

## Health Benefits in Retirement: Set for Extinction?

Mark Merlis, *Consultant*

**OVERVIEW** — *Nearly 18 million people rely on employer-provided retiree health benefits to fill gaps in Medicare's coverage or to provide basic insurance until they reach Medicare age. Rising costs have led many employers to limit benefits, require participants to pay a larger share of the costs, or stop offering coverage at all for workers who have not yet retired. This background paper describes recent developments in retiree health benefits, possible future trends, and policy options for slowing the erosion of coverage or providing alternative ways for retirees to meet their expected medical expenses.*

## Contents

BASICS OF RETIREE COVERAGE .....	4
Eligibility for Benefits .....	5
Retiree Share of Costs .....	6
Figure 1: Distribution of Large Employers by Share of Premium Paid by Retirees, 2005 .....	6
Tax Treatment .....	7
Accounting Standards .....	8
COVERAGE TRENDS .....	9
Figure 2: Population of Retirees and Dependents with Employer-Provided Health Benefits, 2004 .....	9
Figure 3: Population of Retirees with Health Benefits by Ratio of Family Income to Federal Poverty Threshold .....	10
Erosion of Retiree Health Benefits .....	10
Table 1: Percentage of Establishments Offering Retiree Health Benefits by Establishment Characteristics, 1997 and 2003 .....	11
Figure 4: Percentage of Retiree Population with Employer-Provided Health Benefits, 1991, 1998, and 2004 .....	12
Prospects for the Future .....	12
Effect of the Medicare Drug Benefit .....	13
Table 2: Number of Medicare Enrollees with Continued Employer-Based Drug Coverage, as of December 2005 .....	15
PROTECTING RETIREE HEALTH BENEFITS .....	15
Regulation of Pensions and Retiree Health Benefits .....	17
Options for Protecting Health Benefits .....	18
SAVING FOR HEALTH COSTS IN RETIREMENT .....	21
ALTERNATE SOURCES OF RETIREE HEALTH COVERAGE .....	24
Access to Insurance for Non-Medicare Retirees .....	24
Access to Supplemental Coverage for Medicare Retirees .....	27
CONCLUSION .....	28
ENDNOTES .....	29

**National Health Policy Forum**  
Facilitating dialogue.  
Fostering understanding.

2131 K Street NW, Suite 500  
Washington DC 20037

202/872-1390  
202/862-9837 [fax]  
nhpf@gwu.edu [e-mail]  
www.nhpf.org [web]

**Judith Miller Jones**  
*Director*

**Sally Coberly**  
*Deputy Director*

**Monique Martineau**  
*Publications Director*

## Health Benefits in Retirement: Set for Extinction?

As the “baby boom” generation nears retirement, much federal policy discussion has been devoted to future pressures on Social Security, Medicare, and Medicaid long-term care financing. Even if the funding problems for these programs can be solved, many future retirees may have difficulty maintaining their standard of living, because of dwindling pension benefits and low personal savings. Adding to these strains is the steady erosion of employer-provided retiree health benefits, which have been a key component of income security in retirement.

In 2004, 14.2 million retirees received health coverage through their former employers; another 3.6 million people were covered as dependents under a family member’s retiree plan. Early retirees may rely on employer-provided benefits as their primary source of coverage until they qualify for Medicare, usually at age 65. Many early retirees might be unable to find affordable coverage if they had to shop for it on their own because of their age and frequent health problems. For Medicare beneficiaries, retiree health plans help pay for required cost sharing and cover services excluded from Medicare. Even after including the new prescription drug benefit, Medicare’s coverage gaps can expose beneficiaries who do not have supplemental coverage to enormous expenses over a lifetime.

Whether enrolled in Medicare or not, many retirees have relied on the financial support offered by retiree health benefits. However, steadily rising costs, changes in accounting rules, and other factors have led many employers to curtail benefits, tighten eligibility rules, or even eliminate retiree coverage altogether. While some of these changes have affected participants who have already retired, the greater impact has been on people who are still actively employed. Employers are less frequently offering, as many once did, generous lifetime coverage for current workers once they reach retirement age. Workers who were planning to retire before age 65 may have to delay their retirement because nonemployer coverage can be hard to obtain and very costly. Those who expected retiree plans to supplement their Medicare coverage may have to seek alternatives that are more expensive or less comprehensive, or they may have to set aside savings to meet future health care costs on their own.

This background paper describes the fundamentals of retiree health benefits and reviews data on recent coverage trends as well as the likelihood of further erosion of benefits. It then considers three basic approaches to help current and future retirees with the burden of health care costs: (i) providing better incentives for employers to maintain retiree health benefits,

(ii) developing tax-favored savings arrangements that could help retirees meet their own expenses, and (iii) improving access to alternative sources of health insurance for retirees without employer-provided plans. Each of these options might provide some help to people who have already retired or who expect to retire soon. However, with medical costs growing rapidly and personal savings rates at historically low levels, much broader approaches may be needed to assure retirement security for future retirees.

## BASICS OF RETIREE COVERAGE

Retiree health benefit programs commonly treat retirees who are Medicare beneficiaries differently from those who are not yet receiving Medicare. Many data sources on retiree health distinguish participants under age 65—“early retirees”—from those aged 65 or older. However, some retirees do become eligible for Medicare as a result of a disability before turning 65. Conversely, a few people over 65 do not qualify for Medicare because they did not work or did not pay enough Medicare taxes during their working lives. This paper will generally refer to non-Medicare and Medicare retirees, except when cited statistics use an age-based classification.

Although most employers that offer retiree health coverage offer it to both groups, a 2005 survey of large employers found that 6 percent covered only non-Medicare retirees and 1 percent covered only Medicare retirees.<sup>1</sup> When plans cover both groups, they usually provide different benefits to each. For non-Medicare retirees, the employer plan will be the primary source of health insurance. Often the benefits and plan choices are similar to those provided for active workers, although retirees may be required to pay a different share of their premiums. For Medicare retirees, the plan “wraps around” Medicare coverage, paying some or all of the required cost-sharing for Medicare-covered services and picking up the cost of some services not covered by Medicare.

Some employers have allowed or required retirees to join a Medicare Advantage (formerly Medicare+Choice) plan. These plans, chiefly health maintenance organizations (HMOs) or preferred provider organizations (PPOs), contract with Medicare to provide the full scope of Medicare benefits and usually offer reductions in cost-sharing and other supplemental services. An employer may negotiate a benefit package and premium for its retirees that would be different from what the Medicare Advantage plan might offer to other, nongroup Medicare beneficiaries.

Employers have been distinguishing between Medicare and non-Medicare retirees for many years, but there has recently been a dispute over whether this practice is legal. In 2000, a federal circuit court ruled that the distinction violated the federal Age Discrimination in Employment Act (ADEA). Although this ruling only applied in one federal circuit, the Equal Employment Opportunity Commission (EEOC) initially decided to apply it nationally. Employers and unions protested, arguing that if employers could not offer reduced benefits to Medicare retirees they would respond by

**Retiree health benefit programs commonly treat retirees who are Medicare beneficiaries differently from those not receiving Medicare.**

cutting benefits for non-Medicare retirees. In effect, they contended, the EEOC rule would not improve benefits for Medicare retirees but might instead force benefits for all retirees down to the lowest common denominator.

In response, the EEOC reversed itself; in 2004 it planned to publish in the *Federal Register* a new rule explicitly allowing employers to offer different benefits for retirees with Medicare or with coverage under some similar state programs. Before the rule could be issued, AARP obtained a district court injunction forbidding publication on the grounds that the rule violated the circuit court's previous decision. The district court involved has since reversed itself, but the injunction remains in effect pending the outcome of an appeal by AARP.<sup>2</sup>

The Senate-passed version of the Medicare Modernization Act of 2003 would have amended the ADEA to allow different benefits for Medicare and non-Medicare retirees. This provision was not included in the conference agreement on the bill, but the report of the conferees indicates that they "reviewed the ADEA and its legislative history and believe the legislative history clearly articulates the intent of Congress that employers should not be prevented from providing voluntary benefits to retirees only until they become eligible to participate in the Medicare program."<sup>3</sup>

Employer-provided benefits are actually less costly for retirees with Medicare, because Medicare covers most of their expenses. A 2004 survey of firms with 1,000 or more workers found that premiums for retirees under age 65, including both employer and employee shares, averaged \$487 per month, compared to \$262 for older retirees.<sup>4</sup> Much of the spending for Medicare retirees has been for one major service category Medicare has not traditionally covered: outpatient prescription drugs. Employers' costs for these retirees will be affected by the new Medicare prescription drug benefit; see "Effect of the Medicare Drug Benefit," page 13.

## Eligibility for Benefits

Employers may offer retiree benefits to only a portion of their workforce or may provide different benefits for different classes of workers, such as salaried versus hourly, union versus nonunion. Increasingly, employers are offering different benefits to workers hired at different times. An employer may offer one set of benefits to employees hired before a given date and may reduce or simply eliminate those benefits for workers joining the company more recently.

In most cases, in order to receive employer-paid benefits in retirement, retirees must reach a specified minimum age, must have worked for the company for some minimum number of years, or both. Minimum service requirements have been increasing in recent years. For example, one study estimates that almost 90 percent of firms with retiree benefits were providing coverage to Medicare retirees with five or fewer years of service in 1984. By 2001, this number had dropped to about one-quarter of firms, many of which reported they planned to impose longer service requirements for future retirees.<sup>5</sup>

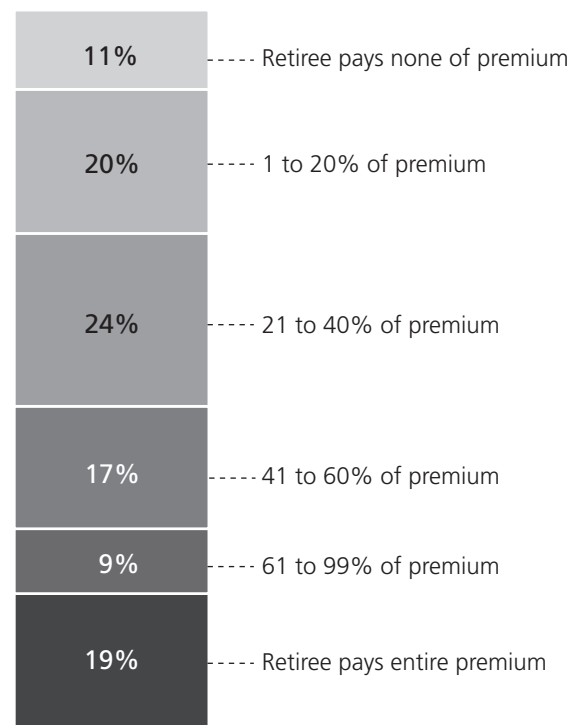
A second key requirement is that the worker usually must retire from the firm offering the benefits. A worker who moves from one firm to another before retirement retains entitlement to pension benefits already accrued but may lose health benefits from the previous job. This limitation can mean that people nearing retirement may lose benefits they had been counting on. Older workers tend to change jobs less frequently than younger ones;<sup>6</sup> job tenure may be longer in the larger firms more likely to offer retiree health benefits. But the lack of portability or “vesting” rights may be an important gap for some older workers leaving their jobs early because of corporate downsizing or other events. This issue will be considered further in the context of pensions and health benefit regulation (see page 17).

