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The Surprising Equality of Retirement Time: Evidence From the Health and Retirement Survey

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THE SURPRISING EQUALITY OF RETIREMENT TIME: EVIDENCE FROM THE HEALTH AND RETIREMENT SURVEY

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This article discusses the impact changes to the retirement age may have on the distribution of retirement time. The author investigates the length of time men and women are alive between the date of their retirement and their death, finding that the most critical factor in determining length of retirement time is and individual's socio-economic status. As a result, the author opines that because individuals in lower economic classes tend to die earlier, increasing the retirement age will impact these individuals disproportionally and increase retirement time inequality.

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I.   INTRODUCTION

In 2012, economic inequality in the United States reached its highest level in 100 years.[1] Increasingly, inequality is considered by global

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[1] Every year from 1913 to 2012 (the earliest and latest years for which data is available) the top 10%, 1% and 0.1% of income earners won a greater share of national 2012-value-income than in any previous year (this is true whether one includes or excludes capital gains). *See* Facundo Alvaredo et al., *The Database*, THE WORLD TOP INCOMES DATABASE, http://topincomes.gmond.parisschool ofeconomics.eu/ (last visited Feb. 22, 2012) (accessed by selecting the "The Database" link and then selecting the corresponding country and years). Census data for the Gini coefficient (which is negatively related with the degree of equality) has steadily increased since 1967 when records began. In 2012 (and 2011) the Gini coefficient was 0.477 – roughly equal to the Gini measure of inequality for Singapore, Kenya, and the Dominican Republic. *See Historical Income Tables: Households* tbl.H-4, U.S. CENSUS BUREAU, http://www.census.

economic and financial leaders to be the principal barrier to economic growth.[2] However, the disparity of wealth and income do not alone convey the deepening stratification of American society. An equally important dimension of well-being is access to time at the end of a person's working life. We identify "retirement time" as a resource that employees consume after permanently exiting the labor market. Retirement time is simply the time between retiring and dying: the difference between the age at death and the age at the start of retirement. Upper income individuals live longer than lower income workers and the longevity gap has grown wider by socio-economic status (SES) over time.[3] We expect the growing inequality of longevity due to SES, coupled with the increasing effort that lower-income older people are making to stay in the labor force, will cause retirement time to become more unequally distributed between SES groups. A growing time-inequality should be avoided because retirement time is one of the only areas where the nation has made significant progress achieving equality among working people.[4]

On average, Americans over age sixty-five are living longer, but longevity gains are unequally distributed between people of different races, between men and women, and among those of different socio-economic status.[5] For example, white men's longevity at age seventy-five increased 25% between 1980 and 2000, whereas black men's increase in life expectancy at age seventy-five grew by 22.9% over the same time period.[6]

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gov/hhes/www/income/data/historical/household/ (follow "Table H-4" hyperlink) (last visited Feb. 17, 2014).

[2] *See* Larry Elliot, *Income Gap Poses Biggest Threat to Global Community, Warns WEF*, THE GUARDIAN, Jan. 16, 2014, *available at* http://www.the guardian .com/business/2014/jan/16/income-gap-biggest-risk-global-community-world-economic-forum.

[3] That is, not only has income and wealth grown wider, so too has the gap in longevity. *See* Julian P. Cristia, *Rising Mortality and Life Expectancy Differentials by Lifetime Earnings in the United States*, (Inter-American Dev. Bank, Working Paper No. 665, 2009); Elizabeth Arias, *United States Life Tables, 2007*, U.S. DEP'T OF HEALTH & HUMAN STATISTICS NAT'L VITAL STAT. REP., Sept. 28, 2011, at 48.

[4] *See infra* App. A.

[5] NAT'L INST. ON AGING, U.S. DEP'T OF HEALTH & HUMAN SERVS., NIH PUBL'N NO. 07-5757, GROWING OLDER IN AMERICA: THE HEALTH & RET. STUDY 20 (2007).

[6] Number of years expected to live from age seventy-five onwards is 10.1 and 12.5 years respectively for white males and females, and 11.7 and 14.1 years respectively for black males and females. *See infra* App. A.

But small differences in rates of change compound over time. The white/black gap in age seventy-five life expectancy in 2010 was only nine months. If trends continue however, in twenty years the difference will be over one year and three months. Though longevity is on track to become more unequal, analysis of the Health and Retirement Survey (HRS)[7] demonstrates that retirement time is still remarkably equal among the last generation of workers – our current retirees – primarily because lower income people tend to retire earlier.

While retirement time had been an equalizing asset between members of different income classes,[8] there is nascent evidence that the distribution of retirement time may become more unequal.[9] Income, of course, is not the only factor driving the distribution of retirement time. Not surprisingly, healthier individuals consume more retirement time because they live longer.[9] Further, although it was not expected, men have more retirement time than women who have retired.[10] Also unexpected is that since lower income workers retire earlier than higher income workers, the lower income groups have, on average, more retirement time.[11] However, these results are reversed among middle class elderly persons (i.e., among the group excluding retirees in the top 20% and bottom 20% of the income distribution).[12] When focusing on the middle 60% of the distribution, there is evidence that retirement time inequality may be on the rise.[13]

Retirement time inequality will also likely increase as a result of the continuing weakness of the U.S. labor market as older workers (especially those with less income) work, or search for work, later into life than previous cohorts. We also expect, as the panel grows larger, the bias in the data set (containing a disproportionate share of people who die earlier than normal) will dissipate. The HRS panel data has only a small

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[7] *See infra* note 41.

[8] Although SES is the key conceptual division, we will avoid the complications of defining precise SES criteria and instead focus simply on full-time labor market income as a rough proxy for SES.

[9] *See* NAT'L INST. ON AGING, NIH PUBL'N NO. 07-5757, *supra* note 5, at 56-60.

[9] *Id.* at 40.

[10] *Id.* at 22, 35, 40.

[11] *Id.* at 51-65.

[12] *Id.*

[13] NAT'L INST. ON AGING, NIH PUBL'N NO. 07-5757, *supra* note 5, at 51-65.

number of respondents who have died after living an average life span,[14] which means the sample is not perfectly representative of the population. However, the large sample currently available is representative in some key dimensions, such as health status. Despite the limitations in the data, we find support for the hypothesis that the distribution of retirement time remains relatively equal because upper-middle class income men work longer and retire at older ages. However, there is nascent evidence that this equity is eroding.

Retirement time inequality should inform policies concerning the appropriate "normal retirement age" in Social Security, Medicare, and other old age programs. If benefits are cut by raising the age participants can collect full benefits, then lower income workers will likely work later into life, eroding their retirement time relative to wealthier and/or healthier individuals. To date, the nation's old age programs are among the few mechanisms that mitigate the impacts of deepening inequality of wealth, income, opportunity and mortality in the United States.

II.   RETIREMENT IN AMERICA – BACKGROUND AND
       RECENT FINDINGS

Since the 1950s, the labor force participation of men over age fifty declined across all income groups as the expansion of Social Security made retirement income more equally distributed than preretirement income.[15] Defined benefit (DB) pension plans were more prevalent in jobs that were physically taxing, so those with lower than average longevity were able to retire sooner.[16] This recent success in achieving some equity in retirement time stems from the design of the American retirement and disability income system, which has its roots in social systems developed for state and municipal employees at the turn of the last century.[17] These systems were extended to most private sector workers with the adoption of Social

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[14] *Id.*

[15] Edward N. Wolff, *Pensions in the 2000s: The Lost Decade?* (Nat'l Bureau of Econ. Research, Working Paper No. 16991, 2011), *available at* http://www.nber .org/papers/w16991.

[16] NAT'L INST. ON AGING, NIH PUBL'N NO. 07-5757, *supra* note 5, at 51.

[17] *See* ROBERT L. CLARK ET AL., A HISTORY OF PUBLIC SECTOR PENSIONS IN THE UNITED STATES 1, 167-71 (2003).

Security in 1935.[18] More workers were able to retire when Social Security old age benefits and disability programs expanded significantly from the 1950s through to the 1970s.[19] This came with the coincident growth of unions and employer-based DB pension plans in the 1940s and continuing until the 1970s.[20] Further, Medicare was established in 1965, providing universal health insurance for those over age sixty-five, which significantly improved the health and longevity of the aged.[21] As a result of these changes, workers in all socioeconomic groups were able to control some of their own leisure time before they died.

In 2008, Teresa Ghilarducci was the first scholar to measure the distribution of retirement time, finding that the distribution of retirement time was strikingly equal for people who died before age sixty-five.[22] Relying on the 2006 HRS sample, Ghilarducci found that the top income-earning quintile of retirees between ages fifty and sixty-five had approximately the same share of retirement time as the other four quintiles in the same age range.[23] The analysis added together retirement times of these retirees before age sixty-five and then found each quintile's relative share of the total sum of retirement time.[24] The top quintile accounted for their proportionate share of retirement time consumed before the age of sixty-five. Specifically, retired men in the top 20% of the asset distribution – those with assets worth over $271,000 – had 5.57 years of retirement time before the age of sixty-five and accounted for 22% of the total amount of retirement time.[25] Men in the bottom 20% – those with an average debt of $6,000 – accounted for 18% of the total retirement time before the age of sixty-five.[26] Furthermore, Ghilarducci noted that although the top 20% of the men had 85% of all the wealth and the poorest 20% were in debt, the distribution of retirement time before age sixty-five was almost equal.[27] For

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[18] *See* Patricia P. Martin & David A. Weaver, *Social Security: A Program & Policy History*, 66 SOC. SEC. BULL. 1, 1-3 (2005).

[19] *Id.* at 1, 7-9.

[20] *Id.*

[21] *Id.* at 8.

[22] *See* TERESA GHILARDUCCI, WHEN I'M SIXTY-FOUR: THE PLOT AGAINST PENSIONS AND THE PLAN TO SAVE THEM 200-01 (2008).

[23] *Id.*

[24] *Id.* at 200.

[25] *Id.*

[26] *Id.* at 201.

[27] Ghilarducci, *supra* note 22, at 201.

women the distribution of pre-sixty-five retirement time was also equal.[28] The top and bottom fifths of women accounted for the same share of retirement time – 22.6% for the top and 22.7% for the bottom.[29]

Furthermore, Ghilarducci found that women and men, blacks and whites, high and low income, have approximately the same amount of retirement time prior to age sixty-five.[30] She argued retirement time is distributed relatively equally because in the United States the "retirement date" is flexible.[31] Many defined benefit plans allow pension collection before age sixty-two, when workers become eligible for early Social Security benefits.[32] Similarly, Social Security and workplace disability pensions are available before age sixty-two for eligible workers (albeit at the cost of reduced benefits).[33] In some pension plans, American workers can start collecting a defined benefit pension as early as age fifty.[34]

Because age discrimination is illegal in the United States,[35] many older workers are able to stay in the labor market beyond age sixty-five.[36] Since professionals are likely to work later into life than blue-collar workers,[37] a retirement system can be more balanced and fair even in the face of longevity differences among social economic classes. In fact, pension systems that allow and encourage people who die sooner than average to retire sooner than average – Social Security and DB pensions have these features[38] – are potentially very progressive. If people who die earlier also retire at younger ages they could conceivably have the same amount of retirement time as higher-income people who live longer. In contrast, 401(k)-type pensions (defined contribution (DC) pensions) accumulate significantly as a person ages and pays out lump sums so that retiring earlier is often difficult for lower income individuals.[39] Finally, people without employer-based pensions or independent assets would need to work longer, as they can rely only on Social Security benefits. Workers

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[28] *Id.*

[29] *Id*.

[30] *Id.* at 214.

[31] *Id.* at 215.

[32] NAT'L INST. ON AGING, NIH PUBL'N NO. 07-5757, *supra* note 5, at 57-62.

[33] *Id.* at 62.

[34] *Id.*

[35] 29 U.S.C. § 623 (2008).

[36] *Id.*

[37] NAT'L INST. ON AGING, NIH PUBL'N NO. 07-5757 *supra* note 5, at 43-44.

[38] *Id.* at 51.

[39] *Id.*

in such situations are predominantly low-income earners with shorter life spans. As DC plans replace traditional DB pensions and as coverage by any employer based retirement plan has stagnated,[40] one of the key equalizing mechanisms of the American retirement system will be lost.

III.   HRS DATA ON RETIREMENT TIME DISTRIBUTION AND METHODOLOGY[41]

HRS is administered by the University of Michigan every two years as a series of in-depth interviews with people age fifty and over.[42] The first cohort began in 1992 and included more than 10,000 respondents.[43] The latest available survey is data from 2010.[44] Our sample comes from each of the ten surveys. Every sixth year (or third survey), the HRS adds approximately 5,000 new participants in order to maintain a sample.[45] The panel nature of the HRS data is essential to determining individuals' time spent in retirement since we need to know the year and month of both retirement and of death. The key variable, retirement time, is measured as the difference between the respondent's year of death and year of retirement, plus the numeric difference between her or his month of death and the month of retirement where months are coded sequentially, with January equal to one and December equal to twelve.[46]

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[40] Craig Copeland, *Employment-Based Retirement Plan Participation: Geographic Differences and Trends*, 2011, 378 EMP. BEN. RES. INST. ISSUE BRIEF 1, 26, 36 (2012), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB _11-2012_No378_RetParticip.pdf.

[41] *Health and Retirement Study*, U. MICHIGAN, http://hrsonline.isr.umich.edu/ (last visited Mar. 19, 2014).

[42] *Id.*

[43] *Id.*

[44] *Id.*

[45] *Id.*; *Sample Sizes and Response Rates*, U. MICHIGAN, http://hrsonline.isr.umich.edu/sitedocs/sampleresponse.pdf (last visited Mar. 19, 2014).

[46] This coding pattern assumes that reported dates occur at the end of the reported month. Alternatively, one could code months as January = 0, February = 1, … December = 11. The reported result would not differ.

$Retirement\ Time$

$$= \left[Death\ Year + \frac{Death\ Month}{12} \right]$$
$$- \left[Retirement\ Year + \frac{Retirement\ Month}{12} \right] \quad (1)$$

Defining the start of retirement can be difficult since many people continue to work, volunteer, or do other activities after they leave a long-term career. Judging what is or is not retirement from work is difficult. We use HRS respondents' own declaration of whether or not they are retired. Specifically, the survey asks respondents if they are retired, disabled or working, and the date of their retirement.[47] However, if an individual reports she is retired in 1994, working in 1996, and then retired again in 1998, equation (1) uses her most recent statement of retirement year and retirement month (i.e., whatever year and month she states in the 1998 survey wave).

To calculate retirement and death ages, we use a similar formula as (1). We calculate individuals' age of retirement based on their latest answer to their year/month of retirement by subtracting the respondent's year and month of birth.

$Retirement\ Age$

$$= \left[Retirement\ Year + \frac{Retirement\ Month}{12} \right]$$
$$- \left[Birth\ Year + \frac{Birth\ Month}{12} \right] \quad (2)$$

Finally we compute age at death with a similar subtraction:

$Death\ Age$

$$= \left[Death\ Year + \frac{Death\ Month}{12} \right]$$
$$- \left[Birth\ Year + \frac{Birth\ Month}{12} \right] \quad (3)$$

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[47] *Health and Retirement Study*, *supra* note 41; *2010 Questionnaire*, U. MICHIGAN, http://hrsonline.isr.umich.edu/modules/meta/2010/core/qnaire/ online /10hr10JCore.pdf (last visited Mar. 19, 2014).

Once these core values are computed, we restrict the data set to respondents who report at least one instance of full-time labor market income.[48] In addition to dividing the sample of 12,033 respondents by their labor market status, this restriction ensures that we analyze the retirement patterns of workers. Since workers report labor market income in various years, we adjust all values to 2008 dollars according to the Census Bureau's consumer price index (CPI) for the appropriate year.[49] After adjusting for inflation, we calculate each respondent's mean full-time income. Thus, if a respondent reports full-time income in only one survey year, this amount is his average real income; if a respondent reports full-time income in three separate surveys her average real income is one-third of the sum of the adjusted values.

The sample sizes for retirement time, retirement age and death age are different because more respondents (5,557) consider themselves retired (and provide the interviewer with a valid retirement year and month) than have died. Since the first HRS wave was in 1992, and the latest available data is from 2010, the youngest respondent would be fifty years old (the age one enters the HRS) plus eighteen years, or sixty-eight years old. This limitation leads to a much smaller number of observed death ages (1,418) since these individuals must have reported at least one year of full-time labor market income before retiring and dying. However, since many respondents may have worked and died without ever retiring, the number of those with a retirement time is about half of those with a death age.[50]

A. DOWNWARD LONGEVITY BIAS

Because the survey is only eighteen years old, the majority of respondents are still alive. Due to this, we cannot know living retirees' total retirement time, which creates a bias in our data set because less than 12% (1,418/12,033 = 11.7%) of the eligible sample are deceased. Among

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[48] We define full-time labor market attachment as respondents who described the "usual" working time as at least thirty-five hours per week and "usual" work frequency as forty weeks per year.

[49] *See* Minn. Population Ctr., Univ. of Minn., *Note on Adjusting Dollar Amount Variables for Inflation (CPI-U)*, IPUMS-CPS, https://cps.ipums.org/cps/intro.shtml (last visited Feb. 12, 2014) ("The IPUMS variable CPI99 provides an easy way to adjust dollar amounts to constant dollars").

[50] An individual could also have no measured retirement time because not all the necessary data points (year of death, month of death, year of retirement and month of retirement) were recorded, so retirement time was not computed.

the deceased, only half (725/1,418 = 51.3%) have a corresponding retirement date by which retirement time can be calculated. The resulting problem is a downward bias in longevity as shown by the low mean death age of 67.9 in our sample. Therefore, the results reported here must be recognized as representing an unfortunate (early death) subgroup of the population. Key variables are summarized in Table 1.

Table 1: Sample Summary for HRS Respondents with Some Full-Time Income

	Observations	Mean Value	Standard Deviation
Total Number of Respondents	12,033		
Death Age	1,418	67.86	7.57
Retirement Age	5,557	62.10	5.57
Retirement Time	725	8.71	5.68
Average Real Income (Full-Time)	12,033	$51,173	$58,550

Employing different techniques or restrictions to correct for the downward bias in death age, however, does not alter the central results of our analysis. One method is restricting the sample to respondents aged sixty or older when they first entered the HRS. To partially mitigate the large reduction in sample size of this approach we drop the *full-time* restriction on labor market income. These two changes generate a sample of approximately 3,100 – about one-quarter the size of our chosen sample. The benefit of this smaller sample is that the downward longevity bias is largely removed as the average age of death increases from 67.9 to 77.4, which is comparable to this generation's expected longevity.[51] However, not only does this approach require an arbitrary age cut off, but the inclusion of part-time income greatly skews the *average real income*

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[51] The current longevity estimate for those born in the 1930s is 83.8 years. *See generally* Arias, *supra* note 3, at 48.

variable downward.[52] Therefore, correcting for one skew in the sample's distribution introduces another, but at the additional cost of many lost observations.

Yet, in spite of these imposed restrictions, the overall results did not substantially change: men still had more retirement time than women, working men retired earlier than working women, and having a pension continues to appear to have little impact on retirement time. Moreover, retirement time in the restricted sample is still negatively related to income overall, but it is positively correlated among the middle 60% of the distribution. Therefore, given the larger, non-arbitrary and more robust results of the sample presented in Table 1, as well as the importance of full-time labor market income to proxy socio-economic status, we proceed with the analysis acknowledging the downward longevity bias and eagerly await more waves of the HRS.

