THE SHIFTING FOCUS OF FEDERAL INTERVENTION IN RETIREE HEALTH BENEFITS

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I. INTRODUCTION

The United States Postal Service (USPS) has teetered on the brink of disaster each fall in recent years. The reasons are manifold, but the tipping point seems to rest improbably on a retirement benefit. Back in 2006, Congress decided the USPS should fund its accumulated future retiree health liability over a ten-year period.[1] That translates to more than $5 billion due each September,[2] which the struggling national mail service institution can ill afford to pay.[3] The USPS problem is extreme and aggravated by unique legislation, but similar issues haunt most employment-based retiree health plans. With millions of current and future retirees and their families depending on such benefits, the federal government has intervened sporadically in this area over the past few decades. While the underlying goal would seem to be preserving these plans as long as possible, the government's focus over time has shifted from participants to employers. This Article follows the path of that shifting focus from the mid-1980s through today.

Employment-based health plans for retirees and their dependents cover at least fifteen million individuals in the United States.[4] Retiree health insurance

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1 Postal Accountability and Enhancement Act (Postal Act or PAEA), 5 U.S.C. § 8909a (2012).

2 *Id.*; *see also* JOSEPH CORBETT, U.S. POSTAL SERVICE, REP. NO. ESS-MA-09-001(R), FINANCIAL MANAGEMENT ADVISORY BOARD—ESTIMATES OF POSTAL SERVICE LIABILITY FOR RETIREE HEALTH BENEFITS 4 (2009), *available at* http://www.uspsoig.gov/foia_files/ESS-MA-09-001R.pdf.

3 CORBETT, *supra* note 2, at 5.

4 Estimates vary. In 2007, one report calculated the number of retirees and dependents covered under an employer plan for early retirees at 6.5 million. Mark Merlis, *Health Policy Brief: Early Retiree Insurance*, HEALTH AFF., Nov. 23, 2010, at 1, *available at* http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_32.pdf. An Employee Benefit

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includes plans for both early retirees and Medicare-eligible retirees.[5] Plans for early retirees—in general, those at least age fifty-five but not yet sixty-five[6]—typically provide primary health insurance, often simply a continuation of active employee coverage; plans for Medicare-eligible retirees are secondary to Medicare and provide wrap-around coverage.[7] For both groups, employment-

Research Institute (EBRI) analysis of early retirees and dependents with employment-based coverage, using 2004 and 2007 data, predicted 1.3 million covered individuals in 2010. Paul Fronstin, *The Early Retiree Reinsurance Program: $5 Billion Will Last About Two Years*, 31 EMP. BENEFIT RES. INST. NOTES, July 2010, at 2, 5–6, *available at* http://www.ebri.org/pdf/notespdf/EBRI_Notes_07-July10.Reins-Early.pdf. The U.S. Department of Health and Human Services (HHS) estimated that more than 4.5 million individuals in employment-based early retiree health plans were helped in 2010 and early 2011 by subsidies through the Early Retiree Reinsurance Program created by health reform. HHS, PROGRESS REPORT ON THE EARLY RETIREE REINSURANCE PROGRAM (2011), *available at* http://cciio.cms.gov/resources/files/errp_progress_report_3_31_11.pdf. On the Medicare side, thirty-four percent of the 40.8 million Medicare beneficiaries in 2007—or slightly less than 13.9 million individuals—enjoyed supplemental insurance through an employer. JULIETTE CUBANSKI ET AL., KAISER FAMILY FOUND., EXAMINING SOURCES OF SUPPLEMENTAL INSURANCE AND PRESCRIPTION DRUG COVERAGE AMONG MEDICARE BENEFICIARIES: FINDINGS FROM THE MEDICARE CURRENT BENEFICIARY SURVEY, 2007, at 4 (2009), *available at* http://www.kff.org/medicare/upload/7801-02.pdf/ (detailing sources of Medicare supplemental insurance); *see also* CTRS. FOR MEDICARE & MEDICAID SERVS. (CMS), DATA COMPENDIUM TABLE IV.1: MEDICARE ENROLLEES SELECTED YEARS (2008), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/16_2008DataCompendium.html (listing numbers of Medicare enrollees by year). The percentage of Medicare beneficiaries with retiree health benefits remained almost constant in 2008. About thirty-three percent of Medicare recipients had supplemental coverage from a former employer in that year. KAISER FAMILY FOUND., KAISER FAST FACTS: SUPPLEMENTAL COVERAGE AMONG MEDICARE BENEFICIARIES, BY INCOME, 2008 (Jan. 18, 2011), http://facts.kff.org/chart.aspx?ch=1931.

[5] If an employer provides retiree health benefits at all, overwhelmingly those retiree health benefits include coverage for early retirees. In 2010, of public and private employers that had 200 or more employees and that offered any form of retiree health plan, ninety-three percent offered retiree health benefits to early retirees, and seventy-five percent offered benefits to Medicare-eligible retirees. Gary Claxton et al., Kaiser Family Found. & Health Research & Educ. Trust (HRET), *Employer Health Benefits*, 2010 ANNUAL SURVEY 1, 166, *available at* http://ehbs.kff.org/pdf/2010/8085.pdf [hereinafter Kaiser Family Found. & HRET, 2010 ANNUAL SURVEY].

[6] Eligibility for retiree health insurance depends on the terms of a particular employer's plan, but usually requires attainment of at least age fifty-five with some number of years of service. A 2002 study of retiree health plans sponsored by large employers determined that the most common service requirements were six to ten years and the next most common were eleven to fifteen years. KAISER FAMILY FOUND. & HEWITT ASSOC., THE CURRENT STATE OF RETIREE HEALTH BENEFITS: FINDINGS FROM THE KAISER/HEWITT 2002 RETIREE HEALTH SURVEY vi (2002), *available at* http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14031. The federal Early Retiree Reinsurance Program (ERRP) created by health reform to support existing employment-based early retiree health plans provides reimbursement for expenses incurred by retirees age fifty-five to sixty-five who are not Medicare-eligible. HHS, *The Affordable Care Act's Early Retiree Reinsurance Program*, HEALTHCARE.GOV (Oct. 4, 2010), http://www.healthcare.gov/news/factsheets/2010/10/early-retiree-reinsurance-program.html.

[7] *See, e.g.*, Greta E. Cowart, *Benefits in a Challenging Economy—The Legacy Cost of Retiree Medical Benefits*, *in* RETIREMENT, DEFERRED COMPENSATION, AND WELFARE PLANS OF TAX-EXEMPT AND GOVERNMENTAL EMPLOYERS 147, § II.A (2009) (ALI-ABA CLE course materials—SR014).

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based coverage is important.[8] For early retirees, it is critical because they typically have few, if any, alternatives to employer-sponsored plans.[9] In fact, individuals with a choice rarely retire before Medicare eligibility unless they qualify for retiree health benefits.[10] For Medicare-eligible retirees, the supplemental insurance available through employers often is both less expensive and more comprehensive than what private Medicare supplemental policies (often referred to as "Medigap" plans[11]) offer. When an employer reduces or terminates that supplemental coverage, the costs shift to retirees, who may not have the resources to adapt easily to new financial demands.

Notwithstanding the importance of these benefits, larger employers—generally, the ones that provide retiree health insurance[12]—have been dropping all types of retiree medical insurance steadily since the late 1980s.[13] A fundamental principle of the United States employee benefits system is that employers are free to choose to provide benefits or not.[14] Only after an employer voluntarily establishes an employee benefit plan does government regulation begin, and employers remain generally free to amend or terminate health benefit plans, including those for retirees, at any time for any reason.[15] Collectively bargained plans are the primary exception, but even then employers have found ways to escape from retiree health commitments when they so desire.[16] By the fall of 2011, only twenty-six percent of surveyed employers with two hundred or more employees provided any form of retiree health benefits, a stunning decline from the sixty-six percent who offered such benefits in 1988.[17]

In light of the importance of retiree health insurance to covered individuals, the federal government has intervened on occasion, first in the 1980s and

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[8] *See infra* Part II.

[9] *See infra* notes 27–37 and accompanying text.

[10] *See* Courtney Monk & Alicia H. Munnell, *The Implications of Declining Retiree Health Insurance* 4 (Ctr. for Ret. Research at Bos. Coll., Working Paper No. 2009-15, 2009), *available at* http://crr.bc.edu/wp-content/uploads/2009/08/wp_2009-15-508.pdf (noting that "retiree health insurance increases the probability of retirement by 30 percent to 80 percent" and citing a wide array of literature on the subject). *See also* Sandra Block, *Early Retirees Try to Fill Gap in Health Coverage*, USA TODAY, Jan. 15, 2008, at 1B; Chris Farrell, *Early Retirement and Health Insurance*, MARKETPLACE (May 8, 2008, 1:27 AM), http://www.marketplace.org/topics/your-money/getting-personal/early-retirement-and-health-insurance (observing "that the deal-breaker to early retirement is usually health insurance").

[11] *See, e.g.*, CMS & NAT'L ASS'N OF INS. COMM'RS, 2012 CHOOSING A MEDIGAP POLICY: A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE 9, 12–13, 18 (2012), *available at* http://www.medicare.gov/Pubs/pdf/02110.pdf.

[12] In 2010, twenty-eight percent of employers with 200 or more employees offered some form of retiree health insurance as compared with only three percent of smaller employers. Kaiser Family Found. & HRET, 2010 ANNUAL SURVEY, *supra* note 5, at 164.

[13] In 1988, sixty-six percent of large employers offered retiree health benefits as compared to only twenty-six percent in 2010. Gary Claxton et al., Kaiser Family Found. & HRET, *Employer Health Benefits*, 2011 ANNUAL SURVEY 1, 161, *available at* http://ehbs.kff.org/pdf/2011/8225.pdf [hereinafter Kaiser Family Found. & HRET, 2011 ANNUAL SURVEY].

[14] *See, e.g.*, Curtiss-Wright Corp. v. Schoonejongen, 514 U.S. 73, 78 (1995) ("ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits.").

[15] *Id.* ("Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans.").

[16] *See, e.g.*, *infra* note 62 and accompanying text.

[17] *See* Kaiser Family Found. & HRET, 2011 ANNUAL SURVEY, *supra* note 13, at 161.

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again as recently as 2010's health reform legislation. At the outset, federal efforts took a participant-oriented approach. Since then, however, the federal government's focus has shifted toward employers, using incentives and accommodations as the tools. After setting the stage for why employment-based retiree health benefits matter and for the challenges facing employers, this Article considers federal action from the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (better known as COBRA)[18] through the incentive approach of the Patient Protection and Affordable Care Act (PPACA)[19] in 2010. In tracing these actions, the Article classifies federal efforts into three loose categories: participant-oriented protection, mandated funding, and employer accommodation/incentives.[20]

II. Why Employment-Based Retiree Health Insurance Matters

People retire before age sixty-five for a multitude of reasons. Choosing to terminate active employment may reflect physical limitations[21] or simply a desire to pursue other interests[22]—whether travel, family time, neglected hobbies, or overdue relaxation.[23] Whatever the impetus, retirement decisions depend on assessments of an individual's financial situation, and access to affordable health insurance is a cornerstone of a stable retirement existence. Should retiree insurance terminate,[24] its absence upends a basic assumption

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[18] Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (codified as amended in scattered sections of 7, 10, 15, 29, 33, 38, 42 U.S.C.) [hereinafter COBRA]. President Reagan signed COBRA into law on April 7, 1986.

[19] The Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 25, 26, 29, 42 U.S.C.), and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of 20, 26, 42 U.S.C.), together constitute 2010's major health reform legislation. For convenience, references herein to "health reform" shall mean either or both of the Affordable Care Act and the Reconciliation Act, as applicable.

[20] There is considerable overlap between these suggested "categories." *See generally infra* Part IV.

[21] *See, e.g.*, Patricia F. Adams et al., HHS, Summary Health Statistics for the U.S. Population: National Health Interview Survey, 2009, at 6 (2010), *available at* http://www.cdc.gov/nchs/data/series/sr_10/sr10_248.pdf (finding that "[p]ersons aged 45–64 and 65–69 years were more than three times as likely to be unable to work due to health reasons as persons aged 18–44 years"). *See also* Beth Fenner, *Work Until We're 70? You Cannot Be Serious*, CNN Money (Sept. 13, 2010, 5:58 PM), http://moremoney.blogs.money.cnn.com/2010/09/13/work-until-were-70-you-cannot-be-serious/.

[22] An AARP survey in 2011 found that working baby boomers were almost evenly divided between forty-three percent who "can't wait to retire" and forty-one percent who want to continue working. AARP & GFK Custom Research N. Am., Baby Boomers Envision What's Next? 4 (2011).

[23] For example, AARP found in 2011 that seventy-one percent of baby boomers expected to spend time with their families in retirement, sixty-six percent expected to spend time with hobbies and other interests, fifty-seven percent perceived retirement as a "time of leisure," forty-nine percent hoped to travel, and forty-five percent planned to "indulge themselves." *Id.* at 5.

[24] Although terminations are the worst scenario, an employer may modify a retiree plan to shift increasing amounts of cost to retirees. Depending on the level of cost shifting, a retiree on a fixed income may eventually be unable to afford the premium and other expenses. For a retiree, such an outcome may be comparable in impact to plan termination if the retiree finds

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upon which retirement was predicated.[25] Making matters worse, losing retiree health benefits leaves a void not easily filled. Depending on the reasons for retirement, an individual may not be willing or able to return to full-time employment to obtain active employee coverage. Even if someone is both willing and able, an older person's chances of returning to a comparable position are limited.[26] Employment-based coverage, once lost, may well be gone forever.

Without employer-provided insurance, early retirees find themselves in a particularly difficult position. Adults who are neither age sixty-five nor disabled currently do not enjoy good alternatives to employer-provided health benefits.[27] Group health insurance through one's work does not discriminate on

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himself or herself unable to sustain employment-based coverage. *See, e.g.*, SOC. SEC. ADVISORY BD., THE UNSUSTAINABLE COST OF HEALTH CARE 1, 7 (2009), *available at* http://www.ssab.gov/documents/TheUnsustainableCostofHealthCare_graphics.pdf (highlighting the impact on retirees and others of rising health care costs).

[25] Admittedly, retirees' assumptions about their healthcare expenses in retirement may well be inaccurate. *See, e.g.*, Sun Life Fin., *Flying Blind: How Working Americans View Healthcare Costs in Retirement*, SUN LIFE FIN. UNRETIREMENT SURV., at 3 (May 4, 2011), http://cdn.sunlife.com/static/unitedstates/Announcements/Press%20releases/2011/Sun%20Life%20Financial%20-%20Flying%20Blind%20Survey%20Results%2005042011.pdf (reporting that ninety-two percent of surveyed employees "either have no idea what their healthcare costs will be in retirement, or vastly underestimate those costs" and that seventy-four percent "lack specific plans to cover retirement healthcare costs").

