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Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement

By Paul Fronstin, EBRI

- This *Issue Brief* examines the cost of health insurance and health care expenses in retirement. It examines recent trends in private- and public-sector retiree health benefits and the impact of these trends on current and future retirees. It also presents options that retirees currently have to supplement the Medicare program, and provides estimates of how much those options will cost current and future retirees.
- ***Individuals have always struggled with retirement income security***: Medicare covers only about one-half of retiree health expenses. Because the majority of workers would have never been eligible for employment-based retiree health benefits, individuals have always had primary responsibility for health care expenses in retirement not covered by Medicare. Furthermore, the minority of workers and retirees that were at some point eligible for benefits are experiencing erosion in those benefits.
- ***Increasing burden on retirees***: This *Issue Brief* finds that a couple both age 65 today living to average life expectancy could need as much as $295,000 to cover premiums for health insurance coverage and out-of-pocket expenses during retirement. A couple who lives to age 95 could need as a much as $550,000.
- ***Options to pay for care:*** Workers have a number of options available to pre-fund health insurance and out-of-pocket health care expenses in retirement. Each of these have advantages and disadvantages but none is completely adequate as currently structured to fully fund the level of savings needed to cover insurance premiums and out-of-pocket retiree medical expenses.
- ***Health savings accounts:*** Health savings accounts are one option workers can currently use to save money for health insurance premiums and out-of-pocket expenses in retirement. The main advantage of using an HSA for health care expenses in retirement is that the account is tax-advantaged, but HSAs have several drawbacks: availability and contributions are limited, HSA owners may tap their accounts to a significant extent for medical expenses during their working years; distributions for retiree health premiums are not allowed until age 65. Because contributions are limited, the maximum amount that an individual could save in his or her account is $46,400 over 10 years.
- ***The value of Medicare benefits:*** The present value of lifetime Medicare benefits for a couple, both age 65 and retiring in 2005, was $328,000. But this *Issue Brief* estimates that among non-institutionalized beneficiaries, Medicare covers only 51 percent of expenses associated with health care services. Individuals are in large part responsible for covering the other 49 percent. Meanwhile, Medicare faces insolvency in 2018 and it is likely that benefits will be reduced in the future. Hence, if Medicare benefits are reduced, a couple age 65 today may need significantly more than $300,000 for health care expenses in retirement.

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Introduction

Research has consistently found that fewer employers are offering retiree health benefits than in the past, and that when retiree health benefits are offered, retirees are experiencing various combinations of rising premiums, higher out-of-pocket expenses, and more stringent eligibility requirements. The Employee Benefit Research Institute (EBRI) published its first analysis of employment-based retiree health benefits in 1988. That study examined the likely effects of early proposals by the Financial Accounting Standards Board (FASB) to change the way retiree health benefits appeared on corporate balance statements and how the proposed changes would cause employers to reconsider their sponsorship role of these benefits. EBRI has continued its work on this subject, and since the mid-1990s numerous other researchers have examined the erosion of employment-based retiree health benefits and its impact on retirees.[1]

It has also been shown that retirees are going to continue to bear an increasing burden of out-of-pocket costs in the future. For retirees with access to employment-based retiree health benefits, to pay the full cost of premiums and out-of-pocket expenses for the rest of their lives, a couple age 65 today will need $295,000. For retirees who do not have access to employment-based retiree health coverage, an average couple age 65 today will need $154,000 to cover premiums for Medicare Parts B and D, Medigap, and out-of-pocket prescription drug expenses if they have average drug use. A couple with drug use significantly above average will need $299,000.

As high as they are, these projections are probably underestimating the amount of money needed in retirement for health care expenses. If health care costs increase faster than projected, or if individuals live beyond average life expectancy, retirees will need more money than suggested above. This analysis documents these scenarios; it does not, however, document how the burden on retirees may grow as policymakers grapple with a $32.1 trillion unfunded liability in the Medicare program, and an insolvency date of 2018 for the Medicare Part A trust fund. The paper also does not document how the burden on retirees will grow as policymakers address the general unsustainability of excess cost growth in health care spending (the difference in the growth of national health spending and growth in gross domestic product, or GDP).

It is generally agreed that public policy change will be needed to address the Medicare budget shortfall, and that Congress is more likely to reduce Medicare benefits than to enhance them. The U.S. Congressional Budget Office (CBO) (2005) discusses various options that would increase the share of costs paid by Medicare beneficiaries, such as raising the eligibility age or increasing beneficiary cost sharing. Furthermore, increasing life expectancy and innovations in medical technology will further put pressure on national health spending, and may ultimately mean that retirees will have to pay an increasing burden of health care costs during retirement.

For the reasons discussed above, this analysis underestimates the amount of money needed in retirement for health care expenses, and also underestimates needed savings because it does not include the cost of long-term care, nor does it examine the cost of health care expenses for retirees under age 65. It also does not look at the impact that employment during retirement may have on needed savings.

The purpose of this *Issue Brief* is to examine recent trends in retiree health benefits and how these trends will affect current and future retirees. The following section examines trends in retiree health benefits and examines the Medicare program. The report presents options that retirees currently have to supplement the Medicare program, and provides estimates of how much those options will cost current and future retirees. Options to allow workers to save money to fund the cost of health care in retirement are also presented. Factors that can affect the provision of retiree health benefits in the future are also discussed.

Trends in Retiree Health Benefits

One of the most important factors (if not the single-most important) that has led to the decline of retiree health benefits was a 1990 rule change issued by the Financial Accounting Standard Board (FASB) that required employers to report their retiree health liabilities. As early as the mid-1980s, employers were aware

that FASB was considering accounting standard changes that would affect the way they would be required to account for retiree health benefits on financial statements. There were a number of studies on the earliest FASB guidelines for "Other Post-Employment Benefits" (OPEBs) and the fuller proposals that were issued in the mid-1980s, such as the EBRI (1988) study noted above, which helped inform the FASB's OPEB standards. The early 1980s standards and the later draft proposals and subsequent research undoubtedly resulted in some employers making changes to retiree health benefits even before FASB's expanded standards were finalized in 1990.

The approval of Financial Accounting Statement No. 106 (FAS 106), "Employer's Accounting for Postretirement Benefits Other Than Pensions," in December 1990 triggered many of the changes that private-sector employers have made to retiree health benefits since the early 1990s.

FAS 106 markedly changed the way most private-sector companies accounted for retiree health benefits. It requires companies to record retiree health benefit liabilities on their financial statements in accordance with generally accepted accounting principles. Specifically, it required private-sector employers to accrue and expense certain future claims' payments as well as actual paid claims. The immediate income statement inclusion and balance sheet footnote recognition of these liabilities dramatically affected a company's reported profits and losses. The impact was greatest on large employers, since small ones typically never offered retiree health benefits.

As a result of FAS 106, companies now recognize the long-term liability of offering retiree health benefits in their footnotes. With the new view of the cost and the increasing cost of providing retiree health benefits, many private-sector employers have overhauled their retiree health programs in ways that controlled, reduced, or eliminated these costs. By now, 16 years after the accounting standard was issued, these cuts would be expected to have had a major impact on employer FAS 106 liabilities. Recently, however, the U.S. Government Accountability Office (GAO) examined the financial statements of 50 randomly chosen Fortune 500 companies, and found that more than 90 percent of the employers offering retiree health benefits experienced an *increase* in their postretirement benefits obligations between 2001 and 2003, with some being 50 percent or more higher (U.S. Government Accountability Office, 2005).

As a result of FAS 106 and the rising cost of providing retiree health benefits, most workers in the United States will never be eligible for health insurance in retirement through a former employer. Very few employers currently offer this benefit, and the number that do has been declining. The Agency for Healthcare Research and Quality (AHRQ) reports that only 13 percent of private-sector establishments offered health benefits to early retirees or Medicare-eligible retirees in 2003, down from 22 percent in 1997 (Figure 1). Furthermore, 13 percent of private-sector establishments offered health benefits to Medicare-eligible retirees in 2003, down from 20 percent in 1997.

Large establishments are much more likely to offer retiree health benefits than small establishments. In 2003, 41 percent of establishments with 1,000 or more employees offered retiree health benefits, compared with 2 percent among establishments with fewer than 10 employees (Figure 2). Inevitably, the percentage of workers employed at establishments offering retiree health benefits also has been falling: In 2003, 22 percent of all workers were employed at an establishment that offered health benefits to early retirees, down from 31 percent in 1997 (Figure 3). However, these data should not be interpreted as indicating that 22 percent of workers are or would be eligible for retiree health benefits should they retire or that those who qualify for a retiree medical plan will receive substantial premium contributions from their employers. Employers have generally made it more difficult for retirees to qualify for health benefits in retirement, so not all those who work for an employer that offers the benefit will qualify to receive it.

Employers have made it more difficult for workers to qualify for retiree health benefits in a number of ways even as they continue to offer these benefits. They have been tightening eligibility requirements to control spending and reward longer-service employees. This might involve requiring workers to attain a certain age and/or tenure with the company before they qualify for retiree health benefits. Overall, the percentage of employers requiring an age of 55 and a service requirement of 10 years for benefit eligibility increased from 30 percent in 1996 to 35 percent in 2004 (Figure 4). Concurrently, some employers instituted a requirement of age 55 and 20 years of service or age 60 and 10 years of service.

In addition to tightening eligibility for benefits, some employers have simply made the cost of participating in retiree health benefits more expensive for retirees. Employers often used service-based

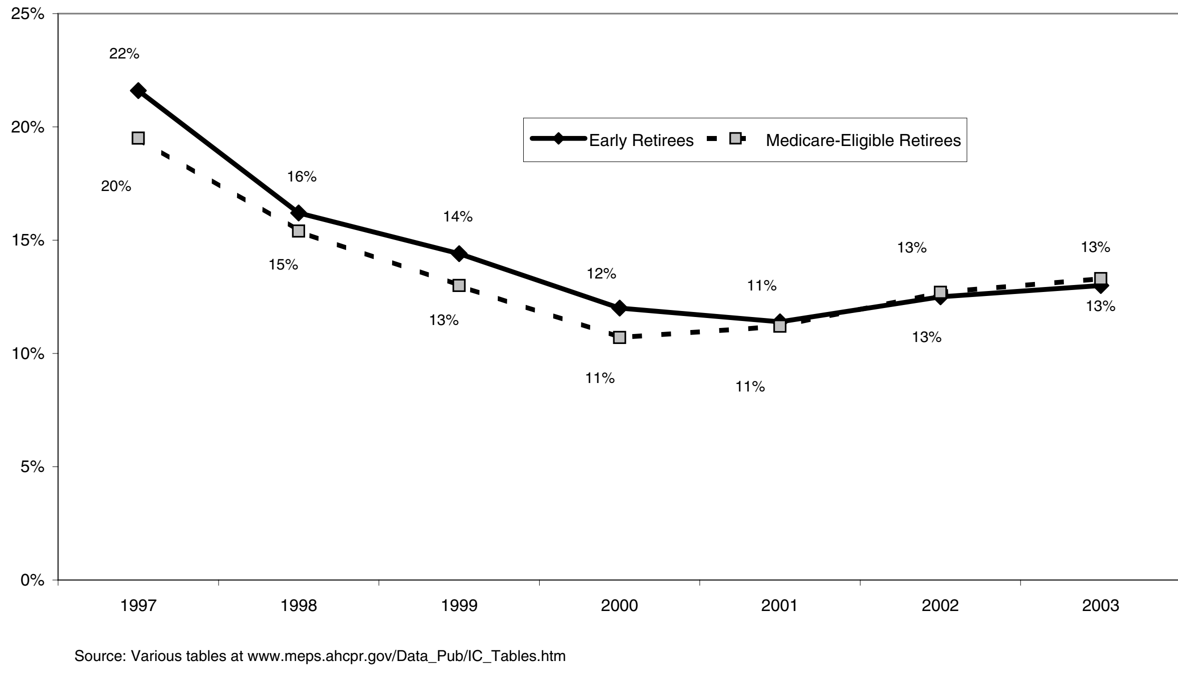


Figure 1
Percentage of Private-Sector Establishments
Offering Health Insurance to Retirees, 1997–2003
25%
20%
15%
10%
5%
0%
22%
20%
16%
15%
14%
13%
12%
11%
11%
11%
13%
13%
13%
13%
Early Retirees
Medicare-Eligible Retirees
1997
1998
1999
2000
2001
2002
2003
Source: Various tables at www.meps.ahcpr.gov/Data_Pub/IC_Tables.htm