B.   RETIREMENT DISTRIBUTION BY DEMOGRAPHIC AND ECONOMIC CATEGORIES

In our sample, 725 people retired and died with an average retirement time of 8.7 years. This group retired at ages 4.5 months (0.38 of a year) older than the average of all the 5,557 retirees. Table 2 displays retirement age, death age and retirement time by sex, race, pension coverage, and health status. The subgroup sizes are listed below the mean value. The last column reports the retirement age of those who died, which are the individuals for whom we calculate their retirement time.

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[52] Approximately one-third of this sample of persons aged sixty or older had an annual labor market income of under $4,500 since, in this case, labor market income is not restricted to full-time workers.

Table 2: Retired, Deceased and Retirement Time Averages by Demographics

Subgroups	Retirement Age	Death Age	Retirement Time	Retirement Age (Deceased)
All	62.10	67.86	8.715	62.48
	5,557	1,418	725	
Women	62.05	66.86	8.46	62.75
	2,535	475	216	
Men	62.14	68.37	8.823	62.37
	3,022	943	509	
Nonwhite	61.6	66.61	9.111	61.02
	1,002	285	141	
White	62.2	68.18	8.619	62.83
	4,555	1,133	584	
No Pension in 1992	63.21	68.2	8.325	63.38
	986	342	173	
Has Pension in 1992	62.05	67.93	8.431	61.74
	2,755	627	393	
Health: Good to Poor	62.02	67.30	8.454	62.44
	2,319	800	397	
Health: Excellent to Very Good	62.15	68.59	9.03	62.52
	3,238	618	328	

Although men and women retire at roughly the same age (62.14 and 62.05, respectively), the 509 retired men who died had over four extra months of retirement time than did the 216 deceased women (8.82 versus 8.46, respectively) because the men lived longer than the women who retired. Also surprising, the non-white workers have half a year more of retirement time than white workers (9.11 versus 8.62) because they retired earlier, at age 61.6 compared to 62.2. Since the number of observations differs for each variable, Table 2 lists the subgroup sizes below each group's mean value. The last column reports the retirement age of those who have died, which are the individuals for whom we calculate retirement time.

The difference in retirement age and death age between those with and without pensions was not significant. Those without pensions had, on average, 8.32 years of retirement time compared to 8.43 years for those with access to pensions – a difference of about five weeks. [53] Not surprisingly those with self-described 'excellent' or 'very good' health had a mean 9.03 years in retirement time, whereas those with 'good', 'fair' or 'poor' health had only 8.45 years of retirement time on average.[54] Since the healthy and less healthy have approximately the same retirement age (62.52 and 62.44, respectively), the difference in retirement time comes entirely from the healthier group's longer-than-average lifespan (68.59 versus 67.30).

Now that we have presented differences by race, sex and health, we examine two income categories:

(i)   Respondents with income above and below the median full-time labor market income $40,000, and;

(ii)   Respondents groups by full-time average real income quintiles.[55]

The bottom 50% of income earners had an average retirement time of 9 years, which is significantly greater than the top half's retirement time of 8.3 years, or 8.4 months more retirement time enjoyed by the lower income half of retired workers, as can be seen in Table 3. Table 3 shows that this negative relation between income and retirement time is driven, to a significant extent, by the top and bottom quintiles which have an average of 7.4 and 10.2 years of retirement, respectively. These extreme differences are not apparent between the second, third and fourth quintiles, which have retirement times of 8.4, 8.2 and 8.9 years, respectively. These stark differences in retirement time are discussed further below, but first we

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[53] Although restricting this part to individuals in the 1992 HRS reduces our potential sample size, for these rows, only a very few individuals not in the 1992 wave have pensions in later waves *and* have a valid retirement time. Thus, the substantive results are not affected by this restriction.

[54] The HRS question regarding personal health status is asked of each respondent in each wave. We have relied on an individual's first reported personal health status – making it perhaps even more surprising that there is such a large division between the self-assessed healthy and unhealthy. We collapse the HRS's five categories into a binary one for ease of analysis.

[55] The minimum average annual incomes to be included in each quintile are $0, $21,906.64, $33,362.48, $47,328.59 and $69,543.62.

consider the distribution of retirement time among income groups of men and women separately.

Table 3: Retired, Deceased and Retirement Time Averages by Income Groups

Subgroups	Retirement Age	Death Age	Retirement Time	Retirement Age (Deceased)
Lower Half of Incomes	62.55	68.27	9.04	62.86
	2,668	776	384	
Upper Half of Incomes	61.67	67.37	8.348	62.05
	2,889	642	341	
Bottom 20%	62.4	69.04	10.16	62.84
	1,065	340	164	
20-40%	62.52	68.02	8.367	63.22
	1,070	293	145	
40-60%	62.61	67.21	8.229	62.68
	1,106	297	152	
60-80%	61.32	67.41	8.934	61.36
	1,235	279	153	
Top 20%	61.74	67.27	7.393	62.25
	1,081	209	111	

We find lower-income women and men retire at approximately the same age, 62.50 and 62.63, respectively. While there is a larger gap (approximately seven months) between the retirement ages of higher-income women (61.27) and men (61.87), higher earning individuals of both sexes retire at earlier ages than their lower-income counterparts, as shown in Table 4. Yet, this equality between the sexes in retirement age does not carry over into retirement time. Both upper- and lower-income women – for whom we can determine retirement time – have almost identical amounts of retirement time: 8.46 and 8.45 years, respectively.[56] However,

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[56] It must be noted that at this level of data, parsing our cell counts (i.e., the number of observations per variable type) are approaching the limit of what can be

higher income men have nearly one year less of retirement time than lower income men. The 281 higher-income males have an average of 8.33 years of retirement, whereas the 228 lower-income males have 9.43 years. Thus, in contrast to our initial expectations, among retired workers, retirement time is not positively correlated with labor market income. However, as demonstrated in Table 5, the "reverse inequality" result (i.e., the poor have more) is driven by including the richest and poorest quintiles of retired men.

Table 4: Retirement Age and Time by Sex and Income Group

Income Class	Women		Men	
	Lower Income	Upper Income	Lower Income	Upper Income
No. Retired	1,596	939	1,072	1,950
Mean Retirement Age	62.50	61.27	62.63	61.87
Obs. Retirement Time	156	60	228	281
Mean Retirement Age if Deceased	62.86	62.46	62.86	61.96
Mean Retirement Time	8.464	8.450	9.434	8.327

Restricting the sample to the middle 60% of the income distribution yields a different income and retirement time relationship than in the full sample. Table 5 presents the same data as Table 4, but with the sample restricted to the middle 60% of the income distribution. In the middle class, the lower income women work for a longer period of time: women in the lower half of the middle class retiree distribution retire a full year later than the upper middle-income class women (62.4 years versus 61.4 years). For men, the 1.2 years gap is even larger. Lower-income, middle class men work until nearly age 63 and upper-income middle class men retire at age 61.8 years. Furthermore, the difference in retirement time is positively related to income. Men in the 50th to 80th percentile range

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considered useful. The smallest cell counts are 60 and 49, which demand one to extrapolate the results with much caution.

have about 8.8 years of retirement, and their counterparts in the 20th to 50th percentile range have less time in retirement, at an average of 8.5 years. Therefore, the negative relationship between retirement time and income class shown in Table 3 is driven entirely by the top 20% and bottom 20% of male income earners.

Table 5: Middle Income Retirees -- 60% of Distribution -- Retirement Age and Time by Gender and Income Group

Binary Income Class	Women		Men	
	Lower Income	Upper Income	Lower Income	Upper Income
No. Retired	920	716	683	1,092
Mean Retirement Age	62.42	61.41	62.98	61.78
Obs. Retirement Time	85	49	135	181
Mean Retirement Age if Deceased	62.54	62.48	63.08	61.81
Mean Retirement Time	7.727	8.825	8.503	8.805

We conclude that the anomalous results of retirement time – that the lower income fare better – for the full sample is driven in particular by the extreme experiences of men in the top 20% and bottom 20% of the income distribution. As discussed, the top 50% and bottom 50% of females have near-identical retirement time. Yet, Table 5 reveals that this similarity evaporates for the middle 60% of women. The upper-half of middle income women have 8.8 years of retirement time, while the lower-half of middle income women have 7.7 years of retirement time. Note the observations are small – involving eighty-five and forty-nine women, respectively. Nevertheless, these observations are numerically important in calculating average retirement times (insofar as they represent a sizeable portion of the total retirement time sample). Therefore, these data for women reinforce the conclusion that it is the top and bottom quintiles of men, specifically, which account for the entirety of the negative relation between income and retirement time.

Next we consider the income class differences according to the health status of respondents. [57] When the bottom and top quintiles are included, lower-income individuals, regardless of health, garner more retirement time than their higher-income counterparts (8.7 versus 8.1 for poorer health individuals; 9.4 versus 8.6 for healthier individuals) even though lower income individuals retire later – at ages 62.4 for the less healthy and 62.7 for the healthier – than the higher income individuals, at ages 61.5 and 61.7, respectively. Note that the retirement time benefit from being healthy is larger for of the lower half of retirees (0.72 years) than wealthier retirees (0.52 years). Overall we confirm, in Table 6, that health status is a key driver of retirement time: healthier individuals, regardless of income, enjoy more time in retirement than their unhealthy counterparts.

Table 6: Retirement Age and Time by Health Status and Income Group in the Full Sample

Health	Good, Fair, Poor		Excellent, Very good	
Income Class	**Lower Income**	**Upper Income**	**Lower Income**	**Upper Income**
No. Retired	1,298	1,021	1,370	1,868
Mean Retirement Age	62.42	61.51	62.68	61.76
Obs. Retirement Time	222	175	162	166
Mean Retirement Age if Deceased	62.78	62.02	62.97	62.09
Mean Retirement Time	8.736	8.095	9.456	8.615

Excluding the extreme 20% at the top and bottom of the income distribution, we see, in Table 7, that healthy and/or wealthy individuals share approximately equal retirement times. Among the lower-income middle class, healthier retirees have nearly a full year more of retirement

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[57] The cross tabulation of retirement time by income class and race does not provide further insights beyond what has been discussed above: nonwhites have more retirement time than whites, and in both cases, the relation is negatively associated with income class for the full sample and positively associated with the restricted, middle 60% sample. More importantly, we do not include these results here because the cell counts for nonwhites becomes unjustifiably small in both cases.

time (8.7 years) than the less healthy lower-income middle class (7.8 years). However, the retirement time differential among the upper-income middle class is insignificant at a mere 0.09 years (although this happens to be in favor of the less healthy). Moreover, these retirement time figures for the upper half of income earners are nearly equal to that of the healthy but poor segment of the middle class. Thus, among the middle 60% of the distribution, it is only the unhealthy, lower middle class that is at a significant disadvantage in obtaining retirement time.

Table 7: Retirement Age and Time by Health Status and Income Group Middle 60% of Distribution

Health	Good, Fair or Poor		Excellent/Very good	
Income Class	**Lower Half**	**Upper Half**	**Lower Half**	**Upper Half**
No. Retired	754	704	849	1,104
Mean Retirement Age	62.47	61.66	62.82	61.62
Obs. Retirement Time	124	122	96	108
Mean Retirement Age if Deceased	62.56	61.61	63.28	62.34
Mean Retirement Time	7.79	8.85	8.74	8.76

Before moving to the regression analysis, we provide a brief explanation of the observed biasness of our sample. If an individual entered the HRS in the first survey wave in 1992, they would have been followed for eighteen years (1992 through 2010). Many individuals have simply not been a part of the survey long enough to have died. Those who have died, and for whom we calculate a retirement time, are those from groups with lower-than-average life expectancy. Since it is well documented that longevity is positively correlated with income, the people who died are more likely to be lower income workers. Moreover, since longevity is normally distributed, the HRS data captures a disproportionate share of lower-income individuals' left tail of their death age distribution, relative to the death age distribution of higher income individuals. That is, because the average death age of wealthier individuals is higher, we observed a smaller segment of this distribution's left tail.

This assessment is borne out in the data present in Tables 8 and 9. The middle three quintiles have roughly equivalent rates of death (12.1%, 12.3% and 11.6%), whereas 14.13% of the bottom 20% of the income distribution died compared to a mere 8.69% of the top 20%. Further, far more men (15.2%), than women (8.14%) have died. The sex disparity, in fact, is larger than the difference between the very healthy individuals who died (8.9%) and the proportion of deceased people with worse health (15.6%) as seen in Table 8. Each of the large differences – between women and men, health status and the top and bottom 20% of the income distribution – are associated with unexpected outcomes in the distribution of retirement time. These rates of death support our focus on the middle 60% of the income distribution. Moreover, given the near-equal death rates among the middle three quintiles, this middle class is likely more representative of the true population. In other words, the middle class subset is a reasonable representation of retirement times.

Table 8: Number and Proportion of Deceased Individuals, Plus Death Age, Retirement Age and Time in the Full Sample

		Proportion Dead	Deceased Individuals with a Retirement Time Value			
			No. Deceased	Mean Death Age	Mean Retirement Age	Mean Retirement Time
Gender	Women	8.14%	216	71.21	62.75	8.460
	Men	15.22%	509	71.19	62.37	8.823
Health Status	Good - Poor	15.63%	397	70.90	62.44	8.454
	Excellent - Very Good	8.94%	328	71.56	62.52	9.030
Income Group	Lower Half	12.89%	384	71.90	62.86	9.040
	Upper Half	10.67%	341	70.40	62.05	8.348
Income Quintile	Bottom 20%	14.13%	164	73.00	62.84	10.160
	20-40%	12.17%	145	71.58	63.22	8.367
	40-60%	12.35%	152	70.91	62.68	8.229
	60-80%	11.59%	153	70.30	61.36	8.934
	Top 20%	8.69%	111	69.64	62.25	7.393

However, the final two rows of Table 9 show that the lower death rate variation among the middle class does not hold across gender and health categories. The proportion of deceased men (16.5%) is still far greater than that of women (7.7%), as is the proportion of the deceased who reported poorer health (16.0%) over those who reported being healthy (9.1%). As a result, we are unable to entirely eliminate all biasness in health and gender dimensions, even though we have eliminated the bias for income groups. Therefore, in the regression analysis, we look at both the full sample and the middle 60% subsample to provide some early insights into the state of retirement in America.

Table 9: Number and Proportion of Deceased Individuals, Plus Death Age, Retirement Age and Time in the Middle Class (Middle Three Quintiles)

		Proportion Dead	Deceased Individuals with a Time Value			Retirement
			No. Deceased	Mean Death Age	Mean Retirement Age	Mean Retirement Time
Gender	Women	7.66%	134	70.65	62.52	8.129
	Men	16.52%	316	71.03	62.36	8.676
Health Status	Good - Poor	16.00%	246	70.41	62.09	8.314
	Excellent - Very Good	9.08%	204	71.53	62.78	8.753
Income Group	Lower Half	12.07%	220	71.08	62.87	8.203
	Upper Half	12.00%	230	70.77	61.96	8.809

D. REGRESSION ANALYSIS

Using an ordinary least squares regression on the full sample, we find higher income reduces retirement time, retirement age, and death age. In fact, average full-time labor market income is the only significant variable in each of the three regressions. Note income and retirement age are negatively correlated: higher income people work longer. That higher income individuals remain longer in the workforce explains much of the anomalous results that higher income workers have less retirement time.

After controlling for income and health, men still have more retirement time than women, but the difference is not statistically

significant. Healthier individuals, after controlling for sex and income, die 1.36 years later and the result is highly significant (p-value = 0). The age of death, seen in the final column of Table 10, is negatively correlated with income. Thus, as expected from the cross tabulations, the top 20% of this sample tend to retire older and die a bit sooner.

Table 10: Retirement Time, Age and Death Age by Income, Gender and Health Status

Full Sample	(1)	(2)	(3)
VARIABLES	*Retirement Time*	*Retirement Age*	*Death Age*
Average Full-time Labor Market Income (Thousands of 2008 $)	-0.0116** (0.00471)	-0.00333** (0.00157)	-0.0109** (0.00488)
Gender (Male = 1; Female = 0)	0.577 (0.468)	0.167 (0.154)	1.721*** (0.433)
Health Status (Excellent/ V. Good = 1; Good to Poor = 0)	0.604 (0.422)	0.168 (0.153)	1.358*** (0.403)
Constant	8.576*** (0.455)	62.07*** (0.151)	66.62*** (0.412)
Observations	725	5,557	1,418
R-squared	0.012	0.001	0.019

Notes: **OLS coefficients with standard errors in parentheses**
*** p<0.01, ** p<0.05, * p<0.1

Working past age sixty-five is correlated with higher income and earlier death in the full sample, but not for the middle class sample, represented in Table 11. Labor market income is now associated with more retirement time, which confirms the findings from the simple cross tabulations. For the middle class, every $10,000 of labor market income increases retirement time by 0.139 years (approximately 6 weeks). Unfortunately, with the reduced sample size, from 725 observations in the full sample in Table 10, to 450 in middle class sample in Table 11, the

coefficient on retirement time is not statistically significant. Nevertheless, the negative relationship between retirement age and labor market income is significant in this sub-sample regression. Therefore, although this second regression loses some of its explanatory power compared to the full sample regression, it supports the hypothesis that, for now, the U.S. retirement system enables lower income individuals to obtain retirement time on an equal basis by enabling them to overcome their shorter life expectancy through earlier retirement.

Table 11: Retirement Time, Age and Death Age by Income, Gender and Health Status

Middle 60% VARIABLES	(1) *Retirement Time*	(2) *Retirement Age*	(3) *Death Age*
Average Full-time Labor Market Income (Thousands of 2008 $)	0.0139 (0.0184)	-0.0464*** (0.00692)	-0.0344* (0.0192)
Gender (Male = 1; Female = 0)	0.497 (0.521)	0.522*** (0.180)	1.488*** (0.529)
Health Status (Excellent/ V. Good = 1; Good to Poor = 0)	0.441 (0.471)	0.197 (0.179)	1.519*** (0.491)
Constant	7.382*** (0.846)	63.70*** (0.312)	67.31*** (0.857)
Observations	450	3,411	869
R-squared	0.006	0.014	0.020

Notes: **OLS coefficients with standard errors in parentheses**
*** p<0.01, ** p<0.05, * p<0.1

IV.   INCOME INEQUALITY AMONG OLDER WORKERS IS
       GETTING WORSE[58]

Finding that the U.S. retirement system equalizes retirement time is in sharp contrast to the growing inequality of income over the past two decades. Using the same data set, we find the income distribution for full-time workers and their households has become more unequal. In 1992, looking at Table 12, the mean full-time labor market income of middle-income earners (i.e., those in the third quintile – the 40th to 60th percentile) was 31.7% of the average full-time labor market income of those in the top quintile.[59] By 2010, the middle quintile of workers' average income was only a quarter (25.3%) of the average income of the top 20%. The disparities in median incomes also grew. In 1992, the middle-quintile's median income was 40.7% of that in the top quintile; by 2010, the median middle-income individual had only one-third (33.3%) of the top 20%'s median income.

Table 12:   Ratio of Third Quintile (40-60%) to Fifth Quintile (80-100%) of Full-time Labor Market Income

Year of HRS Sample	Quintile's Mean Income	Quintile's Median Income
1992	31.7%	40.7%
1994	31.5%	41.8%
1996	32.1%	40.8%
1998	28.2%	35.9%
2000	29.8%	37.3%
2002	27.9%	33.3%
2004	27.3%	34.7%
2006	26.4%	35.0%
2008	26.8%	34.5%
2010	25.3%	33.3%

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[58] *See* NAT'L INST. ON AGING, NIH PUBL'N NO. 07-5757, *supra* note 5, at 57.

