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PROTECTING THE HEALTH BENEFITS OF RETIREES

by Bruce Poyer

Successful efforts to "contain" health care costs have been reported in a number of bargaining units around the country, particularly in larger units which have more bargaining power with providers and insurers. But cost containment programs have not prevented a great deal of cost shifting; for example, from employers directly to working employees, by increasing their out-of-pocket payments, wiping out their "maintenance of benefits" protection against inflation, and requiring the sharing of premium costs. Further, current cost containment programs have yet to deal with the most damaging and probably the most widespread shifting of costs--from the working population to the retirees, from the young to the old--which is the subject of this article.

Most health plans for retirees are supplemental to Medicare, and no one doubts that costs have been shifted from Medicare. The shifts have come from benefits which should have been included in the original program but were omitted, from the impact of long-term inflation, from the cuts in the program and the cost controls implemented by the Reagan Administration, and even from the increasing proportion of retirees to workers. Who pays these shifted costs? The retirees themselves? Their former employers? Their health plans? Or the active (working) members in the bargaining units of the retirees?

There is little data from private sector health plans to show who absorbs the shifted costs, and the first Congressional hearing on the subject was held only last month. But there is at least a cross-section illustration of the problem in the public sector in California.

Protection of Retiree Health Benefits in PERS--California's Public Employee Retirement System (PERS) covers 752,000 state and local government workers (532,500 actives; 220,000 retirees). In 1961, the legislature passed the Public Employees' Medical and Hospital Care Act (PEMHCA), authorizing the PERS Board to approve the health plans which would cover both the working and the retired members of PERS, and their dependents. The Board was authorized to set minimum standards for their health plans, to make surveys and reports on the adequacy of benefits and the standards of care, and to see that "rates charged under any health benefits plan shall reasonably reflect the cost of the benefits provided." PEMHCA has been amended over the years to permit more local government employees to contract for PERS health care coverage (whether they are covered by the PERS retirement system or not). Most of those in the State Teachers Retirement System can be covered for health benefits, as can those in the 20 California counties under retirement plans regulated by the 1937 Act. Employees of the state university system are covered, and those in the University of California Retirement System can be covered for PERS health benefits.

The PERS Board has now approved 68 different health plans which it oversees on behalf of 228,000 active and retired public employees throughout the state, and their 204,000 dependents. Half of the plans cover workers and half are supplement to Medicare plans for retirees. The PERS Health Benefits Division has been active and effective not only in its cost containment efforts, but also in monitoring to maintain high quality of care standards in all approved plans. (Such monitoring is essential in all cost containment programs.) In the private sector in California, there has been no comparable effort by employers or by employee organizations to establish a similar comprehensive, regulated, system-wide approach to health care coverage.

Nevertheless, the PERS health benefits program still covers only 228,000 of the 752,000 government employees in the PERS retirement program (not to mention the additional employees in other retirement systems who are now eligible to participate). Why are so many not enrolled?

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There may be several answers to this question, but chief among them is the original requirement of PEMHCA that in any health plan approved by the PERS Board, the contribution rates for actives and retirees must be the same. The intent of this requirement is to have the working young help pay the higher health care costs of the retired old, so that this burden does not fall directly on the retirees or indirectly on the welfare system. That is what the nation sought to do when Medicare was enacted. The equal contribution rates required in PERS approved plans gives minimal protection to retirees, but it has become more important as Medicare has fallen increasingly short of its original goal to provide the same kind of protection.

For thousands of California public employees who are not in PERS approved plans, the contribution rates for retirees are so much higher than the rates for actives that their employee organizations are unable to negotiate their retired members into the PERS health benefits program. The PERS Board has supported legislative proposals to make it easier for local government agencies to meet the equal contribution rate requirement, by spreading the equalization process over a longer time period. But this effort runs counter to pressure from the Department of Personnel Administration (which carries the governor's negotiating responsibilities for public sector bargaining units) to drop the equal rate requirement altogether--and let the retirees fend for themselves in trying to meet their health care costs.

In fact, DPA has made no secret of its active interest in taking over all responsibilities given to the PERS Board in PEMHCA, even though PERS has carried out these responsibilities with dedication and competence for several decades. Retired public employees have much to lose in this jurisdictional squabble, while the actives have nothing to gain. That situation arises because there is too much concern about "cost savings" which are really cost shifts, and not enough concern about health care.

Comparable Cost Shift Problems in the Private Sector--There is very little private sector data on the extent of health care cost shifting to retirees. But it is clearly an enormous problem in the case of some employers who have sought to cancel altogether the health care coverage of their retired workers. Fortunately, there is a growing list of court decisions holding that if promises are made to provide retiree coverage (in summary plan descriptions, for example), it is legally required (even if there are loop-hole provisions in the plan documents, as in the recent *Bethlehem* case). However, there are more bankruptcies, plant closings, and corporate reorganizations which reduce or wipe out retiree health care coverage. And there are more employers seeking to replace their defined-benefit pension plans with defined-contribution plans. Such plans may also reduce or eliminate the commitment to defined health benefits for retirees.

Other private sector trends are equally ominous for retirees. In collective bargaining, more settlements now require an increasing share of health costs to be met directly by retirees. Also, there are more bargaining units in which the ratio of actives to retirees approaches 50-50, making the economics of equal contribution rates for the two groups more difficult. Finally, the Federal Accounting Standards Board is considering the idea of making retiree health benefits a funded liability of the employer, similar to his funded liability in defined benefit pension plans. This change would require the pre-funding of retiree health benefits.

It has thus become essential for health plan trustees and employee organization officials to shore up their existing protection for retiree health care, and to assert themselves in opposing new take-away proposals for retirees, whether they come from private sector employers or from government units. The leading case in point in California is the threat from the state Department of Personnel Administration to eliminate the PEMHCA requirement for equal contribution rates for actives and retirees. State officials should be cooperating with the PERS Board to develop a secure, predictable, and equitable funding source to meet increasing retiree health costs, instead of moving backward and seeking to renege on past commitments to protect the health care benefits of retirees.

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