

The Past, Present and Future of Retiree Health Benefits

David A. Pratt¹

I. INTRODUCTION

Retiree health benefits are in the headlines again. The Governmental Accounting Standards Board (GASB) has issued new accounting rules that will require state and local government employers to disclose, in more detail and more clearly than ever before, the cost of the post-retirement benefits that they have promised to their employees and retirees.² A recent Credit Suisse report estimated the cost at \$2.1 billion for the City of Boston.³ Boston's health insurance costs have increased by 92% since fiscal year 2001; about 45% of those covered are retirees.⁴

Private sector employers went through this process in the early 1990s, after the

¹ David Pratt is a Professor of Law at Albany Law School. Thanks to the editors of the *Journal* for their excellent editorial assistance.

² See *infra* Part VI.B.

³ Credit Suisse, *You Dropped a Bomb on Me*, GASB, Mar. 22, 2007, available at <http://online.wsj.com/public/resources/documents/DroppedB.pdf>. By contrast, the estimated liability for New York City is \$50.5 billion, which appears to be about 8 times as large as the next highest amount for a city (Detroit). *Id.* Boston ranks 8th among cities. *Id.* However, as the report cautions: "keep in mind that you may be comparing apples and oranges. (The same holds true for the states.) For example, the \$50.5 billion OPEB underfunding for New York City appears to include all of the city's employees, including, teachers, police, fire department, social services, etc. In comparison, the \$1.8 billion in OPEB underfunding for Los Angeles looks down right puny. However, that \$1.8 billion excludes, among other things, the Los Angeles Unified School District, where according to a February 2006 Legislative Analyst's Office report, a 'Jul. 1, 2004, actuarial valuation pegged the unfunded retiree health liability of the district at \$4.9 billion.'" *Id.* New York City's estimated liability is 84% of its assets; Boston's is 78% of its assets. *Id.*

⁴ Matt Viser, *Soaring Healthcare Costs Detailed*, BOSTON GLOBE, Nov. 30, 2006. See also Robert C. Pozen, *Paying for Public Retiree Healthcare*, BOSTON GLOBE, Jan. 25, 2007; Andreae Downs, *Healthcare Costs Soar out of Control*, BOSTON GLOBE, Apr. 15, 2007.

Financial Accounting Standards Board (FASB), the private sector counterpart of GASB, issued its Statement No. 106 on accounting for post-employment benefits.⁵ As a result, and motivated primarily by concerns for the effect on their balance sheets and annual profits, many employers curtailed or eliminated these retiree benefits.⁶

It is too early to tell how public sector employers will react to the new environment. The fact that the costs are now more visible will undoubtedly fuel taxpayer demands to rein in the benefits, particularly since public sector retiree health benefits are typically very generous in comparison to the private sector.⁷ However, it may not be easy to do so. First, in many states, notably New York and California, public sector unions are very powerful and are likely to emphatically resist any attempts to reduce benefits.⁸ Second, in some states these benefits are protected against reduction or elimination by state statutes or by the state constitution.⁹ Third, the legislators who would vote for any such reduction are themselves future recipients of these benefits, so may be less than enthusiastic to reduce them. However, it appears clear that, if state and

⁵ See *infra* Part VI.A.

⁶ See *infra* Part VI.A.

⁷ “The rule opens our eyes finally to the long-term implications of these promises”, said E.J. McMahon, director of the Empire Center for New York State Policy. “A lot of people are going to wonder why something is not done to restructure these benefits to make them more affordable, especially when virtually every private-sector employer is making changes in their health benefits.” Tami Luhby, *Retiree Costs in the Open*, NEWSDAY, Mar. 30, 2007.

⁸ “Some places, such as Brookhaven Town, where contracts don't expire until 2011, have their hands tied. Others, currently in negotiation with employee unions, are trying to whittle down the expense. ‘The No. 1 issue during negotiations is health insurance,’ said Robert Gorman, assistant superintendent for business at the Lindenhurst school district, which spent \$4.4 million on 523 retirees.” *Id.* Also, as Credit Suisse noted in its recent report:

Of course, state and local government's success in passing off this cost may ultimately depend upon how much leverage they have over their workers. Union workers would surely cry foul if these governments announced that they were reducing OPEB benefits or taking them away (especially if workers claim to have accepted lower wages in return for better benefits), resulting in possible business interruptions and loss of revenue. (Remember the NYC transit strike.) In general, the more heavily unionized the workforce, the more difficult it is to cut retiree benefits, a problem for state and local governments where, according to an April 2005 Employee Benefit Research Institute research note, it is estimated that 37.2% of the workforce are members of a union versus only 8.2% for the private sector. Credit Suisse, *supra* note 3, at 18.

⁹ See *infra* Part VIII.A.

local governments do not respond promptly and responsibly to address how they will pay these costs, significant state tax increases are likely and bond ratings will suffer.¹⁰

This article will discuss, briefly, the history of retiree health benefits; the recent decline in the number of employers that provide retiree health benefits; the recent changes to the accounting rules governing retiree health benefits and other post-employment benefits; and the prospects for the future.

II. EMPLOYER-PROVIDED HEALTH BENEFITS

For many years, most Americans with health insurance have received that coverage through an employer-sponsored plan, as an employee or as a spouse or dependent of an employee.¹¹ This is not the result of a considered policy choice, but is a historical accident: during World War II, wage controls prevented employers from competing for scarce labor by offering higher wages, so they started to offer health insurance instead.¹² In 2005, 63.1 percent of workers were covered by a plan from their own employer, 14.9 percent had coverage through an employer as a dependent, and 17 percent were uninsured.¹³ Among workers eligible for health benefits, 84.2 percent were

¹⁰ "Although government entities have the opportunity to reduce their liabilities by contemporaneously funding OPEB plans, many of them will not be able to find sufficient funds in their budgets for such funding. Thus, they may be forced to re-evaluate the benefits they provide to retirees. They may consider reducing the benefits offered, changing eligibility requirements, or setting a cap on employer contributions. Because health care costs account for such a large portion of OPEB costs, employers may consider eliminating health benefits for retirees entirely. Such re-structuring would reduce reported OPEB liabilities significantly. Some analysts have pointed to the private sector's experience with the implementation of standards similar to Statements 43 and 45 to suggest that fewer government employers will provide health benefits to retirees in the future." Terry A. M. Mumford and Ice Miller, *GASB For Lawyers: What You Need To Know About The New Accounting Standards For Postemployment And Termination Benefits Provided By Government Employers*, ALI-ABA COURSE OF STUDY MATERIALS, RETIREMENT, DEFERRED COMPENSATION, AND WELFARE PLANS OF TAX-EXEMPT AND GOVERNMENTAL EMPLOYERS, (Sepr. 2005, Course Number: SE024).

¹¹ See e.g., David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 NEW ENG. J. MED. 82, 83 (2006); Sherry A. Glied & Phyllis C. Borzi, *The Current State of Employment-Based Health Coverage*, 32 J.L. MED. & ETHICS 404, 405 (2004); Catherine Hoffman et al., *Holes in the Health Insurance System - Who Lacks Coverage and Why*, 32 J.L. MED. & ETHICS 390, 391 (2004); Susan E. Cancelosi, *Revisiting Employer Prescription Drug Plans for Medicare-Eligible Retirees in the Medicare Part D Era*, 6 HOUS. J. HEALTH L. & POL'Y 85 (2005).

¹² See, e.g., Jonathan Cohn, *SICK: THE UNTOLD STORY OF AMERICA'S HEALTH CARE CRISIS- AND THE PEOPLE WHO PAY THE PRICE*, HarperCollins (2007).

¹³ Paul Fronstin, *Employment-Based Health Benefits: Access and Coverage, 1988–2005*, EBRI Issue Brief No. 303 (Mar. 2007), available at <http://www.ebri.org/publications/ib/index.cfm?fa=>

covered by their employer, 9.8 percent had coverage through an employer as a dependent, and 4.8 percent were uninsured.¹⁴

In recent years, the employer-based health insurance system has begun to crumble. This result may be largely because of inexorable increases in the cost of health insurance.¹⁵ Additionally, fewer employers now offer health insurance to their employees and fewer workers to whom it is offered actually take it.¹⁶ This is largely because of the recent substantial increases in the levels of employee contributions required as a condition of coverage.¹⁷

Health care costs at current levels override the incentives that have historically supported employer-based health insurance. Now that health costs loom so large, companies that provide generous benefits are in effect paying some of their workers much more than the going wage—or, more to the point, more than competitors pay similar workers. Inevitably, this creates pressure to reduce or eliminate health benefits. And companies that can't cut benefits enough to stay

ibDisp&content_id=3789.

¹⁴ *Id.*

¹⁵ See, e.g., Stephen Heffler et al., *U.S. Health Spending Projections for 2004-2014*, HEALTH AFFAIRS, Feb. 23, 2005, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.74v1>. See also, Cynthia Smith, et al., *National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending*, 25 HEALTH AFFAIRS 186 (2006).

¹⁶ In March, 2006, 71% of workers in private industry had access to employer-sponsored medical care plans, but only 52% were actually covered. Bureau of Labor Statistics, U.S. Dep't of Labor, Nat'l Compensation Survey, Employee Benefits In Private Industry in the U.S. (2006) available at <http://www.bls.gov/ncs/ebs/sp/ebsm0004.pdf> (last visited Jul. 27, 2007). Monthly employee premiums averaged \$296.88 for family coverage and \$76.05 for single coverage. *Id.* The detailed results can be found at the same site. The percentage of U.S. residents with employer-sponsored health coverage decreased from 59.8% in 2004 to 59.5% in 2005, the lowest percentage since 1993. *Id.* In 2001, 62.6% had employer-sponsored coverage. *Id.* "As the largest component of private health insurance coverage, this decline in employment-based coverage essentially explains the decrease in total private health insurance coverage, from 68.2% in 2004 to 67.7% in 2005." *Id.* According to another recent report, "The proportion of all firms offering health care benefits fell from 69 percent in 2000 to 60 percent in 2005, causing 5 million employees to lose their insurance coverage." David Blumenthal, *Employer-Sponsored Insurance: Riding the Health Care Tiger*, N. ENG. J. MED., Jul. 13, 2006, at 195-196 (citing Kaiser Family Found., Employer Health Benefits: 2005 Summary of Findings, www.kff.org). See also, Daily Health Policy Report, Health Care Marketplace, *Percentage of Workers Enrolled in Employer-Sponsored Health Plans at Large Companies Drops*, *New Government Data Show*, Aug. 25, 2006, available at <http://www.medicalnewstoday.com/articles/50574.php>.

¹⁷ Jon Gabel et al., *Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode*, 24 HEALTH AFFAIRS 1273 (2005); David Pratt, *Healthy and Wealthy and Dead: Health Savings Accounts*, 19 ST. THOMAS L. REV. 7 (2006).

competitive—such as GM—find their very existence at risk.¹⁸

This article will not discuss the advantages and disadvantages of an employment-based health insurance system, but one disadvantage is obvious—an individual who, for any reason, loses the job through which the insurance is provided will generally also lose the insurance. If he or she finds another job with comparable insurance benefits, the lapse in coverage may only be brief; however, an older individual, or one who is in poor health, may find it difficult or impossible to find such a job.¹⁹

What are the alternatives for individuals who no longer have access to employment-based health insurance? First, there is privately-purchased health insurance; however, private insurance tends to be much more expensive and to provide less comprehensive coverage than group insurance, and may not be available at an affordable price to an individual who is older or has health problems.²⁰ For a retired

¹⁸ Paul Krugman & Robin Welis, *The Health Care Crisis and What To Do About It*, THE N.Y. REVIEW OF BOOKS, Mar. 23, 2006, at 38 (reviewing HENRY J. AARON ET AL., *CAN WE SAY NO?* (2005), JULIUS RICHMOND & RASHI FEIN, *THE HEALTH CARE MESS* (2006), and JOHN F. COGAN, ET AL., *HEALTHY, WEALTHY, AND WISE* (2005)), available at <http://www.nybooks.com/articles/18802>.

¹⁹ See Richard W. Johnson, *What Happens To Health Benefits After Retirement?*, CENTER FOR RETIREMENT RESEARCH AT BOSTON COLLEGE, Feb. 2007, at 1, available at http://crr.bc.edu/images/stories/Briefs/wob_7.pdf

Because most workers receive health benefits from their employers, retirement often disrupts health insurance coverage. Some employers offer health insurance to retirees, but many firms are cutting retiree health benefits by passing more costs to retirees or eliminating benefits altogether. Few alternatives exist. Private nongroup coverage is generally quite expensive, and few people in their 50s and early 60s qualify for publicly financed benefits. Many workers who cannot obtain retiree benefits from their own employers or their spouses' employers delay retirement to age 65, when Medicare coverage begins. *Id.*

²⁰ ALLIANCE FOR HEALTH REFORM, *COVERING HEALTH ISSUES 2006* 4 (2006), available at http://www.allhealth.org/sourcebook2006/pdfs/chapter_1.pdf (last visited Jul. 27, 2007).

