FIDELITY WORKPLACE SERVICES[SM]

Retiree Health Care Costs:
Addressing the Growing Gap

HEALTH AND WELFARE REPORT

TABLE OF CONTENTS

FIGURES:

EXECUTIVE SUMMARY

In retirement, the majority of people in the United States will incur significant out-of-pocket health care expenses. Few individuals are aware of just how large these expenses are expected to be, and fewer still are likely to have developed explicit plans to cover them.

Using a population- or expected-value approach, Fidelity estimates that a couple retiring today at age 65 would need approximately $160,000 in savings to cover their retirement medical expenses, assuming that they do not have an employer-sponsored plan. This figure covers the Medicare premium, cost-sharing expenses, and the cost of services not covered by Medicare. It does not include the cost of long-term care, except on a very limited basis. For those choosing to retire before age 65, retirement medical expenses will be much larger. A couple retiring today at age 60 needs in excess of $200,000 to cover their medical expenses in retirement. The above estimates are expected-value calculations and will vary from individual to individual. For example, the amounts could be insufficient for those who live well beyond their life expectancy and/or whose health status is significantly worse than average.

Raising awareness of the issues surrounding retiree health care costs is essential in helping individuals clear this significant financial hurdle. There is still sufficient time for the "retirement bubble" baby boomers, who are currently age 38 to 55, to plan for and fund retirement medical expenses. A limited number of funding options is available today, but none is attractive enough to have generated broad interest. Therefore, tax-favored funding vehicles, established specifically for retiree health care, would encourage employers and employees to fund this expense. Enabling legislation is needed to foster the development of such vehicles. By providing tax incentives to the private sector, the projected financial burden on public programs (e.g., Medicaid, Medicare) may be alleviated.

HISTORICAL PERSPECTIVE: THE ORIGINS OF EMPLOYER-SPONSORED HEALTH CARE

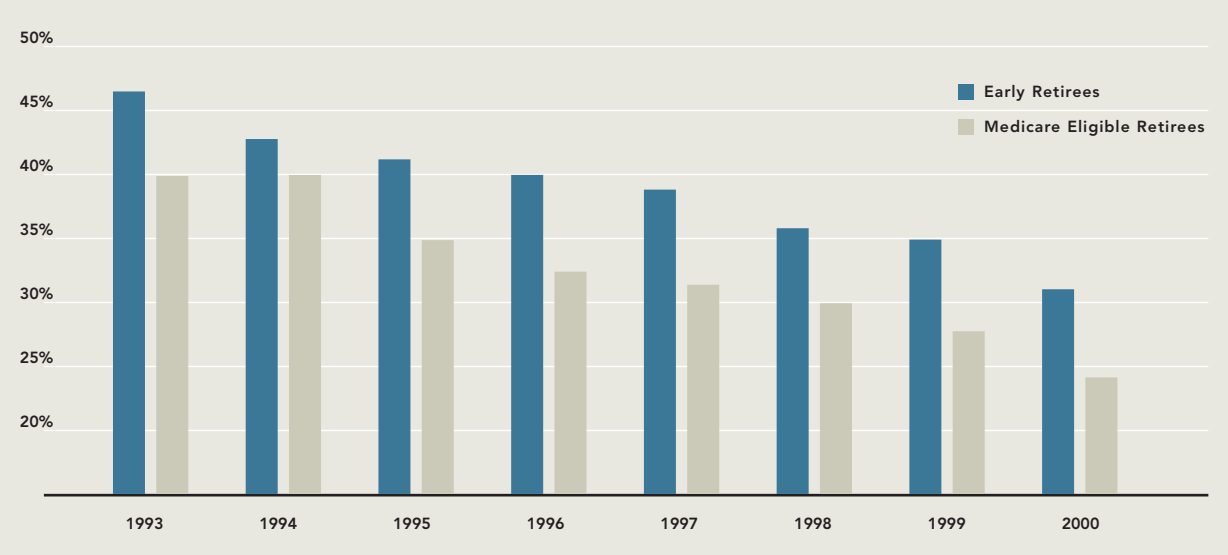
During World War II, national wage freezes and a tight labor market made the extension of health care coverage one of the few means by which employers could offer additional compensation to attract and retain employees. Legislation to exempt the cost of employer-paid health insurance from federal taxable income helped to facilitate this strategy and made this employee benefit a favored way of compensating employees. In a strong post-war economy, with health care costs at a moderate level, many employers also chose to extend these benefits to their retirees. The enactment of Medicare in 1965 further influenced employers to offer retiree medical benefits as much of the cost was shifted away from the employer and onto Medicare.

Historically, employer-sponsored retiree health care programs provided the dual benefits of continuing access to a health plan along with a financial subsidy. Employers accounted for retiree health-benefit costs on a "pay-as-you-go" basis. This accounting treatment, along with the low number of retirees compared to active employees, resulted in a relatively insignificant financial burden for most companies. The number of employers, particularly large employers, sponsoring a retiree program increased steadily, reaching a peak during the mid-1980s. A precipitous decline followed in the '90s, as the chart below illustrates.

The two factors primarily responsible for this decline were the emergence of double-digit health care inflation and the introduction of Financial Accounting Statement (FAS) 106, "Employers' Accounting for Post-retirement Benefits Other Than Pensions."

The high inflation rates in the late '80s through mid-'90s resulted in higher-than-expected costs for employers. While an important development for employers, it was overshadowed by the introduction of the new financial accounting and reporting standard, FAS 106.

