Proposed Rules

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This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

29 CFR Parts 1625 and 1627

RIN 3046–AA72

Age Discrimination in Employment Act; Retiree Health Benefits

AGENCY: U.S. Equal Employment Opportunity Commission.

ACTION: Notice of proposed rulemaking.

SUMMARY: The U.S. Equal Employment Opportunity Commission (Commission or EEOC) proposes to amend its regulations governing age discrimination in employment to exempt from the prohibitions of the Age Discrimination in Employment Act of 1967 the practice of altering, reducing or eliminating employer-sponsored retiree health benefits when retirees become eligible for Medicare or a State-sponsored retiree health benefits program. This exemption will ensure that the application of the ADEA does not discourage employers from providing health benefits to their retirees.

DATES: Comments must be received by September 12, 2003. The Commission will consider any comments received on or before the closing date and thereafter adopt final regulations. Comments received after the closing date will be considered to the extent practicable.

ADDRESSES: Written comments should be submitted to Frances M. Hart, Executive Officer, Office of the Executive Secretariat, U.S. Equal Employment Opportunity Commission, 1801 L Street, NW., Washington, DC 20507. As a convenience to commentators, the Executive Secretariat will accept comments transmitted by facsimile (''FAX'') machine. The telephone number of the FAX receiver is (202) 663–4114 (This is not a toll free number). Only comments of six or fewer pages will be accepted via FAX transmittal. This limitation is necessary to assure access to the equipment. Receipt of fax transmittals will not be acknowledged, except that the sender may request confirmation of receipt by calling the Executive Secretariat staff at (202) 663–4078 (voice) or (202) 663–4077 (TTY). (These are not toll free numbers). Copies of comments submitted by the public will be available for review on weekdays, except federal holidays, at the Commission's library, Room 6502, 1801 L Street, NW., Washington, DC, between the hours of 9:30 a.m. and 5 p.m.

FOR FURTHER INFORMATION CONTACT: Lynn A. Clements, Special Assistant to the Legal Counsel, Office of Legal Counsel, at (202) 663–4624 (voice) or (202) 663–7026 (TTY) (These are not toll free numbers). This notice is also available in the following formats: large print, braille, audio tape, and electronic file on computer disk. Requests for this notice in an alternative format should be made to the Publications Information Center at 1–800–669–3362.

SUPPLEMENTARY INFORMATION: Section 9 of the Age Discrimination in Employment Act of 1967, 29 U.S.C. 621 *et seq.* (ADEA or Act), provides that EEOC ''may establish such reasonable exemptions to and from any or all provisions of [the Act] as it may find necessary and proper in the public interest.'' Implicit in this authority is the recognition that the application of the ADEA could, in certain circumstances, foster unintended consequences that are not consistent with the purposes of the law and are not in the public interest. Such circumstances are rare. Accordingly, EEOC's exercise of this authority has been limited and tempered with great discretion.

After an in-depth study, the Commission believes that the practice of altering, reducing or eliminating employer-sponsored retiree health benefits when retirees become eligible for Medicare or a State-sponsored retiree health benefits program presents a circumstance that warrants Commission exercise of its ADEA exemption authority. For the reasons that follow, and pursuant to its authority under Section 9 of the Act, the EEOC proposes in this notice of proposed rulemaking (NPRM) to add a new section 32 to part 1625 of Title 29 of the Code of Federal Regulations exempting such coordination of employer-sponsored retiree health benefits with Medicare or a State-sponsored retiree health benefits program from all prohibitions of the ADEA.

Basis for Exemption

In August 2001, the Commission announced that it would study the relationship between the ADEA and employer-sponsored retiree health benefit plans that alter, reduce or eliminate benefits upon eligibility for Medicare or a comparable State-sponsored retiree health benefits program. To begin the process, EEOC developed an internal Retiree Health Benefits Task Force headed by its Legal Counsel. The Task Force met with a wide range of Commission stakeholders, including employers, employee groups, labor unions, human resource consultants, benefit consultants, actuaries and state and local government representatives. The Task Force also reviewed available survey data regarding employer-sponsored retiree health benefits; analyzed the May 2001 United States General Accounting Office's Report to the Chairman of the United States's Senate Committee on Health, Education, Labor and Pensions entitled ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion;'' and reviewed numerous professional articles discussing the continued erosion of retiree health benefits.

As a result of its study, the Commission has concluded, as discussed in greater detail below, that the number of employers providing retiree health benefits has declined considerably over the last ten years, even though many retired individuals rely on such employer-sponsored plans for affordable health coverage. Various factors have contributed to this erosion, including the increased cost of health care coverage, an increased demand for such coverage as large numbers of workers near retirement age, and changes in the way accounting rules treat the long-term costs of providing retiree health benefits. The Commission believes that concern about the potential application of the ADEA to employer-sponsored retiree health benefits is adversely affecting the continued provision of this important retirement benefit.

Employers Are Not Obligated To Provide Retiree Health Care

Employers are not legally obligated to provide retiree health benefits and many

do not. In fact, in 2001, only about ''one-third of large employers and less than 10% of small employers offer[ed] retiree health benefits.'' [1] Employers who choose to provide retiree health benefits are not required to provide such benefits indefinitely, absent some contractual agreement to the contrary. Employers that do offer retiree health benefits, however, often do so to maintain a competitive advantage in the marketplace—using these and other benefits to attract and retain the best talent available to work for their organizations.

