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NOTES

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Executive Summary:

The Impact of Immigration on Health Insurance Coverage in the United States, 1994–2006

- ***Research on immigration and the uninsured:*** Research is mixed on how immigration has contributed to the increase in the uninsured population: One study concluded that immigrants who arrived between 1994–1998 accounted for the majority of the growth in the uninsured population, but a similar study concluded that they are not a significant reason for the growth of the uninsured.
- ***Federal law contributes to uninsured immigrants:*** The relative lack of employment-based health coverage for immigrants is compounded by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which imposed a five-year ban on receipt of health and other public programs by most newly arrived legal immigrants.
- ***Statistics on uninsured immigrants:*** More than 12 million immigrants in the United States were uninsured in 2006, accounting for almost 27 percent of all uninsured individuals in the country. Immigrants accounted for 43 percent of the increase in the uninsured between 1994–1998, but 92 percent of the growth between 1998–2003, presumably because of PRWORA restrictions. Over the entire 1994–2006 period, immigrants accounted for 55 percent of the increase in the uninsured. The ranks of the uninsured are likely to grow as immigration continues to increase.

Saving for Health Care in Retirement: The Use of Health Savings Accounts

- ***Use of HSAs:*** Health savings accounts (HSAs) are tax-favored individual accounts that can be used to cover health insurance premiums and out-of-pocket expenses for health care services, and a possible vehicle for funding future retiree health care costs.
- ***HSA potential is limited:*** Statutory contribution limits make it unlikely that these accounts will play more than a minor part in savings for health care costs in retirement. The maximum savings that can be accumulated in an HSA will be far from sufficient to fully cover the savings needed in retirement for insurance premiums and out-of-pocket expenses, especially since individuals can (and may need to) use HSA assets to pay for health care services during their working years or to pay COBRA premiums and insurance premiums during periods of unemployment.

The Impact of Immigration on Health Insurance Coverage in the United States, 1994–2006

by Paul Fronstin, EBRI

Introduction

During nearly every year between 1994 and 2006, the number and percentage of individuals in the United States without health insurance coverage has been increasing. In 2006, 46.5 million persons under age 65 (17.9 percent of the nonelderly population) were uninsured, up from 36.5 million in 1994 (15.9 percent of the nonelderly population).[1]

During the 1990s, the decline in health insurance coverage in the United States was mainly due to an erosion of public sources of health insurance. The percentage of nonelderly individuals covered by Medicaid declined from 12.7 percent in 1994 to 10.5 percent in 1999. The erosion was in large part the result of former welfare recipients entering the work force. Similarly, the percentage of nonelderly persons covered by Tricare or CHAMPVA[2] declined from 3.8 percent to 2.8 percent between 1994 and 2000 in large part due to downsizing in the military. In contrast to the decline in public coverage, the percentage of persons covered by employment-based health benefits *increased* between 1994 and 1999.

The 2000–2003 period saw a reversal of the earlier trend as the weak economy and the rising cost of providing health benefits caused a decline in the percentage of persons covered by employment-based health plans. The percentage of the nonelderly population with employment-based health benefits decreased from 68.4 percent in 2000 to 62.2 percent in 2006. Expansions in the percentage of the population covered by public programs, particularly Medicaid and S-CHIP, to some degree offset the erosion in employment-based health benefits. Between 1999 and 2004, the percentage of nonelderly persons with some form of public coverage increased, and it has been roughly constant since then. However, the expansion in public coverage was not large enough to fully offset the decline in employment-based health benefits. As a result, the percentage of nonelderly population without health insurance coverage increased.

Numerous reasons have been cited for the increase in the uninsured population. The combination of the cost of providing health benefits, which has been rising faster than overall worker wages,[3] and the weak economy has caused fewer small employers to offer health benefits and fewer workers to be covered.[4] Between 2000 and 2007, the percentage of employers with three–199 workers offering health benefits declined from 68 percent to 59 percent, although employers with three–nine workers accounted for most of the decline.[5] In addition, the percentage of workers taking health benefits when they were offered declined from 87.9 percent in 1988 to 83.5 percent in 2005.[6]

Structural changes in the economy have also contributed to the decline in employment-based health benefits. The movement of workers from the manufacturing sector and the decline of unionization have both contributed to the decline in the percentage of individuals with employment-based health benefits.[7]

One factor that has contributed to the increase in the uninsured population is immigration, which has been the focus of previous research. Earlier studies have found that immigrants are disproportionately employed in low-wage jobs, in small firms, and in service or trade occupations, jobs that are less likely to offer health benefits.[8] The relative lack of employment-based coverage is compounded by the fact that the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 imposed a five-year ban on receipt of health and other public programs by most newly arrived legal immigrants. Although these restrictions were subsequently loosened a bit, the fact remains that fewer public benefits were available to recent immigrants during the latter part of this decade than in the former. And even after this five-year ban expires, immigrants may continue to be ineligible for public programs as a result of rules that attribute the income of an immigrant's sponsor to the immigrant.[9]

Previous research has examined the impact of increased immigration on the uninsured in the United States. One study concluded that immigrants who arrived between 1994 and 1998 accounted for the

majority of the growth in the uninsured population since 1993.[10] However, a similar study concluded that, although uninsured rates among recent immigrants are high, this is not a significant reason for the growth in the number of uninsured.[11] More recent studies have found that the time period examined has a significant impact on the estimates.[12]

This article analyzes the issue of immigration and health insurance coverage in the United States. It is important to examine the health insurance status of immigrants, as growth in the immigrant population can drive up the uninsured. Between 1994 and 2006, immigrants accounted for an increasing portion of the nonelderly population, rising from 8.8 percent to 12.8 percent. Data from the Census Bureau's Current Population Survey (CPS) are used to examine health insurance and immigration.[13] The article first examines the status of health insurance coverage among immigrants compared with nonimmigrants. It then examines the impact of immigration over the period 1994–2006, a much longer period than was covered in previous research. The legal status of immigrants is not discussed, as relevant data are not included in the CPS; illegal immigrants probably are included in the analysis, but cannot be identified as such.