Health insurance in the individual market is more expensive than employer-sponsored coverage for several reasons. Almost seven out of 10 people (69 percent) who sought individual coverage in 2001 had difficulty finding a plan they could afford, one survey found. Marketing and administrative costs per insured person are much higher for policies sold one-by-one rather than to groups. In addition, people buying individual coverage must pay the full premium. In contrast, those enrolled in employment-based coverage in 2006

couple under 65, insurance can cost up to \$15,000 per year in New York. Further, "older workers are far more likely to have medical conditions that, even if they don't prevent employment, can make finding insurance hard or impossible."²¹

Second, most individuals who would otherwise lose coverage under an employer-sponsored plan may elect to continue their coverage under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA).²² However, COBRA continuation coverage is generally limited to a maximum of 36 months.²³ Further, COBRA plans require the individual to pay the entire cost of coverage, which most people simply cannot afford to do.²⁴

paid an average of 16 percent of the total premium for themselves alone or 27 percent for family coverage, with the remainder covered by the employer. *Id.*

See Richard W. Johnson, Amy J. Davidoff, and Kevin Perese, *Health Insurance Costs and Early Retirement Decisions*, 56 *INDUS. & LAB. REL. REV.* 716, 716 (2003). "Individuals who retire before they are eligible for Medicare can have difficulty acquiring coverage in the private market. Because many near-elderly adults have pre-existing health conditions, private insurers often deny them coverage or charge premiums that are unaffordable." *Id.* See also Johnson, *infra* note 57, at 2 (stating "[r]elying upon the private nongroup market at older ages has drawbacks, including the high price of coverage (especially for those in less-than-perfect health), the limited benefits provided by many plans, and the possibility that coverage may be denied. Before age 65, adults without dependent children (and those who are not pregnant) can qualify for Medicare or Medicaid only if they are blind or disabled. Medicaid benefits are also subject to strict income and asset tests. In 2004, about 8 percent of adults aged 55 to 64 received Medicaid or Medicare coverage and another 2 percent received military health benefits.").

²¹ Johnson, et al., *supra* note 20. Martha Hamilton describes the case of Pamela Votava who, in her 50s, developed post-polio syndrome. "On the advice of her doctor, she decided to retire in Jul. 2004 at age 61 to help slow the disease's progress.... Votava eventually was able to obtain coverage, but at a high price. Her premiums for the first year were \$1,533 a month, rising the next year to more than \$2,300. Although her family helped, most of the money came out of the couple's retirement savings -- money they had hoped to spend on travel or a bigger house." Martha M. Hamilton, *Health-Care Trends You Dare Not Forget*, *THE WASHINGTON POST*, Mar. 31, 2007, at F01; See also Kaiser Family Found., *How Accessible is Individual Health Insurance for Consumers in Less-Than Perfect Health?*, June 2001, available at <http://www.kff.org/insurance/upload/How-Accessible-is-Individual-Health-Insurance-for-Consumers-in-Less-Than-Perfect-Health-Executive-Summary-June-2001.pdf>. That study found that roughly 90% of applicants in less-than-perfect health were unable to buy individual policies at standard rates, while 37% were rejected outright. *Id.*

²² The Consolidated Omnibus Reconciliation Act of 1985 (COBRA), codified in ERISA, 29 U.S.C. §§ 1161-1169 (West 2000); See also, 26 U.S.C. § 4980B (1986) ("Code") (discussing tax consequences for failure to satisfy COBRA requirements); Public Health Service Act, 42 U.S.C. § 300gg (2007).

²³ ERISA § 602(2), 29 U.S.C. § 1162(2)(A)(ii).

²⁴ ERISA § 604, 29 U.S.C. § 1164(2)(A).

Third, there is Medicaid for the poor and near poor; however, there are stringent income and asset limitations on eligibility, so many people do not qualify.²⁵ Fourth, if the individual is a veteran, or a family member or survivor of a veteran, he or she may qualify to receive health benefits through the Veterans' Health Administration.²⁶ Despite recent adverse publicity concerning Walter Reade and some other hospitals, the Veterans' Health Administration has a very good record for providing quality care.²⁷

Fifth, Medicare provides coverage for over 40 million people; however, Medicare benefits are currently available only to people who are 65 or older, have been disabled (under the stringent Social Security criteria) for at least two years, or suffer from end stage renal disease (ESRD).²⁸ Unlike Social Security, Medicare does not allow a beneficiary to elect to receive benefits early, at or after age 62.²⁹ In addition, even if the individual is eligible for Medicare, the Employee Benefit Research Institute (EBRI) estimates that Medicare covers only 51 percent of health-care expenses for most individuals.³⁰ Further, individuals' out-of-pocket expenses are likely to increase

²⁵ For 2007, the limits for a family of four are \$1,109 of monthly net income and resources of \$6,650, with higher limits for children and pregnant women. See http://www.health.state.ny.us/health_care/medicaid/#income (last visited Jul. 27, 2007). See also Alliance for Health Reform, COVERING HEALTH ISSUES, 2006, Chapter 6: Medicaid, at 81 (2006), available at www.allhealth.org/sourcebook2006/pdfs/chapter_6.pdf (last visited Jul. 27, 2007).

²⁶ See Dept. of Veterans Affairs, Fact Sheet at <http://www1.va.gov/opa/fact/docs/vafacts.pdf> (last visited Jul. 16, 2007).

²⁷ See, e.g., Paul Krugman, *Health Policy Malpractice*, N. Y. TIMES, Sept. 4, 2006, at A15 (noting that "[s]ome still think of the V.A. as a decrepit institution, which it was in the Reagan and Bush I years. But thanks to reforms begun under Bill Clinton, it's now providing remarkably high-quality health care at remarkably low cost").

²⁸ 42 U.S.C. §§426, 426(1), 1395i-2 (2007).

²⁹ 42 U.S.C. § 1395i-2 (b).

³⁰ Martha M. Hamilton, *Health-Care Trends You Dare Not Forget*, THE WASHINGTON POST, Mar. 31, 2007 at F01. See also, What Medicare Covers - And Doesn't Cover, Adapted with permission from the Medicare Rights Center, available at http://www.allhealth.org/sbphotos/4_WhatMedCovers-55.pdf (last visited Jul. 27, 2007). "The average cost per Medicare beneficiary for Medicare-covered services was estimated in one study at \$9,236 (in 2004 dollars). Of this amount, the government pays 67 percent (\$6,170) and beneficiaries pay 33 percent (\$3,066)... And since some health care services are not covered by Medicare, beneficiaries' out-of-pocket medical spending can be even higher. One study found that Medicare beneficiaries not in nursing homes or other institutions spent 22 percent of their income on health care in 2003. This doesn't take into account spending changes related to the Medicare prescription drug benefit, which went into effect on January 1, 2006." Alliance for Health Reform, COVERING HEALTH ISSUES, 2006, Chapter 4: Medicare at 54, available at www.allhealth.org/sourcebook2006/pdfs/chapter_4.pdf (last visited Jul. 27, 2007) (citing Karen Davis, Marilyn Moon, Barbara Cooper, Cathy Schoen, *Medicare Extra: A Comprehensive Benefit Option For Medicare Beneficiaries*, HEALTH AFFAIRS, Oct. 4,

significantly if and when Congress attempts to deal with Medicare's financial problems.³¹

Finally, the individual may be fortunate enough to have worked for an employer that provides health insurance coverage to its retirees, and to have terminated employment in circumstances that entitle him or her to such coverage. The balance of this article will focus on employer-provided retiree health coverage.

III. EMPLOYER-PROVIDED RETIREE HEALTH BENEFITS

From the viewpoint of 2007, it is hard to understand why any employer would have agreed to provide retiree health benefits. Although there is little contemporaneous evidence, it appears that employers originally thought of retiree health coverage as a good will benefit that could be provided at very low cost.³² "Retiree health coverage began in the 1940s and 1950s as, in the words of Financial Accounting Standards Board project manager Diana J. Scott, a "throw-away benefit," inexpensive to provide and lightly granted."³³

Even in their heyday, retiree health benefits were much less widespread than health benefits for active employees, generally being provided by larger employers in the for-profit sector (particularly those in heavily unionized industries).³⁴ In the tax-exempt sector, retiree health benefits were prevalent in educational institutions and other large

2005, available at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.442> (last visited Jul. 27, 2007)).

³¹ See The 2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Health Insurance Trust Funds, Apr. 2007 at 2-4, available at <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2007.pdf> (last visited Jul. 27, 2007).

³² See, e.g., Cancelosi, *supra* note 11 ("In the days before health care expenses dominated national news, and as employer-provided health insurance became commonplace for employees in the 1950s and 1960s, unions began to push employers to continue that insurance into retirement. With health insurance costs relatively low, employers often viewed retiree health insurance as an easy bargaining chip to offer in union negotiations.... After the passage of Medicare, retiree health insurance, at least for Medicare-eligible retirees, tended to be fairly inexpensive as it provided primarily supplemental coverage to wrap around Medicare's generous benefits - with the glaring exception of prescription drug coverage, which generally was not provided by Medicare. There were relatively few retirees as compared to the active population, and retirees often simply remained on the active plans.").

³³ John H. Langbein & Bruce A. Wolk, *PENSION & EMPLOYEE BENEFIT LAW*, 3rd ed., Foundation Press, (2000), at 199.

³⁴ See, Cancelosi, *supra* note 11, at 97 ("by the 1960s, only 56% of Americans over age sixty-five enjoyed any form of health insurance, employer-provided or otherwise. In 1962, only 21% of Americans age sixty-five or older had employer-sponsored health insurance coverage.").

non-profits, and were (and still are) almost universal in state and local governments.³⁵

Fifty years later, the situation is very different. First, health care costs for both active employees and retirees have increased at a rate substantially faster than the cost of living.³⁶ Second, as we have learned in connection with the debate over the solvency of Social Security and Medicare, the proportion of retirees to active workers has increased significantly in recent years, and will continue to increase.³⁷ Third, though the enhanced accounting requirements have not increased the actual cost of providing the benefits, they have increased the reported expense, and have made the cost of the benefits more

³⁵ In a 2004 nationwide survey of 185 higher education and research institutions, TIAA-CREF found that 76% of the institutions surveyed offered retiree health benefits. Larry Grudzien, *The Great Vanishing Benefit, Employer Provided Retiree Medical Benefits: The Problem and Possible Solutions*, 39 J. MARSHALL L. REV. 785, 789 (2006); See, e.g., The Kaiser Family Foundation and Health Research and Educational Trust, EMPLOYER HEALTH BENEFITS, 2006 ANNUAL SURVEY, available at <http://www.kff.org/insurance/7527/upload/7527.pdf> (last visited Jul. 27, 2007). According to Credit Suisse, citing a Kaiser survey, "82% of state and local governments with more than 200 workers provide retiree healthcare coverage. (Note the percentage drops to 29% for those with less than 200 workers.) We found that all but 3 states, Mississippi, Nebraska, and Wisconsin, and all of the 25 largest cities (except Jacksonville, Florida) provide some type of OPEB benefit." Credit Suisse, *supra* note 3, at 5.

³⁶ See, e.g., *CBO Director Testifies on Healthcare Reform*, TAX NOTES TODAY (TNT), 121-48, June 22, 2007 (reporting on testimony of CBO Director Peter R. Orszag, who stated "[o]ver the past four decades, Medicare's and Medicaid's costs per beneficiary have increased about 2.5 percentage points faster per year than has per capita gross domestic product. If those costs continued growing at the same rate over the next four decades, federal spending on those two programs alone would rise from 4.5 percent of GDP today to about 20 percent by 2050; that amount would represent roughly the same share of the economy as the entire federal budget does today. If, instead, those costs grew at the same rate as income -- a scenario that illustrates the pure effect of demographic changes on the two programs -- then the change in spending by 2050 would be much smaller. Indeed, that change would be substantially smaller than the difference between the two scenarios. That observation underscores that the rate at which health care costs grow relative to income is the most important determinant of the long-term fiscal balance; it exerts a significantly larger influence on the budget over the long term than other commonly cited factors, such as the aging of the population. Rising health care costs represent a challenge not only for the federal government but also for private payers. Indeed, the trends for both largely reflect the same underlying forces -- the spread of costly new medical technologies, limited cost-sharing requirements, and other factors -- and cost growth per beneficiary in Medicare and Medicaid has tracked that in the rest of the health system over long periods of time. Total health care spending, which consumed about 8 percent of the U.S. economy in 1975, currently accounts for about 16 percent of GDP, and that share is projected to reach nearly 20 percent by 2016") (citations omitted). See also Kaiser Family Foundation, *Health Care Costs: A Primer*, Aug. 2007, available at www.kff.org.

