



**COVERAGE  
OPTIONS**

Pre-65 and Medicare-Eligible

**FUNDING**

# Health Care in Retirement:

# Retirement:

METHODS for  
Coverage and Funding



**National  
Business  
Group on  
Health**



Institute  
Health <sup>on</sup> Care  
Costs and  
Solutions

# HEALTH CARE IN RETIREMENT: **METHODS FOR COVERAGE AND FUNDING**

National Business Group on Health

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# Introduction

The steady erosion of health care coverage in retirement has prompted stakeholders to re-examine not only coverage options, but also funding methods. According to the 2008 Kaiser/Health Research and Education Trust (HRET) *Employer Health Benefits* survey, 48% of employers with 5,000 or more workers that offer health care coverage also offer coverage during the retirement years. Of those, 93% offer coverage to early retirees (pre-65), while fewer do so for Medicare-eligible retirees (83%).<sup>1</sup>

As employers become less able to fully subsidize health benefits for retirees, it is becoming clear that new hires and some veteran workers will be responsible for coverage on their own. In a perfect world, employees would be aware of this fact and would begin planning for the future as soon as possible. But often, employees are not knowledgeable about this issue. For this reason, it is important that retirement coverage and funding options are explored in greater detail.

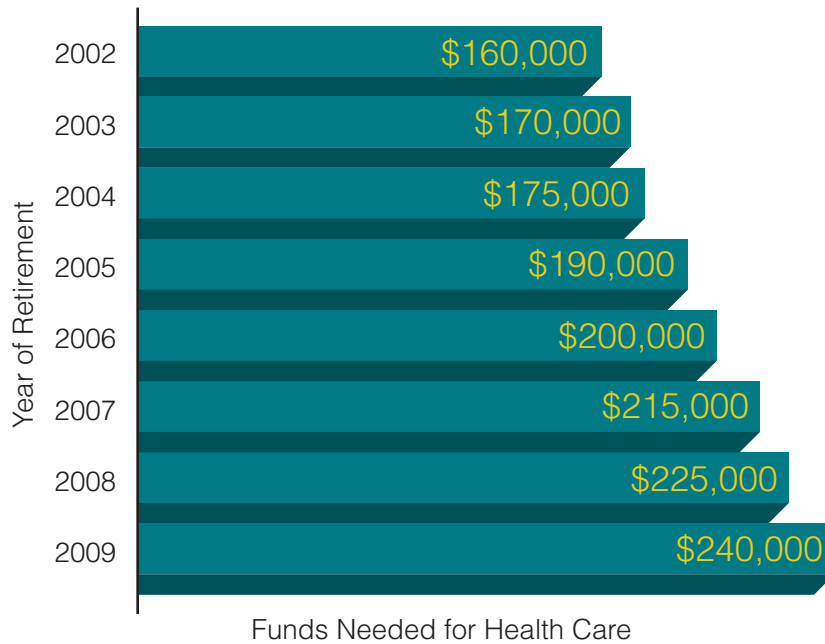
Employees' lack of understanding of retirement coverage has been confirmed by the Employee Benefits Research Institute (EBRI), which found that 36% of employees expect to have access to employer-paid health insurance in retirement.<sup>3</sup> Although this number has declined in recent years, there still is a gap between what employees expect in retirement and what will likely happen. Today's employees are unaware or in denial about the costs of health care in retirement; specifically, how the costs dramatically increase when transitioning from active employee to retiree status.

The reality that lies ahead is daunting. Fidelity Investments projects that, on average, a 65-year-old couple retiring in 2009 will need approximately \$240,000 *just to cover their own share of medical costs in retirement*.<sup>4</sup> Part of the reason that so much money will be needed is that health care costs in retirement have been increasing steadily over the past several years. Figure 1 (on page 4) shows the cost increases between 2002 and 2009. Fidelity reports that the significant drivers of the rising costs (a 6.3% increase from 2008) can be attributed to the following:<sup>5</sup>

- Higher unit costs;
- Higher utilization rates for services; and
- Rising costs associated with the introduction of new technology, such as better diagnostic testing.

With estimates that one in five Americans will be 65 years and older by 2030,<sup>7</sup> practical solutions are needed for both employees and employers. This report examines coverage and financing options in the two stages of retirement: pre-65 and Medicare-eligible.

**Figure 1: Funds Needed to Cover Medical Costs in Retirement, 2002-2009**



**Note:** Assumes individuals do not have employer-sponsored retiree health care coverage.  
*Source: Fidelity Investments. 2007 Fidelity Investments Retiree Health Care Cost*

### THE \$2K DIFFERENCE

A retiree's health status is a crucial indicator of total health care costs. In an analysis of the Health and Retirement Study, RAND found that the average annual health care costs of an early retiree with a BMI over 35 was 50% more than the costs of an early retiree with a healthy weight. For men, that's a difference of over \$2,000 per year.<sup>2</sup> In addition, a moderately active Medicare beneficiary's health care costs will be \$1,690 less than those for a sedentary beneficiary.<sup>6</sup>

# COVERAGE OPTIONS AVAILABLE FOR HEALTH CARE IN **Early Retirement (Pre-65)**

The sources for health care coverage for employees retiring before they are eligible for Medicare coverage can be divided into four categories: Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefits, group-based coverage, individual coverage and public assistance. Any of these may be affected by health insurance reforms being debated in 2009.

## COBRA Health Benefit Provision

COBRA gives early retirees the right to continue coverage for 18 months after a qualifying event, which, in this case, is voluntary termination of employment. Even though employers are, by law, allowed to charge employees 102% of the plan costs, this approach is still usually less expensive than the alternative—purchasing coverage on the individual market. According to *Spencer's Benefits Reports*, average COBRA costs leveled out to be \$9,914 per year.<sup>8</sup>

Ideally, COBRA could serve as a bridge between early retirement and Medicare eligibility. This means that if an active employee retires at 63 1/2 years old, he or she will be able to use COBRA through to Medicare eligibility at age 65. Eleven percent of those expecting to retire before 65 expect to continue coverage through COBRA.<sup>9</sup>

## Group-Based Coverage

A majority of adults age 55-64 are receiving health benefits through group-based coverage, either through their current or former employer, a spouse's employer, a membership organization, a union or by purchasing a group-based plan.

