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Caryn Cucuta

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Defined Contribution Health Plans: Ready or Not, Here They Come

Defined contribution health coverage has been discussed for a number of years with no response from the market. Now, however, it looks as though employers may be ready to make the move to such plans. This article discusses the market and legislative influences that are making this switch more attractive to employers, and outlines various defined contribution plan models.

By Caryn Cucuta

Caryn Cucuta, J.D. graduated from Marquette University Law School in December, 2001. She is a Benefit Specialist for Michael Best & Friedrich in Milwaukee, Wisconsin.

Development of DC Plans

The focus of employee benefits managers has been changing lately as health care expenses soar and the tight labor market loosens. In the past few years, employers have been pulled in both directions at the same time—trying to improve benefits to attract and retain candidates while keeping costs down to maintain a profitable bottom line. It has not been an easy task, and continues to become more challenging as health care costs rise, consumer demand grows stronger, and legislators continue to work against the employer's interests.

“For more than fifty years, employers have been the main providers of health insurance coverage for Americans.”¹ But employers are feeling pinched and are looking for alternatives that will keep employees happy and maintain a profit for the company at the same time. With the economic downturn triggered by the terrorist attacks of September 11th, new possibilities are becoming viable alternatives. “The tight labor market of the past few years kept benefits managers on their toes, as they worked to recruit and retain quality staff with affordable yet comprehensive health packages. However, recent loosening in the job market gives employers a little more leeway.”²

One new prospect for keeping up with the current challenges is the defined contribution health care plan. Employers have seen the success of turning to a defined contribution model in their retirement plans, and the thought of doing the same for their welfare benefits is an intriguing option.

A defined contribution health plan is modeled after a defined contribution retirement plan. Until the 1980s, most employee retirement plans were standard pension plans, or defined benefit plans.³ Defined benefit plans offer a set benefit amount that will be

paid upon retirement. Often this amount is a formula determined by using the employee's tenure and salary history. It is the employer's responsibility to make sure that the retirement account has sufficient funds to pay the benefits upon retirement.⁴

Since the retirement account was a fund maintained by the employer, and since, historically, employers had been enticed at times to take advantage of the large balance in the account to the detriment of employees⁵, ERISA legislation focused on these plans. Laws were strict and cumbersome for employers to manage. Accounting formulas were difficult and funding requirements were daunting. The Pension Benefit Guarantee Corporation (PBGC) required large insurance premiums for maintaining these defined benefit plans.⁶ Employers set out looking for an alternative.

In the mid-1980s the 401(k) plan grew in popularity and allowed smaller employers the opportunity to offer a retirement plan. The lighter administrative burden and lower cost of these plans led to the displacement of many defined benefit plans in favor of the defined contribution plans.⁷

The new defined contribution retirement plans appealed to employees. Employees could control the investment of their own retirement funds. It was satisfying to see the balance in one's retirement account and to have ownership of the account. It was far more practical for employees to have a plan that they could take from one employer to the next. The days of starting and ending a career with one employer had long since passed. Defined contribution plans "suit[ed] the [new] model of corporate employment—one of abbreviated careers and tenures."⁸

The new defined contribution plans appealed equally to employers. There is no PBGC insurance required. There are no minimum funding requirements. Employees maintain control of the accounts, eliminating the employer's liability in times of a failing market economy. The draw of the retirement plan was back, even in a mobile workforce. The appeal of the defined contribution retirement plan has inspired the creation of the defined contribution welfare plan.⁹

Increasingly, employers are looking at their pension benefits as a model. They have successfully moved their retirement programs from defined benefits to Defined Contribution programs like 401(k)s. Employees are happy to control their investments and shape their own

futures. Employers are happy to have a fixed, budgetable obligation administered by professional managers. They wonder whether they can apply the same approach to their health care obligations.¹⁰

Market Influences

Further inspiration for the Defined Contribution Health Plan comes from current market influences.¹¹ The cost of health care has become a rising concern to employers. While in the past, employer sponsored health plans were an easy add-on to employee benefit packages, the changing health care environment has quickly escalated the cost of these plans and the burden has become too much for many employers.¹²