Likewise, employer-sponsored retiree health benefits clearly benefit employees. In many cases, employers offer retiree health benefits as a bridge to Medicare so that younger retirees have access to affordable health care benefits when they leave the workforce before reaching the age of Medicare eligibility. Often those benefits are more generous than Medicare benefits because, for example, the employer simply includes younger retirees in its group plan for existing employees. In other cases, employers wish to offer their retirees age 65 and older health benefit plans that supplement the coverage provided under Medicare so that these retirees have access to comprehensive health care benefits at a time when their health care needs may be greatest. The Commission believes that it is in the best interest of both employers and employees for the Commission to pursue a policy that permits employers to offer these benefits to the greatest extent possible.

The Rising Cost of Health Care

The cost of employee health care has increased consistently for several years, making it difficult for employers to continue to provide retiree health benefits. One report estimates that employers will experience a double-digit increase in their health care costs in 2003 for the third consecutive year.[2] Two widely-cited surveys of employer-sponsored health plans—(1) the Health Research and Educational Trust survey sponsored by The Henry J. Kaiser Family Foundation (Kaiser/HRET) and (2) the William M. Mercer, Incorporated survey (formerly produced by Foster Higgins) (Mercer/Foster Higgins)—estimate that premiums for employer-sponsored health insurance increased an average of about 11% in 2001.[3] The 2002 Kaiser/HRET study found monthly premium costs for employer-sponsored health insurance rose 12.7% between the Spring of 2001 and 2002, while early results from the 2002 Mercer/Foster Higgins study estimate that health care costs increased almost 15% in 2002.[4] The 2001 Kaiser/HRET survey found that these large changes in premiums would affect small employers, defined as those employing between 3–199 workers, at a greater rate than larger employers.[5] Indeed, the 2002 Kaiser/HRET survey suggests that there may be evidence of erosion in the number of small employers offering health benefits; the study reports that the number of small employers offering such benefits dropped 6% between 2000 and 2002.[6] Many employers and benefit experts believe that the rising cost of prescription drug coverage, in particular, has heavily contributed to the rising cost of health care, with 64% of employers responding to the 2001 Kaiser/HRET study citing ''higher spending for drugs'' as a significant factor in health insurance premium increases.[7]

In addition to the rising cost of health care generally, increased longevity and, thus, increased numbers of retirees, will continue to mean larger and more frequent payments for health care services on behalf of retired workers. The United States General Accounting Office (GAO) projects that, by 2030, the number of people age 65 or older will be double what it is today, while the number of individuals between the ages of 55 and 64 will increase 75 percent by 2020.[8] It is well-established that utilization of health care services generally rises with age.[9] Thus, the demand for and cost of retiree health coverage is likely to grow significantly in the next few years, while there will be comparatively fewer active workers to subsidize such benefits.[10] The 2000 Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans showed substantial cost increases for retiree health care coverage between 1999 and 2000, with a 10.6 percent increase for retirees under age 65 and a 17 percent increase for those over 65.[11] A 2002 study by The Henry J. Kaiser Family Foundation and Hewitt Associates (Kaiser/Hewitt) found that retiree health care costs increased an average of 16% between 2001 and 2002 for employers with at least 1000 employees.[12]

Changes in accounting rules also have dramatically impacted the way employers account for the long-term costs of providing retiree health benefits.[13] In 1990, the Financial Accounting Standards Board, which is charged with establishing U.S. standards of financial accounting and

[1] Hearing Before the House Comm. on Education and the Workforce, 107th Cong. (2001) (statement of William J. Scanlon, Director of Health Care Services, GAO).

[2] Hewitt Associates LLC, ''Health Care Cost Increases Expected to Continue Double-Digit Pace in 2003,'' (Lincolnshire, IL: Hewitt Associates LLC Oct. 14, 2002).

[3] The Henry J. Kaiser Family Foundation & Health Research and Educational Trust, ''Employer Health Benefits, 2001 Annual Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2001); William M. Mercer, ''Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2001'' (New York, N.Y.: William M. Mercer Inc. 2002). The 2001 Kaiser/HRET study, conducted between January and May 2001, surveyed more than 2,500 randomly selected public and private companies in the United States. The 2001 Mercer/Foster Higgins study used a national probability sampling of public and private employers and the results represent about 600,000 employers.

[4] The Henry J. Kaiser Family Foundation & Health Research and Educational Trust, ''Employer Health Benefits, 2002 Annual Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2002); Mercer Human Resource Consulting LLC, ''Rate Hikes pushed employers to drop health plans, cut benefits in 2002—but average cost still rose,'' (New York, N.Y.: Mercer Human Resource Consulting LLC December 9, 2002). The 2002 Kaiser/HRET study surveyed 3,262 randomly selected public and private employers.

[5] The Henry J. Kaiser Family Foundation & Health Research and Educational Trust, ''Employer Health Benefits, 2001 Annual Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2001).

[6] The Henry J. Kaiser Family Foundation & Health Research and Educational Trust, ''Employer Health Benefits, 2002 Annual Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2002).

[7] The Henry J. Kaiser Family Foundation & Health Research and Educational Trust, ''Employer Health Benefits, 2001 Annual Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2001).

[8] U.S. General Accounting Office, ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,'' GAO Doc. No. GAO–01–374, at 17 (May 2001).

[9] Anna M. Rappaport, ''Planning for Health Care Needs in Retirement,'' *in Forecasting Retirement Needs and Retirement Wealth*, 288, 288–294 (Olivia S. Mitchell *et al*. eds., University of Pennsylvania Press 2000).

[10] U.S. General Accounting Office, ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,'' GAO Doc. No. GAO–01–374, at 17–18 (May 2001).