### Retiree Share of Costs

Most employers require retirees to contribute to the costs of their coverage. Figure 1 (right), drawn from a survey of employers with 1,000 or more workers, shows the distribution of required premium contributions for new retirees aged 65 and older. Only a few employers pay the retiree’s premiums in full, whereas about one in five require the retiree to pay the entire premium. This latter type of arrangement is known as an “access only” plan: the retiree is simply given the opportunity to buy coverage through the employer group plan. (Note that these rules often apply only to recent or future retirees; people who have already retired from the same firms may be paying a much smaller share of their premiums.)

Access only plans, while costly for the retiree, may still be advantageous. Many retirees may pay lower premiums than they would have to pay for equivalent coverage outside the group because the administrative costs of a large group are lower than those for an individual. While the data are scarce, one recent estimate suggests that administrative costs amount to about 10 percent of large group premiums.<sup>7</sup> In comparison, up to 35 percent of premiums for individually purchased Medicare supplemental insurance (Medigap plans) may go to administrative costs; costs may be even higher for nongroup insurance sold to non-Medicare retirees. In addition, non-Medicare retirees with an access only plan do not face the barriers to coverage they might encounter if they sought nongroup insurance, such as preexisting condition exclusions, denial of coverage for health reasons, or higher premiums charged to applicants with health problems.

**FIGURE 1**  
**Distribution of Large Employers by Share of Premium Paid by Retirees, 2005**



*Note: Premiums for retiree-only coverage for full-time employees retiring at age 65 on or after January 1, 2005.*

*Source: Kaiser Family Foundation and Hewitt Associates, Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins: Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits, December 2005; available at [www.kff.org/medicare/med120705pkg.cfm](http://www.kff.org/medicare/med120705pkg.cfm).*

One possible drawback of access only plans is that healthier retirees may be able to find cheaper coverage outside the group, leaving only the sicker employees participating in the group plan.<sup>8</sup> With fewer healthy beneficiaries to offset the costs of those who are sicker, rates for the group coverage might increase, potentially driving even more low-risk retirees out of the pool. This possible cycle of rate increases and deterioration of the average risk level in an insurance pool is known as a “selection spiral,” or, in the extreme case, a “death spiral.” Ultimately the employer group could wind up with only a few very high-risk retirees paying very high premiums.

When the employer pays at least part of the premium for retirees, its contribution may take the form of a specified percentage of the premium or a fixed dollar amount. Many employers that have been paying a fixed percentage of the premium have now imposed limits on the extent to which their contributions will grow in the future. A plan with a “premium cap” may define the amount by which the employer’s payment will increase each year; if premiums rise more rapidly, the retiree must pay the difference. Or the employer may set an absolute dollar limit on the amount it will pay toward premiums in the future. For example, an employer that is now paying 60 percent of a \$2,000 premium for a Medicare retiree, or \$1,200, might say that it will never pay more than \$1,500 in any future year. If premiums continue to rise after this cap is reached, the employer will be paying a steadily smaller share of the total.<sup>9</sup>

As recently as 1991, virtually no employers used premium caps.<sup>10</sup> By 2004, among retirees of firms with 1,000 or more employees, 54 percent of retirees under age 65 and 51 percent aged 65 or older were in a capped plan. In over 80 percent of these capped plans, the employer’s contribution had already reached the cap or was expected to do so within the next three years.<sup>11</sup> (It should be noted that an employer that has imposed a cap may choose to raise or even waive it in the future.)

Another way of limiting an employer’s future responsibility for premium contributions is through a retiree medical account (RMA) in which the employer typically credits the worker with a certain dollar amount for each year of service. Once the employee retires, the accumulated amount can be drawn on to pay for retiree health coverage or other expenses. An RMA is a “notional” account; that is, the employer isn’t actually depositing money anywhere but is simply crediting the worker with a specified amount to be made available once expenses are actually incurred.

## Tax Treatment

The basic tax rules for retiree health benefits are similar to those for health benefits provided to active workers. The employer’s contribution to

premiums is a deductible business expense for the employer and is not counted toward taxable income for the retiree. Any required premium contribution or cost-sharing payment by the retiree is not tax deductible, unless the combination of premiums and other medical expenses is sufficient to qualify the taxpayer for the limited itemized medical expense deduction.<sup>12</sup>

Although the same restriction theoretically applies to active workers, many can pay their share of premiums and other medical expenses with pre-tax dollars through cafeteria plans under section 125 of the Internal Revenue Code. (One type of section 125 arrangement, a flexible spending account, is described in the discussions of tax-preferred savings, page 22.) No equivalent arrangement is available to retirees; they must pay all premiums and other costs with after-tax income. (One recent commentary has suggested allowing retirees to pay premium contributions with pre-tax dollars, placing them on the same footing as active employees.<sup>13</sup>)

## **Retirees must pay all premiums and other costs for their health coverage with after-tax income.**

### **Accounting Standards**

One commonly cited turning point for retiree health benefits was the imposition of new accounting rules for private firms beginning in 1992. Standards for accounting and financial reporting by private companies are set by the Financial Accounting Standards Board (FASB); uniform standards are meant to assure that investors can rely on the accuracy and comparability of financial statements.

Until the 1990s, private companies were required to show the unfunded amount of their expected future costs for pensions as a liability in their financial reports but were not required to include future costs for other retiree benefits, including health care. Instead they simply showed current-year spending for these benefits as an expense. FASB standard FAS 106 required companies to show estimated costs for future retiree health benefits as a liability in their financial statements (but not on the balance sheet itself) for fiscal years beginning after December 15, 1992.<sup>14</sup> Because reporting a sizeable new liability could affect credit ratings, many companies responded by dropping benefits for future retirees or adopting other cost-cutting measures. Some benefit changes affected costs immediately; others, such as premium caps, made future liabilities more fixed and predictable in comparison to the indeterminate liability of open-ended plans. Still, as health care costs increase, reported liabilities are continuing to grow. One recent analysis of a sample of Fortune 500 companies that included future retiree health costs on their financial statements found that most reported liabilities rising faster than inflation between 2001 and 2003; a few showed increases of 50 percent



or more in just two years.<sup>15</sup> Firms' concerns are likely to be exacerbated by a proposed change in FASB rules that would require retiree health liability to be more conspicuously displayed by moving the amount from a footnote to the actual balance sheet.<sup>16</sup>

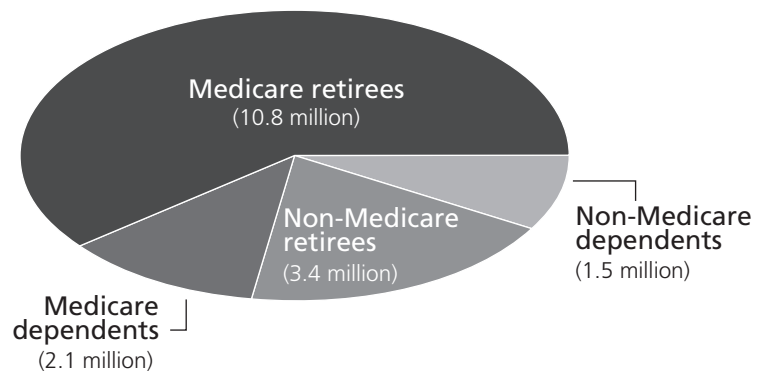
The Governmental Accounting Standards Board (GASB), which sets standards for state and local governments, has only recently adopted rules comparable to FAS 106. Larger government units will have to show liabilities for future benefits on statements for fiscal years beginning after December 15, 2006; the smallest units will have up to two more years to comply. The effects are not yet known but are likely to be substantial, because many governments provide more generous benefits to retirees than private firms. One actuary has estimated that total liabilities nationwide could be as high as \$1 trillion.<sup>17</sup> Changes in some governments' reported liabilities could affect their bond ratings and ability to borrow, giving them a strong incentive to reduce benefits.

## COVERAGE TRENDS

In 2004, 17.8 million people had retiree health benefits (Figure 2, below).<sup>18</sup> Of these, 12.9 million were Medicare beneficiaries, representing one-third of the total Medicare population. Nonelderly Medicare beneficiaries have a much lower coverage rate than the elderly: 17 percent as opposed to 35 percent.<sup>19</sup> One factor might be that people who receive Medicare as a result of disability leave employment before meeting minimum service years or other plan eligibility criteria. About 47 percent of non-Medicare retirees (3.1 million) had retiree health benefits. Coverage rates may be higher for early retirees because they worked in industries most likely to offer coverage or because the availability of health benefits was itself a major factor in the decision to retire early. Another 1.5 million people were covered as dependents under non-Medicare retirees' plans. (The coverage rate for this group cannot be ascertained, because the universe of dependents of non-Medicare retirees cannot be identified using Current Population Survey data.)

