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THE GREAT VANISHING BENEFIT, EMPLOYER PROVIDED RETIREE MEDICAL BENEFITS: THE PROBLEM AND POSSIBLE SOLUTIONS

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I. INTRODUCTION

It seems that every week, a major employer is either reducing or eliminating its retiree medical program. The reality is that employer sponsored retiree medical coverage is a quickly vanishing benefit. According to the Kaiser/HRET Annual Employer Health Benefits Survey, 2005,[1] the number of employers with 200 or more employees offering retiree medical benefits dropped from 66% in 1988 to 33% in 2005. Future reductions are predicted. The Kaiser/Hewitt 2005 Survey on Retiree Health Benefits indicates that 12% of employers eliminated subsidized medical benefits for future retirees last year; 71% of employers increased retiree contributions to premiums; 34% of employers increased retiree cost sharing; 24% of employers raised deductibles; and 11% of employers are likely to terminate subsidized coverage for retirees in 2006.[2]

While this crisis has been building over the last fifteen years, very little has been done by the business community or the federal government to address this issue, such as giving employers alternatives for providing and funding benefits. Over the last few years, the federal government has offered new vehicles to either assist or provide this obligation, such as Health Reimbursement

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1. GARY CLAXTON, ET AL., THE KAISER FAMILY FOUNDATION/HEALTH RESEARCH AND EDUCATIONAL TRUST 2005 HEALTH BENEFITS SURVEY 6-7 (2005) [hereinafter KAISER/HRET], *available at* http://www.kff.org/insurance/7315/ upload/7315.pdf.

2. FRANK MCARDLE, ET AL., PROSPECTS FOR RETIREE HEALTH BENEFITS AS MEDICARE PRESCRIPTION DRUG COVERAGE BEGINS: FINDINGS FROM THE KAISER/HEWITT 2005 SURVEY ON RETIREE HEALTH BENEFITS viii-ix (Dec. 2005) [hereinafter, KAISER/HEWITT], *available at* http://www.kff.org/medicare/upload/7439.pdf.

Arrangements (HRA);[3] Health Savings Accounts (HSA),[4] and employer subsidies under Medicare Part D.[5] The purpose of this article is to discuss the factors that have contributed to this decline in coverage, review possible solutions, and offer some closing thoughts on the situation.

II. FACTORS CONTRIBUTING TO THE DECLINE IN RETIREE MEDICAL COVERAGE

The following factors can be identified as contributing to the decline in employer sponsored retiree medical coverage. They include:

- Accounting Issues,
- Increased Costs,
- International Competition,
- Age Discrimination Issues, and
- Lack of Viable and Flexible Funding Vehicles for Individuals, Employees, and Employers.

A. Accounting Issues

Beginning in 1993, all publicly traded companies were required to accrue the cost of retiree medical benefits during the employment of an employee pursuant to Statement of Financial Accounting Standards (FAS) No. 106 issued by the Financial Accounting Board (FASB).[6] Prior to 1993, employers were only required to recognize this expense when employees became eligible for coverage; thus, it was on a "pay-as-you-go" basis. As a result of the change, employers were required to recognize a current expense for financial accounting purposes for retiree medical benefits even though the actual funding may not occur until years later. Employers could either record their unfunded, and previously unrecognized, Accumulated Postretirement Benefit Obligation (APBO) as a single one-time nonrecurring charge or they could record it through smaller charges taken over as many as twenty years. Some companies recognized this expense immediately, and then dramatically reduced retiree medical benefits through a series of amendments, citing the impact on their financial statements.

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3. 26 U.S.C. § 105 (2000).

4. 26 U.S.C. at § 223 (2000) *amended by* Pub. L. No. 223 (2005).

5. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

6. EMPLOYER'S ACCOUNTING FOR POSTRETIREMENT BENEFITS OTHER THAN PENSIONS, STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 106 (Financial Accounting Standards Bd. 1990), *available at* http://www.fasb.org/pdf/fas106.pdf. *See also* KAISER/HEWITT, *supra* note 2, at 16 n.13.

The affect of the FAS Statement No. 106 on retiree medical coverage has been devastating. In a national survey of nearly 3,000 employers, Mercer Human Resource Consulting, a national consulting firm, found that the percentage of large companies offering medical benefits to early retirees fell from 46% in 1993 to 29% in 2005. At the same time, Medicare-eligible retirees saw their probability of receiving retiree medical benefits drop from 40% to 21% in 2005.[7]

To partially address this deep decline in coverage, the Medicare Prescription Drug Improvement and Modernization Act of 2003 was enacted to give qualifying employers federal subsidies equal to 28% of allowable drug costs between $250 to $5,000 in 2006 (indexed thereafter) for each retiree.[8] To qualify for this drug subsidy, employers must demonstrate that their prescription drug coverage is of an equal or greater value than the Medicare Part D drug benefit.[9]

In January, 2004, the FASB released FASB Staff Position No. FAS 106-1, under which employers were permitted to either (1) recognize the effects of the subsidy, or (2) defer recognition until the earlier of (a) the FASB's issuance of the final rules or (b) any remeasurement of plan assets and obligations after January 31, 2004, due to plan amendment, curtailment, or any other significant event.[10]

Later in May, 2004, FASB released FASB Staff Position No. FAS 106-2, which provided that if an employer believed that its prescription drug program was "actuarially equivalent" when initially accounting for the subsidy, such employer should account for the subsidy's effect on the APBO as an actual experience gain.[11] Because the subsidy affects the employer's share of its plan's costs, the subsidy is included in measuring the costs of benefits attributable to current service. Therefore, the subsidy reduces

7. WILLIAM M. MERCER, INC., NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS 6 (2005), *available at* http://www.imercer.com/us/imercercommentary/healthsurvey/BB-final.pdf.

8. Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003). *See also KAISER/HEWITT*, *supra* note 2, at 35 (noting that the subsidy approach is the least troublesome).

9. KAISER/HEWITT, *supra* note 2, at 35.

10. ACCOUNTING AND DISCLOSURE REQUIREMENTS RELATED TO THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT OF 2003, FASB STAFF POSITION NO. FAS 106-1 (Financial Accounting Standards Bd. 2004), *available at* http://www.fasb.org/fasb_staff_positions/fsp_fas106-1.pdf.

11. ACCOUNTING AND DISCLOSURE REQUIREMENTS RELATED TO THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT OF 2003, FASB STAFF POSITION NO. FAS 106-2 (Financial Accounting Standards Bd. 2004), *available at* http://www.fasb.org/fasb_staff_positions/fsp_fas106-2.pdf.

service cost when it is recognized as a component of net periodic postretirement benefit cost.

This subsidy is the first assistance employers have received in dealing with the retiree medical benefit crisis. The Kaiser/Hewitt 2005 Survey on Retiree Health Benefits reported that 82% of the employers surveyed intended to "maintain prescription drug coverage for their Medicare-eligible retirees in 2006" and apply for the subsidy.[12] In the survey, employers estimated that their average savings will be $644 per individual retiree in 2006.[13] The average savings per individual grows to $826 among those employers who intend to supplement the Medicare Part D drug benefit. When the Medicare Part D drug benefit was proposed, it was hoped that it would "provide employers with sufficient financial relief so they would maintain rather than terminate [medical] coverage for their Medicare-eligible retirees."[14] According to the survey, the total employer savings amounts to 7% of their total drug cost.[15] Only time will tell whether the subsidy is enough of an incentive to maintain retiree medical programs.

To make the situation go from bad to worse, the Government Accounting Standards Board (GASB) released its final statements in 2004 on accounting treatment for retiree medical benefits for governmental organizations (GASB Statement No. 45, Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions). This statement requires many governmental organizations to recognize the cost of providing these benefits in their financial statements on an accrual basis rather than a current cash or pay-as-you go basis.[16] Further, governmental employers will need to establish liabilities on their balance sheets equal to any recognized expense that has not been funded. For any entities with significant liabilities, these requirements will negatively affect the entity's bond-rating.

The effective date of these new requirements will be phased in based on the following tiers:

Tier 1 - governmental employers with annual revenue in excess of $100 million – fiscal years beginning after December 15, 2006.

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12. KAISER/HEWITT, *supra* note 2, at 36.

13. *Id.* at 37.

14. *Id.* at 38.

15. *Id.*

16. ACCOUNTING AND FINANCIAL REPORTING BY EMPLOYERS FOR POSTEMPLOYMENT BENEFITS OTHER THAN PENSIONS, STATEMENT NO. 45 (Governmental Accounting Standards Bd. 2004). *See* Press Release, Governmental Accounting Standards Bd., Employer Reporting of Postemployment Benefits Other Than Pensions (Aug. 2, 2004), *available at* http://www.gasb.org/news/nr080204.html.

Tier 2 - governmental employers with annual revenue of $10 million to $100 million – fiscal years beginning after December 15, 2007.

Tier 3 - governmental employers with annual revenue less than $10 million - fiscal years beginning after December 15, 2008.

In August 2005, GASB issued its "Guide to Implementation of GASB Statements 43 and 45 on Other Postemployment Benefits."[17] The purpose of this guide is to clarify and amplify the provisions of the statements on accounting and financial reporting. Key implementation issues of this guide include:

- Prefunding,
- Actuarial Cost Methods,
- Structure of Entity,
- Amortization of any unfunded Accrued Liability, and
- Actual Assumptions and Asset-Valuation Methods.

For governmental entities, this will be a ticking time-bomb. Many state and local governments offer some form of medical coverage for their retirees. In the 2003 Segal State Health Benefits survey, 70% of the states participating in the survey contributed toward single retirees under age 65, and 62% of the states participating in the survey contributed toward single retirees over age 65.[18] The question to be asked is whether retiree medical coverage for public employees can survive these new accounting requirements. These new requirements will result in further reductions of retiree medical coverage, elimination, or increases in local and state income and property taxes.

In a 2004 nationwide survey of 185 higher education and research institutions, TIAA-CREF found 76% of the institutions surveyed offered retiree health benefits, while 24% did not.[19] Of those offering the benefit, 12% indicated that they were likely to discontinue offering these benefits during the next five years. Thirteen percent reported fully prefunding their liability for retiree health care, 9% were partially prefunding their liability, 47% were not prefunding, and 32% of the administrators were not sure whether their institution was prefunding this obligation.

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17. *See* Press Release, GASB Publishes Implementation Guide to Statements 43 and 45 on Postemployment Benefits Other Than Pensions (Aug. 8, 2005), *available at* http://www.gasb.org/news/nr080805.html.

18. *See* SEGAL STATE HEALTH BENEFITS SURVEY: MEDICAL BENEFITS FOR EMPLOYEES AND RETIREES 6 (2003), *available at*, http://www.segalco.com/publications/surveysandstudies/2003statesurvey_medicalbenefits.pdf (stating that over 30% of states do not contribute money toward single retirees under 65, and approximately 38% of participating states do not contribute toward singles retirees over age 65).