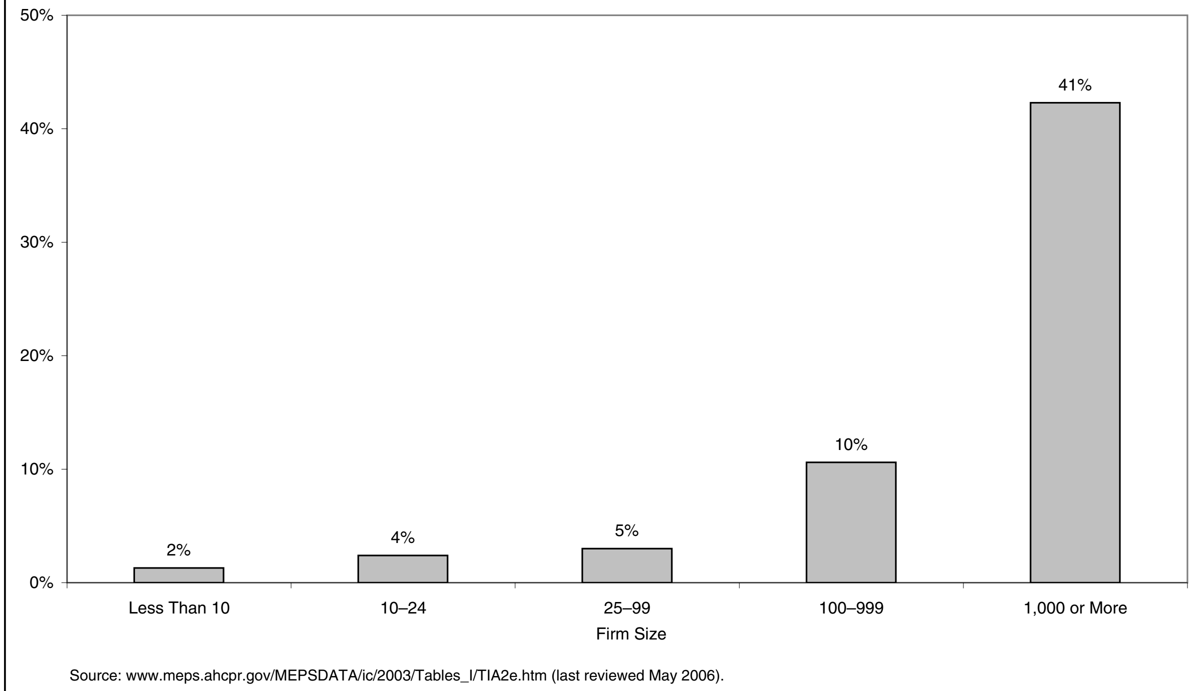
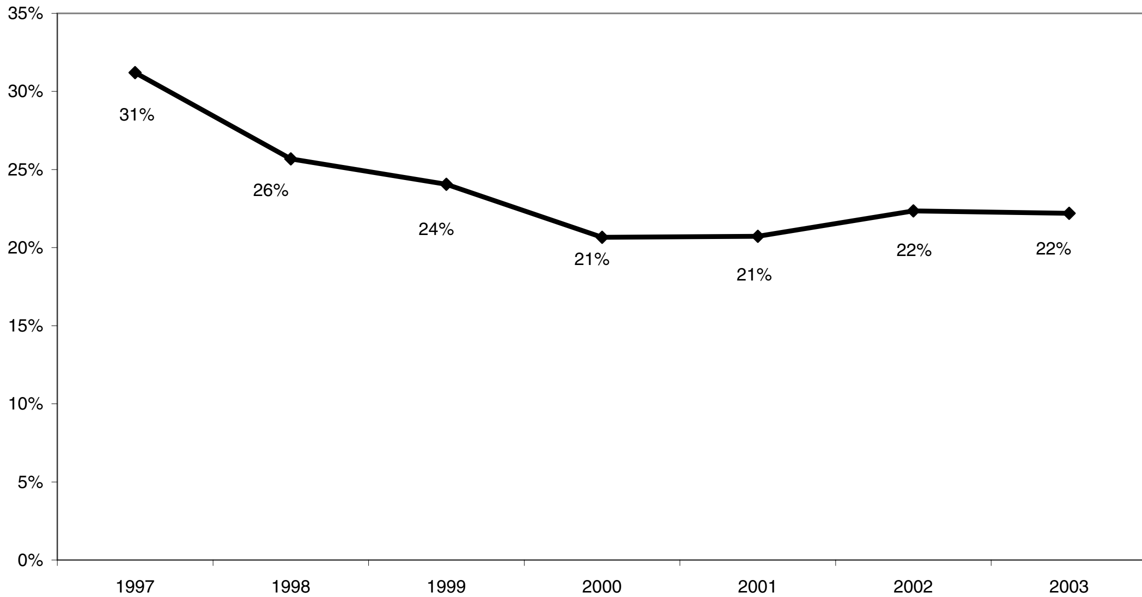


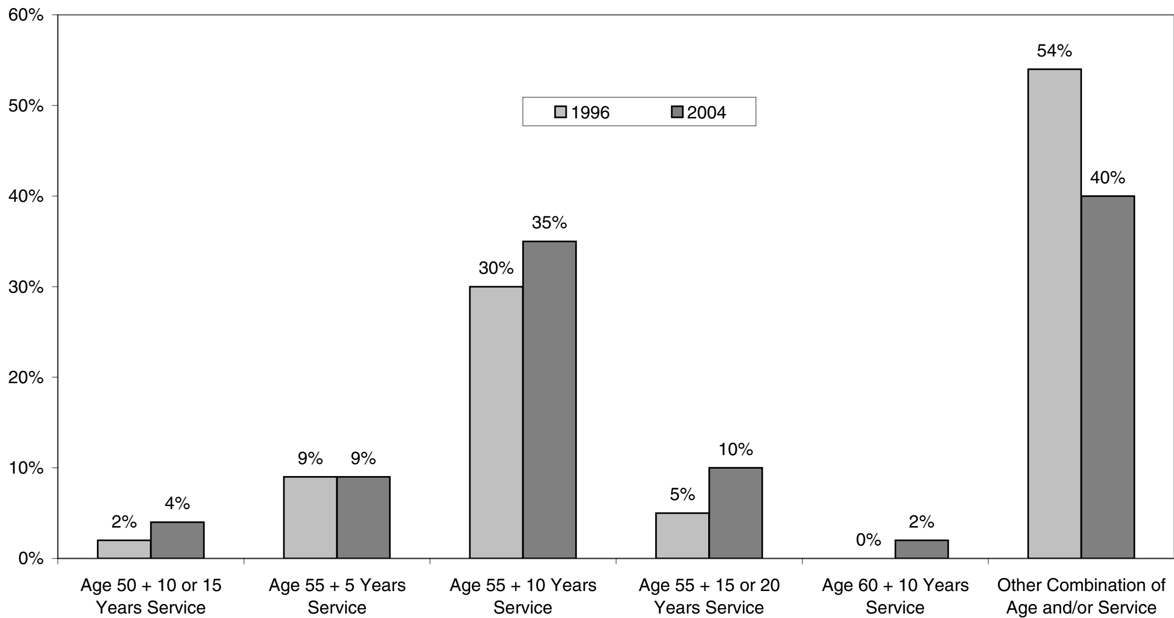
Figure 2
Percentage of Private-Sector Establishments That Offer Retiree
Health Benefits to Medicare-Eligible Retirees, by Firm Size, 2003
50%
40%
30%
20%
10%
0%
2%
4%
5%
10%
41%
Less Than 10
10–24
25–99
100–999
1,000 or More
Firm Size
Source: www.meps.ahcpr.gov/MEPSDATA/ic/2003/Tables_I/TIA2e.htm (last reviewed May 2006).

Figure 3
Percentage of Private-Sector Workers Employed at Establishments Offering Health Benefits to Early Retirees, 1997–2003



Source: Various tables at www.meps.ahcpr.gov/Data_Pub/IC_Tables.htm

Figure 4
Eligibility Requirements for Retiree Health Benefits, Employers With 1,000 or More Employees, 1996 and 2004



Source: Hewitt Associates.

contributions, contributing more for longer-service employees and less for shorter-service ones. Employers have often instituted caps or ceilings on the total amount of money they are willing to spend on retiree health benefits. Under a commonly used approach, once employer spending reaches the caps, the employer subsidy for the retiree health benefit will no longer be increased. These employers often continue to subsidize retiree health benefits, but retirees are responsible for the entire premium in excess of the cap amount each year. Caps erode the level of coverage even for employers continuing to offer retiree health benefits. When employer contributions are capped and retiree premium contributions rise, a significant number of retirees tend to drop their employment-based coverage. For example, 63 percent of employers have a cap on their firm's contribution to retiree health benefits in at least one of the plans offered to retirees.[2] About one-half of employers have a cap on the largest plan offered to Medicare-eligible retirees, and among them, 59 percent have reached the cap, 8 percent expect to reach it within the next year, 19 percent expect to reach it within three years; only 14 percent do not expect to reach the cap in the near future (Figure 5).

Some employers have gone so far as to eliminate their subsidy for retiree health benefits altogether for workers hired (or retiring) after a specific date. According to findings from the Kaiser/Hewitt Survey on Retiree Health Benefits, 13 percent of employers that offered retiree health benefits reported that they had terminated all subsidized health benefits for future retirees during either 2001 or 2002; 10 percent reported terminating all subsidized health benefits for future retirees in 2003; 9 percent reported doing so in 2004; and 12 percent reported doing so in 2005 (Figure 6). Even without an employer subsidy, many retired workers still get significant savings by paying the group-based premiums for health insurance through their former employer (even if they have to pay the entire amount themselves), compared with individual market rates.

Some employers have established fixed-contribution retiree medical accounts (RMAs) for retirees to use to purchase health benefits during retirement. One study found that 2 percent of large employers have adopted RMAs for current retirees, while 7 percent adopted them for future retirees and 13 percent adopted them for new hires (McDevitt et al., 2002). Employers are also starting to examine the feasibility of offering a health reimbursement arrangement (HRA) or health savings account (HSA) that could be used for retiree health benefits. A recent survey found that during 2005, 5 percent of employers added an account-based retiree health plan such as an HRA or HSA.[3] Accounts that can be used for retiree health benefits are discussed below.

The Medicare Program

Medicare, the federal health care insurance program for the elderly and disabled, is the primary payer of health care services for persons who are retired and age 65 and older. The Medicare program contains four parts:

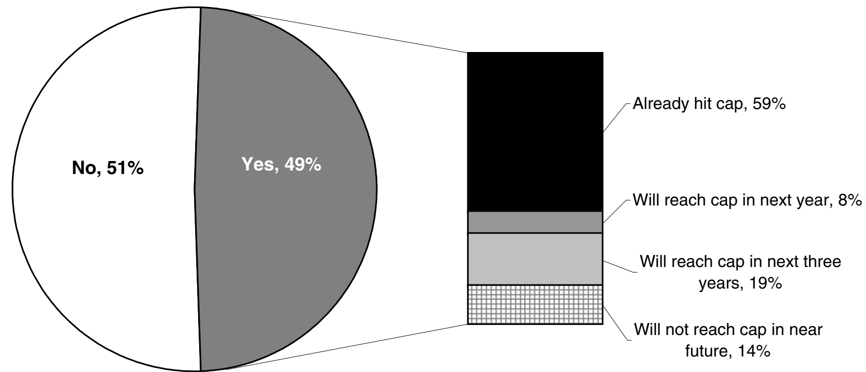
- Part A (Hospital Insurance).
- Part B (Supplementary Insurance).
- Part C (Medicare Advantage).
- Part D (Outpatient Prescription Drugs).

Eligible Medicare beneficiaries in the traditional program automatically receive Medicare Part A at no premium cost. Part A covers inpatient hospital services, skilled nursing facility (SNF) benefits following a three-day hospital visit, home health visits following a hospital or SNF stay, hospice care, and blood (after the member has paid for the first three pints). In 2006, hospital stays are subject to a $952 deductible for days one–60. A $238 per day co-payment is required of Medicare beneficiaries for days 61–90; this increases to $476 per day for days 91–150, although there are a total of 60 lifetime reserve days that can be used for lengths of stay more than 90 days. Medicare beneficiaries are responsible for all costs for each day beyond 150. SNF care costs beneficiaries nothing during the first 20 days, after which a $119 per day co-payment is required until day 100, after which the beneficiary pays all costs.

