

THE BELL IS TOLLING: RETIREE HEALTH BENEFITS POST-HEALTH REFORM

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Millions of retirees rely each year on employment-based health insurance to pay for medical expenses not covered by Medicare. Employment-based health insurance is often the only reasonable means by which early retirees can obtain health insurance coverage because of the exorbitant costs associated with purchasing individual insurance. As the costs of providing health insurance and medical care have skyrocketed, fewer and fewer employers continue to provide retiree health insurance coverage to their employees, and those that do shift much of the cost to the retirees themselves. Within this context Professor Cancelosi examines the future of employment-based retiree health benefits in the wake of the changes to the United States health care system encompassed by the Patient Protection and Affordable Care Act of 2010. She concludes that, although the Act may indeed hasten the erosion of employment-based retiree health plans, the Act's expanded Medicare coverage and increased access to insurance provide hope that in the future retirees will be able to obtain quality, affordable health care under the new system.

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I. Introduction

While health reform may ring in a new era of coverage for America's uninsured, that same bell likely heralds the end of employment-based health benefits for almost fifteen million retirees. When the Patient Protection and Affordable Care Act¹ (Affordable Care Act) and the Health Care and Education Reconciliation Act of 2010² (Reconciliation Act) (together, "the Act") passed in late March 2010, the country took a major step toward expanding access to affordable health care for an estimated forty-plus million uninsured. Since then, attention has swirled primarily around provisions targeting that uninsured population. The legislation, however, contains well over 1000 pages of new rules with the potential to reshape virtually every facet of the U.S. health care system, including existing employer-sponsored health plans for both active workers and retirees. This Article looks at the current state of retiree health insurance in the United States and provides an early assessment of the Act's impact on those benefits.³

Although exact numbers are unknown, employment-based retiree health plans provided primary coverage to an estimated 3.8 million early retirees and dependents in 2005⁴ and supplemental coverage to approximately twelve million Medicare beneficiaries in 2006.⁵ Structurally quite different, both early and Medicare-eligible retiree plans represent long-term commitments by employers that often prove far more expensive to maintain than anticipated.⁶ Both types of

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

2. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

3. Elections in November 2010 returned control of the U.S. House of Representatives to the G.O.P. and placed Republican governors in control of a number of States. A rallying cry for many of these individuals has been repeal of the Act. See, e.g., Jennifer Steinhauer & Robert Pear, *G.O.P. Newcomers Set Out to Undo Obama Victories*, N.Y. TIMES, Jan. 3, 2011, at A1. Although complete repeal is unlikely in the near term with control of the U.S. Senate still in Democratic hands and a Democratic president, the long-term future of the Act is hard to predict. This Article focuses on the provisions of the Act as originally passed, with the caveat that everything could change if political winds blow further to the right over the next few years.

4. See *infra* note 25 and accompanying text.

5. See *infra* note 31 and accompanying text.

6. See *infra* notes 69-73 and accompanying text.

retiree health plans also have served historically as a critical source of health insurance for groups of individuals who are inherently older and less healthy than the population at large.⁷ For early retirees—typically those at least age fifty-five but not yet Medicare-eligible—employment-based retiree health plans have long provided virtually the only way to obtain affordable health insurance.⁸ For Medicare-eligible retirees, employment-based retiree health benefits have consistently plugged many of the glaring coverage gaps in a safety net program riddled with holes.⁹

Despite their importance to covered individuals, retiree health benefits have sharply declined over the past two decades.¹⁰ Struggling to handle rapidly escalating health care costs and preserve active employee insurance, employers often have chosen to terminate retiree coverage.¹¹ Employers who have retained retiree benefits have tried to manage costs in part by shifting expenses to the retirees themselves through increased premiums, deductibles, co-payments, and coinsurance.¹² Over time, retiree health insurance has come to seem almost a relic of an earlier era when compensation packages were generous and long-term employment relationships were commonplace.

The Act affects so much of the U.S. health care system that no one knows exactly how health insurance will look in a decade's time. Some new rules seem guaranteed to increase short-term employer costs even as overall cost control measures take effect.¹³ An employer pay-or-play mandate scheduled to take effect in 2014 will force all but the smallest employers to contribute in some way toward the cost of health insurance for their employees.¹⁴ The question, then, is what will become of retiree health benefits in this shifting landscape. At the outset, the Act strives to prop up plans for early retirees with a direct subsidy to employers, reflecting the dire situation that currently faces an older individual who has left the workforce and loses health coverage.¹⁵ Yet, what Congress gives, Congress takes away. While propping up early retiree plans for at least a year or two, the Act removes

7. See *infra* notes 101–02, 111, 123 and accompanying text.

8. See *infra* notes 118–20 and accompanying text.

9. See *infra* notes 123–34 and accompanying text.

10. See *infra* notes 65–66 and accompanying text.

11. See *infra* notes 69–73 and accompanying text.

12. See *infra* notes 40–44 and accompanying text.

13. See *infra* notes 230–37 and accompanying text.

14. See *infra* notes 185–92 and accompanying text.

15. See *infra* notes 262–73 and accompanying text.

an earlier prop for Medicare-eligible retiree plans by eliminating a key employer tax preference for retiree drug benefits.¹⁶ At the same time, the Act expands Medicare coverage and should eventually create new alternatives for early retirees as well, removing key reasons for retirees to see employer-sponsored plans as critical.

Taken altogether, the Act's provisions seem likely to erode what remains of retiree health insurance benefits. This Article provides context for this prediction. Part II reviews the extent of current retiree plan coverage; Part III explains how retiree plans are structured, why they are expensive, and ongoing issues for both employers and retirees; Part IV surveys the Act's impact on employment-sponsored health benefits generally; and Part V discusses those parts of the Act with both direct and indirect effects on the short- and long-term future of retiree health plans. The Article concludes that the Act's changes may suffice to soften the impact on affected retirees but urges realistic planning toward a future without employment-based retiree health benefits.

II. Current State of Retiree Health Plan Coverage

A. Health Insurance for Early Retirees

Out of an estimated total U.S. population of about 301.2 million individuals in 2008, about 32.7 million—or slightly less than eleven percent—fell between the ages of fifty-five and sixty-four.¹⁷ As a general matter, this age segment tends to be insured at a high rate. In 2007, for example, fully eighty-eight percent of persons in this age range reported some type of health insurance coverage, with almost seventy percent reporting coverage from an employment-based health plan.¹⁸ Almost ten percent of this age group purchased individual

16. See *infra* notes 308–11 and accompanying text.

17. *American Community Survey Demographic and Housing Estimates: 2006–2008*, U.S. CENSUS BUREAU, http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=01000US&-qr_name=ACS_2008_3YR_G00_DP3YR5&-ds_name=ACS_2008_3YR_G00_-lang=en&-sse=on (last visited Apr. 23, 2011). Specifically, the Census Bureau estimated that, out of 301,237,703 individuals total, there were 18,210,745 persons age fifty-five to fifty-nine and 14,471,277 persons age sixty to sixty-four. *Id.* Those numbers translate to approximately 10.8% of the population in 2008 falling between ages fifty-five and sixty-four.

18. Paul Fronstin, *Health Insurance Coverage of Individuals Ages 55–64, 1994–2007*, EMP. BENEFIT RES. INST. NOTES, Aug. 2009, at 2, 2, available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_08-Aug09.InsCvgNr-Eldly1.pdf. The same study determined that only children under age eighteen had a lower rate of uninsurance in 2007 (eleven percent uninsured for children as com-

coverage in 2007, and roughly twenty percent qualified for public health insurance coverage through Medicare, Medicaid, or military programs such as TRICARE.¹⁹ The high coverage rate likely reflects the fact that the majority of individuals in this age segment are either still employed or seeking employment.²⁰ A 2010 Employee Benefit Research Institute (EBRI) analysis of 2007 data indentified only 3.5 million “retired” individuals in the fifty-five to sixty-four age group.²¹

It is difficult, if not impossible, to know precisely how many of those not considered part of the labor force for purposes of employment statistics should be considered actually “retired” for purposes of determining retiree health insurance coverage.²² Some individuals may never have worked and thus never “retire.” Others may not report themselves as “retired” even though they might not be currently

pared to twelve percent uninsured for adults age fifty-five to sixty-four). *Id.* at fig.1. Of the 67.8% of age fifty-five to sixty-four adults with employment-based health coverage, 49.9% received that coverage based on their own employment; 17.9% qualified as a dependent (most likely as a spouse). *Id.* Medicare provides health care to the elderly and disabled under Title XVIII (“Health Insurance for Aged and Disabled”) of the Social Security Act. 42 U.S.C. §§ 1395–1395ccc (2006). Medicaid provides health and related care to certain categories of low-income individuals under Title XIX (“Grants to States for Medical Assistance Programs”) of the Social Security Act. 42 U.S.C. §§ 1396-1 to 1396v. TRICARE is the U.S. Department of Defense’s health insurance program for military retirees and their families. 10 U.S.C. §§ 1071–1110 *et seq* (2006). Individuals with military service may also be eligible for retiree health benefits through the U.S. Department of Veterans Affairs. 38 U.S.C. §§ 1701–1786 (2006).

19. See Fronstin, *supra* note 18, at 5 fig.3. In 2007, 9.7% of individuals age fifty-five through sixty-four reported purchasing individual coverage, 9.5% reported Medicare coverage (presumably due to disability), 7.4% reported Medicaid coverage (likely again to be due to disability), and 6.2% reported coverage under a military program. *Id.*

20. The U.S. Bureau of Labor Statistics reported a civilian non-institutional population of approximately 32,533,000 individuals age fifty-five to sixty-four for 2007, with approximately 11,783,000 persons (36.2%) reporting as “not in labor force” (i.e., neither employed nor seeking employment). *Labor Force Statistics from the Current Population Survey*, BUREAU OF LAB. STAT., <http://www.bls.gov/cps/demographics.htm#older> (data extracted using BLS historical database search) (last visited Apr. 11, 2011). The Employee Benefit Research Institute (EBRI) estimated 68.4% of the same age group in 2007 as “working.” Fronstin, *supra* note 18, at 6 fig.4.

21. Paul Fronstin, *The Early Retiree Reinsurance Program: \$5 Billion Will Last About Two Years*, EMP. BENEFIT RES. INST. NOTES, July 2010, at 2, 9, available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_07-July10.TDFs_Reins.pdf.

Another 3.1 million individuals in the same age group were identified as not working due to illness or disability but not necessarily as “retired.” *Id.*

22. See generally William J. Wiatrowski, *Retiree Health Care Benefits: Data Collection Issues*, BUREAU OF LAB. STAT. (July 29, 2003), <http://www.bls.gov/opub/cwc/cm20030711ar01p1.htm> (offering a discussion of some of the issues that arise in collecting data on retiree health benefits).

employed or seeking employment. Moreover, what qualifies as “retired” for purposes of health insurance plan eligibility will depend on the definition of “retirement” in a particular plan, usually taking into account both age and service with the employer, but those subtleties are likely lost in large-scale surveys of retiree health plan coverage. Statistics may be further complicated by the fact that some retirees covered by health insurance through a former employer obtain such coverage under an active employee plan as a result of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985²³ (COBRA).²⁴ Although those retirees count as having health insurance through a former employer, the employer may not maintain a true retiree health plan that provides coverage specifically for those who have terminated active employment due to retirement. Not surprisingly then, statistics in this area yield disparate coverage estimates, ranging from about 2.3 million retirees with employment-based health benefits in 2005 to around 2.7 million in 2007.²⁵

23. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (codified in scattered sections of the U.S. Code). *See infra* text accompanying notes 113-14.

24. *See Fronstin, supra* note 18, at 6 (“For those covered by a former employer or union, it is not possible to distinguish between retiree health benefits and COBRA . . . coverage. Presumably, given the trends in retiree health benefits . . . , the percentage covered by retiree health benefits has fallen and may have been offset by an increase in the percentage of retirees taking COBRA, but this cannot be determined from the data.”).

25. A 2009 EBRI analysis of health insurance for individuals in the fifty-five to sixty-four age group in 2007 identified 4.8 million “retirees” in that age range, fifty-six percent—or about 2.7 million—of whom were covered by employment-based health insurance. *See Fronstin, supra* note 18, at 8 fig.6. The 2009 study did not attempt to distinguish whether some of those 2.7 million were covered by COBRA as opposed to a retiree health plan. For 2005, EBRI’s review found the same statistics for employment-based coverage, although other types of coverage varied. *See id.* A different study of retiree health insurance for 2005 concluded that approximately 2.3 million retirees age fifty-five to sixty-four received coverage through their prior employer—with dependents added, this totaled 3.8 million early retirees and dependents with retiree health benefits through a former employer. KAISER FAMILY FOUND. & HEWITT ASSOC., RETIREE HEALTH BENEFITS EXAMINED: FINDINGS FROM THE KAISER/HEWITT 2006 SURVEY ON RETIREE HEALTH BENEFITS 40 n.1 (2006) (citing Kaiser Commission on Medicaid and the Uninsured and Urban Institute Analysis of the March 2006 Current Population Survey, 2006), available at <http://www.kff.org/medicare/upload/7587.pdf>. A 2010 EBRI study concluded that 1.3 million persons in 2007, including both retirees and their dependents, were eligible for early retiree health insurance and not Medicare in that year. *See Fronstin, supra* note 21, at 9. The varying numbers between these studies reflect not only different years but also different underlying data sets. For example, the 2009 EBRI analysis used data from the U.S. Census Bureau’s March 2008 Current Population Survey to arrive at its estimate of 2.7 million in 2007 covered by employment-based health insurance. *See Fronstin, supra* note 18, at 1, 8 fig.6.

B. Health Insurance for Medicare-Eligible Retirees

The U.S. Census Bureau estimated for 2008 that slightly fewer than thirty-eight million individuals—or about 12.6% of the population—had reached age sixty-five or older.²⁶ Medicare provides health insurance to the vast majority of that age group—more than ninety-three percent.²⁷ In addition to Medicare, about 20.5 million—or 54.3%—maintained some form of private health insurance.²⁸ For 13.2 million, or about thirty-five percent, the private health insurance was employment based.²⁹ The Census Bureau's numbers do not differentiate between employment-based health insurance obtained by a Medicare-eligible person through a retiree health plan and such insurance obtained by a Medicare-eligible person because he or she has not yet retired from active employment.³⁰ As with early retiree health plan

On the other hand, the 2010 EBRI analysis evaluated data from the 2007 Medical Expenditure Panel Survey and the 2004 panel of the Survey of Income and Program Participation to reach its 1.3 million covered by early retiree health plans and not Medicare. See Fronstin, *supra* note 21, at 9.

26. Specifically, the Census Bureau put the number at 37,980,136 individuals age sixty-five or older. See U.S. CENSUS BUREAU, *supra* note 17.

27. Specifically, approximately 35.3 million of those age sixty-five or older in 2008 were covered by Medicare. Bureau of Labor Statistics & U.S. Census Bureau, *Table H105. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2008*, U.S. CENSUS BUREAU (2009), http://www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm.

28. *Id.* For purposes of the Current Population Survey, private health insurance means “a plan provided through an employer or a union or purchased by an individual from a private company.” CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008, at 20 (2009), available at <http://www.census.gov/prod/2009pubs/p60-236.pdf>. Private health insurance also includes coverage through the military under TRICARE or other similar programs. JOANNA TURNER ET AL., A PRELIMINARY EVALUATION OF HEALTH INSURANCE COVERAGE IN THE 2008 AMERICAN COMMUNITY SURVEY 5 (2009), available at http://www.census.gov/hhes/www/hlthins/data/acs/2008/2008ACS_healthins.pdf.

29. See Bureau of Labor Statistics & U.S. Census Bureau, *supra* note 27. Individuals may participate in employment-based retiree health insurance through their own former employer (about ten million in 2008) or through a family member's employer (about 3.2 million in 2008). See *id.* Aside from employment-based supplemental insurance, about 3.4 million so-called “dual eligibles”—about 8.9% of the total population age sixty-five or older—received coverage from both Medicaid and Medicare, and approximately 2.8 million—or seventy-five percent—qualified for military health coverage. *Id.*

30. It is also possible that some individuals counted in the Census Bureau's numbers of Medicare-eligible beneficiaries with private employment-based health insurance could have elected COBRA. This possible skewing of the numbers seems less likely with Medicare-eligible retirees, however, than with early retirees because of the high cost of COBRA. Most Medicare-eligible retirees would find a private Medicare supplement plan (usually referred to as “Medigap” insurance) a better financial option than electing COBRA.

coverage, estimates of how many Medicare-eligible beneficiaries enjoy employment-based retiree health benefits vary, but most fall in the twelve-plus million range.³¹ When early and Medicare-eligible retirees are considered together, around fourteen to fifteen million persons—or about five percent of the U.S. population—are likely covered by some form of employment-based retiree health benefits.

III. Retiree Health Plan Structure, Costs, and Impact

Employers that offer any form of retiree health insurance overwhelmingly provide the benefits to both early retirees and Medicare-eligible retirees.³² The plans are conceptually different, however, due to the presence of Medicare³³ for those age sixty-five and older.³⁴

31. An EBRI study estimated that approximately twenty-one percent of Medicare-eligible beneficiaries in 2005 had supplemental retiree health benefits from a former employer. See Paul Fronstin et al., *Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement: Findings from a Simulation Model*, EMP. BENEFIT RES. INST. ISSUE BRIEF, May 2008, at 1, 20, available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_05-20081.pdf. The EBRI estimate was significantly higher than other studies. For example, in 2006, HHS stated that approximately twelve million retirees were believed to have supplemental Medicare coverage through a retiree medical plan, with another two million Medicare-eligible beneficiaries receiving benefits through active employee coverage. KAISER & HEWITT, *supra* note 25, at 1 (citing Press Release, U.S. DEP'T HEALTH & HUMAN SERVS., Over 38 Million People with Medicare Now Receiving Prescription Drug Coverage (June 14, 2006)). The Centers for Medicare & Medicaid Services (CMS) in 2006 estimated that 12.4 million Medicare beneficiaries had some kind of employment-based health insurance, of whom 7.2 million received such benefits through a private employer (as opposed to a public employer such as the federal government or a state or local government entity). *Id.* at 40 n.9 (citing CMS Staff Communication, Nov. 2006).

32. A 2006 survey of large private employers (those with 1000 or more employees) found that, of those that offered retiree health benefits, eighty-five percent provided such benefits to both early retirees and Medicare-eligible retirees. KAISER & HEWITT, *supra* note 25, at 4 exhibit 1. Only fourteen percent of surveyed employers provided retiree health insurance solely to pre-sixty-five retirees, and a tiny one percent provided retiree health insurance only to Medicare-eligible retirees. *Id.*

33. See, e.g., Greta E. Cowart, *Benefits in a Challenging Economy - The Legacy Cost of Retiree Medical Benefits*, 14 ALI-ABA 147, 153 (Sept. 10-12, 2009) ("Although most retiree medical plans cover both Medicare-eligible retirees and retirees who are not yet eligible for Medicare, often the retiree medical plans provide different levels of benefits for the two classes of employees, since Medicare can be the primary payer of benefits for Medicare eligible individuals if certain conditions are met.").

34. Although Medicare coverage is primarily available only to those who are at least sixty-five, disabled individuals may also qualify for Medicare. 42 U.S.C. § 1395c (2006). For purposes of simplification in this Article, I am focusing on retirees who become Medicare-eligible at age sixty-five and largely disregarding those who become Medicare-eligible at an earlier age due to disability.

A. Health Insurance for Early Retirees

Early retiree health insurance typically provides primary coverage for participants,³⁵ meaning that the employer health plan pays before any supplemental coverage. Plans for early retirees usually mimic active employee health insurance in terms of coverage.³⁶ Indeed, from the retiree's perspective, early retiree health insurance may feel indistinguishable from the coverage enjoyed during active employment. The cost, however, is not the same as active employee coverage. Older individuals incur greater health care costs than younger persons.³⁷ From an employer's perspective, this translates to increased premiums for the retiree coverage. For example, in 2006, a study of large-employer retiree health plans found that the average premium cost (including both employer and retiree contributions) for retiree-only coverage was \$552 per month,³⁸ compared with \$52 per month for individual-only coverage for active workers in employer-sponsored plans generally.³⁹

An employer may choose to price a retiree plan as part of an overall health plan that includes both actives and retirees. Including the retirees in the risk pool drives up costs overall, leading to increased premiums for everyone and causing active employees to bear some of the financial burden of the retiree health benefits. At the same time, spreading the increased risk of the older individuals over a larger pool that includes younger and presumably healthier active

35. KAISER & HEWITT, *supra* note 25, at 15. See also Cowart, *supra* note 33, at 153 ("Before a covered individual reaches the age of sixty-five, thus becoming eligible for Medicare benefits, the benefits under the retiree medical plan will generally be the covered individual's primary source of healthcare coverage.").

36. See, e.g., U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-355, EMPLOYER-SPONSORED HEALTH AND RETIREMENT BENEFITS: EFFORTS TO CONTROL EMPLOYER COSTS AND THE IMPLICATIONS FOR WORKERS 6 n.5 (2007) ("Employer-sponsored coverage for early retirees often mirrors coverage for current workers.").

37. For example, in 2004, personal health care expenditures on a per capita basis totaled \$7787 for those age fifty-five to sixty-four, \$10,778 for those age sixty-five to seventy-four, \$16,389 for those age seventy-five to eighty-four, and \$25,691 for those age eighty-five and older. CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH STATISTICS GROUP, TOTAL PERSONAL HEALTH CARE PER CAPITA SPENDING, BY AGE GROUP, CALENDAR YEARS, 1987, 1996, 1999, 2002, 2004, available at <http://www.cms.gov/NationalHealthExpendData/downloads/2004-age-tables.pdf>. By contrast, per capita expenditures in 2004 totaled to only \$3370 for those age nineteen to forty-four and \$5210 for those age forty-five to fifty-four. *Id.*

38. KAISER & HEWITT, *supra* note 25, at 15.

39. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, SURVEY OF EMPLOYER HEALTH BENEFITS 2006 chart 5 (2006) [hereinafter KAISER/HRET 2006 SURVEY], available at <http://www.kff.org/insurance/7527/upload/7561.pdf>.

employees lowers the average cost of the retiree coverage. By contrast, if an employer prices retiree coverage separately, not only is the risk pool smaller, but the per capita costs for that group are likely to be much higher, leading to increased retiree premiums. Unfortunately, because health care costs have been rising relentlessly for decades, employers are struggling already to manage expenses for active worker health insurance without pushing too much of the cost onto those active employees.⁴⁰ Lessening the burden on retirees by increasing the cost for active employees thus may not be an appealing solution under the circumstances.

Regardless of how the premium costs are determined, employers who offer coverage to early retirees shift much of the expense to the covered persons. Thus, in 2006, the average retiree share of the premium for retiree-only coverage was \$227 per month—about forty-one percent of the total premium cost—for early retirees.⁴¹ In that same year, seventeen percent of surveyed large employers (those with 200 or more employees) reported that they require new early retirees to pay 100% of the premium cost for retiree coverage.⁴² Such plans—where the entire premium expense is shifted to retirees—are usually referred to as “access-only” plans, meaning they do guarantee early retirees the ability to obtain health insurance coverage at group health rates (without the risk of denial due to preexisting conditions) but offer little more.⁴³

40. See, e.g., U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 36, at 8–11, 18–22 (highlighting various tactics employers have used to limit costs over time, including managed care in the late 1980s, voluntary wellness programs, consumer-directed health plans in recent years, and the introduction of so-called “mini-medical plans” that provide more limited coverage than traditional employment-based health plans). The GAO report noted that, despite the long-term trend of cost-shifting to employees, “some benefits representatives have indicated that this trend may change due to employers’ concerns about workers’ willingness to absorb more costs.” *Id.* at 19.

41. KAISER & HEWITT, *supra* note 25, at 15. By contrast, active employees for that year contributed on average about sixteen percent of the total premium cost. KAISER/HRET 2006 SURVEY, *supra* note 39, at chart 5.

