

**Financial Insecurity:
Facing America's Health Care and Retirement Crisis**
TRANSCRIPT

[Studio Intro]

KELVIN BOSTON (Host):

Americans have never lived longer nor enjoyed such financially comfortable retirements. But this may be coming to an end. From the crippling rise in health insurance costs, to the growing number of the uninsured, to inadequate retirement incomes, Americans face more and more financial insecurity.

[Opening title animation]

KELVIN BOSTON:

Hello I'm Kelvin Boston. Welcome to Financial Insecurity: Facing America's Health Care and Retirement Crisis. On this special, we will explore how these issues impact both employers and employees. We will talk to national experts, meet real people, and give you a better understanding of what this all means for you. We begin by looking at the factors contributing to America's growing financial insecurity, one of which is rising health care costs.

[Documentary]

JIM SMITH, Rand Corporation:

"The average girl born in Santa Monica today has a 50/50 chance of living to 100. This is, at one level, a really good thing. We're getting healthier, the population is healthier, we're living longer. But we have outmoded systems in place to care for them and these systems are too expensive as they are designed right now."

NARRATOR:

America's population is changing. Those more than 80 years old have become the fastest growing age group in America. The share of the American population over age 65 will go from 12 percent today to 20 percent in 2035. Medical advances have helped people stay healthy longer – but at a cost.

STUART ALTMAN, Brandeis University:

"Again, we have our hips replaced. We have our knees replaced. We have all kinds of new radiological techniques that look into our bodies. These are all wonderful. The question is where are we going to find the funding to pay for it? And that is what's scaring a lot of people who worry about the health care system."

NARRATOR:

The cost of health insurance is now growing at twice the rate of the rest of the economy. Between 2000 and 2004, the average annual cost of health insurance for an American family rose from seven thousand dollars to more than ninety three hundred dollars – a 33 percent increase. For working Americans – and for the companies who employ them – paying for health care is becoming a bigger and bigger challenge.

DR. ROBERT GALVIN, Director, Corporate Health Care and Medical Programs,
General Electric:

“I think large employers are for the first time very worried that the whole system of private health care might not survive.”

NARRATOR:

The roots of today’s health care system go back to the 19th century. American Express, then a railroad freight shipper, was the first US company to provide its employees with a pension. In the 1930s, workers building the Grand Coulee Dam became the first to receive comprehensive medical care through their employer -- Henry J. Kaiser.

But company-provided benefits really only became common during World War II. As part of the war effort, the federal government imposed wage controls on private employers. Unable to raise salaries, companies looked for other ways to attract and retain employees.

UWE REINHARDT, Princeton University:

“The companies started to compete for workers with fringes, health insurance being a major one. And so when World War II ended, most corporations offered their employees health insurance, bought it for their workers. Because during the war, that’s what they had to do to get workers.”

NARRATOR:

After the war, tax incentives encouraged a further expansion of benefits. Eventually, two-thirds of working Americans were receiving health insurance through their employers.

But the rising cost of health care has placed the system under stress, and America’s largest employers face hard decisions. General Motors, for example, spends more on employee health care than it does on steel.

UWE REINHARDT, Princeton University:

“If you look at the balance sheets of the auto companies—General Motors, Ford, Chrysler—and you look at all the liabilities they have for pension payment and retirement health care, you get the impression these are not auto companies. They are social security systems, with all these promises, who happen to make automobiles.”

STUART ALTMAN, Brandeis University:

“We have employers who are increasingly finding that the cost of their health insurance - which is averaging \$10,000 for a family around this country today - that more and more employers find if they pay for all this health insurance all, of their profits are gone.”

NARRATOR:

Working Americans may soon find that an increasing share of their compensation will go to pay for health insurance.

UWE REINHARDT, Princeton University:

“People 10 years from now might be making \$50,000 a year. But their insurance policy would cost \$25,000 at current trends. So you’re taking half their wages away just for insurance and you still have to pay Social Security taxes, income taxes, unemployment insurance. All the other things still have to be paid out of that \$50,000. So my prediction is we will price these people out of health care.”

NARRATOR:

Sky rocketing costs and reduced employer coverage have contributed to an increase in the number of the uninsured. There are now 44 million Americans without health insurance.

STUART ALTMAN, Brandeis University:

“In terms of just basic public health, if we have large numbers of Americans that lack insurance, and as a result don’t get needed care and we wind up with certain kinds of communicable diseases which they incur because they didn’t get basic testing, it ultimately could generate a public health problem.”

NARRATOR:

Though the lack of health care is one problem, people going to the doctor too often is another.

JIM SMITH, Rand Corporation:

“So there’s two dimensions. The one most people talk about is the lack of health care for some people and that is an issue. And that’s people under-consuming health care. Much more important are people over-consuming health care. You pony up something, which is called a deductible, say \$1,000, and then pay a fraction of the remaining cost, which is called a co-payment rate of 25 percent. Let’s say we did that with food that you buy, or any other thing that you buy. You have to pay \$500 to \$1,000 and then 25 percent of the rest. And what do you think people are going to do? They’re going to consume a lot of food. If it only costs me 25 cents on the dollar for every item of food I buy, I’m going to consume a lot more food than I would have.”

NARRATOR:

With health care becoming a national issue, we asked a group of people on the streets of New York how the cost of health care is affecting their financial security.

[Man on the Street Interviews]

MAN:

“We’ve been talking about the possibility of buying an RV and touring the country and the only thing that’s stopping us right now is health care. It would be approximately a thousand dollars a month to cover both of us.”

WOMAN:

“I just filled four prescriptions and it cost me \$95.”