**Employer:** Twenty-seven percent of large employers offer coverage to pre-65 retirees. Mercer noted that as the size of the employer increases, so does the availability of pre-65

coverage. In fact, among employers with 20,000+ employees, 47% offer coverage to pre-65 retirees.<sup>10</sup>

For the most part, employers offer pre-65 retirees plan designs similar to those being offered to active employees. This is common practice among National Business Group on Health members. Offering such coverage can ease the transition between active to retired status. If any changes are made to the active plan upon retirement, it would mostly be in the form of cost-sharing. Nineteen percent of employers adopt this strategy by increasing retiree contributions/cost-sharing or by reducing the level of covered services.

**Spouse's employer:** An alternative that may be more cost-effective from the retiree's standpoint is electing coverage through a spouse's employer. University of Michigan data indicate that 11% of recent pre-65 retirees go this route.<sup>11</sup> This path is most likely chosen when the cost-sharing through the former employer is higher or the only alternative is purchasing an individual health plan.

**Membership organizations:** Some membership organizations provide coverage to pre-65 retirees. This new trend has emerged in response to the challenge for retirees in securing coverage on the individual market. By grouping many pre-65 retirees in the same risk pool, organizations such as AARP and HR Policy Association (HRPA) are able to issue coverage to pre-65 retirees at a reduced rate.

- AARP Health Care Options program provides members and their spouses (age 50 and over) access to primary health insurance, supplementary plans, long-term insurance and other kinds of insurance plans. In 2006, 3.5 million members and spouses had enrolled in the program, which provides insurance through UnitedHealthcare. For employers, a minimum of 25 retirees are needed to create a risk pool.<sup>12</sup>

- HSPA developed the Retiree Health Access (RHA) plan in 2006. RHA is designed so that HSPA member employers can offer insurance to retirees of all ages. Provided through Aetna, the plan guarantees access regardless of individual health status or employer subsidy and has no minimum participation requirements. Premiums vary significantly by employer. Some pre-65 retirees will not be able to afford coverage, and relatively healthy individuals may be able to find lower cost options on the individual market.<sup>13</sup> In 2008, approximately 50,000 people were enrolled in the RHA program.<sup>39</sup>
- **Individual health plans:** By purchasing on the individual market, pre-65 retirees who do not have access to group-based coverage can still obtain coverage. However, because the individual market in most states offers less coverage at greater expense, this option is likely to be the retiree's last choice.

It is true, however, that applying for coverage on the individual market has become easier for consumers in the last few years, largely because websites such as [www.ehealthinsurance.com](http://www.ehealthinsurance.com) and [www.insureme.com](http://www.insureme.com) provide free quotes and almost-instant coverage.

From the large employer perspective, providing information to pre-65 retirees about options available on the open market may be difficult, largely because the rules aren't consistent from state to state. Throughout the individual market, one of the biggest challenges is maintaining a balance of low-risk and high-risk policyholders. The overall goal is to set premiums at an attractive level for the former but also affordable for the latter. Because of this concern, companies that offer individual policies must underwrite the policy so that the terms of coverage are set for all individuals in the pool. In an employer-sponsored situation, the risk, or variation, in coverage is absorbed by the company, which is the reason why the same premium can be charged to each retiree. In the individual market, however, the tables are turned; policyholders are responsible for any risk-based coverage pricing.

Is there ever an instance in which a pre-65 retiree will be denied coverage based on health risk or demographics? In most states, the answer is yes. At this point, only five states—New York, Massachusetts, Vermont, New Jersey and Maine—require health coverage providers to guarantee issue of all health insurance products to pre-65 retirees. There is no such guarantee for the rest of the country.<sup>15</sup> Therefore, any pre-65 retiree who needs to get coverage on the individual market should read the fine print of the plan carefully and proceed with caution.

**Unions:** Some unions also offer access to retiree health benefits to those who are not yet eligible for Medicare. According to the National Compensation Survey, 88% of employees who belong to a union have access to a health plan, compared to 71% of all other workers.<sup>14</sup> Therefore, it is possible that in some cases, unions may be able to provide coverage to early retirees, filling in the gap when the employer is unable to do so.

## Individual-Based Coverage

Pre-65 retirees who do not have access to insurance through a group will need to buy coverage on their own. Based on the University of Michigan Health and Retirement study, 8% of first-year pre-65 retirees have individual coverage.<sup>11</sup> Without access to a group-based plan, pre-65 retirees face two major hurdles: getting approved by an individual health plan for coverage and having the ability to pay for it. Pre-65 retirees can purchase health insurance in the following three ways: purchasing directly on the individual market; obtaining insurance by becoming part of a high-risk pool; or purchasing insurance through a broker.

**High-risk pool:** A majority of states (31) do require a high-risk pool for medically eligible individuals.<sup>15</sup> In those states, nonprofit associations provide coverage to those rejected by the individual market because of such factors as age, gender, health status, occupation and geographic location. However, the premiums may be out of reach for many pre-65 retirees. Figure 2 shows the differences in costs between receiving health insurance from an employer-sponsored plan and paying for coverage in the individual market and the percent of pre-65 retirees in each cost bracket.

- **Through a broker:** It is important that pre-65 retirees who are looking to purchase health care coverage on the individual market become well informed. In fact, employers who direct their pre-65 retirees to the individual market are concerned about their ability to evaluate options carefully. When making decisions about standard employer-sponsored plans, active employees can seek guidance from HR and Benefits professionals.

