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Savings Needed to Fund Health Insurance and Health Care Expenses in Retirement: Findings from a Simulation Model

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- ***Modeling retiree health costs:*** This *Issue Brief* examines the uncertainty of health care expenses in retirement by using a Monte Carlo simulation model to estimate the amount of savings needed to cover health insurance premiums and out-of-pocket health care expenses. This type of simulation is able to account for the uncertainty related to individual mortality and rates of return, and computes the present value of the savings needed to cover health insurance premiums and out-of-pocket expenses in retirement. These observations were used to determine asset targets for having adequate savings to cover retiree health costs 50, 75, and 90 percent of the time.
- ***Not enough savings***: Many individuals will need more money than the amounts reported in this *Issue Brief* because this analysis does not factor in the savings needed to cover long-term care expenses, nor does it take into account the fact that many individuals retire prior to becoming eligible for Medicare. However, some workers will need to save less than what is reported if they keep working in retirement and receive health benefits as active workers.
- ***Who has retiree health benefits beyond Medicare?*** About 12 percent of private-sector employers report offering any Medicare supplemental health insurance. This increases to about 40 percent among large employers. Overall, nearly 22 percent of retirees age 65 and older had retiree health benefits in 2005 to supplement Medicare coverage. As recently as 2006, 53 percent of retirees age 65 and older were covered by Medicare Part D, 24 percent had outpatient prescription drug coverage through an employment-based plan. Only 10 percent had no prescription drug coverage.
- ***Individually purchased Medicare supplements, 2008:*** Among those who purchase Medigap and Medicare Part D prescription drug coverage at age 65 in 2008, men would need between $79,000 and $159,000 with median prescription drug expenses (50th percentile and 90th percentiles, respectively), and between $156,000 and $331,000 with prescription spending that is at the 90th percentile. Women would need between $108,000 and $184,000 with median prescription drug expenses (50th and 90th percentiles, respectively), and between $217,000 and $390,000 with prescription spending that is at the 90th percentile. The savings needed for couples would range from $194,000 at the 50th percentile to $635,000 at the 90th percentile.
- ***Employment-based benefits, 2008:*** Among those who have employment-based retiree health benefits to supplement Medicare, but who must pay their own premiums, men would need between $102,000 and $196,000 in current savings (50th and 90th percentiles, respectively) to cover health care costs in retirement. Women would need between $137,000 and $224,000, respectively, due to their greater longevity. The savings needed for couples would range from $154,000 to $376,000.
- ***Individually purchased Medicare supplements, 2018:*** Among those who purchase Medigap and Medicare Part D prescription drug coverage at age 65 in 2018 (currently age 55), men would need between $132,000 and $266,000 with median prescription drug expenses (50th and 90th percentiles, respectively), and between $261,000 and $555,000 with prescription spending that is at the 90th percentile. Women would need between $181,000 and $308,000 with median prescription drug expenses (50th and 90th percentiles), and between $364,000 and $654,000 with prescription spending that is at the 90th percentile. The savings needed for couples would range from $325,000 at the 50th percentile to $1,064,000 at the 90th percentile.
- ***Retiree health may be driving longer time in the work force:*** The declining availability of retiree health benefits may partly explain the rising labor force participation rate among individuals ages 55–64. Between 1996 and 2006, the labor force participation rate increased from 67 percent to 69.6 percent for men and from 49.6 percent to 58.2 percent for women.

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Table of Contents

Introduction....4
Savings Needed for Health Care Expenses in Retirement....6
Savings Needed for a 65-Year-Old in 2018 (Currently Age 55)....9
Employment-Based Retiree Health Benefits....9
Medigap and Medicare Part D....9
Availability of Retiree Health Benefits....11
Public-Sector Trends....14
Impact on Workers and Retirees....17
Impact on Retirees....17
Impact on Workers....20
Reconciling Retiree Trend with Employer Data....20
Conclusion....21
References....24
Appendix: The Medicare Program....26
Endnotes....27

Figures

Figure 1, Savings Needed for Employment-Based Health Premiums, Medicare Part B Premiums, and Out-of-Pocket Costs for Retirement at Age 65 in 2008....8

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 2008....8

Figure 3, Savings Needed for Employment-Based Health Premiums, Medicare Part B Premiums, and Out-of-Pocket Costs for Retirement at Age 65 in 2018....10

Figure 4, 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....10

Figure 5, Percentage of Private-Sector Establishments Offering Health Insurance to Retirees, 1997–2005....12

Figure 6, Percent of Private-Sector Establishments That Offer Retiree Health Benefits, by Firm Size, 2005....12
Figure 7, Percentage of Employers With 500 or More Employees Offering Health Insurance to Retirees, 1993–2007....13
Figure 8, Percentage of Private-Sector Workers Employed at Establishments Offering Health Benefits to Early Retirees, 1997–2005....13
Figure 9, Eligibility Requirements for Retiree Health Benefits, Employers With 1,000 or More Employees, 1996 and 2007....14
Figure 10, Percentage of Employers With Cap on Their Contribution to Retiree Health Benefits for Medicare-Eligible Retirees in Largest Plan, 2006....15
Figure 11, Percentage of Large Private-Sector Employers That Terminated All Subsidized Benefits for Future Retirees, 2002–2006....16
Figure 12, Likelihood of Making Changes to Retiree Health Benefits for the 2007 Plan Year (As Reported in 2006)....16
Figure 13, Percentage of Local Governments With Fewer than 250 Employees Offering Health Insurance to Retirees, 1997–2005....18
Figure 14, Percentage of Local Governments With 5,000–9,999 Employees Offering Health Insurance to Retirees, 1997–2005....18
Figure 15, Percentage of Local Governments With 10,000 or More Employees Offering Health Insurance to Retirees, 1997–2005....19
Figure 16, Percentage of State Governments Offering Health Insurance to Retirees, 1997–2005....19
Figure 17, Retiree Health Benefits: Coverage Among Retirees and Other Nonworkers and Expectations of Coverage Among Workers, 1997–2005....22
Figure 18, Labor Force Participation Rates, Ages 55-64, by Gender, 1986, 1996, 2006....22

Introduction

Private-sector employers have been providing employee benefits for many years, but the nature of those benefits has been changing over the past three decades. While employers continue to provide benefits, there has been a fundamental shift away from the group-based risk management nature of both health and retirement benefits to more individual responsibility and individual risk management within these benefits. For example, since the 1980s, fewer workers have had access to employer-funded defined benefit (DB) pension plans, while more have had defined contribution (DC) plans, typified by the 401(k), which are funded primarily by workers' own contributions. Evidence suggests that workers may appreciate DC plans more than DB plans for a number of reasons (Olsen and VanDerhei, 1997). However, DC plans shift the risk of uncertainty with respect to life expectancy from the group to the individual.

The shift from group-based risk management insurance to more individual responsibility associated with risk uncertainty has also been apparent among workers and retirees with retiree health benefits. Prior to the passage of Medicare in 1965 (the federal health care insurance program for the elderly and disabled), 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 private-sector accounting rule change that is in large part responsible for the decline in availability of retiree health benefits (discussed below), only about one-third of workers ages 46–64 reported they would be eligible for health benefits upon retirement (Fronstin, 1996). In 2001, only about 30 percent of Medicare beneficiaries had retiree health benefits through a former employer as a supplement to Medicare (Salisbury and Fronstin, 2003). 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 Employee Benefit Research Institute (EBRI) published its first analysis of employment-based retiree health benefits in 1988. That study examined the likely effects of early proposals by the Financial Accounting Standards Board (FASB) to change the way retiree health benefits appeared on private-sector balance statements and how the proposed changes would cause employers to reconsider their role in offering these benefits. The Government Accounting Standards Board (GASB) currently is implementing similar guidelines for public-sector employers. EBRI has continued its work on this subject, and since the mid-1990s numerous other researchers have examined the erosion in employer premium payments for employment-based retiree health benefits and its impact on retirees.[1]

For the small minority of retirees who ever would have had retiree health benefits, more and more of them will be assuming the risk of longevity as they plan for health care in retirement—just as reflected in the movement away from DB to DC plans in retirement benefits. Furthermore, these retirees also will be assuming all of the risk associated with uncertain health care cost increases—just as the large majority of retirees who were *never* eligible for retiree health benefits have always faced. It is important not only that retirees understand this risk, but that workers understand it before retiring. Currently, Medicare covers only a little more than one-half of the cost of health care services for elderly Medicare beneficiaries. For various reasons, beneficiaries will be increasingly responsible for covering more of their health care costs in retirement as cost-shifting by both the private- and public-sectors continues.

During 1975–2005, health care cost increases outpaced growth in the economy by 2.1 percent (U.S Congressional Budget Office, 2007). More relevant for retirement planning is the fact that growth in Medicare costs has outpaced growth in the economy by 2.4 percent. The compound effect of such excess cost growth has implications for workers, retirees, and the overall economy. Even when CBO assumes that excess cost growth will decline in the future, the slowdown will not be "painless"—CBO assumes that cost sharing will increase and that new and potentially useful health technologies would be introduced more slowly or utilized at lower rates than would occur otherwise. Even though the growth rate would decline, the real level of health care costs would continue to increase.

Using excess cost growth to predict how fast health care costs have increased suggests that health care cost inflation for Medicare beneficiaries averaged 7.2 percent during 2003–2007. However, most retirees

have been experiencing even larger cost increases for part or all of their health insurance premiums and out-of-pocket expenses for health care services. For example, Medicare 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. Part B is financed by beneficiary premiums that cover 25 percent of the program's cost. General tax revenues finance the balance. Because beneficiary premiums cover a fixed 25 percent of the premium, increases in the premium reflect underlying increases in the cost of operating the program. In 2004, Part B premiums increased 17.4 percent, while in both 2003 and 2005, premiums increased more than 13 percent. While average annual premium increases under current law are projected at 3.7 percent during 2008–2016, if retirees use current-law projections to estimate the amount of money they will need for Part B premiums in retirement, they are likely to grossly underestimate needed savings.

Under current law, Medicare updates to physician payment rates are projected to be negative each year during 2009–2016. A physician update of –4.8 percent took effect in 2002, but that was the only year during 2003–2007 in which a scheduled cut took effect, despite the fact that negative updates were scheduled. It is expected that Congress will continue to override future expected cuts in physician payments in order to keep physicians from dropping out of the Medicare program; however, doing so will have the effect of increasing Part B premiums above the existing law's estimates. Were physician payment updates assumed to match the Medicare economic index, Part B premiums would increase at an average annual rate of 6.3 percent during 2008–2016.