WOMAN:

“Even in small businesses they can’t afford to provide health insurance for their workers. We work in a salon and it’s completely unaffordable if you’re not in a major, working for a major company to have health insurance.”

MAN:

“I have cancer. But most of my treatments are covered, so I’m doing well. But I know so many people who are not.”

MAN:

“We’re freelancers, both of us, and we obviously do not have health insurance. So the risk is incredible. I mean, consequently right now, I don’t have any insurance - I don’t know if you have health insurance?”

WOMAN:

“No”

WOMAN:

“I don’t understand what my benefits are. I don’t understand what’s supposed to be my explanation of benefits.”

MAN:

“I’m concerned about my future. About the rising cost of medicine, of medical treatment, companies cutting back on policies or benefits for retirees and also for employees, employees having to pay a bigger share of the health care cost. It’s a terrible situation.”

WOMAN:

“I’m losing my job so I’m losing my health care. And that’s frightening.”

[Documentary]

NARRATOR:

In response to rising costs, some employers are seeking different solutions -- trying to involve employees more deeply in their own health care decisions. These new insurance

programs are called “consumer driven” plans, and they typically do two things. First, they give participants more control and responsibility for funds allocated to health care. And second, they provide consumers with more information to make better decisions.

PAUL FRONSTIN, Employee Benefit Research Institute:

“A consumer driven health plan can be any type of health plan that asks workers to take more responsibility over some decisions. What they typically look like is a high deductible health plan with a savings account attached to it.”

NARRATOR:

The ability to save unspent funds is a key aspect of some consumer driven plans. The money in a health care reimbursement account can be rolled over year to year to provide savings for future health care needs.

ANNE GAUTHIER, Academy Health:

“Some of these new consumer directed products are going to look very appealing, particularly to those who might want to use the special account as a vehicle to save for future expenses. They’re quite appealing to a healthy population.”

NARRATOR:

But some say that making people better consumers of health care is only part of the solution.

DR. ROBERT GALVIN, Director, Corporate Health Care and Medical Programs; GE Chair, The Leapfrog Group:

“What we’ve seen to date in consumer directed plans gets at half the problem. And half the problem is this idea of waking up consumers and making them realize that they need to use the very good brains that they have, and the very smart consumers they are in other sectors - have to use it in health care as well. But I think that’s half the problem. I think the other half of the problem, and what helps fix the system is: What are they going to do now that they have to spend money? And I think that leads to information and it leads to information on quality. For consumer directed plans to really reach their potential, the sponsors of these plans are going to have to insist on putting data about quality right next to the idea of cost.”

NARRATOR:

Data about the quality of health care is hard to come by for the average consumer, but a recent Rand study revealed that care received by patients varies substantially. For example, cataract patients receive about 79 percent of recommended care, while those suffering from ulcers receive just 30 percent of recommended care.

UWE REINHARDT, Princeton University:

“We are only in the infancy of actually measuring and monitoring quality. It has been reported by the Institute of Medicine that possibly up to 90,000 Americans die every year in hospitals from avoidable medical errors. Now that’s a controversial issue, the hospital

industry doesn't buy this number. But it is certainly - I think most medical experts would agree - as many people die in hospitals from avoidable errors as people die on highways from traffic accidents."

NARRATOR:

Avoidable errors can be as simple as a doctor's bad handwriting. In Texas, the hard-to-read handwriting on this prescription led to a patient's death when a pharmacist incorrectly filled it.

Like any consumers seeking to make smart choices, participants in consumer driven plans will need reliable information about many factors related to the care they receive.

DR. ROBERT GALVIN, Director, Corporate Health Care and Medical Programs; GE Chair, The Leapfrog Group:

"I think where the lead purchasers of health care -- both private sector and government -- are headed is really focused pretty simply. Number one: transparency. Meaning, information about quality and cost need to be public about hospitals and doctors. Number two: it's about education. Government for its beneficiaries, employers for its employees and their families - need to educate them through the complexities of the information. I think third, it's about incentives. I think whether you're in the private sector or the public sector, people need to be engaged in some way financially - fairly and equitably - but financially engaged in their decisions. And I think the fourth piece of it is rewards. Those doctors and hospitals that do better need to get rewarded for quality."

[Case study]

NARRATOR:

Terry Mull is one employee who has learned first-hand how health insurance is changing. After almost two years, she's leaving the Denver Book Company, where she worked as a bookbinder. The 22 year-old is going to work at a local casino which will provide health care coverage for her and her one and a half-year-old daughter, Zoe.

TERRY MULL:

"I took my new job to get better insurance. They cover a higher percent after I pay the deductible. And it's low cost for me and my daughter."

NARRATOR:

Facing rising insurance costs, The Denver Book Company increased employees' co-payments and stopped covering family members. For the fifth generation owner of the company, it was a difficult choice.

GAIL LINDLEY President, Denver Book Company:

"When my grandparents started, they paid 100 percent of everything. And then through the years we've had to water that down where the employee now, through all these different changes and shift costs, they have to pick up half of their coverage."

NARRATOR:

It's a problem that is widespread among small business owners.

JACK FARIS, President & Chief Executive, National Federation of Independent Business Owners:

"Part of what we're hearing over and over again is number one, 'I've got to do away with my insurance. I just can't afford it anymore.' Either that or 'I've got to go out of business. I can't lay off any more people because I couldn't do my job. I can't get the business done.'"

NARRATOR:

The few private insurance companies that would have covered Mull and her daughter quoted her rates as high as \$400 a month – a price she says she couldn't afford.

TERRY MULL:

"For almost five months or more I could not even receive any help from anybody to get insurance for my daughter. My new job and their insurance will cover my little girl. And that's just the best thing -- to know that they will cover my daughter."