[59] Note that these figures for the distribution of full-time income come from the entire full-time workers sample in the HRS and thus are not subject to the sample bias that exists when restricting the sample retirees or the deceased.

V.   RETIREMENT TIME EQUALITY AND THE IMPLICATIONS
          FOR RETIREMENT AGE POLICIES

This study aimed to uncover retirement trends hidden by averages. That the average American man is retiring earlier and living longer hides the potential erosion in a major social accomplishment: Social Security, Medicare, and pension programs allow rich, middle class, and low income workers alike to retire before they die.

The lowest income groups in this sample are retiring early, while others in the middle class are working longer and not enjoying as rapid improvements in longevity. This means retirement time could grow more unequal by social economic class if the age at which Social Security beneficiaries collect full Social Security benefits is raised. It is a mistake to assume that the facts that Americans are living longer and that Americans are retiring earlier are not connected. Retirement improves health, especially for men, so if people work longer, longevity improvements could decrease and access to retirement time could decrease as well.[60] Reforming policies regarding one aspect of aging (e.g., retirement time) because of changes in the average of another (e.g., death age) is, therefore, ill advised.

It is well documented that the average American's life expectancy has increased markedly since World War II.[61] The average American born in 1950 lived to 68 years old.[62] By 1980, life expectancy at birth had increased to 73.9 years and to then nearly 78 years by 2007.[63] These remarkable increases hide a growing disparity of life expectancies among different socio-economic groups. Longevity has not improved equally for all Americans. Life expectancy for those in the top half of the income distribution has improved much more than for those in the bottom half.[64] Stunningly, this increasing inequality of outcomes has occurred with remarkable speed. For example, the Inter-American Development Bank

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[60] *See* Kevin Neuman, *Quit Your Job and Get Healthier? The Effect of Retirement on Health*, 29 J. LAB. RES., 177–201 (2008).

[61] *Life Expectancy at Birth by Race and Sex, 1930-2010*, NAT'L CTR. FOR HEALTH STATISTICS, *available at* http://www.infoplease.com/ipa/A0005148.html.

[62] *Id.*

[63] Arias, s*upra* note 3, at 48.

[64] *See* Cristia, *supra* note 3.

estimates that from the 1983-1997 period to the 1998-2003 period,[65] The differences in life expectancy between the highest 20% and lowest earning 20% of Americans (for those ages 35-76) grew from 0.7 to 1.5 years among women, and from 2.7 years to 3.6 years among men.[66]

To explain the growing disparities in longevity, other studies have sought to isolate a broader range of socio-economic variables. Education is a driving force behind longevity and mortality differentials.[67] Waldron, an economist, finds income is the driving force, though she did not have data on education.[68] Specifically, differentials in life expectancy among race-sex groups (at age twenty-five) remained constant from 1990 to 2000, but that differences significantly increase between high- and low-education groups.[69] Lower-educated women (both white and black) had a statistically significant lower average life expectancy in 2000, compared to better-educated women than they did in 1990.[70]

What are the implications for retirement policy? The evidence suggests that raising the retirement age and implementing other policies that encourage longer working lives may actually reverse longevity gains, so that higher labor incomes may result in a decrease in retirement time. Raising the normal retirement age in Social Security, which is equivalent to cutting benefits for workers, will reduce income for any person in a group that tends to leave the labor force early to compensate for a lower life expectancy. Higher income people also obtain more years of life, but the inequality of life expectancy can be counterbalanced by a well-designed pension system that allows lower income and lower educated workers to collect pensions or disability benefits earlier than higher income and higher educated individuals. On the other hand, pension systems that encourage lower-income, lower-educated people to work longer will create unequal distributions of retirement time.

In sum, sex and health are important factors in predicting who will have more or less retirement time, but economic class is a key factor. If

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[65] These periods were chosen so that the sizes of the two groups considered were approximately equal.

[66] Cristia, *supra* note 3, at 20, 29-30.

[67] *See* Ellen R. Meara et al., *The Gap gets Bigger: Changes in Mortality and Life Expectancy, by Education, 1981-2000*, 27 HEALTH AFFAIRS 350 (2008).

[68] *See* Hilary Waldron, *Trends in Mortality Differentials and Life Expectancy for Male Social Security-Covered Workers by Socioeconomic Status*, 67 SOC. SEC. BULL., no. 3, 2007.

[69] *Id.*

[70] *Id.*

lower socio-economic status individuals are forced to delay retirement because private and/or public pension payments shrink, then retirement time is bound to become more unequal.

Appendix A: Longevity at various ages, by race[71]

Table A: Longevity at Various Ages from 1980-2010, by Race

	White Male	White Female	Black Male	Black Female
At birth	8.2%	4.1%	12.5%	7.6%
At 65 years	25.4%	10.3%	22.3%	14.9%
At 75 years	25.0%	11.3%	22.9%	16.8%

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[71] *See* ROBERT D. GROVE & ALICE M. HETZEL, U.S. DEP'T OF HEALTH, EDUC., & WELFARE, VITAL STATISTICS RATES IN THE UNITED STATES 1940-1960 (1968), *available at* http://www.cdc.gov/nchs/data/vsus/vsrates1940_60.pdf; ELIZABETH ARIAS, U.S. DEP'T OF HEALTH & HUMAN SERV., UNITED STATES LIFE TABLES BY HISPANIC ORIGIN (2010), *available at* http://www.cdc.gov/nchs/data/series/sr_02/sr02_152.pdf; Sherry L. Murphy, et al., *Deaths: Final Data for 2010*, U.S. DEP'T OF HEALTH & HUMAN STATISTICS NAT'L VITAL STAT. REP., May 8, 2013, at 1, 3, 18-21, *available at* http://www.cdc.gov/nchc/data/nvsr/nvsr61/nvsr61_04.pdf.

Appendix B: Definition Variables

Variable Name	Stata code	Explanation	Other Notes
Entry Age	Y_age	Age of respondent when he/she first enters the HRS survey.	Here 'age' is simply the difference between year of birth and survey year
Death Age	death_age	Difference between year/month of death and year/month of birth. Month's (1=January; 12 = December) are divided by 12 and added/subtracted from the difference in years	HRS 2010 Tracker data. HRS records year of death and then verifies with CDC mortality tables.
Retirement Age	ret_age	Difference between year/month of stated date of retirement and year/month of birth	Year and month of retirement is asked if retired `year' == 1 (see below)
Disabled Age	dis_age	Difference between year/month of stated date of when a disability (keeping one from work) began and year/month of birth	
Time in Retirement	ret_time	Difference between retirement or disabled age and death age. If respondent has both a retirement and disability age, retirement age is used.	
Retired	retired{`year'} or retired (0 = not retired; 1 = retired)	Based on the respondents labor force status (reported in each survey), he/she is considered retired only if the first/primary response is "retired". Therefore a respondent may be coded as 1 for several survey years – and may switch to and from retirement.	Each respondent with retired `year' == 1 also states a year and month of retirement. For the calculations of retirement time and age we take the mostly recently reported retirement year and month.

Individual Income	inc{`year'}	Annual income from wages, salaries and business. Positive values only.	RAND income and wealth files, 1992 through 2010. (e.g., r1iearn)
Average Real Income	avg_inc_r	Constructed by adjusting individual incomes by CPI to 2010 US dollars. Average is constructed as the mean for each individuals across the survey years they report an individual income	CPI adjustment figures are taken from IPUMS CPS (CPI99) The variable is restricted to full-time income only (35+ hr/wk; 40+ wk/yr)
Top Half / Bottom Half	avg_topbottom (0 = bottom; 1 = top)	Binary value assigned to each respondent based on whether their average real income is above or below of the median income	The median average income is the median
Income Quintile	avg_quint (1 = poorest 20%; 5 = richest 20%)	Same as Top / Bottom, but dividing individuals into 5 income groups rather than 2.	Cut off points are based on average real income
Sex/Gender	GENDER (0 = Woman; 1 = Man)		HRS 2010 Tracker data
White/Non-White	white (0 = not white; 1 = white)		HRS 2010 Tracker data
Covered by a Pension Plan, 1992	inplan1992 (1 covered by a plan; 0 = not covered)	Whether employed persons in 1992 are or are not covered by a pension plan at work that year.	
Health Status	health1 (0 = not great; 1= great)	Health status is a self-reported 5-level variable with responses: 'Poor', 'Fair', 'Good', 'Very Good' and 'Excellent'. The latter two are coded as 0, the former three are coded as 1.	Health status is asked in each survey year. health1 takes the first reported status

DESPERATE RETIREES: THE PERPLEXING CHALLENGE OF COVERING RETIREMENT HEALTH CARE COSTS IN A YOYO WORLD

RICHARD L. KAPLAN[*]

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This article explores the challenges that retirees face when it comes to selecting and paying for the proper healthcare coverage post retirement. The author examines the rising cost of healthcare as well as the complexities of Medicare plans that often make up a retiree's healthcare coverage package. The author concludes that most retirees are not prepared to pay for healthcare in their retirement years.

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I.   INTRODUCTION

That retirement formulas and templates of earlier times have little relevance to today's retirees is a vast understatement. In virtually every significant aspect of retirement planning, it is a brand new ball game, and almost every change has spawned increasing uncertainty, unpredictability, and anxiety for persons affected by these changes. To encapsulate the direction of these massive changes, I have resorted to a four-letter acronym, YOYO, which stands for You're On Your Own.[1] Quite bluntly, retirees and prospective retirees are now the locus of increasing risks relating to retirement security,[2] and the foreseeable trends suggest that this situation will only exacerbate in the future.

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[1] To be sure, there is a whole sub-industry of advice-providers seeking to assist individuals with the financial aspects of retirement. *See, e.g.,* WALL ST. J., May 13, 2013, at C7 (full-page advertisement showcasing twenty-five "best selling authors" on this topic from a single publisher).
[2] *See* Richard L. Kaplan, *Enron, Pension Policy, and Social Security Privatization*, 46 ARIZ. L. REV. 53 (2004). *See generally* EDWARD A. ZELINSKY,

Rather than try to consider all of these changes, I will explore instead just one very important, but largely neglected, component of the increasingly desperate condition in which today's retirees find themselves – namely, covering the cost of health care during their retirement. The significance of this issue is captured by the most recent Health Confidence Survey that was reported this past January.[3] An analysis of that Survey by the Employee Benefit Research Institute concluded that "[t]he percentage of Americans reporting that health expenses are an important consideration when planning for retirement has always been relatively high, and it has recently increased."[4] The survey results for the most recent three years are summarized in the following table:[5]

Percent of Respondents Citing Medical Expenses as Extremely or Very Important in Planning for Retirement			
	2010	2011	2012
Extremely Important	38	37	45
Very Important	31	33	26
Total	69	70	71

Paying for one's health care is, of course, a major issue throughout a person's life, but many people were able to ignore the fundamental necessity of securing health insurance until they retire, because their employers typically provided health insurance as part of their compensation package.[6] While the specific components of such coverage undoubtedly

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THE ORIGINS OF THE OWNERSHIP SOCIETY: HOW THE DEFINED CONTRIBUTION PARADIGM CHANGED AMERICA (2007).

[3] Paul Fronstin, *Views on Health Coverage and Retirement: Findings from the 2012 Health Confidence Survey*, EMP. BENEFITS RES. INST. NOTES, Jan. 2013 at 2, *available at* http://www.ebri.org/pdf/notespdf/EBRI_Notes_01_Jan-13_HCS-TxExps3.pdf.

[4] *Id.*

[5] *See id*. at 5, fig.3.

[6] *See* Richard L. Kaplan, *Who's Afraid of Personal Responsibility? Health Savings Accounts and the Future of American Health Care*, 36 MCGEORGE L. REV. 535, 537–40 (2005).

changed over the years, the essential availability and general contours of such coverage were generally not a major concern. Employers negotiated with health care providers or insurers, designing one or more packages of benefits that they thought their employees might want, handled much of the attendant paperwork in administering the plan, and facilitated enrollment via their payroll systems.[7] Such employer involvement, if not beneficence, basically disappears once a person retires. As a result, the financial context of health care coverage that retirees confront is fundamentally different than what they had when they were working.

The nature of this contrast can be described in overview as follows: wage earners received periodic income, increased irregularly for reasons of inflation or career advancement, with income taxes withheld from each payment,[8] along with health insurance for themselves and their dependents. Classic pension schemes based on defined benefit plans[9] self-consciously sought to mimic this basic pattern, though usually without any scheduled increases in payment amounts. That is, traditional pensions and retirement annuities provide periodic income, with income taxes withheld from each payment,[10] but no increases for inflation once they commence. But the bigger difference is that most retirees cannot look to their former employer for coverage of their health care expenses. As I have noted elsewhere,[11] retiree health benefits are provided by fewer employers every year, and the benefits that are provided are diminished regularly. Accordingly, employees who had been largely sheltered from the chore of securing coverage for unexpected health care costs must become their own human resources counselors upon retirement. They must learn how to navigate a very different health care system, one that was assembled over several decades with no coherent vision and with precious little regard to consumer friendliness.

Fidelity Investments, the major financial services provider, has estimated that a retired couple aged sixty-five years is likely to need nearly

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[7] *See id.* at 540–41; *see also* David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23 (2001).

[8] I.R.C. § 3402(a)(1) (Supp. IV 2007–2011).

[9] *See generally* LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 361–64 (5th ed. 2010).

[10] I.R.C. § 3405(a)(1) (Supp. V 2007–2012).

[11] *See generally* Richard L. Kaplan et al., *Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits*, 9 YALE J. HEALTH POL'Y L. & ETHICS 287 (2009).

a quarter of a million dollars to pay for their health care costs in retirement.[12] This estimate is necessarily an average figure, and many retirees will need substantially more funds for this essential retirement outlay. Much depends upon how long a specific individual lives, that person's health status, the nature and extent of health care that that person receives, and the rate of health care cost inflation, among other factors. A careful simulation by the Employee Benefit Research Institute determined that a sixty-five year old man would need savings of $135,000 to $185,000,[13] depending on the extent of his prescription drug usage, and a sixty-five year old female would require $154,000 to $210,000.[14] These projections cover anticipated Medicare premiums, deductibles, and co-payment or cost-sharing obligations as well as the cost of certain supplementary arrangements. They do not, however, include the cost of long-term care.[15] But the basic point is that retirees face a large and unpredictable liability in retirement for their health care expenses. That such a prospect is foisted on retirees in a "You're On Your Own" world makes retirement security – the theme of this Symposium – especially problematic.

II.   MEDICARE ELIGIBILITY

Many workers, and much of the public as well, have the mistaken impression that upon retirement, their health care cost concerns are over because they can now access the federal government's Medicare program. But Medicare is no walk in the park in terms of understandability or internal consistency, and it is not generally available to retirees who have not yet reached the statutory eligibility age of sixty-five years.[16] This is a very important point because many Americans retire before that age, not always as a matter of choice. In fact, most retirees begin collecting Social

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[12] FIDELITY BROKERAGE SERVICES LLC, THE INCREASING COST OF HEALTH CARE UPON RETIREMENT (2012), *available at* http://workplace.fidelity.com/sites/default /files/FF_TBO_IncreasingCostofHC.pdf (projecting required savings at $240,000).

[13] Paul Fronstin et al., *Savings Needed for Health Expenses for People Eligible for Medicare: Some Rare Good News*, EMP. BENEFIT RES. INST. NOTES, Oct. 2012, at 2, 4, *available at* http://www.ebri.org/ pdf/notespdf/EBRI_Notes_10_Oct-12. HlthSvg-IRAs.pdf.

[14] *Id.*

[15] *Id*. at 5.

[16] 42 U.S.C. § 1395c(1) (2006).

Security retirement benefits before reaching age sixty-five, and a majority do so as early as age sixty-two.[17] These "early" retirees cannot, however, access Medicare before age sixty-five unless they satisfy the Social Security program's functionality-based criteria for being "disabled" namely, that they are unable to perform "any substantial gainful activity by reason of a medically determinable physical or mental impairment."[18] Moreover, they must have received disability payments under this standard for twenty-four months before they become eligible for Medicare coverage.[19] If they cannot qualify under these requirements, they must wait until their sixty-fifth birthday to enroll in Medicare and therefore must secure health insurance from some other source before then.[20]

Proposals were made near the end of the Clinton Administration to allow retirees who were not yet sixty-five years old to buy into Medicare at actuarially fair prices, but those proposals were soon eclipsed by the Monica Lewinsky scandal and the ensuing presidential impeachment battle.[21] The last time this issue was seriously considered was in the context of the major health care reform legislation enacted during President Obama's first term,[22] known variously as the Affordable Care Act or ObamaCare.[23] That legislation actually jettisoned the prospect of early-access Medicare in favor of universally available health insurance exchanges that are scheduled to begin next year.[24] Although the new law did include a very modest program to subsidize employers that maintained

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[17] *See* Dan Muldoon & Richard W. Kopcke, *Are People Claiming Social Security Benefits Later?*, CTR. FOR RETIREMENT RES., JUNE 2008 at 1, 2, *available at* http:// crr.bc.edu/wp-content/uploads/2008/05/ib_8-7.pdf.

[18] 42 U.S.C. § 416(i)(1)(A) (Supp. IV 2007–2011).

[19] *Id.* §§ 426(b)(2)(A)(i), 1395c(2).

[20] *See* Kaplan et al., *supra* note 11, at 336–37 (explaining the possible availability of "continuation" coverage from a former employer under certain specified circumstances).

[21] *See id.* at 343.

[22] Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010).

[23] *See* Richard L. Kaplan, *Analyzing the Impact of the New Health Care Reform Legislation on Older Americans*, 18 ELDER L.J. 213, 213–14 (2011).

[24] *See* 42 U.S.C. § 18031(b) (Supp. V 2007-2012) (enacted as part of the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 1311(b), 124 Stat. 119, 173 (2010)).

their existing health insurance programs for pre-Medicare retirees,[25] that program disappears entirely in 2014[26] when the state-organized health insurance exchanges will presumably be operational.[27]

In any case, if Medicare's eligibility age is reconsidered amidst the current efforts to tackle America's long-term fiscal dilemma, it is more likely that this age will be *raised* then lowered. Indeed, coordinating Medicare's eligibility age with Social Security's age for full retirement benefits has been seriously considered for some time.[28] That change would boost Medicare's eligibility age to sixty-six currently and eventually to sixty-seven.[29] For what it's worth, if Medicare's eligibility age of sixty-five were adjusted for changes in life expectancy that have occurred since the program was enacted, it would be seventy-three years.[30] The bottom line is that retirees who are not yet sixty-five years old cannot enroll in Medicare, presently or in the foreseeable future.

III.   MEDICARE'S COVERAGE COMPONENTS

Retirees who can enroll in Medicare confront an uncoordinated "system" of separate coverages and confusing options that does not correspond even remotely to what they had during their working lives. The elemental separation of Medicare's disparate coverages into hospital costs (Part A), physicians' charges (Part B), and prescription drug expenses (Part D) is unfathomable to new retirees who are accustomed to the all-inclusive

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[25] Under this program, the federal government paid eighty percent of claims for medical services costing between $15,000 and $90,000 that were incurred between June 22, 2010 and December 31, 2013. 42 U.S.C. § 18002(c)(2), (3) (Supp. IV 2007-2011) (enacted as part of the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 1102(c)(2), (3), 124 Stat. 119, 145 (2010)). The maximum benefit per claim, in other words, was $60,000 (maximum claim of $75,000 × 80%). Among other limitations, this program had a global budget cap of $5 billion, after which no further claims were payable. 42 U.S.C. § 18002(e).

