The HSA in Your Future: Defined Contribution Retiree Medical Coverage

In 2004, when evaluating health savings account (HSA) business opportunities, I predicted: "Twenty-five years ago, no one had ever heard of 401(k); 25 years from now, everyone will have an HSA." Twelve years later, growth in HSA eligibility, participation, contributions and asset accumulations suggests we just might achieve that prediction. This article shares one plan sponsor's journey to help employees accumulate assets to fund medical costs—while employed and after retirement. It documents a 30-plus-year retiree health insurance transition from a defined benefit to a defined dollar structure and culminating in a full-replacement defined contribution structure using HSA-qualifying high-deductible health plans (HDHPs) and then redeploying/repurposing the HSA to incorporate a savings incentive for retiree medical costs.

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Retiree Medical Coverage Prior to 2005

In the past, employers handled employer-sponsored retiree medical coverage in one of three ways. They:

1. Maintained plans adopted decades ago
2. Did not offer retiree health care coverage
3. Changed their plans after decades of double-digit medical inflation and the effective date of Financial Accounting Standard 106 (FAS 106).

When FAS 106 took effect, almost all employers reevaluated existing retiree medical coverage. Some changed benefits for current retirees, and almost all changed benefits for future retirees. It was rare for an employer to add retiree medical benefits after FAS 106 took effect. In fact, typically employers responded to the combination of medical inflation and the new accounting rules by eliminating coverage, sometimes grandfathering current retirees and/or those soon to retire.[1]

As grandfathered participants wane and if coverage reductions continue, fewer and fewer retirees will have employer-sponsored coverage. This uncertainty makes retirement preparation that much more difficult. Even where coverage continues to be offered, future designs likely won't match past, often generous coverage. Future designs increasingly incorporate individual account-based programs, such as health reimbursement arrangements (HRAs) and health savings accounts (HSAs), Medicare Advantage, private exchanges, etc.[2]

Retiree Medical Coverage, 1985-2005—Change From Defined Benefit to Defined Dollar

In 1985, my employer's eligibility requirement for lifetime retiree medical coverage was five years of service and termination after reaching the age of 55, including retirees, spouse and dependents (including a spouse or child acquired after retirement). We offered the same coverage provided to active employees but, unlike for active employees, the coverage was noncontributory for retirees. So everyone enrolled.

After correcting for an accounting error, health actuaries estimated our unfunded liability for retiree medical coverage in 1985 at $1.49 billion. Employees or retirees did not have a savings vehicle specifically earmarked for retiree medical coverage. About 74% of eligible employees participated in the employer's 401(k) plan but, because eligibility was limited to those with three years of service, only 55% of all active employees contributed to the 401(k) plan.

In November 1985, many employers were concerned that courts might "vest" retiree health care benefits.[3] My employer reviewed all available options that would limit liability[4] and decided on the following strategy:

- Make an explicit decision to continue to offer retiree health care.
- Limit coverage to "true" retirees—those who terminate at a "retirement age" after long service.
- Make a clear and unambiguous reservation of rights, repeated annually and confirmed with every future change.
- Implement repeated, perennial changes (eligibility, coverage, etc.) to practically reaffirm asserted rights.
- Adjust employer financial support to prorate based on completion of a significant period of service.
- Prospectively apply any strategic changes (eligibility, coverage, retiree contributions, etc.).

Retiree coverage was changed almost every year after 1986. The plan sponsor also deliberately implemented changes to distinguish retiree groups, changes that affected only future retirees after January 1, 1989:

- **Eligibility:** Terminate after the age of 55 and 15 years of service, with transitions
- **Cost sharing:** Initiate retiree contributions. Set employer financial support at 50% of the cost of the base coverage option for those with 15 years of service, plus 4% per year for added years of service, up to a maximum of 90% at 25 years of service. Retirees pay the difference when electing an option with a higher coverage value.

In 1994, my employer finalized changes that converted the retiree medical coverage from a "defined benefit" to a "defined dollar" structure in terms of employer financial support. Specific changes included:

- Cap employer costs through a 401(h) account added to the defined benefit pension plan
- Limit spouse/dependent eligibility to those eligible as of separation from service date
- Cap dollar amount of employer financial support per year of service, with ad hoc inflation adjustments
- Condition retiree medical coverage on pension benefit commencement
- Increase flexibility by allowing retirees to suspend retiree health coverage in favor of other coverage (second career, spouse's employer's plan, etc.), allowing later reenrollment with proof of continuous coverage.

