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a NEW BENEFIT PLATFORM
for LIFE SECURITY



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THE ERISA INDUSTRY COMMITTEE



a NEW BENEFIT PLATFORM
for LIFE SECURITY

THE ERISA INDUSTRY COMMITTEE

is a non-profit association committed to the advancement of the employee retirement, health, and compensation plans of America's major employers.

May 2007

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THE ERISA INDUSTRY COMMITTEE

The ERISA Industry Committee (ERIC) is a membership organization representing the employee benefit plans of America's largest employers. ERIC's members have for many decades voluntarily provided comprehensive health, retirement, and other benefit and compensation plans to their employees and their employees' families. Together, ERIC member companies have provided and paid for benchmark life security plans directly to more than 10% of the U.S. population.

As major employers, ERIC member companies pioneered many of the retirement, health, and compensation plans that have become the benchmark for private and public employers. Thus, ERIC's members continue to be at the forefront of the intensifying controversy about how to more efficiently and effectively provide quality lifetime retirement and health security to millions of American workers and their families.

ERIC and our members continue to believe that it is essential that major employers, who voluntarily sponsor the nation's most comprehensive private sector life security plans, establish a policy position that will make a positive contribution to the public dialogue on the retirement and health security of American workers.

That is what the New Benefit Platform for Life Security is about.



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EXECUTIVE SUMMARY

Employers' voluntary participation in the American system for providing medical, retirement, and similar "life security" benefits has, over time, served workers and their employers quite well.

Through their benefit plans, employers have:

- Fostered trillions of dollars of disciplined savings
- Met changing times with innovative programs
- Enabled individuals to pool risk and thereby increase the efficiency of money invested in benefit programs
- Educated employees about the need to plan for economic- and health-related risks
- Directly funded many benefits provided

At the same time, life security programs have become an integral part of an employer's ability to recruit and retain the talent they need to make their enterprise thrive.

Employers that today provide retirement, medical, and similar life security benefits, however, are under stress. In addition to increased national and global competition, U.S. employers face complex, often contradictory, and inflexible rules governing benefits, as well as exposure to volatile and often escalating financial commitments and litigation. For many employers, plan sponsorship diverts their focus from competitive business challenges. Under these constraints, employers are finding that establishing mechanisms to address underlying gaps and flaws in delivering benefit security to American workers has become increasingly difficult.

Employer programs alone cannot satisfy the life security needs of American workers in today's highly competitive business environment.

Indeed, traditional life security policy has always envisioned a balance of employer provided benefits, employee savings, and government programs as a "three-legged stool."

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Employer programs alone cannot satisfy the life security needs of American workers in today's highly competitive business environment. At the same time, turning to government programs that are themselves under financial stress or relying too heavily on individuals to pick up the slack is likely to prove unsatisfactory. Indeed, traditional life security policy has always envisioned a balance of employer provided benefits, employee savings, and government programs as a "three-legged stool."

New thinking is required.

OVERVIEW: A NEW BENEFITS PLATFORM FOR LIFE SECURITY

The benefit security needs of all Americans is a troubling issue of increasing importance to employers and to society as a whole; as these issues began to be raised by our members, The ERISA Industry Committee (ERIC) asked a Task Force drawn from its membership and composed of experienced senior benefit professionals to address this issue. The Task Force's assessment and proposal has been reviewed and endorsed by ERIC's policy committees and its Board.

- **The new proposed structure would give employers an alternative method for providing benefits without the "entanglements" of traditional provider sponsorship. This structure complements but would not require replacing the current system for those who find the current system more appropriate.**
- **The new benefits offerings would be administered by competing Benefit Administrators.**
- **Benefit Administrators, in many respects, would assume the role of today's plan sponsors and, particularly with regard to health care, would be organized on a geographic basis.**
- **Employers and individuals would share funding of benefits.**
- **In addition, the structure would also provide a way for individuals to purchase coverage independent from an employer relationship.**

The proposal is centered on certain guiding principles, described in the body of the proposal, such as benefit expansion, simplicity,

flexibility, portability, and the need to balance employer and individual needs and responsibilities. As a significant departure from the present system's increasing reliance on employer-provided benefits, the new system combines a market-based structure with individual choice and group risk sharing. This structure will make possible the continuation and possibly the expansion of employers' role as a facilitator rather than solely as a provider of benefits.

We believe that the New Benefit Platform will also encourage creativity and innovation to the benefit of both employers and individuals.

Administrators would compete with each other based on quality, design, and cost. To ensure that competition among administrators occurs on a level playing field and is transparent to consumers, the federal government would establish, or arrange to be established, a uniform national regulatory structure and uniform standards for measuring plan performance.

An employer could obtain the benefits for its employees, and in some circumstances, an individual could participate directly, without employer involvement. The federal tax consequences for an individual accessing benefits would be the same whether the benefits were accessed individually or through an employer. Contributions by employers providing coverage through an administrator would be tax deductible.

The benefits available through this new structure would initially include retirement (and short-term savings) plans and health care coverage. Life insurance, disability, and other benefits also may be provided.

In the retirement arena, ERIC's proposal significantly rationalizes the current system, making it both more equitable and more attractive to employers and individuals. The proposal:

- Expands opportunity for participation in retirement plans
- Enhances competition by providing better tools and improved information to consumers
- Offers improved asset management
- Increases retirement security by providing the flexibility needed to meet the unique circumstances of each individual

The core structure envisioned builds on the experience of employers and encourages uniform national standards, yet

We believe that the New Benefits Platform will also encourage creativity and innovation to the benefit of both employers and individuals.

encourages incorporation of new ideas to improve financial well being of Americans in retirement.

In the health care arena, ERIC's proposal rationalizes the delivery system in ways that:

- Expand access and creates a level playing field;
- Create the foundation for increased accountability to improve health care quality, transparency, and value to consumers;
- Require greater consumer accountability by providing both the information consumers need to be prudent purchasers and incentives for responsible lifestyle behaviors; and
- Require improved health information technology.

ERIC's proposal is designed to spark new thinking about replacing such limiting silos with more creative options.

OPENING THE DEBATE: HOW THIS PROPOSAL SHOULD BE VIEWED

In the past, proposals to reform access to life security benefits have tended to focus on increasing the responsibilities borne by employers or individuals or the government. ERIC's proposal is designed to spark new thinking about replacing such limiting silos with more creative options.

The conceptual structure described in this document is intended to provide a foundation for responsible discussions that will entail further refinements and, eventually, the legal and operational details needed for complete implementation. Some parts of the proposal would require changes to the legal framework surrounding benefits, while other parts could be implemented under current law.

This is an urgent debate. The life security of millions of Americans, as well as the viability of many American businesses, depends on the outcome. Through ERIC, the major employer community welcomes the dialogue that will change the status quo in a way that meaningfully addresses the life security needs of all Americans while improving the competitive position of American employers.

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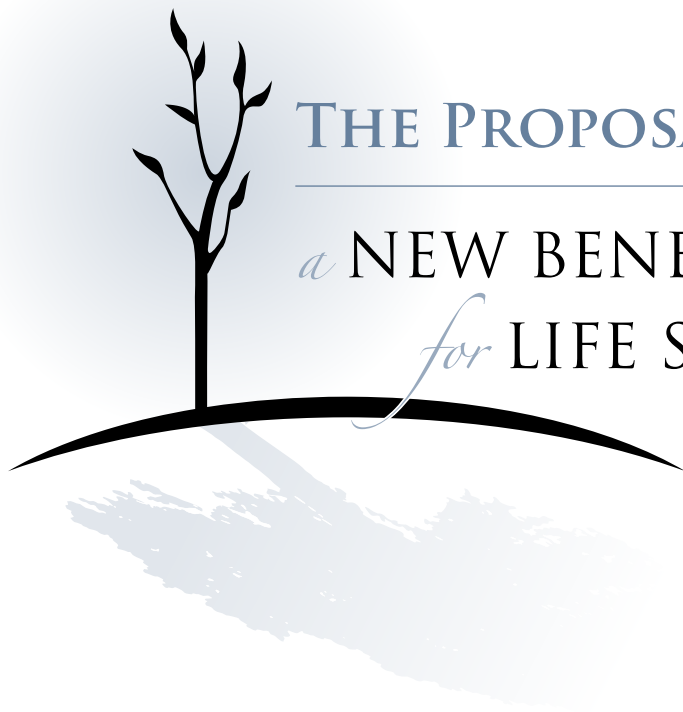
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GUIDING PRINCIPLES FOR LIFE SECURITY BENEFITS

In formulating a new benefits platform for delivering benefits, ERIC was guided by several principles that should be used as a scorecard for evaluating the component parts. The new platform should foster:

1. **Expansion of benefits** to a larger base of the population. More people should have retirement plans that will result in long-term retirement security, and more individuals should have access to different forms of medical plans.
2. **Innovation and creativity** through the development of competing systems that could sponsor, administer, and assume fiduciary responsibility for benefit plans.
3. **Simplicity**, significantly rationalizing the overall benefit design and administrative system.
4. **Incremental implementation**, starting with elements most feasible to incorporate and bearing in mind a long-term vision.
5. **Portability of benefits** as the circumstances of individuals change, while at the same time providing incentives to individuals to maintain continuous coverage.
6. **Balancing employees' and employers' needs**. A participant's need for security reflects a desire for some predictability of benefit resources over time; employers want to support life security benefits but not be encumbered by inflexible commitments that compromise their ability to survive and are not competitive within the United States and globally.
7. **Fairness and equity** so that employers and participants share in the responsibilities entailed in securing retirement, health, and other life security benefits.
8. **Individual responsibility** in terms of long-term retirement security, health and wellness, and ensuring access to quality medical care.
9. **Employer's voluntary funding** to help pay for benefits.