[26] AARP reports that "since the start of the recession, both the number of unemployed and the unemployment rate have increased by a greater percentage for the segment of the workforce aged 55 and over than for younger segments." Sara E. Rix, *The Employment Situation, November 2010: Little Holiday Cheer in the News*, FACT SHEET NO. 208 (AARP Pub. Policy Inst.), Dec. 2010, at 1, *available at* http://assets.aarp.org/rgcenter/ppi/econ-sec/fs208-employment.pdf. Moreover, individuals age fifty-five and older tend to be out of work for long periods even if seeking employment. Nearly sixty percent of those age fifty-five and older who were seeking work had been out of work for at least twenty-seven weeks as of November 2010. *Id.* at 6.

[27] *See, e.g.*, MARILYN MOON, TIAA-CREF INST., TRENDS AND ISSUES: EARLY RETIREE HEALTH INSURANCE ISSUES 8–10 (2007), *available at* http://www1.tiaa-cref.org/ucm/groups/content/@ap_ucm_p_tcp_docs/documents/document/tiaa02029494.pdf (highlighting alternatives for individual insurance for older individuals and noting the expense of such options). Some early retirees may qualify for coverage under a state high-risk health insurance pool. A total of thirty-five states maintain high-risk insurance pools for individuals who are considered otherwise uninsurable, but the pools are limited. *See States That Have Risk Pools*, NAT'L ASS'N OF ST. COMPREHENSIVE HEALTH INS. PLANS (NASCHIP), http://www.naschip.org/states_pools.htm (last visited May 8, 2013); *Member Eligibility*, NASCHIP, http://naschip.org/portal/index.php?option=com_content&view=article&id=100&Itemid=279 (last visited May 8, 2013) (summarizing the eligibility rules used by different state high-risk pools); *Impact on Uninsured Rates*, NASCHIP, http://naschip.org/portal/index.php?option=com_content&view=article&id=106&Itemid=284 (last visited May 8, 2013) (noting that "high-risk pool coverage is available only to a small subset of the uninsured population because it is targeted for uninsured people who have serious health conditions and ailments"). In 2008, a total of only 200,991 individuals were enrolled in coverage through state high-risk pools. *Member Eligibility*, *supra*. To improve the situation, the Affordable Care Act funded a new federal high-risk program—the Pre-Existing Condition Insurance Plan (PCIP)—intended to bridge certain uninsured individuals to 2014. 42 U.S.C. § 18001(a) (2012). *See also* Nancy-Ann DeParle, *Insurance for Americans with Pre-Existing Conditions*, WHITE HOUSE BLOG (July 29, 2010, 8:40 AM), http://www.whitehouse.gov/blog/2010/07/29/insurance-americans-with-pre-existing-conditions; Press Release, HHS, HHS

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the basis of health status; all similarly situated employees are similarly eligible for coverage.[28] The same applies to retiree health plans sponsored by an employer. Eligibility for coverage under such plans depends on retiree status, not health conditions. Individual insurance, on the other hand, historically has come with no such protections, and insurers have routinely denied applications by those whom the companies perceive as poor risks.[29] Because health declines with age,[30] those old enough to qualify for retirement—early or normal—often fall into the poor risk category.[31]

Even if an early retiree can find an insurer willing to issue individual coverage, the cost may outstrip what the individual can afford. For example, in 2010, the average per person monthly health insurance premium was $215 for individual coverage[32] as compared to an average monthly premium contribu-

Secretary Sebelius Announces New Pre-Existing Condition Insurance Plan (July 1, 2010), *available at* http://www.hhs.gov/news/press/2010pres/07/20100701a.html (characterizing the PCIP as a "transitional program until 2014"). To qualify for the federal program, a person must have a pre-existing condition and not have had "creditable" coverage for at least six months. 42 U.S.C. § 18001(d). Because the eligibility requirements are less strict, some early retirees who could not qualify for a state's high-risk pool in prior years may be able to obtain coverage through the PCIP. On the other hand, many early retirees will either still not fit into an eligibility category or be unable to afford the premium cost.

[28] *See, e.g.*, 29 U.S.C. §§ 1182(a)–(b) (2012).

[29] Individual insurance has historically been regulated at the state level as a result of the McCarran-Ferguson Act. 15 U.S.C. §§ 1011–15 (2012). Although some states have created high-risk pools to provide insurance for individuals with health conditions, private insurers have still been allowed to refuse to issue policies to individuals they perceive as comparatively higher risk. *See* MOON, *supra* note 27, at 8. Health reform, however, is supplanting much state regulation with new federal requirements that remove much of the freedom to deny coverage previously granted to insurers. *See* Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, 39 HOFSTRA L. REV. 111, 150 (2010). The Affordable Care Act and Reconciliation Act generally provide that every "health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage." 42 U.S.C. § 300gg-1(a) (2012). This inherently eliminates insurers' ability to reject individual health insurance applicants on the basis of health or age.

[30] Results from the National Health Interview Survey, 2004–2007, revealed that 19.6% of those aged fifty-five to sixty-four reported themselves in fair or poor health as did 32.1% of those aged eighty-five and older. CHARLOTTE A. SCHOENBORN & KATHLEEN M. HEYMAN, HHS, HEALTH CHARACTERISTICS OF ADULTS AGED 55 YEARS AND OVER: UNITED STATES, 2004–2007, at 3 (2009), *available at* http://www.cdc.gov/nchs/data/nhsr/nhsr016.pdf. In the 2009 National Health Interview Survey, 37.9% of those aged eighteen to forty-four reported themselves in excellent health, and 32.8% reported themselves in very good health. ADAMS ET AL., *supra* note 21, at 12. By contrast, only 17% aged sixty-five to seventy-four reported themselves in excellent health; 29.8% reported themselves in very good health. *Id.*

[31] A 2008 review determined that individuals ages sixty to sixty-four were more than twice as likely to be denied individual insurance coverage than individuals ages thirty-five to thirty-nine. GRETCHEN JACOBSON, KARYN SCHWARTZ & TRICIA NEUMAN, KAISER FAMILY FOUND., HEALTH INSURANCE COVERAGE FOR OLDER ADULTS: IMPLICATIONS OF A MEDICARE BUY-IN 5 (2009), *available at* http://www.kff.org/healthreform/upload/7904-02.pdf. Moreover, even when an insurer issued an individual policy to someone in the fifty-five to sixty-four age range, about ten percent of individual policies denied coverage for pre-existing conditions. *Id.*

[32] Kaiser Family Found., *Average Per Person Monthly Premiums in the Individual Market, 2010*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.org/comparemaptable.jsp?ind=976&cat=5 (last visited May 8, 2013). The preceding per-person premium calculated by

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tion of $75 by an employee for single coverage through an employer.[33] One analysis concluded that paying just the individual insurance premium for someone age fifty-five to sixty-four would eliminate twenty-four percent of the median pre-tax family income in 2008; paying the family premium outside the group insurance market would take forty percent of that income.[34] Individuals can pay out-of-pocket for health care, of course, but few retirees have sufficient resources.[35]

The only remaining alternative is government-provided or government-paid care, such as that available through Medicare and Medicaid for certain parts of the population. But healthy, early retirees historically have not qualified for either of the safety net programs. Except for those with serious disabilities or certain terminal conditions, Medicare eligibility begins at age sixty-five.[36] Medicaid eligibility traditionally has required not only that a person fit into specified categories—none of which has been likely for someone age fifty-five-plus who is not disabled—but also that the person be impoverished.[37]

On the other hand, retirees age sixty-five and older start out reasonably well thanks to Medicare's safety net.[38] They still need and use employment-

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Kaiser is based on all individual premiums, without regard to age. Individual premiums for older persons are much higher. In 2009, the average annual premium for someone age fifty-five to sixty-four was $5,349 as compared to an average annual premium of only $1,429 for someone age eighteen to twenty-four. JACOBSON, SCHWARTZ & NEUMAN, *supra* note 31, at 5.

[33] Kaiser Family Found. & HRET, 2010 ANNUAL SURVEY, *supra* note 5, at 73.

[34] JACOBSON, SCHWARTZ & NEUMAN, *supra* note 31, at 5.

[35] The median U.S. net worth for households headed by someone age sixty-five to seventy-four in 2007 was only $239,400. U.S. CENSUS BUREAU, 2012 STATISTICAL ABSTRACT: THE NATIONAL DATA BOOK, at tbl.721 (2012), http://www.census.gov/compendia/statab/cats/income_expenditures_poverty_wealth.html. Fidelity Investments estimated that a couple retiring in 2012 would need $240,000 to pay medical expenses in retirement, not including long-term care costs (such as nursing home care). *Retirees Face Estimated $240,000 in Medical Costs*, FIDELITY (May 16, 2012), http://www.fidelity.com/viewpoints/retirees-medical-expenses. Once individuals reach age sixty-five and Medicare eligibility, the financial situation hardly improves. For example, in 2008, almost one in six individuals age sixty-five or older had income below 125% of the federal poverty level ($10,326 for an individual). ELLEN O'BRIEN ET AL., AARP PUB. POLICY INST., OLDER AMERICANS IN POVERTY: A SNAPSHOT 1 (2010), *available at* http://www.aarp.org/work/retirement-planning/info-04-2010/2010-03-poverty-new.html.

[36] 42 U.S.C. § 1395c (2012).

[37] *See* KAISER FAMILY FOUND., MEDICAID: A PRIMER 7 (2010), *available at* http://www.kff.org/medicaid/7334.cfm. Medicaid eligibility expansion is a key component of health reform. KAISER FAMILY FOUND., EXPLAINING HEALTH CARE REFORM: QUESTIONS ABOUT MEDICAID'S ROLE 1 (2010), *available at* http://www.kff.org/healthreform/upload/7920-02.pdf. *See generally* CTR. FOR HEALTH CARE STRATEGIES, ROBERT WOOD JOHNSON FOUND., MEDICAID STATE PLAN AMENDMENT REQUIREMENTS OF THE AFFORDABLE CARE ACT (2012), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401586 (listing implementation dates of changes to Medicaid policies and eligibility requirements).

[38] For some older individuals, although they are eligible for Medicare coverage, Medicare acts as secondary—or supplemental—insurance to an employer plan as a result of the Medicare Secondary Payer (MSP) rules. 42 U.S.C. § 1395y(b) (2012) (providing that an employer plan may not consider Medicare eligibility and benefits in determining plan benefits for someone whose employer plan coverage results from current employment). For more discussion of the MSP rules, see HINDA CHAIKIND, CONG. RESEARCH SERV., MEDICARE SECONDARY PAYER—COORDINATION OF BENEFITS 2 (2008), *available at* http://aging.senate.gov/

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based coverage, however, because gaps in Medicare coverage make the safety net far less solid than many realize.[39] Thus, for example, annual out-of-pocket health care spending by Medicare beneficiaries averaged $4,241 per beneficiary in 2006, with younger beneficiaries spending far less on average than older ones.[40] The vast majority of Medicare beneficiaries—eighty-nine percent in 2007—therefore obtain some form of secondary insurance to offset these costs.[41] About a third have access to such insurance through a former employer.[42] This remained true even after the Medicare Prescription Drug, Improvement, and Modernization Act (MMA)[43] added Part D prescription drug coverage,[44] closing what had been one of the most glaring benefit holes.

III. The Challenge of Employment-Based Retiree Health Insurance

Employers offer benefits to their employees for a variety of reasons,[45] but any employer will seek to balance the cost of a particular benefit with a corre-

crs/medicare11.pdf. Individuals who remain actively employed are by definition not retired and thus fall largely outside the scope of this Article's concerns. *See also infra* notes 69–75 and accompanying text.

[39] 42 U.S.C. § 1395y(a) (2012) (detailing items and services excluded from Medicare). At a minimum, a beneficiary electing traditional Medicare Parts A (hospital insurance) and B (supplemental insurance), plus Part D drug coverage, must pay the Part A deductible ($1,184 in 2013) for each spell of illness during a year, plus co-insurance (beginning at $296 per day for hospitalization after the first 60 days in a spell of illness). In addition, that beneficiary must pay a monthly Part B premium (for most people, $104.90 per month in 2013, but adjusted upward for higher income beneficiaries), plus at least twenty percent Part B co-insurance every time the beneficiary accesses Part B services. The beneficiary must also pay a Part D premium and co-pays for drugs, all set by the private drug plan insurer that provides the Part D plan the beneficiary elects. Very low-income individuals may qualify for financial assistance with all these costs. CMS, Medicare & You 25, 30, 95–96 (2013), *available at* http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf.

[40] Kaiser Family Found., Kaiser Fast Facts: Average Per Capita Out-of-Pocket Spending by Medicare Beneficiaries, by Age and Health Status, 2006 (2010), *available at* http://facts.kff.org/chart.aspx?cb=58&sctn=168&ch=1787 (indicating that out-of-pocket spending averaged $3,500 per year for beneficiaries age sixty-five to seventy-four, but $7,487 per year for beneficiaries age eighty-five or older).

[41] Cubanski et al., *supra* note 4, at 4.

[42] In 2007, 34% obtained supplemental coverage through an employer plan, 22% elected a Medicare Advantage plan, 17% purchased Medigap coverage, and 15% were covered for out-of-pocket expenses through Medicaid. *Id.* Only 11% did not have supplemental coverage. *Id.* Of course, some number of those age sixty-five and older continue to work in jobs with health coverage (or are covered by health insurance through a spouse who remains in the workforce). In 2010, for example, 16.2% of the population age sixty-five or older remained employed. U.S. Census Bureau, *supra* note 35, at tbl.34.

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

[44] *Id.* § 109.

[45] The unique development of the U.S. employment-based health insurance system has been thoroughly discussed. *See, e.g.*, Colin Gordon, Dead on Arrival: The Politics of Health Care in Twentieth-Century America 12–46 (2003); Inst. of Med., Employment and Health Benefits: A Connection at Risk 49–86 (Marilyn J. Field & Harold T. Shapiro eds., 1993). *See also* Jon R. Gabel, *Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny*, 18 Health Aff. 62, 65 (1999).