[11] Anna M. Rappaport, ''Postemployment Benefits: Retiree Health Challenges and Trends—2001 and Beyond,'' *in Compensation and Benefits Management*, 52, 56 (Autumn 2001) (*citing* William M. Mercer, ''Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2000'' (New York, N.Y.: William M. Mercer Inc. 2001).

[12] The Henry J. Kaiser Family Foundation & Hewitt Associates LLC, ''Kaiser/Hewitt 2002 Retiree Health Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Hewitt Associates LLC 2002). This online survey, conducted between July and September 2002, represents information from 435 private employers (with at least 1000 employees) that currently offer retiree health benefits.

[13] Anna M. Rappaport, ''FAS 106 and Strategies for Managing Retiree Health Benefits,'' *in Compensation and Benefits Management*, 37 (Spring 2001); Paul Fronstin, ''Retiree Health Benefits: Trends and Outlook,'' EBRI Issue Brief No. 236 (Employee Benefit Research Institute Aug. 2001).

reporting, promulgated new rules for retiree health accounting, referred to as Financial Accounting Standards Number 106 or FAS 106. FAS 106 requires employers to apportion the costs of retiree health over the working lifetime of employees and to report unfunded retiree health benefit liabilities in accordance with generally accepted accounting principles beginning with fiscal years after December 15, 1992. Because ''the recognition of these liabilities in financial statements dramatically impacts a company's calculation of its profits and losses,'' [14] some companies have said that FAS 106 led to reductions in reported income, thus creating an incentive to reduce expenditures for employee benefits such as retiree health.

The Incentive for Employers To Reduce Health Care Costs

As a result of these increased costs and accounting changes, employers have actively examined ways to reduce health care costs, including by reducing, altering or eliminating retiree health coverage.[15] During hearings before the U.S. House of Representative's Committee on Education and the Workforce in November 2001, the GAO's Director of Health Care Services testified that only ''one-third of large employers and less than 10% of small employers offer retiree health benefits.'' [16] The 2001 Mercer/Foster Higgins study shows that the number of employers with 500 or more workers who offer retiree health coverage decreased by 17 percent between 1993 and 2001 for both pre- and post-Medicare eligible retirees.[17] The 2002 Kaiser/HRET survey similarly found that a declining percentage of large companies (those with at least 200 employees) offer retiree health benefits; only 34 percent of such employers offered retiree health coverage in 2002, compared to 66 percent of similar companies in 1988.[18] Another survey completed by Hewitt Associates LLC estimates a 15 percent decline in the number of large employers providing pre-age 65 retiree health coverage between 1991 and 2000 and an 18 percent decrease in the number of large employers providing health benefits to retirees age 65 or older during the same period.[19] The 2002 Kaiser/Hewitt retiree health study concluded that this trend will continue, with one in five large employers likely to eliminate retiree health coverage for future retirees within the next three years.[20]

Of those employers offering retiree health benefits, most are more likely to offer such benefits to early retirees and not to Medicare-eligible retirees. A report issued by Kaiser, HRET and The Commonwealth Fund (Kaiser/HRET/Commonwealth) estimates that only 23% of employers with at least 200 workers offered retiree health benefits to Medicare-age retirees in 2001. This is a decline of more than 10 percentage points in a three-year period.[21]

As the number of employers offering retiree health coverage declines, so has the incentive to provide future retirees with such coverage. Unions report that meaningful negotiations about the future provision of employer-sponsored retiree health benefits are becoming increasingly futile. Union representatives have informed EEOC that increasing numbers of employers have refused to include retiree health among the benefits to be provided to employees. A significant number of employers have agreed to provide retiree health only if the benefit terminates when the retiree becomes eligible for Medicare.

Alternatives to employer-sponsored retiree health coverage are costly, offer fewer benefits, and may be limited in availability, particularly for retirees not yet eligible for Medicare.[22] Under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C. 1161 *et seq.* (COBRA), retirees under the age of 65 may be eligible for temporary health coverage from either their spouse's employer or their former employer, although the retiree may be required to pay the entire premium. Other retirees under age 65 must obtain coverage in the private individual insurance market, which often is prohibitively expensive or provides limited benefits.[23] Those unable to afford coverage in the private insurance market rely on public insurance, pay for health care out of pocket, or are uninsured. Retirees age 65 or older often rely on Medicare as their primary source of health coverage. Nonetheless, many retirees in this age group rely on employer-sponsored benefits to cover Medicare's cost-sharing requirements or gaps in Medicare coverage. Retirees who do not have access to employer-sponsored supplemental coverage must obtain private individual ''Medicare supplement'' insurance, which can be prohibitively expensive, particularly if prescription drug coverage is desired.[24] For these reasons, employer-sponsored retiree health coverage is a valuable benefit for older persons that should be protected and preserved to the greatest extent possible.

[14] Paul Fronstin, ''Retiree Health Benefits: Trends and Outlook,'' EBRI Issue Brief No. 236, at 3 (Employee Benefit Research Institute Aug. 2001).

[15] A survey by THAP!, Andersen and CalPERS found that both public and private employers considered controlling health care costs as a top business issue for the next two to three years. THAP! *et al.*, ''Productive Workforce Survey: Report of Findings Private Employer/Public Agency'' (THAP!, Andersen and CalPERS Aug. 2001); *see also* Anna M. Rappaport, ''Postemployment Benefits: Retiree Health Challenges and Trends—2001 and Beyond,'' *in Compensation and Benefits Management*, 52, 56 (Autumn 2001) (''Companies seeking to reduce costs are closely examining retiree medical benefits.'').

[16] Hearing Before the House Comm. on Education and the Workforce, 107th Cong. (2001) (statement of William J. Scanlon, Director of Health Care Services, GAO).