Immigrants and the Uninsured Population

Native-born Americans account for most of the uninsured population in the United States. In 2006, 34.1 million (or 73.4 percent) of the 46.5 million individuals without health insurance were native-born Americans (Figure 1). Overall, foreign-born individuals accounted for 26.6 percent of the uninsured (or 12.3 million persons); slightly over 2 million (or 5 percent) have become citizens of the United States, while 10 million (or 21.6 percent) of the uninsured were foreign-born persons who were not U.S. citizens.

Immigrants are much more likely to be uninsured than native-born citizens. More than 46 percent of foreign-born noncitizens were uninsured in 2006 (Figure 2). This compares with 19.9 percent uninsured among foreign-born individuals who have become U.S. citizens, and 15 percent uninsured among native-born persons.

Whether an immigrant is uninsured is highly correlated with his or her length of time in the United States. Just over 27 percent of foreign-born noncitizens who entered the United States before 1970 were uninsured in 2006 (Figure 3). This compares with 45.5 percent uninsured among foreign-born noncitizens who entered the United States during the 1980s and 49 percent uninsured among foreign-born noncitizens who entered the country during 2000–2006. The likelihood of being uninsured is also correlated with the length of time foreign-born U.S. citizens have been in the United States, but they are about one-half as likely to be uninsured, when controlling for length of time in the United States, compared with foreign-born noncitizens.

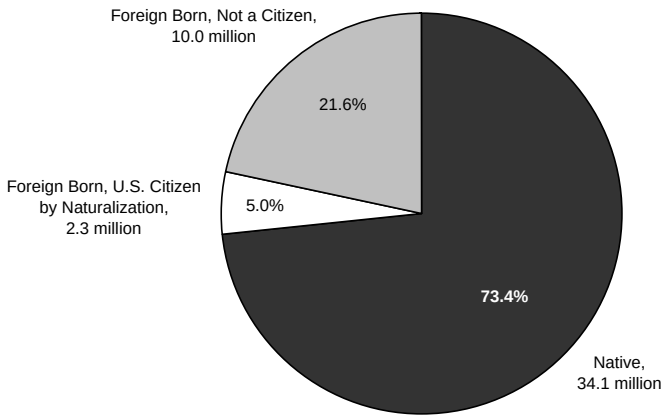
The majority of the uninsured foreign-born noncitizen population is comprised of recent immigrants. Nearly one-half (46 percent) of uninsured noncitizens entered the United States during 2000–2006, while another 36 percent entered during the 1990s (Figure 4). In contrast, only 7 percent of uninsured foreign-born, naturalized citizens entered the United States during 2000–2006. About one-third entered during 1990–1999, while the remainder entered prior to 1990.

The uninsured immigrant population is also highly concentrated in a few states. Based on a three-year average across 2004–2006, it was found that slightly more than one-quarter (27.1 percent) of uninsured immigrants in the United States reside in California (Figure 5). Fourteen percent of uninsured immigrants are in Texas; 9.9 percent reside in Florida; and 7.7 percent reside in New York. Overall, well over half (58.8 percent) of uninsured immigrants reside in California, Texas, Florida, or New York. These four states also have a disproportionate number of uninsured generally (21 percent in California, 27 percent in Texas, 24 percent in Florida, and 15 percent in New York), accounting for 41 percent of the nonelderly uninsured population, and immigrants account for a disproportionate share of the uninsured in these states.

Immigrants and Sources of Health Insurance

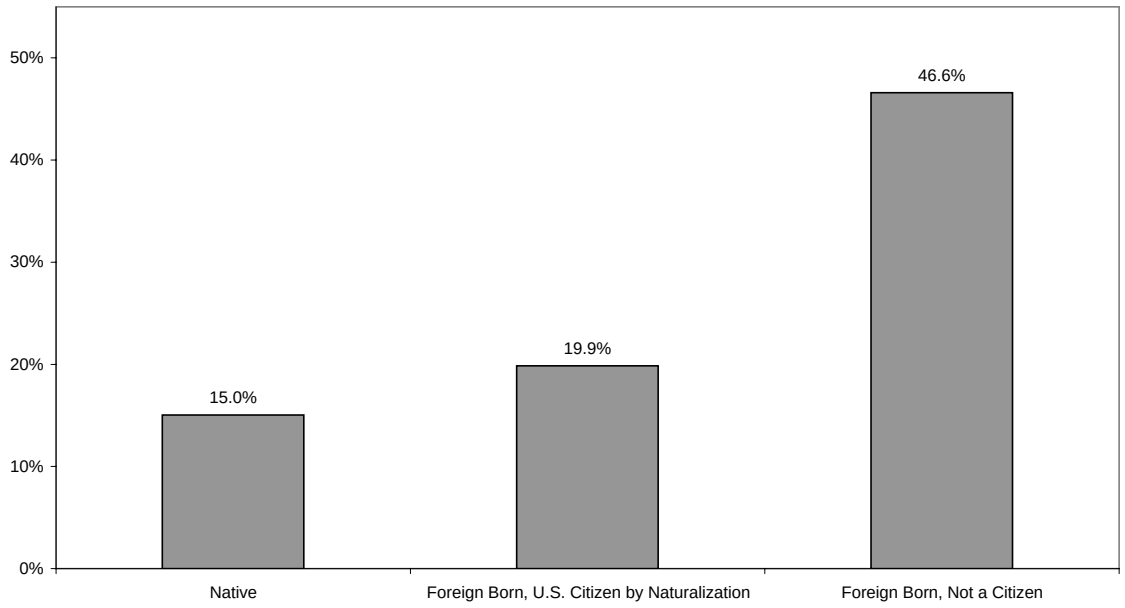
Despite the fact that recent immigrants are banned from receiving benefits under public assistance programs for five years after entering the United States under the provisions of PRWORA (except for native children with foreign-born parents), whether or not immigrants and nonimmigrants have coverage from *employment-based* health benefits is generally a much larger factor than whether they have coverage from *public* programs.