Employer-sponsored coverage among organizations with 500+ employees



Source: EBRI Issue Brief 236.

Under FAS 106, employers no longer had the option of booking the cost of retiree health care benefits, on a "pay as you go" basis. Rather, they would have to recognize the liability for future benefits accrued during the calendar year as an expense on their income statement. This accounting treatment resulted in lower reported earnings and shareholder equity, although there was no actual effect on cash flow.

High medical inflation and the introduction of FAS 106 led many employers to reevaluate their retiree health programs and modify their plans. These modifications included increasing employee contributions, reducing benefits, tightening eligibility, and capping future employer contributions to a fixed-dollar amount.

In the mid-1990s, medical inflation rates began to fall to low single-digit levels. Managed care is credited with bringing cost increases down by targeting the components of total cost—utilization and unit cost.

Utilization was lowered using programs such as pre-authorization review, concurrent case management, and primary care gatekeepers. Unit costs were lowered by leveraging membership volume to obtain discounts with health care providers. The easing of medical inflation rates, along with the plan modifications that had been implemented a few years earlier, eased the financial pressures associated with retiree health care programs.

Unfortunately, utilization programs and provider contracting generated one-time-only savings. By the end of the decade, the benefits of managed care had been largely exhausted, and we had returned to double-digit health care inflation, where we remain today.

CURRENT TRENDS

During the last two years, a number of trends have resurfaced, reapplying the pressure on employer-sponsored retiree health care programs. Medical inflation has reemerged alongside a slowing economy. Inflation has led employers to hit the spending caps they set in the early '90s, forcing them once again to reevaluate their programs. In addition, recent legislative proposals and legal decisions threaten to limit an employer's latitude in dictating plan design and their ability to terminate plans altogether. These forces are compounded by the increasing number of retirees relative to active employees, which results in increasing benefit payouts and decreasing cash flow for employers.

In recent years, many employers have been pushing up against the contribution caps (fixed-dollar limits) they set in the early '90s. Caps were typically set as a multiple of the then-current cost with the expectation that the cap would be reached sometime during the following five to 10 years. A cap serves to reduce FAS 106 liabilities because the employer's maximum annual cost per retiree is limited to a predetermined amount. Once that cap is reached, the employer is no longer obligated to increase future contributions.

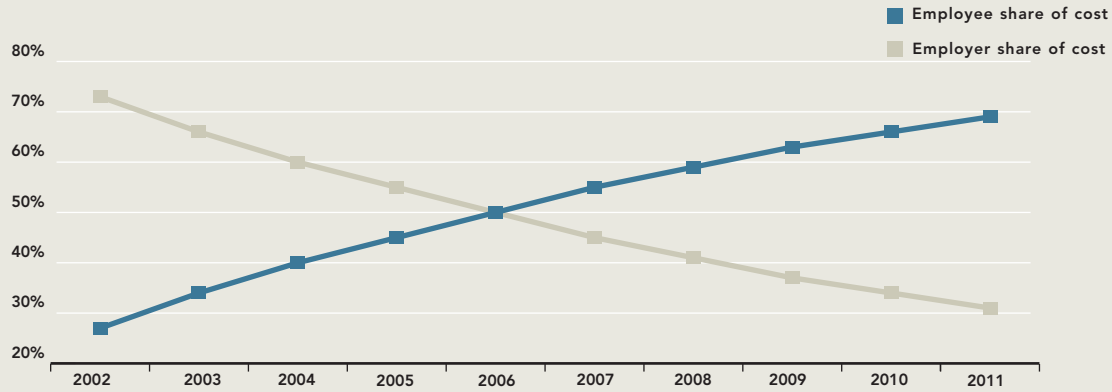
The chart below demonstrates how, under the cap strategy, the financial burden shifts from the employer to the employee once the contribution limit has been reached.

If an employer decides to abandon the fixed cap, other options to reduce or limit future costs include:

- Increasing the level of the original cap
- Changing benefit design
- Restricting eligibility

A problem with repeatedly increasing the cap is that it may lead an accountant to conclude that this course of action is a pattern and, consequently, to disallow the reduction in liability that would be expected to result from the cap. With the exception of increasing the cap, the other cost-containment options available to employers all serve to increase an employee's financial obligation.

Impact of fixing employer cap at current cost levels (assuming 10% medical inflation)



Many retiree health programs have eligibility requirements that are defined by age and length-of-service parameters. The most common vesting provision is age 55 and 10 years of service.[1] With the oldest baby boomers having just turned 55 in 2001, retiree health care stands to have an increasingly greater impact on employer cash flow. Companies with low employee turnover, few new entrants, and an increasing ratio of retirees to actives will feel this impact most acutely. Given the current market forces, it is easy to see why the decision to offer medical benefits to retired employees is being scrutinized.

Of course, as their health care funding options decrease, America's retirees are feeling the effects. Using a population- or premium-based approach, Fidelity estimates that a couple retiring today at age 65—without access to employer-sponsored insurance—would need approximately $160,000 in savings to cover expected postretirement medical expenses. This amount is needed to cover the Medicare premium, expenses associated with Medicare cost-sharing provisions, and the cost of services not covered by Medicare. This estimate does not include the cost of long-term care, except on a very limited basis.

