



University of Pennsylvania  
**ScholarlyCommons**

---

Wharton Pension Research Council Working  
Papers

Wharton Pension Research Council

---

1-1-2005

## Risk-Sharing in Retiree Medical Benefits

George Wagoner  
*Mercer Human Resource Consulting*

Anna Rappaport

Brian Fuller  
*Mercer Human Resource Consulting*

Frank Yeager  
*Mercer Human Resource Consulting*

Follow this and additional works at: [https://repository.upenn.edu/prc\\_papers](https://repository.upenn.edu/prc_papers)

 Part of the [Economics Commons](#)

---

Wagoner, George; Rappaport, Anna; Fuller, Brian; and Yeager, Frank, "Risk-Sharing in Retiree Medical Benefits" (2005). *Wharton Pension Research Council Working Papers*. 386.  
[https://repository.upenn.edu/prc\\_papers/386](https://repository.upenn.edu/prc_papers/386)

The published version of this Working Paper may be found in the 2006 publication: *Restructuring Retirement Risks*.

This paper is posted at ScholarlyCommons. [https://repository.upenn.edu/prc\\_papers/386](https://repository.upenn.edu/prc_papers/386)  
For more information, please contact [repository@pobox.upenn.edu](mailto:repository@pobox.upenn.edu).

---

## Risk-Sharing in Retiree Medical Benefits

### Abstract

Retiree medical care expenditures in the United States are growing at a rapid rate, while the retired portion of the population is increasing. This puts pressure on government and employer programs providing retiree health care coverage. Retirees also face increasing challenges in gaining access to affordable coverage, particularly before eligibility for Medicare. In this chapter we assess prospects for US retiree health coverage and the challenges, risks, and roles of employers, Medicare, and retirees in providing and financing it. We discuss both traditional approaches to retiree health benefits, where the employer assumes most risk, and new defined contribution approaches, where significant risk is shifted to the retiree. We also review government benefits for retirees including new Medicare prescription drug benefits. We model future retiree health care costs and opportunities to save before retiring, highlighting public policy obstacles and issues for employer-provided retiree health benefits

### Disciplines

Economics

### Comments

The published version of this Working Paper may be found in the 2006 publication: [Restructuring Retirement Risks](#).

## Chapter 8

### **Risk-Sharing in Retiree Medical Benefits**

---

*George Wagoner, Anna Rappaport, Brian Fuller, and Frank Yeager*

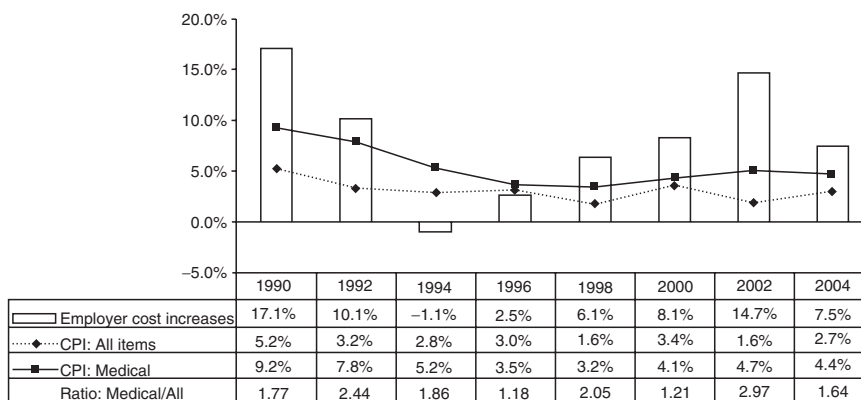
This chapter discusses the changing dynamics and risks of employer-provided retiree health benefits. In the USA, more of the risk of health care in retirement is being shifting to retirees, often without their having access to adequate and affordable health care solutions until becoming eligible for Medicare (generally available at age 65). Employer coverage for health care insurance is therefore very important to those retiring before Medicare eligibility age.

In what follows, we first review US health care expenditures and discuss the impact of demographic changes such as the aging of baby boomers. Next we analyze government-provided retiree health benefits and some of the potential challenges and risks related to this coverage. Against this backdrop we assess the pressures on employer-provided health care benefits,<sup>1</sup> by tracking total health care costs for employees and retirees; this is followed by a summary of employer responses. The discussion also examines the risks facing retirees and indicates what they can do to mitigate those risks. Finally, we review the interactions between government risk, employer risk, and retiree risk, as they relate to public policy. The discussion concludes with an evaluation of the impact of public policy on access to affordable retiree health care coverage, along with some systemwide health care solutions. We conclude that in the USA, health care costs will continue to rise and more risk will be shifted to retirees, posing a major threat to the affordability of a good retirement for many Americans.

#### **The Setting**

US health care expenditures have grown more rapidly than the economy for many years. Figure 8-1 shows that the medical care component of the consumer price index (CPI) increased 5.5 percent from 1990 to 2004, compared to 3.1 percent for all CPI items (USBLS 2005). A national survey of employer-sponsored health plans (Mercer 2004) found that employer health care cost increases in the same period averaged 8.2 percent.<sup>2</sup> These costs can be particularly burdensome for companies who offer health care benefits to both employees and retirees.

## 8 / Risk-Sharing in Retiree Medical Benefits 137



<u>Average annual increase</u>	<u>1990-2004</u>
<b>CPI: all items</b>	<b>3.1 percent</b>
<b>CPI: medical</b>	<b>5.5 percent</b>
<b>Employer cost increases</b>	<b>8.2 percent</b>

Figure 8-1. CPI and active employee health care cost: annual percentage increase. *Source:* Authors' calculations using USBLS (2005) and Mercer (2004).

As a percentage of gross domestic product (GDP), health care spending rose from 5.1 percent in 1960 to almost three times that level by 2000, and the percentages are expected to continue increasing (CMS 2001). The increasingly expensive nature of health care makes it more difficult for companies located in the USA to compete globally. In 2002, Switzerland (at 11.2 percent of GDP) and Germany (at 10.9 percent) were the only industrialized nations other than the USA (at 14.6 percent) where health care costs accounted for more than 10 percent of the GDP (OECD 2004). The public sector in the USA picked up 46 percent of this ever-increasing component of GDP, with Medicare, a federal program mainly for those age 65+, picking up the majority of the costs. Medicaid, for low-income people of all ages, is jointly funded by federal and state governments. Forty percent is paid by the private sector, which includes employers, unions, insurance companies, and others. Individuals pay the balance of the health care bill, 14 percent, through premiums, deductibles, and other payments.

The percentage borne by individuals has been decreasing steadily for over forty years, as shown in Figure 8-2. Many say that consumers are so insulated from the cost of health care that they 'overutilize' health care services (often to their detriment) or fail to consider all treatment options. Increasingly, private- and public-sector experts support more consumerism in the health care marketplace—through increased education and higher

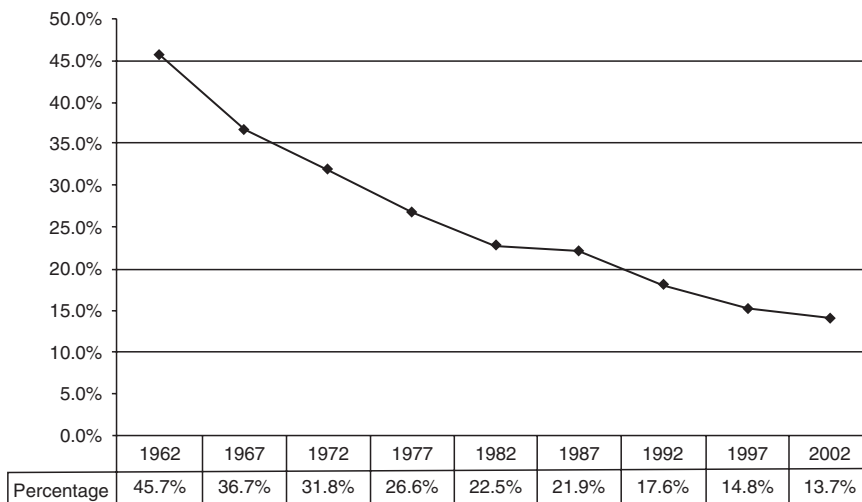


Figure 8-2. Consumer share of health care expenditures.  
*Source:* Authors' calculations using USBLs (2005) and CMS (2004).

out-of-pocket costs—to encourage people to think more carefully about what is needed and what treatment option would be most beneficial. These costs can be particularly burdensome for companies who offer health care benefits to both employees and retirees.