[17] William M. Mercer, ''Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2001'' (New York, NY: William M. Mercer, Inc. 2002).

[18] The Henry J. Kaiser Family Foundation & Health Research and Educational Trust, ''Employer Health Benefits, 2002 Annual Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2002).

[19] Hewitt Associates LLC, ''Trends in Retiree Health Plans'' (Lincolnshire, IL: Hewitt Associates LLC 2001). This conclusion is based on information from Hewitt Associates database of 1,020 large employers, including 85% of Fortune 100 companies and 57% of Fortune 500 companies.

[20] The Henry J. Kaiser Family Foundation & Hewitt Associates LLC, ''Kaiser/Hewitt 2002 Retiree Health Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Hewitt Associates LLC 2002); *see also* The Henry J. Kaiser Family Foundation & Health Research and Educational Trust, ''Employer Health Benefits, 2002 Annual Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2002) (11% of large employers predict they will eliminate retiree health benefits for future retirees).

[21] The Henry J. Kaiser Family Foundation *et al.*, ''Erosion of Private Health Insurance Coverage For Retirees: Findings from the 2000 and 2001 Retiree Health and Prescription Drug Coverage Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation, Health Research and Educational Trust, and The Commonwealth Fund 2002); *see also* The Henry J. Kaiser Family Foundation & Health Research and Educational Trust, ''Employer Health Benefits, 2002 Annual Survey'' (Menlo Park, CA: The Henry J. Kaiser Family Foundation and Health Research and Educational Trust 2002) (96% of employers with at least 200 employees offer health benefits to pre-age 65 retirees, while only 72% of large employers offer health benefits to retirees age 65 and above).

[22] U.S. General Accounting Office, ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,'' GAO Doc. No. GAO–01–374, at 20–24 (May 2001).

[23] U.S. General Accounting Office, ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,'' GAO Doc. No. GAO–01–374, at 20–22 (May 2001).

[24] U.S. General Accounting Office, ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,'' GAO Doc. No. GAO–01–374, at 22–24 (May 2001). GAO estimates that Medigap coverage costs an average of $1,300 per year. Hearing Before the House Comm. on Education and the Workforce, 107th Cong. (2001) (statement of William J. Scanlon, Director of Health Care Services, GAO).

Interplay Between the ADEA and Employer-Sponsored Retiree Health Benefits

Section 4 of the ADEA makes it unlawful for an employer to discriminate against any individual with respect to ''compensation, terms, conditions, or privileges or employment, because of such individual's age.'' 29 U.S.C. 623(a)(1). In 1989, the Supreme Court held in *Public Employees Retirement Sys. of Ohio* v. *Betts*, 492 U.S. 158, 109 S. Ct. 256 (1989), that the ADEA, nevertheless, did not prohibit discrimination in employee benefits, such as health insurance. In response to the Supreme Court's decision in *Betts*, Congress enacted the Older Workers Benefit Protection Act of 1990, Pub. L. No. 101–433, 104 Stat. 978 (1990) (OWBPA), which amended the ADEA and defined the term ''compensation, terms, conditions or privileges of employment'' in Section 4 of the Act as including employee benefits. 29 U.S.C. 630(l).

For many years after, however, there was little discussion about the interplay between the ADEA and the provision of retiree health benefits by employers. Many employers relied on legislative history to the OWBPA which states that the practice of eliminating, reducing, or altering employer-sponsored retiree health benefits with Medicare eligibility is lawful under the ADEA. Specifically, employers looked to a joint ''Statement of Managers'' clarifying several proposed amendments to the OWBPA, which was entered into the congressional records of both the House and Senate and accompanied the final compromise bill. On the subject of ''retiree health,'' the Statement says:

> Many employer-sponsored retiree medical plans provide medical coverage for retirees only until the retiree becomes eligible for Medicare. In many of these cases, where coverage is provided to retirees only until they attain Medicare eligibility, the value of the employer-provided retiree medical benefits exceeds the value of the retiree's Medicare benefits. Other employers provide medical coverage to retirees at a relatively high level until the retirees become eligible for Medicare and at a lower level thereafter. In many of these cases, the value of the medical benefits that the retiree receives before becoming eligible for Medicare exceeds the total value of the retiree's Medicare benefits and the medical benefits that the employer provides after the retirees attains Medicare eligibility. These practices are not prohibited by this substitute. Similarly, nothing in this substitute should be construed as authorizing a claim on behalf of a retiree on the basis that the actuarial value of employer-provided health benefits available to that retiree not yet eligible for Medicare is less than the actuarial value of the same benefits available to a younger retiree.

Final Substitute: Statement of Managers, 136 Cong. Rec. S25353 (Sept. 24, 1990); 136 Cong. Rec. H27062 (Oct. 2, 1990).

