TIAA-CREF institute

POLICY BRIEF

Options and Alternatives to Fund Retiree Health Care Expenditures

By Paul Fronstin, EBRI and TIAA-CREF Institute Fellow
and Paul Yakoboski, TIAA-CREF Institute

FINANCIAL SERVICES
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EXECUTIVE SUMMARY

The percentage of employers offering health benefits to retirees has been declining in the United States for many years with both early retirees and Medicare-eligible retirees experiencing a decline in coverage. Even when benefits are offered, premiums are higher, out-of-pocket expenses are rising, and eligibility requirements are becoming increasingly stringent. The combination of the erosion of retiree health benefits and the fact that the Medicare program is facing a financing crisis means that many future retirees will pay a greater share of insurance premiums and will bear an increasing burden of costs when health care services are needed.

It has been estimated that an individual who retires at age 65 in 2005 and lives to age 90 will need $143,000 in savings to pay for Medicare Part B premiums and employment-based health insurance to supplement Medicare. The individual will need assets of $210,000 if he or she wants to also cover about $1,800 in out-of-pocket expenses each year. Such figures could easily be higher depending on the rate of health care inflation. In a recent survey of TIAA-CREF retirement plan participants, 77% expressed concern about being able to meet their medical expenses during retirement and only 9% have estimated how much they will need to meet these future expenses.

This paper examines a number of mechanisms that employers and employees can use to pre-fund retiree health benefit expenses during work years. While there are obvious benefits to pre-funding retiree health benefits through existing tax-preferred vehicles while an individual is employed, existing options are in large part inadequate to solely fully fund retiree health benefits.

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INTRODUCTION

Numerous studies have examined the erosion of employment-based retiree health benefits and its impact on workers and retirees.[1] These studies have consistently found that fewer employers are offering retiree health benefits. They have also shown that even when retiree health benefits are offered, premiums are higher, out-of-pocket expenses are rising, and eligibility requirements are becoming increasingly stringent.

In a 2004 nationwide survey of 185 higher education and research institutions, TIAA-CREF found that 76% of the institutions surveyed offered retiree health benefits, while 24% did not.[2] Twelve percent of those offering such benefits said they were likely to discontinue offering these benefits during the next five years. Thirteen percent reported fully pre-funding their liability for retiree health care, 9% were partially pre-funding their liability, 47% were not pre-funding, and 32% of administrators were not sure whether their institution was prefunding this obligation.

At the same time, public policymakers are grappling with future benefit payments (net of debt held by trust funds) of $29.6 trillion in the Medicare program over the next 75 years, and an insolvency date of 2020 for the Medicare Part A trust fund.[3] Ultimately, a combination of eroding employment-based retiree health benefits and likely changes to the Medicare program will mean that retirees can expect to pay a significant amount more for health benefits and health care services in retirement than current retirees.

PAYING FOR RETIREE HEALTH EXPENSES

In a recent survey of TIAA-CREF retirement plan participants, 77% expressed concern about being able to meet their medical expenses during retirement and only 9% have estimated how much they will need to meet these future expenses.[4] It has been estimated that an individual who retires at age 65 in 2005 and lives to age 80 will need $76,000 in savings to pay for Medicare Part B premiums and employment-based health insurance to supplement Medicare.[5] The individual will need assets of $112,000 if he or she wants to also cover about $1,800 in out-of-pocket expenses each year.

However, average life expectancy at age 65 is age 82 for males and age 86 for females, and it is highly uncertain for most individuals. To cover these expenses until age 90

requires savings of $143,000 and $210,000, respectively. These estimates are based on an assumed 7% annual increase in premiums and out-of-pocket expenses.[6] If premiums were to increase at a rate of 10%,[7] savings of $218,000 would be needed to cover premiums until age 90 and $328,000 would be needed to cover both premiums and out-of-pocket maximums.

OPTIONS TO PRE-FUND RETIREE HEALTH

There are a number of options currently available to employers and employees to pre-fund retiree health benefit expenses. While each of these options have various advantages and disadvantages associated with pre-funding retiree health benefits, none of the options is completely adequate as currently structured to fully fund the level of expenses mentioned above and presented in prior research. Available options include:

- Health Savings Accounts (HSAs)
- Health Reimbursement Arrangements (HRAs)
- Retiree Medical Accounts (RMAs)
- Voluntary Employee Benefit Associations (VEBAs)

This paper describes each of these options to pre-fund retiree health expenses and discusses the adequacy of each as a funding mechanism.