Individuals with Part A are able to supplement it with Part B. Part B is partially financed by beneficiary premiums that originally covered 50 percent of the program's costs. Today, Part B is financed by beneficiary premiums that cover 25 percent of the program's cost and general tax revenues finance the balance. Persons choosing Part B services pay a $88.50 per month premium in 2006. Under provisions originally contained in

Figure 5

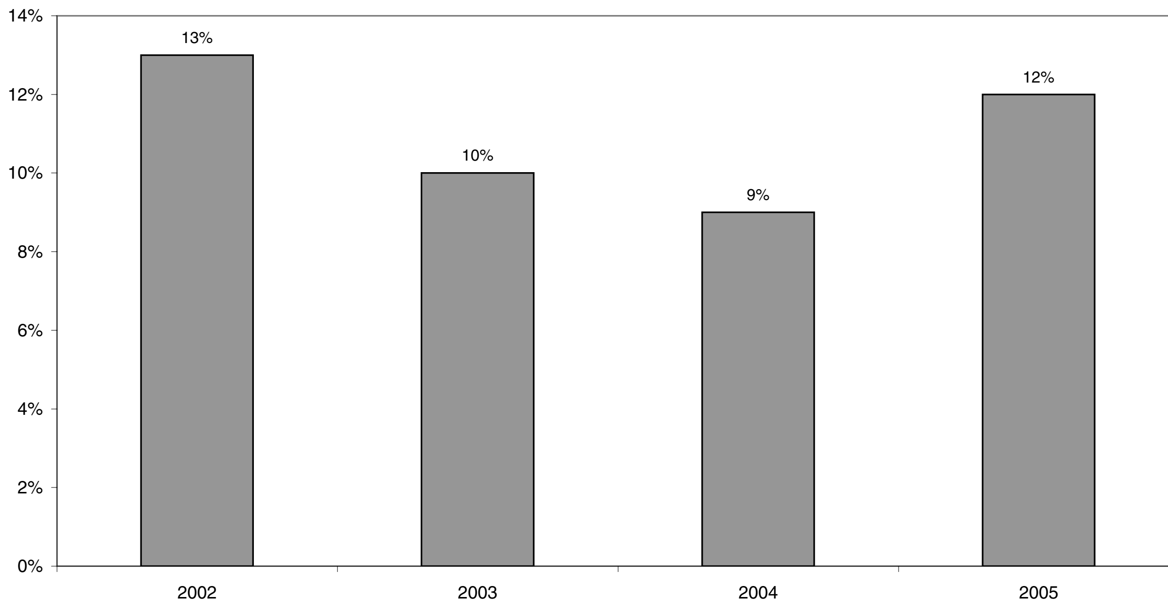
Percentage of Employers With Cap on Their Contribution to Retiree Health Benefits for Medicare-Eligible Retirees in Largest Plan, 2005



Source: Exhibit 10 in www.kff.org/medicare/upload/7439Section3.pdf

Figure 6

Percentage of Large Private-Sector Employers That Terminated All Subsidized Benefits for Future Retirees, 2002–2005[a]



Source: The Henry J. Kaiser Family Foundation and Hewitt Associates, *Findings From the Kaiser/HewittSurvey on Retiree Health Benefits, 2002–2005*

[a] In 2002, survey asked employers about changes made to plan during previous two years. In 2003, 2004, and 2005, employers were asked about the past year.

the Medicare Modernization Act (MMA) and since revised in the 2005 Deficit Reduction Act, higher-income beneficiaries will begin to pay a greater percentage of the Part B premium starting in 2007. Part B covers doctors' services, outpatient care, diagnostic tests, ambulatory services, durable medical equipment, outpatient physical and occupational therapy, mental health services, clinical laboratory services, limited home health care, outpatient hospital services, and blood provided on an outpatient basis. Most of these services are subject to 20 percent coinsurance from the Medicare beneficiary, and some services are also subject to an annual $124 deductible (indexed to inflation). Part B also covers a number of preventive services, such as bone mass measurements, flu shots, and screenings related to cardiovascular health, colorectal cancer, and diabetes.

Because of the MMA, outpatient prescription drug benefits recently became available to Medicare beneficiaries under Part D. Like Part B, Part D is partially financed by beneficiary premiums that cover 25 percent of the program's cost and general tax revenues finance the balance. Persons choosing Part D pay a monthly premium, with estimates of the average premium in the $30–$40 range for the standard plan (U.S. Department of Health and Human Services, 2006; Gold, 2006; and Frakt and Pizer, 2006).[4] When beneficiaries receive drug benefits under the standard plan, they are subject to a $250 deductible. After the deductible is met, beneficiaries are responsible for 25 percent coinsurance on the cost of prescription drugs on the next $2,000 in benefits (or $500). At that point they would be completely responsible for the next $2,850, after which they would be responsible for 5 percent coinsurance. However, more than 80 percent of enrollees in stand-alone Part D plans are choosing more comprehensive plans (Bach and McClellan, 2006), specifically plans with no deductible and low cost sharing for generic drugs.

As an alternative to the traditional Medicare program, Medicare beneficiaries are able to enroll in health plans offered by private insurers. These plans are known as Medicare Advantage (MA) plans and are sometimes referred to as Medicare Part C. MA plans include HMOs, PPOs, Special Needs Plans, and Private Fee-for-Service Plans. These plans provide all Medicare-covered services and may also provide outpatient prescription drug coverage. These plans may also cover health care services not covered by traditional Medicare, such as vision, hearing, dental, and/or health and wellness programs, but can also limit beneficiaries' choice of health care provider to a provider that participates in the health plans' network. MA plans are allowed to charge beneficiaries a premium to enroll in such a plan, which is on top of the Part B premium.

Options to Supplement Medicare Benefits

About 95 percent of all beneficiaries are enrolled in Part B.[5] In addition, most Medicare beneficiaries have some type of health insurance to supplement Parts A and B. In 2002, only 12 percent of beneficiaries did not have some form of health insurance in addition to Medicare Part B. Thirty-five percent of beneficiaries were covered by employment-based health benefits to supplement Medicare; 21 percent were covered by Medigap; 17 percent were covered by Medicaid (the federal-state health care program for poor); and 15 percent were covered by a Medicare HMO.[6] Today, a portion of the 12 percent of beneficiaries who did not have some form of supplemental coverage may have enrolled in the Part D outpatient prescription drug program.[7]

Whether a Medicare beneficiary has supplemental insurance clearly will affect the savings needed to cover the cost of health care services in retirement. For those Medicare beneficiaries with supplemental insurance, the source of that insurance will also affect the amount of money needed for health insurance and health care services. Options offered by the Medicare program to enhance insurance coverage were discussed in the previous section. This section discusses private group and nongroup forms of health insurance.

Employment-Based Retiree Health Benefits

Individuals with employment-based retiree health benefits to supplement Medicare coverage typically have a rich benefit package. Most plans have a deductible, after which the plan covers out-of-pocket costs for inpatient and outpatient services with an out-of-pocket maximum, and nearly all provide prescription drug benefits. One study found the average annual premium of a retiree health plan for retiree-only coverage to be $4,080 for new Medicare-eligible retirees in 2005, of which retirees pay $1,536, or 38 percent of the

total premium.[8] However, 19 percent of employers offering benefits to Medicare beneficiaries require them to pay the full cost of the premium.

Like Medicare, employment-based retiree health benefit programs typically require cost sharing when retirees receive health care services. Slightly more than 70 percent of employer plans have a deductible, although three-quarters cap out-of-pocket expenses for retirees. In 2005, the most common deductible among plans with a deductible was $250, while the most common out-of-pocket maximum was $1,500.[9] Furthermore, it is common for plans to not subject prescription drug coverage to deductibles and out-of-pocket maximums that are separate from other covered services.

Medigap

Medicare beneficiaries are currently able to choose a Medigap plan to supplement Medicare benefits. In all states except Massachusetts, Minnesota, and Wisconsin, a Medigap plan must be one of 12 standardized policies. All Medigap plans provide coverage for Part A coinsurance, 365 additional hospital days during a person's lifetime, Part B coinsurance, and blood (Figure 7). Medigap plans B–L include other combinations of benefits, such as coverage for skilled nursing coinsurance, the Part A deductible, the Part B deductible, and outpatient prescription drugs. Only plans H–J cover outpatient prescription drugs and Medicare beneficiaries are not able to purchase new Medigap plans H–J starting Jan. 1, 2006, because of the new Part D program. Plans K and L were recently added and are generally less costly than the other Medigap options because they cover fewer benefits. Instead of providing full coverage for basic benefits, the skilled nursing coinsurance, and the Part A deductible, Plan K requires beneficiaries to pay 50 percent coinsurance, while Plan L requires beneficiaries to pay 25 percent coinsurance.

Medigap Plan F is the most popular choice among Medicare beneficiaries in plans A–J (U.S. General Accounting Office, 2002). Plan F accounts for 35.2 percent of all Medigap A–J policies. Among the plans that do not provide outpatient prescription drug benefits, Plan F is also the most comprehensive Medigap plan. In 2005, the average (unweighted) annual premium for Medigap Plan F for a 65-year-old female was $1,755, but premiums varied significantly by age, insurer, and by geographic region, ranging from a low of $516 to a high of $10,789.[10] Premiums varied by state, with average premiums ranging from $1,407 (Utah) to $2,490 (Connecticut).[11]

Medicare Advantage Plan

Medicare Advantage (MA) plans often combine coverage for Medicare Parts A, B, D, and other benefits not covered by the traditional Medicare program. The impact of MA plans on savings needed for health care expenses in retirement are not examined in this report for a number of reasons. There are substantially fewer available MA plans per beneficiary than stand-alone Part D plans, and there is wide variation nationally. While the average drug portion of the MA premium is substantially lower than the average premium for stand-alone Part D plans, high federal payouts to these plans may contribute to lower overall cost sharing (Gold, 2006). It is difficult to predict what MA plans will look like in the future because high federal payouts may not continue.

Savings Needed for a 65-Year-Old in 2006

Employment-Based Retiree Health Benefits

Figure 8 provides estimates of savings needed to pay for health insurance premiums, Medicare Part B premiums, and out-of-pocket health care costs during retirement for a person with access to employment-based health benefits. This assumes that the individual is responsible for paying the entire premium, as this practice is becoming more common. It also assumes that the premium grows by 7 percent each year, $750 is spent out of pocket in 2006, and that amount grows each year by 7 percent. As mentioned already, a significant number of employers have terminated subsidized benefits for future retirees (Figure 5).

Figure 8 shows that a 65-year-old retiring in 2006 who lives to age 80 will need $115,000 in savings to pay for premiums and assumed annual out-of-pocket expenses ($750). In contrast, an individual who lives to age 90 will need $214,000 in savings at age 65 to pay for premiums and cover out-of-pocket expenses each year.

Figure 7
Benefits Covered by Standardized Medigap Policies

Benefits	A	B	C	D	E	F[b]	G	H	I	J[b]	K[c]	L[d]
Basic Benefits[a]	x	x	x	x	x	x	x	x	x	x	x	x
Skilled Nursing Coinsurance			x	x	x	x	x	x	x	x	x	x
Part A Deductible		x	x	x	x	x	x	x	x	x	x	x
Part B Deductible			x			x				x		
Part B Excess Charge						x	x		x	x		
Foreign Travel Emergency			x	x	x	x	x	x	x	x		
At-Home Recovery				x			x		x	x		
Basic Drug Benefit								x	x	x		
Preventive Care					x					x		

Source: Centers for Medicare & Medicaid Services. *2006 Guide To Health Insurance For People with Medicare: Choosing a Medigap Policy.* (www.medicare.gov/Publications/Pubs/pdf/02110.pdf).

Note: This figure does not apply to Massachusetts, Minnesota, and Wisconsin, where alternative standards for supplemental insurance exist. Medicare beneficiaries may also choose a Medicare SELECT plan. SELECT plans are a type of Medigap plan that limit coverage for health care services to a network of hospitals and/or doctors.

[a] Basic benefits include 1) the Part A coinsurance amount for days 61–90, and days 91–150 of a hospital stay, 2) coverage of up to 365 more days of a hospital stay during a lifetime, 3) coinsurance or copayment amount for Part B services, and 4) the first three pints of blood.

[b] Plans F and J also have a high deductible option.

[c] Plan K covers 50% of the daily copayment for skilled nursing facility (SNF) days 21–100 and all costs after that, and also covers 50% of the Part A deductible. In addition, there is a $4,000 out-of-pocket limit.

[d] Plan L covers 75% of the daily copayment for SNF days 21–100 and all costs after that, and also covers 75% of the Part A deductible. In addition, there is a $2,000 out-of-pocket limit.