In 2001, my employer froze the employer financial support dollar caps, added access-only retiree medical coverage for those who terminated employment after reaching the age of 55 and completing ten years of service, and introduced a customized tool workers could use to estimate future retiree medical costs.

In part because of litigation concerns, my employer long ago changed retiree medical coverage from a defined benefit to a defined dollar structure, which also involved implementing changes in eligibility, coverage, cost sharing and maximums. (See the 1985-2005 sidebar.)

Active and Retiree Medical Coverage—2005 and Beyond

Tax-preferred medical savings accounts offer significant potential. So my employer adopted an HSA-qualifying high-deductible health plan (HDHP) right after it became

Retiree Medical Coverage, 2009-2016—Change from Defined Dollar to Defined Contribution

In 2009, my employer completed the transition from a "defined benefit" to a "defined dollar" to a "defined contribution" structure by freezing employer financial support at current levels and by limiting future employer financial support to those workers who saved while employed. The redesigned plan:

- Anticipated the impact of health reform, particularly in terms of reducing the plan sponsor's exposure to a retiree's spouse and dependents and the exposure from the costs of covering retirees not eligible for Medicare
- Encouraged active employees to save, invest and fund their future retiree medical needs
- Took advantage of the tax preference potential accorded to HSA assets (particularly with regard to using those HSA assets to pay the premium cost of employer-sponsored Medicare supplemental coverage).

Specific changes included:

- A transition out of the "defined dollar" structure by freezing accumulated past service used for determining employer financial support for retiree medical coverage
- Added after-tax, 401(a) savings plan contributions for non-highly compensated employees (NHCEs)
- Created an HRA notional account for NHCEs, determining credits each calendar year by taking the sum of after-tax 401(a) contributions and any unmatched employee HSA contributions and multiplying it by 33%, up to a maximum credit of $1,000 per year and a maximum number of annual credits of 25 (reduced by years of cost sharing grandfathered under the pre-2010, service-based, defined-dollar, cost-sharing provisions)
- Applied "interest" on credits based on the savings plan's guaranteed investment contract crediting rate
- "Funded" HRA credits and "earnings" by assets accumulated in the pension plan's 401(h) account
- Limited $100 per month "HRA distributions" to pay employer-sponsored, Medicare supplement premiums.

Since 2014, my former employer ensured a singular focus on saving using the HSA-qualifying medical options by:

- Completing the transition to a full-replacement structure that limits enrollment for almost all active employees to one of two HSA-qualifying HDHP options
- Limiting the HRA "matching" credits to workers' HSA contributions (eliminating HRA matching credits for 401(a) after-tax savings).

available. In 2007, the HSA was amended to permit employee contributions up to the annual dollar maximums under Internal Revenue Code (IRC) §223.[5] An employer match was added to incent savings—$1 for every $2 of IRC §125 cafeteria plan HSA deferrals—to fund the deductible (e.g., employees contributed $800 to receive an employer match of $400 to fund an individual deductible of $1,200). Retirees not eligible for Medicare could enroll in an HSA-qualifying HDHP. Retirees were ineligible for the cafeteria plan and the employer match but could contribute to an HSA and take an "above-the-line" tax deduction. In 2009, we completed the transition by changing employer financial support to a defined contribution structure and by repurposing the HSA, lowering employer unfunded liability by almost 95% compared with 1985 estimates. (See the 2009-2016 sidebar.)

The final defined contribution structure delivers a superior result for workers (now and as retirees) while also enabling my employer to continue to offer retiree medical coverage because:

- Preparing for retirement requires an accumulation of wealth for income replacement and retiree medical costs
- It triggers employer liability through an incentive for workers to save during up to 25 years of service
- HSA assets are tax-preferred so retirees need not pay medical expenses with after-tax dollars
- Employer costs are minimized because of:
  - —The eligibility provisions (terminate after the age of 55 and 15 years of service)
  - —The tax-preferred earnings on IRC §401(h) account assets
  - —HRA payout commencement is delayed until Medicare commencement at/after the age of 65.