Currently, persons choosing Part B pay a $96.40 monthly premium, but under provisions originally contained in the Medicare Modernization Act (MMA) and since revised in the 2005 Deficit Reduction Act, higher-income beneficiaries pay a greater percentage of the Part B premium. For example, individuals earning $150,000 in 2008 pay $160.90 per month for Part B coverage. Sen. John McCain's presidential campaign has hinted that it would also require higher-income Medicare beneficiaries to pay a greater percentage of the Part D premium for prescription drug benefits, which currently averages 25 percent of the cost of the program (as does the Part B premium). The next logical extension would be to tie cost sharing (i.e., deductibles and co-payments) to income.

Under current law, an increasing percentage of Social Security benefits will go toward paying Medicare expenses in retirement. In 2004, the average 65-year-old paid 18.6 percent of Social Security income toward Medicare premiums and cost sharing. By 2010, Medicare spending as a percentage of Social Security is expected to be 39.2 percent. Individuals can expect to pay even more in premiums and out-of-pocket for health care services in retirement because of the financial condition of the Medicare program. The Part A trust fund is expected to become insolvent in 2019 under intermediate cost assumptions. Tax revenue collected in 2019 would cover only 78 percent of the expected benefits in that year, meaning that Medicare will be unable to pay promised benefits.

In order to address the funding shortfall, the Medicare trustees indicate that the payroll tax could immediately be increased from 2.9 percent to 6.44 percent if the funding shortfall were to be paid by workers and employers. Were the funding shortfall paid by Medicare beneficiaries, an immediate 51 percent reduction in government spending on the Part A portion of the program would be necessary. Given the magnitude of the changes needed to address the Part A trust fund funding shortfall, it is likely that future retirees will have to pay more for health care services in retirement.

The present value of Medicare's lifetime benefits for a husband and wife turning age 65 in 2010 has been estimated at about $376,000.[2] That means the average husband and wife will need a little less than $376,000 in personal 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. However, 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. Obviously, in the case of a married couple both currently age 65, the probability that at least one of the spouses will still be alive at these various ages is even greater.

Ultimately, the real issue that retirees will face in planning for health care expenses in retirement is uncertainty. The remaining number of years an individual will live is uncertain. Health care cost increases are uncertain. Inflation is uncertain. Interest rates are uncertain. And health status is uncertain. As workers and retirees become increasingly responsible for planning for retirement, the risk of uncertainty will make retirement planning increasingly complicated.

This *Issue Brief* examines the cost and uncertainty of health care expenses in retirement. Past EBRI research has examined how much money an individual needs for health care expenses in retirement, focusing on how savings varies by length of life and health care cost increases. Past research was based on computer modeling that used deterministic (non-random) analytical techniques. The research presented in this *Issue Brief* builds on that earlier work by introducing random (stochastic) computer modeling to more realistically examine the uncertainty of longevity and investment risk as well as future health care cost increases.

This *Issue Brief* begins with a brief discussion of the modeling technique, followed by main findings and updated data on trends in retiree health benefits.

Savings Needed for Health Care Expenses in Retirement

Determining how much money an individual or couple needs in retirement to cover their health care expenses is a complicated process. The amount of money a person needs will depend upon the age at which he or she retires, length of life after retirement, the availability of health insurance coverage after retirement to supplement Medicare and the source of that coverage, health status and out-of-pocket expenses, the rate at which health care costs will increase, and interest rates and other rates of return on investments. In addition, public policy that changes any of the above factors will also affect spending on health care in retirement. While it is possible to come up with a single number that individuals can use to set retirement savings goals, a single number based on averages will be wrong for the vast majority of the population.

This analysis uses a Monte Carlo simulation model[3] to estimate the amount of savings needed to cover health insurance premiums and out-of-pocket health care expenses in retirement. Separate estimates are presented for persons who supplement Medicare with 1) employment-based retiree health benefits, and 2) a combination of individual health insurance through Medigap Plan F coverage and Medicare Part D for outpatient prescription drug coverage. For each source of supplemental coverage, the model simulated 65,000 observations allowing for the uncertainty related to individual mortality and rates of return in retirement[4] and computed the present value of the savings needed to cover health insurance premiums and out-of-pocket expenses in retirement at age 65. These observations were used to determine asset targets for having adequate savings to cover retiree health costs 50 percent, 75 percent and 90 percent of the time. Estimates are also jointly presented for a stylized couple where the male and female are assumed to retire simultaneously at age 65.

The 50th percentile represents the savings needed if the individual's goal is to have a 50 percent chance that he or she will have enough money saved to cover health insurance premiums and health care expenses in retirement. If an individual wants to have a 75 percent chance of having enough savings in retirement to cover premiums and other expenses, then he or she would need to have the amount of money shown for the 75th percentile. And if an individual wants a 90 percent chance of having enough money to cover health insurance premiums and out-of-pocket expenses in retirement, he or she will need to have saved the amount of money shown for the 90th percentile.

Although the median amount (mid-point, half above and half below) needed for a couple is approximately the same as the sum of the amounts needed for each individual spouse at the median, the same is not true at the larger percentiles. Due to the benefits of pooling available even with two people, the 75th percentile total needed for a couple is less than the sum of the 75th percentiles for the male and female separately. The difference between the 90th percentile for a couple and the sum of the 90th percentiles for a single male and a single female are even more pronounced.

Figure 1 provides estimates of savings needed to pay for health insurance premiums, Medicare Part B premiums, and out-of-pocket health care costs during retirement for a person with employment-based retiree health benefits as a supplement to Medicare. The amounts that a married couple will need are also shown. There are two columns of estimates: one where it is assumed that the employer subsidizes a portion of the premium and one where it is assumed that the retiree is responsible for paying the entire premium. Prior

research has found that when employers provide a subsidy, retirees are responsible for about 40 percent of the premium,[5] however, it is becoming more common for employers to provide "access-only" plans where the retiree pays the entire premium, if the employer provides any retiree health benefit at all.

This model uses excess cost growth in Medicare plus per capita growth in the economy to predict health care premium increases. It also assumes that at age 65 an individual spends $750 out-of-pocket annually on health costs and that this amount grows at the same rate as premiums grow. Separate estimates are presented for men and women. Because women have longer life expectancies than men, women will generally need greater savings than men to cover health insurance premiums and health care expenses in retirement when examining needed savings at the median and at the 75th and 90th percentiles. In other words, women will need greater savings ex ante than men when both set a goal, for example, of having a 90 percent chance of having enough money to cover health expenses in retirement.

Figure 1 shows that a 65-year-old man retiring in 2008 with retiree health benefits from a former employer and *premiums subsidized by that former employer* will need $64,000 in current savings if he is comfortable with a 50 percent chance of having enough savings to cover health care expenses in retirement. In contrast, a man who wanted a 90 percent chance of having enough money to cover health care expenses in retirement would need $122,000 in current savings. Women would need savings of $86,000 and $140,000, respectively, or 34 percent more than men at the median and 15 percent more than men at the 90th percentile because of their higher life expectancy. A married couple with subsidized retiree health benefits would need savings of $154,000 at the 50th percentile, $198,000 at the 75th percentile, and $235,000 at the 90th percentile.

Retirees who have employment-based retiree health benefits to supplement Medicare and whose former employer *does not subsidize premiums*—an increasingly common situation—will need to save more money than retirees whose premiums are subsidized. A man without subsidized premiums would need $102,000 in savings to cover health care costs in retirement if he wanted a 50 percent chance of having enough savings, while a woman would need $137,000. In order to have a 90 chance of having enough savings to cover health care costs in retirement, men would need $196,000 and women would need $224,000, when premiums through a former employer are not subsidized. A couple with unsubsidized retiree health benefits will need $246,000 at the 50th percentile, $317,000 at the 75th percentile, and $376,000 at the 90th percentile.

Figure 2 contains the savings estimates for a person who does not have employment-based retiree health benefits to supplement Medicare and instead purchases Medigap Plan F and Medicare Part D outpatient drug benefits. Like a person who has employment-based retiree health benefits, there will be uncertainty related to a number of variables. Among persons with Medicare Part D, there is also the uncertainty related to health status and prescription drug use. Projections of savings needed to cover out-of-pocket expenses for prescription drugs are highly dependent on the assumptions used for drug utilization. There are three columns of estimates in Figure 2: one where prescription drug use is at the median throughout retirement, one where prescription drug use is higher (at the 75th percentile throughout retirement), and one where prescription drug use is much higher (at the 90th percentile throughout retirement).

According to Figure 2, men with median drug expenditures would need $79,000 in current savings and women would need $108,000 if each had a goal of having a 50 percent chance of having enough money saved to cover health care expenses in retirement. If an individual instead wanted a 90 percent chance of having enough savings, $159,000 would be needed by men and $184,000 would be needed by women.

Among individuals with drug expenditures at the 75th percentile, needed savings would be $93,000 among men and $127,000 among women if each wanted a 50 percent chance of having enough savings to cover health care expenses in retirement. This same person would need $189,000 in savings for men and $220,000 in savings for women in order to have a 90 percent chance of having enough money to cover health care expenses in retirement.

At the 90th percentile in drug spending, men would need $331,000 and women would need $390,000 to have a 90 percent chance of having enough money to cover health care expenses in retirement.

A couple both with median drug expenses would need $194,000 to have a 50 percent change of having enough money to cover health care expenses in retirement. They would need $253,000 to have a 75 percent chance of covering their expenses, and they would need $305,000 to have a 90 percent change of covering their expenses.

Figure 1

Savings Needed for Employment-Based Health Premiums, Medicare Part B Premiums, and Out-of-Pocket Costs for Retirement at Age 65 in 2008

	Employer Subsidizes Premiums	No Employer Subsidy of Premiums
Men		
Median	$64,000	$102,000
75th Percentile	96,000	154,000
90th Percentile	122,000	196,000
Women		
Median	86,000	137,000
75th Percentile	112,000	179,000
90th Percentile	140,000	224,000
Married Couple		
Median	154,000	246,000
75th Percentile	198,000	317,000
90th Percentile	235,000	376,000

Source: Authors' simulations based on assumptions described in the text.