It might be expected that retirees with employer-provided coverage would also have higher incomes than other retirees, because they might also receive higher

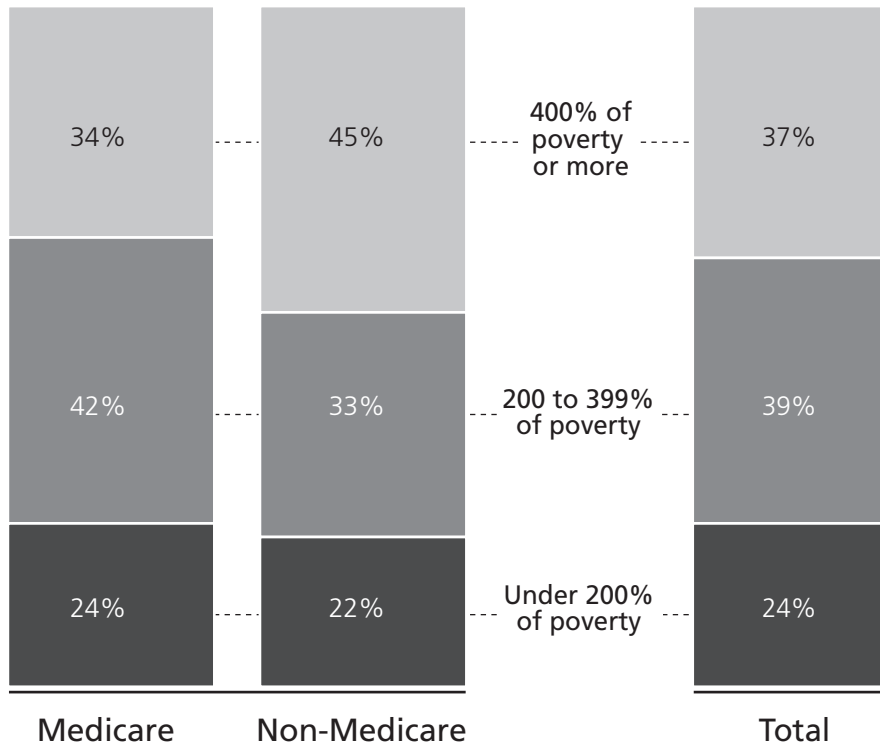
**FIGURE 2**  
**Population of Retirees and Dependents with Employer-Provided Health Benefits, 2004**



*Note: Some people reporting coverage through their former employer may be purchasing COBRA continuation coverage, rather than receiving retiree coverage.*

*Source: Author's analysis of Current Population Survey, 2005 Annual Social and Economic Supplement.*

**FIGURE 3**  
**Population of Retirees with Health Benefits**  
**by Ratio of Family Income to Federal Poverty Threshold, 2004**



Source: Author's analysis of Current Population Survey, 2005 Annual Social and Economic Supplement.

pensions and other benefits. As Figure 3 (above) shows, however, nearly one-fourth of people with retiree coverage have incomes below 200 percent of the poverty threshold (\$18,120 for an elderly individual or \$22,860 for an elderly couple in 2004).<sup>20</sup>

### Erosion of Retiree Health Benefits

The number of medium and large private employers offering retiree health coverage dropped precipitously between the mid-1980s and the early 1990s, possibly in response to the change in FASB accounting rules, then declined more gradually over the ensuing years.<sup>21</sup> The only data series that continuously tracks changes for employers of all sizes is the Medical Expenditure Panel Survey (MEPS) conducted by the Agency for Healthcare Research and Quality. Table 1 (next page) shows some key changes between 1997 and 2003, the latest year available.

Comparatively few small or new private employers have ever offered coverage; retiree health benefits have been largely confined to medium and larger employers and those in business for a long time. Among mid-sized

**TABLE 1**  
**Percentage of Establishments Offering Retiree Health Benefits,**  
**by Establishment Characteristics, 1997 and 2003**

	Under 65		65 and older	
	1997	2003	1997	2003
<b>Private Establishments*</b>	<b>11%</b>	<b>7%</b>	<b>7%</b>	<b>7%</b>
Number of Employees				
Less than 10	3%	0%	0%	1%
10 to 24	7	2	2	2
25 to 99	12	2	2	4
100 to 999	24	10	10	9
1000 or more	52	42	42	40
Number of Years in Operation				
Less than 5	2	0	0	0
5 to 9	3	1	1	1
10 to 19	5	1	1	1
20 or more	23	10	10	11
Union Presence				
No union employees	9	4	4	4
Has union employees	39	37	37	38
<b>State and Local Governments</b>	<b>52%</b>	<b>42%</b>	<b>42%</b>	<b>40%</b>

\* A private establishment is a single work location; one large firm can have multiple establishments.

Source: Author's calculations based on 1997 and 2003 Medical Expenditure Panel Survey (MEPS).

establishments and those in operation for at least 20 years that offered coverage to nonelderly retirees in 1997, more than half had dropped it by 2003. Coverage dropped less sharply among the largest firms.

Public sector employers of all sizes are much more likely than private firms to offer retiree coverage. The coverage declines shown in Table 1 largely reflect changes by smaller local governments; nearly all state governments and most larger local governments still provide benefits.

There was no statistically significant decline in coverage at companies with any union employees. However, more recent surveys have indicated that some unionized companies have terminated benefits for new hires.<sup>22</sup> Increasingly, unions have had to negotiate changes in benefits and cost-sharing; for example, General Motors (GM) and the United Auto Workers (UAW) recently announced an agreement under which higher-income retirees will have to pay premiums, deductibles, and co-pays for the first time.<sup>23</sup>

Figure 4 (next page) shows trends in the percentage of Medicare beneficiaries and non-Medicare retirees with coverage since 1991. The changes in employer policies have not yet had a major effect on coverage of current Medicare retirees, presumably because many had already retired

before those changes took effect. However, there was a significant reduction in coverage of current non-Medicare retirees between 1991 and 2004.

It should be noted that the coverage figures here are heavily affected by the number of federal annuitants covered under the Federal Employees Health Benefits (FEHB) program—1.8 million in 2003, or about one-eighth of all retirees with coverage through their own former employment.<sup>24</sup> If these retirees could be factored out (they cannot using the CPS data), the figures might show slightly greater drops in coverage rates.

### Prospects for the Future

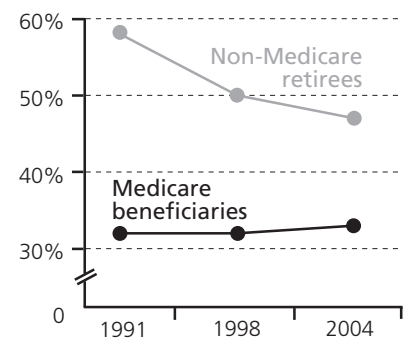
Although employer coverage has not yet declined markedly among people who are now retired, changes already adopted by employers mean that fewer currently active workers will have employer-sponsored health benefits when they reach retirement age. Some people think that the biggest cutbacks have already occurred and that benefits are likely to be more stable in the near term. Others believe that more employers—perhaps especially government units affected by the new GASB rule—will continue cutting benefits in the years to come.

Employers' health care costs have been rising rapidly, both for active workers and for current retirees. One survey of large employers found that their costs for retiree care rose by 10.3 percent between 2004 and 2005; this is slightly more than the 9 percent increase in costs for active workers found in another large employer survey covering the same period.<sup>25</sup> While costs for both groups are obviously of concern for employers, there are several reasons that employers might be more prone to focus on benefits for retirees than those for active workers.

First, if employers are downsizing, they may be covering fewer active workers and more retirees. The experience of the federal government illustrates this trend: the ratio of civilian employees to annuitants and survivors went from 1.46 in 1990 to 1.14 in 2003.<sup>26</sup> Assuming similar trends at other large employers, retiree costs are likely to account for a steadily larger share of employers' overall health care spending. Moreover, while expenses for current employees are incurred in order to recruit and retain the kind of workers the employer needs, expenses for retirees are simply a sunk cost.

Second, it may be easier to cut future benefits for active workers than to cut current benefits for the same workers. A change in the current health plan is felt immediately, whereas a change affecting benefits to be provided many years in the future is not. Younger employees may not care whether future benefits are eliminated, especially if the distant promise of retiree health care is replaced by more immediately attractive benefits like child care or tuition support. Even employees much closer to retirement may not be focusing on future health benefits. One recent

**FIGURE 4**  
**Percentage of Retiree Population with Employer-Provided Health Benefits, 1991, 1998, and 2004**



Note: Figures for non-Medicare retirees exclude dependents.

Source: Author's analysis of Current Population Survey, March 1992 and March 1999 Supplements, and 2005 Annual Social and Economic Supplement.

survey of workers aged 45 to 64 found that only 28 percent recalled ever asking for or receiving information on retiree health coverage. Only 18 percent reported that employers had notified them of any recent reductions in retiree benefits, although employer surveys indicate that most had indeed curtailed retiree health benefits during the period covered.<sup>27</sup>

On the other hand, some factors may make future cuts less likely. First, many of the employers still offering generous coverage are unionized, public sector, or both; their ability to impose changes unilaterally may be limited. Second, even though the costs of covering health care are increasing, employers that are planning further downsizing may retain health benefits as an incentive for older workers to take early retirement, leaving the employer with a younger and less costly workforce. Some employers might also be reluctant to consider further cuts simply out of concern for public relations or employee goodwill. Finally, the potential effects of the new Medicare drug benefit are uncertain. It is unclear whether the new benefit will help stabilize employer coverage of Medicare retirees over the long term or promote further erosion.

Whatever the employers that now offer retiree health benefits decide to do, the workforce is gradually shifting from employers that are offering benefits—chiefly older, large, unionized firms and governments—to newer employers that have never adopted retiree health coverage. This means that overall coverage rates among retirees are likely to decline in the future. Meanwhile, retirees who retain coverage may gradually pay more of their own costs. For example, one analysis estimates that, if a firm has adopted a premium cap, rising premiums in excess of the cap will mean that the employer would be paying only 10 percent of retirees' health care costs by 2031.<sup>28</sup>

### Effect of the Medicare Drug Benefit

Prescription drugs have been a major component of employer spending for Medicare retirees. One study reports that drugs accounted for 45 percent of employers' costs for this group in 2001; more recently, some Fortune 500 companies have estimated that drugs made up 56 to 64 percent of spending for Medicare retirees.<sup>29</sup> Therefore, the new Medicare prescription drug benefit (known as "Part D" to lawmakers) will likely have an impact on retiree plans.

Standard part D coverage is defined as follows. The enrollee will pay:

- The first \$250 in expenses for covered drugs.
- 25 percent of expenses between \$250 and \$2,250.
- 100 percent of expenses above \$2,250, until the enrollee's total out-of-pocket spending for the year reaches \$3,600; after this catastrophic limit is reached, the drug plan will pay all costs. (The participant's exposure to full costs in the \$2,250 to \$3,600 range has come to be called the "doughnut hole.")

The initial deductible and the other coverage thresholds will all be subject to annual increases after 2006 based on growth in participants' per capita drug spending.