[26] 42 U.S.C. § 18002(a)(1).

[27] 42 U.S.C. § 18031(b).

[28] *See* Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL. L. REV. 777, 791–92.

[29] *See* 42 U.S.C. § 416(*l*)(1) (2006).

[30] Life expectancy when Medicare was created (1965) was 70.2 years and was 78.7 years in 2010. *Life Expectancy at Birth by Race and Sex, 1930–2010*, INFO. PLEASE (2011), http://www.infoplease.com/ipa/A0005148.html. Therefore, $78.7 \div 70.2 = 1.12108 \times 65 = 72.9$ years.

health care plans that characterize the modern workplace. To be fair, when Medicare was created in 1965, its designers self-consciously mimicked the "major medical" plans that private health insurance companies were then offering.[31] But those plans evolved over time, while Medicare's fundamental organizational components have not. As a result, a newly retired person faces a program that seems designed for a time long ago and in fact was.

Perhaps the most egregious aspect of this programmatic ossification involves prescription drugs. When Medicare was created in 1965, such medications were few and relatively inexpensive and were used primarily to treat specific maladies over very short time courses. In the ensuing decades, however, pharmacological innovations have brought forth a veritable cornucopia of amazing treatments that control and ameliorate a wide range of common chronic conditions including heart disease, hypertension, diabetes, arthritis, asthma, osteoporosis, and the like. These drug regimens are not cheap and generally must be followed for the rest of a patient's life, but they extend people's lives and improve the quality of the lives they live. Yet, by the time that Medicare was changed to cover outpatient prescription drugs, it was the only health care insurance program in the country that lacked such coverage – a situation that typifies the anachronistic nature of Medicare's basic structure.

IV.   MEDICARE'S COST EXPOSURES

Unbeknownst to most pre-retirees, Medicare is not a comprehensive health care plan.[32] It exposes its beneficiaries to a dizzying array of deductibles and co-payments that can be understood only as historical accidents lacking any sense of medical coherence.

A. HOSPITALS

Medicare Part A covers most of a retiree's hospital costs for up to sixty days in a single "spell of illness" after payment of a per-admission deductible.[33] A "spell of illness" for this purpose begins with the admission

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[31] *See* THE CENTURY FOUND., MEDICARE TOMORROW: THE REPORT OF THE CENTURY FOUNDATION TASK FORCE ON MEDICARE REFORM 47 (2001).

[32] *See* Richard L. Kaplan, *Top Ten Myths of Medicare*, 20 ELDER L.J. 1, 10–11 (2012).

[33] 42 U.S.C. § 1395x(b) (2006).

and ends sixty days after the patient has been discharged.[34] Although a per-admission deductible is a fairly common feature in health care plans, it usually is much lower; e.g., $250. That is not the case with Medicare. The per-admission deductible in 2014 is $1,216,[35] and it increases every year based on increases in health care costs generally. Moreover, retirees tend to use more health care services than the general population and could conceivably face two or even three hospitalizations in the same calendar year.

For example, a retiree might be hospitalized on January 14, discharged two weeks later, and then readmitted in May and perhaps in October as well. If that happened, this retiree would be liable for the per-admission deductible twice or even three times that year. In this context, it is extremely important to note that Medicare has *no annual stop-loss provisions that cap an enrollee's out-of-pocket costs* once that person's expenditures reach some pre-determined amount[36] – again unlike many, if not most, health care plans that are available today to the pre-Medicare population.

Medicare Part A also has a durational limitation on hospital stays that reflects its generally out-of-date orientation. Medicare covers virtually all costs for up to sixty days and then covers costs in excess of a daily deductible for an additional thirty days within the same "spell of illness."[37] That per-day deductible is adjusted annually and in 2014 is $304.[38] The resulting cost exposure, however, is fairly inconsequential because a hospital stay exceeding sixty days is very uncommon, especially after the Diagnostic Range Groupings were implemented in 1987.[39] These groupings limit how many hospital days Medicare will pay for specific treatments and as a result, the average hospital stay of a person age sixty-five and older is less than six days, according to the most recent data available.[40]

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[34] 42 U.S.C. § 1395x(a) (2006).

[35]*Medicare 2014 Costs at a Glance*, MEDICARE.GOV, http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html#collapse-4811 (last visited Mar. 22, 2014).

[36] Katherine Baicker & Helen Levy, *The Insurance Value of Medicare*, 367 NEW ENG. J. MED. 1773, 1773 (2012).

[37] 42 U.S.C. § 1395x(a) (2006).

[38] *Medicare 2014 Costs at a Glance*, *supra* note 35.

[39] *See generally* RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE?, 162–64 (1997).

[40] *See* ADMIN. ON AGING, U.S. DEP'T OF HEALTH & HUMAN SERVS., A PROFILE OF OLDER AMERICANS: 2012 13 (2013), *available at*

B. NURSING HOMES

Medicare Part A's coverage of nursing home care is far more restrictive than its coverage of hospital charges but is similarly time-warped. Nursing home costs are covered by Medicare for the first twenty days within a "spell of illness,"[41] and Medicare then pays all costs beyond a per-day deductible,[42] which in 2014 is $152.[43] This extended coverage, however, cannot exceed eighty days,[44] so Medicare's coverage stops after one hundred days in a nursing home. This coverage design may have been appropriate when Medicare was created in 1965, when most people did not live long enough to develop conditions like Alzheimer's Disease, which can require care in a nursing facility for three to five years or longer. But today, the majority of older residents in nursing homes have such conditions, and a result, Medicare's one-hundred-day coverage limitation seems archaic, if not downright cruel.

Moreover, even this limited coverage of nursing home costs is subject to a major and poorly understood overarching restriction – namely, that the patient requires and receives "skilled nursing care" on a daily basis[45] for the same or a medically related condition that was treated previously in a hospital.[46] Most retirees and their families do not realize that much of the care these facilities provide is actually lower-level "custodial care" rather than "skilled nursing care," which typically entails injections, gastronomy feedings, catheters, administration of medical gases, and the like.[47] Consequently, Medicare does not cover the cost of such care.

Moreover, the prior hospitalization must have lasted at least three days[48] and must have occurred within the thirty days preceding admission

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http://www.aoa.gov/aoaroot/aging_statistics/Profile/2012/docs/2012profile.pdf (reporting that persons aged sixty-five to seventy-four averaged stays of 5.4 days, persons aged seventy-five to eighty-four averaged 5.7 days, and persons aged eighty-five and over averaged 5.6 days).

[41] 42 U.S.C. §§ 1395d(a)(2)(A), 1395e(a)(3) (Supp. III 2007–2010).

[42] *Id.* § 1395e(a)(3).

[43] *Medicare 2014 Costs at a Glance*, *supra* note 35.

[44] 42 U.S.C. § 1395e(a)(3).

[45] 42 U.S.C. § 1395f(a)(2)(B) (Supp. III 2007-2010); 42 C.F.R. § 409.31(b)(1) (2012).

[46] 42 U.S.C. § 1395f(a)(2)(B); 42 C.F.R. § 409.31(b)(2)(ii).

[47] 42 C.F.R. § 409.33(a)-(c) (2012).

[48] 42 U.S.C. § 1395x(i) (2006).

to the nursing home.[49] So, if a retiree enters a nursing home directly from her home, for example, Medicare does not cover any of the ensuing expenses.

Adding insult to injury, the Diagnostic Range Groupings that reduced the number of days that Medicare would pay for hospital care effectively eliminated Medicare's coverage of many nursing home stays. That is, when a hospital stay for a particular medical condition is shortened from three days to two days, a subsequent nursing home stay will not be covered by Medicare because of that program's three-day minimum.[50] The bottom line is that Medicare's coverage of nursing home care is much more limited than it first appears, which means that retirees who require such facilities face considerable financial exposure for the cost of care they receive there. In this context, it should be noted that Medicare provides no coverage whatsoever for care in assisted living facilities, largely because those institutions did not exist when Medicare was created.

C. DOCTORS' FEES

Physicians' charges are another source of major expense for retirees and are covered by Medicare Part B. Medicare pays eighty percent of a participating physician's "approved charge,"[51] and the patient then owes the remaining twenty percent. Nonparticipating physicians can charge patients up to an additional fifteen percent of the "approved charge,"[52] and increasing numbers of health care providers are switching from participating to nonparticipating provider status[53] in response to repeated reductions in Medicare's "approved charge" schedules – the most recent being the two percent reduction mandated by the Budget Control

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[49] *Id.* § 1395x(i)(A).

[50] Exacerbating this problem is the practice of many hospitals to keep patients for several days in "observation" status. *See* Christopher W. Baugh & Jeremiah D. Schur, *Observation Care-High-Value Care or a Cost-Shifting Loophole?,* 369 NEW ENG. J. MED. 302, 303 (2013). Such patients are not treated as being admitted into the hospital, so the days they spend in "observation" do not count toward the three-day minimum. *See id.*

[51] 42 U.S.C. § 1395*l*(a)(1) (2006).

[52] *Id.* § 1395w-4(g)(2)(C).

[53] *See* Melinda Beck, *More Doctors Steer Clear of Medicare*, WALL ST. J., July 29, 2013, at A1, A4, *available at* http://online.wsj.com/news/articles/SB1000 14241278873239712045786261510172418 98 (reporting a 2.9% increase in nonparticipating providers from 2010 to 2012).

Act's sequestration provisions.[54] In effect, such payment reductions can indirectly increase retirees' health care costs as more physicians change their status to nonparticipating provider, a phenomenon that is likely to increase as federal budgetary pressures worsen.

Moreover, it should be emphasized that doctors' bills are not occasional expenditures for most Medicare beneficiaries. Fully forty percent of Medicare's population has three or more so-called "chronic conditions," such as heart disease, asthma, osteoporosis, hypertension, arthritis, diabetes, and chronic obstructive pulmonary disease.[55] These conditions typically require regular appointments with various medical specialists to control the patient's health and to forestall expensive complications and hospitalizations. Doctors' visits, in other words, are far more frequent and less episodic for retirees than for pre-retirees as a general matter.

V. MEDICARE PART B OPTIONS

As noted previously in passing, the coverage for physicians' charges just described is provided under Medicare Part B rather than Part A, a distinction that has significant financial implications for retirees. Medicare Part A is financed by a payroll tax of 1.45 percent imposed on an employee's wages and salaries,[56] with a comparable amount paid by that person's employer.[57] After that worker (or the worker's spouse)[58] has earned forty "quarters of coverage,"[59] Medicare Part A is provided without any further premiums being charged.[60] In contrast, Medicare Part B is a

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[54] 2 U.S.C. § 901a(8) (Supp. V 2007-2012) (enacted as part of the Budget Control Act of 2011, Pub. L. No. 112–25, § 302(a), 125 Stat. 240, 258 (2011)).

[55] KAISER FAMILY FOUND., MEDICARE AT A GLANCE 1 fig. 1 (2012), *available at* http://www.kff.org/medicare/upload/1066-15.pdf.

[56] I.R.C. § 3101(b)(6) (Supp. V 2007–2012).

[57] *Id.* § 3111(b)(6).

[58] 42 C.F.R. § 406.10(a) (2012); 42 U.S.C. § 402(b)(1), (c)(1) (2006). The divorced spouse of a Medicare-eligible worker is also entitled to Medicare Part A if the divorced spouse is at least sixty-five years old and if this person was married to the Medicare-eligible worker for at least ten years. 42 C.F.R. § 406.10(a)(1) (2012); 42 U.S.C. §§ 402(b)(1), (c)(1), 416(d)(1) (2006).

[59] 42 U.S.C. § 414(a)(2) (2006).

[60] Persons who have not earned the requisite forty "quarters of coverage" may purchase Medicare Part A if they have lawfully lived in the United States at least five years. 42 U.S.C. § 1395i-2(a)(3) (2006). The monthly premium for such

separate program that requires annual enrollment and monthly premiums paid by the retirees themselves.[61] In 2014, this monthly premium is $104.90,[62] which is calculated to cover approximately twenty-five percent of the program's projected expenditures.[63] This monthly outlay, in other words, represents a seventy-five percent subsidy from general tax revenues.

Since 2006, higher-income enrollees have been required to pay surcharges to reduce the extent of the subsidy that they receive.[64] The amount of these so-called "means-tested" surcharges is based on an enrollee's taxable income as determined for the second-preceding calendar year.[65] Thus, the following table[66] displays the monthly cost of Medicare Part B in 2014 as a function of a retiree's income for federal income tax purposes in 2011:

Income (if unmarried)	Monthly Payment
$85,000 or less	$104.90
$85,001 - $107,000	$146.90
$107,001 - $160,000	$209.80
$160,001 - $214,000	$272.70
Over $214,000	$335.70

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coverage is adjusted annually and in 2013 was $441. *Medicare 2014 Costs at a Glance*, *supra* note 35.

[61] 42 U.S.C. § 1395j (2006). *See generally* FROLIK & KAPLAN, *supra* note 9, at 76–83.

[62] *Medicare 2014 Costs at a Glance*, *supra* note 35.

[63] 42 U.S.C.§ 1395r(a)(1), (3) (Supp. V 2007–2012); *see* MEDICARE HANDBOOK § 6.02[C][1], at 6–11 (Judith A. Stein & Alfred J. Chiplin, Jr. eds., 2013).

[64] 42 U.S.C. § 1395r(i)(1), (4)(B)(i) (2006).

[65] *See generally* Richard L. Kaplan, *Means-Testing Medicare: Retiree Pain for Little Governmental Gain*, J. RETIREMENT PLANNING, May-June 2006, at 22.

[66] *See Part B Costs*, MEDICARE.GOV, http://medicare.gov/your-medicare-costs/part -b-costs/part-b-costs.html (last visited Jan. 27, 2014).

Note that the applicable income thresholds are doubled for married couples.[67] Moreover, these thresholds were frozen through the year 2019, rather than being adjusted for inflation, by the Affordable Care Act.[68] Accordingly, increasing numbers of retirees are likely to face income-based surcharges for Medicare Part B in the future.

The principal point, however, is that Medicare Part B is optional coverage. Thus, retirees must decide as an initial matter whether they want such coverage at all. Retirees who do not anticipate having many physician encounters might forego such coverage, but they will then be subject to a delayed enrollment penalty if they subsequently enroll in this program.[69] This penalty is ten percent of the regular Medicare Part B monthly premium for every twelve-month period in which the retiree did not enroll in the program when she was first eligible.[70]

Assume, for example, that Denise delayed enrolling in Medicare Part B for forty months, so there are three twelve-month periods within that delayed enrollment period. She will therefore owe a penalty of thirty percent (ten percent for each twelve-month delayed enrollment period) of the monthly Medicare Part B premium. Most importantly, this penalty provision never ceases! That is, Denise will owe thirty percent more for her Medicare Part B benefits as long as she is enrolled in Medicare Part B.

VI. "MEDIGAP" COVERAGE

As noted previously, the various deductibles and co-payment obligations in Medicare Part A and Medicare Part B represent an open-ended liability. That is, there is no annual cap on the amount of such costs. For that reason, many Medicare beneficiaries decide to supplement their Medicare coverage with private insurance that is usually called "Medigap" insurance.[71] Some retirees are able to purchase such supplemental coverage from their former employer or from their union, while others obtain such

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[67] 42 U.S.C. § 1395r(i)(3)(C)(ii), (iii) (2006).

[68] 42 U.S.C. § 1395r(i)(6) (Supp. V 2007-2012) (enacted as part of the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 3402(4), 124 Stat. 119, 489 (2010)).

[69] 42 U.S.C. § 1395r(b) (Supp. V 2007-2012).

[70] *Id.*

[71] *See generally* FROLIK & KAPLAN, *supra* note 9, at 97–103.

coverage individually.[72] In any case, the question of supplemental insurance presents retirees with further choices, each of which has financial implications.

First, retirees must decide whether to purchase Medigap insurance at all. Such policies are not inexpensive and their cost is usually borne by the retirees. The federal government does not provide any financial subsidies for Medigap insurance, although it does regulate its content[73] and mandates that retirees cannot be denied Medigap insurance because of pre-existing medical conditions if they purchase this insurance within the first six months of their enrolling in Medicare Part B.[74]

Second, retirees must then select among the eleven different but standardized Medigap insurance packages that include various benefits.[75] Medigap insurers can determine what they will charge for particular policies, but the scope of any specific "plan" does not vary from one insurer to another. Thus, a retiree must first determine which combination of specific benefits most closely fits his or her needs and then look for the best price from the insurers that offer that plan. For example, a prospective retiree may choose Medigap coverage for the per-hospital-admission deductible under Part A or decide instead to self-insure for that liability by not obtaining such coverage. Similarly, a retiree who expects to travel outside the United States might want to add the "foreign travel emergency" benefit. In general, the more extensive the coverages included, the higher the plan's cost. But the point is that Medigap itself presents a series of distinct choices that a retiree must consider.

To summarize, a retiree must decide first whether to enroll in Medicare Part B presently, whether to enroll at some later time and pay the corresponding delayed enrollment penalty, or whether to forego Medicare Part B entirely. This retiree must then decide whether to buy a Medigap policy to cover the unlimited cost exposure of Medicare Parts A and B presently or to wait until some later time and lose the guaranteed

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[72] *See* JULIETTE CUBANSKI ET AL., KAISER FAMILY FOUND., MEDICARE CHARTBOOK 60 (4th ed. 2010), *available at* http://www.collaborationhealthcare. com/11-9-10KFFMedicareChartBook2010.pdf (stating that ninety percent of Medicare beneficiaries have some supplemental health insurance).

[73] 42 U.S.C. § 1395ss(o), (p), (w), (y) (2006 & Supp. IV 2007–2011).

[74] *Id.* § 1395ss(s)(2)(A) (2006).

[75] *See* CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., MEDICARE & YOU 67–72 (2014), *available at* http://www.medicare. gov/ Pubs/pdf/10050.pdf.

insurability that is available within the first six months of Medicare Part B enrollment. Finally, the retiree must decide which specific Medigap policy to buy.

VII. PRESCRIPTION DRUG COVERAGE OPTIONS

The level of complexity and cost exposure described above actually pales in comparison to what is involved regarding Medicare's coverage of prescription drugs. Once again, the threshold decision is whether to buy prescription drug coverage at all, or whether to pay for prescribed drugs as the need for them arises. While the private companies that provide Medicare Part D coverage cannot deny coverage because of a retiree's pre-existing medical conditions, there is a delayed enrollment penalty in Part D that is structured similarly to the delayed enrollment penalty in Medicare Part B that was considered previously.[76] To some extent, the decision to forego Medicare Part D coverage presently is a bet that one will not need such coverage any time soon – even though new medications are being developed every year to treat existing maladies and one never knows whether he or she might be diagnosed with such conditions in the future.

If a retiree does decide to obtain prescription drug coverage under Medicare Part D, the next step is determining which plan to buy. This is no easy decision, because there is no single Medicare Part D plan or even standardized Medicare Part D plans comparable to the federally standardized Medigap plans described above.[77] Instead, private insurers offer different plans in different states that cover some medications and not others, and some dosage amounts and frequencies but not others. Thus, a given plan might cover 20 milligrams of Lipitor® twice a day, another plan will cover 40 milligrams of that drug once a day, and still another plan will not cover Lipitor® at all. In essence, a retiree must gather the various medications that he or she is taking currently and then enter their names, dosage amounts, and dosage frequencies into Medicare's website to find the available plans that cover these medications.[78] Additional

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[76] 42 U.S.C. § 1395w-113(b)(1) (2006). For the mechanics of how this penalty is calculated, see FROLIK & KAPLAN, *supra* note 9, at 88.