19. PAUL FRONSTIN & PAUL YAKOBOSKI, TIAA-CREF INSTITUTE POLICY BRIEF, OPTIONS AND ALTERNATIVES TO FUND RETIREE HEALTH CARE EXPENDITURES 2 (July 2005), *available at* http://www.tiaa-crefinstitute.org/research/policy/docs/pol070105.pdf.

What makes this situation difficult for governmental entities is that these retiree medical benefits are part of a collectively bargained agreement. It may be much harder for them to reduce or eliminate these benefits than it is for private employers. They will have to negotiate any reductions of these benefits under threat of either possible strikes or local political repercussions, like those seen in California, New York, and other states.

B. Increased Costs

According to the 2006 Towers Perrin Health Care Cost Survey, costs of retiree medical plans escalated sharply once again in 2006 for participants under age 65.[20] The total cost for pre-65 retirees is $562 per month for retiree-only coverage ($6,744 annually), up 10% from 2005, and substantially higher than the 8% projected rise for active employees.

According to the Tower's survey, retirees' overall contribution will exceed more than 42% of the total cost of their medical coverage in 2006, up from 40% in 2005. This is compared to 21% for active employees. Retirees under age 65 will pay an average of $216 per month ($2,592 annually, up from $2,172 for 2005) for retiree only coverage and $411 per month ($4,932 annually) for retiree plus one dependent coverage, while retirees age 65 and older will pay an average of $107 a month ($1,284 annually for retiree–only coverage, up from $1,248 for 2005) and $236 a month ($2,832 annually) for retiree plus one dependent coverage.[21]

To deal with the increased costs, the Kaiser/Hewitt 2005 Survey on Retiree Heath Benefits indicates that many employers are increasing the retiree portion of the premiums and reducing benefits.[22] These measures include:

- Nearly two-thirds of all survey firms (63%) place a cap on their company's contributions to retiree health benefits in any plan offered to retirees;
- Half (49%) have a cap on their company's contributions to retiree health benefits in the largest post-65 plan offered in 2005;
- Nearly three in four employers (71%) increased retiree contributions to premiums between 2004 and 2005;

20. TOWERS PERRIN, 2006 HEALTH CARE COST SURVEY (2006). *See also* Press Release, Towers Perrin, Towers Perrin Projects An 8% Increase In Employer-Sponsored Health Care Costs For 2006 As Annual Cost per Employee Reaches $8,424 (Sept. 28, 2005), *available at* http://www.towersperrin.com/hrservices/webcache/towers/United_States/press_releases/2005_09_28/2005_09_28.htm.

21. TOWERS PERRIN, *supra* note 20.

22. KAISER/HEWITT, *supra* note 2, at 15.

- Over one-third (34%) of employers increased retiree contributions, almost one-quarter (24%) raised deductibles, and nearly two in ten (19%) increased retiree out-of-pocket limits.[23]

Because of the yearly increases in health care costs and reductions in coverage, some retirees will be forced to drop employer sponsored retiree medical coverage entirely, and instead buy individual medical insurance policies. Other retirees will be forced to accept increased premiums to continue employer sponsored coverage because they can not obtain individual policies. With many employers either eliminating or cutting qualified retirement plans, retirees will be in a real money crunch to find ways to pay for coverage.

C. Age Discrimination Issues

The Age Discrimination in Employment Act of 1967 ("ADEA") prohibits employers from discriminating "against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age. . . ."[24] Protected individuals include retired employees. Since the enactment of the Older Workers Benefit Protection Act of 1990 (OWBPA), this prohibition has extended to employer-provided medical benefits.[25] In the past, many employers relied on the legislative history of the OWBPA, which appeared to indicate that eliminating, reducing, or altering employer-sponsored retiree medical benefits when an individual is eligible for Medicare as permissible under ADEA.

This understanding was challenged in *Erie County Retirees Ass'n v. County of Erie*.[26] In that case, the Court of Appeals for the Third Circuit held that an employer that coordinates its retiree medical benefits with Medicare violated the ADEA if the employer provided less benefits to older Medicare eligible retirees than to younger retirees.[27] As a result of the decision, the employer, Erie County, decided to reduce benefits for pre-age 65 retirees.

The EEOC supported the decision in *Erie County* and adopted it as its official position. As a result of its enforcement effort, many employers cut retiree benefits. In 2004, the EEOC changed its position and issued a final rule exempting from the ADEA the practice of coordinating employer provided retiree medical coverage with eligibility for Medicare or comparable state-sponsored medical benefit programs.

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23. *Id.* at vii-viii.

24. Age Discrimination in Employment Act of 1967, 29 U.S.C. § 623(a)(1)(2000).

25. Older Workers Benefit Protection Act of 1990, 29 U.S.C. § 621 (2000).

26. Erie County Retirees Ass'n v. County of Erie, 220 F.3d 193 (3d Cir. 2000) *cert. denied*, 121 S. Ct. 1247 (2001).

27. *Id.*

The AARP (formerly the American Association of Retired Persons) filed suit against the EEOC in the Third Circuit to enjoin the enforcement of the rule.[28] The question before the court was the validity of the EEOC's final rule. The EEOC argued that it had the power to exempt conduct otherwise prohibited under the ADEA provided that the exemption was "reasonable" and "necessary and proper in the public interest."[29]

In March 2005, the court rejected the EEOC's argument on three grounds[30] and found that the EEOC could not:

- issue regulations or rules contrary to the intent of Congress;
- exercise its rule making authority when it takes precedence over substantive provisions and prohibitions of the statute under which the EEOC has exercised it authority; and
- issue rules and exemptions where the Congress has left no gaps or ambiguity in the law and the court found no such gap or ambiguity in the ADEA as it relates to retiree medical benefits.[31]

In May 2005, the EEOC appealed the case to the Third Circuit U.S. Court of Appeals.

On June 30, 2005, the EEOC asked the district judge to reconsider her March 2005 decision in light of the U.S. Supreme Court's recent decision in *Nat'l Cable & Telecomm. Assoc. v. Brand X Internet Serv.*, regarding agency deference.[32] While the Supreme Court's decision has nothing to do with age discrimination or retiree medical issues, it establishes standards that accorded greater deference to an agency's interpretation of a statute. In reexamining her decision in light of these standards, the district judge concluded that the EEOC's interpretation was appropriate.

In an opinion issued on September 27, 2005, the court vacated its March 2005 decision, concluding that in light of *Brand X,* the court was not bound by the *Erie County* decision in determining whether the EEOC could go forward with its regulation.[33] Specifically, the court said that because the opinion in *Erie County* did not say that it was the only permissible interpretation of the ADEA, the *Erie County* opinion could not foreclose a later contrary interpretation by the EEOC.[34] In so ruling, the court said that

28. AARP v. E.E.O.C., 383 F.Supp.2d 705 (E.D. Pa. 2005).
29. *Id.* at 70.
30. *Id.* at 710-11.
31. *Id.*
32. 125 S.Ct. 2688, 2700-01 (2005).
33. *AARP v. E.E.O.C.*, 390 F.Supp.2d 437, 450 (E.D. Pa. 2005).
34. *Id.* at 456-57.

Erie County was not a basis for preventing the EEOC from going forward with its regulation.[35]

Although the court vacated the March 2005 order that permanently enjoined the EEOC from publishing its regulation, the injunction is still in effect pending the appeal of the March order. In addition, the AARP has recently appealed the court's September 2005 decision.

This is the latest development in what is expected to be a continuing effort by the EEOC to implement an exemption to the ADEA that it believes is necessary to avoid the unintended consequence of discouraging plan sponsors from offering retiree health coverage.

These are a very important series of cases because to control health care costs, most employers coordinate their retiree medical coverage with eligibility for Medicare for post-65 retirees. If the AARP wins its appeal, its immediate impact will only be felt by employers in Delaware, New Jersey, Pennsylvania, and the Virgin Islands as they are within the jurisdiction of the Third Circuit Court of Appeals. Eventually, other federal courts will be asked to join in and, if Congress does not act, it could ultimately be a decision left for the U.S. Supreme Court. How the Supreme Court rules in this situation could determine the future of retiree health benefits.

D. International Competition

With competition coming from all over the world, many American employers are reevaluating the cost of promising medical benefits to its retirees in the cost of providing goods and services to its customers. American employers are discovering that they have a large disadvantage because many of their foreign competitors either do not have this liability, or they are being helped by governmental subsidies in providing these retiree benefits.

This disadvantage is especially felt by American manufacturers because they have offered generous pension and health benefits. Health costs are one-third higher in manufacturing than in the service sector as reported in the September 27, 2005 edition of the *De Moines Register*.[36] Another factor that has affected this sector is the responsibility of these employers to pay health insurance benefits to a large number of retirees. As they have downsized, their numbers of retirees have increased. Newer, service-sector companies, however, have not been burdened by these retiree health costs.

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35. *Id.*

36. Editorial, *Separate Health Insurance From Jobs*, THE DES MOINES REGISTER, Sept. 27, 2005, at 8A.

In an article published in the September 15, 2004 issue of *Risk & Insurance*, author Len Strazewski indicates that "steadily rising health benefits costs, underfunded pension plans, and increasing costly retiree medical benefits are combining to create a new level of enterprise risk for many employers."[37] Mr. Strazewski goes on to indicate that these costs are no longer just a balance sheet liability, but the greater the benefits liability, the lower level of reserve capital will be available to fund growth and corporate opportunities.

In Mr. Strazewski's article, Stephen Metz, principal of PriceWaterhouseCoopers HR Services in Philadelphia, is also quoted as indicating that "[i]f you have retiree medical benefits, has a serious business risk."[38] Mr. Metz went on to say "[i]f your competitors don't have that liability on their books, they appear more profitable."[39]

A good example of this situation was reported in the April 20, 2005 edition of the *Detroit Free Press*.[40] Tom Walsh, a columnist for the newspaper, reported that General Motors, the world's largest automaker with 2.5 retirees and dependents for every active worker, spent $5.2 billion last year on retiree health care in the United States.[41] In the article, GM Chairman, Rick Wagoner indicated that GM's retiree health-care bill was $4 billion more than that of Toyota, the world's No. 2 auto producer.[42] It was widely reported that health-care costs for active and retired employees add $1,500 to the price of every car General Motors makes.

Even smaller manufacturers are facing large retiree medical benefits. It was reported in the September 27, 2005 issue of the *Des Moines Register* that the Maytag Corporation, with a worldwide active workforce of 18,000 employees, is facing a retiree medical benefit obligation of $60 million per year.[43] This is due to the fact that between 2000 and 2004, the number of retirees eligible for health benefits increased 25% to 7,000. It is further estimated that Maytag's obligation could grow to $80 million by

37. Len Strazewski, *A 'Tsunami' toward U.S. shores: Using sand-bags to defend corporations against a tidal wave of rising benefits expenses is unlikely to do much good. More drastic measures are necessary, experts say, and employees look as if they most likely will have to bear the burden*, RISK & INSURANCE, Sept. 15, 2004, *available at* http://www.looksmartrealty.com/p/articles/mi_m0BJK/is_11_15/ai_n6212320.