HEALTH SAVINGS ACCOUNTS (HSAs)

A health savings account (HSA) is a tax-exempt trust or custodial account that an individual can use to pay for health care expenses.[8] Contributions to the account are deductible from taxable income and distributions for qualified medical expenses and certain premiums, including retiree health insurance premiums, are not counted in taxable income. Earnings on contributions are also not subject to income taxes.

In order for an individual to qualify for tax-free contributions to an HSA, the individual must be covered by a high-deductible health plan, defined as a plan that has an annual deductible of not less than $1,000 for self-only coverage and $2,000 for family coverage. Certain preventive services can be covered in full and are not subject to the deductible. The out-of-pocket maximum may not exceed $5,100 for self-only coverage and $10,200 for family coverage, with the deductible counting toward this limit. Network plans may impose higher deductibles and out-of-pocket limits for out-of-network services.

Both individuals and employers are allowed to contribute to an HSA. Contributions are excluded from taxable income if made by the employer and deductible from adjusted gross income if made by the individual. The maximum annual contribution is $2,650 for self-only coverage and $5,200 for family coverage in 2005. But the maximum permissible contribution cannot exceed the plan deductible. This means that an individual with a $1,000 deductible is not allowed to contribute more than $1,000 to an HSA. Contribution limits are also indexed to inflation.[9]

To be eligible for an HSA, individuals may not be enrolled in other health coverage, such as a spouse's plan, unless that plan is also a high-deductible health plan. However, individuals are allowed to have supplemental coverage without a high-deductible for such things as vision care, dental care, specific diseases, and insurance that pays a fixed amount per day (or other period) for hospitalization.[10] Individuals enrolled in Medicare are not eligible to make HSA contributions, although they are able to withdraw money from the HSA for qualified medical expenses and certain premiums.[11] Individuals also may not make an HSA contribution if claimed as a dependent on another person's tax return.

Individuals who have reached age 55 and are not yet enrolled in Medicare may make catch-up contributions. In 2005, a $600 catch-up contribution is allowed. A $1,000 catch-up contribution will be phased-in by 2009.[12]

HSAs are completely portable. There is no use-it-or-lose-it rule associated with them, as any money left in the account at the end of the year automatically rolls over and is available in the following year. Individuals are able to roll over funds from one HSA into another HSA without subjecting the distribution to income and penalty taxes as long as the rollover does not exceed 60 days. Rollover contributions from Archer MSAs are also permitted.

Distributions from an HSA can be made at any time. An individual need not be covered by a high-deductible health plan to withdraw money from his HSA (although he must have been covered by a high-deductible health plan at the time the funds were placed in the HSA). Distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under Internal Revenue Code (IRC) Sec. 213(d).[13] Distributions for premiums for COBRA, long-term care insurance, health insurance while

receiving unemployment compensation, and insurance while eligible for Medicare other than for Medigap, are also tax-free. *This means that distributions used to pay Medicare Part A or B, Medicare Advantage plan premiums, and the employee share of the premium for employment-based retiree health benefits are allowed on a tax-free basis.*

HSAs have several drawbacks as an accumulation vehicle for funding retiree health insurance premiums. First, availability is limited to those with a high-deductible health insurance plan. Second, contributions are limited; the maximum annual contribution in 2005 is $2,650 for self-only coverage and $5,200 for family coverage (but the maximum permissible contribution cannot exceed the plan deductible); persons age 55 and older can make catch-up contributions.[14] Third, given the coupling with high-deductible medical plans, it is likely that HSAs owners will tap these accounts to a significant extent for current medical expenses prior to the time of retirement. Fourth, distributions can be used for employment-based retiree health insurance premiums once the individual has reached age 65 only; so early retirees would not have immediate access to these funds.

If an individual were to contribute $2,650 annually (the maximum allowed for self-only coverage) to his or her HSA, the accumulation would total $48,100 after 10 years, $120,100 after 20 years and $248,300 after 30 years (Figure 1). Such saving levels are inadequate given the estimates earlier regarding what is needed to fund retiree health insurance.

