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Disciplines

Economics

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July 2014

PRC WP2014-19

Pension Research Council Working Paper

Pension Research Council

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The Backdrop: A Long-term Decline in Retiree Health Care Benefits

Employer-provided health benefits have been declining for many years in the United States. In 2010, 17.7% of workers were employed by companies that offered health coverage to early retirees; this figure was 28.9% in 1997. Among state government employers, 70% offered early retiree medical benefits in 2010 versus 94.9% in 2003 (Adams and Fronstin, 2012). Many have argued that the genesis for this downward trend in coverage was the 1990 Financial Accounting Standards Board's issuance of Statement no. 106, *Employer's Accounting for Postretirement Benefits Other Than Pensions*. FAS 106 required employers to account for unfunded future postretirement health care benefits as a liability on their financial statements and to expense costs for future retiree health benefits over an employee's working lifetime. For many companies, FAS 106 had a significant impact. For example, in 1992, the first year in which companies were required to comply with FAS 106, General Motors ("GM") and Ford Motor Company ("Ford") reported a \$20.8 billion and a \$7.5 billion charge, respectively, to account for these liabilities (Moore, 2008). In 2004, the Government Accounting Standards Board (GASB) issued similar requirements for public plans.

Prior to these rulings, private and public employers were only required to expense current-year spending for retiree health benefits. The sudden accounting for significant retiree health care liabilities led many employers to reduce coverage. Additionally, the rapidly rising cost of medical care has made these liabilities and the incentives for reducing them all the more significant. This paper is primarily concerned with the experiences of non-government

employers; however the trends and implications are very similar. The experience of the private sector may serve as a leading indicator of public sector policies.

A Brief Background on VEBAs

As expenses related to retiree health benefits have come to the fore over the past two decades, the VEBA structure became attractive as a tax-exempt savings vehicle and as a compromise solution between employers looking to shed their liability and employees wanting to safeguard their benefits. VEBAs are tax-exempt organizations set up to pay for employee health and welfare benefits; they are typically set up as trusts, but they can also be structured as corporations or associations. A VEBA must be a voluntary association of employees who have a common employment-related bond.

VEBAs were codified under Section 501(c)(9) of the Internal Revenue Code; the structure was initially established in 1928. While traditional, employer-controlled VEBAs have long been used to set aside assets for specific benefit functions, the past ten years have seen the development of the “stand-alone VEBA” model (Moore, 2008). The stand-alone model establishes the VEBA as an independent entity, separating it from the employer and divesting the employer’s future benefit obligations.

That VEBAs have been particularly common among unionized workforces is a result of two factors. First, the requirement of a voluntary association with a common employment bond is easily satisfied by a collective bargaining agreement or membership in a labor union. Second, the tax benefits for union plans are more favorable than those for non-union plans. Non-union VEBAs are limited in the amount of tax-deductible contributions they can make each year; future health costs can be pre-funded, but this funding must be based on current costs, with no

adjustments allowed for inflation or utilization growth. Any contributions above these limits will incur unrelated business income tax to the employer. Union plans have no such funding limits and are not subject to the unrelated business income tax (Borzi, 2009).

Unlike defined benefit pension benefits, U.S. employers are not required to fund post-retirement health benefits in advance. Most do not, opting instead to use a pay-as-you-go structure (O'Brien, 2008). In 2012, funding of other post-retirement benefits (OPEB) across S&P 500 companies was reported to be 22.3%; companies had set aside \$67 billion in assets to meet \$302 billion in reported OPEB obligations. In contrast, the funding ratio for pension plans was 77.3% (Silverblatt, 2013). This lack of funding is partly a result of the difficulty in pre-funding these obligations. There are few tax-advantaged structures which allow non-unionized employers to pre-fund; the VEBA allows for pre-funding but only at current costs and assumptions. While FAS 106 required firms to account for postretirement health care benefits, there is no concurrent requirement to fund these benefits and there are limited structures in place to provide for this funding.