³⁷ See, Stephen R. Miller et al., *Postretirement Medical Benefits Plans: An Analysis of Funding and Termination Issues*, 12 J. PENSION PLANNING & COMPLIANCE 193 (1986).

visible to investors, taxpayers, bond rating agencies and other stakeholders.³⁸ Finally, in an era of governmental belt-tightening and enhanced competition for tax dollars, there is a legitimate question as to whether this is an appropriate way for governmental employers to be spending so much taxpayer money.

Retiree medical benefits began as a nice "extra" by which employers would promise their current workers continued health coverage upon their retirement. As health-care costs soared in the 1980's, what began as a side perk for employees soon became a critical element of their overall compensation plan. At the same time, from the employer's side of the fence, the increasing costs of health care began to transform this benefit into the proverbial money pit. Because most employers traditionally paid retiree medical benefits on a pay-as-you-go basis, there was a bit of a lag time between the point when health-care costs started skyrocketing and when employers started feeling the effects. In certain shrinking industries, particularly those in which the ratio of retirees to current employees grew at alarming rates, employers quickly concluded that an unacceptable proportion of their overall labor costs were being spent on people who were not even providing them any current productivity.³⁹

Most employer-provided health plans, for active employees and/or retirees, are "employee benefit plans," and thus are subject to regulation by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").⁴⁰ Benefit plans maintained by certain employers, notably governmental employers and church employers, are exempt from ERISA, and thus are regulated primarily by state law, though other federal statutes (such as the federal age discrimination laws) do apply to them.⁴¹

³⁸ See *infra* Part VI.

³⁹ Daniel Keating, *Why the Bankruptcy Reform Act Left Labor Legacy Costs Alone*, 71 MO. L. REV. 985, 987 (2006).

⁴⁰ Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, codified (as amended) in scattered sections of Titles 26 and 29 of the U.S. Code.

⁴¹ ERISA § 4(b)(1), (2), 29 U.S.C. § 1003 (b)(1), (2). See, e.g., § 4 of the Age Discrimination in Employment Act of 1967, 29 U.S.C. § 623; *Erie County Retirees Association v. County of Erie*, 220 F.3d 193 (3d Cir., 2000), cert. denied, 121 S. Ct. 1247 (2001) (coordination of retiree health benefits with Medicare); EEOC Semiannual Regulatory Agenda, 67 Fed. Reg. 33, 885 (May 13, 2002). ("This item will amend regulations governing age discrimination in employment to exempt from the prohibitions of [the ADEA] the practice of altering, reducing, or eliminating employer-sponsored retiree health benefits when retirees become eligible for Medicare or comparable State

Under ERISA, an employee benefit plan is classified as either a "pension plan" or a "welfare plan."⁴² A pension plan is a plan, fund or program that "(i) provides retirement income to employees, or (ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond, regardless of the method of calculating the contributions made to the plan, the method of calculating the benefits under the plan or the method of distributing benefits from the plan."⁴³ By contrast, a welfare plan is a "plan, fund or program [that] was established or is maintained for the purpose of providing for its participants or beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits..."⁴⁴

Under these definitions, it is clear that a health plan that covers active employees, their spouses and dependents is a welfare plan rather than a pension plan, as it provides current health benefits rather than deferred benefits. However, it is less easy to classify a plan that provides health care for retirees, whether it is the same plan as for active employees or a separate plan for retirees only. Does the plan have the same character (i.e., a welfare plan) for the retirees as it did for them when they were active employees? Or should a retiree health plan be categorized as a pension plan, on the basis that (1) it provides retirement income in the form of valuable health benefits and (2) it increases the retiree's retirement income by freeing him or her from expending other funds in paying for the health benefits provided by the plan?

A plan that provides health benefits across a worker's retirement period functions as a type of pension plan, a pension plan that pays in specie rather than in dollars. If the plan did not supply medical services, the retiree would have to spend pension dollars to buy medical services. . . . Because a retiree health plan resembles a pension plan in function, it differs importantly from the garden variety welfare benefit plan. Welfare benefit plans. . . are excused from ERISA's funding and vesting rules on the view that they are current-account plans.⁴⁵

retiree health benefits. This new rule will ensure that the application of the ADEA does not discourage employers from providing health benefits to their retirees."). AARP challenged the proposed regulation, but on June 4, 2007, the Third Circuit granted summary judgment to the EEOC. *AARP v EEOC*, 489 F. 3d 558, 3rd Cir., (2007).

⁴² ERISA § 3(3), 29 U.S.C. § 1002(3).

⁴³ ERISA § 3(2), 29 U.S.C. § 1002(2).

⁴⁴ ERISA § 3(1), 29 U.S.C. § 1002(1).

⁴⁵ JOHN H. LANGBEIN & BRUCE A. WOLK, *PENSION & EMPLOYEE BENEFIT LAW*, 3rd ed., Foundation Press, 2000, at 211.

The cases involving retiree health benefits assume that a retiree health plan is a welfare plan rather than a pension plan: is this assumption sound? As *Musmeci v. Schwegmann* shows, the ERISA definition does not require that pension benefits be paid in cash.⁴⁶ If a retiree health benefit plan is a pension plan, then ERISA requires that benefits under the plan become vested (non-forfeitable) in accordance with statutory requirements; one of these requirements ensures that benefits will be fully vested if the employee is still employed at normal retirement age, typically age 65.⁴⁷ These statutory vesting requirements do not apply to welfare plans.⁴⁸ Furthermore, because ERISA generally preempts state laws that "relate to" a benefit plan subject to ERISA, it seems clear that a state law requiring welfare benefits to vest would be preempted with respect

⁴⁶ *Musmeci v. Schwegmann Giant Super Markets, Inc.*, 332 F.3d 339 (5th Cir., 2003), *cert. den.* 157 L. Ed. 2d 898 (2004).

⁴⁷ *Id.* The court stated:

Neither ERISA's statutory provisions nor the federal regulations define the term "income." However, they do not affirmatively require that the pension benefit be paid in cash. Moreover, the Department of Labor (DOL) refused to declare as a general policy whether in-kind benefits are regulated by ERISA. See ERISA Advisory Op. (March 26, 1999), 1999 ERISA LEXIS 11. We have likewise found no controlling case law directly addressing the issue. Relying on the definition of "income" used for the purposes of determining taxable income under the Internal Revenue Code (IRC), 26 U.S.C. §1, et seq., the district court found that the grocery vouchers constituted retirement income. We believe that the district court's analysis is sound given the close connection between ERISA and the IRC.... As noted by the Supreme Court in *Lukhard v. Reed*, the term "income" is commonly understood to mean a "gain or recurrent benefit usually measured in money." *Lukhard v. Reed*, 481 U.S. 368, 374, 95 L. Ed. 2d 328, 107 S. Ct. 1807 (citing Webster's Third International Dictionary 1143(1976)). Because the vouchers provided a gain or benefit to SGSM employees and could readily be measured in money, they would constitute income as the term is generally understood. *Id.* at 344-346; ERISA § 203(a), 29 U.S.C. § 1053(a).

Under the Internal Revenue Code of 1986, as amended ("Code"), the same requirement applies to benefits under a qualified retirement plan. See Code § 411(a)(1); ERISA § 203(a), 29 U.S.C. § 1053(a). The term "normal retirement age" is defined as the earlier of (A) the time a plan participant attains normal retirement age under the plan or (B) the later of age 65 or the 5th anniversary of his or her commencement of participation in the plan. ERISA § 3(24), 29 U.S.C. § 1002(24).

⁴⁸ See § 201 of ERISA, 29 U.S.C. § 1051 (providing that "This part shall apply to any employee benefit plan described in § 4(a) (and not exempted under section 4(b)) other than (1) an employee welfare benefit plan...").

to any ERISA-covered welfare plan.⁴⁹ However, an employer's promise to provide welfare benefits can create a vested benefit.⁵⁰

IV. THE PREVALENCE OF RETIREE HEALTH BENEFITS

By the late 1980s, the majority of larger employers - including 66% of firms with 200 or more employees - offered some form of retiree health insurance.⁵¹ According to a November, 2006, Hewitt Associates study prepared for a TIAA-CREF Institute symposium, the percentage of employers offering retiree health benefits declined among employers with 200 or more employees, from 66% in 1988 to 35% in 2006.⁵² According to Paul Fronstin, director of the Employee Benefit Research Institute's health research and education program, "you are not likely to have retiree coverage unless you fall into one of three groups: high-level executive; union worker in a large manufacturing company; or civil servant."⁵³

Virtually all large firms (200 or more workers) that offer retiree benefits offer them to early retirees under the age of 65 (94%). A lower percentage (77%) offers them to Medicare-age retirees.⁵⁴ In 2006, "[a]bout 10 million retirees ages 55 - 64 have health coverage through their former employers. Furthermore, 13 million individuals ages 65 and older have some form of employment-based health benefits - either as an active worker or a retiree."⁵⁵ However, according to a new study by Watson Wyatt and the National Business Group on Health, only 18 percent of companies that provide retiree health benefits do so for new hires.⁵⁶

⁴⁹ See ERISA § 514(a), 29 U.S.C. § 1144(a).

⁵⁰ See, e.g., *Devlin v. Empire Blue Cross and Blue Shield*, 247 F.3d 69, 76 (2nd Cir., 2001); *Abbruscato v. Empire Blue Cross and Blue Shield*, 274 F.3d 90 (2nd Cir., 2001); See also, *infra* Part VIII.

⁵¹ Cancelosi, *supra* note 11.

⁵² *Id.*; See also The Kaiser Family Foundation and Health Research and Educational Trust, RETIREE HEALTH BENEFITS EXAMINED: FINDINGS FROM THE KAISER/HEWITT 2006 SURVEY ON RETIREE HEALTH BENEFITS, Dec. 2006, available at <http://www.kff.org/medicare/upload/7587.pdf>.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ ALLIANCE FOR HEALTH REFORM, COVERING HEALTH ISSUES 2006, CHAPTER 2: PRIVATE HEALTH COVERAGE 23, http://www.allhealth.org/sourcebook2006/pdfs/chapter_2.pdf.

⁵⁶ Workforce Management, Retiree Health Coverage An Endangered Species, Apr. 4, 2007, available at <http://www.workforce.com/section/00/article/24/84/22.html> (last visited Jul. 27, 2007).

According to Richard Johnson:

In 1997 about 32 percent of private sector workers were employed at establishments offering retiree health benefits. By 2003 this figure was down to 25 percent. Expressed in levels, this change means that the number of private sector workers with access to retiree health benefits fell by about 6.4 million. Employers are slightly more likely to offer coverage for retirees younger than age 65 than for those who qualify for Medicare.

Evidence of substantial declines in retiree health benefits in the private sector stand in sharp contrast to the situation in the public sector, which employs about 16 percent of the workforce. The federal government continues to offer health benefits to its retirees, as do 82 percent of state and local governments employing 200 or more workers in 2006. However, retiree health benefits for public sector workers are also under pressure. Like private employers, public employers face rising health care costs and an aging workforce. Although a recent study found no retrenchment in retiree health benefits for government workers in the early 2000s, a change in government accounting rules, to take effect in 2006 and 2007, will require state and local governments to recognize the expected future health care costs promised to current and future retirees as a long-term liability. It is impossible to predict the impact of this change on public sector retiree health benefits, but government failure to address these liabilities could reduce state and municipal credit ratings, raising borrowing costs.⁵⁷

One 2006 survey concluded:

For active workers, the prospects for receiving retiree health benefits are increasingly uncertain. To begin with, retiree health benefits in the private sector are mainly offered by large employers; many employees are working in smaller firms with little or no access to such coverage. On a positive note, most large, private employers in this survey report that their largest retiree health plan is available to new retirees as of January 1, 2006, and the majority reports that they offer retiree health benefits to new employees. Yet, about one in ten surveyed employers

⁵⁷ RICHARD W. JOHNSON, CTR. FOR RETIREMENT RESEARCH AT BOSTON COLL., WHAT HAPPENS TO HEALTH BENEFITS AFTER RETIREMENT? 5 (2007), available at http://ctr.bc.edu/images/stories/Briefs/wob_7.pdf.

say they eliminated subsidized health benefits for a future group of pre-65 and age 65+ retirees between 2005 and 2006. The full effect of these changes may not be realized in the immediate future because current retirees are largely shielded from outright terminations and many employees may have their coverage grandfathered. Yet these changes will no doubt have a more pronounced and greater impact on retirement security for current workers as they approach the end of their working years.