For those choosing to retire early, the postretirement medical obligation will be noticeably larger. Many of these individuals will not have access to an employer-sponsored policy, and will have to access the individual market for insurance. Costs in the individual market are likely to exceed $10,000 annually (in today's dollars) for two-party coverage. Thus, a couple retiring today at age 60 needs in excess of $200,000 to fund expected lifetime medical expenses.

Consumer-driven health care

The concept of consumer-driven (CD) health care has been gaining attention recently as a means for mitigating medical inflation. CD health care plans aim to engage the consumer in the medical purchasing decision by shifting financial risk for noncatastrophic expenses to the individual. The idea has some promise, but savings may be limited because the approach focuses on non-catastrophic expenses, which represent only 20% to 30% of total medical costs. Additionally, like managed care, any realized savings would result in a one-time-only savings, with the "normal" trend resuming after cost efficiencies had been achieved. While these and other strategies may help to mitigate future medical inflation, it is unlikely—given both the insatiable demand for better medicine and an aging population—that health care costs will be tamed any time soon.

Including comprehensive long-term care coverage beginning at age 65 would increase these estimates by approximately $130,000. Thus, a couple retiring at age 65 would need $290,000, or if retiring at age 60, in excess of $330,000.

These estimates assume that insurance is purchased to cover medical expenses. Without insurance, expenses will vary greatly from individual to individual because of differences in health status.

[1]EBRI Issue Brief 236.

OUTLOOK

The aging baby boomer generation is now beginning to place additional pressure on employer costs. By 2020, the number of individuals in the 55 to 65 age group is projected to increase by 75% and, by 2030, those over age 65 are expected to double,[2] creating the largest percentage of the U.S. population in retirement in the nation's history. These demographic projections merely compound the financial pressures on employer-sponsored coverage discussed earlier.

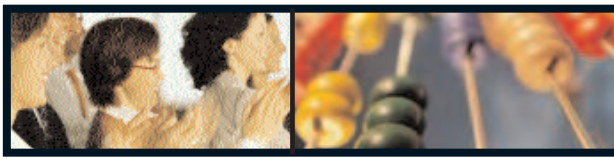
If, in fact, current trends lead to further cutbacks in employer-sponsored coverage, it is doubtful that the federal government will be able to fill the void. The General Accounting Office (GAO) reports that Medicare is fiscally unsustainable as currently structured. The Hospital Insurance Trust Fund, which provides funding for Medicare Part A, is expected to experience a growing annual cash deficit in just 15 years.[3]

Without employer-sponsored coverage, a growing majority of early retirees will have to access the individual market for health insurance until they reach age 65. Today, costs in the individual market can easily approach $10,000 annually for a couple. If medical inflation continues to outpace general inflation, as is widely forecasted, the costs for securing individual coverage will continue to increase in constant or real dollars. The result will be that fewer and fewer individuals will be able to afford this coverage.

With Medicare available at age 65, there is some comfort in knowing that a subsidized (prefunded) form of insurance coverage exists. However, there are large financial "gaps" in Medicare coverage. These gaps include significant cost-sharing provisions (deductibles and coinsurance), as well as one important expense—prescription drugs—that isn't covered at all. Another gap is the Medicare Part B premium, which is the responsibility of the participant. Currently, this collective financial gap accounts for 45% of total health care costs, or approximately $7,000 per annum, per couple.[4]

Today, access to medical care is not overly sensitive to income/asset level, and the majority of individuals have access to and are able to afford similar levels of medical care. However, as individuals become more responsible for their medical costs, it is highly probable that future health-care access will become more income/asset sensitive.

Given the present outlook, preretirees may indeed want to begin planning for the health care expenses of their retirement years. Tax-sheltered funding vehicles dedicated to future health care expenses, offered either through employer-sponsored programs or individual accounts, would likely encourage savings.



[2]GAO-01-374

[3]GAO-01-1010T

[4]GAO-01-1010T

HEALTH INSURANCE OPTIONS FOR EARLY RETIREES (BEFORE AGE 65)

Individuals choosing to retire early have several options for health insurance. They are:

- Secure employer-sponsored coverage
- Elect COBRA
- Access the individual insurance market
- Apply for Medicaid assistance
- Be uninsured

Employer-sponsored programs

Employer-sponsored programs generally represent the most attractive option for early retirees seeking medical insurance. These programs typically provide access to either a health plan or a financial subsidy to retirees who meet the firm's eligibility requirements. (See Appendix A.)

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers with 20 or more employees to continue health care coverage for employees and their dependents who do not have access to another employer-sponsored health plan. The continuation of coverage under most circumstances is for a term of 18 months. (See Appendix A.)

Individual insurance

The individual market is usually the market of last resort. Rates can be very high compared with group policies, and the choice of plans is often limited. (See Appendix A.)

Medicaid

Medicaid is a joint venture between the federal and state governments that provides medical assistance to families who have low incomes and inadequate assets. (See Appendix A.)

Uninsured

Going without insurance is a high risk–low reward proposition. Early retirees with no underlying coverage, such as Medicare, assume full financial responsibility beginning with the first dollar of expense incurred. (See Appendix A.)