Figure 1
Distribution of Uninsured Population, by Immigration Status, U.S. Population Under Age 65, 2006



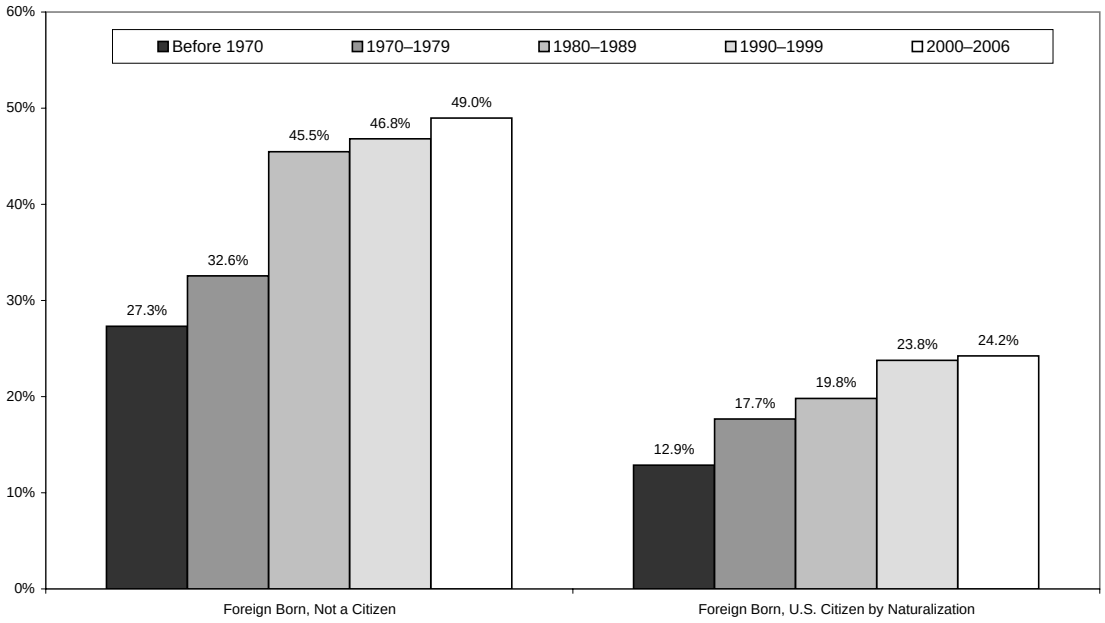
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2007 Supplement.

Figure 2
Likelihood of Being Uninsured, by Immigration Status, U.S. Population Under Age 65, 2006



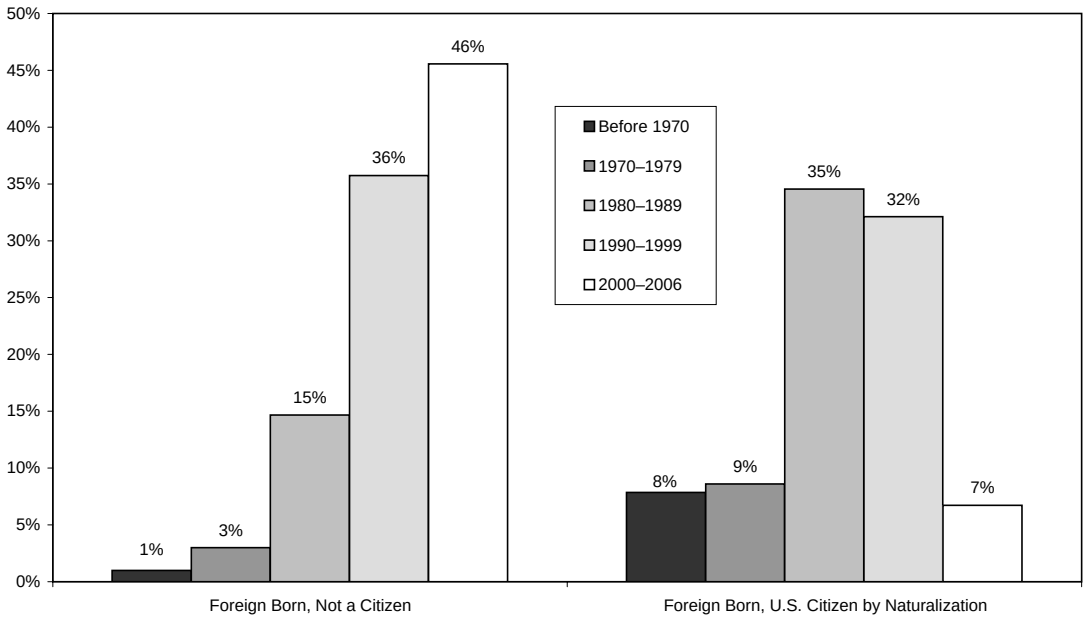
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2007 Supplement.