Absent the availability of other affordable coverage options for pre-65 retirees, current employees will have strong financial incentives to work longer and retire later. Early retirees are likely to be asked to finance a larger portion of their health care costs themselves, compared to previous generations of retirees. Increasingly, retirees are being offered access to employer group health plans, but being asked to pay the full premium. For all of these reasons, access to, and affordability of coverage for pre-65 retirees may take a more prominent place in the upcoming debates over health policy issues in the new Congress.⁵⁸

V. THE COST OF RETIREE HEALTH BENEFITS

Fidelity Investments, which has been tracking retiree health-care costs since 2002, calculated in a report last week that a 65-year-old couple retiring this year will need about \$215,000 to cover medical costs in retirement, up 7.5 percent from the previous year. For about 40 percent of the retirees whose primary source of income is Social Security, health expenses could eat up as much as half of their retirement benefits, Fidelity said. Some estimates of retiree health costs have been even higher.⁵⁹

According to EBRI, out of pocket medical expenses will cost \$295,000 for a 65-year-old couple retiring without employer-provided health benefits and living to an average life expectancy, without including long term care.⁶⁰ Another recent report

⁵⁸ RETIREE HEALTH BENEFITS EXAMINED: FINDINGS FROM THE KAISER/ HEWITT 2006 SURVEY ON RETIREE HEALTH BENEFITS, 39 (Dec. 2006), available at <http://www.kff.org/medicare/upload/7587.pdf> (last visited Jul. 27, 2007).

⁵⁹ Martha M. Hamilton, *Health-Care Trends You Dare Not Forget*, THE WASHINGTON POST, Mar. 31, 2007, at F01.

⁶⁰ Kaiser Family Found., *Daily Health Policy Report*, Dec. 6, 2006, available at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=41501 (last visited Jul. 27, 2007).

found a wide range of possible costs for a worker aged 35 in 2006 who is assumed to retire at age 60:

[W]e see a wide range of potential results: these start at a low of \$76,000 for a typical FAS 106 trend (if the employer pays 100 percent of cost—probably unlikely in 2031) to a high of \$2.26 million with a 10 percent trend and the retiree paying full cost. Note that the values vary importantly with changes in trend, discount rate, mortality, and other assumptions. While these hypothetical examples illustrate potential outcomes, results for individuals can vary significantly.⁶¹

Any buyer of Chrysler would inherit \$16.5 billion in pension and health liabilities for retirees, according to an estimate by Goldman Sachs.⁶² General Motors is considering proposals to reduce its \$64 billion liability for retiree health-care, but union leaders suggest that any comprehensive change will be rejected.⁶³

GM and the UAW last year agreed to a court settlement requiring union retirees to pay part of their health-care costs for the first time. The accord included a \$3 billion fund set up by GM that requires union contributions to help defray retirees' expenses. GM agreed then to not to try to alter those retiree health-care benefits until after 2011.⁶⁴

Nassau County, New York, expects to spend about \$100 million on premiums for nearly 12,000 retirees in 2007.⁶⁵ Suffolk County pays \$246 million for insurance for roughly 20,750 members, 36 percent of whom are retirees.⁶⁶ According to a report

⁶¹ George Wagoner et al., *Risk-Sharing in Retiree Medical Benefits*, in *RESTRUCTURING RETIREMENT RISKS*, 136, (David Blitzstein et al. eds., Oxford University Press, 2006). See also RICHARD W. JOHNSON AND RUDOLPH G. PENNER, CTR. FOR RETIREMENT RESEARCH AT BOSTON COLL., *WILL HEALTH CARE COSTS ERODE RETIREMENT SECURITY?*, 1 (2004) (projecting that health care spending for older married couples will increase from 16 percent of net after-tax income in 2000, to 35 percent in 2030; that unmarried older adults will face an increase from 17 percent to 30 percent; and that the problems will be most severe for lower income people, and for unhealthy individuals).

⁶² Joe Guy Collier, *Huge Costs Await Chrysler Suitors*, DETROIT FREE PRESS, Mar. 23, 2007.

⁶³ Jeff Green, *GM Weighs Plans to Cut Union Health Costs, People Say*, BLOOMBERG, Apr. 13, 2007, available at <http://www.bloomberg.com/apps/news?pid=20601087&refer=home&sid=aZBw7gVScJAo>. (Jul. 27, 2007).

⁶⁴ *Id.* The settlement, and benefit changes for salaried workers, helped GM to cut retiree liabilities by 21 percent from \$81.2 billion at the end of 2005. GM has about \$17 billion set aside in a VEBA, to pay the future costs. *Id.*

⁶⁵ Luhby, *supra* note 7.

⁶⁶ Luhby, *supra* note 7.

released in January, 2007 by Moody's Investors Service, pay-as-you-go costs of health care and other non-pension retiree benefits for the 55 largest U.S. cities increased by an average of 10 percent annually from 1999 through 2004.⁶⁷

According to one 2006 survey, the total monthly retiree health benefit cost for retirees under the age of 65 was \$562 per month for single coverage.⁶⁸ According to another survey:

The weighted average retiree-only total premium (employer and retiree) for newly retiring pre-65 retirees in the largest plan is \$552 per month (\$6,624 per year), and \$270 per month (\$3,240 per year) for new age 65+ retirees.

The weighted average retiree contribution to premium is \$227 per month (\$2,724 per year) for newly retiring pre-65 retirees in the largest plan, and \$110 per month (\$1,320 per year) for new 65+ retirees in the largest plan (including firms that do not require retiree contributions to premiums).

Looking at retiree contributions as a share of the total premium, new retirees in the largest plan – both pre-65 and age 65+ retirees – each contribute 41% of the total premium, on average.⁶⁹

That survey also found:

The majority of surveyed employers increased retiree contributions to premiums between 2005 and 2006, though a larger share did so for pre-65 retirees.

–74% increased pre-65 retiree contributions to premiums.

–58% increased age 65+ retiree contributions to premiums.

⁶⁷ Retiree Health Costs of Cities Still Rising, Moody's Investors Service Says, BNA PENSION & BENEFITS REPORTER, Feb. 20, 2007, 425.

⁶⁸ TOWERS.PERRIN, 2006 HEALTH CARE COST SURVEY (2006), available at <http://www.towersperrin.com/tp/getwebcachedoc?webc=HRS/USA/2006/200605/link.pdt> (last visited Jul. 27, 2007).; see also Larry Grudzien, *The Great Vanishing Benefit, Employer Provided Retiree Medical Benefits: The Problem and Possible Solutions*, 39 J. MARSHALL L. REV. 785 (2006).

⁶⁹ RETIREE HEALTH BENEFITS EXAMINED: FINDINGS FROM THE KAISER/ HEWITT 2006 SURVEY ON RETIREE HEALTH BENEFITS, 15 (Dec. 2006), available at <http://www.kff.org/medicare/upload/7587.pdf> (last visited Jul. 27, 2007).

Employers also increased retiree cost-sharing requirements and out-of-pocket limits.⁷⁰

Employers have adopted a variety of approaches:

Employer efforts to control retiree medical costs have been varied, including (1) tightening eligibility requirements; (2) increasing deductibles, copays, and other retiree out-of-pocket costs and thereby reducing amounts paid by the employer's plan (in keeping with the movement to consumerism in employee health care plans); (3) increasing the percentage of premium paid by retirees; (4) increasing the management of care; and (5) prefunding the employer's liability (through vehicles such as a 501(c)(9) trust [known as a VEBA], 401(h) sub-accounts in pension plans, and trust-owned health insurance). Another tack has been to take a "defined contribution" approach to health care (DC Health), which defines the employer's obligation as a fixed dollar amount. In addition to "defining" their contribution, employers must also decide on the types of health insurance benefits that retirees will be able to purchase.⁷¹

As with plans for active employees, the trend has been to increase the retiree's share of the total cost:

The Mercer 2004 Survey showed that 38 percent of employers offering retiree health care plans required enrollees to pay the entire premium as well as out-of-pocket benefit costs: such plans offer coverage, but not necessarily affordable coverage. Only 13 percent of employers provided coverage at no cost to retirees. For the 49 percent that shared the cost with retirees, the average retiree portion was 34 percent of the plan cost. The results for Medicare-eligible plan coverage were similar: 37 percent require the retirees to bear the full cost; 15 percent provide coverage at no cost to retirees; and 47 percent share the cost, requiring retirees to pay 35 percent of it.⁷²

⁷⁰ *Id.* at 19.

⁷¹ George Wagoner et al., *Risk-Sharing in Retiree Medical Benefits*, in *RESTRUCTURING RETIREMENT RISKS*, 136, (David Blitzstein et al. eds., Oxford University Press, 2006).

⁷² *Id.*

VI. THE ACCOUNTING RULES

A. The Financial Accounting Standards Board

Since 1993, private sector employers have been required to accrue the cost of retiree medical benefits during the employment of an employee, under Statement of Financial Accounting Standards (FAS) No. 106 issued by the Financial Accounting Board (FASB).⁷³ Prior to 1993, employers were only required to recognize the expense when it was actually paid (i.e., when employees retired and became eligible for coverage), on a "pay-as-you-go" basis.⁷⁴ Employers are required to recognize a current expense for financial accounting purposes, even though the actual funding may not occur until many years later.

When FAS No. 106 took effect, employers had a choice: to report the unfunded, and previously unrecognized, Accumulated Postretirement Benefit Obligation (APBO) as a one-time nonrecurring charge, or to report it through annual charges taken over a period of up to 20 years. Many companies chose to recognize the expense immediately.⁷⁵

FASB 106 resulted in huge one-time charges as companies booked the liabilities for retrospective conversion to FASB 106 standards. IBM's FASB 106 writeoff was \$2.3 billion, GE's was \$1.8 billion, AT&T's 6.6 billion. The Big Three automakers booked \$33.2 billion in charges: \$20.8 billion for GM, \$7.5 billion for Ford, \$4.7 billion for Chrysler. The change eliminated three fourths of the net worth of GM.⁷⁶

These new accounting requirements had a significant effect on the prevalence and scope of retiree health coverage. One survey found that 46% of large companies offered medical benefits to early retirees in 1993, but only 29% did so in 2005.⁷⁷ Over

⁷³ FINANCIAL ACCOUNTING STANDARDS BOARD, STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 106, EMPLOYER'S ACCOUNTING FOR POSTRETIREMENT BENEFITS OTHER THAN PENSIONS, (1990), available at <http://www.fasb.org/pdf/fas106.pdf>; see also Larry Grudzien, *The Great Vanishing Benefit, Employer Provided Retiree Medical Benefits: The Problem and Possible Solutions*, 39 J. MARSHALL L. REV. 785 (2006).

⁷⁴ JOHN H. LANGBEIN & BRUCE A. WOLK, PENSION & EMPLOYEE BENEFIT LAW, 211 (3rd ed., Found. Press, 2000).

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ WILLIAM M. MERCER, INC., NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS (2005), available at <http://www.imercer.com/us/imercercommentary/healthsurvey/BB-final.pdf>

the same period, the percentage of large companies offering benefits to retirees eligible for Medicare fell from 40% to 21%.⁷⁸ As one commentator has noted:

With the onset of FASB-forced recognition of the current value of retiree medical benefits, and the skyrocketing cost of medical benefits generally, there has been, and doubtless will continue to be, a wave of litigation over attempts to eliminate or modify retiree medical insurance plans.⁷⁹

In September, 2006, FASB issued a new Statement, FAS Statement No.158, that amends Statements No. 87, 88, 106 and 132(R).⁸⁰ A major reason for the new Statement was that, under the prior standards, very large liabilities were not recorded in the employers' financial statements:

A major SEC publication of June 16, 2005. . . suggests that approximately \$414 billion in net pension liabilities may remain off-balance sheet and \$121 billion in other postretirement benefit liabilities may remain off-balance sheet (these numbers are extrapolations based on a sample of U.S. issuers). This amounts to a staggering pre-tax amount of \$535 billion that the FASB in Phase I recommends be fully recognized in issuers' financial statements. Recent studies performed by Credit Suisse and Towers Perrin substantiate further the magnitude of the off-balance sheet liabilities. The Credit Suisse study estimates that implementing Phase I would decrease the equity of the S&P 500 by \$248 billion or 6 percent while the Towers Perrin study on the U.S. Fortune 100 companies' pension plans estimates that shareholders' equity would decrease by \$180 billion or 9.3 percent.⁸¹

(last visited Jul. 27, 2007):

⁷⁸ *Id.*

⁷⁹ Frank Cummings, *ERISA Litigation: An Overview Of Major Claims And Defenses*, SM031 A.L.I.-A.B.A. (2007).

⁸⁰ Financial Accounting Standards Board, Statement of Financial Accounting Standards No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans*, An Amendment of FASB Statements No. 87, 88, 106 and 132(R), September, 2006. *See also* FASB Summary of Statement No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans—an amendment of FASB Statements No. 87, 88, 106, and 132(R)*.

