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TRENDS AND ISSUES

Retiree Health Care:
Individuals Picking Up Bigger Tab

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EXECUTIVE SUMMARY

Over the past two decades, health care spending has tended to grow at twice the rate of overall economic growth. Today's seniors each spend, on average, more than $9,200 per year on health care costs. Employers have been forced to cut back their share of the costs for retiree health care coverage, and growing numbers of employers have dropped coverage altogether. Medicare participation is nearly universal but the coverage is not comprehensive, meaning that most individuals need to cobble together a mixture of public and private health insurance. The new Medicare prescription drug plan will be subsidized by the government and likely will be an advantageous new benefit for people lacking insurance for prescription drugs. In short, as people are living longer and longer, retiree health care will cost more and more. Individuals need to be as informed as possible about their options and plan ahead for funding retiree health care.

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Funding Retiree Health Care: A Growing Challenge

Health care is expensive and likely to remain so for the foreseeable future. For most Americans, this is not news; indeed, although employer-sponsored health insurance is subsidized for employees, the costs of premiums, cost sharing and uncovered services have been rising rapidly. Over the past two decades, health care spending has tended to grow about twice as fast as the economy as a whole. No wonder that the share of Gross Domestic Product going to health care has risen from 12 percent in 1990 to 15.3 percent in 2003.

Imagine, then, what this means for the costs of health care in retirement. Many people aged 65 and over have chronic conditions that make health care more costly for them than it is for younger persons—and more difficult to turn over to private insurers without major government protections. The rate of growth is not much different, but the base is substantially larger. Health care spending on people age 65 and over runs about four times as much as that for the rest of the population. Currently, it averages more than $9,200 annually per senior, not counting long-term care expenses.

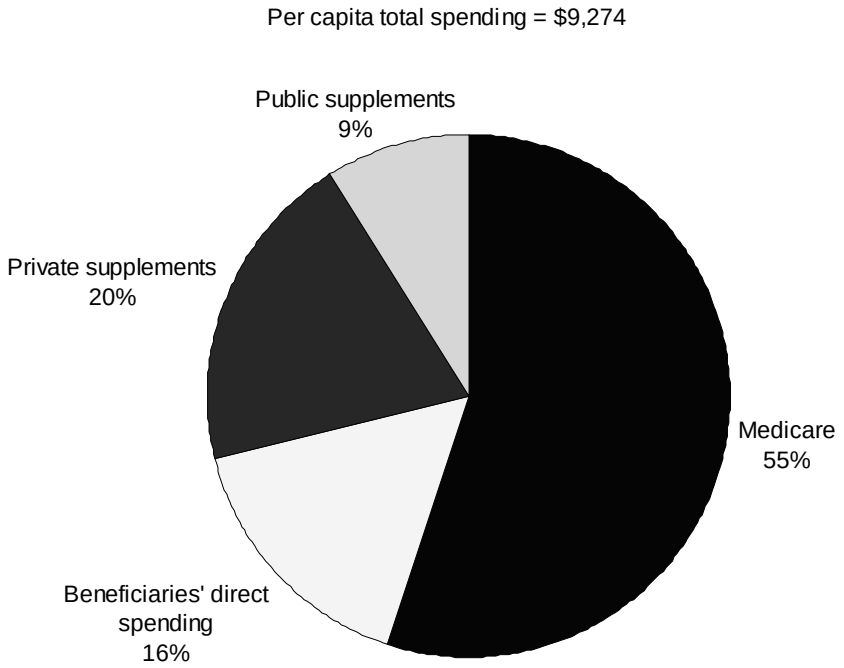
In the 1960s, most seniors did not have health insurance. They either could not afford it or it was not available at any price. Insurers avoided older Americans. Medicare, enacted in 1965, changed the picture considerably. Initially, all persons aged 65 and over were eligible for benefits. Today, people eligible for any type of Social Security benefit are eligible for Medicare. This translates to about 98 percent of all persons aged 65 and over in the U.S. having Medicare coverage.

Piecing Together a Health Care Plan

While participation is nearly universal, the benefits themselves are not fully comprehensive. The benefit package has changed little since 1965 when it was established to mimic standard private insurance of the time. Medicare requires substantial deductibles and cost sharing and has no upper bound limit on coverage as is often the case with employer-sponsored insurance. Its largest gap in acute care services is the absence of a prescription drug benefit, although that will change in 2006 with the introduction of a new drug benefit. And, like most health insurance, long term care--supportive services for people with substantial physical or mental limitations--is not covered by Medicare. Consequently, Medicare covers about 55 percent of the health care spending of the 65 and over population (Figure 1).