Figure 8
Savings Needed For Employment-Based Health Premiums,[a] Medicare Part B Premiums, and Out-of-Pocket Costs for Retirement at Age 65 in 2006, Assuming 4% After-Tax Rate of Return on Investments

	7% Increase in Employment-Based Retiree Health Premiums and Out-of-Pocket Costs	
Age at Death	For an Individual	For a Couple[b]
80	$115,000	$230,000
85	162,000	324,000
90	214,000	428,000
95	275,000	550,000
100	343,000	686,000

Source: EBRI estimates based on various assumptions.
[a] Premiums and out-of-pocket maximum assumptions based on data found in www.kff.org/medicare/7439.cfm
[b] Living to the same age.

Figure 9
Savings Needed For Medigap Premiums,[a] Medicare Part B Premiums Part D Expenses for Retirement at Age 65 in 2006, Assuming 4% After-Tax Rate of Return on Investments, by Prescription Drug Spending

	Prescription Drug Spending	
	Median	90% Percentile
Age at Death	7% Increase in Medigap Premium, and Increases in Other Costs as Defined in Assumptions Section	7% Increase in Medigap Premium, and Increases in Other Costs as Defined in Assumptions Section
80	$60,000	$118,000
85	84,000	164,000
90	111,000	214,000
95	141,000	270,000
100	175,000	332,000

Source: EBRI estimates based on various assumptions.

[a] Benefits package for Medigap Plan F averaged across all plans in 2006, containing the following benefits:
Inpatient Hospital Care: covers the cost of Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.
Medical Costs: covers the Part B coinsurance (generally 20% of Medicare-approved payment amount) or copayment amount which may vary according to the service.
Blood: covers the first three pints of blood each year.
Also covers the Part A inpatient hospital deductible, the Part B deductible, 100% of the Part B excess charges, the skilled nursing facility coinsurance, and emergency foreign travel.

These estimates are for an individual; the amount of savings needed for a couple would mean doubling the estimates if the couple lived to the same age. Using life expectancy of 82 for men and 85 for women, an average couple will need $295,000 at age 65 for premiums and out-of-pocket expenses. Were a couple instead to live to age 95, they would need $550,000 to cover premiums and out-of-pocket expenses. Again, these amounts are for retirees who have access to retiree health benefits from a former employer but pay the full premium.

Medigap and Part D

While 25.5 percent of Medicare-eligible retirees in 2002 were covered by employment-based retiree health benefits, the percentage of Medicare-eligible retirees with employment-based coverage has been declining, and most future retirees will not have access to retiree health benefits through a former employer (Fronstin, 2005). Instead, their options for supplementing traditional Medicare will be limited to purchasing a Medigap plan with or without Medicare Part D, or a Medicare Advantage plan. This section focuses on savings that would be needed for an individual to pay:

- Premiums for Medigap.
- Premiums for Medicare Part D (prescription drugs).
- Out-of-pocket expenses for prescription drugs not covered by Medicare Part D.
- Premiums for Medicare Part B (Supplementary Insurance).

This analysis is complicated by the fact that utilization of prescription drugs by an individual Medicare beneficiary is not constant over time. Projections of savings needed to cover out-of-pocket expenses for prescription drugs are highly dependent on the assumptions used for drug utilization. In this analysis, drug spending is based on data from the 2003 Medical Expenditure Panel Survey. For illustrative purposes, it is assumed that an individual will have the standard prescription drug plan under Medicare Part D. Using this assumption provides an upper bound estimate on savings needed for health care expenses in retirement. For illustrative purposes, the savings needed for an individual using the median amount of drugs throughout retirement are examined, and for comparison purposes, the savings needed for an individual at the 90th percentile of drug spending throughout retirement are also examined.

Figure 9 shows the amount of savings needed to cover Medigap premiums, Medicare Part D premiums, and out-of-pocket prescription drug expenses. The first column in the figure shows the various levels of savings needed depending upon a Medicare beneficiary's age at the time of death, assuming that Medigap premiums increase 7 percent and an individual uses the median amount of prescription drugs throughout retirement. An individual retiring at age 65 in 2006 with Medigap Plan F and the standard Medicare Part D plan will need $60,000 if he or she lives to age 80. In contrast, an individual who lives to age 90 will need $111,000 at age 65. An individual who uses enough prescription drugs to put himself or herself at the 90th percentile in drug use, as shown in the second column of Figure 9, and who lives to age 80 will need $118,000 at age 65. A person living to age 90 will need $214,000 at age 65.

As noted above, these estimates are for an individual. Using life expectancy of 82 for men and 85 for women, an average couple will need $154,000 at age 65 for Medigap, Part B, and Part D premiums and median out-of-pocket prescription drug expenses. While this represents enough money for an "average" couple, it is not enough money for a couple that lives beyond average life expectancy. A couple both living until age 95 will need $282,000. Furthermore, with average life expectancy but drug expenses at the 90th percentile level, this couple will need $299,000. Finally, a couple both living to age 95 and at the 90th percentile in drug use will need $541,000.

Savings Needed for a 65-Year-Old in 2016 (Currently Age 55)

While the estimates in Figures 8 and 9 are useful, individuals who have already reached age 65 generally do not have time to save for health care expenses in retirement if they haven't already done so. The general rule of thumb has always been the earlier an individual starts saving for retirement, the easier it will be to meet his or her goals. Previous EBRI research has shown that during the decade ending 2030, retirees will

face a shortfall of at least $400 billion between expected retirement income compared with what they will need to cover basic expenditures and any expense associated with an episode of care in a nursing home or from a home health care provider (VanDerhei and Copeland, 2003). This study also found that older individuals were generally likely to need to save an *additional* 25 percent of income to meet retirement needs, while younger individuals only needed to save an additional 5 percent of compensation for the remainder of one's career. The remainder of this section focuses on the amount of money an individual will need to save to cover health insurance premiums and out-of-pocket expenses in retirement for a person 55 years old in 2006 who will not retire until age 65 in 2016.

Employment-Based Retiree Health Benefits

Figure 10 provides estimates of savings needed to pay for health insurance premiums, Medicare Part B premiums, and out-of-pocket health care costs during retirement for a person with access to employment-based health benefits. The estimates in this figure are for an individual who is 55 years old today and does not retire until age 65 in 2016. It is also assumes that the individual will have access to retiree health benefits through a former employer, but the plan is an access-only plan, such that the individual is responsible for paying the entire premium. Finally, it is assumed that there are no major public policy changes (such as changes to the Medicare program that are anticipated due to the pending insolvency of the Part A trust fund in 2018).

Figure 10 shows that a 65-year-old retiring in 2016 who lives to age 80 will need $219,000 in savings (at age 65) to pay for premiums and to cover out-of-pocket expenses each year. In contrast, an individual who lives to age 90 will need $409,000 at age 65 in savings to pay for premiums and out-of-pocket expenses.

To determine the amount of savings needed for a couple would mean doubling the estimates if the couple lived to the same age. Using life expectancy of 82 for men and 85 for women, an average couple will need $560,000 at age 65 for premiums and out-of-pocket expenses.[12] Of course, couples who live past average life expectancy will need to save more money than in the example, while those who do not reach average life expectancy would need to save less.

Medigap and Part D

Figure 11 shows the level of savings needed for a 55-year-old in 2006 retiring at age 65 in 2016 to cover Medigap premiums, Medicare Part D premiums, and out-of-pocket prescription drug expenses. The first column in the figure show the various levels of savings needed depending upon a Medicare beneficiary's age at the time of death, assuming average prescription drug use. An individual retiring at age 65 in 2016 with Medigap Plan F and Medicare Part D will need $112,000 at age 65 if he or she lives to age 80. In contrast, an individual who lives to age 90 will need $207,000 at age 65. If drug use was at the 90th percentile, as shown in the second column of Figure 11, the person living until age 80 will need $215,000 at age 65, while the person living to age 90 will need $390,000 at age 65.

Using life expectancy of 82 for men and 85 for women, an average life expectancy couple who have median drug expenses will need $285,000 at age 65 for Medigap, Part B, and Part D premiums and out-of-pocket prescription drug expenses.[13] Since about one-half of the population will live beyond average life expectancy and not have enough savings at these levels to cover health care expenses in retirement, and about one-half of the population will be younger than average life expectancy at the age of their death, individuals will have to cope with longevity risk—that is, the risk of outliving one's assets. A couple living until age 95 with median drug expenses will need $530,000.[14] This serves to underscore the advantage of social insurance and group purchasing that pool risk, thereby minimizing longevity risk for retirees.

Vehicles to Save for Health Care Expenses in Retirement

There are a number of options currently available to employers and workers to pre-fund health insurance and out-of-pocket expenses for health care in retirement. While each of these options have various advantages and disadvantages associated with pre-funding retiree health benefits, none of these options is completely adequate as currently structured to fully fund the level of savings needed to cover insurance premiums and out-of-pocket expenses. Available options include:

- Health savings accounts (HSAs).
- Health reimbursement arrangements (HRAs).
- Retiree medical accounts (RMAs).
- Voluntary employee benefit association (VEBAs).

The following section discusses HSAs. The other types of funding vehicles are presented in an appendix because they are in large part vehicles that employers can use to pre-fund or account for retiree health benefits.

Health Savings Accounts (HSAs)

A health savings account is a tax-exempt trust or custodial account that an individual can use to pay for health care expenses. Contributions to an HSA are deductible from taxable income and distributions for qualified medical expenses and certain premiums, including retiree health insurance premiums, are not counted in taxable income. Once enrolled in Medicare, beneficiaries are not permitted to continue making contributions to an HSA. Earnings on contributions are also not subject to income taxes.

In order for an individual to qualify for tax-free contributions to an HSA, he or she must be covered by a high-deductible health plan (HDHP), defined as a plan that has an annual deductible of at least $1,050 for individual coverage, and $2,100 for family coverage in 2006.[15] Certain preventive services can be covered in full and not subject to the deductible. Out-of-pocket maximums are limited to $5,250 for individual coverage, and $10,500 for family coverage. Network plans may impose higher deductibles and out-of-pocket maximums for health care services received outside of the network.

Both workers and employers can contribute to an HSA. Contributions are excluded from taxable income if made by an employer and deductible from adjusted gross income if made by an individual. The maximum annual contribution in 2006 is $2,700 for individual coverage and $5,450 for family coverage. However, the maximum permissible contribution cannot exceed the plan deductible. Contribution limits are also indexed to inflation. Individuals who have reached age 55 and are not yet enrolled in Medicare may make catch-up contributions. In 2006, a $700 catch-up contribution is allowed, and will be phased in to $1,000 by 2009.[16]

To be eligible for an HSA, an individual may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also a HDHP. However, an individual is allowed to have supplemental coverage without a high deductible for such things as vision care, dental care, specific diseases, and insurance that pays a fixed amount per day (or other period) for hospitalization. An individual is also not allowed to make a contribution to an HSA if he or she is claimed as a dependent on another person's tax return.

HSAs are completely portable, although the HDHP itself may not be. There is no use-it-or-lose-it rule associated with them, as any money left in the account at the end of the year automatically rolls over and is available in the following year. Distributions from an HSA can be made at any time. An individual need not be covered by a HDHP to withdraw money from his or her HSA. Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under Internal Revenue Code (IRC) Sec. 213(d).[17] Distributions for COBRA, long-term care insurance, health insurance while receiving unemployment compensation, and insurance while eligible for Medicare other than for Medigap, are also tax free. This means that distributions used to pay Medicare Part A, B, or D, Medicare Advantage plan premiums, and the employee share of the premium for employment-based retiree health benefits for Medicare beneficiaries are allowed on a tax-free basis.

HSAs have several drawbacks as an accumulation vehicle for funding health insurance premiums and out-of-pocket expenses in retirement. First, availability is limited to those with a HDHP. Second, contributions are limited; the maximum annual contribution in 2006 is limited to the lesser of the deductible amount or $2,700 for individual coverage and $5,250 for family coverage, though persons age 55 and older can make catch-up contributions. Third, given the coupling with HDHPs, it is likely that HSA owners will tap their accounts to a significant extent for medical expenses incurred during their working years. Fourth, distributions can be used for employment-based retiree health insurance premiums only once an individual has reached age 65; early retirees do not have immediate access to these funds for retiree health premiums.