⁸¹ PricewaterhouseCoopers, *Rethinking Postretirement Benefits*, available at [www.pwc.com/extweb/pwcpublishings.nst/docid/130848181CEF96068525718D00710F63/\\$FILE/pension-paper.pdf](http://www.pwc.com/extweb/pwcpublishings.nst/docid/130848181CEF96068525718D00710F63/$FILE/pension-paper.pdf) (last visited Jul. 27, 2007), citing SEC Special Report: Report and Recommendations Pursuant to Section 401(c) of the Sarbanes-Oxley Act of 2002 on

According to the new Statement:

This Statement improves financial reporting by requiring an employer to recognize the overfunded or underfunded status of a defined benefit postretirement plan (other than a multiemployer plan) as an asset or liability in its statement of financial position and to recognize changes in that funded status in the year in which the changes occur through comprehensive income of a business entity or changes in unrestricted net assets of a not-for-profit organization. This Statement also improves financial reporting by requiring an employer to measure the funded status of a plan as of the date of its year-end statement of financial position, with limited exceptions. . . . The Board issued this Statement to address concerns that prior standards on employers' accounting for defined benefit postretirement plans failed to communicate the funded status of those plans in a complete and understandable way. Prior standards did not require an employer to report in its statement of financial position the overfunded or underfunded status of a defined benefit postretirement plan. Those standards did not require an employer to recognize completely in earnings or other comprehensive income the financial effects of certain events affecting the plan's funded status. Prior accounting standards allowed an employer to recognize in its statement of financial position an asset or liability arising from a defined benefit postretirement plan, which almost always differed from the plan's overfunded or underfunded status.⁸²

An employer with publicly-traded equity securities is required to recognize the funded status of a postretirement plan, and to provide the required disclosures, as of the end of the first fiscal year ending after December 15, 2006. An employer without publicly-traded equity securities is required to do so as of the end of the first fiscal year

Arrangements with Off-Balance Sheet Implications, Special Purpose Entities, and Transparency of Filings by Issuers; Credit Suisse, May 5, 2006, *The Hit to Equity*, and Towers Perrin, January 2006, *Assessing the Impact of the Planned Changes in Accounting for Pensions and Other Postretirement Benefits*. The report also notes that "The funded status of the plans — the fair value of plan assets as compared with the projected benefit obligation for pensions or accumulated postretirement benefit obligation for other postretirement benefit plans — is currently merely disclosed in the notes to companies' financial statements. Under FAS 158, this information will be moved to the balance sheet." *Id.*

⁸² Financial Accounting Standards Board, *Statement of Financial Accounting Standards No. 158*, *supra* note 80.

ending after June 15, 2007; however, it must disclose certain information in the notes to its financial statements for any fiscal year ending after December 15, 2006, but before June 16, 2007, unless it has applied the provisions of Statement No. 158 in preparing the financial statements. The requirement to measure plan assets and benefit obligations as of the date of the employer's fiscal year-end statement of financial position is effective for fiscal years ending after December 15, 2008.⁸³ Earlier application of the new rules is encouraged, but early application must be for all of an employer's benefit plans. Retrospective application of the Statement is not permitted.⁸⁴

B. The Governmental Accounting Standards Board

In 2004 and 2005, the Governmental Accounting Standards Board (GASB) released three final statements including GASB Statement No. 45, which, similarly to FAS 106, requires governmental employers to recognize the cost of post-retirement benefits other than pensions (OPEB) on an accrual basis rather than a pay-as-you go basis.⁸⁵ Like FASB:

GASB takes the position that OPEB are part of the compensation for services rendered by employees and are, as such, part of an exchange transaction. Under this model, benefits are "earned," and employers incur the cost for those benefits, whether or not they choose to fund the benefits concurrently. Thus, benefit obligations accrue as services are rendered (that is, during employment). However, payment is typically deferred until after employment. For most employees, there will be a long gap in time between the accrual of the benefit obligation and its payment.⁸⁶

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ GASB Statement No. 45, Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions. The other Statements are Financial Reporting For Postemployment Benefit Plans Other Than Pension Plans, Statement on Governmental Accounting Standards No. 43 (2004) and Accounting For Termination Benefits, Statement on Governmental Accounting Standards No. 47 (2005). GASB has also issued a "Guide to Implementation of GASB Statements 43 and 45 on Other Postemployment Benefits", August, 2005. Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions, Statement No. 45 (Governmental Accounting Standards Bd. 2004). See also Press Release, Governmental Accounting Standards Bd., Employer Reporting of Postemployment Benefits Other Than Pensions (Aug. 2, 2004), available at <http://www.gasb.org/news/nr080204.html> (last visited Jul. 27, 2007); Mumford, *supra* note 10.

⁸⁶ Mumford, *supra* note 10.

Employers must also report a liability on their balance sheets for the amount of any expense that has not been funded. Also, as under the FASB rules, implicit rate subsidies must be recognized as OPEB.

Instead of providing for retiree health care, some employers allow retirees to access the employer's health care plan and pay premiums based on a "blended rate," which takes into account both active employees and retirees. In such a situation, the premiums paid by the retirees may be lower than they would have been if the retirees were insured separately. Although it appears that retirees are paying for the entire cost of health care, the employer is in fact subsidizing the retirees' artificially low rate (by paying a higher premium for active employees' health care). This subsidy is a benefit to the retiree and, under Statement 45, must be recognized as an OPEB in its own right.⁸⁷

The effective date of the new requirements is phased in: for governmental employers with annual revenue exceeding \$100 million, the rules are effective for fiscal years beginning after December 15, 2006; for employers with annual revenue between 10 million and \$100 million, the rules are effective for fiscal years beginning after December 15, 2007; and for employers with annual revenue less than \$10 million, the effective date is fiscal years beginning after December 15, 2008.⁸⁸

As Credit Suisse pointed out in a recent report:

The old rules made it very easy for most state and local governments to promise their employees OPEB benefits in retirement, as doing so had no effect on their balance sheets, and the costs were only reflected in the budget and on the income statement when the benefits were paid to retirees (many years later, long after the politicians that had made these promises left office). In fact, most didn't even bother to measure the promises they made.⁸⁹

Implementation of the new accounting rules will have a major effect on many governmental employers.⁹⁰ A Cato Institute report found the average unfunded OPEB

⁸⁷ *Id.*

⁸⁸ GASB Statement No. 45, *supra* note 85.

⁸⁹ Credit Suisse, *supra* note 3.

⁹⁰ See, e.g., Fitch Ratings, The Not So Golden Years: Credit Implications of GASB 45, Special Report, Sept. 25, 2005, available at <http://www.treasurer.ca.gov/cdiac/seminars/slides/>

liability to be \$135,000 per worker, and extrapolated this to a total national unfunded liability of \$1.4 trillion.⁹¹

What's being revealed is not too pretty: we estimate over \$1.5 trillion in unfunded OPEB liabilities. It's not as if GASB 45 is creating this obligation. (State and local governments did that all by themselves.) However, GASB 45 does highlight another large legacy obligation where a promise made to U.S. workers is going to be hard to keep, presenting difficult challenges for the U.S. economy. . . . We estimate \$558 billion in unfunded OPEB liabilities for the 50 states, and then another \$951 billion for local governments (e.g., cities, counties, etc.); that's over \$1.5 trillion in unfunded liabilities. To put that into perspective, the size of the municipal bond market at the end of 2006 was \$2.4 trillion and the OPEB plans of the companies in the S&P 500 were "only" \$326 billion underfunded at the end of 2005. . . . In the aggregate, we found the OPEB underfunding of the 50 states was about 34% of their \$1.6 trillion in assets, while it was 32% of the \$284 billion in total assets for the 25 largest cities. There were 21 states where the OPEB underfunding was more than one-third of total assets on balance sheet (versus the S&P 500 where no companies have OPEB underfunding greater than one-third of total assets), including . . . 11 states. . . where it was more than half. Note that both New Jersey and Connecticut could have OPEB underfunding that is greater than their total assets. Now you can understand why New Jersey is considering selling off the New Jersey Turnpike, its lottery, and other revenue producing assets—it's in a deep hole that will be difficult to dig out from. Speaking of big digs, check out New York City and Boston. . . , with estimated OPEB underfunding that exceeds 75% of each city's total assets. Maybe some state and local government balance sheets aren't as strong as they initially appear.⁹²

New York City has estimated that its obligation for retiree health-care is \$53.5

20060925/implications.pdf (last visited Jul. 27, 2007).

⁹¹ Cato Institute Bulletin, *Unfunded State and Local Health Costs: \$1.4 Trillion*, Oct., 2006, available at http://www.cato.org/pubs/tbb/tbb_0925-40.pdf (last visited Jul. 27, 2007).

⁹² Credit Suisse, *supra* note 3. See also Cynthia Burton, *N. J. Treasurer: Don't Fix Pension by Leasing Assets*, PHILA. INQUIRER, Apr. 12, 2007, available at http://www.philly.com/inquirer/local/20070412_N_J_treasurer_Dont_fix_pension_by_leasing_assets.html (last visited Jul. 27, 2007).

billion.⁹³ In California, one school district found that its unfunded OPEB liability was equal to 80% of its annual budget, while another district's liability was double the annual budget.⁹⁴ California has appointed a 12 member Public Employee Post-Employment Benefit Commission to assess the scope of unfunded liabilities for pensions, health care and other retiree benefits.⁹⁵ It is to report to the governor and legislature by January 1, 2008.⁹⁶ The Legislative Analyst's Office has estimated that unfunded liabilities for future retiree health care benefits for employees and dependents are between \$40 billion and \$70 billion, and has launched a new web site to carry news from around the country on public sector retiree health benefits.⁹⁷ A report issued by the Civic Committee of the Commercial Club of Chicago estimated that Illinois' unfunded retiree health liability is between \$43 and \$53 billion.⁹⁸

Some Texas legislators and the Texas state comptroller are seeking to make the rules inoperable in Texas. There are no labor contracts between the state and its employees, so these officials argue that, if there is no formal contract, there is no obligation to disclose. The GASB chairman disagrees: "These retiree health care benefits are a form of compensation for services, in the same way as salaries and pensions are. They're deferred compensation. So there is a real obligation there, whether there is a written contract or not."⁹⁹

Because it is not a governmental agency, GASB has no power to

⁹³ Mary Williams Walsh, *Texans Want to Strike Rule on Projecting Retiree Care*, N.Y. TIMES, Mar. 12, 2007. New York State's estimated liability is \$50 billion. See also, Luhby, *supra* note 7.

⁹⁴ Wisconsin Policy Research Institute Report, *The Mounting Cost of Deferred Responsibility in Government: The Future Impact in Wisconsin*, Jan., 2007, available at <http://www.wpri.org/Reports/Volume%2020/Vol20no2.pdf> (last visited Jul. 27, 2007).

⁹⁵ California Commission Formed for GASB Vows Reasonable Look at Government Costs, BNA PENSION & BENEFITS REPORTER, Mar. 20, 2007, at 656.

⁹⁶ *Id.*

⁹⁷ *Id.* See also Kentucky Governor Establishes Commission to Study Unfunded Liabilities for Retirees, BNA PENSION & BENEFITS REPORTER, Feb. 13, 2007, at 366; Maine's Gov. Baldacci Outlines Proposal to Fund State Retiree Health Benefits, BNA PENSION & BENEFITS REPORTER, Feb. 20, 2007, at 428; Delaware Governor Seeks Increase in State Payments for Retiree Benefits, BNA PENSION & BENEFITS REPORTER, Jan. 30, 2007, at 269; Proposal Calls for \$439 Million in FY 2008 To Address South Carolina Health Liabilities, BNA PENSION & BENEFITS REPORTER, Jan. 23, 2007, 203; The newly-launched web site is available at <http://www.lao.ca.gov/retireehealth> (last visited Jul. 16, 2007).

⁹⁸ *Chicago Business Group Announces Plan Aimed at Illinois' Mounting Funding Gap*, BNA PENSION & BENEFITS REPORTER, Jan. 9, 2007, at 74.