Part of the reason for this trend in the USA is population aging. People born between 1946 and 1964, called Baby Boomers, were age 41–59 in 2005; this group made up 44 percent of the USA prime age population (20–64) and 26 percent of the total population (US Census 2005). As shown in Figure 8-3, substantially more people will attain age 65 and become eligible for Medicare by 2010, a process that fuels the overall upward trend in health care costs.

Health care costs increase with age and vary by gender, as shown in Figure 8-4. Women tend to use more health care services at younger ages, primarily because of maternity-related costs, while men have greater expenses at older ages.

### **Government-Provided Retiree Health Care Benefits**

The cost of employer-provided retiree health benefits in the USA is strongly influenced by government programs. This is because the government pays for well over half of all health care costs for people covered by Medicare, and significantly more for people with both Medicare and Medicaid coverage. As the Medicare Part D prescription drug coverage takes effect, the

## 8 / Risk-Sharing in Retiree Medical Benefits 139

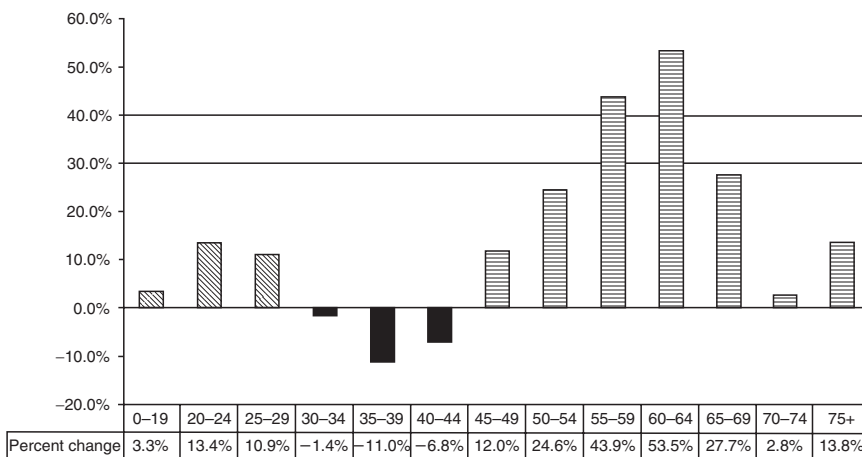


Figure 8-3. Percent change in population by age group, 2000–2010.  
*Source:* Authors' calculations from US Census Bureau (2005)

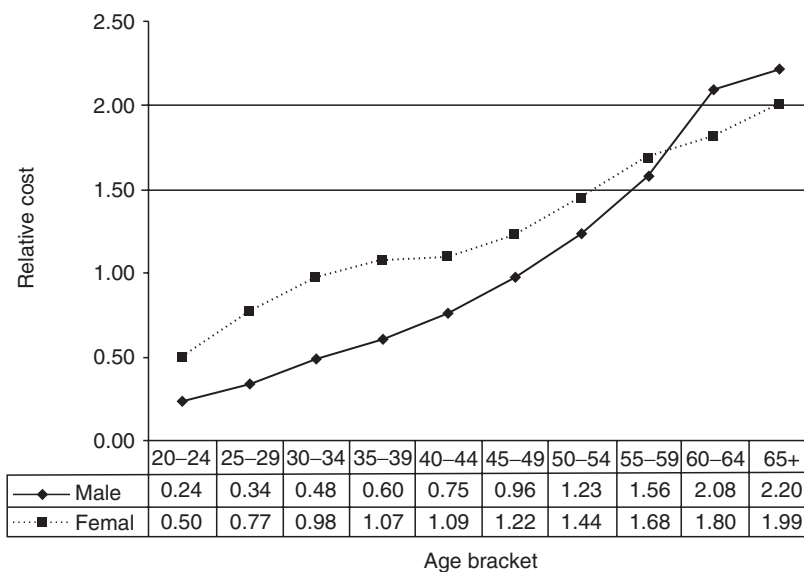


Figure 8-4. Relative health care costs by age and gender for employer-sponsored health plans.  
*Source:* Authors' calculations using Mercer proprietary data.

government will take on an even larger portion of the costs. For retirees not yet eligible for Medicare (pre-Medicare retirees), government programs provide very little health care coverage with the exception of Medicaid programs for lower-income people and Medicare for those disabled for more than twenty-four months.

Because of the significant impact of Medicare on employer-provided retiree health benefits, we will briefly review that program, including the recently enacted Medicare reform law (known as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003).<sup>3</sup> In 1965 when Medicare started, it had two parts known as Part A, providing hospital insurance and Part B, providing supplementary medical insurance. This nomenclature is still in effect: Part A covers inpatient hospital, skilled nursing facility, hospice, and home health care; and as Part A is financed by a payroll tax collected from employees and employers, enrollees do not pay a Part A premium. Part B covers physician care, outpatient hospital care, lab tests, medical supplies, and some home health care not covered in Part A. Part B coverage is voluntary, and people opting for it must pay a premium that covers one quarter of the cost of Part B (DHHS 2005). The remainder of Part B is financed through general revenues. Neither Part A nor Part B has traditionally covered outpatient prescription drugs, except in a few narrowly defined circumstances (such as pain medications for people qualifying for hospice benefits and certain cancer and immunosuppressive drugs).

Over the years, many Medicare enrollees have purchased supplemental health care coverage from employers, unions, or private companies; Medigap coverage can be purchased from private companies in all fifty states. Federal law requires a six-month initial enrollment period that begins when a person is first eligible for Part B coverage. During this time, a person cannot be denied Medigap coverage or charged a higher price because of current or past health problems. Under the Medicare reform law, beginning in 2006, these Medigap plans may continue to supplement Parts A and B of Medicare, but they may not supplement Part D. Also, Medigap carriers will be able to offer two new lower-priced products (called Medigap plans K and L).

In 1982, Congress created what was then called Medicare Risk Plans; subsequent legislation in the Balanced Budget Act then expanded the concept and changed the name to 'Medicare + Choice' or Medicare Part C, and the 2005 Medicare reform law further expanded the concept. Today these plans are called Medicare Advantage (MA) plans. These are offered by insurance companies and others who receive a payment per member per month in return for assuming the risk. Medicare Advantage plans must agree to cover all services covered by original Medicare, and most cover additional services as well; they are permitted to charge enrollees a premium if their costs are higher than what Medicare pays them. The most

common type of MA plan is a health maintenance organization (HMO) in which networks of doctors and hospitals, and their members, may use only network or other approved providers except for medical emergencies. Two other MA plans that use networks are point-of-service (POS) and preferred provider organization (PPO) plans. The POS and PPO plans allow members to use out-of-network providers, but members then pay more out-of-pocket costs. From 2006, the Medicare reform law requires that these three types of MA vendors must offer at least one plan that includes prescription drug benefits at least as rich as those under Medicare Part D.

An additional MA option is the private fee-for-service (PFFS) plan. Private insurance companies and vendors offer these plans, and they receive a predetermined amount of money each month from Medicare to provide benefits that are at least as rich as Parts A and B. These plans are not required to have a provider network, and they are often offered in more rural areas than the other MA plans. The PFFS plans can charge additional premiums over what people pay under Medicare Part B, just like other MA plans. The PFFS plans, however, are not required to offer prescription drug benefits equivalent to those of Medicare Part D.

The concept behind the MA plan is that, by aggressively managing care, private companies can control costs more effectively than the 'non-managed' original Medicare, bringing about lower premiums for members, benefit packages that cover more services than original Medicare, and/or lower costs for the federal government. These advantages have been realized in many instances. As Table 8-1 shows, 56 percent of people eligible for Medicare lived in counties where they could purchase an MA plan at a 'zero premium' in 2005, that is, at no additional payment above the Part B

TABLE 8-1 Retirees Eligible for Medicare Summarized by the Lowest Premium for Available MA Plans

<i>Lowest premium available</i>	<i>Retirees eligible for Medicare</i>	<i>Percent of eligible retirees (%)</i>	<i>Cumulative (%)</i>
\$0	23,917,775	56	56
\$0.01–\$35.00	4,905,508	12	68
\$35.01–\$70.00	5,572,282	13	81
\$70.01–\$100.00	848,816	2	83
\$100.01–\$160.00	489,114	1	84
Subtotal	35,733,495	84	84
No MA plan	6,888,486	16	100
Grand total	42,621,981	100	100

*Source:* CMS (2005a, 2005b, 2005c) and authors' calculations.



payment (which all Medicare and MA enrollees must pay). In total, using proprietary data we compute that 84 percent of people eligible for Medicare lived in counties where they could purchase an MA plan. Both health care costs and Medicare reimbursement to MA plans can vary by county, so the premiums and coverage also vary by county, sometimes significantly.