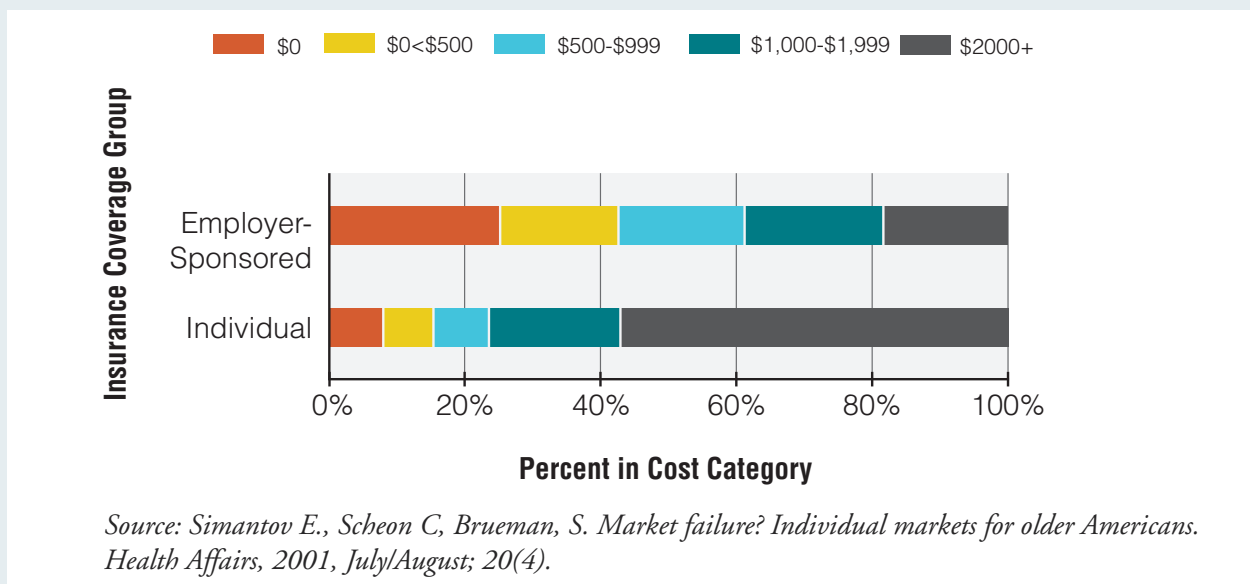
Similarly, to receive help in making decisions about insurance options on the individual market, pre-65 retirees can use an independent broker.

## Public Insurance

Pre-65 retirees may receive coverage through federal and state assistance programs, such as Medicaid, Medicare or the military. In 2007, about 2% of pre-65 retirees received military health benefits through providers such as TriCare.<sup>11</sup> About 8% of adults age 55-64 received Medicaid and Medicare. Not too many people are eligible for this benefit because the prerequisites, listed below, are quite strict.<sup>11</sup>

- Adults without dependent children and those who are not pregnant can qualify for Medicare or Medicaid only if they are permanently and totally disabled.
- Applicants for Medicaid are subject to strict income and asset requirements.
- Requirements vary from state to state.

**Figure 2: Annual Out-of-Pocket Premium Costs, Adults Age 50-64**



# COVERAGE OPTIONS AVAILABLE FOR HEALTH CARE IN **Post-65 Retirement**

When employees reach the age of 65, they are automatically eligible for Medicare Part A. At this time, they also should enroll in Part B, which includes numerous options for different levels of coverage. For prescription drug benefits, Medicare offers Part D, but some employees may have the option of using a prescription drug plan offered by their former employer.

Eligible beneficiaries have the opportunity to purchase Medigap supplemental coverage to fill in gaps in traditional Medicare coverage. Alternatively, they also may elect to enroll in a Medicare Advantage private plan, which combines the Medicare parts into one plan, simplifying the process for the Medicare enrollee.

In the following sections, these options are explained in more detail.

## **Medicare Part A**

**Part A:** Covers inpatient hospital services, skilled nursing facilities, benefits following a three-day hospital visit, some home health visits, hospice care and blood.

Eligible Medicare beneficiaries receive Part A with no premium costs. In 2009, the deductible for hospital stays is \$1,068 for the first 60 days, with subsequent increasing co-payments. Skilled nursing facility care does not require payment for the first 20 days; after that, there is a \$133.50 per day co-payment up to day 100.<sup>16</sup>

## **Medicare Part B**

**Part B:** Supplements Part A; covers other medical care (doctors' services, outpatient care, diagnostic tests, ambulatory services, durable medical equipment, outpatient physical and occupational services, behavioral health services, laboratory services, some home health care, and blood on an outpatient basis). Beneficiaries are responsible for enrolling or they will be penalized.

In 2009, Part B premiums for those beneficiaries earning less than \$82,000 per year (\$164,000 for married couples) are \$96.40 per month. For those earning more than \$82,000, the premium increases on a sliding scale according to income. Part B is financed by beneficiary premiums that subsidize 25% of the program's costs. Most Part B services have an annual \$135 deductible; many preventive services are covered, with some outside of the deductible or with no co-payment/coinsurance.<sup>16</sup>

## **Medicare Part D**

**Part D:** Prescription drug coverage; many choices available to beneficiaries. Medically necessary drugs must be covered. Private companies approved by Medicare offer the plans. Offered alongside Parts A and B or a Medicare Advantage plan.

Premiums average about \$37.29 per month and, based on level of coverage, range from \$10.30 to \$136.80. As of October 2008, a total of 17 million Medicare beneficiaries were enrolled in a Part D plan.<sup>17</sup>

The defined “standard benefit” for a Part D Prescription Drug Plan (PDP) has a \$295 deductible and a 25% coinsurance up to an initial coverage limit of \$2,700. At that point, the retiree enters the “donut hole” and is required to pay 100% of the costs of medication until those costs reach \$4,350. Then catastrophic insurance kicks in until the end of the calendar year, when Part D resumes.