HEALTH INSURANCE OPTIONS FOR MEDICARE ELIGIBLE RETIREES (AGE 65 AND OLDER)

The options available for retirees beginning at age 65 are as follows:

- Enroll in Medicare
- Purchase Medicare Supplement policies
- Enroll in a Medicare+Choice HMO
- Secure employer-sponsored supplemental insurance
- Apply for Medicaid Assistance
- Be uninsured (for Medicare gap)

While Medicare provides a basic layer of insurance protection, it does not cover some essential services, such as prescription drugs. Additionally, the cost-sharing provisions are fairly substantial, particularly when compared with HMO coverage. On average, costs associated with noncovered services, Medicare cost sharing, and the Medicare premium itself account for about 45% of total retiree health care expenditures.[5] This is a large "gap" in coverage, and many individuals, therefore, elect insurance coverage or aid beyond the traditional Medicare plan.

Medicare (Fee-for-Service Plan)

Medicare is a health insurance program sponsored by the federal government. For an individual attaining age 65, eligibility is met if the individual or his or her spouse has worked for at least 10 years in Medicare-covered employment. (See Appendix B.)

[5]GAO-01-713T

Medicare Supplement (Medigap) Policies

Medicare does not pay for all types of medical services, nor does it cover the full cost of services that it does cover. Medigap policies partially fill these gaps in coverage. There are 10 standardized policies that are available in all but three states. The exempted states—Massachusetts, Minnesota, and Wisconsin—have received waivers for alternative simplification programs. (See Appendix B.)

Medicare HMOs (Medicare+Choice Plan)

Those eligible for Medicare may also elect to enroll in an HMO if available in a participating health plan's geographic service area. (See Appendix B.)

Employer-sponsored supplemental insurance

Since Medicare is the primary insurance mechanism for individuals over age 65, the employer-sponsored plan is needed only to provide coverage for gaps in Medicare. (See Appendix B.)

Summary of expected medical costs after age 65 for retirees covered by Medicare			
	Per Member Per Month Cost	Present Value at 65 with Life Expectancy Equal to 15 Years	Present Value at 65 with Life Expectancy Equal to 20 Years
Part A Inpatient Deductible and Coinsurance	$20	$4,400	$6,400
Part B Premium	$50	$11,000	$15,900
Part B Deductible	$5	$1,100	$1,600
Part B Coinsurance	$60	$13,300	$19,100
Prescription Drugs	$125	$27,600	$39,700
Other, Incl. Benefits Not Covered by Medicare	$40	$8,800	$12,700
TOTAL (MEDICAL INFLATION = 8%)	**$300**	**$66,200**	**$95,400**
Total (medical inflation = 6%)	$300	$57,800	$78,900
Total (medical inflation = 10%)	$300	$76,300	$116,100

Amounts shown above are expected values and do not take into consideration costs for individuals who may live well beyond their life expectancy and/or whose health status is significantly worse than average.

Medicaid

Medicare recipients whose income and asset levels fall below certain thresholds can obtain financial assistance through the Medicaid program to help pay for Medicare out-of-pocket expenses and some costs not covered by Medicare. In most states, recipients of Supplemental Security Income (SSI) are eligible for full Medicaid benefits. (See Appendix B.)

Uninsured (for Medicare gaps)

The risk of not securing insurance is not as great as for those under 65, but it is still significant. This is because there are certain services and supplies that are not covered by Medicare, the most notable being prescription drugs. (See Appendix B.)

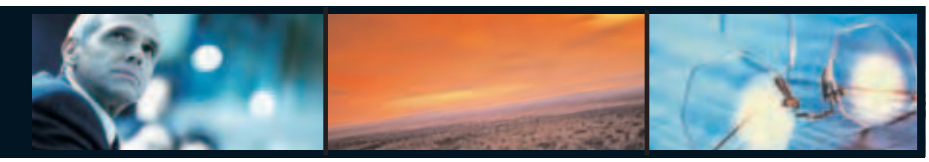
PLANNING AND FUNDING FOR RETIREE MEDICAL EXPENSES: AN INDIVIDUAL PERSPECTIVE

As medical inflation remains high and the percentage of employers sponsoring a retiree program continues to decline, individual planning for retiree health care will become increasingly more important. Planning for retiree heath care requires individuals to determine the source from which insurance coverage will be secured, estimate the costs associated with the coverage and the savings that will be required at retirement, select a funding vehicle, and calculate the annual contribution required to meet the savings objective.

Individuals will need to consider their expected retirement age, the availability of employer-sponsored coverage, premium levels, and expected out-of-pocket expenses during the planning process. Once options are evaluated, priced, and selected, the individual must focus on the most efficient way to fund the estimated costs.

Currently, there are no individual, tax-sheltered savings vehicles targeted specifically for health care expenses. Tax deductibility of health care expenses is limited to the provision in the tax code allowing for an itemized deduction of medical expenses that exceed 7.5% of adjusted gross income. There are group arrangements, such as the employee-pay-all voluntary employee beneficiary association (VEBA) that employers can offer employees. The employee-pay-all VEBA allows for tax-free growth and withdrawal for approved retiree health care expenses, but contributions are made on an after-tax basis. Few of these arrangements are in use today.

Medical savings accounts (MSAs) have a savings vehicle component that may allow for retiree savings. However, due to current limitations on participation, these accounts may not be a viable option for most individuals.



With the current lack of retiree health care savings vehicles, individuals must utilize "generic" savings instruments. These include 401(k) plans, IRAs, mutual funds, and other investment vehicles. There are limitations and restrictions on some of these instruments, such as the 401(k), which has maximum annual contribution levels.