Today's health care consumers have higher expectations of what their health plans should cover and what services their doctors should provide. While managed care plans were able to keep the rate of health inflation to a more reasonable level during the later years of the 1990s, the push by consumers and providers alike for more freedom of choice has become a contributing factor in the increased rate of health care inflation once again.¹³

Where indemnity plans with high deductibles used to be the norm, consumers have become accustomed to the no-deductible, full coverage of managed care programs of the late 1990s. Consumers are insisting that these plans, which were able to function only through their cost-restricting models, give up on the very models that allowed them to keep costs down and yet continue to provide comprehensive full-coverage care. There is little tolerance for the limited list of physicians allowed under an HMO. Furthermore, the cost analysis done by the health insurer during the referral approval process has become a major point of contention.

As a result of the backlash, "the relaxation of utilization review and medical management practices among managed care plans has led to increased use of health care services..."¹⁴ The Patient's Bill of Rights is in part a backlash against the restrictive nature of the managed care programs of the 1990s. At the same time, the demand for more coverage continues. Health insurance premiums skyrocket as a result.

"Employers are also being hit as providers obtain big increases in their reimbursement rates with health plans, which pass those costs on to employers. 'Hospital costs, in particular, are increasing at a higher rate than other cost components.'"¹⁵ In addition, hospitals and provider groups are becoming

savvier negotiators, armed with new financial software that will, predictably, have an impact on the capitated rates they will accept from insurers.¹⁶

Besides the decreasing effectiveness of managed care plans, the health care consumer has put additional burdens on employer health plans. Health care consumption has changed along with the progression of science and technology.

Fifteen years ago, pain was rarely considered as a treatment issue.... If you had cancer, you were going to experience pain.... The focus was on trying to save your life and therefore the drugs for pain were not reimbursed, not administered.... Today, such thinking seems primitive, thanks to the emergence of better pain management therapies, and new treatments for nausea and fatigue that are further enhancing the lives of cancer patients.¹⁷

Expectations change as science advances. Issues of comfort and happiness have reached center stage as life-preservation issues are conquered. Well-being and quality-of-life issues are the new frontier for health care providers.¹⁸ As new treatments and benefits become available, society follows with expectations and demands for the newly available treatments.¹⁹ Viagra, for example, is a primary example of a quality-of-life drug over which insurance coverage has been contemplated and debated. Insurers feared that coverage may cause pharmacy bills to soar and would establish a precedent that would force coverage of other lifestyle drugs and conditions in the future. However, some plans have decided to cover it nonetheless.²⁰

In response, as some predicted, lawsuits are now cropping up alleging disparate treatment violating equal rights laws since women's fertility treatments are not covered under the same plans.²¹ Courts have already held that expense is not a legitimate defense for excluding coverage where such coverage is "necessary to avoid or correct discrimination."²² Ultimately, with the demands for greater coverage, higher payments to providers, greater liability and less control, health care insurers have no choice but to raise premiums. "To date health care inflation has forced employers... to decide whether to cut benefits, raise employee premiums or increase copays.... Defined contribution... 'allows the employer to get out from under those types of decisions by taking the decision and putting it in the hands of employees.'"²³

Legislation

The push by consumers to get legislators to pass the Patient's Bill of Rights, allowing lawsuits against providers and employers, attempts to pry the control of managed care programs from insurers' grips. The Patient's Bill of Rights (PBOR) is another substantial influence in the consideration of a defined contribution health plan. "The bill... sets federal standards for private health insurance and widens access to specialists and hospital services. But most galling to business and insurance groups, it allows patients to sue their health plans and perhaps their employers in state or federal court."²⁴

Currently, many employers are depending upon their plan's status as a self-funded health plan to avoid the state mandates that allow suit against the insurer. Now, the federal government is threatening to put them even further at risk with no escape by allowing suit against the employer as well as the insurer.²⁵ "Some say the coming law would cause an increasing number of companies to drop employee health coverage altogether to avoid liability."²⁶ Short of not offering coverage altogether (and impacting the company's market position for recruiting and retention), is the option of offering a defined contribution health care plan—eliminating the status of "monkey in the middle between employees and health plans, doctors and government."²⁷ It is a notion whose time is fast approaching as the job market loosens, premiums skyrocket and companies' profitability wanes in the aftermath of the terrorist attacks of September 11th.