401(k) Maximization

My employer sought to maximize employee participation and contributions to our 401(k) plan with the following measures:

- **Participation:** Perennial automatic enrollment for all non-participants at 3% (2007-08), 4% (2009), 5% (2010), 6% (2011 on). (Each person who opts out is again defaulted into participation each year.)
- **Contributions:** Perennial automatic escalation of 1% per year until employee deferrals reached 6% (2007-08) or 12% (2009 on). The target rate of savings was 15% of pay.
- **Options:** Pretax and Roth 401(k) and, for non-HCEs on or after January 1, 2010, after-tax 401(a)
- **Results:**
  - —Each year since 2007, 95+% of eligible employees are contributing.
  - —Each year since 2009, about 95% of eligible employees received the full employer match (50% of first 6% of pay contributed).

—Payouts are limited to $100 per month and only to defray the cost of employer-sponsored, retiree-pay-all Medicare Advantage/Medicare supplement coverage.

Maximizing Savings and Investments—2005 and Beyond

In 2006, my employer adopted provisions to maximize 401(k) participation/contributions. (See the 401(k) Maximization sidebar.) The HSA-qualifying HDHP has always focused on maximizing participation, contributions and the investment of HSA assets (for example, by using automatic features):

- **Participation:** Upon enrolling in an HSA-qualifying HDHP, employee automatically is enrolled in an HSA
- **Contributions:**
  - —Upon initial enrollment in an HSA-qualifying HDHP, default contributions are equal to:
    - ❏ The amount necessary to fully fund the deductible (2007–2014)
    - ❏ The amount necessary to receive the full employer match (2015 on).
  - —At annual enrollment, default HSA contributions for the following year are the greater of:
    - ❏ The current HSA contribution election or
    - ❏ The amount necessary to receive the full employer match.
- **HSA—Investments:**[6]
  - —At inception in 2005:
    - ❏ Did not incorporate a debit card for claims processing
    - ❏ Set a default investment option
    - ❏ Offered four investment options, besides a cash equivalent investment.
  - —Communications separated the limited medical flexible spending account (FSA) for "spending" and the HSA for "saving."
  - —2016 asset accumulations: The average HSA balance was about $2,000, with a range from $0 to about $58,000. Accounts were invested in:
    - ❏ Money market/liquid assets: about 80%
    - ❏ Other investment options:[7] about 20%. (For comparison, Employee Benefit Research Institute (EBRI) data show only 6% of HSAs had an associated investment account, where assets were held for purposes other than reimbursing medical expense claims.)[8]

Among the enrollment results in 2016**:**

- 82% of eligible employees enrolled in HSA-eligible HDHP.
- Of those selecting HDHP coverage, the percentage who contribute to an HSA and the average annual HSA contribution:
  - —Self-only: 88% enrolled, $949 (employee), about $440 (employer), about $1,300 (total)
  - —Not self-only: 93% enrolled, $2,217 (employee), about $880 (employer), about $3,000 (total)
- About 97% of HSA participants contribute enough to receive full employer match.
- 3% of HSA participants elected "catch-up" contributions, averaging about $900.
- Percentage of HSA-eligible employees contributing the HSA maximum:

TABLE I

Why HSA Contributions May Be Superior to 401(k) Contributions

	HSA	401(k)
Contributions	Employee: Pretax for federal, most states, FICA and FICA-Med	Employee: Pretax for federal, most states, NOT for FICA, FICA-Med
	Employer: Same as employee	Employer: Also FICA/FICA-Med pretax
Payout	Any time, any reason	Hardship, separate, 59½+
Investments	Most options available	Most options available
Vesting of contributions	Employee: Always 100%, no forfeiture	Employee: Always 100%, no forfeiture
	Employer: Always 100%, no forfeiture	Employer: Graded or cliff vesting
Flexibility	Prospectively change contributions any time	Prospectively change contributions any time
2015 maximum employee contribution	Varies by tier: $3,350, $6,650 Varies by age: +$1,000 per person aged 55+	Limit to actives: $18,000 Varies by age: $6,000 more aged 50+
Taxation of distributions	Medical: Tax-free	Ordinary income
Other	Ordinary income, plus 20% penalty if under the age of 65	Ordinary income, plus 10% penalty if paid before the age of 59½

—Self-only: 9%

—Not self-only: 7%.