One of the difficulties in using an HSA to save money for premiums and out-of-pocket expenses during retirement is that individuals also can (and may need to) use the money in the account to pay for health care services during their working years or to pay COBRA premiums and insurance premiums while they are unemployed. Distributions from the account prior to becoming eligible for Medicare will erode the value of the account. In fact, if an individual takes distributions averaging only 10% of the end-of-year account balance each year, then the HSA accumulations are $30,800, $52,700, and $78,400, respectively, after 10, 20 and 30 years. Some individuals may choose to forego withdrawals from the HSA to pay for out-of-pocket expenses if able to pay those expenses on an after-tax basis.

Figure 1

Potential Savings in an HSA, Assuming 5% Rate of Return, Individual Rolls Over Various Amounts of End-of-Year Account Balance and Makes Maximum Catch-Up Contributions

Years contributing to HSA	Percent of End of Year Account Balance Rolled Over					
	10%	25%	50%	75%	90%	100%
	$1,000 Annual Contribution/ $1,000 Deductible, 20% Co-insurance, $5,100 Out-of-Pocket Maximum in 2005					
10	$ 3,200	$ 3,900	$ 6,100	$ 11,000	$ 15,800	$ 23,700
20	3,200	3,900	6,200	12,700	23,600	45,600
30	3,200	3,900	6,200	12,900	28,700	79,000
40	3,200	3,900	6,200	12,900	32,800	133,400
	$2,650 Annual Contribution/$2,650 Deductible, 20% Co-insurance, $5,100 Out-of-Pocket Maximum in 2005[a]					
10	$ 5,800	$ 7,100	$ 10,900	$ 19,400	$ 30,800	$ 48,100
20	6,900	8,400	13,000	25,900	52,700	120,100
30	8,200	10,000	15,500	32,700	78,400	248,300
40	10,000	12,100	18,700	39,800	107,900	474,200

Source: EBRI.

[a] Maximum allowable HSA contribution and out-of-pocket maximum are indexed for inflation.

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs)

A health reimbursement arrangement (HRA) is an employer-funded health plan that reimburses employees for qualified medical expenses.[15] Employees are eligible for an HRA only when their employer offers such a plan.

HRAs are typically part of a health benefits package that includes comprehensive health insurance after a deductible has been met. As an example, an employer may provide a comprehensive health insurance plan with a high deductible, for instance, $2,000. In order to help employees pay for expenses incurred before the deductible is reached, the employer would also provide a HRA with $1,000 that they would use to pay for the first $1,000 of health care services. Employers have a tremendous amount of flexibility in designing health plans that incorporate an HRA. For example, the amount of money that

is placed in the account, the level of the deductible, and the comprehensiveness of the health insurance are all subject to variation.

There is no statutory requirement that an employee have a high-deductible health plan in order to also have an HRA. However, it is standard practice among employers that an employee must also choose a high-deductible health plan in order to have an HRA. Since so few employers offer an HRA, there is not a wealth of data on deductibles and employer contributions. One study examined 23 plans to get a sense of the magnitude of deductibles and contributions and found that the median deductible for employee-only coverage was $1,500 with an $800 employer contribution to the HRA (Mercer Human Resources Consulting, 2004). This study found a median deductible of $4,000 for family coverage with a $1,900 employer contribution to the HRA. The study also found at least 90% enrollment at three employers, and an average of 11 % enrollment among the rest.

HRAs are typically set up as notional arrangements and exist only on paper. Employees behave as if money was actually funding an account, but employers do not incur expenses associated with the arrangement until an employee incurs a claim. By contrast, were employers to set up the HRA on a funded basis, they would incur the full expense at the time of the contribution, even if an employee had not incurred any expenses.

At the employer's discretion, leftover funds at the end of each year can be carried over to the following year, allowing employees to accumulate funds over time, and, in principle, creating the key incentive for individuals to make health care purchases responsibly. Employers can place restrictions on the amount that can be carried over. Funds in the HRA can accumulate tax-free as long they remain employer-provided funds paid out only for qualified medical expenses.

Generally, distributions are excluded from taxable income if they are used to pay for qualified medical expenses as defined under IRC Sec. 213(d), although employers can place restrictions on the use of an HRA. Since unused funds are allowed to roll over, employees are able to accumulate funds over time. Employers can allow former employees to use any leftover money in the HRA to continue to cover qualified medical expenses. Funds can be used for out-of-pocket expenses and premiums for insurance, long-term care, COBRA, and retiree health benefits. However, employers are not required to make unused balances available to workers when they leave.