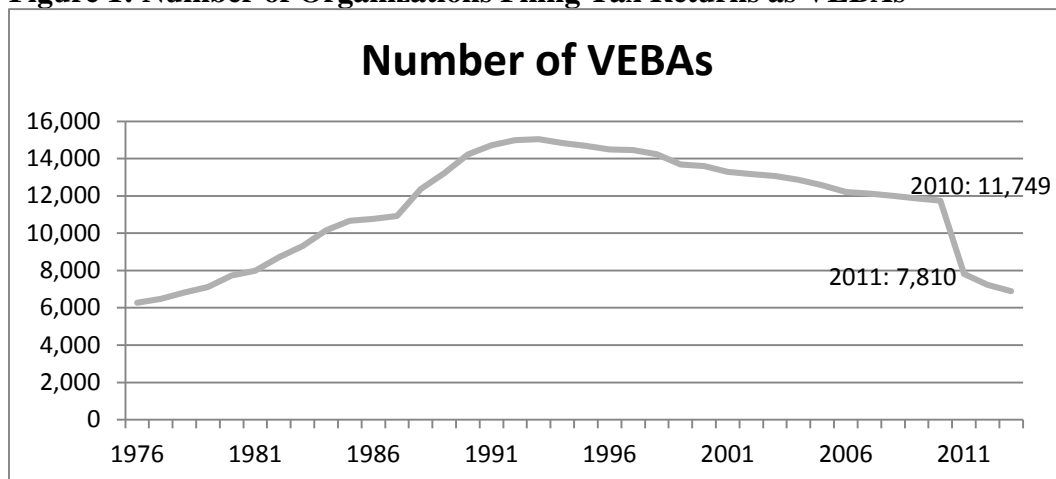
Also unlike pension obligations, retiree health care benefits do not vest to employees under the Employee Retirement Income Security Act of 1974 (ERISA) and are thus less likely to be considered legally-enforceable obligations. Company managements contend that retiree health care is a voluntary benefit offered by the employer and can thus be amended or reversed at any time (Bernstein, 2010). Courts have offered mixed decisions on employers' legal obligations. In practice, courts have been more likely to uphold the benefit obligation if it was made as a result of collective bargaining or if the employer has made statements or taken actions that could be construed as a contractual promise to provide retiree health coverage (Moore, 2008).

These actions could include the establishment of a well-funded retiree health care asset pool such as a VEBA. The nature of the pay-as-you-go structure for employee health benefits and the fact that the obligation is more likely to be viewed as voluntary and amendable on the part of the employer has thus limited the funds set aside for retiree health benefits. While data on the overall funding status of the average VEBA trust is not available, it is assumed that most VEBAs, similar to OPEB obligations as a whole, are significantly underfunded (Cancelosi, 2014). VEBA trusts are irrevocable; companies are also hesitant to move funds from their general asset pool into a VEBA because they lose the optionality to re-allocate those funds should the employer alter benefits or should another business need arise.

Growth and Decline in VEBA Plan Numbers

As shown in Figure 1, in 2013 some 6,884 organizations that filed tax returns as VEBAs with the IRS. The number of VEBAs had peaked earlier, in 1993, with more than 15,000 but this figure declined since then, concurrent with the overall decline of retiree health care benefits. Notably, there was a marked drop-off in the number of VEBAs between 2010 and 2011 (IRS Data Book Table 25, 1991-2013).

Figure 1: Number of Organizations Filing Tax Returns as VEBAs



Source: 1991-2013 data: Internal Revenue Service Data Book; 1976-1990 data: Bernstein, 2010

It seems likely that this sharp decline is directly correlated with the passage of the Affordable Care Act in 2010. Given the ACA provision restricting tax-exempt accounts from paying for exchange premiums or supplemental coverage, many companies may be abandoning their VEBA plans in favor of HSA or defined contribution health care accounts. These restrictions are discussed in more detail below.

The 2007 agreement between the UAW and the Big Three US auto companies that funded an independent VEBA with assets of \$57 billion was a major milestone for retiree health care benefits, as both the automakers and the UAW made concessions in order to broker a deal and protect benefits. Because VEBAs move assets beyond the reach of a firm's creditors, the structure has been popular for firms in financial distress or emerging from bankruptcy restructuring (Borzi, 2009). Most recently, a VEBA plan has been approved for general retirees in the Detroit bankruptcy (Dolan, 2014). Although there is continued growth in stand-alone VEBA plans, the number of traditional plans is declining.

The 2010 passage of the Patient Protection and Affordable Care Act (ACA) is likely to accelerate many employers' exit from providing retiree health coverage. Prior to the ACA, pre-65 aged retirees not yet eligible for Medicare had few good options for affordable health insurance. This has now changed with the establishment of national health insurance exchanges. Employers seeking to reduce or terminate retiree health benefits will be able to direct former employees to the exchanges as a replacement for the foregone benefits. Therefore, there are likely to be fewer employers offering retiree health benefits and, subsequently, a reduced need for VEBAs (Reuther, 2011). Data on the number of VEBA plans seem to offer evidence of this.