Figure 3
Likelihood of Being Uninsured, by Year Entered U.S. and Immigration Status, U.S. Population Under Age 65, 2006



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2007 Supplement.

Figure 4
Distribution of Nonelderly Immigrant Uninsured Population, by Year Entered United States and Immigration Status, U.S. Population Under Age 65, 2006



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2007 supplement.

In 2006, 64.3 percent of native-born and 64 percent of U.S. citizens who were foreign-born were covered by employment-based health benefits, whereas 39.2 percent of foreign-born noncitizens had employment-based coverage (Figure 6).

With respect to public coverage, however, 13.9 percent of native-born were covered by Medicaid or S-CHIP, compared with 10.8 percent of foreign-born noncitizens and 9 percent of U.S. citizens who were foreign-born.

The Uninsured, 1994–2006

While the uninsured population is still dominated by native-born Americans, it is becoming increasingly comprised of immigrants. In 1994, immigrants accounted for 18.8 percent of the uninsured population, while native-born Americans accounted for 81.2 percent (Figure 7). In contrast, by 2006, immigrants accounted for 26.6 percent of the uninsured population, while native-born Americans accounted for 73.4 percent.

The likelihood of being uninsured also increased for both native-born Americans and immigrants between 1994 and 2006. In 1994, 34 percent of immigrants were uninsured, and this grew to 37.2 percent by 2006, a 9 percent increase (Figure 8). In contrast, the uninsured rate among native-born Americans grew from 14.1 percent in 1994 to 15 percent in 2006, a 6 percent increase.

The uninsured immigrant population increased from 6.9 million in 1994 to 12.3 million in 2006, an 80 percent increase. In comparison, the uninsured native-born population increased from 29.7 million to 34.1 million, a 15 percent increase over the same period. As a result, immigrants accounted for about 55 percent of the increase in the uninsured population between 1994 and 2006. Clearly, while the uninsured rate among immigrants has grown by 9 percent, compared with an increase of only 6 percent among native-born Americans, between 1994 and 2006, the fact that there were only 6.9 million uninsured immigrants in 1994 explains why immigrants comprised only 55 percent of the increase in the uninsured over this period.

The findings in this study help put earlier findings in context. Holahan et al. found that native-born Americans accounted for 64 percent of the increase in the uninsured between 1994 and 1998, while immigrants accounted for 36 percent. In fact, using updated data, the EBRI analysis confirms their findings. As part of this analysis, it was determined that native-born Americans accounted for 57 percent of the growth in the uninsured between 1994 and 1998, while immigrants accounted for only 43 percent.[14] However, if the analysis is limited to the impact of immigration between 1998 and 2003, it can be determined that native-born Americans accounted for only 8 percent of the growth in the uninsured, while immigrants accounted for 92 percent, a major difference from the conclusion of Holahan et al., mainly because different periods of time were examined. A view of the longer time frame of 1994–2006 shows that immigrants accounted for 55 percent of the increase in the uninsured.

Conclusion

More than 12 million immigrants in the United States were uninsured in 2006, accounting for 26.6 percent of the 46.5 million uninsured individuals in the country. Immigrants accounted for 43 percent of the increase in the uninsured between 1994 and 1998, but between 1998 and 2003 they were 92 percent of the growth in the uninsured, presumably because of PRWORA restrictions on the availability of public assistance programs for five years after entering the United States. Over the entire 1994–2006 period, immigrants accounted for 55 percent of the increase in the uninsured.

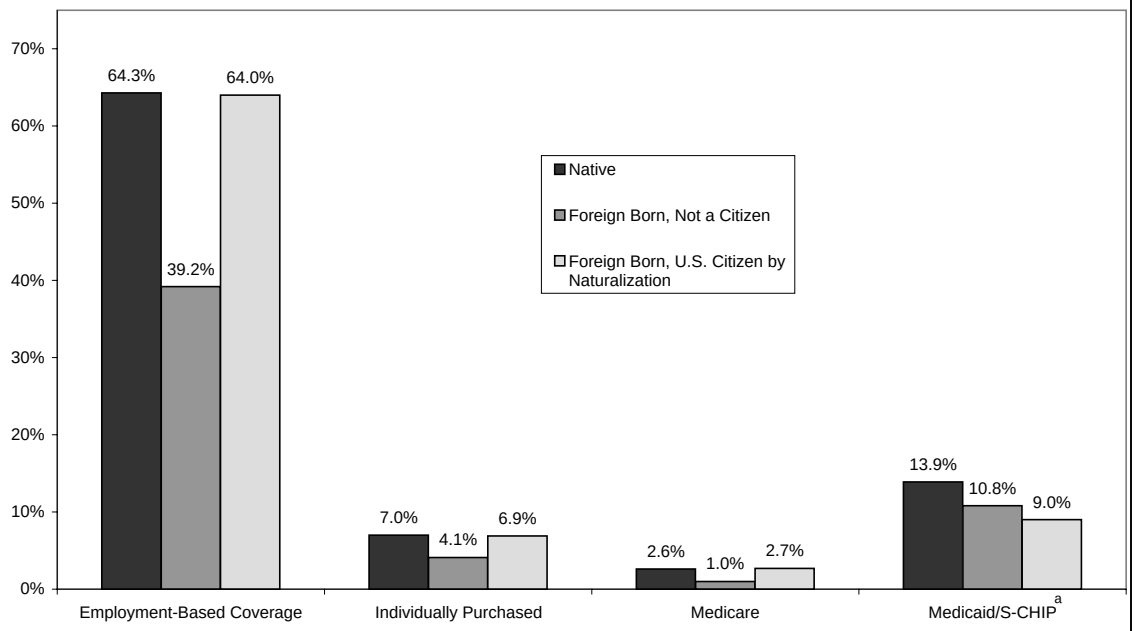
Given that foreign-born entrants to the United States have a high likelihood of being uninsured, it is likely that the uninsured will also grow as a proportion of the population as immigration continues to increase.