Regardless of the funding vehicle chosen, it is critical that individuals begin to save for their retiree medical expenses as early as possible. The table below shows the estimated costs for a couple retiring today who do not have employer-sponsored coverage. Also shown is the corresponding annual savings required for retirees who began to save at age 35 and age 45.

Additional assumptions underlying the calculations in the table below are that the after-tax investment returns during the accrual period will be 8% and that medical inflation will be 8% going forward. A simplifying assumption—that individual policies for the next several years will cost $10,000 annually for two-party coverage—also is made.

Saving for retiree health care costs

Age at Retirement	Total Savings Required	Annual Savings Required Starting Age 35	Annual Savings Required Starting Age 45
55	$260,000	$5,260	$16,620
60	$210,000	$2,660	$7,160
65	$160,000	$1,310	$3,240

PLANNING AND FUNDING FOR RETIREE MEDICAL EXPENSES: AN EMPLOYER PERSPECTIVE

Factors such as competitive business pressures, the macroeconomic environment, and demographics can affect a company's decision about whether to offer retiree medical benefits with or without a financial subsidy. Typically, however, the key driver in a consideration is affordability, especially in the context of a cost/benefit analysis.

Employer strategies need not be limited to two options—to offer or not to offer a plan. As baby boomers get closer to retirement, employers may find it beneficial to offer retirees nonfinancial assistance with health care. Viable options include:

- *Educational programs:* These programs can help raise awareness of retiree health care costs and issues among employees. Discussions of expected costs and coverage options, such as COBRA and Medigap policies, will be of interest, particularly to those close to retirement.
- *Employee-pay-all funding vehicles:* In other words, supporting employees to save on their own for postretirement medical expenses. An example of this type of vehicle is the employee-pay-all VEBA. The employer does not incur any direct costs with these vehicles, and indirect costs are limited to implementation and ongoing administration.

Companies that continue to offer some level of employer-sponsored benefits for retirees find that there are certain advantages to prefunding those benefits—even if FAS 106 does not require them to pay ahead. These potential advantages include a reduction in the FAS 106 cost resulting from investment earnings, tax benefits, security for beneficiaries, and an inherent fairness to different generations of shareholders. Common funding vehicles used by employers include employer-funded VEBAs, 401(h) accounts, and pension surplus transfers.

It's worth noting, however, that each of these vehicles carries its own benefits and limitations, and must be considered individually regarding:

- Pretax contributions by the employee or a tax-deductible contribution by the employer
- Investment earnings that are tax sheltered
- Benefits that are tax free to the beneficiary

ENHANCING INDIVIDUAL FUNDING OPTIONS

Funding options dedicated to retiree health care are important from a public policy perspective as well as from an individual needs perspective. Segregating retiree health care savings from more general savings pools serves to focus attention on this significant liability and to encourage savings toward this nondiscretionary expense.

Assuming that individual funding options are critical to fulfilling the health care needs of America's retirees, how should such a program be structured? These are among the characteristics that could maximize the potential benefit of an employer-sponsored savings program:

- *Tax status:* Providing favorable tax treatment to savings vehicles is critical to generating interest and participation. The ideal vehicle would allow for pretax contributions and tax-free accumulations and withdrawals.
- *Allowed expenses:* Allowing for premiums as well as out-of-pocket insured expenses should be sufficient. However, allowing for noninsured expenses (e.g., eyeglasses, hearing aids) should be considered, as greater flexibility will lead to an increased willingness to fund.
- *Contribution limits:* Limits should be high enough to allow, at a minimum, for full funding of expected retiree costs. By definition, funding equal to the expected cost will be insufficient for approximately 50% of all individuals. Thus, the funding limit, ideally, would exceed the expected costs level. Age-graded contribution limits should be considered, as each individual's time horizon (i.e., years to retirement) will be different.
- *Earliest withdrawal age:* Two generic options for consideration are withdrawal at age 65 and withdrawal at some age prior to 65. Age 65 is attractive from a public policy perspective as it focuses savings on alleviating Medicare's financial pressures. From an individual's point of view, however, allowing withdrawals prior to age 65 will increase the flexibility and thus the attractiveness of the product.
- *Covered individuals:* The two basic options are an individual account or a joint account with spouse. Since flexibility is increased if coverage can be extended to include a spouse, this may be the more attractive option.
- *Definition of retirement:* Assuming the funding vehicle allows for withdrawals for early retiree expenses, say beginning at age 60, should an individual who is employed full time, with or without health insurance, be allowed to withdraw from this fund? The stricter the definition of retirement, the less attractive the vehicle will be.

- *Portability:* Allowing individuals the opportunity to move an account and to make postemployment contributions is important. Individuals leaving an employer need assurance that if their future employer does not offer a funding vehicle, they will be able to continue implementing their health care savings strategy.
- *Rollover:* The ability for individuals to consolidate funds from various accounts is an attractive feature that will aid in the management of these accounts.
- *Withdrawals for hardship/other reasons:* Allowing individuals to withdraw their savings for nonretiree medical expenses (with penalties likely) is very important, as individuals will want to have access to these funds in case of emergency.
- *Withdrawal process:* Individuals will likely have to submit eligible expenses for reimbursement. Payments made directly to individuals, as opposed to medical providers, would make the administration simpler.

Two individual retiree medical savings vehicles in existence today are the retirement medical benefit account (RMBA) and the employee-pay-all VEBA. Both must be sponsored by an employer and are specifically established to help employees save for retiree health care expenses.