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 2008

	Median Prescription Drug Expenses Throughout Retirement	75th Percentile of Prescription Drug Expenses Throughout Retirement	90th Percentile of Prescription Drug Expenses Throughout Retirement
Men			
Median	$79,000	$93,000	$156,000
75th Percentile	122,000	144,000	248,000
90th Percentile	159,000	189,000	331,000
Women			
Median	108,000	127,000	217,000
75th Percentile	143,000	170,000	296,000
90th Percentile	184,000	220,000	390,000
Married Couple			
Median	194,000	228,000	390,000
75th Percentile	253,000	299,000	518,000
90th Percentile	305,000	363,000	635,000

Source: Authors' simulations based on assumptions described in the text.

Savings Needed for a 65-Year-Old in 2018 (Currently Age 55)

While the estimates in Figures 1 and 2 are useful, individuals who have already reached age 65 generally do not have time to save for health care expenses in retirement if they have not already done so. The general rule of thumb has always been the earlier an individual starts saving for retirement, the easier it will be to meet his or her goals. Previous EBRI research has shown that during the decade ending 2030, retirees in the United States will face a shortfall of at least $400 billion between expected retirement income compared with what they will need to cover basic expenditures and any expense associated with an episode of care in a nursing home or from a home health provider (VanDerhei and Copeland, 2003). The remainder of this section focuses on the amount of money an individual will need to save to cover health insurance premiums and out-of-pocket expenses in retirement for a person 55 years old in 2008 who will not retire until age 65 in 2018.

Employment-Based Retiree Health Benefits

Figure 3 provides estimates of savings needed for health insurance premiums, Medicare Part B premiums, and out-of-pocket expenses during retirement for a person with employment-based retiree health benefits. The estimates in this figure are for an individual who is 55 years old in 2008 and does not retire until age 65 in 2018. In one column, estimates are presented for a retiree whose premiums are subsidized by his or her former employer. In the second column, estimates are presented based on the assumption that the individual will have access to retiree health insurance through a former employer but that the plan is an access-only plan, such that the individual is responsible for paying the entire premium.

Figure 3 shows that a median 65-year-old man retiring in 2018 will need $108,000 in savings at age 65 to pay for his portion of premiums and out-of-pocket expenses each year and a woman would need $144,000 if she had subsidized employment-based retiree health benefits. In contrast, a man at the median who pays the entire premium for health benefits through a former employer will need $171,000 in savings, while a woman would need $230,000. A retiree at the median would have a 50 percent chance of outliving his or her savings for medical expenses. If a retiree wanted a 90 percent chance of having enough savings to cover health insurance premiums and out-of-pocket health care expenses in retirement, men would need $204,000 and women would need $235,000 if premiums were subsidized by a former employer and $329,000 for men and $375,000 for women if premiums were not subsidized and the retiree was responsible for the entire premium. As mentioned above, employers are increasingly moving to access-only plans. Married couples would need $630,000 if premiums were not subsidized and the couple wanted a 90 percent chance of having enough money to cover health insurance premiums and out-of-pocket expenses in retirement.

Medigap and Medicare Part D

Figure 4 shows the level of savings for a 55-year-old retiring at age 65 in 2018 to cover Medigap premiums, Medicare Part D premiums, and out-of-pocket prescription drug expenses. The three columns contain estimates that vary with prescription drug expenses during retirement.

According to Figure 4, men with median drug expenditures would need $132,000 and women would need $181,000 in savings if they want a 50 percent chance of having enough money saved to cover health care expenses in retirement. If an individual instead wanted a 90 percent chance of having enough savings, men would need $266,000 while women would need $308,000.

Among individuals with drug expenditures at the 75th percentile, needed savings would be $156,000 for men and $213,000 for women to have a 50 percent chance of having enough savings to cover health care expenses in retirement. This same person would need $317,000 (men) and $369,000 (women) in savings to have a 90 percent chance of having enough money to cover health care expenses in retirement.

Men at the 90th percentile in drug spending would need $555,000 and women would need $654,000 to have a 90 percent chance of having enough money to cover health care expenses in retirement.

Figure 3

Savings Needed for Employment-Based Health Premiums, Medicare Part B Premiums, and Out-of-Pocket Costs for Retirement at Age 65 in 2018

	Employer Subsidizes Premiums	No Employer Subsidy of Premiums
Men		
Median	$108,000	$171,000
75th Percentile	161,000	258,000
90th Percentile	204,000	329,000
Women		
Median	144,000	230,000
75th Percentile	188,000	300,000
90th Percentile	235,000	375,000
Married Couple		
Median	258,000	412,000
75th Percentile	332,000	531,000
90th Percentile	394,000	630,000

Source: Authors' simulations based on assumptions described in the text.

Figure 4

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: Authors' simulations based on assumptions described in the text.

Availability of Retiree Health Benefits

One of the most important factors (if not the single-most important) that has led to the decline in the availability of retiree health benefits was a 1990 rule change issued by the Financial Accounting Standards Board (FASB) that required employers to report their retiree health liabilities in the footnotes to their annual financial reports. In the early 1980s, employers were aware that FASB was considering accounting standard changes that would affect the way to account for retiree health benefits on financial statements. There were a number of studies on the earliest FASB guidelines for "Other Post-Employment Benefits" (OPEBs) and the fuller proposals that were issued in the mid-1980s, such as one done by EBRI (1988). The early 1980s standards and the later draft proposals and subsequent research undoubtedly resulted in some employers making changes to retiree health benefits even before FASB's expanded standards were finalized in 1990.

The approval of Financial Accounting Statement No. 106 (FAS 106), "Employer's Accounting for Postretirement Benefits Other Than Pensions," in December 1990 triggered many of the subsequent changes that private-sector employers have made to retiree health benefits. FAS 106 requires companies to record retiree health benefit liabilities on their financial statements in accordance with generally accepted accounting principles. Specifically, it requires private-sector employers to accrue and expense certain future claims' payments as well as actual paid claims. The immediate income statement inclusion and balance sheet footnote recognition of these liabilities dramatically affected many companies' reported profits and losses, primarily affecting large employers (since small employers typically never offered retiree health benefits).

As a result of FAS 106, companies now recognize the long-term liability of offering retiree health benefits. With the new view of the expenses and the increasing cost of providing retiree health benefits, many private-sector employers overhauled their retiree health programs in ways that controlled, reduced, or eliminated these expenses. By now, 18 years after the accounting standard was issued, these cuts would be expected to have had a major impact on employer FAS 106 liabilities. Recently, however, the U.S. Government Accountability Office (GAO) examined the financial statements of 50 randomly chosen Fortune 500 companies, and found that more than 90 percent of the employers offering retiree health benefits experienced an increase in their postretirement benefits obligations between 2001 and 2003, with some being 50 percent or more higher (U.S. Government Accountability Office, 2005).

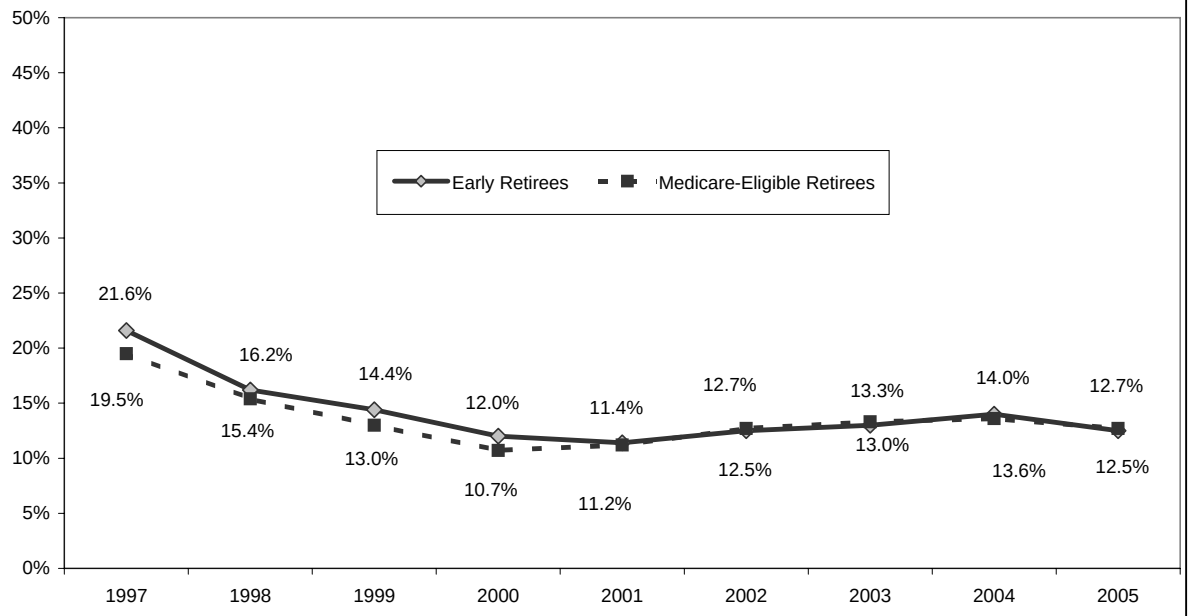
FAS 106 and the rising cost of providing retiree health benefits will result in most workers in the United States never becoming eligible for health insurance in retirement through a former employer. Very few employers currently offer this benefit, and the number that do has been declining. The Agency for Healthcare Research and Quality (AHRQ) reports that only about 13 percent of private-sector establishments offered health benefits to early retirees or Medicare-eligible retirees in 2005 (Figure 5). AHRQ finds that the trend has been flat since about 2000, but before that the percentage of employers offering coverage was as high as 21.6 percent for early retirees and 19.5 percent for Medicare-eligible retirees.

Large establishments are much more likely to offer retiree health benefits than small establishments. In 2005, 41 percent of establishments with 1,000 or more workers offered retiree health benefits to early retirees, compared with 2 percent among establishments with fewer than 10 workers (Figure 6). For the most part, small business never offered health insurance as a benefit to retirees.

Hence, the trend away from retiree health benefits is mainly a large-firm phenomenon and a much stronger trend when excluding small employers from an analysis of the trend. Among employers with 500 or more employees, 31 percent offered health benefits to early retirees and 21 percent to Medicare-eligible retirees in 2007, down from 46 percent and 40 percent, respectively (Figure 7).