In reality, only about 10% of national PDPs actually offer the defined standard benefit.<sup>18</sup> Most other national PDPs charged co-payments instead of the 25% coinsurance, and 55% of the PDPs do not have a deductible. A majority of national plans surveyed by the Kaiser Family Foundation were using a three-tier cost-sharing, as shown in Table 1, all with flat co-pays. From 2006 to 2008, the average cost-sharing for a 30-day supply of non-preferred drugs increased 29%.

As Table 1 shows, according to 2008 data, preferred and non-preferred prescriptions are more costly under a PDP design than they are under an employer-sponsored plan, as is coinsurance. Generic drugs, however, are less costly to the beneficiary under the PDP design.<sup>19</sup>

## Medigap

**Medigap:** Medicare supplementary policy to fill in gaps in Parts A and B coverage. A number of employers, unions and membership organizations offer this coverage.

Beneficiaries can purchase additional coverage to fill in gaps not covered by the basic Medicare plans (Parts A and B). Employers provided this supplementary benefit to 35% of Medicare beneficiaries.<sup>18</sup>

**Table 1: Comparison of the Prescription Drug Benefit: Medicare PDPs and Employer Plans**

Benefit Design	Medicare PDP	Employer Plan
Generic	\$5.32	\$10
Preferred brand	\$29.86	\$26
Non-preferred brand	\$71.31	\$46
Specialty (coinsurance)	30.2%	28%

*Source: Kaiser Family Foundation, Medicare Part D spotlight: Benefit design. Menlo Park, CA; 2008.*

## Medicare Advantage

**Medicare Advantage:** Alternative to traditional Medicare coverage through a private plan. Provides all Medicare-covered services with other services, such as vision, dental, health and wellness. Beneficiaries have a broad choice of plans (an average of 20); however, they are subject to provider network limitations.

The Medicare Advantage (MA) plan currently has 9.4 million beneficiaries enrolled in it. Of this figure, 1.55 million are in employer group MA plans.<sup>20</sup> Plan types include:

- **Local coordinated plans:** HMOs, PPOs and provider-sponsored organizations (PSO) plans cover Medicare Parts A, B and often D services within provider networks.
- **Private fee- for-service plans (PFFS):** Different from local coordinated plans in that they are not required to establish provider networks, report quality measures, or have the Centers for Medicare & Medicaid Services (CMS) review or negotiate bids.
- **Special needs plans (SNP):** Only available to beneficiaries who are eligible for both Medicare and Medicaid as well as other specific groups, such as those with severe disabling chronic conditions. Only 478 beneficiaries enrolled in a SNP in 2007.
- **Medical savings accounts (MSA):** Not available in all markets. Medicare makes an annual deposit in an interest-bearing account, which beneficiaries can use for qualified medical expenses.
- **Regional PPOs:** Introduced to provide greater accessibility to beneficiaries in rural areas. They are available in all areas.

About 12% of beneficiaries who are receiving a higher level of coverage are subject to an additional premium based on level of coverage,<sup>20</sup> which averages \$58 per month in addition to the Part B premium.<sup>21</sup>

# FUNDING OPTIONS AVAILABLE FOR **Health Care in Retirement**

While there are a variety of funding methods that may be used by both employees and employers, retirees should not rely on any one option in its entirety. Following the rule of the “three-legged stool,” retirees should lean on the following funding sources to pay for premiums, cost-sharing and out-of-pocket costs:

- Social Security
- Personal investments
- Employer-sponsored plans

The following section presents different ways that retirees can “mix and match” to pay for their health care in retirement. These approaches involve using the three options listed above.

## Employee Funding Options

**Pay as you go:** Increasingly, retirees will need to rely on their personal savings and Social Security payments to pay for health benefits. This practice is not optimal because once an employee is retired, no health care costs can be paid for using non-taxed money. And, for many younger workers, it is unclear what the status of Social Security will be by the time they retire.

- Currently, however, benefits through **Social Security** provide monthly payments to eligible beneficiaries beginning as early as age 62 or as late as age 70. The monthly payments are based on lifetime earnings (indexed against the 35 years that the employee earned the most), age of retirement and year of birth:

- **If an employee retires before age 67**, the normal retirement age, his or her monthly benefit could be reduced by 20% to 30% of what it would be if they waited until the normal retirement age. It is a general rule, however, that employees choosing early retirement would still yield the same total Social Security benefits over their lifetime.
- **If an employee retires at age 67**, the normal retirement age, he or she should expect to receive the full benefit he or she is eligible for up until 2041, when the new payment structure goes into effect. The average benefit dollars paid to retired workers is \$1,156 per month.<sup>22</sup>
- Some employees choose to delay benefits until **after normal retirement age**, often because they are still working and bringing in “excess earnings.” Beneficiaries may receive an additional credit, ranging from 3% to 8% per year of delayed retirement, to compensate

### Social Security and the Younger Workforce

Relying on Social Security benefits is perhaps most risky for younger employees. Starting in 2041, benefits for all retirees could be reduced by 22% and could continue downward each year thereafter. Also, if employees born 1960 or later choose to retire before their normal retirement age (age 67), they will be subject to a 30% reduction in their benefit after age 67.

*Source: Social Security's Future FAQs*

for the years they did not receive the benefit. The additional credits are null after the beneficiary reaches age 70.<sup>23</sup>

Experts advise beneficiaries not to view Social Security benefits as the sole source of payment for health care coverage in retirement, if a source at all. However, 33% of pre-retirees (55+) will rely on Social Security benefits as their greatest source of income.<sup>24</sup> In addition, the status of Social Security after year 2041 has massive implications for today's (and tomorrow's) workers. In order to sustain the current scheduled levels, the federal government would have to take one or more of the following measures:<sup>25</sup>

1. Increase payroll taxes
  2. Reduce benefits for future retirees
  3. Find another source of revenue, such as transfers from general revenues
- Retirees may rely on **private savings** to subsidize health care costs during their non-working years. This vehicle will play a larger role in subsidizing health care as pensions become nearly impossible for large employers to sustain and as the outlook for Social Security becomes less clear for today's workers. The following list highlights the pros and cons of using different sources of income.
  - Non-investment strategies, such as **basic savings accounts, money market accounts or certificate of deposits**, do not offer the tax advantages of other funding methods, discussed on the next page. On average, pre-retirees (55+) save at the rate of 4.1% of their current income, while baby boomers (age 43-61) save at about 4.3%.<sup>24</sup> This is a far cry from where both groups need to be in order to properly replace their pre-retirement income, let alone be able to pay for health care costs in retirement.

