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Retiree Health Benefits: Concerns for Employers and Employees

NOTE: Income caps on participation in qualified retirement programs often prevent top credit union executives from replacing their pre-retirement income at the same level afforded to other employees. D. Hilton Associates frequently works with credit unions to identify options that will help them enable key executives to maintain their current standard of living in retirement.

In conducting research on retirement income needs, it has come to our attention that health coverage is a looming issue for retirees in the United States, and especially for those in the credit union industry, where retiree health insurance is offered less frequently than is true in the nation as a whole. The following information, drawn from a variety of sources, indicates a pressing need for credit union staff members to consider their health needs when they budget for their golden years.

The percentage of private-sector employers providing medical benefits to retirees has been shrinking steadily for a number of years. That trend accelerated in the 1990s with the approval of FAS 106 by the Financial Accounting Standards Board, which requires companies to record retiree health benefit liabilities on their financial statements in accordance with generally accepted accounting principles. The new view on costs FAS 106 inspired, coupled with the spiraling expense of providing retiree health benefits, induced many private-sector firms to modify their retiree health benefit programs in ways that “controlled, reduced or eliminated their costs,” concludes Paul Fronstin of the Employee Benefits Research Institute (EBRI).

As a result of these cost-cutting measures, only 13% of private-sector firms offered benefits to Medicare-eligible retirees (those 65 or older) in 2002, down from 20% in 1997. The same percentage offered benefits to younger retirees, down from 22%. CUNA estimates that retiree benefits are even less common in the credit union industry. Vicki Joyal, CUNA’s Vice President of Research Services, recently told credit union executives attending the Floyd Forum Leadership Conference that only 8% of credit unions currently offer retiree health insurance.

What are the Costs?

Based on analysis by the AARP Public Policy Institute, the average non-institutionalized Medicare beneficiary 65 or older spent \$3,455 on health care in 2003, 45% of which went for premiums for Medicare Part B, private Medicare plans, and private supplemental insurance. However, the AARP analysis also indicates that out-of-pocket spending tends to rise with age (from \$2,920 for those 65 to 74 years of age to \$4,615 for those 85 years of age or older). Health status also affects expenditures, with those whose health is rated “fair” or “poor” enduring the greatest out-of-pocket expenses, at an average of \$4,000.

Other factors also complicate the process of estimating an adequate budget for medical expenses in retirement. Projecting this amount “is tentative and

complex,” EBRI notes, explaining that the process “requires conclusions about the range by which medical inflation will exceed consumer prices generally, as well as assumptions about whether medical practices will change in a way that makes Medicare coverage for a given ailment more or less likely.”

Out-of-Pocket Spending by Medicare Beneficiaries*		
	% Of Medicare Beneficiaries 65+ (N = 34.7 million)	Average Out-of-Pocket Spending on Health Care
Total	100%	\$3,455
Age		
65-74	51%	\$2,920
75-84	37%	\$3,815
85+years	12%	\$4,615
Health Status		
Fair/Poor	23%	\$4,000
Good	33%	\$3,615
Very Good	28%	\$3,165
Excellent	16%	\$2,845
<small>(Source: AARP Public Policy Institute projections using the Medicare Benefits Model, v.5.306.)</small>		
<small>* Non-institutionalized Medicare beneficiaries age 65 and older.</small>		

A study by Fidelity Investments cited in a recent *Wall Street Journal* observed that a 65-year-old couple with no employer sponsored health insurance that retires today will need approximately \$190,000 to pay medical bills for things like prescription drugs and Medicare premiums over the coming 15 to 20 years. However, that figure excludes dental services, over-the-counter medications, and long-term care.

EBRI research points out that health care will only become more expensive in the coming years. By that organization’s estimates a 65-year-old retiring in 2004 could expect to need between \$72,000 and \$580,000 to cover insurance

For more information on DHA’s Retention and Retirement Practice, contact Debbie J. Hilton at 800.367.0433 ext. 121 or e-mail recruit@dhilton.com

d. hilton associates inc.

9450 Grogan’s Mill Rd., Suite 200
The Woodlands, Texas 77380
toll free: 800.367.0433
fax: 281.292.8893
www.dhilton.com

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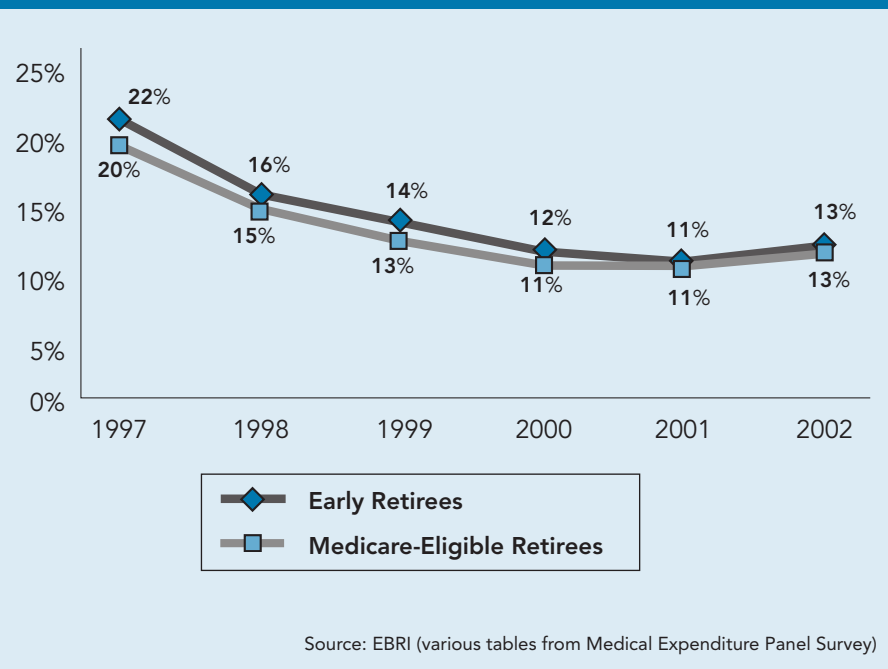
premiums and out-of-pocket expenses; a 65-year-old who retires in 2014 can expect to need between \$137,000 and \$1.5 million. Factors affecting actual expenditures include longevity and the pace of increase in insurance premiums.