38. *Id.*

39. *Id.*

40. Tom Walsh, *GM's CEO Must Cope With Retiree Benefit Cost*, DETROIT FREE PRESS, April 20, 2005.

41. *Id.*

42. *Id.*

43. Editorial, *supra* note 36, at 8A.

2010, and that more than 9 million retirees receive health benefits from their former employers.

Continued health coverage for active and retired employees has been a major issue in every labor dispute over the last five years. Many American employers are now at a crossroad. They must either reduce or eliminate their retiree medical liability to remain in business and make reductions in coverage for active employees. To resolve this situation, can state and federal governments provide subsidies to employers to continue these benefits and stay in business? Employers need assistance to both provide and fund retiree health benefits.

III. WAYS TO FUND THE OBLIGATION TO PROVIDE BENEFITS

To lessen the negative impact of accounting rules on the balance sheet, many employers pre-fund all or part of their retiree health obligations. In the past, employers were not given many choices of funding alternatives. The most common funding alternatives included:

- Voluntary Employee Beneficiary Association (VEBA),
- 401(h) Accounts,
- Corporate Owned Life Insurance,
- Integral Part Trusts,
- Health Reimbursement Arrangements, and
- Health Savings Accounts.

A. Voluntary Employee Beneficiary Association (VEBA)

A VEBA is a tax-exempt trust under Internal Revenue Code ("Code") Section 501(c)(9).[44] Benefits provided under a VEBA trust must be provided on a nondiscriminatory basis under Code Section 505(b).[45] Deductible contributions that an employer may make to a VEBA are limited by Code Section 419A.[46] Under this vehicle, an employer is prohibited from pre-funding for future increases in retiree health care costs. As a tax-exempt entity, VEBAs are subject to significant qualification and reporting rules with the IRS. The major advantage of a VEBA is that an employer may create reserves for other self-funded benefits, and the trust does not have to pay income taxes on its earnings.

For many small and medium sized employers, the use of a VEBA is not a good alternative because it is too costly and complex to maintain. It requires the establishment of a new employee organization and trustee (independent of the employer). Once an employer makes a contribution to a VEBA, it cannot receive back any contributions unless the VEBA is terminated, as provided in

44. 26 U.S.C. § 501(c)(9) (2000), *amended by* Pub. L. No. 109-135 (2005).
45. 26 U.S.C. § 505(b).
46. 26 U.S.C. § 419A.

IRS Regulations Section 1.501(c)(9)-4(d).[47] At termination, an employer may receive payment of any remaining assets only after satisfaction of all liabilities to existing benefits are applied to purchases of insurance, life, sick, accident or other permissible benefits under Code section 501(a)(9), as provided in IRS Regulation Section 1.501(c)(9)-4(d).[48] Such payments of benefits are allowed if the criteria to provide benefits do not provide for a disproportionate share of benefits to officers, shareholders, or highly compensated employees.

A VEBA can be a good alternative to fund benefits if the employer understands the commitment and provides a number of self-funded health and welfare benefits, and also maintains the VEBA for a number of years. Because of the difficulties of terminating a VEBA, an employer should only consider termination if it is undergoing either a major corporate or benefit restructuring.

B. 401(h) Accounts

Code Section 401(h) allows an employer to transfer assets for retirement liabilities into individual participant accounts to fund certain medical retiree benefits under a qualified pension or annuity plan if all six of the following requirements are met:

- The benefits are subordinate to the retirement benefits provided by the plan;
- A separate account is established and maintained for these benefits;
- The employer's contributions to the separate account are reasonable and ascertainable;
- The principal or income of the separate account cannot be diverted to any purpose other than providing the benefits prior to the satisfaction of all liabilities under the plan;
- If all liabilities to provide these benefits under the plan are satisfied, any amount remaining in the separate account must be returned to the employer; and
- For each key employee, a separate account must be established and maintained.[49]

Such accounts have to be established inside the employer's qualified pension or annuity plan. For any year, not more than 25% of the employer's total contribution to the plan (other than

47. Treas. Reg. § 1.501(c)(9)-4(d) (1981).
48. *Id.*
49. I.R.C. § 401(h).

contributions to fund past service benefits) may be used to provide retiree health benefits through the 401(h) accounts.[50]

The advantage of these accounts is that the employer does not have to establish a separate entity to provide the benefit and may use any excess assets to fund the benefit. Over the last ten to fifteen years, this funding alternative is becoming less and less viable because, according to a National Compensation Survey released by the Bureau of Labor Statistics in 2004, only 21% of employees are participating in defined benefit plans, compared to 42% participating in defined contributions plans.[51] In addition, 401(h) accounts are no longer an alternative for employers who still sponsor qualified retirement plans because they can no longer fund them.[52] According to the National Center of Policy Analysis, Brief Analysis No. 540, "the majority of existing [defined benefit] plans are significantly underfunded."[53] This funding crisis stems from both the growing number of retirees receiving benefits and the growing number of employers forced into bankruptcy due to benefit costs.

C. Corporate-Owned Life Insurance

Under this option, employers could purchase life insurance on the lives of key employees, with the employer serving as the beneficiary. This is treated as a corporate asset and the employer may use the proceeds at the employee's death or use the inside buildup of cash surrender value to fund benefit obligations. Since Corporate-Owned Life Insurance ("COLI") does not meet the definition of plan assets, it does not directly reduce the liability on the balance sheet for accounting purposes.[54] COLI does, however, offset (balance) the booked liability and demonstrate the employer's financial responsibility in planning to meet the projected liability. As a result, the use of COLI is a very limited alternative. In addition, another drawback to the use of COLI is that any premiums paid by the employer are not deductible under Code Section 264(a).[55] The only deduction allowed is for interest on policy loans, but they are restricted to $50,000 of the policy on a per employee basis under Code Section 264(e).[56]

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50. *Id.*

51. BUREAU OF LABOR STATISTICS NATIONAL COMPENSATION SURVEY, EMPLOYEE BENEFITS IN PRIVATE INDUSTRY IN THE UNITED STATES 1 (2004), *available at* http://www.bls.gov/ncs/ebs/sp/ebnr0009.pdf.

52. I.R.C. § 401(h).

53. WILLIAM B. CONERLY, NATIONAL CENTER FOR POLICY ANALYSIS, THE DEFINED BENEFIT PENSION CRISIS 1 (Dec. 21, 2005), *available at* http://www.ncpa.org/pub/ba/ba540/ba540.pdf.

54. I.R.C. § 264(a).

55. *Id.*

56. I.R.C. § 264(e).

D. Integral Part Trusts

Government entities can use this vehicle to hold employer and employee contributions for the exclusive purpose of providing health benefits to retirees, as provided under Treasury Regulations Section 301.7701-1(a)(3)[57] and Private Letter Ruling 200012084.[58] The basis for the tax exemption of the trust is that the assets are restricted to a use that is considered an integral function of the entity. For the trust to qualify as an "integral part of the employer," the employer must exert "substantial control" in directing the plan and have "substantial financial involvement" in funding the plan. "Substantial control" means that the employer controls the entity by holding the power to amend or terminate and by naming the parties that manage the daily operations of the entity, including the trustees. The trustees can be named solely by the employer, named in conjunction with the employee groups covered by the trust, or can be a directed trustee hired by the employer.

These trusts are much more flexible to use than VEBAs because there is not an extensive set of rules and regulations. There is no need for the governmental entity to obtain a determination letter and they can be used with health reimbursement arrangements.

E. Health Reimbursement Arrangements ("HRA")

These arrangements are provided under Code Section 105[59] and are authorized by the IRS under IRS Revenue Ruling 2002-41[60] and IRS Notice 2002-45.[61] Like Health Flexible Spending Accounts (FSAs) under Code Section 125,[62] an employer would establish individual accounts for participants to reimburse eligible medical expenses. But unlike FSAs, HRAs can only be employer funded, may allow unused amounts to be carried over to succeeding years, and can be used to reimburse health insurance premiums. Since HRAs are funded only by employer contributions, the employer has a right to design the program to only reimburse certain medical expenses or premiums, to determine the amount of the carry-over of unused amounts, and to determine the period over which unused amounts can be carried over. None of the cafeteria plan rules under Code Section 125[63] apply, but nondiscrimination rules under Code Section 105(h) do

57. Treas. Reg. § 301.7701-1(a)(3).
58. I.R.S. Priv. Ltr. Rul. 200012084 (Dec. 28, 1999).
59. I.R.C. § 105.
60. Rev. Rul. 2002-41, 2002-2 C.B. 75 (2002).
61. I.R.S. Notice 2002-45, 2002-2 C.B. 93.
62. I.R.C. § 125.
63. *Id.*

apply.[64] So far, the Department of Labor has not required that the employer's promise to provide these accounts be funded. If the employer decides not to fund its obligation to provide benefits under a HRA, such obligation will be treated as a liability on the employer's balance sheet.

Employers are using HRAs to provide retiree medical benefits in two situations. First, some employers are allowing employees to carry-over unused benefits for a number of years, and then allowing them to use their benefits after termination of employment to reimburse expenses and premiums, even if COBRA is not elected.

Employers are also using HRAs to determine benefit amounts during an employee's working life for use during the employee's retirement. An employee may earn a specified dollar amount for each year of employment with the employer. The employer designs the program so the promise to provide health benefits is not an open-ended promise, but rather a promise to provide this accumulated benefit. When the employee retires, the employee's total accumulated amount is available to pay health care premiums or eligible health care expenses. Unlike other types of retiree programs, the promise to provide retiree health benefits is based on a defined contribution model instead of a defined benefit model. In using this method, the employer's promise to provide a retiree medical benefit is no longer an unlimited promise. By defining its retiree benefit liability on this defined contribution model, an employer will be better able to honor its promise to provide retiree health benefits in the future.

But for employees, there are problems with participating in HRAs. An employee may lose the right to any benefits under the program if he or she terminates employment before retirement or before eligibility for benefits under the program. Since the employer controls the terms of the HRA program, it could change the terms for benefits before either the employee becomes entitled to the benefit or terminates the program entirely. The employee has little or no recourse in forcing the employer to provide the benefit.

F. Health Savings Accounts ("HSAs")

HSAs provide eligible individuals with a tax-free basis for paying current medical expenses as well as an ability to save on a tax-favored basis for future medical expenses. HSAs are provided under Code Section 223[65] and have been available since January 1, 2004. HSAs are tax-exempt trusts or custodial accounts created exclusively to pay for the qualified medical expenses of an

64. I.R.C. § 105(h).
65. I.R.C. § 223.

employee, and those of his/her spouse and dependents that are subject to rules similar to those applicable to individual retirement arrangements ("IRAs").