- **Individual retirement accounts (IRAs)** allow employees to make pre-tax contributions while deferring taxes associated with any investment income. Employees under age 50 may contribute up to \$5,000 to an IRA or Roth IRA annually (in 2009); employees over age 50 may contribute up to \$6,000 to an IRA or Roth IRA. Forty percent of surveyed workers contribute to an IRA.<sup>26</sup> Participation in an IRA multiplies as income and age increase, illustrating the primary use of these accounts: as an addition to a jointly sponsored funding vehicle, such as a health savings account.
- **Roth IRAs** differ from traditional IRAs in that the contributions are taxed on the front end, investment earnings are untaxed and the distributions are tax-free. If the tax rates are lower in retirement, this strategy will produce a lower return on investments. Those with higher incomes (above \$120,000/single; \$176,000/married couples) are not eligible to make contributions to a Roth IRA.

## Jointly Sponsored Options

- Created in 2003, **health savings accounts (HSAs)** were offered in part as a way for both employers and employees to fund future health care costs in retirement. Four percent of large employers offer a health savings account to pre-65 retirees, and 3% of all employers do so for Medicare-eligible retirees.<sup>27</sup> Unlike many of the other methods discussed in this report, funds in HSAs can be used only for medical expenses as defined in the Internal Revenue Code §213(d). Any other uses are subject to a 10% withdrawal penalty; this creates an incentive that strongly encourages employees to reserve the funds for current and future medical expenses.

Unlike other savings methods, HSAs have a “triple tax” advantage:

1. Employee and employer contributions are made on a pre-tax basis;
2. Investment earnings are not taxed; and
3. Withdrawals from the account are 100% tax free when used for qualified medical expenses.

The challenge that many employees will face is managing current medical expense in concurrence with saving for future costs. Sixteen percent of employees in an account-based health plan actively use their account to save for health care in retirement.<sup>28</sup> At this point, however, employees should not be relying on HSAs as their sole vehicle for saving for health care in retirement; based on a 2004 Employee Benefit Research Institute simulation, an employee would need to contribute the maximum amount allowable, starting at age 41 or 42, in order to reach the amount needed to pay for health care after 65.<sup>29</sup>

- **401(k) plans** are the predominant funding mechanism available for employees to set aside funds for their own retirement savings.<sup>30</sup> Forty-four percent of all workers report participating in an employer-sponsored retirement savings plan.<sup>3</sup> The maximum annual contribution allowed for 401(k) plans (\$16,500) is significantly greater than the IRA limit of \$5,000; however, the average contribution among participants remains at about \$3,512 annually. With an average account balance of \$64,000, 401(k) plans steer employees in the right direction, but they may not meet the goal of sustaining standards of living and paying for health care.<sup>31</sup>

## Employer Funding Options

Large employers will continue to play a role in funding health care in retirement. Twenty-three percent of companies provide traditional medical coverage for pre-65 employees retiring in 2008; 20% will provide similar coverage for those over 65. Nonetheless, only 12% of new hires are offered retiree medical coverage.<sup>32</sup> For those who do receive health care coverage in retirement, employers have a variety of methods through which they can fund this benefit under a defined contribution structure.

- **Voluntary Employee Beneficiary Associations (VEBAs)** allow employers to finance their retiree health obligations. In particular, large employers have been drawn to this method as a way to offset obligations via tax-free distributions for expenses that would otherwise be included as an asset on Federal Accounting Standard (FAS) 106, which requires that employers recognize the annual expense and total liability of retiree health benefits on their financial statements. Nine percent of companies that currently offer retiree health benefits utilize this method.<sup>33</sup> In addition to health care, VEBAs also can be used to fund life and accident insurance as well as other benefits.
- Employers looking for a less administratively complex solution are turning to **health reimbursement arrangements (HRA)** to allocate notional credits to employees to use at point of retirement. The level of funding is often a set amount of credits per year of service. There is no limit to the amount an employer can set aside for employees. HRAs do not enjoy the same popularity that HSAs

do; only 4% of large employers offer one to pre-65 retirees, while 2% of employers do so for Medicare-eligible retirees.<sup>27</sup>

HRAs have many advantages over health savings accounts. Mainly, the notional credits are not portable; therefore, the funds are more likely to stay with the employer if an employee is terminated. Another cost benefit is that all the funds are typically available upon retirement, not in increments, as HSAs are. This feature will also help future retirees in differentiating between “current health care costs” and “retiree health care costs” funds.

- Employers also may provide additional **pension income** to fund health care in retirement. However, from the retiree’s perspective, this is not as tax-efficient, because he or she will have to pay income tax on the pension income as well as use after-tax dollars to pay for health benefits. Fifty-nine percent of today’s workers expect to receive a traditional pension plan in retirement; 58% of today’s retirees actually receive this form of payment.<sup>3</sup> The median annual pension benefit for private employees in 2006 was \$7,200.<sup>34</sup>
- **401(h) accounts** allow employers to contribute to a sub-account with a defined benefit or a money purchase pension plan. The employer contributions are deductible and the earnings and distributions are tax-free. Employees also may contribute on a tax-free basis. The cumulative contribution is limited to 25% of the cumulative pensions from the date health benefits are first provided.<sup>30</sup>
- **Health stock option plan (HSOP)** is established by setting up an employee stock option plan and a 401(h) account with a money purchase pension plan. Individual accounts are established and tracked. The employer contributions are deductible for the employer and tax free to the employee/retiree. These plans are administratively complex and have not been a point of discussion for many large employers.