In August 2000, the United States Court of Appeals for the Third Circuit became the first federal court of appeals to examine whether an employer's coordination of its retiree health plans with Medicare eligibility violated the ADEA. *Erie County Retirees Ass'n* v. *County of Erie*, 220 F.3d 193 (3rd Cir. 2000). Prior to 1992, Erie County offered current employees and retirees separate but similar traditional indemnity health insurance coverage. *Id.* at 196. In February 1998, however, in an effort to control escalating health benefit costs, the county began to require all eligible retirees over age 65 to accept a coordinated health care plan provided through a health maintenance organization (HMO) and Medicare. Eligible retirees had to have Medicare Part B Medical Insurance in order to participate in the plan. *Id.* at 197. Retirees not yet eligible for Medicare continued to be covered by a traditional indemnity plan until October 1998 when they were transferred to a hybrid point of service plan where each insured could select between an HMO and the traditional indemnity option on an as-needed basis. *Id.* In a class action lawsuit, the Medicare-eligible retirees alleged that the county violated the ADEA by offering them health insurance coverage that was inferior to that offered to the county's younger retirees. *Id.* at 193. In examining whether the county's practice violated the Act, the Third Circuit held that the Statement of Managers language was not controlling and that the ADEA prohibits an employer from treating ''retirees differently with respect to health benefits based on Medicare eligibility,'' unless the employer can meet any of the affirmative defenses provided in section 4 of the ADEA. *Id.* at 213–14.[25] The one affirmative defense examined in detail by the Third Circuit was the equal benefit/equal cost defense set forth in 29 U.S.C. 623(f)(2)(B)(i). The equal benefit/equal cost defense has been part of the ADEA's regulatory framework since 1967.[26] Consistent with Congress' concern that employers might not hire older workers because many employee benefits become more costly with age, Department of Labor and EEOC regulations interpreted section 4(f)(2) of the ADEA as permitting employers to offer lower levels of certain employee benefits to older workers as long as the benefit cost incurred on behalf of older workers is no less than that incurred for younger workers. 29 CFR 1625.10. In the OWBPA, Congress adopted this test in section 4(f)(2)(B)(i) of the ADEA, thereby codifying the EEOC's equal benefit/equal cost rule.

In *Erie County*, the Third Circuit found that the costs Medicare incurs on behalf of retirees over age 65 cannot be considered when evaluating whether an employer has satisfied the equal cost prong and remanded the case so the district court could determine whether the county could nonetheless meet the equal benefit/equal cost test. *Id.* at 216. On remand, the county conceded that it could not meet the equal cost prong using the Third Circuit's formulation of the test. *Erie County Retirees Ass'n* v. *County of Erie*, 140 F. Supp.2d 466, 477 (W.D. Pa. 2001). The district court then found that the county did not provide equal benefits to its retirees because (1) age 65 retirees were required to pay a greater portion of the total cost of their health insurance premiums than younger retirees; (2) the health plan offered to older retirees did not allow participants to alternate between different forms of coverage, while the plan offered to younger retirees did; and (3) the health plan for younger retirees did not restrict participants to a prescription drug formulary, while the plan for older retirees did contain such a restriction. *Id.* at 475–77.

Many benefit experts cautioned that the *Erie County* decision would exacerbate the erosion of employer-sponsored retiree health benefits.[27] The

[25] The Commission submitted an *amicus curiae* brief in *Erie County*, asserting, based on the plain language of the ADEA, that (1) retirees are covered by the ADEA and (2) employer reliance on Medicare eligibility in making distinctions in employee benefits violated the ADEA, unless the employer satisfied one of the Act's specified defenses or exemptions. In its October 2000 Compliance Manual Chapter on ''Employee Benefits,'' the Commission explicitly adopted the position taken by the Third Circuit in *Erie County* as its national enforcement policy. When the Commission announced in August 2001 that it wished to further study the relationship between the ADEA and employer-sponsored retiree health plans, the Commission unanimously voted to rescind those portions of its Compliance Manual that discussed the *Erie County* decision.

[26] In *Public Employees Retirement Sys. of Ohio* v. *Betts*, 492 U.S. 158, 109 S. Ct. 256 (1989), the Supreme Court held that the equal benefit/equal cost test did not apply to the ADEA. Congress believed the test should apply, and the regulatory equal benefit/equal cost test was codified in the OWBPA.

[27] *See* Anna M. Rappaport, ''Postemployment Benefits: Retiree Health Challenges and Trends—2001 and Beyond,'' *in Compensation and Benefits Management*, 52, 55 (Autumn 2001) (*Erie County* will force employers to examine the application of the ADEA to their retiree health plans with ''little or no legal precedent''); Paul Fronstin, ''Retiree Health Benefits: Trends and Outlook,'' EBRI Issue Brief No. 236, at 12–14 (Employee Benefit Research

Continued

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

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).

[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

of retirees over age 65 rely on employer-provided retiree health plans to supplement Medicare,[29] the Commission believes that such a result is contrary to the public interest and necessitates regulatory action.

The Commission's Proposed Exemption

When enacting the ADEA, Congress recognized that enforcement of the Act required a case-by-case examination of employment practices.[30] In light of this recognition, Congress authorized the Commission to ''establish such reasonable exemptions to and from any or all provisions of [the Act] as it may find necessary and proper in the public interest.'' 29 U.S.C. 628. Pursuant to that authority, the Commission proposes a narrowly drawn exemption that permits the practice of coordinating employer-provided retiree health coverage with eligibility for Medicare or a State-sponsored retiree health benefits program and shows due regard for the remedial purposes of the ADEA. Section 2(b) of the Act firmly establishes the goal of ''encouraging employers and workers [to] find ways of meeting problems arising from the impact of age on employment.'' 29 U.S.C. 621(b). Unrestricted coordination of employer-sponsored retiree health benefits with Medicare or a State-Sponsored health benefits program permits employers to provide a valuable benefit to early retirees who otherwise might not be able to afford health insurance coverage and allows employers to provide valuable supplemental health benefits to retirees who are eligible for Medicare.

The proposed exemption shows due regard for the Act's prohibition against arbitrary age discrimination in employment—a central concern of Congress when it enacted the ADEA. The exemption also is consistent with the Act's purpose of promoting the employment of older persons and is in accord with the Statement of Managers. *See* Final Substitute: Statement of Managers, 136 Cong. Rec. 25353 (Sept. 24, 1990); 126 Cong. Rec. H.27062 (Oct. 2, 1990).[31] Therefore, the Commission believes that the remedial purposes of the Act will be better served by allowing employers to coordinate retiree health benefits with Medicare or a State-sponsored retiree health benefits program.