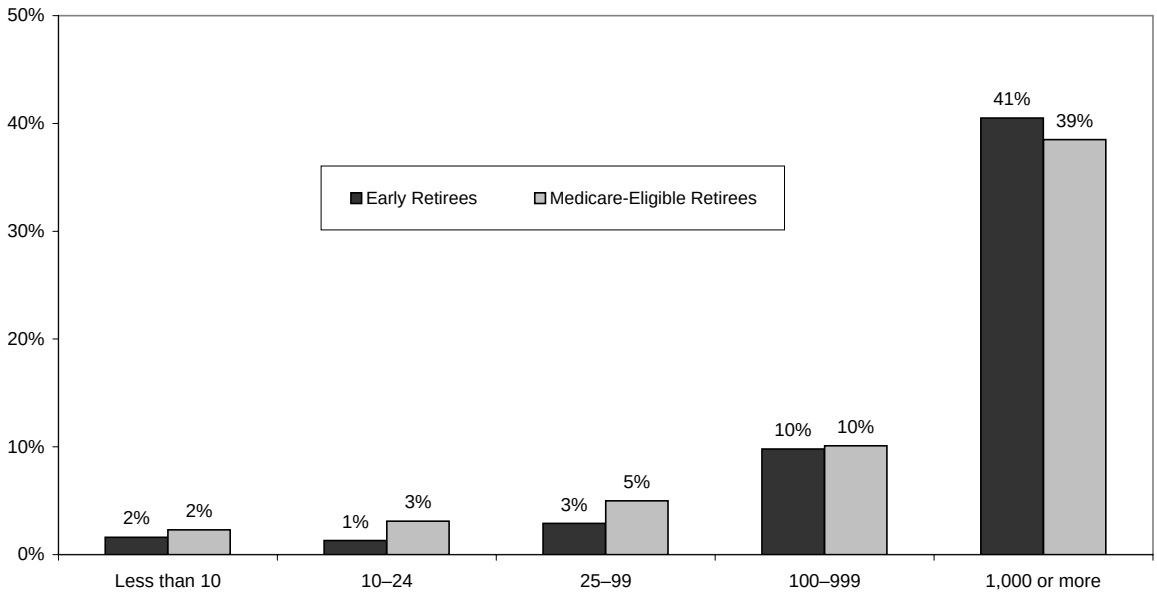
Inevitably, the percentage of workers employed at establishments offering retiree health benefits has been falling: In 2005, 21 percent of all workers were employed at an establishment that offered health benefits to early retirees, down from 31 percent in 1997 (Figure 8). Because workers in small business generally were never offered health benefits, and small business accounts for roughly one-half of all jobs in the United States (Fronstin, 2007), the erosion in the availability of retiree health benefits is not as great as one would expect it to be. Furthermore, these data should not be interpreted as indicating that 22 percent of workers are or would be eligible for health benefits in retirement should they retire or that those who qualify for a retiree medical plan will receive a substantial premium contribution from his or her employer.

Figure 5
Percentage of Private-Sector Establishments Offering Health Insurance to Retirees, 1997–2005



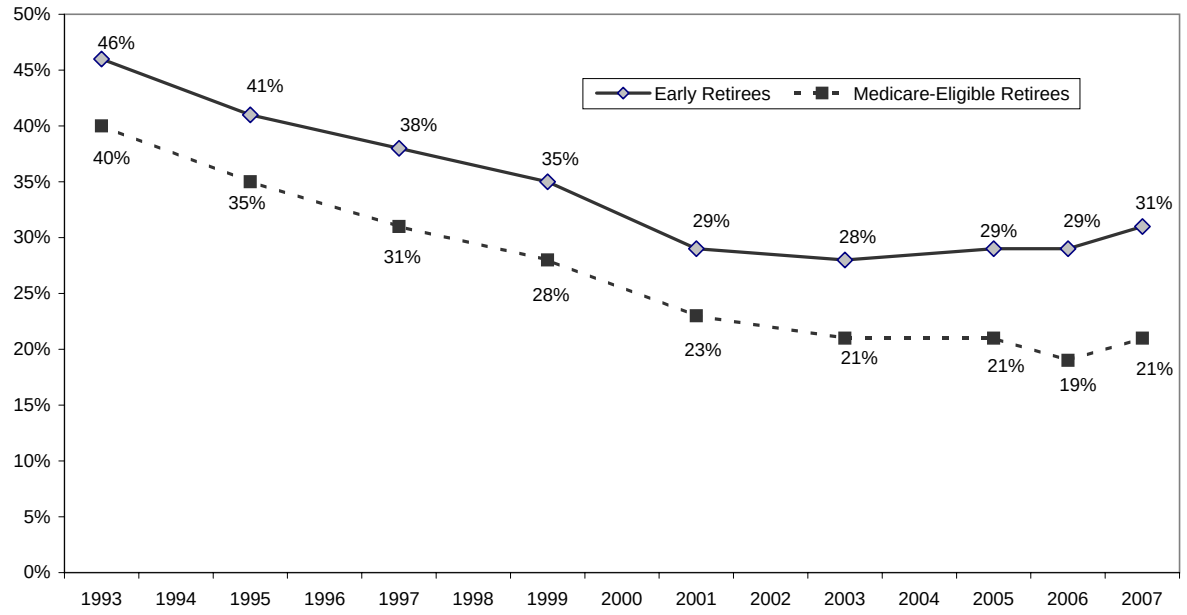
Source: Various tables at www.meps.ahcpr.gov/Data_Pub/IC_Tables.htm

Figure 6
Percentage of Private-Sector Establishments That Offer Retiree Health Benefits, by Firm Size, 2005



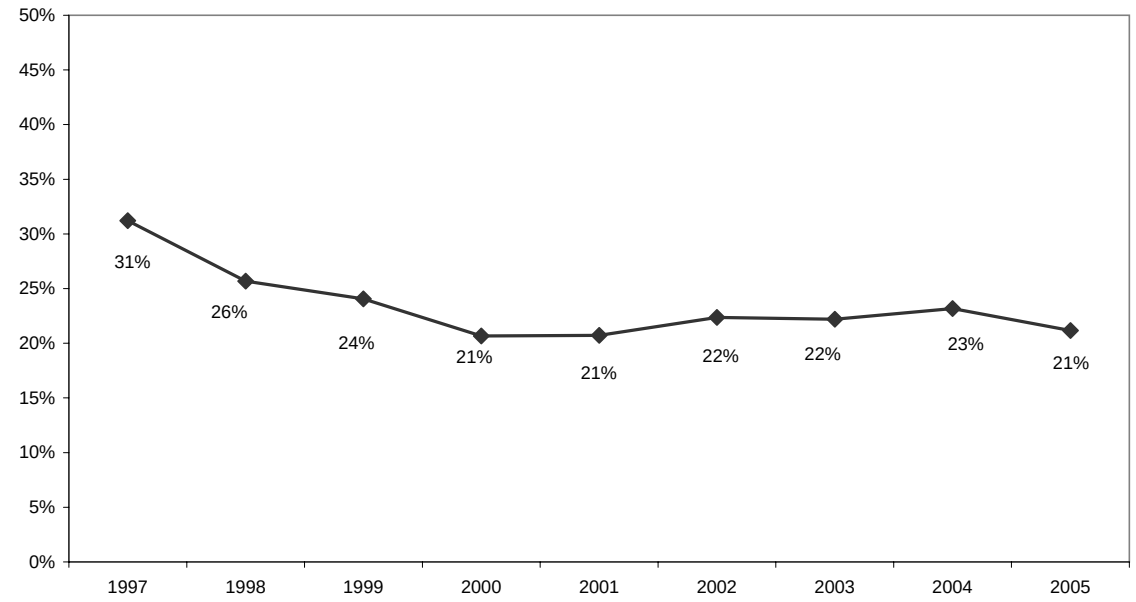
Source: http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2005/tia2e.htm

Figure 7
Percentage of Employers With 500 or More Employees Offering Health Insurance to Retirees, 1993–2007



Source: Mercer National Survey of Employer-Sponsored Health Plans.

Figure 8
Percentage of Private-Sector Workers Employed at Establishments Offering Health Benefits to Early Retirees, 1997–2005



Source: Various tables at www.meps.ahcpr.gov/mepsweb/data_stats/quick_tables.jsp.

Employers have generally made it more difficult for retirees to qualify for health benefits in retirement, so not all of those who work for an employer that offers the benefit will qualify to receive it. They have been tightening eligibility requirements to control spending and reward longer-service employees. This might involve requiring workers to attain a certain age and/or tenure with the company before they qualify for health benefits in retirement. Overall, the percentage of employers requiring an age of 55 and a service requirement of 10 years for benefit eligibility increased from 30 percent in 1996 to 36 percent in 2007 (Figure 9). The percentage of employers requiring age 55 and at least 15 years of service doubled between 1996 and 2007, increasing from 5 percent to 10 percent. Concurrently, while only 1 percent of employers had a minimum age requirement of 60 to receive benefits, in 1996 there were no employers requiring age 60.

In addition to tightening eligibility for benefits, some employers have simply made the cost of participating in retiree health benefits more expensive for retirees. Employers often used service-based contributions or subsidies, contributing more for longer-service employees and less for shorter-service ones. Employers have often instituted caps or ceilings on the total amount of money they are willing to spend on retiree health benefits. Under a commonly used approach, once employer spending reaches the cap, the employer subsidy for the retiree health benefit will no longer be increased. Caps can take the form of a per-person cap or a global cap. Employers who have instituted caps often continue to subsidize retiree health benefits, but retirees are responsible for the entire premium in excess of the cap amount each year, and as the cost of coverage increases, the retiree cost increases, but the employer cost does not. In 2006, one-half of employers had a cap on the largest plan offered to Medicare-eligible retirees, and among them, 61 percent had reached the cap, and 9 percent had expected to reach the cap within the next year (which would have been 2007) (Figure 10). Caps erode the level of coverage even for employers continuing to offer retire health benefits: When employer contributions are capped and retiree premium contributions rise, a significant number of retirees tend to drop their coverage.