# SUPPORT AVAILABLE TO RETIREES **During the Enrollment Process**

## Calculators

The complexity of planning for health care in retirement has driven employees to use online calculators to estimate how much money they will need to save in order to pay for medical expenses. These tools ask a series of questions, with the most common results displaying how much money is required to produce the desired outcome (e.g., live until 90 years). Metrics include the following:

- Desired age of retirement
- Expected age of death
- Current salary
- Post-retirement income (including Social Security )
- Assets (401(k), IRA, savings investments)
- Tax rate and inflation

AARP conducted a comprehensive analysis of twelve calculators and found that the estimated amount varies tremendously based on the calculator used. For example, a 50-year-old female who inputs a retirement date of 65 and age of death of 85 can see estimates ranging from \$215,757 to \$1,046,275.

The AARP analysis reveals that these calculators do a poor job of zeroing in on health care costs in retirement. As of the date of this publication, there are no calculators on the market that control purely for health care costs.

## Counseling Services

- **Advantage Freedom Inc.** (AFI benefits; <https://afibenefits.com>) provides a service to employers through which their Medicare-eligible beneficiaries can receive assistance in selecting a Medicare Advantage or Medicare Supplement and Prescription Drug Plan. Retirees can call Personal Benefits Specialists to ask questions about the various plans available to them. AFI counselors do not make the choice for the retiree, but they do help in the decision-making process. AFI also provides Medicare information and a comparison tool on its website. Beneficiaries enroll through AFI.
- **Extend Health** (<http://www.extendhealth.com/>) offers two services to employers for their retirees: ExtendRetiree® for Medicare-eligible retirees and ExtendChoice® for early retirees. ExtendRetiree® allows retirees to purchase individual Medicare plans through HRA funds. Personalized statements that display plan choices most similar to the retiree's former health plan are made available to help the retiree select the right plan. ExtendChoice® allows employers to move to a defined contributions plan for their pre-65 retirees. Plans vary based on reimbursable amounts, frequency of visits, deductible levels, coinsurance levels, co-pays and annual benefit amounts.

- **Senior Educators**

(<http://www.senioreducators.com>)

contracts with employers that provide retiree health funding through a health reimbursement arrangement. Through this program, a personalized website, which lays out options for coverage, is created for each retiree. Each retiree receives one-on-one counseling and electronic resources to help them through the enrollment process.

- **Transition Assist**

(<http://www.transitionassist.com>)

acts as a Medicare coordinator when an individual is converting from his or her employer's group plan to an account-based plan. This program aims to ensure that Medicare-eligible beneficiaries understand the impact of this transition. Transition Assist offers Medicare Advantage Plans, Medicare Supplement Plans, prescription drug plans and dental and vision products. In addition, benefits specialists are available to help with the enrollment process.

## **Self-Service Decision Support Information**

Employers, along with their health carriers, usually offer basic information to employees making the transition into retirement or Medicare. However, employees may seek information on their own to complement what is provided to them at the workplace. Below are five organizations, which mostly focus on Medicare coverage, that future retirees are often referred to and can turn to for help.

- **AARP** is the largest membership organization for 50-plus Americans, serving 40 million members. Its website features a landing page specifically for insurance and Medicare that includes articles, recent press releases, interactive tools and guides for members. Specifically, the following resources are available:

- **What to Do When You Lose Your Group Insurance** – A guide for employees who are considering retiring before they are Medicare eligible.

- A step-by-step guide to **Choosing the Right Medicare Plan for You**.

- An **online community** in which members can discuss such issues as navigating Medicare and individual coverage, health care reform and specific health conditions and procedures.

- **National Council on Aging**

provides an interactive self-service tool, **BenefitsCheckUp®**, which offers a range of services; options include allowing retirees to assess if they are eligible to receive additional benefits through federal, state, local and private programs and providing assistance with prescription medication costs based on factors such as age, income/assets and location.

- **The Centers for Medicaid & Medicare Services (CMS)**

hosts **Medicare.gov**, the primary source of information on Medicare from the federal government. The site features a tool on finding the right prescription drug plan based on key inputs such as costs, drugs covered

and participating pharmacies. Basic information on items such as appeals, claims, eligibility, and providers also is available through the site. Medicare.gov has a navigation tab specifically dedicated to **preventive services** to guide beneficiaries on what services they should receive under the Medicare program.

- **The Center for Medicare Advocacy, Inc.** has a slightly different model in serving Medicare beneficiaries. This group works to ensure that all beneficiaries have equal access to quality health care. The Center provides numerous materials, including informational booklets and webinar recordings, for purchase, ranging in price from \$1 to \$275. Materials cover topics such as:

- How to file an appeal;
- TriCare and Medicare;
- Plan D Enrollment; and
- The 2009 guide to Medicare.

- **Medicare Interactive (MI)**, an independent website provided by the Medicare Rights Center, provides Medicare information in a consumer-friendly format. Retirees can log on to find answers to real-world questions from Medicare beneficiaries, advocates and caregivers. In addition to providing up-to-date information on basic Medicare features and how to coordinate benefits, MI has a **Guide Me** feature, which asks the retiree a series of questions and then directs the individual to the information he or she needs to help resolve a particular situation.

## COVERAGE IN **the Future**

Retirees are at serious risk of not having sufficient coverage in retirement. Based on the information in this report, it is evident that a large majority of future retirees will not be prepared for the high cost of health care. This situation is further complicated by the expected loss of the employer cost share and growing interest of Congress in taxing health benefits and charging higher income beneficiaries increased premiums. In looking to the future, this report concludes with a discussion of several key questions, which will define the outlook for retiree health care:

- Can our health care system survive the convergence of baby boomers entering retirement?
- Will active employees continue working later in life to avoid the bleak situation they face in retirement?
- Will Medicare continue funding coverage at the current level for future retirees?
- Will the state of retirees' health continue to decline as the number of obese retirees increase?