42. KAISER & HEWITT, *supra* note 25, at 15. The same study found that eight percent of such employers required no contribution from retirees for early retiree coverage. *Id.*

43. See, e.g., U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-05-205, RETIREE HEALTH BENEFITS: OPTIONS FOR EMPLOYMENT-BASED PRESCRIPTION DRUG BENEFITS UNDER THE MEDICARE MODERNIZATION ACT 25 (2005) (“Implementing access-only coverage is often part of a broader movement by plan sponsors to restrict eligibility or offer reduced benefits for employees who are hired or retire after a certain date.”). There is a tendency to view an access-only plan as equivalent to no health insurance, but that is an inaccurate perception in the context of early

Retirees also shoulder a variety of other cost-sharing obligations. For example, seventy-seven percent of early retirees in 2006 were required to pay some level of annual deductible, with the average being \$389.⁴⁴

B. Health Insurance for Medicare-Eligible Retirees

Unlike early retiree health benefits, retiree plans for Medicare-eligible beneficiaries coordinate with Medicare instead of providing primary coverage.⁴⁵ In other words, the cost of coverage is split in some way between Medicare and the employer plan, with the specifics determined by the individual plan's design. Employment-based retiree coverage for Medicare-eligible retirees follows one of three alternative models—a “maintenance of benefits” structure, a “coordina-

retirees who may find it difficult or impossible to otherwise obtain private health insurance, particularly if they have any health issues that insurers perceive as risky.

44. KAISER & HEWITT, *supra* note 25, at 7 exhibit 5. The most common deductible for early retiree plans in that year was \$250. *Id.* Employers typically include out-of-pocket limits to protect retirees from catastrophic health care costs. For 2006, eighty-seven percent of early retiree plans included out-of-pocket limits at an average level of \$2097, and the most common limit was \$1500. *Id.*

45. See, e.g., Cowart, *supra* note 33, at 153–54 (“After an individual becomes eligible for Medicare, the retiree medical benefits under the employer’s plan will generally either be coordinated with the benefits available to the individual under Medicare, or will supplement Medicare benefits by covering expenses not covered by Medicare, but will not duplicate the Medicare coverage.”). See also U.S. GOV’T ACCOUNTABILITY OFFICE, *supra* note 36, at 6 n.5 (“Retiree coverage for Medicare-eligible retirees’ supplements benefits covered under Medicare and provides additional cost-sharing protections, such as limiting retiree out-of-pocket expenses, which traditional Medicare fee-for-service does not provide.”). This practice of coordinating benefits with Medicare came under fire in the early 2000s following a decision by the Third Circuit in *Erie County Retirees Association v. County of Erie*, 220 F.3d 193 (3d Cir. 2000) (holding, in effect, that the Age Discrimination in Employment Act required employers to either provide the same benefits or spend the same amount on benefits for Medicare-eligible and early retirees). Faced with intense negative reaction to the decision from employers, the Equal Employment Opportunity Commission responded by issuing a rule that permitted employers to maintain their long-standing practice of coordinating benefits with Medicare for Medicare-eligible retirees. 29 C.F.R. § 1625.32 (2009). See also Press Release, Equal Employment Opportunity Commission (EEOC), EEOC Moves to Protect Retiree Health Benefits (Dec. 26, 2007), available at <http://www.eeoc.gov/eeoc/newsroom/release/12-26-07.cfm> (quoting EEOC Vice Chair Leslie E. Silverman as saying, “The *Erie County* decision would have made most existing retiree health plans unlawful. EEOC’s new rule will ensure that employers can continue to offer their retirees much needed health benefits.”). The EEOC rule was challenged—unsuccessfully—up to the U.S. Supreme Court by AARP. *AARP v. EEOC*, 383 F. Supp. 2d 705 (E.D. Pa. 2005), *cert denied*, 552 U.S. 1279 (2008).

tion of benefits” form, or a “carve-out” model.⁴⁶ Depending on which model an employer chooses, the cost to a retiree will vary considerably.

Under the maintenance of benefits model, Medicare pays to whatever extent it covers the claim; the employer plan then applies its provisions—including any deductible and co-payments—toward any amount that remains after Medicare’s payment.⁴⁷ This approach means that a retiree will have to pay at least the employer plan deductible and any co-payments out-of-pocket.

Under the coordination of benefits approach to retiree health insurance, Medicare again pays to whatever extent it covers a claim; the employer plan then pays either what it would have paid had Medicare not existed or, if less, the full amount remaining after Medicare’s payment.⁴⁸ Alternatively phrased, the total benefit payable by Medicare is added to the total benefit payable by the employer plan. The combination of these two is then compared to the actual claim total. If that claim is less than the sum of the Medicare benefit plus the employer benefit, 100% of the claim is covered, with no deductible or co-payment required of the retiree.

With the carve-out model, Medicare yet again pays to whatever extent it covers a claim; the employer then calculates what it would have paid in the absence of Medicare, applies Medicare’s payment as though it were the employer’s own payment, and the plan covers whatever remains.⁴⁹ In this last model, the employer plan is truly only supplemental to Medicare—a structure sometimes called a “wrap-around” plan type. Although the three models sound similar when described, in application the carve-out model is the least expensive for employers and has thus been widely adopted by larger employers.⁵⁰

In all three plan design structures, because Medicare pays first, the cost to employers is reduced from what it would be for the same claim under an early retiree or active plan design where the employer plan is primary.⁵¹ Retiree plans for Medicare-eligible retirees thus are

46. See JEFFREY D. MAMORSKY, HEALTH CARE BENEFITS LAW § 9.01 (2004), available at Westlaw HCBL § 9.01.

47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.* See also Cowart, *supra* note 33 (giving an alternative description of the three models with slightly different terminology but the same substantive effect).

51. Indeed, the expansion of retiree health benefits after the mid-1960s is often attributed in large part to the introduction of Medicare in 1965. See, e.g., Patricia H.

inherently less expensive than plans for early retirees.⁵² For example, in 2006, the average premium for new retiree-only coverage for retirees age sixty-five and older in large employer plans was \$270 per month, compared with the \$552 per month for newly retiring pre-sixty-five retirees.⁵³ The lower premium amount applied to Medicare-eligible retirees even though they were paying the same percentage—forty-one percent—of the overall premium as pre-sixty-five retirees.⁵⁴ On the other hand, because health care expenses increase with age⁵⁵ and Medicare-eligible retirees are by definition older, employer plans for Medicare-eligible retirees still remain expensive to maintain when compared with plans for active workers.

As with plans for early retirees, employers shift significant costs to Medicare-eligible retirees. Thus, fifteen percent of surveyed large employers who offered plans for Medicare-eligible retirees in 2006 required those retirees to pay 100% of the premium cost for that insurance.⁵⁶ Most Medicare-eligible retiree plans also require covered individuals to satisfy deductibles and other cost-sharing obligations, though the impact can be lessened by out-of-pocket limits on retiree contributions.⁵⁷ On the other hand, employers have shifted costs at a lesser rate with regard to Medicare-eligible retirees as compared with early retirees. For example, between 2005 and 2006, the increase in the retiree share of premiums was only 9.6% for Medicare-eligible reti-

Born & Alice M. Zawacki, *Manufacturing Firms' Decisions Regarding Retiree Health Insurance* 1 (U.S. Census Bureau Ctr. Econ. Studies, CES-WP-03-14, June 7, 2003), available at http://www.ces.census.gov/index.php/ces/cespapers?limit=5&paper_year=2003; Robert L. Clark et al., *Retiree Health Insurance and Pension Coverage: Variations by Firm Characteristics*, 49 J. GERONTOLOGY S53, S53 (1994).

52. As early as 1993, one survey found that “employers pay 3 to 4 times more for [early retirees’] health care than for retirees with Medicare.” U.S. GENERAL ACCOUNTING OFFICE, GAO/HRD-93-125, *RETIREE HEALTH PLANS: HEALTH BENEFITS NOT SECURE UNDER EMPLOYER-BASED SYSTEM* 1 (1993).

53. KAISER & HEWITT, *supra* note 25, at 15.

54. *Id.*

55. See generally CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 37.

56. KAISER & HEWITT, *supra* note 25, at 15. Similar to employers sponsoring plans for early retirees, nine percent of large firms offering Medicare-eligible retiree benefits in 2006 did not require any retiree contribution to premiums. *Id.*

57. The leading retiree health plan survey in 2006 found that eighty-one percent of large employer plans for Medicare-eligible retirees included deductibles, with the average deductible at \$326 and \$300 the most common deductible. KAISER & HEWITT, *supra* note 25, at 7 exhibit 5. The same study found that eighty-four percent of such plans protected Medicare-eligible retirees with out-of-pocket limits, with an average level of \$1900 per year and with the most common limit at \$2000 per year. *Id.*

rees, compared with 15.1% for early retirees.⁵⁸ Moreover, eight percent of firms offering health benefits to such retirees actually lowered the required retiree contribution to premiums between 2005 and 2006, presumably due to the implementation of Medicare's prescription drug benefit effective January 1, 2006.⁵⁹

C. Costs and Trends

Taking into account both early retiree and Medicare-eligible plans, the projected 2006 costs for a select group of 302 large private employers providing retiree health benefits to 5.2 million individuals reached \$20.9 billion for that one year alone.⁶⁰ A 2004 study of large employers reported that retiree health insurance expenses constituted twenty-nine percent of the firms' total health benefit costs in that year.⁶¹ A Standard & Poor's Ratings Service evaluation of liabilities for "Other Post-Employment Benefits" (OPEB)—which are overwhelmingly retiree medical benefits—found that 293 of the large private sector companies in the S&P 500 offered such benefits, with a total accrued liability in 2009 of \$275.7 billion, which was almost entirely unfunded.⁶² In the public sector, where retiree health benefits are far more common today than in the private sector,⁶³ the total unfunded

58. *Id.* at 2. The percentage increase for early retirees between those years was 15.1%. *Id.*

59. *See id.* at 15.

60. *Id.* at 2, 11.

61. KAISER FAMILY FOUND. & HEWITT ASSOC., CURRENT TRENDS AND FUTURE OUTLOOK FOR RETIREE HEALTH BENEFITS: FINDINGS FROM THE KAISER/HEWITT 2004 SURVEY ON RETIREE HEALTH BENEFITS 11 (2004), available at <http://www.kff.org/medicare/7194>.

62. HOWARD SILVERBLATT & DAVE GUARINO, S&P INDICES, S&P 500 2009: PENSIONS AND OTHER POST EMPLOYMENT BENEFITS (OPEB) 9 (2010), available at <http://www.standardandpoors.com/indices/index-research/en/us>. Only \$61.1 billion was funded as of 2009. *Id.* Standard & Poor's is an independent credit rating company that has maintained tracking information since the 1950s on 500 large publicly traded company stocks through its S&P 500 index. *See About Standard & Poor's*, STANDARD & POOR'S, <http://www.standardandpoors.com/about-sp/main/en/us/> (last visited Apr. 24, 2011).

63. The 2007 Kaiser Family Foundation and Health Research and Educational Trust survey found that, of employers with at least 200 employees that offered health insurance benefits to active workers, eighty percent of state and local government employers provided retiree health insurance benefits. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2007 ANNUAL SURVEY 176 exhibit 11.2 (2007), available at http://www.kff.org/insurance/7672/sections/upload/7672_Section_11.pdf. By contrast, of private sector employers with at least 200 employees that offered health insurance benefits to active workers, only forty-seven percent of employers in the transportation, communications, and utilities industries and fifty-three percent of employers in the finance

accrued liabilities for future retiree health benefits are only beginning to be understood, but estimates placed the total by the end of the 2008 fiscal year around \$587 billion, a liability that—as in the private sector—is largely unfunded.⁶⁴

The magnitude of the liabilities currently faced by employers somewhat overshadows the fact that retiree health benefits have been in sharp decline in the private sector for the past twenty-plus years. From a high in the late 1980s when a majority of all larger employers—taking into account both public and private for this purpose—offered some form of retiree health insurance,⁶⁵ retiree plan sponsorship dropped to about twenty-nine percent by 2009.⁶⁶ The most severe reduction in the private sector came in the early 1990s—from sixty-six percent in 1988 to thirty-six percent by 1993⁶⁷—as a direct result of the implementation of Financial Accounting Standards Board Statement of Financial Accounting No. 106 (FAS 106).⁶⁸ Effective generally at the end of 1992, FAS 106 required most large private sector companies to reflect on their current balance sheets the accrued cost of future retiree health benefit promises.⁶⁹ FAS 106 sent shock waves through the private sector as large employers realized their accrued

industry offered retiree health benefits, but these percentages were far higher than in any other private sector areas. *Id.* The next highest percentage was thirty-two percent of employers in the service industry. *Id.*

64. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-223, STATE & LOCAL GOV'T RETIREE BENEFITS: CURRENT FUNDED STATUS OF PENSION AND HEALTH BENEFITS 3 (2008). See also PEW CTR. ON THE STATES, THE TRILLION DOLLAR GAP: UNFUNDED STATE RETIREMENT SYSTEMS AND THE ROADS TO REFORM 5 (2010), available at http://downloads.pewcenteronthestates.org/The_Trillion_Dollar_Gap_final.pdf.

65. Slightly more than sixty percent of large private sector employers in 1988 offered retiree health insurance; fifty-plus percent of large public sector employers did the same in that year. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO/HEHS-97-150, RETIREE HEALTH INSURANCE: EROSION IN EMPLOYER-BASED HEALTH BENEFITS FOR EARLY RETIREES 7 fig.1 (1997), available at <http://www.gao.gov/archive/1997/he97150.pdf>.

66. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2009 ANNUAL SURVEY 165 exhibit 11.1 (2009) [hereinafter KAISER/HRET 2009 ANNUAL SURVEY], available at <http://ehbs.kff.org/pdf/2009/7936.pdf>. Kaiser/HRET data shows that sixty-six percent of all large employers (those with 200 or more employees) offered retiree health benefits in 1988. *Id.*

67. *Id.*

68. H. Fred Mittelstaedt et al., *SFAS No. 106 and Benefit Reductions in Employer-Sponsored Retiree Health Care Plans*, 70 ACCT. REV. 535, 549 tbl.2 (1995).

69. FIN. ACCOUNTING STANDARDS BD., STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 106: EMPLOYERS' ACCOUNTING FOR POSTRETIREMENT BENEFITS OTHER THAN PENSIONS 5 (1990), available at <http://www.fasb.org/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobkey=id&blobwhere=1175820919124&blobheader=application%2Fpdf>.

commitments sometimes exceeded their total assets.⁷⁰ Many companies reacted by terminating retiree health plans,⁷¹ leading to the sharp drop in numbers immediately after FAS 106's implementation. Since then, retiree health plan sponsorship has continued to slope downward but at a much more level rate.⁷² The ongoing decline is often blamed on the ongoing increase in overall health care costs in the United States, combined with such demographic changes as an aging population with increased longevity.⁷³

Employers who still maintain retiree health plans tend to have 200 or more employees,⁷⁴ tend to be unionized,⁷⁵ and tend to be either state or local governments or be in one of a handful of industries.⁷⁶ In

70. See, e.g., Pat Widder, *Benefit Deals Face Retirement; Navistar Neither First nor Last to Cut*, CHI. TRIB., Aug. 30, 1992, at C1. Accrued retiree health liabilities of the Fortune 500 companies in the late 1980s were estimated at around \$2 trillion, while total assets of the same firms came to only about \$1.3 trillion. *Id.*

71. Mittelstaedt et al., *supra* note 68, at 549. At the outset, questions arose as to whether employers could legally terminate retiree health benefits. Over time, those have been largely resolved in favor of employers. See Richard L. Kaplan et al., *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 YALE J. HEALTH POL'Y L. & ETHICS 287, 296-98 (2009). See generally Donald T. Weckstein, *The Problematic Provision and Protection of Health and Welfare Benefits for Retirees*, 24 SAN DIEGO L. REV. 101 (1987); Larry Grudzien, *The Great Vanishing Benefit, Employer Provided Retiree Medical Benefits: The Problem and Possible Solutions*, 39 J. MARSHALL L. REV. 785 (2006); David A. Pratt, *The Past, Present and Future of Retiree Health Benefits*, 3 J. HEALTH & BIOMED. L. 103 (2007).

72. See, e.g., U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-05-205, RETIREE HEALTH BENEFITS: OPTIONS FOR EMPLOYMENT-BASED PRESCRIPTION DRUG BENEFITS UNDER THE MEDICARE MODERNIZATION ACT 13 (2008) ("The percentage of employers offering health benefits to retirees, including those who are Medicare-eligible, has decreased since the early 1990s, according to employer benefit surveys, but offer rates have leveled off in recent years."). One explanation for the sharp drop from 1988 through 1993, followed by the much slower erosion rate since, is simply that those who could terminate benefits did so around the time FAS 106's impact became evident. See *id.* at 16 ("[S]ome officials we interviewed . . . told us that plan sponsors that could eliminate benefits had already done so, which is consistent with the period of leveling off shown in the . . . surveys.").

73. See, e.g., Cowart, *supra* note 33, at 147 ("The dramatic rise in health care costs, the aging population, early retirement all made more individuals eligible to participate in retiree plans, coupled with cutbacks in government sponsored health care coverage have all contributed to the sharp rise in costs associated with retiree medical plans.").

74. KAISER/HRET 2009 ANNUAL SURVEY, *supra* note 66, at 164 (finding that twenty-nine percent of employers with 200 or more employees provided retiree health insurance as compared to only five percent of smaller employers).

75. *Id.* (finding forty-seven percent of large employers offering retiree health benefits were unionized; only twenty-two percent of large employers with no union employees offered retiree health benefits in 2009).

76. *Id.* at 166 exhibit 11.2. In 2009, eighty-one percent of large (meaning 200 or more employees) state and local government employers offered retiree health ben-

the case of unionized employers, collective bargaining agreements make termination of retiree benefits difficult,⁷⁷ even if employers would prefer to cease sponsoring such plans.⁷⁸ The high rate of unionization among public sector employees⁷⁹ thus partially explains why retiree health benefits remain prevalent at the state and local government levels. Moreover, the provision of public sector retiree health benefits is sometimes written into governing law, such as state constitutions.⁸⁰ In addition, many public employers believe that they must

efits as compared to fifty percent of similarly sized employers in transportation/communication/utilities industries, forty-one percent of such employers in finance industries, thirty-four percent of such employers in agriculture/mining/construction industries, and thirty percent of employers in manufacturing industries. *Id.* Large employers in other industries were much less likely to offer such benefits: service (twenty-two percent), health care (twenty percent), wholesale (eighteen percent), and retail (twelve percent). *Id.* Among those industries with comparatively higher levels of retiree health plan sponsorship, unions also tend to be more prevalent. *Id.* at 167 exhibit 11.3. Thus, in 2009, 22.2% of workers in transportation and utilities companies were unionized as were sixteen percent of telecommunications workers and 14.5% of construction workers. News Release, U.S. Dep't of Labor, Bureau of Labor Statistics: Union Members - 2010 tbl.3 (Jan. 21, 2011) [hereinafter BLS News Release], available at <http://www.bls.gov/news.release/pdf/union2.pdf>.

77. See William T. Payne & Pamina Ewing, *Union-Negotiated Lifetime Retiree Health Benefits: Promise or Illusion*, 9 MARQUETTE ELDER'S ADVISOR 319, 340-41 (2008). Despite the difficulties, employers often have won disputes over their right to terminate retiree health benefits unilaterally. *Id.* at 341 (citing *Allied Chem. & Alkali Workers of Am. v. Pittsburgh Plate Glass Co.*, 404 U.S. 157 (1971)).

78. See, e.g., U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 43, at 16. ("[A]lthough the provision of health benefits for all retirees by employers is generally voluntary, officials we interviewed noted that employers that continue to offer retiree health benefits may be limited in their ability to decrease benefits further because of existing contracts with unions, which are generally negotiated every 3 to 5 years.").

79. For example, in 2009, 37.4% of public sector employees were unionized as compared to only 7.2% of private sector employees. BLS News Release, *supra* note 76, at tbl.3.

80. See *State Cases Addressing Public Sector Health Benefits*, NAT'L CONF. PUB. EMP. RETIREMENT SYS. (Mar. 15, 2007), <http://www.ncpers.org/Files/News/03152007HealthBenefitProtections.pdf> (summarizing different challenges brought against public sector employer efforts to reduce or eliminate benefits). Notwithstanding the court cases that have resulted when public sector employers have attempted to modify health benefits, in general, retiree medical benefits enjoy far less protection than do pension benefits. See, e.g., U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-07-1156, STATE AND LOCAL GOVERNMENT RETIREE BENEFITS: CURRENT STATUS OF BENEFIT STRUCTURES, PROTECTIONS, AND FISCAL OUTLOOK FOR FUNDING FUTURE COSTS 25 (2007) ("To the extent retiree health benefits are legally protected, it is generally because they have been collectively bargained and are subject to current labor contracts."). State administrators, however, seem to perceive that they are limited in their ability to change such benefits. In a survey cited by the GAO, "62 percent of respondents said that statutory or regulatory obligations affected their ability to change retiree health coverage; 25 percent said that retiree health coverage was subject to collective bargaining; and 17 percent said

offer generous benefits to offset lower compensation levels and compete for quality employees against higher pay rates in the private sector.⁸¹ Similarly, large private sector employers in certain industries where retiree health plans remain common⁸² may feel they must offer certain benefit packages in order to remain competitive in attracting employees. Employers in both the public and private sector also face the likelihood of negative publicity⁸³ and decreased employee morale if they terminate retiree health insurance.

Just because an employer continues to offer retiree health benefits, however, does not mean that it will do so on the same terms as in the past. Employers attempt to control costs by a variety of means.⁸⁴ The most direct involves increased cost-shifting to retirees. For example, between 2005 and 2006, fifty-eight percent of surveyed large employers increased retiree premium contributions for Medicare-eligible retirees, twenty-four percent increased cost-sharing obligations, and

that other factors affected their ability to change retiree health coverage." *Id.* at 25. See generally Jenna Amato Moran, *The OPEB Tsunami: Riding the Wave of Public Sector Postemployment Health Benefits*, 58 BUFF. L. REV. 677 (2010) (providing careful analysis of the state of public sector retiree health benefits and the various legal issues involved in their modification or termination).

81. Traditionally, public sector employers have offered more generous benefits, including pensions and retiree health insurance, than have been available in the private sector. This disparity has begun to draw political fire in a sputtering economy. PEW CTR. ON THE STATES, PROMISES WITH A PRICE: PUBLIC SECTOR RETIREMENT BENEFITS 10-11 (2007), available at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State_policy/pension_report.pdf ("The gap between public and private sector benefits fuels the political debate, as taxpayers notice that they are contributing to government employee retirement benefits that are increasingly unavailable in the private sector."). Still, in a 2008 survey taken after the recent financial meltdown and after the extent of liability for public sector retiree health benefits had become evident, a significant majority of state benefit administrators viewed the maintenance of retiree health plans as "central to their recruitment, retention, and retirement timing goals" DENNIS M. DALEY & JERRELL D. COGGBURN, CTR. FOR STATE & LOCAL GOV'T EXCELLENCE, RETIREE HEALTH CARE IN THE AMERICAN STATES 1 (2008).

82. See KAISER/HRET 2009 ANNUAL SURVEY, *supra* note 66, at 166 exhibit 11.2.

83. See, e.g., PEW CTR. ON THE STATES, *supra* note 64, at 25 ("Even in states that have more flexibility to change benefits for current employees, the political difficulties are formidable. No legislature wants to antagonize government employees who, at the least, vote in elections and, at worst, can turn into powerful political foes.").

84. Although this Article focuses on retiree health benefits, all of the observations about employer cost-cutting efforts apply equally to employment-based health insurance for active employees. See, e.g., KAISER/HRET 2009 ANNUAL SURVEY, *supra* note 66, at 8 ("[L]arge percentages of firms report that in the next year they are very or somewhat likely to increase the amount workers contribute to premiums (42%), increase deductible amounts (36%), increase office visit cost sharing (39%), or increase the amount that employees have to pay for prescription drugs (37%).").

sixteen percent increased out-of-pocket limits.⁸⁵ Over that same period, employers also increased the amount they required new early retirees to contribute toward health premiums.⁸⁶ Looking forward to 2007 for both early retiree and Medicare-eligible retiree plans, eighty percent of surveyed large employers said they were “likely to increase retiree contributions to premiums,” forty percent said they were “likely to increase retiree cost-sharing requirements,” and thirty percent said they were “likely to raise out-of-pocket limits.”⁸⁷

In addition to cost-shifting, some employers have introduced consumer-directed health plans⁸⁸ – typically through health savings accounts and other similar defined contribution models⁸⁹ – in which an employer promises to contribute only so much toward the cost of health care and leaves it to the covered individual to determine how the funds are applied.⁹⁰

85. KAISER & HEWITT, *supra* note 25, at 21 exhibit 18.

86. Specifically, the increase was 15.1% between those years. *Id.* at 15.

87. *Id.* at 21.