Eligibility to contribute to an HSA program is determined on a month-by-month basis. For any month, an individual is eligible to contribute to an HSA under Code Section 223(c)(1)(A) if he or she:

- is covered only by a high-deductible health plan ("HDHP") as of the first day of such month;
- is not also covered by any other health plan that is not a HDHP (with certain exceptions for plans providing certain limited types of coverage);
- is not enrolled in benefits under Medicare; and
- is not be claimed as a dependent on another person's tax return.[66]

Under Code Section 223(c)(2)(A), a HDHP is an insured or self-insured health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses.[67] In the case of individual coverage, the plan must have an annual deductible of not less than $1,050 for 2006, and in the case of family coverage, the plan must have an annual deductible of not less than $2,100 for 2006. In addition, the plan's annual deductible for out-of-network services is not taken into account in determining the annual contribution limit. Rather, the annual contribution limit is determined by reference to the deductible for services within the network.

In addition, the maximum out-of-pocket expense limit on covered expenses can not exceed $5,250 for 2006 in the case of individual coverage, and $10,500 for 2006 in the case of family coverage under Code Section 223(c)(2)(A)(ii).[68] Out-of-pocket expenses include deductibles, co-payments, and other amounts (other than premiums) that the individual must pay for covered benefits under the plan.

Within limits, contributions to HSAs are deductible if made by or for an eligible individual and are excludable from such individual's income and wages for employment tax purposes if made by the employer of an eligible individual or if made by the employee in the form of pre-tax salary deferral contributions under a cafeteria plan. The maximum annual contribution to an HSA is the sum of the limits determined separately for each month, based on status, eligibility, and health plan coverage as of the first day of the month. Any individual who begins HDHP coverage in mid-month would not be eligible to make an HSA contribution until the

66. I.R.C. § 223(c)(1)(A).
67. I.R.C. § 223(c)(2)(A).
68. I.R.C. § 223(c)(2)(A)(ii).

beginning of the following month, as provided in IRS Notice 2004-50, Q/A-11.[69]

The maximum monthly contribution for eligible individuals with individual coverage under an HDHP, as provided in Code Section 223(b)(2), is 1/12 of the lesser of 100% of the annual deductible under the HDHP (minimum of $1,050 for 2006), but not more than $2,700 for 2006.[70] For eligible individuals with family coverage under an HDHP, the maximum monthly contribution, as provided in Code Section 223(b)(2)(B), is 1/12 of the lesser of 100% of the annual deductible under the HDHP (minimum of $2,100 for 2006), but not more than $5,450 for $2006.[71]

In addition to the maximum contribution amount, catch-up contributions are provided under Code Section 223(b)(3).[72] If an employee has reached age 55 by the end of the taxable year, the HSA annual contribution limit is increased by $700 in 2006, $800 in 2007, $900 in 2008, and $1,000 in 2009 and thereafter. As with the annual contribution limit, the catch-up contribution is also computed on a monthly basis.

Under Code Section 223(f)(2)[73] and IRS Notice 2004-2, Q/As 25-26,[74] distributions from an HSA for "qualified medical expenses" of the individual and his/her spouse or other dependents generally are excludable from gross income and can be made at anytime. In general, amounts in an HSA can be used for "qualified medical expenses" even if the individual is not currently eligible for contributions to an HSA, as long as the expense is incurred after the HSA was established, as provided in IRS Notice 2004-2, Q/As-25 and 26.[75]

Under Code Section 223(f)(1), distributions from an HSA that are not used to pay medical care expenses are includible in the employee's gross income.[76] Distributions includible in gross income are also subject to an additional 10% tax unless made after death, disability, or if the individual attains the age of Medicare eligibility (i.e., age 65), as provided in Code Section 223(f)(4).[77]

If the HSA account holder's surviving spouse is the named beneficiary of the HSA, then, after the death of the HSA account holder, the HSA becomes the HSA of the surviving spouse and the amount of the HSA balance may be deducted when computing the

69. I.R.S. Notice 2004-50, Q&A-11, 2004-33 I.R.B. 196 (2004).
70. I.R.C. § 223(b)(2).
71. I.R.C. § 223(b)(2)(B).
72. I.R.C. § 223(b)(3).
73. I.R.C. § 223(f)(2).
74. I.R.S. Notice 2004-2, Q&A-25-26, 2004-2 I.R.B. 269 (2004).
75. *Id.*
76. I.R.C. § 223(f)(1).
77. I.R.C. § 223(f)(4).

decedent's taxable estate, pursuant to the estate tax marital deduction, as provided in Code Section 223(f)(8).[78] In IRS Notice 2004-2, Q/A-31, the IRS provides that the surviving spouse is not required to include any amount in gross income as a result of the death; the general rules applicable to the HSA apply to the surviving spouse's HSA (e.g., the surviving spouse is subject to income tax only on distributions from the HSA for nonqualified expenses).[79] The surviving spouse can exclude from gross income amounts withdrawn from the HSA for expenses incurred by the decedent prior to death, to the extent they otherwise are qualified medical expenses.

If, upon death, the HSA passes to a named beneficiary other than the decedent's surviving spouse, then Code Section 223(f)(8) provides that the HSA ceases to be an HSA as of the date of the decedent's death, and the beneficiary is required to include the fair market value of HSA assets (as of the date of death) in gross income for the taxable year that includes the date of death.[80] The amount includible in income is reduced by the amount of the HSA used, within one year after death, to pay qualified medical expenses incurred by the decedent prior to the death. As is the case with other HSA distributions, whether the expenses are qualified medical expenses is determined at the time the expenses were incurred. In computing taxable income, the beneficiary may claim a deduction for that portion of the federal estate tax on the decedent's estate that was attributable to the amount of the HSA balance.

If there is no named beneficiary of the decedent's HSA, the HSA ceases to be an HSA as of the date of death, and the fair market value of the assets in the HSA at such date is includible in the decedent's gross income for the year of the death. This rule applies in all cases in which there is no named beneficiary, even if the surviving spouse ultimately obtains the rights to the HSA assets (e.g., if the surviving spouse is the sole beneficiary of the decedent's estate).

In President Bush's State of the Union Address in January, he urged expansion of HSAs and increased portability of health coverage to make health care more affordable.[81] Under the President's proposal, premiums for HDHP policies purchased independent of employment would be deductible from income taxes.[82] In addition, the President supports an income tax credit to

78. I.R.C. § 223(f)(8).

79. I.R.S. Notice 2004-2, Q&A-31, 2004-2 I.R.B. 269 (2004).

80. I.R.C. § 223(f)(8).

81. President's Address Before a Joint Session of the Congress on the State of the Union, 42 WEEKLY COMP. PRES. DOC. 145 (Feb. 6, 2006).

82. Remarks on the National Economy and a Question-and-Answer Session in Serling, Virginia, 42 WEEKLY COMP. PRES. Doc. 80, 84 (Jan. 19, 2006).

make up for payroll tax savings that employees enjoy when they pay pre-tax health insurance premiums through their employer.

Additional tax incentives would be extended to HSA account holders. President Bush's plan would permit employees and their employers to make deductible HSA contributions up to their out-of-pocket costs under the HDHP, not just the annual deductible pursuant to current law.[83] Employees who do not contribute through a cafeteria plan would also receive a credit for payroll taxes paid on HSA contributions.

Enhanced HSAs would be created for those dealing with low incomes or chronic illness. Families of four with an annual income of $25,000 or less would be allowed a refundable tax credit of $3,000 to assist in the purchase of HDHP policies to cover major medical expenses. Up to $1,000 would be allowed in an HSA to cover routine costs. For those with chronic illness, employers would be allowed to make higher contributions to HSAs to assist in funding out-of-pocket expenses.

The use of existing or expanded HSAs to pay for medical expenses is only one solution in funding health care costs in the future. As explained in the next section, HSAs have both positive and negative characteristics. Before either an employer or employee participates in an HSA program, these characteristics should be communicated and understood by both parties. It may be years before the full effect of HSAs can be felt because it will take time for employers and employees to enroll and accounts balances to accumulate. As a result, HSAs are not used as a short-term solution in providing and funding health benefits.

IV. POSSIBLE SOLUTIONS

To solve the retiree health care crisis, a number of solutions have been suggested. They include:

- the use of Health Savings Accounts (HSAs);
- the use of consumer-driven health care plans for both active employees and retirees;
- the expansion of Medicare to allow pre-age 65 retirees to buy-in to the program
- the adoption of a universal health care system in the United States; and
- the allowance of employers to form and join "Association Health Plans" (AHPs).

A. The Use of Health Savings Accounts (HSAs)

As discussed above, the Bush administration has pushed for greater use of HSAs, arguing that the accounts will make people more judicious about their health-care spending. "The plans

83. *Id.*

[accounts] can grow tax-free, which is an encouragement for people to make wise decisions about how they treat their body," the President said.[84] The proposal to increase the amount a person can put into an HSA each year is intended to make the accounts a more useful savings vehicle and more palatable for people with high out-of-pocket medical spending. The proposal to increase the deposit threshold to the annual out-of-pocket spending limit for HSA plans would allow people save a few thousand dollars more each year tax-free. "That would certainly help people with chronic conditions who use up the money each year," said Paul Fronstin, director of the Washington nonpartisan group Health Research and Education Program at the Employee Benefit Research Institute, told the *Wall Street Journal*.[85] "The other benefit is it allows you to accumulate more, faster. If you're using this account to save money for medical expenses in retirement, that would be valuable," he said.[86]

Every month, new studies indicate that more and more employers are adopting high deductible health plans ("HDHP") with Health Savings Accounts ("HSAs"). According to a recent study conducted by America's Health Insurance Plans ("AHIP"), "at least three million consumers currently receive health coverage through high-deductible health plans offered in conjunction with [HSAs]. . . ."[87] The study reported that "enrollment in the new insurance policies eligible for HSAs has roughly tripled since [ ] March 2005 when a similar AHIP survey found that 1,031,000 individuals were covered by HSA-compatible insurance policies."[88] This growth in HSAs brings many advantages to both the employer and employee. These include:

- Lowering of health care premiums under the HDHP for coverage for employees;
- Lowering the employer's administrative costs;
- Providing employees an opportunity to contribute for future health care expenses under the HSA for him or herself and his or her dependents;
- Providing any employee who contributes to an HSA with a tax deduction and/or an income tax and payroll tax free contribution;

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84. *Id.*

85. Sarah Lueck, *Bush to Seek Bigger Health-Savings Tax Break*, WALL ST. J., Jan. 21, 2006, at A3, *available at* http://www.gahealthplans.org/index.php?module=pagesetter &func=viewpub&tid=3&pid=246.