Defining the DC Health Plan

"In its purest form, a defined contribution health plan hands the employee money to buy insurance from any insurer he or she wants, and the employee—not the employer—is the policyholder."²⁸ The contribution is the employee's, to do with as he or she sees fit. Whether he or she decides to pocket the money or to purchase comprehensive coverage is up to the individual employee.

The pure DC plan proposes the idea that employees would purchase individual policies on the open market based upon their individual needs. There are variations of the defined contribution health plan modes (see comparison *infra*), but the pure DC model, built off of the DC retirement plan model, presents the option in its most extreme form—with the greatest opportunity for flexibility, portability and

control by the employee and the greatest amount of risk for the employee who for the first time must attempt to purchase and manage his or her own health insurance coverage.

Applying the Pure DC Model to Health Plans Advantages to Employees

There are pros and cons for both employees and employers when applying the defined contribution model to health plans. In the employer-sponsored health care plan design, the employer makes decisions as to what is best for its employees based upon budget issues, risk assessments, and generalities. The needs of individuals may not always be best served by the employer-selected plan. The defined contribution plan in its purest form gives employees dollars to use to purchase their own health plans.

Proponents of this plan argue that each individual is the best-suited person to choose coverage that fits his or her personal needs.²⁹ Where specific coverage is of a high degree of importance, the employee can be sure to elect a plan with such coverage. For example, if a family history of heart problems presents a concern to a subscriber, he or she can be sure to choose a plan that includes the leading heart center in his or her area and perhaps a plan that allows coverage for a heart transplant or organ procurement fees. The employer would not necessarily make these personal considerations.

There are some immediate advantages to the health care consumer when purchasing individual coverage. The individual plans are not subject to the state and federal mandates affecting group plans. These mandates serve to increase the cost of health care to the consumer by requiring coverage that may or may not be of interest to the individual purchaser. For example, the state of Illinois, along with many other states, currently mandates treatment of infertility.³⁰ A person who is beyond his or her childbearing years could benefit by purchasing an individual plan that is not subject to the additional cost of the state-mandated coverage.

Other examples of mandated coverage include immunizations for children, routine ob/gyn labwork, mammograms, coverage for contraceptives, etc.³¹ These coverages all affect a limited portion of the population but premiums are distributed over the entire group. Individual plans can escape the burden of these additional costs that are imposed upon group plans.

Another benefit is that employees can choose from any health plan on the market. Some employees will have the advantage of being able to purchase more coverage on the open market at rates less than they would pay for the group coverage the employer would have offered. Health status, age, and sex are all considerations when buying individual policies.³² A young healthy non-smoking male, for example, may be able to purchase greater coverage at a lower cost than a plan provided by a small company with a history of high claims experience. The employee could purchase additional coverage, have the benefit of the extra income, or save the extra money for future health care needs.

Being able to purchase an individualized plan allows for the selection of a high deductible plan for those able to self-insure for small claims, saving on the guaranteed out-of-pocket expense of premiums when catastrophic coverage is all that is necessary. In some circumstances, employees will be able to pocket the employers' contributions that exceed the cost of their insurance premiums. If this money is set aside for future medical expenses, it can create savings on subsequent years' premiums by allowing individuals to purchase coverage with higher deductibles while self-insuring with the money saved in previous plan years.

The individual policies purchased under a defined contribution health plan allow for greater portability and independence than the group plans provided by employers. The retention of health benefits associated with employment can often be a serious consideration when contemplating a job change. The defined contribution health plan works better for the mobile work force of today. Employees with individual policies can carry their coverage from one employer to the next—or on through spells of unemployment.³³ There is no tie directly to the employer other than the assistance in paying the monthly premiums on their individual policy. The new freedom created by the individually held policies means that employees are no longer bound to employers because of their health benefits.