10. **Fiduciary accountability and responsibility**, focusing on entities that have expertise in benefits administration as their core business.
11. **Flexibility** to permit employers to determine the speed and the extent to which they use the new system for delivering benefits to their employees. The new system should supplement the current employment-based model and should allow employers to choose between the current system and the proposed new structure.



A NEW LIFETIME SECURITY SYSTEM FOR ALL AMERICANS

INTRODUCTION

American workers have benefited extensively from employers' voluntary participation in the nation's private benefits system. In fact, those with employment-based benefits have received a greater degree of economic stability during their working years, as well as in retirement, than those without such benefits. U.S. employers have also developed significant expertise in managing retirement and medical benefits, often serving as a catalyst for new ideas that have improved retirement and medical plans for all Americans.

Today, however, deficiencies in the current system clearly are challenging employers and, in some cases, the viability of the benefits system in general. Employers that sponsor plans face complex, sometimes contradictory, and inflexible rules, as well as exposure to volatile and often escalating financial commitments and litigation. For many employers, plan sponsorship can divert their business focus just when they need all their resources to meet new and ongoing competitive challenges. Under these constraints, employers also are finding that establishing mechanisms to address underlying gaps and flaws in delivering benefits is increasingly difficult.

Thus, today's employers need new options that will allow them both to assist employees and to maximize their business focus. In addition, significant numbers of Americans do not benefit from the present system. Many work for employers that find the cost of benefit plans prohibitive, whereas others have inadequate personal retirement resources and are at risk for the costs of needed medical care.

The structure that ERIC proposes here is based on the *practical experience* of U.S. employers in sponsoring and administering retirement, medical, and other life security plans. Applied to a “Life Security Plan” (LSP), this experience is intended to benefit not only individuals who participate in plans that are sponsored by employers but also all Americans. Our proposal is a significant departure from the present system.

The New Platform combines a market-based structure with individual choice and large-group risk sharing. Thus, the new structure makes possible a solid base of employer funding that may continue and even expand. This structure, in conjunction with appropriate subsidies from state and Federal governments and reasonable contributions from individual Americans, is intended to establish a solid economic foundation for the new system that will ensure its long-term viability.

The structure that ERIC proposes here is based on the *practical experience* of U.S. employers in sponsoring and administering retirement, medical, and other life security plans.

HOW THIS PROPOSAL SHOULD BE VIEWED

Past proposals to reform how American workers access life security benefits have tended to focus on increasing responsibilities borne by employers or individuals or the government. ERIC’s proposal was designed to spark new thinking about replacing such limiting silos with creative new options.

The conceptual structure described in this document is intended to provide a foundation for responsible and open discussions by policymakers, legislators, regulators, employers, worker representatives, the health industry, consumer groups, and others with an interest in seriously tackling—and working to resolve—the challenges confronting retirement and health care security. We hope that the discussions will produce further refinements and, eventually, legal and operational details that are needed for complete implementation.

Full implementation of a Lifetime Security Plan for All Americans is expected to proceed incrementally, starting with those elements of the plan for which there are reasonable levels of consensus and ending with those elements for which consensus might be more difficult to achieve and where major changes in the current statutory and regulatory framework will be required. For example, aspects of the new structure envisioned here already are well developed in the outsourcing of defined contribution retirement benefits. In other areas, more original development will be required.

OBJECTIVES FOR THE CONCEPTUAL MODEL

The design of the proposed conceptual model for delivering retirement and medical benefits is based on ERIC's Guiding Principles articulated elsewhere in this document and is intended to accomplish the following objectives:

1. Incorporate the innovations and lessons from the employment-based benefits system into a new structure that can broadly meet the needs of employers, their employees, and other individual Americans.
2. Eliminate the deficiencies of the current employment-based and individual benefit systems to create the foundation for a superior new benefits structure.
3. Encourage and incorporate new ideas that will increase the potential for higher levels of participation, improved cost efficiency, higher quality delivery systems, better equity, and, in the end, greater health and financial well-being for all Americans.

Incorporate innovations...
eliminate deficiencies...
and encourage and
incorporate new ideas.

BENEFITS INCLUDED IN THE NEW LIFE SECURITY PLAN (LSP)

Initially, the following core benefits would be incorporated into the new Lifetime Security Plan:

- **Retirement and Short-Term Savings Plans** would be structured to create opportunities and incentives for individuals to financially prepare for retirement and other significant lifetime events that require substantial financial resources.
- **Health Plans** would be structured to provide all Americans access to quality health care resources at an affordable price.

In later stages of LSP development, other core benefits would be added, such as life and disability insurance.

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THE CORE STRUCTURE FOR THE LIFETIME SECURITY PLAN

Effective and fair competition in a responsibly regulated system will deliver greater value to both employers and individual Americans.

Delivering the LSP will require that there will be competition among third-party Benefit Administrators. These administrators, who would be trusted intermediaries, must have significant expertise in designing, delivering, and managing retirement and other financial benefits, as well as health plans. Benefit Administrators could be direct providers or assemblers of affiliated providers. Examples might include banks, mutual fund/investment companies, insurers, health plans, or new “platform” administrators. Ensuring competition among Benefit Administrators would reduce costs and improve service by simplifying the current, cumbersome administrative system to eliminate fragmentation and unnecessary “middlemen” that add little value to the ultimate consumer.

Two or more Benefit Administrators would be available to every employer and individual consumer. Benefit Administrators would be aggressive and innovative in competing for business from both employers and individuals. The element of competition is intended to promote continuous improvement in all aspects of the benefit delivery system, significantly increasing the health and financial well-being of all Americans.

Other general attributes of the core structure underlying the LSP include:

1. **Establishment of Uniform Service Areas within the United States:** The federal government would establish uniform service areas for each of the LSP’s core benefits. These service areas may vary from benefit to benefit. For example, there may be larger national service areas for retirement savings benefits and regional, state, or even

The element of competition is intended to promote continuous improvement in all aspects of the benefit delivery system, significantly increasing the health and financial well-being of all Americans.

community service areas for health plans that are based on major medical markets. Uniform service areas would ensure that all Americans have guaranteed access to the LSP benefits regardless of where they live and would prevent geographic “anti-selection.”

2. **Establishment of Uniform National Standards:** To simplify administration, the federal government would establish uniform national standards for the benefits included in the LSP. This will help individual Americans make rational “apples-to-apples” choices between the competing systems of Benefit Administrators. This, in turn, should result in a system with lower costs that is more consumer friendly.
3. **The Employer’s Role in the LSP:** The LSP system should not be wholly dependent on the employer community. Employers would have the option of establishing a formal relationship with one or more Benefit Administrators for their employees and their families. Employers also could choose to continue in the current system and arrange for their own retirement and health plans. Alternatively, employers may choose to provide financial resources to their employees to purchase retirement, health, and other benefits independently from the employer from among Benefit Administrators operating in their markets.
4. **Assignment of Fiduciary or “Contract” Responsibility:** The Employee Retirement Income Security Act (ERISA) sets forth responsibility for ensuring that plan sponsors fulfill their benefit promises and responsibly manage plan assets. Under the new structure, the competing Benefit Administrators and their affiliates would assume the appropriate “fiduciary” or contract liability associated with the benefits they provide. “Benefits administration” would be the core business of the manager. This structure would actually rationalize and improve fiduciary accountability over the current system.
5. **Tax Treatment of LSP Benefits:** The tax treatment of qualified life security benefits should be uniform for all Americans regardless of whether they access the LSP directly or through a sponsoring employer. Similar to current law, the federal government would establish favorable tax treatment for retirement, health, and other benefit savings. Employers would maintain the tax treatment they have in the current system.
6. **Nondiscrimination Rules:** The current morass of complicated nondiscrimination rules would be replaced with simplified standards. It would include benefit-based, “safe harbor” designs to encourage broad-based availability of benefits.

7. **Participant Advocate:** Each Benefit Administrator would maintain an independent office of participant advocacy responsible for serving as an ombudsman for individual participants as well as fulfilling oversight and investigatory functions similar to those of inspectors general.
8. **Additional Benefits:** Competing Benefit Administrators would be free to offer optional benefits outside the LSP's core benefits. These might include life and disability insurance until they are included as core benefits. Additional benefits might also include group auto and homeowners' insurance and others that are offered as "voluntary" benefits in the current employment-based system.
9. **Administrative Efficiencies:** Providing common benefits structures should assist in reducing administrative complexity and fees. In addition, in many instances, an individual's retirement and health benefit administration could be combined, simplifying communications and benefit processing for the Benefit Administrator, a participating employer, and the individual. To some degree, some of the attributes that combine employer and employee participation with a professional Benefit Administrator already exist in the current defined contribution retirement plan market.