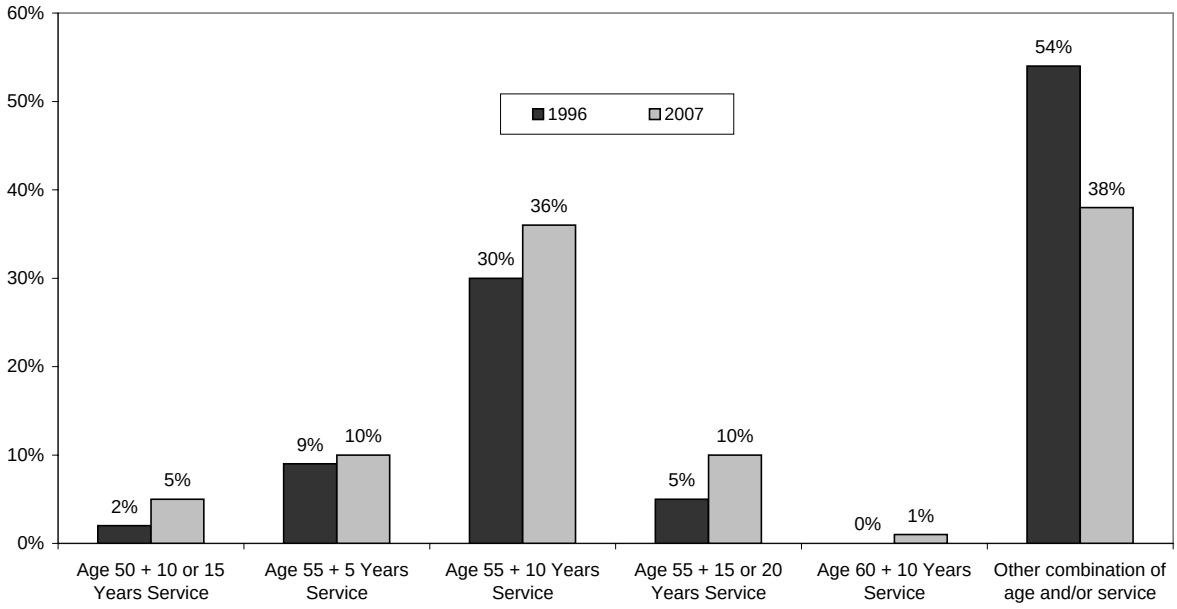
Some employers have gone so far as to eliminate their subsidy for retiree health benefits altogether for workers hired (or retiring) after a specific date. According to findings from the Kaiser/Hewitt Survey on Retiree Health Benefits, 13 percent of employers that offered retiree health benefits reported that they had terminated all subsidized health benefits for future retirees in either 2001 or 2002; 10 percent reported doing so in 2003; 9 percent reported it in 2004; 12 percent reported it in 2005; and another 9 percent reported that they terminated all subsidized health benefits for future retirees in 2006 (Figure 11). These employers have not necessarily dropped benefits altogether. They may be offering a plan but requiring certain retirees (not necessarily all retirees) to pay the full cost of the benefit. These plans are known as "access-only" plans. While many retirees will drop or not sign up for coverage under an access-only plan, even without an employer subsidy, many retirees still get significant savings by paying the group-based premiums for health insurance through their former employer, compared with premiums for the same product in the nongroup market.

While most, if not all, employers have changed some aspect of retiree health benefits since FAS 106 was introduced, employers are not done making changes. In 2006, many employers reported that they plan to continue increasing retiree premiums (79 percent), and a number of employers plan to make other changes as well (Figure 12). Specifically, 40 percent were very or somewhat likely to increase cost sharing, 36 percent were very or somewhat likely to raise drug cost sharing, and 30 percent were very or somewhat likely to increase out-of-pocket maximums. Less than 20 percent were very or somewhat likely to move to a health savings account (HSA) or health reimbursement arrangement (HRA), replace drug co-payments with coinsurance and place a new cap on company contributions. Ten percent were either very or somewhat likely to terminate subsidized benefits for future retirees.

Public-Sector Trends

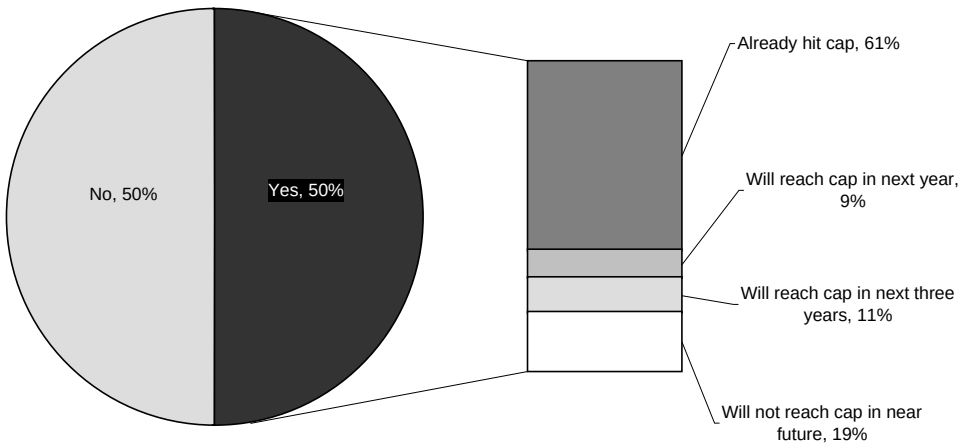
The public sector has been experiencing different trends from the private sector. Small local public-sector employers (defined as those with fewer than 250 workers) are much more likely than private-sector establishments of the same size to offer retiree health benefits. In 2005, 32 percent of local governments with fewer than 250 employees offered retiree health benefits to early retirees (Figure 13). This compares with only 20 percent among private-sector establishments with 100–999 workers and even fewer among smaller establishments (Figure 6).

Figure 9
Eligibility Requirements for Retiree Health Benefits, Employers With 1,000 or More Employees, 1996 and 2007



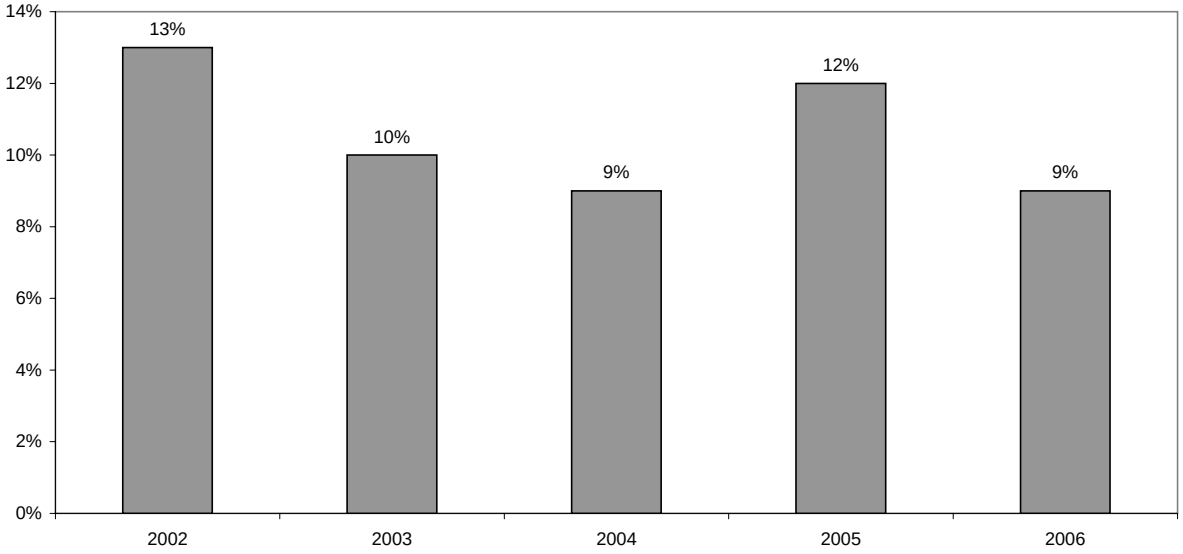
Source: Hewitt Associates.

Figure 10
Percentage of Employers With Cap on Their Contribution to Retiree Health Benefits for Medicare-Eligible Retirees in Largest Plan, 2006



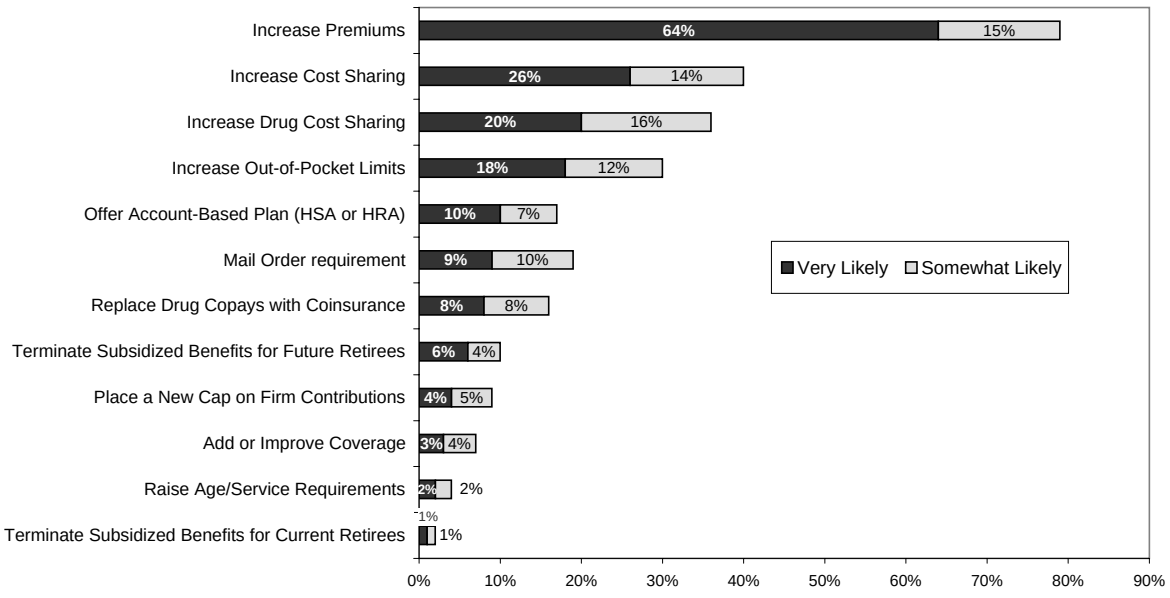
Source: Exhibit 13 in http://www.kff.org/medicare/upload/7587.pdf

Figure 11
Percentage of Large Private-Sector Employers That Terminated All Subsidized Benefits for Future Retirees, 2002–2006[a]



Source: The Henry J. Kaiser Family Foundation and Hewitt Associates, *Findings From the Kaiser/Hewitt Survey on Retiree Health Benefits, 2002–2006.*
[a] In 2002, survey asked employers about changes made to plan during the previous two years. In 2003–2006, employers were asked about the past year.