For our example employer, a worker with other than self-only coverage in 2016 would contribute $1,800 to the HSA to obtain the maximum employer HSA match of $900 (total $2,700). Then, to obtain the $1,000 maximum notional HRA credit for retiree medical coverage, the employee would contribute an additional $3,000 to the HSA (total $5,700). Providing an incentive to make the maximum HSA contribution minimizes situations where workers must use after-tax dollars to pay out-of-pocket medical expenses.

Survey data show that the earlier an account is opened (and the longer it is in place), the higher the account balance. Account balances also are much higher when HSAs incorporate investment options.[9] The default autoenrollment into the HSA, coupled with the match, is designed to maximize asset accumulation. Importantly, HSAs also have a "ZEBRA-like" capability.[10] Say a worker opens an HSA on January 1, 2005. She might not save in the HSA for ten years until she knows what her out-of-pocket medical expenses will be. Those contributions, starting in 2015, can be used to reimburse medical expenses she incurred at any time after January 1, 2005. And she can wait another, say, 20 years to claim reimbursement to allow earnings to accumulate tax-deferred and, ultimately, tax-free. So most workers can avoid using after-tax dollars if they maximize their HSA contributions every year.

The average balance shown above is modest. However, those accounts don't include all HSA assets—contributions outside of the cafeteria plan by employees, former employees, retirees, a spouse and/or (no longer dependent) adult children. Because of the automatic features, the average HSA account balance remains mostly unchanged over the past five years, despite the addition of a significant number of new HSA accounts that resulted from implementing a "full-replacement" strategy.

Finally, full replacement to an HSA structure is successful only if participants save in anticipation of having to meet the deductible.[11] To be successful, employers need to do more than offer automatic enrollment in HSAs. That is, because many employees live paycheck to paycheck,[12] my employer

TABLE II

Why HSA Contributions/Distributions May Be Superior to Health Care FSA Contributions/Distributions

HSA	Health Care FSA
Save	Spend
Any time, any reason*	Qualified medical expense only
Invest, accumulate earnings	Nominal account, no earnings
No forfeiture	Use or lose
Flexibility—contributions, transitions	Flexibility—grace period or carryover
Tax-free if qualified expense:	Tax-free, except:
• COBRA premiums	• COBRA premiums
• Long-term care insurance	• Long-term care insurance
• Medicare Part A, B, D	• Medicare Part A, B, D
• Employer-sponsored plan retiree medical contributions once Medicare-eligible.	• Employer-sponsored plan retiree medical contributions once Medicare-eligible.

*Taxable unless qualifying medical expense, plus 20% penalty if tax paid prior to the age of 65.

Note: HSA tax-favored contributions can continue after separation.

facilitated successful preparation for unanticipated, out-of-pocket costs by also:

- Adding a compensation loan feature that met the requirements of IRC §7872[13]
- Changing the "match" structure in 2011 to front-load 50% of the employer's contribution.

Sometimes HSAs Are Superior to 401(k)s as a Retirement Savings Vehicle

The HSA superiority to 401(k) plans may be simple math: The tax preferences on both HSA contributions and HSA reimbursements/payouts are superior, and there is a comparable survivor benefit value. Combined, these preferences will generally exceed the higher penalty tax on pre-aged 65 HSA distributions that are not used to offset qualifying medical expenses. If an individual must choose between pretax HSA and pretax 401(k) contributions (after obtaining all available employer match), it isn't a contest—HSA all the way! (See Table I.)

Why HSAs Are Clearly Superior to Health Care FSAs as a Retirement Savings Vehicle

HSA superiority to health FSAs is also straightforward, as shown in Table II.

- HSAs avoid "use or lose."
- More expenses qualify for tax-free HSA reimbursement, such as long-term care insurance premiums, out-of-pocket long-term care expenses, employer-sponsored Medicare supplement premiums, premiums for continued health insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Medicare Part B and Part D premiums (if the HSA account owner is Medicare-eligible), etc.[14]
- HSA assets can be used for nonmedical purposes.