Stand-Alone VEBAs

Most VEBAs are set up and maintained by employers, in order to segregate assets that will be used to pay for current employee medical benefits. An employer's contribution is tax-deductible and the VEBA earns tax-free interest. The employer also controls the funding and administration of the VEBA. Traditional VEBAs are likely to cover both retirees and current employees. These VEBAs are typically used to pay for current health care costs; most are not substantially pre-funded due to the restrictions on pre-funding for non-union companies and the irrevocable nature of the trust (O'Brien, 2008).

In addition to these traditional company-run VEBAs, a new model of stand-alone VEBAs has grown in popularity in the last 10 years: the independent entities, separate from employer sponsors. In this latter case, a company typically makes a large one-time contribution to fully or partially fund the VEBA, in exchange for divesting itself of the current and future benefit obligation. The first stand-alone VEBA was formed in the early 1980s; however, the model has become more common during the 2000s (Sibson Consulting, 2008). The establishment of the UAW Retiree Medical Benefits Trust following the UAW's 2007 negotiations with the US automakers was a highly-publicized stand-alone VEBA, and it generated a great deal of interest in this structure. Stand-alone VEBAs typically arise from bankruptcy, class action settlements, or proactive negotiation, often from a company facing financial difficulty.

A 2008 benefits consulting study conducted by Sibson Consulting cited corporate bankruptcy as the most common reason for the formation of a stand-alone VEBA (Sibson Consulting, 2008). Employers may use the bankruptcy process to modify or terminate health benefit obligations, but these changes must be approved by the bankruptcy court. As part of these negotiations, the company may set up a defeasance VEBA in order to settle the retiree benefit claims. While the contribution to these VEBAs is typically much less than the full

amount of the benefit obligation, it still may be a favorable compromise for retirees who otherwise simply hold a general unsecured claim and hence stand to receive very little through the course of bankruptcy proceedings. The stand-alone model works well out of bankruptcy because it establishes an organization separate from the company, which may or may not be a going concern out of bankruptcy. The VEBA will be responsible for the administration of benefits and the investment of remaining assets. Examples of VEBAs formed out of bankruptcy include the Dana Corporation (Borzi, 2009), which set up both union and non-union VEBAs, and the City of Detroit, which has recently agreed to set up a VEBA for retired city workers (Dolan, 2014).

When a company terminates or modifies its retiree health care benefit plan, retirees may file a class action lawsuit to prevent such a change in benefits. Since ERISA does not require that retiree health benefits be vested, the retirees' case will hinge on whether the company has contractually agreed to the vesting of such benefits. Courts are generally more likely to rule in favor of the employees in cases involving collective bargaining agreements (Moore, 2008). Settlement of the class action lawsuit may result in a stand-alone VEBA. For instance, Goodyear Tire & Rubber Company funded a VEBA for retirees of the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (USW) in 2008 following a class action lawsuit filed by the USW after Goodyear modified benefits; nevertheless, the USW was able to successfully defend much of the benefits. Goodyear funded the VEBA with \$1 billion in assets; a funded ratio of 83% given its \$1.2 billion liability (O'Brien, 2008).

Stand-alone VEBAs have also been established in the absence of bankruptcy or class action. These can be formed where there is a fear of financial distress; in such an instance, the

company seeks to reduce its liability while the union is willing to accept the VEBA structure as preferable to the possibility of company bankruptcy. The best example of this is the UAW VEBA agreement with the US automakers in 2007.

The UAW Retiree Medical Benefits Trust

A more detailed discussion of the UAW VEBA is worthwhile as this was by far the largest transaction of its kind and helped to publicize the VEBA structure as a win-win solution for employers and workers with large retiree health care benefits. The establishment of the UAW Retiree Medical Benefits Trust marked an unprecedented offloading of company benefit obligations from their balance sheets. General Motors, Ford, and Chrysler established the VEBAs with a total of \$56.5 billion in funding, removing a total \$88.7 billion liability from the automakers' financial statements (O'Brien, 2008). This difference was partly the result of changes to accounting assumptions and partly made up by union contributions.

At the time of the 2007 UAW-automaker labor negotiations, the Big Three US automakers were shouldering substantial payments for retiree health care liabilities. It was clear during the 2007 labor negotiations between the UAW and General Motors¹ that retiree health benefits had become a key issue. Leading up to this point, General Motors had become the largest private purchaser of health care in the US, spending \$5.4 billion on medical benefits in 2005 to cover 1.1 million active and retired workers. Of this health care burden, more than two-thirds was spent on retiree coverage. Retiree health care costs added \$1,045 to the cost of each GM vehicle, on average. In comparison, Japanese automakers spent \$450 per vehicle on all medical benefits, for both active employees and retirees (Sixth Circuit Court of Appeals, 2007).