⁹⁹ *Id.* See also Robert Elder, *Texas Revolts Against Benefits Reporting Rule*, AUSTIN AMERICAN-STATESMAN, Mar. 8, 2007, available at <http://www.statesman.com/search/content/region/legislature/stories/03/08/8govaccount.html> (last visited Jul. 27, 2007).

mandate compliance with the standards it issues. However, most government entities issue reports that comply with GASB's standards. Some are required to do so by state or local statute, while others comply with GASB in order to maintain good credit ratings in the municipal bond market. In addition, the Code of Professional Conduct of the American Institute of Certified Public Accountants (AICPA) requires auditors to note any departures from GASB when they express an opinion on financial reports that are presented in conformity with GAAP. As such, governments are usually expected to prepare financial statements in accordance with these standards.¹⁰⁰

VII. FUNDING

According to a 2006 survey:

A quarter of all surveyed employers (25%) report they are pre-funding retiree health care obligations and have made contributions to the fund within the last three years. A Voluntary Employees' Beneficiary Association (VEBA) is the most common vehicle used for pre-funding. VEBAs are tax-exempt trusts authorized by the Internal Revenue Code Section 501(c)(9) that may pay death, health, accident, or other benefits to members, their dependents and/or beneficiaries. While 40% of larger firms (with 20,000 or more employees) report they are pre-funding retiree health obligations, only 16% of smaller firms (fewer than 5,000 employees) do so. Pre-funding can have both advantages and disadvantages for employers, depending on their situation. Under current accounting rules, pre-funding reduces the amount that companies report on their financial statements in terms of their retiree health liability. The lower the amount pre-funded, the greater the unfunded liability on the balance sheet. In lieu of pre-funding retiree health benefits, most firms pay for retiree health benefits out of general funds; in many cases, companies may have identified other uses of the funds with a higher return on investment. In addition, the pre-funding vehicles available to private for-profit entities generally have tax law restrictions that limit the tax effectiveness of these funding vehicles and the ability to fully fund retiree health benefits.¹⁰¹

¹⁰⁰ Mumford, *supra* note 10.

¹⁰¹ *Retiree Health Benefits Examined: Findings from the Kaiser/ Hewitt 2006 Survey on Retiree Health Benefits*, Dec. 2006, available at <http://www.kff.org/medicare/upload/7587.pdf> (last visited Jul. 27,

According to a December, 2005 report by Standard & Poor's, companies in the S. & P 500 Index had funded 22% of future retiree health liabilities, compared to 88% of pension liabilities.¹⁰²

One possible funding vehicle is a VEBA (voluntary employees' beneficiary association), which is usually tax-exempt under section 501(c)(9) of the Code. However, sections 419 and 419A of the Code, enacted by the Deficit Reduction Act of 1984 (DRA), impose severe limitations on the ability to fund retiree benefits through a VEBA on a tax-favored basis.¹⁰³

In 2006, New York City set aside \$1 billion for future retiree health care costs and it plans to put in another \$1 billion this year.¹⁰⁴ According to Thomas Sanzillo, first deputy New York State comptroller, the state could reduce its annual costs by about \$1.3 billion per year by prefunding its entire OPEB liability.¹⁰⁵

IRS has ruled that payments to and from a trust established for retiree health benefits were excludable from gross income.¹⁰⁶ IRS has also ruled that elective contributions to a plan to pay for medical expenses after retirement are not excludable from gross income under section 106 and are includible in gross income under section 61.¹⁰⁷ Pending bills (H.R. 1110, S. 773) would allow federal and military retirees to pay their share of the premiums with pre-tax income.¹⁰⁸

2007).

¹⁰² *New Accounting Rule Likely To Prompt U.S. Companies To Reduce Retiree Health Benefits*, KAISER DAILY HEALTH POLICY REPORT, Dec. 21, 2005, available at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=34451 (last visited Jul. 27, 2007).

¹⁰³ Deficit Reduction Act of 1984, Pub. L. No. 98-369; HENRY BRIGHT & JOHN J. SAVILICH, *POSTRETIREMENT WELFARE BENEFITS* (noting that "[e]ffectively, the result of the DRA curtailment is to subject all investment earnings on retiree medical reserves to taxation as unrelated business income"); *EMPLOYEE BENEFITS HANDBOOK*, 41-48 (Jeffrey D. Mamorsky, ed., 3rd ed. 1992).

¹⁰⁴ Luby, *supra* note 7.

¹⁰⁵ *Public Employers in New York State Taking Steps to Comply With GASB 45*, BNA PENSION & BENEFITS REPORTER, Feb. 13, 2007, at 380. See also *Unfunded Pension and Benefit Liabilities in Wisconsin Demand Action, Report Finds*, BNA PENSION & BENEFITS REPORTER, Feb. 13, 2007, at 365; *Minnesota Could Face Billions of Dollars of Unfunded Retiree Benefits, Auditor Says*, BNA PENSION & BENEFITS REPORTER, Feb. 13, 2007, at 365.

¹⁰⁶ P.L.R. 200709007 (Mar. 2, 2007); P.L.R. 200708006 (Feb. 23, 2007).

¹⁰⁷ P.L.R. 200704005 (Jan. 26, 2007).

¹⁰⁸ *Federal Retirees Could Pay Health Premiums With Pre-Tax Income Under House Legislation*, BNA PENSION & BENEFITS REPORTER, Feb. 27, 2007, at 476; *Federal Retirees Could Pay FEHBP Premiums With Pre-Tax Dollars Under Senate Legislation*, BNA PENSION & BENEFITS REPORTER, Mar. 13, 2007, at 611.

Section 845 of the Pension Protection Act of 2006 allows eligible retired public safety officers to elect to exclude from gross income up to \$3,000 of distributions from a governmental retirement plan to pay insurance premiums, for the retired officer, his or her spouse and dependents, for health insurance or qualified long-term care insurance.¹⁰⁹ In order to be eligible for the exclusion, the premiums must be paid directly by the plan to the insurer.¹¹⁰

On December 20, 2006, the board of the California Public Employees' Retirement System (CalPERS) approved regulations that will allow the system to offer a pre-funding plan to public entities.¹¹¹ CalPERS has created a new trust fund that allows public employers that contract with CalPERS for employee health benefits to pre-fund the future cost of their retiree health insurance benefits and other post-employment benefits.¹¹²

Fidelity Investments is eliminating its defined benefit pension plan for 32,000 employees, and instead will offer an enhanced 401(k) plan and a \$3,000 annual health savings account (HSA) credit to help pay retiree medical expenses.¹¹³ Fidelity said that surveys showed that 71% of its employees did not know how they would pay for health care in retirement.¹¹⁴ Commentators have discussed the use of HSAs to pay retiree medical expenses.¹¹⁵ However, this is unlikely to be a complete solution. According to a recent study, if a person saves the maximum annual HSA amount under current law—\$2,850—and earns seven percent annually, he will only save \$155,000 in 20 years.¹¹⁶ Retirement health costs are formidable, says Jay Savan, a senior health care consultant with Towers Perrin, and most people aren't prepared.¹¹⁷ "You will need \$600,000 if health care costs grow at the rate they are growing now," he says.¹¹⁸

¹⁰⁹ Pension Protection Act of 2006, § 845 (adding § 402(f)); *See also id.* at § 414(d) (defining governmental retirement plan).

¹¹⁰ Code § 402(l), added by § 845 of the Pension Protection Act of 2006.

¹¹¹ *Schwarzenegger Forms Commission to Study California Retiree Pension, Health Care Costs*, BNA PENSION & BENEFITS REPORTER, Jan. 9, 2007, at 72.

¹¹² *See* CalPERS, available at <http://www.calpers.ca.gov> (last visited Jul. 18, 2007).

¹¹³ *See* Sarah Rubenstein, *How to Manage a Health Savings Account to Cover Your Medical Bills in Retirement*, WALL ST. J., Dec. 20, 2006, at D1.

¹¹⁴ *See* Plansponsor, available at <http://newsmail.plansponsor.com/cgi-bin1/DM/y/eBL4O0SgCeM0CBD0ISye0Es> (last visited Jul. 18, 2007).

¹¹⁵ Rubenstein, *supra* note 12.

¹¹⁶ GEORGE WAGONER, ANNA RAPPAPORT, BRIAN FULLER & FRANK YEAGER, *Risk-Sharing in Retiree Medical Benefits*, RESTRUCTURING RETIREMENT RISKS, 136-166 (David Blitzstein et al. eds., Oxford University Press 2006).

¹¹⁷ *Id.*

¹¹⁸ *See* Workforce Management, News in Brief, *Retiree Health Coverage: An Endangered Species*, Apr.

Even retirees who have enough financial resources and discipline to save in an HSA and not use the funds before retirement would need to use other savings, work longer, or work for an employer who provides a very generous retiree health care plan if they want to retire before becoming eligible for Medicare. Many may face the same challenges even when eligible for Medicare.¹¹⁹

In December, 2006, Goodyear agreed with the United Steelworkers to transfer health care liabilities for current and future retirees to a trust fund.¹²⁰ This transaction will save the company \$610 million through 2009 and is expected to reduce the obligation for other post-employment benefits by about \$525 million.¹²¹ General Motors (GM) CEO Rick Wagoner has said that he is looking at that agreement as he prepares for negotiations with the United Auto Workers.¹²² GM had an \$81 billion retiree health-benefit obligation at the end of 2005.¹²³

Many local governments began turning to their pension funds to help pay for health care for retired public workers in the 1990s. Some are now regretting it.¹²⁴

Under prior law, companies sponsoring over-funded defined benefit pension plans could transfer from the plan to a Code section 401(h) "health benefits account" an amount equal to the lesser of (1) the excess of pension plan assets over 125 percent of

4, 2007, available at <http://www.workforce.com/section/00/article/24/84/22.html> (last visited Jul. 27, 2007).

¹¹⁹ Wagoner, et al., *supra* note 116.

¹²⁰ See Mike Ramsey, *Goodyear Ends Pensions, Raises Retirees' Health Costs (Update4)*, Feb. 28, 2007, available at <http://www.bloomberg.com/apps/news?pid=20601103&sid=akBObeMRDnI&refer=news> (last visited Jul. 27, 2007).

¹²¹ *Id.* The company had a retiree health liability of \$1.3 billion for members of the United Steelworkers of America: it set up a new trust fund with a one-time \$1 billion payment in cash and stock. After its payment, the company will have no further health-care obligation to current or future union retirees. The agreement came after an 85-day strike. Jeff Green, *GM Weighs Plans to Cut Union Health Costs, People Say (Update3)*, Bloomberg, Apr. 13, 2007 available at <http://www.bloomberg.com/apps/news?pid=20601087&refer=home&sid=aZBw7gVScJAo> (last visited Jul. 27, 2007). In February, 2007, the company announced that it will raise premiums for retirees and terminate its defined benefit pension plan, to save up to \$90 million per year.

¹²² Ramsay, *supra* note 120.

¹²³ See *id.* See also Jeffery McCracken, *Detroit Talks May Augur Sea Change*, WALL ST. J., Jan. 23, 2007, at A3; Kris Maher, *Now Someone Else Has To Tell Retirees No*, WALL ST. J., Jan. 29, 2007, at B1; Bryce G. Hoffman, *UAW May Run Health Care for Retirees*, THE DETROIT NEWS, Jan. 24, 2007.

¹²⁴ See Mary Williams Walsh, *Paying Health Care from Pensions Proves Costly*, N.Y. TIMES, Dec. 19, 2006, at A1.

its liabilities or (2) the estimated “qualified current retiree health liabilities” (generally, the pay-as-you-go cost for retiree health benefits) for the current year.¹²⁵ Under the Pension Protection Act of 2006, additional transfers are allowed.¹²⁶ The 125 percent of liabilities threshold is reduced to 120 percent, increasing the amount of assets available for transfer.¹²⁷ However, a plan sponsor making such a transfer must ensure that the pension plan does not become underfunded during a 10 year “transfer period.”

The employer may make a “qualified future transfer” to cover up to 10 years of future costs.¹²⁸ Generally, retiree health benefits must be maintained during the transfer period, and for four years afterwards, at a cost that is not less than the highest annual per participant cost for the two years preceding the transfer. Alternatively, for collectively bargained benefits, an amount may be transferred to cover costs for the shorter of (1) the remaining lifetime of covered retirees and their covered spouses and dependents or (2) the period of coverage provided for them by the collectively bargained health plan.¹²⁹ Generally, in this case, retiree health benefits must continue for that period at a cost that is not less than the amount specified by the collective bargaining agreement.

The measurement of the other post-employment benefits (OPEB) liability is very heavily dependent on the assumptions used and whether (and, if so, to what extent) the benefits are funded. As a recent Credit Suisse report explains:

OPEB liabilities are long-duration obligations; that’s why the OPEB underfunding is very sensitive to changes in the discount rate. Take New York as an example. Assuming the plan is not funded, it uses a discount rate of 4.10%, resulting in \$54 billion of OPEB underfunding. However, assuming the plan is funded, the discount rate jumps to 8%, and the funded status improves to \$27 billion underfunded. In other words, a 390 basis point increase in the discount rate results in an 100% or \$27 billion reduction in the amount the OPEB plan is underfunded. ...In addition, the rating agencies have made clear that they would

¹²⁵ Internal Revenue Code, 26 U.S.C. § 420 (2006). See also Alson R. Martin, *Pension Protection Act of 2006*, ALL-ABA COURSE OF STUDY MATERIALS, REPRESENTING PROFESSIONAL AND CLOSELY HELD BUSINESSES: QUALIFIED PLANS, WELFARE BENEFITS, AND TAX PLANNING, (Sept. 2006).

¹²⁶ The Pension Protection Act of 2006, Pub. L. 109-280, §§ 841-842 (2006).