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sponding value to the employer.[46] This fundamental point remains key to understanding employers' choices. Including health insurance in a benefits package may attract and retain qualified workers. Depending on the industry, employer-provided health insurance may be so commonplace as to put any employer that does not provide coverage at a competitive disadvantage. Once someone is hired, access to affordable health insurance helps ensure that employee's continuing ability to perform his or her job functions. Further, beginning in 2014, employers will be subject to tax penalties should they fail to provide a specified level of affordable health insurance to active workers.[47] Taken together, these factors coalesce into a fairly strong incentive for employers to continue active employee insurance.

Similar incentives historically applied to retiree health insurance. When most large employers offered retiree health benefits,[48] to do otherwise could have impeded hiring and retention efforts. Qualifying for coverage could give valuable long-term employees a powerful reason to stay with a particular employer. Conversely, the availability of retiree coverage might encourage an older worker to leave voluntarily[49] and avoid potential problems with the Age Discrimination in Employment Act of 1967[50] (ADEA).

Once an individual retires, however, employer incentives fade. While the availability of retiree health benefits may have attracted an individual to the

[46] *See, e.g.*, EBRI, DO EMPLOYERS/EMPLOYEES STILL NEED EMPLOYEE BENEFITS? 2 (Dallas L. Salisbury ed., 1998), *available at* http://www.ebri.org/pdf/publications/books/need_emp_benefits.pdf (quoting Michael Losey, then-president of the Society for Human Resource Management, as saying: "Benefits are a big cost of doing business, and as a big cost, the shareholders and the CEOs are going to say, 'What am I getting for my money, what's the return on my investment?' "). In 1967, one benefits consultant characterized the situation as follows: "Employee benefits have been viewed as a motivational tool, as protection for an employee's standard of living, as a bargaining device in union negotiations, as a way of meeting competition in an ever tightening labor market, and even as a necessary evil." George C. Foust, Jr., *The Total Approach Concept*, *in* THE TOTAL APPROACH TO EMPLOYEE BENEFITS 9, 9 (Arthur J. Deric ed., 1967). *See also* ROBERT D. GRAY, CAL. INST. OF TECH., APPRAISING AND INTEGRATING EMPLOYEE BENEFITS 17 (1956) ("Although benefit plans are often referred to as employee benefits, it is necessary that the employer also benefit.").

[47] I.R.C. § 4980H (2012).

[48] *See supra* note 13.

[49] For employers in shrinking industries or in worsening economies, early retirement incentives offer a relatively painless way to reduce workforces without involuntary terminations. Often, older workers cost more in wages, which means that their termination reduces payroll expenses more than laying off a less expensive younger worker. Even when an employer's goal does not include reducing the size of a workforce, that employer may still want to ease older workers out to give younger employers room to grow. For example, writing in the mid-1960s, a vice president with Towers, Perrin, Forster, and Crosby, Inc. included "replacement of the superannuated" and facilitation of "early retirement" as key objectives of an employer's pension program. Foust, Jr., *supra* note 46, at 16. Mr. Foust also noted a movement toward earlier retirement, observing that with "automation as an impetus, the trend to earlier retirement is becoming more pronounced." *Id.* at 17. Similarly, more than four decades later, consulting firm Towers Watson noted that "[r]etiree medical programs can add an important component to a company's reward portfolio, and provide valuable support for retirement readiness and an organization's related workforce management goals." TOWERS WATSON, 2010 HEALTH CARE COST SURVEY 8 (2010).

[50] Age Discrimination in Employment Act of 1967, Pub. L. No. 90-202, 81 Stat. 602 (codified as amended at 29 U.S.C. §§ 621–634) [hereinafter ADEA].

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employer at the outset of employment, that employer has already reaped the reward by attracting and retaining the individual during his or her employment period. An employer no longer cares whether a retiree can perform job functions because the individual is by definition no longer part of that employer's workforce. And the PPACA's coverage penalties do not apply to retiree health plans.[51] The worst the employer faces by terminating or reducing the value of retiree health benefits is the possibility of a lawsuit, which the employer is likely to win.[52]

Meanwhile, the cost of retiree health benefits weights the scale against their maintenance. One study concluded that the cost of providing employment-based health benefits to retirees in 2010 would increase six percent for pre-sixty-five retirees and four percent for Medicare-eligible retirees, matching prior years' increases.[53] That translates to a per-person cost of $7,596 per early retiree and $3,840 for the Medicare-eligible retiree, as compared to $5,184 per active employee for single coverage.[54] Even though employers have largely dealt with this problem by shifting costs to retirees,[55] 10% of large employers

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[51] *See, e.g.*, I.R.C. § 4980H (imposing penalties on employers who fail to satisfy certain health insurance requirements, but only with regard to "full-time employees" and not retirees).

[52] *See, e.g.*, Richard L. Kaplan, Nicholas J. Powers & Jordan Zucker, *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 YALE J. HEALTH POL'Y L. & ETHICS 287, 305 (2009). Arguably, an employer might also attract unwelcome negative publicity. *See, e.g.*, David Shepardson, *Supplier Retirees to Get Fed Health Care Help*, DETROIT NEWS, Oct. 20, 2011, at 1A.

[53] Press Release, Towers Watson, Towers Perrin's 2010 Retiree Health Care Cost Survey Shows Continuing Affordability and Access Concerns (Nov. 18, 2009), *available at* http://www.towersperrin.com/tp/showdctmdoc.jsp?url=master_Brand_2/USA/Press_Releases/2009/20091118/2009_11_18.htm.

[54] *Id.* The significantly lower per-person cost for Medicare-eligible retirees reflects the fact that retiree health plans for such individuals provide only supplemental coverage to Medicare, with the federal program picking up the bulk of the expenses. *See, e.g.*, *supra* note 7 and accompanying text.

[55] Retirees today pay much of the cost of their coverage. Only forty-five percent of employers offering retiree health insurance in 2010 still subsidized that coverage for current retirees. Towers Watson, *supra* note 53. The remainder offered access-only insurance. An access-only plan guarantees a retiree the ability to purchase health coverage at group insurance rates, but the covered individual shoulders the entire premium cost. Such plans are far less generous to retirees than active employee coverage because employers usually subsidize much of the premium cost for their workers. In 2010, in large firms that provided health insurance to active employees, the average annual premium cost paid by a worker for single coverage was only $917, but employers paid an average of $4,133 as their share of the premium for that worker's insurance. Kaiser Family Found. & HRET, 2010 ANNUAL SURVEY, *supra* note 5, at 80. In 2006, 17% of large employers offering retiree health benefits charged new early retirees 100% of the premium cost of the coverage. KAISER FAMILY FOUND. & HEWITT ASSOCS., RETIREE HEALTH BENEFITS EXAMINED: FINDINGS FROM THE KAISER/HEWITT 2006 SURVEY ON RETIREE HEALTH BENEFITS 16 (2006), *available at* http://www.kff.org/medicare/upload/7587.pdf [hereinafter RETIREE HEALTH BENEFITS EXAMINED]. Among employers who still pay something, most keep their subsidy relatively low. For example, in 2010 pre-sixty-five retirees paid on average $3,984 for single coverage, more than half the premium cost. Towers Watson, *supra* note 53. In addition, employers have moved other costs to retirees through increased deductibles and co-insurance. For example, in 2006, 34% of large employers reported that they had increased cost-sharing requirements for early retirees, and 24% had done so for Medicare-eligible beneficiaries. RETIREE HEALTH

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surveyed in 2006 predicted that they were "very" or "somewhat" likely to terminate coverage altogether for future retirees, with another 2% predicting that they were "very" or "somewhat" likely to terminate coverage for current retirees.[56] A 2010 survey similarly found that ten percent of companies with existing retiree health plans were "planning to exit, and 20% are seriously considering this option for the future."[57] An early 2011 study reported that almost 60% of surveyed large employers currently offering retiree plans were "rethinking" their programs for 2012 or 2013.[58]

IV. Federal Intervention over the Years

To the extent one believes the federal government should take some responsibility for protecting vulnerable segments of the population, the need for federal intervention to preserve retiree health plans might seem clear in light of the foregoing. That has not always been true. While the enactment of Medicare in 1965 demonstrated the political efficacy of targeting health insurance reform proposals to the elderly,[59] the experience did not translate into sustained Congressional attention to the issue. The Employee Retirement Income Security Act of 1974 (ERISA) when enacted paid only cursory attention to welfare plans in general, focusing instead on protecting retirement income benefits.[60] None of ERISA's participation, vesting, and funding rules, nor the insurance provided by the Pension Benefit Guaranty Corporation, extended to welfare plans.[61] ERISA instead left retirees on their own to craft arguments in the fed-

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Benefits Examined, *supra* at 20–21. Looking forward, 80% of surveyed large employers in 2006 said they were very or somewhat likely to increase retiree premium costs, 40% said they were very or somewhat likely to increase other retiree cost-sharing obligations, and 30% were very or somewhat likely to increase out-of-pocket cost limits. *Id.* at 22. Further, all cost-shifting will increase over time because many companies have imposed caps on the total amount they will contribute toward retiree health insurance. In 2006, 46% of large employers reported that they had placed a cap on expenditures for their early retiree plans, and 50% had done the same for their plans for Medicare-eligible retirees. *Id.* at 13–14. That same year, 60% of large employers also reported that they had already reached the cap for the early retiree plan, and 61% had reached the cap for the Medicare-eligible retiree plan. *Id.* Once expenditures reach the cap amount, all future costs automatically pour over to covered plan participants (i.e., retirees).

[56] *Id.* at 22.

[57] Towers Watson, *supra* note 53.

[58] Towers Watson & Int'l Soc'y of Certified Emp. Benefit Specialists, Redefining Retiree Medical Strategy 5 (2011), *available at* http://www.towerswatson.com/assets/pdf/4634/Towers-Watson-ICEBS-2011.pdf. With regard to early retiree plans specifically, forty-three percent of responding employers planned to revisit their approach in the next three years, with only twenty-five percent anticipating that they will maintain the status quo. *Id.* at 7–8. Towers Watson concluded that, out of surveyed employers with early retiree health plans, "nearly 42% will consider terminating plan sponsorship and encourage pre-Medicare retirees to elect more favorable coverage in the insurance exchanges.' " *Id.*

[59] *See, e.g.*, Theodore R. Marmor, The Politics of Medicare 10–12, 15 (2d ed. 2000).

[60] Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended at 29 U.S.C. §§ 1001–1461) [hereinafter ERISA]. *See generally* James A. Wooten, The Employee Retirement Income Security Act of 1974: A Political History (2004).

[61] *See, e.g.*, 29 U.S.C. §§ 1051 (participation and vesting coverage), 1081 (funding coverage), 1302 (Pension Benefit Guaranty Corporation coverage) (2012).

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eral courts to try to enforce employer health plan commitments, with limited success.[62] At least some of the explanation lies in the fact that ERISA followed the shutdown of the Studebaker-Packard Corporation's South Bend auto manufacturing plant and the failure of its pension plan to meet obligations to covered hourly workers.[63] Retiree health benefits barely registered on the collective federal legislative mind. The late Michael S. Gordon described the situation thus: "Unlike pension plans there was no crisis in health plans in 1974. No one was complaining about the loss of health benefits as they were about pensions."[64]

In the late 1970s and early 1980s, to the extent Congress focused on the health insurance issues of the aged, it concentrated on Medicare's climbing costs. Between 1970 and 1975 alone, federal expenditures for Medicare almost doubled—from approximately $7.1 billion in 1970 to almost $14.8 billion in 1975.[65] By 1980, the federal government's Medicare cost had reached almost $35 billion[66] with predictions that Medicare expenditures could top $61 billion by fiscal year 1984.[67] The early years of the Reagan era thus included a number of reforms intended to reduce long-term spending in federal social welfare programs.[68] At least one of these reforms—the addition of the Medicare Secondary Payer (MSP) provisions[69]—directly affected employer plans even though they were more collateral damage than the intended targets.

The MSP provisions generally prohibit employers that offer health insurance coverage from differentiating between an active employee (and his or her spouse) who is Medicare-eligible and one who is not.[70] In other words, an employer cannot change an active employee's health insurance from primary to supplemental coverage just because that employee becomes eligible for Medicare. Without the MSP rules, an employer would have a clear financial incentive to make exactly such a switch and pay for the employee's health care costs

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[62] *See, e.g.*, Kaplan, Powers & Zucker, *supra* note 52, at 305; William T. Payne, *Lawsuits Challenging Termination or Modification of Retiree Welfare Benefits: A Plaintiff's Perspective*, 10 LAB. LAW. 91, 92 (1994).

[63] *See generally* James A. Wooten, *"The Most Glorious Story of Failure in the Business": The Studebaker-Packard Corporation and the Origins of ERISA*, 49 BUFF. L. REV. 683 (2001).

[64] Michael S. Gordon, *Introduction to the Second Edition: ERISA in the 21st Century*, *in* ABA SECTION OF LABOR & EMPLOYMENT LAW, EMPLOYEE BENEFITS LAW lxiii, lxviii (Steven J. Sacher et al. eds., 2d ed. 2000).

[65] Alfred M. Skolnik & Sophie R. Dales, *Social Welfare Expenditures, 1950–75*, 39 SOC. SECURITY BULL. 3, 7 (1976).

[66] Ann Kallman Bixby, *Social Welfare Expenditures, Fiscal Year 1980*, 46 SOC. SECURITY BULL. 9, 10 (1983).

[67] *See* U.S. CONG., CONG. BUDGET OFFICE, AN ANALYSIS OF PRESIDENT REAGAN'S BUDGET REVISIONS FOR FISCAL YEAR 1982, at 41 (1981), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/101xx/doc10188/81doc11b.pdf.

[68] *See, e.g.*, Robert Pear, *Hospitals Worry over Fixed Rate Set for Medicare*, N.Y. TIMES, Aug. 23, 1983, at A1. *See also* Lynn Etheredge, *Reagan, Congress, and Health Spending*, 2 HEALTH AFF. 14, 15 (1983).

[69] *See* Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 953, 94 Stat. 2599, 2611 (codified as amended in scattered sections of 5, 26, 42 U.S.C.); Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 116, 96 Stat. 324, 353 (codified as amended in scatted sections of I.R.C.).

[70] 42 U.S.C. § 1395y(b)(1)(A)(i) (2012).