Figure 5
Distribution of Nonelderly Immigrant Uninsured Population, by State, U.S. Population Under Age 65, 3-Year Average 2004–2006

	Total Number of Uninsured (millions)	Number of Uninsured Natives (millions)	Number of Uninsured Immigrants (millions)	Distribution of Uninsured Immigrants	Percentage of Uninsured Accounted for by Immigrants
Total	44.6	32.9	11.7	100%	26.3%
California	6.6	3.4	3.2	27.1	48.5
Texas	5.4	3.8	1.7	14.1	30.4
Florida	3.6	2.4	1.2	9.9	32.7
New York	2.5	1.6	0.9	7.7	36.7
New Jersey	1.2	0.7	0.5	4.5	42.1
Illinois	1.7	1.3	0.4	3.7	25.4
Arizona	1.1	0.7	0.4	3.5	35.6
Georgia	1.6	1.2	0.4	3.3	24.2
North Carolina	1.4	1.1	0.3	2.4	20.6
Maryland	0.7	0.5	0.2	2.1	32.6
Virginia	1.0	0.7	0.2	2.0	24.7
Colorado	0.8	0.6	0.2	1.8	27.4
Massachusetts	0.6	0.5	0.2	1.5	26.4
Washington	0.8	0.6	0.1	1.3	19.3
Nevada	0.4	0.3	0.1	1.1	30.3
Tennessee	0.8	0.7	0.1	1.1	17.0
States not listed	14.4	12.9	1.5	13.0	10.6

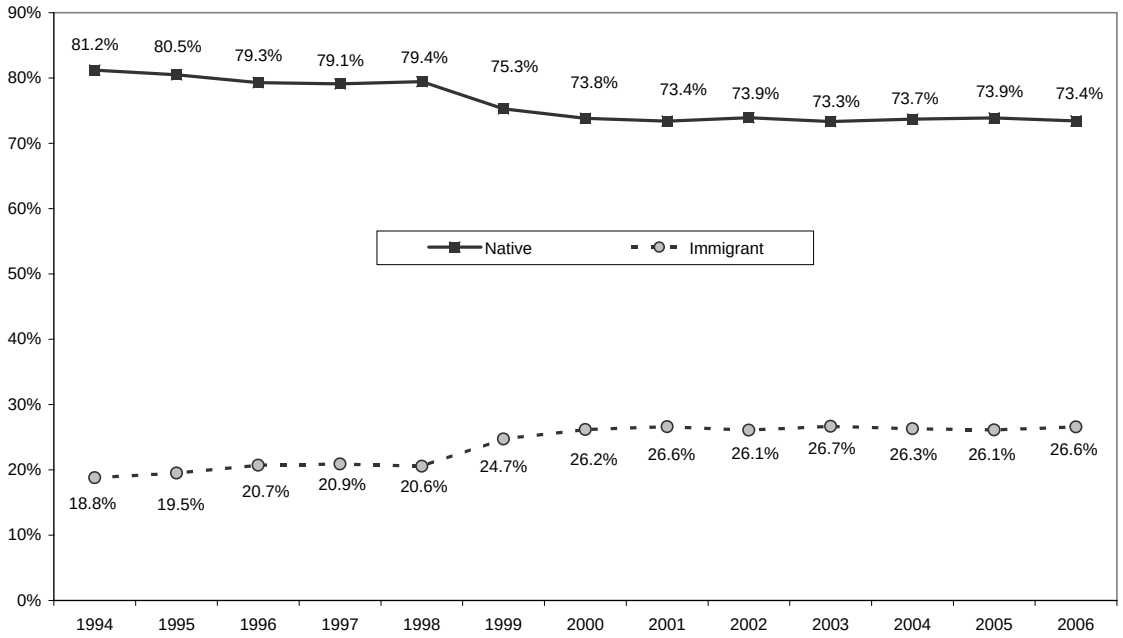
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2005–2007 supplements.
Note: Only states with at least 100,000 uninsured immigrants are shown separately.

Figure 6
Selected Sources of Health Insurance, by Immigration Status, U.S. Population Under Age 65, 2006