The prescription drug benefits under current retiree plans are often superior to the standard Medicare prescription drug coverage. Most plans offered by employers with 1,000 or more workers in 2005 had no separate deductible for drugs, and few had a benefit limit.<sup>30</sup>

Employers have four basic options for dealing with the overlap of the Part D benefit and retiree benefits. Employers with different plans or groups of retirees may choose a different approach for each group.

1) The employer can continue its current drug plan as an alternative to part D. If this plan is at least actuarially equivalent to the part D coverage—providing roughly equal benefits, taking into account required premiums and cost-sharing—the plan may qualify for a federal subsidy. In 2006, this subsidy will cover 28 percent of spending between \$251 and \$5,000 for each participant. The Congressional Budget Office has estimated that the cost of this subsidy will be lower than the cost to Medicare if retirees dropped their coverage and shifted to part D.<sup>31</sup> The subsidy thus produces net federal savings while providing at least some incentive for employers to continue plans that are often more generous than the minimum part D benefit.

**Most retirees with employer-sponsored drug benefits are in plans that have qualified for a federal subsidy.**

2) The employer can convert its drug plan to a wraparound benefit, which would fill the holes (that is, the doughnut hole and the cost-sharing requirements) in the part D benefit in the same way that retiree plans have traditionally filled gaps in other Medicare benefits.

3) The employer can pay retirees' premiums for an approved Medicare prescription drug plan or Medicare Advantage plan. Or the employer's own retiree plan could apply for recognition as a part D plan and receive the full Medicare payments made to such plans, instead of the more limited subsidy for plans deemed equivalent (option 1, above).

4) The employer can drop drug coverage altogether, possibly replacing it with improvements in other health benefits or some unrelated benefit(s).

Employers choosing to retain current benefits and seek the federal subsidy were required to apply by October 31, 2005. As of December 22, 2005, most retirees with employer-provided drug benefits were in plans that had qualified for the subsidy or whose applications were still being processed. The major federal retirement programs, FEHB program and Tricare, are continuing their coverage without the subsidy (which would simply have transferred funds from one federal agency to another). As shown in Table 2 (next page), relatively few retirees were in plans that chose to qualify directly as a part D plan or provide wraparound coverage.

It is uncertain whether the drug subsidy will prevent employers from reducing or dropping drug benefits over the long term. Many employers are still uncertain about what strategy they will adopt in future years. A survey of employers with 1,000 or more workers found that 82 percent were “very” or “somewhat” likely to continue drug benefits and accept the federal subsidy in 2007. Only 50 percent report that the same is true for 2010, whereas 28 percent do not know what they will do.<sup>32</sup> At least some employers may have continued existing benefits for the time being only because they are locked into their current plan through agreements or contracts with health insurers and pharmacy benefit managers. Others may have found the alternatives too difficult to implement in the short time available.

Over time, many employers might find that it is more costly to continue their current drug plans, even with the federal subsidy, than to pay retirees’ premiums for an outside part D plan and provide wraparound coverage.<sup>33</sup> The trade-offs are likely to vary, depending on the outside plans available where retirees live, the employer’s tax situation, and other factors. Moreover, many employer plans that qualify for federal subsidies now might not in the future: if growth in employer contributions is limited by an already-established premium cap, the plan may cease to meet the actuarial equivalency test for the subsidy.<sup>34</sup>

If more employers do modify or drop their drug benefits in the coming years, some may not find it worthwhile to continue any form of health coverage for Medicare retirees. Employer-provided coverage has generally been more comprehensive than individual Medigap plans, but the difference has been chiefly attributable to drug coverage. In 2002, per capita benefit payments by employer plans for Medicare beneficiaries were 58 percent higher than per capita payments by Medigap or other nonemployer plans. If only nondrug expenses are included, the difference shrinks to 20 percent.<sup>35</sup> Employers might eventually find it less cumbersome to help retirees with premiums for an outside Medigap or Medicare Advantage plan, rather than continue offering their own supplemental plan.

## PROTECTING RETIREE HEALTH BENEFITS

When an employer offers a worker some benefit in the future, such as a pension or health coverage, this benefit is part of a total compensation package for the services the worker is performing in the present. At least in theory, the worker is accepting lower wages today in return for something of value to be furnished at the time of retirement. The trade-offs are made

**TABLE 2**  
**Number of Medicare Enrollees with Continued Employer-Based Drug Coverage, as of December 2005**

	Enrollees (millions)
Continued employer plan with federal subsidy	<b>5.9</b>
Federal subsidy application still in process	<b>0.6</b>
Employer-based part D plan or wraparound	<b>1.0</b>
Federal retirees	<b>3.1</b>
Other*	<b>0.5</b>

\* Continuing without subsidy or noncalendar year plans not yet receiving subsidy.

Source: “More than 21 Million Medicare Beneficiaries to Be Covered for Prescription Drugs as of January 1, 2006,” press release, U.S. Department of Health and Human Services, December 22, 2005; available at [www.os.dhhs.gov/news/press/2005pres/20051222.html](http://www.os.dhhs.gov/news/press/2005pres/20051222.html).

explicit when the terms of employment are subject to collective bargaining: when a union and an employer negotiate a new or amended contract, current wages, current benefits (such as health or dependent care), and future benefits are all on the table. Other workers may rarely negotiate their compensation in this direct way. But employers are implicitly balancing different components of compensation to develop an overall package that will attract the kind of workers the employer seeks to hire.

A promise of pension benefits is rather straightforward. The employer may offer a “defined benefit”: on retirement, the worker will receive so many dollars a month per year of service, or some specified percentage of his or her average wages during, for example, the last five years of service. Or the employer may offer a “defined contribution”: each month, the employer will deposit a fixed amount of money into a retirement account, such as a 401(k) plan or other pension fund, from which the worker may draw later in life.

Defined benefits are risky for employers. An actuary can estimate how much money the employer needs to set aside today in order to make expected payouts in the future, given assumptions about likely investment earnings, life expectancy of workers and their survivors after retirement, and other factors. But any of these assumptions may prove wrong, and the employer may find itself in the future having to spend more than it anticipated. Under defined contribution plans, on the other hand, the workers bear the risk. What the employer pays into the retirement fund is fixed, but how much the worker can eventually draw out depends on how well the fund performs during the years before retirement. (Retirees also bear the risk, unless they purchase an annuity, that if they live longer than expected they will exhaust their savings.)

Because of the risks involved in defined benefit plans, some employers have been shifting from defined benefit pension plans to defined contribution plans or to a sort of hybrid known as a cash balance plan.<sup>36</sup> For example, IBM has just “frozen” its pension plan, effective in 2008. Workers will remain entitled to the pension benefits earned during past years of service, but in the future the company will only contribute to the employees’ 401(k) accounts.<sup>37</sup> Many other employers have imposed partial freezes, closing the defined benefit plan to new workers or shifting workers below a certain age to a defined contribution system.<sup>38</sup>

Retiree health benefit plans have almost always taken the form of defined benefits. Plans that offer a specified package of health coverage in the future are even riskier to the employer than defined benefit pensions, because the employer’s ultimate costs will depend on medical care inflation, changes in utilization of services, and other unknowns. Employers have moved to reduce the degree of uncertainty about their future obligations by imposing caps on future premium contributions. But a capped health plan is still a defined benefit: an offer to pay \$100 a month toward health premiums is very much like an offer to pay \$100 a month in retirement income.



However, there is a key difference between pension and health plans. Pension plans can be changed only prospectively. An employer can reduce or even eliminate any promise of pension benefits for services rendered by workers in the future, but it remains obligated to pay out the benefits promised in return for past years of service. Employers have no such obligation with respect to retiree health benefits. Unless these benefits are specifically protected, for example by a union contract, the employer can at any time modify or even eliminate health benefits previously offered to current workers or even currently provided for people who have already retired.

The rest of this section will briefly compare the current rules and protections for defined benefit pension plans and health benefits and will then consider whether any of the principles governing pensions might be applied to retiree health benefits. The next section will review possible savings options that might make retiree health benefits more like defined contribution plans.

### Regulation of Pensions and Retiree Health Benefits

Retiree health plans, like health plans for active workers and other employee benefits, are subject to regulation by the Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974. Whereas ERISA includes detailed requirements for pension plans, requirements for “employee welfare benefit plans,” including health plans, are minimal. First, employers must provide workers with a summary plan description (SPD), which spells out the terms of the plan, and must provide written notice of any later changes in the plan. Second, plan administrators have a general fiduciary responsibility to manage the plan for the benefit of its participants.

Following are some of the key differences between basic ERISA protections for pension plans and for retiree health benefits.

**Vesting and portability** — Employees participating in a pension plan are “vested” after a specified period of service with the firm; for example, five years after the start of employment. If the employee completes the vesting period but then leaves the firm before the established retirement age, he or she retains the right to whatever benefits he or she has already accrued. For example, suppose a plan provides for payment at age 65 of \$100 a year for each year of creditable service. If a younger employee leaves the firm after 10 years of service, he or she remains permanently entitled to receive \$1,000 a year after reaching 65. There is no such vesting for health benefits; if an employee entitled to retiree health benefits leaves the firm before retirement, he or she may lose all entitlement to retiree health coverage.

**Modification or termination of plan for active workers** — An employer can change its pension plan only prospectively, not retroactively. For example, an employer that was offering \$100 a year for each year of creditable service might declare that, from now on, employees will receive only \$50 per year of service, or it might eliminate pension benefits

**Unless retiree health benefits are specifically protected, for example by a union contract, the employer can at any time modify or even eliminate them.**

altogether. But employees who have some years of service at the time the change is announced remain entitled to \$100 a year for the years already accrued. There is no such protection for retiree health benefits. An employer can notify its active workers at any time that it no longer intends to provide the benefits previously offered.

**Modification or termination of plan for people already retired** — Once an employee retires, the employer is permanently required to provide the pension benefits promised during the employee's years as an active worker. The same is true for retiree health benefits if the plan in effect on the date of retirement promises permanent benefits. But many SPDs include blanket language allowing the employer to modify the benefits after retirement.

**Funding** — Employers must prefund a defined benefit pension plan, setting aside sufficient cash or investments in a secure fund to assure that the plan will be able to pay all promised benefits. (Under defined contribution plans, the employer has already fulfilled its promise when it deposits money in the worker's retirement account.) Most private plans offering defined benefit pensions are insured through the Pension Benefit Guarantee Corporation (PBGC). The plan pays an annual premium for each participant, plus an additional premium if the plan is underfunded, that is, if it has insufficient assets to meet projected future obligations. If an employer goes bankrupt or otherwise defaults, the PBGC pays promised benefits up to fixed limits per participant.