[77] *See supra* text accompanying note 75.

[78] *See Medicare Plan Finder*, MEDICARE.GOV, https://www.medicare.gov/ find-a-plan/ questions/home.aspx (last visited Jan. 27, 2014). (follow "General Search" hyperlink (entering zip code); enter basic information on next page (step 1

differentiating variables among the offered plans might include convenience of pharmacy locations and availability of mail order renewals.

Most Medicare Part D plans impose an annual deductible that is fairly modest. In 2013, for example, fifty-five percent of Medicare Part D plans had an annual deductible, usually $325.[79] Such plans typically provide several distinct "tiers" of cost coverage. That is, a plan might require a low or no co-payment for certain generic medications while charging a higher co-payment for a preferred brand-name drug and an even higher co-payment for a nonpreferred brand-name drug. Most plans also have a coverage gap that is generally denominated the "donut hole" in which annual drug expenditures above a specified amount are covered to a lesser extent.[80] In 2013, two out of three Medicare Part D plans had coverage gaps that began at $2,970 in annual drug costs.[81] The Affordable Care Act purports to close this "donut hole," but the closing process phases in over ten years and will still leave enrollees with a co-payment obligation of twenty-five percent when it is complete.[82] Thus, retirees in 2014 are responsible for seventy-two percent of the cost of generic drugs and forty-seven and a half percent of the cost of brand-name drugs for costs incurred within the "donut hole."[83]

In any case, the procedure for finding a Medicare Part D prescription drug plan must be repeated *every year*, because plan providers regularly change their formularies in advance of the annual enrollment process. Thus, a Humana plan that reasonably met a retiree's needs one year may not meet those needs the next year, may be much more expensive, or may not even be offered. I am not making this up!

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of 4), then see step 2 of 4 "Enter your Drugs" (plan selection and estimate can be generated by completing questionnaire)).

[79] JACK HOADLEY ET AL., MEDICARE PART D: A FIRST LOOK AT PART D PLAN OFFERINGS IN 2013 3 (2012), *available at* http://kaiserfamilyfoundation.files.word press.com/2013/01/8375.pdf.

[80] For an explanation of how this curious provision came about, see Richard L. Kaplan, *The Medicare Drug Benefit: A Prescription for Confusion*, 1 NAELA J. 167, 170–74 (2005).

[81] *See* HOADLEY ET AL., *supra* note 79, at 3.

[82] 42 U.S.C. § 1395w-102(b)(2)(C)(ii) (Supp. V 2007-2012) (generic drugs); *id*. § 1395w-102(b)(2)(D)(i)(I), (ii)(VI) (brand-name drugs). For a graphic representation of the phase-in process, see Kaplan, *supra* note 23, at 219–220.

[83] CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 75, at 91.

VIII.   THE MANAGED CARE ALTERNATIVE

As the preceding discussion has demonstrated, retirees seeking to pay for their health care expenses in retirement confront a bewildering if not overwhelming array of disjointed coverages under Medicare, each with its own programmatic limitations and cost-sharing provisions. There is an alternative approach, however, in the form of Medicare's managed care component, which is legally designated as Medicare Part C, but is more popularly styled Medicare Advantage.[84] For a single monthly premium and nominal co-payment obligations, one organization provides the sort of all-inclusive health insurance arrangement that many retirees had when they were still working. Such arrangements typically limit an enrollee's access to specific hospitals, doctors, pharmacies, and other health care providers, while services obtained from "out-of network" providers are covered at substantially higher cost to the enrollee, or not at all.[85] While such restrictions are endemic to managed care plans generally, the prospect of losing access to favored specialists is often very troubling to retirees who have established relationships with particular health care providers. In fact, only twenty-eight percent of Medicare's population was enrolled in a Medicare Advantage plan in 2013.[86]

If a retiree is comfortable with the basic concept of managed care, that person must then select from among the Medicare Advantage plans that are available in that person's geographic area. This decision, moreover, will probably need to be revisited annually, because Medicare Advantage plans regularly change the array of health care providers that they include, adding some and dropping others, as well as the scope of benefits they provide and the monthly cost they charge to enrollees. This process is generally undertaken during the annual "re-enrollment period" that runs from October 15 to December 7,[87] but certain changes can be made at other times as well, such as when an enrollee moves out of the geographic area that his or her current Medicare Advantage plan covers.[88]

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[84] 42 U.S.C. § 1395w-21 (2006).

[85] *See generally* FROLIK & KAPLAN, *supra* note 9, at 104–06 (describing Medicare's managed care component).

[86] KAISER FAMILY FOUND., MEDICARE ADVANTAGE FACT SHEET 1 (2013), *available at* http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/.

[87] 42 U.S.C. § 1395w-21(e)(3)(B)(v) (Supp. V 2007–2012).

[88] *Id.* § 1395w-21(e)(4)(B) (2006).

Near term, such plans may become less available or less appealing due to the Affordable Care Act. The drafters of that legislation believed that Medicare managed care plans were overpaid by the federal government, so payments to these plans are to be reduced beginning in 2014.[89] In fact, more than a quarter of the cost savings in Medicare from ObamaCare come from cuts in payments to Medicare Advantage plans.[90] These plans, therefore, are likely to curtail some of the nonmandatory benefits that they provide currently, such as vision care and hearing aids, and some plans may terminate their participation in Medicare entirely. Little wonder, therefore, that Medicare's Chief Actuary when the Affordable Care Act was being considered predicted that enrollment in Medicare Advantage would drop by half when the projected cuts are "fully phased in."[91] As even more retirees opt for the disjointed Medicare components examined previously instead of Medicare managed care, this population will likely face greater health care cost exposure and fiscal uncertainty.

IX.   THE PREMIUM SUPPORT ALTERNATIVE?

The relatively recent and highly controversial enactment of health care reform in 2010 suggests that any serious effort to rethink how health care for older Americans should be financed is unlikely any time soon. In fact, ObamaCare is a staggering testament to the power of path dependency. Despite all the heated rhetoric that accompanied its gestation and the impassioned allegations of a government "takeover" of the health care system, rampant socialism, and even death panels, the Affordable Care Act left the basic structure of the Medicare program intact. The noncoordinated components of Medicare Parts A, B, and D, though largely accidents of history, were not reformed or rationalized in any meaningful

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[89] *See* Kaplan, *supra* note 23, at 239–40.

[90] *See* Memorandum of Richard S. Foster, Chief Actuary, Ctrs. for Medicare & Medicaid Servs., Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended 2, 8 (Apr. 22, 2010), *available at* http://graphics8.nytimes.com/packages/pdf/health/oactmemo1.pdf; *see also* Letter from Douglas W. Elmendorf, Director, Cong. Budget Office to John Boehner, Speaker of the House 5 (July 24, 2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43471-hr6079.pdf (showing that twenty-one percent of the projected Medicare savings in the Affordable Care Act derive from cuts to the Medicare Advantage program).

[91] Memorandum of Richard S. Foster, *supra* note 90, at 11.

way. In fact, the only paradigmatic alternative to this basic structure – namely, Medicare managed care – was actually the focus of significant budget cuts.

In 2011, the chair of the House Budget Committee, Congressman Paul Ryan, proposed transforming the Medicare program into a marketplace where beneficiaries could select from various comprehensive offerings, with the federal government providing premium support or "vouchers" for these offerings.[92] Instead of the present one-size-fits-all approach, the retirement health care universe would look more like what Americans under age sixty-five typically have. Congressman Ryan's plan included very few details, but the basic vision it propounded would look fairly familiar to persons who have never enrolled in Medicare. Be that as it may, the 2012 elections effectively sidelined that effort for the foreseeable future, and President Obama's full-throated defense of entitlement programs such as Medicare in his Second Inaugural Address[93] makes major systemic change unlikely.

From the perspective of current and near-retirees, however, the Ryan proposal would have been irrelevant by its very terms. His original proposal would have applied only to persons who first became eligible for Medicare in the year 2022.[94] That provision essentially exempts the current Medicare population, as well as a significant portion of the vaunted Baby Boom generation that is gaining access to Medicare with each passing day. Even more to the point, Ryan subsequently adopted a feature suggested by Senator Ron Wyden that would retain the existing Medicare program as one of the alternatives in the marketplace that he intends to create.[95] In

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[92] *See* H. COMM. ON THE BUDGET, 112TH CONG., THE PATH TO PROSPERITY RESTORING AMERICA'S PROMISE 46–47 (Comm. Print 2011), *available at* http://budget.house.gov/UploadedFiles/ PathToProsperityFY2012.pdf (primarily the work of Chairman Paul Ryan).

[93] *See* Barack H. Obama, *Full Text of President Barack Obama's Second Presidential Inaugural Address*, U.S. NEWS & WORLD REP. 2 (Jan. 21, 2013), http://www.usnews.com/news/articles/2013/01/21/full-text-of-president-barack-obamas-second-inaugural-address_print.html ("The commitments we make to each other: through Medicare, and Medicaid, and Social Security, these things do not sap our initiative; they strengthen us. They do not make us a nation of takers; they free us to take the risks that make this country great.").

[94] H. COMM. ON THE BUDGET, *supra* note 92, at 46.

[95] *See* SEN. RON WYDEN & REP. PAUL RYAN, GUARANTEED CHOICES TO STRENGTHEN MEDICARE AND HEALTH SECURITY FOR ALL 7 (2011), *available at* http://budget.house.gov/uploadedfiles/wydenryan.pdf. Senator Wyden

other words, the latest iteration of Ryan's proposal would actually keep the existing discombobulated Medicare program in place as long as any Medicare-eligible retiree, now or in the future, selects it.

X.   IMPLICATIONS FOR RETIREES

As retirees contemplate the accumulated balances in their defined contribution retirement plans, they must consider how much of those balances they will need to spend on health care in retirement, which is likely to be one of their largest budget items. Current cost projections are undoubtedly understated if past trends are indicative. The history of medical, and especially pharmacological, progress makes conditions that were previously untreatable newly treatable if not curable. Newly concocted drug regimens may be much less expensive than hospitalizations and their medically intensive therapies, but such drug regimens are not cheap either. Even though the cost of pharmaceutical interventions is shared by retirees and the Medicare program, a significant portion of those costs is paid by the retirees themselves, so increasing drug costs represent a rising cost burden to retirees generally.

By contrast, most of the money saved by fewer hospitalizations would have been paid by the Medicare program itself. After the per-admission deductible is paid, most other hospital costs are paid by Medicare, as noted previously. And if future medical innovations translate into more nursing home stays instead of hospitalizations, the resulting nursing home care may not be the "skilled nursing care" that Medicare pays for.[96] Even if it is, Medicare's liability for such costs is limited to one hundred days, so any additional days in the nursing home is an expense of the retiree rather than of Medicare. As a consequence, Medicare's hospital expenditures may decrease, but retirees' outlays for nursing home care will likely increase. That phenomenon explains, in part, this graph from the *New England Journal of Medicine,*[97] which shows that the cumulative cost of a person's health care expenditures (solid line) increases the longer that

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subsequently distanced himself from this proposal. *Sen. Wyden Distances Himself from Medicare Plan He Crafted with Ryan*, THE HILL (Aug. 13, 2012, 04:43PM), http://thehill.com/blogs/healthwatch/politics-elections/243387-wyden-downplays-medicare-plan-he-crafted-with-ryan.

[96] *See supra* text accompanying notes 45–47.

[97] Brenda C. Spillman & James Lubitz, *The Effect of Longevity on Spending for Acute and Long-Term Care*, 342 NEW ENG. J. MED. 1409, 1411 (2000).

person lives, but the cumulative cost paid by Medicare (long dash/short dash line) does not.

Figure 1. Cumulative Health Care Expenditures from the Age of 65 Years until Death, According to the Type of Health Service and the Age of Death:
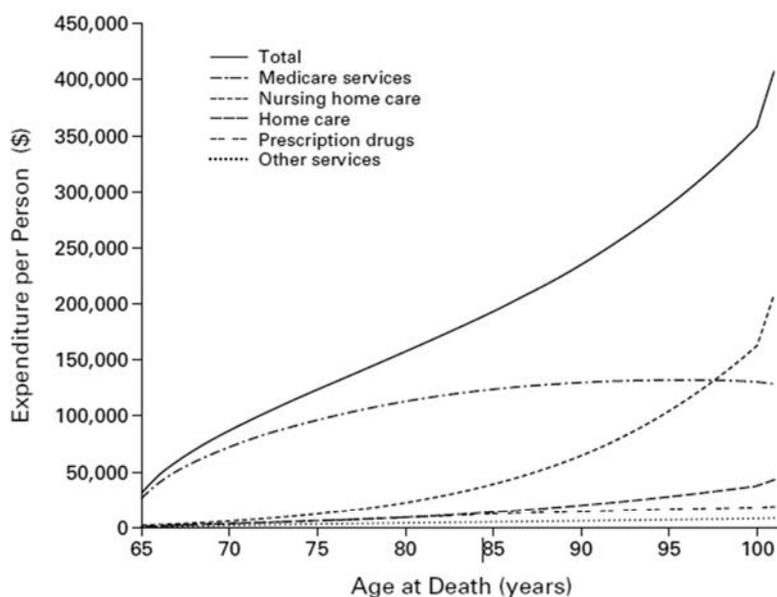
In other words, extended longevity may increase per capita medical expenditures, but much of that increase will not burden the Medicare program. To put the matter bluntly, the additional medical costs associated with increased longevity will largely be on the retiree's dime.

XI. FUNDING LONG-TERM CARE

Retirees' responsibility for their own long-term care costs is a major and largely unrecognized variable in assessing retirement funding adequacy. This is a huge point, as I explained in my article entitled "Retirement Planning's Greatest Gap: Funding Long-Term Care."[98] Not

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[98] *See generally* Richard L. Kaplan, *Retirement Planning's Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407 (2007) (examining the

only is Medicare Part A's coverage of nursing homes severely limited,[99] its coverage of home health care is limited to no more than twenty-eight hours per week[100] of specified types of care[101] that are provided by Medicare-certified home health agencies[102] pursuant to a physician's plan of care.[103] Moreover, only someone who cannot leave his or her home without assistance is eligible for this care.[104] A joint federal and state government program called Medicaid[105] does cover many forms of long-term care, but Medicaid has severe assets and income qualification standards[106] and as a result, few retirees plan to avail themselves of its provisions. Moreover, budgetary pressures on state governments result in ever-tightening eligibility standards, making Medicaid an increasingly unreliable source for funding future long-term care needs.[107] From the perspective of retirement security, in other words, the cost of long-term care is essentially a private expense.

And a considerable expense it can be. According to the most recent survey of long-term care costs in the United States,[108] the median costs of long-term care are as follows:

- licensed home health aide – $19 per hour
- adult day care – $65 per day
- assisted living facility – $3,450 per month, and
- nursing home (private room) – $230 per day.

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major missing component of retirement planning: how to finance the potentially explosive cost of long-term care).

[99] *See supra* text accompanying notes 41–50.

[100] 42 U.S.C. § 1395x(m) (2006).

[101] *Id.* § 1395x(m)(1), (2).

[102] *Id.* § 1395x(m), (o).

[103] *Id*. § 1395x(m).

[104] *Id.* §§ 1395f(a)(2)(C), 1395n(a)(2).

[105] *See generally* FROLIK & KAPLAN, *supra* note 9, at 110–38.

[106] *See* Kaplan, *supra* note 98, at 423–25. In addition, the value of the benefits received from Medicaid must be recovered when the Medicaid recipient dies. *See id.* at 429–30.

[107] *See, e.g.,* Save Medicaid Access and Resources Together Act, 2012 Ill. Legis. Serv. 120 (enacting tightened restrictions on eligibility for Medicaid benefits).

[108] GENWORTH, GENWORTH 2013 COST OF CARE SURVEY 4 (10th ed. 2013), *available at* https://www.genworth.com/dam/Americas/US/PDFs/Consumer /corporate/130568_032213_Cost%20of%20Care_Final_nonsecure.pdf.

This last amount translates into an annual cost of $83,950. These figures, moreover, represent *national* medians, and the cost differentials among states and within states are considerable.[109]

A. LONG-TERM CARE INSURANCE

Private long-term care insurance has been developed to respond to this need, but its problems are legion. The cost of such insurance is high and premiums of current policyholders are regularly increased by fifty percent or more a year.[110] Policy options are unstandardized and confusing,[111] and insurer solvency is a major concern[112] – especially as more long-term care insurance companies exit this marketplace.[113] Moreover, nearly a quarter of sixty-five-year-olds are medically ineligible to buy such insurance,[114] even if they were willing to bear the associated expense.

Just the briefest overview of what is involved in acquiring long-term care insurance can be discerned from the following table[115] of policy choices and premiums offered by one prominent insurer:

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[109] *See id.* at 14–72 (compilations by cities and states for each care category).

[110] *See Do You Need Long-Term-Care Insurance?,* CONSUMER REP., Nov. 2003, at 20, 22; *see also* Jennifer Levitz & Kelly Greene, *States Draw Fire for Pitching Citizens on Private Long-Term Care Insurance,* WALL ST. J., Feb. 26, 2008, at A1 (reporting a 260% increase in premiums in only three years); Kelly Greene & Leslie Scism, *Long-Term-Care Insurance Leaves Customers Groping*, WALL ST. J., July 2, 2013, at A1 (reporting a 77% increase in one year); *see generally* Kaplan, *supra* note 98, at 440–41.

[111] *See* Kaplan, *supra* note 98, at 438–39.

[112] *See id.* at 441-42; M.P. McQueen, *Insurer Casts Off Long-Term-Care Policies*, WALL ST. J., Dec. 3, 2008, at D1.

[113] *See* Kelly Greene, *Long-Term Care: What Now?,* WALL ST. J., Mar. 10, 2012 (noting that ten of the top twenty long-term care insurers by sales volume have left this market within the past five years).

[114] *See* Christopher M. Murtaugh et al., *Risky Business: Long-Term Care Insurance Underwriting*, 32 INQUIRY 271, 277 (1995).

[115] *See* Nancy Ann Jeffrey, *Your Needs, Plus Your Budget, Equals What to Pay on Long-Term Care Policy,* WALL ST. J., Mar. 21, 1997, at C1 (rates for John Hancock Life Insurance Co.).

ANNUAL COST OF AN INDIVIDUAL POLICY			
Age at Issue	55	65	75
$100 daily benefit for nursing-home; home-health coverage; 4 years coverage; 100-day deductible period	$510	$990	$2,830
Shorter coverage period: 2 years	380	720	2,010
Lower home-health-care benefit: $50 daily	410	810	2,350
Shorter deductible period: 20 days	643	1,247	3,566
Richer benefits: $200 daily for nursing home and home-health care	1,020	1,980	5,660
Inflation-indexed benefits: annual increases at 5% compounded rate	1,090	1,740	4,230

The premiums quoted above are over a decade old, and premiums are undoubtedly higher today, but the long-term care insurance industry does not generally make price information available outside of a personalized – read, pressurized – presentation by a sales agent.[116] Even so, this table can convey some of the complex choices that a prospective buyer of long-term care insurance must confront:

- Whether to buy a long-term care insurance policy at all, or plan instead to fund long-term care needs as they arise by accessing the equity in one's residence via a "reverse mortgage."[117]
- If an insurance policy is desired, how much should the daily benefit be?
- How long should these benefits last?