Disadvantages to Employees

Although the benefits the DC health plans have to offer to employees are appealing, the same points that make the DC model attractive to one employee may be the reason the plan is unworkable for another. For example, employees with poor health status

may not be able to find a policy on the market other than a state mandated HIRSP-type plan due to evidence of insurability requirements of individual plans.

Where some employees may be able to “pocket” the extra from the employer’s contributions, for others the same employer contribution will surely be insufficient to cover their individually rated premium and some employees may be left with an out-of-pocket expense far greater than they would have under a traditional employer HC plan. “Extremely wide variations in benefits and premiums offered on the individual market are highly dependent on the age, residence and health status of the applicant, according to a new study... This study highlights the need for greater accessibility and affordability...”³⁴

“Comprehensive coverage is often not available even to healthy consumers. Coverage for maternity benefits, mental health care and prescription drugs tend to be very limited in the individual market, particularly compared to benefits offered through most group health plans.”³⁵

Employees may only be able to purchase plans with poor coverage because of their health status and will end up underinsured. Moreover, employees may not even be aware of the importance of thoroughly researching their options and making an informed choice. They may simply assume that the coverage offered to them by their local sales persons will cover their needs when they arise. After all, their employers’ plans always have. “Sometimes choice is not a good thing—especially in health care, which has huge implications. ... An employee may not realize he or she is underinsured, or that specific procedures are not covered until a crisis occurs.”³⁶

Employees are not in a position to manage the complexities of the health care marketplace on their own. Most workers, whether laborers, software programmers or bond traders, can’t be expected to navigate a complex health care market and make intelligent purchasing decisions on their own. The system is too arcane. The employer is vital to the system. Protecting employees, they negotiate with insurers, insisting upon specific plan provisions and provider panels; they conduct fee negotiations, analyze contracts, monitor quality and measure vendor performance. If employers are removed from the equation, a whole new set of problems will emerge that we are not yet ready to manage.³⁷

The changing of the guard is not a move that can happen overnight. Consumers will have to be educated as to how to go about choosing the correct plan for their family. Just as the change in retirement plans has created a population of informed and confident investors who welcome all the investment advice and counseling their employers are willing to hand out, a change will have to occur for the employee as a health care consumer as well. If it happens too soon, or improperly, and consumers are prematurely forced into “...making medical purchasing decisions, it is easy to predict that some will make ill-informed decisions that result in under-insurance. A new brand of backlash will strike when sick employees are denied treatment because they didn’t understand the fine print regarding the plan they thought they purchased over the Internet.”³⁸

Another significant impact on the coverage in individual plans is the loss of group plan status. Non-group coverage is clearly distinguished from group coverage in existing government controls. Where government mandates control of many aspects of group coverage including pre-existing condition limitations, minimal coverage standards, eligibility requirements and disclosure requirements,³⁹ many of these mandated benefits and plan terms are not required in individual policies. Coverage that employees have always relied upon in their employers’ plans may disappear on their individual policies without the employees even taking notice. Employees lose these state and federal protections when purchasing individual policies. Moreover, where group coverage must accept everyone in the group who meets the definition of an eligible employee, individual policies allow discrimination by requiring evidence of insurability and individual premium rating based upon one’s health status.⁴⁰

The effect of the change to individual plans that are not subject to the state mandates is that there can be gaps in coverage that the health care consumer may not be expecting. State-mandated minimum levels of mental health benefits are required on a Wisconsin-citused group plan offering mental health benefits.⁴¹ An individual plan purchaser will have to be careful to read the small print on the plan to be sure the mental health benefits he or she has are provided at the level to which he or she has become accustomed to expect under the state mandates. Other coverages that can be difficult to obtain on individual plans are maternity benefits and

prescription drug coverage.⁴² The onus would be on the individual consumers to be sure they are purchasing the coverage they need.