Primary drawbacks with HRAs as vehicles to pre-fund retiree health expenses are that they are notional accounts that do not involve actual pre-funding and they do not permit worker contributions. Since they are typically combined with a high-deductible health plan, they are likely to be used to fund current expenditures and thus realistically will provide limited accumulations for retiree medical needs *if* the employer allows rollovers of unused balances over time.

RETIREE MEDICAL ACCOUNTS (RMAs)

RMAs are HRA-like employer-sponsored accounts, but differ in that they can only be used by individuals to purchase health benefits during retirement. However, they are more similar to 401k plans than HRA-based plans because they are not tied to health insurance for active employees. Employees do not need to have a high-deductible health plan to participate in an RMA and they cannot use the RMA to pay for health insurance or health care expenses while working.

RMAs are available to workers only when offered by their employer. RMAs are notional accounts that are *not* pre-funded; the accounts are a bookkeeping device to track the dollars that will be available for a worker to spend on health benefits during retirement. Employers make "contributions" to a worker's "account" based on the worker's age and years of service. Workers can also make contributions to their account but those contributions must be made on an *after-tax* basis. Contributions are generally credited with a rate of interest over time. In retirement, an individual can use the money in his or her account to purchase health insurance. The insurance could be provided by the employer – meaning, the employer would continue to decide what benefits to offer and at what price or the employer could allow retirees to buy insurance on their own and pay an insurer of the retiree's choice directly. Distributions from RMAs for retiree health benefits are tax-free.

RMAs appear to be the most attractive of available options for an employer wanting to sponsor a mechanism to pay for retiree health insurance. RMAs could reduce future employer costs for retiree health benefits. Under an RMA arrangement, an employer decides how much to contribute to retiree health benefits while a person is working. The employer contribution is often set independently of the cost of retiree health benefits or

the predicted cost growth. One drawback is that workers cannot make pre-tax contributions. Also, lack of employer prefunding means that sponsoring employers will have unfunded liabilities for these accounts years (even decades) into the future, though they will likely be less than they would have been had an employer remained with a traditional retiree health benefit program. Finally, RMAs are not available to all workers; only to those whose employer sponsors one.

VOLUNTYARY EMPLOYEE BENEFIT ASSOCIATIONS (VEBAs)

Voluntary Employee Benefit Associations (VEBAs) are arrangements which include a trust established to fund certain benefit plans. They were originally established for use by multiemployer plans through the Internal Revenue Code (IRC) and the Labor Management Relations Act of 1947 (Taft-Hartley Act). As a result of increasing health care costs and increasing inflation, ERISA extended these trusts to single-employer plans. VEBAs must be based on voluntary membership, and qualifications for membership eligibility must be defined by objective standards of an employment-related "common bond."

Employers can make tax-deductible contributions; however, contributions are limited to the sum the qualified direct cost of the benefits provided for the taxable year and any permissible additions to a qualified asset account (reserve account). The qualified asset account limit must be funded over the employees' working lives, must be determined actuarially, and must be based on covered costs. As a result of this last requirement, inflation cannot be taken into account when estimating future costs. Furthermore, when reserves are above permissible levels, additional contributions to the VEBA are not deductible and earnings on excess reserves are subject to tax as unrelated business income. Hence, these limits effectively counteract any possible advantage of using a VEBA to prefund retiree health benefits.

Investment income is not exempt from tax for most plans (it is taxable as unrelated business income unless invested in tax-exempt instruments), although for VEBAs established under a collective bargaining agreement, the contributions are unlimited and earnings accumulate tax free. Expenses for disability, medical benefits, and group-term life insurance purchases are also tax free to the recipient, although other benefits are taxable on receipt.[16]

Nondiscrimination regulations were added by the Deficit Reduction Act of 1984 (DEFRA) and state that each plan benefit is subject to Internal Revenue Service (IRS) overview to prohibit discrimination in both design and operations.[17] DEFRA disallowed accounting for future inflation in funding VEBAs and changed the law to subject earnings to federal income tax.[18] DEFRA also imposed a 100 % excise tax on employers whose welfare benefit fund provides any type of disqualified benefit.