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LSP CORE BENEFITS: RETIREMENT AND SHORT-TERM SAVINGS PLANS

ERIC believes strongly in the need for a system that meets the retirement security needs of all Americans. Our proposal would significantly simplify the current system, making it more equitable and attractive to both employers and individuals. It would also expand participation in retirement plans; provide better tools and improved information to consumers; enhance competition; improve asset management; and ultimately increase retirement security and provide greater flexibility to meet the unique circumstances of each individual.

Specifically, ERIC proposes a three-pronged strategy:

- A defined benefit plan, hereafter the *“Guaranteed Benefit Plan”*
- A defined contribution plan, hereafter the *“Retirement Savings Plan”*
- *A short-term security account*

The above plans would be supported by several additional initiatives and offered independently or in combination with one another to provide additional retirement resources beyond Social Security. They also offer the opportunity for individuals to accumulate assets to pay for significant lifetime events that require substantial financial resources.

Our proposal would significantly simplify the current system, making it more equitable and attractive to both employers and individuals; ... expand participation in retirement plans; provide better tools and improved information to consumers; enhance competition; improve asset management; and ultimately increase retirement security...

THE GUARANTEED BENEFIT PLAN

The Guaranteed Benefit Plan (GBP) component of the LSP could include various hybrid retirement arrangements. Employers would not be prevented from offering traditional defined benefit plans. It would be uniformly available to employers and individuals and could be used as a single-source retirement plan to supplement Social Security or in conjunction with the Retirement Savings Plan (see below). Each of the competing Benefit Administrators would be required to offer a GBP. It would have the following general attributes:

- **Employer Participation:** Employers could make contributions on behalf of an employee to a GBP sponsored by the Benefit Administrator(s) chosen by the employer. They could also offer contribution credits or vouchers to their employees, who would then choose their own GBP.
- **Individual Contributions:** Individuals could make contributions on the same basis as those sponsored by employers.
- **Principal Guarantee:** The Benefit Administrator or its affiliate would guarantee the security of the “principal” contribution.
- **Investment Credits:** The Benefit Administrator would establish a minimum guaranteed investment credit that would apply to the balance of each individual account. The interest credit could be a fixed guarantee (e.g., 3%) or an index (e.g., composite corporate bond rate).
- **Loans and Withdrawals:** The GBP would be strongly focused on retirement. Withdrawals and loans would not be available.
- **Portability:** The portability of a GBP would be based on reasonable standards necessary to maintain the viability of Benefit Administrators and their affiliates.
- **Asset Management:** The Benefit Administrator or its affiliates would be responsible for asset management. There would be no self-directed accounts.
- **Distributions:** Distributions would be available at retirement and only paid in an annuity form.
- **Guarantee:** The GSB would be designed so that it would be guaranteed by the Pension Benefit Guaranty Corporation (PBGC).

THE RETIREMENT SAVINGS PLAN

The Retirement Savings Plan (RSP) component of the LSP would be uniformly available to employers and individuals. It could be used as a single-source retirement plan to supplement Social Security or in conjunction with the GBP. Each of the competing Benefit Administrators would be required to offer an RSP. The RSP would be somewhat similar to the current 401(k) program, including Roth provisions. The accounts would have the following attributes:

- **Employer Contributions:** Employers could contribute directly to the RSP, or they could offer contribution credits or vouchers to their employees, who could then choose their own RSP.
- **Individual Contributions:** Individuals could make contributions to the RSP on the same basis as those sponsored by employers.
- **Loans and Withdrawals:** The RSP would allow loans and withdrawals, but also include restrictions that focus the use of RSP account balances for retirement purposes.
- **Asset Management:** The accounts in the RSP may be self-directed or professionally managed.
- **Preset Asset Allocations:** Each Benefit Administrator, in conjunction with its RSP vendor, would be required to establish “preset” fund mixes based on age or other appropriate criteria to encourage reasonable and stable asset allocations and to discourage frequent changes in asset mixes.
- **Automatic Enrollment:** The RSP would be structured to facilitate automatic enrollment and scheduled increases in contributions for participants enrolled through an employer.
- **Portability:** The RSP would be portable among competing Benefit Administrators and their affiliated vendors.

SHORT-TERM SECURITY ACCOUNTS

The LSP would also include a component for short-term savings—Short-Term Security Accounts (STSAs)—consolidating other existing tax-deferred savings vehicles. The STSAs could be created as a separate account within or independent of the RSP. The preferred structure would be refined as this proposal is discussed and adopted. Some of the desired attributes of these accounts are:

- **Simplification:** The STSAs are intended to simplify the complexity attributed to the large number of savings vehicles in the current system.

- **Contributions:** Both employers and individuals could make contributions to the accounts.
- **Use Restrictions:** The use of the funds in the STSAs would be restricted to a prescribed set of defined lifetime events. These may include medical expenses not covered by a health plan and educational expenses, as well as other events to be determined.
- **Conversion at Retirement:** Unused balances at an individual's retirement or at a specified age would be available for withdrawal without penalty for retirement or post-retirement medical expenses.
- **Portability:** The accounts would be completely portable from one Benefit Administrator to another.
- **Investment Credits:** Benefit Administrators and their affiliates would be required to specify an "investment credit" that would be applied to account balances. In most cases, these investment credits would be provided via investments in traditional savings plan instruments.

SUPPLEMENTAL INITIATIVES

There are several supplemental initiatives that apply generally to the GBP, RSP, and STSA. They are intended to further define the ERIC proposal and to enhance the viability of the LSP.

- **Educational Financial Planning Services:** Each Benefit Administrator and/or affiliate would be required to make available comprehensive educational and independent advice programs to help participants achieve financial security in retirement and manage their financial resources. To eliminate any potential conflict of interest, financial planning services would have to be made available through non-commissioned professionals.
- **Transparency of Expenses and Performance:** A standardized system would be defined through regulation to provide full disclosures of fees, expenses, and performance associated with the management of assets in the GBP, RSP, and STSA. To enable consumers to make informed decisions and to promote fair competition, this information would be available to the public in standardized, easy-to-understand formats.
- **Contribution Limits:** Limits for both before- and after-tax contributions would be established for each of the LSP component plans and the aggregate of the LSP.

- **Tax Treatment of Contributions and Earnings:** Recommendations for the tax treatment of individual and employer contributions (and the earnings from invested assets) remain to be determined. ERIC believes that tax proposals should provide sufficient incentives to maintain and expand employer participation and to encourage individuals to contribute to their own retirement security.
- **Mandatory Individual Contributions:** To improve retirement security beyond Social Security, a minimum mandatory individual contribution to either the GBP or the RSP would ensure greater retirement security for individuals, earlier retirement savings, and a reduction in pressure on federal entitlement programs.

ERIC believes that tax proposals should provide sufficient incentives to maintain and expand employer participation and to encourage individuals to contribute to their own retirement security.

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LSP CORE BENEFITS: HEALTH CARE COVERAGE

There is an urgent need to eliminate the significant waste in the current health care delivery system, establish a foundation for responsible cost management in the future, and systematically ensure quality health care for all Americans. To this end, ERIC strongly supports a competitive, pluralistic health care system in which employers and individuals have choices among several health plans. At the same time, too many reforms pursued in the past have made changes at the edges of health care delivery when fundamental structural changes are needed. ERIC believes a properly designed pluralistic system will be far superior to a single-payer system for correcting the deficiencies in the current system and for producing significant improvements in both cost and quality.

ERIC believes a properly designed pluralistic system will be far superior to a single-payer system for correcting the deficiencies in the current system and for producing significant improvements in both cost and quality.

The foundation of ERIC's proposal is our belief that health care and health care financing are best managed in local/regional major medical markets. The Benefit Administrators that are the core of ERIC's proposed new structure and their affiliates would be in a much better position than individual employers to bring entire communities together to create a rational and accountable health care system.

The proposed structure would create a simplified system intended to expand access to health care and equitably serve the needs of both employers and individuals. It would also establish the foundation for major improvements in accountability for providers to improve health care quality and provide better value to consumers. In addition, the new system will create more accountability for consumers by giving them information to make them more prudent purchasers, as well as incentives to encourage responsible lifestyle

behaviors. Finally, the proposal includes new innovative recommendations to improve payer accountability and eliminate the administrative waste that is prevalent in the current system.

The ERIC proposal incorporates both essential initiatives that are critical to the success of the conceptual model as well as ideas that should be considered in the broader discussions of health care reform and how access can be expanded, quality improved, and costs more effectively managed. While many ongoing reforms, such as health care quality and technology innovations, can—and should—continue, our proposal also assumes that fundamental restructuring of the current system will be required to achieve desired results. The problems of the current system and the realization of the results being demanded by the American public cannot be achieved by tinkering with the current system.