[116] *But see Long-Term Care Sample Rates*, CAL. DEP'T OF INS., https://interactive.web.insurance.ca.gov/survey/survey?type=longTermCareSurvey &event=longTermCareSearch (last visited Jan. 22, 2014) (making rates available online for certain specified insurance packages in California); *Long-Term Care Insurance Rate Gide Sample Policy* 1, TEX. DEP'T OF INS., http://www.tdi.texas.gov/pubs/consumer/lrg policy1.html (last visited Jan. 22, 2014) (making rates available in Texas).

[117] *See generally* FROLIK & KAPLAN, *supra* note 9, at 212–22. Another possible funding source might be "accelerated benefits" on an existing life insurance policy that can be accessed for long-term care. *See id*. at 156–58.

- How long should the deductible or "elimination period" be?
- Should home health care be covered and if so, at what daily rate?
- Should the daily benefit be increased for inflation and if so, what metric (consumer price index, five percent simple, five percent compounded) should apply?

There are other policy decisions as well that are not captured by the preceding chart, such as whether to have premiums waived when benefits begin, whether to have the premiums refunded if no benefits are ever paid, and so forth.[118] But the main point is that securing insurance to cover possible long-term care expenses is not a simple or straightforward process.

B. GOVERNMENTAL COVERAGE OF LONG-TERM CARE COSTS

In this context, it is notable that the Affordable Care Act included a voluntary long-term care insurance program called Community Living Assistance Services and Supports, or CLASS.[119] This program would have covered some – but not all – long-term care costs in various settings, but its benefits were targeted to less costly care environments, such as home health care and community-based services, rather than assisted living facilities and nursing homes.[120] In any case, the enabling legislation mandated that the CLASS program be fiscally self-sustaining,[121] a requirement that the Obama Administration's Department of Health and Human Services determined was impossible to satisfy. In October 2011, the Secretary of that Department declared that the CLASS program would not be implemented,[122] and these now-moribund provisions were then

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[118] *See* Kaplan, *supra* note 98, at 439.

[119] 42 U.S.C. §§ 300*ll*–300*ll*-9 (Supp. IV 2007–2011) (enacted as part of the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 8002, 124 Stat. 119, 828–47 (2010)).

[120] 42 U.S.C. §§ 300*ll*-1, 300*ll*-2, 300*ll*-4 (Supp. IV 2007–2011); *see generally* Richard L. Kaplan, *Financing Long-Term Care After Health Care Reform,* J. RETIREMENT PLAN., July–Aug. 2010, at 7.

[121] 42 U.S.C. § 300*ll*-7(a), (b) (Supp. IV 2007–2011).

[122] *See* Letter from Kathleen Sebelius, Sec'y Dep't of Health & Human Servs., to Congress (Oct. 14, 2011), *available at* http://www.hhs.gov/healthcare/facts/blog/ 2011/10/class10142011.html.

repealed by the legislation that forestalled the "fiscal cliff" at the very beginning of 2013.[123] In its place, Congress created that most quintessentially worthless alternative, a commission to study how long-term care should be financed.[124] The bottom line is that the federal government will probably not be increasing its role in financing long-term care outside the poverty-based space that is presently occupied by Medicaid any time soon.

XII.   CONCLUSION

        Retirees are never more "on their own" than when they try to cover their retirement health care expenses. In fact, a comprehensive analysis of twelve prominent online retirement calculators found that all but two did not even consider health and long-term care expenses.[125] Yet, seniors who consulted a professional regarding retirement planning indicated that their number one concern was "the future of Medicare," followed closely by "paying for long-term care" and "paying for healthcare."[126] With health care constituting one of the largest and the least predictable of all retirement expenses,[127] retirees with defined contribution plans will be increasingly desperate as they contemplate the daunting challenge of covering these critical costs.

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[123] American Taxpayer Relief Act of 2012, Pub. L. No. 112–240, § 642(a), 126 Stat. 2313, 2358.

[124] American Taxpayer Relief Act of 2012, Pub. L. No. 112–240, § 643, 126 Stat. 2313, 2358–62.

[125] BRYAN DOWD ET AL., AARP PUB. POL. INST., PLANNING FOR RETIREMENT? WEB CALCULATORS WEAK ON HEALTH COSTS 7–8 (2008), *available at* http://assets.aarp.org/rgcenter/health/ 2008_12_savings.pdf.

[126] ALLSUP, ALLSUP MEDICARE ADVISOR® SENIORS SURVEY: MEDICARE PLANNING AND TRENDS AMONG SENIORS WITH FINANCIAL PLANNERS 7 (2012), *available at* http://www.allsup.com/portals/4/AMA-Seniors-Survey-Financial Plan ners-Oct2012.pdf.

[127] *See* Allison K. Hoffman & Howell E. Jackson, *Retiree Out-of-Pocket Healthcare Spending: A Study of Consumer Expectations and Policy Implications*, 39 AM. J.L. & MED. 62, 83–85 (2013) (comparing estimates of future health care spending of 1,700 near and current retirees with experts' estimates).

AN AFFORDABLE CARE ACT FOR RETIREMENT PLANS?

AMY B. MONAHAN[*]

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In the United States, the availability of tax subsidies for retirement savings is largely based on an individual's employment status and whether such individual's employer has voluntarily chosen to offer a tax-favored savings vehicle. Even where an individual has access to an employer-sponsored retirement plan, such plans are too often suboptimally designed. This article proposes an incremental reform that ensures universal access to tax-favored retirement savings irrespective of employment status or employer decisions. Borrowing from the model of the Affordable Care Act, the article calls for the creation of an optional, universally available retirement plan, which would be designed according to both retirement savings and behavioral best practices. Such a plan would be designed to increase the number of Americans saving for retirement, as well as the likelihood that individuals will accumulate sufficient savings to maintain their standard of living throughout retirement. After discussing the design details for such a plan, the article concludes by examining the legal and practical challenges of implementing a universal retirement plan at either the federal or state level.

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I.   INTRODUCTION

Given the current challenges of implementing the Affordable Care Act (ACA), it is perhaps unwise to suggest that the ACA's model should be replicated in the retirement plan context, as the title of this article suggests. However, the basic structure of the ACA, which provides all Americans with access to health insurance regardless of their employment status or their employer's choices, provides a promising model for enhancing retirement savings and security.

Many Americans are ill equipped for their retirement, having failed to save a sufficient amount to maintain their standard of living in

retirement.[1] Much blame for this failure has been placed on the widespread shift in the design of employer-sponsored retirement plans.[2] Instead of being offered traditional, defined benefit pension plans that offer a set level of lifetime income, most employees are now offered only a defined contribution plan, usually in the form of a 401(k) plan.[3] These defined contribution plans depend for their success on individual participants making rational decisions and executing them in a timely manner. Yet, there is significant evidence suggesting that many individuals fail to make rational decisions and implement them in a timely manner. As one prominent scholar succinctly put it, "It's crazy that we ended up with this as our retirement system."[4] The popular 401(k) plans, she explained, were meant to supplement traditional forms of lifetime income, such as social security and defined benefit pension plans.[5] "It was supposed to be money that you could use to go to Paris. Instead, it's become our basic system."[6]

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[1] *See, e.g.*, Jack VanDerhei & Craig Copeland, *The EBRI Retirement Readiness Rating: Retirement Income Preparation and Future Prospects*, 334 EMP. BENEFIT RES. INST. ISSUE BRIEF 1 (2010), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1645412 (estimating that 47.2% of early baby boomers are at risk of not having sufficient resources to pay for basic retirement expenditures and uninsured health costs). One large administrator of 401(k) plans recently reported that average 401(k) plan balances for those age 65-69 were $136,800. Jill Schlesinger, *The Latest on America's 401(k)s*, CHI. TRIB., Feb. 27, 2013, *available at* http://articles.chicagotribune.com/2013-02-27/business/sns-201302271600--tms--retiresmctnrs-a20130227-20130227_1_retirement-savings-fidelity-plans-fidelity-investments.

[2] *See, e.g.*, Edward A. Zelinsky, *The Defined Contribution Paradigm*, 114 YALE L.J. 451 (2004); James M. Poterba, *Individual Decision Making and Risk in Defined Contribution Plans*, 13 ELDER L.J. 285 (2005); Susan J. Stabile, *Is It Time to Admit the Failure of an Employer-Based Pension System?*, 11 LEWIS & CLARK L. REV. 305 (2007).

[3] Craig Copeland, *Retirement Plan Participation and Asset Allocation, 2010*, 34 EMP. BENEFIT RES. INST. NOTES 9, 11 (2013), *available at* http://www.ebri.org/pdf/notespdf/EBRI_Notes_04_Apr-13_CDHPs-RetPart1.pdf (finding that among working heads of households who participated in an employer-sponsored retirement plan, 18.9% participated only in a defined benefit plan, 65% participated only in a defined contribution plan, and 16.1% participated in both).

[4] Jeff Sommer, *Suddenly, Many Nest Eggs Look Fragile*, N.Y. TIMES, June 15, 2013, http://www.nytimes.com/2013/06/16/your-money/suddenly-retiree-nest-eggs-look-more-fragile.html?pagewanted=all&_r=0.

[5] *Id.*

[6] *Id.*

While the problems associated with individual retirement savings decisions are well documented, this article seeks to highlight another weakness of our current reliance on 401(k) plans to deliver retirement security – suboptimal *employer* decision-making. Our retirement savings system relies on employers voluntarily offering retirement plans. Some employees do not have access to tax-favored retirement savings plans simply because their employer does not offer one.   And even when employers do offer a plan, they often offer a plan that is not well-designed to help participants accumulate sufficient retirement savings. These plans often minimize employer costs while failing to take into account the abundant literature on 401(k) plan designs that can help overcome some of the well-known weaknesses in individual retirement savings decisions. To address the potential problems with employer decision-making in the 401(k) plan context, this article suggests both federal and state solutions that borrow from the ACA model for health insurance to ensure that all Americans who wish to save for retirement have a well-designed option available to them in the event their employer either fails to offer a plan or offers a plan that is suboptimally designed. The goal of this proposal is to minimize both suboptimal participant-level decisions regarding retirement saving and also suboptimal employer-level decisions regarding plan design.

II.   WEAKNESSES IN THE CURRENT MODEL OF RETIREMENT SAVINGS

The weaknesses in individual decision-making within participant-directed 401(k) plans are well documented. Individuals struggle to begin saving at an early enough age to meet their retirement goals, they often fail to contribute sufficient amounts, and have difficulty navigating investment and distribution options. Less appreciated is the fact that many employers make poor decisions when they design their 401(k) plans. This Part will review the weaknesses in the 401(k) plan model that might explain why so few Americans appear to be able to achieve financial security through such plans.

A. INDIVIDUAL DECISION-MAKING

Section 401(k) plans are premised on classic economic theory, which posits that welfare will be optimized where each individual makes his or her own rational savings and consumption decisions within a fully

functioning market.[7] The success of a 401(k) plan in providing adequate retirement income depends on an individual making several important decisions: whether and when to participate in the plan, what amount of salary to defer to the plan, where to invest plan contributions, when (if at all) to access retirement savings prior to retirement, and the rate at which to withdraw savings once retirement age has been reached. If an individual is perfectly rational, this type of retirement plan should work very well, as it can be customized to match the individual's preferences.[8]

We have good reason to believe, however, that most individuals are not perfectly rational and do not make optimal decisions within the 401(k) plan context.[9] These problems with participant-level decision-making have been well documented elsewhere,[10] and therefore this article provides only a high-level overview of the key findings. For plans that require an individual to take affirmative action to enroll in the plan, participants often procrastinate in implementing the decision to participate, thereby shortening the period of time they are saving for retirement.[11] In addition, many studies have shown that once individuals elect to participate they are overwhelmed by the decisions they are required to make, such as selecting a contribution level and making investment decisions, and therefore stick to the defaults or allow the plan's framing of choices to

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[7] *See* Amy B. Monahan, *Addressing the Problem of Impatients, Impulsives and Other Imperfect Actors in 401(k) Plans*, 23 VA. TAX REV. 471, 480–81 (2004).

[8] *See id.*

[9] *See, e.g.,* James J. Choi et al., *For Better or for Worse: Default Effects and 401(k) Savings Behavior, in* PERSPECTIVES ON THE ECONOMICS OF AGING (David A. Wise ed., 2004); Julie R. Agnew & Lisa R. Szykman, *Asset Allocation and Information Overload: The Influence of Information Display, Asset Choice, and Investor Experience*, 6 J. BEHAV. FIN. 57 (2005); Shlomo Benartzi & Richard H. Thaler, *Heuristics and Biases in Retirement Savings Behavior*, 21 J. ECON. PERSPECTIVES 81 (2007); Brigitte C. Madrian & Dennis F. Shea, *The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior*, 116 Q.J. ECON. 1149 (2001); Olivia S. Mitchell & Stephen P. Utkus, *Lessons from Behavioral Finance for Retirement Plan Design* (Pension Research Council, Working Paper No. 2003-6, 2003). For a helpful overview of the literature on retirement savings decisions, see Melissa A. Z. Knoll, *The Role of Behavioral Economics and Behavioral Decision Making in Americans' Retirement Savings Decisions*, 70 SOC. SEC. BULL. 1 (2010).

[10] *See* sources cited *supra* note 9.

[11] Knoll, *supra* note 9, at 8–9.

impact their decisions.[12] There is also strong evidence that hyperbolic discounting affects retirement savings decisions causing individuals to give more weight to current consumption than to future needs, thereby under-saving for retirement.[13] Many studies have shown that simply changing plan defaults results in dramatic changes in behavior – which would not be predicted under standard economic theory.[14] According to standard economic theory, a rational decision-maker will simply opt out of any defaults that do not maximize her preferences.[15] Yet, the evidence on the impact of defaults in the retirement savings context suggests that cognitive biases are impacting many individuals' decision-making.[16]

B. EMPLOYER DECISION-MAKING

A less explored weakness inherent in relying on 401(k) plans to provide retirement security is the fact that they depend on sound employer decision-making.[17] In theory, employers should act as effective agents for their employees and offer retirement plans that maximize their employees' preferences.[18] But there are various reasons why employers may not, in fact, offer plans designed to produce adequate retirement income. The subparts below illustrate the ways in which employer decision-making can negatively impact employees' retirement security.

1. Failing to Offer a Plan

Employers are not required to offer any type of retirement plan to their workers. It is a completely voluntary decision, driven by labor market

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[12] *See, e.g.*, Agnew & Szykman, *supra* note 9, at 66; Choi et al., *supra* note 9, at 125.

[13] *See, e.g.*, David Laibson, *Golden Eggs and Hyperbolic Discounting*, 112 Q.J. ECON. 443 (1997).

[14] *See, e.g.*, Choi et al., *supra* note 9.

[15] *See id.* at 81.

[16] *See id. See also* Madrian & Shea, *supra* note 9.

[17] For an examination of the role of employers in employees' health and retirement security, see Amy B. Monahan, *Employers as Risks*, 89 CHI. KENT L. REV. 751 (2014).

[18] *See* Gregory Acs & Eugene Steuerle, *The Corporation as Dispenser of Welfare and Security*, *in* THE AMERICAN CORPORATION TODAY: EXAMINING THE QUESTIONS OF POWER AND EFFICIENCY AT THE CENTURY'S END 360, 361 (Carl Kaysen, ed. 1996).

pressures.[19] We would expect an employer to voluntarily offer a retirement plan in lieu of other forms of compensation where it believes that doing so will help it attract and retain workers.[20] Indeed, pension formation is typically explained as a contract driven by worker demand to provide workers with security and income protection.[21] But it is widely acknowledged that pensions also offer other benefits to employers, in addition to simply helping them attract and retain employees. For example, pensions can help employers control their employees' tenure and turnover by designing plans to encourage retirement at certain ages.[22]

But allowing labor market pressures to determine whether a retirement plan is offered has shortcomings. It aggregates the preferences of employees. If the majority of employees of a given employer do not value retirement benefits, the employer is unlikely to offer a plan. For those minority employees that would value a retirement plan, their only option would be to find a different employer that offers the desired benefits. Because many factors enter into a decision to work at one firm over another, it may be that many who desire a retirement plan are not offered one. And bear in mind that a job switch is in fact the only complete solution if an employee's current employer fails to offer a retirement plan. While there are individual tax-favored retirement accounts available outside of the employment context, none can duplicate the extent of the tax benefits available to employer plans. An employee can currently defer up to $17,500 of her salary tax-free per year to a 401(k) plan,[23] but can only contribute $5,500 annually to an Individual Retirement Account (IRA).[24]

Prior to health care reform, we saw the same dynamic at play in an employer's decision to offer a health plan to employees. Employers

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[19] *See* TERESA GHILARDUCCI, LABOR'S CAPITAL: THE ECONOMICS AND POLITICS OF PRIVATE PENSIONS 2 (1992).

[20] *See* Alan L. Gustman et al., *The Role of Pensions in the Labor Market: A Survey of the Literature*, 47 INDUS. & LABOR REL. REV. 417, 426 (1994).

[21] GHILARDUCCI, *supra* note 19. For alternative explanations of pension formation, see *id.* at 2–7.

[22] *Id*. at 2–3.

[23] I.R.S. News Release IR-2013-86 (Oct. 31, 2013), http://www.irs.gov/uac/IRS-Announces-2014-Pension-Plan-Limitations;-Taxpayers-May-Contribute-up-to-$17,500-to-their-401(k)-plans-in-2014. Participants who are age fifty or older are permitted to contribute an addition $5,500 each year, for a total of $23,000 per year. *Id.*

[24] *Id*. Participants who are age fifty or older may contribute an additional $1,000 per year to an IRA, for a total annual contribution of $6,500. *Id.*

decided to offer a health plan based on labor market pressures,[25] and employees had little ability to replicate the benefits of an employer plan by seeking individual level coverage.[26] Health care reform will change this reliance on employers, as discussed in more detail in Part II.

2. Offering a Suboptimal Plan

Even if an employer offers a retirement plan, it may nevertheless be the case that an employer offers a plan that, from an employee's perspective, is suboptimally designed. Employers offer retirement plans in order to recruit and retain valued workers. Retirement plans help recruit and retain workers when workers find them to be a positive addition to their compensation package. Employers should therefore structure their retirement plans in a way that employees find attractive.[27] In other words, we would expect employers to be effective agents for their employees when they design their retirement plans.[28] Employees, however, are unlikely to be familiar with all of the features of their retirement plan, and are likely, when evaluating an employer plan, to focus on only a few features that are highly salient to employees.[29] For example, it seems plausible that employees would focus on whether a plan is offered at all, and the amount and structure of any employer contributions to the plan, such as matching or profit sharing contributions. Most employees, when deciding whether to accept or retain an offer of employment from a firm, probably do not examine plan details such as plan defaults, the quality of plan investments, investment fees, or forms of distribution. If employers believe or discover that employees focus only on a handful of highly salient features, employers are likely to respond by structuring their plans only around those features and otherwise acting to minimize their costs. For example, an employer might offer a 401(k) plan with a matching

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[25] *See, e.g.*, Michael Chernew et al., *Quality and Employers' Choice of Health Plans*, 23 J. HEALTH ECON. 471, 472 (2004).

[26] *See* Amy B. Monahan & Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 IOWA L. REV. 1935, 1944 (2013).

[27] For an overview of pension theories, see GHILARDUCCI, *supra* note 19, at 1–7.

[28] *See* Chernew et al., *supra* note 24, at 472.