The Medicare reform law of 2005 brought about the most fundamental change in the program since it was launched in 1965, mainly through the addition of Medicare Part D, a benefit for outpatient prescription drugs. The Part D benefit is delivered by prescription drug plans (PDPs) or as Medicare Advantage prescription drug plans (MA-PDPs). While this new drug benefit does offer some additional protection, many people will still have significant out-of-pocket costs. With Part D coverage, people must pay an initial \$250 deductible, then 25 percent coinsurance for the next \$2,000 in costs, then 100 percent of costs until they reach a \$3,600 out-of-pocket level. (These values are indexed in future years.) Amounts paid by employers or insurance companies do not count toward the retirees' out-of-pocket cost requirement. Part D pays roughly 95 percent of remaining costs after a person's expenses reach the out-of-pocket requirement. Enrollees are intended to pay about one quarter of the cost of Part D coverage, which has been estimated at under \$500 per year in 2006, with the remainder paid from general revenues.

### **Employer-Provided Retiree Health Care Benefits**

In the USA, employers expend substantial amounts on employee and retiree health care costs. As Figure 8-1 shows, employer health care cost increases have tended to track increases in the medical component of the CPS, but cost swings for employer coverage have been greater. During the 1990s, cost increases moderated because of the increased popularity of managed care plans; cost increases then again accelerated in the late 1990s and early 2000s mainly due to some mis-estimation of the incremental impact of managed care on costs.

These patterns also drive employer-provided retiree medical care costs. Indeed, retiree health care costs in 2004 rose 8 percent faster than in 2003 for pre-Medicare retirees, and 7.8 percent higher for Medicare enrollees; Figure 8-5 shows that the pre-Medicare group's cost per retiree was greater than the cost per employee, while the Medicare group's cost was less than for employees. The cost differential between pre- and post-Medicare retirees is partly reflective of rising costs with age; it can also vary depending on retirees' age and sex mix, the level of dependent coverage, and whether disabled people, who have higher claims, are included with the early retirees or employees.<sup>4</sup> Lower costs for the Medicare group are also attributable to the significant amount of retiree expenses paid by Medicare.

## 8 / Risk-Sharing in Retiree Medical Benefits 143

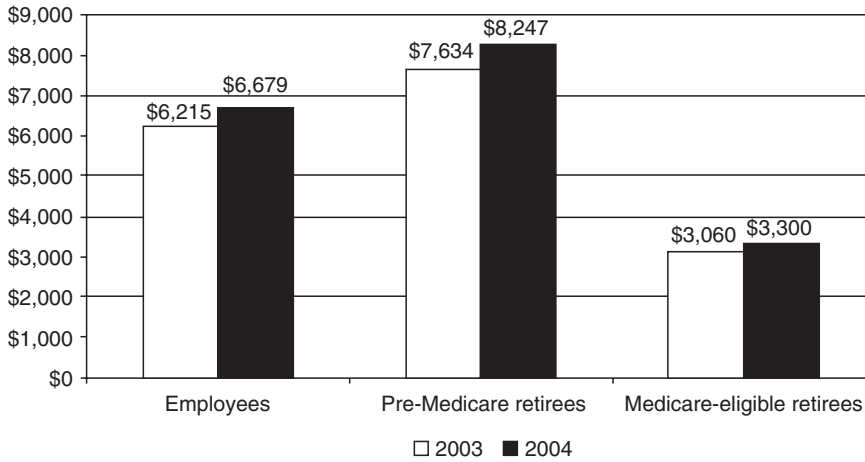


Figure 8-5. Employer costs for employees and retirees: 2003 and 2004.

Source: Authors' calculations using Mercer (2004).

\* Includes covered dependants.

When considering costs for both employees and retirees, another important factor is 'adverse selection', sometimes called 'intelligent employee choice'. As employers increase the premium that employees or retirees have to pay, some healthier people will tend to drop health care coverage. Consequently, the average cost for the remaining covered group will tend to go up faster than the underlying cost increase. In turn, even more people might leave the program, putting still more pressure on the price. As this adverse selection cycle continues, the program can quickly move into a 'death spiral' unless an employer takes corrective action. This adverse selection phenomenon is fueled by the fact that a very small number of people can account for the majority of the cost. As shown in Figure 8-6, the most expensive 5 percent of the claimants can account for over 50 percent of the total cost, while the healthiest 50 percent accounted for less than 5 percent of the total cost.<sup>5,6</sup>

As the number of retirees with health care coverage began to rise after World War II in the USA, the Financial Accounting Standards Board (FASB) became concerned that employers were not appropriately recognizing that expense. (Unlike pension costs that were accrued over a working person's lifetime, retiree health care costs were not.) Accordingly FASB (1990) issued its Statement of Financial Accounting Standards Number 106 (FAS 106), requiring corporations to begin accounting for retiree health care costs on an accrual cost instead of on a cash basis. Expenses using the accrued liability, based on the present value of

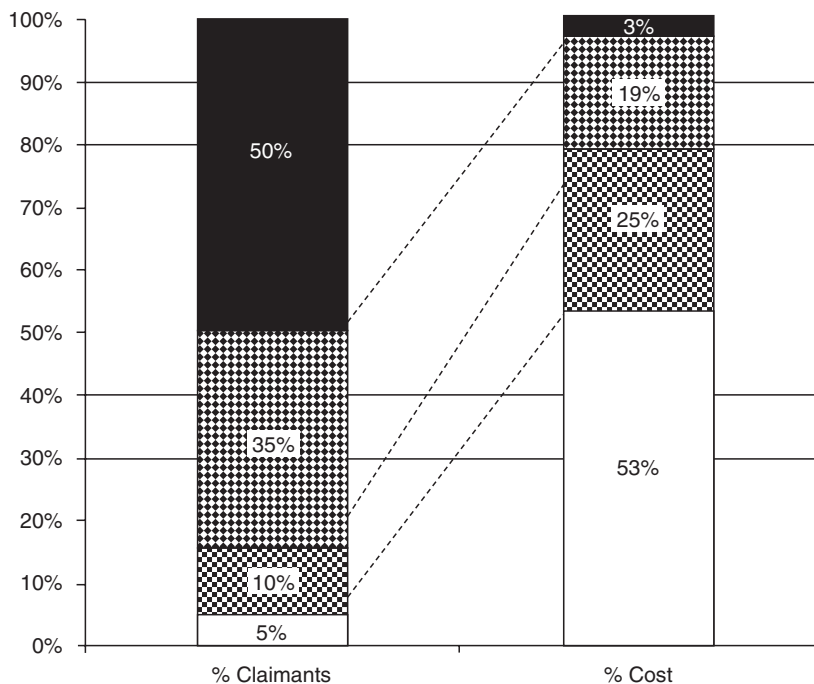


Figure 8-6. Few claimants incur the majority of cost.  
 Source: Authors' calculations using Mercer (2004).

future retiree health care costs, proved to be substantially higher than cash costs; indeed estimated FAS 106 liabilities often rivaled firms' pension liabilities, but, unlike pension plans, typically had no offsetting assets.

In response to the increased awareness of the cost of these plans, many private-sector employers began tying decisions about future coverage more closely to their overall business plan. Some continued offering retiree coverage because they wanted to attract mid-career employees, wanted employees to retire before age 65 to improve productivity, or had collective bargaining pressure. Others, however, decided to reduce or eliminate the coverage entirely. Figure 8-7 shows the consequent and steady decrease in retiree health care coverage from over time.

In 2004, the Governmental Accounting Standards Board (GASB) issued new accounting standards for governmental retiree benefits other than pensions. This statement (GASB 43) will require public-sector employers to follow accounting guidelines similar to those of FAS 106, generally beginning in 2007.<sup>7</sup>

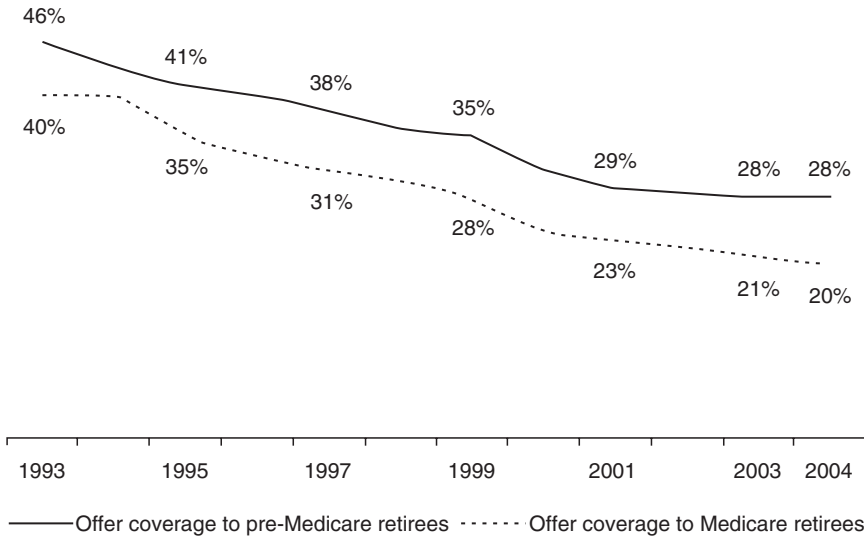


Figure 8-7. Percentage of US employers offering medical coverage to retirees\* .  
 Source: Authors' calculations using Mercer (2004) for employers with 500 or more employees.