88. In 2006, ten percent of surveyed large employers reported that they “offered an account-based retiree health plan such as an HRA (health reimbursement arrangement) or HSA (health savings account) for pre-65 retirees.” *Id.* at 19. Only three percent did the same for Medicare-eligible retirees. *Id.* Although the Kaiser/HRET 2009 employer benefits study did not distinguish between retiree and active worker plans, it found that eleven percent of firms having between three and 199 workers and twenty-one percent of firms with 200 or more employees offered some type of high-deductible health plan with a savings option. KAISER/HRET 2009 ANNUAL SURVEY, *supra* note 66, at exhibit 4.3.

89. A “health savings account,” or “HSA,” is a tax-exempt account into which funds can be deposited by an employer or individual for the individual to apply to specified types of medical expenses. *See generally* INTERNAL REVENUE SERV., PUBLICATION 969: HEALTH SAVINGS ACCOUNTS AND OTHER TAX-FAVORED HEALTH PLANS (2010), available at <http://www.irs.gov/pub/irs-pdf/p969.pdf> (providing a taxpayer-oriented overview of the different types of tax-advantaged individual accounts available to help fund medical expenses). An HSA must be coupled with a so-called “high-deductible health plan,” or “HDHP,” but is not necessarily maintained by an employer. *Id.* at 2-3. A “health reimbursement arrangement,” or “HRA,” allows an employer to make contributions to an individual account for an employee, again to be used at the employee’s direction for specified types of medical expenses. *Id.* at 18-19. The employer contributions are not taxable to the employee. *Id.* HRAs are employer-sponsored benefit plans, and only the employer may contribute funds to such accounts. *Id.* An older form of consumer-driven but employment-based health savings account is the health “flexible spending account,” or “FSA,” which allows contributions to be made on a pre-tax basis to an individual account to be used for specified types of medical expenses. *Id.* at 15-16. Health FSAs are employer-sponsored plans and are often structured as an option under an employer’s cafeteria plan. Employers may contribute funds to a health FSA, but more commonly, employees make the contributions by directing withholding from their pay. *Id.*

90. HSAs and consumer-directed health care generally became popular in the last decade or so as a result of efforts to encourage individual awareness and re-

Many employers have also adopted caps on their retiree benefit obligations, seeking to place an outer limit on their long-term liability.⁹¹ For example, in 2006, forty-six percent of surveyed large employers reported that they had capped their contributions to the largest plan they offered for early retirees, and fifty percent reported they had capped their contributions to their largest plan for Medicare-eligible retirees.⁹² Of course, as companies with caps reach those limits, the caps translate to increased cost-shifting to retirees.⁹³

Some large unionized employers in recent years have sought to escape retiree health care obligations by negotiating with their unions to transfer liability to free-standing voluntary employees' beneficiary associations, better known as VEBAs.⁹⁴ A VEBA is a type of tax-exempt trust that employers have historically used to fund a variety of non-pension benefits, most commonly retiree health expenses.⁹⁵ Be-

sponsibility for health care spending. See, e.g., William M. Sage, *The Wal-Martization of Health Care*, 28 J. LEGAL MED. 503, 510-11 (2007) ("Over the past 10 years, political support has intensified for 'consumer-directed health care' as a guiding principle of health reform. This movement reflects the belief that private solutions are preferable to government solutions, that insurance induces moral hazard among beneficiaries, and that information transparency about both the price of services and their quality is an essential aspect of making competition work."). The movement has generated significant debate, specifically as to whether HSAs, HRAs, and similar arrangements could suffice to ease retiree health care costs. See, e.g., Paul Fronstin, *The Use of Health Savings Accounts for Health Care in Retirement*, EMP. BENEFITS RES. INST. NOTES, Apr. 2010, at 2, 2.

91. See, e.g., U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 43, at 26 (noting that "[e]mployers began to implement caps in response to rising retiree health costs and to accounting changes introduced in the early 1990s [due to FAS 106]").

92. KAISER & HEWITT, *supra* note 25, at 13-14 exhibits 12, 13.

93. See, e.g., U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 43, at 27. For example, Caterpillar, Inc., in 1992, said it would cap retiree health benefit costs beginning in 2000 at its 1999 expense, shifting any additional costs to retirees through increased premiums. Amended Complaint, *Winnett v. Caterpillar, Inc.*, No. 3:06-CV-0235, 2006 WL 5328387, at *26 (M.D. Tenn. Sept. 5, 2006). Eventually, it established a VEBA to help fund those costs. *Id.* at *28.

94. See generally PHYLLIS C. BORZI, HENRY J. KAISER FAMILY FOUND., *RETIREE HEALTH VEBAS: A NEW TWIST ON AN OLD PARADIGM: IMPLICATIONS FOR RETIREES, UNIONS AND EMPLOYERS* (2009); Kathryn L. Moore, *The New Retiree Health VEBAs*, in NYU REV. EMP. BENEFITS & EXEC. COMP., 7-1 (2008); AARON BERNSTEIN, *CAN VEBAS ALLEVIATE RETIREE HEALTH CARE PROBLEMS?* (2008), available at http://www.law.harvard.edu/programs/lwp/pensions/publications/occpapers/occasionalpapers_Ap9_fin2.pdf; ELLEN O'BRIEN, AARP PUB. POL'Y INST., *WHAT DO THE NEW AUTO INDUSTRY VEBAS MEAN FOR CURRENT AND FUTURE RETIREES?* (2008), available at http://assets.aarp.org/rgcenter/econ/i4_veba.pdf; Susan E. Cancelosi, *VEBAs to the Rescue: Evaluating One Alternative for Public Sector Retiree Health Benefits*, 42 J. MARSHALL L. REV. 879 (2009) (explaining the VEBA option for funding retiree health benefits).

95. VEBAs are authorized by section 501(c)(9) of the Internal Revenue Code of 1986, as amended. 26 U.S.C. § 501(c)(9) (2006). See also John L. Utz, *AMERICAN BAR*

ginning in the early 1990s, manufacturing companies with crippling liabilities tied to collectively bargained retiree health benefits began to negotiate with their unions to establish stand-alone VEBAs that would assume full responsibility for retiree health obligations in exchange for largely up-front funding by the companies.⁹⁶ The best-known of these “new” VEBAs was agreed upon by the UAW⁹⁷ and the Detroit Big Three automakers⁹⁸ in late 2007, at a time when the demise of one or more of the Detroit auto companies appeared imminent.⁹⁹ Once a stand-alone VEBA is funded as agreed by the relevant company, the VEBA becomes a self-sufficient, independent health insurance plan that is expected to provide retiree medical benefits to the covered retirees and their dependents in much the same way as the company, but largely without future recourse back to the original employer company should the VEBA’s assets prove insufficient over time.¹⁰⁰ As a result, stand-alone VEBAs represent a defined contribution approach to retiree health care that fixes, and is intended to limit permanently, an employer’s long-term obligation.

D. Effect of Health Insurance on Retirees

All of these developments in retiree health insurance mean that what a retiree today receives may well be less in value than what he or she anticipated. On the other hand, even if less valuable than in the past, retiree health coverage offers much to those still enjoying it. As a preliminary matter, older individuals are generally less healthy than younger persons,¹⁰¹ leading to higher health care costs.¹⁰² At the same

ASS’N CONTINUING LEGAL EDUC., VOLUNTARY EMPLOYEES’ BENEFIT ASSOCIATIONS (2008); DAVID S. DUNKLE, VEBAS AND OTHER SELF-INSURED ARRANGEMENTS, 395-2nd (1993).

96. William Atkinson, *VEBAs Employers to Unions: See If You Can Do Better*, 5 BIOTECH. HEALTHCARE 16, 16-17 (2008).

97. The “UAW” is the commonly used acronym for the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America. See *Who We Are*, UAW, <http://www.uaw.org/node/39> (last visited Apr. 24, 2011).

98. References to the Detroit “Big Three” or to the “Detroit automakers” should be interpreted to mean Chrysler Group LLC (Chrysler), Ford Motor Company (Ford), and General Motors Corp. (GM) as such companies existed before the 2009 bankruptcy filings and subsequent restructuring of both Chrysler and GM.

99. See, e.g., Micheline Maynard, *G.M.-Union Deal Could End Business as Usual in Detroit*, N.Y. TIMES, Sept. 27, 2007, at A1.

100. See Steven J. Sacher, *Issueman Tackles the New VEBAs*, 35 BNA PENSION & BENEFITS REP. 820, 824 (2008).

101. For example, the National Health Interview Survey in 2009 discovered that, based on self-reporting of health status, “the percentage of persons with ex-

time, as most people age, their income both declines and shifts toward fixed sources, such as Social Security and retirement benefits.¹⁰³ For example, in 2008, the median income was \$50,000 for individuals age fifty-five to sixty-one, but only \$19,412 for those age eighty or older.¹⁰⁴ Also in 2008, while 80.9% of individuals age fifty-five to sixty-one still had earnings from wages, salaries, or self-employment, that figure dropped to 67.3% for those age sixty-two to sixty-four, to 47.8% for those age sixty-five to sixty-nine, and down to 8.0% for those eighty or older.¹⁰⁵ As earnings from employment decline, retirement benefits—both from Social Security and pensions—take over. Thus, while only 12.3% of individuals age fifty-five to sixty-one in 2008 received Social Security payments,¹⁰⁶ that percentage jumped to 42.7% for those age

cellent or very good health decreased with age: 83.6% for those under 18 years, 64.5% for those aged 18–64, and 41.6% for those aged 65 and over.” CTRS. FOR DISEASE CONTROL, EARLY RELEASE OF SELECTED ESTIMATES BASED ON DATA FROM THE 2009 NATIONAL HEALTH INTERVIEW SURVEY 71 fig.11.3 (2010), available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/201006_11.pdf.

102. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 37.

103. For example, the 2000 Census revealed that, while 45.7% of households with a householder age sixty-five to seventy-four still had some degree of income from employment, the same was true of only 22.6% of those with a householder age seventy-five to eighty-four, and an even lower 12.8% of those with a householder age eighty-five and older. YVONNE J. GIST & LISA I. HETZEL, U.S. CENSUS BUREAU, WE THE PEOPLE: AGING IN THE UNITED STATES 8 fig.10 (2004), available at <http://www.census.gov/prod/2004pubs/censr-19.pdf>. By contrast, 87.9% of those with a householder age sixty-five to seventy-four received Social Security Income as did 92.0% of those with a householder age seventy-five to eighty-four, and 91.3% of those with a householder age eighty-five and older. *Id.* 49.8% of households with a householder age sixty-five to seventy-four received retirement income as did 47.7% of those with a householder age seventy-five to eighty-four, and 38.6% of those with a householder age eighty-five or older. *Id.* For these purposes, “retirement income” was defined as: “(1) retirement pensions and survivor benefits from a former employer; labor union; federal, state, or local government; and the U.S. military; (2) income from workers’ compensation; disability income from companies or unions; federal, state, or local government; and the U.S. military; (3) periodic receipts from annuities and insurance; and (4) regular income from IRA and KEOGH plans.” *Id.*

104. SOC. SEC. ADMIN., INCOME OF THE POPULATION 55 OR OLDER, 2008, at 82 tbl.3.A1 (2010), available at http://www.ssa.gov/policy/docs/statcomps/income_pop55/2008/incpop08.pdf. Median income was \$43,000 for those age sixty-two to sixty-four, \$35,257 for those age sixty-five to sixty-nine, \$27,043 for those age seventy to seventy-four, and \$22,578 for those age seventy-five to seventy-nine. *Id.*

105. *Id.* at 37 tbl.2.A1. The percentage of individuals with earnings from active employment declined further to 30.6% for those seventy to seventy-four and 18.5% for those age seventy-five to seventy-nine. *Id.*

106. *Id.* Social Security benefits for those not yet age sixty-two are largely reserved for individuals with disabilities. Most people cannot elect even early Social Security retirement benefits until they reach at least age sixty-two. See SOC. SEC. ADMIN., RETIREMENT BENEFITS 6–7 (2010), available at <http://www.ssa.gov/pubs/10035.pdf>.

sixty-two to sixty-four—reflecting Social Security’s early retirement eligibility at age sixty-two—and then to 79.7% for those age sixty-five to sixty-nine.¹⁰⁷ In 2008, among families headed by an individual age sixty-five or older, 34.7% of family income came from Social Security, 32.5% from earnings, 18.2% from pensions and other retirement income, and 12.1% from income from investments.¹⁰⁸ Of perhaps more concern is the fact that 8.5 million individuals age sixty-five or older—or twenty-three percent of the elderly population—in 2008 relied on Social Security benefits for ninety percent or more of their family income.¹⁰⁹ While above the federal poverty threshold, the median annual Social Security benefit remains low—only \$14,966 for an individual age sixty-five or over in 2008.¹¹⁰ This combination of limited and generally fixed income at a time of likely higher medical expenses underscores the importance of preserving funding for an individual’s health care expenses in retirement.

When facing the twin challenges of increasing expense and finite resources, early retirees who are not yet Medicare-eligible find few alternatives for health care funding other than through a former em-

107. SOC. SEC. ADMIN., *supra* note 104, at 37 tbl.2.A1. The percentage of individuals receiving Social Security benefits increased further to 89.0% for those age seventy to seventy-four, 90.1% for those age seventy-five to seventy-nine, and 91.1% for those age eighty or older. *Id.* Similarly, the percentage of those receiving income in 2008 from retirement benefits other than Social Security increased steadily from 14.7% of those age fifty-five to sixty-one to 28.9% of those age sixty-two to sixty-four, 39.2% of those age sixty-five to sixty-nine, 41.6% of those age seventy to seventy-four, 42.1% of those age seventy-five to seventy-nine, and 40.6% of those age eighty or older. *Id.* Benefits other than Social Security for these purposes include other public pensions—such as Railroad Retirement benefits and government employee pensions from the military and federal, state and local government employers—as well as private employer pensions. *Id.*

108. ELLEN O’BRIEN ET AL., AARP PUB. POL’Y INST., *OLDER AMERICANS IN POVERTY: A SNAPSHOT* 27 fig.28 (2010), available at <http://assets.aarp.org/rgcenter/ppi/econ-sec/2010-03-poverty.pdf>.

109. *Id.* at 28 figs.29 & 30. Social Security represented 100% of family income for fourteen percent of individuals age sixty-five or older in 2008 and at least seventy-five percent of family income for thirty-two percent of that elderly population. *Id.* at 28 fig.29.

110. SOC. SEC. ADMIN., *supra* note 104, at 152 tbl.5.A1. The federal poverty threshold for an individual age sixty-five or older in 2008 was \$10,326. *Poverty Thresholds 2008*, U.S. CENSUS BUREAU, <http://www.census.gov/hhes/www/poverty/data/threshld/thresh08.html> (last visited Apr. 24, 2011). Generally, since the introduction of Medicare in 1965, elder poverty has dropped significantly, with the consistent result that the elderly as a group appear statistically better off than other age groups. *See, e.g.,* O’BRIEN ET AL., *supra* note 108, at 8 (noting that in 2008, the “elderly poverty rate (9.7%) is significantly lower than the child poverty rate (19%) and lower than the poverty rate for adults aged eighteen to sixty-four (11.7%)”).

ployer's health plan.¹¹¹ Individuals in the United States obtain health insurance primarily through an employer but may also purchase an individual private policy directly from an insurance company or qualify for publicly funded coverage through Medicare, Medicaid, or the military.¹¹² An individual who terminates active employment and who participated in an employer-sponsored health plan while employed may elect COBRA continuation coverage.¹¹³ COBRA coverage allows such an individual to maintain his or her employment-based health coverage for a specified period of time—in most cases eighteen months—following termination of employment.¹¹⁴ For early retirees who are no more than eighteen months away from reaching age sixty-five, COBRA may thus bridge between employer coverage and Medicare eligibility. For other early retirees, however, COBRA continuation coverage may be valuable, but the value is limited by the coverage's short duration.

Once COBRA expires, without other health insurance through an employer, a non-disabled individual under age sixty-five (thus, not yet Medicare-eligible) who does not qualify for military coverage is left with purchasing an individual policy or seeking Medicaid coverage. Relatively few early retirees historically have qualified for Medicaid.¹¹⁵ Before health reform,¹¹⁶ Medicaid eligibility rules required generally that a person seeking benefits not only have extremely limited financial resources, but also fall into one of a handful of coverage categories: pregnant or with dependent children, blind, disabled,

111. See generally Lynn A. Karoly & Jeannette A. Rogowski, *The Effect of Access to Post-Retirement Health Insurance on the Decision to Retire Early*, 48 INDUS. & LAB. REL. REV. 103 (1994).

112. See, e.g., Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2008 Current Population Survey*, EMP. BENEFITS RES. INST. ISSUE BRIEF, Sept. 2008, at 5 fig.1, available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_09a-2008.pdf.

113. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986).

114. 26 U.S.C. § 4980B (2006); 29 U.S.C. §§ 1161-1169 (2006). See also DEP'T OF LABOR, EMP. BENEFITS SEC. ADMIN., AN EMPLOYEE'S GUIDE TO HEALTH BENEFITS 12 (2006), available at <http://www.dol.gov/ebsa/pdf/cobraemployee.pdf>. Employers are allowed to charge up to 102% of the full premium cost for COBRA coverage. 26 U.S.C. § 4980B(f)(2)(C).

115. For example, in 2007, only 7.4% of individuals age fifty-five to sixty-four—or 2.5 million—were covered by Medicaid. Fronstin, *supra* note 18, at fig.1.

116. See KAISER COMM'N ON MEDICAID & THE UNINSURED, KAISER FAMILY FOUND., THE MEDICAID PROGRAM AT A GLANCE 1 (2010), available at <http://www.kff.org/medicaid/upload/7235-04.pdf>.

or at least age sixty-five.¹¹⁷ The comparatively healthy early retiree in most cases would not fit into any of these groups.

With public programs and employer-based options unavailable, an early retiree's last option is to purchase an individual policy directly from an insurance company. Such private insurance is widely perceived to be both expensive and difficult to obtain.¹¹⁸ For example, a White House Fact Sheet on health reform stated that "[i]ndividual market insurance is often not an option [for early retirees]: premiums have increased more for older than younger Americans."¹¹⁹ Similarly, the U.S. Department of Health and Human Services (HHS) in an early rule implementing part of health reform explained that "[p]eople in the early retiree age group often face difficulties obtaining insurance in the individual market because of advanced age or chronic conditions that make coverage unaffordable and inaccessible."¹²⁰ A 2010 study found that persons age fifty to sixty-four with private, non-group insurance paid on average \$4822 in annual premiums for individual coverage and \$8677 for family coverage, compared with \$2843 for individual coverage and \$6864 for family coverage paid in annual premiums by persons age thirty-five to forty-nine.¹²¹ Even with high premiums for individual insurance, the quality of that coverage may not be what people expect. In other words, someone may have purchased an individual policy (thus, be counted as insured on a survey), but that coverage might come with a high premium, high deductibles

117. See THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., MEDICAID: A PRIMER 8 (2010), available at <http://www.kff.org/medicaid/upload/7334-04.pdf>.

118. See, e.g., Karoly & Rogowski, *supra* note 111 ("Before workers become eligible for Medicare at age 65, they could purchase an individual health insurance policy when they retire early. But if they do so, they might encounter some problems. First, the costs of individual health insurance can be prohibitively expensive, especially if premiums are based on the retiree's age and health status. Second, in some cases, insurers may consider such individuals 'bad risks' and refuse to extend coverage to them or agree to cover them but only by excluding preexisting conditions.").

119. *Fact Sheet: Early Benefits from the Affordable Care Act of 2010 Reinsurance Program for Early Retirees*, WHITEHOUSE.GOV, http://www.whitehouse.gov/sites/default/files/rss_viewer/reinsurance_early_retirees_fact_sheet.pdf (last visited Apr. 24, 2011) [hereinafter *Fact Sheet: Early Benefits*].

120. Early Retiree Reinsurance Program, 75 Fed. Reg. 24,450, 24,450 (May 5, 2010) (to be codified at 45 C.F.R. pt. 149).

121. KAISER FAMILY FOUND., SURVEY OF PEOPLE WHO PURCHASE THEIR OWN INSURANCE 4 (2010), available at <http://www.kff.org/kaiserpolls/upload/8077-R.pdf>. For comparison, in 2009, the average employer plan premium for individual coverage was \$4824, but employers typically pay a significant portion of those premiums for active employees. *Id.* at app. 2.

and other cost-sharing, and be subject to low coverage limits, all of which makes the policy far less generous than a typical employer plan. Moreover, insurance companies are regulated almost entirely by state law and have historically been able to drop coverage or increase premiums based on changes in health status of individuals.¹²²

Medicare-eligible retirees also face challenges paying for health care costs without the benefit of employment-based insurance. Although Medicare provides a significant safety net once an individual reaches sixty-five, that safety net is truly a net—with numerous holes or gaps in coverage. Overall, in 2006, Medicare covered only about sixty percent of beneficiary health care expenses.¹²³ For example, traditional Medicare—the original components of the program as enshrined in Medicare Parts A and B¹²⁴—includes an income-adjusted premium for Part B,¹²⁵ Part A and B deductibles (in 2010, \$1100 for Part A and \$155 for Part B),¹²⁶ coinsurance in varying amounts for different Part A services,¹²⁷ and twenty percent coinsurance for Part B

122. See *id.* at 1, 6–8; JANET L. KAMINSKI, CONN. GEN. ASSEMB. OFFICE OF LEGIS. RESEARCH, 2007-R-0131, ERISA PREEMPTION AND STATE HEALTH CARE REFORM (2007), available at <http://www.cga.ct.gov/2007/rpt/2007-R-0131.htm>.

123. Paul Fronstin et al., *Savings Needed for Health Expenses in Retirement: An Examination of Persons Ages 55 and 65 in 2009*, EMP. BENEFIT RES. INST. NOTES, June 2009 at 2, 2, available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_06-June09.HlthSvg-RetFndg1.pdf.

124. Medicare is structured as four separate programs, referred to unimaginatively as Parts A, B, C, and D. *Medicare Benefits*, MEDICARE.GOV, <http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/medicare-benefits-overview.aspx> (last visited Apr. 24, 2011). Part A—subtitled “Hospital Insurance Benefits for the Aged and Disabled”—pays for inpatient hospital care, limited skilled nursing care, some home health care, and hospice services. 42 U.S.C. § 1395c (2006). Part B—subtitled “Supplementary Medical Insurance Benefits for the Aged and Disabled”—pays for physician charges and a range of outpatient services and other health-related expenses. 42 U.S.C. § 1395(k). Part C—also known as “Medicare Advantage”—allows Medicare beneficiaries to elect private insurance alternatives to Parts A and B. 42 U.S.C. § 1395W-21. Part D offers prescription drug coverage through private insurers. 42 U.S.C. § 1395W-101.

125. In 2010, the base monthly Part B premium was \$96.40. See *2010 Part B Premium Amounts for Persons with Higher Income Levels*, MEDICARE.GOV (Oct. 19, 2009), http://questions.medicare.gov/app/answers/detail/a_id/2261. An individual Medicare beneficiary with more than \$85,000 in income (\$170,000 for a married couple) could pay up to \$353.60 per month, depending on his or her income level, for Part B coverage. *Id.* Most Medicare beneficiaries do not pay a premium for Part A coverage. See *Medicare Premiums and Coinsurance Rates for 2010*, MEDICARE.GOV (Apr. 4, 2010) [hereinafter *Medicare Premiums*], https://questions.medicare.gov/app/answers/detail/a_id/2260/~/medicare-premiums-and-coinsurance-rates-for-2010.

126. *Medicare Premiums*, *supra* note 125.