¹ UAW collective bargaining policy is to negotiate a deal with one of the three automakers, in this case GM. The other two automakers have typically agreed to uphold similar deal terms.

For the UAW, these health care benefits had been put in place over many years of labor contract negotiations and were counted on by employees.

While the establishment of the stand-alone UAW VEBA in 2007 was unprecedented in its size and funding arrangement, a 2005 agreement between GM and the UAW paved the way for this transaction. In 2005, the union agreed to concessions that reduced GM's \$67.6 billion retiree health care obligation by \$17 billion. The UAW further gave up \$5.6 billion in future wage hikes and cost of living adjustments. Additionally, GM set up a traditional VEBA, funded with cash and a portion of future profit sharing (Bernstein, 2010).

In both the 2005 and then the 2007 negotiations, GM made retiree healthcare a key bargaining issue. GM demanded that the UAW agree to significant cuts in retiree medical benefits. Initially, the UAW refused. GM then threatened to simply impose the cuts anyway, arguing that it had the right under ERISA to modify welfare benefits. The UAW was faced with a decision: the union could agree to negotiate benefit cuts or it could file a class action lawsuit if the company cut the benefits separately. Although courts have generally given weight to collective bargaining agreements, there was no guarantee as to how a court would rule.

In the past, the UAW had resisted cuts to retiree medical benefits. Now, however, the UAW could not ignore the troubled financial state of the US automakers. All three companies had experienced steep stock market declines, concurrent with falling earnings. GM's credit rating fell to junk status at the beginning of 2005. The companies had attempted to respond; GM laid off 37,000 employees, closed factories, made cuts to executive salaries, and slashed its dividend (Sixth Circuit Court of Appeals, 2007). Even before the financial crisis devastated the US economy, the US automakers faced a very real threat of bankruptcy. While pension promises are guaranteed in bankruptcy by the Pension Benefit Guaranty Corporation, there is no such

organization to backstop health care benefit promises. If the UAW held out for a hard bargain, it risked contributing to further financial woes at GM and the other automakers. In the event of bankruptcy, it risked substantial benefit cuts.

Faced with this possibility, the union decided to compromise. A stand-alone VEBA had the potential to benefit both parties. At the time of the negotiation settlement, GM's retiree health care liability was \$51 billion, more than twice its market capitalization of \$21 billion (Ahrens and Freeman, 2007). For the union, having control of these benefit assets would mean that they would be out of reach of bankruptcy claims should the companies' financial troubles continue.

The UAW insisted that the VEBA trust be fully funded to meet the future retiree obligations; however, the union made concessions on the financial assumptions used to value the obligation in order to make full funding a reality. To determine costs that the VEBA would be expected to incur in the future, both sides had to agree on an appropriate medical inflation figure, eventually settling on 5%. The return assumption agreed to was 9% (Bernstein, 2010). Although these figures were not outside the range of acceptable values, the UAW was viewed as having made concessions on both figures. For the inflation rate, a 5% assumption was well below the recent level of health care cost increases. Yet this assumption is to be used over the VEBA's long-term time horizon of 80 years and is in line with other organizations' projections, including Medicare. The 9% rate of return assumption could also be viewed as aggressive, given that GM uses a much more conservative 6% to project its own asset growth (Bernstein, 2010).

These aggressive financial assumptions reduced the amount of assets required to bring the VEBA to full funding. Using the 5% assumption for medical inflation, the present value of the retiree health care obligation was \$47 billion, below the \$51 billion GM had carried on its books. Additionally, given that the 9% rate of return assumption was higher than the 6%

assumption GM used on its financial statements, the present value was further reduced from \$47 billion to \$38 billion. GM was able to further benefit from this accounting change as it was able to book an accounting profit for this difference (Bernstein, 2010).

Nevertheless, these concessions did heighten the risk of funding shortfalls in the future, in the event that the cost and return assumptions prove too aggressive. To alleviate union concerns about underfunding, GM agreed to backstop the VEBA: the company set aside \$1.74 billion in contingency payments. Moreover, GM agreed that it will make a payment to the VEBA in any year in which the Trust assets fall below the present value of the subsequent 25-year obligation (Bernstein, 2010).