If an individual were to contribute $2,700 annually to his or her HSA, $34,700 could be accumulated after 10 years, $91,300 after 20 years, and $183,600 after 30 years, assuming the catch-up contributions were not made (Figure 12). Even if the maximum catch-up contribution was made, after 10 years there would be

Figure 10

Savings Needed For Employment-Based Health Insurance Premiums,[a] Medicare Part B Premiums, and Out-of-Pocket Costs for Retirement at Age 65 in 2016, Assuming 4% After-Tax Rate of Return on Investments

Age at Death	7% Increase in Employment-Based Retiree Health Premiums and Out-of-Pocket Costs
80	$219,000
85	307,000
90	409,000
95	524,000
100	656,000

Source: EBRI estimates based on various assumptions.

[a] Premiums and out-of-pocket maximum assumptions based on data found in www.kff.org/medicare/7439.cfm

Figure 11

Savings Needed For Medigap Premiums,[a] Medicare Part B Premiums, and and Medicare Part D Expenses for Retirement at Age 65 in 2016, Assuming 4% After-Tax Rate of Return on Investments, by Prescription Drug Spending

	Prescription Drug Spending	
	Median	90% Percentile
Age at Death	7% Increase in Medigap Premium, and Increases in Other Costs as Defined in Assumptions Section	7% Increase in Medigap Premium, and Increases in Other Costs as Defined in Assumptions Section
80	$112,000	$215,000
85	156,000	298,000
90	207,000	390,000
95	265,000	491,000
100	332,000	601,000

Source: EBRI estimates based on various assumptions.

[a] Benefits package for Medigap Plan F averaged across all plans in 2006. The plan contains the following benefits:

Inpatient Hospital Care: covers the cost of Part A coinsurance and the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.

Medical Costs: covers the Part B coinsurance (generally 20% of Medicare-approved payment amount) or copayment amount which may vary according to the service.

Blood: covers the first three pints of blood each year.

Also covers the Part A inpatient hospital deductible, the Part B deductible, 100% of the Part B excess charges, the skilled nursing facility coinsurance, and emergency foreign travel.

Figure 12

Potential Savings in a Health Savings Account (HSA), Assuming 5% Rate of Return, Individual Rolls Over Various Amounts of End-of-Year Account Balance and Does Not Make Catch-Up Contributions[a]

Years Contributing to HSA	Percentage of End-of-Year Account Balance Rolled Over			
	50%	75%	90%	100%
	$1,050 Annual Contribution in 2006			
10	$2,400	$4,800	$8,600	$13,500
20	2,400	5,300	13,800	35,500
30	2,300	5,100	16,000	71,400
40	2,300	5,100	17,500	129,800
	$2,700 Annual Contribution in 2006			
10	$6,100	$12,300	$22,200	$34,700
20	6,100	13,700	35,500	91,300
30	5,800	13,000	41,100	183,600
40	5,800	13,000	45,100	333,900

Source: EBRI.

[a] HSA contributions are indexed for inflation.

$46,400 in the HSA (Figure 13). Such savings levels by themselves are inadequate given the estimates provided in this report regarding the amounts needed to fund health insurance premiums and out-of-pocket expenses in retirement.

One of the difficulties in using an HSA to save money for premiums and out-of-pocket expenses during retirement is that individuals also can (and may need to) use the money in the account to pay for health care services during their working years or to pay COBRA premiums and insurance premiums during periods of unemployment. Distributions from the account prior to becoming eligible for Medicare will erode the value of the account, often significantly. In fact, if an individual takes distributions averaging only 10 percent of the end-of-year account balance each year, then the HSA accumulations are $29,800, $43,500, and $50,600, respectively, after 10, 20, and 30 years, instead of $46,400, $103,900, and $196,200. Some individuals may choose to forego withdrawals from the HSA to pay for out-of-pocket expenses if they are able to pay those expenses on an after-tax basis.

Figure 13
Potential Savings in a Health Savings Account (HSA), Assuming 5% Rate of Return, Individual Rolls Over Various Amounts of End-of-Year Account Balance and Makes Maximum Catch-Up Contributions[a]

Years Contributing to HSA	Percentage of End-of-Year Account Balance Rolled Over			
	50%	75%	90%	100%
	$1,050 Annual Contribution in 2006			
10	$4,600	$9,200	$16,300	$25,200
20	4,600	9,800	21,800	48,100
30	4,600	9,800	24,600	84,000
40	4,600	9,800	26,300	142,400
	$2,700 Annual Contribution in 2006			
10	$8,300	$16,700	$29,800	$46,400
20	8,400	18,100	43,500	103,900
30	8,400	18,200	50,600	196,200
40	8,400	18,200	55,000	346,400

Source: EBRI.
[a] HSA contributions are indexed for inflation.

Factors That Could Affect Retiree Health Benefits in the Future

Governmental Accounting Standards Board (GASB)

Recently, the Governmental Accounting Standards Board (GASB) released Statements No. 43 and No. 45, which impose new accounting standards on public-sector sponsors of retiree health benefits that are similar to those required of private-sector employers under FAS 106. Under GAS 42 and 45, public-sector sponsors are required to accrue the cost of postretirement health benefits during their covered workers' years of service, as opposed to reporting the cost on a pay-as-you-go basis. Both the GAO and AARP have speculated about the impact of these statements. According to the AARP (as cited by GAO), it is unclear what impact GAS 43 and 45 would have on retiree health benefit programs in the public sector. According to one estimate, the unfunded liability for public-sector retiree health benefit programs could exceed $1 trillion.[18] Thus, GAS 43 and 45 may simply trigger changes to retiree health benefits in the public sector that the private sector has been experiencing since the mid-1990s. The likely result is that governmental employers will also begin to restrict or eliminate retiree health benefits to public-sector workers.

Financial Accounting Standards Board (FASB)

Currently, FASB has proposed new requirements that would affect the way retiree health benefits are recognized on private-sector financial statements.[19] Employers would be required to recognize whether any retiree health plan was overfunded, underfunded, or not funded directly on the balance sheet instead of simply disclosing it in a footnote. The effects of this change are still being debated, although any step that

would make retiree health benefit costs more visible may accelerate the existing movement away from providing health benefits to retirees in the private sector. In a second phase of its project, FASB will address how the liability for retiree health benefits should be measured, which could result in larger liability calculations.

Medicare Modernization Act (MMA)

On Dec. 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA (P.L. 108-73). This act creates Medicare Part D, an outpatient prescription drug benefit for Medicare beneficiaries. There was much concern among policymakers and retirees with drug benefits from former employers that the availability of a Medicare drug benefit might cause employers to drop coverage for retirees. Prior to the passage of MMA, researchers provided a range of estimates on the impact that the availability of a Medicare drug benefit would have on the provision of retiree health benefits. The Congressional Budget Office (CBO) reported that 2.7 million Medicare beneficiaries (or 23 percent of participants in the Medicare drug program with employment-based prescription drug benefits) would no longer have those benefits. Another study found that of all Part B enrollees with employment-based drug coverage, 17 percent would lose that coverage as a result of employer decisions to eliminate drug coverage for retirees (Holtz-Eakin, 2003). Similarly, Thorpe (2003) found that about one-quarter of retirees with drug benefits, or roughly 2.1 million private-sector retirees, would lose coverage.

The above estimates reflected expected employer behavior over a 10-year budget estimating period, and did not take into consideration other factors that may affect employers' decisions to continue to offer drug coverage to retirees. An EBRI analysis found that between 2 percent and 9 percent of current Medicare beneficiaries with employment-based retiree health benefits for prescription drugs would lose those benefits if Medicare provided outpatient prescription drug coverage. Other environmental factors, such as business, accounting, and cost trends, were already causing a decrease in the percentage of employers offering retiree health benefits, regardless of policy changes in the Medicare program (Salisbury and Fronstin, 2003).

Because of the concern that employers would drop retiree prescription drug coverage if such a benefit were available through Medicare, Congress added a provision in the MMA that subsidizes some employer costs for prescription drugs for retirees. Employers are able to receive a subsidy equivalent to 28 percent of qualified prescription drug costs between $250 and $5,000 (in 2006) for each retiree and qualified dependent.

Since MMA was enacted, there has been much interest in how employers would respond to the subsidy provision: Employers could use the subsidy to cover some of the cost of retiree drug benefits, or they could offer drug benefits that would "wrap around" (or supplement) the benefits provided through Part D. Both options would presumably lower employer costs for retiree drug benefits. However, employers also could drop benefits altogether and save even more money than they would save under either the subsidy option or the wrap-around option.

An early study found that many employers were planning to continue to offer drug benefits while accepting the subsidy. The study, conducted in 2004, found that 58 percent of private-sector employers were planning to continue offering drug benefits while accepting the 28 percent subsidy, 17 percent were going to offer a supplemental plan to Medicare, and 8 percent were going to discontinue drug coverage for retirees (Figure 14). In 2005, a follow-up study found that 79 percent of private-sector employers were planning to continue offering drug benefits while accepting the 28 percent subsidy, 10 percent were going to offer a supplemental plan to Medicare, 9 percent were going to discontinue drug coverage for retirees, and 2 percent were going to become a Medicare drug plan. This study also found that discontinuing drug coverage would affect 2 percent of private-sector retirees in the largest plan offered by surveys employers.

Even before Medicare prescription drug coverage became available in January 2006, many employers were reflecting the potential savings from the subsidy on their financial statements. The GAO found that 27 of 39 Fortune 500 employers filed with the SEC had reported reductions in their FAS 106 liability, some in excess of $100 million. This should not be interpreted as suggesting that employers will stop making other changes to retiree health benefits. In 2005, 71 percent of employers increased retiree contributions to premiums, 34 percent increased copayments or coinsurance, and 24 percent increased deductibles (Figure 15), and employers taking the subsidy to maintain retiree health benefits are likely to make changes to drug benefits in 2006 as well (Figure 16).

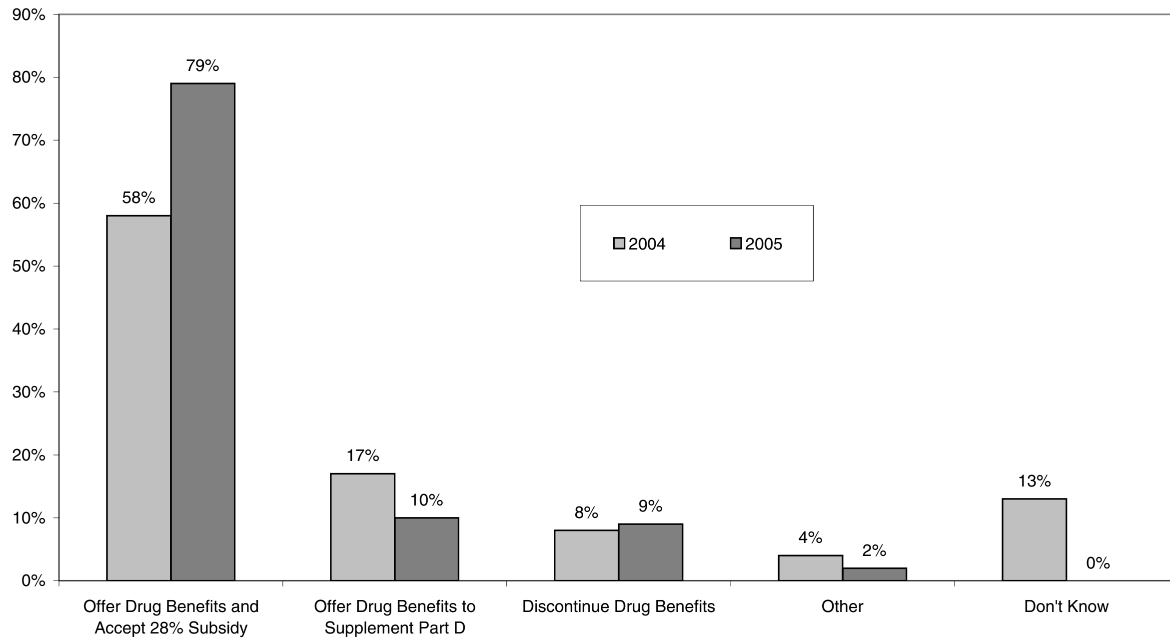


Figure 14
Strategies Private-Sector Employers Are
Likely to Choose Under Medicare Drug Law
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2004
2005
58%
79%
17%
10%
8%
9%
4%
2%
13%
0%
Offer Drug Benefits and Accept 28% Subsidy
Offer Drug Benefits to Supplement Part D
Discontinue Drug Benefits
Other
Don't Know
Source: The Henry J. Kaiser Family Foundation and Hewitt Associates.