\*Represents employers planning to offer coverage to current employees and new employees when they retire.

**Controlling Retiree Health Care Costs.** Employer efforts to control retiree medical costs have been varied, including (a) tightening eligibility requirements; (b) increasing deductibles, copays, and other retiree out-of-pocket costs and thereby reducing amounts paid by the employer's plan (in keeping with the movement to consumerism in employee health care plans); (c) increasing the percentage of premium paid by retirees; (d) increasing the management of care; and (e) prefunding the employer's liability (through vehicles such as a 501(c)(9) trust [known as a VEBA], 401(h) sub-accounts in pension plans, and trust-owned health insurance). Another tack has been to take a 'defined contribution' approach to health care (DC Health), which defines the employer's obligation as a fixed dollar amount. In addition to 'defining' their contribution, employers must also decide on the types of health insurance benefits that retirees will be able to purchase.

The choice between self-funded or insured approaches determines how precisely an employer has defined the cost of coverage and what level of future involvement will be required. The impact of three approaches can be summarized as follows:

- If an employer offers self-funded coverage, the firm first projects plan costs and then sets the retiree premium to pay what is not covered by

the employer's DC premium. When actual experience varies from what was assumed when setting the retiree's contribution, the employer's actual per capita contribution will vary from the 'defined' amount.

- If the employer sponsors an insured plan, the employer's per capita contribution is defined because the insured cost (the premium) is guaranteed at least for a term. Insuring coverage does not relieve employers of long-term involvement because they must renew coverage annually, with significant premium increase or terminated coverage a possibility. Also, there is often pressure for greater subsidy of the employer plan.
- If an employer does not sponsor a plan, individual coverage must be purchased in the marketplace. This approach, like the prior one, may define the employer's contribution; it also may get the employer out of the retiree health care coverage business, eliminating even the requirement to negotiate with carriers. The retiree bears the risk that coverage may be inadequate, very expensive, or not available at all.

Employers adopting the DC health approach have a great deal of flexibility in defining their commitment to retirees through the use of various account-based approaches. Accounts can be defined on a periodic basis (such as monthly, annually) or an aggregate basis; they can provide amounts on a retiree-only basis or include additional payments for dependants; and the accounts can be funded or unfunded.<sup>8</sup> For both the periodic and aggregate amounts, the tax code contains opportunities for the contribution to be tax deductible to the employer and not taxable to the retiree. For example, the contribution amount could be provided through a Health Reimbursement Arrangement (HRA) or under other plans satisfying Sections 105 or 106 of the Internal Revenue Code. If the DC approach were to be used for pre-Medicare retirees, it would typically be in conjunction with an employer's self-funded medical plan because of the dearth of insured products in the pre-Medicare market. For retirees eligible for Medicare, however, the situation is quite different. As previously mentioned, MA products are available to over 80 percent of those eligible for Medicare. Medigap supplement plans are available to virtually 100 percent upon initial eligibility for Medicare. It is quite feasible to arrange either an employer-sponsored insured product or to let retirees purchase coverage in the open market. With the addition of Part D prescription drug coverage to Medicare, even those who do not buy coverage other than Medicare may still be able to cover a large portion of their expenses.

As employers move to DC options, many will make a number of changes in their underlying retiree health care benefit strategy. Employers often offer more choices in plan design (such as a 'high option plan' that is very similar to the employee plan as well as some more affordable options). They may also provide opportunities for employees to save for future

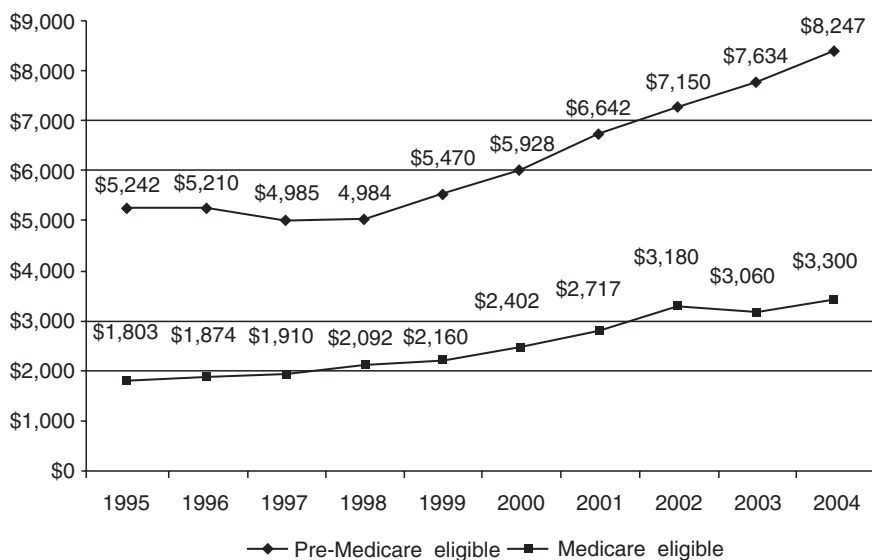
retiree health care expenses; or increase communication with employees and retirees on general health issues, the need to save for future health care expenses, and the business rationale for the change.

**Challenges and Risks for Employers Offering Retiree Health Plans.** As noted, rising retiree health care costs present significant challenges for employers. The level of increase has varied over the years, as shown in Figure 8-8, but the trend has been relentless. Typically, employers require retirees to pay a portion of the cost for health care coverage. The Mercer 2004 Survey showed that 38 percent of employers offering retiree health care plans required enrollees to pay the entire premium as well as out-of-pocket benefit costs: such plans offer coverage, but not necessarily affordable coverage. Only 13 percent of employers provided coverage at no cost to retirees. For the 49 percent that shared the cost with retirees, the average retiree portion was 34 percent of the plan cost. The results for Medicare-eligible plan coverage were similar: 37 percent require the retirees to bear the full cost; 15 percent provide coverage at no cost to retirees; and 47 percent share the cost, requiring retirees to pay 35 percent of it.

Another major challenge facing employers is the growing ratio of retirees to active workers, combined with the possibility that the federal government might increase cost-shifting as the Medicare program approaches insolvency. Larger-than-anticipated Medicare premium increases or benefit reductions could seriously challenge both employers and retirees. An additional employer risk is adverse selection, particularly with DC health approaches. For example, relatively healthier Medicare-eligible retirees may drop employer coverage and purchase lower cost insured coverage (via an MA or a Medigap plan), or rely fully on Medicare as the gap widens between the premium charged and the employer's DC. Remaining less-healthy retirees will have higher health care costs, forcing still higher premiums. If only the sicker retirees remain covered in employer plans, these plans may go into a death spiral where cost increases cannot be appropriately reflected in the premium.

### **Retiree Options and Challenges**

Retirees confront substantial risk regarding both health care expenditures and employer-provided health insurance benefits. In the case where the employer offers coverage, retirees below age 65 face higher premiums for coverage in the open market; and in some areas, it is virtually impossible for someone in poor health to purchase needed coverage. Even for retirees enrolled in Medicare, premiums plus out-of-pocket costs can still be quite high, even unaffordable for some. Furthermore, Medicare Parts B and D premiums (set to cover one quarter of program costs) will clearly rise with total Medicare spending, likely to grow faster social security benefits. Private insurance premiums, premiums for employer coverage, and direct payments to providers are also likely to increase in a similar manner. If



Year	Average increases in annual health plan costs	
	Pre-Medicare retirees	Medicare-eligible retirees
1999–2004	8.6 percent	8.8 percent
1995–2004	5.2 percent	6.9 percent

Figure 8-8. Average employer health plan cost per retiree.  
 Source: Authors' calculations using Mercer (2004).

employer contributions are capped or otherwise limited, retiree premium increases will be even higher.