127. Part A coinsurance in 2010 for a hospital stay was \$275 per day for each day of hospitalization after the first sixty and up to ninety in a single spell of illness, and \$550 per day for each day of hospitalization after the first ninety days,

services.¹²⁸ Premiums, deductibles, and coinsurance for Part C Medicare Advantage and Part D prescription drug coverage, both of which are offered only through private insurance companies, depend on the particular terms of the plan a beneficiary selects.¹²⁹

In addition to cost-sharing obligations, Medicare beneficiaries may incur some out-of-pocket costs simply because certain health-related expenses are excluded altogether from Medicare coverage. The most glaring of those exclusions for almost forty years was Medicare's absence of outpatient prescription drug coverage, a gap only partially closed by the creation of Part D,¹³⁰ effective in 2006 by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA).¹³¹ Other notable coverage exclusions have been preventive care expenses (such as annual wellness exams), regular dental and vision care, and long-term care costs.¹³² Most Medicare beneficiaries—eighty-nine percent in 2007—mitigate the impact of these gaps by maintaining some form of supplemental insurance.¹³³ For thirty-four percent of Medicare-eligible retirees, that supplemental insurance in 2007 came from an employer's retiree health insurance plan.¹³⁴ Another twenty-two percent the same year elected a Medicare Advantage plan in lieu of traditional Medicare Parts A and B;¹³⁵ seventeen percent paid for private supplemental plans, better known as "Medi-

up to a maximum of 150 days total. *See id.* Days 91 to 150 are considered "Lifetime Reserve Days" that can be used only once, no matter how many spells of illness. *Id.* Part A coinsurance for a stay in a skilled nursing facility was \$137.50 in 2010 for each day in the facility after the first twenty and up to a maximum of 100 days. *Id.*

128. *See id.*

129. For a beneficiary-oriented overview of Medicare, see generally CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE & YOU (2011), available at <http://www.medicare.gov/publications/pubs/pdf/10050.pdf>.

130. *See infra* Part V.F.2 for further discussion of the gaps in prescription drug coverage remaining after Part D.

131. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (codified in scattered sections of 42 U.S.C. and 26 U.S.C.).

132. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 129, at 2, 46.

133. KAISER FAMILY FOUND., EXAMINING SOURCES OF SUPPLEMENTAL INSURANCE AND PRESCRIPTION DRUG COVERAGE AMONG MEDICARE BENEFICIARIES: FINDINGS FROM THE MEDICARE CURRENT BENEFICIARY SURVEY, 2007, at 2 (2009), available at <http://www.kff.org/medicare/upload/7801-02.pdf>.

134. *See id.* at 2.

135. *See id.* Medicare Advantage plans must provide the same core benefits as traditional Medicare Parts A and B but may also provide additional, supplemental benefits. LYNN QUINCY, CONSUMERS UNION, CONSUMER OPTIONS WHEN MEDICARE ADVANTAGE PLANS WITHDRAW OR CHANGE THEIR BENEFITS 2 (2010), available at <http://prescriptionforchange.org/pdf/When%20MA%20Plans%20Withdraw.pdf>.

gap” insurance;¹³⁶ and fifteen percent qualified for Medicaid.¹³⁷ Despite such supplemental coverage, Medicare-eligible beneficiaries nonetheless incur significant out-of-pocket health care costs. In 2006, for example, even after implementation of Part D prescription drug coverage, one study found that health care costs consumed 14.1% of total household income for Medicare beneficiaries.¹³⁸

Overall, retirees with access to employer-based health insurance remain better off financially than their counterparts without such plans. Thus, an analysis of the savings for health care expenses required by a single man turning sixty-five in 2009 estimated that such an individual on average would need \$68,000 if he had retiree health insurance but \$111,000 without employment-based retiree health benefits.¹³⁹ To the extent that an individual retired expecting such financial support, elimination of retiree health benefits may be a far more significant financial hit than the absence of such benefits might be to an individual who never anticipated such support and thus chose to retire based on other resources. Not surprisingly, studies show that a key component of many individuals’ retirement decision-making process is whether their employer offers retiree health benefits.¹⁴⁰ The problem for retirees—whether early or Medicare-eligible—then becomes whether those retiree health benefits will continue as expected.

136. See KAISER FAMILY FOUND., *supra* note 133, at 2. Medigap plans are highly regulated supplemental insurance. By federal law, there are only thirteen alternative benefit packages—denoted by letters A through N—that private insurers may offer as Medigap insurance. See CTRS. FOR MEDICARE & MEDICAID SERVS., CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE 2011, at 9–11 (2011), available at <http://www.medicare.gov/publications/pubs/pdf/02110.pdf>.

137. See KAISER FAMILY FOUND., *supra* note 133, at 2.

138. JULIETTE CUBANSKI ET AL., KAISER FAMILY FOUND., HEALTH CARE ON A BUDGET: AN ANALYSIS OF SPENDING BY MEDICARE HOUSEHOLDS 2 (2009), available at <http://www.kff.org/medicare/upload/7859.pdf>. Average out-of-pocket health care spending by households with Medicare beneficiaries was \$4068 in 2006. *Id.* Health insurance premiums, including Medicare Part B and D premiums and supplemental insurance coverage, represented 62.9% of the health care expenses for those households; prescription drugs (18.1%), medical services (15.3%), and medical supplies (3.8%) were responsible for the rest of the costs. *Id.* at 3.

139. Fronstin et al., *supra* note 123, at 6 fig.2.

140. See Fronstin, *supra* note 18, at 4 (“In 1998, 74 percent of workers reported that they would not retire before becoming eligible for Medicare if their employer did not provide retiree benefits. In fact, some potential retirees have chosen to remain in the labor force longer than planned.”). See also Karoly & Rogowski, *supra* note 111 (noting that “health insurance is indeed an important determinant of early retirement among male workers”).

IV. Health Reform and Employer Plans Generally

Against this backdrop arrived the Affordable Care Act in late March of 2010, almost immediately followed with amendments in the Reconciliation Act. Structured to attack perceived weaknesses in the U.S. health care system from multiple sides simultaneously, the Act seems destined to change the American health insurance system in fundamental ways.¹⁴¹ The Affordable Care Act—the base legislation—contains ten Titles that span an enormous range of topics, including creating state-based health insurance “Exchanges” in Title I,¹⁴² expanding Medicaid coverage in Title II,¹⁴³ changing the Medicare payment processes (and lowering Medicare Advantage reimbursement) in Title III,¹⁴⁴ supporting chronic disease management and improved public health management in Title IV,¹⁴⁵ developing the health care workforce in Title V,¹⁴⁶ targeting potential sources of health care

141. In remarks before signing the Affordable Care Act, President Barack Obama characterized the new law as “enshrin[ing] . . . the core principle that everybody should have some basic security when it comes to their health care.” Jesse Lee, “On Behalf of My Mother,” WHITE HOUSE BLOG (Mar. 23, 2010, 1:33 PM), <http://www.whitehouse.gov/blog/2010/03/23/belief-my-mother>. The New York Times called the legislation “the most sweeping piece of federal legislation since Medicare was passed in 1965.” David Leonhardt, *Health Care Overhaul Becomes the Law of the Land: In the Process, Pushing Back at Inequality*, N.Y. TIMES, Mar. 24, 2010, at A1. An optimistic HHS summary of the law’s impact reflects the sweeping scope of the legislation, stating that it will: (1) “[r]ein in the worst excesses and abuses of the insurance industry with some of the toughest consumer protections this country has ever known;” (2) “[h]old insurance companies accountable to keep premiums down and prevent denials of care and coverage, including for pre-existing conditions;” (3) “[m]ake health insurance affordable for middle class families and small businesses with one of [the] largest tax cuts for health care in history—reducing premiums and out-of-pocket costs;” (4) “[p]rovide the security of knowing that if you lose your job, change your job, or start that new business, you’ll always be able to purchase quality, affordable care in a new competitive health insurance market that keeps costs down;” (5) “[s]trengthen Medicare benefits with lower prescription drug costs for those in the ‘donut hole,’ chronic care, free preventive care, and nearly a decade more of solvency for Medicare;” and (6) “[i]mprove our nation’s fiscal health by reducing our deficit by more than \$100 billion over the next decade, and more than \$1 trillion in the decade after that.” *About*, HEALTHREFORM.GOV, <http://www.healthreform.gov/about/index.html> (last visited Apr. 24, 2011).

142. Patient Protection and Affordable Care Act, §§ 1311–1313, 124 Stat. at 173–85 (to be codified at 42 U.S.C. §§ 18031–18033).

143. Patient Protection and Affordable Care Act, §§ 2001–2955, 124 Stat. at 271–353 (to be codified in scattered sections of 42 U.S.C.).

144. Patient Protection and Affordable Care Act, §§ 3001–3602, 124 Stat. at 353–538 (to be codified in scattered sections of 42 U.S.C.).

145. Patient Protection and Affordable Care Act, §§ 4001–4402, 124 Stat. at 538–588 (to be codified in scattered sections of 42 U.S.C.).

146. Patient Protection and Affordable Care Act, §§ 5001–5701, 124 Stat. at 588–684 (to be codified in scattered sections of 42 U.S.C.).

fraud and abuse in Title VI,¹⁴⁷ and supporting “innovative medical therapies” in Title VII.¹⁴⁸ Despite the legislation’s overall breadth, the core provisions affecting employment-based plans appear primarily in Title I, with amendments in Title X and in the Reconciliation Act. The new rules attempt both to strengthen and expand the reach of employment-based health insurance while also curbing certain perceived flaws.

A. Background

Neither the Employee Retirement Income Security Act of 1974, as amended (ERISA),¹⁴⁹ nor the Internal Revenue Code of 1986, as amended (the Code), the two major federal statutes regulating employment-based health insurance before the Act, require employers to provide any form of health benefit to employees. Only if an employer chooses to provide such benefits do ERISA and the Code apply. The Act, however, will affect almost all employers eventually, even if they do not choose to offer health insurance.¹⁵⁰

Employers that currently sponsor health benefit plans were affected by the Act almost immediately after enactment, with various provisions phasing in during a transition period leading to full implementation in 2014. Exactly when certain rules phase in depends on such considerations as whether a plan is collectively bargained;¹⁵¹

147. Patient Protection and Affordable Care Act, §§ 6001–6607, 124 Stat. at 684–782 (to be codified in scattered sections of 42 U.S.C.).

148. Patient Protection and Affordable Care Act, §§ 7001–7103, 124 Stat. at 804–28 (to be codified in scattered sections of 42 U.S.C.). Title VIII shifts away from traditional health care to create a national voluntary long-term care insurance program through the “Community Living Assistance Services and Supports” (CLASS) Act. Patient Protection and Affordable Care Act, §§ 8001–8002, 124 Stat. at 828–47, amended by § 10801, 124 Stat. at 1015 (to be codified at 42 U.S.C. §§ 30011 to 11-9). Title IX contains a number of tax provisions intended to levy funds to support health reform. Patient Protection and Affordable Care Act, §§ 9001–9023, 124 Stat. at 847–83 (to be codified in scattered sections of I.R.C.). Title X then amends the preceding nine Titles, with the Reconciliation Act continuing those amendments.

149. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001–1461 (2006)).

150. During the transition period that extends through 2013, however, an employer that does not currently offer health insurance to its employees may continue to avoid doing so. See *infra* Section IV.C.

151. If an employer maintains a health insurance plan pursuant to a collective bargaining agreement (CBA) that was ratified before March 23, 2010, that plan need not comply with certain of the Act’s rules—such as the prohibition on the lifetime benefit limits—until after expiration of the bargaining agreement. Patient Protection and Affordable Care Act, § 1251(d), 124 Stat. at 162 (to be codified at 42 U.S.C. § 18011(d)).

whether it was in effect on or before the March 23, 2010, enactment date of the Act (thus, may qualify as “grandfathered”¹⁵²); whether an employer is self-insured or purchases coverage through an insurer;¹⁵³ the employer’s size;¹⁵⁴ and the type of benefits a plan offers.¹⁵⁵

152. A plan in which individuals were enrolled on the date of enactment—i.e., March 23, 2010—may qualify as a “grandfathered” plan under the Act. Grandfathered plans are expressly exempt from some of the Act’s new rules, however, the Act does not detail what changes in a plan could result in loss of grandfathered status, leaving that to regulations. The Act does state, however, that employees may re-enroll and new employees (and their dependents) may join a plan without affecting the grandfathering. Patient Protection and Affordable Care Act, §§ 1251(a)–(c), 124 Stat. at 161 (to be codified at 42 U.S.C. §§ 18011(a)–(c)). In June 2010, the HHS issued interim regulations addressing the question. *See* Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan, 75 Fed. Reg. 34, 538 (June 17, 2010) (to be codified at 45 C.F.R. pt. 147). These regulations make it difficult for employers to preserve grandfathered status. Thus, one study found that ninety percent of surveyed companies “anticipate losing grandfathered status by 2014, with the majority expecting to do so in the next two years.” HEWITT ASSOCS., SURVEY HIGHLIGHTS EMPLOYER REACTION TO HEALTH CARE REFORM: GRANDFATHERED STATUS SURVEY 1 (Aug. 2010), available at http://www2.hewittassociates.com/_MetaBasicCMAssetCache_/Assets/Articles/2010/ER_Reaction_HC_Grandfathered.pdf. In most cases (approximately seventy-two percent), employers cited future plan design changes as the likely trigger for loss of grandfathered status. *Id.* at 2.

153. Since ERISA’s passage in 1974, the difference in regulation between a self-insured and an insured plan has been significant. A self-insured plan (as opposed to an insured plan) is one in which the employer bears the risk of the health insurance benefits—i.e., that claims will exceed premiums paid—instead of an insurance company. *See, e.g.,* EMP. BENEFIT RESEARCH INST., HEALTH PLAN DIFFERENCES: FULLY-INSURED V. SELF-INSURED 1 (2009), available at <http://www.ebri.org/pdf/FFE114.11Feb09.Final.pdf>. Large employers often choose to self-insure their health plans because doing so brings them under the protection of ERISA’s broad preemption clause that exempts them from state insurance regulation. *Id.* *See also* 29 U.S.C. § 1144 (2006). Smaller employers, on the other hand, usually purchase group health insurance policies from insurance companies, with the insurers bearing the financial risk under the policy. In 2009, for example, seventy-seven percent of employers with 200 or more employees sponsored a self-insured plan as compared with only fifteen percent of employers with fewer than 200 employees. KAISER/HRET 2009 ANNUAL SURVEY, *supra* note 66, at 156. Because ERISA does not pre-empt state law as it applies to companies licensed to sell insurance within that state, a group health policy purchased from an insurance company is subject to state regulation, typically including a variety of mandated benefits and other provisions. KAMINSKI, *supra* note 122. The Act removes much of the distinction between insured and self-insured group health plans by applying its provisions broadly. As a result, many employers who are accustomed to disregarding mandated benefit rules, among other requirements, due to their self-insured status may be surprised by the degree to which new rules apply to their plans even before 2014. *See* Shearman & Sterling LLP, *Self-Insured Medical Plans After Health Reform*, EXECUTIVE COMPENSATION & EMP. BENEFITS (Apr. 29, 2010), available at <http://www.shearman.com/files/Publication/4c7a54d4-748c-4d2b-a68e-14063a5b38fb/Presentation/PublicationAttachment/8789de05-4a85-48f9-820a-d7f110a6e6c6/ECEB-042910-Self-Insured-Medical-Plans-after-Health-Reform.pdf>.

B. Provisions Applicable Generally Before 2014

A number of new rules applicable before 2014 became effective for the first plan year beginning on or after six months after the date of enactment—i.e., the first plan year beginning on or after September 23, 2010. For most employer-sponsored health plans, that translated to a January 1, 2011, effective date.

1. EXPANDED COVERAGE OF DEPENDENTS

Under the Act, all employer-sponsored plans, including grandfathered ones, that provide medical coverage for dependents must allow participants to elect coverage for their children until a child reaches age twenty-six, effective for the first plan year beginning on or after September 23, 2010.¹⁵⁶ Grandfathered plans do not need to cover an adult child before January 1, 2014, if that child is eligible to enroll in another “eligible employer-sponsored health plan” (other than the group health plan of a parent).¹⁵⁷ Before the amendments made by

for an interesting discussion of various issues applicable to self-insured plans, including what may be technical glitches in the legislation.

154. A number of the Act’s provisions target small employers in an effort to encourage their provision of health insurance. These provisions reflect a significant disparity in available benefits between large and small employers. Currently smaller employers are much less likely to offer health insurance benefits than their larger counterparts. The March 2009 National Compensation Survey found that only fifty-five percent of employers with fewer than fifty employees offered health benefits as compared to seventy-one percent of employers with fifty to ninety-nine employees, eighty-one percent of employers with 100 to 499 employees, and eighty-eight percent of employers with 500 or more employees. U.S. DEP’T OF LABOR, BUREAU OF LABOR STATISTICS, NATIONAL COMPENSATION SURVEY tbl.9 (2009), available at <http://www.bls.gov/ncs/ebs/benefits/2009/ownership/private/table05a.pdf>.

155. For example, a number of Act provisions affect FSAs, HSAs, HRAs, and similar vehicles for tax-advantaged individual savings toward health care expenses. See Patient Protection and Affordable Care Act, § 9003, 124 Stat. at 854 (to be codified in scattered sections of I.R.C.). The Act generally imposes new restrictions on all these types of accounts, and many employers are likely to be affected by at least some of the new limits. Similarly, employers who sponsor cafeteria plans under I.R.C. § 125—in effect, funding mechanisms through which employees may elect to pay for various benefits on a pre-tax basis—will find that they must make adjustments over the next few years to comply with certain Act rules that directly target these arrangements.

156. Patient Protection and Affordable Care Act, § 1001, 124 Stat. at 132, amended by Health Care and Education Reconciliation Act, § 2301, 124 Stat. at 1081–82 (to be codified at 42 U.S.C. § 300gg-14).

157. Health Care and Education Reconciliation Act, § 2301, 124 Stat. at 1082. See also Interim Final Rules for Group Health Plans and Health Insurance Issues Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 27,122 (May 13, 2010) (to be codified at

the Act, many employer plans covered dependent adult children only if the dependents were both full-time students and under a certain age. Young adults between eighteen and twenty-six years of age often have been uninsured or underinsured.¹⁵⁸ Although requiring employer plans to extend such coverage necessarily imposes an additional long-term expense on a plan, many large health insurers announced in mid-2010 that they were willing to immediately extend coverage to children under age twenty-six if employers elected to do so.¹⁵⁹ The Act further targets coverage for dependents by prohibiting—effective for the first plan year beginning on or after September 23, 2010—pre-existing condition exclusions for children under age nineteen.¹⁶⁰ The prohibition on pre-existing condition exclusions applies to all group health plans beginning in 2014.¹⁶¹

2. RESTRICTED/PROHIBITED ANNUAL AND LIFETIME LIMITS

Also applicable for the first plan year beginning on or after September 23, 2010, the Act prohibits lifetime dollar limits on coverage for “essential health benefits.”¹⁶² In addition, for plan years beginning on

45 C.F.R. pts. 144, 146–47 and scattered titles of the C.F.R.); I.R.S. Notice 2010-38 (Apr. 22, 2010), available at <http://www.irs.gov/pub/irs-drop/n-10-38.pdf>.

158. See Timothy Jost, *Implementing Health Reform: Young Adult Coverage*, HEALTH AFF. BLOG (May 11, 2010, 6:43 PM), <http://healthaffairs.org/blog/2010/05/11/implementing-health-reform-young-adult-coverage/> (noting that HHS estimates in 2010 that, of the 29.5 million individuals in this age group, 3.44 million are uninsured).

159. See Press Release, White House, *Young Adults and the Affordable Care Act: Preventing Coverage Gaps, Lowering Administrative Costs and Eliminating Burdens on Businesses and Families* (Apr. 22, 2010), available at http://www.whitehouse.gov/sites/default/files/rss_viewer/fact_sheet_young_adult_tax_treatment.pdf. It is unclear how many employers will take advantage of this option. See, e.g., Michelle Andrews, *Why Won't My Insurance Cover My Son Until 2011?*, N.Y. TIMES BLOG (May 24, 2010, 9:00 AM), <http://prescriptions.blogs.nytimes.com/2010/05/24/why-cant-i-cover-my-son-until-2011/?hpw>. A May 2010 study found that about seventy-seven percent of surveyed employers (representing 500 companies with 6.9 million covered employees) had no intention of extending coverage to adult children before the time required by the Act. HEWITT ASSOCS., *HEALTH CARE REFORM: COVERAGE FOR ADULT CHILDREN SURVEY 1 (2010)*, available at http://www2.hewittassociates.com/_MetaBasicCMAssetCache_/Assets/Articles/2010/Hewitt_HealthCareReformAdultChildren.pdf.

160. Patient Protection and Affordable Care Act, § 1201, 124 Stat. at 154–55, amended by § 10103(e)(2), 124 Stat. at 895; Health Care and Education Reconciliation Act, § 2301, 124 Stat. at 1081–82 (to be codified at 42 U.S.C. §§ 300gg-1 to gg-4).

161. Patient Protection and Affordable Care Act, § 1253, 124 Stat. at 162 (to be codified at 42 U.S.C. § 300gg).

162. Patient Protection and Affordable Care Act, §§ 1001, 1004, 124 Stat. at 131, 140, amended by § 10101(a), 124 Stat. at 883–84; Health Care and Education Reconciliation Act, § 2301, 124 Stat. at 1081–82 (to be codified at 42 U.S.C. § 300gg-11).

or after September 23, 2010, but before January 1, 2014, the Act allows only “restricted” annual limits on essential benefits coverage; beginning in 2014, annual limits are prohibited on such coverage.¹⁶³ The term “essential health benefit” includes such categories as emergency care, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, hospitalization, pediatric care, ambulatory patient services, laboratory services, certain preventive and wellness services, chronic disease management, and rehabilitative services.¹⁶⁴ Historically, plan sponsors and insurers have used annual and lifetime dollar limits to cap their exposure to medical costs. Without such limits, potentially much greater risk is shifted to whoever bears the ultimate cost of a particular plan (either an insurance company or the employer in a self-insured plan).¹⁶⁵

3. EXPANDED REPORTING AND DISCLOSURE

The Act also requires all plans – whether grandfathered or not – to provide participants with a “summary of benefits and coverage explanation” that meets standardized guidelines as to appearance, content, and language.¹⁶⁶ These disclosure rules generally take effect in 2010 but do not require that the uniform explanation be provided to individuals until March 23, 2012 (two years after the Act’s enactment).¹⁶⁷ Because ERISA applies to welfare benefits such as medical insurance,¹⁶⁸ employer-sponsored plans have long been subject to reporting and disclosure requirements that mandate delivery of a summary plan description (SPD) to participants and enumerate certain types of information that must be included.¹⁶⁹ Exactly how a particu-

163. Patient Protection and Affordable Care Act, § 1001, 124 Stat. at 131, amended by § 10101(a), 124 Stat. at 883–84 (to be codified at 42 U.S.C. § 300gg–11).

164. Patient Protection and Affordable Care Act, § 1302(b), 124 Stat. at 163–65 (to be codified at 42 U.S.C. § 18022). The Act authorized the Secretary of HHS to determine the specifics of what constitutes both a permissible “restricted annual limit” and an “essential health benefit.” Patient Protection and Affordable Care Act, § 1001, 124 Stat. at 883–84 (to be codified at 42 U.S.C. § 300gg–11).

165. Plan sponsors may purchase stop-loss insurance policies to mitigate the risk.

166. Patient Protection and Affordable Care Act, § 1001, 124 Stat. at 132–35, amended by §§ 10101(b)–(c), 124 Stat. at 883–84 (to be codified at 42 U.S.C. § 300gg–15); Patient Protection and Affordable Care Act, § 10103(d), 124 Stat. at 895 (to be codified at 42 U.S.C. § 18011).

167. Patient Protection and Affordable Care Act, § 1001, 124 Stat. at 133–34 (to be codified at 42 U.S.C. § 300gg–15).

168. 29 U.S.C. § 1002(1) (2006).

169. See, e.g., 29 U.S.C. § 1022 (2006).

lar employer plan chooses to structure the SPD and present the material, however, has been largely discretionary, subject to ERISA's directive that an SPD be written "in a manner calculated to be understood by the average plan participant."¹⁷⁰ The new Act rules may be viewed as an extension of the ERISA effort to allow plan participants to understand their benefits. Separately, however, the Act also imposes other new reporting requirements.¹⁷¹ Taken together, the various reporting and disclosure requirements will add to employers' administrative burden, increasing plan costs.