Much of the subsequent negotiation focused on how funding would be divided. Both sides made significant compromises, and ultimately the funding amount was shared by the UAW and GM: \$30.21 billion was funded by GM, with \$8.1 billion from the union. For GM, funding was split between a transfer from the existing VEBA, additional cash assets, a note convertible to GM stock, excess pension assets, and a prior negotiated VEBA-payment. The UAW funded its portion with foregone wage raises from the 2005 contract as well as additional foregone wages and cost of living adjustments.

Similar structures were put in place with Ford and Chrysler. Ford contributed \$13.6 billion and Chrysler contributed \$10.6 billion. The resulting UAW Retiree Medical Benefits Trust was actually three distinct VEBAs set up for the three automakers, although the trusts were to be governed and invested similarly. Indeed, they are often referred to as a single entity. In total, the three companies pledged \$56.5 billion to the new VEBAs, thereby reducing the uncertainty of a \$88.7 billion retiree health care liability from their financial statements (O'Brien, 2008).

These transactions generated a great deal of buzz, and the press lauded the structure as an example of an innovative compromise. Yet shortly after the VEBA settlement agreements were put into place, the global economy entered a recession and the automotive industry was severely impacted. GM and Chrysler borrowed \$14 billion from the Bush Administration's Troubled Assets Relief Program in the fall of 2008 (Ghilarducci, 2010). After seeking additional government loans in early 2009, Chrysler and General Motors filed for Chapter 11 bankruptcy in April and June 2009, respectively. The US government assisted in these bankruptcies, expediting the legal process and taking an equity stake in the companies through debtor-in-possession financing as well as additional financial support following the restructurings.

At the time of their Chapter 11 filings, GM owed \$20 billion to the UAW VEBA and Chrysler owed \$10.6 billion. Because these funds had not yet been transferred into the VEBA trust, the VEBA was considered an unsecured creditor, though the VEBA funding had been agreed to under a Federal District Court settlement agreement in 2008 (Ghilarducci, 2010). Because of this, these claims were considered more secure than they otherwise would have been, although the Obama administration received criticism that it was favoring union retirees at the expense of taxpayers (Sherk and Zywicki, 2012). As a result of the bankruptcy proceedings, both GM and Chrysler replaced half of their remaining VEBA funding with company stock. Of GM's \$20 billion owed, approximately \$10 billion of the obligation was paid in shares of post-bankruptcy GM stock that gave the UAW as much as a 39% percent ownership stake in the restructured firm. Similarly, of Chrysler's \$10.6 billion, \$6 billion was granted in Chrysler shares, giving the VEBA a 55% ownership stake in the restructured Chrysler. Additionally, the VEBA received seats on both the General Motors and Chrysler Boards (Ghilarducci, 2010).

At year-end 2012, the UAW Retiree Medical Benefits Trust had combined assets of \$58.8 billion. The Trust paid \$4.2 billion in medical benefits in 2012 and administrative fees of \$284 million (UAW Retiree Medical Benefits Trust, 2013). While the Trust does not release the amount of its outstanding liability, it is believed that the funded ratio has improved since the Trust's inception following a rebound in financial markets. In 2010, the Trust was underfunded by roughly \$20 billion. In calendar year 2011, Trust assets fell to \$52.4 billion while the benefit obligation rose to \$85.3 billion, a \$33 billion shortfall (Seetharaman and Woodall, 2012). Given the level of underfunding, the Trust expects cost sharing with retirees to increase (Greene, 2012).

While the UAW accepted shares of GM and Chrysler in place of a portion of their cash contributions to the VEBAs, the UAW did not intend to remain a long-term shareholder of these companies. The VEBA has reduced its ownership of General Motors' shares over time (UAW Retiree Medical Benefits Trust, 2013), and it sold its remaining shares in Chrysler in early 2014 to Fiat SpA as part of that carmaker's purchase of Chrysler (Trop, 2014).

Impact of the Affordable Care Act

In 2010, Congress passed the Patient Protection and Affordable Care Act (the "ACA") instituting a national health care program that would set up health care exchanges for individuals not covered under their employer plans. Recognizing the unsustainability of the current model, the UAW supported the passage of a national health insurance program. In fact, the labor agreements that established the UAW VEBAs called for the auto companies to donate \$30 million to establish a National Institute for Health Care Reform (O'Brien, 2008). Within the text of the agreements, the companies also agreed to support efforts to "improve the affordability,

accessibility, and accountability of the U.S. health care system and the pursuit of a lasting solution to our national health care crisis.”