**Employers are not required to prefund health benefits, and there is no backup arrangement if employers default.**

The protection of pension plans is by no means perfect. Some employers have underfunded their plans, using overly optimistic assumptions about fund performance or future costs, or delaying payments to the funds in order to improve their apparent short-term financial performance. If too many of these employers ultimately default, the PBGC might have insufficient funds to meet its obligations, raising the possibility that a federal bailout might be needed.<sup>39</sup> Even if the PBGC can meet its obligations, limits on individual payouts mean that not all retirees will receive the full benefits they were promised. Congress is considering measures to strengthen funding requirements and other features of the pension system.

Employers are not required to prefund health benefits, although doing so can reduce the amount of the future liability they must report in financial statements, and there is no backup arrangement if employers default. As of December 2005, employers included in the Standard & Poor's 500 had funded just 21.7 percent of their expected costs for health and other nonpension retiree benefits, compared to 88.3 percent of their expected pension liability.<sup>40</sup>

### Options for Protecting Health Benefits

In theory, it would be possible to subject retiree health benefits to the same regulatory scheme that applies to defined benefit pension plans. However, the risks and burdens imposed by current pension rules are a key factor in the shift to defined contribution plans. Mandating similar protections for health benefits would almost certainly lead employers to cut those benefits

even more rapidly than they are now. An alternative might be a voluntary system that would give employers better incentives to prefund their retiree health plans in exchange for firmer guarantees to future retirees.

**Funding** — Current law makes it much more difficult to prefund retiree health benefits than to prefund pensions.

The principle vehicle for prefunding health benefits is a tax-favored trust arrangement known as a Voluntary Employee Benefits Association (VEBA). A VEBA may be established by employers, groups of multiple employers, or unions. Employer contributions to the VEBA are a deductible business expense, and distributions to pay for employee and retiree benefits are also tax-exempt. Some VEBAs also receive contributions from employees, although employee contributions come from after-tax income.<sup>41</sup>

One prominent recent example of a VEBA is a new independent trust formed as part of the contract agreement negotiated by GM and UAW in October 2005. Over time, GM will contribute \$3 billion to the VEBA; funds will help pay part of the new premiums and cost-sharing required for current and future retirees and help maintain stable benefits in the future. Active workers will not pay into the VEBA directly but will contribute indirectly by forgoing some scheduled future wage increases.<sup>42</sup>

VEBAs have two important drawbacks. First, because of past abuses in the use of VEBAs—to shelter profits or make inappropriate investments—Congress in the 1980s sharply restricted the tax-exempt amounts employers can contribute. In the case of retiree health benefits, employers can make contributions to cover current retiree costs as well as projected future expenses for employees who are still working. However, their contributions for current workers must assume that expenses for these workers after retirement will be the same as expenses for current retirees. The employer may not make any allowance for future inflation or utilization changes. This limit means that employers that are still promising specific health benefits (as opposed to a fixed contribution) can only prefund a fraction of their true expected future costs, even though the FASB rule requires them to report full expected costs as a liability. The contribution limit could be eliminated, but doing so might entail at least some risk of reviving the abusive practices that led to its imposition in the first place. This could be reduced, at the price of added administrative complexity, through stronger scrutiny of actuarial assumptions used in determining contribution levels.

Second, VEBAs formed by for-profit employers must pay taxes on investment earnings. (Income of a VEBA formed by a government, nonprofit entity, or union can accumulate compounding income tax-free.) To fully prefund benefits, an employer must set aside much more than if the account were allowed to earn compounding interest tax-free. Allowing tax-exempt income for VEBAs could help equalize treatment of health and pension prefunding.

If changes in VEBA rules promoted broader use of these arrangements, one result could be a significant increase in federal tax expenditures. This

might be justifiable if the result were stronger protections for beneficiaries. Which of the rules now applied to pension plans might reasonably be applied to health plans?

**Limiting benefit cuts** — As under pension rules, employers could be forbidden to reduce health benefits already offered to future retirees. This would be very burdensome for employers that are still offering a fixed package of benefits, as opposed to those providing only a specified future dollar contribution. However, if VEBA contribution rules were loosened, it might be fair to require employers using these arrangements to guarantee that participants would receive the benefits assumed in determining their contributions.

A more drastic option would be to prohibit employers from modifying benefits for people who have already retired. In the 109th Congress, H.R. 1322 would forbid all but the smallest employers from changing benefits and would require employers that have already reduced benefits for current retirees to restore the benefits in effect on their retirement date. The bill also would provide for hardship exemptions, as well as a federal loan guarantee program to help employers meet the costs. Applying this requirement to current retirees, even just prospectively and not retroactively, would be extremely costly for employers that have not prefunded the benefits.

**Portability and vesting** — This principle of the pension system would be difficult to apply to retiree health benefits. Under a defined benefit pension plan, the employer's promise to pay a certain sum of money in the future is binding for a vested worker even if he or she moves to another employer before retirement. Under a retiree health plan, the employer usually promises to make a contribution for the specific group health insurance plan or for plans the employer offers. Vesting would mean allowing a worker who had left the employer group some years earlier to rejoin the group on reaching retirement. In addition, in plans that do not yet use a premium cap to lock in the amount of the employer's future payment, vesting for former employees would mean an open-ended liability for growth in medical care costs.

The concept of vesting might be more workable for plans under which the employer is crediting fixed dollar amounts per year of service to a notional retiree medical account or to a health reimbursement account (HRA, described in "Saving for Health Costs in Retirement," page 21). These amount to nonportable savings arrangements. Allowing the worker to carry over credited amounts on changing employment could be justified on the grounds that the amount credited to the worker for each year of service was part of the worker's compensation for that year. On the other hand, employers might argue that allowing portability would take away one tool they have for retaining experienced workers.

**Protecting benefits in bankruptcy** — When an employer reorganizes under a chapter 11 bankruptcy proceeding, it can often rescind health benefits promised to its retirees; this has occurred in several recent bankruptcies of airlines and other companies.<sup>43</sup> In the 109th Congress, S. 329

would provide some limited protection by requiring such employers to pay retirees an amount equivalent to 18 months' worth of health benefits. One recent commentary has suggested providing broader protection through a Health Care Benefit Guarantee Corporation, which would provide an employer-funded safety net comparable to that provided by PBGC.<sup>44</sup> However, given current concerns about the potential need for a federal bail-out of the PBGC, it seems doubtful that lawmakers will be eager to clone the concept.

It is unclear how many employers would be willing to sign on to an arrangement that provided more attractive funding options in exchange for stronger benefit protections. Even if some would participate, it is likely that they would strictly limit their future commitments; for example, premium caps might be set even lower than the revocable caps now imposed by many firms. While this might seem self-defeating, it could be argued that, if employers had to guarantee benefits, they might be more realistic about what they were really prepared to deliver. And, if benefits were reduced as a result, active workers could at least be sure about what they would be getting and could make other plans to meet their likely future costs.

**People entering retirement without health benefits will need substantial savings to meet their health care costs.**

## SAVING FOR HEALTH COSTS IN RETIREMENT

People entering retirement without employer health benefits—and even many people with employer benefits that are capped or otherwise leave the retiree exposed to high costs—will need substantial savings to meet their health care costs in retirement. One recent analysis estimated that an average couple retiring without employer benefits at age 65 in 2005 would need \$190,000 in savings to cover future Medicare premiums and cost-sharing as well as costs for non-Medicare services. This estimate assumes average life expectancy and health status.<sup>45</sup>

Another more elaborate set of projections (dating from before enactment of the Medicare drug benefit and using a range of different assumptions about life expectancy, premiums, and other cost increases) estimated that an individual retiring at age 65 in 2003 with some employer-provided benefit would have needed between \$37,000 and \$150,000 to cover lifetime costs; someone with no employer coverage would have needed between \$47,000 and \$1,458,000.<sup>46</sup> Neither set of estimates takes into account possible costs for nursing home and other long-term care, most of which is covered neither by Medicare nor by employer-sponsored or nongroup Medicare supplemental coverage. Of course, these projected savings requirements are in addition to whatever people need to save in order to meet their other living expenses in retirement.

Under current law, there are a limited number of vehicles that allow employees to accumulate tax-favored savings specifically for health expenses, either on their own or with some employer contribution (see next page).<sup>47</sup>

Continued, page 23 ►

## Tax-Preferred Savings for Health Expenses

**Flexible spending accounts (FSAs)** allow employees to designate a sum to be deducted from their wages and deposited into the FSA; the amount deposited is tax-exempt. The employee may draw on the account to pay coinsurance or deductible requirements under the health plan, or to pay for medical services not covered under the plan. However, the funds must be used to pay expenses during the year they are deposited or shortly thereafter. (Under a May 2005 Treasury ruling, an employer may now allow workers to use the FSA for expenses incurred up to two and one-half months after the end of the year.)

**Health savings accounts (HSAs)** are a new option created by the Medicare Modernization Act of 2003. An employee may make pre-tax contributions to an HSA, and any employer contributions are deductible for the employer and tax-exempt for the employee. An employee may contribute to an HSA only if he or she is covered by a high-deductible health plan (HDHP)—one with a minimum deductible of \$2,500 for an individual or \$5,000 for a family—and has no other health insurance. (Separate plans for dental, prescription, or other services are permitted.) Contributions during a year may not exceed the lesser of the HDHP deductible or a statutory limit. Amounts in an HSA may be used to pay the deductible or other cost-sharing under the HDHP or to pay for any other qualified medical expenses.\* Unused amounts can be carried over, with interest income tax-exempt. The balance in an HSA is available for medical expenses permanently, regardless of whether the employee ceases to participate in the HSA/HDHP arrangement, changes jobs, or retires. (An NHPF background paper provides more information on HSAs.†)

One other arrangement, the **Medicare Advan- tage medical savings account (MSA)** is quite

similar to the HSA/HDHP option. Medicare beneficiaries can establish an MSA if they agree to obtain their Medicare benefits through a high-deductible plan with a Medicare contract; as no such plan has ever contracted with Medicare, this is a dormant option.

In **health reimbursement arrangements (HRAs)**, an employer can make tax-exempt contributions to an HRA; employees cannot supplement these contributions. Amounts in an HRA can be drawn on at any time to pay for qualified medical expenses, and unused amounts may be carried over into future years. However, the employer is free to decide what specific categories of expenses may be covered, and the employer may or may not allow the worker to continue drawing on the HRA balance if he or she changes jobs. Like retiree medical accounts, HRAs are usually notional: the employer is not actually depositing money anywhere but is simply crediting the worker with a specified amount to be made available as expenses are actually incurred.