4. MISCELLANEOUS OTHER PROVISIONS

Also effective the first plan year beginning on or after September 23, 2010, is a rule barring any group health plan (or health insurance issuer), including grandfathered ones, from rescinding coverage from a covered individual in the absence of fraud or material misrepresentation.¹⁷² An additional set of provisions effective at the same time do not apply to grandfathered employer-sponsored plans, which may exempt some existing plans for a few more years.¹⁷³ These rules include a requirement that a plan must provide 100% coverage of specified preventive care services,¹⁷⁴ a prohibition on discrimination in favor of highly compensated employees,¹⁷⁵ new internal and external claims processes,¹⁷⁶ and a prohibition on required preauthorization or referral for obstetrical/gynecological and emergency room services (as well as on increased cost-sharing for emergency services).¹⁷⁷

170. 29 U.S.C. § 1022.

171. *See, e.g.*, Patient Protection and Affordable Care Act, § 1001, 124 Stat. at 125-36 (to be codified at 42 U.S.C. § 300gg-17) (requiring reporting to HHS within two years of the Act's enactment as to plan benefits and structures that "improve health outcomes" and otherwise improve quality of care).

172. Patient Protection and Affordable Care Act, §1001, 124 Stat. at 131 (to be codified at 42 U.S.C. § 300gg-12); Health Care and Education Reconciliation Act, § 2301, 124 Stat. at 1081-82 (amending Patient Protection and Affordable Care Act, § 10103(d), 124 Stat. at 895).

173. Plans may lose grandfathered status comparatively easily, however. *See HEWITT ASSOCS., supra* note 152, at 1.

174. Patient Protection and Affordable Care Act, §1001, 124 Stat. at 131-32 (to be codified at 42 U.S.C. § 300gg-13).

175. Patient Protection and Affordable Care Act, §10101(d), 124 Stat. at 884 (to be codified at 42 U.S.C. § 300gg-16).

176. Patient Protection and Affordable Care Act, §10101(g), 124 Stat. at 887-88 (to be codified at 42 U.S.C. § 300gg-19).

177. Patient Protection and Affordable Care Act, § 10101(h), 124 Stat. at 887-91 (to be codified at 42 U.S.C. § 300gg-19a).

Various other rules phase in from 2011 through 2013. For example, the Act requires employers to begin reporting in 2011 the total cost of employer-sponsored medical benefits on employee W-2s.¹⁷⁸ Also effective in 2011, neither flexible savings accounts (FSAs), health savings accounts (HSAs), nor health reimbursement accounts (HRAs) may continue to reimburse over-the-counter drugs unless they qualify as a “prescribed drug,” a term not defined in the Act.¹⁷⁹ Beginning in 2013, the Medicare hospital tax—which is collected by employers—is scheduled to increase from 1.45% to 2.35% on wages over \$200,000 for individuals filing single tax returns (\$250,000 for individuals filing joint returns).¹⁸⁰ Another 2013 change caps contributions to an FSA through a cafeteria plan at \$2500 (indexed for subsequent years) per participant.¹⁸¹ Although these changes affect individuals far more directly than their employers, the new requirements will necessitate administrative changes by employers, including payroll system updates. Such changes can be expensive, again driving up the overall cost of maintaining health benefits to a company.

C. Provisions Applicable Generally in 2014

All of the Act provisions effective before 2014 may be seen as just a warm-up for the overhaul of the U.S. health insurance system that takes effect January 1, 2014. For as long as modern health insurance has existed in this country, most individuals have obtained coverage, if at all, through their employers.¹⁸² Employers, however, have re-

178. Certain health-related amounts, such as salary reduction contributions to an FSA, are excluded from the tax reporting requirement. Patient Protection and Affordable Care Act, § 9002, 124 Stat. at 853–54 (amending I.R.C. § 6051(a)).

179. The limitation also applies to reimbursements from an Archer medical savings account. Patient Protection and Affordable Care Act, § 9003, 124 Stat. at 854 (codified in scattered sections of I.R.C.). Reimbursement of over-the-counter drugs on a tax-free basis through FSAs and the like was a relatively recent rule. Rev. Rul. 2003-102, 2003-2 C.B.559. See also I.R.S. News Release JS-695 (Sept. 3, 2003), available at <http://www.drinkerbiddle.com/files/Publication/efe047a3-0211-4ef0-b6db-a4ec9225122c/Presentation/PublicationAttachment/ae04bbbed-5f36-4292-b44f-408e0b4995bb/TreasuryandIRS.pdf>. Also, reimbursement of other over-the-counter health-related purchases, such as bandages, does not appear to be prohibited by the Act.

180. Patient Protection and Affordable Care Act, § 9015, 124 Stat. at 870–71, amended by § 10906, 124 Stat. at 1020 (amending I.R.C. §§ 3101–3102).

181. Patient Protection and Affordable Care Act, § 10902, 124 Stat. at 1016, amended by Health Care and Education Reconciliation Act, § 1403, 124 Stat. at 1063 (to be codified at I.R.C. § 125(i)).

182. In 2008, even after decline driven by the economic downturn, 63.3% of adults age nineteen to sixty-four, and 58.8% of children age eighteen or younger,

tained almost complete discretion to offer health benefits or not, subject to private contractual obligations through collective bargaining and otherwise. The Act ushers in a completely different approach.

Beginning in 2014, assuming nothing changes before then, health insurance will cease to be discretionary. Individuals will be subject to tax penalties—phased in over several years—if they do not maintain “minimum essential coverage,” with exemptions for low-income individuals and certain other groups (such as incarcerated persons).¹⁸³ The term “minimum essential coverage” includes coverage under an employer-sponsored health plan that meets certain requirements.¹⁸⁴

Concurrently, larger employers will also be subject to penalties—a “pay or play” provision—if they fail to provide a specified level of health insurance. So-called “large” employers—generally, those with an average of fifty or more full-time employees during the prior calendar year¹⁸⁵—must pay an assessment of \$2000 per full-time employee (excluding the first thirty such employees) if the employer does not offer “minimum essential coverage” and at least one such employee obtains subsidized coverage through a state-based American Health Benefit Exchange (an “Exchange”).¹⁸⁶ This \$2000-per-full-time-employee penalty applies without regard to how many employees receive federally subsidized coverage. Thus, if just one full-

had employer-sponsored insurance. See JOHN HOLAHAN & ALLISON COOK, KAISER COMM’N ON MEDICAID & THE UNINSURED, CHANGES IN HEALTH INSURANCE COVERAGE, 2007–2008: EARLY IMPACT OF THE RECESSION 4–5 (2009), available at <http://www.kff.org/uninsured/upload/8004.pdf>.

183. Patient Protection and Affordable Care Act, § 1501(b), 124 Stat. at 244–49, amended by Patient Protection and Affordable Care Act, §§ 10106(b)–(d), 124 Stat. at 909–10; Health Care and Education Reconciliation Act, § 1002, 124 Stat. at 1032–33 (to be codified at I.R.C. § 5000A).

184. Patient Protection and Affordable Care Act, § 1501(b), 124 Stat. at 248 (to be codified at I.R.C. § 5000A(f)).

185. A full-time employee for this purpose is defined as one who is “employed on average at least 30 hours of service per week.” Patient Protection and Affordable Care Act, § 1513(a), 124 Stat. at 254–55, amended by §§ 10106(e)–(f), 124 Stat. at 910–11; Health Care and Education Reconciliation Act, § 1003, 124 Stat. at 1033 (to be codified at I.R.C. §§ 4680H(d)(2), (4)).

186. Patient Protection and Affordable Care Act, § 1513(a), 124 Stat. at 253, amended by §§ 10106(e)–(f), 124 Stat. at 910–11; Health Care and Education Reconciliation Act, § 1003, 124 Stat. at 1033 (to be codified at I.R.C. § 4680H(a)). The \$2000 penalty amount is annualized, but the actual penalty computation is monthly. HHS calls the new Exchanges, operational in 2014, “a new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans.” *Healthy Individuals Have More Affordable Options for Health Coverage*, HEALTHCARE.GOV, <http://www.healthcare.gov/foryou/healthy/index.html> (last visited Apr. 24, 2011).

time employee qualifies for and receives the subsidy, the employer must pay the \$2000 for all full-time employees.¹⁸⁷ This penalty provision appears intended to induce employers to provide coverage sufficiently adequate in benefits and affordable in price to avoid employees preferring federally subsidized coverage, yet some employers may determine that \$2000 per full-time employee—even computed for all full-time employees after the first thirty—is less than what they currently expend for health benefits on a per-participant basis. If so, the provision could trigger decisions to cease providing benefits and simply pay the \$2000 per employee penalty.

Moreover, even if an employer does offer adequate coverage to its employees, if one or more full-time employees enroll in subsidized coverage through an Exchange instead, the employer must pay a penalty of \$3000 for each such employee, subject to an overall cap of \$2000 multiplied by the total number of full-time employees (after the first thirty).¹⁸⁸ No penalty applies with regard to employees who refuse employer-sponsored coverage and enroll in coverage through an Exchange, but who do not qualify for federally subsidized assistance in paying for the Exchange coverage.¹⁸⁹ In general, an employee eligible for employer-sponsored coverage can qualify for subsidized coverage through an Exchange only if the employee's household income does not exceed 400% of the federal poverty level for a family of the applicable size and either the employee's required contribution toward the cost of coverage exceeds 9.5% of the individual's house-

187. Patient Protection and Affordable Care Act, § 1513(a), 124 Stat. at 253, amended by §§ 10106(e)-(f), 124 Stat. at 910-11; Health Care and Education Reconciliation Act, § 1003, 124 Stat. at 1033 (to be codified at I.R.C. § 4680H(a)).

188. Patient Protection and Affordable Care Act, § 1513(a), 124 Stat. at 253-54, amended by §§ 10106(e)-(f), 124 Stat. at 910-11; Health Care and Education Reconciliation Act, § 1003, 124 Stat. at 1033 (to be codified at I.R.C. § 4680H(c)). The \$3000 penalty amount is annualized, but the actual penalty computation is monthly.

189. Any "qualified individual" may enroll in a plan through an Exchange. See Patient Protection and Affordable Care Act, §§ 1312(a), (d), 124 Stat. at 182-83 (to be codified at 42 U.S.C. §§ 18032(a), (d)). A "qualified individual" under the Act means "with respect to an Exchange, an individual who (i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange, and (ii) resides in the State that established the Exchange" Patient Protection and Affordable Care Act, § 1312(f)(1)(A), 124 Stat. at 183-84 (to be codified at 42 U.S.C. § 18032(f)).

hold income or the employer plan does not cover at least sixty percent of the cost of minimum essential coverage.¹⁹⁰

In addition, employers must provide “free choice vouchers” to any employee whose household income does not exceed 400% of the federal poverty level for the applicable family size and whose required contributions for minimum essential coverage through the employer’s plan are more than 8.0% (but less than 9.8%) of the employee’s household income for the year.¹⁹¹ The amount of the voucher is calculated as the employer’s share of the cost of coverage under the employer plan using the plan option with the largest share covered by the employer.¹⁹²

In addition to the various mandates on providing and purchasing health insurance coverage, beginning in 2014, employer-sponsored plans face other requirements that are intended to enhance the quality of coverage for participants but also will tend to increase employer costs. For example, the prohibition on applying pre-existing condition exclusions to children under age nineteen¹⁹³ extends to all enrollees beginning in 2014.¹⁹⁴ Both lifetime and annual limits on the dollar value of benefits are barred; the exception for “restricted annual limits” does not apply after 2013.¹⁹⁵ Employers that offer health insurance and have more than 200 full-time employees must automatically enroll new full-time employees in coverage, although employees may then opt out of coverage.¹⁹⁶ Waiting periods of more than ninety

190. Patient Protection and Affordable Care Act, § 1401, 124 Stat. at 215–17, amended by §§ 10105(a)–(d), 124 Stat. at 906; Health Care and Education Reconciliation Act, § 1001(a), 124 Stat. at 1030–31 (to be codified at I.R.C. § 36B(c)).

191. Patient Protection and Affordable Care Act, §§ 10108(a)–(c), 124 Stat. at 912 (to be codified at 42 U.S.C. §§ 18101(a)–(c)).

192. Patient Protection and Affordable Care Act, § 10108(d), 124 Stat. at 912–13 (to be codified at 42 U.S.C. § 18101(d)). The value of the vouchers is excluded from taxable income. Patient Protection and Affordable Care Act, § 10108(f), 124 Stat. at 913 (to be codified at I.R.C. § 139D). Employees may apply the value of the voucher toward coverage under an exchange. Patient Protection and Affordable Care Act, § 10108(d)(2), 124 Stat. at 913 (to be codified at 42 U.S.C. § 18101(d)(2)).

193. Patient Protection and Affordable Care Act, § 1201, 124 Stat. at 154–55, amended by § 10103(e)(2), 124 Stat. at 895; Health Care and Education Reconciliation Act, § 2301, 124 Stat. at 1081–82 (to be codified at 42 U.S.C. §§ 300gg–1 to gg–4). See *supra* note 171 and accompanying text.

194. Patient Protection and Affordable Care Act, § 1253, 124 Stat. at 162 (to be codified at 42 U.S.C. § 300gg).

195. Patient Protection and Affordable Care Act, § 1001, 124 Stat. at 131, amended by § 10101(a), 124 Stat. at 883–84 (to be codified at 42 U.S.C. § 300gg–11).

196. Patient Protection and Affordable Care Act, § 1511, 124 Stat. at 252 (to be codified at 29 U.S.C. § 218A).

days for plan eligibility are also barred beginning in 2014,¹⁹⁷ a provision with potential cost implications for industries that experience high turnover rates. Participant cost-sharing (i.e., deductibles, coinsurance, and similar payments)¹⁹⁸ in non-grandfathered plans may not exceed the out-of-pocket dollar limits applicable under the Code for high-deductible health plans (with adjustments for 2015 and later years).¹⁹⁹ At the same time, however, employers are allowed to create rewards—with a value of up to “30 percent of the cost of employee-only coverage under the plan”—to encourage employee participation in wellness programs.²⁰⁰

At the same time that increased pressure is placed on employers to offer coverage at a certain level, significant reform to individual and small group insurance markets will take effect, presumably easing small employers' struggle to provide health insurance for employees.²⁰¹ Thus, individuals and small employers (generally, those with 100 or fewer employees)²⁰² will be able to purchase regulated and standardized coverage packages through state-based health insurance Exchanges.²⁰³ Smaller employers (generally, those with twenty-five or

197. Patient Protection and Affordable Care Act, § 1201, 124 Stat. at 161, amended by § 10103, 124 Stat. at 892 (to be codified at 42 U.S.C. § 300gg-7).

198. Patient Protection and Affordable Care Act, § 1302(c)(3), 124 Stat. at 166-67 (to be codified at 42 U.S.C. § 18022(c)(3)).

199. Patient Protection and Affordable Care Act, § 1302(c)(1), 124 Stat. at 166-67 (to be codified at 42 U.S.C. § 18022(c)(1)).

200. Patient Protection and Affordable Care Act, § 1201, 124 Stat. at 157-58 (to be codified at 42 U.S.C. § 300gg-4(j)(3)(A)).

201. See generally Patient Protection and Affordable Care Act, §§ 1201-1253, 1311-1313, 124 Stat. at 154-62, 173-85 (to be codified in scattered sections of 42 U.S.C.).

202. See Patient Protection and Affordable Care Act, § 1311(b)(1), 124 Stat. at 173 (to be codified at 42 U.S.C. § 18031(b)(1)) (relating to establishment of American Health Benefit Exchanges); Patient Protection and Affordable Care Act, § 1311(d)(2)(A), 124 Stat. at 176 (to be codified at 42 U.S.C. § 18031(d)(2)(A)) (providing that an Exchange “shall make available qualified health plans to . . . qualified employers”); Patient Protection and Affordable Care Act, § 1312(f)(2)(A), 124 Stat. at 183-84 (to be codified at 42 U.S.C. § 18032(f)(2)(A)) (defining a “qualified employer” as a “small employer”); Patient Protection and Affordable Care Act, § 1304(b)(2), 124 Stat. at 172 (to be codified at 42 U.S.C. § 18024(b)(2)) (defining a “small employer” for purposes of Title I of the Act as “an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.”) A state may elect in 2014 and 2015 to lower the 101-employee threshold to a 51-employee level, thereby limiting access to an Exchange in those years. Patient Protection and Affordable Care Act, § 1304(b)(3), 124 Stat. at 172 (to be codified at 42 U.S.C. § 18024(b)(3)).

203. Patient Protection and Affordable Care Act, §§ 1311(b)-(d), 124 Stat. at 173-78 (to be codified at 42 U.S.C. §§ 18031(b)-(d)).

fewer employees and average wages of \$50,000 or less) will be eligible for an increased tax credit to offset the cost of insurance but only for two years and only if they purchase coverage through an Exchange.²⁰⁴ States may permit larger employers to participate in the Exchanges beginning in 2017.²⁰⁵ Among its many rules aimed at controlling health insurer behavior, the Act requires all health insurers to offer guaranteed issue²⁰⁶ and renewability²⁰⁷ (meaning that an individual generally cannot be refused or dropped from coverage) and permits basing premiums on only a limited range of factors (family structure, geography, age, and tobacco use).²⁰⁸

Because 2018 remains almost a decade in the future, at which point the U.S. will have a new presidential administration, the key provision with a significantly deferred effective date may not be worth too much consideration at this point.²⁰⁹ If the law remains as

204. In an effort to address the disparity between large and small employers with regard to providing health benefits, the Act attempts to make health insurance more affordable for smaller employers, initially by offering a tax credit beginning in 2010 to offset health insurance expenses for certain small employers (generally, those with twenty-five or fewer employees who pay no more than \$50,000 in average annual wages, and who cover at least fifty percent of employee health care premiums). For years before 2014, the maximum tax credit for non-tax-exempt small employers is computed generally as thirty-five percent of what the small employer pays in health insurance premiums for its employees (using, however, the average premium in a specified small group market in lieu of the actual premiums paid if the average premium amount would result in a lower tax credit amount). The credit phases out for employers with more than ten full-time equivalent employees or more than \$25,000 (pre-2014) in average annual wages. Beginning in 2014, the maximum percentage increases to fifty percent but is limited to a two-consecutive-year period that begins with the first year the employer offers its employees a health plan through an Exchange, an incentive clearly designed to nudge small employers toward using an Exchange. Patient Protection and Affordable Care Act, § 1421, 124 Stat. at 237–41, *amended by* § 10105(e), 124 Stat. at 906 (to be codified at I.R.C. § 45R); *see supra* note 154 and accompanying text (regarding the disparity between large and small employers with regard to health benefits). See I.R.S. Notice 2010-44 (May 17, 2010), for more information about how the tax credit will be implemented.

205. Patient Protection and Affordable Care Act, § 1312(f)(2)(B), 124 Stat. at 184 (to be codified at 42 U.S.C. § 18032(f)(2)(B)).

206. Patient Protection and Affordable Care Act, § 1201, 124 Stat. at 156 (to be codified at 42 U.S.C. § 300gg-1).

207. Patient Protection and Affordable Care Act, § 1201, 124 Stat. at 156 (to be codified at 42 U.S.C. § 300gg-2).

208. Patient Protection and Affordable Care Act, § 1201, 124 Stat. at 155–56 (to be codified at 42 U.S.C. § 300gg).

209. Going into the 2010 mid-term congressional elections, Republicans were already focused on efforts to limit the effect of the Affordable Care Act. *See, e.g.,* Robert Pear, *Short of Repeal, G.O.P. Will Chip at Health Law*, N.Y. TIMES, Sept. 20, 2010, <http://www.nytimes.com/2010/09/21/health/policy/21repeal.html> (citing

currently written, health insurance issuers (employers in the case of HSAs) will face a forty percent “Cadillac plan” excise tax on employer-sponsored health insurance coverage worth more than \$10,200 per individual (or \$27,500 per family) – with adjustments upward in those amounts for early retirees and individuals in certain other categories, including high-risk industries, where increased health costs may be likely.²¹⁰ These threshold amounts are indexed upward in subsequent years. Although dental and vision coverage is excluded from the computation of value,²¹¹ many employer plans could trigger the penalty as currently structured.²¹²

D. Overall Impact on Employers

Employment-based health benefits have faced financial strain for decades, with their decline and possible demise long predicted.²¹³ Still, in 2009, among employers who still maintained health insurance for their employees, the vast majority expected to continue to do so.²¹⁴ Meanwhile, President Obama made part of his health reform mantra the oft-quoted assurance that “[i]f you like your current insurance,

interviews “with a wide range of Republican lawmakers, who said they were determined to chip away at the law if they could not dismantle it”).

210. Patient Protection and Affordable Care Act, § 9001(a), 124 Stat. at 847–53, amended by § 10901, 124 Stat. at 1015–16; Health Care and Education Reconciliation Act, § 1401, 124 Stat. at 1059–60 (to be codified at I.R.C. § 4980I).

211. Patient Protection and Affordable Care Act, § 9001(a), 124 Stat. at 847–53, amended by § 10901, 124 Stat. at 1015–16; Health Care and Education Reconciliation Act, § 1401, 124 Stat. at 1059–60 (to be codified at I.R.C. § 4980I).

212. One survey conducted by Mercer before the Act passed concluded that one in five employer plans could trigger the “Cadillac” excise tax and that many affected employers would trim benefits to avoid the penalty. Press Release, Mercer, Majority of Employers Would Reduce Health Benefits to Avoid Proposed Excise Tax, Survey Finds 1 (Dec. 3, 2009), available at http://www.kaiserhealthnews.org/Stories/2009/December/02/~/_media/Files/2009/Health%20Care%20Reform%20Survey%20release%20%20final2.ashx.

213. See, e.g., INST. OF MED. & COMM. ON EMP’T-BASED HEALTH BENEFITS, EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 14 (Marilyn J. Field & Harold T. Shapiro eds., 1993) (predicting in the early 1990s that, without some degree of change, “the system of voluntary employment-based health benefits will significantly deteriorate and even collapse in some sectors”); see also Alain C. Enthoven & Victor R. Fuchs, *Employment-Based Health Insurance: Past, Present, and Future*, 25 HEALTH AFF. 1538, 1539 (2006) (“Regardless of data source, it appears that the best days of employment-based insurance are in the past.”).

214. KAISER/HRET 2009 ANNUAL SURVEY, *supra* note 66, at 8 (noting that “relatively few firms report that they are very likely (2%) or somewhat likely (6%) to drop coverage”).

you will keep your current insurance.”²¹⁵ Similarly, shortly before the Affordable Care Act passed Congress in March 2010, House supporters made the rosy statement that the “legislation lowers health care costs to allow American businesses to focus on what they do best” and alleged further that the “bill assists employers in providing coverage to their employees.”²¹⁶

The Act does contain numerous provisions aimed at reining in health care costs.²¹⁷ These reflect an everything-plus-the-kitchen-sink approach to cost control that includes such diverse tactics as regulation of insurance company rate setting,²¹⁸ increased national standardization of electronic health records,²¹⁹ changes and reductions in Medicare payments,²²⁰ expanded public preventative health efforts,²²¹

215. See, e.g., President Barack H. Obama, Remarks on the Patient Protection and Affordable Care Act (Mar. 23, 2010), (transcript available at <http://www.gpoaccess.gov/presdocs/2010/DCPD-201000197.pdf>); see also Robert Pear, *Senator Tries to Allay Fears on Health Overhaul*, N.Y. TIMES, Sept. 23, 2009, at A1 (“Mr. Obama has said repeatedly that ‘if you like your health care plan, you will be able to keep it.’”).

216. HOUSE COMM. ON WAYS & MEANS, ENERGY & COMMERCE, & EDUC. & LABOR, HEALTH INSURANCE REFORM AT A GLANCE: EMPLOYERS AND HEALTH REFORM 1 (2010), available at <http://docs.house.gov/energycommerce/EMPLOYERS.pdf>.

217. See generally DAVID M. CUTLER ET AL., COMMONWEALTH FUND & CTR. FOR AMERICAN PROGRESS, THE IMPACT OF HEALTH REFORM ON HEALTH SYSTEM SPENDING (2010), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/May/1405_Cutler_impact_hlt_reform_on_hlt_sys_spending_ib_v4.pdf.