## The Future of the U.S. Population Distribution

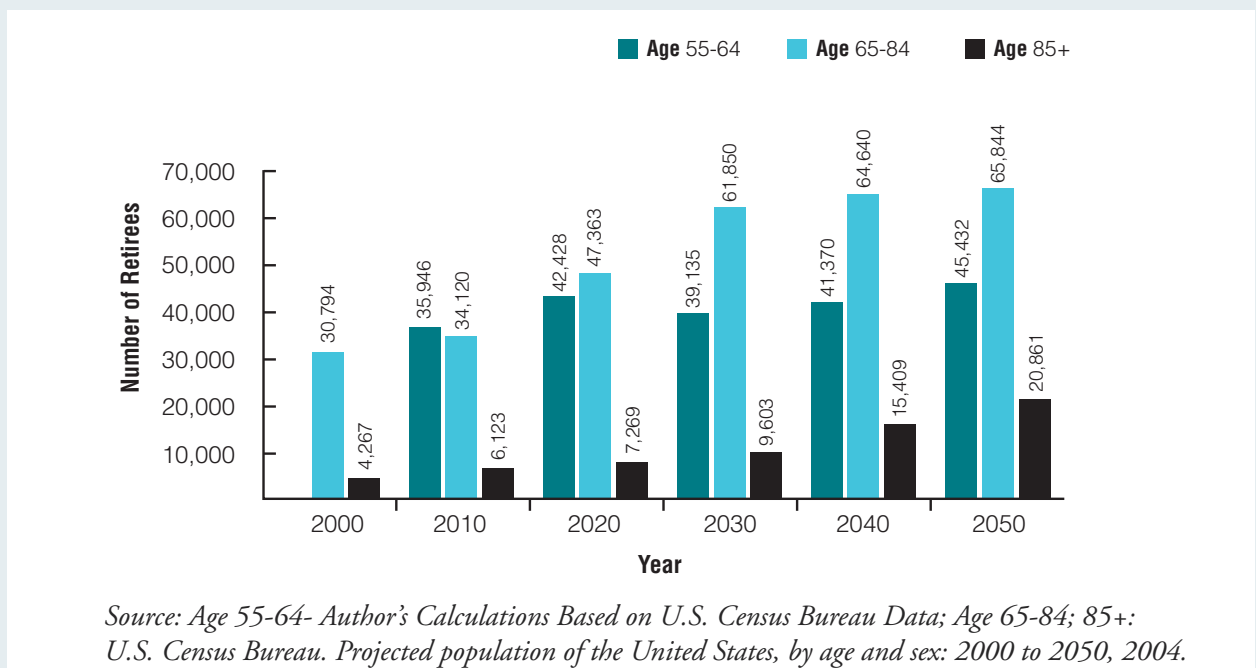
The year 2008 marked the onset of the first surge of baby boomers into retirement. This movement will overburden Social Security, which is the main reason for the need to increase the official age of retirement.

As Figure 3 shows, it is projected that by 2050, the age 65-84 cohort will have more than doubled since 2000.

## The Future of Retirement Dates

The economic downturn of 2008-2009 caused prospective retirees to re-consider their date of retirement; in fact, 28% of retirees surveyed have changed their retirement dates, with a large majority (89%) postponing retirement.<sup>3</sup> The top reasons given for this change include

**Figure 3: Total Population, Age 65+**



the following:

- The poor economy (36%)
- The need to make up losses in the stock market (28%)
- The desire to make sure there is enough money saved (24%)
- Job loss/change in employment (10%)

Interestingly, the worst economy in 70 years may have produced a slightly positive result; prospective retirees are actually stopping to think about the amount of money needed to sustain their current lifestyles. This is a good sign for advocates who are concerned that today's workers are not adequately prepared for retirement.

For additional information on delayed retirement, please refer to the *Critical Issue Update: Older Workers Who Can't Retire: Trends and Impacts* produced by the National Business Group on Health.

## The Future of Medicare

Retirement patterns are clearly affected by the availability of post-retirement medical coverage: the average retirement age is 61 when it's offered and 64 when it is not.

—Derek Guyton, Mercer

As of the date of this publication, experts predict that the Medicare Part A (Hospitalization) benefit will be insolvent in 10 years. This does not necessarily mean that Medicare will disappear completely, but it does point to the fact that the current level of benefit, which is less generous than the typical large employer-sponsored coverage, cannot be sustained without instituting a new funding stream and being more aggressive in driving health care delivery

system changes that will reduce costs.<sup>35</sup>

Numerous proposals have been outlined that, if implemented, could extend the solvency date for Medicare. The Congressional Budget Office presented to the House and Senate Committees on the Budget five options for closing the gap between Medicare spending and expenses.<sup>36</sup> These options, listed below, vary in scope, source of funding and amount, as well as the time when the funds would be recouped.

### 1. Increase the payroll tax for Part A

**expenses by one percentage point:** This would be achieved by increasing the payroll tax rate paid by employers and employees by 1.95% and the rate paid by self-employed workers by 3.9% OR by raising the hospital insurance payroll tax rate by one percentage point for those who earn over \$150,000 annually.

### 2. Limit the growth in Medicare per capita spending to that of the gross domestic product, plus one percentage point:

This strategy would combat the projected per-beneficiary cost increases (which are deemed to be more problematic than the increased number of total beneficiaries) by giving the Secretary of Health and Human Services (HHS) discretion in changing beneficiaries' co-payments, the measure that increases payments to hospitals, or benchmark levels for the Medicare Advantage Program.

### 3. If a Medicare Funding Warning is issued, create an enforcement structure to control general revenue funding:

If the general revenue funding is projected to exceed 45% over a seven-year period, a

Federal Spending for Medicare and Medicaid as a percentage of the gross domestic product will rise from 4% in 2008 to 12% in 2050.