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only to the extent those costs exceed what Medicare covers. According to the Centers for Medicare & Medicaid Services (CMS), which administers Medicare, "[t]he purpose was to shift costs from the Medicare program to private sources of payment."[71] While this purpose may have been desirable from a Medicare program perspective, the MSP rules inevitably burdened employers who could no longer piggyback coverage for the working aged on Medicare. Whether this affected retiree plans over time is hard to know. At least in the mid-to-late 1980s, Medicare-eligible retirees with employment-based supplemental coverage generally enjoyed an insurance package comparable to that of active employees.[72] In such circumstances, the MSP rules should be irrelevant to an individual evaluating continued active employment vs. retirement. Looking solely at health insurance costs, an employer logically should prefer an individual to retire and drop down to employment-based Medicare supplemental coverage, allowing Medicare to pick up the bulk of health care costs. The Age Discrimination in Employment Act of 1967 (ADEA) would prohibit an employer's taking any direct action to push such retirement due to an individual's age, however.[73] The MSP rules in their infancy therefore should have had little or no impact on retiree health plans. Today, as employment-based retiree medical benefits have become less generous and reliable,[74] the MSP rules might prompt a wise individual to push off retirement as long as possible, potentially reducing the need for retiree plans.[75]

Whatever the indirect MSP rule effect, direct Congressional intervention in employment-based retiree health insurance did not begin in earnest until the mid-1980s, and then only in limited circumstances. This was not necessarily a matter of negligence or oversight. Although employers had been litigating their terminations of retiree health benefits for at least a decade,[76] the risk to retirees

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[71] CMS, MEDICARE SECONDARY PAYER (MSP) MANUAL § 10 (2012), *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c01.pdf. *See also* Robert L. Roth, *The Medicare Secondary Payer Program: New and Continuing Issues*, *in* HEALTH AND WELFARE BENEFIT PLANS—THE WAVE OF THE FUTURE IS NOW: WHAT TO DO TODAY AND HOW TO PLAN FOR TOMORROW 1, 1–3 (ABA Center for Continuing Legal Education ed., 1998) (ABA CLE course materials—N98HWBB ABA-LGLED G-1) ("Congress sought to use the MSP provisions to reduce the growth of Medicare by shifting primary payment responsibility to employer plans 'to place the burden where it could best be absorbed.' " (citing Provident Life & Accident Ins. Co. v. United States, 740 F. Supp. 492, 498 (E.D. Tenn. 1990)).

[72] *See* Michael A. Morrisey, Gail A. Jensen & Stephen E. Henderlite, *Employer-Sponsored Health Insurance for Retired Americans*, 9 HEALTH AFF. 57, 57, 59 (1990) (discussing how retirees with employment-based health insurance were instrumental in calling for the successful repeal of the Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, and providing a useful description of the state of retiree health insurance coverage in the 1980s).

[73] ADEA, *supra* note 50.

[74] *See, e.g.*, *supra* notes 53–58 and accompanying text.

[75] *Cf.* Gopi Shah Goda, John B. Shoven & Sita Nataraj Slavov, *A Tax on Work for the Elderly: Medicare as a Secondary Payer* 1–2 (Nat'l Bureau of Econ. Research, Working Paper No. 13383, 2007), *available at* http://www.nber.org/papers/w13383.pdf (arguing that the MSP rules in effect created an additional tax for older workers).

[76] *See, e.g.*, Frank H. Stewart & Jeffrey B. Kelly, *Insurance Premiums for Retirees After the Union Contract Expires*, 44 OHIO ST. L.J. 521, 522–23 (1983).

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did not engage the national consciousness until the mid-1980s.[77] Indeed, as late as 1990, one group of scholars evaluating retiree health benefit data from 1988 and earlier years concluded that "it appears that an increasing number of retirees will have employer-sponsored coverage" and moreover that the data "suggests good days ahead for retirees . . . ."[78] Time has proved such predictions wrong,[79] but their cautious optimism highlights how quickly retiree health plan fortunes fell.

Any history of federal efforts to preserve and protect retiree health benefits thus deals with an inherently brief period of time, and this Article focuses only on understanding the federal actions of the past twenty-five or so years. Although they could be described chronologically, the various statutory and administrative efforts are perhaps best evaluated when sorted into a limited number of categories. The following sections thus loosely group federal interventions into employer-sponsored retiree health plans into one of three types: participant-oriented protection, mandatory funding, and employer accommodation/incentives. As is always the case with any classification system, one might argue that any particular act fits into more than one group, but the sorting that follows reflects a perception as to the dominant goal of the particular federal endeavor. The following sections also attempt to provide some sense as to whether the federal intervention at issue succeeded in achieving its purpose.

A. *Participant-Oriented Protection*

In fairness, on a macro level, any federal effort that targets retiree health benefits could be characterized as protective of participants because all such efforts directly or indirectly attempt to preserve and protect the availability of existing plans for retirees. I have classified the actions described in this section as primarily "participant-oriented" and "protective" because they all seem to focus on the participant with relatively little consideration of other factors. Perhaps not surprisingly, most were enacted in the immediate aftermath of retiree health benefits' own mini-Studebaker[80] crisis: the LTV bankruptcy.

The LTV Corporation filed for Chapter 11 bankruptcy protection on July 17, 1986, citing downturns in its core steel and oil businesses.[81] At the time, LTV operated the second-largest steel company in the United States.[82] In connection with its Chapter 11 filing, the company unilaterally terminated health plan benefits for 78,000 of its retirees, triggering a strike and widespread out-

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[77] *See, e.g.*, Milt Freudenheim, *Company Expenses for Retirees Soar*, N.Y. TIMES, Sept. 9, 1985, at A1.

[78] Morrisey, Jensen & Henderlite, *supra* note 72, at 71. The authors cautioned, however, that both legal and accounting developments on the horizon could alter the rosy future predicted by their data. *Id.*

[79] *See* Kaiser Family Found. & HRET, 2010 ANNUAL SURVEY, *supra* note 5, at 163.

[80] For more explanation of the significance of Studebaker in pension plan reform, see *supra* note 63 and accompanying text.

[81] Michael A. Hiltzik, *Debt-Laden LTV Corp. Goes into Bankruptcy: 2nd-Largest U.S. Steel Firm, Hard Hit by Slumps in that Industry and Oil, Seeks Chapter 11 Help*, L.A. TIMES, July 18, 1986, at 1; *see also* Thomas C. Hayes, *LTV Corp. Files for Bankruptcy; Debt Is $4 Billion*, N.Y. TIMES, July 18, 1986, at A1.

[82] Hiltzik, *supra* note 81, at 1.

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cry.[83] The U.S. bankruptcy court quickly approved resumption of the benefits,[84] but the initial LTV benefit termination shocked Congress into action.[85]

LTV filed for bankruptcy protection barely three months after President Ronald Reagan signed COBRA into effect in 1986.[86] At the time, the statute's health plan continuation coverage rules received relatively little attention.[87] Generally, when COBRA applies,[88] it requires an employer group health plan to extend insurance coverage to an individual who would otherwise lose that coverage,[89] provided the individual elects such coverage[90] and makes premium payments[91] in a timely manner. COBRA applies only to a "qualified beneficiary"[92] who loses health insurance coverage under the employer's plan due to a "qualifying event."[93] A qualified beneficiary must make the COBRA election within a specified period—at least sixty days—after he or she loses coverage due to the qualifying event.[94] Even then, COBRA continuation coverage is not unlimited. For most individuals who elect COBRA for themselves and their dependents following a termination of employment, COBRA provides a maximum of only eighteen months of continued coverage.[95]

As originally enacted, COBRA did not target retiree health plans although then and now an astute older employee considering retirement could time his or her termination of employment to take advantage of COBRA's eighteen-month

[83] *See, e.g.*, Steven Greenhouse, *Retired LTV Steelworkers Battle to Avert Loss of Health Benefits*, N.Y. Times, Aug. 25, 1986, at A15.

[84] *See* Steven Greenhouse, *Health Plans Are Feeling a Little Peaked*, N.Y. Times, Aug. 24, 1986, at E5.

[85] *See, e.g.*, *Oversight on the LTV Corporation Filing for Bankruptcy under Chapter 11 of the Federal Bankruptcy Code: Hearing Before the S. Comm. on the Judiciary*, 99th Cong. 1–2 (1986) (statement of Sen. Howard M. Metzenbaum).

[86] *See* COBRA, *supra* note 18.

[87] New York Times personal finance columnist Deborah Rankin, writing a month after COBRA became law, characterized the continuation coverage rules as "[a] little-noticed provision of the new budget reconciliation act." Deborah Rankin, *Hanging on to Your Health Insurance*, N.Y. Times, May 11, 1986, at F11.

[88] COBRA does not apply to an employer that "normally employ[s] fewer than 20 employees on a typical business day during the preceding calendar year." 29 U.S.C. § 1161(b) (2012).

[89] *Id.* §§ 1161–67. For a useful layperson-oriented guide to COBRA, see U.S. Dep't of Labor, Emp. Benefits Sec. Admin., An Employee's Guide to Health Benefits Under COBRA (2010), *available at* http://www.dol.gov/ebsa/pdf/cobraemployee.pdf.

[90] 29 U.S.C. § 1165.

[91] *Id.* § 1162(2)(C) (allowing a plan to terminate COBRA coverage if a covered individual fails to make required premium payments in a timely manner); *id.* § 1162(3) (allowing a plan to charge up to 102% of the full cost of the coverage).

[92] A "qualified beneficiary" for COBRA purposes means both a "covered employee" who loses coverage due to termination of employment (other than for gross misconduct) or reduction of hours and such a covered employee's spouse and/or dependent children if they obtain health coverage under the employer plan through the employee. *Id.* § 1167(3).

[93] In most cases, the "qualifying event" that triggers COBRA obligations is loss of health insurance coverage due to the covered employee's termination of employment for whatever reason (other than gross misconduct), but certain other situations—for example, a covered employee's death, divorce, or eligibility for Medicare—may also count as qualifying events if they result in a qualified beneficiary's loss of coverage under the employer plan. *Id.* § 1163.

[94] *Id.* § 1165.

[95] *Id.* § 1162(2)(A)(i).

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continuation coverage protection and use it to bridge to Medicare at age sixty-five. Setting aside such planning, however, once a covered employee leaves active employment and moves into an employer-sponsored retiree health plan, nothing in COBRA requires an employer to maintain that retiree plan. In fact, the original definition of a "qualifying event" that activates COBRA did not include any termination or reduction of retiree benefits.[96] Only after the LTV bankruptcy filing and related retiree health benefit losses did Congress turn to COBRA as a mechanism to protect retirees against a repeat of an LTV-type debacle.

The Omnibus Budget Reconciliation Act of 1986[97] (OBRA) retroactively amended COBRA to extend its reach to retirees who lose benefits in connection with their former employers seeking Chapter 11 bankruptcy protection.[98] OBRA added to the list of COBRA qualifying events a loss—or "substantial elimination"—of coverage for a retiree (or covered spouse, widow, or dependent)[99] within one year before or after an employer's Chapter 11 bankruptcy filing.[100] The protection applies only with regard to an employer "from whose employment the covered employee retired" and only if that employer begins bankruptcy proceedings on or after July 1, 1986,[101] a date that easily covered the LTV filing in mid-July 1986.

Congress continued its efforts with several measures intended to force LTV (and any similarly situated plan sponsors) to maintain retiree health benefits on a temporary basis.[102] Within two years, still focused on the plight of LTV retirees,[103] Congress permanently strengthened protection for retirees of bankrupt employers with the Retiree Benefits Bankruptcy Protection Act of

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[96] COBRA, *supra* note 18, 100 Stat. at 224–25.

[97] Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, 100 Stat. 1874 (codified as amended in scattered sections of U.S.C.) [hereinafter OBRA].

[98] As amended by OBRA, COBRA includes as a "qualifying event," the occurrence of which triggers the continuation coverage requirement, the loss of employment-based health insurance—or "substantial elimination" in such coverage—as a result of Chapter 11 bankruptcy proceedings for an employer from whom the covered employee retired. 29 U.S.C. § 1163. A "qualified beneficiary" entitled to elect continuation coverage under such circumstances is defined to include a covered employee who had retired on or before the date of the substantial elimination in coverage and such individual's covered dependents. *Id.* § 1167(3)(C).

[99] *Id.* § 1167(3)(C).

[100] *Id.* § 1163.

[101] *Id.*

[102] *See* D. Ward Kallstrom, *Employee Welfare Benefits in Bankruptcy*, *in* 1 Employee Welfare Benefit Plans 523, 531–32 (Practising Law Inst. (PLI), Tax Law and Estate Planning Series, No. 291, 1989) (explaining that the Continuing Appropriations Resolution, Pub. L. No. 99-591, 100 Stat. 3341 (1986), as amended by Pub. L. No. 100-41, 101 Stat. 309 (1987) and Pub. L. No. 100-99, 101 Stat. 716 (1987) required LTV—and any other company already in or filing for bankruptcy protection after October 2, 1986—to maintain retiree health benefits through October 15, 1987)).

[103] *See* S. Rep. No. 100-119, at 1 (1987), *reprinted in* 1988 U.S.C.C.A.N. 683, 683–84 ("The LTV action prompted a congressional examination of how the Bankruptcy Code affected the obligations of a reorganizing company to provide insurance benefits to its retirees.").

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1988 (RBBPA).[104] The RBBPA focuses on "medical, surgical, or hospital care benefits [payable] in the event of sickness, accident, disability, or death"[105] for retirees and their dependents, but only in the case of plans established or maintained by an organization prior to its filing for Chapter 11 bankruptcy protection.[106] Although the RBBPA does not prohibit modification or termination of retiree health benefits,[107] it imposes a process for such changes that precludes unilateral action by the employer.[108] Among other requirements, the RBBPA specifies that a proposal for changes must be submitted to

> the authorized representative of the retirees, based on the most complete and reliable information available at the time of such proposal, which provides for those necessary modifications in the retiree benefits that are necessary to permit the reorganization of the debtor and assures that all creditors, the debtor and all of the affected parties are treated fairly and equitably.[109]

Only after such submission—and subsequent negotiation—may proposed changes be filed with the bankruptcy court for approval.[110]

From the OBRA revisions to COBRA through the RBBPA, Congress was clearly motivated by the fear of another LTV. Perhaps because of this, the legislation is myopic in that it focuses only on the concerns of retirees whose former employer files for bankruptcy. The concerns of other retirees are ignored. It is possible, of course, that this narrow focus reflects the legislation being a pure reaction to LTV. But other explanations also exist. First, in the mid-to-late 1980s, when these statutes were enacted, employers had not yet begun widespread termination or reduction of retiree health benefits.[111] Indeed, at the time of OBRA, many employers may not have fully appreciated the expenses to come. Before the Financial Accounting Standards Board issued Statement of Financial Accounting Standards No. 106 (better known as FAS 106) in the early 1990s, employers were not required to compute the cost of their future retiree health benefit commitments.[112] Congress may reasonably

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[104] Retiree Benefits Bankruptcy Protection Act of 1988, Pub. L. No. 100-334, 102 Stat. 610 (codified as amended at 11 U.S.C. § 1114) [hereinafter RBBPA].