**Employee pay-all VEBAs** are a variant of the VEBA arrangements previously described in which only the employee pays into the VEBA and the contributions are not tax-deductible. However, interest income on the VEBA is tax-exempt, unlike income of VEBAs established by for-profit employers. Distributions from the VEBA are also tax-free. (The VEBA may be thought of as similar to a Roth IRA, which also involves after-tax contributions but tax-free earnings and distributions.)

\* *Qualified medical expenses are those that would be deductible under the itemized medical expense deduction, including premiums for health or long-term care insurance, cost-sharing, and most other medical expenses.*

† *Beth Fuchs and Julia A. James, Health Savings Accounts: The Fundamentals, National Health Policy Forum, Background Paper, April 11, 2005; available at [www.nhpf.org/pdfs\\_bp/BP\\_HSAs\\_04-11-05.pdf](http://www.nhpf.org/pdfs_bp/BP_HSAs_04-11-05.pdf).*

► **Continued** from page 21

Each of the available vehicles offers an opportunity to make pre-tax contributions for future expenses, accumulate tax-free investment earnings, and/or make tax-free withdrawals when expenses are incurred. However, each has important shortcomings as a way of saving for medical costs in retirement. FSAs allow only limited contributions meant for immediate use and are not available to retirees. HRAs and employee pay-all VEBAs may or may not be portable after a job change or retirement. HSAs are portable, but they are available only to employees willing to accept a high-deductible health plan in place of more comprehensive benefits. Finally, all of these arrangements are available for active workers' current health spending, not just anticipated costs after retirement. Many participants are likely to use up much or all of the balances before reaching retirement age.

There are a variety of proposals to modify the current options in order to promote more saving for future health needs. President Bush's 2004 budget proposal would have allowed up to \$500 per year in unused FSA balances to be carried over, apparently indefinitely, or shifted to a retirement account or an HSA.<sup>48</sup> Many similar proposals have been offered in the 109th Congress. Because FSAs were designed for immediate use, they are not expected to earn interest income; if they did earn interest, any such income would not be tax-exempt.

Two bills in the 109th Congress, H.R. 2063 and H.R. 3873 would allow tax-free rollovers from 401(k)s and other retirement funds to HSAs. This option would only be available to people qualifying for an HSA under the current rule that requires a high-deductible health plan. Another proposal, H.R. 3075, would allow establishment of an HSA without a high-deductible plan. An individual could deposit up to \$8,000 a year in the account; the limit would be indexed for inflation. President Bush's fiscal year 2007 budget would retain the high-deductible health plan requirement but raise HSA contribution limits and allow higher contributions for chronically ill employees.

Another approach would be to retarget non-health savings vehicles to promote their use for health expenses. Currently, 401(k)s and other funds allow tax-exempt contributions and can earn tax-free investment income; however, amounts withdrawn from the fund after retirement are taxable. Several proposals would allow tax-free withdrawals to pay health expenses. At least one would also waive current limits on annual 401(k) contributions when the contribution was intended for future health costs.<sup>49</sup>

More sweeping proposals would create entirely new vehicles for retirement health savings. One recent plan calls for Medicare Health Accounts: workers could agree to have up to 1 percent of wages deducted on a pre-tax basis and placed in a savings account to be maintained by Medicare; the account could be drawn on later in life, again tax-free, for expenses Medicare does not cover. A survey of adults aged 50 to 70 in a family with

at least one working member found that 69 percent would be interested in this arrangement.<sup>50</sup> The proposal apparently does not contemplate that the savings fund would earn any interest or other income. Another option would be a separate 401(k), IRA, or other private savings arrangement earmarked specifically for health costs. Like other retirement savings options, these funds would grow through compounding investment earnings.<sup>51</sup>

Although improved vehicles for health savings could be helpful for some future retirees, these proposals may need to be considered in the context of the broader retirement savings problem. Only 62 percent of workers report that they are currently saving any money for retirement, and many of those who are saving see themselves as behind schedule in preparing for retirement needs. Factors reportedly limiting the ability to save include everyday living expenses, child care costs, and current medical spending.<sup>52</sup> Possibly better education about future health needs and stronger incentives for saving would encourage some of these workers to set aside more money if they are able to do so. But it could also be that new options for health savings would be taken up largely by higher-income people who are already making the maximum contributions to other forms of tax-favored savings.

Proposals that would allow tax-free withdrawals from savings for health care, while withdrawals from savings for other expenses are taxable, raise a second question: why should health spending be preferred in this way? Some people would contend that current tax incentives for health insurance and health spending may encourage unnecessary or inefficient care, and that the tax system should not be used to promote some kinds of consumption rather than others. On the other hand, it could be argued that the tax system already privileges health spending by active workers; these proposals would merely extend the same preference to retirees.

**Improved vehicles for health savings may need to be considered in the context of the broader retirement savings problem.**

## **ALTERNATE SOURCES OF RETIREE HEALTH COVERAGE**

Retirees who are losing access to employer-sponsored health benefits, or those leaving firms that never offered the benefits in the first place, face high costs and other barriers to obtaining basic health coverage or a Medicare supplement. Policymakers could consider alternative ways of helping retirees obtain affordable coverage.

### **Access to Insurance for Non-Medicare Retirees**

Retirees who seek insurance in the nongroup market may face very high premiums, especially if they have a history of medical problems; may be offered coverage only with preexisting condition exclusions or other restrictions; or, in most states, may be denied private insurance altogether. These problems might be addressed by improving access to affordable



coverage in the nongroup market, by extending COBRA protections to cover retirees for a longer interval after leaving employment, or by allowing retirees to purchase coverage through Medicare or another public program.

**Nongroup market reforms** — Options to improve access to private insurance have been discussed for many years and continue to be advanced in the context of proposals that would provide tax credits or other financial assistance with the cost of premiums. These options, including stronger regulation of the nongroup market, high-risk pools or reinsurance arrangements, or allowing enrollment through the FEHB program or a similar system, are generally meant to apply to the entire uninsured population, including active workers without employer coverage and retirees. The general problem of access to insurance is beyond the scope of this paper; an NHPF background paper, *Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform*, provides an overview of the issues and possible solutions.<sup>53</sup>

**Extended COBRA coverage** — Under rules established by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, people who lose coverage under an employer plan usually may continue to buy coverage through the employer group for a specified period—18 months, in the case of those losing coverage because of early retirement or other termination of employment.<sup>54</sup> Employers are permitted to charge COBRA participants 102 percent of their average cost for active workers in the same plan. (Higher charges are allowed for certain participants receiving extended coverage as a result of a disability.)

The 18-month limit means that someone retiring before the age of 63 and one-half may face some period of uninsurance before qualifying for Medicare. Some proposals would allow a longer period of COBRA coverage for retirees. In the 109th Congress, S. 1826 would allow workers retiring at age 62 or later to buy COBRA coverage for up to 36 months—that is, until they qualify for Medicare. Because these retirees are likely to cost more than other COBRA participants, the bill would allow employers to charge 120 percent, rather than 102 percent, of average annual costs.

Dependents who lose employer coverage when the policyholder qualifies for Medicare can currently buy COBRA coverage for a maximum of 36 months. However, in 2004, 40 percent of married couples had an age difference greater than three years, meaning that many spouses of people turning 65 would lose COBRA before they themselves became Medicare-eligible.<sup>55</sup> Spouses of Medicare beneficiaries could be allowed to extend COBRA coverage until they reached Medicare age.

COBRA coverage is expensive for participants because they pay the full premium without an employer contribution. A single retiree in 2005 would face an average premium of \$4,104, compared with an average employee contribution for an active worker of \$610. A retiree wishing to cover all family members would pay an average of \$11,098.<sup>56</sup> Partly

as a result, a 2004 survey of 173 employers found that only one in five eligible employees purchases COBRA on leaving employment.<sup>57</sup> There have been a variety of proposals to encourage take-up of COBRA by people who would otherwise be uninsured through tax credits or other premium subsidies, and surveys have found that a generous subsidy could more than double participation.<sup>58</sup> One bill in the 109th Congress, H.R. 4173, would provide a refundable tax credit to pay up to 50 percent of the COBRA premium.

COBRA is also costly for employers. The minority of eligible people who choose to buy COBRA are likely to be those who expect above average health care expenses. One survey found that average claim costs for COBRA participants were 46 percent higher than for active workers.<sup>59</sup> The disparity might be greater for the older participants who would want COBRA benefits if some form of extended coverage were made available for non-Medicare retirees. Employers could be allowed to charge a higher premium to this group, as they now can for disabled COBRA participants. But this would make the coverage even less affordable for potential participants, or would require larger premium subsidies.

**Medicare buy-in** — There have been numerous proposals to allow non-Medicare retirees to buy Medicare coverage until they become Medicare-eligible. The Clinton administration repeatedly proposed a buy-in for people aged 62 to 64. The last of these proposals, in the fiscal year 2001 budget, would have required participants to pay a premium equal to their full average projected costs, and a tax credit would have covered 25 percent of the premium.<sup>60</sup> In the 109th Congress, H.R. 2072 would allow people aged 55 to 64 who were ineligible for other federal coverage to buy Medicare. A refundable income tax credit would cover 75 percent of the premium. For applicants with existing retiree coverage, the employer could choose to pay the remaining 25 percent and cover non-Medicare services.

The size of the premium, net of any subsidy, would affect both the level of participation and the extent to which Medicare would displace existing employer and nongroup benefits. A 2002 study analyzed a plan that would cover only people aged 62 to 64 and would be closed to people eligible for employer-based coverage. It found that about 37 percent of eligible people would participate if rates were equal to average costs; most participants would be middle-income and would shift from private nongroup coverage. With income-based subsidies, participation would increase to 52 percent, with higher participation by low-income people. The more costly the plan, the more likely it would attract people with health problems, raising the possibility of adverse selection and a premium spiral.<sup>61</sup> On the other hand, a generous subsidy might make the buy-in much more attractive than most employer-provided retiree coverage. It could also lead most retirees buying private nongroup coverage to shift into Medicare, raising federal costs and prompting resistance from the insurance industry.

