Publications

District Court Holds on Remand that Erie County's Retiree Health Program Flunks ADEA's

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SERVICES

On April 16, 2001, the United States District Court for the Western District of Pennsylvania issued a much-awaited ruling on remand from Erie County Retirees Ass'n v. County of Erie, Pennsylvania, 220 F.3d 193 (3d Cir. 2000), cert. denied, 69 U.S.L.W. 3409 (March 5, 2001). The district court held that Erie County's retiree health benefit program fails to satisfy the "equal cost or equal benefit" safe harbor codified in the Age Discrimination in Employment Act (ADEA). Among other things, the court found that benefits paid to Medicare-eligible participants through a Medicare HMO unlawfully are lesser in amount than those paid to pre-Medicare retirees through a point-of-service (POS) plan.

Many fear that the Erie County Retirees rulings portend a new wave of ADEA class action litigation over retiree health benefits. Erie County's program is substantially similar to those sponsored by many non-government employers. The rationale of the Erie County Retirees rulings, moreover, arguably extends to many other commonly-used techniques for coordinating plan benefits with the federal Medicare program. Efforts to clarify these issues through legislation or administrative action soon may be underway.

Background

Last August, the United States Court of Appeals for the Third Circuit issued a landmark ruling about age discrimination and retiree health benefits. The ruling held that the terms of a retiree health benefit plan presumptively violate ADEA when they make benefit distinctions based upon a retiree's eligibility for Medicare. More specifically, the ruling held that Erie County, Pennsylvania had presumptively violated ADEA by requiring most of its Medicare-eligible retirees to accept health benefit coverage through a Medicare HMO while allowing its pre-Medicare retirees to accept coverage through a traditional indemnity plan (for periods before October 1, 1998) or through a POS plan (for periods after October 1, 1998). Erie County Retirees Ass'n v. County of Erie, Pennsylvania, 220 F.3d 193 (3d Cir. 2000), cert. denied, 69 U.S.L.W. 3409 (March 5, 2001).

The Third Circuit remanded the case to the district court for a determination whether the County's program, while discriminatory, nonetheless fit within the statute's "equal cost or equal benefit" safe harbor. That safe harbor shelters age-based disparities in employee benefits provided that, for each benefit or benefit package, "the amount of payment made or cost incurred on behalf of the older worker is no less than that made or incurred on behalf of a younger worker," as permissible under EEOC regulations. ADEA ¤ 4(f)(2)(B)(i), 29 U.S.C. ¤ 623(f)(2)(B)(i).

The District Court's Ruling on Remand

On April 16, 2001, the United States District Court for the Western District of Pennsylvania ruled that Erie County's program flunked the "equal benefit" prong of the statutory safe harbor in three areas.

(1) The first area concerned premium requirements. Erie County purchased all three forms of retiree health coverage from an outside insurer. The total per capita cost of insurance was highest under the indemnity plan, somewhat less under the POS plan, and the lowest under the Medicare HMO. In all three cases, most or all of the total premium cost was paid from the County's own pocket. But participants had to pay some portion of the total premium cost from their pocket, depending on the form of coverage provided.

Specifically, participants had to pay $12 per month toward the cost of the indemnity plan, but nothing toward the cost of the POS plan. With respect to the Medicare HMO, participants likewise paid nothing directly to the County or to the insurer. Instead, Medicare-eligible participants were required to continue having a Medicare Part B premium of roughly $50 per month deducted from their Social Security checks.

The district court observed that an EEOC ADEA regulation specifically addresses the subject of employee contributions in support of voluntary employee benefit plans. That regulation provides, in part, that older employees can be required to pay more than younger employees for participation in a voluntary benefit program, but only if the older employees are not required to bear "a greater proportion of the total premium cost" than younger employees. 29 C.F.R. ¤ 1625.10(d)(4)(ii). As the district court saw things, a Medicare-eligible retiree's Part B premium of roughly $50 per month accounted for a substantially higher percentage of total premium costs (i.e., employer-paid plus participant paid) as compared to amounts required, at any time, by pre-Medicare retirees under either the indemnity plan or the POS plan. From this, the court held that the County's program violated the prohibition on disproportionate contribution structures set forth in the EEOC's regulation.

(2) The second area addressed by the district concerned the fact that the Medicare HMO generally paid only for services provided by "in-network" providers. The district court found that this aspect of the program did not result in an illegal diminution in benefits as compared to the traditional indemnity plan that the County had in place prior to October 1, 1998. The district court explained its rationale as follows:

We believe that the relative benefit of either plan is largely in the eye of the beholder. While Plaintiffs may prefer the traditional indemnity plan for its greater choice of service providers, other retirees are likely to prefer [the Medicare HMO] for its low co-payments or other unique attributes such as coverage for eye examinations and dental visit. In light of the above, we find that absent the demonstration of some objective diminishment, i.e., a lower quality of health care, Plaintiffs' preference for the traditional indemnity plan's mechanism of insuring medical services is a subjective preference outside the scope of the regulation.

Remarkably, the district court then used this same rationale to conclude that the Medicare HMO's in-network restriction did result in an unlawful diminution in benefits as compared to the POS plan. In doing so, the district court noted that the POS arrangement had attributes of both an HMO and a traditional indemnity plan. Participants could chose, at each point of service, either an in-network provider or an out-of-network provider. Choosing the former gave the participant a reduced out-of-pocket cost, just like the HMO, while choosing the latter gave the participant a broader choice of providers, just like the traditional indemnity plan. According to the district court, this "dual program" of the POS arrangement gave each retiree an "objective advantage" that resulted in a greater amount of benefit payments as compared to the Medicare HMO:

The objective advantage of a dual program is that the insured's preference for either mechanism may consistently be accommodated. Because Plaintiffs are unable to similarly accommodate their preferences under [the Medicare HMO], we find that the plan is a lesser benefit under [the EEOC regulation].

(3) The third and final area addressed by the district court concerned prescription drug coverage. The Medicare HMO restricted insureds to a prescription drug formulary. The traditional indemnity plan and POS plan did not.

The traditional indemnity plan instead required retirees to pay a deductible and, thereafter, an uncapped percentage of their prescription drug costs. The district court found that this did not result in an illegal benefit differential:

The greater choice afforded by the traditional indemnity plan does not, in other words, objectively render the plan a greater benefit than [the Medicare HMO] because the value of this aspect in this context is, in our view subjective.

The POS plan likewise required retirees to pay deductibles, but in smaller amounts as compared to the Medicare HMO. The district court concluded that this aspect of the POS plan "is objectively a greater benefit than the restricted choice at a higher cost provided by [the Medicare HMO], and we therefore find that it is a lesser benefit under the regulation."

With these three sets of "equal benefit" findings, the district court moved to the "equal cost" prong of the statute's safe harbor. The court quickly concluded that the County's program could not meet this prong of the safe harbor, citing the detailed instructions on this point in the Third Circuit's August 2000 decision. From this, the district court granted partial summary judgment for the plaintiff class of retirees on the issue of liability. The court reserved for a later ruling the question of how the County is to remedy the actions that were found to have violated ADEA.