NARRATOR:

For the Denver bookbinding company, the rising cost of health insurance could mean more tough choices.

GAIL LINDLEY (Denver Book Company):

"You know what it's going to mean, is that we're going to have one less employee to offset that cost. And when you're in business, sometimes you have to make the hard decisions and if it's between you and someone else sometimes that someone else is the one who has to suffer."

NARRATOR:

To help us understand how health care is changing, we asked two experts to join the discussion. Meredith Rosenthal is Professor of Health Economics at Harvard University. Dennis Scanlon is Professor of Health Policy at Penn State University. We began by looking at what happened to Terry Mull and the Denver Book Company.

[Studio discussion]

KELVIN BOSTON:

"Meredith, is this common?"

MEREDITH ROSENTHAL, Professor of Health Economics at Harvard University:

"This problem is increasingly common and again as we were talking about, there are sort of fundamental drivers of health care costs. These drivers make it harder and harder for small companies in particular to afford insurance coverage. The problem is you can't really get a very cheap insurance plan. All insurance plans cover the latest technology

and therefore, you know, as health care spending goes up some companies get priced out, essentially, from offering coverage. And incrementally, of course, they cut back on coverage as well.”

KELVIN BOSTON:

“Dennis what did you take away from this story?”

DENNIS SCANLON, Professor of Health Policy at Penn State University:

“I think it really is a situation – particularly among small employers who are probably more faced with that immediate decision about whether to continue to offer or shift costs to employees, but even the larger employers are facing similar situations. I know of no company who is immune to this in terms of the rise in health care cost. And I think another point that’s worth mentioning is when employees or companies have to do without insurance this adds to the growing problem of the uninsured in this country. And I think one of the myths about the uninsured, we have 40 or 45 million Americans without insurance, is that these are the poor people, these are non-working people. That, in fact, is not true. Many of these people, or a sizeable portion, actually are working families, individuals of significant means but health care is becoming too expensive for them to afford.

KELVIN BOSTON:

What positive things are companies doing to try to address this issue?

DENNIS SCANLON:

I think what a lot of companies are trying to do is realize that there are potential solutions if they can get involved in and engage both consumers as well as engage providers in changing really the way health care is delivered and financed. One of the things about health care, when you really get into the nitty gritty of it, is that we don’t have real good incentives for, not only consumers, but also providers. If you look at some of the evidence, for example, some studies indicate that people get the right quality care for chronic illness, for example, only about half the time. Changing that - making sure that people get the care that they should get - it’s possible, it’s feasible. Introducing things like the use of electronic information systems in health care. Surprisingly, unlike any other industry, health care is still on paper. If we change that, many people view that as being one factor that might help to improve the system and at the same time generate some cost savings. Once again we talked a little bit about consumers, getting consumers more involved, having them become more responsible, more prudent shoppers, just like you would if you were buying a car.

KELVIN BOSTON:

And with the rising costs of health care, do you think that many of our corporations are between a rock and a hard place? Are they really going to be able to keep up in terms of paying these high premiums?

MEREDITH ROSENTHAL:

I think that's the most important question here. And fundamentally they need to come up with a way of either getting the trend under control - and whether employers are really in the best position to do that or not is unclear. They either have to do that, or they're going to have to share more of the costs with consumers. So it does put them between a rock and a hard place because essentially they're trying to keep their employees happy, that's fundamentally why they offer benefits. So it does make a lot of difficulty for employers in that position.

KELVIN BOSTON:

Now let's look at how one employer and one hospital are taking new approaches to health care.

[Case Study]

NARRATOR:

In Dallas Texas, a new approach to health benefits is underway at one of the area's largest employers: Baylor Health Care System, with more than 15,000 employees.

VENITA MCCCELLON-ALLEN. Baylor Health Care System:

"Consumer-driven health has been good for our participants. It's been good for health care and it's been good for us as an employer as we've helped to maintain and decrease future costs for employees."

NARRATOR:

Participating employees are provided cash in a health reimbursement account to spend on their medical expenses. For example, an employee is given one thousand dollars in their health reimbursement account in Year One. If the employee spends only five hundred dollars on health care, they can roll over the remaining funds to the next year, giving them a starting total in Year Two of fifteen hundred dollars.

VENITA MCCCELLON-ALLEN. Baylor Health Care System:

"Employees take ownership of their decisions and the dollars they spend."

NARRATOR:

The plan has worked to substantially reduce costs.

VENITA MCCCELLON-ALLEN. Baylor Health Care System:

"They have the opportunity to price shop. We've seen higher percentage usage of generics in the Consumer Driven plans than we have in our other plans."

NARRATOR:

Employees are also given information about where to get the best quality care.

VENITA MCCCELLON-ALLEN. Baylor Health Care System:

“Some of those quality indicators are provided on our web site: maybe customer satisfaction, patient satisfaction information, information around publicly available statistics. And those are provided for participants to consider as they make their decisions.”

NARRATOR:

Maimonides Medical Center is a hectic urban hospital in Brooklyn, New York. Like many hospitals, it is responding to the call for more public accountability about the quality of care it delivers.

PAMELA BRIER, President, Maimonides Medical Center:

“Patients have to feel secure when they go into a hospital that they’re going to be safe, and that the staff use all the means at their disposal to make sure that the care is as good as possible and it’s as safe as possible. So, how do you tell what’s safe and good? One is the volume of procedures. The second is all ordering has to be done by the computer which we do – which we’ve done for many, many years now. And the third component is that intensive care units have to have intensivists - critical care specialists working in them almost all the time.”

NARRATOR:

Having critical care specialists, with access to technology, is a key aspect of protecting patients. Maimonides’ safety measures are tested when a critically ill diabetic arrives in the Emergency Room.