[105] 11 U.S.C. § 1114(a) (2012).

[106] *Id.*

[107] By contrast, ERISA strictly limits the circumstances in which a defined benefit pension plan may be terminated. *See, e.g.*, 29 U.S.C. § 1341(a)(1) (providing the "exclusive means of plan termination" for defined benefit pension plans). ERISA also prohibits reduction of accrued retirement benefits. *See id.* § 1054(b)(1)(G).

[108] *See, e.g.*, 11 U.S.C. § 1114(f)(1).

[109] *Id.*

[110] *Id.* § 1114(g). At the time, at least some commentators interpreted the legislative history as allowing courts to approve modification of retiree health benefits only if necessary to avoid liquidation of the employer. *See, e.g.*, Michael A. Lawson, *Employee Benefits and Reorganization Under Chapter 11: Is Shareholder Value Being Eroded?*, *in* 18TH ANNUAL EMPLOYEE BENEFITS INSTITUTE 165, 180 (PLI, Tax Law and Estate Planning Series, No. 280, 1988).

[111] *See supra* note 13.

[112] Statement of Financial Accounting Standards No. 106 (Employers' Accounting for Postretirement Benefits Other Than Pensions) was issued in final form in December 1990, effective generally for fiscal years beginning after December 15, 1992. *See* FIN. ACCOUNTING STANDARDS BD., STATEMENT OF FINANCIAL ACCOUNTING STANDARDS NO. 106, at 9 (1990), *available at* http://www.fasb.org/pdf/fas106.pdf. FAS 106 requires generally that post-retirement benefit obligations, including welfare benefits such as health plan benefits, be recog-

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have perceived the problem as primarily one in the bankruptcy arena. In addition, unions retained a fair amount of political power in the mid-1980s.[113] Given the degree to which the statutes of the late 1980s apply primarily to unionized workers, they may reflect union influence.[114]

Whatever their instigation, the statutes may have indirectly prompted undesirable employer actions.[115] Thus, for example, one critic opined that "the

nized for accounting purposes at the time the obligation is accrued (i.e., when an employee performs services) instead of on a pay-as-you-go basis. *Id.* at 5. When FAS 106 first took effect, the impact on large corporations was stunning. By some estimates, the accrued costs were expected to "end up totaling 4 or 5 times more than the number generated under a pay-as-you-go system." Craig Douglas Hampton, *Retiree Health Benefits and COBRA Issues*, *in* PLANNING FOR AGING OR INCAPACITY 1994: LEGAL AND FINANCIAL ISSUES 525, 530 (PLI, Tax Law and Estate Planning Series, No. D-231, 1994) (citing *Health Insurance Options: Health Insurance Costs of Large Corporations: Hearing Before the Subcomm. of the H. Health, Ways and Means Comm.*, 102d Cong. (1991) (statement of Gregory J. McDonald, Assoc. Dir. for Income Sec. Issues, Gen. Accounting Office)).

[113] In 1983, 20.1% of the U.S. workforce—public and private sector—belonged to a union; by 2010, only 11.9% of the overall workforce was unionized. Press Release, U.S. Dep't of Labor, Bureau of Labor Statistics, Union Members—2010 (Jan. 21, 2011), *available at* http://www.bls.gov/news.release/archives/union2_01212011.pdf. Similarly, in 1985, 14.3% of private sector workers were unionized as compared to only 6.9% in 2010. U.S. CENSUS BUREAU, *supra* note 35, at tbl.666. Given the decline in union membership in recent decades, one might overlook the role of unions in today's retiree health plan issues. *See id.* Unions, however, were critical in the expansion of employment-based retiree health insurance and remain a key stakeholder. *See, e.g.*, G. Lawrence Atkins, *The Employer Role in Financing Health Care for Retirees*, *in* 5 PROVIDING HEALTH CARE BENEFITS IN RETIREMENT 100, 108 (Judith F. Mazo et al. eds., 1994) (observing that employment-based retiree health insurance "was a benefit that emerged, largely without design or intent, through the collective bargaining over benefits in the 1950s and 1960s" and that "[m]edical benefits were often viewed by employers as a 'throwaway' in collective bargaining, because the cost was such a small portion of total compensation"). Today, the presence of at least some collectively bargained employees in a workforce increases the chance that the employer will provide some type of retiree health plan. For example, in 2011, forty-four percent of large employers offering retiree health benefits reported that their workforce was partially unionized. *See* Kaiser Family Found. & HRET, 2011 ANNUAL SURVEY, *supra* note 13, at 163.

[114] It is worth noting in this context that the RBBPA model is clearly best suited for a collectively bargained setting. The RBBPA forces an employer to disclose and negotiate with retiree representatives before modifying or terminating retiree health benefits. *See supra* notes 107–110 and accompanying text. For retirees whose benefits were negotiated pursuant to a collective bargaining agreement, the appropriate representative is naturally the union (unless it declines). 11 U.S.C. § 1114(c). For non-unionized retirees, the statute authorizes appointment of a "committee of retired employees" named by the bankruptcy trustee. *Id.* § 1114(d). As a general matter, a union is far more likely to have the resources and structure to be able to evaluate and negotiate an employer proposal than any stand-alone committee of "retired employees."

[115] *See, e.g.*, Shirley A. Coffey, Note, *One Bankruptcy is Enough, 78,000 Is Too Many—Protection of Retirement Benefits Under the Retiree Benefits Bankruptcy Protection Act of 1988*, 61 U. CIN. L. REV. 715, 716–17 (1992) (pointing to the unanticipated negative impact of the RBBPA on benefit trusts established to fund retiree healthcare for mine and coal workers). *See also* Leslie T. Gladstone, *Retiree Benefits Bankruptcy Protection Act of 1988: Welfare Benefits in Need of Reform*, 65 AM. BANKR. L.J. 427, 427 (1991) (arguing that the RBBPA not only "departs from nonbankruptcy law by disregarding the importance of contractual enforcement" but also "departs from bankruptcy law in preferring one special interest above all others, and thus it undermines the policies of reorganization"). A bankruptcy court judge observed that "Section 1114 . . . 'has spawned diverse and sometimes inconsis-

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impact of Section 1114 [the core RBBPA requirement] may be to cause creditors to seek liquidation rather than reorganization,"[116] a result that would undercut the value to retirees, who lose altogether if their former employer ceases operation.[117] A number of court cases during the 1990s convinced most practitioners that the RBBPA did not limit employers' ability to terminate or modify retiree health benefits as long as those employers had otherwise reserved the right to make such unilateral terminations or modifications.[118] This conclusion has come under review recently,[119] but the fact remains that the RBBPA seems to have had little effect in limiting retiree health plan reductions.[120] Professor Daniel Keating thus displayed considerable prescience when he observed, shortly after the RBBPA's passage, that the statute "does little to increase the likelihood that retirees will receive their promised health and life insurance benefits."[121]

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tent interpretations and theories as to the substantive and procedural standards necessary for modification of retiree benefits. Expressed colloquially, these interpretations are all over the lot.' " Susan J. Stabile, *Protecting Retiree Medical Benefits in Bankruptcy: The Scope of Section 1114 of the Bankruptcy Code*, 14 CARDOZO L. REV. 1911, 1913 (1993) (citing *In re* Ionosphere Clubs, Inc., 134 B.R. 515, 517 (Bankr. S.D.N.Y. 1991)).

[116] Karen E. Wagner, *Employee Benefit Claims in Bankruptcy*, *in* EMPLOYEE BENEFITS LITIGATION 329, 353 (1993) (ALI-ABA CLE course materials—C793).

[117] Some have attributed the growth in asset sales during the 1990s to employer efforts to evade the restrictions of the RBBPA. *See, e.g.*, *Protecting Employees and Retirees in Business Bankruptcies Act of 2007*, 27 AM. BANKR. INST. J., July/Aug. 2008, at 10 (quoting Babette Ceccotti's testimony before the U.S. House Judiciary Subcommittee claiming that "[d]ebtors are taking aim at retiree health costs notwithstanding § 1114, in many instances by trying to evade the statutory requirements altogether. Asset sales in bankruptcy have become pitched battles where buyers pick up distressed assets and leave employees and benefits behind."). *See also* Daniel Keating, *Automobile Bankruptcies, Retiree Benefits, and the Futility of Springing Priorities in Chapter 11 Reorganizations*, 96 IOWA L. REV. 261, 264 (2010) (arguing that the "asset-sale development is a natural consequence of the Bankruptcy Code being weighed down by the significant springing-priority status of retiree medical benefits.").

[118] *See, e.g.*, Susan P. Serota, *ERISA Litigation Update*, *in* PENSION, PROFIT-SHARING, AND OTHER DEFERRED COMPENSATION PLANS 459, 468 (1992) (ALI-ABA CLE course materials—C725) (citing a Second Circuit opinion, *In re Chateaugay*, 945 F.2d 1205 (2d Cir. 1991), where the court held that the RBBPA "applies only where the debtor has a contractual obligation to provide retiree benefits," and a bankruptcy court decision, *In re Doskocil Cos.*, 130 B.R. 870 (Bankr. D. Kan. 1991), finding that the RBBPA "did not bar the debtor from unilaterally modifying the terms of its retiree health plan where the terms of the plan expressly reserved to the company the right to modify, amend or terminate the plan"). *See also* Ralph Brubaker, *Postpetition Modification of At-Will Retiree Benefits in Chapter 11: An Irreconcilable Clash of Legislative Policy Prerogative*, 30 BANKR. L. LETTER, Dec. 2010, at 1 (noting that "[m]ost courts . . . have concluded that those provisions [the RBBPA and related provisions] do not restrict a Chapter 11 debtor's ability to freely modify or terminate retiree benefit payments under a benefit plan that permits such modification or termination by its terms").

[119] In 2010, the Third Circuit issued a ruling that requires employers to follow the procedural process laid out in Section 1114 even with regard to benefits otherwise terminable at will by employers. *In re* Visteon Corp., 612 F.3d 210 (2010) (discussed at length in Brubaker, *supra* note 118, at 1–4).

[120] *See supra* note 13.

[121] Dan Keating, *Good Intentions, Bad Economics: Retiree Insurance Benefits in Bankruptcy*, 43 VAND. L. REV. 161, 163 (1990) [hereinafter Keating, *Good Intentions*]. Professor Keating continued to critique the RBBPA a few years later with the observation that "this

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On the other hand, another early commentator—looking at the OBRA revisions of COBRA—called that legislation "a very modest, but nevertheless potentially significant, legislative first step toward rectifying the incongruity and injustice of leaving the continuance of retired workers' health insurance benefits to the unbridled discretion of the employer."[122] Early on, another scholar saw potential in the RBBPA for "prevent[ing] a debtor from ever terminating or modifying any retiree medical benefits during a Chapter 11 case other than in accordance with the procedures set forth therein."[123]

Overall, while the flaws and limitations of OBRA and the RBBPA are clear, they nonetheless take an inherently protective stance toward affected plan participants. And they do so by concentrating on rights for retirees. In the case of OBRA, those are rights to elect COBRA continuation coverage, a protection otherwise unavailable for those who lose benefits under a retiree medical plan.[124] In the case of the RBBPA, those rights come in the form of giving retirees a voice in bankruptcy proceedings.[125] While Congress surely could have been more aggressive, these steps were better than nothing. They mark the start of more than two decades of Congressional efforts to preserve retiree health benefits on some level. At the time, they may also have been all that was possible. In 1987, Reps. Ronnie Flippo and Rod Chandler introduced the Retiree Health Protection Act of 1987 in the U.S. House of Representatives, referencing the "LTV Corp.'s attempt to abandon its retiree health benefit obligations" as "the first signs of the storm to come."[126] The proposed statute would have encouraged pre-funding of retiree health benefits.[127] It failed.[128]

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legislative solution may amount to sound and fury signifying little." Daniel Keating, *Bankruptcy Code § 1114: Congress' Empty Response to the Retiree Plight*, 67 AM. BANKR. L.J. 17, 18 (1993). Two decades later, he returned to the attack. *See* Keating, *supra* note 117, at 264–65 (characterizing the RBBPA as "a classic example of an ill-advised springing priority which is not particularly effective" and pointing to the Chrysler and GM bankruptcy cases as examples where "it was the nonbankruptcy leverage of the retirees rather than the bankruptcy-specific priority of section 1114 that ended up giving the retirees medical benefits. And what medical benefits the retirees did receive were still much less than what the two auto companies originally promised them.").

[122] David L. Gregory, *COBRA: Congress Provides Partial Protection Against Employer Termination of Retiree Health Insurance*, 24 SAN DIEGO L. REV. 77, 80 (1987).

[123] Stabile, *supra* note 115, at 1913–14.

[124] *See supra* notes 97–101 and accompanying text.

[125] *See supra* notes 103–10 and accompanying text.

[126] 133 CONG. REC. E2719 (daily ed. July 1, 1987) (statement of Rep. Ronnie G. Flippo).

[127] *See* H.R. 2860, 100th Cong. (1987).

[128] *See id.* The Internal Revenue Code (Code) makes pre-funding of retiree health benefits difficult, if not impossible, for most non-unionized employers. *See, e.g.*, David S. Dunkle, *VEBAs and Other Welfare Benefit Funding Arrangements*, *in* PORTFOLIO NO. 395-3d, TAX MANAGEMENT PORTFOLIOS, at § III (BNA 2013). Before the passage of the Deficit Reduction Act of 1984, Pub. L. No. 98-369, 98 Stat. 494 (DEFRA), employers could use a type of tax-exempt trust known as a voluntary employees' beneficiary association (VEBA) to accumulate assets for future retiree health plan obligations. Contributions were deductible as "ordinary and necessary" business expenses under Code Section 162. I.R.C. § 162(a) (1982). Congress became concerned that a number of businesses had begun using VEBAs as inappropriate tax shelters. *See, e.g.*, John H. Eggertsen & Michael J. Hainer, *Recent Tax Act Affects Employee Benefit Plans*, NAT'L L.J., Oct. 21, 1985, at 15 ("[C]losely held and professional corporations often used group insurance contracts and VEBAs as investment vehicles to defer compensation for highly compensated employees/shareholders."). To curb the per-

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At least superficially, enacted legislation that favored retiree rights continued into the early 1990s. In 1989, the U.S. Supreme Court ruled in *Public Employees Retirement System of Ohio v. Betts*[129] that the ADEA did not prohibit plan provisions that extended disability income benefits only to employees who terminated employment due to disability before age sixty.[130] The ruling overturned both District Court and Court of Appeals rulings against the Ohio Public Employees Retirement System.[131] Both lower courts had relied on an Equal Employment Opportunity Commission (EEOC) regulatory interpretation of the ADEA that, in relevant part, allowed "age-related reductions in employee benefits" only if "justified by the increased cost of providing those benefits to older employees."[132] The Supreme Court disagreed with the EEOC and rejected the regulatory interpretation.[133]

Congress reacted a year later with the Older Workers Benefit Protection Act of 1990 (OWBPA).[134] The OWBPA expressly overturned the result in *Betts* and clarified that the ADEA was intended "to prohibit discrimination against older workers in all employee benefits except when age-based reductions in employee benefit plans are justified by significant cost considerations."[135] The new statutory language in effect endorsed the regulatory position the EEOC had maintained all along.