The ERIC proposal consists of five key strategies:

1. Simplified *community-based* systems that would:
 - Be founded on national standards across major medical markets
 - Be uniformly available equally to employers and individuals
 - Expand financial access to health care for all Americans
2. A *level playing field* that is consumer friendly and that would result in competition among Benefit Administrators and their affiliated health plans on a fair and equitable basis.
3. A *transparent* system to improve quality, better manage costs, and create significantly more accountability for both payers and providers of health care.
4. *Incentives* to encourage providers to be responsive to cost and quality issues and consumers to live better and purchase wisely.
5. Expanded *health information technology* to improve both the efficiency and quality of our health care system.

COMMUNITY-BASED SYSTEMS

ERIC's proposal would require the federal government to establish, or facilitate the establishment of, community-based structures with the following attributes:

- **Standard Benefit Plans:** Each Benefit Administrator would have to offer, directly or indirectly, three to five standard health benefit plans to be defined by the Federal government, the

National Association of Insurance Commissioners (NAIC) or another federally sanctioned entity. These plans would be equally available to all residents of the defined major medical market and would be designed consistent with the philosophy used to define qualified Medicare Supplement plans. This would provide a standard, simplified foundation for the comparison of relative values among medical plans. Low-cost benefits options also would be available.

- **Individual Access to Health Plans:** Independent from their employment, individuals would be allowed to purchase health coverage from Benefit Administrators available in their community at equal prices.
- **Individual Mandate:** There would be a federal mandate (with standards established at the federal level) that every American individually be covered by a plan sponsored by a qualified Benefit Administrator or through some other qualified system. The individual mandate would be structured as follows:
 - Individuals enrolled in Medicare and Medicaid would automatically be in compliance with the mandate requirement.
 - Individuals enrolled in any other government-sponsored medical plan would automatically be in compliance with the mandate requirement.
 - Individuals enrolled in employer-sponsored plans would be in compliance with the mandate requirement.
 - With few exceptions (for example, depending on the evolution of subsidy programs for disadvantaged persons), all other individuals would be expected to obtain medical coverage through a qualified Benefit Administrator.
 - Although a method of certifying compliance with the individual mandate must be developed, compliance monitoring could probably be coordinated through qualified Benefit Administrators.
- **Subsidies for Financially Disadvantaged Persons:** The nature of an individual mandate requires a system of subsidies using tax credits or other mechanisms to assist financially disadvantaged individuals. We anticipate that full implementation of the ERIC proposal would generate significant cost savings and make the subsidy affordable. The details of the subsidy program remain open to discussion.
- **Employer Role in Funding Health Benefit Plans:** Employers would continue to voluntarily play a major role in funding health benefits for American workers:
 - The employer would be able to choose one or more Benefit Administrators to sponsor benefits for its employees.

Employers would continue to voluntarily play a major role in funding health benefits for American workers.

Alternatively, it might choose to make a direct payment to a Benefit Administrator chosen by the employee. The employer might also provide a voucher that employees could use to select their own plan offered by a Benefit Administrator.

- Each employer would determine the contribution it would make available for the purchase of a standard health benefit plan. The employee would be required to pay the difference between the employer contribution and the cost of the medical plan selected. The purpose of the fixed employer contribution is to assure that employees are sensitive to the different costs among health plans.

A LEVEL PLAYING FIELD

The establishment of uniform service areas based on major medical markets and the creation of standard health plans are significant steps toward leveling the playing field. Additional initiatives that are important to promote fairness and equitable competition include:

- **Modified Community-Rated Premiums:** Each plan would be required to offer a “modified community rated” premium based on the following principles:
 - All plans in a defined service area would uniformly bear the cost of disease and injury.
 - There would be standardized risk adjustments to the premium of each health plan in the service area based on the actual claims data in a previous period.
 - Age banding of premiums would be permitted for individually purchased policies to reflect reasonable cost differences related to age. (Employer-sponsored groups would be exempt from age banding.)
 - Adjustments related to self-imposed lifestyle risks, such as smoking, alcohol consumption, and avoidance of personal risk, should be considered.
 - Benefit Administrators and their affiliated health plans would be permitted to differentiate their premiums based on efficiencies generated by better administrator practices. And they would also benefit from efficiencies derived from superior disease management, utilization management, case management, lifestyle management, “pay-for-performance” systems, and other innovative initiatives designed to lower costs, increase quality, and improve accountability.

- **Disclosure of Administrative Practices:** The relative administrative performance of each Benefit Administrator must be available to consumers. (This is described in the next section.)

TRANSPARENCY AND ACCOUNTABILITY

The current health care system is difficult for consumers to navigate. There is very little reliable information on the comparative costs and quality of health care from one provider or provider system to another. There is also scant information on the relative performance of health plan administrators. ERIC believes that in a new system there must be total transparency of the comparable efficiency and quality of health care providers and the comparable quality of administrative practices of health plans. Some health providers and health plans are better than others.

Consumers, providers, employers, and health plans have the right to know how plans compare with each other. Total transparency of the health care system will promote better competition and will improve quality, lower costs, and increase plan performance. ERIC proposes the following initiatives to create a more transparent and accountable health care system:

- **Provider Transparency and Accountability:** Health providers (including physicians, nurses, hospitals, integrated systems, and pharmacies) are the cornerstone of a quality-oriented and efficient health care system. To give consumers better information to make good decisions and to help providers improve quality and efficiency, we propose the following:
 - A broad collaborative effort that includes providers, public- and private-sector representatives, payers, and consumers should develop definitions and standards for quality care. These standards should cover both process and outcome measures and be applied to individual physicians, groups of physicians, hospitals, integrated systems, and perhaps an entire enterprise. When completed, performance against these standards should be organized for each standard service area and be made publicly available in consumer friendly formats. The foundation for these standards should arise from evidence-based medicine, continuously updated and expanded.
 - A similar collaborative effort should be established to develop standardized measures and report health care cost information, including comparisons of cost differences created by how often certain treatments are dispensed in a

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standard population, cost differences in episodes of care, and differences in the “price” of each input that is part of an episode of care.

- We expect the provider community to aggressively use this information in conjunction with other initiatives to create care processes and guidelines that would eliminate unnecessary medical care and assure that patients receive the care they need every time.
- Standardized information should also be generated and made publicly available on the relative care experience reported by consumers with individual providers and integrated health care systems.
- **Health Plan Transparency and Accountability:** Health plans play a vital role in managing the interface between financing and health care delivery. Health plan administrators must be held accountable for their claims administrative practices, including overhead costs, delayed claims payments, errors, lost claims, and aggressive denial of claims. In any system, plans should not be financially advantaged simply because they become expert in denying payment for legitimate claims or they are slow or sloppy in their adjudication practices. There is very little information publicly available, however, about the relative performance of health plans. ERIC proposes uniform standards be developed through a collaborative process between the public- and private-sector stakeholders to measure and report, among other things, the following:
 - Full disclosure of expense loadings for each plan
 - The number and cost of denied claims
 - The cost of denied claims that is transferred to providers
 - The average out-of-pocket expense incurred by participants in each standard plan
 - The relative efficiency and quality of claims administration and other administrative; processes for each Benefit Administrator
 - Consumer assessments of each Benefit Administrator

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INCENTIVES FOR PROVIDERS AND CONSUMERS

Very weak financial incentives exist for both providers and consumers in the current health care system. Government and private plans generally pay the same amount regardless of the quality of care. In addition, those providers who consistently try to manage costs and avoid unnecessary care are paid less, whereas those who aggressively provide unnecessary care (and, in some cases, abuse the system) often end up profiting from their practices.

At the same time, consumers have few incentives to be prudent purchasers of health care and to improve “healthy living” by following prescribed medical protocols. Although the initiatives articulated in transparency and accountability section will help, ERIC recommends Benefit Administrators and their affiliated health plans implement the following additional initiatives:

- **Health care Providers:** Benefit Administrators and affiliated health plans should be proactive in developing payment methodologies that reward high quality care and responsible cost management by providers. The foundation work on pay-for-performance may be helpful, but far more needs to be done. Expanding electronic medical records and implementing other health information technologies will also help. (See next section.)
- **Consumers:** Consumers must take greater responsibility for better health care decisions. Benefit Administrators and their affiliated health plans should develop innovative incentives and approaches to promote healthy living and compliance with effective health treatments. For example, premium reductions could be used as incentives for individuals who demonstrate a commitment to improve their health status.

HEALTH INFORMATION TECHNOLOGY

The U.S. health care system is one of the last industries to adopt the efficiencies of information technology. Where it has been adopted, it is largely isolated within silos of large organizations or individual or small practices that are unable to communicate with each other or make information available to consumers.

Currently, few national standards exist for exchanging health information except for the administrative standards adopted because of the Health Insurance Portability and Accountability Act (HIPAA). Moreover, less than 25 percent of physicians have adopted electronic medical records. The modern health care system is an information-intensive industry with a significant need for data exchange, even among competing silos. The lack of interoperable standards results in higher costs, poorer health care quality, increased medical errors, and consumer ignorance about their own medical care and health conditions. ERIC strongly believes this deficiency in our health care system must be corrected and recommends implementation of the following initiatives:

- A consortium from the American health information community, including representatives from health care professions, government agencies, insurers, employers,

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and patients, should work together to establish national interpretable standards to create a framework for efficiently and effectively exchanging health information across the entire health care industry. This would entail:

- Nationally standardized messages and codes to allow information exchange
- Nationally standardized connectivity methodologies to improve how information is exchanged
- Nationally standardized security principles for exchanging information that would be reliable and ensure authenticity between the entities receiving and sending information
- Regional Health Information Organizations that are community-based and that effectively meet the needs of the health care system in each of the defined health services area
- Specific initiatives should be adopted to rapidly expand the use of electronic medical records.
- Benefit Administrators and their health plan affiliates should be engaged in the above initiatives and should quickly adopt applicable standards as they become available.
- The adoption and adherence to accepted methodologies should be required for participation in federal and private reimbursement programs and should ultimately become a condition for all medical providers.