PATIENT (in a conversation with the doctor):

“Fine, thank you.”

DR. EUSTACE LASHLEY, Medical Director, Department of Emergency Medicine (in a conversation with a patient):

“So why you come in to see us today? What’s the issue?”

PATIENT (in a conversation with the doctor):

“Um, I’m getting back pains and a pain on the side. I’m a diabetic. I take, uh, insulin 7-30 twice a day, 40 mg....”

DR. RICHARD SAVEL, Maimonides Medical Center

“What we have here is our physician order entry system, so that when a physician wishes a patient to receive a medication that has to be entered into a computer. Fortunately, that technology can help the physician both in entering the order properly, to make sure that the patient if they have any allergies that that gets mentioned, and if there’s any interactions with drugs that they’re on currently and the drug that you want to provide.”

NARRATOR:

The hospital’s computerized systems allow doctors to safely prescribe the proper medication.

DR. EUSTACE LASHLEY (to Doctor in a conversation about a patient):
“She’s a diabetic but her diabetes is pretty much under control.”

DR. RICHARD SAVEL, Maimonides Medical Center
“Nobody that I take care of wants to be here. Nobody wants to be critically ill. But the fact is when they come into the unit we have to do many things simultaneously. And so the issue of quality comes up because there’s so much information that’s required to appropriately take care of a critically ill patient now, that you have to use computers to help keep track of it.”

[Studio discussion]

KELVIN BOSTON:
Meredith, are we seeing more of this type of occurrence across the country?

MEREDITH ROSENTHAL:
That’s right. As they showed in that videotape, there’s a big push to get more information, both to consumers but also to the people who pay for health care to try to figure out who is doing the right thing to improve health care quality, patient safety in the case of hospitals. So this is a very widespread trend.

KELVIN BOSTON:
Now, in this piece we looked at consumer plans. And some would ask the question, ‘Is this just a disguise to have the employees pick up the cost for their medical benefits?’

DENNIS SCANLON:
I think the verdict, frankly, is still out on that. I think some people view it that way. Personally, I’d like to think that the consumer is a very important piece of the puzzle here but not the only piece. We need to get the consumer more involved and more engaged. And to get back to your earlier question, I think the reason for that is because at the end of the day the money is coming out of their pocket one way or the other; in the form of lower wages, in the form of taxation, to pay for the government programs. So the consumer is a very important piece in controlling one’s individual health and health status is going to impact the bottom line.

But having said that, I think it’s not just the consumer approach alone. We need to also engage providers. The health care system is fraught with example after example of doctors and hospitals, if they do the right thing, not getting rewarded for doing the right thing or, not being penalized for doing the wrong thing. And one of the things that many people are working at in health care right now is to try to provide incentives for people to do the right thing that ultimately will improve health but also potentially lower costs.

KELVIN BOSTON:
Now, why should consumers be told that they need to change their behavior, as well as some doctors, as they look at the health care situation? Again, we have talked about entitlement, people feeling that in America we deserve good health care.

MEREDITH ROSENTHAL:

Well, I think, as you sort of get the impression in that video clip, there are a lot of things that go on that help to determine patient safety, health care quality, and I think we are trying to use as many levers as possible. And one big lever is if you get consumers to actually go to the hospitals that do better on these measures that will give the hospitals an incentive to get the intensivists there, get the equipment they need to improve patient safety. So we're hoping to try to drive good behavior on the part of providers by getting consumers to be responsive to it, just like we do in other kinds of markets. It's not the only solution, we're working on other methods of getting providers to respond too, but this is one big lever.

KELVIN BOSTON:

In the short term and long term future what should we be looking at? What holds promise in terms of dealing with this issue?

MEREDITH ROSENTHAL:

Well, I would say, plans like the one you saw in the video clip are becoming increasingly popular. And again the hope is really that by getting consumers engaged; get them to ask the right questions of their physicians about, 'Well, do I really need this intervention? Is it going to provide me with a lot of value?' Start thinking about the questions of trade-offs, of costs and benefits. We hope that that will have some positive impact on reducing the trend in health care spending.

DENNIS SCANLON:

I think there's a lot of encouraging programs like these going on right now, where it's a joint partnership. Not only just trying to save money but trying to distribute that savings to encourage people to do the right thing.

KELVIN BOSTON:

If you were sitting down talking to someone and saying I want you to understand one thing about health care and what's going on in America today, what would that one thing be?

DENNIS SCANLON:

I guess I'd probably say we have a lot of problems and I don't think that would surprise too many people. But I think the good news is there's a lot of people trying to address those problems. I think it's yet to be answered whether we're going to be able to do that successfully and whether we can be innovative and sort of get through the politics - and there are a lot of politics when it comes to health care - to really define and develop good solutions so that we can have a better health care system.

KELVIN BOSTON:

Meredith, what would be the one thing you would want people to understand?

MEREDITH ROSENTHAL:

Well I think actually Dennis raised it earlier, which is that the health care system is set up so that everyone seems to have the wrong incentives. And I think the really good news is that we are recognizing that and thinking about, well if we want good health care quality, then we should pay hospitals and doctors to improve quality and not just to provide more visits or more hospital days.

KELVIN BOSTON:

I know this is such an important topic and there's so much that we could talk about. I appreciate you sharing your thoughts with us today.

KELVIN BOSTON:

Now let's turn our attention to another issue impacting financial insecurity in America: Retirement.

[Documentary]

FRANKLIN ROOSEVELT:

"The civilization of the past 100 years, with its startling industrial changes has tended more and more to make life insecure."

