

Retiree Health Benefits: Savings Needed to Fund Health Care in Retirement

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Issue Brief

- This *Issue Brief* presents illustrations of how much money a person may need to save to completely pay for health insurance and out-of-pocket health care costs during retirement. The combination of the erosion of retiree health benefits and limited benefits from Medicare and Medigap means that retirees should expect to pay a significant amount of money for health insurance and health care services during retirement. Various illustrations of needed savings are presented in this report, based on a number of assumptions regarding insurance premium levels and how they might change over time, the source of coverage, rates of return on investment, age at retirement, and life expectancy.
- Many private-sector employers have been overhauling their retiree health benefit programs by limiting contributions or eligibility, or dropping the benefit for future or even current retirees. These changes have been driven by accounting rule changes that forced private-sector employers to recognize the long-term liability of the benefit, coupled with rapidly rising health costs.
- Very few employees are expected to be eligible for retiree health benefits in the future. Retiree health coverage generally is offered only by large employers, as very few small employers ever offered the benefit and more than half of private-sector workers are in firms with fewer than 500 employees. In 2000, only 11 percent of all U.S. private establishments offered retiree health benefits to Medicare-eligible retirees and only 12 percent offered it to “early” retirees under age 65.
- An individual with access to employment-based health benefits in retirement to supplement Medicare will have needed to save a present value of between \$37,000–\$750,000 to retire at age 65 in 2003. The range is determined by various assumptions regarding age at time of death, premium levels, annual changes to premiums, and out-of-pocket expenses. An individual without access to employment-based health benefits who instead purchases Medigap coverage will have needed to save between \$47,000–\$1,458,000, to retire at age 65 in 2003. Estimates also are provided for early retirees.
- The illustrations presented from the model used in this report may underestimate health care expenses in retirement. Expenses for long-term care are not included in this discussion. Services (such as nursing home care) typically cost \$50,000 or more per year. The estimates are also for individuals; married couples would need to save roughly double the individual amount, depending upon retirement age and age at death. (Prepare your own illustration at www.choosetosave.org with the *Retiree Health Savings Calculator™*.)
- Policymakers may address the erosion of retiree health benefits in a number of ways, including expanding Medicare or other public programs to cover more retiree health expenses; attempting to level the playing field with respect to the tax treatment of health insurance and health care expenses among employers, active workers, and retirees; mandating employers to make or maintain commitments to provide retiree health benefits; and undertaking public education campaigns to make people aware of the health insurance costs they are likely to face in retirement and the need to personally save for them.

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Introduction

Most Americans have always found that they were solely responsible for having saved if they

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For further background on this topic, see *EBRI Issue Brief* no. 236, "Retiree Health Benefits: Trends and Outlook," August 2001. These publications are available for purchase online. Visit www.ebri.org/publications or call (202) 659-0570.

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wanted to supplement their Social Security benefits with other income, in order to enjoy a comfortable retirement. But few Americans have done so, which is why roughly one-half of all current retirees rely *exclusively* on Social Security to cover their living expenses, and more than two-thirds rely *primarily* on it.¹ Prior to the enactment of Medicare,² this personal savings extended to the payment of all health care services in retirement, and has since included health expenses not covered by Medicare. Many recent reports have focused on how large employers have been changing the way they provide benefits for retirement income and retiree health, even though "individual responsibility" has always been an inherent national characteristic for most Americans.

This *Issue Brief* seeks to look at retiree health from the perspective of the individual, examining such questions as the following: What does an individual need to save in order to purchase health insurance and cover out-of-pocket health expenses in retirement? How would the amount needed to be saved be affected if the individual could treat health insurance and expenses on a tax-favored basis, the same way as health plan sponsors and active workers can do? How do needed savings levels change with estimated age at time of death, which is a more appropriate measure for individuals than average life expectancy? This *Issue Brief* provides insight into how much of current savings is needed for medical expenses for persons near retirement.

Background

In 1982, the Financial Accounting Standards Board (FASB)³ issued its first guidance on accounting for post-employment benefits. Studies were undertaken,⁴ hearings were held, and in December 1990, the FASB approved Financial Accounting Statement No. 106 (FAS 106), “Employers’ Accounting for Postretirement Benefits Other Than Pensions.” FAS 106 put into place a schedule for the concepts set forth in 1982 and markedly changed the way most private-sector companies accounted for their retiree health benefits (Fronstin, 1996). FAS 106 requires companies to record retiree health benefit liabilities on their financial statements in accordance with generally accepted accounting principles, beginning with fiscal years after Dec. 15, 1992. It requires private-sector employers to accrue and expense certain future claims’ payments as well as actual paid claims.⁵ The recognition of these liabilities dramatically impacts a company’s calculation of its profit and losses. It affected mainly large employers, since small ones typically never offered retiree health benefits.

As a result of FAS 106, companies started to recognize the long-term liability of offering the benefit. With the new view of the cost, and the increasing cost of providing retiree health benefits in general, many private-sector employers began a major overhaul of their retiree health benefit programs.⁶ Some employers placed caps on their contributions toward retiree health benefits. Some added age and service requirements, while others moved to retiree medical accounts. Some completely dropped retiree health benefits for future retirees, and others dropped benefits for current retirees, although this happened less frequently than other changes mentioned above.

In contrast to private-sector employers, those in the public sector, especially the federal government, continue to offer retiree health programs. It is relatively easy for federal employees to qualify for retiree health benefits. Federal retirees usually receive a 72–75 percent subsidy for the premium, and they are able to choose from all of

the health plans that participate in the Federal Employees Health Benefits Program (FEHBP).

So far, the changes in the private sector do not appear to be having an impact on the percentage of current retirees reporting that they receive health insurance from a former employer. In 2001, 37 percent of retirees ages 55–64 had insurance coverage from a former employer, which is unchanged from 1994 (Fronstin, 2001).⁷ However, current retirees are likely paying more for insurance than in the past, and retirees without access to employment-based health benefits may find it extremely difficult to find affordable health insurance on their own, despite provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).⁸ And workers without access to retiree health benefits may have delayed retirement.⁹ Previous research has shown that workers who do not expect to have retiree health benefits are more likely than those who expect the benefit to plan to work until they qualify for Medicare benefits at age 65 (Fronstin, 1999).

Because of these developments, the erosion of retiree health benefits will be felt more by future retirees. Where employers continue to offer retiree health benefits, they have made it harder for today’s workers to qualify for them when they retire. In addition, today’s workers are more likely to pay the full cost of retiree health benefits when they retire if they are eligible for benefits. As noted above, this pertains mainly to large employers because very few small employers ever offered the benefits: Recent estimates from the Agency for Healthcare Research and Quality (AHRQ) (an agency within the federal Department of Health and Human Services (DHHS)), reports that only 12 percent of all private establishments in the United States offered health benefits to retirees under age 65 in 2000, and only 11 percent offered them to Medicare-eligible retirees.¹⁰ Large firms are much more likely to offer retiree health benefits than small firms. In 2001, 29 percent of firms with 500 or more employees offered retiree health to early retirees (William M. Mercer, 2002), and in 2002, 72 percent of private firms with at least 1,000 employees

TAX TREATMENT OF INSURANCE AND OUT-OF-POCKET EXPENSES**I. Plan Sponsor**

1. Contributions toward health benefits are deductible as a business expense by the employer and also are not counted toward taxable income for either active workers or retirees.

II. Active Employee

1. Employer contributions toward health benefits are not counted toward taxable income.
2. Employee contributions toward health benefits are not counted toward taxable income if the employer sets up the plan as such.
3. Out-of-pocket expenses can be paid on a pretax basis through a flexible spending account when offered by the employer.
4. Total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income (AGI), and only the amount that exceeds 7.5 percent of AGI is deductible. Individuals need to itemize their deductions in order to claim this deduction.

III. Retiree

1. Employer contributions toward health benefits are not counted toward taxable income.
2. Retiree contributions toward health benefits cannot be deducted from taxable income, except to the degree that they meet the 7.5 percent AGI test mentioned above.
3. Out-of-pocket expenses cannot be deducted from taxable income, except to the degree that they meet the 7.5 percent AGI test mentioned above.

offered it (Hewitt Associates, 2002).

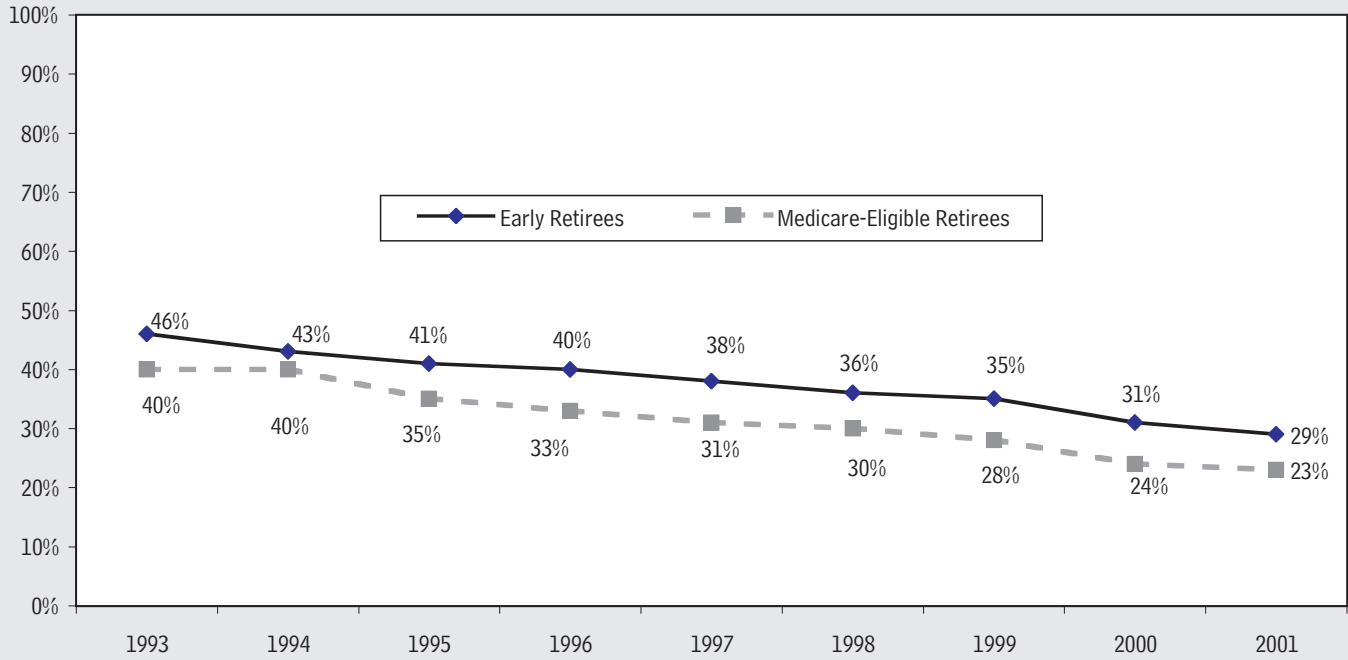
Since 56 percent of private-sector employees are employed in firms with fewer than 500 employees, and 62 percent are employed in firms with fewer than 1,000 employees (Fronstin, 2002a), very few employees are expected to be eligible for retiree health benefits in the future. Most early retirees will be on their own to pay for health insurance in retirement, although in some cases they may benefit from group rates if employers provide access-only plans in which the former employer provides the grouping mechanism and insurance at group rates, but does not provide a formal contribution. Most retirees age 65 and older will have only Medicare, unless they purchase private "Medigap" coverage on their own to cover services and expenses excluded by Medicare.