Figure 12
Likelihood of Making Changes to Retiree Health Benefits for the 2007 Plan Year (As Reported in 2006)



Source: Exhibit 19 in http://www.kff.org/medicare/upload/7587.pdf

However, the trend among public-sector employers is less clear. Among local governments with fewer than 250 employees, between 1997 and 2000, the percentage offering health benefits to both early retirees and Medicare-eligible retirees declined from 39 percent to 22 percent for early retirees, and from 34 percent to 17 percent for Medicare-eligible retirees. Then between 2002 and 2005, the share of local governments offering health benefits to early retirees increased from 19 percent to 32 percent and the share offering them to Medicare-eligible retirees increased from 15 percent to 24 percent.[6]

In contrast to the 1997–2000 downward trend (followed by an expansion during 2002–2005) among local governments with fewer than 250 workers, larger local governments experienced somewhat of an expansion in coverage over the longer time period, although there were years in which offer rates contracted. Among local government employers with 5,000 to 9,999 workers, the percentage offering health benefits to both early retirees and Medicare-eligible retirees increased between 1997 and 2000 (Figure 14). The number offering benefits to Medicare-eligible retirees continued to expand through 2002, increasing from 61 percent in 1997 to 80 percent in 2002. Between 2002 and 2005 it contracted slightly. In contrast, after expanding from 75 percent to 93 percent between 1997 and 2000, the percentage of these local governments offering benefits to early retirees fell and bounced around in the mid-80 percent range between 2001 and 2005.

Among the largest of the large local government employers (those with 10,000 or more employees), the number offering coverage to early retirees has bounced around the high-80 percent to low-90 percent range between 1997 and 2004, before settling at 94 percent in 2005 (Figure 15). In contrast, the number offering benefits to Medicare-eligible retirees increased between 1997 and 1999, then decreased from 87 percent to 71 percent between 1999 and 2002, before increasing to 85 percent in 2005. Among state governments, the percentage offering benefits to early retirees increased from the 70–75 percent range in 1997 to the 90 percent range in 2001 (Figure 16). As of 2005, 96 percent of state governments were offering benefits to early retirees, while 88 percent were offering them to Medicare-eligible retirees.

Despite the recent trends in public-sector retiree health benefits, these trends may change as the public sector addresses implications related to recent accounting rule changes that affect them similarly to the way in which FAS 106 affected the private sector. Recently, the Governmental Accounting Standards Board (GASB) released Statements No. 43 and 45, which impose new accounting standards on public-sector sponsors of retiree health benefits. Under GAS 43 and 45, public-sector sponsors are required to accrue the cost of postretirement health benefits during their covered workers' years of service, as opposed to reporting the cost on a pay-as-you-go basis. According to the Government Accountability Office, studies have estimated that state and local government unfunded liabilities for retiree health benefits are between $600 billion and $1.6 trillion,[7] and governments have typically paid for these benefits on a pay-as-you-go basis instead of setting aside money for postretirement health benefits in the same way they have for pensions (U.S. Government Accountability Office, 2008a). Because these estimates raise concerns about the fiscal challenge that public-sector employers will face in the future, the estimates also raise concern over the impact that the GASB statements ultimately will have on the future of retiree health benefits in the public sector. GAS 43 and 45 may simply trigger changes to retiree health benefits in the public sector that the private sector has been experiencing since the mid-1990s. The likely result is that public-sector employers will also begin to restrict or eliminate retiree health benefits to public-sector workers.

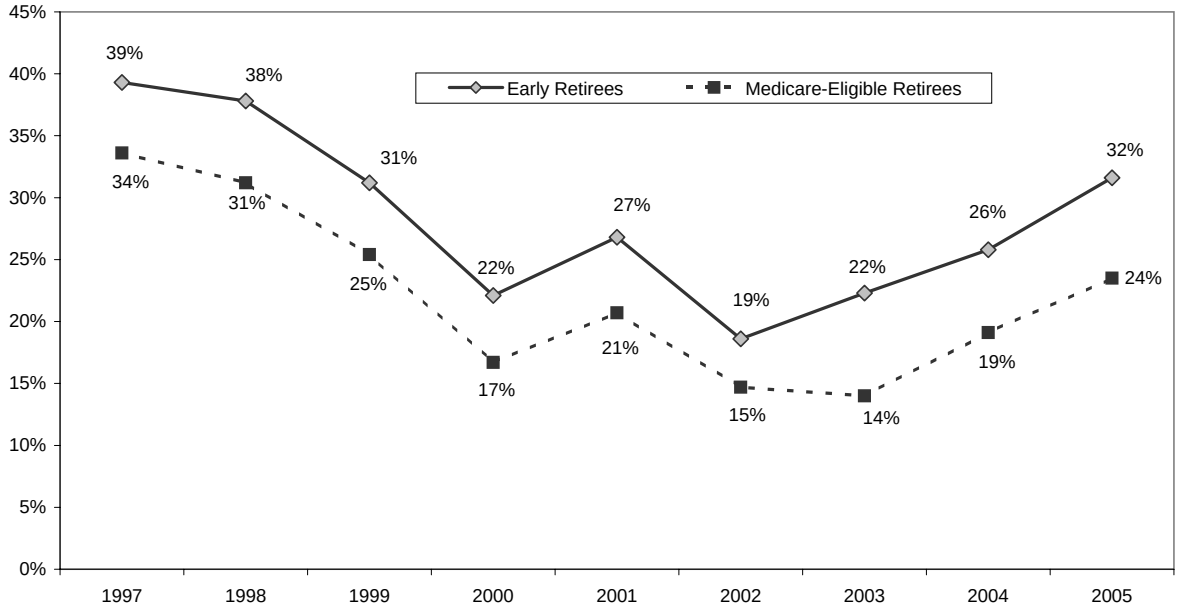
Impact on Workers and Retirees

In order to understand the impact that the erosion in the availability of retiree health benefits has had on retirees and workers, data from the Survey of Income and Program Participation (SIPP) are examined. SIPP, conducted by the U.S. Census Bureau, is a nationally representative longitudinal survey of the civilian noninstitutionalized U.S. population. Data for this *Issue Brief* come from the 1996, 2001, and 2004 SIPP panels. In Wave 5 of each panel, questions were asked regarding health benefits in the work place and health benefits in retirement. These topical questions were asked in 1997, 2002, and 2005.

Impact on Retirees

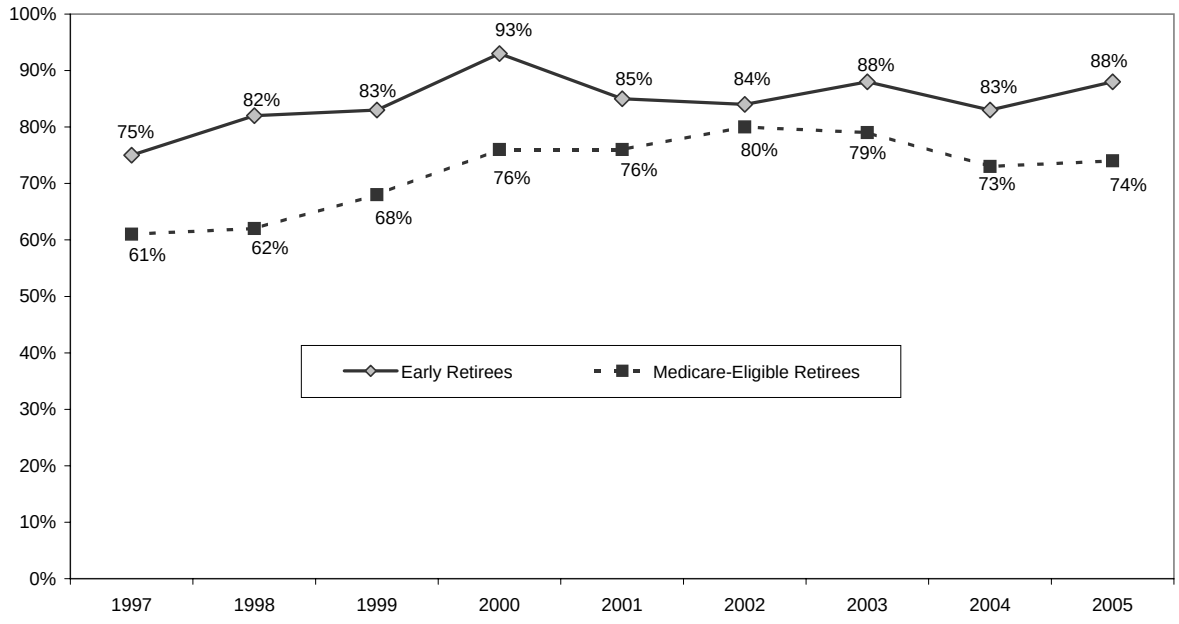
Among early retirees (retirees under age 65), the percentage with retiree health benefits has not changed much during 1997–2005. Between 1997 and 2002, the percentage of early retirees with retiree health benefits from a former employer fell from 26.9 percent to 23.4 percent (Figure 17). Between 2002 and 2005,

Figure 13
Percentage of Local Governments With Fewer than 250 Employees Offering Health Insurance to Retirees, 1997–2005