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ See *id.* Additional rules limit the availability of collectively bargained transfers.

prefer state and local governments to prefund their OPEB plan instead of continuing to fund on a pay-as-you-go basis.¹³⁰

The same report discusses the extent to which governmental employers have funded their liabilities:

It appears that 28 states fund their OPEB plans on a pay-as-you-go basis, while only 13 states partially prefund their OPEB plans. (The remaining nine states either don't have OPEB plans or it is not clear how they are financing their plans.) The state that appears to have most aggressively prefunded its OPEB plan is Ohio, which has accumulated nearly \$11 billion in assets against a \$30 billion OPEB obligation; the plan is still only 37% funded. A few states have recently set up trust funds (some in response to GASB 45) that will eventually be used to accumulate assets to help meet their OPEB obligations. For example, Maryland set up the State Employees and Retirees Health & Welfare Benefits fund, and Georgia included the following discussion in its 2006 CAFR: In response to the GASB Statements, the General Assembly has made statutory changes to create a trust fund, in which employer contributions for future retiree health costs may be accumulated and invested, and which is expected to facilitate the separate financial reporting of these benefits. New York City also set up the NYC Retiree Health Benefits Trust Fund in fiscal year 2006, and contributed \$1 billion.¹³¹

From a financial accounting standpoint, more funding is clearly advantageous. However, there is a major practical problem:

[W]here are they going to get the funds with which to prefund. One good old fashioned way is to borrow. Just as state and local governments have issued pension obligation bonds to help fund their pension plans, we expect to see them issue taxable OPEB bonds to help fund their OPEB plans. In fact, there are a few of these that have already been issued. . . . When you get down to it, issuing these bonds is nothing more than trading one form of debt (OPEB underfunding) for another. In fact, they're moving from what is generally a more flexible

¹³⁰ Credit Suisse, *supra* note 3.

¹³¹ Credit Suisse, *supra* note 3.

form of debt to one that's less flexible. So why would a state or local government decide to make this trade? From an accounting perspective, it's a home run. Let's say the state issues OPEB bonds and uses the proceeds to begin funding its OPEB plan. First of all, the plan will get healthier since there are now some assets set aside to meet the obligation; even more powerful is the effect that funding the plan will have on the discount rate—it increases the discount rate, potentially cutting the OPEB obligation significantly, depending upon the duration of the liability. In other words, contributing to the OPEB plan appears to improve the health of the plans by much more than the amount of the contribution. With the plan better funded, OPEB costs on the income statement shrink. Let's not forget that by borrowing to prefund, there is a piece of debt that shows up on balance sheet and debt service costs to deal with.¹³²

However, despite its accounting advantages, this is not a risk-free approach:

What appears to be a riskless strategy is actually a very risky arbitrage. If the returns on the assets invested in the OPEB plan don't exceed the cost of servicing the debt it's a bet gone bad that the taxpayer will bear the brunt of. The rating agencies have expressed their own opinions on OPEB funding bonds, see Exhibit 21 where we provide some excerpts from reports done by Fitch, Moody's, and Standard & Poor's.¹³³

VIII. TERMINATION OR MODIFICATION OF RETIREE HEALTH BENEFITS¹³⁴

This section will assume that retiree health benefits are correctly categorized as welfare plans rather than health plans, so that ERISA itself does not limit an employer's

¹³² See *Credit Suisse*, *supra* note 3.

¹³³ *Credit Suisse*, *supra* note 3. See also Girard Miller, *Bonding with OPEB: Look before You Leap*, Apr. 1, 2007, available at <http://www.governing.com/articles/4miller.htm> (last visited Jul. 27, 2007) (stating "The Government Finance Officers Association is wary, advising considerable caution. Not only is GFOA right, but now is a dicky time for issuers to be selling OPEB bonds, from a business-cycle standpoint").

¹³⁴ For a detailed discussion of the vagaries of the case law, see Frank Cummings, *ERISA Litigation: An Overview of Major Claims and Defenses*, ALL-ABA COURSE OF STUDY MATERIALS, ALL-ABA COURSE OF STUDY, EMPLOYMENT AND LABOR RELATIONS LAW FOR THE CORPORATE COUNSEL AND THE GENERAL PRACTITIONER (Feb. 2007).

ability to terminate or modify retiree benefits.¹³⁵ However,

[N]othing in ERISA forbids an employer from designing a plan that vests welfare benefits in retirement. Where a plan or plan sponsor makes a promise of vested or unalterable benefits, the promise can be enforced under ERISA. If the promise also is embodied in a collective bargaining agreement, the promise can be enforced under federal labor law, as well.¹³⁶

This raises two further issues. First, what additional factors must be present in order for a court to find that retiree medical benefits are vested?¹³⁷ Second, if they are

¹³⁵ See *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (noting that ERISA generally permits employers "to adopt, modify, or terminate welfare plans" at any time); See also Retiree Benefits Bankruptcy Protection Act of 1988, 11 U.S.C. § 1114 (stating that an employer in reorganization under Chapter 11 of the Bankruptcy Code must continue retiree health, disability and death benefits unless and until a modification is agreed to by retirees or ordered by a court); Daniel Keating, *Why the Bankruptcy Reform Act Left Labor Legacy Costs Alone*, 71 MO. L. REV. 985, 993-994 (2006) (noting "If Congress wanted to elevate retiree benefit claims relative to other claims in bankruptcy, then it should have assigned a clear, specific, relative priority to ensure that these benefits were paid before other creditors. Instead, Congress created a strong-sounding, but ultimately nebulous edict in §1114 that allows employers to quit paying retiree medical benefits if it is "necessary" to permit the employer's reorganization. Incidentally, on the question of relative priorities with other claimants, both §1113 and §1114 include the noble-sounding but rather empty directive that any modifications allowed by the judge should "assure that all creditors, the debtor and all of the affected parties are treated fairly and equitably"); Steven L. Willborn, *Workers in Troubled Firms: When Are (Should) They Be Protected?*, 7 U. PA. J. LAB. & EMP. L. 35 (2004); Susan J. Stabile, *Protecting Retiree Medical Benefits in Bankruptcy: The Scope of Section 1114 of the Bankruptcy Code*, 14 CARDOZO L. REV. 1911 (1993). There are also special rules for coal industry employers. See The Coal Industry Retiree Health Benefit Act of 1992, 26 U.S.C. §§ 9701-9722; Lillian M. Spiess, *Paying What Was Promised: The Guarantee of Benefits Under the Coal Industry Retiree Health Benefit Act of 1992*, 25 QUENNIPIAC L. REV. 73 (2006).

¹³⁶ See Louis T. Mazawey, Thomas S. Gigot and Stephanie L. Napier, *Controlling Costs of Retiree Medical and Life Insurance Plans - Legal Issues and Risks*, ALI-ABA COURSE OF STUDY MATERIALS, RETIREMENT, DEFERRED COMPENSATION, AND WELFARE PLANS OF TAX-EXEMPT AND GOVERNMENTAL EMPLOYERS, (Sept. 2003). See also U.S. Dep't of Labor, *Can the Retiree Health Benefits Provided by Your Employer Be Cut?* (Jul. 18, 2007) available at http://www.dol.gov/ebsa/publications/retiree_health_benefits.html ("Employees and retirees should know that private-sector employers are not required to promise retiree health benefits. Furthermore, when employers do offer retiree health benefits, nothing in federal law prevents them from cutting or eliminating those benefits--unless they have made a specific promise to maintain the benefits. The key to understanding your retiree health benefits lies in the documents governing your plan").

¹³⁷ See *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 400 (6th Cir. 1998) (stating that "an employer's commitment to vest such benefits is not to be inferred lightly; the intent to vest must

vested, what are they vested in? Under a retirement plan, this is not a complex question, as there is a quantifiable account balance (under a defined contribution plan) or accrued monthly benefit (under a defined benefit plan). Under a health plan, would the retiree be vested in (1) a particular package of health benefits, or (2) a benefit package that costs the employer a certain amount, with or without indexing for inflation, or (3) a given level of retiree deductibles and copayments, with or without indexing for inflation, or (4) some other combination of features and, if so, what? If the retiree has worked for more than one employer, and is eligible for retiree benefits from more than one, how will the benefits be coordinated?¹³⁸ Unlike a pension plan, where the employer need not subsidize survivor benefits, coverage of a spouse and/or dependents under a retiree health plan is an additional cost.

A. Public Sector Employers

The rules governing the provision of retiree health benefits to retired state or local government employees (and their spouses and dependents) are generally contained in state legislation or in implementing regulations issued by state or local government agencies. In some states, retiree benefits are protected against curtailment or elimination, either by the state constitution or by state legislation.¹³⁹ In other cases,

be found in plan documents and must be stated in clear and express language”). However, there continues to be a lot of litigation, and the results are mixed. A series of 2006 cases held that retiree benefits were vested: *See, e.g.,* Yolton v. El Paso Tenn. Pipeline Co., 435 F.3d 571 (6th Cir. 2006); Cole v. ArvinMeritor, Inc., 2007 U.S. Dist. LEXIS 28281 (E.D. Mich.); Halliburton Co. Benefits Comm. v. Graves, 463 F.3d 360 (5th Cir. 2006) (breach of corporate merger agreement), *reh'g denied*, 2007 WL 446442 (5th Cir.); Zielinski v. Pabst Brewing Co., 463 F.3d 615 (7th Cir. 2006); Bailey v. AK Steel Corp., 2006 U.S. Dist. LEXIS 68781 (S.D. Ohio); Angotti v. Rexam, Inc., 2006 U.S. Dist. LEXIS 71117 (N.D. Cal.). *See also* Wood v. Detroit Diesel Corp., 2007 U.S. App. LEXIS 1309 (6th Cir.) (upholding an injunction barring Detroit Diesel Corp. from requiring retirees to make premium contributions); *Sixth Circuit Upholds Injunction That Bars Detroit Diesel From Modifying Health Benefits*, PENSION & BENEFITS REPORTER (PNA), 215 (Jan. 23, 2007). But see the following 2006 cases, which found no vesting: Bouboulis v. Transport Workers' Union of Am., 442 F.3d 55 (2nd Cir. 2006) (silence of SPD could not be read as promise that benefits were vested); Senior v. NSTAR Elec. & Gas Corp., 449 F.3d 206 (1st Cir. 2006); Balestracci v. NSTAR Elec. & Gas Corp., 449 F.3d 224 (1st Cir. 2006); Chapman v. ACF Indus., LLC, 430 F. Supp. 570 (S.D. W.Va. 2006); Angotti v Rexam, Inc., 2006 U.S. Dist. LEXIS 78087 (D. Minn.).

¹³⁸ *See* Employee Benefit Research Institute, *Issue Brief, Employer-Paid Retiree Health Insurance: History and Prospects for Growth*, (Oct. 1985), available at <http://www.ebri.org/pdf/briefspdf/1085ib1.pdf> (last visited Jul. 27, 2007) (noting “the possibility of vesting in more than one retiree health insurance plan represents a practical problem in coordinating benefits from multiple plans, as well as Medicare, and constitutes an additional source of uncertainty in forecasting plan costs”).

¹³⁹ *See, e.g.,* Duncan v. Retired Pub. Employees of Alaska, Inc., 71 P.3d 882 (Alaska 2003) (holding that a state constitutional provision that “accrued benefits ...shall not be diminished or

retiree benefits are explicitly protected by the terms of a collective bargaining agreement between the governmental employer and a union.

At present, the federal government pays, for employees and annuitants (single or family coverage), 72 percent of the weighted average premium of all federal health plans.¹⁴⁰ In its February 2007 Budget Options book, the Congressional Budget Office (CBO) suggested that, instead of paying a percentage of premiums, the government would pay a flat amount.¹⁴¹ At first, the government would cover the first \$3,600 of premiums for an individual and the first \$8,400 for a family.¹⁴² In future, those payments would increase in line with overall inflation rather than premium increases.¹⁴³ CBO estimated that this would save the federal government \$9.7 billion over five years.¹⁴⁴ President Bush's budget proposal calls for the federal government to pay a smaller portion of retiree health premiums for federal retirees with fewer than 10 years of service.¹⁴⁵

B. Private Sector Employers with Collective Bargaining Agreements

If there is a collective bargaining agreement between the employer and a union, that agreement may specifically define the scope and duration of retiree benefits provided to individuals who are or were (while actively employed) members of the bargaining unit. If so, then the provisions of the agreement will control. Unfortunately,

impaired" vested retiree welfare benefits but allowed changes to the benefits, provided that the level and value of benefits to retirees was not reduced); *McMinn v. City of Okla. City*, 952 P.2d 517, 521-22 (Okla. 1997); *State ex rel. City of Wheeling Retirees Ass'n, Inc. v. City of Wheeling*, 407 S.E.2d 384 (W. Va. 1991) (same level of medical benefits required for active employees and retirees); *Dadisman v. Moore*, 384 S.E.2d 816, 829-31 (W. Va. 1988) (state must appropriate additional funds for retiree health insurance). Some state courts have held that retiree welfare benefits receive less protection than pension benefits. *See, e.g., Davis v. Wilson County*, 70 S.W.3d 724, 727-28 (Tenn. 2002); *Musselman v. Governor*, 533 N.W.2d 237 (Mich. 1995), *modified*, 545 N.W.2d 346, 347-48 (Mich. 1996); *Colo. Springs Fire Fighters Ass'n, Local 5 v. City of Colo. Springs*, 784 P.2d 766, 773 (Colo. 1989).