- HSA account balances grow with the credit of investment earnings.

Are We Done Yet?

Similar to the shift to defined contribution plans for income replacement in retirement, we are just getting started in developing retiree medical savings initiatives and coverage options. Back in 1981, the Internal Revenue Service issued proposed regulations about something it once called a *salary-reduction savings plan.* One 1990 study showed that after approximately ten years, there were almost 100,000 plans with a 401(k) feature, with nearly 20 million participants and total assets of $385 billion.[15] However, one of those 401(k) plans was my employer's savings plan, which included after-tax employee contributions, employer contributions and earnings on those monies, accumulated by tens of thousands of workers in a thrift savings plan adopted 22 years earlier (1968). Early on, few envisioned the explosive growth in 401(k) assets.[16]

The growth in HSAs is also just getting started, assuming future legislative and regulatory requirements don't impede adoption/development.[17] If the rate of growth in HSA assets continued at the 37.67% per year pace estimated by Devenir during the period December 31, 2006 through December 31, 2015, assets would grow from an estimated $30.2 billion (year-end 2015) to $3.6 trillion (year-end 2030). Even at half the historical growth rate, HSA assets would grow to $402 billion by 2030. And, because no one can peer far enough into the future to accurately calculate the costs workers and retirees will face in 15 or 20 or more years, today's rapid expansion in HSA access, contributions and participation may increase once workers clearly understand the potential challenge.[18]

What Else Can Be Done?

From a statutory perspective, Congress can enhance the attractiveness of HSA-qualifying HDHP options and expand the retiree medical options available to plan sponsors by taking one or more of the following actions:

- Approve pending HSA legislation to expand HSA eligibility to those covered only under Medicare Part A.[19]
- Expand that pending legislation not only to include those enrolled in Medicare Part A but to create an HSA-qualifying HDHP as a Medicare Part C (Medicare Advantage) option that would be available to retirees, disabled individuals, and older workers and their families.
- Expand IRC §401(h) to include two words, *profit sharing,* and follow that with regulatory guidance comparable with regulations that apply to pension plans.[20]
- Clarify that IRC §401(a)(13)(A) provisions allowing for voluntary, revocable assignment of retirement income benefits in a payout status can allow a plan sponsor to amend its plan to enable retirees to voluntarily assign up to 10% of payouts to the plan sponsor (assets remaining in the plan) where the plan sponsor would, in turn, pay an equivalent amount toward retiree medical insurance premiums.

From a plan sponsor perspective, the next few years will see a "natural" boost to higher deductible medical coverage options as employers continue to manage the cost of coverage and attempt to stay below the high-cost health plan dollar thresholds.[21] So this may be an opportune time for plan sponsors to reconsider their retiree medical strategy and to deploy an HSA-qualifying HDHP with automatic features as well as transition provisions that would facilitate savings, asset accumulation and investment.

Today, there is no significant risk to adding an HSA-qualifying HDHP. Similarly, there is no significant risk to adding

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employer-sponsored, retiree-pay-all, insured Medicare Advantage options that can be funded with tax-preferred HSA savings. If retirement preparation is a priority for employers and their workers, they can facilitate retirement preparation by adding an HSA-qualifying HDHP to accumulate tax-preferred (tax-deductible, tax-deferred, tax-free) savings that retirees can use to fund no-company-cost Medicare Advantage coverage. Employers may have much to gain and little to lose. BQ

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Endnotes

1. Society for Human Resource Management (SHRM), *2015 Employee Benefits: A Research Report by SHRM,* showed that only 30% of surveyed employers contribute to a health savings account (HSA), while only 23% of surveyed employers offer one form or another of retiree medical coverage. Accessed February 24, 2016 at www.shrm.org/Research/SurveyFindings/Articles/Documents/2015-Employee-Benefits-Tables.pdf. See also: Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2015 Annual Survey,* which showed 23% of large firms (200+ workers) that offer health coverage to their employees also offered retiree coverage, down from 66% in 1988. Accessed February 24, 2016 at http://files.kff.org/attachment/report-2015-employer-health-benefits-survey.