Effect of Exemption

As with any exemption from remedial legislation, the proposal is a narrow exemption from the prohibitions of the ADEA. The exemption permits employee benefit plans to lawfully provide health benefits for retired participants that are altered, reduced or eliminated when the participant is eligible for Medicare health benefits or for health benefits under a State-sponsored retiree health benefits program. No other aspects of ADEA coverage or benefits other than retiree health benefits are affected by this exemption.

The proposed exemption would become effective on the date of publication of a final rule in the **Federal Register**. It is intended that the exemption shall apply to existing, as well as newly created, employer-provided retiree health benefit plans. As the Appendix to the proposed exemption indicates, it also is intended that the exemption shall apply to dependent and/or spousal health benefits that are included as part of the health benefits provided to retired participants. However, dependent and/or spousal benefits need not be identical to the health benefits provided for retired participants. Consequently, dependent and/or spousal benefits may be altered, reduced or eliminated pursuant to the exemption whether or not the health benefits provided for retired participants are similarly altered, reduced or eliminated.

Additional Amendments

In addition to the proposed exemption discussed above, the Commission proposes to redesignate subpart C of part 1627 as subpart C of part 1625 of Chapter XIV of Title 29 of the Code of Federal of Regulations. Subpart C of part 1627 currently includes two sections. The first, which will be redesignated as section 1625.30, outlines procedures by which the Commission may exercise its exemption authority under Section 9 of the ADEA. The second, redesignated as section 1625.31, explains the parameters of an already existing exemption for special employment programs. Redesignation does not alter either the procedures by which the Commission may exercise its exemption authority under Section 9 of the ADEA or the Special Employment Programs exemption.

Comments

The Commission invites comments on this proposed exemption from all interested parties, including employee rights organizations, labor unions, employers, benefits groups, actuaries, and state and local governments. In particular, the Commission would welcome comments on other types of government-sponsored retiree health benefit programs, including state and local government retiree health plans, that are comparable to Medicare.

In proposing this exemption, the Commission coordinated with other federal agencies in accord with Executive Order 12067, and incorporated, where appropriate, agency comments in the proposal.

Executive Order 12866 and Regulatory Flexibility Act

The proposed rule has been drafted and reviewed in accordance with Executive Order 12866, section 1(b), Principles of Regulation. This rule is considered a ''significant regulatory action'' under section 3(f)(4) of that Order and was reviewed by the Office of Management and Budget (OMB). The Commission does not believe that the proposed exemption will have a significant impact on small business entities under the Regulatory Flexibility Act because it imposes no economic or reporting burdens on such firms.

The ADEA applies to all employers with at least 20 employees. 29 U.S.C. 630(b). The Act prohibits covered employers from discriminating in employment against any individual who is at least 40 years of age. 29 U.S.C. 623, 631. The Bureau of Labor Statistics estimates that there are 74,347,000 individuals in the U.S. labor force that are age 40 or above.[32] According to Census Bureau information, approximately 1,976,216 establishments employed 20 or more employees in 2000.[33]

The proposed exemption would apply to all covered employers who provide health benefits to their retirees. In 2001, the GAO concluded that about one-third of large employers and less than 10% of small employers provided such benefits to current retirees.[34] According to the

Fronstin, ''Retiree Health Benefits: Trends and Outlook,'' EBRI Issue Brief No. 236, at 6–7 (Employee Benefit Research Institute Aug. 2001).

[29] The Henry J. Kaiser Family Foundation *et al.*, ''Erosion of Private Health Insurance Coverage For Retirees: Findings from the 2000 and 2001 Retiree Health and Prescription Drug Coverage Survey,'' at iv (Menlo Park, CA: The Henry J. Kaiser Family Foundation, Health and Research Educational Trust and The Commonwealth Fund April 2002).

[30] H.R. Rep. No. 90–805 (1967), *reprinted in* 1967 U.S.C.C.A.N. 2213; S. Rep. 90–723 (1967).

[31] While the Third Circuit in *Erie County* did not find the Statement of Managers controlling, the Commission, in the exercise of its exemption authority, is free to take a broader look at the legislative record in determining whether the proposed exemption is consistent with the Act's purpose of promoting the employment of older persons. The Statement of Managers strongly suggests that it is.

[32] Bureau of Labor Statistics, U.S. Department of Labor, Current Population Survey (April 2003).

[33] Census Bureau, U.S. Department of Commerce, Statistics of U.S. Businesses (2000).

[34] Hearing Before the House Comm. on Education and the Workforce, 107th Cong. (2001) (statement

Continued

GAO, in 1999, such employer-sponsored health plans were relied on by 10 million retired individuals aged 55 and over as either their primary source of coverage or a supplement to Medicare coverage.[35]

The proposal—which exempts certain practices from regulation—will decrease, not increase, costs to covered employers by reducing the risks of liability for noncompliance with the statute. When the Third Circuit held that the practice of coordinating retiree health benefits with Medicare eligibility was unlawful unless an employer could meet the equal benefit/equal cost test, there was widespread concern that employers who currently provide such retiree health benefits would either have to provide greater benefits to older retirees or reduce benefits for younger retirees to comply. The Commission believes that, if required to make a choice between paying more or less to comply with the ADEA, many employers will choose to pay less by reducing or eliminating health coverage for retirees who are not yet eligible for Medicare. This result is particularly likely given the rising costs of health care in general. The proposed exemption seeks to eliminate this incentive by making clear that the ADEA permits employers to freely coordinate the provision of retiree health benefits with Medicare eligibility. This approach also benefits the significant number of employees who rely on employer-sponsored retiree health coverage and otherwise would have to obtain retiree health coverage in the private individual marketplace at substantial personal expense.