Prior to the ACA, pre-65 retirees (those not yet eligible for Medicare) had few alternatives for insurance outside of employer-provided promises. Individual coverage for this age cohort was extremely expensive (McArdle, 2014). The creation of the health insurance exchanges offers this population a viable alternative for coverage.

As the national exchanges established under the ACA now provide a suitable option for pre-Medicare retirees, employers will be even more incentivized to reduce their own retiree coverage as the pushback from current and former employees losing coverage is likely to be less significant. As a result, the ACA is likely to accelerate the employer trend away from providing retiree health benefits. To the extent that the ACA reduces the need or obligation of employers to provide retiree health care, there is likely to be a reduced role for VEBA plans going forward.

Evidence of this is seen in the sharp drop in the number of VEBA plans from 2010 to 2011 (Internal Revenue Service, 2010 and 2011). Based on this drop, it is unclear whether employers are simply shifting their health care funding to defined contribution-style health care accounts or whether they are moving away from coverage for retirees altogether. ACA experts such as Ezekiel Emanuel, an architect of the ACA and University of Pennsylvania Professor, predict that employers will drop health insurance for their employees as faith in the exchanges grows (Mandelbaum, 2014).

While most employers have indicated that they do not intend to alter coverage for active employees, Dr. Emanuel’s prediction may play out among retiree medical benefits first. In the 2014 Towers Watson/National Business Group on Health Survey, nearly two-thirds of companies that currently provide an employer-sponsored health care plan to pre-65 retirees said

they were likely to eliminate these programs in the next few years and move their pre-Medicare retirees to the public exchanges (Towers Watson and the National Business Group on Health, 2014). A 2013 ACA Impact Survey conducted by the International Foundation of Employee Benefit Plans found 27% of employers with more than 5,000 workers considering moving retirees to the exchanges (Figure 2). This is a lower but still substantial percentage.

Figure 2: Employers Considering Moving Retirees to Exchanges

Considering Private Exchanges for Retiree Groups by Employer Size (n=879)					
	0-50	51-499	500-4,999	5,000-9,999	10,000+
<i>Coverage for retirees aged 65 and older</i>					
Actively pursuing	0.0%	2.0%	3.3%	7.6%	9.8%
Considering pursuing	4.1%	5.6%	10.5%	14.1%	17.6%
<i>Coverage for early retirees (55-64 years old)</i>					
Actively pursuing	0.0%	1.0%	1.5%	1.1%	3.9%
Considering pursuing	6.2%	8.1%	14.4%	27.2%	26.5%
<i>Coverage for future retirees</i>					
Actively pursuing	0.0%	1.0%	1.8%	1.1%	3.9%
Considering pursuing	7.2%	10.6%	14.1%	23.9%	28.4%

Source: International Foundation of Employee Benefit Plans, 2013 Employer-Sponsored Health Care: ACA's Impact Survey

The Affordable Care Act includes several provisions which directly impact pre-65 retirees. A discussion of these provisions and their potential impact on the VEBA structure follows.

Health Insurance Exchanges – By far the most significant piece of the legislation for retirees.

The exchanges will provide guaranteed issue access to insurance for the 15% of retirees aged 55 to 64 without any health coverage and the 11% of those who have individually purchased plans (McArdle, 2014). Employers may elect to cancel their coverage and send retirees to the

exchanges. Additionally, retirees will be able to choose between an employer plan and coverage through the exchanges (Reuther, 2014).

Early Retiree Reinsurance Program (ERRP) – The ERRP was set up as a temporary reinsurance program for employers providing benefits to retirees over age 55 and not yet eligible for Medicare. The program was intended to incentivize employers to maintain retiree benefits until the public health exchanges became operational (Fronstin, 2010). The program was funded with \$5 billion to provide employers, but demand quickly exceeded this amount. The program was wound down January 1, 2014; however, the significant demand for help in funding retiree coverage highlighted the need for employer relief from retiree medical costs (McArdle, 2014). The popularity of this program suggests that employers are eager to find solutions for growing retiree medical costs and seems to suggest that many employers will seek to move retirees to the exchanges. This trend would lower the number of VEBA trusts.

“Cadillac tax” on high-cost health plans. Beginning in 2018, the ACA will impose a non-deductible excise tax on high-cost employer-sponsored plans. For pre-65 retirees, the tax will be equal to 40% of the value of coverage in excess of \$11,850 for an individual or \$30,950 for a family (McArdle, 2014). This tax will likely encourage employers to scale back benefits further or, at a minimum, to review the coverage offered. This review may contribute to the trend away from employer-provided coverage.