To obtain comprehensive health insurance, most retirees supplement the Medicare program with other insurance. The private supplemental category in Figure 1 captures the share of spending

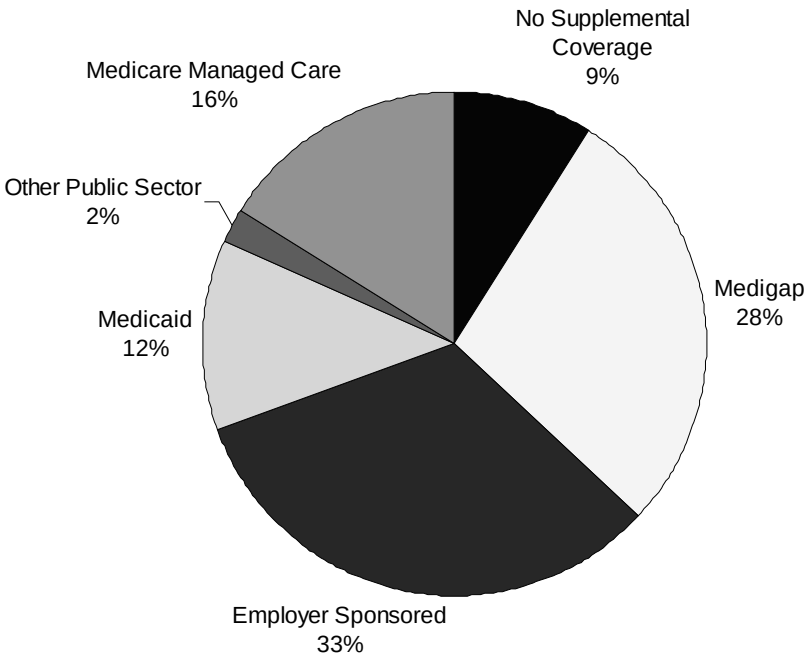
Figure 1
Total spending on health care services for noninstitutionalized FFS Medicare beneficiaries, by source of payment, 2001



Source: 2004 Medicare Payment Advisory Commission analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001

that such supplemental benefits cover. Once Medicare offered a basic floor of protection, private insurers and many employers have been willing to offer such coverage. The very fortunate retirees have employer-subsidized insurance. If available, it is almost always the best way to go and pays a greater share of total costs. Those who do not have such supplemental coverage usually choose to purchase private supplemental insurance (Medigap)—which is considerably less generous--or enroll in Medicare's private plan option, Medicare Advantage, which normally covers a more extensive benefit package in exchange for getting care from a restricted set of doctors, hospitals and other care providers. Finally, those with low incomes either receive help from the federal/state Medicaid program available to the very poor or make do without any supplemental support. Figure 2 on the next page indicates the proportion of the Medicare population that each of these groups represent.

Figure 2
Sources of supplemental coverage among noninstitutionalized Medicare beneficiaries, 2001



Source: 2004 Medicare Payment Advisory Commission analysis of Medicare Current Beneficiary Survey, Cost and Use file, 2001

Although there has been a great deal of controversy about the affordability of Medicare over time, it is very likely that Medicare, in some form, will be there when people retire. Government protections to guarantee access to care and to subsidize its expense are still needed. But, Medicare's coverage of health care expenses is likely to remain less comprehensive than what most workers now have, and the share of the costs of insurance that individuals are asked to pay will likely rise in the future. Thus, it is important to plan for health expenses when thinking about retirement.

Planning for Retiree Coverage

Not all companies offer retiree coverage and when they do, rules for eligibility can be complicated. Many people changing jobs do not think to ask whether the employer will subsidize coverage in retirement. But that benefit can be worth a great deal. For example, retiree

insurance on average fills in over 70 percent of the gap left by Medicare. Anyone considering job offers should ask about this potential benefit. Larger companies that place a value on longevity on the job are more likely to offer such insurance, although the number of companies doing so has been declining over time.

When retiree benefits are available, they may simply allow the former worker to continue in the employer's plan, paying some or all of the premium costs. When the premium is subsidized, there are usually requirements to qualify that can vary substantially across employers. For example, the subsidies offered may be pro-rated by years of employment and may have different rules for the worker and spouse. A 2001 Watson Wyatt survey of corporate sponsors of retiree health benefits indicated that 90 percent required service of 10 years or more to qualify. In addition, companies sometimes require that a spouse be covered under the regular health plan at the time of retirement in order to qualify for retiree benefits. Increasingly, companies that offer retiree benefits to persons below age 65 may not continue them once the retiree becomes eligible for Medicare. In addition, the premium share paid by the retiree and the generosity of coverage itself has been changing over time, shifting more of the burden onto retirees. Planning ahead means thinking about time on the job, the likely costs of premiums and uncovered services, and, in the case of a working couple, whose insurance it is best to be under in retirement.