While retirees will assume more responsibility for choosing and paying for health insurance and health care expenses, they will not be able to take advantage of certain tax-favored funding vehicles and tools to fund health insurance and out-of-pocket expenses that some were able to use when they were active workers. Expenses for retiree health benefits are treated differently for both employers and retirees, too (see Box 1). If an employer pays for retiree health benefits, the value of the benefit is not be counted as taxable income for the

retiree. However, retirees' contributions must be made on an after-tax basis and retirees do not have a vehicle to pay out-of-pocket expenses on a pretax basis.¹¹ In contrast, for active workers, the value of health benefits is not counted as taxable income, their own contributions toward health insurance are deducted from taxable income, and they often have access to flexible spending accounts (FSAs) which allow them to pay out-of-pocket expenses on a pretax basis. Policy incentives to allow retirees to use a vehicle to pay health insurance premiums and out-of-pocket expenses on a pretax basis would not only make health insurance more affordable but might also spur financial planners to focus on health care expenses much more than they do today as a lifelong savings need.¹²

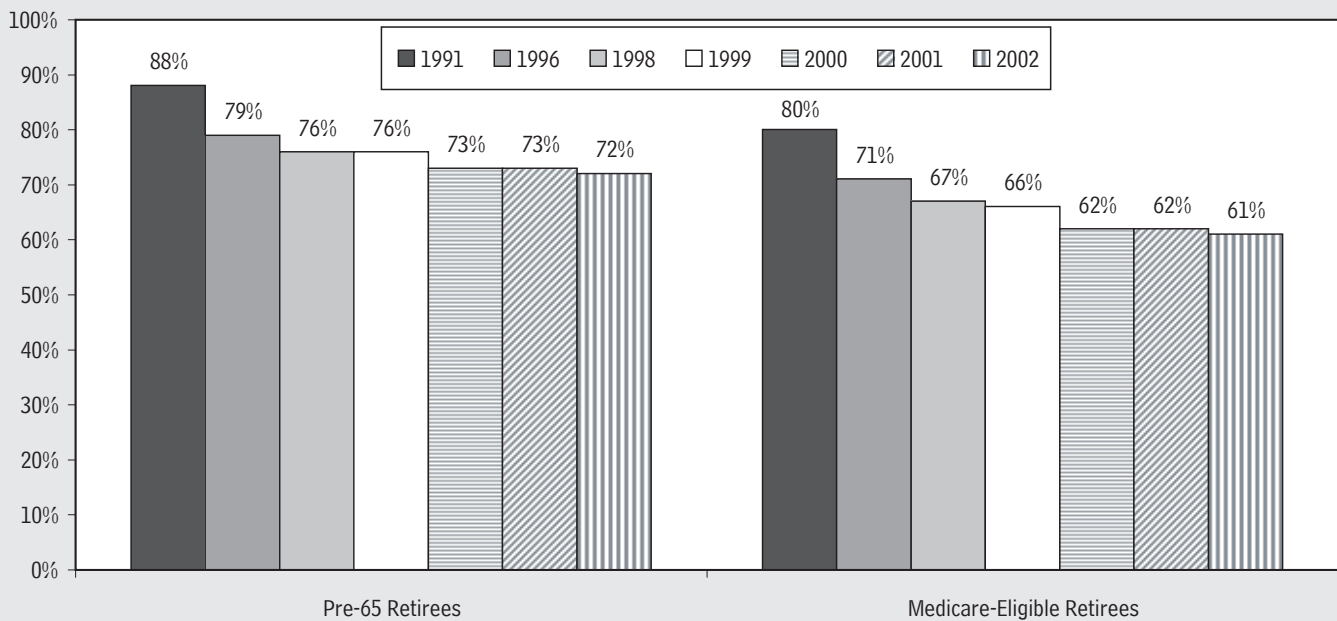
This *Issue Brief* presents estimates of how much money a person will need to save to retire and completely pay for health insurance and out-of-pocket health care costs for the rest of his or her life.¹³ Various illustrations of needed savings are presented, based on a number of assumptions regarding insurance premium levels and how they might change over time, the source of coverage, rates of return on investment, age at retirement, and age at death. The following section provides background information on recent changes in retiree

Figure 1
**PROVISION OF RETIREE HEALTH BENEFITS FOR CURRENT AND ALL FUTURE RETIREES,
 BY EMPLOYERS WITH 500 OR MORE EMPLOYEES, 1993-2001**



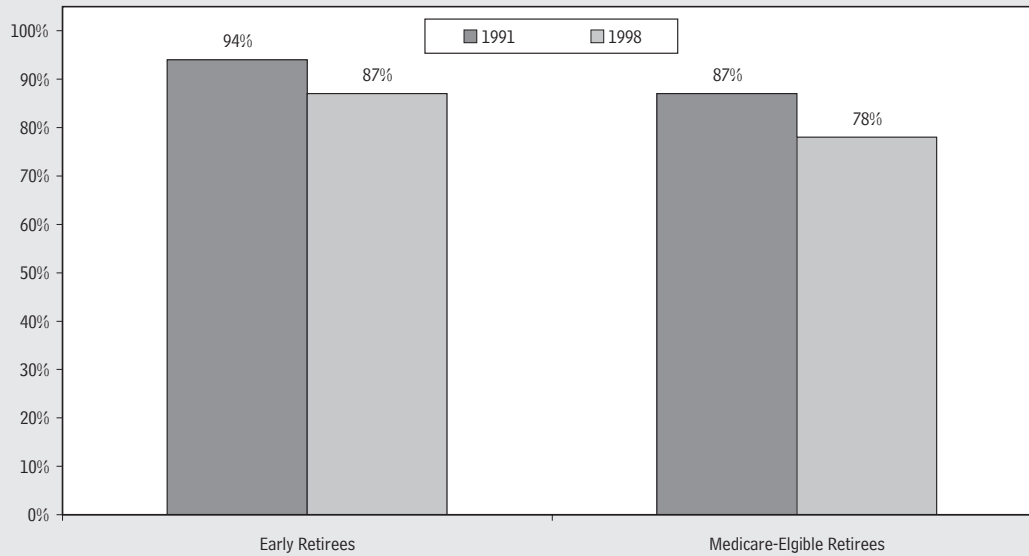
Source: William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 2002: Report on Survey Findings* (William M. Mercer, Inc., New York, NY, 2002).

Figure 2
**PROVISION OF RETIREE HEALTH BENEFITS BY EMPLOYERS
 WITH 1,000 OR MORE EMPLOYEES, 1991-2002**



Source: Frank McArdle et al., *Retiree Health Coverage: Recent Trends and Employer Perspectives and Future Benefits* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, October, 1999); Steve Coppock and Andrew Zebrak, "Finding the Right Fit: Medicare, Prescription Drugs and Current Coverage Options," testimony before the U.S. Senate, Committee on Finance; and Hewitt Associates, personal communication.

Figure 3
**LIKELIHOOD OF EMPLOYERS PROVIDING RETIREE HEALTH BENEFITS,
 SAMPLE OF SAME EMPLOYERS WITH 1,000 OR MORE EMPLOYEES IN 1991 AND 1998**



Source: Frank McArdle et al., *Retiree Health Coverage: Recent Trends and Employer Perspectives and Future Benefits* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, October, 1999); Steve Coppock and Andrew Zbrak, "Finding the Right Fit: Medicare, Prescription Drugs and Current Coverage Options," testimony before the U.S. Senate, Committee on Finance; and Hewitt Associates, personal communication.

health benefit trends. The next section discusses the Medicare program and Medigap insurance options for retirees. The following section presents estimates of savings needed to pay for retiree health benefits. The final section discusses policy options to address health care costs in retirement.

Recent Trends in Retiree Health Benefits

Besides Medicare, most workers will never be eligible for any other type of subsidized health insurance in

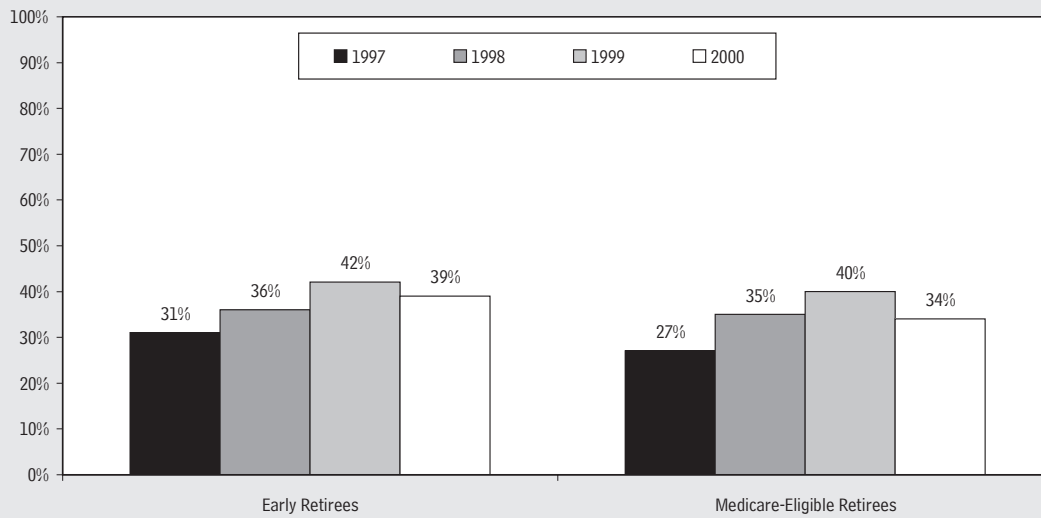
retirement, and, on average, Medicare covers roughly 50 percent of health expenses.¹⁴ In general, among workers who currently expect to receive retiree health benefits, the percentage of employers offering them to future retirees seems to be declining rapidly. As mentioned above, AHRQ reports that only 12 percent of all private establishments offered health benefits to early retirees (under age 65) in 2000 and only 11 percent offered them to Medicare-eligible retirees. These estimates are down from 22 percent for early retirees and 20 percent for Medicare-eligible retirees in 1997.¹⁵

An annual national survey of employers with 500

or more workers shows that the percentage that currently expect to continue offering health benefits to future early retirees declined from 46 percent in 1993 to 29 percent 2001 (Figure 1). The survey also found that the percentage of employers offering health benefits to Medicare eligible retirees today and planning to offer them to future Medicare eligible retirees is declining. Another survey of larger employers (most with 1,000 or more employees) also showed that the percentage of employers offering retiree health benefits has declined: Within this group, the likelihood of offering retiree health benefits to early retirees declined from 88 percent in 1991 to 72 percent in 2002 (Figure 2).¹⁶

The decline in the likelihood that an employer offered retiree health benefits in both Figure 1 and 2 is mainly due to two factors: (1) some employers are terminating existing benefits, and (2) new organizations are choosing not to offer retiree health benefits at all. To some degree, the data presented in Figures 1 and 2 overstate the extent to which employers are dropping retiree health benefits. When broad cross sections of employers are studied over time, it appears that employers are dropping retiree health benefits; however, new large employers most likely never offered retiree health benefits at all. (Cross sections that include these new employers are not examining individual employer behavior over time but are providing snapshots of the availability of retiree health benefits at a point in time to population groups across many employers.)