The proposed exemption has no reporting requirements. A major concern regarding the inequitable impact of regulation on small firms is that reporting and accompanying record keeping requirements can be as costly to smaller firms as large ones. The absence of reporting requirements eliminates this concern.

It is not likely that the proposed regulation will disrupt the efficient functioning of the economy and private market forces. Until recently, when structuring retiree health benefits, many employers relied on legislative history to the OWBPA which states that the practice of eliminating, reducing, or altering employer-sponsored retiree health benefits with Medicare eligibility is lawful under the ADEA. The proposed regulation permits the practice of unrestricted coordination of retiree health benefits with Medicare eligibility to continue.

Under other proposals considered by the Commission, many employers would have been forced to discontinue retiree health coverage if they could not afford the required actuarial analysis. 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. Larger employers who maintain multiple plans for different categories of employees also would face significant expense complying with alternative proposals. 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 under alternative proposals considered by the Commission would have been cost prohibitive for many employers.

List of Subjects

29 CFR Part 1625

Advertising, Aged, Employee benefit plans, Equal employment opportunity, Retirement.

29 CFR Part 1627

Aged, Equal employment opportunity, Reporting and recordkeeping requirements.

For the Commission.

Cari M. Dominguez,

Chair.

For the reasons discussed in the preamble, the Equal Employment Opportunity Commission proposes to amend 29 CFR chapter XIV as follows:

PART 1627—RECORDS TO BE MADE OR KEPT RELATING TO AGE: NOTICES TO BE POSTED

1. Revise the heading of Part 1627 to read as set forth above.

2. The authority citation for 29 CFR Part 1627 shall continue to read as follows:

Authority: Sec. 7, 81 Stat. 604; 29 U.S.C. 626; sec. 11, 52 Stat. 1066, 29 U.S.C. 211; sec. 12, 29 U.S.C. 631, Pub L. 99–592, 100 Stat. 3342; sec. 2, Reorg. Plan No. 1 of 1978, 43 FR 19807.

3. In § 1627.1, remove paragraph (b) and redesignate paragraph (c) as new paragraph (b).

4. In Part 1627, redesignate Subpart C and sections 1627.15 and 1627.16 as Subpart C of Part 1625 and sections 1625.30 and 1625.31, respectively.

PART 1625—AGE DISCRIMINATION IN EMPLOYMENT ACT

5. The authority citation for 29 CFR Part 1625 is revised to read as follows:

Authority: 81 Stat. 602; 29 U.S.C. 621; 5 U.S.C. 301; Secretary's Order No. 10–68; Secretary's Order No. 11–68; Sec. 9, 81 Stat. 605; 29 U.S.C. 628; sec. 12, 29 U.S.C. 631, Pub. L. 99–592, 100 Stat. 3342; sec. 2, Reorg. Plan No. 1 of 1978, 43 FR 19807.

6. In newly redesignated Subpart C of Part 1625, revise the heading of newly redesignated § 1625.31 and the first sentence of paragraph (a) to read as follows:

§ 1625.31 Special employment programs.

(a) Pursuant to the authority contained in section 9 of the Act and in accordance with the procedure provided therein and in § 1625.30(b) of this part, it has been found necessary and proper in the public interest to exempt from all prohibitions of the Act all activities and programs under Federal contracts or grants, or carried out by the public employment services of the several States, designed exclusively to provide employment for, or to encourage the employment of, persons with special employment problems, including employment activities and programs under the Manpower Development and Training Act of 1962, Public Law No. 87–415, 76 Stat. 23 (1962), as amended, and the Economic Opportunity Act of 1964, Public Law No. 88–452, 78 Stat. 508 (1964), as amended, for persons among the long-term unemployed, handicapped, members of minority groups, older workers, or youth. * * * * * * * * * *

7. Add section 1625.32 to Subpart C of Part 1625 to read as follows:

§ 1625.32 Coordination of retiree health benefits with Medicare and State health benefits.

(a) *Definitions.* (1) *Employee benefit plan* means an employee benefit plan as defined in 29 U.S.C. 1002(3).

(2) *Medicare* means the health insurance program available pursuant to Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*

(3) *Comparable State health benefit plan* means a State-sponsored health benefit plan that, like Medicare, provides retired participants who have attained a minimum age with health benefits, whether or not the type, amount or value of those benefits are equivalent to the type, amount or value of the health benefits provided under Medicare.

(b) *Exemption.* Some employee benefit plans provide health benefits for retired participants that are altered,

of William J. Scanlon, Director of Health Care Services, GAO).

[35] U.S. General Accounting Office, ''Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion,'' GAO Doc. No. GAO–01–374, at 1 (May 2001).

reduced or eliminated when the participant is eligible for Medicare health benefits or for health benefits under a comparable State health benefit plan. Pursuant to the authority contained in section 9 of the Act, and in accordance with the procedures provided therein and in § 1625.30(b) of this part, it is hereby found necessary and proper in the public interest to exempt from all prohibitions of the Act such coordination of retiree health benefits with Medicare or a comparable State health benefit plan.

(c) *Scope of exemption.* This exemption shall be narrowly construed. It does not apply to the use of eligibility for Medicare or a comparable State health benefit plan in connection with any act, practice or benefit of employment not specified in paragraph (b) of this section. Nor does it apply to the use of the age of eligibility for Medicare or a comparable State health benefit plan in connection with any act, practice or benefit of employment not specified in paragraph (b) of this section.