Retiree-only plan exemptions - Retiree-only plans are exempt from some of the more costly requirements of the ACA, such as extending medical plan eligibility to adult children through age 26, unlimited annual or lifetime expenses for essential health benefits, and fully-covered preventive health services with no patient cost sharing. For employers who currently offer a combined health care plan for both active and retired workers, there will an incentive to split

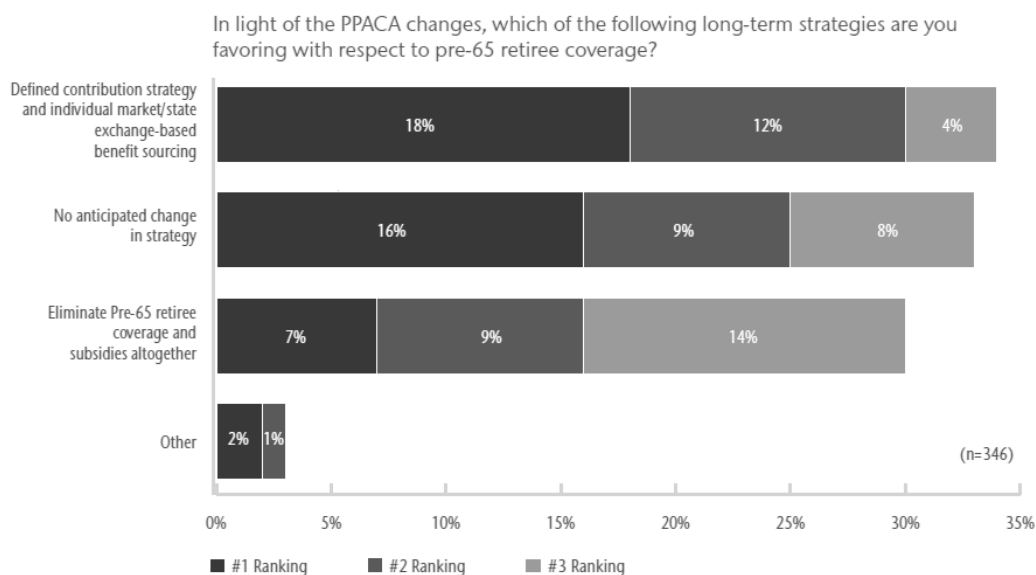
these plans in order to reduce costs within the retiree plan (McArdle, 2014). This splitting could lead to growth in VEBA plans as employers set up new structures specifically for their retirees. Yet it seems possible that any carve-out of retirees may encourage employers to reevaluate and reduce these benefits, potentially recommending that the retirees move onto the exchanges for coverage.

Restrictions on VEBA fund payouts – The ACA’s greatest blow to the VEBA plan structure may be the restrictions placed on VEBA trust payments. The ACA legislation prohibits tax-advantaged accounts, including VEBAs, flexible spending accounts (FSAs), and health reimbursement accounts (HRAs) from paying all or part of a beneficiary’s exchange premiums (Reuther, 2011). This means that even as the trend is likely to move towards placing pre-65 retirees on the national exchanges, the VEBA structure will not be available to support this trend by offsetting the costs of the premiums. Additionally, VEBA payouts cannot be used for supplemental wrap coverage to any retiree electing coverage through the state or government exchanges (Woodward, 2014).

These restrictions were put in place to avoid “double dipping” of public subsidies; they restrict the use of tax-advantaged funds in paying for subsidized exchange benefits (Reuther, 2011). VEBAs are at a further disadvantage, however, because their structure does not allow them to make taxable payouts either. Therefore, the use of VEBA funds will be severely limited. For employers who wish to move retirees to the exchanges, or at least keep this option available, VEBAs look less attractive under the ACA. Already, defined contribution health care plans appear to be gaining in popularity as they offer employees greater flexibility. In the 2013 Aon Hewitt Retiree Health Care Survey, when employers were asked what long-term strategies they

avored in light of the ACA changes, the highest percentage responded that they were considering a defined contribution strategy (Figure 3).

Figure 3: Long-Term Strategies for Pre-65 Retirees



Source: Aon Hewitt, 2013 Retiree Health Care Survey

VEBAs may still have a role to play, particularly for trusts set up at large employer or union plans. Unlike active employees, who are restricted from seeking coverage through the exchanges if their employer offers coverage, retired employees will be able to shop between the VEBA-provided health plan and the exchanges. In many cases, the VEBA plan is likely to be more generous, particularly where unions have negotiated the packages. Union pressure is also likely to limit the movement of unionized workers to the exchanges if benefits are not as rich.