The RMBA allows employees to direct their employer's profit sharing contribution to an account that can be used for health care expenses. The primary advantage to the employee is that withdrawals from this account will occur on a tax-free basis. Contributions are deductible for the employer and earnings accumulate tax free. Currently, significant drawbacks include:

- Lack of a private letter ruling from the IRS
- No allowance for contributions beyond the employer profit-sharing amount
- A 25% incidental requirement that does not allow more than this share of contributions to be directed to the health care account
- No hardship provisions

The employee-pay-all VEBA is a trust established by employers that allows individuals to save for retiree health care costs. The trust allows individuals to save for retiree medical expenses on a voluntary basis. Earnings and withdrawals are tax free. However, there are significant drawbacks, including the following:

- Contributions are after tax
- Accounts are not portable
- Hardship features may not exist

Having briefly explored the individual retiree health care savings vehicles available today and their important shortcomings, we next evaluate potential enhancements for these vehicles as well as for other generic savings vehicles. Again, this is done in the context of maximizing private-sector savings for these expenses.

Potential enhancements to existing savings vehicles

Vehicle	Potential Enhancements
Profit Sharing/RMBA	• Private letter ruling • Allow employee contributions • Allow contributions not to be subject to qualified plan limits • Rollover/portability provisions
Employee-Pay-All VEBA	• Allow pretax contributions • Rollover/portability provisions
401(k)/(m)	• Allow tax-free withdrawals for eligible medical expenses • Establish side account for health care expenses • Exclude health care account contributions from 401(k) limits
Health Care IRA (does not exist today)	• Tax-free withdrawals • Rollover from employer accounts • No income limit for deductibility of contributions
Roth 401(k) (effective 2006)	• Establish side account for health care expenses with deductible contributions • Exclude health care account contributions from income limits
MSA with proposed changes	• Eliminate requirement to purchase high deductible plan • Increase limits on deductible contributions • Allow funds to be used for postretirement premium payments

CONCLUSION

Retiree health care costs are certain to gain a great deal more attention in the coming years as baby boomers enter retirement, medical inflation remains high, and the number of employer-sponsored programs continues to decline. Individuals surely will take more interest in understanding retiree health care options as they come to realize the sizeable financial liability they are likely to incur. Educational tools and funding vehicles are needed to assist individuals.

To date, there have been few educational efforts aimed at individuals. A survey of popular financial-planning tools reveals that none explicitly accounts for medical expenses, though these expenses will be, for many, a very significant expenditure in retirement. With the exception of recent press attention on prescription drugs costs for seniors, very little media coverage has been directed at the health care obligation facing many retirees. A number of individuals have been forced to learn about the potentially high costs of postretirement medical care through their parents' hardships.

Many baby boomers in the 38 to 55 age group still have adequate time to plan for and fund their retiree medical expenses. Efforts to educate individuals and encourage savings can only help them achieve financial security in retirement.

APPENDIX A

Employer-sponsored programs

Today, of the employers sponsoring a retiree health care program, approximately two-thirds offer both access and a subsidy, and one-third of employers offer only plan access.[6] Large employers are more likely than small employers to offer a retiree program.

For those employers providing access, the offering is usually a plan currently available to active employees. The plan generally offers a comprehensive range of benefits, which is appropriate given that Medicare is not available until age 65. Technically, access is important to early retirees, but is not necessarily critical, because the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees portability from group to individual coverage. The reality, however, is that individual market plans may not be accessible for many, due to high costs. Two-party early retiree premium rates in excess of $10,000 annually are not uncommon in the individual market.

The employer-sponsored plan, even without an employer subsidy, is likely to be significantly less expensive than a similar plan in the individual market. This is primarily because of "adverse selection" in the individual market, which drives up costs. Additionally, employers that do not provide an explicit financial subsidy sometimes do so implicitly by pooling retirees with the active population and calculating a single premium based on the average cost for the entire pool. In this case, the active population provides a subsidy, because retirees' true costs are two to three times the cost for the average active employee.

Approximately 65% of employers that provide a retiree health program provide an explicit financial subsidy. This can take the form of a premium subsidy or a contribution to a retiree health care account when no underlying plan exists. Subsidies vary greatly from employer to employer.

It is important to note that neither access to the plan nor a continuation of plan subsidies is typically guaranteed. The plans are one-year "term" policies, which can be modified or discontinued at the employer's discretion.

COBRA

COBRA requires employers with 20 or more employees to offer a continuation of their active plan. Thus, the insured continue with their most recently elected plan, generally for 18 months.

Under COBRA, the retiree must pay 102% of the full-premium equivalent. As an active employee, it is likely that the individual was paying only a small percentage of the premium equivalent or total premium. Active employees on average pay approximately 20% to 30% of the premium equivalent, while the employer pays the remaining 70% to 80%. Assuming an 80%–20% split, COBRA individuals would pay more than five times their active contribution under the active plan. Furthermore, the premium would be paid with after-tax dollars, whereas active payments are made on a pretax basis.

[6]EBRI Issue Brief Number 236.

COBRA is a useful stop-gap for employees who do not have employer-sponsored retiree coverage. For individuals retiring at age 63½ or older, COBRA is sufficient to bridge the gap to Medicare. For those retiring earlier than age 63½, COBRA provides coverage that, while very expensive versus active rates, still costs much less than is typically found in the individual market.