86. *Id.*

87. Press Release, America's Health Insurance Plans, Over 3 Million Enrolled in High-Deductible/HAS Plans (Jan. 26, 2006), *available at* http://www.ahip.org/content/pressrelease.aspx?docid=14641.

88. *Id.*

- The inability of the employer to forfeit any contributions made by or for the employee to an HSA;
- Providing an employer with an opportunity to contribute to eligible employees at any time and at any amount up to statutory limits;
- Giving employees immediate access to their HSAs for any reason;
- Providing for tax-free distributions at any time for health care expenses incurred after the HSA has been established if the expense was neither reimbursed from any other source or deducted by the employee;
- Providing for reimbursement of health care expenses after the employee's death, if he or she names the spouse as the beneficiary under the HSA;
- Providing either a trust or custodial account that accumulates earnings on a tax free basis;
- Getting the employer out of the business of substantiating health care claims;
- Avoiding the requirements of ERISA (and COBRA and HIPAA) if the employer does not make participation in the HSA mandatory; and
- Giving the employees who participate in an HSA complete portability in transferring their accounts at any time.

1. The Dark Side of HSAs

At the same time that HSAs offer many advantages, they also come with a number of disadvantages that should be explained to both employers and employees. HSAs are very complex and, if not administered properly, could cause adverse tax consequences to employees. The following will discuss these complexities and disadvantages of HSAs so as to provide a complete picture of the account.

a. Administration of the HSA

When an employer participates in an HSA program, the responsibility for administering the account is transferred to the employee. It is the employee who decides:

- Whether he or she is eligible to make contributions to an HSA;
- The amount of the eligible contribution to the HSA for any calendar year;
- The withdrawal of any excess contributions;
- How funds in his or her HSA will be spent; and
- Whether the distributions are taxable or nontaxable.

Employees are prohibited from delegating any of the above responsibilities to either the employer or the HSA trustee or

custodian. Since the employee is in control of the HSA, he or she is responsible for reporting all contributions and distributions to the IRS on his or her Form 1040, using Form 8889.[89] If the employee makes any errors, he or she must pay any additional tax or penalties to the IRS and not to either the employer or HSA trustee or custodian.

b. Eligibility to Participate

If an employee is covered under a spouse's health plan, that coverage can affect the employee's ability to contribute to an HSA. This coverage also includes reimbursements under a spouse's Health Flexible Spending Account ("FSA"). For any month that a spouse could submit an employee's expenses for reimbursement, the employee is ineligible to make a contribution to an HSA. Since a spouse's coverage could change at any time during a calendar year, it is the employee's responsibility to determine eligibility to make a contribution to an HSA. Neither the employer nor the HSA trustee or custodian can make that determination for the employee. As discussed below, if an employee makes a contribution to an HSA when ineligible, the entire contribution is considered to be an excess contribution and the employee will be penalized for this contribution.

c. Amount of Contribution

In the case of married couples, if either spouse has family coverage then both are treated as having family coverage, unless they do not cover each other and cover other dependents, as provided in Revenue Ruling 2005-25.[90] If each spouse has family coverage under a separate health plan, then both spouses are treated as covered under the plan with the lowest deductible, if they cover each other as provided in IRS Notice 2004-2, Q/A-15.[91] The contribution limit for the spouses is the lowest amount, divided equally between the spouses unless they agree on a different division.

As in determining eligibility, a spouse's coverage could affect the amount that an employee can contribute to an HSA even if the employee is not covered under the spouse's coverage. The following examples illustrate the point:

> Dick and Jane are married and working for two different employers with HDHP coverage. Depending on the different coverages and different deductibles, they ask how much they

89. I.R.S. Form 8889.
90. Rev. Rul. 2005-25, 2005-18 I.R.B. 971 (2005).
91. I.R.S. Notice 2004-2, Q&A-15, 2004-2 I.R.B. 269 (2004).

can contribute to their HSAs for 2006. They are both under age 55.

Q. Dick has family coverage with a $3,000 deductible and Jane has family coverage with a $4,000 deductible. They cover each other. How much can they both contribute to their HSAs for 2006?

A. Since they cover each other, the maximum contribution between both can not exceed $3,000, the lowest deductible. Therefore, if Dick contributes $2,000 to his HSA, Jane could only contribute $1,000 to hers.

Q. Same facts as in the question above, but Dick and Jane have family coverage which covers only their dependent children and not each other. How much can they both contribute?

A. There is no clear answer. Some argue that Dick can contribute $3,000 and Jane can contribute $4,000. Others argue that between the two, the contribution can not exceed the family limit of $5,450 for 2006, because the family limitation would apply. IRS guidance is needed to clarify the situation.

Q. Dick has single coverage with a $2,100 deductible and Jane has single coverage with a $3,000 deductible. How much can be contributed to Dick and Jane's HSAs for 2006?

A. Dick can contribute up to $2,100 to his HSA and Jane can contribute up to $2,700 to hers. Dick and Jane cannot contribute the entire contribution of $4,800 in either Dick or Jane's HSA. Dick's HSA can not accept more than $2,100 for 2006, and Jane's HSA can not accept more than $2,700, as a contribution for 2006.

Q. Dick has single coverage with a deductible of $2,100. Jane has family coverage with a $4,000 deductible covering the dependent children and excluding Dick. How much can they contribute to their HSAs for 2006?

A. The answer is unclear. Some argue that Dick can contribute $2,100 to his HSA and Jane can contribute $4,000 to hers. Others argue that HSA contributions for both Dick and Jane are limited to $5,450 for 2006.

Q. Dick has single coverage with a deductible of $2,100 and Jane has family coverage with a deductible of $4,000, covering the dependent children and Dick. How much can be contributed to Dick and Jane's HSAs for 2006?

A. Dick and Jane are treated as having only family coverage and they can make a $4,000 HSA contribution between the two of them. Therefore, if Dick contributed $2,100 to his HSA, Jane could only contribute $1,900 to hers.

The determination of an individual's proper HSA contribution is a complex calculation. Since only the employee will have the information needed to determine the proper amount, neither the employer nor the HSA trustee or custodian can help in the determination. After the end of the calendar year, the employee should seek proper tax assistance to make the determination or the employee will have to pay the consequences.

d. Excess Contributions

If an employee contributes more than the stated limits for the taxable year, these contributions are not deductible under Code Section 223(a).[92] Contributions made by an employer over the limits are included in the employee's income.

In addition, an excise tax applies to contributions in excess of the maximum contribution amount, as provided in Code Section 223(f)(3).[93] The excise tax is generally equal to 6% of the cumulative amount of excess contributions that are not distributed from the HSA to the contributor, as provided under Code Section 4973(g).[94]

However, if the excess contributions for a taxable year and the net income attributable to such excess contributions are paid to the individual before the last day prescribed by law (including extensions) for filing the individual's federal income tax return for the taxable year, then the net income attributable to the excess contributions is included in the individual's gross income for the taxable year in which the distribution is received, but the excise tax is not imposed on the excess contribution and the distribution of the excess contribution is not taxed. If the eligible individual is under age 65 and is not dead or disabled, he or she will be subject to the 10% penalty tax on the earnings as provided in Code Section 223(f)(3).[95]

92. I.R.C. § 223(a).
93. I.R.C. § 223(f)(3).
94. I.R.C. § 4973(g).
95. I.R.C. § 223(f)(4).

Remember, it is the employee who must report and pay the penalty or withdraw the excess to avoid the penalty. Neither the employer nor the HSA trustee or custodian can be involved in the determination of the excess or withdrawal of the excess. It is the employee who must initiate the process.

e. Distributions

Since HSA contributions are nonforfeitable, it is the employee who controls when and for what purpose withdrawals can be made from the HSA. In Notice 2004-2, Q/A-24, the IRS indicates that an employee is permitted to receive distributions from an HSA at any time.[96] In IRS 2004-50, Q/A-79, the IRS further states that trust or custodial agreements are prohibited from containing provisions restricting distributions made only for an employee's qualified medical expenses and confirming that the employee is entitled to distributions for any purpose.[97]

Those withdrawals made by an employee from the HSA are nontaxable if they reimburse eligible medical expenses incurred by the employee and/or his or her dependents after the HSA has been established, and are not otherwise reimbursed from any other source or deducted by the employee, as provided in Code Section 223(f)(2)[98] and IRS Notice 2004-2, Q/As 25-26.[99] This means that an employee could be reimbursed for eligible medical expense that occurred many years in the past. Since the employee has to report the treatment of withdrawals on IRS Form 1040, the employee must justify the treatment if audited by the IRS. Employees should be advised to keep evidence of any medical expenses incurred in the past.

f. Lack of Control

As indicated above, employees are in complete control of their HSA; the employer has no control how the funds in the HSA are spent. Most HSA trustees or custodians give employees full access to their HSAs by providing employees and their dependents checking accounts and/or debit cards. No one can stop an employee from using his or her HSA to buy chips and beer while picking up a prescription at the local drug store.

Under IRS Notice 2004-50, Q/A-79, an HSA trustee or custodian may place reasonable restrictions on both the frequency and the minimum amount withdrawn from an HSA.[100] An HSA trustee or custodian may prohibit distributions for amounts of less

96. I.R.S. Notice 2004-2, Q&A-24, 2004-2 I.R.B. 269 (2004).
97. I.R.S. Notice 2004-50, Q&A-79, 2004-33 I.R.B. 207 (2004).
98. I.R.C. § 223(f)(2).
99. I.R.S. Notice 2004-2, Q&A-25-26, 2004-2 I.R.B. 269 (2004).
100. I.R.S. Notice 2004-50, Q&A-79, 2004-33 I.R.B. 207 (2004).

than $50 or only allow a certain number of distributions per month.

If an employer is contributing all or a part of the HSA contribution for the employee, it must understand that it cannot control how the contributions are spent or invested in the HSA. The employer has to trust that its employees will use and invest their HSAs wisely.

g. Employee's inability to contribute

Some employers must realize that there will be a segment of their employee population that can never afford to contribute to an HSA on their own. Unless the employer makes contributions to employees' HSAs, some employees will not have balances in their HSA. If an employer cannot contribute to employees' HSAs and adopt a HDHP, there may come a day when an employee indicates to the employer that he or she cannot pay his or her portion of medical expenses incurred under the employer's health plan, has not contributed to an HSA, and may lose a house or car because of unpaid medical bills.

In adopting an HDHP, the employer has to educate and communicate to its employees their greater responsibility to fund and pay for medical expenses. Unlike Health FSAs, employers are not responsible for fronting any funds for employees in their HSAs. Once the employee's HSA funds are gone, it will be the employee's responsibility to pay for the expense. As employers further cut-back medical benefits by raising deductibles and increasing the employee's share of coinsurance amounts, employees will be facing a real financial burden if they suffer a major medical expense and have not contributed to an HSA.

h. Portability

Under IRS Notice 2004-50, Q/A-79, an HSA trust or custodial agreement cannot restrict the employee's ability to rollover or transfer an amount from that HSA.[101] If an employer requires an employee to establish an HSA at a particular financial institution so as to either receive an employer contribution and/or contribute through payroll deduction, then the employee has the ability to transfer funds to another HSA sponsored by another financial institution at any time. The first institution may make it difficult for an employee to make this transfer by imposing fees, but cannot altogether prohibit transfers or rollovers.