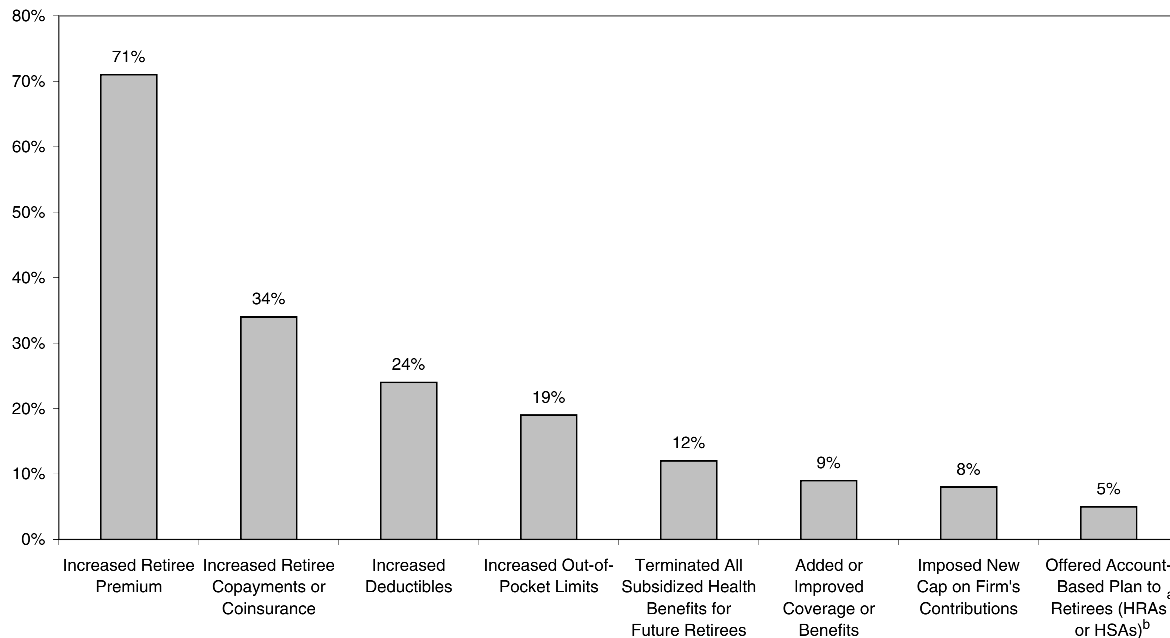


Figure 15
Percentage of Employers That Made Changes
to Retiree Health Benefits During 2005
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
34%
24%
19%
12%
9%
8%
5%
Increased Retiree Premium
Increased Retiree Copayments or Coinsurance
Increased Deductibles
Increased Out-of-Pocket Limits
Terminated All Subsidized Health Benefits for Future Retirees
Added or Improved Coverage or Benefits
Imposed New Cap on Firm's Contributions
Offered Account-Based Plan to Retirees (HRAs[a] or HSAs)[b]
Source: Exhibit 16 in www.kff.org/medicare/upload/7439.pdf
[a] Health reimbursement arrangements.
[b] Health savings accounts.

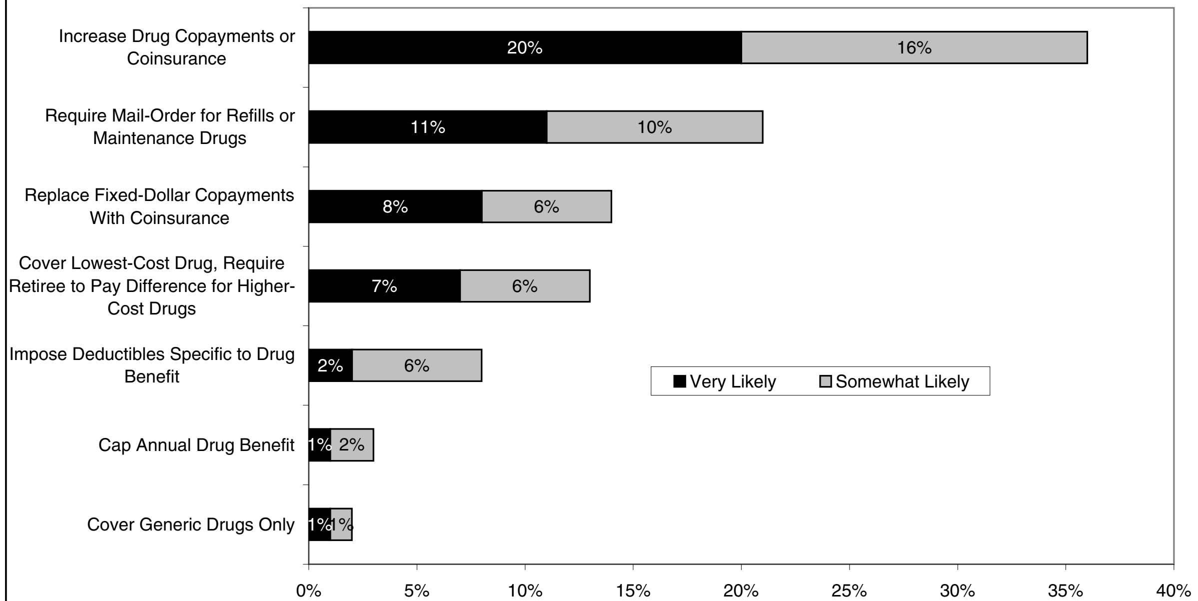


Figure 16
Likelihood of Making Changes to Manage Retiree Drug Costs for the 2006 Plan Year, Among Employers Taking the Subsidy in 2006
Increase Drug Copayments or Coinsurance
20%
16%
Require Mail-Order for Refills or Maintenance Drugs
11%
10%
Replace Fixed-Dollar Copayments With Coinsurance
8%
6%
Cover Lowest-Cost Drug, Require Retiree to Pay Difference for Higher-Cost Drugs
7%
6%
Impose Deductibles Specific to Drug Benefit
2%
6%
Cap Annual Drug Benefit
1%
2%
Cover Generic Drugs Only
1%
1%
Very Likely
Somewhat Likely
0%
5%
10%
15%
20%
25%
30%
35%
40%
Source: Exhibit 18 in www.kff.org/medicare/upload/7439.pdf

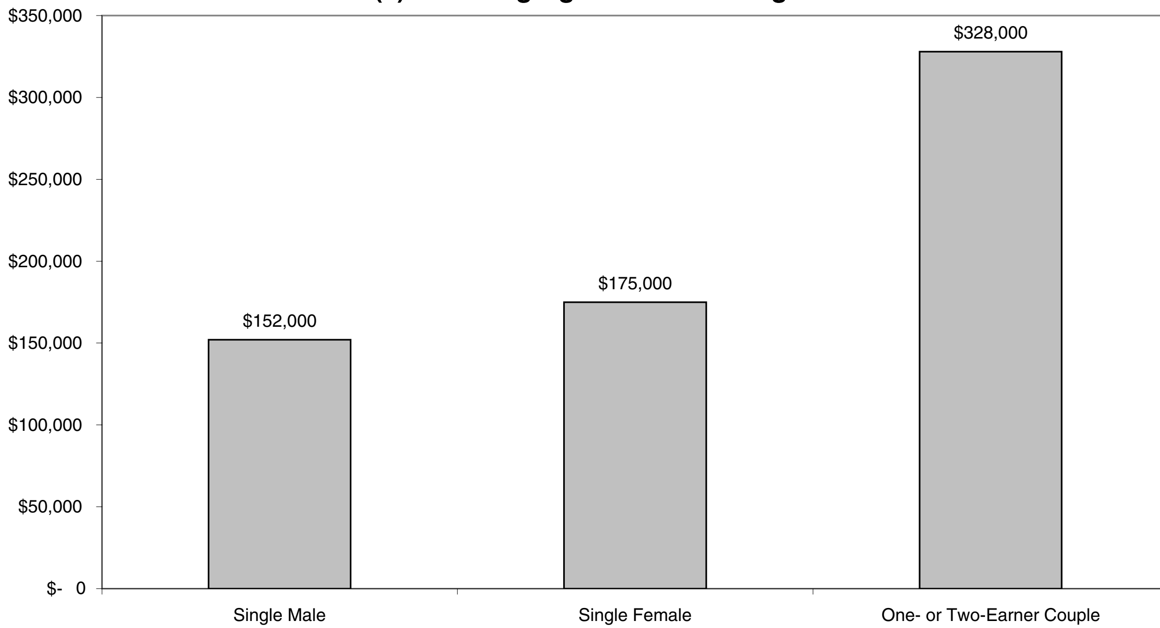


Figure 17
Present Value of Lifetime Medicare Benefits for Person(s) Reaching Age 65 and Retiring in 2005
$350,000
$300,000
$250,000
$200,000
$150,000
$100,000
$50,000
$- 0
$152,000
$175,000
$328,000
Single Male
Single Female
One- or Two-Earner Couple
Source: Eugene Steurele, personal communication, June 30, 2006.

Medicare

The Medicare program provides a substantial amount of benefits to those who receive them. The present value of lifetime Medicare benefits for a couple both age 65 retiring in 2005 is $328,000 (Figure 17). However, the Medicare program does not cover everything: Among noninstitutionalized Medicare beneficiaries, the Medicare program covers 51 percent of expenses associated with health care services (Figure 18). Our estimates on savings needed to supplement Medicare show that, on average, they account for the other 49 percent of health insurance and out-of-pocket spending for noninstitutionalized Medicare beneficiaries.

Beneficiaries not only incur cost sharing for health care services now, but they can expect to incur substantial cost sharing in the future. The Medicare program is facing serious financial issues: The Medicare Part A trust fund is expected to be insolvent in 2018, and it is possible that the projected insolvency date will be moved up as it has been in the past (in 2003, the expected insolvency date was 2026). Currently, the trust fund is spending more money to cover health care services than it is receiving from payroll tax income. Were it not for interest income, the trust fund would be running a deficit. In 2010, the trust fund will be spending more money to cover health care services than it will receive in income from all sources. At that point, the trust fund will need to redeem accumulated assets, which means that if the federal government is running a deficit, either tax rates will have to increase or additional money will need to be borrowed. The trust funds' unfunded liability over 75 years is $11 trillion, while the combined unfunded liability for Parts A, B, and D is $32.1 trillion (Antos, 2006).

This deficit could be eliminated through a combination of payroll tax increases (which would affect workers) and benefit reductions (which would affect Medicare beneficiaries). If the payroll tax were immediately increased to eliminate the deficit, it would need to be increased 121 percent. If, instead, benefits were cut, an immediate 51 percent cut in the value of benefits would be required to eliminate the deficit. The longer policymakers wait to address this program, a larger combination of payroll tax increases and benefit cuts will be needed. Regardless, because of the dire financial situation of the Medicare program, it is highly likely that future Medicare beneficiaries will assume greater responsibility for the cost of health care services in retirement.

Conclusion

Medicare covers about one-half of the cost of health care for noninstitutionalized beneficiaries. Recent estimates indicate that the present value of Medicare benefits for a couple age 65 retiring in 2005 is $328,000. This report estimates that an average couple age 65 today and retiring today with access to retiree health benefits through a former employer could need as much as $300,000 in savings to cover the entire cost of premiums as well as out-of-pocket expenses throughout retirement. These estimates represent the other one-half of health care expenses not covered by Medicare. Were a couple instead to live to age 95, they would need $550,000 to cover premiums and out-of-pocket expenses.

Most workers have always had the responsibility for their health care in retirement. The fact that the elderly had greater financial needs but less financial protection than younger workers is one reason leading up to the passage of Medicare (Institute of Medicine, 1993). As mentioned above, nearly 90 percent of Medicare beneficiaries have some form of insurance coverage to supplement Medicare Parts A and B. As employers continue to move away from providing retiree health benefits, more of the retirees who have had subsidized employment-based coverage in the past will have to assume for themselves the financial risk associated with longevity. Predicted future erosion in Medicare benefits will exacerbate longevity risk.