NARRATOR:

When President Roosevelt signed the Social Security Act more than sixty years ago it was a key step towards putting a healthy and comfortable retirement within reach for most Americans.

STEVEN SASS (Center for Retirement Research at Boston College):

"Well after WWII, you had what I think you can call the emergence of retirement as a stage of life. Between Social Security and employer plans, a lot of people began to retire. They weren't well off, but they had enough money that they were retiring at about 65. And longevity began increasing fairly dramatically as well, due to medical advances, health conditions. And so the period between 65 and when you died became increasingly long."

NARRATOR:

But as the years in retirement and the cost of medical care continue to rise, the financial burdens of health care in retirement are increasing as well.

PAUL FRONSTIN, Employee Benefit Research Institute:

"A person 65 retiring today will need anywhere from between \$75,000 to \$600,000 right now to cover their health care expenses in retirement."

NARRATOR:

Medicare – the federal health insurance program intended for the elderly -- covers only a portion of the costs of health care for most retirees.

UWE REINHARDT, Princeton University:

“Well at the moment we have the following social contract: Medicare on average pays for about 52-percent of the average health spending per elderly. Medicare didn’t cover drugs and even now will cover only 25 percent of the cost of drugs for the elderly. It doesn’t cover long-term care. It has caps on hospital stays. So it’s a very skimpy program. The rest of that had been picked up by large - particularly large businesses told their workers, ‘What ever Medicare doesn’t pay, when you retire we’ll pay it.’”

NARRATOR:

But this is now changing. The proportion of large companies offering retiree health benefits has fallen from 66 percent in 1988 to only 33 percent today.

PAUL FRONSTIN, Employee Benefit Research Institute:

“Most people do not know that they will not be eligible for health benefits in retirement from an employer. Very few of today’s workers are going to qualify for those benefits; and when they do qualify for those benefits chances are they are going to be asked to pay a full premium for that benefit. So I think for a large part most people aren’t aware that they are on their own.”

[Man on the Street Interviews]

MAN:

“I fear that health care costs will sap my retirement funds. That’s my big fear. That’s going to be the biggest cost, I know, in retirement.”

MAN:

“I am completely mystified as to what the heck I’m going to be doing in my retirement. The whole new Medicaid thing is very confusing to me. And I’m not sure exactly what is going to happen in terms of health care costs.”

WOMAN:

“I had a hard time getting insurance after I retired. I’m not old enough to be on Medicare. I’m a senior, but yet I’m not a senior. It took me, I would say, almost sixteen months before I can get anything affordable, and it’s not really what I want.”

MAN:

“I’ve been looking at investments that actually track inflation and grow with inflation, so there’s some inflation protections. But none of them grow as fast as health care inflation.”

WOMAN:

“Do I think anything is wrong? I have no problem.”

[Documentary]

NARRATOR:

While life expectancy has increased, the age of retirement has declined -- from 67 in the 1950s to around 62 today. But even as they face rising health care costs and the prospect of longer life, the baby boom generation isn't saving very much. The average combined 401(k) and IRA savings for Americans in their 40s and 50s is only \$37,000, far short of what is required in retirement.

ALICIA MUNNELL, Center for Retirement Research at Boston College; Member of the President's Council of Economic Advisers, Clinton Administration; Assistant Secretary of the Treasury, Clinton Administration:

"It is not at all possible for people to continue to retire at age 62 and think that they can maintain their pre-retirement living standards. It's just not a realistic option. Something is going to have to change."

NARRATOR:

One major trend that will affect many people's retirement is the movement to put more responsibility on the shoulders of the individual. Only about half of working Americans are covered by pensions. Of those covered, people with traditional pensions declined from 40 to 19-percent between 1992 and 2001. During that period, households covered by 401-K plans grew from 37 to 58-percent. Unlike traditional pensions, 401-K plans require workers to make their own savings and investment decisions -- those decisions are not always wise.

ALICIA MUNNELL, Center for Retirement Research at Boston College; Member of the President's Council of Economic Advisers, Clinton Administration; Assistant Secretary of the Treasury, Clinton Administration:

"Mistakes are at every step along the way. 25 percent of people who are eligible to participate in 401(k) plans do not participate. Less than 10 percent of those who participate contribute the max. Half the people don't diversify their initial investments at all. They're either all in stock or all in fixed income. People over-invest in company stock. No one changes their allocation over time. You know financial planners tell you to move away from stocks. More than half the people cash out their payments when they move from one employer to another. When they get the lump sum they risk either living too frugally or exhausting their sources before they die."

NARRATOR:

Yet there are many things employers can do to help. Shlomo Benartzi is a UCLA finance professor and 401(k) expert. His research has shown ways companies can help employees make better decisions about their 401(k) plans.

SHLOMO BENARTZI, UCLA Anderson School of Management:

"For example, they could create retirement plans that are easier to enroll, or maybe employees are automatically enrolled in, that are easier to encourage employees to save more, maybe even the max that they could save, and are easier for employees to find a

well diversified portfolio. Those actions that employers could take could make it much easier for most employees in this age.”

NARRATOR:

Employers can also help by negotiating lower 401(k) management fees for their employees. Costs for managing a 401(k) might be small, yet even a minor reduction in these fees can dramatically affect returns. Reducing management fees by 1 percent can increase the total value of this typical portfolio thirty years later by two hundred thousand dollars.

SHLOMO BENARTZI (UCLA Anderson School of Management):

“That’s lots of money. People have to pay very careful attention to investment management fees.”

NARRATOR:

Yet even with better 401(k) plans with lower fees, employees still have to save if they ever hope to retire.