On the surface, the OWBPA seems overtly protective of retirees, in some ways a natural extension of the Congressional approach in the 1980s. Practice, however, diverged from this theory. Thanks to the presence of Medicare's

ceived abuses, Congress included deduction limits in DEFRA that effectively eliminated the practice for all but collectively bargained plans. *See* DEFRA § 511(a). As a result of DEFRA, the Code provides that contributions to a "welfare benefit fund" (which includes a VEBA) are deductible under Code Sections 419 and 419A, not under Code Section 162, and then restricts deductions under 419 and 419A. I.R.C. §§ 419, 419A (2012). *See also* Treas. Reg. § 1.162-10T, Q&A (2) (1992). Code Section 419A contains an exception for collectively bargained plans. I.R.C. § 419A(f)(5); Treas. Reg. § 1.419A-2T (1986). Code Section 401(h) also allows for some accumulation of assets for retiree health benefits under a qualified retirement plan, but only if such benefits are "subordinate to" retirement income benefits. I.R.C. § 401(h). So-called 401(h) accounts are rarely used as a result of the restrictions. *See, e.g.*, Robert R. Trumble & Deborah A. Bigdely, *Pensions, Health Care, and Workforce Planning: The Baby Boom Impact*, 20 J. COMPENSATION & BENEFITS, May/June 2004, at 15, 20 (observing that 401(h) account plans "are not used much and are more common in industries where workers tend to stay for long periods of time"). As late as 2006, only about a quarter of larger employers offering retiree health benefits had pre-funded those obligations in any way. *See* KAISER FAMILY FOUND. & HEWITT ASSOCS., *supra* note 55, at 12.

[129] Pub. Emps. Ret. Sys. of Ohio v. Betts, 492 U.S. 158 (1989).

[130] *Id.* at 162. The plaintiff in *Betts* did not qualify for disability income benefits because she was over age sixty; instead she received significantly less generous retirement income benefits, leading to her lawsuit. *Id.* at 163.

[131] *Id.* at 160; *see* Betts v. Hamilton Cnty. Bd. of Mental Retardation, 631 F. Supp. 1198 (S.D. Ohio 1986); *see also* Betts v. Hamilton Cnty. Bd. of Mental Retardation & Developmental Disabilities, 802 F.2d 456 (6th Cir. 1986) (unpublished); *see also* Betts v. Hamilton Cnty. Bd. of Mental Retardation & Developmental Disabilities, 848 F.2d 692 (6th Cir. 1988).

[132] *Betts*, 492 U.S. at 164, 170 (referencing 29 C.F.R. § 1625.10 (1988)).

[133] *Id.* at 175.

[134] Older Workers Benefit Protection Act (OWBPA), Pub. L. No. 101-433, 104 Stat. 978 (1990) (codified as amended at 29 U.S.C. §§ 621–626 (2012)).

[135] *Id.* § 101.

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safety net coverage for those age sixty-five and older, employers can reduce retiree health expenses dramatically by the simple step of subordinating coverage to Medicare for eligible retirees.[136] Thus, while an employer might maintain an early retiree on coverage identical to active employee health insurance, that employer-sponsored insurance might drop to supplemental coverage (or stop altogether) once the retiree attains Medicare eligibility.[137] The individual retiree is not necessarily adversely affected as long as the employer supplemental coverage, when added to Medicare's own coverage, raises the level of insurance in total to approximately the same as what an early retiree enjoys through the employer alone. Because Medicare eligibility could be considered a proxy for an age-based reduction in benefits, and because the employer is not spending the same amount for the older retiree compared to the younger one, the OWBPA would seem to prohibit the practice. The legislative history of the OWBPA,[138] however, indicated that the new law was not intended to attack the Medicare retiree health plan coordination structure that had become pervasive among employers. As a result, notwithstanding the OWBPA, employers continued to coordinate with Medicare throughout the 1990s exactly as they had before.[139]

What might one take away from the five years of Congressional efforts from OBRA through the OWBPA? Given that employer retiree health plan sponsorship plummeted from 66% in 1988 to 46% in 1991 and then down to 36% in 1993,[140] federal intervention in the late 1980s and early 1990s proved stunningly ineffective. Even if one ascribes altruistic participant-oriented protective goals to Congress and ignores other possible explanations for why legislation was structured in certain ways, the degree of failure to protect retirees in these years remains remarkable. It also makes whatever goals Congress may have pursued somewhat irrelevant. Within a very few years, retiree health benefits slid from a standard compensation component to more of a luxury offered by a minority of employers.[141] When one considers the flurry of federal activity

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[136] *See supra* notes 70–75 and accompanying text.

[137] *See, e.g.*, JAMES P. BAKER, JONES DAY, ERISA LITIGATION: THE LAW OF UNINTENDED CONSEQUENCES 2–3 (2005), *available at* http://www.jonesday.com/files/Publication/9410bc12-d6e6-4b34-8636-92f5044c096c/Presentation/PublicationAttachment/79e69d4a-4cb9-44f6-9695-b2d86feb50ea/Law%20of%20Unintended.pdf (noting that, after the OWBPA, "[o]ne thing seemed certain: Employer-provided retiree medical benefits would not be affected because OWBPA's legislative history indicated that the prior employer practices of eliminating, reducing, or altering retiree medical benefits would remain lawful").

[138] *See* Erie Cnty. Retirees Ass'n v. Cnty. of Erie, 220 F.3d 193, 205–208 (3d Cir. 2000) (discussing at length 136 CONG. REC. S13,597–S13,611 (daily ed. Sept. 24, 1990)).

[139] *See* Alan M. Sandals, *Retiree Medical Benefits Litigation—Theories of Recovery and Key Issues*, *in* EMPLOYEE BENEFITS LITIGATION 193, 196 (2011) (ALI-ABA CLE course materials—ST027). The Third Circuit's *Erie County* decision in 2000, discussed below, shook everyone's understanding. *See infra* Part IV.C. For a critique of the OWBPA's impact on employer strategies in general, see Michael C. Harper, *Age-Based Exit Incentives, Coercion, and the Prospective Waiver of ADEA Rights: The Failure of the Older Workers Benefit Protection Act*, 79 VA. L. REV. 1271 (1993).

[140] Kaiser Family Found. & HRET, 2011 ANNUAL SURVEY, *supra* note 13, at 161.

[141] The dramatic decline in retiree health benefits in the early 1990s is usually attributed to the looming implementation date for FAS 106, which became effective for most employers at the end of 1992. *See supra* note 112.

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in the immediate aftermath of LTV's bankruptcy filing and then reflects upon the results, one might question why Congress bothered to do anything at all. At the very least, this history should caution against hope of success with similar participant-oriented legislation in the future.

B. Mandated Funding

A distinctly different approach to the problem of employment-based retiree health insurance can be seen in two statutes separated by more than a decade: the Coal Industry Retiree Health Benefit Act of 1992[142] (Coal Act) and the Postal Accountability and Enhancement Act of 2006 (Postal Act).[143] In both cases, Congress took the unusual step of mandating funding of previously promised retiree health benefits. The Coal Act created something akin to withdrawal liability for multiemployer pension plans,[144] but limited to multiemployer welfare benefit trust funds intended to support health benefits for certain retired coal miners and their dependents.[145] Originally, companies engaged in coal mining had negotiated funding obligations for these funds based on the proportionate amount of coal mined.[146] As time passed, many of the employers ceased mining operations, vitiating any obligation to contribute to the funds for retiree health benefits.[147] Eventually, as the health benefit trusts neared insolvency, Congress passed the Coal Act in an effort to stabilize funding.[148] Among the Coal Act's restructuring rules were provisions that imposed ongoing liability on entities—and their successors—that had previously employed covered miners, without regard to whether those employers had long since left the mining business.[149] The Coal Act did not fare well despite its protective goal. Various court challenges by affected companies ensued, with the U.S. Supreme Court eventually ruling that certain key funding obligations under the Coal Act constituted an unconstitutional taking.[150]

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[142] Coal Industry Retiree Health Benefit Act of 1992, Pub. L. No. 102-486, § 19141, 106 Stat. 2776, 3036 (codified as amended at I.R.C. §§ 9701–22).

[143] Postal Accountability and Enhancement Act, Pub. L. No. 109-435, 120 Stat. 3198 (2006) (codified as amended in scattered sections of 39 U.S.C.).

[144] For a detailed discussion of the complexities of multiemployer pension plan withdrawal liability, see *Multiemployer Plan Withdrawal Liability*, *in* EMPLOYEE BENEFITS LAW, *supra* note 64, at 1235, 1235–1332.

[145] *See* Coal Industry Retiree Health Benefit Act § 19142(a)(2), 106 Stat. at 2776 (finding that "in order to secure the stability of interstate commerce, it is necessary to modify the current private health care benefit plan structure for retirees in the coal industry to identify persons most responsible for plan liabilities in order to stabilize plan funding and allow for the provision of health care benefits to such retirees").

[146] *See generally* U.S. GEN. ACCOUNTING OFFICE (GAO), REP. NO. GAO-02-243, RETIRED COAL MINERS' HEALTH BENEFIT FUNDS: FINANCIAL CHALLENGES CONTINUE (2002) [hereinafter GAO, REP. NO. GAO-02-243] (providing background on the Coal Act and describing the state of the funds in 2001). *See also A Brief History of UMWA Health and Retirement Funds*, UNITED MINE WORKERS AM.(UMWA), http://www.umwa.org/?q=content/brief-history-umwa-health-and-retirement-funds-0 (last visited May 9, 2013).

[147] GAO, REP. NO. GAO-02-243, *supra* note 146, at 1.

[148] *See id.*; I.R.C. § 9702 (2012).

[149] The Coal Act applied to what it calls a "signatory operator," defined as a "person which is or was a signatory to a coal wage agreement" as well as related entities and successors in interest to such entities. I.R.C. § 9701(c).

[150] E. Enters. v. Apfel, 524 U.S. 498, 500 (1998).

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More than a decade later, the Postal Act focused on another struggling business: the nation's mail service. Hobbled with a changing marketplace and expensive employee commitments, the USPS struggled for years, prompting various reform attempts.[151] The Postal Act was one of those attempts.[152] The legislation included a handful of provisions requiring pre-funding of the USPS's retiree health benefit liability through a Postal Service Retiree Health Benefit Fund.[153] In particular, the Postal Act imposed fixed payment requirements on the USPS for each year from 2007 through 2016, with annual required payments ranging from $5.4 billion for 2007 up to $5.8 billion for 2016.[154] The retiree health provisions came in response to revelations that the USPS had been overfunding pension liabilities for its retirees and mounting concern that the USPS's historic pay-as-you-go approach to retiree health expenses would prove inadequate to meet its future obligations.[155]

Mandated funding created its own problems. The USPS lost billions of dollars in 2006, 2007, 2008, and 2009.[156] In 2009, after the Postmaster General warned that the USPS could not pay the scheduled amount as due, Congress reduced the required payment for that year to $1.4 billion from $5.4 billion.[157] Financial problems did not abate.[158] Although the USPS made the $5.5 billion payment due for fiscal year 2010, it subsequently reported that it would "not be able to make the required $5.5 billion prefunding payment for retiree health benefits currently due by November 18, 2011, or the required $5.6 billion prefunding payment for retiree health benefits that is due by September 30, 2012."[159] Congress extended the due date for the fiscal year 2011 $5.5 billion three times in 2011 and eventually pushed the deadline out to August 1, 2012.[160] In late July 2012, the USPS announced that not only would it not

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151 *See, e.g.*, 151 CONG. REC. H6511–12 (2005) (Rep. Burton (Indiana) stating, with regard to a predecessor to the Postal Act in 2005, that "[i]f we do not do something about postal reform, what is going to happen is the costs are going to go through the roof, and instead of this being an agency that deals with the expenses themselves, we are going to be seeing taxpayers footing the bill for additional costs for postal service").

152 For an overview of key provisions of the Postal Act and discussion of ongoing challenges, see KEVIN R. KOSAR, CONG. RESEARCH SERV., R40983, THE POSTAL ACCOUNTABILITY AND ENHANCEMENT ACT: OVERVIEW AND ISSUES FOR CONGRESS (2009), *available at* http://www.fas.org/sgp/crs/misc/R40983.pdf; see also Lauren T. Andrews, Note, *Going Postal: What Can Reform Do for You?*, 2 WM. & MARY BUS. L. REV. 357 (2011).

153 5 U.S.C. § 8909a (2012).

154 *Id.* § 8909a(d)(3)(A).

155 *See, e.g.*, KOSAR, *supra* note 152, at 1–2.

156 *Id.* at 7 (citing USPS, ANNUAL REPORT (Form 10-K) 12 (2009), *available at* http://about.usps.com/who-we-are/financials/10k-reports/fy2009.pdf).

157 Legislative Branch Appropriations Act, 2010, Pub. L. No. 111-68, § 164, 123 Stat. 2023 (2009).

158 *See generally* GAO, REP. NO. GAO-10-455, U.S. POSTAL SERVICE: STRATEGIES AND OPTIONS TO FACILITATE PROGRESS TOWARD FINANCIAL VIABILITY (2010), *available at* http://www.gao.gov/new.items/d10455.pdf.

159 USPS, ANNUAL REPORT (Form 10-K) 6 (2011), *available at* http://about.usps.com/who-we-are/financials/10k-reports/fy2011.pdf.