Figure 4
**PERCENTAGE OF LARGE EMPLOYERS REQUIRING RETIREE
 TO PAY FULL COST OF RETIREE HEALTH BENEFITS,
 EMPLOYERS WITH 500 OR MORE EMPLOYEES, 1997-2000**



Source: William M. Mercer, *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 2000* (New York, NY: William M. Mercer, Inc., 2001).

To understand how employers that offer retiree health benefits are changing their offer rate, it is important to examine a constant sample of employers.

McArdle et al. (1999) examined a constant sample of employers between 1991 and 1998 and found that there had been a decline in the availability of retiree health benefits, but it was not as large as that portrayed in Figure 2. Figure 3 shows the trend for the constant sample of employers and finds that there was a 7 percentage point drop in the likelihood that employers offered retiree health benefits to early retirees and a 9 percentage point drop in the offer rate for Medicare-eligible retirees over the same period.

Most employers that are continuing to offer retiree health benefits have made changes in the benefit package. Modifications to cost-sharing provisions are a common change, with employers asking retirees to pay for a greater share of the cost of coverage. In 2000, 39 percent of employers with 500 or more workers offering early retiree health benefits required retirees to pay 100 percent of the premium for coverage, up from 31 percent of employers in 1997 (Figure 4).¹⁷

Employers are also tightening eligibility requirements to control spending (McCormack et al., 2002). This might involve requiring workers to attain a certain age and/or tenure with the company before they can receive any retiree health benefits. Overall, the percentage of employers requiring an age of 55 and a service require-

ment of 10 years for benefit eligibility increased from 30 percent in 1996 to 38 percent in 2002 (Figure 5). Concurrently, some employers instituted a requirement of age 55 and 20 years service or age 60 and 10 years service for the first time.

Employers also have 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 an employer reaches the cap the subsidy toward retiree health benefits will no longer be increased. Employers do continue to provide subsidies for retiree health, but retirees are responsible for the entire increase in premiums each year. In 2002, 45 percent of large employers had a cap for early retirees, while 50 percent had a cap for Medicare-eligible retirees (Figure 6). Among employers that have instituted a cap for early retirees, 49 percent have already hit the cap, while 14 percent anticipate reaching it in the next year and 21 percent within three years. Sixteen percent do not anticipate hitting the cap.

Some employers have reduced the subsidy for workers hired (or retiring) after a specific date, while other employers have eliminated benefits altogether for workers hired after a certain date. According to EBRI estimates,¹⁸ about 16 percent of employers with 500 or more employees offering retiree health benefits offer them only to current retirees or those hired before a specific year. Similarly, McArdle, et al. (2002) found that

Figure 5
ELIGIBILITY REQUIREMENTS FOR RETIREE HEALTH BENEFITS, EMPLOYERS WITH 1,000 OR MORE EMPLOYEES, SELECTED YEARS, 1996-2002

	1996	2000	2002
Age 50 + 10 Years Service	1%	2%	3%
Age 50 + 15 Years Service	1	1	1
Age 55 + 5 Years Service	9	10	10
Age 55 + 10 Years Service	30	38	38
Age 55 + 15 Years Service	5	8	8
Age 55 + 20 Years Service	0	2	2
Age 60 + 10 Years Service	0	1	2
Based on Age/Service Points	1	5	7
Based on Age and/or service Plus Age/Service Points	6	3	2
Two or More Alternatives	35	19	18
"Other (e.g., age-only or service-only)"	11	11	9

Source: Hewitt Associates LLC, *Salaried Employee Benefits Provided by Major U.S. Employers in 1993* (Lincolnshire, IL, 1993); *Salaried Employee Benefits Provided by Major U.S. Employers, 2000-2001* (Lincolnshire, IL, 2000); and *Salaried Employee Benefits Provided by Major U.S. Employers, 2002-2003* (Lincolnshire, IL, 2002).

Figure 6
PERCENTAGE OF LARGE EMPLOYERS THAT HAVE A CAP ON THEIR FIRM'S CONTRIBUTIONS TO RETIREE HEALTH BENEFITS, 2002

	Pre-65 Retirees	Medicare-Eligible Retirees
Percentage With a Cap	45%	50%
Have Already Hit Cap	49	57
Anticipate Hitting Cap Within the Next Year	14	11
Anticipate Hitting Cap Within the Next Three Years	21	17
Do Not Anticipate Hitting Cap	16	15

Source: Frank McArdle et al., *The Current State of Retiree Health Benefits: Findings from the Kaiser/Hewitt 2002 Retiree Health Survey* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, December 2002).

13 percent of employers with 1,000 or more employees reported that they had terminated all subsidized health benefits for future retirees.

Some employers have established retiree medical accounts (RMAs) for retirees to use to purchase health benefits during retirement. RMAs are typically notional accounts, which means they are not actually funded but are a bookkeeping device that allows employers and employees to keep track of the dollars that will be made available to the worker for health benefits during retirement. In an RMA, participants typically are credited a fixed dollar amount for each year of plan participation. Credits can also vary based on a combination of age and service. Credits in the account may accumulate interest and the value of the credits could grow over time or could vary with age or years of service, but it is possible that the value of the account would not grow as fast as the anticipated cost of providing retiree health benefits. Essentially, in this type of model the

risk of unpredictable health benefit cost inflation is borne by employees.

When a worker retires, he or she could then use the money in the account to purchase health insurance, although the money in the account may or may not be enough to pay for health insurance in retirement. A recent study found that 2 percent of large employers 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).

Driven by rising health insurance costs, employers continue to consider additional changes to retiree health benefits, including dropping coverage for some and shifting costs onto others. Sixty-four percent of firms are very likely to increase retiree contributions to premiums, and 54 percent are very likely to increase cost sharing (Figure 7). Only 10 percent are very likely to move toward an access-only plan for retirees, while 6 percent are very likely to move toward an access-only plan for

Figure 7

EMPLOYERS' LIKELIHOOD OF MAKING SELECTED CHANGES TO RETIREE HEALTH BENEFITS WITHIN THE NEXT THREE YEARS

	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
Increase Retiree Contribution to Premiums	64%	18%	6%	12%
Increase Cost-Sharing	54	22	12	12
Shift to a Defined Contribution Approach	4	21	28	47
Provide Access Only	10	15	28	48
Terminate All Subsidies for Future Retirees	6	16	26	52
Add or Improve Coverage or Benefits for Retirees	5	7	21	67
Terminate All Subsidies for Current Retirees	1	4	18	78
Eliminate Prescription Drug Coverage	1	3	25	71

Source: Frank McArdle et al., *The Current State of Retiree Health Benefits: Findings from the Kaiser/Hewitt 2002 Retiree Health Survey* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, December 2002).

future retirees.

It will be a few more years before enough time has passed to assess how workers and retirees are ultimately affected by cutbacks in retiree health benefits. Many workers may never qualify for retiree health benefits because their employers offer them only to workers hired before a specific date or because they may never reach the age and/or service requirements needed to qualify for benefits. Some workers may delay retirement, while others may be able to retire when they want to because they can get health insurance through a working spouse. Ultimately, however, it is probable that future retirees will pay more for health benefits and health care services in retirement than current retirees. Policymakers have recently introduced various proposals that they hoped would help end the erosion of retiree health benefits in the private sector. But in fact, some of these proposals may exacerbate the erosion of private-sector retiree health benefits.¹⁹

Federal Employees

In contrast to private-sector trends, the federal government provides a very rich package of retiree health benefits to its workers. To carry health insurance into retirement, a federal employee must have been continuously enrolled (or covered as a family member) in the FEHB program for the five years of service immediately before the date their annuity started, or if less than five years, for the full period of service since their first opportunity to enroll. Federal retirees and their surviving spouses are able to retain their eligibility for health coverage in the FEHB program at the same cost as

current employees. This means that for most retirees, the federal government contribution equals the lesser of: (1) 72 percent of amounts the Office of Personnel Management (OPM) determines are the programwide weighted average of premiums in effect each year, for self-only and for self-and-family enrollments, respectively, or (2) 75 percent of the total premium for the particular plan an enrollee selects. Federal retirees not only pay the same premiums as active workers in the FEHB program, but can also choose from the same broad range of health plan options.

The Medicare Program

Medicare is the primary payer of health care services for persons who are retired and age 65

and older.²⁰ The Medicare program contains Parts A and B. Eligible Medicare beneficiaries in the traditional program automatically receive Medicare Part A (Hospital Insurance) at no premium cost and are able to supplement it with Medicare Part B (Supplementary Insurance) and private Medigap insurance. Persons choosing Part B services currently pay a \$58.70 per month premium. On average, elderly persons spent 26 percent of their income on health care in 2000, although this figure does not include spending for long-term care expenses (Maxwell, Moon and Segal, 2001).