SHLOMO BENARTZI (UCLA Anderson School of Management):

“Whether it’s saving more when they get the paycheck, whether it saving their pay raises, whether it’s saving their bonuses, whether it’s saving an inheritance; whatever it is, they have to find a way to increase their savings.”

[Man on the Street Interviews]

MAN:

“I’m not even saving for tomorrow yet.”

WOMAN:

“I have 401(k)s and I have other options. But as far as how will I manage if I get sick when I’m older, I’m worried about it.”

WOMAN:

“I’m not actually saving for retirement.”

MAN:

“I have a fairly state decent retirement plan, and I have some money set aside in a retirement account. And I’m just hoping without investigating, that it will be sufficient with social security, Medicare, that I’ll be okay.”

MAN:

“I save a lot for my retirement. I recommend everyone do. I participate in my 401(k). I buy my company’s stock. Whatever extra money get from the market, I invest in real estate. I invest every penny I possibly can.”

WOMAN:

“I have a retirement account also which I don’t understand, but our human resources representative convinced me that it was necessary to sign up for it.”

WOMAN:

“Retirement planning is... In this time and age right now, in the time that we live in, I don’t even know. I don’t have this - I don’t have this sense of hope.”

WOMAN:

“One never saves enough for retirement.”

WOMAN:

“I don’t feel very secure about the future. Or my future.”

[Case Study]

MICHAEL LEE (to his children playing on swings):

“Good job, yeah.”

NARRATOR:

To see how one family is saving for retirement, we visited the Lees in suburban Maryland.

MICHAEL LEE(to his children playing on swings):

“Good job Michael and Makayla. Way to go.”

NARRATOR:

Michael and Kimberly Lee have big plans for their retirement future.

KIMBERLY LEE:

“I’d like to get to a point where we don’t have to work, that’s what we are working toward. We would have a house that we would be living in, our retirement home paid for, no car payments, full college fund set aside and paid for.”

NARRATOR:

Like many Americans, the Lees started saving for retirement through plans offered by their employers.

KIMBERLY LEE:

“I was a flight attendant for a major airline and I had a 401(k). I think I was average, an average saver.”

MICHAEL LEE:

“I had taken out a 401(k) plan, became fully vested in that plan. Even though I knew the 401(k) plan was an option, or vehicle toward savings, I knew we had to do much more than that.”

NARRATOR:

The Lees started out on the right track. But they hit a roadblock when they emptied out their retirement accounts to start Michael’s I-T computer company and Pamela’s cosmetic consulting business.

MICHAEL LEE:

“We’ve had to make some adjustments. My wife and I transitioned our careers from becoming employees to actually becoming employers, so that took a significant investment in terms of getting our business started. We had to leverage some of our retirement funds for that. So there was a slight – we became dormant - our retirement – our savings became dormant for a while.”

NARRATOR:

With the birth of Michael Junior, the Lee’s once again got serious about saving for retirement. They are working with their financial planner, Divead Weedon, to come up with a strategy to catch up.

DIVEAD WEEDON, Financial Planner:

“Where the Lees are right now, they’re at a position where they almost have to double their efforts to achieve the same results in the same time horizon that they had identified earlier, and that’s very key.”

NARRATOR:

As a first step, the Lees will have to change their lifestyle in order to save more and invest more. They plan to cut back on living expenses, forego buying unnecessary items, eat out less, and sell one of the family cars. Additionally, Weedon has suggested a diversified and aggressive retirement savings plan.

MICHAEL LEE:

“And now we’re starting to pick back up again. We have a myriad of vehicles like annuity plans, mutual funds, stocks, Roth IRA’s, etc. Right now we’re probably saving about 5 percent. Based on our financial objectives, our retirement targets we’re looking at, we know we will have to increase that from 5 percent up to about 20 percent.”

KIMBERLY LEE:

“We’ve chose an aggressive plan. There’s going to be some set backs but I believe we can catch up with it.”

NARRATOR:

To shed light on the problems of saving for retirement we asked two experts to join our conversation. Bridget Madrian is a Professor of Business and Public Policy at the

Wharton Business School. William Gale is a Senior Fellow at the Brookings Institution. We started our discussion by looking at the Lee's decision to increase their retirement savings.

[Studio Discussion]

KELVIN BOSTON:

Brigitte, what do you want to take away from that piece? I mean what, what jumped out at you?

BRIGITTE MADRIAN, Professor of Business and Public Policy at the Wharton Business School:

Well, what jumped out at me was that this family had actually gone out and solicited the help of a financial planner. And I think that's an important thing to note. A lot of people are overwhelmed about saving for retirement; and the retirement landscape has changed so that people are increasingly burdened with the responsibility of saving for retirement on their own.

KELVIN BOSTON:

Are their issues common?

WILLIAM GALE:

What struck me about that excerpt was that this is a family that has planned ahead. They have thought about the future. So already they are way ahead of the game. And even for them it's hard because other things come up like businesses or education that get in the way of saving for retirement.

KELVIN BOSTON:

Now when you look at this on the national landscape though, is our system - is our retirement system in trouble?

BRIGITTE MADRIAN:

Certainly there are a lot of people who are saving for retirement; who have a company sponsored pension plan or who are saving for their 401(k). But there are a lot of people who aren't or who aren't doing enough of that.

And I think the problem with the system is that the system - we're moving to a system where you have to save on your own, one based largely on employer sponsored 401(k) or individual saving through an IRA, or some other vehicle. And that puts all of the savings burden on employees, whom we've noted many of whom don't feel well equipped to do that.

And in terms of systemic changes, I think we need to think about ways to make doing the right thing, the thing that happens automatically. Or the thing that is easy to have happen rather than the difficult choice, which is the way it is right now.