Other than through employer programs, retired workers not yet eligible for Medicare can be rather limited: low-income people may qualify for Medicaid or other governmental programs, and those eligible for social security disability benefits for twenty-four months are eligible for Medicare. But anyone who is healthy and meets insurance underwriting rules might have to pay the full cost of coverage, which will seem quite high compared to the subsidized cost paid before retirement. Retirees often pay more because of premium caps or other limits on employer contributions, and because employers may boost out-of-pocket benefit costs (deductibles, copays, and out-of-pocket maximums) as they seek to control retiree coverage costs and maintain consistency with the move to consumerism and higher cost sharing for those still working and enrolled in employee plans. The other problem is that early retirees often receive lower pension and social security payments, compared to those retiring later. The dual

problems of accessibility and affordability of coverage mean that employees will have to save more money for retiree health care expenses, allocate more financial resources to health care, work longer, rely on help from family, or use a combination of these approaches. Unless people are healthy, or government regulations support guaranteed access, many people might find it advisable or necessary to work until they become eligible for Medicare even if they have enough funds to pay for coverage.

For those retirees covered by Medicare, the picture is brighter. Accessibility has not been a problem, as they can participate in Medicare Parts A, B, and D, and Part C coverage is available to many. During the first six months of eligibility for Medicare, anyone in original Medicare is guaranteed the right to purchase a Medigap policy to supplement Parts A and B of Medicare at 'standard' rates. Yet even with Medicare coverage, many older Americans will face affordability problems: premiums for Medicare coverage are expensive, as are premiums for Medigap insurance and employer-sponsored insurance, or private insurance. In addition, direct payment to providers of service for deductibles, copays, and coinsurance are costly, as are other expenses not covered by Medicare. And even with the new Part D coverage, prescription drugs will remain a large expense for many people. In addition to health care expenses, some retirees will also have significant long-term care (LTC) expenses, primarily custodial in nature. For those who qualify, Medicaid covers a significant percentage of LTC services. Because Medicare provides only limited LTC coverage, people who are not eligible for Medicaid must rely on LTC insurance they purchase, on their own funds, or on financial assistance from family members and others.

**Possible Roles for Tax-Favored Saving Opportunities.** Several challenges face future retiree expenses and opportunities to save for retiree medical costs. To these we turn next.

*Potential Retiree Expenses.* According to Fronstin and Salisbury (2003), a person age 65 with employer-paid benefits might need between \$37,000 and \$750,000 to pay future claims that Medicare does not cover; a retiree lacking employment-based benefits who purchases Medigap coverage could need from \$47,000 to \$1,458,000. Using Mercer Survey data, we modeled average future expenses using five sets of assumptions. First, we assumed that cost trends over the most recent five years of the Mercer Survey would be repeated in future years, and second we hypothesized that the historical trends from the most recent decade years would be repeated. Third, we averaged findings from the two previous sets. Last, we assumed that health care cost trends would be consistent with FAS 106 assumptions for large employer plans and that the trend would have shown 10 percent increase per year. These variants were used to project costs to 2006 and adjust the projection for the impact of Medicare reform on Medicare enrollees. Next we projected these costs to 2031 using the five sets of trend assumptions, shown in Table 8-2.<sup>9</sup>



TABLE 8-2 Hypothetical Average Cost for Individual Retirees in 2031

	Estimated 2006 cost		Trend assumption for projection to 2031			
	Mercer Survey projected <sup>1</sup>	1999-2004 Experience repeated <sup>6</sup>	1995-2004 Experience repeated <sup>7</sup>	Average of two experience periods	Representative FAS 106 trend	10 percent trend
<b>Pre-Medicare</b>						
Employer plan cost (ErPC) <sup>1,2</sup>	\$5,712	\$44,928	\$20,284	\$32,606	\$25,099	\$61,885
Retiree benefit out-of-pocket <sup>3</sup> (OOP)	\$1,008	\$7,928	\$3,580	\$5,754	\$4,429	\$10,921
OOP + 50 percent ErPC	\$3,864	\$30,392	\$13,722	\$22,057	\$16,978	\$41,863
OOP + 100 percent ErPC	\$6,720	\$52,856	\$23,864	\$38,360	\$29,528	\$72,806
<b>Medicare-eligible</b>						
Employer plan cost <sup>1,2</sup>	\$1,423	\$11,720	\$7,545	\$9,633	\$6,253	\$15,418
Retiree benefit OOP <sup>4</sup>	\$1,290	\$10,627	\$6,841	\$8,734	\$5,670	\$13,980
Medicare premiums <sup>5</sup>	\$1,459	\$12,018	\$7,737	\$9,877	\$6,412	\$15,810
Total retiree OOP	\$2,749	\$22,645	\$14,578	\$18,611	\$12,082	\$29,790
OOP + 50 percent ErPC	\$3,461	\$28,505	\$18,350	\$23,428	\$15,208	\$37,499
OOP + 100 percent ErPC	\$4,172	\$34,365	\$22,123	\$28,244	\$18,335	\$45,208

Source: Authors' calculations.

*Notes:*

<sup>1</sup>Employer plan cost does not include retiree out-of-pocket costs. The individual pre-Medicare cost is derived from an amount that includes covered dependents, assuming 1.65 risk units per covered retiree (individual cost = total cost ÷ 1.65). Medicare-eligible cost was derived from an amount that includes covered dependents, assuming 1.60 risk units per covered retiree.

<sup>2</sup>Based on 2004 Mercer Survey data for individual retiree cost in 2004, projected to 2006 using the average 'starting costs' of two historical periods; the Medicare groups' cost adjusted for impact of Medicare reform law assuming employer plan is secondary to Medicare Parts B and D with nonduplication of benefits integration. (Assumed Part D offset of \$976 to employer cost or 55.6 percent of the \$1,755 estimated part D cost.)

<sup>3</sup>Assumes an employer plan that covers 85 percent of total cost.

<sup>4</sup>Based on pre-Medicare benefits integrated with Medicare A, B, and D using the nonduplication of benefits approach ('carveout') and 2.5 percent aging factor for 10 years.

<sup>5</sup>Assumes Medicare-eligible retiree pays Part B premium (assumed to be \$85 per month in 2006) and Part D premium (\$36.60 per month) out-of-pocket. In addition, the retiree pays benefit expenses out-of-pocket.

<sup>6</sup>Based on Mercer Survey data from 1999 through 2004, the pre-Medicare annual trend is 8.6 percent, and the Medicare-eligible annual trend is 8.8 percent.

<sup>7</sup>Based on Mercer Survey data from 1995 through 2004, the pre-Medicare annual trend is 5.2 percent, and the Medicare-eligible annual trend is 6.9 percent.

To obtain a better understanding of the funds needed at the time of retirement for future health care expenses, we considered people who were age 35 in 2006 and retiring in 20, 25, 30, or 35 years. Using these scenarios, we calculated the present value of future costs at retirement for each age, using the five alternative trend assumptions and a discount rate of 5 percent along with mortality, termination of coverage, and other assumptions from representative FAS 106 valuations. The present value of future costs at retirement can be thought of as the amount of money needed in a bank account at retirement so that expected future payments can be made using principal and interest earned at an assumed rate, with the bank account running out when the expected period ends. Table 8-3 shows the present values at retirement for an age 35 worker in 2006, assuming he or she retires in 25 years at age 60. Present values are shown where the retiree pays out-of-pocket benefit costs (for copays, coinsurance, and deductibles) plus a range of costs for premiums.

Even under these simple assumptions and using the same average starting cost, we see a wide range of potential results: these start at a low of \$76,000 for a typical FAS 106 trend (if the employer pays 100 percent of cost—probably unlikely in 2031) to a high of \$2.26 million with a 10 percent trend and the retiree paying full cost. Note that the values vary importantly with changes in trend, discount rate, mortality, and other assumptions. While these hypothetical examples illustrate potential outcomes, results for individuals can vary significantly. Values for retirement at ages 55, 60, 65, and 70 are shown in Figure 8-9.