This report's estimates comparing the savings needed for an average-life-expectancy couple with a couple that lives to age 95 highlight the risk associated with not being average. While workers will have a difficult time saving enough money to cover health care expenses in retirement whether they live to average life expectancy or beyond, many are generally unprepared for health care expenses in retirement and retirement expenses. In fact, many individuals will need more money than the amounts reported in this *Issue Brief* because this analysis does not factor in the savings needed to cover long-term care expenses, nor does it take into account the fact that many individuals retire prior to becoming eligible for Medicare. However,

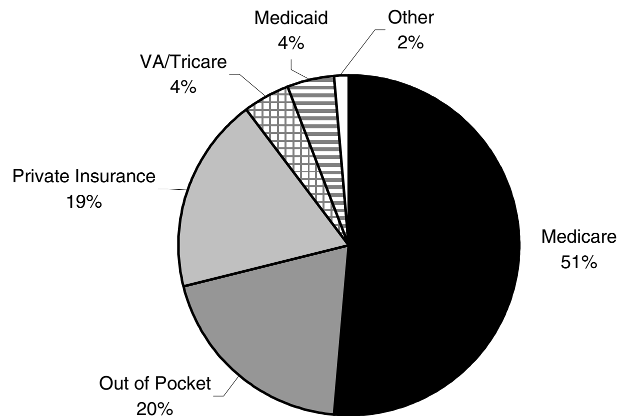
some workers will need to save less than what is reported if they choose to work during retirement and receive health benefits as active workers.

Forthcoming research from EBRI will introduce risk modeling into the assessment and also look at the relative value of retiree purchase of annuities and long-term care insurance as a way to increase the likelihood of having enough money to cover all basic expenses in retirement. That research will also allow individuals to see how savings needs vary depending on the likelihood they desire of not running out of money. As this report documents, living longer means having to save a lot more, and the forthcoming work shows how other factors affect outcomes. This research will then be used to develop a new Monte Carlo probability version (computational algorithms) of the Ballpark E$stimate® savings program (www.choosetosave.org) that will allow individuals to interactively assess their saving needs, annuity and long-term care insurance needs, and investment allocation of savings that are not annuitized.

The research in this *Issue Brief* is reinforced by the fact that current workers are already struggling to save for retirement because of rising health care costs today. EBRI's research has found that one-quarter of individuals responding to a recent survey reported that they have decreased their contributions to a retirement plan as a result of the increased cost of health care, and almost one-half report they have decreased their contributions to other savings as well (Fronstin, 2006).

Finally, issues surrounding retirement income security are certain to become a even greater challenge in the future, as employers continue to scale back retiree health benefits, and when policymakers begin to realistically address financial issues in the Medicare program with solutions that are likely to shift more responsibility for health care costs to Medicare beneficiaries.

Figure 18
Sources of Coverage for Elderly Health Care Costs
(Medical Expense Coverage Sources for
Medicare Beneficiaries Age 65 and Older)



Source: EBRI estimates from the 2003 Medical Expenditure Panel Survey.

Appendix

Assumptions to Project Health Care Expenses in Retirement

The combination of the erosion of retiree health benefits, coupled with limited benefits from Medicare, inevitably means that retirees can expect to pay a significant amount of money out-of-pocket for health insurance and health care services in retirement. If a person were to try to save for these expenses, the amount of money needed would vary with a number of factors. This sector discusses the assumptions used to determine savings needed to pay for health insurance and health care services in retirement.

Cost Projection Assumptions:

Total spending on health care services has been growing faster than the overall economy for many years. Since 1960, spending on health care services has grown an average of 2.6 percent faster than the entire economy has (U.S. Congressional Budget Office, 2005). While the difference in growth between health care spending and the overall economy slowed to 1.9 percent between 1990 and 2003, long-term projections of spending for Medicare are subject to considerable uncertainty. While the CBO presents projections of Medicare (and Medicaid) spending as a percentage of GDP under three alternative assumptions about excess cost growth (Figure 19), it concludes the following:

> "There is no evidence to suggest that excess cost growth will slow significantly in the short run. Moreover, some level of excess cost growth is likely to continue for some time to come."

The CBO projects that gross domestic product (GDP) will increase at an annual rate of 4.7 percent between now and 2016. In turn, this means that overall spending on health care services will increase at an annual average rate of between 6.6 percent and 7.3 percent between now and 2016. The Centers for Medicare & Medicaid Services (CMS) is also projecting a 7.2 percent annual average rate of increase in health care spending between now and 2016 (Borger et al., 2006).

Private Insurance Premium Assumptions—CMS and a number of other organizations have projected increases in the cost of providing health care services. CMS predicts that premiums for private health insurance will grow 6.8 percent in 2005. This is in contrast to a number of other surveys reporting actual increases in costs for retiree health benefits. For example, according to the 2005 Kaiser/Hewitt Survey on Retiree Health Benefits, while cost increases for Medicare-eligible retiree health benefits have been falling, they remain in double digit rates (Figure 20).

To estimate the cost of an access-only retiree health plan, this analysis uses the average premium for a new Medicare-eligible retiree in 2005 as determined by the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits, which was estimated to be $4,080 in 2005. While this is an average premium across many plans, it is weighted by the fact that the Kaiser/Hewitt survey found that 71 percent of plans surveyed had a deductible, with the most common deductible being $250, and 76 percent of the plans had a maximum out-of-pocket payment per beneficiary, with the most common level being $1,500, as mentioned above. Furthermore, over one-half of the plans surveyed did not impose a separate deductible or maximum out-of-pocket limit for prescription drugs.

To estimate the cost of a Medigap plan, Plan F was chosen. It is the most comprehensive plan that does not include prescription drug benefits, and is the most popular choice among beneficiaries. As mentioned above, the average premium for women ages 65 for Plan F was $1,755 in 2005. This premium is used for men as well. For illustrative purposes, the analysis in this report examines annual average premium increases of 7 percent and 10 percent.

Medicare Part B Premium—Medicare Part B premiums cover 25 percent of the cost of the Part B program. As the cost of the Part B program increases, so does the premium. The Part B premium increased over 13 percent in 2004 and 2006, and it increased over 17 percent in 2005. However, CMS projects an average annual increase of 3.7 percent during 2006–2015, and CBO estimates that the Part B premium will increase at an average annual rate of 4.7 percent during 2006–2016. Recent premium increases have been much higher than expected because of last- minute changes to the physician payment system that were intended to cut payments to physicians. Because of uncertainty related to projecting Medicare Part B

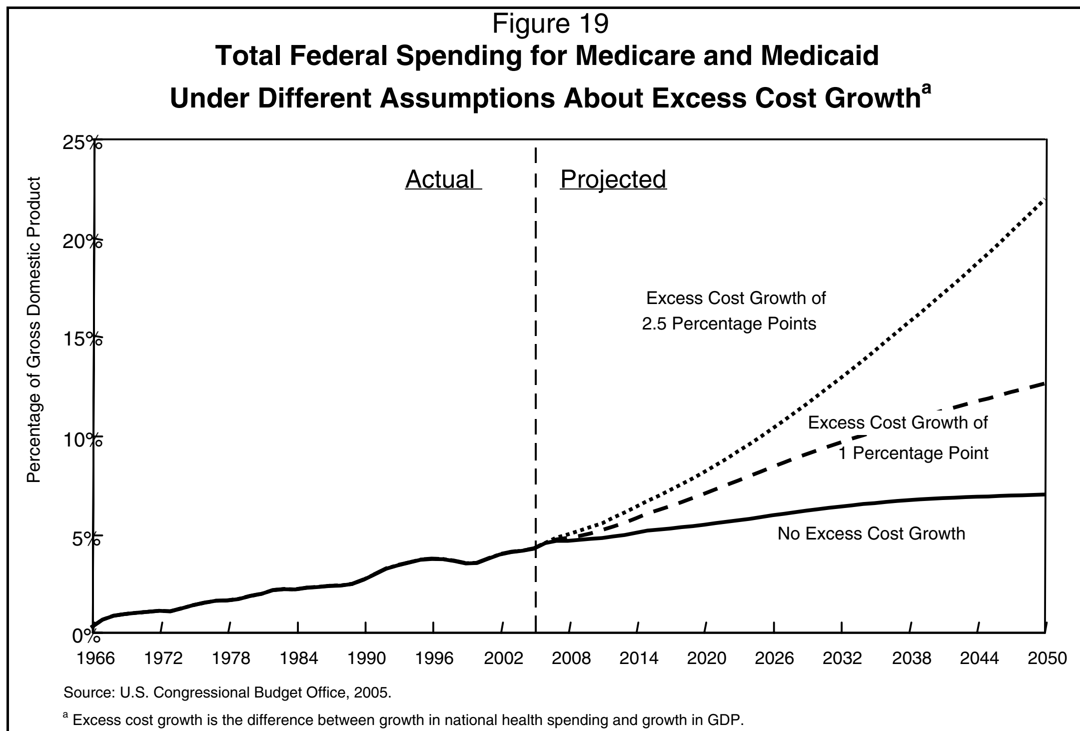


Figure 19
Total Federal Spending for Medicare and Medicaid
Under Different Assumptions About Excess Cost Growth[a]
Percentage of Gross Domestic Product
25%
20%
15%
10%
5%
0%
Actual
Projected
Excess Cost Growth of
2.5 Percentage Points
Excess Cost Growth of
1 Percentage Point
No Excess Cost Growth
1966
1972
1978
1984
1990
1996
2002
2008
2014
2020
2026
2032
2038
2044
2050
Source: U.S. Congressional Budget Office, 2005.
[a] Excess cost growth is the difference between growth in national health spending and growth in GDP.

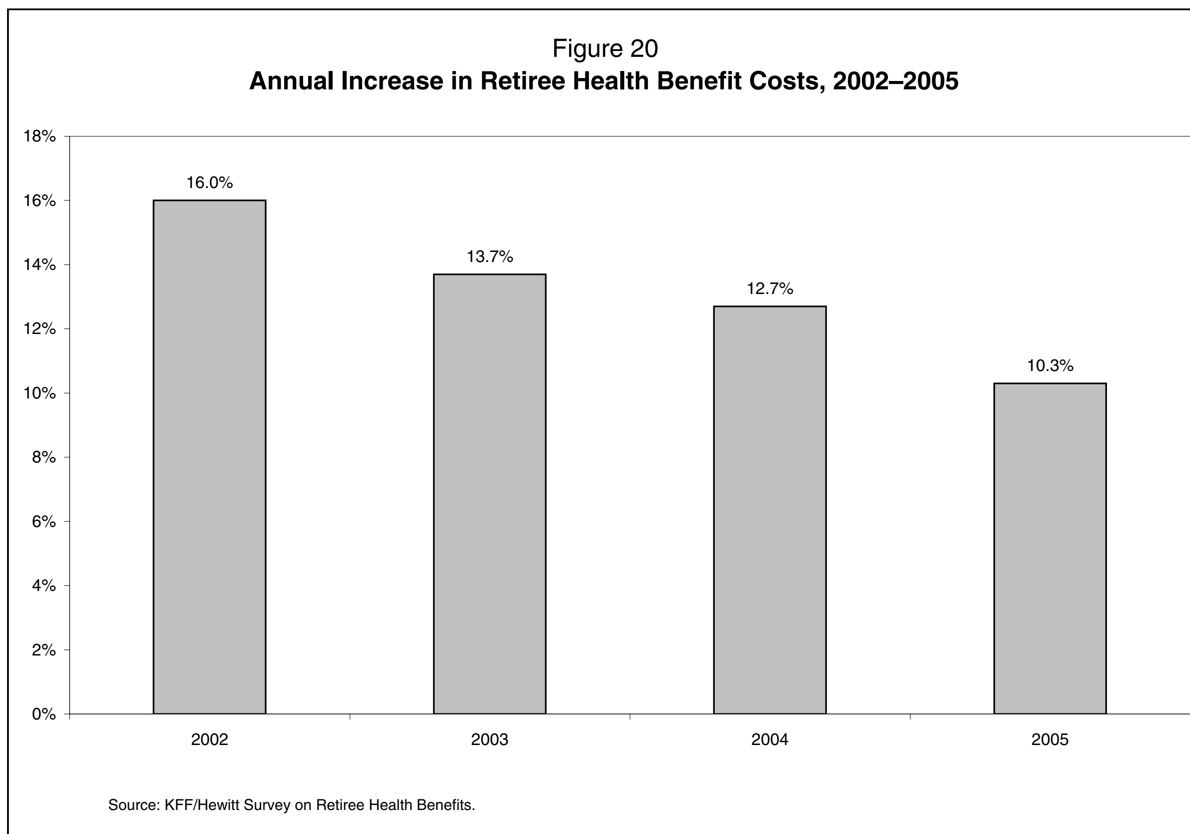


Figure 20
Annual Increase in Retiree Health Benefit Costs, 2002–2005
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
16.0%
13.7%
12.7%
10.3%
2002
2003
2004
2005
Source: KFF/Hewitt Survey on Retiree Health Benefits.

premiums, this analysis uses CMS projections through 2015, and then assumes a 3.9 percent flat annual increase thereafter because CMS projects the Part B premium to increase 3.9 percent in 2015. However, premium increases could prove to be far greater than what has been reported by CBO or in the Trustees' annual report if Congress continues not to allow future reductions in provider payments to take effect.