KELVIN BOSTON:

Bill, what are your thoughts about the national landscape?

WILLIAM GALE:

I think it's important to think of the retirement system as evolving. Retirement is a relatively recent phenomenon. 100 years ago people didn't retire for 20 years and live off their pensions. And the institutions we have are evolving. It takes a long time to get institutions right.

So the types of things that Bridgette just said I think are exactly right. We have a system right now that puts the entire onus on workers, or almost all the onus on workers. But we haven't helped workers get the tools they need to make that system work.

KELVIN BOSTON:

Some people are suggesting that maybe we are leaving American retirees in the cold. They're told that they need to take more responsibility, but maybe they're still thinking that they're going to have some help from their company or from the government. What's your thought?

WILLIAM GALE:

People right now who are middle age and workers saw their parents retire under a different system than the one they are going to retire under. And if their expectations are based on what happened to their parents, they are going to be hurt badly. So, as we go forward we need to be educating workers and even students on the new reality of how one goes about doing this.

KELVIN BOSTON:

Is it difficult though, Brigitte, for people to save?

BRIGITTE MADRIAN:

Oh, I think it's difficult. I mean, who wouldn't rather go spend that money on something nice? If you want to have some money to live off of in retirement and social security isn't sufficient and your employer isn't providing a pension, then you have to make some tough choices and you will have to make sacrifices, and I think we just need to make it easy for people to do that.

KELVIN BOSTON:

We often talk about -- from a financial planning perspective -- 'Well you need to have a goal.' When you think about the goal, some of the statistics I've been reading suggest that people need to have at least 90 percent of their pre-retirement income to enjoy the same type of life style after they retire.

BRIDGETTE MADRIAN:

I don't think there's one magic number. But I think people need to sit down and figure out what is the right number for them. And then you've got to do something about it. It's really easy when saving, thinking about things like saving for retirement where it's

not a decision that has any negative consequences tomorrow if you do anything about it today. It's really easy to put that off and to procrastinate.

KELVIN BOSTON:

Now let's look at how two people are dealing with the challenges of managing their retirement savings.

[Case Study]

NARRATOR:

Jack Ott enjoys a rewarding retirement. He gardens, fishes and runs his own political blog on the internet. But it is not the lifestyle he had dreamed of, even though he thought he had planned for the future. For 29 years, he was an employee at Qwest Communications and its predecessors US West and Mountain Bell. Before retiring, he fully participated in the company's 401(k) retirement plan.

JACK OTT:

"When I set mine up, I set it up to be about half stock, company stock, and the rest were different investment options. When I retired then, I had a pretty sizable nest egg saved up. And Qwest stock at that time was about 55 and it went briefly up to about 60.

When I finally sold the Qwest stock it was about 4-and-a-half. So I lost roughly 90 percent of it when I finally did sell.

The way I look upon it is it was my decision to hold onto it. I can't blame Qwest for my holding onto the stock. I always thought that it would come back and of course it never did.

I live a pretty comfortable lifestyle. I, you know, I'm not to the point where I'm eating dog food or anything like that, not like some of the stories you hear. The only other thing I would say is that I won't be able to leave as much behind when I go."

NARRATOR:

The accounting practices at Qwest Communications have come under federal investigation, and several senior executives have reached settlements with the SEC. Qwest not only offers 401(k)s, but also provides traditional pensions as well as other retiree health benefits. But even these added benefits are still not enough to guarantee a secure retirement for many retirees -- including financially savvy ones like Mike Pasley, a former Qwest manager who spent 21 years with the company in its various forms. His early retirement has ended. He has had to go back to work.

MIKE PASLEY:

"I felt secure in where my portfolio was going. Now that I've lost that money, I don't feel as secure with investments anymore. And, I don't feel quite as secure about buying things that I might want or want to have. You know, it's just a lack of security that you have that your nest egg is big enough to take care of you for the remainder of your life. If

I had had the same amount of money that I had had before, I wouldn't have to be working now and not worry about it at all."

NARRATOR:

Mike had heavily invested in Qwest stock before it went down. Since retiring from the company, he has started his own successful furniture company and supplements his income by teaching wood working at the community college.

MIKE PASLEY:

"I think we'll be able to eventually retire. But it won't be near as soon as we thought we would. The woodworking will keep me on until I'm in my 80's, I hope."

[Studio Discussion]

KELVIN BOSTON:

What did you both take away from that story?

BRIGITTE MADRIAN:

Well, Mr. Ott and Mr. Pasley unfortunately learned one of life's important lessons the hard way. Don't put all of your eggs in one basket. And that's true with eggs and that's true with stocks. And putting a significant fraction of your investment in company stock is not a whole awful lot different than taking your nest egg to Atlantic City or buying lottery tickets with it. It's a very risky investment strategy to pursue.

KELVIN BOSTON:

Did you take anything out of that particular piece?

WILLIAM GALE:

Two things: one is I want to underscore not only is investing in all of your assets in one stock a bad thing to do, investing it all in the one stock that's the company that you also work for is a particularly bad thing to do, as the workers at Enron found out. Because you can lose your job at the same time that you lose your retirement nest egg. The other thing that struck me about those two individuals was that they were basically in good health and in decent financial shape, so they're going to pay a price but not as big as it might have been if, for example, there was needed health care or disabilities that would make their retirement situation even more stressful.

KELVIN BOSTON:

What should we be looking at to get better performance? Should we be concerned about fees for example?

BRIGITTE MADRIAN:

Yes, you should definitely be concerned about fees. And many times fund companies will try and hide some of their fees. So find out what the expense ratio is, find out whether or not there is a load. Make sure it's a company that has a good track record.