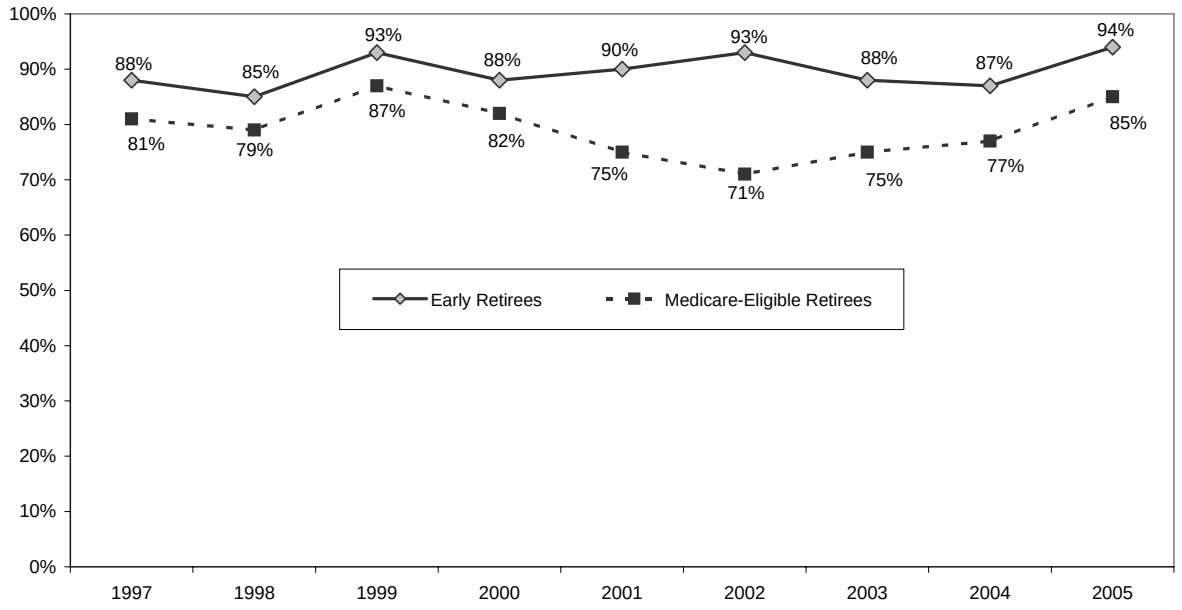
Source: Various tables at www.meps.ahcpr.gov/Data_Pub/IC_Tables.htm

Figure 14
Percentage of Local Governments With 5,000–9,999 Employees Offering Health Insurance to Retirees, 1997–2005



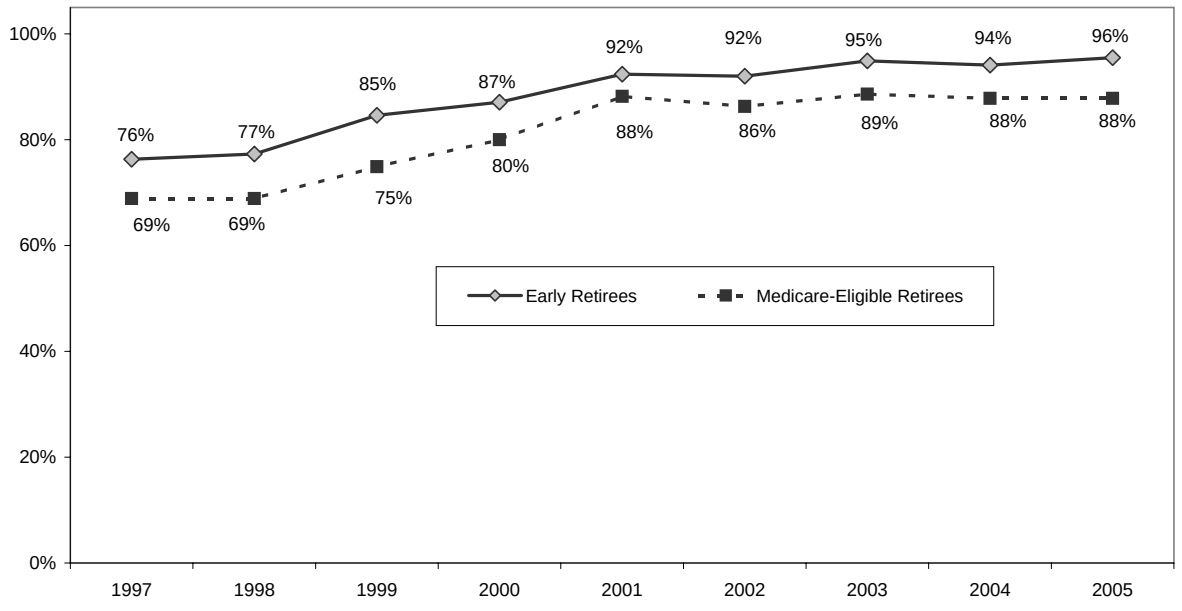
Source: Various tables at www.meps.ahcpr.gov/Data_Pub/IC_Tables.htm

Figure 15
Percentage of Local Governments With 10,000 or More Employees Offering Health Insurance to Retirees, 1997–2005



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

Figure 16
Percentage of State Governments Offering Health Insurance to Retirees, 1997–2005



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

the percentage increased to 26.4 percent. Very few other nonworkers (whether they are not working due to health status or for other reasons) had retiree health benefits.

A similar trend was found for Medicare-eligible retirees. Between 1997 and 2002, the percentage of Medicare-eligible retirees with retiree health benefits from a former employer fell from 20 percent to 18.9 percent, and then increased to 21.5 percent by 2005.

Impact on Workers

Workers not yet eligible for Medicare are increasingly unlikely to expect retiree health benefits in retirement. In 1997, 44.9 percent of workers who had never retired from a job reported that they expected to receive retiree health benefits in retirement. That declined to 43.3 percent in 2002 and to 35.8 percent by 2005. A similar trend was found among workers under age 65 who had previously retired from a job.

Interestingly, workers are more likely to report that they expect to receive retiree health benefits than retirees are to report having them. In 2005, 35.8 percent of workers ages 45–64 who have never retired from a job reported that they expected to receive retiree health benefits upon retirement, but only 26.4 percent of early retirees and 21.5 percent of Medicare-eligible retirees reported actually having the benefit. Workers who have never retired from a job may not be aware of the changes that have occurred with retiree health benefits.

Workers who have retired from a job are clearly more aware of the availability of retiree health benefits than workers who have not retired from a job. In 2005, 26.2 percent of workers ages 45–64 who had retired from a job expected to receive retiree health benefits upon retirement. This compares with 26.4 percent of retirees ages 45–64 who report that they have retiree health benefits. It appears that it is only recently that workers who have not retired from a job report expectations in line with retirees. In 1997 and 2002, a higher percentage of workers who had retired from a job reported that they expected to receive retiree health benefits upon retirement, compared with retirees reporting that they had such coverage.

Reconciling Retiree Trend With Employer Data

There appears to be an inconsistency in the data on availability of retiree health benefits. On the one hand, surveys show that fewer employers are offering retiree health benefits and that, when the benefit is offered, retirees are paying more for the benefit and are facing tougher eligibility requirements. On the other hand, the percentage of retirees with benefits is in large part unchanged during 1997–2005, based on SIPP data presented above. The same lack of trend is found for the most part when examining data from other sources (Fronstin, 2008). Rates of retiree health benefits coverage may not be falling for various reasons.

There is a strong link between the availability of retiree health benefits and the decision to retire early (Fronstin, 1997). Workers often remain in the labor force longer than they expected in order to maintain health insurance. EBRI's Health Confidence Survey (HCS) has found that 30 percent of workers expecting to retire before becoming eligible for Medicare would not do so if they did not receive retiree health benefits.[8] Among those workers age 40 and older who expect to receive retiree health benefits and retire before age 65, two-thirds would not retire early if retiree health benefits were suddenly not available through their former employer or union.

The declining availability of retiree health benefits may in part explain the rising labor force participation rate among individuals ages 55–64. Between 1996 and 2006, the labor force participation rate for men increased from 67 percent to 69.6 percent, while for women it increased from 49.6 percent to 58.2 percent (Figure 18). The percentage of retirees with health coverage from a former employer may not be declining as quickly as the availability of retiree health benefits because workers without access to this benefit may be remaining in the labor force longer than workers with access to retiree health coverage.

Conclusion

This report provides estimates for savings needed to cover health insurance to supplement Medicare and out-of-pocket expenses for health care services in retirement. It finds that a male age 65 in 2008 and retiring at age 65 will need anywhere from $64,000 to $159,000 in savings to cover health insurance premiums and out-of-pocket expenses in retirement if they are comfortable with a 50 percent chance of having enough money and $196,000 to $331,000 if they prefer a 90 percent chance.

- Men with subsidized retiree health benefits will need $64,000, if comfortable with a 50 percent chance of having enough savings to cover health care expenses in retirement.
- Those with unsubsidized retiree health benefits who want a 90 percent chance of having enough savings will need $196,000.
- Men who supplement traditional Medicare with Medigap and Medicare Part D and who have relatively high prescription drug expenses will need $156,000 if comfortable with a 50 percent chance of having enough savings, while those who prefer a 90 percent chance of having enough savings would need $331,000.

Women age 65 retiring in 2008 will need anywhere from $86,000 to $184,000 in savings to cover health insurance premiums and out-of-pocket expenses in retirement if they are comfortable with a 50 percent chance of having enough money, and $223,000 to $390,000 if they prefer a 90 percent chance.

- Women with subsidized retiree health benefits will need $86,000 if comfortable with a 50 percent chance of having enough savings to cover health care expenses in retirement.
- Those with unsubsidized retiree health benefits who want a 90 percent chance of having enough savings will need $224,000.
- Women who supplement traditional Medicare with Medigap and Medicare Part D and who have relatively high prescription drug expenses will need $217,000 if comfortable with a 50 percent chance of having enough savings, while those who prefer a 90 percent chance of having enough savings would need $390,000.

Persons currently age 55 will need even greater savings when they turn 65 in 2018. Needed savings for men range from $107,000 to $550,000, while needed savings for women range from $144,000 to $654,000, depending on the source of health insurance coverage to supplement Medicare, any employer subsidies, prescription drug use, and their savings goal related to their comfort level with having a 50 percent, 75 percent, or 90 percent chance of having enough savings to cover health insurance premiums and out-of-pocket health care expenses in retirement.