[29] *See* James R. Bettman et al., *Constructive Consumer Choice Processes*, 25 J. CONSUMER RES. 187, 199 (1998) (discussing that increased numbers of alternatives facing the consumer when choosing retirement products lead to a greater use of non-compensatory strategies which eliminate alternatives).

contribution that equals or exceeds that offered by its competitor firms, but in order to reduce its costs associated with the plan might select a plan provider that offers high fee investments, defaults that do not address participants' likely cognitive biases, and distribution forms that do not help participants manage income in retirement. The end result may be that even where employers offer plans, they offer plans that are not designed to maximize participants' retirement security.

Again, much the same dynamic is at play in how employers approach health plan design. Employees are likely to focus only on highly salient features when evaluating a health plan – in this case on premium levels, copays, and whether their current doctor is in-network.[30] And employers are likely to respond to this employee focus by designing plans around the highly salient features, potentially at the expense of other important plan design features such as the quality of the plan or providers.[31]

If this hypothesis regarding employer plan design is correct, the implications for retirement and health security are significant. In the retirement plan context, it would mean that even if every employer made a 401(k) plan available to its workers, the problem of insufficient retirement savings would not be solved. While we know relatively little regarding how employer plan design decisions are made and the factors that motivate those design decisions, data regarding plan features provide support for the hypothesis that the majority of employers do not offer plans that are optimally designed. Plans often have defaults that work against retirement savings. Individuals that desire to participate must take active steps to enroll in the plan, instead of being defaulted into participation.[32] Even where participants are automatically enrolled in a plan, default contribution

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[30] See Amy B. Monahan, *Why Tax High-Cost Employer Health Plans?*, 65 TAX L. REV. 749, 764–765 (2012).

[31] See Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 58–59 (1999) (explaining how health insurance companies are likely to structure health plans given consumers' focus on only a handful of highly salient features).

[32] *See* Alicia H. Munnell, *401(k) Plans in 2010: An Update from the SCF*, ISSUE IN BRIEF (Ctr. for Ret. Research at Bos. C., Boston, MA), July 2012, at 1, 4, *available at* http://crr.bc.edu/wp-content/uploads/2012/07/IB_12-13-508.pdf (finding that fewer than half of all 401(k) plans offered automatic enrollment in 2010).

rates are often too low to provide adequate savings.[33] Many plans allow easy access to savings prior to retirement,[34] and nearly all have a lump sum distribution as either the default or the only form of distribution available.[35]

In addition, plans sometimes work against participants' savings goals by offering poor investment choices and little investment advice.[36] As we have seen through countless class action lawsuits, many employers allegedly offer a menu of investments that charge excessive fees.[37]

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[33] *See id. See also* DELOITTE, ANNUAL 401(K) BENCHMARKING SURVEY 9 (2012), *available at* http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Consulting/us_cons_hc_401ksbecnchm arkingsurvey2012.pdf (finding that the average default contribution rate was 3%, an amount unlikely "to support a comfortable retirement").

[34] For example, approximately 90% of 401(k) plan participants participate in a plan that offers plan loans. John Beshears et al., *The Availability and Utilization of 401(k) Loans* 2 (John. F. Kennedy Sch. of Gov't, Working Paper No. 11-023, 2011), *available at* https://research.hks.harvard.edu/publications/getFile.aspx?Id =693. Sixty-six percent of all 401(k) plans permit participants to take hardship distributions prior to retirement. INTERNAL REVENUE SERV., SECTION 401(K) COMPLIANCE CHECK QUESTIONNAIRE FINAL REPORT 6 (2013), *available at* http://www.irs.gov/pub/irs-tege/401k_final_report.pdf. Studies are, however, mixed on the extent to which such pre-retirement access threatens retirement security. *See generally* sources cited *infra* note 64.

[35] *See* INTERNAL REVENUE SERV., *supra* note 34, at 59 (finding that 99% of 401(k) plans offer a lump sum distribution, while only 19% offer a qualified joint and survivor annuity). *See also* HEWITT ASSOC., TRENDS AND EXPERIENCES IN 401(K) PLANS 7 (2009) *available at* http://www.retirementmadesimpler.org/ Library/Hewitt_Research_Trends_in_401k_Highlights.pdf (finding that all 401(k) plans offered a lump sum option, while 14% offered annuities).

[36] *See, e.g.,* James Kwak, *Improving Retirement Savings Options for Employees*, 15 U. PA. J. BUS. L. 483, 511–12 (2013) (examining the weaknesses of 401(k) investment options); Karen Blumenthal, *Thanks but No Thanks on 401(k) Advice*, WALL ST. J., Nov. 7, 2011, http://online.wsj.com/news/articles/ SB10001424052970204346104576638933476020932 (finding that while a majority of 401(k) plans offer investment advice, only around a quarter of participants offered some form of investment advice utilize the service).

[37] For a detailed examination of this litigation and its effects, see Mercer Bullard, *The Social Costs of Choice, Free Market Ideology and the Empirical Consequences of the 401(k) Plan Large Menu Defense*, 20 CONN. INS. L.J. 335 (2014) and Ian Ayres & Quinn Curtis, *Beyond Diversification: The Pervasive Problem of Excessive Fees and "Dominated Funds" in 401(k) Plans* 13-20 (Feb. 21, 2014 (unpublished manuscript) *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2399531. *See also* Kelly

Employers often offer employer stock as an investment option, even though in many cases it is unwise for a participant who depends on an employer for her current income to invest in that employer's stock for her long-term savings.[38] And finally, plans are permitted to, and often do, pass along to participants nearly all of the administrative costs of running the plan, further reducing participants' rate of return.[39]

There has been one area of plan design that has improved significantly over the last decade. Beginning in the 1990s, several 401(k) plan sponsors began experimenting with automatic enrollment provisions, which provide that an eligible participant will automatically participate in the employer's plan unless he or she takes affirmative action to opt out.[40] The number of employers utilizing automatic enrollment grew following the passage of the Pension Protection Act of 2006, which offered employers various incentives for putting such procedures in place. However, a well-known potential weakness of automatic enrollment provisions is that plan sponsors can choose default contribution levels and investment options that are too low and too conservative to produce adequate retirement savings. When automatic enrollment provisions first gained traction in the late 1990s and early 2000s, default investment options were primarily conservative, capital-preserving investments.[41] However, a recent survey found that 82% of plans with automatic enrollment now had as their default investment option a lifecycle or target-date fund, designed to invest appropriately given the participant's years to

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Greene, *Letters About 401(k) Plan Costs Stir Tempest*, WALL ST. J., July 24, 2013, http://online.wsj.com/news/articles/SB10001424127887323971204578626103409 341648 (describing Yale Law Professor Ian Ayres' letter writing campaign to 401(k) plan sponsors regarding their fee levels, and the reaction such letters have provoked).

[38] *See generally* Ning Tang et al., *The Efficiency of Sponsor and Participant Portfolio Choices in 401(k) Plans*, 94 J. PUB. ECON. 1073 (2010).

[39] *See* DELOITTE, *supra* note 33, at 19 (finding that 51% of plans paid all administrative and recordkeeping fees through investment revenue).

[40] *See* Jack VanDerhei & Craig Copeland, *The Impact of PPA on Retirement Savings for 401(k) Participants*, 318 EMP. BENEFIT RES. INST. ISSUE BRIEF 1, 4 (2008), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_06-20087.pdf.

[41] *See* PROFIT SHARING/401(K) COUNCIL OF AMERICA, AUTOMATIC ENROLLMENT 2001: A STUDY OF AUTOMATIC ENROLLMENT PRACTICES IN 401(K) PLANS *available at* http://www.pcsa.org/data/autoenroll2001.asp (finding that among plans with automatic enrollment, 66% had a conservative default investment option such as a stable value or money market fund).

retirement.[42] Note, however, that this change was likely brought about by a change in Department of Labor regulations that protected plan fiduciaries from liability where they offered a "qualified investment" as the default investment option.[43] This change does not appear to have been the result of employers independently making a decision to improve the quality of the plan's default investment option. As a result, this improvement does not provide significant evidence against the hypothesis that employers often lack motivation to design optimal retirement plans. Indeed, when the state of 401(k) plan design is viewed as a whole, it seems reasonable to conclude that even when participants are lucky enough to be offered an employer-sponsored retirement plan, that plan in many cases will not be designed to maximize retirement security.

III.   THE ACA MODEL

While there is reason to be less than confident in our current retirement savings system, the structure of federal health care reform provides an interesting model of how dependence on employers can be reduced, and portions of its structure might successfully be borrowed to improve retirement savings.   As noted above, there are important similarities between employer-sponsored health and retirement plans. Both types of plans depend on employer decision-making for their success. An employer must decide to offer a plan if an employee is to have access to the benefit at all, since neither type of plan can be duplicated outside of the employment context.[44] And the quality of the benefit provided depends in large part on how employers decide to structure the benefit plan. If an employer makes suboptimal choices in a health plan, an individual's health

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[42] *See* DELOITTE, *supra* note 33, at 11.

[43] Default Investment Alternatives Under Participant Directed Individual Account Plans, 29 C.F.R. § 2550.404c-5 (2008). Each of the three qualified default investment options is diversified in order to minimize the risk of large losses but also to provide long-term growth potential.

[44] Health plans, like retirement plans, depend on employer sponsorship for the individual to receive the most favorable tax treatment. If an employee buys health insurance on her own, she must pay for the coverage with after-tax dollars, whereas an employee who participates in an employer plan may pay premiums with pre-tax dollars. This tax advantage did not change with the passage of the ACA. In addition, purchasing coverage through an employer gives the employee access to group coverage, which tends to be more affordable than individual coverage. *See* Monahan & Schwarcz, *supra* note 26, at 1942–44.

security can be jeopardized, much the same way an individual's retirement security can be compromised if an employer designs a suboptimal retirement plan.

For health plans, however, this should begin to change as the major reforms of the ACA take effect.[45] Once the ACA's provisions are fully effective, individuals who are not offered health coverage through an employer, or are offered a plan that does not satisfy their preferences, should have a meaningful coverage alternative. Such individuals can freely purchase any individual coverage available on their state's health insurance exchange[46] and, assuming these markets function well post-reform, should have a broad variety of plan designs and premium levels from which to choose.[47] The ACA requires all plans sold on the state exchanges (referred to as "qualified health plans") to satisfy various plan design, content and quality requirements in order to ensure that the options available meet minimum standards.[48] In other words, one underappreciated function of the ACA is to act as a backstop for *employer* choices that might be suboptimal from an employee's perspective. While not perfect (an employee purchasing health insurance on an exchange would have to purchase coverage with after-tax instead of pre-tax dollars), the ACA should give an individual a much greater ability to secure desired health care coverage without regard to his or her employer's choices.[49] For example, if an employee is offered health insurance coverage by her employer that has a deductible too high for the employee to afford, or that fails to offer a broad network of providers, that employee is no longer effectively stuck with what the employer offers, but will instead have the option of going to her state's health insurance exchange and buying coverage that satisfies her preferences.

The ACA's provision of a universal option available to all individuals without regard to employment status or employer decision-making provides an interesting model that might be of use in improving retirement security in the United States. Part IV below explores ways in

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[45] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.).

[46] *See* 42 U.S.C. 18031(b) (Supp. V 2012).

[47] *See* 42 U.S.C. 18022 (Supp. V 2012).

[48] *See id.*

[49] For a discussion of some of the implications of these choices, see Brendan S. Maher, *Some Thoughts on Health Care Exchanges: Choice, Defaults, and the Unconnected*, 44 CONN. L. REV. 1099 (2012).

which both the federal and state governments could borrow from the ACA to provide a meaningful alternative to suboptimal employer-sponsored retirement plans.

IV.   A UNIVERSAL BACKSTOP RETIREMENT PLAN

Both the federal and state governments have the ability to use law to improve retirement security for many Americans. This Part begins by exploring the use of a universal "backstop" retirement plan, similar to the concept of a qualified health plan under the ACA, which could help to address the problem of flawed employer decision-making. It then discusses the possibilities and impediments associated with establishing such a backstop at either the federal or state level.

A. BACKSTOP RETIREMENT PLAN DESIGN

There are myriad problems in our current retirement savings system. Employer plans provide the greatest tax benefit for retirement savings, but are far from universal.[50] Even when employer plans are available, they are often not designed to address the well-documented mistakes that individuals make in their retirement savings decisions.[51] While there are Individual Retirement Accounts universally available, these savings vehicles have much lower contribution limits than employer-sponsored plans,[52] involve even more complex participant decision-making

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[50] *See* EMP. BENEFIT RESEARCH INST. & MATHEW GREENWALD & ASSOCS., 2013 RCS FACT SHEET #3, at 5 (2013), *available at* http://ebri.org/pdf/surveys/ rcs/2013/Final-FS.RCS-13.FS_3.Saving.FINAL.pdf. (reporting that only 72% of workers are offered a retirement plan by their employer); *See* Emp. Benefit Research Inst., *Pension Plan Participation,* FAST FACTS (Emp. Benefit Research Inst., Washington, D.C.), March 28, 2013, *available at* http://www.ebri.org/ pdf/FF.225.DB-DC.28Mar13.pdf. (finding that in 2011, 3% of private sector workers participated in a defined benefit plan, 11% participated in both a defined benefit and defined contribution plan, and 31% participated only in a defined contribution plan).

[51] *See supra* Part II.B.2.

[52] *See* I.R.S. Notice 2012-67, 2012-50 I.R.B. 671 (stating that in 2013, individuals can contribute $17,500 to an employer-sponsored 401(k) plan, but can contribute only $5,500 to an IRA).

than employer plans,[53] and are not designed to counteract cognitive biases in retirement savings decisions.[54]

There are many ways to address the perceived shortcomings of our current system. We could reform Social Security so that it provided more complete income replacement in retirement. We could implement a government-sponsored, universal pension plan. We could raise contribution limits on IRAs. The proposal offered in this article is an incremental reform that is based on the premise that 401(k) plans, and defined contribution retirement plans in general, are here to stay and that a wholesale shift away from either defined contribution plans or employer-provided plans is unlikely to be politically viable. Instead, the universal backstop retirement plan is designed to work within the existing employer-based system to ensure that all individuals have access to a quality retirement plan designed to maximize the likelihood that a participant will have adequate income in retirement. The goal is, as best we can, to minimize both suboptimal participant-level decisions regarding saving and investing *and* suboptimal employer-level decisions regarding plan design.

As the ACA will do for health plans, the idea of a backstop retirement plan is to have a plan available to all individuals, regardless of whether they are employed or have access to other retirement plans through an employer. It is offering a new option, not supplanting the existing system. One significant advantage of this type of reform is that it lets the backstop plan compete against employer offerings. It lets participants choose the plan that best meets their needs. In this way, a backstop retirement plan is superior to direct regulation of employer plan offerings. Employers remain free to design a plan that best meets the needs of their

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[53] The decision-making process to establish and fund an IRA is more complicated than participation in a 401(k) plan because there are a greater number of options. An IRA can be established with numerous investment firms, in contrast to an employer that would offer only a single plan. And once an IRA provider is selected, an individual can essentially invest her contributions in any publicly traded security – making the investment decision more complex compared with a 401(k) plan that often offers a limited menu of investment options.

[54] Because IRAs must be initiated and established by an individual, design features such as automatic enrollment, automatically increasing contribution rates, and default investment options typically cannot be utilized. This could change if the law required the establishment of so-called payroll IRAs or automatic IRAs, recently proposed by President Obama. *See Retirement Security for American Families*, WHITEHOUSE.GOV 3, http://www.whitehouse.gov/assets/documents/ Retirement_Savings_Fact_Sheet.pdf (last visited Feb. 16, 2014).

employees, or even forgo a plan, but employees will not bear any ill consequences of the employer's decision. In fact, the backstop retirement plan may incent some employers to improve their plan offerings. It is possible, of course, that employers may drop their retirement plans if a backstop retirement plan becomes available. It is important to note that this is not necessarily a bad outcome, if the backstop plan is appropriately designed. Employers dropping retirement plans is only problematic if their doing so leaves employees worse off with respect to retirement savings. An appropriately designed backstop plan, as discussed in more detail below, should prevent such an outcome.

While in reality designing a backstop plan would be a difficult process relying on input from many experts and stakeholders, I offer here some initial thoughts on basic approaches to the backstop plan and issues to be considered. Some of the design features mentioned would require changes to either federal or state law, an issue I discuss in the next subpart.

The first issue to tackle would be designing the plan to encourage participation. The evidence seems clear that automatic participation, with the ability to opt-out, would be preferable to requiring affirmative action to begin saving.[55] But given that this is a backstop plan, and not merely the plan of a single employer, implementing automatic enrollment is complicated. We have three potential categories of participants: employees who have access to an employer-sponsored plan, employees without an employer plan, and self-employed individuals. It would be easiest to implement automatic enrollment for employed individuals without access to an employer plan. Those individuals could simply be defaulted into the backstop plan through required payroll deduction. For those employees who are offered an employer plan, the question becomes *which* plan they should be automatically enrolled in – the backstop plan or the employer plan? The best approach for an employee would depend on how the employer plan compares to the backstop plan, so that is of little help in determining the default. One simple solution would be to default the employee into the backstop plan only if the employer plan does not provide for automatic enrollment. For self-employed individuals, automatic

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[55] *See, e.g.,* Richard H. Thaler & Shlomo Benartzi, *Save More Tomorrow: Using Behavioral Economics to Increase Employee Saving*, 112 J. POL. ECON. S164, S169 (2004); John Beshears et al., *The Importance of Default Options for Retirement Savings Outcomes: Evidence from the United States*, *in* SOCIAL SECURITY POLICY IN A CHANGING ENVIRONMENT 167–95 (Jeffrey Brown et al. eds., 2009).

enrollment is impossible to implement because payroll deduction is not practical. But there are other methods to encourage participation. Self-employed individuals could face a small fee for failing to participate in the plan (or an equivalent retirement savings vehicle), or they could be required to state when filing their federal tax return whether they wish to participate in the plan, and be given the ability to direct any tax refund to the backstop plan. These are not ideal, of course, but illustrations of how participation can be encouraged without the ease of payroll deduction.

After tackling the issue of getting individuals into the backstop plan, the next design issue is contributions, both participant and employer. Ideally, the default contribution level for participants would be a percentage of wages which, if contributed over an average working life, and taking into account an appropriate investment return assumption, would result in a level of income replacement at retirement that would be sufficient to provide seventy to eighty percent of pre-retirement income for the average life expectancy.[56] Obviously, such a contribution level would not be ideal for everyone, and in fact may be so large as to result in participants either dropping out of the plan entirely or lowering their contribution rate.[57] Further study would be necessary to select a contribution rate that would maximize plan participation and contribution rates. One possibility would be to adjust the contribution rate based on a

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[56] Financial planners often suggest that, for most individuals, retirement savings should aim to replace 70% to 80% of pre-retirement income, although this is at best a rough guide. *See, e.g.*, Jason Jenkins, *The New Rule of Thumb for Retirement Savings*, INVESTMENT U (2012), *available at* http://www.investmentu. com/2012/October/new-rule-of-thumb-for-retirement-savings.html. For a more sophisticated analysis of retirement savings needs, see Jonathan Skinner, *Are You Sure You're Saving Enough for Retirement?* (Nat'l Bureau Econ. Research, Working Paper No. 12981, 2007), *available at* http://www.nber.org/papers/w 12981.pdf?new_window=1.