Awareness of VEBAs is not widespread among higher education and research institution administrators, with only half indicating that they are at least "somewhat familiar" with VEBAs. Overall interest in a VEBA for funding retiree health care is somewhat low, with 28% expressing some interest in using this approach. The primary reason being that administrators were unfamiliar with the viability of a VEBA (29%); in addition, 14% said they have no interest in pre-funding the liability or that their liability is currently being reduced or eliminated (11%).[19]

DISCUSSION

The percentage of private-sector employers offering health benefits to retirees has been declining in the United States for many years. In 2002, 13% of private-sector employers offered retiree health benefits to early retirees, down from 22% in 1997 (Fronstin, 2005). Similarly, in 2002, 13% of private-sector employers offered retiree health benefits to Medicare-eligible retirees, down from 20% in 1997. With the announcement of GASB Statements No. 43 and No. 45 by the Governmental Accounting Standards Board, the public sector may follow the private sector lead on retiree health benefits.

The impact of the erosion of retiree health benefits is already being felt by workers and retirees. Workers are less likely to expect to receive retiree health benefits in retirement than they were in the past. In 2002, 47% of workers ages 45-64 reported that they expect to receive retiree health benefits in retirement, down from 50% in 1997.

Both early retirees and Medicare-eligible retirees have experienced a decline in coverage for retiree health benefits. Between 1997 and 2002, the percentage of early retirees with retiree health benefits declined from 39% to 29%, while the percentage of Medicare-eligible retirees with retiree health benefits declined from 28% to 26%.

The combination of the erosion of retiree health benefits and the fact that the Medicare program is facing a financing crisis means that many future retirees will pay a greater share of insurance premiums and will bear an increasing burden of costs when health care services are needed. This paper examined a number of mechanisms that employers and employees can use to pre-fund retiree health benefit expenses during work years. While there are obvious benefits to pre-funding retiree health benefits through existing tax-preferred vehicles while an individual is employed, the options examined in this paper are in large part inadequate to solely fully fund retiree health benefits.

TIAA-CREF asked higher education and research institutions about hypothetical tax enhancements that the government could implement to encourage the pre-funding of retiree health expenses. These included:

- Creating special retiree health care accounts to which employers and/or employees could contribute; contributions would not count as current income for tax purposes; and withdrawals during retirement for qualified medical expenses would be tax-free.
- Allowing retirees to make tax-free withdrawals from their defined contribution retirement plans for qualified medical expenses.

Institutions preferred allowing tax-free withdrawals from existing defined contribution plans because of the ease and flexibility associated with this option. In addition 59% of TIAA-CREF retirement plan participants were interested in the concept of tax-free withdrawals from their current defined contribution plan as a way to fund retiree health expenditures.[20] Such a change would require legislative action, however, and no such action is imminent.

Beyond potential legislative changes, however, it is also important for current workers to clearly understand the retiree health benefits provided by their employer, if any, and to understand the amount they then must save in order to have adequate retiree health insurance coverage, especially if they plan to retire before becoming Medicare-eligible. Efforts by employers, retirement savings plan providers, and the government would be valuable to workers in this regard.

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ENDNOTES

[1] See Fronstin (1996, 2001 & 2005), Fronstin and Salisbury (2003 & 2004), Gabel (2002), McArdle et al. (1999 & 2004), McDevitt et al. (2002), and Mercer Human Resources Consulting (2004).

[2] *Retiree Health Care Savings Study*, TIAA-CREF, November 2004.

[3] See www.gao.gov/cghome/rms052605/img7.html, last reviewed June 23, 2005.

[4] *Retiree Health Care Savings Study*, TIAA-CREF, November 2004.

[5] Source: Update of estimates presented in Fronstin, Paul and Dallas Salisbury. "Health Care Expenses in Retirement and the Use of Health Savings Accounts." *EBRI Issue Brief* No. 271 (Employee Benefit Research Institute, July 2004).

[6] The Centers for Medicare & Medicaid Services (CMS) projects premiums for private health insurance to increase at an average annual rate of 7.6 percent between 2002 and 2013.

[7] CMS projects premiums for private health insurance to increase 10.4 percent in 2003.

[8] It has been estimated that just over 1 million individuals were enrolled in HSA-based plans by March 2005 (See www.ahipresearch.org/pdfs/HSAExceedMillion050405_full.pdf.) HSAs were first introduced by a select number of insurers in January 2004. Employers waited for Treasury Department and IRS guidance before offering a plan. 2006 is viewed as the year many employers will begin to offer HSAs, as it was too late for most employers to design and implement a new plan in time for the 2005 open enrollment season during the Fall of 2004.