2. Paul Fronstin, Nevin Adams, "Employment-Based Retiree Health Benefits: Trends in Access and Coverage, 1997-2010," EBRI *Issue Brief* 377, October 2012. Accessed April 9, 2016 at www.ebri.org/pdf/briefspdf/EBRI_IB_10-2012_No377_RetHlth.pdf. See also: Paul Fronstin, "Retiree Health Benefits, Trends & Outlook," *Issue Brief* 236, August 2001. Accessed April 19, 2016 at www.ebri.org/pdf/briefspdf/0801ib.pdf. See also: Frank McArdle, Tricia Neuman, Jennifer Huang, "Retiree Health Benefits At the Crossroads," Kaiser Family Foundation, April 14, 2014. Accessed April 9, 2016 at http://kff.org/medicare/report/retiree-health-benefits-at-the-crossroads/.

3. See: *In Re White Farm Equipment Company,* 42 B.R. 1005, 1021-22 (N.D.Ohio 1984), 788 F.2d 1186 (6th Cir. 1986). Accessed February 23, 2016 at http://law.justia.com/cases/federal/appellate-courts/F2/788/1186/300893/. See also: *International Union, United Automobile, Aerospace, and Agricultural Implement Workers of America and Local 134 v. Yard-Man, Inc.,* 716 F.2d 1476 (6th Cir. 1983), cert. denied, 465 U.S. 1007, 104 S.Ct. 1002, 79 L. Ed. 2d 234 (1984). Accessed February 23, 2016 at http://law.justia.com/cases/federal/appellate-courts/F2/716/1476/278162/. There, the Sixth Circuit explicitly found the plan language was unambiguous, but the collective bargaining agreement (CBA) was ambiguous. The language "will provide insurance benefits equal to the active group" could reasonably be construed to be read two ways, either as a reference to the nature of retiree benefits and/or to incorporate a duration limit. So, the court looked to other CBA provisions for evidence of intent and an interpretation that is harmonious with the entire document. The court's examination of the CBA persuaded the court that Yard-Man and the union intended to vest retiree insurance benefits to continue beyond the life of the CBA. See also: *M&G Polymers USA, LLC v. Tackett,* 135 S.Ct. 935 (2015), accessed February 23, 2016 at www.supremecourt.gov/opinions/14pdf/13-1010_7k47.pdf. There, the U.S. Supreme Court struck down the Sixth Circuit's longstanding inference of vested retiree welfare benefits, termed the *Yard-Man inference,* which held that the courts should presume that retiree welfare benefits provided in CBAs were vested or guaranteed for the life of any employee who retired under a CBA. *Tackett* held that the Yard-Man inference is inconsistent with ordinary principles under contract law, the Employee Retirement Income Security Act of 1974 (ERISA) and the Labor-Management Relations Act of 1947 (LMRA). See also *Gallo v. Moen Inc.,* No. 14-3633 (6th Cir. Feb. 8, 2016), sourced on 2/24/16 at: http://www.ca6.uscourts.gov/opinions.pdf/16a0030p-06.pdf. There, the Sixth Circuit, in light of *Tackett,* confirmed that "ordinary principles of contract law" rarely will require a company to freeze outdated benefits in place. The court confirmed the three-year CBA did not include any provision agreeing to lifetime benefits, noting that courts "should not expect to find lifetime commitments in time-limited agreements." The court also noted, in comparison, that the CBA explicitly vested pension benefits for life.

4. Options considered included but were not limited to insurance purchase, conditioning access on workers making after-tax contributions (employee only) to a voluntary employee benefits association trust, increased employer match in the Internal Revenue Code (IRC) Section 401(k) plan, funding via an IRC §401(h) account and, with regard to the retirees' contributions, implementing a scheme of voluntary assignment of pension benefits under IRC §401(a)(13)(A).

5. The Tax Relief and Health Care Act of 2006 (Pub. L. 109–432, 120 Stat. 292) included tax extenders and provisions enhancing HSAs.

6. ~26,000 active and former associates have not elected to remove all assets from this specific trusteed account as of December 31, 2015.

7. Since inception in 2005, this plan sponsor has facilitated the offer of a specific trusteed account that includes four investment options that allow for diversification of investment risks (similar to that required for individual-directed investments in a 401(k) plan designed to qualify under ERISA §404(c)).