STEPS TO IMPLEMENTATION

ERIC's proposal is comprehensive and aggressive. It targets not only the major issues that are of concern to employers but also the heart of most of the systemic problems that are part of the retirement, savings, and health care system. As such, this proposal touches many organizations, vested interests, and people. Accordingly, the challenges of obtaining a solid base of support are substantial. Clearly, there are areas of these recommendations that need further evaluation and assessment, and we look forward to discussions with other stakeholders before the provisions of this proposal can be implemented.

ERIC believes its comprehensive proposal is superior to those that are limited to tinkering with one narrow area without consideration of the overall benefits scheme as a whole.

There is significant frustration with the current system. There is an absolute certainty that health care reform will be a centerpiece of the national health policy debate during the 2008 presidential election. Many alternatives will be put before policy makers and the American public. And despite enactment of the Pension Protection Act in 2006, concerns about the adequacy of retirement savings will continue to foster legislative initiatives.

ERIC believes its comprehensive proposal is superior to those that are limited to tinkering with one narrow area without consideration of the overall benefits scheme as a whole. We have taken many of the internal steps needed to quickly refine and advance this package so that it can be a significant option for stakeholders and policymakers.

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APPENDICES

a NEW BENEFIT PLATFORM
for LIFE SECURITY

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THE AMERICAN EMPLOYEE BENEFITS SYSTEM: AN OVERVIEW

The U.S. benefits system today is an arrangement between businesses, individual workers and their families, and the government. It is made up of both voluntary and government-mandated benefits. Many companies, including most major employers, provide pensions, savings, health care coverage, life insurance, and disability insurance benefits on a voluntary basis. Social Security, Unemployment Insurance, and Workers' Compensation are funded in part by employers but mandated by federal and state governments. (For a detailed inventory of employment-based benefits, see the chart on p. 32.)

Employment-based benefits serve a variety of purposes. They are effective as a tool to attract and retain quality employees, and they help employers convey a message of caring that goes beyond the work place. They also form a foundation of economic security for employees by providing some protection against financial harm in uncertain life events during a working career and beyond.

In many cases, employees consider their benefits as separate from compensation, and sometimes they do not even acknowledge the benefits (particularly if they are not heavy users of a particular benefit, such as health care, or if a benefit will not be accessed until much later in life, such as retirement/savings plans, especially traditional defined benefit plans).

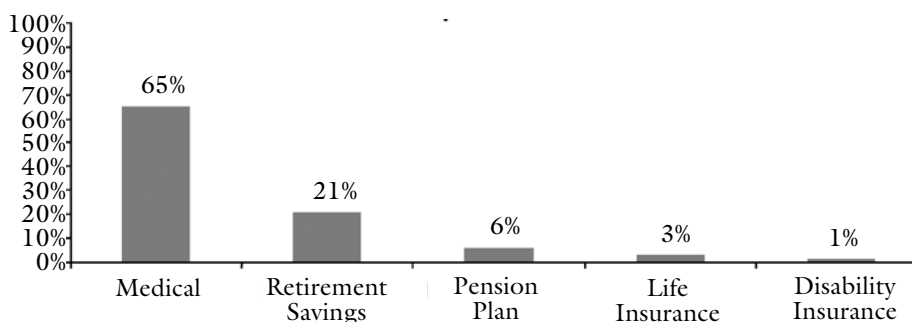
EMPLOYEE ATTITUDES ABOUT BENEFITS

In many cases, employees consider their benefits as separate from compensation, and sometimes they do not even acknowledge the benefits (particularly if they are not heavy users of a particular benefit, such as health care, or if a benefit will not be accessed until much later in life, such as retirement/savings plans, especially traditional defined benefit plans). In reality, however, the benefits are an integral part of the total compensation

package and, therefore, are viewed by employers in an aggregate cost basis. Economic studies have demonstrated the relationship of benefits to wages and salaries: if an employer provides rich benefits, it is more likely to pay less in wages; likewise, if benefits are minimal, an employer might have the latitude to pay more. Employees often do not appreciate the relationship between the cost of benefits and total compensation.

The relative importance to employees of different employment-based benefits varies from benefit to benefit. The following table summarizes responses to the question, “Which one of the employment sponsored benefits is most important to you?”

Figure I
The Relative Importance of Different Benefits



For employers, the implications of employee attitudes about benefits are significant. For example, health care costs over the past several years have resulted in significant premium increases that have had a serious impact on employers’ cost of doing business and competing in their global and domestic markets. At the same time, employees view medical benefits as the most important benefit they receive. Employers, therefore, must constantly strive to find lower cost medical benefits but face the reality that the result is often less medical coverage and higher out-of-pocket costs for their employees.

In addition, many companies experience difficulties in changing retirement benefits, especially for older employees. Employers that have aggressively altered their retirement programs—even when sound business reasons warrant doing so—have encountered severe negative reactions, not only from their employees but also from the media and the government.

It is clear that U.S. corporations cannot ignore employee attitudes about benefits. It is also clear that a “new structure” for delivering life security benefits must carefully consider the desires of American workers, balanced by opportunities for workers to take greater responsibility to achieve their expectations.

SOURCE OF SELECTED BENEFITS IN THE UNITED STATES

Figure II

Source of medical benefits	No. in millions	Percentage of population
Companies and government as employer	174	59.5
Government nonemployee	79.9	27.3
Direct purchase	26.6	9.1
Uninsured	46.6	16
Total Insured	245.9	84

Sources of Medical Benefits in the United States

As shown in Figure II, employers remain the most important source of health plan coverage, but government-sponsored programs are increasingly significant. Direct purchase of individual health insurance is a relatively insignificant means of coverage and is often difficult for individuals who have medical problems to access, maintain, and afford. The most important factor that determines whether an individual has access to a medical plan is the presence of a third party, such as employers and the government, to pay a significant portion of the premiums. Those who do not have such sponsorship are much less likely to have a medical plan and in most cases are uninsured.

Similarly, employers provide a significant source of retirement income for workers, separate from benefits provided under the Social Security system (see Figure III).

Figure III

Sources of Retirement Benefits in the United States

Source of retirement benefits	Percentage of families with an adult who has a retirement plan from a current job
U.S. Employers	40.3
IRA/Keogh Plan	21.1
From any source	56.9

Significant numbers of U.S. families continue to have no retirement plan other than Social Security. Yet, among families with a retirement plan, many have inadequate amounts to provide meaningful support in retirement. A recent EBRI study found that the average account balance in an IRA/Keogh account is about \$30,000.

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PRESERVING THE STRENGTHS OF THE CURRENT BENEFITS SYSTEM

Because employer participation in the current American benefits system has served many Americans extraordinarily well, attributes that encourage and maintain companies' involvement should be preserved under any new system. There is no doubt that programs sponsored by employers have provided workers financial access to health care and security in retirement. In addition, participation in the current system has helped employers achieve many of their important objectives, including attracting and retaining valuable talent, improving productivity, and providing a way for American workers to transition out of the workforce in a dignified manner.

Because employer participation in the current American benefits system has served many Americans extraordinarily well, attributes that encourage and maintain companies' involvement should be preserved under any new system.

ERIC's proposal seeks to preserve these key qualities:

1. **Attracting and Retaining a Quality Workforce.** Benefits allow an employer to differentiate itself from other employers in order to recruit employees. An employer can also develop specialized benefit features unique to its own organization and industry. The employer can also demonstrate through its benefit program, the company's unique culture, commitment to employees, and employment demographics, and it can tailor those benefits to respond to a competitive marketplace.
2. **Rewarding Long Service and Stabilizing Turnover.** An employer can structure benefits to encourage employees to stay longer, thereby creating a more stable workforce. For example, workers who highly value a pension plan are more likely to stay with an employer that offers one.

Employers have been at the forefront in creative solutions to improve the cost effectiveness and quality of benefits, particularly in the health care arena.