Measures to make insurance coverage more accessible for retirees without employer benefits might have two potentially undesirable effects. First, they might hasten the erosion of employer coverage; future retirees who were confident they could get other insurance might prefer other compensation in lieu of health benefits. Second, they could lead more workers to retire early: many people keep working until they are eligible for Medicare precisely because they are concerned about access to health insurance.<sup>62</sup> More early retirements could have financial effects on Social Security and could also mean that more retirees would ultimately outlive their own savings.

On the other hand, some people retire early because they are no longer able to do their jobs, even though they may not meet the stringent criteria for Social Security and Medicare disability coverage. Moreover, if older workers could be sure of access to health insurance, many would not retire but would instead shift to other jobs or self-employment.<sup>63</sup> Reliance on employer benefits may keep them locked into their current jobs, with negative consequences for both workers and employers.

### Access to Supplemental Coverage for Medicare Retirees

Even with the new prescription drug benefit, Medicare beneficiaries without supplemental coverage may remain exposed to very high out-of-pocket costs. Unlike most private insurance plans, Medicare has no out-of-pocket limit to protect against catastrophic costs. Average beneficiary liability for Medicare-covered services was \$832 in 2002; 8.5 percent of beneficiaries had liability of \$3,000 or more.<sup>64</sup> Currently, beneficiaries without retiree health benefits may obtain supplemental coverage in three ways: by buying a nongroup Medigap policy, by joining a Medicare Advantage plan, or by qualifying for Medicaid. (Medicaid assistance with Medicare deductibles and coinsurance is generally available only to beneficiaries with incomes below 100 percent of the federal poverty income guideline, \$9,800 for a single person in 2006.)

As was noted earlier, many Medicare beneficiaries currently receiving employer-sponsored supplemental coverage have fairly low incomes. In the absence of retiree coverage, they may have difficulty finding an affordable alternative. At age 65, a female beneficiary would pay a national average of \$1,159.85 for the least generous Medigap plan.<sup>65</sup> For a beneficiary just above the poverty level, and hence ineligible for cost-sharing assistance under Medicaid, this amounts to 12 percent of her income. Moreover, many Medigap plans use “attained age” rating: premiums rise, at a rate faster than inflation, as the policyholder grows older. So maintaining coverage would require a steadily higher share of income over time even for retirees’ whose income is indexed for inflation.<sup>66</sup> Medicare Advantage plans may provide less costly coverage at the price of restrictions on choice of and access to providers; at this writing, comparative information on benefit offerings and premiums for 2006 is not yet available. The following are two alternatives for improving access to supplemental coverage.

**Many Medigap plans use “attained age” rating: premiums rise, at a rate faster than inflation, as the policyholder grows older.**

**Catastrophic add-on to Medicare** — Medicare could provide its own catastrophic benefit, covering all cost-sharing once a certain out-of-pocket limit is reached.<sup>67</sup> To eliminate any budgetary impact, this might be a voluntary add-on with the full cost covered through a beneficiary premium. Because Medicare’s administrative costs are much lower than those of private insurers—about 2 percent of benefits—the coverage could be much cheaper than an equivalent private plan. In addition, having claims processed by one payer, rather than separately by the Medicare intermediary and a Medigap insurer, might be more efficient and less confusing for beneficiaries. One recent proposal, for a comprehensive “Medicare Extra” plan that would provide reduced coinsurance and broader prescription drug benefits as well as catastrophic coverage, would likely face resistance from insurers, who could lose a substantial market.<sup>68</sup> A catastrophic add-on may meet less resistance from insurers, because the number of beneficiaries to buy such a plan might be smaller.

**Access to Medigap** — People who qualify for Medicare when turning 65 have a one-time Medigap open enrollment opportunity: carriers may not refuse or limit coverage to applicants during the first six months following their Medicare enrollment. (Beneficiaries who decline Medigap on turning 65 because they have employer coverage have an open enrollment opportunity later on if the employer terminates the coverage.) This rule does not apply to younger beneficiaries qualifying for Medicare as a result of disability; Medigap carriers are free to decline coverage to nonelderly beneficiaries because of health status or medical history. Newly eligible disabled beneficiaries could be given the same open enrollment option as the elderly. Insurers would resist this change; the different treatment of nonelderly beneficiaries exists in the first place because insurers fear attracting too many high-risk enrollees. On the other hand, Medicare Advantage plans are already required to accept both elderly and disabled applicants at all times without regard to health status. A change in the rules for the disabled might just level the playing field.

## CONCLUSION

Over one-third of retirees are now receiving some form of employer health coverage, but many firms that have offered these benefits are reducing their commitments to future retirees (especially those most recently hired), and most newer employers are not offering retiree benefits at all. This report has considered three sets of options for helping future retirees meet their health care costs:

**Stronger regulation of retiree health benefits in exchange for improved prefunding arrangements** — If employers were willing to participate, this approach would protect workers who are trading some current compensation for future coverage and would allow them to plan for retirement with some confidence about what the employer will be providing. However, the very development that makes this option feasible—the shift from

open-ended employer commitments to fixed-dollar limits on future benefits—means that the coverage locked in would defray only a fraction of the retirees’ future costs.

**Incentives to save for future health costs** — Existing tax-favored savings programs could be modified, or new vehicles developed, to encourage workers to set aside money for future expenses. However, many workers are not saving enough to meet general living expenses in retirement. Unless new health savings options lead to increases in overall savings, the effect might simply be to earmark a portion of current savings for one specific category of future spending.

**Alternative sources of affordable insurance** — Improving access to private coverage or broadening coverage under public programs could help both retirees who are losing employer-sponsored coverage and those who never had it in the first place. However, development of attractive alternatives could speed the erosion of employer coverage. It could also induce workers under age 65 to retire sooner.

The problem of retiree health benefits may be seen as arising from the convergence of two larger social policy concerns: steadily rising medical costs and the general inadequacy of savings for living expenses in retirement, including health care and long-term care. Some analyses (perhaps using pessimistic assumptions) suggest that future retirees will need to accumulate hundreds of thousands of dollars to meet their expected medical costs. If these estimates are correct, neither direct health-related savings nor the indirect savings represented by retiree health benefits are likely to be much help. Conversely, if people reach retirement age without sufficient overall resources to meet their probable lifetime needs, earmarking limited savings for health care might leave them even less able to maintain their quality of life.

The specific solutions discussed in this paper might provide relief to current retirees or some workers just reaching retirement age. Assuring health and income security for the next generation of retirees will require addressing the underlying problems of medical costs and savings.

---

## ENDNOTES

1. Kaiser Family Foundation and Hewitt Associates (Kaiser/Hewitt), *Prospects for Retiree Health Benefits as Medicare Prescription Drug Coverage Begins: Findings from the Kaiser/Hewitt 2005 Survey on Retiree Health Benefits*, December 2005; available at [www.kff.org/medicare/med120705pkg.cfm](http://www.kff.org/medicare/med120705pkg.cfm).
2. *AARP et al. v. Equal Employment Opportunity Commission*, U.S. District Court for the Eastern Division of Pennsylvania, Case 2:05-cv-00509-AB, memorandum and order filed September 27, 2005.
3. U.S. Congress, House of Representatives, *Conference Report to accompany H.R. 1, Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, House Report H.R. 108-391, 108th Congress, 1st Session, November 21, 2003.

Endnotes / continued ►

**Endnotes / continued**

4. Kaiser/Hewitt, *Current Trends and Future Outlook for Retiree Health Benefits: Findings from the Kaiser/Hewitt 2004 Survey on Retiree Health Benefits*, December 2004; available at [www.kff.org/medicare/med121404pkg.cfm](http://www.kff.org/medicare/med121404pkg.cfm).
5. Watson Wyatt Worldwide, *Retiree Health Benefits: Time to Resuscitate?* 2002, 16.
6. Bureau of Labor Statistics, "Employee Tenure in 2004," press release, U.S. Department of Labor, September 21, 2004; available at [www.bls.gov/news.release/tenure.nr0.htm](http://www.bls.gov/news.release/tenure.nr0.htm).
7. U.S. General Accounting Office (GAO), *Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage*, GAO-02-8, October 2001; available at [www.gao.gov/cgi-bin/getrpt?GAO-02-8](http://www.gao.gov/cgi-bin/getrpt?GAO-02-8).
8. Paul Fronstin and Dallas Salisbury, *Retiree Health Benefits: Savings Needed to Fund Health Care in Retirement*, Employee Benefit Research Institute, Issue Brief 254, February 2003; available at [www.ebri.org/pdf/briefspdf/0203ib.pdf](http://www.ebri.org/pdf/briefspdf/0203ib.pdf).
9. Some employers cap aggregate spending for all retirees in a plan, rather than per individual; others vary the cap for each retiree depending on the number of service years accrued at the time of retirement [Hewitt Associates, *Retiree Health Trends and Implications of Possible Medicare Reforms* (Washington: Kaiser Family Foundation, 1997)].
10. Hewitt Associates, *Retiree Health Trends*.
11. Kaiser/Hewitt, *Current Trends and Future Outlook*. For retirees aged 65 and older in 2005, 86 percent of employers with caps were at or near the limit [Kaiser/Hewitt, *Prospects for Retiree Health Benefits*].
12. Medical expenses and premiums are deductible to the extent that they exceed 7.5 percent of the taxpayer's adjusted gross income (AGI).
13. Fronstin and Salisbury, *Retiree Health Benefits*.
14. This standard has now been replaced by FAS 132.
15. U.S. Government Accountability Office (GAO), *Retiree Health Benefits: Options for Employment-Based Prescription Drug Benefits*, GAO-05-205, February 2005; available at [www.gao.gov/new.items/d05205.pdf](http://www.gao.gov/new.items/d05205.pdf).
16. K. Lewis, "Retiree Medical Benefits on the Block," *Newark Star-Ledger*, December 20, 2005.
17. Milt Freudenheim and Mary Williams Walsh, "The Next Retirement Time Bomb," *The New York Times*, December 11, 2005.
18. These figures exclude people who are still working full time, even if they have reported retiring from a previous job, because it is not possible to determine whether their coverage came from the current or the former job. Note also that the Current Population Survey (CPS) does not survey people in nursing homes or other institutions, some of whom may have retiree benefits.
19. Author's analysis of Current Population Survey, 2005 Annual Social and Economic (ASEC) Supplement.
20. The CPS poverty estimates use Census Bureau poverty thresholds, which vary by age, instead of the Department of Health and Human Services poverty income guidelines used to determine eligibility for Medicaid and other programs.
21. Kaiser/Hewitt, *Prospects for Retiree Health Benefits*; and Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET), *Employer Benefits 2005 Annual Survey*, (Menlo Park, CA: Kaiser Family Foundation, September 2005), available at [www.kff.org/insurance/7315/index.cfm](http://www.kff.org/insurance/7315/index.cfm).
22. Kaiser/Hewitt, *Prospects for Retiree Health Benefits*.