218. For example, the Act establishes minimum medical loss ratios—the percentage of premiums spent on health care services (as opposed to administrative overhead and similar expense not related to providing health-related benefits)—for individual policies, as well as for small and large group plans. Patient Protection and Affordable Care Act, § 10101(f), 124 Stat. at 885–86 (to be codified at 42 U.S.C. § 300gg-18(a)). Effective January 1, 2011, health insurers must rebate premiums to the extent the required medical loss ratio for the applicable policy is not satisfied. Patient Protection and Affordable Care Act, § 10101(f), 124 Stat. at 886 (to be codified at 42 U.S.C. § 300gg-18(b)(1)(A)). In 2014 and later years, the Act also regulates the methods used by insurers to establish premiums, barring, in particular, consideration of health status. Patient Protection and Affordable Care Act, § 1201(4), 124 Stat. at 155–56 (to be codified at 42 U.S.C. § 300gg).

219. Patient Protection and Affordable Care Act, § 1104, 124 Stat. at 146–54, amended by § 10109, 124 Stat. at 915–17 (to be codified in scattered sections of 42 U.S.C.).

220. For example, beginning in 2013, a so-called “value-based purchasing program” will be implemented to tie Medicare payments to hospitals to specified quality improvement measures. Patient Protection and Affordable Care Act, § 300I(a)(1), 124 Stat. at 353–59 (to be codified at 42 U.S.C. § 1395ww(o)). The Act pushes similar value-based purchasing models for skilled nursing facilities (SNF) and home health agencies (HHA) and creates a “value-based payment modifier” to be applied to the physician fee scheduled used in determining certain other provider payments under Medicare. Patient Protection and Affordable Care Act,

and enhanced enforcement efforts against health care fraud and abuse.²²² Whether the Act can or will do everything promised is highly debatable, of course.²²³ The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimated shortly before the Act's passage that the legislation would lead to \$124 billion in net reductions to the federal deficit over the next decade as a result of the health care and revenue provisions of the Act.²²⁴ A Commonwealth Fund analysis that looked beyond the Act's effect on the federal budget (the primary focus of the CBO/JCT review) concluded that the cumulative effect of health reform on overall national health care spending would be a \$590 billion reduction over the period from 2010 to 2019.²²⁵

On the other hand, the CBO and JCT also observed that, in the near decade following health reform's passage (i.e., 2010–2019), the Act would increase the “federal budgetary commitment to health care” — a “term that CBO uses to describe the sum of net federal outlays for health programs and tax preferences for health care” — by ap-

§ 3006, 124 Stat. at 372–73 (requiring the Secretary of HHS to submit a plan to Congress by 2012 as to how to apply value-based purchasing to SNFs and HHAs); Patient Protection and Affordable Care Act, § 3007, 124 Stat. at 373–76 (to be codified at 42 U.S.C. § 1395w–4(p)).

221. For example, the Act provides funding for both school-based health centers to expand access to care for school-age children and community-based health programs directed at adults age fifty-five to sixty-four. Patient Protection and Affordable Care Act, § 4101, 124 Stat. at 546–50 (to be codified at 42 U.S.C. §§ 280h–4, 280h–5) (school-based health centers); Patient Protection and Affordable Care Act, § 4202, 124 Stat. at 566–70 (to be codified at 42 U.S.C. § 300u–14) (healthy aging programs).

222. The Act directs \$100 million in annual funding toward health care fraud and abuse enforcement. Patient Protection and Affordable Care Act, § 6402(i)(1), 124 Stat. at 760–61 (amending 42 U.S.C. § 1395i(k)); Health Care and Education Reconciliation Act, § 1303(a)(1)(A), 124 Stat. at 1057–58 (further amending 42 U.S.C. § 1395i(k)).

223. The promises about keeping existing health insurance have drawn particular fire from the legislation's opponents. *See, e.g.,* REP. JOHN BOEHNER, OBAMACARE: THREE MONTHS OF BROKEN PROMISES 2 (2010), available at <http://www.speaker.gov/UploadedFiles/ObamaCare3MonthsBrokenPromises.pdf> (“The Obama Administration has been forced to acknowledge that the new law will force some 87 million Americans to drop their current coverage despite President Obama's promise that Americans would be able to keep the coverage that they have.”).

224. Letter from the Congressional Budget Office to the Honorable Nancy Pelosi 2 (Mar. 20, 2010) [hereinafter Letter to Pelosi], available at <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

225. CUTLER ET AL., *supra* note 217, at exhibit 1. The Commonwealth Fund analysis of the Act's effect on the federal deficit was also significantly higher than the CBO/JCT estimate: \$400 billion over the 2010–2019 period. *Id.* at exhibit 4.

proximately \$390 billion.²²⁶ Employers similarly anticipate near-term health care cost increases as a result of health reform.²²⁷ A PricewaterhouseCoopers' study of medical cost trends predicted that the growth rate for medical costs will actually decline in 2011 from 2010²²⁸ but observed that this resulted primarily from an increase in COBRA enrollees due to temporary subsidies and the hiring of younger workers: "If it were not for these confounding effects, our estimate of the trend would be lower in 2010 and higher in 2011."²²⁹

For employers, an underlying problem is that the new rules impose additional burdens almost immediately,²³⁰ while the Act's health

226. Letter to Pelosi, *supra* note 224, at 15.

227. For example, one benefits consulting firm observed, "Employers have little hope that the Patient Protection and Affordable Care Act (PPACA) will help them achieve their top goals to decrease the health care cost trend and improve workforce health." TOWERS WATSON, HEALTH CARE REFORM: LOOMING FEARS MASK UNPRECEDENTED EMPLOYER OPPORTUNITIES TO MITIGATE COSTS, RISKS AND RESET TOTAL REWARDS 1 (2010), available at [http://www.towerswatson.com/assets/pdf/1935/Post-HCR_Flash_survey_bulletin_5_25_10\(1\).pdf](http://www.towerswatson.com/assets/pdf/1935/Post-HCR_Flash_survey_bulletin_5_25_10(1).pdf) (reporting that ninety percent of surveyed employers anticipated higher costs as a result of health reform even while eighty-nine percent "expect health care reform to have a positive impact on reducing the number of individuals without health coverage" and another fifty-six percent "predict it will improve access to care"). See also, e.g., Martha Lynn Craver, *What Firms Will Do with Health Care Reform*, THE KIPLINGER LETTER, Mar. 22, 2010, <http://www.kiplinger.com/businessresource/forecast/archive/health-care-bill-wont-help-employers-cut-costs.html> ("There's a growing recognition that the health care bill . . . won't help lower costs in the short term In fact, many employers believe the pending health bill will only add to their problems."). A Hewitt survey of employer health care practice characterized the situation as "The Road Ahead: Under Construction with Increasing Tolls." HEWITT ASSOCS., THE ROAD AHEAD: UNDER CONSTRUCTION WITH INCREASING TOLLS 2010 (2010), available at <http://www2.hewittassociates.com/Intl/NA/en-US/KnowledgeCenter/ArticlesReports/ArticleDownload.aspx?fid=317>.

228. For 2010, medical costs are expected to grow at a 9.5% rate; for 2011, that growth rate is expected to slow slightly—to only 9.0%. PRICEWATERHOUSECOOPERS, HEALTH RESEARCH INST., BEHIND THE NUMBERS: MEDICAL COST TRENDS FOR 2011, at 5 (2010), available at <http://www.pwc.com/us/medicalcosts2011>. PwC noted three "primary deflators that will help hold down the medical trend"—employer efforts to shift toward increased deductibles and coinsurance that require "workers to spend more out-of-pocket at the point of care;" increased use of generic drugs (in part due to major brand-name drugs such as Lipitor becoming generic in 2011); and fewer COBRA elections as COBRA subsidies expire and terminated workers choose not to pay the high COBRA premiums—and key "inflators" coming primarily from increased provider costs, in part due to cost-shifting as hospitals face Medicare cuts. *Id.*

229. *Id.* at 9.

230. See, e.g., Joanna C. Kerpen, *Enacted Health Care Legislation: Effect on Employers*, MCDERMOTT WILL & EMERY HEALTH CARE L. REF. BLOG (Mar. 26, 2010), <http://www.healthcarelawreform.com/2010/03/articles/employee-benefits/enacted-health-care-legislation-effect-on-employers/> ("These provisions will cost

care cost control efforts will require time to have noticeable effect.²³¹ Thus, for example, health reform rules that affect employers in the next few years—such as requiring coverage of adult children to age twenty-six,²³² barring pre-existing condition limits for children under age nineteen,²³³ and prohibiting lifetime and most annual limits²³⁴—could easily increase plan costs long before any overall decline in health care expenses begins to be felt.²³⁵ Then, beginning in 2014, employers face direct penalties under the pay-or-play mandate and re-

employers monetarily and increase employers' administrative burdens. Employers have many more compliance issues to monitor as a result of this legislation.”)

231. While the Congressional Budget Office concluded that health reform would increase the federal government's health care expenditures in the next decade (2010–2019), it also found that in the following decade (i.e., 2020–2029) the “effects of the provisions of the two bills combined that would tend to decrease the federal budgetary commitment to health care would grow faster than the effects of the provisions that would increase it”—in other words, that health reform will lower health care costs for the government in the second decade after enactment. Letter to Pelosi, *supra* note 224, at 15. Economist Paul Krugman says, “[T]here's good reason to believe that all such estimates are too pessimistic. There are many cost-saving efforts in the proposed reform, but nobody knows how well any one of these efforts will work. And as a result, official estimates don't give the plan much credit for any of them.” Paul Krugman, *Health Reform Myths*, N.Y. TIMES, Mar. 12, 2010, at A27. Not everyone is so optimistic. A Deloitte commentary made the cautious assessment that “whether health care reform will contain or lower costs is conjecture, dependent on successful demonstration projects and pilot programs in the bill, and efficient management of services for an aging population and the newly insured.” Robert W. Clarke et al., *Good Medicine or a Bitter Pill? Implications of Health Care Reform for Businesses in America*, DELOITTE REV., no.7, 2010, at 128, available at http://www.deloitte.com/view/en_US/us/Insights/Browse-by-Content-Type/deloitte-review/6411d6082dea9210VgnVCM100000ba42f00aRCRD.htm.

232. Patient Protection and Affordable Care Act, § 1001, 124 Stat. 119, 132, amended by Health Care and Education Reconciliation Act, § 2301, 124 Stat. at 1081–82 (to be codified at 42 U.S.C. § 300gg–14).

233. Patient Protection and Affordable Care Act, § 1201, 124 Stat. at 154–55, amended by § 10103(e)(2), 124 Stat. at 895; Health Care and Education Reconciliation Act, § 2301, 124 Stat. at 1081–82 (to be codified at 42 U.S.C. §§ 300gg–1 to gg–4).

234. Patient Protection and Affordable Care Act, §§ 1513(a)–(b), 124 Stat. at 253–56 (to be codified at I.R.C. §§ 4680H(a)–(b)), amended by Patient Protection and Affordable Care Act, §§ 10106(e)–(f), 124 Stat. at 910–11; Health Care and Education Reconciliation Act, § 1003, 124 Stat. at 1033. See *supra* notes 162–65 and accompanying text. Many employer plans have already removed such limits. As a result, PwC in 2009 estimated that “raising or removing lifetime limits would elevate monthly premiums by 1%.” PRICEWATERHOUSECOOPERS, *supra* note 228, at 10.

235. In evaluating medical cost trend long-term, PwC observed that “[o]ne of the overarching implications of health reform is a move away from siloed payment toward more coordinated care.... [T]his will bring disruption to the system, which could drive up costs in the short term, but eventually may drive them down.” PRICEWATERHOUSECOOPERS, *supra* note 228, at 19.

lated provisions.²³⁶ If the law remains as currently written, in 2018, many employers could even face penalties under the Cadillac plan excise tax.²³⁷

Notwithstanding the additional pressures health reform may well push onto existing employer plans over the next few years, employers who currently sponsor health plans appear committed to maintaining their plans for active workers and their families.²³⁸ This does not mean, however, that those plans will continue in exactly the same way. A Towers Watson study in May 2010 found that sixty-eight percent of employers “plan to reexamine their health benefit strategy for active employees” in the wake of health reform.²³⁹ Even before the Act’s passage, significant numbers of companies in 2009 expected to increase employee cost-sharing obligations in the future.²⁴⁰ In reaction to health reform, employers predicted near-term increased cost-sharing for employees, as well as potential benefit cut-

236. See Patient Protection and Affordable Care Act, § 1513(a), 124 Stat. at 253–55 (to be codified at I.R.C. § 4680H). Some costs linked to the pay-or-play mandate may be less obvious. For example, the Act defines a full-time employee for purposes of the mandate as, generally, anyone working on average thirty hours a week. See *supra* note 185 and accompanying text. If an employer defines a full-time employee eligible for benefits as a person working more than thirty hours a week, the Act’s definition in effect means that the employer must cover additional employees or be subject to penalties. A Deloitte analysis of health reform pointed to the definition of full-time employee, along with the imposition of the ninety-day maximum eligibility waiting period, as provisions that will “create new costs that could impact a company’s financial performance as well as its workforce structure.” *Health Care Reform for CFOs: Employee Benefits Considerations*, DELOITTE, http://www.deloitte.com/print/en_US/us/Insights/Browse-by-Content-Type/Newsletters/CFO-Insights/51e25676c94f8210VgnVCM100000ba42f00aRCRD.htm (last updated Aug. 4, 2010). In light of the new costs, Deloitte concluded: “Some companies will be able to afford maintaining their existing workforce model. Others may have to reduce the number of part-time and temporary workers by converting them into full-time staff or reduce the number of hours their part-time employees work to avoid the 30-hour threshold. Some companies may even elect to not offer health care coverage.” *Id.*

237. See *supra* note 210 and accompanying text.

238. In one study, an overwhelming eighty-seven percent of surveyed employers said they planned to maintain employee health benefits. Press Release, Int’l Found. of Emp. Benefit Plans, *New Survey Reveals Employers Pursuing Early Retiree Reinsurance Payments; Considering Their Options in Reaction to Health Care Reform* (June 21, 2010), http://www.ifebp.org/AboutUs/PressRoom/Releases/pr_062110_us.htm.

239. TOWERS WATSON, *supra* note 227, at 3.

240. Of surveyed employers in 2009, forty-two percent considered it likely that employee premiums would increase, thirty-six percent that deductibles would rise, thirty-nine percent that the employee share of office visit costs would increase, and thirty-seven percent that the employee share of prescription drug expenses would rise. KAISER/HRET 2009 ANNUAL SURVEY, *supra* note 66, at 8.

backs.²⁴¹ For example, a study by PricewaterhouseCoopers noted that employers are quickly “returning to pre-managed care benefit design by increasing deductibles and replacing co-pays with coinsurance.”²⁴² A survey by the International Foundation of Employee Benefit Plans found that forty-eight percent of surveyed employers “are focusing on redesigning their health plans so that by 2018, their plans will avoid triggering the excise ‘Cadillac’ tax for high-value plans.”²⁴³

V. Health Reform and Retiree Health Plans

With employers evaluating their health plans for active workers in light of health reform, retiree health benefits cannot be far behind.²⁴⁴ Competitive reasons for preserving employer-sponsored health insurance—particularly employee recruitment and retention²⁴⁵—are less relevant in the context of retiree benefits, particularly in a difficult economic climate. Perhaps more importantly, health reform has the potential to alter fundamentally the landscape against

241. TOWERS WATSON, *supra* note 227, at 4. Employers told Towers Watson that “they plan to pass on the increase to employees (88%) or reduce health benefits and programs (74%).” *Id.*; see also Craver, *supra* note 227 (“‘Health reform will result in increased costs for employees, and that will mean less generous benefits for employees,’ says Helen Darling, president of the National Business Group on Health.”).

242. PRICEWATERHOUSECOOPERS, *supra* note 228, at 11 (commenting that the “trend in deductibles has been remarkably fast”—in 2008 and 2009, the “most common plan had no deductible” while in 2011, “most employers are expected to have a deductible of \$400 or more”).

243. Int’l Found. of Emp. Benefit Plans, *supra* note 238. PwC believes that “employers will need to increase cost sharing, reduce benefits, move to more tightly managed care, or come up with other approaches to trim benefit costs in order to avoid the excise tax.” PRICEWATERHOUSECOOPERS, *supra* note 228, at 19.

244. In the Towers Watson survey, sixty-eight percent of employers reported that they would “reexamine their health benefit strategy for active employees” by the end of 2010, and an additional twenty-six percent expected to do so in 2011 or later, while forty percent said they would do the same in 2010 for retiree benefits. TOWERS WATSON, *supra* note 227, at 3 fig.3. Another eighteen percent expected to examine their retiree benefit strategy in 2011 or later. *Id.* Interestingly, thirty-seven percent of surveyed employers in the Towers Watson study said they did not plan to review their approach to retiree benefits, a much higher percentage than with active benefits. *Id.* It is possible that this reflects the fact that many retiree health plans are maintained pursuant to collective bargaining agreements that allow employers little leeway to change benefits for current retirees. See *supra* notes 77–78 and accompanying text.

245. Int’l Found. of Emp. Benefit Plans, *supra* note 238 (reporting that eighty-seven percent of employers would maintain active employee health insurance benefits “because they are critical to employee recruitment, retention and remaining competitive”).

which employers evaluate their retiree benefit choices.²⁴⁶ For both early and Medicare-eligible retirees, by providing reasonable alternatives to employment-based benefits, health reform may undercut key motivations for continued employer sponsorship of retiree health plans.²⁴⁷ Confronted with increased employee health benefit costs overall,²⁴⁸ employers in the long run may finally determine that the value of retiree insurance no longer offsets the expense. Congress appears to have reached much the same conclusion. The following sections look both at what health reform does and does not do with regard to retiree health benefits, highlighting key legislative choices as they seem likely to affect employer-sponsored retiree medical insurance.

A. Proposed Bar on Terminating Health Benefits for Current Retirees

For a while during the health reform debates, the House of Representatives appeared inclined to protect retirees from losing their employment-based benefits. The Affordable Health Care for America Act, the House-passed precursor to what became the Affordable Care Act, contained section 110—“Prohibition Against Postretirement Reductions of Retiree Health Benefits by Group Health Plans.”²⁴⁹ Section 110(a) would have added a new section 717 to ERISA to prevent group health plans “from reducing the benefits provided under the plan to a retired participant . . . if such reduction affects the benefits

246. See *supra* Part III.

247. Parikh framed the questions facing employers with retiree health plans as follows: “Is there economic value to employer-provided retiree health coverage? Should the employee attribute any value while working to the promise of postretirement coverage? If this promise is perceived as valuable, does the employee then act in ways that bring additional value to the company? Is the additional value that the company receives worth the expense of the plan? Is the cost volatility acceptable?” Alan Parikh, *Should Companies Still Provide Retiree Health Care?*, HUM. RESOURCE EXEC. ONLINE (Dec. 1, 2006), <http://www.hreonline.com/HRE/printstory.jsp?storyId=8401540>.

248. See *supra* note 230 and accompanying text.

249. Affordable Health Care for America Act, H.R. 3962, 111th Cong. § 110 (2009). The U.S. House of Representatives passed H.R. 3962 on November 7, 2009, by a vote of 220 to 215. *Final Vote Results for Roll Call 887*, OFF. OF THE CLERK: U.S. HOUSE OF REPRESENTATIVES, <http://clerk.house.gov/evs/2009/roll887.xml> (last visited Apr. 24, 2011). The Senate bill contained no similar provision to section 110. Marlene P. Frank et al., *Health Care Reform: House Bill Would Make It Nearly Impossible to Reduce Retiree Medical Benefits*, JONES DAY (Nov. 2009), <http://www.jonesday.com/newsknowledge/publicationdetail.aspx?publication=de28862f-5655-449d-9852-ecd1a6c09248&RSS=true>.

provided to the participant . . . as of the date the participant retired for purposes of the plan and such reduction occurs after the participant's retirement."²⁵⁰ The prohibition would not have applied to any reduction "also made with respect to active participants."²⁵¹ By its terms, the proposed language allowed employers to make changes that affected only future retirees; the anti-cutback restriction kicked in *only* "as of the date the participant retired."²⁵² The proposed section further provided that a "reduction in benefits" for these purposes included either a substantial increase in premiums or, with "respect to other cost-sharing and benefits," a substantial decrease in the actuarial value of the benefit package; "substantial" in both circumstances was defined as meaning "greater than 5 percent."²⁵³

Somewhat mitigating the potential impact of section 110, the proposed language did not preclude a plan from "enforcing a total aggregate cap on amounts paid for retiree health coverage that is part of the plan at the time of retirement."²⁵⁴ This language meant that a plan could still increase premiums and other cost-sharing once it reached its previously imposed cap on contributions, effectively negating the point of the proposed anti-cutback language. A 2006 survey of large private sector employers with retiree health plans found that forty-six percent had imposed a cap on their contributions to the largest plan they sponsored for early retirees and fifty percent had done the same for the largest plan they sponsored for Medicare-eligible retirees.²⁵⁵ The proposed section also included the possibility of a waiver "if the employer can reasonably demonstrate that meeting the requirements of this section would impose an undue hardship on the employer."²⁵⁶

Despite the fact that approximately half of all employers with retiree health benefits already had caps in place that would offset the effect of the proposal and that all employers could easily impose caps—or otherwise reduce benefits—for future retirees, the proposed language quickly drew fire.²⁵⁷ One large law firm urged employers to

250. H.R. 3962 at § 110(a) (adding new ERISA § 717(a)).

251. *Id.*

252. *Id.* at § 110(b).

253. *Id.* at § 110(a) (adding new ERISA § 717(c)).

254. *Id.*

255. KAISER & HEWITT, *supra* note 25, at 12–13 exhibits 12, 13.

256. H.R. 3962 at § 110(a) (adding new ERISA § 717(c)).

257. See, e.g., David Hogberg, *House Bill May Roil Retiree Health Care: Bid to Stop Benefit Cuts May Backfire and Raise Burden on Taxpayers*, INVESTOR'S BUS. DAILY

“consider acting quickly—before the potential new restrictions may become effective.”²⁵⁸ The American Benefits Council and the AFL-CIO jointly urged Congress to change the proposed language on the theory that “as written, it could well create a stampede by employers to dump retiree medical benefits altogether before the new restrictions could become law.”²⁵⁹ Section 110 did not survive the legislative process. When the Act eventually passed both the Senate and House four months later, section 110 was long gone.

B. Early Retiree Reinsurance Program

What did survive the legislative process in terms of protecting retiree health benefits now goes by the acronym-friendly name “Early Retiree Reinsurance Program” (ERRP).²⁶⁰ Unlike the doomed section 110 with its direct prohibition of retiree plan cutbacks, a version of the ERRP appeared in both the House and Senate precursors to the Act.²⁶¹ Effective in June 2010 and continuing until January 1, 2014 (or until funding is exhausted, if earlier),²⁶² the ERRP provides a temporary subsidy to prop up existing employment-based health plans that cov-

(Nov. 5, 2009), <http://www.allbusiness.com/government/government-bodies-offices/13406325-1.html> (quoting Rep. Phil Gingrey, R-Ga., saying “This section is really troublesome. Companies that need to make sound financial decisions, if they can’t get retirees to pick up more of the cost, they’ll just stop offering those benefits.”).

258. Frank et al., *supra* note 249.

259. *Id.* at n.2 (citing Letter from Diann Howland, Vice President of Legislative Affairs, Am. Benefits Council and William Samuel, Dir. of the Dep’t of Legislation, AFL-CIO, to Nancy Pelosi, Speaker, U.S. House of Representatives (Nov. 2., 2009)).

260. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1102, 124 Stat. 119, 143–45, amended by § 10102, 124 Stat. at 892 (to be codified at 42 U.S.C. § 18002).