101. *Id.*

i. Use of Health Reimbursement Arrangements ("HRA") or Health Flexible Spending Accounts ("Health FSA") with HSAs

In Revenue Ruling 2004-45, the IRS mandates that an employee cannot participate in both a Health FSA, HRA, and HSA in the same calendar month, unless the employee's situation is one of the following:

- The employee's expenses reimbursed under a Health FSA and/or HRA are limited to dental, vision and/or preventive care benefits ("Limited Purpose Health FSA or HRA").
- If an employee suspends participation in an HRA for the year ("Suspended HRA").
- Health FSA or HRA pays expenses above the deductible of the HDHP ("Post-Deductible Health FSA or HRA"). If the deductible limits of the HDHP and the HRA are different, contributions to the HSA are limited to the lower of the deductibles.
- HRA pays or reimburses the employee's expenses incurred after the employee retires ("Retirement HRA").[102]

In adopting an HSA program, an employer must limit or eliminate the use of devises (such as Health FSAs) that their employees have used for many years. There could be situations in which some employees could contribute less under an HSA than they did under a Health FSA, depending on the limits that the employer imposed under the Health FSA.

j. Transfer Because of Divorce

Under Code Section 223(f)(7), an employee's interest in an HSA can be transferred to an HSA established for the spouse (or ex-spouse) under a decree of divorce or separate maintenance, or a written instrument incident to such decree.[103] In the event of such transfer, the distribution is not taxable to either the employee or spouse, nor is it subject to the 10% excise tax, and the spouse (or ex-spouse) becomes the account holder of the newly created HSA. An employee's interest in an HRA or Health FSA is not subject to this transfer requirement.

k. Uniform Coverage Rule does not Apply

For participants in Health FSAs, employers are required to reimburse them for the entire amount they elected to defer for the plan year at any time during the plan year. This requirement is called the "uniform coverage rule" and is provided in Proposed

102. Rev. Rul. 2004-45, 2004-22 I.R.B. 971 (2004).
103. I.R.C. § 223(f)(7).

Treasury Regulations Section 1.125-2. Q/A-7.[104] This rule does not apply to HSAs. Participants may only receive reimbursement for expenses up to the balance contained in their HSA.

Under Notice 2004-50, Q/A-60, an employer may accelerate HSA funding up to the maximum amount elected by employees to cover incurred claims, so long as (a) the employee has elected to make HSA contributions through a cafeteria plan; (b) the accelerated contribution is equally available to all participating employees throughout the year and is provided on the same terms; and (c) the employee is required to repay the amount advanced by the end of the plan year.[105]

l. Use of HDHP

To be eligible to contribute to a HSA for any month, an employee must participate in a HDHP. As discussed above, a HDHP is defined as a health plan under Code Section 223(c)(2)(A) that satisfies certain requirements with respect to deductibles and out-of-pocket expenses.[106] In the case of individual coverage, the plan must have an annual deductible of not less than $1,050 for 2006, and in the case of family coverage, the plan must have an annual deductible not less than $2,100 for 2006. Below the deductible limits, the employee is responsible to pay for expenses except for dental, vision, and preventive care expenses. There can be no drug or office co-pays under HDHP below the plan's deductible. The switch to a HDHP to be eligible to contribute to a HSA can be very costly for employees who have chronic conditions. When adopting a HDHP, many employers are offering it as an option to a traditional comprehensive health plan. But, the employer who is making this arrangement has to be careful to avoid adverse selection in the traditional comprehensive health plan because younger, healthier employees may be attracted to the HDHP.

The switch to providing health coverage through a HDHP and a HSA is a major change in providing coverage to employees. The employee will have to take more responsibility in funding and spending health care dollars. Since employees will be spending more of their own funds, will they hesitate in obtaining care? HSAs and HDHPs may become part of a greater movement to reduce costs for active and retired employees and retirees through the use of "consumer driven health care" plans.

As indicated above, HSAs cannot be a solution for employers to provide retiree health benefits for those former employees who are retired or will retire in the next five years. There will be

104. Prop. Treas. Reg. § 1.125-2 Q&A-7, 54 FR 9460 (Mar. 7, 1989).
105. I.R.S. Notice 2004-50, Q&A-60, 2004-33 I.R.B. 207 (2004).
106. I.R.C. § 223(c)(2)(A).

pressure on employers to adopt HDHPs as a way to lower costs. The problem with such adoption is that the employer is passing more of the cost of providing health benefits to a population who can least afford it and who will immediately bear the brunt of the higher costs. But, many employers are faced with this situation if they either adopt an HDHP program or drop health coverage for all employees, including the retirees.

B. The Use of Consumer Driven Health Care for Active and Retired Employees

As premium increases continue, many small and medium-sized employers are looking for any medical delivery system that can assist in either eliminating or reducing the rate of premium increases. Many health care consultants have been recommending "consumer driven health care" as a solution. They suggest that consumer-driven health plans could potentially:

- Control costs and enhance efficiency,
- increase the choices available, and
- allow for greater consumer involvement in health care.

The following will examine consumer-driven health care and address the following questions:

- What is consumer health care?
- Do consumer-driven health plans reduce health care costs?
- How do participants receive consumer-driven health plans once an employer has installed the program?
- What are the possible pitfalls?

1. What is "Consumer Driven Health Care"?

In the late 1990s, it was generally accepted that managed care (HMOs and PPOs) failed to control costs. One of the problems with managed care was that the true cost of health care was hidden from both doctors and patients with co-payments. In fact, in many HMOs, participation was encouraged with low office co-pays and comprehensive services. In addition, many consumers rebelled against the HMO's limitations of the choice of physicians and hospitals to only those associated with the HMO and against the "gatekeepers" (a gatekeeper is a primary care physician or insurance company official who approved all referrals to specialists or hospitals).

In developing consumer driven health plans, health care economists and employee benefits professionals wanted to provide a health care delivery system and coverage provisions which encouraged individuals to become actively involved in making their own health care decisions, choosing their service providers, selecting health care services, and managing their own fitness and

wellness. To deliver on these goals, consumer driven health care plans contain the following elements: a high deductible health plan (HDHP), a personal account in the form of an HRA or an HSA to pay for care, and a gap between the annual amount contributed to the personal account (which the participant is responsible to pay) and an internet-based decision support system.

The main element of consumer driven health care is the employer's adoption of a high deductible plan. Under these plans, the deductible limit can be in the range of $1,000 to $3,000 and will result in immediately lower premiums for the employer. Depending on the size of the employer, they may allow employees to choose among various plan designs or give the employees the opportunity to tailor their premium cost by making personal choices about key design features (such as the amount of the deductible, the group of covered providers and the level of co-pays and coinsurance). In providing the employee's personal account, many employers partially fund the deductible, co-pays, and co-insurance amounts by the use of HRAs.

The last two elements of consumer driven health care are health information systems and wellness programs. Since under consumer driven health care, employees will be spending more of their own money, employees are given access to information through the web to allow them to make health care cost and quality comparisons. At this point, the quality of information can vary by program, and some employers have problems as to educating employees on how to use the information to choose quality health care at a reasonable price.

One of the most important and common elements of consumer driven health care programs is a wellness program. This program will help employees to stop smoking or to lose weight, or assist employees in learning to use preventive care and other techniques that ultimately reduce their health care expenses. This program will involve individual health risk assessments and provide education in areas such as nutrition, fitness or first-aid. As part of this program, employees will be given financial incentives for participating.

2. *Do Consumer Driven Health Plans Reduce Health Care Costs?*

The universe of those employers offering consumer driven health plans is still quite small, but growing. Many employers who have adopted them have done so only over the past several years. A number of recent surveys reflect this point. In 2004, just 4% of companies with at least 500 employees offered a consumer-driven plan, according to Mercer Human Resource Consulting's annual benefits survey of 3,020 employees.[107] However, one-fourth

107. Press Release, Mercer Human Resource Consulting, US Health Benefit

planned to implement the approach by 2006. A recent Aon Consulting/ISCEBS survey found that only 22% of the ISCEBS members responding to the survey were currently offering a consumer-driven health plan.[108] Of those who offered these plans, 74% began offering the plan in 2004 or 2005. In the Deloitte's 2005 Consumer-Driven Health Care Survey, "[22% of respondents (up from 19% last year and 11% in 2003) have consumer-driven health plans in place.[109] Of the employers responding to the survey, 50% had adopted the plan for the first time as of January 1, 2005. Among the remaining respondents, nearly one-half adopted the plan prior to 2004 and the other half adopted the plan sometime during 2004.

Recent surveys have found that consumer-driven health care plans provide employers with real savings. According to *The Segal Company 2004 Survey of Consumer-Driven Health Plans*, at least half of the survey respondents said that, "since introducing a [consumer-driven health plan], their overall medical trend and prescription drug costs or claims have decreased."[110] It was also reported 65% of respondents saw increases in generic substitutes for brand name drugs. Deloitte's 2005 Consumer-Driven Health Care Survey reported that 77% of respondents indicated that these plans changed employee purchasing patterns.[111] They also found that 56% of the respondents felt that the adoption of these plans resulted in an immediate cost savings for the employer, and 43% of the respondents felt that these plans will reduce the long-term health care trend. In a recent Fidelity survey, the difference in costs between consumer-driven health plans and traditional comprehensive health plans among surveyed employers projected considerably lower costs for family coverage under consumer driven health plans relative to more traditional health plan offerings in 2006, with the average coverage under a consumer driven health plan expected to cost $875 per month compared to $936 per month for a traditional health plan.[112]

Cost Rises 7.5% in 2004, Lowest Increase in Five Years (Nov. 22, 2004), *available at* http://www.mercerhr.com/pressrelease/details/jhtml/dynamic/idContent/1162645.

108. INT'L SOC'Y OF CERTIFIED EMPLOYEE BENEFITS SPECIALISTS, ISCEBS SURVEY RESULTS 4 (2005), *available at* http://www.iscebs.org/PDF/cdhcsrvy05.pdf.

109. DELOITTE, 2005 CONSUMER-DRIVEN HEALTH CARE SURVEY 2 (2005), *available at* http://www.deloitte.com/dtt/cda/doc/content/us-consulting_cdhSynopsis_04.pdf.

110. THE SEGAL COMPANY, THE SEGAL COMPANY'S 2004 SURVEY OF CONSUMER-DRIVEN HEALTH PLANS: HIGHLIGHTS 1 (2004), *available at* http://www.segalco.com/publications/surveysandstudies/spring05CDHP.pdf.