The likelihood of having retiree health benefits is somewhat different for faculty at institutions of higher learning as compared to all workers. Although the sample size of respondents to a recent Watson Wyatt survey was relatively small, it points out that requirements to qualify are generally lower (e.g. service requirements of 5 years or less) and that a greater share of institutions participates than for corporate America. Public institutions that responded were more likely to offer retiree health benefits and to have lower service requirements than private universities. The trend towards limiting retiree benefits in higher education is likely to be similar to that for other employers, however, as costs of supplemental insurance rise and the ratio of retirees to current employees continues to go up.

Two things are happening that may change employers' willingness to offer retiree coverage in the near future. First, a recent court ruling makes it difficult for employers to offer coverage for retirees only until they become eligible for Medicare—an option that some employers had chosen. Some observers believe that this may cause companies to drop coverage altogether rather than extending it over their retirees' full lifetimes. Second, the new Medicare prescription drug benefit, which will begin in January 2006, may offer an excuse for companies to pull out of retiree coverage. At present, drug benefits are a very large and expensive part of retiree benefits. If a company was planning to eventually cut back on coverage anyway, the timing of

the new drug benefit may give them a good rationale. (On the other hand, the legislation will offer subsidies to employers to continue offering this benefit, which may keep some employers in the business of retiree health longer.) Many people interested in health benefits will be watching closely to see what happens at the end of this year.

For people planning retirement (and not aged 65 or older) whose companies do not offer retiree benefits or who do not qualify for such benefits, several options are likely available. First, new retirees may be eligible for HIPAA coverage, which requires former workers to pay the full cost of the insurance their former company offers. This can be expensive and it only lasts for 18 months. However, individual insurance is likely to be even more costly and may not be available for those who have health problems. People in their early 60s are often shocked when private insurance plans cost $1,000 a month or more.

Legislation at the end of 2003 established the ability of people under the age of 65 to create Health Savings Accounts (HSAs). These accounts differ from flexible spending accounts that some employees have because they allow individuals to put tax-free money aside for future health expenses that can be saved over time. Such accounts can help to cover out-of-pocket costs for people choosing high deductible plans, for example. But alone, they are not a good alternative. Everyone needs at least some insurance against catastrophic health costs. An unexpected problem, such as the need for heart bypass surgery, can generate hundreds of thousands of dollars in expenses. In that case, a Health Savings Account would not do the job.

Medicare Choices at Age 65

People eligible for Social Security for any reason qualify for Medicare at age 65. That includes most Americans, whether retired or not. Part A is Hospital Insurance that is supported by payroll taxes. Part B, Supplementary Medical Insurance (covering physician and other ambulatory care), is considered voluntary and is paid in part by a premium taken out of the Social Security check. At age 65, people drawing Social Security benefits are automatically enrolled in Parts A and B of the program, unless the individual specifically opts out of Part B. Most people elect to receive Part B, however, because it is heavily subsidized by general revenues, so it is a much better deal than purchasing such insurance on one's own. Delaying enrollment in Part B normally results in higher premiums because of a penalty assessed for each year of delay.

The situation is different for people still in the labor force and not drawing Social Security. People who fall into this category need to opt in at age 65 in order to get Part A started. At that

time, they may decide to delay enrolling in Part B (and paying its premium) if they keep their employer-offered health insurance. In that case, individuals are saving the federal government money since private insurance is considered "primary" and the government normally pays very little towards health care costs. Consequently, such individuals will not have to pay a penalty if they wait to enroll in Part B until their employer coverage ends.

A New Drug Benefit under Medicare in 2006

The new Medicare prescription drug benefit will operate differently than other parts of the program. Eligible individuals must elect to enroll regardless of whether Parts A and B begin automatically. Delaying enrollment will also result in a penalty unless a person has other insurance for drugs that is just as good as the Medicare benefit. This is done in order to prevent healthier beneficiaries from waiting until they need drugs. Thus, even if someone has employer-provided insurance, it must be deemed "comparable" in order to avoid a penalty for delayed enrollment in the Medicare benefit.