—Congressional Budget Office

“Medicare Funding Warning” is issued. In the event that such a warning is issued, this proposal will apply an automatic 1% reduction in payments for services in the fee-for-service section as well as a 1% reduction in Medicare Advantage rates for the next year.

**4. Set a target date to reduce Medicare spending by 1%:** Through administrative action, require the Secretary of HHS to reduce spending in the program through a greater ability to make programmatic changes (as explained in option #2).

**5. Increase funding for the Health Care Fraud and Abuse Control Program** in Medicare and Medicaid beyond the current allocation so that more resources may be put into background checks of Medicare providers, staff-dedicated anti-fraud offices and audit claims submitted for payment by

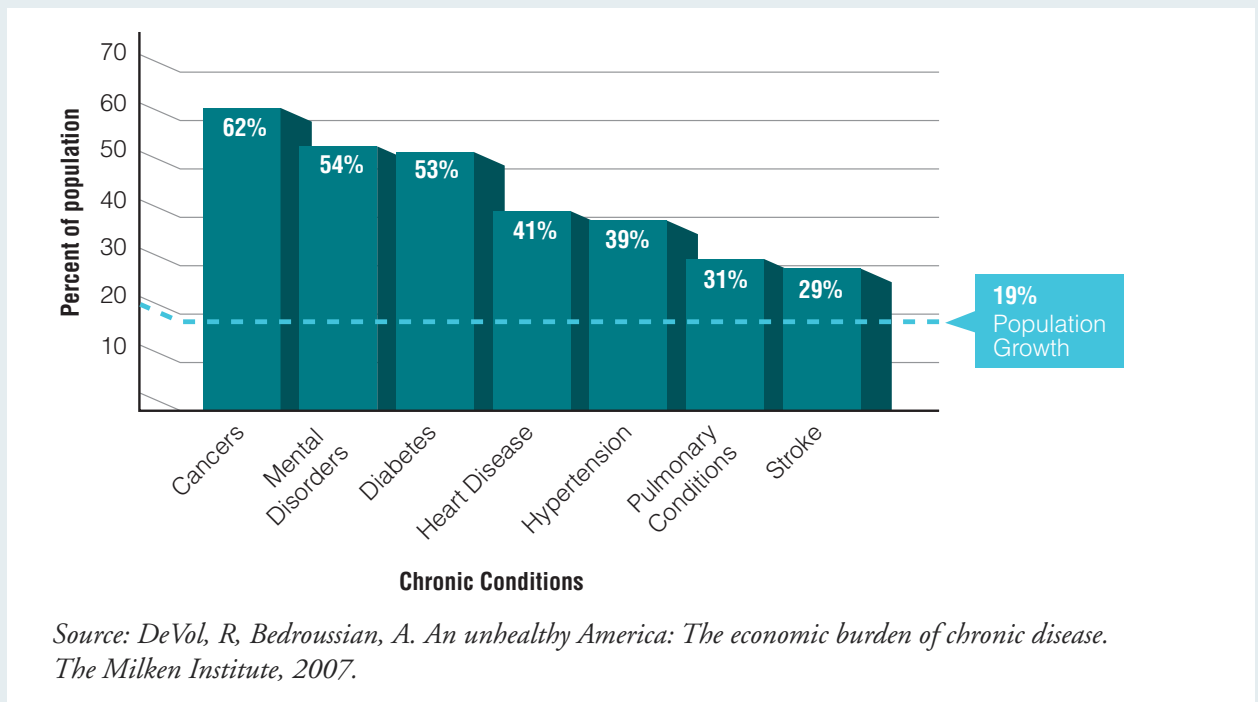
Medicare providers.

Medicare reform is a topic that must be discussed by lawmakers, and it is clear that there needs to be major changes. At this point, however, there is little agreement on a solution.

## The Future of Retirees’ Health

In addition to aging considerations, it is important to take into account how Americans’ health status will change over the next few years. Based on the aging progression outlined on page 18, the migration of the baby boomers into the 55-64 and 65+ cohorts will have major implications for health status: 18% of Americans ages 55-64 report being in fair or poor health, as do almost 22% of those 65-74 years old. It is important to note, however, that these projections are based

**Figure 4: Growth in Specific Chronic Diseases Through 2023**



on current trend; they do not take into account any major interventions that could have a positive effect on Americans' health.

In addition to these projections, a 2008 analysis conducted by researchers at Johns Hopkins University found that if trends continue at the same rate, 86.3% of adults will be overweight or obese by 2030. Of that number, 51% will be obese.<sup>37</sup> For the impact of obesity on health care costs, see the National Business Group on Health's report: [Weighty Matters: How Obesity Drives Poor Health and Health Spending in the U.S.](#)

Another indicator of declining health status is the rise in chronic diseases. Figure 4 on the previous page based on data from the Milken Institute, shows the growth of specific chronic diseases through 2023. Note that these numbers take into account population growth (19%); the excessive increase in chronic diseases beyond what is due to the aging of the American population, as well as a rise in other risk factors.<sup>38</sup>

Since the likelihood of having a chronic disease increases as an individual ages, this projected increase is a major source of concern for employers, retirees and payers alike.

## Conclusion

This report paints a bleak picture of the future of health care benefits for retirees. Not only are the costs increasing steadily, it appears that the baby boomers will use up most of the options currently set aside for this purpose. Based on current projections, Social Security benefits will be restructured in 2041, and without additional funding, Medicare could be insolvent within 10 years.

Clearly, employers and employees need to be aware of the seriousness of the situation and begin planning now for the future. At the same time, lawmakers need to address the future of Medicare and take action on one of the five options currently under consideration. Only by addressing this problem on all fronts will retirees be able to continue to receive health care benefits at an affordable rate.

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# Health Care in Retirement: Methods for Coverage and Funding

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The Institute on Health Care Costs and Solutions, an initiative of the National Business Group on Health, was established in 2001. Its mission is to provide an intense focus on finding effective solutions to the high cost of health care benefits confronting large employers.

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