8. Paul Fronstin, "Health Savings Account Balances, Contributions, Distributions, and Other Vital Statistics, 2014: Estimates from the EBRI HSA Database," *Issue Brief* 416, July 2015. Accessed April 9, 2016 at www.ebri.org/pdf/briefspdf/EBRI_IB_416.July15.HSAs.pdf.

9. Id. See also: Devenir Research, *2015 Year-End HSA Market Statistics & Trends,* which confirmed that the average account balance for HSAs adopted in 2005 was $7,223, while the average account balance for HSAs adopted in 2015 was $843. Accessed February 24, 2016 at www.devenir.com/devenirWP/wp-content/uploads/2015-Year-End-Devenir-HSA-Market-Research-Report-Executive-Summary.pdf.

10. Zero-balance reimbursement accounts. As reference, see Gary Klott, "Cafeteria Plans Face I.R.S. Curb," *The New York Times,* May 4, 1984. Accessed May 16, 2016 at www.nytimes.com/1984/05/04/business/cafeteria-plans-face-irs-curb.html

11. For an obvious example of failure to prepare for HDHP coverage, see: Jacob Hacker, *The Great Risk Shift,* 2006, who cites a University of Minnesota professor's experience with an HDHP where the professor was "hit for hefty bills for his 11-month-old son's hospitalization." The professor described his dilemma in trying to decide whether to admit his son due to an infection: "If you're negotiating a car, you can always say, 'I'll walk off the lot.' (However) If your one-year-old kid has an IV in his arm, you don't have the same situation." Here, the professor had a choice of coverage and selected the HDHP over the other option—But he failed to "save up" in advance of the effective date of coverage. See also: Lydia Mitts, Families USA, "The Trouble With HDHPs Paired With HSAs," February 22, 2016, where she notes: " . . . Lower-income consumers don't have a lot of disposable income. They rarely have savings that they can afford to set aside for healthcare costs. . . . And so I think we don't see them as a health coverage option that truly meets the needs of lower-income consumers . . . ." Accessed February 24, 2016 at www.ajmc.com/newsroom/lydia-mitts-explains-the-trouble-with-hdhps-paired-with-hsas. See also: Robert Pear, "Many Say High Deductibles Make Their Health Law Insurance All but Useless," *The New York Times,* November 14, 2015. Accessed September 14, 2016 at www.nytimes.com/2015/11/15/us/politics/many-say-high-deductibles-make-their-health-law-insurance-all-but-useless.html. So, as health reform induces

Americans to select coverage with ever higher deductibles as a means to control premium expense, it is increasingly clear that most any deductible will be "too much" without preparation.

12. *Getting Paid in America Survey,* Question No. 6, American Payroll Association, September 2015. Accessed April 9, 2016 at www.nationalpayrollweek.com/documents/NPW2015SurveyResults.pdf.

13. The plan sponsor sponsored a no-interest compensation loan designed to be repaid during the same calendar year, qualifying under IRC §7872 Treatment of Loans With Below Market Interest Rates. IRC Section 7872(c)(1)(B) provides for imputation of interest as income to the extent that a below-market rate was charged, except for compensation loans in amounts less than $10,000.

14. IRS Publication 969, 2015. Accessed April 9, 2016 at www.irs.gov/pub/irs-pdf/p969.pdf.

15. "EBRI Fact Sheet: History of 401(k) plans, An Update," February 2005. Accessed February 24, 2016 at www.ebri.org/pdf/publications/facts/0205fact.a.pdf.

16. IRC §401(k) was added to the Internal Revenue Code as part of the Revenue Act of 1978, where the Joint Committee on Taxation identified the legislative goal to be to "curtail disparate deferrals by higher paid workers" and estimated the revenue effect as "This provision will have a negligible effect upon budget receipts."

17. Devenir Research, *2015 Year-End HSA Market Statistics & Trends,* confirmed that HSA assets exceed $30 billion, and the number of HSA accounts exceeds 16 million, reflecting a 25% increase in assets and 22% increase in accounts, comparing December 31, 2015 with December 31, 2014. However, 24% of HSAs were unfunded at year-end 2015. HSA investment assets exceeded $4.2 billion, up 33% compared with December 31, 2014. Accessed February 24, 2016 at www.devenir.com/devenirWP/wp-content/uploads/2015-Year-End-Devenir-HSA-Market-Research-Report-Executive-Summary.pdf.