Hewitt Associates, a human resources consulting firm that works principally with large employers, has projected that workers should assume health care costs in retirement will consume about 20% of their pre-retirement income. Yet another human resources consulting firm, Watson Wyatt, reported that, assuming no additional growth in life expectancies, lifetime medical expense for a person retiring in 2001 would equal 162% of median final pay, but said that figure would likely rise to 220% of projected final pay by 2031. By 2031, the firm anticipated that employer financial support would drop to less than 10% of the total expense.

For retirees without employer-provided health benefits to supplement Medicare, a privately purchased Medigap policy is often a solution to unanticipated expenses for items that Medicare does not cover. Premiums for such policies differ by state and can vary widely depending not only on location but also on level of coverage. At the lowest level, Plan A programs averaged about \$1,113 in 2004 while Plan J, with the most comprehensive benefits, averaged nearly \$3,324 according to findings from Weiss Ratings, Inc. Buyers may also find Plan K and L options, which provide lower levels of coverage and lower costs.

If retiree medical costs seem staggering for individuals, they are equally daunting for employers. The 2004 Kaiser/Hewitt Survey on Retiree Health Benefits, which is based on a non-probability sample of large private-sector firms that offer retiree health benefits, helps to illustrate the challenges for employers. For new retirees 65 and older, the weighted average total monthly premium recorded by these

Private Sector Establishments Offering Health Insurance to Retirees



firms for retiree-only coverage was \$262. Of that amount, the employer paid \$161 and the retiree \$101. For both retiree and spouse, the average total monthly premium rose to \$600, of which the employee's share was \$209. However, considering that the employers that responded to the Kaiser/Hewitt survey provide health benefits to an estimated 3.5 million Medicare-eligible retirees and their spouses, the total financial obligation, obviously, is considerable.

As an example, Dr. Vincent Kerr, director of health care management for Big Three automaker Ford Motor Company, told a congressional subcommittee in 2002 that the company's cost for retiree health benefits amounted to \$2.5 billion in 2001, a 25% increase over the previous year. He also noted that although retirees at Ford represented less than half the covered population, their health costs accounted for nearly two-thirds of the total cost in 2001. Since that time, Ford and other leading U.S. automakers have been scaling back benefits, and even eliminating some coverage altogether for future retirees.

What Does the Future Hold?

Although increases in medical costs are expected to moderate for the near term, which should result in some slowing in the double-digit increases in health insurance premiums being paid by employers, costs seem certain to continue moving upward. An article released earlier this year noted that between 2003 and 2014, national health spending is expected to continue growing more rapidly than gross domestic product (GDP), with the result that its share of the GDP will rise from 15.3% in 2003 to 18.7% by 2014. The authors also note:

**Between 1998 and 2003, private health insurance premiums per enrollee rose at an annual rate of 9.3 percent, while per capita disposable personal income grew by only 5.0 percent annually, a gap of more than four percentage points per year. We expect per enrollee premium growth to continue to exceed that of per capita disposable personal income by 1.4 percentage points from 2004 to 2014.*

Whether—and how much—they will pay for retiree health coverage will become more critical for employers in the near future. In 2008, leading-edge baby boomers will reach 62 and become eligible for early retirement under Social Security; in 2011, they become eligible for Medicare. In testifying before the Budget Committee of the U.S. Senate recently Federal Reserve Board Chairman Alan Greenspan said, “I fear that we may have already committed more physical resources to the baby-boom generation in its retirement years than our economy has the capacity to deliver. If existing promises need to be changed, those changes should be made sooner rather than later.”

Employers appear to be taking that sentiment to heart, and are making it known that future retirees will pay a larger share of their health care expenses.

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— Alan Greenspan

In large firms, this frequently means that caps on the amount the company will pay are being implemented. While caps can take a variety of forms, one option is a set yearly cost per employee (e.g., for Medicare-eligible employees, the employer subsidy will not exceed \$2,000 per year). Any expenses beyond that cap would be passed directly to the retiree.

Numerous large firms have already implemented caps for current employees, and others are putting them

in place for new hires. According to one report, virtually all plans now capped will hit that figure within the next five years. To compensate, younger employees may be encouraged to establish Health Savings Accounts to meet their expenses for health care in retirement.

Finally, we also note that Medicare and Medigap insurance do not cover expenses for Long Term Care (such as nursing home or extended in-home health assistance). Insurance for this type of care requires separate coverage, forcing seniors to choose between an additional expense or a level of risk they may consider unacceptable.

For more information about retiree health care costs, see the resources listed below, which were used in compiling this summary.

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*Stephen Heffler, Sheila Smith, Sean Keehan, Christine Borger, M. Kent Clemens, and Christopher Truffer, “U.S. Health Spending Projections for 2004-2014,” *Health Tracking*, February 23, 2005, <www.ahipresearch.org/pdfs/Wf_74Heffler.pdf>