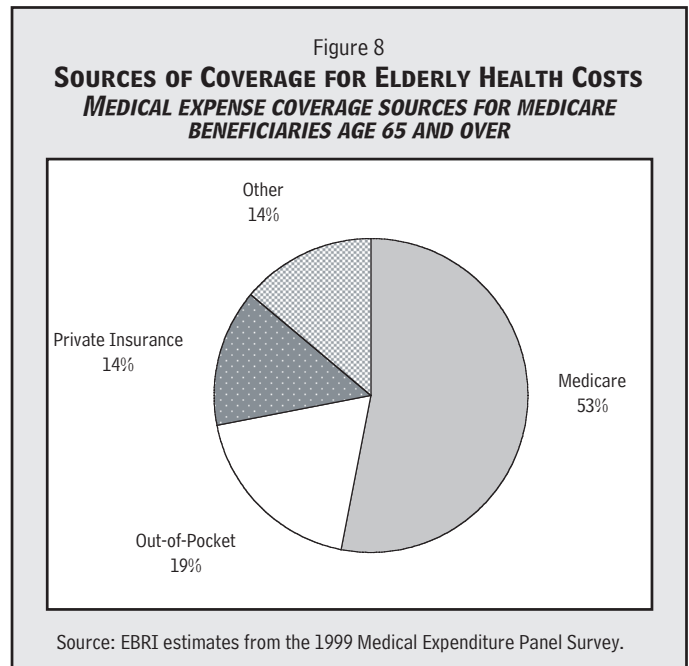
Part A covers inpatient hospital services, skilled nursing facility (SNF) benefits following a three-day hospital visit, home health visits following a hospital or SNF stay, hospice care, and blood (after the member has

paid for the first three pints). Hospital stays are subject to an \$840 deductible for days one–60. A \$210 per day co-pay is required of Medicare beneficiaries for days 61–90; this increases to \$420 per day for days 91–150. Medicare beneficiaries are responsible for all costs for each day beyond 150, although there are a total of 60 lifetime reserve days that can be used. SNF care costs nothing during the first 20 days, after which a \$105 per day co-pay is required until day 100, after which the beneficiary pays all costs.

Medicare Part B is partially financed by beneficiary premiums that originally covered 50 percent of the program’s cost. General tax revenues finance the balance of Medicare Part B. Today, Part B is financed by beneficiary premiums that cover 25 percent of the program’s cost. 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 \$100 deductible. Part B also now covers a number of preventive services.

Like employment-based health benefits and retiree health benefits of the 1960s, Medicare was not designed to cover all medical expenses of Medicare beneficiaries. In addition to the deductibles, coinsurance, and copayments for inpatient and outpatient care, Medicare does not cover outpatient prescription drugs, there are no out-of-pocket maximums, and there is very limited coverage for long-term care expenses. Medicare beneficiaries pay for an average of 19 percent of the cost out-of-pocket, and private insurance covers an average of 14 percent. Other sources account for the remainder (Figure 8).

Medicare beneficiaries can purchase a Medigap



plan directly from a private insurance company to cover health care services that are not covered by the Medicare program. Under federal law, beneficiaries can choose from among 10 types of Medigap plans to help pay for hospital stays, skilled nursing coinsurance, the Medicare Part B annual deductible, and covered services and outpatient prescription drugs. Not all 10 plans will cover all benefits, and in many cases the benefits are far from comprehensive. Even the most comprehensive Medigap plan offers very limited prescription drug benefits. For example, Medigap Plans H through J cover outpatient prescription drug costs but the benefits are limited to \$1,250 annually in Plans H and I, and \$3,000 annually in Plan J, with 50 percent coinsurance. Furthermore, not all 10 plans are available in each state.

As part of the 1997 Balanced Budget Act, Congress created the Medicare+Choice program to increase beneficiary choice of health plans and to control rising government spending for Medicare benefits.

Medicare+Choice built on the existing Medicare health maintenance organization (HMO) program by expanding the types of plans that beneficiaries could choose and also reformed the payment system that applies to participating plans. These plans generally allow members to visit only health care providers who agree to treat members of the plan, and often require members to get a referral to see specialists. Medicare pays a set amount of money every month to the private insurer or HMO that the Medicare beneficiary chooses. Often private insurers and HMOs provide benefits that are not covered by traditional Medicare, such as outpatient prescription drugs, and they are allowed to charge an additional monthly premium for these benefits.

Savings Needed to Fund Health Care in Retirement

The combination of the erosion of retiree health benefits and limited benefits from Medicare and

Medigap means that retirees should expect to pay a significant amount of money for health insurance and health care services during retirement. If a person were to try to save for these expenses, the amount of money needed would vary with a number of factors, such as:

- The source of insurance, premium level, and benefits covered.
- Annual increases in insurance premiums.
- Age at time of death.
- Retirement age.
- Rate of return on investment.
- Out-of-pocket expenses and health status.
- Medicare Part B premiums.

This report uses various assumptions about these factors to provide a set of *illustrations* of the savings level that may be needed to pay for insurance premiums and out-

of-pocket expenses. The remainder of this section shows the amount of money needed at ages 55 and 65 to cover insurance premiums and out-of-pocket expenses under various combinations of assumptions. The relevant assumptions are discussed in each section.

Savings Needed for Retirement at Age 65 in the Group Market

There are a number of important factors to consider when estimating the amount of money needed to fund health insurance and health care expenses in retirement. Two of the most important factors are premium levels and annual growth of premiums. Persons retiring at age 65 will have only a few options for insurance, so we can assume they have only a few insurance premiums from which to choose. For instance, in this model, two kinds of insurance premiums are assumed: one that individuals will face if they are covered by employment-based health benefits with group market premiums, and one they would face when purchasing Medigap. Both plans supplement Medicare benefits.

An annual group market premium of \$2,631 in 2002 is used as a starting point for comprehensive group coverage to supplement Medicare.^{21, 22} This premium would provide comprehensive benefits with a \$250 deductible and 80 percent coinsurance thereafter. It would also provide prescription drug benefits after a \$50 deductible and 70 percent coinsurance thereafter. A \$150 annual preventive care benefit is included, and the combined medical and prescription drug out-of-pocket maximum is \$1,500.

While some employers will provide subsidies for this coverage, as mentioned above, some employers are moving away from providing subsidies for retiree health benefits and are instead moving toward access-only plans. Therefore, for illustrative purposes, estimates are presented where the retiree pays 50 percent of the premium and the retiree pays the full premium in calculating the estimates

Figure 9
**SAVINGS NEEDED FOR EMPLOYMENT-BASED HEALTH BENEFITS FOR RETIREMENT AT AGE 65 IN 2003
 (INCLUDES PREMIUM,^a MEDICARE PART B PREMIUM,^b AND OUT-OF-POCKET EXPENSES)^c**

Annual Increase in Premiums									
	<u>Illustration #1</u> 7%			<u>Illustration #2</u> 14%			<u>Illustration #3</u> 14% Grading Down to 5% Over 10 Years ^d		
	50% of Premium (\$1,316) + Part B Premium	100% of Premium (\$2,631) + Part B Premium	100% of Premium (\$2,631) + \$1,500 Maximum Out- of-Pocket + Part B Premium	50% of Premium (\$1,316) + Part B Premium	100% of Premium (\$2,631) + Part B Premium	100% of Premium (\$2,631) + \$1,500 Maximum Out- of-Pocket + Part B Premium	50% of Premium (\$1,316) + Part B Premium	100% of Premium (\$2,631) + Part B Premium	100% of Premium (\$2,631) + \$1,500 Maximum Out- of-Pocket + Part B Premium
Age at Death									
80	\$37,000	\$62,000	\$80,000	\$56,000	\$100,000	\$117,000	\$42,000	\$73,000	\$90,000
85	52,000	88,000	109,000	93,000	171,000	192,000	58,000	100,000	121,000
90	69,000	117,000	141,000	151,000	281,000	305,000	75,000	128,000	152,000
95	88,000	150,000	176,000	239,000	453,000	479,000	92,000	158,000	185,000
100	109,000	188,000	216,000	377,000	722,000	750,000	111,000	190,000	218,000

Source: EBRI estimates based on various assumptions.

^a Benefits package for the \$2,631 premium was developed by PricewaterhouseCoopers LLP on behalf of the Mellon College Retirement Project. It contains the following benefits: Major Medical Benefit: \$150 annual preventive care benefit, \$250 deductible, 80% coinsurance. Outpatient Prescription Drug Benefit: \$50 deductible, 70% coinsurance. Maximum out-of-pocket: \$1,500 (medical and prescription drug combined).

^b Medicare Part B premiums are from cms.hhs.gov/publications/trusteesreport/2002/tabivc1.asp. In years 2012 and beyond an annual increase of 5.5 percent was assumed.

^c All estimates assume a 4 percent after-tax rate of return on investments.

^d A grading down to 5% is currently the most common assumption in corporate disclosures under FAS 106 guidelines. See Deloitte and Touche (2001).

of needed savings. As another illustration, this report also shows how much money would be needed for persons paying the full premium and also reaching their out-of-pocket maximum each year, although it is recognized that most people will not reach it each year.

Figure 9 provides estimates of savings needed under various assumptions to pay for health insurance premiums, Medicare Part B premiums, and maximum out-of-pocket health care costs during retirement for a person with access to coverage through an employer. In this figure, it is assumed that assets will have an after-tax rate of return of 4 percent. This is a reasonable estimate, and may even be too high, since prominent projections of “long-term” stock returns are about 7 percent²³ but persons age 65 and older are much more likely to put their assets in safe or less-volatile investments, meaning that they are much less likely to see a 7 percent pretax rate of return. The first section of the figure shows that, when health insurance premiums are assumed to increase 7 percent per year over the next 35 years, the amount of assets needed range from a present value of \$37,000 to \$216,000, depending on age at time of death.²⁴ Currently, according to the Social Security trustees’ intermediate projections, life expectancy for a 65-year-old male is 15.8 years (80.8 years of age) and for a female it is 19 years (84 years of age), although life expectancy is expected to

increase in the future with technological innovation in the delivery of health care.²⁵ This means that, on average, the most relevant numbers are between \$37,000 and \$80,000 needed in present-value assets for a male, and \$52,000 and \$109,000 for a female, depending upon what is assumed for premiums and out-of-pocket costs. The higher numbers in the range include the amount that would be needed to cover both 100 percent of the premium and maximum out-of-pocket expenses.

While life expectancy numbers are highlighted in the previous paragraph, this should not be interpreted as discounting the likelihood that some portion of the population will live beyond their life expectancy. Life expectancy tables are appropriate for employer calculations to determine funding levels for retiree health benefits because the cost of benefits to the employer for people who live past their life expectancy will be offset by the cost for those who die before their life expectancy. Life expectancy tables may be a starting point for financial planning for individuals, but the use of averages for individuals will understate the savings needed for a substantial portion of the population. Individuals do not know how long they will live and should use appropriate tools to estimate how long they can expect to live (see Box 2). For people expected to live beyond average life expectancy, they will need to save more money than those who meet their life expectancy. For instance, a

LIFE EXPECTANCY CALCULATORS

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:²⁶

- a) moneycentral.msn.com/investor/calcs/n_expect/main.asp
- b) www.nmfn.com/tn/learnctr—lifeevents—longevity
- c) www.beeson.org/Livingto100/quiz.htm
- d) diskworld.wharton.upenn.edu/~chuac/perl/CalcForm.html
- e) healthyontario.com/english/health_tools/calc_life.asp?channel_id=6&text_id=243
- f) www.healthcentral.com/healthview/lifeexpectancy.cfm?CFID=6852126&CFTOKEN=58209703&2&

person living to age 90 will need to have saved \$141,000 to cover retiree health benefit premiums and maximum out-of-pocket expenses, while a person living to age 95 will need to have saved \$176,000.²⁷

The second part of Figure 9 shows similar data, but uses 14 percent as the annual increase in health insurance premiums. The figure shows that a person would need \$192,000 at age 65 to cover 100 percent of the premium and maximum out-of-pocket costs were he or she to live to age 85. They would need \$305,000 if they were to live to age 90, and they would need \$479,000 if they were to live to age 95. A person living to age 100 would need \$750,000.