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

This analysis also highlights the longevity and investment risks, as shown in the significant differences between the savings needed for a person based on a 50 percent chance and a 90 percent chance of having enough money to cover health insurance premiums and out-of-pocket health care costs. While workers will have a difficult time saving enough money to cover health care expenses in retirement whether they live to average life expectancy or beyond, many are generally unprepared for health care expenses in retirement and retirement expenses (VanDerhei and Copeland, 2003). In fact, many individuals will need more money than the amounts reported in this *Issue Brief* because this analysis does not factor in the savings needed to cover long-term care expenses, nor does it take into account the fact that many individuals retire prior to becoming eligible for Medicare. However, some workers will need to save less than what is reported if they choose to work during retirement and receive health benefits as active workers. Moreover, the use of certain risk management tools such as annuitization may reduce the overall amount of financial resources needed to cover this risk, especially at the 90th percentile.[9]

The research in this *Issue Brief* is reinforced by the fact that current workers are increasingly struggling to save for retirement because of rising health care costs today. EBRI's research has found that 36 percent of individuals responding to a recent survey reported that they have decreased their contributions to a retirement plan as a result of the increased cost of health care in 2006, up from 25 percent in 2004 (Helman and Fronstin, 2007). The survey also found that 52 percent of respondents had decreased other savings in 2007, up from 45 percent in 2005.

Finally, issues surrounding retirement income security are certain to become an even greater challenge in the future as employers continue to scale back retiree health benefits, and when policymakers begin to realistically address financial issues in the Medicare program with solutions that are likely to shift more responsibility for health care costs to Medicare beneficiaries. These findings indicate that the lack of funding for health care in retirement is getting worse, and is a problem that will most likely continue to grow.

Figure 17

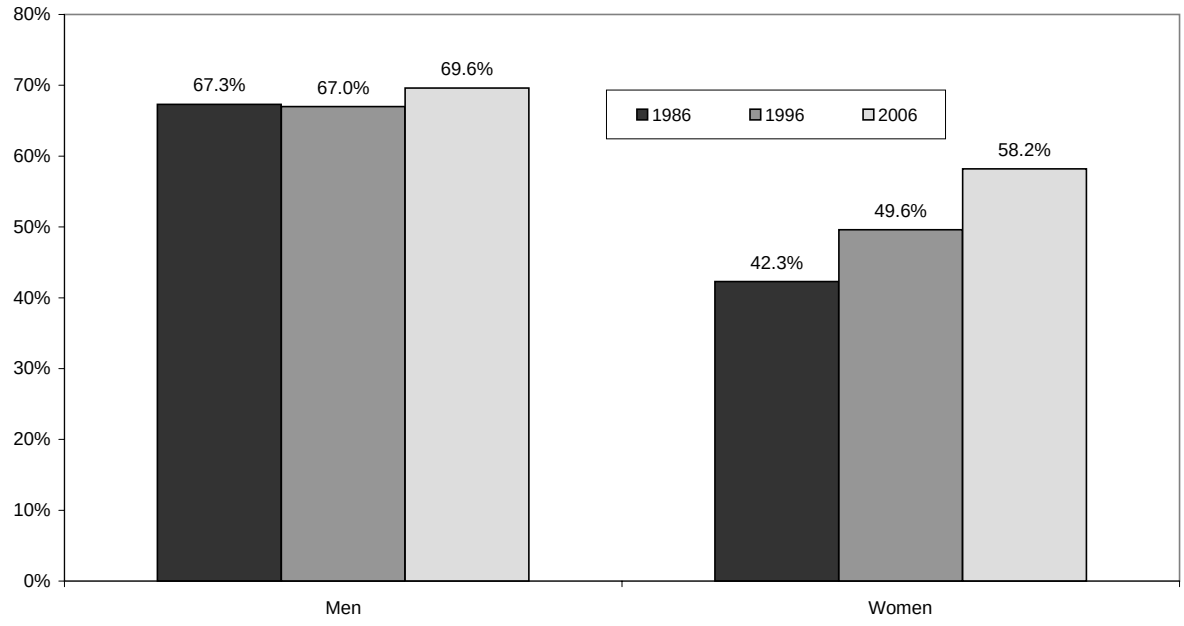
Retiree Health Benefits: Coverage Among Retirees and Other Nonworkers and Expectations of Coverage Among Workers, 1997–2005

Data set	1996 Panel Wave 5	2001 Panel Wave 5	2004 Panel Wave 5
Data collection time frame	July 1997–Oct 1997	Feb 2002–Aug 2002	Feb 2005–Aug 2005
Percentage of Nonworkers with Retiree Health Benefits			
45–64 Year Olds			
Retired	26.9%	23.4%	26.4%
Not working due to health status	3.5	2.1	3.4
Other	1.1	1.2	1.2
65 and Older			
Retired	20.0	18.9	21.5
Not working due to health status	3.7	8.4	1.1
Other	0.0	3.9	1.0
Percentage of Workers Expecting Retiree Health Benefits			
45–64 Year Olds			
Working, never retired	44.9	43.3	35.8
Working, ever retired	33.4	32.5	26.2
65 and Older			
Working, never retired	23.0	26.4	29.2
Working, ever retired	11.4	14.9	11.3

Source: Employee Benefit Research Institute estimates from the Survey of Income and Program Participation.

Figure 18

Labor Force Participation Rates, Ages 55–64, by Gender, 1986, 1996, 2006



Source: http://www.bls.gov/emp/emplab05.htm

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Appendix: The Medicare Program

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

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

Eligible Medicare beneficiaries in the traditional Medicare program automatically receive Medicare Part A at no premium cost. Part A covers inpatient hospital services, skilled nursing facility (SNF) benefits following a three-day hospital visit, home health visits following a hospital or SNF stay, hospice care, and blood (after the member has paid for the first three pints). In 2008, hospital stays are subject to a $1,024 deductible for days one–60. A $256 per day co-payment is required of Medicare beneficiaries for days 61–90; this increases to $512 per day for days 91–150, although there are a total of 60 lifetime reserve days that can be used for lengths of stay more than 90 days. Medicare beneficiaries are responsible for all costs for each day beyond 150. SNF care costs beneficiaries nothing during the first 20 days, after which a $128 per day co-payment is required until day 100, after which the beneficiary pays all costs.

Individuals with Part A are able to supplement it with Part B. Part B is partially financed by beneficiary premiums that originally covered 50 percent of the program's costs. Today, Part B is financed by beneficiary premiums that cover 25 percent of the program's cost and general tax revenues finance the balance. Persons choosing Part B services pay a $96.40 per month premium in 2008, but under provisions originally contained in the Medicare Modernization Act (MMA) and since revised in the 2005 Deficit Reduction Act, higher-income beneficiaries pay a greater percentage of the Part B premium. For example, individuals earning $150,000 in 2008 pay $160.90 per month for Part B coverage. 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 an annual $135 deductible. Part B also covers a number of preventive services, such as bone mass measurements, flu shots, screenings related to cardiovascular health, colorectal cancer, and diabetes.

Because of the MMA, outpatient prescription drug benefits became available to Medicare beneficiaries under Part D. Like Part B, Part D is partially financed by beneficiary premiums that cover 25 percent of the program's cost and general tax revenues finance the balance. Persons choosing Part D pay a monthly premium, with estimates of the average premium paid in 2008 estimated to be about $28, though this premium has been shown to vary from $9.80 for basic benefits to $107.50 for enhanced benefits.[10] When beneficiaries receive drug benefits under the standard plan, they are subject to a $275 deductible. After the deductible is met, beneficiaries are responsible for 25 percent coinsurance on the cost of prescription drugs on the next $2,235 in benefits (or $559). At that point, they would be completely responsible for the next $3,216, after which they would be responsible for 5 percent coinsurance. A 2006 study found that more than 80 percent of enrollees in stand-alone Part D plans are choosing plans with no deductible and low cost sharing for generic drugs, while it was found in 2008 that only 18 percent of Part D enrollees chose had coverage that filled in part of the $3,216 coverage gap.[11]

As an alternative to the traditional Medicare program, Medicare beneficiaries are able to enroll in health plans offered by private insurers. These plans are known as Medicare Advantage (MA) plans and are sometimes referred to as Medicare Part C. MA plans include HMOs, PPOs, Special Needs Plans, and Private Fee-for-Service Plans. These plans provide all Medicare-covered services and may also provide outpatient prescription drug coverage. These plans may also cover health care services not covered by traditional Medicare, such as vision, hearing, dental, and/or health and wellness programs, but can also limit beneficiaries' choice of health care provider to a provider that participates in the health plans' network. MA plans are allowed to charge beneficiaries a premium to enroll in such a plan, which is on top of the Part B premium. Among plans that charged an additional premium, the average additional premium was $58 per month (U.S. Government Accountability Office, 2008b). Thirty-five percent of beneficiaries were in plans that charged an additional premium.[12]

Endnotes

[1] See, for example, Employee Benefit Research Institute (1989), Fronstin (1996, 2001, 2005, and 2006), Fronstin and Salisbury (2003 and 2004), Gabel (2002), McArdle et al. (various years), McDevitt et al. (2002), and Mercer Human Resources Consulting (2007).

[2] Eugene Steuerle, personal communication. The analysis used a 2 percent real interest rate.

[3] A technique used to estimate the likely range of outcomes from a complex process by simulating the process under randomly selected conditions a large number of times.

[4] Nominal after-tax rates of return were assumed to follow a log-normal distribution with a mean of 1.078 and a standard deviation of 0.101. This provides a median nominal annual return of 7.32 percent. Additional sensitivity analysis of the requisite amount of financial resources required for a 50, 75 and 90 percent probability of adequacy under alternative marginal tax rates and various forms of tax-advantaged saving vehicles will be published in a forthcoming *EBRI Notes* article.

[5] See http://www.kff.org/medicare/med121306pkg.cfm.

[6] The apparent sharp increases and decrease in Figure 5 between 2000 and 2002 appears out of place and may reflect trends in the marketplace at that time.

[7] According to the GAO report, estimates presented in these studies are limited by their methodologies and are not generated from a nationally representative sample of public-sector employers. For more information, see U.S. Government Accountability Office (2008a).

[8] See http://www.ebri.org/pdf/surveys/hcs/2003/03hcspq.pdf.

[9] See VanDerhei (2006) for an illustration of how the appropriate degree of annuitization can be used to deal with the longevity risk.

[10] See http://www.kff.org/medicare/upload/7044_08.pdf.

[11] See Bach and McClellan, 2006; and http://www.kff.org/medicare/upload/7044_08.pdf.

[12] The 35 percent is among participants in a plan that received a rebate to reduce premiums, reduce cost sharing, or offer enhanced benefits. Roughly 90 percent of MA plans received such rebates.

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