111. DELOITTE, *supra* note 109.

112. Press Release, Fidelity Investments, Fidelity Study Shows Upsurge In Consumer-Driven Health Plan Offerings For 2006 Annual Enrollment (Nov. 3,

However, cost savings for single coverage under a consumer driven health plan is expected to be less significant, with average costs projected at $302 per month, while more traditional health plans are expected to cost $319 per month. Employee contributions toward consumer driven health plan compared to traditional health plans seem to consistently correspond to employer cost differences, with the average consumer driven health plan coverage costing employees $58 per month for single coverage and $187 per month for family coverage. The average employee cost for traditional health plans is projected at $68 per month for single coverage and $204 per month for family coverage.

3. How do Participants receive Consumer Driven Health Plans once an Employer has Adopted the Program?

In a recent survey conducted by the Employee Research Institute (EBRI) and the Commonwealth Fund, it was found that only 42% of those employees with consumer driven health plans are satisfied with their insurance, far below the 63% who are pleased with traditional coverage.[113] It was also found that individuals in consumer-driven health plans are significantly more likely to avoid, skip, or delay health care because of costs compared to those in traditional health insurance plans, with problems particularly pronounced among those with health problems or incomes under $50,000. About one-third of individuals in consumer driven health plans and 31% in high deductible health plans reported delaying or avoiding care, compared with only 17% of those in traditional health plans.

The EBRI survey also found that among those people who do receive care, there is evidence that they are more cost-conscious than those in traditional comprehensive health plans. Participants in consumer driven health plans were significantly more likely to report that the terms of their health plans made them consider costs when deciding to see a doctor when sick or filling a prescription. Participants also reported that they had checked whether their health plan would cover their costs as well as the price of a service prior to receiving care, and discussed treatment options and cost of care with their doctors.

The EBRI survey also found that few plans of any type provide cost and quality information about providers to assist employees to make informed decisions about their health care.

2005), *available at* http://content.members.fidelity.com/Inside_Fidelity/fullStory/1,,6145,00.html.

113. Press Release, Employee Benefit Research Inst., New EBRI-Commonwealth Fund Research; Consumer-Directed Health Plan Participants Less Satisfied Than Those With Comprehensive Insurance, Survey Finds (Dec. 8, 2005), *available at* http://www.cmwf.org/newsroom/newsroom_show.htm?doc_id=325939.

The study also found very low levels of trust in the information provided by health plans.

As with HSAs, consumer driven health plans cannot be a solution for employers providing retiree health benefits to those former employees who are retired or will be retiring in the next few years. For these plans to work in the future, retirees must be educated on the new features and responsibilities. But, as discussed above, some employers may be forced to adopt these plans to reduce costs in the near future. Employers should take care when switching to these plans that they take time to communicate and educate this vulnerable group in understanding their new roles under the program.

C. The Expansion of Medicare to Allow pre-age 65 Retirees to Buy-in

The expansion of Medicare was first proposed by President Clinton's administration in 1999, when times were good and the government was experiencing record surpluses. President Clinton first proposed to increase health insurance coverage by first allowing certain individuals ages 62 to 64 to purchase Medicare coverage.[114] To the extent that premiums paid at those ages did not cover any of the additional benefits provided, participants would have to pay an additional premium from age 65 to 84. Next, the President proposed to allow displaced workers ages 55 to 61 to purchase Medicare coverage.

It was found by the Congressional Budget Office that because the high cost of the specified premiums and the stringency of the eligibility criteria, only 6% of people ages 62 to 64 and 0.1% of people ages 55 to 61 would be eligible to participate by 2003.[115] If the premiums were reduced or the eligibility requirements relaxed, then participation in the programs could be greater and federal costs could be much higher.

However, even with few individuals eligible for the program, the Congressional Budget Office estimated that "the Medicare buy-in for people ages 62 to 64 would raise outlays for Medicare benefits by $8.9 billion" from 1999 to 2003.[116] According to the Congressional Budget Office, "[o]f the 320,000 people who would participate in 1999, two-thirds would otherwise have purchased

114. BOB LYKE, ET AL., MEDICARE EXPANSION: PRESIDENT CLINTON'S PROPOSALS TO ALLOW COVERAGE BEFORE AGE 65 98-73 (March 31, 1998), *available at* http://digital.library.unt.edu/govdocs/crs//data/1998/upl-meta-crs-502/98-73epw_1998Mar31.pdf?PHPSESSID=4a25962f7ee9876ba2d7716f72194dbe.

115. CONGR. BUDGET OFFICE, AN ANALYSIS OF THE PRESIDENT'S BUDGETARY PROPOSALS FOR FISCAL YEAR 1999 37 (Mar. 1998), *available at* http://www.cbo.gov/ftpdocs/3xx/doc387/pb03-98.pdf.

116. *Id.* at 38.

private coverage and about 30 percent would have been uninsured. The remainder would consist of people induced to retire because of the buy-in option."[117]

In a study conducted by The Urban Institute for the Henry J. Kaiser Foundation in February 2002, researchers found that a Medicare buy-in program for individuals ages 62 to 64 would:

- induce 490,000 individuals or 37% of eligible persons to purchase Medicare;
- only modestly reduce uninsurance rates from 10% to 9% of those individuals ages 62 to 64, as most of these participants would drop non-group coverage in favor of the less expensive buy-in option if premiums were at a $300 per month level;
- reduce those with no insurance from 10% to 6% if premiums were related to income; and
- be attractive to those individuals with health problems, raising pre-enrollee costs of the program.[118]

Another reason why the Medicare buy-in proposal has not been advanced is the current state of Medicare funding and financing. According to the *Medicare Board of Trustees 2005 Trustee's Annual Report*, spending on Hospital Insurance (HI) (Medicare Part A) trust fund reserves are projected to be exhausted by the beginning of 2012.[119] The HI trust fund assets are projected to be exhausted in 2020. The Supplemental Medical Insurance (SMI) (Medicare Part B and Part D) trust fund assets are projected to be adequate because each year, beneficiary premiums and general revenue contributions are set to match expected outlays for Part B and Part D. According to the report, the trustees expect that SMI costs increase at a faster rate than the economy (as measured by growth in the Gross Domestic Product (GDP) both through 2014 and beyond). Over the long-term, the aging baby-boom generation, a decline in the number of workers per beneficiary, and increasing life expectancy will all present fiscal challenges for Medicare. According to the Kaiser Family Foundation Fact Sheet (publication 73050), from 2000 to 2030, the number of people on Medicare is projected to rise from 40 million to 78 million, while the number of workers to support beneficiaries is projected to decline from 4.0 to 2.4 workers per beneficiary.[120]

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117. *Id.*

118. RICHARD JOHNSON ET AL., KAISER FAMILY FOUNDATION, A MEDICARE BUY-IN FOR THE NEAR ELDERLY: DESIGN ISSUES AND POTENTIAL EFFECTS ON COVERAGE (Feb. 2002), *available at* http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14142.

119. KAISER FAMILY FOUNDATION, MEDICARE AT A GLANCE FACT SHEET (2005), *available at* http://kff.org/medicare/upload/1066-08.pdf.

120. *Id.*

The expansion of Medicare to provide a buy-in for those retirees ages 62 to 64 could be a real short-term solution, but for the cost of such expansion. As more employers drop retiree health coverage and/or reduce their workforce, there will be pressure to provide some kind of health coverage to those displaced workers. With budget deficits, the war in Iraq, and the rebuilding costs from Hurricane Katrina, any additional funds from the federal government will not be available.

D. The Adoption of Universal Health Care System for all Citizens of the United States

The American health care system is a hybrid with 60% of health care publicly financed but most health care privately delivered, according to S. Woolhandler and S. Himmelstein in the article *Paying for National Health Insurance and Not Getting It*.[121] Private employers are covering only 43% of all Americans and pay less than one-fifth of the total health care spending, according to Carraquillo, D. Himmelstein, S. Woolhandler and A. Bor, in *A Reappraisal of Private Employers Role in Providing Health Insurance*.[122] In all, 34% of all Americans have government-paid insurance, 7% own their own coverage, and 16% are uninsured. Americans pay the highest health care taxes in the world despite having the smallest percentage of the population covered by government assured coverage in most developed countries.[123]

Among the countries in the Organization for Economic Cooperation and Development (OECD) that provide for universal coverage, the United States spends:

- considerably more on health care than any other OECD country, according to U. Reinhart, P. Hussey and G. Anderson, in *U.S Health Care Spending in the International Context*,[124] and
- the highest proportion of gross domestic product on health care, according to G. Anderson, P. Hussey, B. Frowner and H. Waters, in the article *Health Spending in the United States in the Rest of the Industrialized World*.[125]

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121. Steffie Woolhandler & David U. Himmelstein, *Paying for National Health Insurance and Not Getting It*, 21(4) HEALTH AFF. 88 (2002).

122. O. Carraquillo, D. Himmelstein, S. Woolhandler and A. Bor, *A Reappraisal of Private Employers Role in Providing Health Insurance*, 340 NEW ENG. J. MED. 109 (1999).

123. *Id.*

124. Uwe E. Reinhart, Peter S. Hussey & G. Anderson, *U.S Health Care Spending in the International Context*, 23(3) HEALTH AFF. 10 (2004).

125. Gerard F. Anderson, Peter S. Hussey, Bianca K. Frowner & Hugh R. Waters, *Health Spending in the United States in the Rest of the Industrialized World*, 24 HEALTH AFF. 903 (2005).

In addition, Americans pay higher prices for health care-related services than citizens of other countries, and U.S. physicians spend more time on administrative tasks, according to S. Woolhandler in the article *Health Care Administration in the United States and Canada: Micromanagement, Macro Costs*.[126]

In 2003, Representative John Conyers of Michigan introduced HR 676, The United States National Health Insurance Act.[127] Under HR 676, Medicare would be extended and improved so all individuals residing in the United States would receive care and affordable health services.[128] Under this program, participants would receive a national health insurance card and receive all medically necessary services by physicians of their choice, with no restrictions on what providers they could visit. Services provided would include primary care, dental, mental health, prescription drugs, and long-term care.

Under this program, all employers would pay a 3.3% payroll tax, while eliminating their payments towards private health plans. According to Representative Conyers, it is expected that the United States National Health Insurance Act will reduce overall annual health care spending by $109 billion (the average cost to an employer for an employee earning $35,000 per year will be reduced to less than $100 a month and a family who pays $5,000 to $7,000 a year in health insurance will pay less than $50 a month).[129] Total household expenditures would drop from $326.7 billion to $65.9 billion annually.

So far, the United States National Health Insurance Act remains in a House Committee and because of the current political climate in the United States, the adoption of a national single payer universal health care system is unlikely. Over the last several years, there are a number of states that have considered universal health care initiatives, including:

- CALIFORNIA: A single payer bill SB 840, passed the California Senate and passed the State Assembly Health Committee.[130] The bill will be reconsidered when the State Assembly reconvenes in 2006.