261. H.R. 3962 at § 111; Patient Protection and Affordable Care Act, S. Amdmt 2786 to H.R. 3590, 111th Cong. § 1102 (2009) (as presented to Senate on Nov. 19, 2009). The U.S. Senate passed the bill on December 24, 2009, by a vote of 60 to 39. *U.S. Senate Roll Call Votes 111th Congress – 1st Session*, U.S. SENATE, http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00396. Although the two bills were worded differently, the two versions of the ERRP were substantially the same in effect, except that the House version included \$10 billion for funding, whereas the Senate version included only \$5 billion. Compare H.R. 3962 at § 111(d)(1)(B) with S. Amdmt 2786 to H.R. 3590, 111th Cong. § 1102(e) (2009) (as presented to the Senate on Nov. 19, 2009).

262. The Act authorizes the Secretary of HHS to close the ERRP to further reimbursement applications based on the program’s funding status. Patient Protection and Affordable Care Act, § 1102(f), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18002(f)).

er early retirees and their dependents.²⁶³ The Act defines “early retiree” for this purpose as any individual who is at least age fifty-five but not yet Medicare-eligible and who is not an “active employee of an employer maintaining, or currently contributing to,” the applicable retiree plan.²⁶⁴ Eligible plans include not only private sector employer-sponsored plans, but also retiree health plans maintained by public sector employers, as well as plans maintained by unions and VEBAs.²⁶⁵ In order to receive the subsidy, a plan sponsor must go through an application process established and administered by HHS and must show that the plan has “implement[ed] programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions”²⁶⁶

If a plan qualifies for the subsidy, HHS will reimburse claims for eighty percent of the plan’s medical and prescription drug expenses each year per early retiree or dependent to the extent those expenses exceed \$15,000, subject to a \$90,000 cap (a maximum of \$60,000 in reimbursement per individual per year).²⁶⁷ The dollar amounts are subject to annual adjustment.²⁶⁸ According to the statute, reimburse-

263. According to HHS’s implementing interim regulations, the ERRP “provides needed financial help for employer-based plans to continue to provide valuable coverage to plan participants, and provides financial relief to plan participants.” Early Retiree Reinsurance Program, 75 Fed. Reg. 24,450 (proposed May 5, 2010) (to be codified at 45 C.F.R. pt. 149). The federal government’s ERRP website claims that the “purpose of the reimbursement is to make health benefits more affordable for plan participants and sponsors so that health benefits are accessible to more Americans than they would otherwise be without this program.” *Regulations and Guidance*, ERRP.GOV, http://www.errp.gov/about_errp.shtml (last updated Oct. 19, 2010).

264. Patient Protection and Affordable Care Act, § 1102(a)(2)(C), 124 Stat. at 144 (to be codified at 42 U.S.C. § 18002(a)(2)(C)).

265. Patient Protection and Affordable Care Act, § 1102(a)(2)(B), 124 Stat. at 144, amended by § 10102, 124 Stat. at 892 (to be codified at 42 U.S.C. § 18002(a)(2)(B)).

266. Patient Protection and Affordable Care Act, § 1102(b), 124 Stat. at 144 (to be codified at 42 U.S.C. § 18002(b)). HHS takes a fairly broad view of what suffices as cost-savings programs to manage chronic and high-cost conditions. In implementing interim regulations, HHS notes “[o]ur belief that the Congress intends this to be an inclusive program, not a program that excludes potential sponsors merely because they did not develop programs to address the specific conditions we might identify in our guidance.” Early Retiree Reinsurance Program, 75 Fed. Reg. 24,450, 24,454 (proposed May 5, 2010) (to be codified at 45 C.F.R. pt. 149).

267. Patient Protection and Affordable Care Act, § 1102(c), 124 Stat. at 144–45 (to be codified at 42 U.S.C. § 18002(c)). See also *Fact Sheet: The Early Retiree Reinsurance Program*, WHITEHOUSE.GOV (May 4, 2010), <http://www.whitehouse.gov/the-press-office/fact-sheet-early-retiree-reinsurance-program>.

268. Patient Protection and Affordable Care Act, § 1102(c)(3), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18000(c)(3)) (adjusting the \$15,000 base and \$90,000

ment amounts “shall be used to lower costs for the plan” either by reducing the plan sponsor’s premium costs or by “reduc[ing] premium contributions, co-payments, deductibles, coinsurance, or other out-of-pocket costs for plan participants.”²⁶⁹ Subsidy payments may not, however, “be used as general revenues” for the plan sponsor.²⁷⁰ HHS interim regulations elaborate on the use of ERRP payments:

Because the statute requires that the funds dispersed under this program not be used as general revenue, we are requiring sponsors to maintain the level of effort in contributing to support their applicable plan or plans. Otherwise, sponsors might circumvent the prohibition on using the program funds as general revenue by using, dollar for dollar, sponsors’ funds not otherwise used for health benefits due to the program reimbursement, as general revenue. We expect that sponsors will use the reimbursement to pay for increases in, for example, the sponsor’s premium, or increases in other health benefit costs (or to reduce plan participants’ costs).²⁷¹

The ERRP application form thus requires a sponsor that intends to use reimbursement amounts to offset its own health benefit premiums or health benefit costs to “explain how your organization will continue to maintain the level of support for this plan.”²⁷² Amounts received through the ERRP are not taxable to plan sponsors.²⁷³

By structuring the ERRP with a carrot in the form of the subsidy, combined with the maintenance-of-effort requirement in the regulations, the Act creates strong support for existing programs as long as subsidy funds are available. Unlike the House bill’s proposed section 110’s flat prohibition on benefit cutbacks, with its potential for triggering a rush to terminate or reduce benefits before the effective date,²⁷⁴ the reimbursement approach targets the underlying problem of retiree health plans: the burden of continuing a benefit that may simply have grown too expensive for many employers in the face of other financial

cap “each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of \$1,000) for the year involved.”).

269. Patient Protection and Affordable Care Act, § 1102(c)(4), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18000(c)(4)).

270. *Id.*

271. Early Retiree Reinsurance Program, 75 Fed. Reg. 24,450, 24,456 (proposed May 5, 2010) (to be codified at 45 C.F.R. pt. 149).

272. DEP’T HEALTH & HUMAN SERVS., EARLY RETIREE REINSURANCE PROGRAM APPLICATION 7, available at http://www.errp.gov/download/ERRP_Application.pdf.

273. Patient Protection and Affordable Care Act, § 1102(c)(5), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18002(c)(5)).

274. See *supra* notes 249, 259 and accompanying text.

challenges.²⁷⁵ It is entirely likely, after more than two decades of retiree plan terminations, that employers who wanted and were able to eliminate such plans have already done so.²⁷⁶ By contrast, those who still offer retiree health insurance are probably not seeking exit so much as relief. In other words, if an employer still provides such benefits, that employer will probably continue to do so as long as it is financially able, and the ERRP may extend that financial ability.²⁷⁷

Unfortunately, the Act allocated only \$5 billion to fund the ERRP.²⁷⁸ A May 2010 survey of large employers offering early retiree benefits to approximately 1.3 million individuals revealed that seventy-six percent planned to apply for reimbursement under the ERRP.²⁷⁹ Before the program opened, HHS estimated that “approximately 4500 plan sponsors will apply to participate” – 3000 private sector and 1500 state and local government employers.²⁸⁰ By the end of 2010, HHS reported that 5452 employers – almost half representing state and local governments – had applied for ERRP funding and been accepted into the program, with \$535 million already disbursed in reimbursements.²⁸¹ In light of the tens of billions of dollars of retiree health lia-

275. Thus, for example, the White House Fact Sheet on the ERRP noted that the reinsurance/subsidy approach “was advocated by large businesses, which wanted it to be part of the Affordable Care Act because they believe it will defray the high and often unpredictable cost of early retirees, helping them to maintain retiree benefits at affordable levels.” See *Fact Sheet: Early Benefits*, *supra* note 119.

276. See *supra* notes 65–72 and accompanying text.

277. One large actuarial firm estimated that the “average federal reimbursement will represent between \$2,000 and \$3,000 per pre-65 retiree per year . . .” *Most U.S. Companies Planning to Apply for Temporary Federal Reinsurance Program, According to New Hewitt Survey*, HEWITT ASSOCIATES (May 25, 2010) [hereinafter *U.S. Companies Planning*], <http://www2.hewittassociates.com/Intl/NA/en-US/AboutHewitt/Newsroom/PressReleaseDetail.aspx?cid=8475>.

278. Patient Protection and Affordable Care Act, § 1102(e), 124 Stat. at 145 (to be codified at 42 U.S.C. § 18002(e)).

279. *U.S. Companies Planning*, *supra* note 277.

280. Early Retiree Reinsurance Program, 75 Fed. Reg. 24,450, 24,465 (proposed May 5, 2010) (to be codified at 45 C.F.R. pt. 149).

281. U.S. DEP’T HEALTH & HUMAN SERVS., REPORT ON IMPLEMENTATION AND OPERATION OF THE EARLY RETIREE REINSURANCE PROGRAM DURING CALENDAR YEAR 2010, at 3–4 (2011), available at <http://www.healthcare.gov/center/reports/retirement03022011a.pdf>. As of December 31, 2010, 47.0% of accepted plan sponsors were government employers, 27.5% were private sector for-profit employers, 15.1% were non-profit employers, 10.0% were unions, and the remaining 0.4% were religious organizations. *Id.* at 4 fig.1. Those numbers reflect a significant increase in approved employers during the fall of 2010. See Press Release, U.S. Dep’t Health & Human Servs., Nearly 2,000 Employers and Unions Approved into New Program (Aug. 31, 2010), <http://www.hhs.gov/news/press/2010pres/08/20100831a.html>. In announcing the status of applications, HHS noted that it had “received applications from more than 50 percent of Fortune 500 companies, all

bility that exists in both the private and public sector,²⁸² the \$5 billion in ERRP funding may not last long. A 2010 EBRI study predicted that half of the funding was likely to be exhausted in 2010, with the remaining funds distributed in 2011, leaving nothing for 2012 and 2013.²⁸³ Those predictions so far have proved overly pessimistic, but ERRP funds will be distributed on a largely “first-come, first-served” basis, placing considerable pressure on sponsors to apply quickly before funds vanish.²⁸⁴

C. Retiree-Only Plan Exception

In addition to creating direct support for early retiree plans through the ERRP, Congress also relieved retiree plans of some of the impact of the Affordable Care Act by leaving intact an existing exemption for such plans from certain coverage mandates. ERISA provides that certain coverage requirements do “not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.”²⁸⁵ Before the Act, the same provision appeared also in the Public Health Service Act and the Internal Revenue Code.²⁸⁶ Often known as the “retiree plan exception,”²⁸⁷ this provision has been interpreted to mean that most employer plans that cover only retirees²⁸⁸

major unions, and government entities in all 50 States and the District of Columbia.” *Id.*

282. See *supra* notes 60–64 and accompanying text.

283. Fronstin, *supra* note 21, at 2.

284. Shearman & Sterling LLP, *Opportunity for Reimbursement for Retirees Requires Prompt Action by Plan Sponsors*, HEALTH REFORM UPDATE, 1 (May 12, 2010) <http://www.shearman.com/Publications/List.aspx?viewAll=true> (scroll down to “12 May 2010” and click link to article).

285. 29 U.S.C. § 1191a(a) (2006).

286. Public Health Service Act, Pub. L. No. 78–410, § 2721(a), 58 Stat. 682 (1944) (codified as amended in scattered sections of 42 U.S.C.); I.R.C. § 9831(a).

287. Marlene P. Frank et al., *The Retiree-Only Plan Exception: Is It Still Effective After Health Care Reform?*, JONES DAY (July 2010), http://www.jonesday.com/retiree_only_plan_exception/.

288. Employers can choose to cover both active employees and retirees under a single health plan or to sponsor separate plans for actives and retirees. Maintaining separate plans allows an employer to take advantage of the retiree-only plan exemption. Thus, according to one experienced benefits lawyer, “[t]o obtain the advantage of the Exception, employers have purposefully separated their retiree plans from their active employee plans by drafting separate plan documents and filing separate Form 5500s.” *Id.*

are exempt from a range of health coverage mandates,²⁸⁹ including limits on plan consideration of pre-existing conditions,²⁹⁰ nondiscrimination by plans on the basis of health status,²⁹¹ parity between mental health coverage and other benefits,²⁹² and continued coverage of dependent students during a medically necessary leave.²⁹³ The Affordable Care Act deleted the retiree plan exception language in the Public Health Service Act but did not include parallel amendments to ERISA and the Code.²⁹⁴ Other language in the Affordable Care Act, however, incorporated changes to the Public Health Service Act into both ERISA and the Code,²⁹⁵ raising the issue of whether the retiree plan exception survived health reform.²⁹⁶

When HHS issued interim regulations governing grandfathered plans in accordance with the Affordable Care Act, the agency took the opportunity to clarify the status of the retiree plan exception. In the preamble to the interim regulations, HHS stated directly that “the exceptions of ERISA section 732 and Code section 9831 for . . . certain retiree-only health plans . . . remain in effect and, thus ERISA section 715 and Code section 9815 . . . do not apply to such plans.”²⁹⁷ Furthermore, HHS announced that it “does not intend to use its resources

289. See, e.g., Questions for the Department of Labor for JCE Technical Session on May 8, 2002, at 3, available at http://www.americanbar.org/content/dam/aba/migrated/2011_build/employee_benefits/2002_qa_dol.authcheckdam.pdf.

290. Frank et al., *supra* note 287 (The mandate is codified at 29 U.S.C. § 1181 (2006)).

291. *Id.* (The mandate is codified at 29 U.S.C. § 1182).

292. *Id.* (The mandate is codified at 29 U.S.C. § 1185a).

293. *Id.* This mandate, which is codified at 29 U.S.C. § 1185c, is sometimes known as “Michelle’s Law” in memory of the college student whose case inspired the legislation. *Id.* Many of the other mandates were imposed by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1998 (1996).

294. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§ 1562(a)(1), (c)(12)(A), 124 Stat. 119, 264, 268–69.

295. Patient Protection and Affordable Care Act, §§ 1562(e)–(f), 124 Stat. at 270 (redesignated as §§ 1563(e)–(f) by Patient Protection and Affordable Care Act, § 10107(b), 124 Stat. at 911), adding new ERISA § 715 and new I.R.C. § 9815(a)(1).

296. See, e.g., Frank et al., *supra* note 287 (stating that “many practitioners concluded that the Retiree Plan Exception was also eliminated from ERISA and the Code, and that stand-alone retiree plans would now be subject to the HIPAA Coverage Mandates, as amended by PPACA . . .”). See generally AM. BENEFITS COUNCIL, EXEMPTIONS FOR RETIREE-ONLY PLANS MUST BE PRESERVED (2010), available at http://www.appwp.org/documents/hcr_retiree-only_analysis_052110.pdf.

297. Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan, 75 Fed. Reg. 34,538, 34,539 (June 17, 2010) (to be codified in scattered parts of the C.F.R.).

to enforce the requirements of HIPAA or the Affordable Care Act with respect to nonfederal governmental retiree-only plans” and urged the States “not to apply the provisions of [the Affordable Care Act] to issuers of retiree-only plans.”²⁹⁸ Because these statements appear only in the preamble and not in the regulations themselves, some practitioners remained wary.²⁹⁹ From a higher level policy perspective, however, the agency’s position on retiree-only plans seems likely to relieve retiree plans from at least some of the additional costs employment-based plans face in the short term under health reform, and anything that eases employers’ financial burden for retiree health benefits increases the chances that those employers may maintain the plans.

D. Medicare Part D Retiree Drug Subsidy Deduction

While professing to support retiree benefits through the ERRP, Congress separately chopped off at the knees another support for retiree health plans. Since 2006, employers who provide retiree prescription drug coverage have been eligible for a subsidy under the MMA as long as the retiree coverage meets certain standards.³⁰⁰ Back in 2003, when the MMA was being debated, many in Congress became concerned that employers would eliminate retiree prescription drug coverage—or perhaps drop retiree benefits altogether—if outpatient prescription drug coverage was available under Medicare. At the time, employer-sponsored retiree health insurance served as the single largest source of prescription drug coverage for the elderly, with twenty-eight percent of the 34.2 million non-institutionalized Medicare beneficiaries in 1999 obtaining prescription drug coverage through a retiree plan.³⁰¹ The MMA retiree drug subsidy was Con-

298. *Id.* at 34,540.

299. *See, e.g.*, Frank et al., *supra* note 287.

300. 42 U.S.C. § 1395w-132 (2006). Employer-sponsored plans seeking the subsidy must provide coverage that CMS determines is at least actuarially equivalent to the MMA’s “standard prescription drug coverage.” 42 U.S.C. § 1395w-132(a)(2)(A).

301. KAISER FAMILY FOUND., FACT SHEET: MEDICARE AND PRESCRIPTION DRUGS (2003), available at <http://www.kff.org/medicare/upload/Medicare-and-Prescription-Drugs-Fact-Sheet-Fact-Sheet.pdf>. After employer-sponsored retiree drug plans, the next largest source of drug coverage were Medicare HMOs (private plans available under Medicare Part C, then known as “Medicare+Choice” but renamed by the MMA as “Medicare Advantage”) with fifteen percent of beneficiaries, followed by Medicaid at ten percent, Medigap private supplemental plans at seven percent, and other public plans (including state-based drug assis-

gress's way to avoid a feared abandonment of employer-based retiree drug benefits, much as the ERRP subsidy is the Act's mechanism for prolonging early retiree health coverage until 2014.

Under the MMA, the retiree drug subsidy reimburses employers for twenty-eight percent of a retiree's qualified drug costs up to a specified limit (\$1677.20 per retiree in 2010 and 2011³⁰²).³⁰³ In addition, the subsidy is not treated as taxable income to employers yet counts in determining the total prescription drug costs they are allowed to deduct.³⁰⁴ Thus, to use a simple example, if an employer's prescription drug expense under a retiree health plan totaled \$100 in one year, that employer could deduct the \$100 as an ordinary and necessary business expense. Under the Part D retiree drug subsidy, \$28 of that \$100 would be reimbursed to the employer by the federal government. The employer under the MMA could still deduct the full \$100—assuming it otherwise qualified as an ordinary and necessary business expense—even though that employer's effective actual expense was only \$72 as a result of the subsidy payment.

After Medicare Part D prescription drug coverage became effective January 1, 2006, an estimated eighty-two percent of employers with retiree drug plans qualified for and received the MMA subsidy,³⁰⁵ with seventy-eight percent expecting to do the same in 2007.³⁰⁶ The dire warnings as to the imminent demise of retiree health benefits following the MMA proved wrong. With the subsidy in place, most employers simply maintained what they had. By 2009, CMS reported that about 6.4 million Medicare beneficiaries still received prescription drug coverage through an employer plan supported by the subsidy.³⁰⁷

tance plans) at two percent. *Id.* Fully thirty-eight percent of all Medicare beneficiaries in fall 1999 had no outpatient prescription drug coverage, a situation that eventually helped lead to the passage of the MMA. *Id.*

302. HEIDI RACKLEY & FRAN BRUNO, MERCER, GRIST REPORT: PROJECTED 2011 RETIREMENT PLAN, SAVER'S CREDIT, IRA AND OTHER BENEFIT-RELATED LIMITS 6 (2010), available at <http://www.ribgh.org/resources/GristProjectedRetirement.pdf>.

303. 42 U.S.C. § 1395w-132(a)(3).

304. I.R.C. § 139A. Section 139A contains only two sentences: "Gross income shall not include any special subsidy payment received under section 1860D-22 of the Social Security Act. This section shall not be taken into account for purposes of determining whether any deduction is allowable with respect to any cost taken into account in determining such payment." *Id.*

305. KAISER & HEWITT, *supra* note 25, at 24.

306. *Id.* at 25.

307. CTR. FOR MEDICARE & MEDICAID SERVS., DATA COMPENDIUM: MEDICARE PART D AND RETIREE DRUG SUBSIDY ENROLLMENT BY STATE 2009, at tbl.VII.7 (2009), available at http://www.cms.gov/DataCompendium/15_2009_Data_Compen

Although it is impossible to know exactly why employers as a group make specific benefit decisions, the retiree drug subsidy surely affected the decision-making process and shored up retiree health plans by reducing their overall cost.

The Act, however, may change the situation. Beginning in 2013, the tax preference for the retiree subsidy will be removed, lowering the available deductions on employers' corporate tax return.³⁰⁸ In other words, employers lose up to twenty-eight percent of their deduction for retiree prescription drug expenses, subject to the dollar limit for the applicable year. Losing a deduction translates to additional tax dollars owed, increasing the real dollar cost of an employer continuing to maintain a retiree benefit plan. Even before the reduced deduction takes effect, accounting rules forced many employers who sponsor retiree health plans to recognize the impact immediately. FAS 106 requires current balance sheet recognition of future retiree benefit commitments.³⁰⁹ When a law change affects the computation of the value of those future commitments, FAS 106 requires companies to reflect the change, generally in the fiscal quarter in which the law is enacted. Because of the late March 2010 enactment date of the Act, many large employers reflected the impact of the retiree drug subsidy tax treatment change in the first quarter of 2010. The numbers were often massive. For example, AT&T reported a \$1 billion change in charges against earnings, Deere & Company a \$150 million change, Caterpillar a \$100 million change, and 3M a charge between \$85 and \$90 million.³¹⁰ A Hewitt study of employer reactions to health reform found that seventy-three percent of surveyed companies expect to change their retiree health plan strategy in response to the elimination of the retiree drug subsidy tax preference, with sixty-

dium.asp (scroll down to "Downloads", select "VII. State Data" to open zip file and retrieve Table VII.7).

308. Patient Protection and Affordable Care Act, § 9012, 124 Stat. at 868, amended by Health Care and Education Reconciliation Act, § 1407, 124 Stat. at 1067 (amending I.R.C. § 139A).

309. FIN. ACCOUNTING STANDARDS BD., STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 106, EMPLOYERS' ACCOUNTING FOR POSTRETIREMENT BENEFITS OTHER THAN PENSIONS 12 (1990).

310. *Major Employers Announce Costs of Drug Subsidy Change; Long-Term Impact Is Uncertain*, WOLTERS KLUWER (Apr. 4, 2010), <http://hr.cch.com/news/benefits/041410.asp>.

five percent planning to do so by 2011 and ninety-four percent by 2013.³¹¹

E. 2014 Employer Pay-or-Play Mandate

Although not specifically referencing retiree health plans the way either the ERRP or the elimination of the retiree drug subsidy tax preference do, the employer pay-or-play mandate that takes effect in 2014³¹² is significant for retiree benefits precisely because it does not apply to them. Despite Congressional concern over preserving retiree health insurance as illustrated in both the MMA's retiree drug subsidy and the Act's ERRP, employers must pay a penalty beginning in 2014 only if they fail to provide adequate coverage for active employees. Nothing similar extends to retirees. For early retirees, the assumption appears to be that, once the Exchanges become operational in 2014, such individuals will have adequate options without the need for employer-based benefits.³¹³ For Medicare-eligible retirees, perhaps the wide array of Medicare-oriented reforms are expected to suffice to protect Medicare beneficiaries.³¹⁴ Alternatively, perhaps more cynically, eliminating the tax preference for the retiree drug subsidy may reflect the need for revenue-raising provisions in the Act. In any case, the fact that the Act forces employers to choose to pay or provide adequate coverage for one group whom they have traditionally cov-

311. HEWITT ASSOCS., EMPLOYERS' INITIAL REACTION TO HEALTH CARE REFORM: RETIREE STRATEGY SURVEY 2010, at 2 (2010), available at http://www.hewittassociates.com/_MetaBasicCMAssetCache_/Assets/Articles/2010/HealthCareReform_RetireeStrategy_Highlights.pdf; see also Emily Brandon, *Firms Plan to Eliminate Retiree Health Plans*, U.S. NEWS & WORLD REP. BLOG (May 28, 2010), <http://www.usnews.com/money/blogs/planning-to-retire/2010/05/28/firms-plan-to-eliminate-retiree-health-plans.html> (discussing a bleak future for employer-sponsored retiree health plans).

312. See *supra* notes 185-90 and accompanying text.

313. For example, in explaining the Affordable Care Act's Early Retiree Reinsurance Program, the government's pro-health reform website concluded with the observation that the program "ends on January 1, 2014, when early retirees . . . will be able to choose from a range of coverage options that will be available in new competitive private health insurance Exchanges." *The Affordable Care Act's Early Retiree Reinsurance Program*, HEALTHREFORM.GOV, http://www.healthreform.gov/newsroom/early_retiree_reinsurance_program.html (last visited Apr. 24, 2011).