Advantages to Employers

The advantages of the pure DC health plan model to employers are many, but they are focused around three factors: increasing employee morale, decreasing costs, and decreasing administrative burdens. The pure DC health plan model...

takes the employer out of the business of choosing and managing health care plans, lowers administrative costs and probably increases employee morale. The firm's contribution can be determined by business resources and labor market demands. The responsibility of the firm would be limited to using payroll withholding for the employee contribution and forwarding that along with the firm's contribution to the health plan chosen by the worker.⁴³

When the employer has committed to giving the employee cash instead of vouchers to use toward the purchase of health care, the administrative burden is lessened even further by eliminating the employer's role in forwarding the payments to the individual insurance carriers.

Disadvantages to Employers

There is a tax roadblock to administering defined contribution health plans. Currently, contributions to employees' health plans are not taxable under IRS code. There is no provision that would clearly allow defined contributions toward employee health care purchases the same tax break. A change in the code is necessary to alter this significant deterrent to DC Health Plans. "The part of the Internal Revenue Service Code that governs the tax-free provision of health care to employees is Section 105. The section states, however, that if an employee receives a benefit whether or not a medical expense is incurred, then that benefit is not covered under section 105."⁴⁴

Another important factor impacting the feasibility of the Individual Market Model is the ability of the individual to purchase a plan on the open market. Health status may eliminate some employees from qualifying for individual plans. Furthermore, some employees will choose not to shop for coverage on the open market. A high-risk pool or employer-sponsored group option must be available

for these high-risk employees. The employer would have to provide a default plan for these people who are unwilling or unable to secure a plan elsewhere.⁴⁵ This default plan puts the employer back in the position of offering group health coverage for its employees. Only now, the group plan will have the adverse selection resulting from the flight of the low-risk employees to lower premium individual plans. As a result, the employer plan's premiums will spiral upward until the premiums become unaffordable for those uninsurable employees who can't shop the market.

In addition, the administrative savings associated with the elimination of a group-sponsored health plan are lost when the employer is put back in the position of offering such a plan. Beyond the group plan administration, the employer has taken on the administrative burden of doling out monthly contributions to employees, or paying individual insurers of the employee's choosing for monthly premiums.

Systemic Reasons Why the Pure DC Health Plan Won't Work

"Health care market dynamics are not like other market forces. The market's infrastructure is geared for groups, not individuals. All the underwriting doctrines, risk sharing principles and administrative procedures are wired for hundreds or thousands of participants at a pop, not for 161 million individuals surfing at random...."⁴⁶

"Unfortunately, federal and state law chops the insurance market into discrete markets, with very different rules for each. Substantially different rules apply to individual..., small group, and large group insurance." ERISA and HIPAA are two significant employee benefits laws regulating coverage. HIPAA, although it purports to be about portability, primarily addresses guaranteed issue for employer plans. Any plans that the employer contributes to the cost of the premium become an employer plan under ERISA and HIPAA; however, the portability advantage of DC Health Plans comes only with truly individual plans—or "nongroup" coverage. This contradiction makes the Defined Contribution Health Plan nearly impossible under current federal law.⁴⁷

Furthermore, the individual market is not prepared for the employer-backed health care consumer. Traditionally, the individual market has been flooded with older, sicker, and poorer purchasers than the

participants on group plans. The individual market has been challenged with the task of collecting premiums from the individual policy holders who often let coverage lapse during times of good health or when money was tight.⁴⁸ Because of the different consumers of individual plans, underwriting standards are also tighter on individual plans than on group plans. These market differences leave the individual plan marketplace unprepared for the new, young, healthy consumer backed with employer dollars. It also makes it a difficult task for the individual to find a workable plan in the current marketplace.

Alternative Models of DC Health Plans

The defined contribution health plan has an assortment of models, some of which present workable alternatives to the problems of the pure DC Health Plan model. These models range between the pure individual nongroup market and managed competition.⁴⁹ The more workable models tend to be those that favor some employer intervention as opposed to the individual market end of the spectrum.

Individual Market Model

At one extreme is the Individual Market Model of defined contribution health plans. This approach is the pure defined contribution approach, in which employees are given vouchers to use to purchase their own individual coverage on the open market. This approach offers the greatest amount of choice for employees and also poses the greatest challenges.