While VEBAs cannot pay exchange premiums for pre-65 retirees, they can be used to pay employee Medicare premiums. This will likely remain an important role for already-established VEBAs (Woodward, 2014). However, if VEBAs create a gap in employer coverage because they are unable to pay for pre-65 retiree exchange premiums or supplemental coverage, they are unlikely to bring retirees back into the plan once they become Medicare-eligible.

Overall, the Affordable Care Act should lead to improved medical benefits for retirees, particularly those ineligible for Medicare who had few options under the current system. Given the high cost associated with provided pre-65 retiree medical coverage and the availability of the insurance exchanges, it is expected that many employers will consider reducing their retiree coverage. The reduction in retiree medical benefits will reduce the overall need for VEBA plans. The restrictions on using VEBA assets to pay exchange premiums will accelerate this decline in usage.

In sum, VEBAs will continue to play a useful, albeit reduced, role in providing employee and retiree health benefits. While the overall trend is moving away from employer-provided retiree medical care, this has been much slower within unionized plans. As a reference point, in 2006, 86% of collectively-bargained employers continued to offer retiree health benefits (Cancelosi, 2009). Unions have been relatively successful in protecting these benefits, and VEBAs have helped them do so. VEBAs also continue to be a primary vehicle for safeguarding benefit assets for firms in or near financial distress. Also, as public plans come under increased pressure to manage their pension and welfare benefits, the VEBA structure could be an attractive compromise for these governments and retirees.

Have VEBAs served their purpose?

Traditional VEBAs have certainly benefited many employees, since the VEBA is one of the few ways for employers to fund employee health care in a tax-advantaged structure. These tax advantages have become more and more important as health care costs have grown and as accounting rules require companies to disclose the full amount of their medical benefit liabilities. There is expected to be a reduced need for traditional VEBAs going forward as the Affordable

Care Act provides new options for employee health care and as it restricts the uses of VEBA funds.

Stand-alone VEBAs have also provided a benefit to employees; however, the outcome varies widely from plan to plan. Ultimately, the stand-alone model moves the risk and responsibility for employee benefits out of the employer's hands and into the care of the VEBA trust, typically run in practice by a union or a collection of employees. Stand-alone VEBAs are often significantly underfunded, especially when formed out of a bankruptcy event or a class action lawsuit. Employees are thus forced to accept benefits below the level they expected. Nevertheless, VEBAs have been valuable to employees because they have offered a favorable compromise between the company and its workers. For firms in financial distress, a VEBA structure offers the best way to ensure benefits will be safeguarded from other creditors in the event of bankruptcy. For firms in bankruptcy, the VEBA structure may be the best way to administer and distribute benefits to employees when the future of the company is in question.

VEBAs have also been very important in providing benefits to pre-Medicare retirees, who had few options for good health insurance prior to the Affordable Care Act's insurance exchanges. By pooling retirees under a VEBA, the plans could now offer affordable coverage. The VEBA structure also safeguarded these benefits which were quickly being modified or terminated by employers.

Conclusions

The past two decades have seen U.S. employers reduce the health benefits they provide to retirees, as health care costs and the balance sheet liabilities for these costs have grown. For

many employers and retirees, VEBA plans have served as creative compromises to protect retiree health coverage.

In particular, stand-alone VEBAs have been formed by companies that face financial distress or those in bankruptcy proceedings. By separating the benefit risk and responsibility from the employer, the employer is able to reduce this uncertainty from its books. While the employees must assume this risk, they benefit by safeguarding these benefits from future credit issues. In this way, VEBAs have offered a tax-advantaged and innovative compromise for employers and workers.

Nevertheless, the Affordable Care Act is likely to accelerate the employer trend away from offering retiree health care as insurance exchanges provide a satisfactory alternative to employer-provided coverage. Even for employers who do wish to offer employees supplemental coverage or help paying premiums, the VEBA structure does not support these payments and employers may look to defined contribution health care plans as more versatile alternatives. VEBA plans will remain a presence for some time; many outstanding VEBAs, including the UAW Retirement Trusts, have long horizons, VEBAs continue to remain a favored vehicle for carving out employee health benefits in bankruptcy, and the tax advantages to union workforces continue to make these appealing. We predict, however, that the overall role and number of VEBA plans will continue to decline.

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