3. **Improving Productivity.** A comprehensive benefit program typical of that offered by large U.S. corporations is effective in keeping employees focused on their jobs and in improving productivity. Workers who do not have to worry about financial access to health care and long-term security can more effectively pay attention to their job duties and responsibilities and are demonstrably more likely to be more productive.
4. **Providing a Dignified Transition to Retirement.** Quality retirement benefits allow employees to transition out of employment with dignity when they are ready.
5. **Providing Benefits on a Tax-Effective Basis.** For most benefits, taxes are deferred for the employee until the benefit payment is made or the cost of the benefit is excluded from the employee's tax liability. The cost of benefits generally is deductible by the employer. The tax advantages create an incentive for employers to provide benefits, which in turn results in less dependence on government entitlement programs.
6. **"Risk Pooling" for Health Coverage.** Effective insurance schemes require a broad risk pool to distribute risk and minimize adverse selection. Employers form the basis of a natural risk pool, thereby producing more equitable pricing of health insurance products.
7. **Driving Innovations.** Employers have been at the forefront in creative solutions to improve the cost effectiveness and quality of benefits, particularly in the health care arena.
8. **Negotiating Capabilities.** Because employers purchase large quantities of benefits and have developed considerable expertise in cost and quality matters, they are in a more powerful position than individuals to obtain greater value and greater quality in obtaining retirement, health, life, and disability plans.
9. **Encouraging Improved Individual Behaviors.** Because of the relationship an employer has with its workforce, it is in an influential position to encourage positive behaviors to improve employees' quality of life, encourage long-term financial planning and awareness, and make individuals better purchasers of services related to their health and retirement security.
10. **Conveying an Attitude of Caring.** Employment-based benefits provide employers tools to demonstrate their appreciation and concern about their employees.



RESOLVING MAJOR PROBLEMS IN THE CURRENT BENEFITS SYSTEM

Employer participation in today's benefits system confronts many regulatory challenges. But there are other issues of concern that, when taken together, form the foundation for the questions ERIC raises about the way short- and long-term security benefits are delivered to individual Americans. In short, the current system both actively discourages employers from participating in it and inhibits positive actions to address the system's gaps and flaws.

The objective and the opportunity of a new benefits platform are: (1) to facilitate employer participation through a realistic structure that recognizes the changed world in which employers must compete and (2) to establish mechanisms that work to ameliorate the underlying problems.

Examined below are some of the factors that actively discourage employer participation in the American benefits system today:

1. **Long-Term Liabilities:** In the 1960s and before, retirement and medical plans were considered "fringe benefits" that were not a part of core compensation. They were a form of supplementary compensation that was provided at the discretion of the employer primarily to assist in hiring and retaining a quality workforce. Employers did not anticipate the dramatic long-term cost implications and liabilities of their benefit offerings. Workers had shorter life expectancies than they do today, and there were fewer retirees in proportion to active workers. Since then, life expectancy has increased and many employers have experienced an opposite trend in the ratio of active to retired

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workers. Spending an increasingly longer portion of life in retirement has become an expectation for greater numbers of workers, leading many to view employer-provided benefits, not as a tool in their personal security program (e.g., Social Security, employer pension, savings, and health care) but as an entitlement program.

Over the years, the rules that govern employer-sponsored benefits also changed. The Employee Retirement Income Security Act's (ERISA) vesting rules in effect transformed retirement plan contributions into deferred salary. In addition, the Financial Accounting Standards Board's (FASB) accounting standards required employers to recognize the present value of future benefit obligations. The cost of benefits thus became significantly greater than employers anticipated, making the balancing of employee's need for security with the employer's ability to pay for these long-term commitments increasingly difficult. Benefit plans have become more central to compensation, and employers have struggled to manage obligations that not only have become increasingly expensive but also often exceed the life cycle of an employer's business products, its line of business, or even the enterprise itself.

As employers have attempted to adapt—by making changes to benefit plans or to the contributions to the plans - they have found themselves subject to legal constraints, growing litigation, and societal pressures that make change difficult. Benefits voluntarily provided by employers have, in the minds of some, evolved from optional voluntary “fringe” benefits to an “entitlement” program.

2. **Undesirable Assignment of Fiduciary Responsibility:**

The current regulatory regime extends fiduciary liability to individuals and institutions that, in many cases, have no idea that they are fiduciaries and frequently are not competent in the complex issues associated with the structure and administration of employer-sponsored benefit programs. Many employers are willing to provide meaningful retirement and welfare benefits but are wary of the increasing fiduciary liabilities inherent in sponsoring these plans. The courts, the Internal Revenue Service (IRS), and the Department of Labor (DOL) have expanded the interpretation of the once-stable fiduciary rules. This is very unsettling to employers. They are increasingly concerned that they not only are the sponsor of the plan but also will become liable for events that were unanticipated or not subject to liability at the time of plan implementation. When combined with the complexity of the laws, fiduciary responsibilities issues can pose significant impediments to plan sponsorship.

Many employers are willing to provide meaningful retirement and welfare benefits but are wary of the increasing fiduciary liabilities inherent in sponsoring these plans.

3. **Funding Volatility:** The combination of changing interest rates and inconsistent investment returns in conjunction with short-term measures of pension obligations and contribution requirements have combined to make the funding of defined benefit pension plans difficult if not impossible for employers to manage. This actively discourages plan sponsorship. The increased funding volatility inherent in the 2006 Pension Protection Act (PPA) is likely to create even greater funding volatility and accelerate a retreat from traditional defined benefit plans.
4. **Complexity:** Complexity in benefits law is a function of various restrictive and proscriptive statutes that seek to accomplish different, often conflicting, purposes. After its enactment in 1974 and for many years thereafter, ERISA was considered a “highly reticulated statute”; that is, it was not necessary to look to other laws to understand the rules that applied.

Over time, however, other statutes (the Equal Employment Opportunity Act, the Older Workers Benefit Protection Act, and the Age Discrimination in Employment Act, among others) and related regulations have effectively “dereticulated” ERISA, piling on and complicating the regulatory scheme and forcing employers to reach into a hornets’ nest of statutes and regulations to avoid compliance-related problems.

Accordingly, plan sponsors now face a multiplicity of regulatory schemes that attempt to accomplish social policy objectives while ensuring fairness. Federal tax policy attempts to optimize revenues while promoting retirement security. To achieve these dual objectives, the tax code imposes a complex set of nondiscrimination rules that have evolved over time and that are inconsistently applied for different benefits, difficult to understand, and costly to administer. Laws and regulatory schemes typically lump together large and small businesses that, in many cases, have very different employment-based retirement and health care coverage concerns and time frames.

As a result, the complex, current regulatory regime is difficult for both employers and employees to understand or rationalize. It also has resulted in the growth of several new industries that have a business purpose of helping employers understand all the complexities inherent in sponsoring benefit plans. In addition, it has spawned a class action litigation industry that takes advantage of regulatory complexity by initiating litigation and other threats against plan sponsors. In many cases, employers have resorted to settlements, not because they were in fact liable, but because it was cheaper or less disruptive to settle than to face years of litigation.

The complexity and breadth of ERISA has simply gotten out of hand. For example, in 1998, the American Bar Association Joint Committee on Employee Benefits two-day course on “ERISA Basics” included 13 faculty and authors and 534 pages of materials. Only eight years later—in 2006—“ERISA Basics” required three days, 23 faculty and authors, and 1,377 pages of materials.

In many court cases, as well as legislative proposals, plaintiffs charge that employers have failed to adhere to a concept of “vested rights of expectation”—an unsupported and misguided idea that an employer should be required to deliver what the employees hope for rather than what is clearly articulated by the plan.

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- 5. Increasing Litigation:** Increasing litigation inflicts additional cost and uncertainty for employer-sponsored plans. Employers are vulnerable to legal challenges that result from the complexity of the rules and unintended errors. The expansion of cash balance pension plans came to a virtual halt due to litigation challenges. The *Erie County* case has raised questions about pre-Medicare, post employment medical plans. Moreover, several cases have led employers to hesitate in making any changes in their current benefit plans. In many court cases, as well as legislative proposals, plaintiffs charge that employers have failed to adhere to a concept of “vested rights of expectation”—an unsupported and misguided idea that an employer should be required to deliver what the employees hope for rather than what is clearly articulated by the plan.

More recently, the “risks” associated with communication issues in employer-sponsored plans are becoming more and more vexing. These are just a few examples of litigation that has created uncertainty among employers, making them reconsider what they are willing and not willing to do and whether sponsoring a plan is worth the risk and costs.

- 6. Inflexibility:** The current legal and political systems have combined to lock in benefits that were intended and understood to be part of voluntary actions by employers. This has limited the flexibility that both employers and employees need. Employers find that responding to changing economic circumstances is difficult, even when the competitive environment has changed dramatically or when the plan sponsor may have changed its business purpose and requires different employee skills to survive. In addition, employees are not always able to effectively use benefit dollars in ways that are consistent with their own individual circumstances.
- 7. Erosion of ERISA Preemption:** The courts have eroded once sacrosanct ERISA preemption that is vital to plans that are administered in more than one state. Several cases related to “patient rights” were spawned by the managed care backlash. For example, “any willing provider” suits raise questions about selective contracting that was designed to improve health care cost management and health care quality (*Kentucky Assn. of Health Plans v. Miller*). There have also been attempts to limit subrogation rights under state law that were once considered protected by ERISA (*Great West Life & Annuity v. Knudson*).

And there have been concerns about state withholding laws where companies desire to implement “automatic enrollment” in their retirement savings plans.