126. Steffie Woolhandler, Terry Campbell, & David Himmelstein, *Health Care Administration in the United States and Canada: Micromanagement, Macro Costs*, 31 INT'L J. OF HEALTH SERVICES 65 (2004).

127. H.R. 676, 108th Cong. (2003).

128. *Id.*

129. PHYSICIANS FOR A NAT'L HEALTH PROGRAM BALTIMORE CITY COUNCIL ENDORSES HR 676 SINGLE PAYER HEALTHCARE (Mar. 17, 2005), *available at* http://www.pnhp.org/news/2005/march/baltimore_city_counc.php.

130. *See* HealthCareForAll.org, A Background History of SB 840, http://www.healthcareforall.org/background_history.html (last visited Apr. 6, 2006) (laying out a timeline of the bill's history).

- ILLINOIS: The Health Care Justice Act of 2004 created a commission that would make recommendations for implanting universal health care in Illinois.[131]
- MASSACHUSETTS: All citizens of the state are required to buy health insurance by July 1, 2007. Their choices for coverage will be expanded to include a range of new and inexpensive policies- ranging form about $250 per month to nearly free-from private insurers subsided by the state. It was signed in to law April 13, 2006. If individuals do not buy insurance, the state will fine them by taking away their personal state exemption, now worth $150 for the first year and half the monthly premium of an affordable plan of the second year. There are no criminal penalties for not buying insurance. In addition, employers with 11 or more employees will be required to provide health coverage pay a per-employee annual fee of $295. Employers who uninsured workers make multiple use for emergency room care would have to pay between 10% and 100% of the portion of these medical bills exceeding $50,000.[132]
- MARYLAND: The Maryland Health Care for All Coalition is putting forth a new resolution to rise the state tobacco tax by $1 per pack in order to fund an expansion of the HealthChoice program.[133] The state legislature overrode the governor's veto of a bill that would require all Maryland employers who employ more than 10,000 employees to devote 8% of their budgets to employee health care.
- MAINE: In recent months, there has been a heated fight to protect the finances of Dirigo, Maine's health insurance plan for the self-employed, retired and small businesses.
- NEW MEXICO: The New Mexico Health Security Act would establish a single-payer system.[134]
- NEW YORK: The New York City, City Council passed the New York City Health Care Security Act of 2005. It would require medium and large grocers to provide certain levels of health care to employees.[135]
- PENNSYLVANIA: The Pennsylvania Balanced and Comprehensive Health Reform Act of 2005 was

131. Health Care Justice Act, H.B. 2268, 93rd Gen. Assem. (Ill. 2004) (enacted).

132 MASS. ANN. LAWS ch. 58 (LexisNexis 2006).

133. H.B. 441, 2006 Leg., 421st Sess. (Md. 2006).

134. Health Security Act, H.B. 746, 47th Leg., First Sess. (N.M. 2005).

135. N.Y., N.Y., Law No. 2005/89, Int. No. 468-A (Aug. 15, 2005).

introduced. It creates a single-payer bill that also contains medical malpractice reform.[136]

- WISCONSIN: The Wisconsin AFL-CIO has proposed a plan (the Wisconsin Health Care Plan) to insure health care access that will be financed primarily by a per-worker assessment on employers.[137]

Before considering a single-payer universal health care program nationally, numerous models should be tested and studied in the states. Only through this testing can the best provisions and procedures be discovered and implemented. Time is growing short, and as the number of uninsureds grow, there will be increasing pressure to adopt a single-payer universal health program to cure all the ills in the current health care system. However, before such a system is adopted, one must ask whether it would serve the needs of a large and complex society. Will the adoption of such a system cure the problem of escalating health care costs or would it merely hide it from public view?

E. The Allowance of Employers to Form and Join "Association Health Plans" (AHPs)

As part of his State of the Union address, President Bush urged Congress to pass legislation to allow small businesses to form association health plans ("AHP") in order to help small employers compete with larger ones and to expend AHPs so that civic, community, and religious groups could offer health coverage to their members.[138]

The Small Business Health Fairness Act of 2005[139] ("Act") would amend the Employee Retirement Income Security Act of 1974 ("ERISA")[140] in allowing small businesses to join together to purchase insurance in AHPs. AHPs are group health plans whose sponsors are trade, industry, professional chambers of commerce, or similar business associations. Through preemption of state laws under ERISA, AHPs would be exempt, with certain exceptions from state regulation of health insurance laws, including state consumer protection laws.

The Act passed the House in March 2005, but has been stalled in the Senate. AHP legislation has passed the House five

136. H.R. 1085, 2006 Gen. Assem. (Pa. 2006).

137. Wisconsin State AFL-CIO, The Wisconsin Health Care Plan (June 16, 2005), *available at* http://www.wisaflcio.org/features/Wis%20Health%20Care%20Proposal.htm.

138. President's Address Before a Joint Session of the Congress on the State of the Union, 41 WEEKLY COMP. PRES. DOC. 127 (Feb. 2, 2005).

139. H.R. 525, 109th Cong. (2005).

140. Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 et seq. (2000).

times since 1997. A version of the Act is expected to be voted on by the Senate in May 2006.[141]

According to the National Federation of Independent Business and the U.S. Chamber of Commerce, as reported in the *Pension and Benefits Reporter*, August 2, 2005 edition, this Act, by allowing associations to be federally regulated under ERISA, would result in a uniform oversight system and lower health insurance costs for small firms, thereby lowering the number of uninsureds.[142] It is also reported that the Act would cut the number of uninsured Americans by 8 million.

The House Committee on Education and The Workforce Democratic Staff stated in a report that they oppose the Act because it would undermine state insurance laws and segment insurance markets, leaving older and unhealthy small groups stuck with higher priced health insurance as healthier groups leave state-regulated insurance markets to buy cheaper coverage through AHPs.[143] The Committee further provides that the Act would lead to the reduction of health coverage for 7 million Americans who will lose the right to vital medical coverage, such as OB/GYN and pediatrician services, cervical, colon, mammography, prostate cancer screening and treatment, maternity, well-care child services, and diabetes treatment.

If the concerns of the Democratic members of Congress can be addressed, the adoption of AHPs can be a short-term solution for both reducing the number of uninsureds and health care costs. More and more small businesses are dropping coverage for active and retired employees because of increasing costs. According to the *Kaiser Foundation and Health Insurance Educational Trust Employer Health Benefits 2005 Annual Survey*, three in five firms (60%) offered coverage to workers in 2005, down significantly from 69% in 2000 and 66% in 2003.[144] This drop stems almost entirely from fewer small businesses offering health benefits, as nearly all businesses (98%) with 200 or more workers offer such benefits. What would become of additional assistance if former employees could continue under these plans after either retirement or termination of employment?

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141. S. 406, 109th Cong. (2006); Tiana Velez, *Small-Business Insurance Groups Likely After Seven Flops, Senate on Verge of Acceptance,* ARIZ. DAILY STAR, April 3, 2006.

142. *National Federation of Independent Business and the U.S. Chamber of Commerce*, PENSION AND BENEFITS REPORTER, Aug. 2, 2005. *See also* Auto Facts, House Passes AAIA-Supported AHP Bill, http://www.aftermarket.org/wholesale/Auto_Facts/AutoFacts_072805.htm (last visited April 6, 2006).

143. DEMOCRATIC STAFF OF H. COMM. ON EDUCATION AND THE WORKFORCE, 109th Cong., SMALL BUSINESS HEALTH FAIRNESS ACT OF 2005 (Comm. Print 2005).

144. KAISER/HRET, *supra* note 1.

V. FINAL THOUGHTS

The next several years will be a crucial time in determining the future of employer provided retiree health benefits. If health care costs are not controlled, more and more employers will be forced to do away with these benefits. What factors are causing these increases in health care costs for active and retired employee?

According to a study entitled *The Factors Fueling Rising Healthcare Costs*, prepared by PricewaterhouseCoopers for America's Health Insurance Plans in January 2006, three broad components make up premium increases for 2005.[145] They include:

- general inflation;
- health care price increases in excess of inflation, and
- increases in utilization.[146]

Health care price increases in excess of inflation make up almost 30% of the total premium increases. The major factors that drive these price increases include the movement to broad-access plans, higher-priced technologies, and cost-shifting from Medicaid and the uninsured to private-payers. The cost of providing care to the uninsured is estimated to add as much as 8.5% to the cost of premiums.

Increased utilization makes up over 43% of the total premium increases. The major factors that drive utilization are increased consumer demand, new treatments and more intensive diagnostic testing. The aging population and lifestyle changes also contribute to increased utilization. It is estimated that the aging of the population in health plans alone contributed to 5% of the premium increases in 2005. Lifestyle challenges including obesity, smoking, drug abuse, and physical inactivity, have contributed to 3% of the increases. New treatments include new imaging technologies, biologics, injectables for existing serious illness as well as "lifestyle" drugs for conditions that were once not considered illnesses. These new treatments made up over 11% of the premium increases in 2005. It is estimated that more intensive diagnostic testing contributed to over 9% of premium increases. The increase in consumer demand is fueled by factors including the proliferation of information on medical treatments and demand-pull strategies such as direct-to-consumer advertising. Increased consumer demand accounted for almost 14% of the premium increases in 2005.

Nothing that is being currently proposed will cause these increases to immediately disappear. As reported by the 2005

145. PricewaterhousesCoopers, The Factors Fueling Rising Healthcare Costs 5 (2006), *available at* http://www.mahp.org/Policy/Commercial%20Health %20Plans/2006/AHIP %20Cost%20Drivers—Power%20Point.pdf

146. *Id.*

Kaiser/HRET Annual Employer Health Benefits Survey, the rate of premiums increase has slowed over the last several years (from 13.9% in 2003, 11.2% in 2004 to 9.2% in 2005).[147] Consumer driven health care HSAs and HRAs are a good start in providing more flexibility in providing medical benefits and cutting costs, but they will not provide any immediate relief for employers who want to continue providing future retiree medical benefits. Both state and federal governments must provide more incentives to employers to adopt and maintain health coverage for both active and retired employees until health costs are brought under control. The Medicare Part D subsidy is only an important first step in this process. In addition, employers should be given incentives to adopt new health plans for both active and retired employees.

Once health care costs are brought under control, then the long-term future of health care can be debated. The final goal of this debate should be to find a way to cover as many Americans with health benefits as possible with the least amount of administrative costs. To accomplish this goal, there are many possible solutions. It could be a combination of employer-provided and government-provided programs. This includes the use of most of the solutions discussed in combination. It must be remembered that the use of one solution cannot solve the majority of problems in our health care system.

147. DEMOCRATIC STAFF OF H. COMM. ON EDUCATION AND THE WORKFORCE, *supra* note 143.