Medicare Part D Premiums and Cost Sharing—Under the MMA, outpatient prescription drug benefits became available to Medicare beneficiaries in 2006 under Medicare Part D. Monthly premiums were initially estimated to start at $35. CMS has determined that the average premium offered by a Part D plan was $32.20 in 2006,[20] but other studies have estimated the average premium to be $37 (Frakt and Pizer, 2006, and Gold, 2006), and CMS predicts that the average premium *paid* by beneficiaries will be $25 in 2006.

Under the standard plan, beneficiaries are subject to a $250 deductible in 2006. After the deductible is reached, beneficiaries are then responsible for 25 percent of the cost of prescription drugs on the next $2,000 in benefits (or $500). At that point they are completely responsible for the next $2,850 (the so-called "donut hole"), after which they would be responsible for 5 percent coinsurance. As noted above, most Part D enrollees are not in the standard plan.

Deductibles and coinsurance thresholds are indexed to annual growth in per capita Part D drug spending by Medicare beneficiaries. CMS projects Part D premiums will increase 7.1 percent annually between 2006 and 2015, and cost-sharing thresholds will increase 7.7 percent annually. In contrast, CBO projects premium increases averaging 11.9 percent (although that includes an increase of 38.8 percent in 2007), and a 9.3 percent increase in cost-sharing thresholds. For illustrative purposes, this analysis examines annual average premium increases of 7 percent that start at $25 in 2006.

Life Expectancy Assumptions:

According to estimates based on data from the Centers for Disease Control and Prevention, average life expectancy for a 65-year old male is 16.8 years (81.8 years of age) and for a female it is 19.8 years (84.8 years of age).[21] Life expectancy has been increasing and is expected to continue increasing with technological innovation in the delivery of health care. Employers use average life expectancy when calculating future health benefit liabilities because they can expect roughly one-half of their retirees to live past the average, while roughly one-half will not live as long as the average.

Life expectancy may be a good starting point for financial planning for individuals, but simply using average life expectancy without considering other factors could lead to significant shortfalls in savings for many individuals. Not only is longevity a major threat to retirement income security, but individuals also tend to underestimate longevity.[22] If all individuals saved based on having enough money to meet average life expectancy, approximately one-half will outlive savings because they will live too long (beyond average life expectancy). For example, men age 65 in 2003 have a 25 percent likelihood of living to age 88, while women have a 25 percent chance of living to age 92.[23] Furthermore, 10 percent of 65-year-old men in 2003 will live to age 94 and 10 percent of women will live to age 97. Publications that recognize the longevity risk will still report savings estimates based only on average life expectancy (Fidelity Investments, 2003). See the Life Expectancy Calculators box on page 30 for more information.

Rate of Return Assumptions:

This analysis generally assumes that assets will have an after-tax annual rate of return of 4 percent. While projections of "long-term" stock returns are generally higher than 4 percent, persons age 65 and older are much more likely to put their assets in safe or less-volatile investments. If a 4 percent after-tax rate of return assumption is too high, individuals will need to save an even greater sum of money than the estimates shown in this report.

Employers' Options to Prefund or Account for Retiree Health Benefits

Health Reimbursement Arrangements (HRAs):

A health reimbursement arrangement (HRA) is an employer-funded health plan that reimburses employees for qualified medical expenses. HRAs are typically part of a health benefits package that includes

comprehensive health insurance after a deductible has been met. Unlike an HDHP with an HSA, there is no statutory requirement that an employer combine the HRA with a HDHP, although most do. In 2005, the average annual deductible for an HRA-based plan was $1,870 for single coverage and $3,686 for family coverage (Claxton et al., 2005). In fact, employers have a tremendous amount of flexibility in designing health plans that incorporate an HRA. For example, the amount of money that is available in the HRA, the level of the deductible, and the comprehensiveness of the health insurance are all subject to variation. Employees are eligible for an HRA only when their employer offers such a plan, but cannot make their own contributions to the account.

HRAs are typically set up as notional arrangements and exist only on paper. Employees may behave as if money was actually funding an account, but employers do not incur expenses associated with the arrangement until an employee incurs a claim. By contrast, were employers to set up the HRA on a funded basis, they would incur the full expense at the time of the contribution, even if an employee had not incurred any expenses.

At the employer's discretion, funds leftover at the end of each year can be carried over to the following year, allowing employees to accumulate funds over time, and, in principle, creating the key incentive for individuals to make health care purchases responsibly. Employers can place restrictions on the amount that can be carried over. Funds in the HRA can accumulate tax free as long as they remain employer-provided funds paid out only for qualified medical expenses.

Generally, distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under IRC Sec. 213(d), although employers can place restrictions on the use of an HRA. Since unused funds are allowed to roll over, employees are able to accumulate funds over time. Employers can allow former employees to use any leftover money in the HRA to continue to cover qualified medical expenses. Funds can be used for out-of-pocket medical expenses and premiums for insurance, long-term care, COBRA, and retiree health benefits. Employers are not, however, required to make unused balances available to workers upon job separation.

Primary drawbacks with HRAs as vehicles to prefund retiree health expenses are that they are notional accounts that do not involve actual prefunding and they do not permit worker contributions. Since they are typically combined with a HDHP, they are likely to be used to fund current expenditures on health care, and thus realistically will provide limited accumulations for retiree medical needs if the employer allows rollovers of unused balances over time.

Retiree Medical Accounts (RMAs):

RMAs are HRA-like employer-sponsored accounts, but differ in that they can only be used by individuals to purchase health benefits during retirement. However, they are more similar to 401k plans than HRA-based plans because they are not tied to health insurance for active employees. Employees do not need to have a HDHP to participate in an RMA and they cannot use the RMA to pay for health insurance or health care expenses while working.

RMAs are available to workers only when offered by their employer. RMAs are notional accounts that are not prefunded; the accounts are a bookkeeping device to track the dollars that will be available for a worker to spend on health benefits during retirement. Employers make "contributions" to a worker's "account" based on the worker's age and years of service. Workers can also make contributions to their account but those contributions must be made on an after-tax basis. Contributions are often credited with a rate of interest over time. In retirement, an individual can use the money in his or her account to purchase health insurance. The insurance could be provided by the employer, meaning that the employer would continue to decide what benefits to offer and at what price or the employer could allow retirees to buy insurance on their own and pay an insurer of the retiree's choice directly. Distributions from RMAs for retiree health benefits are tax free.

RMAs could reduce future employer costs for retiree health benefits. Under an RMA arrangement, an employer decides how much to contribute to retiree health benefits while a person is working. The employer contribution is often set independently of the cost of retiree health benefits or the predicted cost growth. One drawback is that workers cannot make pretax contributions. Also, lack of employer prefunding means that sponsoring employers will have unfunded liabilities for these accounts years (even decades) into the future,

although they will likely be less than they would have been had an employer remained with a traditional retiree health benefit program. Finally, RMAs are not available to all workers, only to those whose employer sponsors one.

Voluntary Employee Benefit Associations (VEBAs):

Voluntary Employee Benefit Associations (VEBAs) are arrangements which include a trust established to fund certain benefit plans. They were originally established for use by multiemployer plans through the Internal Revenue Code and the Labor Management Relations Act of 1947 (Taft-Hartley Act). As a result of increasing health care costs and increasing inflation, ERISA extended these trusts to single-employer plans. VEBAs must be based on voluntary membership, and qualifications for membership eligibility must be defined by objective standards of an employment-related "common bond."

Employers can make tax-deductible contributions; however, contributions are limited to the sum of the qualified direct cost of the benefits provided for the taxable year and any permissible additions to a qualified asset account (reserve account). The qualified asset account limit must be funded over the employees' working lives, must be determined actuarially, and must be based on covered costs. As a result of this last requirement, inflation cannot be taken into account when estimating future costs. Furthermore, when reserves are above permissible levels, additional contributions to the VEBA are not deductible and earnings on excess reserves are subject to tax as unrelated business income.

Investment income is not exempt from tax for most plans (it is taxable as unrelated business income unless invested in tax-exempt instruments), although for VEBAs established under a collective bargaining agreement, the contributions are unlimited and earnings accumulate tax free. Expenses for disability, medical benefits, and group-term life insurance purchases are also tax free to the recipient, although other benefits are taxable on receipt.[24]

Nondiscrimination regulations were added by the Deficit Reduction Act of 1984 (DEFRA) and state that each plan benefit is subject to Internal Revenue Service (IRS) overview to prohibit discrimination in both design and operations.[25] DEFRA disallowed accounting for future inflation in funding VEBAs and changed the law to subject earnings to federal unrelated business income tax.[26] DEFRA also imposed a 100 percent excise tax on employers whose welfare benefit fund provides any type of disqualified benefit.

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Life Expectancy Calculator

An individual's life expectancy varies with a number of factors, such as gender, age, weight, height, education, family medical history, personal medical history, health status, diet, exercise, and general lifestyle. Some life expectancy calculators use more detailed information than others in determining age at death.

See the following Web sites for various personal life expectancy calculators:

moneycentral.msn.com/investor/calcs/n_expect/main.asp
www.livingto100.com
gosset.wharton.upenn.edu/~foster/mortality/

The sites in this box are listed for information only. EBRI offers no endorsement of, and assumes no liability for, the currency, accuracy, or availability of any information on these sites.

Endnotes

[1] See Employee Benefit Research Institute (1989), Fronstin (1996, 2001, and 2005), Fronstin and Salisbury (2003 and 2004), Gabel (2002), McArdle et al. (1999 and 2004), McDevitt et al. (2002), Mercer Human Resources Consulting (2005), and Congressional Research Service (2006).

[2] www.kff.org/medicare/upload/7439Section3.pdf

[3] See Exhibit 10 in www.kff.org/medicare/upload/7440.pdf

[4] Part D plans with a deductible below $250 have an average premium of $41 per month, and those with gap coverage have premiums that usually range from $50–$60.

[5] Calculated from Table II.B1 in www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2006.pdf

[6] See Figure 3.1 in www.kff.org/medicare/upload/Medicare-Chart-Book-3rd-Edition-Summer-2005-Section-3.pdf

[7] According to CMS data, www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartDTotalBeneficiariesCoverage.zip, 8.9 million individuals were enrolled in a stand-alone prescription drug plan as of May 7, 2006.

[8] Calculated from Exhibit 12 in www.kff.org/medicare/upload/7439.pdf

[9] See Exhibit 3 in www.kff.org/medicare/upload/7439.pdf

[10] See www.weissratings.com/News/Ins_Medigap/20050830medigap.pdf.

[11] See www.weissratings.com/News/Ins_Medigap/20050829medigap_rates.pdf

[12] The present value in 2006 of savings needed is $378,000.

[13] The present value in 2006 of savings needed is $193,000.

[14] The present value in 2006 of savings needed is $369,000.

[15] Minimum required deductibles are indexed to inflation and will likely increase each year.

[16] The catch-up contributions is not indexed to inflation after 2009.

[17] Distributions for nonqualified medical expenses are subject to regular income tax as well as a 10 percent penalty, which is waived if the owner of the HSA dies, becomes disabled, or is eligible for Medicare.

[18] www.usatoday.com/news/health/2006-05-18-medicare_x.htm

[19] See www.fasb.org/draft/ed_pension&postretirement_plans.pdf

[20] See Table V.C2 in www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2006.pdf

[21] See www.cdc.gov/nchs/data/hus/hus05.pdf#027

[22] See Fidelity Investments, 2003; Henrikson, 2004; Schellman, 2006; and the collaborative Mathew Greenwald & Associates, Inc., and Employee Benefit Research Institute study conducted on behalf of the Society of Actuaries (2004).

[23] Employee Benefit Research Institute estimates based on data in www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_14.pdf

[24] Disability and medical expenses are tax free to the extent provided in IRC Secs. 104 and 105, which list the nonincludable expenses specifically.

[25] This holds only for contributions for postretirement medical and death benefits in 501(c)(9) trusts, or VEBAs. Also, nondiscrimination rules do not apply to plans maintained through a collective bargaining agreement. VEBA nondiscrimination rules are in IRC sec. 505.

[26] This does not apply to VEBAs covering groups that are at least 90 percent collectively bargained. Assets held before enactment of the Deficit Reduction Act of 1984 are grandfathered. Also, the taxability of earnings holds only for postretirement medical benefits, as these may not be taken into account when figuring reserve limits. Earnings on reserves for other benefits are not taxed as long as the reserves for these benefits do not exceed the new funding limits.

EBRI Issue Brief

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