Appendix to § 1625.32—Questions and Answers Regarding Coordination of Retiree Health Benefits with Medicare and State Health Benefits

Q1. Why is the Commission issuing an exemption from the Act?

A1. The Commission recognizes that while employers are under no legal obligation to offer retiree health benefits, some employers choose to do so in order to maintain a competitive advantage in the marketplace—using these and other benefits to attract and retain the best talent available to work for their organizations. Further, retiree health benefits clearly benefit workers, allowing such individuals to acquire affordable health insurance coverage at a time when private health insurance coverage might otherwise be cost prohibitive. The Commission believes that it is in the best interest of both employers and employees for the Commission to pursue a policy that permits employers to offer these benefits to the greatest extent possible.

Q2. Does the exemption mean that the Act no longer applies to retirees?

A2. No. Only the practice of coordinating retiree health benefits with Medicare (or a comparable State health benefit plan) as specified in paragraph (b) of this section is exempt from the Act. In all other contexts, the Act continues to apply to retirees to the same extent that it did prior to the issuance of this section.

Q3. May employers continue to offer ''Medicare carve-out plans'' that deduct from the health benefits provided to Medicare-eligible retirees those health benefits that Medicare provides, while continuing to provide to Medicare-eligible retirees those health benefits that Medicare does not provide?

A3. Yes. Employers may continue to offer such ''carve-out plans'and make Medicare the primary payer of health benefits for Medicare-eligible retirees. Employers may also continue to offer ''carve-out plans'' to those retirees eligible for health benefits pursuant to a comparable State health benefit plan and make the comparable State health plan the primary payer of health benefits for these State-eligible retirees.

Q4. Does the exemption also apply to dependent and/or spousal health benefits that are included as part of the health benefits provided for retired participants?

A4. Yes. Because dependent and/or spousal health benefits are benefits provided to the retired participant, the exemption applies to these benefits, just as it does to the health benefits for the retired participant. However, dependent and/or spousal benefits need not be identical to the health benefits provided for retired participants. Consequently, dependent and/or spousal benefits may be altered, reduced or eliminated pursuant to the exemption whether or not the health benefits provided for retired participants are similarly altered, reduced or eliminated.

Q5. Does the exemption permit employers to use Medicare (or comparable State health benefit plan) eligibility, or the age of Medicare eligibility (or the age of eligibility for a comparable State health benefit plan) as a basis for other acts, practices or decisions regarding retirees?

A5. No. Employer use of Medicare (or comparable State health benefit plan) eligibility or the age of Medicare eligibility (or the age of eligibility for a comparable State health benefit plan) in a manner other than as specified in paragraph (b) of this section likely would be considered reliance upon an age-defined factor. Reliance upon an age-defined factor in making distinctions in employee benefits violates the Act, unless the employer satisfies one of the Act's specified defenses or exemptions.

Q6. Does the exemption apply to existing, as well as to newly created, employee benefit plans?

A6. Yes. The exemption applies to all retiree health benefits that coordinate with Medicare (or a comparable State health benefit plan) as specified in paragraph (b) of this section, whether those benefits are provided for in an existing or newly created employee benefit plan.

Q7. Does the exemption apply to health benefits that are provided to current employees who are at or over the age of Medicare eligibility (or the age of eligibility for a comparable State health benefit plan)?

A7. No. The exemption applies only to retiree health benefits, not to health benefits that are provided to current employees. Thus, health benefits for current employees must be provided in a manner that comports with the requirements of the Act. Moreover, under the laws governing the Medicare program, an employer must offer to current employees who are at or over the age of Medicare eligibility the same health benefits, under the same conditions, that it offers to any current employee under the age of Medicare eligibility.

[FR Doc. 03–17738 Filed 7–11–03; 8:45 am]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[Docket No. 030409081–3081–01; I.D. 032103B]

RIN 0648–AQ72

Fisheries of the Northeastern United States; Magnuson-Stevens Fishery Conservation and Management Act Provisions; Northeast (NE) Multispecies Fishery

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Withdrawal of a portion of a proposed rule.

SUMMARY: NMFS withdraws a portion of a proposed emergency rule, published on April 24, 2003, which proposed continuation of NE multispecies management measures implemented on August 1, 2002, and DAS Leasing Program (Program). NMFS will not implement that portion of the proposed emergency rule that proposed the Program.

FOR FURTHER INFORMATION CONTACT: Thomas Warren, Fishery Policy Analyst, (978) 281–9347, fax (978) 281–9135, e-mail Thomas.Warren@noaa.gov.

SUPPLEMENTARY INFORMATION:

Background

On August 1, 2002, NMFS published an interim final rule (67 FR 50292), which implemented the Settlement Agreement in Conservation Law Foundation, et al. v. Evans, et al. Civil No. 00–1134 (D.D.C.). The August 1, 2002, interim final rule was in response to a Remedial Order issued on May 23, 2002, by the U.S. District Court for the District of Columbia (Court). Pursuant to the Court's Remedial Order, the measures implemented in the August 1, 2002, interim final rule are expected to remain in place until implementation of Amendment 13 to the NE Multispecies Fishery Management Plan (FMP). Because the Court granted an extension of the Amendment 13 implementation date until May 1, 2004, and because the August 1, 2002, interim final rule was to expire on July 27, 2003, NMFS published a proposed emergency rule on April 24, 2003, (68 FR 20096) that would continue the current measures until implementation of Amendment 13.

In addition to continuing the management measures that were first implemented on August 1, 2002, (as