Furthermore, the flat contribution for all employees may be discriminatory. At the very least, it is inequitable. The cost of sufficient health coverage on the open market is not comparable for a healthy twenty-year-old male and a sixty-three-year-old female with a history of heart problems and asthma. The task of determining a fair contribution for employees based upon health status, age, sex, and health history becomes a difficult and burdensome task. The question remains: Is basing contributions on factors such as age and health history discriminatory, or is it discriminatory *not* to do so?

One good result of using the Individual Market Model is the retention of the tax advantages of health insurance contributions because the money is available solely for health insurance purchases.⁵⁰ However, this advantage applies only to the money used to purchase health care. Any money over and above the amount that employees use for their health care

purchases must be taxed. The employer might reimburse the employees for premiums paid or may elect to pay the insurers directly through payroll withholding.⁵¹ With all the hurdles of the individual health model, it is fairly agreed upon that the pure defined contribution model does not pose a workable option.⁵²

Decision Support Model

The plan design that has the most market attention is one that focuses on giving control to the employees but still maintains group coverage for health benefits. While some of the portability and selection possibilities associated with individual policies are eliminated, this design also eliminates much of the risk involved in such individual policies. This plan design is referred to by the CDHA⁵³ as the decision support model. It generally offers “on-line tools and personal assistance to help employees choose from multiple health plans... priced by varying deductible levels.”⁵⁴ An employer-funded spending account and a high deductible catastrophic health insurance plan are the other essential plan components for this design structure.⁵⁵

One of the problems with setting up a plan under the decision support-model is the inability, under current tax law, to roll over balances in flexible spending accounts from year to year. However, some employers are moving ahead in anticipation of the passage of Bush's budget proposal provision allowing rollovers of up to \$500.⁵⁶ Other possible breakthroughs include proposals allowing distributing unused funds as taxable income at year-end or rolling over up to \$3,000, including a rollover into retirement plans.⁵⁷ While these proposals have not yet been passed, some employers are relying upon their interpretation of the code in creating a hybrid account under Section 125 and Section 105 in which unused funds roll over to pay for future health care expenses called a personal care account.⁵⁸

The focus of this plan design, and a driving force behind the move to DC health plans in general, is the hope that getting the dollars in consumers' hands will help curb total health care spending.⁵⁹ “As [Nobel Prize-Winning economist] Milton Friedman said, ‘[n]obody spends somebody else's money as carefully as they spend their own.’”⁶⁰ The establishment of a flexible spending account in conjunction with plan alternatives gives employees security with dollars set aside to cover their medical expenses and

gives employers a chance to put money toward the employees' health care needs without sacrificing the tax break.

It has been estimated by one source that less than one percent of employers are using a plan labeled as a DC Health Plan, while others have offered something quite similar for years via cafeteria plans that allow employees to choose from a range of employee benefits.⁶¹ Large employers have traditionally offered a selection of benefit plans—perhaps an HMO option, a PPO option, and the self-insured plan of the employer—possibly alongside the option of participating in a flexible spending account or medical savings account. These cafeteria plan selections are the precursors of the new DC Health Plan. The University of Minnesota took the extra step for 2002 and is offering its 16,000 employees the option of an HMO, a PPO, and a DC plan from Definity Health.⁶² On the cutting edge of benefits, this DC plan offers a catastrophic health plan provided by the employer and a personal care savings account that allows employees to roll over unspent balances to subsequent years.⁶³

Web-based Models

Another component often included in defined contribution health plan designs is the use of the Internet as a tool to link employees with their health care resources. "Internet-based health plans that include employer-funded savings accounts under a layer of catastrophic coverage—similar to the experimental medical savings accounts" are one such plan design.⁶⁴

One article suggests that "[t]he convergence of defined-contribution approaches and Web-based healthcare retailing will transform the health benefits world."⁶⁵ The prediction rests on the assumption that "e-retailers" will create sites offering a "wide variety of (other people's) products, lots of information and a very low-cost transactions environment"⁶⁶ where DC health plan participants would obtain their benefits and information. Ultimately, "[a]n employee, armed with defined-contribution dollars from his/her employer, would access an online retailer (an "HMOs'R'Us.com," say) and would make his/her plan selection based on the features, risks and pricing that best meet his/her needs."⁶⁷