314. See, e.g., U.S. DEP'T HEALTH & HUMAN SERVS., AMERICA'S SENIORS AND HEALTH INSURANCE REFORM: PROTECTING COVERAGE AND STRENGTHENING MEDICARE, HEALTHREFORM.GOV, <http://www.healthreform.gov/reports/seniors/seniorsreport.pdf> (last visited Apr. 24, 2011) (addressing a wide array of changes to Medicare, but without reference to the elimination of the retiree drug subsidy tax preference).

ered—i.e., active employees—without doing the same for retirees certainly will not bolster retiree coverage. Congress appears to be sending a message that retirees will have other options than employment-based coverage—and that they need not continue to be employers' concern.

F. Provisions Affecting Retirees

The foregoing sections have focused on Act provisions that directly affect employer-sponsored retiree health plans. Other provisions of the Act, however, may indirectly alter retiree benefits by changing the perception of covered individuals. Employers weigh the overall cost of maintaining benefits packages, including retiree benefits, against the value they derive from providing such non-wage compensation. Because retiree health insurance requires significant financial commitment, employers must perceive that they receive significant compensating value in return.

In addition to building public good will and a positive corporate image, employers' primary concern with benefits will likely be the perception and morale of current and potential employees, not of those who have already left the workforce.³¹⁵ As those current and potential employees look toward retirement, where they rank an employer's promise of retiree health benefits should depend in part on what other options they expect to find. In the past, early retirees have found nothing,³¹⁶ presumably imbuing employment-based retiree health insurance with considerable value in those individuals' eyes. Medicare-eligible retirees have faced a better picture thanks to the Medicare safety net, yet some of the gaps in Medicare coverage³¹⁷—especially when compared with what most employer plans offer—

315. I do not suggest that all employers are lacking in a sense of moral obligation to their former employees. On the other hand, as workforce habits have shifted in recent decades, relatively few employees remain with the same employer for long periods of time. This trend means that long-term commitments on either side are less today than in the past, a shift also reflected in the movement away from defined benefit plans. For employers who currently provide retiree health benefits, decisions to terminate or significantly reduce those benefits must factor in the risk of potential litigation and negative publicity, in addition to other considerations. See, e.g., *Health Care Reform: Elimination of Retiree Drug Subsidy Deduction*, MCDERMOTT WILL & EMERY (July 21, 2010), http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object_id/cf01898e-7d77-4627-999d-5d912eab92be.cfm.

316. See *supra* notes 111–22 and accompanying text.

317. See *supra* notes 123–32 and accompanying text.

have likely sufficed to polish employment-based retiree plans in those individuals' eyes as well. Thus, before the Act, in the absence of good alternatives, employees might reasonably have ascribed significant value to employer promises of future retiree health benefits, encouraging employer maintenance of those benefits as long as financially feasible. The Act, however, over time should create new alternatives for individuals and improve existing options, reducing the relevance of employers' future retiree health plan promises.

1. EARLY RETIREES

The Act may change little for early retirees before 2014, other than potentially extending the lifespan of existing retiree health plans through the ERRP. Without access to such employment-based benefits, early retirees still face a desolate landscape for health insurance.³¹⁸ Although some insurance market reforms directed at individual policies take effect relatively quickly, they generally affect only policies insurance companies otherwise choose to issue. Thus, for example, the Act's restrictions and prohibitions on annual and lifetime limits extend not only to group health plans, but also to insurers issuing individual policies, in both cases effective for the first plan or policy year beginning on or after September 23, 2010.³¹⁹ Similarly, the Act's limits on the circumstances in which an insurer can refuse to renew or rescind coverage apply to individual policies just as to group health plans, again effective for the first plan or policy year beginning on or after September 23, 2010.³²⁰ But the more fundamental individual market changes wrought by the Act—the creation of the Exchanges, guaranteed availability and renewal rules, prohibitions of pre-existing condition exclusions and discrimination on the basis of health status, and controlled rate setting, to name only a few—do not take effect until January 1, 2014.³²¹

318. See *supra* notes 111–22 and accompanying text.

319. See *supra* notes 162–65 and accompanying text.

320. See *supra* note 172 and accompanying text.

321. Patient Protection and Affordable Care Act, § 1311, 124 Stat. at 173–81 (to be codified at 42 U.S.C. § 18031) (relating to establishment of the American Health Benefit Exchanges); Patient Protection and Affordable Care Act, § 1201, 124 Stat. at 156 (to be codified at 42 U.S.C. §§ 300gg–1, 300gg–2) (relating to guaranteed issuance and renewal); Patient Protection and Affordable Care Act, § 1201(2), 124 Stat. at 154 (amending 42 U.S.C. § 300gg) (relating to the prohibition of preexisting condition limitations); Patient Protection and Affordable Care Act, § 1201(4), 124 Stat. at 156 (to be codified at 42 U.S.C. § 300gg–4) (relating to bars on discrimination by insurers on the basis of health status); Patient Protection and Affordable

An individual with a pre-existing condition may seek coverage under a temporary high-risk pool created by the Act once he or she has been uninsured for at least six months.³²² Like the ERRP, the high-risk pool—called the “Pre-Existing Condition Insurance Plan” (PCIP) by HHS³²³—is intended to last only until the Exchanges become effective in 2014 and has limited funding of \$5 billion.³²⁴ The Act limits premiums and out-of-pocket costs for participants in the high-risk pool,³²⁵ attempting to make coverage relatively affordable for individuals who qualify.³²⁶ Individuals who are contemplating early retirement but have the choice to continue working with active employee health insurance, however, are unlikely to see the PCIP as a good alternative for the simple reason that, if they have a pre-existing condition and thus could eventually qualify for PCIP coverage, they probably need ongoing health care and would have to forego that for six months in order to meet the PCIP’s uninsured eligibility rule. On the other hand, for individuals who are covered by a retiree plan that terminates after they have left active employment but before they reach Medicare eligibility,³²⁷ the PCIP may provide at least some protection after six months of being uninsured.

Care Act, § 1201(4), 124 Stat. at 154–55, *amended by* § 10103(a), 124 Stat. at 892 (to be codified at 42 U.S.C. § 300gg) (relating to controls on premium rates).

322. Patient Protection and Affordable Care Act, §§ 1101(a), (d), 124 Stat. at 141–42 (to be codified at 42 U.S.C. §§ 18001(a), (d)). *See also* U.S. DEP’T HEALTH & HUMAN SERVS., THE AFFORDABLE CARE ACT—WHAT IT MEANS FOR THOSE WITH PRE-EXISTING CONDITIONS (2010), <http://www.healthcare.gov/center/brochures/pcip.pdf>.

323. *See Pre-Existing Condition Insurance Plan (PCIP)*, HEALTHCARE.GOV (July 1, 2010), <http://www.healthcare.gov/law/provisions/preexisting/index.html>.

324. Patient Protection and Affordable Care Act, §§ 1101(a), (g), 124 Stat. at 141, 143 (to be codified at 42 U.S.C. §§ 18001(a), (g)).

325. Patient Protection and Affordable Care Act, § 1101(c), 124 Stat. at 141–42 (to be codified at 42 U.S.C. § 18001(c)).

326. Announcing the start of the PCIP, Jay Agnoff, Director of the HHS Office of Consumer Information and Insurance Oversight (or “OCIIO,” which is charged with administering the PCIP) said, “Health coverage for Americans with pre-existing conditions has historically been unobtainable or failed to cover the very conditions for which they need medical care. The Pre-Existing Condition Insurance Plan is designed to address these challenges by offering comprehensive coverage at a reasonable cost.” News Release, U.S. Dep’t of Health and Human Servs., HHS Secretary Sebelius Announces New Pre-Existing Condition Insurance Plan (July 1, 2010), <http://www.hhs.gov/news/press/2010pres/07/20100701a.html>.

327. COBRA coverage does not help an individual whose retiree medical coverage terminates. The COBRA continuation coverage election period runs for sixty days after the date of termination of employment, not from the date of termination of coverage. Unless a retiree health plan terminates before the end of the standard COBRA election period, a retiree will no longer be able to take advantage of COBRA to bridge to Medicare. *See FAQs for Employees About COBRA Continuation*

The Act also expands Medicaid eligibility, opening the possibility for coverage of an individual who is not yet age sixty-five, but only if that person meets extremely strict income guidelines.³²⁸ As with the PCIP, if an individual is only contemplating early retirement and has the choice to continue working with health coverage, that person most likely will not perceive Medicaid coverage as an appealing option. Except for very low-wage workers, any kind of full-time employment with benefits generally provides a higher income level than what Medicaid accepts. An individual would thus be choosing less money just to access Medicaid health coverage, hardly a logical decision if the full-time employment includes affordable health coverage. Moreover, the Act does not require states to expand Medicaid eligibility before 2014.³²⁹ Almost all states are already struggling to balance their budgets with their current Medicaid obligations, a fact that makes the chances of early expansion of Medicaid eligibility slim at best.³³⁰ There is at least the possibility, however, that some low-income early retirees who find themselves without coverage through an employer plan could be rescued by Medicaid.

Beginning in 2014, if the Act's insurance market reforms and the Exchanges function as well as hoped, individual early retirees should finally have a range of affordable options that make employment-based plans much less critical. Medicaid by then will expand to provide coverage for the lowest-income persons, and those with more resources should be able to choose among highly regulated individual policies through the Exchanges. If that happens, employer plans may lose much of their perceived worth in the eyes of both current and future retirees.

Health Coverage, U.S. DEPT OF LABOR, <http://www.dol.gov/ebsa/faqs/faq-consumer-cobra.html> (last visited Apr. 24, 2011).

328. The new eligibility category covers adults who are at least age nineteen and not yet sixty-five, not otherwise eligible for Medicaid, and whose income is 133% or less of the federal poverty level. Patient Protection and Affordable Care Act, § 2001(a), 124 Stat. at 271-75 (amending 42 U.S.C. § 1396a).

329. Patient Protection and Affordable Care Act, § 2001(a), 124 Stat. at 271 (amending 42 U.S.C. § 1396a).

330. See, e.g., KAISER COMM'N ON MEDICAID AND THE UNINSURED, STATE MEDICAID AGENCIES PREPARE FOR HEALTH CARE REFORM WHILE CONTINUING TO FACE CHALLENGES FROM THE RECESSION 7 (2010), available at <http://www.kff.org/medicaid/upload/8091.pdf>.

2. MEDICARE-ELIGIBLE RETIREES

Unlike early retirees, for whom the Act's more significant impact will be deferred another few years, Medicare-eligible retirees were affected immediately by certain key Medicare reform provisions. Among the most visible of these for beneficiaries was the Act's 2010 start to eliminating the Part D donut hole.³³¹ The phrase "donut hole" refers to a coverage gap in Medicare Part D that stops Medicare coverage for outpatient prescription drugs once a beneficiary reaches a specified threshold in drug costs for the year (\$2830 in 2010), forcing a beneficiary to cover 100% of his or her outpatient prescription drug costs until he or she reaches the catastrophic coverage threshold (\$6440 in 2010).³³² Under the Part D standard benefit package, a beneficiary must pay an annual deductible (\$310 in 2010), then cover twenty-five percent of qualified drug costs until he or she reaches the donut hole threshold (again \$2830 in 2010); once past the donut hole, the beneficiary qualifies for catastrophic coverage—with Medicare picking up approximately ninety-five percent of qualified drug costs.³³³ These numbers mean that a Medicare beneficiary in 2010 under the standard benefit package³³⁴ needed to incur \$4550 in out-of-pocket costs before Part D catastrophic coverage applied.³³⁵ Although by no means a majority, large numbers of Medicare beneficiaries—an esti-

331. The Act targets Medicare from almost every conceivable angle. Only a few key provisions are mentioned here in light of space constraints.

332. CTRS. FOR MEDICARE & MEDICAID SERVS., ANNOUNCEMENT OF CALENDAR YEAR (CY) 2010 MEDICARE ADVANTAGE CAPITATION RATES AND MEDICARE ADVANTAGE AND PART D PAYMENT POLICIES 37 (2009), available at <http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2010.pdf>.

333. 42 U.S.C. § 1395w-102(b) (2006); CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 332, at 37.

334. Because Part D prescription drug coverage is provided through private insurers, the "standard benefit package" specified in the MMA is not necessarily what an individual beneficiary will find. The MMA gives private insurers the freedom to design prescription drug policies as they wish as long as coverage is at least actuarially equivalent to the standard benefit package. HEALTH POLICY ALTS., KAISER FAMILY FOUND., PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES: AN OVERVIEW OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT OF 2003, at 2 (2004), available at <http://www.kff.org/medicare/upload/Prescription-Drug-Coverage-for-Medicare-Beneficiaries-An-Overview-of-the-Medicare-Prescription-Drug-Improvement-Act-2003.pdf>.

335. See, e.g., CMS Releases 2010 Medicare Part D Benefit Parameters, FOR YOUR INFORMATION (Buck Consultants), Apr. 2009, available at http://www.buckconsultants.com/buckconsultants/Portals/0/Documents/PUBLICATIONS/Newsletters/FYI/2009/FYI_04_13_09.pdf.

mated 3.4 million (or fourteen percent) in 2007—incur sufficient drug expenses to enter the donut hole each year.³³⁶ The donut hole has been extraordinarily unpopular since enactment of the MMA, and its elimination formed a cornerstone of Democratic health reform promises during the 2008 presidential election.³³⁷

Fulfilling those campaign promises, the Act should eventually remove the donut hole from Part D.³³⁸ In the near term, the Act took immediate action to ease individual woes by providing a \$250 rebate in 2010 to each Medicare beneficiary who entered the donut hole.³³⁹ Additional provisions then not only phase out the donut hole by 2020,³⁴⁰ but also require drug manufacturers to discount brand-name drugs in the donut hole by fifty percent starting in 2011.³⁴¹ Beginning in 2011, a Medicare beneficiary's cost-sharing obligation for generic drugs in the donut hole slants downward from one hundred percent in 2010 to only twenty-five percent in 2020.³⁴² For brand-name drugs, in addition to the fifty percent manufacturer discount that begins in 2011, participant cost-sharing for the remaining fifty percent of costs moves from 47.5% in 2013 and 2014 (down from fifty percent in 2011 and 2012) to twenty-five percent in 2020.³⁴³ Thus, by 2020, coverage in the “donut hole” should look like coverage in the stretch before the donut hole—i.e., participants will be responsible for only twenty-five

336. JACK HOADLEY ET AL., KAISER FAMILY FOUND., *THE MEDICARE PART D COVERAGE GAP: COSTS AND CONSEQUENCES IN 2007*, at 4 (2008), available at <http://www.kff.org/medicare/upload/7811.pdf>.

337. See, e.g., Susan E. Cancelosi, *Unlocking the Truth: Evaluating 2008 Election Issues for Elderly Minorities as a Key to Understanding Medicare Reform*, 10 BERKELEY J. AFR.-AM. L. & POL'Y 226, 243–44 (2008).

338. Health Care and Education Reconciliation Act, 124 Stat. at 1036–40 (amending 42 U.S.C. §§ 1395w-102, 1395w-152). See KAISER FAMILY FOUND., *EXPLAINING HEALTH CARE REFORM: KEY CHANGES TO THE MEDICARE PART D DRUG BENEFIT COVERAGE GAP 1* (2010), available at <http://www.kff.org/healthreform/upload/8059.pdf>.

339. Health Care and Education Reconciliation Act, § 1101(a)(1), 124 Stat. at 1037 (to be codified at 42 U.S.C. § 1395w-152(c)).

340. Health Care and Education Reconciliation Act, § 1101(b)(3), 124 Stat. at 1038–39 (amending 42 U.S.C. § 1395w-102(b)).

341. Patient Protection and Affordable Care Act, § 3301(b), 124 Stat. at 462–68, amended by Health Care and Education Reconciliation Act, § 1101(b)(1)–(2), 124 Stat. at 1037–38 (adding 42 U.S.C. § 1395w-114a).

342. The beneficiary's share of costs in the donut hole drops by seven percent per year from 2011 through 2019 (starting at ninety-three percent in 2011), with a final twelve percent drop from thirty-seven percent in 2019 to twenty-five percent in 2020. Health Care and Education Reconciliation Act, § 1101(b)(3), 124 Stat. at 1038 (to be codified at 42 U.S.C. § 1395w-102(b)(2)(C)(ii)).

343. Health Care and Education Reconciliation Act, § 1101(b)(3), 124 Stat. at 1038–39 (to be codified at 42 U.S.C. § 1395w-102(b)(2)(D)(ii)).

percent of qualified drug expenses. Through 2019, the Act also lowers the total out-of-pocket limit for participants so that those with significant prescription drug costs reach catastrophic coverage somewhat more quickly than before. The result should be much-improved Part D coverage from beneficiary perspectives. The donut hole—a unique and odd feature in Medicare—meant that most employer plans were inherently more generous than Part D plans, because the employer-provided retiree benefits did not contain a comparable coverage gap.³⁴⁴ Retirees presumably thus ascribed more value to their employer-based plans. As the donut hole slowly shrinks, however, the perceived comparative generosity of employer-sponsored drug coverage may fade as well.

Also beginning in 2011, Medicare-eligible retirees will enjoy enhanced coverage of preventive care services under Medicare. The Act provides that traditional Medicare Parts A and B will no longer either charge coinsurance or apply deductibles to medical bills for certain common preventive care screenings and services.³⁴⁵ Moreover, Medicare will begin paying for a free wellness exam each year and related preventive care planning.³⁴⁶ All of these are benefits traditionally covered at little or no charge under employer plans, illustrating yet another area in which retiree health plans have historically been more generous than Medicare. By plugging Medicare's coverage gaps with these services, the Act takes another step toward smoothing the differences between private retiree health insurance and Medicare. From a retiree's perspective, the more comprehensive Medicare's benefit package, the less need for employer-sponsored supplemental coverage—and, by extension, the less value inherent in that coverage.

Of course, not all changes to Medicare may strike retirees as enhancing the government option over the private employer alternative. Beginning in 2011, Part D premiums will become income-adjusted in

344. See, e.g., MCDERMOTT WILL & EMERY, *supra* note 315 (“Although Medicare Part D has historically had a gap in coverage (the donut hole) that made the program a much more expensive option for retirees compared with coverage under an employer’s prescription drug plan, the PPACA established a system to eliminate this gap. . . . This enhanced Medicare Part D coverage provides many employers with an additional reason to consider eliminating retiree drug benefits.”).

345. Patient Protection and Affordable Care Act, §§ 4103(b)–(c), 124 Stat. at 553–56 (to be codified at 42 U.S.C. § 1395x).

346. Patient Protection and Affordable Care Act, §§ 4103, 10402(b), 124 Stat. at 553–56, 975 (to be codified at 42 U.S.C. § 1395x).

much the same way as Part B premiums have been since the MMA.³⁴⁷ The income threshold for adjusting Part B premiums will be frozen through 2019 at 2010 levels, meaning that an increasingly higher percentage of Medicare beneficiaries may find themselves subject to the higher premium requirements.³⁴⁸ Separately, but also in 2011, the Act in effect freezes payments to Medicare Advantage plans at the 2010 level, then changes how payments are calculated so as to lower reimbursement levels in 2012 and 2013.³⁴⁹ Medicare Advantage plans are private insurance alternatives to traditional government-run Medicare Parts A and B. Medicare Advantage plans provide the same benefits as traditional Medicare Parts A and B but may also provide additional benefits—such as expanded preventive care and prescription drug benefits or reduced cost-sharing—wrapped into a single package through the private insurer/plan sponsor.³⁵⁰ While Medicare Advantage plans provide more generous coverage than traditional Medicare, they typically cost more. In an effort to support the expansion of Medicare Advantage, the MMA provided enhanced reimbursement to the private insurers.³⁵¹ Like the donut hole, the enhanced Medicare Advantage payments have been a Democratic target since the MMA passed, and the Act's provisions reflect those criticisms.³⁵² Beneficiaries currently enjoying the expanded coverage available through Medicare Advantage plans are likely to see either premium costs rise or coverage shrink as reimbursement rates decline. Either result could make employer retiree health plans more appealing.

347. Patient Protection and Affordable Care Act, § 3308, 124 Stat. at 472–73 (amending 42 U.S.C. § 1395w-113(a)).

348. Patient Protection and Affordable Care Act, § 3402, 124 Stat. at 488–89 (amending 42 U.S.C. § 1395r(i)).

349. Health Care and Education Reconciliation, § 1102, 124 Stat. at 1040–47 (to be codified at 42 U.S.C. § 1395w-23 and scattered sections of 42 U.S.C.).

350. *Medicare Advantage Part C*, MEDICARE.GOV, <http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-c.aspx?AspxAutoDetectCookieSupport=1> (last visited Apr. 24, 2011).

351. 42 U.S.C. § 1395w-23 (2006).

352. See generally U.S. DEP'T HEALTH & HUMAN SERVS., HEALTH INSURANCE REFORM AND MEDICARE: MAKING MEDICARE STRONGER FOR AMERICA'S SENIORS, available at <http://www.healthreform.gov/reports/medicare/medicare.pdf>; KAISER FAMILY FOUND., EXPLAINING HEALTH REFORM: KEY CHANGES IN THE MEDICARE ADVANTAGE PROGRAM (2010), available at <http://www.kff.org/healthreform/upload/8071.pdf>.

VI. Conclusion

Standing in the midst of historic change, prognostication is risky. No one can say with any certainty what will happen to the U.S. health care system over the next year, much less the next decade, and the Act's changes reach far into the future. On the other hand, certain basics remain constant. Employers must balance how much they spend on employee benefits with the value they derive from that expenditure. Weighed against active employee health insurance, retiree health plans have been losing ground since the 1980s. If nothing else had occurred, if health reform had remained wishful thinking rather than law, it is entirely possible that retiree health benefits would have slid slowly out of sight over future decades as more and more employers eventually negotiated or litigated their way out of the obligations.

Health reform has occurred, however. Already, employers sponsoring health plans must satisfy new rules, many of them increasing short-term costs. Within a few short years, health insurance may well become a responsibility spread across most individuals and employers in the country. That reality cannot help but redraw the background against which retiree health plans exist. The ERRP will support existing early retiree plans for a while, but not long. What then happens? One possibility is that employers simply swallow the returning cost, view the ERRP funds as a pleasant break, and continue as they had before—or at least continue to maintain the plans, but shift costs even more to retirees. Another option is that employers terminate the early retiree plans as soon as they can following ERRP fund exhaustion. Still another alternative is that employers wait until the Exchanges become operational in 2014, when early retirees should in theory finally have viable alternatives, and then terminate the retiree plans. Given that most employers who offer early retiree health benefits today would probably have eliminated those benefits already if they could or wanted to do so, there may be a reasonable chance that they will maintain those benefits until 2014. If this proves true, the ERRP funding will have accomplished its goal: aiding employers just long enough that they can afford to maintain a bridge to the brighter future of the Exchanges. After 2014, however, even Congress did not concern itself with early retiree plans, leaving little hope for their long-term prospects.

For Medicare-eligible retirees, the Act's impact is relatively immediate. The value of the Part D retiree drug subsidy will drop precipitously in 2013, about the same time that ERRP funds almost undoubtedly will have vanished. Employers in the same year may thus face suddenly increased expenses for both early and Medicare-eligible plans. A year later, the pay-or-play mandates will hit. Over the same period, as Medicare's own coverage expands, retirees may be more and more able to meet their health insurance needs without recourse to employer plans. Why, then, would rational employers continue to provide an increasingly expensive benefit to individuals who may view it as less valuable than in the past? In the long run, there may be no good answer to that question.

With this background and perspective, the Act indeed may hasten the demise of employer-sponsored retiree health benefits. If so, employers, retirees, and other stakeholders—mainly unions, the stand-alone VEBAs, and the government—should acknowledge the future and prepare for it consciously. Far better that retiree benefit plans end their time in a controlled, thoughtful manner than in a random splattering of terminations as employers, one by one, drop away. Successful health reform should give individuals the opportunity to access quality, affordable health care without regard to their employment status. For retirees, as long as a viable alternative to employment-based health benefits exists, leveling access is not necessarily a bad result. The bell may thus be tolling for retiree health plans. Whether that is cause for mourning will depend largely on the future of health reform.