) ("because of the legal and cost concerns raised by the *Erie County* decision, [employers] are more likely to cut back on benefits for early retirees" or eliminate retiree health benefits).