[57] *See* Thaler & Benartzi, *supra* note 55, at S169–72 (citing behavioral analysis which indicates that many individuals who perceive themselves as unable to meet current expenditures will not be interested in increasing their participation in savings plans if a rate above their perceived ability to save is suggested); *See* Beshears et al., *supra* note 55, at 171 (noting that employers often set automatic enrollment contribution levels low due to the commonly held belief that high contribution levels will encourage employees to opt out).

participant's income.[58] Another well-tested plan design would be to start participants at a low initial contribution rate, and increase that contribution rate automatically at specified intervals to gradually bring a participant to an adequate savings level.[59]

It is important that employers be able to contribute to an employee's account in the backstop plan. It is easy to imagine that many employers would, if a backstop retirement plan were in place, no longer sponsor their own 401(k) plan. But without the ability of employers to contribute directly to their employees' retirement, an important source of savings would be lost. Therefore, making it easy (and tax advantaged) for an employer to contribute to an employee's retirement savings, whether through an employer-sponsored plan or the backstop plan, would be an important design feature.

Assuming that participation is encouraged at an adequate savings rate, the next design issue, and potentially the most difficult one, is to determine both the default and alternative investment options. The ideal default investment is likely a passive fund that offers the appropriate mix of risk and return characteristics appropriate for the individual's savings horizon.[60] Target date funds, which are designed to automatically shift the fund's asset allocation as the target retirement date nears, are attractive because they are designed around the participant's investment time horizon, and they offer one-stop shopping.[61] Theoretically, a participant could put all of their savings in a single target date fund. These funds are not without risks,[62] but they may provide a better default option than others readily available.[63]

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[58] Varying contribution rates by income level may be more palatable to low-income individuals, and could also be designed to reflect the fact that social security replaces a larger percentage of income for low-income individuals.

[59] A plan design with automatically increasing contribution rates was pioneered by economists Richard Thaler and Shlomo Benartzi. *See* Thaler & Benartzi, *supra* note 55.

[60] *See* Kwak, *supra* note 36.

[61] Julie R. Agnew et al., *What People Know About Target-Date Funds: Survey and Focus Group Evidence* 4 (Fin. Sec. Project at B.C., Working Paper 2011-2), *available at* http://crr.bc.edu/wp-content/uploads/2011/05/FSP-WP-2011-2.pdf.

[62] *See* Zvi Bodie et al., *Unsafe at Any Speed? The Designed-in Risks of Target-Date Glide Paths*, J. FIN. PLAN. (March 15, 2010), *available at* http://www.fpanet .org/journal/CurrentIssue/TableofContents/UnsafeatAnySpeed/.

[63] Zvi Bodie et al., *Life Cycle Finance and the Design of Pension Plans*, 1 ANN. REV. OF FIN. ECON. 249, *available at* http://papers.ssrn.com/sol3/papers.cfm?

An important issue worth considering is whether the backstop plan should *not* have participant-directed investment, but should instead operate as a cash balance plan, where participants are guaranteed a rate of return on their contributions.[64] If a cash balance approach is taken, participants would not face significant investment risk, a distinct advantage over current 401(k) plans.[65] The price, of course, is that such plans typically have conservative rates of return, which may be insufficient to provide adequate retirement income given reasonable contribution rates.[66] Another option would be to default participants into the cash balance plan and allow individuals to opt out of the cash balance plan and into a participant-directed 401(k) plan if desired. Doing so would allow more sophisticated investors to seek higher rates of return than the cash balance plan offers, while still offering unsophisticated or risk-adverse investors a guaranteed rate of return.

Another approach to participant investments would be to invest contributions in deferred life annuities, similar to a recent proposal by Senator Hatch for public pension plans.[67] Investing contributions in annuities would both protect employees against investment risk and provide them with a guaranteed income stream at retirement. However, like the cash balance option described above, such a structure would not necessarily guarantee that the amount of the income stream would be adequate.

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abstract_id=1396835. For an interesting example of an investment option that utilizes both target date funds and annuities that provide a guaranteed level of lifetime income, see Tara Seigel Bernard, *A 401(k) That Promises Never to Run Dry: [Your Money]*, N.Y. TIMES Nov. 14, 2012, at F.4, *available at* http://www.nytimes.com/ 2012/11/14/your-money/a-401-k-that-promises-income-for-life.html?r=0.

[64] Kevin E. Cahill & Mauricio Soto, *How Do Cash Balance Plans Affect the Pension Landscape?*, AN ISSUE IN BRIEF (Ctr. For Ret. Research. Bos. Coll., Boston, MA), Dec. 2003, at 1, 1.

[65] *See id*. at 3; Richard W. Johnson & Cori E. Uccello, *Cash Balance Plans: What Do They Mean For Retirement Security?*, 57 NAT'L TAX J. 315, 316–18 (2004).

[66] *See* Cahill & Soto, *supra* note 64 at 3 (noting that cash balance plans on average offer a 5.6% rate of return, compared to a market-average rate of return of 7.6%).

[67] *See* The Secure Annuities for Employees Retirement Act, S. 1270, 113th Cong. (2013).

The final major design decision concerns plan distributions, both before and during retirement. Allowing easy access to retirement savings prior to retirement may significantly endanger retirement security.[68] However, individuals may be more likely to participate in the first place if they know that they can access their savings in the event of a financial hardship.[69] To balance these competing concerns, the plan could offer pre-retirement distributions only for specific financial hardships,[70] instead of offering relatively unrestricted pre-retirement access as many employer 401(k) plans do currently.[71] Consideration should be given to whether pre-retirement access should only be the form of plan loans,[72] or whether an outright distribution will be permitted, and in what circumstances.

The other major design decision with respect to distributions will be the form of retirement distributions. Most participants in 401(k) plans receive lump sum distributions.[73] However, what most individuals require

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[68] *See* Alicia H. Munnell & Annika Sundén, *401(k) Plans Are Still Coming Up Short*, ISSUE IN BRIEF (Ctr. for Ret. Research Bos. C., Boston, MA), Mar. 2006, at 1, 5, *available at* http://crr.bc.edu/wp-content/uploads/2006/03/ib_43.pdf.

[69] The evidence regarding whether or to what extent access to funds pre-retirement increases participation are mixed. *Compare* Alicia H. Munnell et al., *What Determines 401(k) Participation and Contributions?* 16 (Ctr. for Ret. Research Bos. Coll., Working Paper No. 2000-12, 2000), *available at* http://crr.bc.edu/wp-content/uploads/2000/12/wp_2000-12.pdf ("the ability to borrow increases the contribution rate by about 1 percentage point"), *with* U.S. GEN. ACCOUNTING OFFICE, 401(K) PENSION PLANS: LOAN PROVISIONS ENHANCE PARTICIPATION BUT MAY AFFECT INCOME SECURITY FOR SOME 5 (1997), *available at* http://www.gao.gov/archive/1998/he98005.pdf ("[p]articipation rates in plans with loan provisions are about 6 percentage points higher than plans with no loan provisions").

[70] The IRS publishes a list of "safe harbor" reasons for hardship distributions, which could be used in the loan context as well. *See* Treas. Reg. § 1.401(k)-1(d)(3)(iii) (2011).

[71] PROFIT SHARING/401(K) COUNCIL OF AM., PLAN LOAN RESTRICTION STUDY (1999), *available at* http://www.psca.org/RESEARCHDATA/PlanLoanRestriction Study/tabid/176/Default.aspx (reporting that 82% of plans did not place restrictions on the purposes for which a plan loan would be granted).

[72] Loans have the advantage of allowing the participant to return the retirement savings to the plan with interest, but loan repayment may not be possible in some financial circumstances.

[73] *See* U.S. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, BULL. NO. 2749, NATIONAL COMPENSATION SURVEY: HEALTH AND RETIREMENT PLAN PROVISIONS IN PRIVATE INDUSTRY IN THE UNITED STATES, 2009, at 125 (2010),

in retirement is lifetime *income*.[74] For this reason, having a life annuity as the default form of retirement distribution likely makes the most sense, with notice and consent required for other forms of distributions such as lump sum or installments.[75]

1. A Federal Backstop?

With the design basics in place, the next issue to consider is whether a backstop plan is best offered at the federal or state level. A backstop retirement plan created at the federal level has some advantages over state-based plans. Assuming there is political will to put such a plan in place, the federal government could easily pass a law establishing the backstop plan that has the basic design features described above. States, on the other hand, would have to work around existing federal law to put such a plan in place, as is discussed in more detail below. A federal plan may also make sense given that retirement savings goals and related plan design likely do not vary significantly by state, as some other types of programs might, and there are also likely to be economies of scale associated with a single backstop plan, versus fifty individual plans.

The biggest impediment to establishing a federal backstop plan, in addition to political will, is the cost. Assuming that the backstop plan would involve extending the tax benefits of employer-sponsored plans to

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available at http://www.bls.gov/ncs/ebs/detailedprovisions/2009/ebbl0045.pdf (finding that 90% of plan participants had a lump sum distribution option, while 27% were offered installments and 15% were offered an annuity); VANGUARD, DISTRIBUTION DECISIONS AMONG RETIREMENT-AGE DEFINED CONTRIBUTION PLAN PARTICIPANTS 6 (2010), *available at* https://institutional.vanguard.com/iam/pdf/CRRDDP.pdf (finding that only 2% of retirement-aged participants elected installments, whereas 47% took a lump sum distribution and the remainder left their account in the plan).

[74] *See* Lawrence A. Frolik, *Protecting Our Aging Retirees: Converting 401(k) Accounts into Federally Guaranteed Lifetime Annuities*, 47 SAN DIEGO L. REV. 277, 285–86 (2010) (explaining the process of managing retirement wealth to produce an income stream in retirement).

[75] While legislative action to require annuities does not seem imminent, the Department of Labor has recently proposed regulations that would require defined contribution plans to provide on participant's benefit statements an estimated lifetime income stream based on current retirement savings. Pension Benefit Statements, 78 Fed. Reg. 26727, 26737–38 (proposed May 8, 2013) (to be codified at 29 C.F.R. pt. 2520).

the backstop plan, the cost of an already expensive tax expenditure would increase.[76] Given our current fiscal realities, it may be difficult to persuade Congress to spend money now in order to save money on supporting retirees in the future.

One potentially revenue-neutral way to expand tax benefits to the backstop plan would be to lower the current 401(k) deferral limits. In other words, to shift some of the current tax benefits available exclusively to employer-provided plans to a wider population. While there are sound equity-based arguments for lowering the tax benefit but extending it to a wider population, objections might be raised that doing so would have the perverse effect of lowering existing rates of retirement savings by those in employer plans. Further study would be necessary to better understand the effects of shifting the tax benefit. The maximum salary deferral in 2014 is $17,500, but historical data shows that few participants contribute the maximum amount.[77] Not surprisingly, the number of participants contributing the maximum amount to a 401(k) plan is closely correlated to income level.[78] While twenty-eight percent of those earning $100,000 or more contribute the maximum to a 401(k) plan, only one percent of those earning between $40,000 and $60,000 do so.[79] On average, participants contribute between 7.5 and 8% of their income.[80] These data suggest that the maximum pre-tax deferral to 401(k) plans could be lowered without adversely affecting the majority of participants, and the minority that would be affected would be relatively high-income

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[76] The tax expenditure for employer-sponsored defined contribution plans is estimated to be $57 billion in 2013. JOINT COMM. ON TAXATION, 113TH CONG., ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2012–2017, at 39 (Comm. Print 2013), *available at* https://www.jct.gov/publications.html?func=start down&id=4503.

[77] *See* Munnell, *supra* note 32, at 5.

[78] *Id.*

[79] *Id.*

[80] *See* Craig Copeland, *401(k)-Type Plans and Individual Retirement Accounts (IRAs)*, EBRI NOTES (Emp. Benefit Research Inst., Washington, D.C.), Oct. 2007, at 1, 6, *available at* http://www.ebri.org/pdf/EBRI_Notes_10a-2007.pdf (reporting average deferral rate of 7.5%); *Fidelity Average 401(k) Balance Climbs to Record High at End of 2012*, FIDELITY.COM (Feb. 14, 2013), http://www.fidelity.com/ inside-fidelity/employer-services/fidelity-analysis-finds-record-high-average-401k-balance (reporting 8% average annual deferral rate among Fidelity 401(k) plan participants).

participants (who are likely to save for retirement even in the absence of a tax benefit).[81]

Another way to address the tax issue would be to structure the plan as an after-tax plan. One way to do so, which would require no change to tax laws, would be to have contributions to the plan be made on an after-tax basis and have participants subject to capital gains taxation when gains or losses are realized.[82] Another option would be for Congress to make the plan operate like a Roth IRA, where contributions are after-tax, but distributions are tax-free.[83]

2. A State Backstop?

Theoretically, states could take legislative action to do much the same thing as the federal solutions described above. States could create their own state-based retirement plan available to all workers, designed to produce adequate income replacement for the average worker.   But implementing a state-based solution is difficult because of current federal limitations. First, the federal Employee Retirement Income Security Act of 1974 (ERISA), preempts any state law that "relates to" an employee benefit plan.[84] Without getting into the complex details of ERISA preemption, suffice it to say that a state law that required employer participation in a retirement plan or significantly penalized an employer for failing to participate in a retirement plan would be preempted by ERISA.[85] As a

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[81] *See generally* Eric M. Engen et al., *The Illusory Effects of Saving Incentives on Saving*, 10 J. ECON. PERSP. 113 (1996) (examining whether and to what extent tax incentives increase the level of retirement savings).

[82] Depending on the investment strategy pursued, conventional savings accounts without tax deferral can be just as tax efficient as tax-favored accounts that tax gains at ordinary rather than capital gains rates. *See generally*, John B. Shoven & Clemens Sialm, *Asset Location in Tax-Deferred and Conventional Savings Accounts*, 88 J. PUB. ECON. 23 (2003) (describing how locating assets optimally can significantly improve the risk-adjusted performance of retirement saving).

[83] For an overview of the relative tax advantages of Roth IRAs, see Leonard E. Burman et al., *The Taxation of Retirement Saving: Choosing Between Front-Loaded and Back-Loaded Options*, 54 NAT'L TAX J. 689 (2001).

[84] 29 U.S.C. § 1144(a) (2006).

[85] For a more detailed overview of ERISA preemption in this context, see Edward A. Zelinsky. *California Dreaming: The California Secure Choice Retirement Savings Trust Act*, 20 CONN. INS. L.J. 547 (2014).

result, states would be unable to require employer contributions to a state retirement plan, although they should be able to require employers to facilitate payroll deduction contributions to a state retirement plan.

In addition, the federal tax code currently grants tax benefits for retirement savings in limited circumstances – either when an employer plan is utilized, or when a qualified individual retirement account is used. As a result, if a state were to adopt a state-based retirement plan, it may not be able to take advantage of federal income tax preferences. A state backstop retirement plan would not be an employer-provided plan, and therefore would be ineligible for existing federal tax benefits for employer plans. And while the state plan might be able to qualify as an IRA, structuring the plan in such a way would likely prohibit the use of a cash balance design,[86] and would only provide the lower tax benefits available to IRA holders.[87]

Still, there is some reason to believe that this is an area where states may be more interested and nimble than the federal government. Indeed, California has passed a law requiring employers to either sponsor a retirement plan or participate in a state-based retirement plan.[88] That law, however, is effectively on hold until the state can get favorable ruling from the federal government on the tax and ERISA issues noted briefly above and described in more detail in Professor Zelinsky's article in this issue.[89]

States could, of course, design a plan that avoids ERISA preemption and does not depend on federal tax benefits for its success. As mentioned in the previous section regarding a federal backstop plan, a state plan could allow individuals to invest on a post-tax basis, with any gains then being taxed at capital gains rates when realized. Alternatively, the state could offer state-tax benefits to attempt to offset, at least in part, the absent federal tax benefits. For example, a state could exempt from its income tax retirement savings contributions regardless of whether such contributions were made to an employer-based or state-based plan.[90] While this would help improve the tax advantage of the state plan, it would not

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[86] *See id.*

[87] *See* I.R.S. Notice 2012-67, 2012-50 I.R.B. 671.

[88] *See* CAL. GOV'T CODE § 20139 (2013).

[89] See generally Zelinsky, supra note 85.

[90] While states often adhere to the federal definition of income for tax purposes, they are of course free to define income for state income tax purposes in any manner they see fit. For an in-depth discussion of federal-state tax conformity, see Ruth Mason, *Delegating Up: State Conformity to the Federal Tax Base*, 62 DUKE L.J. 1267 (2013).

put participants in the same tax position they would be in if they participated in an employer plan. A state could, however, offer a state matching contribution equal to the estimated value of the federal income tax benefit if the contribution had been made to an employer-plan. Doing so could put the individual in the same position as she would have been in if federal income tax law treated employer and individual retirement savings equally, but it would obviously do so at a cost to state governments. If a state were to expend money on a retirement plan through the use of state tax benefits it would likely want to address how to treat participants in the state plan who move to a different state either before or during retirement. One possibility would be to have a claw back provision that would require repayment of the tax benefit upon losing state residency. On the whole, while states may be good laboratories for experiments in this area, existing federal law may make it difficult for states to meaningfully pursue retirement savings improvements.

3. Which Plan Provider?

Regardless of whether the backstop retirement plan was established at the federal or state level, thought would need to be given to which entity would most appropriately administer the plan and any investment options. One approach would be to designate either a governmental agency or an independent agency to administer the plan. For example, the California law establishing a state retirement plan for all workers allows the state to designate CALPERS (the California Public Employee Retirement System) as the plan administrator.[91] Another approach would be to take a free market approach, and allow any licensed investment firm to offer a retirement plan structured around legal design and investment requirements. Providers could also be made subject to basic fiduciary duties with respect to participants' accounts. While this option involves less direct government action than the first proposal, it would also be in many ways harder to implement, and may cost participants more if fees are not very closely regulated. If there were numerous providers for these plans, it would be difficult to auto-enroll participants, unless some entity wanted to take responsibility of assigning individuals to certain providers. In addition, it would complicate payroll deduction significantly, given that employers would be responsible for transferring contributions to many different providers instead of a single entity.

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[91] See CAL. GOV'T CODE Sec. 20139 (2013).

B. CONGRESSIONAL ACTION TO ALLOW STATE INNOVATION

There may not be political will at the federal level to implement a backstop retirement plan, and states may be hampered in their reform efforts by existing federal laws that constrain their options. One available compromise would be for Congress to amend ERISA to allow state governments to require automatic enrollment in state retirement plans and allow employer contributions to such plans without triggering ERISA preemption. Doing so would significantly broaden states' reform options. If this reform is perused, careful thought should be given to whether ERISA should apply to such state plans and, if so, whether any of its requirements should be modified.[92]

In addition to addressing the ERISA barriers to state action, Congress could also amend the tax code to provide tax benefits for state-based plans that are equivalent to those afforded to private-employer plans. There would again be the issue of increased cost, but perhaps Congress would be willing to do so in order to see the results of state-based retirement plan experiments.

V.   CONCLUSION

The system of retirement savings on which many Americans currently rely does not generate sufficient capital for most individuals to adequately replace their income in retirement. While a widespread shift to 401(k) plans has likely contributed to this outcome, this article has suggested that it is not 401(k) plans per se that are to blame, but rather a bad combination of flawed individual decision-making and poor employer plan design. The federal government could take a lesson from the ACA and create a universally available retirement plan designed to reflect the many lessons learned from behavioral economics about encouraging retirement savings. If it is unwilling to do so, it could at the very least make it possible for states to meaningfully experiment with universal retirement savings options.

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[92] Historically there has been little political interest in subjecting state retirement plans to ERISA regulation. *See* Amy B. Monahan & Renita K. Thukral, *Federal Regulation of State Pension Plans: The Governmental Plan Exemption Revisited*, 28 ABA J. LAB. & EMP. L. 291, 297 (2013).