¹⁴⁰ Ralph Smith, *How Safe Are Your Federal Benefits? Don't Answer Too Fast*, FEDSMITH, Mar. 1, 2007, available at <http://www.FedSmith.com/articles/articles.showarticle.db.php?intArticleID=1179>.

¹⁴¹ Bush Proposes 3 Percent Raise in FY 2008 But Would Cut Some Retiree Health Benefits, BNA PENSION & BENEFITS REPORTER, Feb. 13, 2007, at 356.

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ Karen Rutzick, *Budgeting Benefits*, GOVERNMENTEXECUTIVE.COM, Mar. 1, 2007, available at http://www.govexec.com/story_page.cfm?filepath=/dailyfed/0307/030107pb.htm.

¹⁴⁵ *See supra* note 141.

however, the provisions relating to retiree benefits are often ambiguous or elliptical, sometimes being defined unhelpfully by reference to the benefits provided for active employees. A frequent problem is that the bargaining agreement does not specifically state whether retiree benefits are to survive its expiration.¹⁴⁶ In these situations, where the agreement is unclear, the court attempts to ascertain the "intent of the parties" which, given that the agreement does not clearly provide the answer, is generally a fairly artificial process, with the result being largely unpredictable.¹⁴⁷

C. Private Sector Employers: No Collective Bargaining Agreement

This is the situation that has given rise to the most litigation, and there continue to be numerous cases.¹⁴⁸ The outcomes seem to be very fact specific, and it is hard to identify consistently-applied principles in the decisions.¹⁴⁹ The basic issue is essentially one of contract: what, if anything, did the employer promise, and what (if any) limitations did the employer place on the scope and duration of the promise.¹⁵⁰

These cases tend to arise from two distinct fact patterns. In the first, the employee retires, at a normal or early retirement age, and becomes entitled to retiree health benefits under the established terms of the employer's plan. In the second, the employer offers an early retirement incentive, often available for only a limited time, including enhanced retiree health benefits, and a group of employees accepts the offer. In either case, the affected retirees seek to invalidate future modification (often, increased cost-sharing by the retirees) or termination of the benefits.

¹⁴⁶ See, e.g., *John Morrell & Co. v. United Food & Commercial Workers Int'l Union*, 37 F.3d 1302 (8th Cir., 1944), cert. den., 515 U.S. 1105 (1995); *Int'l Union v. Yard-Man, Inc.*, 716 F.2d 1476 (6th Cir., 1983), cert. den. 465 U.S. 1007 (1984); *Turner v. Local Union No. 302, et al.*, 604 F.2d 1219 (9th Cir., 1979).

¹⁴⁷ See, e.g., *Bidlack v. Wheelabrator Corp.*, 993 F.2d 603 (7th Cir., 1993), cert. den. 510 U.S. 909 (1993).

¹⁴⁸ See, e.g., *supra* note 137.

¹⁴⁹ "We've complained more than once that the fact-intensive nature of many of these decisions makes them poor predictors of decisions in other cases, not to mention making them a challenge to slog through." *Devlin v. Empire Blue Cross and Blue Shield and Abbruscato v. Empire Blue Cross and Blue Shield: Second Circuit Issues Plaintiff-Friendly Opinions on Retiree Welfare Benefits*, 10 NO. 1 ERISA LITIG. REP. (NEWSL.) 6 (Apr. 2002). See also *In re Unisys Corp. Retiree Med. Benefits "ERISA" Litig.*, 58 F.3d 896 (3rd Cir., 1995).

¹⁵⁰ See, e.g., *Sprague*, *supra* note 137. "The breadth of GM's victory in *Sprague* was so great that it seemed as if employers should and would win in the future all but the clearest cases in plaintiffs' favor." *James v. Pirelli: Sixth Circuit Sustains Retiree Health Claims*, 10 NO. 5 ERISA LITIG. REP. (NEWSL.) 16 (Dec. 2002). See also *In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig.*, 57 F.3d 1255 (3d Cir. 1995).

The evidence generally consists of the terms of the retiree health plan, as set forth in the plan document and/or summary plan description; any written materials given to the employees prior to their retirement; and oral presentations made by employer representatives, either one-on-one or at a group meeting. The key issue is generally expressed as being whether the employer clearly reserved the right to amend the plan in the future and, if so, whether that reservation was adequately communicated to the employees.¹⁵¹ The issue is often clouded by (1) discrepancies between the plan document (which is typically not seen by the employees) and the summary plan description (SPD) (which is required by ERISA to be distributed to the plan participants and beneficiaries), (2) discrepancies between different versions of the written materials that are given to different employee groups and (3) discrepancies between what the documents say and what is said orally by the employer representatives.¹⁵²

IX. RETIREE HEALTH BENEFITS AND THE DECISION TO RETIRE¹⁵³

The lack of adequate health insurance, particularly for those not yet eligible for Medicare, is a growing problem. "Surveys have found that retiree health insurance plays a bigger role in the timing of retirement than pensions do."¹⁵⁴ This leads to a conflict between two policy goals, each important: on the one hand, the absence of adequate

¹⁵¹ See, e.g., *Sprague*, *supra* note 137.

¹⁵² ERISA § 102, 104(b), 29 U.S.C. §§1022, 1024(b); See, e.g., *Devlin*, *supra* note 50, and *Abbruscato*, *supra* note 50 (noting that SPD included no general reservation of the right to amend the plan and described benefits provided for eligible retirees at specified levels "for the remainder of their lives"). See, e.g., *James v. Pirelli Armstrong Tire Corp.*, 305 F.3d 439 (6th Cir. 2002). Most courts have held that a specific reservation of the right to amend or terminate a plan overrides ambiguous or contradictory oral statements. In *Moore v. Metro. Life Ins. Co.*, 856 F.2d 488 (2nd Cir., 1988), and *Musto v. American Gen. Corp.*, 861 F.2d 897 (6th Cir., 1988), *cert. den.* 490 U.S. 1020 (1989) (holding that oral promises would not override express reservation of rights language in the plan documents, in the absence of evidence "tantamount to proof of fraud").

¹⁵³ See *Johnson, et al*, *supra* note 19.

¹⁵⁴ John O'Neil, *Want to Retire Early and Hang a Shingle? It'll Cost You*, N.Y. TIMES, Apr. 11, 2006, at 4 (quoting Cara Jareb, Director of Retiree Health Consulting at Watson Wyatt). See also Rudolph G. Penner & Richard W. Johnson, *Health Care Costs, Taxes, and the Retirement Decision: Conceptual Issues and Illustrative Simulations* (Center for Retirement Research at Boston College, Working Paper No. 2006-20, 2006), available at www.bc.edu/centers/crr/wp_2006-20.shtml; Leora Friedberg, *The Recent Trend Towards Later Retirement*, Center for Retirement Research at Boston College (Mar. 2007), available at http://crr.bc.edu/images/stories/Briefs/wob_9.pdf (stating that "A dramatic decline in work at older ages persisted over most of the twentieth century. Recently, however, retirement ages stabilized, prompting debate as to whether the early retirement trend had stopped or simply paused. This brief shows that the trend towards earlier retirement has not just leveled off but has apparently reversed, with especially large increases in labor supply of women in late middle age.").

insurance coverage for retirees, particularly those under the age of 65, may jeopardize the continued good health of those who lack insurance. On the other hand, encouraging employees to work longer, particularly those with skills or knowledge that are hard to replace, is good for employers, helps employees to accumulate additional funds to meet their living expenses in retirement, and helps the financial condition of Social Security and Medicare.¹⁵⁵

One drawback of recent proposals to extend Medicare to retirees below the age of 65 is that "they might encourage early retirement. As society ages and concerns intensify about the burden of supporting the retired population, policies that discourage work at older ages merit special scrutiny."¹⁵⁶ A 2003 study concluded that retiree health insurance (RHI) offers:

[I]ncrease retirement rates by 26% for men and 31% for women, because the premium cost of retirement is generally substantially lower for individuals with RHI offers than for those with employer-sponsored coverage who are not offered RHI benefits. These findings are consistent with evidence from other studies that the potential loss of employer-sponsored coverage can lock workers into particular employment relationships and that RHI benefits significantly accelerate retirement. Policy simulations based on our model indicate that lowering the Medicare eligibility age from 65 to 62 would raise retirement rates for workers with employer-sponsored coverage who are not offered RHI benefits. Under the current system, these workers face steep increases in insurance costs when they retire before age 65. If they could receive Medicare coverage at age 62 at the heavily subsidized premium prices that elderly beneficiaries pay, retirement rates would increase by about one-sixth for workers with employer-sponsored coverage who lack RHI offers. However, retirement effects would be more modest if near-elderly adults were instead permitted to buy into the Medicare program at prices that approximately covered the cost of services.¹⁵⁷

¹⁵⁵ See *Working Longer May Be Part of Realistic Plan for Retirement, Comptroller General Says*, BNA PENSION AND BENEFITS REPORTER, Mar. 6, 2007, at 524.

¹⁵⁶ See Johnson, et al., *supra* note 19, at 717.

¹⁵⁷ See Johnson, et al., *supra* note 19, at 727-728 (citations omitted).

As Richard Johnson has pointed out:

The overall uninsured rate is not particularly high at older ages. About 12 percent of adults aged 55 to 64 lacked health insurance in 2004. By contrast, about 15 percent of adults aged 45 to 54 and 19 percent of adults aged 35 to 44 lacked coverage. However, lack of coverage creates special difficulties at older ages, because older adults are more likely than younger adults to develop health problems and need expensive medical care. In fact, median health care expenditures in 2004 were almost four times as high at ages 55 to 64 than at ages 35 to 44. Uninsured rates are relatively steep among older people with limited incomes and health problems, groups arguably in greatest need of health insurance. For example, 28 percent of adults aged 55 to 64 with incomes below the federal poverty level lacked insurance in 2004, compared with 6 percent of those with incomes in excess of four times the poverty level. Whereas 16 percent of those in fair or poor health were uninsured, only 9 percent of those in excellent or very good health lacked coverage.¹⁵⁸

X. CONCLUSION

The decline in the availability of retiree health benefits is part of a broader trend: replacement of defined retiree pension and health benefits with account-based savings arrangements with no guarantees that the accumulations will be adequate.¹⁵⁹

Although millions of older Americans still rely on retiree health benefits from former employers to help pay their medical expenses, coverage appears to be slowly disappearing, possibly jeopardizing retirement security for future generations. As health care costs rise, the workforce ages, and global competition intensifies, many employers seem to be concluding that they can no longer afford to offer subsidized health insurance to retirees. . . . long-term fiscal imbalances may soon lead to Medicare cutbacks and further cutbacks in Social Security. Even if these programs are not cut, and retiree health plans continue at their current levels of generosity, rising health care costs will force future generations of retirees to devote ever increasing shares of their incomes

¹⁵⁸ Richard W. Johnson, *What Happens To Health Benefits After Retirement?*, Center for Retirement Research at Boston College (Feb. 2007).

¹⁵⁹ See, e.g., JACOB S. HACKER, *THE GREAT RISK SHIFT: THE ASSAULT ON AMERICAN JOBS, FAMILIES, HEALTH CARE, AND RETIREMENT AND HOW YOU CAN FIGHT BACK* (Oxford University Press 2007).

to health care.¹⁶⁰

For those who are not yet retired, the answer is straightforward, if unpalatable:

The dual problems of accessibility and affordability of coverage mean that employees will have to save more money for retiree health care expenses, allocate more financial resources to health care, work longer, rely on help from family, or use a combination of these approaches. Unless people are healthy, or government regulations support guaranteed access, many people might find it advisable or necessary to work until they become eligible for Medicare even if they have enough funds to pay for coverage.¹⁶¹

¹⁶⁰ See Johnson, *supra* note 158; See also RESTRUCTURING RETIREMENT RISKS, 136-165 (David Blitzstein, Olivia S. Mitchell, & Stephen P. Utkus, eds., Oxford University Press, 2006) (“We conclude that in the US, healthcare costs will continue to rise and more risk will be shifted to retirees, posing a major threat to the affordability of a good retirement for many Americans.”)

¹⁶¹ See RESTRUCTURING RETIREMENT RISKS, *supra* note 60.