Monitor your investments so you know what's going on. If you're not sure how to invest your money, talk to a financial planner. Find out how much you should have in stocks, how much you should have in bonds.

KELVIN BOSTON:

What other thoughts would you have to improve performance on your retirement accounts?

WILLIAM GALE:

The first thing individuals need to do is get in the system. They need to actually actively participate, put money in. If they don't the system can't help them at all.

KELVIN BOSTON:

Can employers do anything else to really help employees? I mean, besides just shifting the responsibility, or more of the responsibility to them.

BRIGITTE MADRIAN:

The answer is a resounding "yes". Employers can recognize that not all employees want to be do-it yourself mechanics when it comes to saving for retirement. And 401(k) plans are by and large set up to help the savvy investors who understand financial markets and who want to take control of their retirement savings. And employers can do a lot by just re-designing their plans in a way that helps the reluctant investors, if you want to call them that, do the right thing or do the sensible thing.

KELVIN BOSTON:

I want to thank you both for being here now and helping us understand this issue.

BRIGITTE MADRIAN & WILLIAM GALE:

Thank you.

KELVIN BOSTON:

And now let's look at some trends in the future.

[Documentary]

NARRATOR:

As more and more Americans lose their health benefits from their employer and have to buy health insurance on their own, they could find themselves in the situation of Jody Miller. She and her husband, both freelancers, were surprised when they attempted to buy health insurance on their own, in the individual market.

JODY MILLER:

"So we get back, you know, several - I guess a month or so later a rejection letter for both of us. We said, 'Okay, this has to be mistake and we have to fix it and let's figure out what's going on'. We look at the reasons, and I'm rejected for the following reasons:

Flonaise. Face creams. I woke up one morning with a crick in my neck and the only reason they knew that is for one week, actually probably less than a week, maybe five days, I took a steroid pack.”

NARRATOR:

Jody applied again, only to be rejected again. This time for a new set of reasons.

JODY MILLER:

“I was uninsurable for the following reason: I went in once, in my over forty years of life, because I had a pain in the jaw the day after an intense business crisis. And my doctor said, ‘You know, I think it might, you might have just grind your teeth that night. You might have been grinding your teeth.’ And I then went, you know, I said, ‘What should I do?’ He said, ‘Don’t do anything. It’ll go away in a couple of days. If not we’ll talk about it.’ He made a notation in his file that this might have been TMJ. Two days later it went away. I am uninsurable, except for the catastrophic policy, until I go six months without having to see a doctor for this condition and for the rest of my life I will have a 20 percent premium increase.”

NARRATOR:

Eventually, Jody’s husband went to work for an employer with group health coverage.

JODY MILLER:

“We got lucky in that my husband was able to affiliate with an institution that offered health care that he was excited to be affiliating with. But I can tell you there’s not a day that goes by that I am not concerned that if something happens to that affiliation, one of us is going to have to dramatically change our career focus in order to get us health care. And that seems absurd. We are not unhealthy people. If we can’t get insurance, we’ve got to solve this problem.”

NARRATOR:

One possible solution is to pool individual uninsured workers together. Some large companies are already working to create such arrangements, in order to provide insurance to their freelance and part-time workers.

MARISA MILTON, HR Policy Association:

“A lot of individuals, who can even afford it, can’t get through those barriers to actually get the coverage. So the goal is here, by joining a group of people to try to get access to these products, to be able to negotiate better terms than what they get in the individual market.”

NARRATOR:

Grouping individuals could help solve some of the problems of the working uninsured.

MARISA MILTON, HR Policy Association:

“There are a number of problems. Its mind boggling the number of problems we have in our system. But we think that it is a good solution. And that it is something that hopefully can be modeled and expanded in the future.”

NARRATOR:

Whatever solutions the future may hold, people will still have to plan carefully, as they face increased responsibility for managing their health care and retirement. Their future financial security is at risk.

FRANKLIN ROOSEVELT:

“We can never insure 100 percent of the population against 100 percent of the hazards and the vicissitudes of life.”

PAUL FRONSTIN, Employee Benefit Research Institute:

Financial security for Americans is changing. We’re moving away from a paternalistic society where employers provided very comprehensive benefits. Workers and retirees will bear the burden of the risks associated with investing money, the risks associated with how long you live, and the risks associated with how fast prices increase.

ALICIA MUNNELL, Center for Retirement Research at Boston College; Member of the President’s Council of Economic Advisers, Clinton Administration; Assistant Secretary of the Treasury, Clinton Administration:

“It makes a big difference to individuals to have a plan and to not be hit by sort of unexpected events as they enter their 60’s.”

NARRATOR:

Ultimately, though, the problems in health care and retirement are far reaching. There is no one simple fix. A true solution will require the active cooperation of everyone involved.

JIM SMITH, Rand Corporation:

“Something has to happen. That’s not the question. The question is, do we make - do the reforms in an intelligent way and do we do them soon enough? That’s the only question.”

STUART ALTMAN, Brandeis University:

“We’re going to have to have all the players in the act. We’re going to need to have government do what it needs to do. We’re going to need to have employers be a part of the force. We’re going to have to have us as patients be part of it. We’re going to need the employer community to work. And most importantly, we’re going to need the providers: the doctors and the hospitals and the nurses to be an active force as well.”

KELVIN BOSTON:

There may be no quick or easy fixes for the problems we have seen. But at the very least both employers and employees need to face America’s growing financial insecurity. Employers can help by providing education and better-designed health and retirement

plans. And employees need to become aware of their health care options and make realistic decisions about their retirement savings. Taking these few steps will be a good start to making all Americans more financially secure.

I'm Kelvin Boston. Thanks for watching.

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ROLL & END-