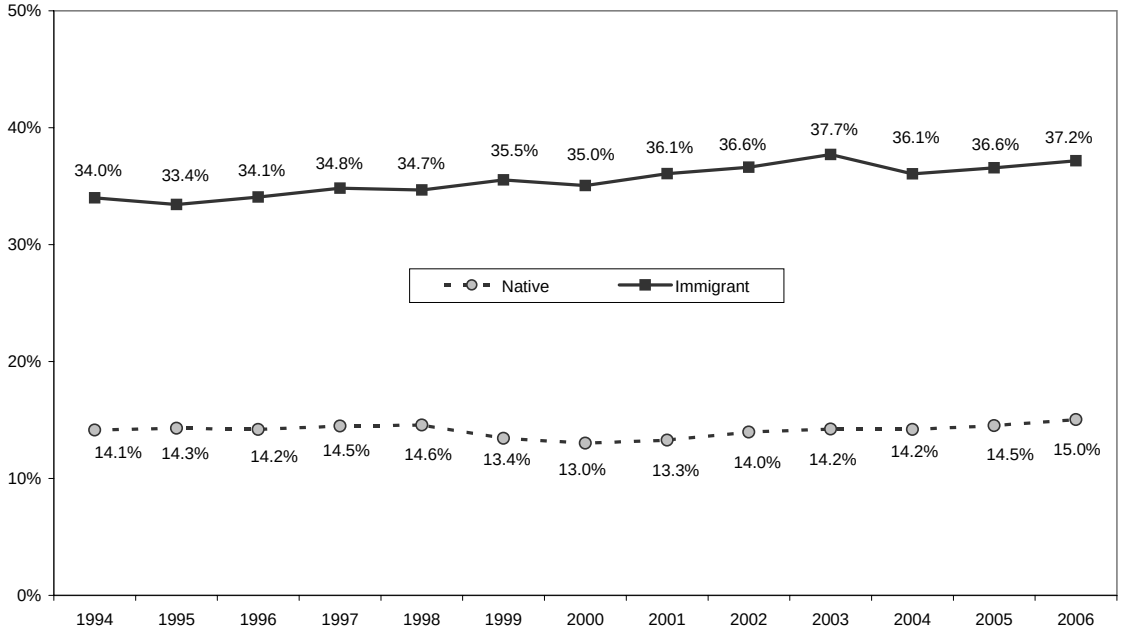
Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 2007 Supplement.
[a] State Children's Health Insurance Program.

Figure 7
Distribution of Uninsured Population, by Immigration Status, Population Under Age 65, 1994–2006



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995–2007 Supplements.

Figure 8
Likelihood of Being Uninsured, by Immigration Status, Population Under Age 65, 1994–2006



Source: Employee Benefit Research Institute estimates from the Current Population Survey, March 1995–2007 Supplements.

Endnotes

[1] Paul Fronstin, "Sources of Coverage and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey," *EBRI Issue Brief*, no. 310 (Employee Benefit Research Institute, October 2007).

[2] TRICARE (formerly known as CHAMPUS) is a program administered by the Department of Defense for military retirees as well as families of active duty, retired, and deceased service members. CHAMPVA, the Civilian Health and Medical Program for the Department of Veterans Affairs, is a health care benefits program for disabled dependents of veterans and certain survivors of veterans.

[3] Gary Claxton et al., "Health Benefits In 2007: Premium Increases Fall To An Eight-Year Low, While Offer Rates And Enrollment Remain Stable," *Health Affairs*, Vol. 26, no. 5 (September/October 2007): 1407–1416.

[4] Fronstin (op. cit., 2007).

[5] Claxton, et al. (op. cit., 2004).

[6] Paul Fronstin, "The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?" *EBRI Issue Brief*, no. 312 (Employee Benefit Research Institute, December 2007).

[7] See Paul Fronstin, "The Impact on Employment-Based Health Benefits of the Shift From a Manufacturing Economy to a Service Economy," *EBRI Notes*, no. 6 (Employee Benefit Research Institute, June 2004): 1–3; and Paul Fronstin, "Union Status and Employment-Based Health Benefits," *EBRI Notes*, no. 4 (Employee Benefit Research Institute, April 2005): 2–6.

[8] Joan C. Alker, and Marcela Urrutia, "Immigrants and Health Coverage: A Primer," The Kaiser Commission on Medicaid and the Uninsured, Publication no. 7088 (June 2004).

[9] Alker and Urrutia (ibid., 2004).

[10] S. Camarota, and J.R. Edwards, "Without Coverage: Immigration's Impact on the Size and Growth of the Population Lacking Health Insurance," Center for Immigration Studies (July 2000), www.cis.org/articles/2000/coverage/index.html.

[11] See John Holahan, Leighton Ku, and Mary Pohl, "Is Immigration Responsible for the Growth in the Number of Uninsured?" The Kaiser Commission on Medicaid and the Uninsured, Publication no. 2221 (February 2001), http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13751.

[12] See Paul Fronstin, "The Impact of Immigration on Health Coverage in the United States," *EBRI Notes*, no. 6 (Employee Benefit Research Institute, June 2005): 2–8; and John Holahan and Allison Cook, "Are Immigrants Responsible for Most of the Growth of the Uninsured?" The Kaiser Commission on Medicaid and the Uninsured, Publication no. 7411 (October 2005), http://www.kff.org/uninsured/upload/Are-Immigrants-Responsible-for-Most-of-the-Growth-of-the-Uninsured-issue-brief.pdf.

[13] See Fronstin (op. cit., 2007) for more information.

[14] These estimates are available upon request from the author. They are slightly different from those published in Holahan et al. because of methodological changes to the way in which the uninsured population is identified in the CPS. They are also different because they are based on updated data from what was previously published (Fronstin, op. cit., 2005) because of a correction to the Current Population Survey that affected the historical trend. More information about the correction can be found in Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Updated Analysis of the March 2006 Current Population Survey," *EBRI Issue Brief*, no. 305 (Employee Benefit Research Institute, May 2007).