8. **Adverse Impact of Accounting Rules:** New accounting rules, although well intended and perhaps necessary, have brought new forms of cost recognition to the system. Recently adopted FASB rules will move cost recognition from a company’s footnotes directly to its financial statements, creating a perception of “higher costs” for benefits. This, in turn, has resulted in employers’ benefit-restructuring initiatives by making defined benefit pensions and postretirement medical benefits less generous in an effort to make them less costly.
9. **Diversion of Business Focus:** Related to the complexity and fiduciary liability issues are the demands on many plan sponsors to develop multiple competencies relating to benefits, an area outside of their core enterprise. They are forced to develop expertise in the many facets of benefits administration, including the hiring and the oversight of:
 - A benefits consulting firm
 - An investment advisor
 - An actuarial firm
 - A custodian for the assets held in employer plans
 - One or more investment firms or mutual fund companies to manage money
 - A communications firm to provide plan information to participants
 - A record-keeping firm to maintain participant requests
 - An accounting or financial planning firm to help participants devise appropriate investment strategies
 - Various medical, dental, disability, and life insurance companies to provide welfare benefit plans
 - A claims processing agent
 - A variety of companies to provide value-added benefits
 - Legal counsel to provide comprehensive compliance monitoring

For employers that administer benefits in-house, the need for the broad range of expertise can be overwhelming, and this remains true for those that partially or totally outsource benefits administration.

New accounting rules, although well intended and perhaps necessary, have brought new forms of cost recognition to the system.

10. **Hgh Health Care Costs:** The sharply rising costs continue to challenge the financing system and the capacity of U.S. companies to contribute toward these costs. In 2004, employer health care costs were estimated at \$6,400 per person and projected to increase to \$11,000 by 2014. This is significantly higher than any other industrialized country, including, for example, Canada (\$2,931), Germany (\$2,817), and France (\$2,736).

The concerns outlined above are exacerbated by *underlying problems* that are difficult to address under the current benefits system. ERIC believes that a fundamental restructuring of the system would place employers, individuals, and the government in a better position to tackle many of these underlying problems.

UNDERLYING PROBLEMS THAT WILL BE ADDRESSED IN A NEW BENEFITS PLATFORM:

1. **Lack of Portability:** Some aspects of employment-derived benefits do not lend themselves to optimal portability in a society where individuals change jobs throughout their careers and where vesting requirements have made retirement plans resemble deferred wages and salaries. Portability concerns are most significant for defined benefit retirement plans and retiree medical benefits. However, portability issues also are raised for health insurance, by limiting an employee's mobility within the labor force, for example. The lack of portability can create "job-lock" that might not be in the best interest of either employers or employees. On the other hand, constrained portability can help employers retain employees. Furthermore, when employees change employers and have to deal with different benefit programs and administration, there is the potential loss of continuity that could result in less-than-optimal use of benefits, thereby compromising their retirement security and other related issues.
2. **Changing Demographics and Retirement Patterns:** The duration of life in retirement has increased dramatically over the past 50 years. This has important implications for the cost of retirement plans for employers and the activities of older persons during the traditional retirement years. In addition, more than seven in ten workers say they would prefer to phase out of the workforce rather than have a "cliff" transition from working to retirement. Phased retirement, however, does not affect all employers in the same way in all industries.
3. **Defined Contribution Plans Have Become Predominant but Might Not Provide Adequate Retirement Income:** Most defined contribution plans in their present form were initially not intended to serve as a primary source of retirement security. Rather, they were to provide a tax effective way of

strengthening the “savings” leg of the retirement security stool, the other two legs being Social Security and defined benefit plans. Nevertheless, defined contribution plans began to surpass defined benefit plans as the predominant retirement vehicle in the U.S. starting in about 1988. Today, about 44 percent of U.S. workers are covered by a defined contribution plan; by contrast, defined benefit plans cover only 17 percent of the private workforce, down from the 41 percent in 1978.

A full career worker contributing between 10 percent and 15 percent of pay every year to a defined contribution plan can achieve retirement income security, but few do this. An analysis by the Employee Benefit Research Institute found that median income replacement rates at age 65 for persons retiring between 2030 and 2036 are projected to be between 51 percent and 67 percent (depending on income) for those who are continuously covered by a defined contribution plan, and 28 percent for those who are intermittently covered. Because of job change patterns, however, one-half of households near retirement age have \$10,000 or less in a 401(k) or IRA. Moreover, one-fourth of those who can participate in a plan do not. The average account balance for workers aged 65 is \$100,000. These accumulations are not sufficient to provide retirement security. This has enormous implications for individuals’ quality of life and for the Social Security and Medicare programs.

4. **Lack of Full Retirement Plan Coverage:** Fewer than 50 percent of workers have access to a retirement plan through their employer. At the same time, Americans have been saving less of their income for the future, despite the availability of numerous individual savings options. The President’s Advisory Panel on Federal Tax Reform estimated that the net U.S. savings rate has fallen from about 9 percent of gross domestic income to about 2 percent. One reason that financial advisors cite for this decline is the “paralysis” investors experience when presented by the range of tax-preferred saving choices. ERIC believes strongly in the importance of an organized retirement system that meets the broad-based needs of society to provide income security to older Americans. The lack of such a system would result in more impoverished elderly, which would be destabilizing and unacceptable to our society.
5. **Increasing Health Care Costs Make Changes Difficult:** While employers have provided access to increasingly sophisticated health care to the majority of workers and their families, they are only part of a larger health care delivery and financing system that has had scant success in managing the rate of growth in health care costs over time. The Centers for Medicare & Medicaid Services reported that total U.S. expenditures on health care in 2004 were nearly \$1.9 trillion,

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more than two and one-half times the \$717 billion spent in 1990 and more than eight times the \$255 billion spent in 1980. The 2004 tally represents 16 percent of the U.S. Gross Domestic Product (GDP), three times larger than the industry's share in 1960.

Many entities are part of the current problem. Enormous sums of money associated with the current system are dispersed among different enterprises that threaten to become a health industrial complex with a vested interest in perpetuating the status quo and ensuring that their financial interests are protected. This kind of fracturing makes efforts to manage costs and improve quality very difficult, and imposes intractable inertia that perpetuates the current system. Employers are increasingly discouraged from participating in the system and are often stymied when they attempt to work positively on the problems.

The health care system insulates consumers from the full cost of benefits and from their responsibility for many important decisions about the use of benefits. It also insulates providers from the demands for the same quality that consumers expect from other services.

6. **Cumbersome Administrative Systems:** The United States is on the verge of having a health industrial complex that is unmanageable and out of control. There are brokers; provider networks; provider intermediaries; utilization and disease management firms; repricing services; coding, consulting, and software systems for providers; coding and editing services and systems for payers; pharmacy benefit managers; and other entities that hope to expand their cut of the \$2 trillion spent on health care in the United States. A new structure must aggressively simplify and streamline the administrative system to generate real value for consumers.
7. **Problems with Health Care Quality:** There are documented cases of less-than-optimal care that go back many years. Still, the United States is making very slow progress in addressing and resolving the health care quality issues. There remain too many medical errors; the Institute of Medicine indicated that 40,000 to 98,000 deaths annually are due to medical errors.
8. **Consumer Responsibility:** The health care system insulates consumers from the full cost of benefits and from their responsibility for many important decisions about the use of benefits. It also insulates providers from the demands for the same quality that consumers expect from other services. Part of the problem rests with the complexity of the system and the perceived need for a third party (e.g., the employer) to optimize an individual's ability to make sound decisions.

Employers pay the bulk of health care costs, with consumers paying an average of 20 percent. The result of this degree of cost sharing is that consumers fail to be sensitive to the total cost as long as they are insured. Moreover, if they are uninsured, they may receive "free" care at the emergency room,

arguably the most expensive means of obtaining care. For some consumers, there is a perception that “someone else” will and should pay for their health care regardless of how much they consume or how much it costs. This makes pricing incentives weak for both consumers and providers. This perception has been aggravated by the fact that the employer-based system largely insulates consumers from the effects of rising costs. Even as worker costs have gone up, employer costs have gone up much more as employers have absorbed the majority of health care cost increases.

With limited exceptions, the health care system does not reward individuals who take responsibility for their own health by eating properly, getting proper exercise, avoiding personal habits that can adversely affect health, and complying with prescribed medical protocols for known illnesses or predispositions to illness. To the contrary, the current system does not require any accountability for those who fail to take responsibility for their own health. Many health-related problems and their attendant costs could be avoided or reduced if individuals changed some of their personal health behaviors. If certain risk factors were used to differentiate risk for the purpose of establishing health insurance premium rates, there would be visible incentives for individuals to manage their self-imposed risk profiles.

However, consumer responsibility concerns are not limited to health care issues. Individuals also avoid making decisions that would optimize their potential for retirement security until they have reached older ages, by which time catching up is made exponentially more difficult. In many cases, education programs have been ineffective and, as a result, employees are poorly equipped to make appropriate decisions. There is concern that too little has been expected from employees for taking personal responsibility for their own health and retirement.

9. **Provider Accountability:** There is considerable evidence of the need for greater provider accountability in our health care system. Research has demonstrated five to ten times more hospitalizations for certain medical procedures from one community to another. A RAND corporation study found inappropriate care about 14 percent to 32 percent of the time. This has significant cost implications for the U.S. health care system.