The Medicare drug benefit will be provided by a private company for those enrolled in the traditional part of the program. It is expected that most Medicare beneficiaries will have a choice among a number of such plans. At this point, no one knows how confusing or complex the choices for a drug benefit may be. Plans will have a lot of flexibility in terms of what drugs they cover, what the co-pays and restrictions will be, and what premiums they will charge. While it has been criticized as not very generous, this benefit is still subsidized by the government and is likely to be the best deal for those having to purchase it on their own. Thus, for most people who do not have access to good retiree or employee coverage (or whose employer chooses to drop existing coverage), this will be a good opportunity to get prescription drug coverage. Medicare beneficiaries will be bombarded with information at the end of 2005 and 2006; it makes sense to take that information seriously.

Traditional Medicare or Medicare Advantage

Another choice under Medicare when people turn 65 and annually thereafter is whether to enroll in traditional Medicare or to choose the option of enrolling in a private plan that contracts with Medicare to serve beneficiaries. In the latter case, the private plans are usually some type of managed care with restrictions on what doctors and hospitals are covered. In exchange, such plans often offer additional benefits beyond what Medicare covers at little or no additional premium. Another advantage of this "Medicare Advantage" options is that the drug benefit will normally be available through the same plan, simplifying insurance choices.

On the other hand, people choosing traditional Medicare usually do so because they have more choices of doctors and hospitals. In order to improve the comprehensiveness of traditional Medicare's benefit package, private supplemental policies are available. Those who sign up within 6 months of turning age 65 are guaranteed to be accepted into Medigap plans. These plans fill in the deductible and coinsurance amounts in Medicare. Many people with traditional Medicare, thus, will likely end up with three insurance arrangements: Medicare, Medigap and a drug plan. Millions of beneficiaries manage the two plans successfully, which coordinate coverage rather automatically, but this does add to complexity of health coverage. And the new drug benefit will mean yet another set of rules to track.

A Summary of Decisions to Make

Unlike most working families that each year can choose among a few insurance options, or who simply must take what their employer offers, retirees face many choices—not all of them easy to make. Retirement planning needs to include gathering information on these choices from objective sources before deciding exactly when to retire or what health insurance plans to choose. And many of us will have to live with those choices for 20 years or more, so it is important to get it right.

Fortunately, there are some resources that can help. Many benefits offices at peoples' work have counselors very knowledgeable about the choices. And Medicare offers an 800 number with basic information and helps to fund, in each state, an insurance counseling program that can often be very helpful for people who want more detailed support. But most of these choices will fall to individuals. Some of them should be done well before age 65 or retirement, and some come at age 65:

1. People in their late 40s and early 50s should consider employment options and likely retiree health coverage;

2. Couples should plan their retirement strategy together and compare their respective employers' plans;

3. Whatever arrangements are possible, people need to expect to have considerable health care expenses during their retirement years and need to include that in funds budgeted for retirement;

4. When enrolling in Medicare (which happens automatically for those drawing Social Security), several specific choices need to be made in the first 6 months:

    - Anyone who wants to enroll in Medigap private supplemental insurance needs to do so to be assured of being accepted;
    - Anyone who wants to enroll in Part D (the new drug benefit) must do so within 6 months or face a higher premium for the rest of their lifetime (unless they continue to have good drug insurance elsewhere);
    - Enrollment in Part B (physician and other ambulatory services) happens automatically for those on Social Security unless they specifically decline; others must sign up—again within a 6 months window following their 65th birthday.

Additional Information

The Outlook Of Retiree Health Benefits," by Sylvester J. Schieber, Watson Wyatt Worldwide and TIAA-CREF Institute Fellow, TIAA-CREF Institute Research Dialogue, September 2004, http://www.tiaa-crefinstitute.org/Publications/resdiags/issue81.pdf.

"Do We Have a Retirement Crisis in America?" by Douglas Fore, TIAA-CREF Institute Research Dialogue issue 77, September 2003. http://www.tiaa-crefinstitute.org/Publications/resdiags/issue77.pdf.

About the Author

Marilyn Moon, Ph.D., is Vice President and Director of the Health Program at the American Institutes for Research. She also serves as a TIAA-CREF Institute Fellow. A nationally-known expert on Medicare and social insurance, Dr. Moon previously served as a Senior Fellow at the Urban Institute and as a public trustee for the Social Security and Medicare trust funds. Dr. Moon has published extensively on health policy, both for the elderly and the population in general, and has served on a number of boards for non-profit organizations. Currently, she is president of the board of the Medicare Rights Center. She earned a Ph.D. in economics from the University of Wisconsin-Madison.