Saving for Health Care Expenses in Retirement: The Use of Health Savings Accounts

by Paul Fronstin, EBRI

Introduction

Prior to the passage of Medicare in 1965, almost all Americans assumed responsibility for health insurance and out-of-pocket payments for health care in retirement. When Medicare was established, some employers, primarily the very largest, began to offer health benefits to supplement Medicare. In 1988, prior to the accounting rule change that is in large part responsible for triggering the decline in the availability of retiree health benefits, only about one-third of workers ages 46–64 reported that they would be eligible for health benefits on retirement (Fronstin, 1996). In 2005, only about 20 percent of Medicare beneficiaries had retiree health benefits through a former employer as a supplement to Medicare (Fronstin, Salisbury, and VanDerhei, 2008). Thus, for most retirees, saving for health insurance and out-of-pocket expenses in retirement should have always been a consideration in saving for retirement and in the timing of retirement.

The present value of lifetime benefits from Medicare for a husband and wife turning age 65 in 2010 has been estimated at about $376,000.[1] Hence, the average husband and wife will need a little less than $376,000 in savings to cover what is not covered by Medicare because Medicare, on average, covers a little more than one-half of health care costs for beneficiaries. But as previous research has shown (Fronstin, Salisbury, and VanDerhei, 2008), the problem with using this average is that individuals cannot simply assume to be average. While 50 percent of men turning age 65 in 2008 will live to age 81 and 50 percent of women will live to age 84, 25 percent can be expected to live until ages 87 and 90, respectively. Furthermore, 1 in 10 men currently age 65 can expect to live until 91, while 1 in 10 women can expect to live to 95. Uncertainty related to life expectancy and other factors makes saving for retirement increasingly complicated.

This analysis revisits the savings needed to cover health insurance premiums and out-of-pocket expenses for health care services in retirement and evaluates the use of health savings accounts (HSAs) to save for those expenses. Proponents of HSAs often tout them as a vehicle for funding future retiree health care costs. But, while HSAs represent an important option for consumers seeking more control over their health care spending, statutory contribution limits make it unlikely that these accounts will play more than a minor part in savings for health care costs in retirement. The following analysis uses the savings estimates presented in Fronstin, Salisbury, and VanDerhei (2008) as the basis for examining how HSAs can be used to save for health insurance premiums and out-of-pocket health care expenses in retirement.

The Use of HSAs to Save for Health Care Expenses in Retirement

A number of options are currently available to workers to pre-fund health insurance and out-of-pocket expenses for health care in retirement. Each option has various advantages and disadvantages. They include:

- Health savings accounts (HSAs).
- Health reimbursement arrangements (HRAs).
- Retiree medical accounts (RMAs).
- Voluntary employees' beneficiary associations (VEBAs).

Only HSAs are discussed here because these are the only accounts that are always portable for the worker and are owned by the worker. HRAs, RMAs, and VEBAs are discussed in Fronstin (2006).

An HSA 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. Earnings on contributions are also not subject to income taxes. Once enrolled in Medicare, beneficiaries are not permitted to continue making contributions to an HSA.

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 $1,100 for individual coverage and $2,200 for family coverage in 2008.[2] Certain preventive services can be covered in full and not subject to the deductible. Out-of-pocket maximums are limited to $5,600 for individual coverage, and $11,200 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 2008 is $2,900 for individual coverage and $5,800 for family coverage. Contribution limits are also indexed to inflation. Individuals who have reached age 65 and are not yet enrolled in Medicare may make catch-up contributions. In 2008, a $900 catch-up contribution is allowed, increasing to $1,000 in 2009.[3] Because accounts are owned by an individual and are technically not family accounts, when both a husband and wife are eligible to make catch-up contributions they must own separate accounts to do so.

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).[4] Distributions for COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), 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 as noted above. 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 cannot be used for employment-based retiree health insurance premiums until an individual has reached age 65. Early retirees do not have immediate access to these funds for retiree health premiums.

An individual age 55 in 2008 who contributes $2,900 annually to his or her HSA could accumulate $59,000 after 10 years, assuming the catch-up contributions are made (Figure 1). A couple, both age 55, could accumulate $118,000 over 10 years if both made the maximum contribution and also made catch-up contributions. The husband and wife would each have to own an HSA in order to make catch-up contributions. Such savings levels, by themselves, are inadequate given the estimates provided in Figure 2 regarding the level of savings needed to fund health insurance premiums and out-of-pocket expenses in retirement.

According to the estimates in Figure 2, a man age 55 in 2008 would need between $132,000 and $261,000 by the time he reaches age 65 in 2018, depending upon his use of prescription drugs in retirement, to have a 50 percent chance of having enough money to cover premiums and out-of-pocket expenses for Medigap and Medicare Part D. Thus, a 55-year-old man would be able to use an HSA to save between 23 percent and 45 percent of targeted savings for insurance premiums and out-of-pocket expenses in retirement if he is comfortable with a 50 percent chance of having enough savings. If instead