The fees charged by providers also vary substantially from provider to provider. In many cases, consumers are unaware or have little information about the services for which fees are charged. In some cases, excessive fees are passed on to consumers. In a restructured system, providers would be accountable for the cost of health care they dispense, the fees they charge, the elimination of care that has no value, and ensuring that individual Americans receive the recommended care all of the time.

Even as worker costs have gone up, employer costs have gone up much more as employers have absorbed the majority of health care cost increases.

In addition, consumers are frustrated with challenges in scheduling appointments with providers, the amount of time they must wait after they arrive for the appointment, and the quality of the provider interaction they experience in the care setting.

10. **Accountability of Benefit/Health Plan Administrators:**

Health plan administrators need to be accountable for the quality of their administrative practices and processes. There are increasing complaints from both providers and consumers related to slow claims payments, errors, lost claims, and refusals to pay legitimate claims. Administrative practices of certain third parties, according to a recent New York Times article, have been estimated to add as much as 20 percent of a physician's overhead costs. In addition, the cost of inappropriately denied claims in many cases is often passed on to individual patients. There are also indications that the aggressiveness of claims administrative practices varies from health plan to health plan. Administrators should not be financially advantaged simply because they become expert in denying payment for legitimate claims or they are slow and/or sloppy in their adjudication practices.

11. **Inability to Expand Access to Health Care:** Nearly 46 million people in the United States are uninsured, and a significant additional number are underinsured. Over the years, the modest gains in the number of people with individually purchased health insurance have reversed course. The government has made efforts to expand Medicaid and other programs, but funding limitations have kept success from being achieved. Employer participation in the current system is under tremendous pressure to contract and is not well situated to address the need to expand health care. The individual market has failed to fill the gap as well, because too many Americans simply cannot afford health insurance offered in that market.



A TIMELINE OF EMPLOYER PARTICIPATION IN THE AMERICAN BENEFITS SYSTEM¹

An understanding of the history of employer participation in the American benefits system and of the evolution of the regulatory framework that governs benefits programs sheds light into the challenges facing U.S. corporations today. The following highlights trace that development.

- **1600s—Early Programs:** Life security benefit programs sponsored by employers, although not widespread until the twentieth century, have existed in America since the seventeenth century. Early programs included the Plymouth Colony Settlers Military Retirement Program in 1636, Gallitan Glassworks Profit Sharing Plan in 1797, American Express Company’s pension plan in 1875, and Montgomery Ward’s Group Health Life and Accident Insurance program in 1910.
- **1921–1942—Government as a Catalyst:** The federal government became a catalyst for employer-provided benefits by enacting special tax treatment for plans and stipulating that benefits must not discriminate in favor of the highly compensated. (See the Revenue Acts of 1921, 1926, 1928, 1938, 1939, and 1942.)
- **1935—Impact of the Great Depression:** Responding to serious concerns about the long-term security of American workers, The Nation in 1935 enacted the Social Security Act, thereby directly involving the federal government and employers in the provision of retirement benefits.
- **Post-World War II—Expansion of Employer Plans:** Collective bargaining agreements increasingly included employer-sponsored pension, health, and welfare plans. In 1947, pension benefits became a mandatory subject of bargaining and the Nation enacted the Taft-Hartley Act to safeguard money contributed to plans administered jointly by an employer and a union. The 1958 Welfare and Pension Plans Disclosure Act laid the foundation for the extensive reporting system that exists today.

¹The source of a major portion of this “timeline” was from “American Bar Association, Employee Benefits Law (BNA Books, 1991). The ERISA Industry Committee supplemented that information including citations for the statutes.

- **1965—Federal Health Insurance:** A 1945 call by President Harry Truman for a national health insurance program culminated in the 1965 creation of the Medicare and Medicaid programs as part of President Lyndon Johnson’s “Great Society.” In 1972, Medicare eligibility was extended to people with disabilities and people with end-stage renal disease.
- **1974—Employer Plan Expansion leads to ERISA:** Disparate regulatory actions by State Insurance Commissioners and the demise of the Studebaker Company and its pension plans in 1962–63 resulted in a Kennedy administration study, completed in 1965, to identify reforms needed in the employee benefits system. Nearly a decade later, the Employee Retirement Income Security Act (ERISA) established national uniformity; imposed sweeping vesting, funding, reporting, fiduciary, and disclosure rules on plans; and established a benefit guarantee system funded by participating employers.
- **1978–1981—Employer Plans Encouraged:** After ERISA, new incentives were enacted for employee stock ownership plans (ESOPs), cash-or-deferred arrangements under tax code section 401(k) were enacted, Individual Retirement Accounts (IRAs) became universally available, and nondiscrimination standards were strengthened and new funding standards on multiemployer pension plans were imposed. (See the Revenue Act of 1978, Miscellaneous Revenue Act of 1980, Multiemployer Pension Plan Amendment Act of 1980, and Economic Recovery Tax Act of 1981.)
- **1982–1994—Employer Plans as a Revenue Source Mingle with Reforms:** Faced with ballooning deficits following the large federal tax cuts enacted in 1981, laws almost annually to restrict contributions to and benefits paid from all forms of tax-qualified plans were enacted. The actions delayed and restricted the ability of baby boom workers to prepare for retirement. They also effectively precluded high-paid employees from meaningful participation in tax-favored plans, leading to the development and significant expansion of “nonqualified” plans. In addition, nondiscrimination rules and deduction limits were imposed on welfare plans, and Medicare was made secondary payer for workers covered by an employer plan. Parallel to the enactment of laws that fiscally restricted benefit plans, other statutory changes complicated plan administration. Reforms to protect the interests of women, for example, were followed by two amendments (in 1987 and 1994) of the pension funding rules, the imposition of “reversion taxes” on excess assets returned to the employer, the addition of special requirements applicable to retirement plan distributions, the adoption of new coverage and nondiscrimination rules, continued health coverage accessibility in certain circumstances, and the application of age nondiscrimination laws to benefit plans. (See

the Tax Equity and Fiscal Responsibility Act of 1982, Retirement Equity Act of 1984, Deficit Reduction Act of 1984, Consolidated Omnibus Budget Reconciliation Act of 1985, Tax Reform Act of 1986, Omnibus Budget Reconciliation Acts of 1986, 1987, 1988, 1989, 1990, and 1993, Technical and Miscellaneous Revenue Act of 1988, Older Workers Benefit Protection Act of 1990, and Uruguay Round Agreements Act of 1994.)

- **1983–1988—Federal Programs Also Restricted:** The 1983 Social Security Amendments raised the Federal Insurance Contribution Act (FICA) taxes and restricted benefits in the face of financial pressures on the program; a 1988 foray into providing Medicare catastrophic coverage resulted in the repeal of that law the following year.
- **1996–2006—Health Plan Regulation Intensified; for Pensions, Some Relief:** In 1996, Congress required greater health coverage portability, established Medical Savings Accounts, mandated standards for maternity hospital stays, and imposed “parity” between mental and conventional health benefits. At the same time, it reduced regulatory burdens on retirement plans and expanded benefits that could be provided through tax-favored programs. These retirement reforms were followed by a second set of reforms in 1997 and by a large package of changes and expansions enacted in 2001 and made permanent in 2006. (See the Health Insurance Portability and Accountability Act, Mental Health Parity Act, Newborns’ and Mother’s Health Protection Act, and Small Business Job Protection Act (all of 1996), Taxpayer Relief Act of 1997, Economic Growth and Tax Relief Reconciliation Act of 2001, and Pension Protection Act of 2006.)
- **2003—Federal Health Expanded:** The most significant expansion of Medicare since the program’s inception was enacted - including a prescription drug benefit and myriad other reforms, some designed to introduce competitive market forces into the program.
- **2006—Pension Reform Redux:** The collapse of employee 401(k) plans at Enron and WorldCom, growing concern that savings in 401(k) plans are insufficient, the demise of the 30-year Treasury bond (a cornerstone of the 1987 and 1994 pension funding reforms), legal challenges to hybrid pension plan designs, a series of high-profile pension plan terminations (primarily in the steel and airline industries), and a drumbeat of publicity contending that the Pension Benefit Guaranty Corporation was financially insecure, resulted in a period of intense uncertainty and ultimately increased financial liabilities for plan sponsors and the most comprehensive pension reforms enacted since ERISA in 1974. (See also the Sarbanes-Oxley Act of 2002, Job Creation and Worker Assistance Act of 2002,

Pension Funding Equity Act of 2004, and American Jobs Creation Act of 2004.)

- **1990s–2007—FASB Pressures Long-Term Commitments:** Standards imposed by the Financial Accounting Standards Board beginning in the 1990s required employers to recognize the present value of health benefits that would be paid in the future under the employers' current programs, resulting in a steady demise of health benefits covering retirees. Beginning in 2007, projected benefit obligations under defined benefit pension plans must be reflected on a company's balance sheet, raising speculation that plans might be frozen or terminated to minimize the cost of employers' future obligations.

Conclusion. There is no reason to presume that the government's frequent changes in rules governing benefit plans sponsored by employers will abate in the future. To the contrary, employers sponsoring plans are likely to face a constantly shifting regulatory environment in which some changes are sought by employers and many others are imposed upon them.

Embargo To 06/13/07

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