160 Continuing Appropriations Act, 2012, Pub. L. No. 112-33, § 124, 125 Stat. 363, 366 (2011) (extending funding payment deadline to Oct. 4, 2011); Continuing Appropriations Act, 2012, Pub. L. No. 112-36, § 124, 125 Stat. 386 (2011) (extending funding payment deadline to Nov. 18, 2011); Consolidated and Further Continuing Appropriations Act, 2012,

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make the 2011 payment by the August 2012 extension date, but that it also would not be able to make the 2012 payment due in September 2012.[161] Intense concern continues over the USPS's long-term outlook and ability to meet the payment obligations of the Postal Act's retiree health fund.[162]

The mandated funding approach follows the path Congress chose for defined benefit pension plans in ERISA almost four decades ago.[163] In the case of ERISA, of course, Congress strove to establish a system to avoid the devastation of failed pension plans like that of Studebaker. In the early 1970s, no one seems to have thought retiree health liabilities might need the same protections.[164] Even if someone had thought such protection could be needed, the fear of depressing voluntary employer sponsorship might have sufficed to squelch any action. By the early 1990s, however, the risk for retiree health benefit commitments was clear. Not only had LTV's termination vividly demonstrated how insecure retiree plans had become, but FAS 106 revealed the extent of retiree health promises.[165] In addition, the approach of empowering participants through expanded rights had also proved less than successful.[166] Trying a direct funding mandate may thus have seemed a logical alternative approach. As observed by Professor Keating in the context of the RBBPA:

> Probably the greatest weakness of the new retiree benefits legislation is that it fails to address the real problem behind crises like that in the LTV reorganization: the failure to prefund the corporate promise to provide insurance benefits to retirees. If a company has not set aside assets to cover its promise to retirees, a mere change in the Bankruptcy Code cannot overcome that void.[167]

One might question why Congress limited its funding requirement to only the coal mining trust fund in the early 1990s. The answer may be pure pragmatism. In the early 1990s, under FAS 106's glaring disclosure light and the concomitant termination of almost half the retiree health plans in the country, Congress would not have considered requiring all employers to fund future retiree health plan liabilities. Financial ruin might have followed.[168] Why just

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Pub. L. No. 112-55, div. D, § 101, 125 Stat. 552, 710 (2011) (extending funding payment deadline to Dec. 16, 2011); Consolidated Appropriations Act, 2012, Pub. L. No. 112-74, div. C, tit. 6, § 632, 125 Stat. 786, 928 (2011) (extending funding payment deadline to Aug. 1, 2012).

161 Press Release, USPS, Postal Service Statement on Retiree Health Benefits Payment (July 30, 2012), *available at* http://about.usps.com/news/national-releases/2012/pr12_0730 rhbpayment.htm.

162 *See, e.g.*, KEVIN R. KOSAR, CONG. RESEARCH SERV., R41021, THE U.S. POSTAL SERVICE'S FINANCIAL CONDITION: OVERVIEW AND ISSUES FOR CONGRESS 4–5 (2012), *available at* http://www.fas.org/sgp/crs/misc/R41024.pdf (noting that "the effects of the PAEA's mandatory payments to the Postal Service Health Benefits Fund on the USPS's profitability were considerable. . . . [I]f the USPS did not have to pay into this fund each year, it would have experienced no operating losses until FY2009").

163 *See* 29 U.S.C. §§ 1001, 1081 (ERISA's funding provisions, enacted in 1974).

164 Despite broad statements of intent, "ERISA in fact subjected welfare benefit plans to virtually no substantive regulation other than the reporting and disclosure and fiduciary duty rules." *Regulation of Welfare Plans Generally*, *in* EMPLOYEE BENEFITS LAW, *supra* note 64, at 351, 355.

165 *See* FIN. ACCOUNTING STANDARDS BD., *supra* note 112, at 5.

166 *See supra* notes 124–25 and accompanying text.

167 *See* Keating, *Good Intentions*, *supra* note 121, at 163.

168 *See supra* note 112 and accompanying text.

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the coal mining industry? As with earlier Congressional efforts, the answer may be focused lobbying by affected unions.[169] It may also be that the numbers of affected coal mining retirees—and thus the overall obligation—were relatively small.[170] No matter the reason, the result was a comparable level of failure to the participant-oriented protective efforts of the last half of the 1980s.[171] On some level, requiring proactive funding by the USPS may also reflect the uniqueness of the situation—in the case of the USPS, a stand-alone quasi-public institution—rather than any kind of endorsement of mandated funding as a viable alternative for organizations generally.[172]

C. Employer Accommodation/Incentives

With the failures of both the participant-oriented protective rights approach of the late 1980s and the mandated funding approach, Congress has transitioned from a retiree-focused orientation to an employer-focused perspective. With the passage of the MMA[173] at the end of 2003, Congress tried an incentive—or carrot—approach. The MMA expands Medicare by offering prescription drug coverage through private insurers under a new Part D.[174] Congress, however, also wanted to preserve existing employer-sponsored retiree drug plans.[175] To encourage employers, the MMA provides a direct subsidy to employers who maintain retiree drug plans with coverage determined to be at least actuarially equivalent to "standard prescription drug coverage" under Part D.[176] The subsidy equals twenty-eight percent of a covered individual's "allowable retiree costs" for prescription drugs under the retiree plan—to the extent

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169 *See supra* notes 113–14 and accompanying text.

170 By 1998, only 71,337 individuals were receiving benefits through the coal retiree health trust funds. GAO, REP. NO. B-281186, EMPLOYEE BENEFITS: STATUS OF THE UMWA COMBINED BENEFIT FUND, at 5 (1998), *available at* http://www.gao.gov/products/HEHS-99-7R.

171 *Id.* at 6 (concluding that, even before the Supreme Court struck down part of the funding mechanism in the Coal Act, "the Combined Fund is expected to be insolvent by 2000 and its balance could continue to deteriorate thereafter").

172 Interestingly, in hearings on the Coal Act in 1995, one speaker observed, "I am deeply troubled by the thought that as other employers have difficulty in funding retiree health benefits in the future, public policymakers might turn to the 1992 statute as a model." *Coal Industry Retiree Health Benefit Act of 1992: Hearing Before the H. Subcomm. on Oversight of the Comm. on Ways and Means*, 104th Cong. 4 (1995) (statement of Nancy L. Johnson, Chairperson, Subcomm. on Oversight), *available at* http://www.gpo.gov/fdsys/pkg/CHRG-104hhrg36420/pdf/CHRG-104hhrg36420.pdf.

173 MMA, *supra* note 43.

174 For an excellent and detailed summary of the political process leading to the enactment of the MMA, see Thomas R. Oliver, Philip R. Lee & Helene L. Lipton, *A Political History of Medicare and Prescription Drug Coverage*, 82 MILBANK Q. 283, 318 (2004) (explaining that the MMA's retiree drug subsidy provisions "addressed one of the AARP's principal concerns and earlier estimates (2003) by the Congressional Budget Office that approximately one-quarter of Medicare beneficiaries with current employer-sponsored drug coverage would lose it once the benefit was enacted").

175 Before the MMA created Part D, employment-based retiree health plans constituted the single largest source of prescription drug coverage for retirees. *See, e.g.*, KAISER FAMILY FOUND., FACT SHEET: MEDICARE AND PRESCRIPTION DRUGS (2003) ("Employer-sponsored plans, the leading source of drug coverage for seniors" in 2003).

176 42 U.S.C. § 1395w-132 (2012).

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those costs exceed a threshold and up to an annual maximum.[177] The subsidy is not taxable to the employer, and—until health reform passed in 2010—employers were allowed to disregard any subsidy payments in computing their deduction for retiree drug plan costs.[178]

Although some employers dropped retiree prescription drug coverage in response to the enactment of Part D,[179] the percentage of large employers maintaining retiree health plans actually increased slightly in 2006 (when the MMA took effect) from 2005—up to thirty-four percent from thirty-two percent—before resuming its slow downward slip in 2007.[180] It is impossible to know whether Part D in fact convinced some employers to continue benefits they might otherwise have reduced or terminated, but certainly no dramatic declines occurred in 2006 as had happened in prior years. As a classification matter, the MMA may be categorized as the first of a string of efforts to accommodate and directly incentivize desired employer action.

At virtually the same time that Congress established the MMA's retiree drug subsidy, the EEOC waded into retiree health plan issues with a proposed regulation to clarify that employers could indeed "coordinate" retiree health benefits with Medicare.[181] The regulation was an administrative response[182] to a Third Circuit decision from 2000[183] in which the court held that the ADEA applies when "an employer offers its Medicare-eligible retirees health insurance coverage allegedly inferior to the coverage offered to retired employees not eligible for Medicare."[184] The case arose out of efforts by Erie County, Pennsylvania, to manage its retiree health costs for former county employees by differentiating between retirees who had reached age sixty-five and become Medicare-eligible and early retirees who were not yet Medicare-eligible.[185] The county's plan generally placed Medicare-eligible retirees in a less expensive insurance option—one that the retirees viewed as less desirable.[186] A group of Medicare-eligible retirees argued that the county's approach discriminated against them on the basis of age, a violation of the ADEA unless an exception

[177] *Id.* § 1395w-132(a)(3)(A). For 2012, the threshold was $320, and the maximum was $6,500. *See Cost Threshold and Cost Limit by Plan Year*, CMS: RETIREE DRUG SUBSIDY (Aug. 3, 2012), http://www.rds.cms.hhs.gov/reference_materials/threshold_limit.htm.
[178] *See* I.R.C. § 139A (2012).
[179] KAISER FAMILY FOUND. & HEWITT ASSOCS., *supra* note 55, at 24 (finding that eight percent of surveyed large employers dropped retiree drug coverage in 2006).
[180] Kaiser Family Found. & HRET, 2011 ANNUAL SURVEY, *supra* note 13, at 161 (reporting 32% of large employers sponsoring some form of retiree health benefits in 2007, 29% in 2008, 28% in 2009, and 26% in both 2010 and 2011).
[181] *See* ADEA; Retiree Health Benefits, 68 Fed. Reg. 41,542, 41,542–47 (proposed July 14, 2003) (to be codified at 29 C.F.R. pts. 1625, 1627).
[182] *See* Press Release, EEOC, EEOC Moves to Protect Retiree Health Benefits (Dec. 26, 2007), *available at* http://www.eeoc.gov/eeoc/newsroom/release/12-26-07.cfm (stating that the "EEOC proposed the rule in response to a controversial decision in 2000 by the U.S. Court of Appeals for the Third Circuit in Erie County Retirees Association v. County of Erie" and quoting then-EEOC Vice Chair Leslie E. Silverman as saying, "The Erie County decision would have made most existing retiree health plans unlawful. EEOC's new rule will ensure that employers can continue to offer their retirees much needed health benefits.").
[183] Erie Cnty. Retirees Ass'n v. Cnty. of Erie, 220 F.3d 193 (3d Cir. 2000).
[184] *Id.* at 196.
[185] *Id.* at 196–97.
[186] *Id.* at 197.

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applies. The Third Circuit agreed and remanded the case to the District Court to determine if the county's practice satisfied an ADEA safe harbor that an employer "either must provide equal benefits to older and younger workers, or must incur the same costs on behalf of older and younger workers."[187]

The *Erie County* decision alarmed a range of stakeholders[188] because employers had consistently relied on the common understanding of the OWBPA's legislative history as permitting the coordination practice.[189] Employer outcry then prompted the EEOC in August 2001 to announce that it had "begun a review of its policy concerning the application of the [ADEA] to employer-sponsored retiree health benefit plans."[190] In the process, the EEOC also rescinded its prior policy that "retiree health plans that are reduced or eliminated on the basis of age or Medicare-eligibility violate the ADEA."[191] The review concluded with issuance of the proposed regulation in the summer of 2003.

The EEOC took the position from the beginning that its goal was to develop "a new policy, consistent with the ADEA, that does not discourage employers from providing this valuable benefit."[192] The proposed regulation focused on the decline in retiree health benefits generally and the risk that employers would eliminate or reduce benefits for early retirees, rather than increasing benefits for Medicare-eligible retirees, if the ADEA were interpreted to require equal cost/equal benefit between the two groups.[193] Indeed, the EEOC noted, in the aftermath of the *Erie County* litigation, the Erie County early retirees ended up with a less generous health insurance plan while Medicare-eligible retirees remained at the same level because the county equalized the two groups by reducing the package for early retirees.[194] Rather than accepting this result, the EEOC proposed a new regulatory safe harbor to the ADEA that "permits the practice of coordinating employer-provided retiree health coverage with eligibility for Medicare or a State-sponsored retiree health

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[187] *Id.* at 199 (referencing 29 C.F.R. § 1625.10 (1989)); *see also id.* at 217 (holding "(1) that appellants have established a claim under 29 U.S.C. § 623(a)(1) because they have been treated differently in their 'compensation, terms, conditions, or privileges of employment, because of . . . age' and (2) that the safe harbor provided under 29 U.S.C. § 623(f)(2)(B)(i) is applicable if the County can meet the equal benefit or equal cost standard").

[188] *See, e.g.*, *Access to Adequate Health Insurance: How Does the Equal Employment Opportunity Commission's Recent Rule Affect Retiree Health Benefits: Hearing Before the S. Special Comm. on Aging*, 108th Cong. 8 (2004) (statement of Leslie E. Silverman, EEOC Comm'r), *available at* http://aging.senate.gov/publications/5172004.pdf. Upon remand, the District Court found in favor of the retirees, holding that the County's benefit program did not satisfy the ADEA safe harbor. Erie Cnty. Retirees Ass'n v. Cnty. of Erie, 140 F. Supp. 2d 466, 477 (2001). At approximately the same time, the U.S. Supreme Court denied certiorari with respect to the Third Circuit decision. Erie Cnty. v. Erie Cnty. Retirees Ass'n, 532 U.S. 913 (2001).

[189] *See supra* notes 138–39 and accompanying text.

[190] Press Release, EEOC, EEOC Rescinds Guidance; Will Review Policy on Retiree Health Plans (Aug. 20, 2001), *available at* http://www.eeoc.gov/eeoc/newsroom/release/archive/8-20-01.html.

[191] *Id.*

[192] *Id.*

[193] *See* ADEA; Retiree Health Benefits, 68 Fed. Reg. 41,542 (proposed July 14, 2003) (to be codified at 29 C.F.R. pts. 1625, 1627).

[194] *Id.* at 41,546.