*Tax-Favored/Saving Opportunities.* Using these estimates of what future retirees will need for health care costs, we next examine what options they might have to start boosting their saving rates. In the US case, there is an increasing number of tax-advantaged savings options to employees: Table 8-4 outlines six of these. For example, a health savings account (HSA), authorized under the Medicare reform law, provides outstanding saving opportunities for employees who can meet the requirements and have the financial resources and discipline to save. Both employees and employers can contribute to an HSA before employee entitlement to Medicare, as long as the employees participate in a qualifying high deductible health plan (HDHP). These plans must have a minimum deductible (of at least \$1,000 in 2004 for an individual and \$2,000 for family, both values indexed thereafter), and they must meet other requirements (the least attractive of which is the prohibition on having almost any other health coverage during the periods that HSA contributions are made by or for an individual). The maximum contribution, from employee and employer, is the lesser of the deductible in the HDHP and \$2,600 (\$5,150 for a family, both values indexed from 2004). The range of possible contributions for an individual in 2004 was

TABLE 8-3 Hypothetical Present Value of Future Benefits at Retirement Age for an Employee Age 35 in 2006, Retiring at Age 60 in 2031<sup>1</sup> (Thousands)

<i>Retiree cost basis</i>	<i>Trend assumption for projection to 2031</i>				<i>Representative FAS 106 trend</i>	<i>10 Percent trend</i>
	<i>1999-2004 Experience repeated<sup>4</sup></i>	<i>1995-2004 Experience repeated<sup>5</sup></i>	<i>Average of two experience periods</i>			
Out-of-pocket (OOP) <sup>2</sup>	\$214.1	\$98.1	\$156.1	\$76.0	\$339.4	
OOP + 33 percent ErPC <sup>3</sup>	\$614.6	\$281.6	\$448.1	\$218.0	\$974.1	
OOP + 50 percent ErPC	\$820.9	\$376.1	\$598.5	\$291.2	\$1,301.0	
OOP + 67 percent ErPC	\$1,027.1	\$470.6	\$748.9	\$364.3	\$1,628.0	
OOP + 100 percent ErPC	\$1,427.6	\$654.1	\$1,040.8	\$506.4	\$2,262.6	

Source: Authors' calculations.

Notes:

<sup>1</sup> Assuming a 5 percent discount rate.

<sup>2</sup> Benefit OOP, plus premium OOP for Medicare Part B and Part D after Medicare eligibility.

<sup>3</sup> Employer plan cost.

<sup>4</sup> Based on Mercer Survey data from 1999 through 2004, the pre-Medicare annual trend is 8.6 percent, and the Medicare annual trend is 8.8 percent.

<sup>5</sup> Based on Mercer Survey data from 1995 through 2004, the pre-Medicare annual trend is 5.2 percent, and the Medicare-eligible annual trend is 6.9 percent.

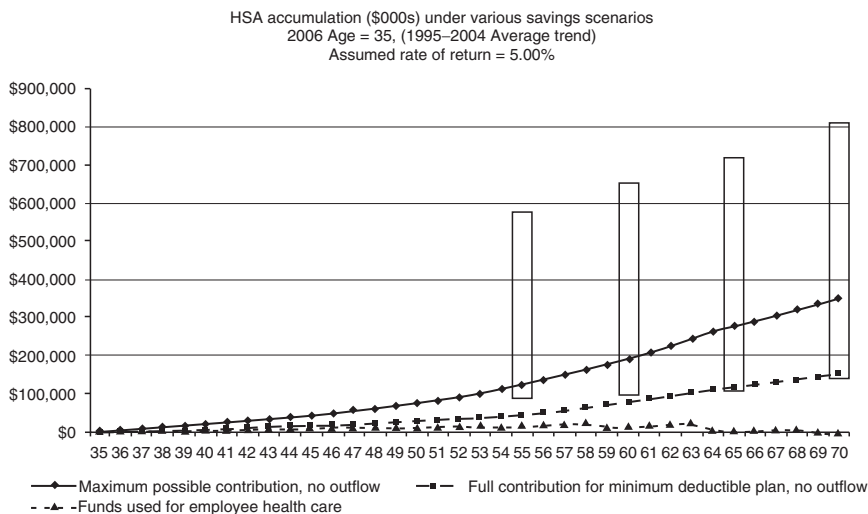


Figure 8-9. HSA accumulations assuming 5 percent return investment compared to expenses assuming repeat of historical Mercer Survey experience from 1995 to 2004.

Source: Authors' calculations using Mercer (2004). Range of cost will vary depending on retiree's health, employer plan, etc.

Costs and accumulations at retirement age for people 35 years of age in 2006, assuming average trend from 1995–2004 Mercer Surveys, and 5 percent HSA investment return

Retirement		PVFC-R <sup>1</sup> for out-of-pocket benefit cost plus percentage of premium for employer plan			HSA funds, No out-flow		HSA with out-flow <sup>4</sup>
		0 Percent contribution	33 percent contribution	100 percent contribution	Maximum contribution <sup>2</sup>	Minimum contribution <sup>3</sup>	
Age	Year						
55	2026	\$86,602	\$248,548	\$577,347	\$122,337	\$47,989	\$14,856
60	2031	\$98,119	\$281,601	\$654,126	\$191,741	\$80,500	\$14,828
65	2036	\$108,101	\$310,249	\$720,672	\$277,325	\$120,373	\$6,319
70	2041	\$143,186	\$363,693	\$811,389	\$353,945	\$153,630	\$0

Notes:

<sup>1</sup>Present value of future costs at retirement, based on a 5 percent discount rate. Trends for 1995–2004 are 5.2 percent pre-Medicare and 6.9 percent for people eligible for Medicare.

<sup>2</sup>Maximum contribution allowed (\$2,600 in 2004, indexed); no outflow.

<sup>3</sup>Maximum contribution allowed with minimum deductible (\$1,000 in 2004, indexed); no outflow.

<sup>4</sup>Maximum contribution of \$1,000 with minimum deductible of \$1,000 in 2004, indexed; experience of four times average out-of-pocket benefit costs once every four years.

## 8 / Risk-Sharing in Retiree Medical Benefits 155

TABLE 8-4 Comparison of Tax-Advantaged Savings Vehicles

<i>Savings vehicle</i>	<i>Contribution</i>	<i>Investment earnings</i>	<i>Disbursements for health care</i>	<i>Limitations on contributions</i>
HSA	Pretax	Tax-free	Not taxable	Maximum contribution, HDHP <sup>2</sup>
401(k)	Pretax	Tax-deferred	Taxable	Employer must offer plan; pretax and total contribution limits; minimum required distributions after specified age
Traditional IRA	Pretax	Tax-deferred	Taxable	Maximum contribution; tax-deduction limit for active retirement plan participant based on income; minimum required distributions after specified age
Roth IRA	Posttax	Tax-free	Not taxable <sup>1</sup>	Contribution limits based on income
VEBA	Posttax	Tax-free	Not taxable	Employer must offer plan
Roth 401(k)	Posttax	Tax-free	Not taxable <sup>1</sup>	Not available until 2006; can designate portion of 401(k) contributions as after-tax; contribution limits unclear; additional regulations expected

*Source.* Authors' calculations.

*Notes:*

<sup>1</sup>Distributions are not taxable after age 59½ and 5 years of participation.

<sup>2</sup>High deductible health plan; minimum deductible of \$1,000 in 2004; indexed; maximum contribution of \$2,600 in 2004 (indexed).

\$1,000–\$2,600 (indexed thereafter), depending on the level of the deductible. The contributions are before taxes, investment earnings are not taxable, and withdrawals from the account for health care—either while an employee or a retiree—are not taxable. The funds in an HSA are portable, nonforfeitable, and can be carried over into retirement.

As an example of what an individual employee could save, we assess the HSA in three situations: (a) saving the maximum each year (\$2,600 in 2004, indexed thereafter) and spending no HSA funds for current health care costs (Scenario A); (b) saving the largest amount possible while in a plan with the lowest deductible level allowed (\$1,000 in 2004, indexed) and spending nothing on current health care costs (Scenario B); and (c) saving the largest amount allowable while in the plan with the lowest deductible

but using the HSA for current health care costs (Scenario C). The first two situations are unlikely and not possible unless the employee had virtually no health care expenses while still employed, or had enough income and discipline to pay those health care costs from non-HSA sources. We find that accumulations after 25 years (in 2031 for someone starting to save in 2006) are approximately \$192,000 under Scenario A, \$80,000 under Scenario B, and \$15,000 under Scenario C.

*Comparison of Expenses to Savings.* Figure 8-9 also shows the annual accumulation for all three scenarios and compares them to the present value of future health care costs at retirement for four ages at retirement: 55, 60, 65, and 70 (the amount that should be ‘in the bank’ at retirement so that projected future retiree costs could be paid from principal and interest). For each age at retirement, we show the range of out-of-pocket costs (copays, coinsurance, and deductibles plus premiums for Parts B and D), and premium payments for the employer-sponsored retiree coverage from 0 to 100 percent, based on cost increase trends that duplicate experience in the Mercer Survey data from 1995 to 2004 (average annual trends of 5.2 percent for pre-Medicare and 6.9 percent for Medicare-eligible retirees).