[9] The maximum annual contribution is actually the sum of the limits that are determined separately for each month. The monthly contribution limit is 1/12 of the lesser of the annual deductible or the maximum annual contribution. If an individual first becomes covered by a high-deductible health plan mid-year, the annual contribution limit is pro-rated, and the monthly contribution limit is based on the number of full months of eligibility. As an example, an individual who enrolled in a plan on July 1 with a $1,000

deductible would be eligible to contribute one-half (6/12) of the annual maximum contribution or $500 to the HSA.

[10] Permitted insurance also includes worker's compensation, tort liabilities, and liabilities related to ownership or the use of property (such as automobile insurance).

[11] Only Medicare enrollee's ages 65 and older are allowed to pay insurance premiums from an HSA. A Medicare enrollee under age 65 cannot use an HSA to pay insurance premiums.

[12] The catch-up contribution is not indexed to inflation after 2009.

[13] Distributions for nonqualified medical expenses are subject to regular income tax as well as a 10 percent penalty, which is waived if the owner of the HSA dies, becomes disabled, or is eligible for Medicare.

[14] Persons age 55 and older, but not yet enrolled in Medicare, can make catch-up contributions. Currently, a catch-up contribution of $500 is allowed; this will phase up to $1,000 in 2009.

[15] IRS Revenue Ruling 2002-41 and Notice 2002-45 (published in *Internal Revenue Bulletin* 2002-28, dated July 15, 2002) provide guidance clarifying the general tax treatment of HRAs; the benefits offered under an HRA; the interaction between HRAs and cafeteria plans, FSAs, and coverage under COBRA; and other matters under current law. See www.irs.gov/pub/irs-utl/revrul2002-41.pdf and www.irs.gov/pub/irs-drop/n-02-45.pdf (last reviewed July 2004).

[16] Disability and medical expenses are tax free to the extent provided in Internal Revenue Code (IRC) secs. 104 and 105, which list the nonincludable expenses specifically.

[17] This holds only for contributions for postretirement medical and death benefits in 501(c)(9) trusts, or voluntary employee beneficiary associations (VEBAs). Also, nondiscrimination rules do not apply to plans maintained through a collective bargaining agreement. VEBA nondiscrimination rules are in IRC sec. 505.

[18] This does not apply to VEBAs covering groups that are at least 90 percent collectively bargained. Assets held before enactment of the Deficit Reduction Act of 1984 are

grandfathered. Also, the taxability of earnings holds only for postretirement medical benefits, as these may not be taken into account when figuring reserve limits. Earnings on reserves for other benefits are not taxed as long as the reserves for these benefits do not exceed the new funding limits.

[19] *Retiree Health Care Savings Study*, TIAA-CREF, November 2004.

[20] Ibid.

ABOUT THE AUTHORS

Paul Fronstin is a senior research associate with the Employee Benefit Research Institute, a private, nonprofit, nonpartisan organization committed to original public policy research and education on economic security and employee benefits. He is also Director of the Institute's Health Research and Education Program. He has been with EBRI since 1993.

Dr. Fronstin's research interests include trends in employment-based health benefits, consumer-driven health benefits, the uninsured, retiree health benefits, employee benefits and taxation, and public opinion about health care. He currently serves on the steering committee for the Emeriti Retirement Health Program, the board of advisors for CareGain, and on the Maryland State Planning Grant Health Care Coverage Workgroup. In 2001, Dr. Fronstin served on the Institute of Medicine Subcommittee on the Status of the Uninsured.

Dr. Fronstin earned his Bachelor of Science degree from SUNY Binghamton and his Ph.D. in economics from the University of Miami.

Paul Yakoboski is a Principal Research Fellow with the TIAA-CREF Institute. In addition to his research responsibilities, he serves as director of the Institute's Fellows Program and is editor of Policy Briefs.

Yakoboski conducts research on issues related to retirement income security, including saving and planning for retirement and funding retiree health insurance. Prior to joining the Institute, he held positions as Director of Research for the American Council of Life Insurers, Senior Research Associate with the Employee Benefit Research Institute and Senior Economist with the U.S. General Accounting Office. He is a member of the

National Academy of Social Insurance and the American Economic Association, and has served as Director of Research for the American Savings Education Council. He serves on the editorial advisory board of Benefits Quarterly.

Yakoboski received his Ph.D. (1990) and M.A. (1987) in economics from the University of Rochester (Rochester, NY) and his B.S. (1984) in economics from Virginia Tech.