A 14 percent trend for premium increases was chosen to simply provide an alternative illustration to the 7 percent illustration because of uncertainty over choosing a future annual premium increase. In fact, 14 percent is (hopefully) unrealistically high for the long term. The Medicare Trustees Advisory Panel recommends that medical trends be set at 1 percent higher than gross domestic product (GDP) trends on a per-person basis. In order to provide an alternative illustration to the 14 percent trend example, estimates are also presented assuming that annual increases start at 14 percent, but grade down to 5 percent over 10 years, the most common assumption in corporate disclosures under FAS 106 guidelines.²⁸

In this illustration, a person would need \$121,000 at age 65 to cover 100 percent of the premium and maximum out-of-pocket costs were he or she to live to age 85, \$152,000 if living to age 90, and \$185,000 if living to age 95. A person living to age 100 would need \$218,000.

These illustrations highlight the extremes. As mentioned above, it is recognized that most people will not

reach their out-of-pocket maximum each year. In fact, many people will need to save less than the combined premium and out-of-pocket maximums. In most cases, the savings needed will fall somewhere between the premium-only estimates and the premium-plus-maximum-out-of-pocket estimates. In addition, this model assumes that the benefits package does not change: Specifically, it assumes that the \$1,500 out-of-pocket maximum at age 65 is not increased over time. If out-of-pocket maximums were to increase with inflation, an individual reaching the out-of-pocket maximum each year would need more money than the amount indicated in Figure 9.

As high as the estimates from these illustrations may seem, they all assume that an individual will have access to employment-based health benefits at group rates. In fact, the vast majority of retirees will not have access to employment-based health benefits and will instead only have access to Medigap. These estimates are addressed in the next section.

Retirement at Age 65 in the Individual Market

Most retirees are not going to have access to retiree health benefits through a former employer. Instead, their options will be limited to purchasing either traditional Medicare or Medicare+Choice. A person choosing traditional Medicare will be able to purchase a Medigap policy directly from an insurer to cover some of the expected expenses not covered by traditional Medicare. This section focuses on how much money individuals will need to save to cover their Medigap premiums, Medicare Part B premiums, and average out-of-pocket expenses if

Figure 10
SAVINGS NEEDED FOR MEDIGAP COVERAGE FOR RETIREMENT AT AGE 65 IN 2003
(INCLUDES PREMIUM,^a MEDICARE PART B PREMIUM,^b AND OUT-OF-POCKET EXPENSES^c)^d

Annual Increase in Premiums									
	<u>Illustration #1</u> 7% (includes 3% health inflation + 4% age effect)			<u>Illustration #2</u> 14% (includes 10% health inflation + 4% age effect)			<u>Illustration #3</u> 14% Grading Down to 5% Over 10 Years (includes 4% age effect)		
	50% of Premium (\$1,818) + Part B Premium	100% of Premium (\$3,635) + Part B Premium	100% of Premium (\$3,635) + Average Out-of-Pocket Expenses + Part B Premium	50% of Premium (\$1,818) + Part B Premium	100% of Premium (\$3,635) + Part B Premium	100% of Premium (\$3,635) + Average Out-of-Pocket Expenses + Part B Premium	50% of Premium (\$1,818) + Part B Premium	100% of Premium (\$3,635) + Part B Premium	100% of Premium (\$3,635) + Average Out-of-Pocket Expenses + Part B Premium
Age at Death									
80	\$47,000	\$82,000	\$116,000	\$73,000	\$133,000	\$194,000	\$54,000	\$98,000	\$137,000
85	66,000	115,000	164,000	123,000	230,000	335,000	74,000	135,000	189,000
90	87,000	153,000	219,000	200,000	380,000	558,000	95,000	173,000	243,000
95	112,000	197,000	282,000	321,000	615,000	907,000	117,000	214,000	300,000
100	139,000	247,000	354,000	508,000	985,000	1,458,000	141,000	257,000	359,000

Source: EBRI estimates based on various assumptions.

- ^a Benefits package for a \$3,635 premium for Medigap Plan J in Florida priced at www.aarphealthcare.com for a 65 year old in 2002 living in Florida, after all possible discounts are taken. 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 3 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, Emergency Foreign Travel, At-Home Recovery, Preventive Care and Extended Prescription Drug Coverage (\$3,000 limit)
- ^b Medicare Part B premiums are from cms.hhs.gov/publications/trusteesreport/2002/tabivc1.asp. In years 2012 and beyond we assume an annual increase of 5.5 percent.
- ^c Based on estimates from the 1999 Medical Expenditure Panel Survey, \$1,100 is used for average out-of-pocket expenses for prescription drugs and \$700 as the average out-of-pocket expenses for other health care services for people who used health care services.
- ^d All estimates assume a 4 percent after-tax rate of return on investments.

they use health care services under traditional Medicare at various assumptions about age at the time of death and annual increases in premiums and out-of-pocket expenses.²⁹

Figure 10 provides estimates of savings needed under various assumptions to pay for health insurance premiums and average out-of-pocket health care costs during retirement for a person who buys Medigap Plan J directly from an insurer. While Medigap Plan J is the most comprehensive plan an individual can purchase, premiums for it vary substantially by state. For example, the annual premium for Plan J for a 65 year old in Washington, DC, is \$1,620; in Arizona it is \$1,896, while in Florida it is \$3,635.³⁰ Figure 10 uses the amount that a person in Florida would need to purchase Medigap, although estimates are also shown for 50 percent of the premium (\$1,818), which may be closer to other geographic regions, such as Arizona. Again, it is also assumed that assets will return an after-tax rate of 4 percent. The first section of the figure shows that the savings needed range from \$47,000 to \$354,000, depending on age at the time of death, premiums, and average

out-of-pocket expenses, when health insurance premiums are assumed to increase 7 percent per year. (In contrast to the illustrations for employment-based coverage, what is called a “premium increase” includes a 4 percent age effect, which accounts for the fact that premiums automatically increase with age even if the benefits package and the cost of providing the services is not increasing.)

A person retiring in Florida would need \$115,000 to cover his or her premium only, and \$164,000 to cover out-of-pocket expenses if he or she lived until age 85. This person would need \$197,000 to cover the Medigap premium only and \$282,000 to cover average out-of-pocket expenses if he or she lived until age 95.

These estimates are also presented with assumptions that when increases in Medigap premiums, health care costs, and the age effect are combined, premiums increase 14 percent per year. In this case, an individual living until age 85 in Florida would need \$335,000 to cover premiums and average out-of-pocket expenses, but an individual living to age 95 would need \$907,000, and one living to age 100 would need \$1.5 million. When assuming that overall premiums are currently increasing

Figure 11
**SAVINGS NEEDED FOR VARIOUS SOURCES OF COVERAGE FOR RETIREMENT DURING
 AGES 55–64 STARTING IN 2003 (INCLUDES PREMIUMS^a AND OUT-OF-POCKET EXPENSES)^b**

Annual Increase in Premiums									
	Illustration #1 7% (includes 3% health inflation + 4% age effect)			Illustration #2 14% (includes 10% health inflation + 4% age effect)			Illustration #3 14% Grading Down to 5% Over 10 Years (includes 4% age effect)		
	Premium Only	Premium+ \$4000 Prescription Drug Out-of- Pocket+	Premium+ \$4000 Prescription Drug Out-of- Pocket+ Out-of-Pocket Maximum	Premium Only	Premium+ \$4000 Prescription Drug Out-of- Pocket+	Premium+ \$4000 Prescription Drug Out-of- Pocket+ Out-of-Pocket Maximum	Premium Only	Premium+ \$4000 Prescription Drug Out-of- Pocket+	Premium+ \$4000 Prescription Drug Out-of- Pocket+ Out-of-Pocket Maximum
Source of Insurance									
Employment-Based PPO (\$4,636)	\$51,000	n/a	\$75,000	\$70,000	n/a	\$94,000	\$59,000	n/a	\$83,000
Individual Market Underwritten PPO (\$4,260)	47,000	80,000	140,000	64,000	97,000	158,000	54,000	87,000	148,000
Individual Market HIPAA PPO (\$12,804)	140,000	173,000	234,000	193,000	226,000	286,000	162,000	195,000	256,000

Source: EBRI estimates based on various assumptions.

^a Premiums from a health plan in Washington, DC, containing the following benefits:

Employment-Based PPO:

In Network: No deductible, no coinsurance.

Out of Network: \$300 deductible, 80%/20% coinsurance, \$3,000 out-of-pocket maximum.

Prescription Drugs: unlimited benefit.

Individual Market Underwritten PPO:

In Network: \$300 deductible, 90%/10% coinsurance, \$2,500 out-of-pocket maximum.

Out of Network: \$300 deductible, 70%/30% coinsurance, \$5,000 out-of-pocket maximum.

Prescription Drugs: \$10 generic copay, \$20 brand name copay, \$100 deductible, \$1,500 annual maximum.

Individual Market HIPAA PPO:

In Network: \$100 deductible, 90%/10% coinsurance, \$2,500 out-of-pocket maximum.

Out of Network: \$300 deductible, 70%/30% coinsurance, \$5,000 out-of-pocket maximum.

Prescription Drugs: \$10 generic copay, \$20 brand name copay, \$100 deductible, \$1,500 annual maximum.

^b All estimates assume a 4 percent after-tax rate of return on investments.

at 14 percent but grade down to 5 percent over 10 years, the estimates are closer to those that indicated when a flat 7 percent increase in premiums was assumed.

Again, these illustrations highlight extreme examples. Not everyone will have the average out-of-pocket expense each year, and many people will need to save more or less than the combined premium and average out-of-pocket expense. In some cases, the savings needed will fall somewhere between the premium-only estimates and the premium-plus-average-out-of-pocket expense, but in other cases, there will be people whose out-of-pocket expense level is above average, although not necessarily in every year of retirement. In contrast to the illustration for a 65-year-old with employment-based retiree health benefits presented in Figure 9, average out-of-pocket expenses that started at \$1,800 in 2002 for a 65-year-old are assumed to increase each year at the same rate as Medigap premiums to adjust for inflation over time.

Furthermore, a total premium increase of 14 percent is not sustainable over time, although a 5 percent increase that includes a 4 percent age effect is unrealistically too low.