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benefits program."[195] Despite a legal challenge from the AARP,[196] the EEOC regulation became final in the winter of 2007, providing employers with security that they could terminate plans, or otherwise coordinate benefits with Medicare, for Medicare-eligible retirees while preserving more generous benefits for early retirees who were not yet Medicare-eligible.[197]

The most recent federal efforts involving employment-based retiree health plans form small parts of the monumental health reform legislation from 2010.[198] I have argued elsewhere that, while health reform overall may eventually turn out to be a positive development for retirees, the cumulative effect on the continuation of employer-sponsored retiree health plans is likely negative.[199] For purposes of this Article, three provisions of PPACA deserve further discussion: the Early Retiree Reinsurance Program (ERRP), a change in tax treatment for the MMA's retiree drug plan subsidies, and an absence of any ongoing mandate for employers to maintain health insurance for retirees.

The ERRP picked up the essence of an idea from the old Clinton Health Savings Act to let the federal government act as a reinsurer for employer-sponsored health plans for early retirees (i.e., those at least age fifty-five but not yet Medicare-eligible).[200] The ERRP, however, was comparatively limited in scope. Funded with only $5 billion and scheduled to end no later than January

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[195] *Id.* at 41,547.

[196] AARP v. EEOC, 383 F. Supp. 2d 705 (E.D. Pa. 2005). The AARP initially won its challenge to the regulation, convincing a district court to issue an injunction against the rule. *Id.* at 712. Subsequently, however, the district court reversed its position based on different grounds. AARP v. EEOC, 390 F. Supp. 2d 437, 441 (E.D. Pa. 2005). The second district court ruling was upheld on appeal by the Third Circuit. AARP v. EEOC, 489 F.3d 558, 561 (3d Cir. 2007). The U.S. Supreme Court denied certiorari on AARP's appeal of the Third Circuit decision. AARP v. EEOC, 552 U.S. 1279 (2008).

[197] ADEA; Retiree Health Benefits, 72 Fed. Reg. 72,938, 72,938–43 (2007).

[198] *See* The Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 25, 26, 29, 42 U.S.C.).

[199] *See generally* Susan E. Cancelosi, *The Bell Is Tolling: Retiree Health Benefits Post-Health Reform*, 19 ELDER L.J. 49 (2011).

[200] The Clinton Administration's proposed health plan contained a provision that would have shifted early retirees age fifty-five to sixty-four to so-called "regional alliances" and required their former employers to pay twenty percent of the premium cost of the coverage if the employers had previously been sponsoring a retiree health plan for the affected individuals. *See* Health Security Act, H.R. 3600, 103d Cong. §§ 1004, 6112, 6114, 6121 (1993). The federal government would have covered the remaining eighty percent of the premium cost, effectively subsidizing an enormous percentage of retiree health insurance costs previously shouldered by employers. The General Accounting Office estimated that the arrangement would reduce employers' accrued retiree health benefit liability by $188 billion over a three-year period. GAO, REP. NO. B-257695, EARLY RETIREE HEALTH: HEALTH SECURITY ACT WOULD SHIFT BILLIONS IN COSTS TO FEDERAL GOVERNMENT 3 (1994), *available at* http://www.gao.gov/assets/90/89756.pdf. The subsidy evaporated with the Clinton plan itself, and the Clinton administration settled for a more incremental legislative approach to health insurance and related issues. *See* David Cutler & Jonathan Gruber, Health Policy in the Clinton Era: Once Bitten, Twice Shy 2–3 (Harvard Ctr. for Bus. and Gov't, June 27–30, 2001) (unpublished manuscript), *available at* http://www.hks.harvard.edu/m-rcbg/Conferences/economic_policy/CUTLER-GRUBER.pdf. Thus, for example, near the end of the decade, the administration floated an extension of COBRA for early retirees who lost coverage for any reason as well as an opening of Medicare to buy-in by involuntary early retirees age fifty-five and older and all those age sixty-two to sixty-four. *See* RICHARD W. JOHNSON, MARILYN MOON & AMY J. DAVIDOFF, KAISER FAMILY FOUND., A MEDICARE BUY-IN FOR

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1, 2014,[201] the ERRP reimbursed employers for eighty percent of costs for an individual plan participant once that person incurred at least $15,000 in medical expenses, with a maximum of $90,000 in expenses taken into account.[202] The ERRP thus would pay potentially up to $60,000 in subsidies per individual per year. The PPACA included virtually no restrictions on which employers could qualify for the ERRP subsidies as long as an employer offered health insurance for early retirees, and large numbers of government employers applied for and received the subsidies.[203] The ERRP's success turned out to be its downfall. By May 6, 2011, CMS, which administers the ERRP, had stopped accepting new applications for reimbursement under the program.[204] By December 9, 2011, CMS reported that $4.5 billion in ERRP funds had been paid out for claims and announced that no reimbursement would be made for claims incurred after December 31, 2011.[205] The ERRP thus lasted less than two years and ended for all practical purposes two full years before its scheduled sunset.

Meanwhile, the other primary provision of the PPACA that directly targets employment-based retiree health benefit takes effect in 2013. Effective for tax years beginning after 2012, health reform ends the double dipping created by the MMA to allow employers to calculate their deduction for retiree drug costs without backing out the value of the federal government subsidy.[206] Eliminating that tax benefit translates to higher taxes for affected employers, making employer-sponsored drug plans for retirees noticeably more expensive. Accounting rules required many large employers to report the impact of the tax change by the end of the first quarter of 2010 when health reform was enacted.[207] Employers reported dramatic numbers almost immediately—for example, AT&T took a $1 billion charge against earnings, and Verizon reported a $970 million charge.[208]

Finally, one last PPACA provision deserves notice—largely because of its absence. While the PPACA creates incentives and penalties to push employers

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THE NEAR-ELDERLY: DESIGN ISSUES AND POTENTIAL EFFECTS ON COVERAGE i, 2 (2002) (providing analysis of different Medicare buy-in proposals).

[201] 42 U.S.C. § 18002(a)(1) (2012); *see also* Early Retiree Reinsurance Program, 75 Fed. Reg. 22,450 (May 5, 2010) (to be codified at 45 C.F.R. pt. 149).

[202] 42 U.S.C. § 18002(c) (adjusting the $15,000 base and $90,000 cap "each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of $1,000) for the year involved").

[203] *See, e.g.*, CMS, EARLY RETIREE REINSURANCE PROGRAM: REIMBURSEMENT UPDATE (June 17, 2011), *available at* http://cciio.cms.gov/resources/files/errp_reimbursement_update_06172011.pdf.

[204] Early Retiree Reinsurance Program, 76 Fed. Reg. 18,766 (Apr. 5, 2011).

[205] CMS, EARLY RETIREE REINSURANCE PROGRAM: REIMBURSEMENT UPDATE 1 (Dec. 9, 2011) [hereinafter CMS, REIMBURSEMENT UPDATE (Dec. 2011)], *available at* http://cciio.cms.gov/resources/files/Files2/12092011/errp_disbursement_12_02_2011_508.pdf.

[206] *See* I.R.C. § 139A(a) (2012), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1407, 124 Stat. 1029 (amending I.R.C. § 139A). *See also supra* note 178 and accompanying text.

[207] *See* FIN. ACCOUNTING STANDARDS BD., *supra* note 112, at 5–6, 12.

[208] Amy Thomson & Olga Kharif, *Verizon Joins AT&T, Caterpillar in Booking Expenses from Health-Care Law*, BLOOMBERG (Apr. 1, 2010, 10:01 PM), http://www.bloomberg.com/news/2010-04-02/verizon-joins-at-t-in-booking-health-care-costs.html.

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to maintain a minimal level of health insurance for their employees,[209] it does nothing whatever to encourage comparable behavior with regard to retirees. The ERRP was always scheduled to end in 2013 at the latest.[210] At the same time, however, a host of new regulations directed at insurers and the implementation of a new controlled marketplace for individual insurance purchases suggest that retirees should have more opportunity beginning in 2014 to purchase individual coverage than has historically been available. Congress's implicit assumption in health reform appears to have been that retiree plans need stabilization only until the new world of individual coverage options come online. Thus, the employer penalty provisions of PPACA target only active employee plans,[211] leaving retiree plans completely to the discretion of employers.

After the participant-oriented focus of the late 1980s and the mandated funding experiments of the Coal Act and the Postal Act, evaluating the latest category of federal intervention is difficult. The participant-focused efforts failed to protect retirees against plan terminations in the late 1980s and early 1990s;[212] mandated funding spawned other problems.[213] How successful the incentive/accommodation approach will be in the long run is hard to know. In the years immediately after introduction of Part D and the retiree drug plan subsidy, the percentage of larger employers offering retiree medical insurance indeed bumped up ever so slightly (in 2006 from 2005), but then settled back down to the slow downward slippage pattern that has existed since the early 1990s.[214] The increase in 2006 may well have reflected a temporary boost from the retiree drug subsidy, but no similar incline appeared for 2010 and 2011 even though ERRP funds were being disbursed in those years. It is, of course, possible that the number of retiree health plans would have plunged in recent years without the incentives, but that is merely supposition.

The downside of the incentive approach lies in its cost. Propping up employer plans with subsidies may work because the government assumes much of the financial burden, but paying employers to continue benefits creates at best a limited stopgap. The "success" of the ERRP provides an excellent example.[215] All types of retiree health plan sponsors across the country, from

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[209] I.R.C. § 4980H(a).
[210] 42 U.S.C. § 18002(a)(1).
[211] *See* I.R.C. § 4980H(a).
[212] *See supra* notes 138–39 and accompanying text.
[213] *See supra* notes 148, 154–62 and accompanying text.
[214] *See* Kaiser Family Found. & HRET, 2011 Annual Survey, *supra* note 13, at 161. From 36% in 1993, the number of large employers sponsoring some type of retiree health plan rose to 40% in 1995, 1998, and 1999, before dropping back down to 34% in 2000. Through 2007 the percentage hovered in the low to mid-thirty percentiles until it slipped down to 29% in 2008 and has declined slowly since then. *Id.*
[215] A similar example can be seen with COBRA. Congress did not expand COBRA to require employers to extend COBRA to retirees in the event of benefit reduction or termination outside of bankruptcy, most likely in recognition of the cost. When Congress passed the American Recovery and Reinvestment Act of 2009, the federal government granted a tax credit for a limited time equal to sixty-five percent of employers' premium cost for eligible individuals in an effort to make continuation coverage more widely accessible. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 3001, 123 Stat. 115; *see also* U.S. Dep't of Labor, Fact Sheet: COBRA Premium Reduction (2010), *available at* http://www.dol.gov/ebsa/pdf/fsCOBRApremiumreduction.pdf. One study estimated that

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governments to unions to private employers,[216] applied as quickly as possible for funds. But $5 billion in funding, intended to bridge to 2014, covered barely more than a year and a half of expenses.[217] What will happen now? Was the cost reprieve adequate to permit plans to survive until 2014, or will plans start falling away over the next two years, leaving early retirees without coverage before 2014 and arrival of the PPACA health insurance exchanges? Any time the government starts paying directly to prompt desired behavior, that financial support creates an artificial sense of stability. In the case of the ERRP, Congressional efforts to allocate additional funds failed in the midst of 2011's summer budget crisis.[218] Sooner or later, the MMA retiree drug subsidy—currently without an end date or a financial cap—may taper off also if the economy does not improve. Without government money, programs that employers can no longer afford—which may well include almost all retiree health plans—are likely to end.[219]

The complete absence of long-term incentives in the PPACA to encourage employer maintenance of retiree health plans underscores the lack of collective concern over this benefit's survival. At best, the MMA and the ERRP try to shore up existing plans, but even then not forever. The EEOC has jumped to the employer side to accommodate existing practice rather than nudging it in a different direction. It is as though Congress has acceded to the belief that retiree health benefits cannot be saved for the future. As long as the federal government directly offers money, employers will accept it, and this might prolong life for a while. But that seems to be all anyone at the federal level is willing to do. Could this reflect the decline of union influence, a key historic defender of retiree health plans? Maybe. Could it reflect a more business-oriented shift overall at the federal level over the past two decades? Maybe. Could it reflect a tacit acquiescence to a reality that many have recognized, willing or not? Maybe. As compared to the approaches of the past, could employer accommodation be construed as more successful? That likely depends on how one measures success.

between a quarter and a third of subsidy-eligible workers utilized the COBRA subsidy for continuing health insurance. U.S. TREASURY DEP'T, COBRA INSURANCE COVERAGE SINCE THE RECOVERY ACT: RESULTS FROM NEW SURVEY DATA 1, http://www.treasury.gov/resource-center/economic-policy/Documents/cobra%20final%20report.pdf (last visited May 9, 2013). The cost to the federal government was $3.7 billion. *Tax Benefit Programs*, RECOVERY.GOV, http://www.recovery.gov/Transparency/fundingoverview/Pages/taxbenefits-details.aspx#COBRA (last visited May 9, 2013).

[216] *See, e.g.*, CMS, REIMBURSEMENT UPDATE (Dec. 2011), *supra* note 205.

[217] *See supra* notes 204–05 and accompanying text.

[218] Retiree Health Coverage Protection Act, S. 1088, 112th Cong. 2 (2011), *available at* http://www.gpo.gov/fdsys/pkg/BILLS-112s1088is/pdf/BILLS-112s1088is.pdf (representing a failed effort to allocate an additional $5 billion in funds to the ERRP).

[219] One risk with employment-based health insurance is that plans can continue to exist in name, but shift costs increasingly to participants through higher premiums, deductibles and co-payments. Eventually, such cost-shifting can largely undercut the value of the plan to the participants. *See supra* note 55.

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V. Conclusion

In light of the vulnerability of retirees, federal intervention to ensure access to health insurance has been understandable, but hardly successful. Returning for a moment to the retirees themselves, it is worth remembering that different groups of retirees have differing levels of vulnerability with regard to employer-sponsored health insurance. The choices made by the EEOC with its ADEA regulation and by health reform with its ERRP subsidy reflect an implicit acknowledgement that all retirees are not equally in need. In both situations, the government chose to protect and support early retirees over Medicare-eligible ones. In a world of limited resources, this allocation of resources makes logical sense. After all, Medicare-eligible beneficiaries—unlike early retirees without employer-based coverage—already have some reasonable level of acceptable health insurance. Similarly, the decisions in the PPACA to reduce the value of the retiree drug plan subsidy (through elimination of the tax benefit) and to end the ERRP when individual insurance becomes available reflect a balancing determination. As long as individuals have access to some degree of health insurance, as a nation we seem comfortable that we have met our obligations. Whether those individuals can afford that health insurance, or the out-of-pocket costs the insurance does not cover, apparently troubles us less. The participant-oriented concerns of a few decades ago have ceded to a deferential, supportive focus on employer challenges and desires. That shift cannot be positive for retirees, but its full ramifications will take a few more years to be felt.

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