Individual Insurance

The individual insurance market is regulated at the state level, and plan offerings, underwriting restrictions, and rate levels vary greatly from state to state.

In certain states, insurance companies write individual policies only because state regulations require this in order for them to do business in other, more desirable markets. Generally, the individual market is not attractive for insurers, primarily because of the potential for "adverse selection." Adverse selection refers to the ability of individuals who are aware of their higher-than-expected probability of illness/claim to seek insurance coverage. Medical underwriting (the process by which an individual's health status is reviewed) can mitigate this phenomenon. In states that permit the practice of medical underwriting, insurers may use an individual's health status to determine expected claim rates and to charge a premium that reflects, to the extent allowable, the individual's risk.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires in all states that insurers in the individual market must, at a minimum, guarantee some coverage to those individuals deemed eligible for group-to-individual portability because they had continuous group coverage of a prescribed duration prior to application. In this case, individual coverage is to be made available without medical underwriting. However, in states that allow carriers also to maintain an underwritten block, there is the possibility that risk segmentation can result, making the open plans unaffordable. In states that have not exceeded the requirements of HIPAA, individuals in poor health who have not secured eligibility for group-to-individual portability can have coverage denied or may be subject to preexisting condition exclusions at the outset of the policy.

HIPAA itself does not restrict the extent to which carriers may reflect health status in their premium rates. However, many states have put restrictions on allowable rate increases, and some also have limited the degree to which age-related costs can be reflected. Even with these state and federal protections, individual insurance can be very costly due to the varying nature of the pool of individuals likely to access this market.

Medicaid

As a joint venture, the federal government provides general guidelines for the Medicaid program, with specifics determined at the state level. The majority of recipients are pregnant women or families with young children. Most individuals do not meet the low income and asset thresholds required for participation in Medicaid. Unfortunately, some that do meet the threshold levels do so because of a catastrophic medical episode that has consumed much of their wealth.

The Medicaid program provides eligible individuals with a comprehensive plan and very little cost sharing.

Uninsured

While not insuring saves the premium expense, it also exposes an individual to the possibility of a catastrophic claim. If an individual can afford to purchase insurance, it is unlikely to be in that person's best interest to self-insure medical risks. This is not as critical an issue for post-65 coverage when Medicare is available.

APPENDIX B

Medicare (Fee-for-Service Plan)

The Medicare program covers a fairly comprehensive range of benefits, with outpatient prescription drugs being a significant exception.

Medicare has two programs, Part A and Part B. Part A is also known as Hospital Insurance (HI), and Part B is known as Supplementary Medical Insurance (SMI). Part A covers services provided in hospitals and skilled nursing facilities, hospice care and, on a limited basis, home health care. Part B covers physician services, hospital outpatient services, and other ancillary services, such as ambulance and durable medical equipment. Notable exclusions from Medicare coverage are prescription drugs, certain preventive care services, vision and hearing exams, and eyeglasses and hearing aids.

Medicare payroll taxes fund Part A expenses, while premium collection and general tax revenues fund Part B expenses. The Part B premium is calculated to equal 25% of expected total costs. In 2001, this amount was $50 per member per month.

Medicare enrollees incur out-of-pocket expenses as services are utilized. These expenses take the form of deductibles, copayments, and coinsurance. The table below summarizes the most salient cost-sharing provisions.

Cost-sharing provisions and the Medicare Part B premium represent approximately 23% of total Medicare expenditures on average.[7] If services not covered by Medicare are considered, approximately 45% of total medical expenditures are borne by the individual. Thus, while Medicare provides a basic level of coverage, the individual still is required to shoulder a fairly significant portion of the costs. It is important to note that, unlike the provisions in most active plans, there are no out-of-pocket maximums under Medicare. Individuals must continue to pay coinsurance regardless of total expenditures in a given year.

Medicare cost-sharing provisions

Coverage	Beneficiary Cost Responsibility[8]
Inpatient Hospital	$792 deductible per admission $198 copayment per day for days 61–90 $396 copayment per day for days 91–150 All costs beyond 150 days
Skilled Nursing Facility	$99 copayment for days 21–100 All costs beyond 100 days
Physician	$100 deductible per year 20% coinsurance for most services 50% coinsurance for mental health
Outpatient Hospital	Varies by service, can exceed 50%

[7]HCFA, Medicare & You 2001

[8]GAO-01-713T.

There has been talk about legislation that would expand Medicare coverage. It is our opinion that passage of such legislation is unlikely given the future financial shortfalls predicted under the current program structure.

Medicare Supplement (Medigap) Policies

The 10 standardized Medigap policies are categorized as "Plan A" through "Plan J". Plan A offers the lowest level of benefits, while Plan J offers the most comprehensive range of benefits. However, even Plan J does not cover such services as vision, dental care, and hearing aids. Additionally, even the broadest prescription drug benefit, available with Plan J, has significant cost-sharing provisions (a $250 deductible and 50% coinsurance) and a low benefit maximum of $3,000 per year.

Medicare SELECT policies have the same plan design as the standardized policies, but they also have restrictions on the providers enrollees can utilize. Providers' participation in these plans is contingent upon their agreement to comply with policies to promote proper utilization of services and the delivery of cost-efficient, high-quality care. By limiting care to this restricted network, insurers are able to charge less than they would for "standard" Medigap policies. Whereas Medigap policies are available in all 50 states, there are 15 states that currently have no insurer that offers a SELECT policy.[9]

Access to Medigap policies is guaranteed during a six-month open enrollment period. This period begins on the first day of the month in which an individual is age 65 or older and is enrolled in Medicare Part B. Individuals cannot be denied coverage for any available plan or charged higher rates due to health status during this time. HIPAA affords retirees beyond the initial eligibility period access to a limited array of Medigap plans should their employer terminate retiree health care coverage.