Retirement at Age 55

A person retiring at age 55 does not have many options for purchasing health insurance. Like some Medicare-eligible retirees, some early retirees may be able to get retiree health benefits through a previous employer and they can also buy insurance directly from an insurer in the individual market.³¹ If a retiree were to obtain insurance in the individual market he or she may be subject to underwriting, which means that pre-existing conditions could either be excluded from coverage or the insurer may simply refuse to sell them coverage. A person who does have a pre-existing condition that could affect his or her ability to get coverage could choose a HIPAA plan that would guarantee coverage for pre-

existing conditions.

Figure 11 presents estimates for the amount of money a 55-year-old would need to cover health insurance premiums and out-of-pocket costs until becoming eligible for Medicare at age 65. These amounts are in addition to the savings needed to pay for health insurance premiums and out-of-pocket expenses at and after age 65. Estimates are presented for premiums and out-of-pocket costs for three sources of coverage: an employment-based preferred provider organization (PPO), an individual market-based underwritten PPO, and an individual market-based HIPAA PPO. The premiums were provided by a health insurer in Washington, DC, and may not be representative of average premiums in the United States, although they are age-rated. The annual premium for the employment-based plan is \$4,636 and provides for very comprehensive benefits.³² The annual premium for the underwritten individual market-based PPO is \$4,260, and is less comprehensive than the employment-based PPO, especially when it comes to prescription drug benefits. The individual market-based HIPAA PPO annual premium is \$12,804, and is otherwise as comprehensive as the underwritten product.³³ Figure 11 also presents estimates based on three assumptions regarding annual increases to premiums.

As can be seen in Figure 11, a person at age 55 buying insurance through an employment-based plan would need \$51,000 to cover the employment-based premium if premiums were expected to increase 7 percent per year until he or she reached age 65. If premiums were expected to increase 14 percent per year, the individual would need \$70,000, although if premiums were expected to grade down to 5 percent, the amount would be \$59,000. When the \$3,000 out-of-pocket maximum is added to the model, the savings needed to cover this 10-year period range from \$75,000 to \$94,000.

A person buying the underwritten policy in the

individual market would need to save \$47,000 for the premium only, which is less than the amount needed for the employment-based premium only, but he or she would need substantially more to cover the out-of-pocket maximum because the benefits are not as comprehensive in the individual market as they are in the group market. A person reaching their out-of-pocket maximum each year and using \$4,000 worth of prescription drugs would need to have saved between \$140,000 and \$158,000, depending on the assumptions used regarding annual increases to premiums.³⁴

An individual buying the HIPAA policy would need to have saved between \$140,000 and \$193,000 just to cover the premiums, but could need as much as \$286,000 to cover premiums and out-of-pocket expenses were he or she to reach the out-of-pocket maximum and also spend \$4,000 out-of-pocket on prescription drugs each year until reaching Medicare eligibility. Again, not all individuals will spend \$4,000 on prescription drugs and reach their out-of-pocket maximum on inpatient and outpatient services, so these estimates, whether buying an underwritten policy or a HIPAA policy, should be considered upper-bound estimates.

To get an idea of the number of people who would qualify for underwritten coverage and the number who would qualify for HIPAA coverage, the findings of Pauly and Nichols (2002) were examined. In this study, they report on offers to prospective buyers of nongroup insurance from one insurer. They found that 57 percent of the insurer's offers went to the best health risk class and 14 percent of applicants were rejected, and conclude that the individual market works acceptably well for about 80 percent of candidates for nongroup coverage. These data may or may not be representative of the experience of early retirees, who are far more likely to have a pre-existing condition than the general population. While data from one insurer are useful for more general observations because they reflect the experience

Figure 12
**SAVINGS NEEDED FOR EMPLOYMENT-BASED HEALTH BENEFITS FOR RETIREMENT AT AGE 65 IN 2013
 (INCLUDES PREMIUM,^a MEDICARE PART B PREMIUM,^b AND OUT-OF-POCKET EXPENSES)^c**

Annual Increase in Premiums									
	<u>Illustration #1</u> 7%			<u>Illustration #2</u> 14%			<u>Illustration #3</u> 14% Grading Down to 5% Over 10 Years Starting in 2002 ^d		
	50% of Premium (\$1,316 in 2002, \$2,588 in 2012) + Part B Premium	100% of Premium (\$2,631 in 2002, \$5,176 in 2012) + Part B Premium	100% of Premium (\$2,631 in 2002, \$5,176 in 2012) + \$1500 Maximum Out-of-Pocket + Part B Premium	50% of Premium (\$1,316 in 2002, \$4,877 in 2012) + Part B Premium	100% of Premium (\$2,631 in 2002, \$9,754 in 2012) + Part B Premium	100% of Premium (\$2,631 in 2002, \$9,754 in 2012) + \$1500 Maximum Out-of-Pocket + Part B Premium	50% of Premium (\$1,316 in 2002, \$3,249 in 2012) + Part B Premium	100% of Premium (\$2,631 in 2002, \$6,948 in 2012) + Part B Premium	100% of Premium (\$2,631 in 2002, \$6,948 in 2012) + \$1500 Maximum Out-of-Pocket + Part B Premium
Age at Death									
80	\$70,000	\$120,000	\$137,000	\$183,000	\$347,000	\$364,000	\$74,000	\$128,000	\$146,000
85	98,000	169,000	190,000	314,000	601,000	622,000	100,000	173,000	194,000
90	130,000	225,000	249,000	518,000	1,000,000	1,024,000	128,000	219,000	243,000
95	166,000	288,000	315,000	835,000	1,626,000	1,653,000	157,000	269,000	295,000
100	207,000	361,000	390,000	1,334,000	2,614,000	2,642,000	187,000	321,000	349,000

Source: EBRI estimates based on various assumptions.

^a Benefits package for the \$2,631 premium in 2002 was developed by PricewaterhouseCoopers LLP on behalf of the Mellon College Retirement Project. It contains the following benefits:

Major Medical Benefit: \$150 annual preventive care benefit, \$250 deductible, 80% coinsurance.

Outpatient Prescription Drug Benefit: \$50 deductible, 70% coinsurance.

Maximum out-of-pocket: \$1,500 (medical and prescription drug combined).

^b Medicare Part B premiums are from cms.hhs.gov/publications/trusteesreport/2002/tabiv1.asp. In years 2012 and beyond we assume an annual increase of 5.5 percent.

^c All estimates assume a 4 percent after-tax rate of return on investments.

^d A grading down to 5% is currently the most common assumption in corporate disclosures under FAS 106 guidelines. See Deloitte and Touche (2001).

of an entire group of individuals, they may understate the application rejection rate among early retirees who are, on average, older and less healthy than the general population.

Retirement at Age 65 in 2013

Persons age 55 in 2003 who planned to work until they reached age 65 in 2013 would face much higher health insurance premiums. The same employment-based benefits package used in Figure 9 that cost \$2,631 in 2002 would cost \$5,176 in 2012 if insurance premium increases averaged 7 percent over the next 10 years; it would cost \$9,754 in 2012 if insurance premiums increased 14 percent; and it would cost \$6,948 in 2012 if insurance premiums were increasing 14 percent in 2003 but phased down to 5 percent by 2013. (Again, premium increases are the combined effect of Medicare Part B premiums, Medigap premiums, and the age effect.) In order to pay premiums only, a 65-year-old with a life expectancy of age 80 would have had to save \$62,000 in 2003 (Figure 9), but a 65-year-old in 2013 will need to

have saved \$120,000, as shown in Figure 12, if premiums increased 7 percent per year. A person age 65 in 2013 with a life expectancy of age 90 would need to have saved \$225,000 just to pay their premiums.

If health insurance premiums increased 14 percent annually between 2003 and 2013, persons age 65 in 2013 would need to have saved between \$347,000 and \$2.6 million to cover just their insurance premiums, depending upon their age at the time of death.

The estimates in Figure 13 show the costs of Medigap coverage for a 55-year-old in 2003 when he or she reaches age 65 in 2013. In order to pay premiums only, a 65-year-old with a life expectancy of age 80 would have had to save \$82,000 in 2003 to cover premiums (Figure 10), but a 65-year-old in 2013 will need to have saved \$158,000, as shown in Figure 13, if premiums increased 7 percent per year. If premiums increased 14 percent between 2003 and 2013, persons age 65 in 2013 will need to have saved between \$471,000 and \$3.6 million to cover their insurance premiums, depending upon their age at the time of death.

Figure 13

**SAVINGS NEEDED FOR MEDIGAP COVERAGE FOR RETIREMENT AT AGE 65 IN 2013
(INCLUDES PREMIUM,^a MEDICARE PART B PREMIUM,^b AND OUT-OF-POCKET EXPENSES^c)^d**

Annual Increase in Premiums									
	Illustration #1 7% (includes 3% health inflation + 4% age effect)			Illustration #2 14% (includes 10% health inflation + 4% age effect)			Illustration #3 14% Grading Down to 5% Over 10 Years (includes 4% age effect)		
	50% of Premium (\$1,818 in 2002, \$3,575 in 2012) + Part B Premium	100% of Premium (\$3,635 in 2002, \$7,151 in 2012) + Part B Premium	100% of Premium (\$3,635 in 2002, \$7,151 in 2012) + Maximum Out-of-Pocket + Part B Premium	50% of Premium (\$1,818 in 2002, \$6,738 in 2012) + Part B Premium	100% of Premium (\$3,635 in 2002, \$13,476 in 2012) + Part B Premium	100% of Premium (\$3,635 in 2002, \$13,476 in 2012) + Maximum Out-of-Pocket + Part B Premium	50% of Premium (\$1,818 in 2002, \$4,489 in 2012) + Part B Premium	100% of Premium (\$3,635 in 2002, \$8,977 in 2012) + Part B Premium	100% of Premium (\$3,635 in 2002, \$8,977 in 2012) + Maximum Out-of-Pocket + Part B Premium
Age at Death									
80	\$89,000	\$158,000	\$256,000	\$246,000	\$471,000	\$694,000	\$95,000	\$169,000	\$243,000
85	125,000	223,000	319,000	424,000	820,000	1,212,000	128,000	228,000	327,000
90	166,000	297,000	426,000	702,000	1,367,000	2,027,000	163,000	289,000	415,000
95	212,000	382,000	549,000	1,137,000	2,230,000	3,312,000	199,000	354,000	508,000
100	266,000	479,000	689,000	1,822,000	3,591,000	5,343,000	238,000	423,000	606,000

Source: EBRI estimates based on various assumptions.