Even retirees who have enough financial resources and discipline to save in an HSA and not use the funds before retirement would need to use other savings, work longer, or work for an employer who provides a very generous retiree health care plan if they want to retire before becoming eligible for Medicare. Many may face the same challenges even when eligible for Medicare. Given the substantial fluctuation in health care costs over the last ten years, any estimate should be viewed only as a hypothetical projection of what future experience could be. Funds actually needed for retiree health care coverage will vary depending on retiree health status, employer coverage, and other factors that will be different for each individual. Even if actual investment earnings are higher and retiree costs are lower than the range projected in Figure 8-9, older adults may still have to devote significant portions of their income to health care in retirement. Many baby boomers’ situations may not prepare them for retirement as well as they have hoped. The financial challenges and burdens of health care costs will be particularly painful for lower-income adults who do not have employer coverage and who do not qualify for Medicaid.

## **Outstanding Policy Issues**

The US health care system faces serious challenges. Solutions to the problems, or lack thereof, will be a major force behind changes in retiree health care coverage. While a full outline of all the challenges and solutions is beyond the scope of this chapter, we briefly discuss these and then focus on issues specific to retiree health care coverage.

US health care delivery and financing is the result of a hybrid system of employer coverage, government-sponsored programs, individual insurance, and individual payments, with many people uninsured. Solutions to cover all US citizens have been discussed and rejected in the past, although Medicare is essentially universal coverage for the age 65 and older population. Going forward, some believe incremental changes will be sufficient to meet the challenges; reforms to adapt current programs have been suggested to help early retirees, including reducing Medicare's eligibility age, allowing some early retirees to purchase Medicare, and mandating COBRA<sup>10</sup> coverage for early retirees.<sup>11</sup> Others believe that reform of the individual insurance market will provide solutions. A major obstacle is the current practice of underwriting individual risk to determine whether to offer coverage and how much to charge for the coverage. This underwriting, which adds to the challenge of covering sicker people, reduces the insurance companies' problem of adverse selection. Fundamental change would be needed in the individual insurance market before providers can offer a solution to the unhealthy uninsured.

Some policy experts believe small, incremental changes will be insufficient to effect systemic reform, favoring instead comprehensive, system-wide solutions such as employer mandates supplemented with individual mandates as necessary; expansion of current public programs; creation of new programs that target subsets of the uninsured; and establishment of a universal, publicly financed program (Simmons 2005). The debate continues as to how—and whether—employers provide health care coverage to retirees. If health care reform relies on incremental changes, employer programs are not likely to change much. If employer mandates occur, there will be a significantly greater role for employers in providing retiree health care coverage. But a single-payer national program could mean no direct employer role in providing health care to retirees.

**Retiree Health Care Policy Issues.** Retirees, employers, and the government—the three sources of funds to finance health care cost in retirement—face challenges and should have a seat at the retiree health care policy table. In evaluating their challenges and roles, we first consider issues of accessibility and affordability of coverage for retirees' eligible for Medicare and those not eligible for Medicare; then we turn to challenges for Medicare; and finish with an assessment of the impact of federal policy on employer-provided health care coverage.

*Access and Affordability of Retiree Health Care Coverage.* Historically, retirees have faced the dual challenges of access to coverage and affordability of coverage. The addition of Part D prescription drug coverage makes access less of a concern for retirees able to access Medicare, though affordability



will still be a problem. Projections by Johnson and Penner (2004) indicate that health care spending for older married couples will rise increasing from 16 percent of net after-tax income in 2000 to 35 percent in 2030; they further estimate that unmarried older adults will face an increase from 17 to 30 percent. The problems will be most severe for lower-income people, and for unhealthy individuals.

Retirees ineligible for Medicare will face even more obstacles. Some with low income or employer-provided coverage, and those disabled under social security for twenty-four months, will have access to benefits. Others may obtain coverage if they are healthy enough to pass underwriting or because they qualify through HIPAA,<sup>12</sup> COBRA, high-risk pools, or insurers of last resort. Yet a significant number is still unable to purchase adequate coverage, while others choose not to purchase coverage. The National Academy of Social Insurance (NASI 2001) found that 15 percent of people age 55–64 were uninsured in 1999.<sup>13</sup> As to affordability of coverage, people ineligible for Medicare face even greater challenges than those eligible: coverage is more expensive for them because there is no government benefit to pay some of the costs, and they have additional years when they need coverage. They also have fewer years as an employee to save for future health care expenses.

*The Future of Medicare.* Medicare faces serious long-term financing challenges because the population eligible for Medicare is growing more rapidly than the number of active workers, and health care costs are increasing at a higher rate than the economy as a whole. A related risk is the reaction of employers to similar problems; as economic pressures cause employers to cut back on retiree health care coverage, there will be growing pressure to increase Medicare benefits. Direct cost pressure will also come to Part D of Medicare if employers end the coverage for which they get a tax-free subsidy. Medicare's cost per retiree for those in Part D will be greater on average than its cost for the employer subsidy, and therefore Medicare's total cost will increase when retirees move from the employers' plans to Part D (US CBO 2004). Regarding long-term financing challenges, the American Academy of Actuaries has defined four major areas for addressing future Medicare policy: these include long-term access to care, maintaining access to care while avoiding unnecessary utilization, meeting the insurance needs of Americans age 55–64, and private-sector competition strategies (American Academy of Actuaries 2005).

Clearly much uncertainty surrounds Medicare in the future. Some want Medicare to remain a government-run program, while advocates of competition want to see much more participation by the private sector, with vendors assuming risk such as allowed under the MA and prescription drug provisions of the Medicare reform law.<sup>14</sup> There is also uncertainty

about how private providers will respond to increased market opportunities. Experience with prior legislation may offer some guidance. The 1997 Balanced Budget Act encouraged a substantial shift of risk to private-sector Medicare + Choice plans, predecessors of MA plans. After some initial success, these plans faltered and declined; many employers strongly promoted Medicare + Choice plans in the 1990s, but they then became skeptical as plans closed and physicians dropped out. Insurers and other potential sponsors of MA plans may still be skeptical of their future. While there has been recent growth in the number of plans and enrollees, it remains to be seen how many plans will be available in future years and whether they will be stable. Similar issues may affect market participation in the new Medicare Part D. Uncertainty about Medicare is a backdrop for uncertainty about the future distribution of risk-sharing of retiree health care costs among the government, employers, and retirees.

*Federal Policy and the Role of the Employer.* In the USA, there has long been a strong connection between receiving health care benefits and one's employment, yet some health policy experts are now challenging that nexus. That is, there is a sense in which employers might not be the best option for providing health benefits for employees or retirees. The tax system has also been an important force encouraging and supporting the current system. Employers can deduct expenses for health benefits, and employees and retirees do not pay taxes on their value. From a federal budget point of view, employee benefits constitute a large tax expenditure. Of course, though employer programs do decrease tax revenue, they still benefit a large number of people. One of the strengths of employer-provided coverage is that it automatically spreads risk and enables coverage of sicker as well as healthier people. This is not true for individual coverage or retiree-pay-all employer plans where selection becomes a huge issue.

Employer health care plans in the USA are voluntary; nevertheless, they are still subject to extensive regulation such as employee benefits law, requirements that employer health plans must be offered for a limited period after termination of employment, and requirements that individual insurance plans must accept people who had previously been covered by employer plans.<sup>15</sup> While employer sponsorship of both pensions and retiree health benefits is voluntary, regulations are more specific and extensive for DB pension plans than health benefits. Pension law generally requires vesting, includes minimum coverage rules, and outlines benefit accrual requirements. There are no similar requirements for retiree health plans. Pensions are subject to mandatory funding, but retiree health benefits are generally not prefunded. (Even if an employer wants to prefund voluntarily, it is difficult to do so on a tax-favored basis.) The application of

age discrimination law creates uncertainty for both types of benefits. Legal requirements and uncertainty about them interact with cost and financial risk to discourage employers from offering both retiree health and conventional pension benefits.

## **Conclusions**

The dynamics and risks of employer-provided retiree health care benefits are changing. The combination of health care costs increasing at a faster rate than the overall economy and the increasing ratio of retirees to employees is challenging both government and employer programs. Employers continue to reduce benefits or terminate retiree health benefits plans entirely. The projected insolvency of the Medicare Part A Trust Fund by 2020 could force Congress to raise premiums and/or cut benefits.

Of all those who pay for health care, retirees face the greatest uncertainty and potential risk. Finding affordable coverage is a major challenge today, one likely to become more difficult in the future. Even when coverage is available, it is often expensive. Tax-favored savings vehicles, such as HSAs, can help some people save for retiree health care expenses. However, many will not be able to save enough to pay for future health care coverage without diverting other funds to health care coverage needs and/or working longer.

Retiree needs for affordable health coverage and adequate retirement income will greatly affect retirement security in the future, and their problems will likely grow more severe. It seems likely that solutions must be part of a broader national approach to health care reform. Nevertheless, agreement on a specific approach does not appear likely in the near term.