Benefits covered by standardized Medigap policies

	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Coinsurance Parts A and B	■	■	■	■	■	■	■	■	■	■
Skilled Nursing Facility Coinsurance			■	■	■	■	■	■	■	■
Part A Deductible		■	■	■	■	■	■	■	■	■
Part B Deductible			■			■				■
Part B Balance Billing						■	■		■	■
Foreign Travel Emergency			■	■	■	■	■	■	■	■
Home Health Care				■			■		■	■
Prescription Drugs*								■	■	■
Preventive Medical Care					■					■

*Plans H and I have a $250 deductible, 50% coinsurance, and a maximum payment equal to $1,250; Plan J is similar, except maximum is $3,000.

[9]GAO-01-941.

Both those initially eligible for Medigap coverage and those eligible for coverage due to the provisions of HIPAA may be subject to preexisting condition limitations under certain circumstances. After the open-enrollment period, insurers can medically underwrite individuals, and do so, especially on plans that include prescription drug coverage. All Medigap insurers are required to offer Plan A. Most insurers also opt to offer other standardized plans, though few offer the three plans that include prescription drug coverage, due to the potential risk of adverse selection during the open enrollment period.

Medigap purchasers can still incur significant out-of-pocket costs. For 2001, these costs were estimated to average between $1,600 and $1,800. These figures do not include the premiums required for Medicare Part B and the Medigap policy.[10]

About 10.7 million individuals, or one-fourth of all Medicare beneficiaries, purchased a Medigap policy in 1999. Only 8% of the Medigap policies sold included prescription drug coverage. Nationally, about 64% of Medigap policies sold were written by United HealthCare or a Blue Cross/Blue Shield Plan.[11]

[10]GAO-01-941 (data source provided 1998 data; a trend rate was applied to arrive at the approximation).

[11]GAO-01-941.

Medicare HMOs (Medicare+Choice Plan)

The HMO's enrollee must pay the Medicare Part B premium and any insurance premium that the HMO charges, which is typically fairly low. HMO premium rates in excess of $50 per month are unusual. Cost sharing for enrollees is typically limited to copays for office visits and other services. Additional benefits not covered by Medicare are often included as well. The drawback for enrollees is that the HMO's network of providers must be utilized. Also, patient care is subject to managed care programs, such as gatekeepers and utilization review.

Many health plans have been losing money on their Medicare membership and have begun to pull out of markets. Some plans have stopped short of pulling out and have, alternatively, increased premiums or reduced benefits. Recently, United HealthCare increased the inpatient hospital copay for Wisconsin beneficiaries from $0 to $295 per day. The recent federal policy of increasing payments to HMOs in the hope of persuading them to stay in the Medicare program has largely been a failure. Although these plans may be attractive to individuals, their long-term viability is questionable.

Employer-sponsored supplemental insurance

There are three ways in which an employer can coordinate payment with Medicare to fill gaps. They are as follows:

- Carve Out
- Maintenance of Benefits
- Coordination of Benefits

Carve out benefits are determined by subtracting the Medicare benefit from the employer payment that would have been made had Medicare coverage not been in place. Maintenance of benefits coverage applies a benefit formula to costs that exceed Medicare payments. Coordination of benefits has the employer paying the lesser of the plan benefit in the absence of Medicare coverage and the difference between the covered expenses and the Medicare payment. The carve-out and maintenance-of-benefits approaches typically leave the retiree with some cost sharing. Depending on the underlying design of the employer plan (i.e. deductible and coinsurance levels), the financial relief may or may not be significant. With a coordination-of-benefits plan, it is likely that the employer will, in many instances, cover the entire Medicare cost-sharing amount. Unfortunately for retirees, however, very few plans use the coordination-of-benefits approach.

It is imperative to recall that employer-sponsored policies may be unilaterally terminated by the employer.

Medicaid

In most states, recipients of Supplemental Security Income (SSI) are eligible for full Medicaid benefits. In this situation, subject to state payment limits, Medicaid benefits are wrapped around the Medicare plan, helping to pay for Medicare out-of-pocket expenses and some costs not covered by Medicare. Lower levels of Medicaid assistance are available to Medicare beneficiaries who do not qualify for full Medicaid coverage but who still have limited assets and income. For Medicare beneficiaries with assets at or below twice the standard allowed under the SSI program and income at or below the federal poverty level (FPL), Medicaid will pay the Medicare cost sharing and Part B premium. Those with slightly higher income levels, in the range of 100% to 120% of the FPL, are exempted from payment of Part B premiums. In 2002 the SSI asset limit is $2,000 for individuals and $3,000 for couples, though certain items such as the applicant's primary residence and car are excluded from the test. The current FPL for a family of two is defined as gross income of $11,940.

See the Medicaid listing under "Health Insurance Options for Early Retirees" for additional background.

Uninsured (for Medicare gaps)

For services that are covered by Medicare, cost-sharing provisions are not limited by out-of-pocket maximums; thus, the potential liability is theoretically unlimited. For most individuals it is not financially prudent to self-insure.

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