18. Various studies suggest that the cost of retiree medical coverage and out-of-pocket expenses for a couple, both aged 65 in 2015, may exceed $245,000. See: Fidelity, "Health Care Costs for Couples in Retirement Rise to an Estimated $245,000." Accessed February 24, 2016 at www.fidelity.com/about-fidelity/employer-services/health-care-costs-for-couples-retirement-rise. See also Anthony Well and Natalia Zhivan, *How Much is Enough? The Distribution of Lifetime Health Costs.* Boston College Center for Retirement Research, 2009. The authors confirmed an estimate that a " . . . typical household age 65 has a 5-percent risk of the present value of its lifetime health care costs exceeding $311,000 . . . ." Accessed February 24, 2016 at http://crr.bc.edu/wp-content/uploads/2010/02/wp_2010-1-508.pdf. See also: Michael W. Crook, Ronald Sutedja, *Will Long Term Care Ruin Retirement Plans?* UBS, July 24, 2016. Accessed September 14, 2016 at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2813771. Other estimates of retiree medical spending in this endnote assume $0 for long-term (custodial) care. Crook and Sutedja estimate that approximately 85% of couples will utilize long-term care prior to death. Note that health savings account assets receive favorable tax treatment when used to offset long-term care costs or when used to pay qualifying long-term care insurance premiums. See also: Perspective Partners, How Integrated Benefits Optimization Can Benefit Employers & Employees, 2015. Accessed September 14, 2015 at www.perspectivepartners.com/documents/21869/0/NestUp+Managed+Deferrals+White+Paper/1f35dbd4-be2b-40ee-aca4-7972086088fa. Expect to see worker decision making at annual enrollment change in two ways—from a focus on anticipated needs for the next year to considering multiple years and from a focus on needs as an active employee to considering needs as a retiree.

19. See the Health Care Savings Act of 2016, authored by Senate Finance Committee Chairman Orrin Hatch (R-Utah) and House Ways and Means Committee member Congressman Erik Paulsen (R-Minnesota), which would allow individuals who are only enrolled in Medicare's hospital insurance, Part A, to be otherwise eligible to contribute to an HSA.

20. IRC §401(h) has been part of the Internal Revenue Code since 1962. IRC Section 401(k) plans were added to the Tax Code as part of the Revenue Act of 1978. So, perhaps inadvertently, when adding §401(k), Congress failed to amend §401(h) to allow adoption of a 401(h) account as part of a profit-sharing plan, such as the 401(k). Such a change would be consistent with the change in retirement benefits across America—where postemployment medical costs are increasingly being shifted from employers to individual retirees and, to some extent, taxpayers. This change anticipates that some, perhaps many, employers would adopt a 401(h) account for their 401(k) plans, say, as a match provision. Today, a typical structure would be a 50% match on the first 6% of pay. But, once 401(h) is available, the typical match might be based on the first 8% of pay, where the 50% employer match is split, 3% of pay would continue to be paid to the 401(k) account and used primarily for income replacement after retirement, and 1% of pay would be paid to the 401(h) account for postemployment health coverage and out-of-pocket costs. Such a change would likely have bipartisan support because (1) adding a 401(h) account is voluntary, (2) funding is limited to employer contributions, (3) it need not substantially increase recordkeeping costs, (4) it will likely spur increased 401(k) contributions and (5) it will have substantially less impact on the federal budget than previously proposed retiree medical savings accounts (such as retiree medical accounts as proposed by former Senate Majority Leader Bill Frist in an address to the National Press Club on July 12, 2004). See Edwin Park and Robert Greenstein, "New Retirement Medical Account Proposal Would Create Lucrative Tax Shelter and Swell Deficits, But Do Little to Help Low- and Moderate-Income Seniors," Center on Budget and Policy Priorities. Revised July 22, 2004. Accessed February 24, 2016 at www.cbpp.org//archiveSite/4-19-04health.pdf.

21. IRC §4980I, the so-called Cadillac tax.

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