## **Endnotes**

1. In this chapter we do not cover long-term care benefits which are custodial in nature.
2. The Mercer Survey has been conducted annually since 1993, and it is based on a statistically valid random sample of all US employers with ten or more employees; it is projectable to the US labor force. (For private firms in the survey, a random sample is drawn from the Dun & Bradstreet database. All state governments are included; a random sample of county and local governments comes from the Census of Governments.) The survey includes only employers who sponsor insurance. For each plan type that they sponsor, respondents provide information about the plan with the largest enrollment. In 2004, the total number of participants was 3,020.
3. Further information on benefits and program details are available in DHSS (2005).
4. The Mercer Survey data on cost per person include costs for covered dependents.
5. Authors' calculations based on unpublished Mercer proprietary data.

## 8 / Risk-Sharing in Retiree Medical Benefits 161

6. Figure 8-6 shows that in any year, 15 percent of the population can account for roughly 75 percent of health care spending. In this group are chronically ill people who account for substantial costs year after year. In most areas, individual insurance regulations allow private health insurers to underwrite and insure only the better risks. In such markets, people in poorer health are either unable to purchase coverage, or if they can, they do so at a very high price. Healthier people, on the other hand, are sometimes reluctant to share in the cost of care for the sicker population in a system of voluntary purchase. The combination of the risk distribution and use of underwriting has been a barrier to the development of a working private individual insurance market that serves the entire population well. An alternative to permitting underwriting is risk adjustment or mandatory risk-sharing so that payments to health care plans are redistributed on the basis of anticipated health care utilization and status of the covered population. Risk adjustment is used by Medicare and in some states for individual coverage, but experience is currently limited.
7. The Governmental Accounting Standards Board (GASB) has issued similar accounting standards (GASB Statement 45) for governmental employers that offer retiree health and other nonpension postemployment benefits (OPEB). The GASB 45 establishes accrual accounting and financial reporting requirements for OPEB, including a requirement to disclose unfunded OPEB obligations, that could lead to lower debt ratings for some governmental employers. The GASB 45 was phased in for large employers beginning December 2006; one year later for medium-sized employers; and two years later for small employers. A related standard (GASB 43) on financial reporting funded by OPEB plans takes effect one year earlier.
8. As an example of a monthly account, the plan could give each retiree \$600 per month before Medicare eligibility and \$200 per month after Medicare coverage begins. This amount could vary by years of service or be the same regardless of service. The amount could increase annually at a specific index (such as the CPI or a flat percentage); it could remain at the initial level; or it could be increased on an ad hoc basis. The amount not used could be carried over to future years, or the funds not used could be forfeited. An example of an aggregate or 'lump sum' approach is the commitment of an aggregate amount such as \$20,000 (based, e.g. on \$1,000 per year for 20 years of service or a flat \$20,000 for all retirees) to be used over the life of the retiree to pay for health care premiums and/or expenses. A retiree would not receive funds from this account until health care expenses are actually incurred or premiums are paid. Prefunding would not be required, although the employer could prefund through some of the methods mentioned previously. Accounts could be credited with interest or not; the funds could be used on a draw-down basis as expenses are incurred, or the aggregate amount could be converted to a monthly payment amount similar to an annuity.
9. More detail on the calculation methods is available from the authors.
10. The Consolidated Omnibus Budget Reconciliation Act (COBRA) was passed in 1986, requiring employers with 20+ employees to allow those leaving service to continue medical coverage (if offered) by paying 102 percent of the cost for employee coverage (150 percent for those disabled).

11. The American Academy of Actuaries recently examined future policy issues for Medicare and they outlined some conditions needed to make buy-ins and focused on adequate participation and getting a reasonable spread of lives including healthy lives (American Academy of Actuaries 2005).
12. The Health Insurance Portability and Accountability Act (HIPAA) law passed in 1996 increases availability of health insurance to people with preexisting conditions if they have maintained continuous health care coverage.
13. In 1999, 66 percent of people aged 55–64 had employer-sponsored health coverage; 11 percent had public program coverage; 8 percent had individually purchased coverage; and 15 percent were uninsured; 77 percent of those employed and 48 percent of those not employed had employer coverage. Of those in the labor force, 13 percent were uninsured while 18 percent of those not in the labor force were uninsured. Three percent of those in the labor force and 24 percent of those not in the labor force were covered by public programs. Seven percent of those in the labor force and 10 percent of those not in the labor force had individually purchased coverage (NASI 2001).
14. The Medicare reform law shifts the majority of risk for MA plans and prescription drug plans to private-sector programs. The new law also encourages employers to share in the risk of offering prescription drug coverage in return for a tax-free subsidy. However, the details of risk shifting sometimes do not make it attractive to the private sector.
15. State regulations also shape benefit mandates, though self-insured employee benefit plans are exempt from state law under the federal Employee Retirement Income Security Act.

## References

- American Academy of Actuaries (2005). *Medicare: Next Steps*. American Academy of Actuaries. Issue Brief. Washington, DC: AAoA. February: 1–8.
- Centers for Medicare and Medicaid Services (CMS) (2001). *An Overview of the United States Health Care System: Two Decades of Change, 1980–2000*. Washington, DC: CMS, p. 2. <http://www.cms.hhs.gov/charts/healthcaresystem/chapter1.pdf>
- (2004). *Medicare and Medicaid Expenditures as Share of GDP*. Office of the Actuary, National Health Statistics Group [www.cms.hhs.gov/charts/series/sec1.ppt](http://www.cms.hhs.gov/charts/series/sec1.ppt)
- (2005a). *The 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: CMS: 3, 23, 115–116. <http://www.cms.hhs.gov/publications/trusteesreport/tr2005.pdf>
- (2005b). *Medicare Managed Care Contract (MMCC) Plans—Monthly Summary Report*. Washington, DC. <http://www.cms.hhs.gov/healthplans/statistics/mmcc/default.asp>
- (2005c). *National Health Accounts*. Washington, DC. <http://www.cms.hhs.gov/statistics/nhe/default.asp#download>
- Department of Health and Human Services (DHHS) (2005). *Medicare and You*. Washington, DC: USGPO. [www.medicare.gov/publications/pubs/pdf/10050.pdf](http://www.medicare.gov/publications/pubs/pdf/10050.pdf)
- Financial Accounting Standards Board (FASB) (1990). *Employers' Accounting for Post-Retirement Benefits Other Than Pensions*. Statement of Financial Accounting Standards Number 106 (FAS 106), Hartford, CT: FASB.

## 8 / Risk-Sharing in Retiree Medical Benefits 163

- Fronstin, Paul and Dallas Salisbury (2003). *Retiree Benefits: Savings Needed to Fund Health Care in Retirement*. Washington, DC: *EBRI Issue Brief*, 254: 1–28.
- Governmental Accounting Standards Board (GASB) (2004). *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions*. June 2004, Norwalk, CT.
- Johnson, Richard W. and Rudolph G. Penner (2004). *Will Health Care Costs Erode Retirement Security?* Washington, DC: *CRR Issues in Brief*, 23: 1–10.
- Mercer Human Resource Consulting (Mercer) (2004). *Mercer National Survey of Employer-Sponsored Health Plans*. Chicago, IL: Mercer.
- National Academy of Social Insurance (NASI) (2001). *Health Insurance Coverage of People in the Ten Years Before Medicare Eligibility*. Washington, DC: NASI.
- Organization for Economic Co-operation and Development (OECD) (2004). *Total expenditures on health, percent GDP*. <http://www.oecd.org/dataoecd/13/13/31963469.xls>
- Simmons, Henry F. (2005). *Our Nation's Health Care Crisis: Solutions for Reform*. Washington, DC: National Coalition on Health Care. <http://www.nchc.org/materials/speeches/NCCMP.pdf>
- United States Census Bureau (US Census) (2004). *Statistical Abstract of the United States: 2004–2005*, 124th edn. Washington, DC: USGPO, Table 139, p. 103.
- (2005). *Interim Projections Consistent with Census 2000*. Washington, DC: USGPO. <http://www.census.gov/ipc/www/usinterimproj/natprojtab02a.xls>
- United States Congressional Budget Office (USCBO) (2004). *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*. Washington, DC: USGPO.
- United States Department of Health and Human Services (USDHHS) (2005). 'Medicare & You', <http://www.medicare.gov/publications/pubs/pdf/10050.pdf>
- United States Department of Labor, Bureau of Labor Statistics (USBLS) (2005). *Bureau of Labor Statistics Data*. Washington, DC: USGPO <http://www.bls.gov/data/home.htm>