Alternative Models

Each group or sales organization tries to classify its products into different models or classes.⁶⁸ As of yet,

there is not an agreement as to how exactly to classify the varied models available. They come with names such as the Benefit Design model, the Time of Need Network model, the Advance Selection Network model, the Hybrid model, the Aggregator model, the Non-Employer Group Coverage model, the Business model, and the list will continue to expand as more brokers enter the market, to be sure.⁶⁹ These different models have some design similarities and some differences. The notable differences include tax differences, availability of employee's selections, whether the employee's coverage is individual or group coverage, whether the plan is portable between employers, and what minimum level of benefit, if any, the employee is guaranteed.⁷⁰

"In pre-tax business models, for example, funds in employee DC-health accounts revert back to the employer if the employee quits or retires."⁷¹ The tax implications and the post-employment benefit vary from the post-tax models where "... the money exits the company along with the employee."⁷² "Some DC business models offer employees a limited choice of plans and a health care account. Some offer a health care 'supermarket' and a health care account. Still others offer catastrophic plans and a personal health account (PHA), which holds funds for health care combined with a transferable medical record."⁷³

An interesting alternative is the Aggregator model plans, whereby a group of employers form a trust to set up group plans from which employees can elect coverage.⁷⁴ A similar design has the group plans marketed through a fraternal organization, church, or professional marketing association—increasing the portability of the group plans from one employer to another if both employers are associated with the same group.⁷⁵

Conclusion

Although it has been discussed for a number of years with no response from the market, it appears that employers have finally reached a point where the move to defined contribution health plans may be right. The escalating costs of providing benefits coupled with the loosened job market makes the change to a defined contribution health plan a tempting option.

However, with the tax code issues and the uncertainty of the employee's response to such a change, as well as the market's ability to support such plans, only the very daring are testing the waters at this

point. The next few years should prove to be interesting for benefits managers evaluating their new alternatives.

Endnotes

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19. *Id.*
20. *Id.* at 8.
21. See *EEOC: Excluding Contraceptives While Covering Other Preventive Services Is Sex Discrimination*, *EMPLOYEE BENEFIT PLAN REVIEW*, Jan. 2001, at 12.
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49. *Id.*
50. *Id.*
51. See *supra* note 33. (Despite the tax advantage that is retained, the administrative burden of obtaining receipts and reimbursing employees for premiums paid or setting up payroll deductions and payments on a monthly schedule to an unlimited number of insurers becomes an administrative task of considerable proportion.)
52. See *Some Say DC Health "Inevitable"*, EMPLOYEE BENEFIT NEWS, July 2001, at 1, 14.
53. See Jill Elswick, *Business Models Emerge for Consumer-Driven Health Care*, EMPLOYEE BENEFIT NEWS, Sept. 1, 2001, at 11, 12. ("Consumer Driven Health Care Association", eight DC health benefit providers working to market consumer-driven health care and find terminology to classify the offerings.)
54. *Id.*
55. *Id.*
56. EMPLOYEE BENEFIT NEWS, June 15, 2001, at 11.
57. See *id.*
58. See *supra* note 1.
59. EMPLOYEE BENEFIT NEWS, June 15, 2001, at 11.
60. EMPLOYEE BENEFIT NEWS, Sept. 1, 2001, at 12.
61. See *Less Than Meets the Eye*, PLAN SPONSOR, July 2001, at 14.
62. See Len Strazewski, *New Direction in Benefits*, RISK & INS., Sept. 16, 2001, at 23-24.
63. *Defined Plans Catch On*, RISK & INS., Oct. 1, 2001, at 12.
64. RISK & INS., Sept. 16, 2001, at 23-24.
65. *Supra* note 33.
66. *Id.*
67. *Id.*
68. See *supra* note 38; *supra* note 1.
69. *Id.*
70. *Id.*
71. *Supra* note 54.
72. *Id.*
73. *Supra* note 26.
74. See *supra* note 1.
75. *Id.*