^a Benefits package for a \$3,635 premium for Medigap Plan J in Florida priced at www.aarphealthcare.com for a 65-year-old in 2002 living in Florida, after all possible discounts are taken. 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 3 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, Emergency Foreign Travel, At-Home Recovery, Preventive Care and Extended Prescription Drug Coverage (\$3,000 limit)

^b Medicare Part B premiums are from cms.hhs.gov/publications/trusteesreport/2002/tabiv1.asp. In years 2012 and beyond we assume an annual increase of 5.5 percent.

^c Based on estimates from the 1999 Medical Expenditure Panel Survey, we use \$1,100 for average out-of-pocket expenses for prescription drugs and \$700 as the average out-of-pocket expenses for other health care services for people that used health care services.

^d All estimates assume a 4 percent after-tax rate of return on investments.

A Long-Run 14 Percent Cost Increase?

As mentioned above, health inflation of 14 percent (whether or not it includes the 4 percent aging effect) is not likely to continue in the long-run. However, during the late 1980s and early 1990s, insurance premiums increased 14 percent or more in many years. Today, many employment-based plans are experiencing double-digit insurance premium increases, and benefit consultants are predicting that health insurance premiums will increase 15 percent this year. Without public policy or private market changes, there is no reason to expect this trend not to continue until changes take place. **Irrespective of the inflation rate, these illustrations show the significant savings potential for individuals who have access to retiree health benefits through an employment-based group health plan, as opposed to purchasing insurance in the individual market.** This is true even if retirees are asked by employers or unions to pay the full cost of their insurance.

Policy Options to Reduce the Effective Cost of Retiree Health

Retiree expenses for health insurance and out-of-pocket health care costs are treated differently from

active worker expenses and employer expenses. Health insurance premiums paid by employers are deductible as a business expense, and are excluded, without limit, from workers' taxable income.³⁵ The self-employed, partners and Subchapter S owners are also able to exclude the full cost of health insurance from their taxable income. Most workers are able to pay their contributions toward health insurance with pretax dollars and if their employer sponsors a flexible spending account (FSA), they are able to pay some health care expenses with pretax dollars.

Figure 14
**SAVINGS NEEDED FOR EMPLOYMENT-BASED HEALTH BENEFITS FOR RETIREMENT AT AGE 65 IN 2003
 (INCLUDES PREMIUM,^a TAX DEDUCTIBILITY OF PREMIUM, AND TAX-FREE BUILDUP^b)^c**

	Annual Increase in Premiums								
	Illustration #1 7%			Illustration #2 14%			Illustration #3 14% Grading Down to 5% Over 10 Years ^d		
	100% of Premium (\$2,631) & No Tax Deductibility	100% of Premium (\$2,631), Tax Deductibility of Premium	100% of Premium (\$2,631), Tax Deductibility of Premium, Tax-Free Build Up	100% of Premium (\$2,631) & No Tax Deductibility	100% of Premium (\$2,631) & Tax Deductibility of Premium	100% of Premium (\$2,631), Tax Deductibility of Premium, Tax-Free Build Up	100% of Premium (\$2,631) & No Tax Deductibility	100% of Premium (\$2,631) & Tax Deductibility of Premium	100% of Premium (\$2,631), Tax Deductibility of Premium, Tax-Free Build Up
Life Expectancy									
80	\$62,000	\$54,000	\$50,000	\$100,000	\$85,000	\$79,000	\$73,000	\$62,000	\$58,000
85	88,000	75,000	69,000	171,000	145,000	132,000	100,000	85,000	78,000
90	117,000	99,000	90,000	281,000	239,000	211,000	128,000	109,000	99,000
95	150,000	127,000	113,000	453,000	385,000	331,000	158,000	135,000	120,000
100	188,000	159,000	138,000	722,000	614,000	513,000	190,000	161,000	141,000

Source: EBRI estimates based on various assumptions.

^a Benefits package for the \$2,631 premium was developed by PricewaterhouseCoopers LLP on behalf of the Mellon College Retirement Project. It contains the following benefits:

Major Medical Benefit: \$150 annual preventive care benefit, \$250 deductible, 80% coinsurance.

Outpatient Prescription Drug Benefit: \$50 deductible, 70% coinsurance.

Maximum out-of-pocket: \$1,500 (medical and prescription drug combined).

^b A marginal tax rate of 15 percent in making these estimates was used.

^c All estimates assume a 4 percent after-tax rate of return on investments and include Medicare Part B Premiums.

^d A grading down to 5% is currently the most common assumption in corporate disclosures under FAS 106 guidelines. See Deloitte and Touche (2001).

Retirees who do pay all or part of their contribution toward health insurance and/or have out-of-pocket expenses may be able to deduct a portion of those expenses from their taxable income. Total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income (AGI), and only the amount that exceeds 7.5 percent of AGI is deductible. However, for the most part, retiree contributions to health insurance and payments for out-of-pocket expenses must be made on an after-tax basis. While the portion that an employer contributes to retiree health benefits is not included in the taxable income of the retiree, the retiree contribution must be made on an after-tax basis.

As employers drop retiree health benefits or require retirees to pay a greater share of their cost, especially as they move toward access-only plans, policymakers may examine ways in which to use the tax code to make health care in retirement more affordable for Americans. There are a number of options that policymakers may consider to try to “level the playing field” between employer expenses, active worker expenses, and retiree expenses for health insurance and out-of-pocket expenses. Options include the following:

- Allowing retirees to exclude their contributions toward health insurance from taxable income.
- Allowing retirees to have an FSA that they could use to pay out-of-pocket expenses.

These two options would allow health insurance expenses and out-of-pocket expenses to be treated the same way for active workers and retirees. The savings would vary for retirees, depending upon their marginal tax rate and the amount of money they put into the FSA at the beginning of the year. Figure 14 shows the savings required under three scenarios: no tax deductibility, tax deductibility of premiums only, and tax deductibility of premiums and tax-free buildup.³⁶ This figure includes only estimates of the premium for employment-based coverage. Assuming that individuals will take the tax savings and “reinvest” them by using them to offset the cost in future years means that individuals will need to have saved less, especially as age at the time of death increases. For example, a person paying federal tax at a 15 percent marginal rate expected to live until age 85 would need to save \$75,000 instead of \$88,000 by the time he or she is age 65 if premiums for health insurance in retirement were excluded from income and insurance premiums were increasing 7 percent per year (Figure 14).³⁷

Figure 14 also includes an illustration of the savings needed if the lump sum that an individual had at age 65 for retiree health benefits was then allowed to accumulate tax-free. In this case, for a person in a 15 percent tax bracket, a 4 percent after tax rate of return is equivalent to a 4.71 percent pretax rate of return, so the savings needed would be even lower. For example, a person expected to live until age 85 would need to save \$69,000 instead of \$88,000 by the time he or she is age 65 if insurance premiums were increasing 7 percent per year. There may also be additional tax savings if accumulations and distributions were not subject to state or local income taxes.

There are a number of other options policymakers may also consider. They might consider allowing tax-free distributions from 401(k) plans and other retirement accounts for either health insurance premiums or out-of-pocket expenses. This should be more beneficial to retirees than allowing them to deduct the cost of health insurance and out-of-pocket expenses from their taxable income. Currently, contributions to these accounts are made with pretax dollars and are able to accumulate tax-deferred. It is at the point when a retiree draws funds from the account that distributions are counted as taxable income. If persons are able to withdraw money tax free to purchase health insurance, they are benefiting from having made the contribution when they may have been in a higher tax bracket and they are also benefiting from the tax-free accumulation of capital appreciation.³⁸

Policymakers may also consider allowing individuals to prefund retiree health benefits through so-called retiree medical accounts (RMAs) or health reimbursement accounts (HRAs). Policymakers could allow individuals either to contribute to an employment-based RMA on a pretax basis or set up their own RMA with contributions to it dedicated toward paying for health insurance premiums and out-of-pocket expenses during retirement. This would allow employee money to be used

the same way employer money can be used under the tax code. It may also give individuals an incentive to start saving early for retiree medical expenses if they understood that contributions would be made on a pretax basis, capital appreciation would not be subject to income tax, and distributions for qualified medical expenses could be taken tax-free.

Implications of Access-Only Plans

As mentioned above, many employers have moved or are moving all of their future retirees to access-only

plans. Under these plans, employers allow retirees to buy into the health plan, but do not provide retirees with a subsidy. Because retirees must pay the full cost of these plans, and premiums are often based on the group of retirees (as opposed to mixing retirees with active workers), retirees with costly health conditions will be more likely to take these plans than healthy retirees. In fact, the same phenomenon (known as “adverse selection”) already occurs with COBRA benefits (continuation of access to a former employers’ health plan under certain circumstances). Persons at high risk for needing health care services are more likely to pay for COBRA benefits than people in average health. As a result, COBRA beneficiaries cost roughly 50 percent more to insure than active employees (Huth, 2000). Over time, access-only retiree health plans may be more likely to attract people with health conditions than healthy individuals. This will inevitably drive up the cost of these plans, making it more difficult for individuals to afford them, which would result in an anti-selection “death spiral.”³⁹

Conclusion

The news media have widely reported that catastrophic medical costs are a significant

factor in personal bankruptcies. They have also spent years reporting on the impact on retirees of health costs when retirees find themselves ill. Few, however, have focused on the need for individuals to save for meeting anticipated health costs in retirement, or the amount that needs to be saved. And, when work has been done, it has often used average life expectancy as the basis for calculations, thus understating the need for at least half of all individuals. Most retirees have only had Medicare as a source of health protection since 1964, plus what they purchase on top of it. Even among unions and large employers, provision of Medicare supplements has touched only about one-third of retirees.

FASB issued initial accounting guidance in 1982 for employers that offered retiree health benefits and followed with FAS 106 in 1990. These actions triggered substantial changes to retiree health benefits, and have been compounded by continued health care cost increases. Employers grapple with federal limits affecting their ability to prefund retiree health benefits.⁴⁰ Over the past decade, these forces have resulted in a variety of ways that these benefits have been cut back: Some employers have capped their spending on retiree health benefits. Some have required employees to meet age and service requirements before becoming eligible for retiree health benefits. Some moved to “defined contribution” health benefits.⁴¹ Still others completely dropped retiree health benefits. The overall impact of these changes means that even fewer workers will be eligible for retiree health benefits in the future and when they are eligible it will cost them more to participate (although a minority of workers would have been eligible for retiree health

benefits even without these changes). It may also mean that retirement behavior patterns will change as employees nearing retirement age postpone their decision to retire upon learning that without a job, they may not be able to obtain affordable health insurance coverage. As mentioned, the labor force participation of men ages 60–64 has been increasing since the mid-1990s, and workers who do not expect to have retiree health benefits are more likely than those who expect to receive retiree health benefits to plan to work until they qualify for Medicare benefits (Fronstin, 1999). While the percentage of retirees ages 55–64 with retiree health benefits was unchanged at roughly 37 percent between 1994 and 1999 (Fronstin, 2001), it is possible that the number would have declined had workers not delayed retirement when retiree health benefits became unavailable or unaffordable.⁴²

This *Issue Brief* has illustrated the amounts of money a person may need to save by his or her date of retirement in order to pay for insurance premiums and out-of-pocket costs in retirement. The estimates vary with assumptions on insurance premium levels, growth of insurance premiums over time, estimated age at time of death, rates of return on investments, out-of-pocket expenses, and retirement age. These are *important factors* in determining savings needs and, just as important, they are *uncertain factors*. The analysis also shows how estimated savings needs can vary based on tax code changes that affect individuals funding for insurance premiums.