**Endnotes / continued ►**

**Endnotes** / continued

23. UAW International, *UAW GM Report*, October 2005; available at [www.uawlocal598.org/healthcare\\_changes.pdf](http://www.uawlocal598.org/healthcare_changes.pdf).
24. U.S. Office of Personnel Management (OPM), *The Fact Book: Federal Civilian Workforce Statistics*, Washington, 2004; available at [www.opm.gov/feddata/factbook/](http://www.opm.gov/feddata/factbook/).
25. Kaiser/Hewitt, *Prospects for Retiree Health Benefits*; Kaiser/HRET, *Employer Benefits 2005 Annual Survey*.
26. OPM, *The Fact Book*.
27. C. L. Schur *et al.*, "Paying for Health Care in Retirement: Workers' Knowledge of Benefits and Expenses," *Health Affairs Web Exclusive* (July 14, 2004): W4-385; available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.385/DC1>.
28. Watson Wyatt Worldwide, *Time to Resuscitate*.
29. GAO, *Retiree Health Benefits* (GAO-05-205).
30. Kaiser/Hewitt, *Prospects for Retiree Health Benefits*.
31. U.S. Congressional Budget Office (CBO), *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, July 2004; [www.cbo.gov/showdoc.cfm?index=5668&sequence=0](http://www.cbo.gov/showdoc.cfm?index=5668&sequence=0).
32. Kaiser/Hewitt, *Prospects for Retiree Health Benefits*.
33. For retirees in plans that retain their current drug coverage, the federal subsidy to the employer is less than the value of the federal subsidies for Medicare beneficiaries enrolled in nonemployer prescription drug plans. This means that, even after the federal subsidy, combined spending by the employer and the retiree for the portion of the employer benefit that overlaps part D coverage may be more than the retiree would have to spend for an equivalent outside part D plan. (The difference might be offset by lower administrative costs for the employer plan.)
34. GAO, *Retiree Health Benefits* (GAO-05-205).
35. Author's analysis of 2002 Medical Expenditure Panel Survey data. Estimates exclude administrative costs and are based on beneficiaries with coverage throughout the year and with no shifts in private coverage source. The nonemployer estimate does not include enrollees in Medicare Advantage plans.
36. A cash balance plan is technically a defined benefit plan: the employer guarantees that a certain lump sum amount will be available to the employee on retirement but does not guarantee a specific level of retirement income. The employee bears the risk for investment performance after retirement.
37. IBM, "IBM Changes U.S. Pension Plans, Effective in 2008, as Part of Ongoing Global Retirement Plan Strategy Shift," press release, Armonk, NY, January 5, 2006.
38. E. Schultz and T. Francis, "How Safe Is Your Pension?" *Wall Street Journal*, January 12, 2006.
39. See GAO, "Private Pensions: The Pension Benefit Guaranty Corporation and Long-Term Budgetary Challenges," testimony before the Committee on the Budget, House of Representatives, GAO-05-772T, June 9, 2005; available at [www.gao.gov/cgi-bin/getrpt?GAO-05-772T](http://www.gao.gov/cgi-bin/getrpt?GAO-05-772T). Employers contend that the risks to the PBGC have been overstated and can be addressed through modest legislative changes [Optimal Benefit Strategies, LLC, *Promises to Keep: The True Nature of the Risks to the Defined Benefit Pension System*, report prepared for the American Benefits Council, September 2005; available at [www.americanbenefitscouncil.org/documents/pbgcdraft092205.pdf](http://www.americanbenefitscouncil.org/documents/pbgcdraft092205.pdf)].
40. Howard Silverblatt, "S&P 500 Update: Pensions and Other Post-Employment Benefits," Standard & Poor's, December 2005.

**Endnotes** / continued ►

**Endnotes / continued**

41. For an explanation of VEBAs, see Joint Committee on Taxation, "Present Law and Background on Federal Tax Provisions Relating to Health Care," JCX-26-98, U.S. Congress, 1998; available at [www.house.gov/jct/x-29-99.htm](http://www.house.gov/jct/x-29-99.htm).
42. UAW International, *UAW GM Report*.
43. Retirees have an "unsecured" claim for unpaid health and other benefits; that is, they may recover only after all priority creditors have been satisfied, which rarely occurs.
44. T. Healey and R. Steel, "For Retirees, The Day of Reckoning," *Washington Post*, August 16, 2005, p. A13.
45. Rick Sauder, *The Rising Cost of Health Care and Your Retirement*, Fidelity Workplace Services, 2005; available at <https://powertools.fidelity.com/healthcost/glossary/paper.pdf>.
46. Fronstin and Salisbury, *Retiree Health Benefits*.
47. An Internal Revenue Service publication, *Health Savings Accounts and Other Tax-Favored Health Plans* (Pub. 969; available at [www.irs.gov/publications/p969/index.html](http://www.irs.gov/publications/p969/index.html)), summarizes the rules for all these options except employee-pay-all VEBAs.
48. The proposal antedated the new HSA option and actually referred to Archer MSAs, which no longer exist.
49. Fronstin and Salisbury, *Retiree Health Benefits*; and Fidelity Workplace Services, "Retiree Health Care Costs: Addressing the Growing Gap," September 2002, available at [https://www.fidelity.com/workplace/PublicSites/DCL/UploadedFiles/325879\\_retiree\\_whitepaper\\_2724.pdf](https://www.fidelity.com/workplace/PublicSites/DCL/UploadedFiles/325879_retiree_whitepaper_2724.pdf).
50. S. R. Collins *et al.*, "Medicare Health Accounts: A New Policy Option to Help Adults Save for Health Care Expenses Not Covered by Medicare," The Commonwealth Fund, June 2005; available at [www.cmwf.org/publications/publications\\_show.htm?doc\\_id=282157](http://www.cmwf.org/publications/publications_show.htm?doc_id=282157).
51. Fidelity Workplace Services, "Retiree Health Care Costs."
52. Ruth Helman *et al.*, *Encouraging Workers to Save: The 2005 Retirement Confidence Survey*, Employee Benefit Research Institute, Issue Brief 280, 2005; available at [www.ebri.org/pdf/briefspdf/0405ib.pdf](http://www.ebri.org/pdf/briefspdf/0405ib.pdf).
53. Mark Merlis, *Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform*, National Health Policy Forum, Background Paper, April 13, 2005; available at [www.nhpf.org/pdfs\\_bp/BP\\_Underwriting\\_04-13-05.pdf](http://www.nhpf.org/pdfs_bp/BP_Underwriting_04-13-05.pdf).
54. COBRA does not apply to employers with fewer than 20 workers.
55. Fewer children are affected: only about 1 percent of householders aged 65 or older had children under age 18 in 2004 [Bureau of the Census, table F1, "Family Households, by Type, Age of Own Children, Age of Family Members, and Age, Race and Hispanic Origin of Householder: 2004," in "America's Families and Living Arrangements: 2004," updated June 29, 2005; available at [www.census.gov/population/www/socdemo/hh-fam/cps2004.html](http://www.census.gov/population/www/socdemo/hh-fam/cps2004.html)].
56. Author's calculations based on Kaiser/HRET, *Employer Benefits 2005 Annual Survey*.
57. Lauren Bikoff and Stephen Huth, "2004 COBRA Survey: Fewer Were Eligible, More Elected, Cost Was 146 Percent of Active Employee Cost," *Employee Benefit Plan Review*, 59, no. 6 (December 2004): 10–16.
58. Jennifer N. Edwards, Michelle M. Doty, and Cathy Schoen, "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care," The Commonwealth Fund, Issue Brief, August 2002.
59. Bikoff and Huth, "2004 COBRA Survey."
60. U.S. Department of Health and Human Services, untitled document available at [www.hhs.gov/budget/fy01budget/hhs2001.pdf](http://www.hhs.gov/budget/fy01budget/hhs2001.pdf), accessed October 2005.

**Endnotes / continued** ►



**Endnotes / continued**

61. Richard W. Johnson, Amy J. Davidoff, and Marilyn Moon, *Insuring the Near Elderly: The Potential Role for Medicare Buy-In Plans*, Urban Institute, Brief Series, no. 13, January 2002; available at [www.urban.org/UploadedPDF/310419\\_Brief13.pdf](http://www.urban.org/UploadedPDF/310419_Brief13.pdf).
62. Sophie Korczyk, *Is Early Retirement Ending?* AARP, October 2004; available at [www.aarp.org/research/work/retirement/is\\_early\\_retirement\\_ending.html](http://www.aarp.org/research/work/retirement/is_early_retirement_ending.html).
63. Lynn A. Karoly and Julie Zissimopoulos, *Self-Employment and the 50+ Population*, AARP, March 2004; available at [www.aarp.org/research/work/employment/aresearch-import-844-2004-03.html](http://www.aarp.org/research/work/employment/aresearch-import-844-2004-03.html).
64. Stephanie Maxwell, Matthew Storeygard, and Marilyn Moon, *Modernizing Medicare Cost-Sharing: Policy Options and Impacts on Beneficiary and Program Expenditure*, Washington, Urban Institute, November 2002; available at [www.cmwf.org/usr\\_doc/Maxwell\\_modernizingmedicare\\_571.pdf](http://www.cmwf.org/usr_doc/Maxwell_modernizingmedicare_571.pdf).
65. Weiss Ratings, Inc., "Striking Price Differences Persist in Medigap Despite Identical Benefits," press release, Jupiter, FL, August 29, 2005.
66. It is possible to buy policies that base rates on "issue age"; premiums rise with inflation but not with policyholder age. However, these policies can be substantially more costly at the outset.
67. The Medicare Catastrophic Coverage Act of 1988 provided such a benefit, along with prescription drug coverage, funded by beneficiary premiums and a tax surcharge for higher-income beneficiaries. Beneficiaries' objections to the tax were the major factor in the repeal of this benefit one year later.
68. Karen Davis *et al.*, "Medicare Extra: A Comprehensive Benefit Option For Medicare Beneficiaries," *Health Affairs Web Exclusive* (October 4, 2005): W5-442; available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.442/DC1>.



*The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at [www.nhpf.org](http://www.nhpf.org).*