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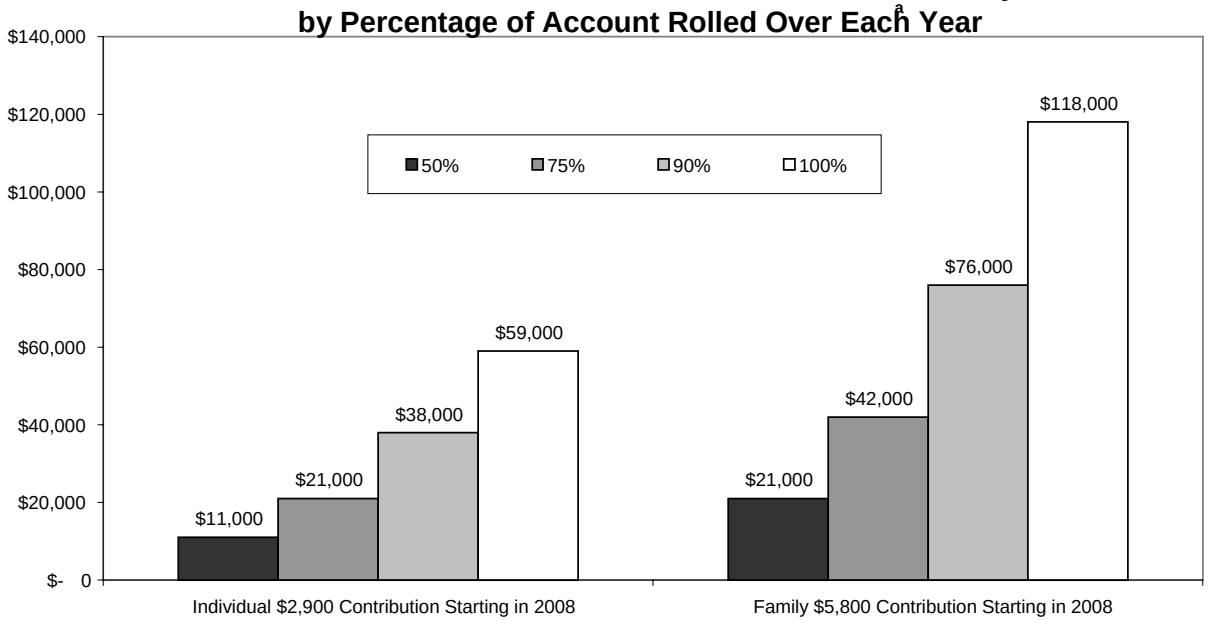
he wants a 90 percent chance of having enough savings in retirement to cover premiums and out-of-pocket costs, the maximum HSA savings would cover between 11 percent and 22 percent of the targeted savings amount.

Figure 1
Potential Savings in a Health Savings Account After 10 Years of Contributions for a 55-Year-Old Individual or a Family, by Percentage of Account Rolled Over Each Year[a]



Source: EBRI estimates.
[a] Assuming 7.32 percent interest on the account. Individual rolls over various percentages of end-of-year account balances and makes maximum catch-up contributions. Contributions are also indexed for inflation.

Figure 2
Savings Needed for Medigap Premiums, Medicare Part B Premiums, Medicare Part D Premiums, and Out-of-Pocket Drug Expenses for Retirement at Age 65 in 2018

	Median Prescription Drug Expenses Throughout Retirement	75th Percentile of Prescription Drug Expenses Throughout Retirement	90th Percentile of Prescription Drug Expenses Throughout Retirement
Men			
Median	$132,000	$156,000	$261,000
75th Percentile	204,000	241,000	416,000
90th Percentile	266,000	317,000	555,000
Women			
Median	181,000	213,000	364,000
75th Percentile	240,000	285,000	496,000
90th Percentile	308,000	369,000	654,000
Married Couple			
Median	325,000	382,000	654,000
75th Percentile	424,000	501,000	868,000
90th Percentile	511,000	608,000	1,064,000

Source: Paul Fronstin, Dallas Salisbury, and Jack VanDerhei, "Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement: Findings from a Simulation Model," *EBRI Issue Brief,* no. 317 (Employee Benefit Research Institute, May 2008).

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Because women, on average, live longer than men, they will need greater savings, but will not be able to save more than a man through an HSA over 10 years. Women age 55 will be able to save the same $59,000 as 55-year-old men, but will need between $181,000 and $364,000 by the time they reach age 65 in 2018 to have a 50 percent chance of having enough savings to cover premiums and out-of-pocket expenses in retirement. Thus, a 55-year-old woman can use an HSA to save between 16 percent and 33 percent of the targeted savings amount. Should a 55-year-old woman in 2008 want a 90 percent chance of having enough savings to cover premiums and out-of-pocket expenses, she would need to save between $308,000 and $654,000 by age 65 in 2018, and could use an HSA to cover between 9 percent and 19 percent of that amount.

As mentioned above, a husband and wife both age 55 in 2008 would be able to save $118,000 in an HSA by 2018 if both were to make the maximum catch-up contribution. Each person would have to have an HSA in order to make catch-up contributions, so in effect there would be two $59,000 accounts after 10 years. As shown in Figure 2, a husband and wife would need to save a combined $325,000–$654,000 by the time both reach age 65 in 2018 to have enough money to cover their premiums and out-of-pocket expenses 50 percent of the time. If, instead, the couple has a goal of having a 90 percent chance of having enough savings in retirement to cover premiums and out-of-pocket expenses, a fully funded HSA with no distributions for medical expenses while covered by a high-deductible health plan could be used to save for between 11 percent and 23 percent of the amount needed to save overall ($511,000–$1,064,000).

Conclusion

This research shows that while HSAs can be used to save for health care expenses in retirement, the maximum savings that can be accumulated in an HSA will be far from sufficient to fully cover the savings needed in retirement for insurance premiums and out-of-pocket expenses. 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.

For example, if an individual preserves as much as 90 percent of the end-of-year account balance each year, the HSA account balance would be $38,000 after 10 years for an individual, instead of $59,000, and $76,000 instead of $118,000 for a husband and wife. Distributions from the HSA prior to becoming eligible for Medicare will erode the value of the account and drive a greater wedge between needed savings and the amount of money in an HSA when a person retires.

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Endnotes

[1] Eugene Steuerle, personal communication.

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

[3] The catch-up contributions are not indexed to inflation after 2009.

[4] 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.

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