The illustrations provided in this report are a first step toward understanding the amount of money that will be needed to pay for insurance premiums and out-of-pocket expenses in retirement, and how they vary depending upon where insurance is purchased, what is covered, any automatic age increase in premium, and other factors. The illustrations presented from the model

CURRENT WORKERS' CHECK LIST

- Look into what kind of retiree health benefits or access are provided by your employer or your spouse's employer. If retiree health benefits are available, find out how much they cost, and factor in preretirement tax-favored savings opportunities that may be provided.
- Estimate the amount of medical care you use today and factor this into savings projections based on whether you are an average user or a high user.
- If you plan to retire before age 65, consider how pre-existing conditions may affect the cost of health insurance or exclusions from coverage.
- Visit the Internet and do a life expectancy/estimated year of death calculation.
- Take life expectancy/year of death estimate and compare it to the tables in this *Issue Brief* to get an estimate of how much you might need to save for medical expenses.
- If married, do a life expectancy estimate for your spouse and find a second savings number in the tables.
- Focus on how long you may need to continue working in order to save enough to pay your medical expenses.
- Visit www.ourhealthbenefits.org on the Internet and begin to do your health and wellness planning that could serve to hold down your health costs. The site also provides aid in finding health insurance.
- Go to www.choosetosave.org and use both the *Retiree Health Savings Calculator*TM and the *Ballpark Estimate Retirement Planning Worksheet*[®] to estimate your total retirement savings needs and how much you need to start saving now (don't forget to consider possible long-term care expenses).⁴⁴

used in this report may underestimate health care expenses in retirement for many. Expenses for long-term care, which are perhaps the biggest expense many retirees will incur, are not included in this discussion. Services (such as nursing home care) typically cost \$50,000 or more per year, and in some geographic regions can be considerably higher (U.S. General Accounting Office, 2002). The estimates are also for individuals; married couples would need to save roughly double the individual amount, depending upon the retirement age and age at death. Other EBRI studies have examined in more detail expected retirement income with expected expenses for health and housing in retirement.⁴³

Policymakers may address the erosion of retiree health benefits in a number of ways, including:

- a) Expanding Medicare or other public programs to cover more retiree health expenses.
 - b) Attempting to level the playing field with respect to the tax treatment of health insurance and health care expenses among employers, active workers, and retirees.
 - c) Mandating employers to make or maintain commitments to provide retiree health benefits.
- d) Undertaking public education campaigns to make people aware of the health insurance costs they are likely to face in retirement and the need to personally save for them.

At the same time, they may consider other ways to help retirees obtain more affordable health insurance and health care in retirement. Options that have already been discussed publicly include lowering the Medicare eligibility age, allowing uninsured retirees to buy into Medicare, adding a Medicare prescription drug benefit, adding a maximum out-of-pocket limit to the traditional Medicare program, and extending COBRA coverage for retirees.

With or without policy changes, it is clear from these findings that few retirees will have access to subsidized retiree health benefits. Even if policymakers take concrete steps for government action, if workers hope to afford a comfortable retirement they will have to start saving early and take into account reasonable estimates of their personal life expectancy in order to understand the financial resources that will be needed to pay for health insurance and health care expenses in retirement (see Box 3).

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Endnotes

¹ See www.ssa.gov/statistics/incpop55/2000/index.html (last reviewed

December 2002).

² Medicare is the federal health care insurance program for the elderly and disabled, enacted as part of the Social Security program. Social Security, enacted by Congress in 1935, is the federal retirement system that requires the current working generation to contribute to the support of older, retired workers.

³ Since 1973, FASB has been the designated private-sector organization for establishing standards of financial accounting and reporting. Those standards govern the preparation of financial reports and are officially recognized by the Securities and Exchange Commission and the American Institute of Certified Public Accountants. For more information, see FASB's Web site at www.fasb.org/ (last reviewed January 2003).

⁴ See Employee Benefit Research Institute (1988) for a study that analyzed an early FASB draft proposal that formed the basis of FAS 106. The study illustrated a range of liabilities for three hypothetical companies and indicated the annual expenditures required to finance the benefits during the covered workers' terms of employment.

⁵ The public sector is set to have similar accounting requirements under the Government Accounting Standards Board. However, issuance of the final standards is currently delayed until 2004, with implementation now expected sometime between 2006 and 2009.

⁶ Employers are currently dealing with similar issues for active worker health benefits. Because of the rising cost of providing health benefits, many employers have either made or are considering making changes to their benefits. See Fronstin (2002a) for more information.

⁷ Nearly 18 percent of early retirees are uninsured, while 12 percent purchased health insurance directly from an insurer, 19 percent were covered by someone else's employment-based plan, and 26 percent were covered by a public program.

⁸ The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains a group-to-individual portability provision, which guarantees that a person's pre-existing conditions will not be excluded from coverage. The individual must have exhausted COBRA coverage, if available. Premiums for HIPAA plans are not regulated at the federal level, though they may be regulated at the state level.

⁹ The labor force participation rate among older men is increasing. According to statistics from the Bureau of Labor Statistics, 57 percent of men ages 60–64 were participating in the labor force in 2001, up from 53 percent in 1994.

¹⁰ www.meps.ahrq.gov/MEPSDATA/ic/2000/Tables_II/TIIA2e.pdf (last reviewed December 2002).

¹¹ Total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of adjusted gross income (AGI), and only the amount that exceeds 7.5 percent of AGI is deductible.

¹² Currently, surveys of financial planners indicate that most clients have over \$100,000 in income, which accounts for less than 5 percent of all workers.

¹³ The estimates in this report do not include long-term care expenses or premiums for long-term care insurance.

¹⁴ EBRI estimates from the 1999 Medical Expenditure Panel Survey.

¹⁵ www.meps.ahrq.gov/MEPSDATA/ic/1997/Tables_II/TIIA2e.pdf (last reviewed December 2002).

¹⁶ The offer rates are much higher in Figure 2 than in Figure 1 because Figure 1 includes employers with 500–999 employees, while Figure 2 includes employers with mostly 1,000 or more employees.

¹⁷ The apparent decline between 1999 and 2000 in the percentage of employers requiring retirees to pay

the full cost of retiree health benefits is not statistically significant. In addition, the survey used in this chart includes public-sector employers and nonprofit sector employers, which are more likely than private-sector for-profit employers to require retirees to pay the full cost of retiree health benefits.

¹⁸ Calculated from U.S. General Accounting Office (2001) and William M. Mercer (2001).

¹⁹ Proposals include adding prescription drugs to Medicare, prohibiting employers from dropping or cutting back on retiree health benefits, expanding COBRA coverage, and allowing a buy-in to Medicare. See Fronstin (2001) for more details on these proposals.

²⁰ Medicare covers some disabled people below age 65 and also covers persons with end-stage renal disease.

²¹ The premium was derived by PricewaterhouseCoopers for the Mellon College Retirement Project. More information about the project can be found at www.union.edu/PUBLIC/MELLPROJ/ (last reviewed January 2003).

²² This report does not consider premiums for family coverage.

²³ Warren Buffet predicts that long-term stock returns will average 7 percent, as cited in the March 18, 2002, issue of *Pensions & Investments*.

²⁴ The Centers for Medicare & Medicaid Services is projecting 6.4 percent per person increases in health spending between 2000 and 2010 (Heffler, et al, 2002).

²⁵ www.ssa.gov/OACT/TRTR02V_demographic.html#90100 (last reviewed December 2002).

²⁶ Last reviewed January 2003. These sites 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.

²⁷ See Box 2 for a listing of various life expectancy calculators.

²⁸ Companies often select a series of medical cost trend rates and grade down over time to one level. In a 2001 survey, Deloitte and Touche found that 44 percent of companies used an ultimate trend rate of 5 percent in calculating their FAS 106 liability.

²⁹ This report does not focus on premiums and out-of-pocket expenses for persons choosing a Medicare+Choice plan.

³⁰ These premiums were found on www.aarphealthcare.com (last reviewed December 2002).

³¹ Early retirees can also continue to be covered by employment-based health benefits under COBRA; however, this coverage is available only for 18 months.

³² McDevit et al. (2002) reports a premium of \$5,300 for early retirees in 2001, which is \$700 higher than the listed premium for 2002.

³³ The U.S. General Accounting Office (1999) found that insurance carriers in their survey in states using HIPAA standards would charge a HIPAA-eligible with a specified health condition a higher-than-standard rate, and that nearly half of these carriers would charge 300–464 percent of the standard rate.

³⁴ Out-of-pocket expenses for prescription drug costs were set randomly at \$4,000 for purposes of this illustration. If \$2,000 had been chosen instead, the estimates shown in Figure 10 would be roughly \$17,000 lower for the columns with prescription drug costs.

³⁵ One exception is in some cases to highly compensated employees (HCEs) when the benefits discriminate in favor of HCEs in non-fully insured plans.

³⁶ The tax deductibility of FSAs is not addressed in this model.

³⁷ A 15 percent marginal tax rate is assumed in deriving these estimates because many retirees will be in a lower tax bracket when they retire, compared with when they were working.

³⁸ Some employers have used a dual-purpose defined contribution plan to allow workers to accumulate pretax dollars for tax-free use in paying for retiree health, but they require advance election that specifies this is how the dollars will be used. Thus, for those who have already been contributing for many years or are near retirement, a dual-purpose plan established at this time would not be of assistance.

³⁹ The anti-selection death spiral occurs when the healthiest enrollees in a plan continue over time to drop out of the plan, leaving only the highest of high users in the plan. At some point, the plan will have to raise premiums to a level beyond which anyone can afford.

⁴⁰ More detailed information regarding the timing of FAS 106, other FASB statements, and public policy affecting retiree health benefits can be found in McDevit et al. (2002), pp: 10–12.

⁴¹ See Fronstin (2001).

⁴² The finding that current retirees have not experienced a decline in coverage may be due to the fact that the courts have ruled that employers have a right to terminate or amend retiree health benefits only if they have proved that such a right has been reserved or stated in specific language and on a widely known basis (Davis, 1991).

⁴³ See VanDerhei and Copeland (2002a and 2002b).

⁴⁴ These two Web sites are part of EBRI health- and retirement-related education programs: The Consumer Health Education Council (CHEC) and the Choose to Save® program.

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