

Avoiding Disaster

November 2006

Planning for Health Care in Retirement

A Double Edged Sword

Who could argue with the proposition that a principle purpose of financial planning is to foster a happier and more meaningful retirement? Lifestyle and health are, naturally, two key components of a successful retirement. Therefore, health care issues intersect with retirement planning in critical and interrelated ways.

Life would be infinitely happier if we could only be born at the age of 80 and gradually approach 18.
Mark Twain

First, two fundamental questions we ask ourselves in developing a retirement plan are: How long can or will I work? and How long will I live? The answers provide some of the basic assumptions for our capital funding analysis.

Second, managing the health care maze, including general health and long term care, directly impacts our ability to enjoy and fund a successful retirement. Unmanaged injury or illness may impede our ability to enjoy recreational and vocational activities to which we have been looking forward. And, failure to properly finance health care may require us to divert valuable resources from other important goals—such as family, leisure and philanthropy—to doctor and hospital bills.

A recent survey by McKinsey & Co. revealed that 43% of retirees had underestimated their retirement spending needs, the most frequent cause being unavoidable health care costs. Planning gaps can cause substantial exposures. And the affluent are not immune. Fidelity Investments estimates the average 65-year-old couple will need \$200,000 to fund out-of-pocket health care expenses during retirement. The old axiom, to plan on spending 80% of our pre-retirement income, is being replaced by suggestions that we plan on *increasing* our spending by 20%.

Finally, research increasingly demonstrates that financial stress, which may result from our inability or failure to plan for these issues, contributes to deteriorating health as we age. Inadequate attention to the risks associated with health care can result in a downward physical, emotional and financial spiral.

What follows is a discussion of some of these issues and an introduction to how you can build a strategy for dealing with this complex task.

Early Retirement: A Health Insurance Black Hole

Many Americans obtain health insurance during their working years from their employers. And most of us will qualify for Medicare at age 65. But a growing number would like (or are encouraged or forced) to leave the organized work force before we become eligible for government-funded health insurance.

Traditionally, large employers provided health insurance to their retirees, often with better coverage and smaller contributions from the insured than Medicare. That is changing as firms struggle to contain pension and other retirement costs. Employers have begun to limit and eliminate coverage for retirees.

Following termination of employment (other than for gross misconduct) employees of companies with 20 or more employees are generally entitled under COBRA to continue their health insurance coverage for 18 months by paying premiums out of their own pockets. Thereafter, you are on your own. Until this moment, many of us are unaware of what the actual costs of employer paid health insurance may have been. In some cases, premiums may run upwards of \$10,000 per year.

For these reasons, many people are choosing to delay retirement—or even partial retirement—for the sole purpose of maintaining health insurance. Particularly problematic are cases in which one spouse is eligible for Medicare but a younger spouse or other dependents are not.

Pre-existing conditions present another vexing problem. Once coverage is lost, insurers are generally not required to provide coverage to those who are already ill or have been injured. If insurance is made available, the premiums can be prohibitively expensive. Many states have created high-risk pools for citizens facing this difficulty. One such program is CoverColorado (www.covercolorado.org).

One solution is creative part time work in which health insurance may be available. Couples forming a small business may sometimes be able to obtain health insurance at group rates with open enrollment and not be subject to medical underwriting typically required for an individual policy.

Another innovation is a High Deductible Health Plan (HDHP) coupled with a Health Savings Account (HSA). Introduced in 2004, these plans require minimum deductibles of \$1,050/individual or \$2,100/family (deductibles may be higher); out-of-pocket payments are capped at \$5,250/individual and \$10,500/family each year. The insured may then make tax-deductible contributions to the HSA.

HSAs grow-tax free and withdrawals are tax-free for qualified medical expenses. The maximum contribution for 2006 is \$2,700/individual and \$5,450/family. There are a good number of financial institutions offering custody of HSA accounts, including some who offer low cost mutual fund choices. Unused funds may be used for any purpose after the age of 65. Enrollment in HSAs tripled to 3 million people between March 2005 and January 2006.

Navigating Medicare: Mind Your ABCs and a D

At age 65 (for those eligible for Social Security benefits), you may enroll in Medicare. Original Medicare is a fee-for-service model consisting of Part A (coverage for hospitalization and related services) and Part B (medical services, outpatient care and some preventive medicine). Part A is generally free, while Part B requires payment of a monthly premium. The standard premium for 2007 is \$93.50. It is critical to enroll in the program upon eligibility—even if delaying Social Security—to avoid higher premiums.

Medicare has a number of coverage gaps, including co-pays (20%), deductibles and services that are not covered. A complete description is available in the “Your Medicare Benefits” publication (www.medicare.gov). However, the government permits private companies to sell insurance policies to cover many of these gaps. Most states allow you to choose from one of 12 standardized Medigap policies.

In 1997, Congress created Part C (now called Medicare Advantage), which brought managed care to Medicare, in the form of the now familiar PPOs and HMOs and certain other kinds of plans. Enrolling in one of these plans allows you to essentially combine your hospitalization, medical coverage and Medigap with one provider, frequently at a lower premium than with the combination of Part B and a Medigap policy. However, as with such non-Medicare health insurance plans, you will generally be limited to receiving care from in-network providers.

Drug Coverage and The Donut Hole

Beginning on January 1, 2006, Medicare Part D began providing coverage for prescription drugs. Drug coverage is obtained via private insurance companies, through standalone plans, by enrolling (between November 15 and December 31) and paying a monthly premium. (Or drug coverage can be obtained as part of a Medicare Advantage plan.) In most states in 2007, Medicare beneficiaries will be able to choose from among 50 or more plans. Nationwide, premiums range from under \$10 to over \$100 per month, depending on the level of coverage.

For 2007, there is an annual deductible of \$265 (up from \$250) and then co-payments of 25% are required on the next \$2,135 of prescription costs, until your total costs reach \$2,400. Then you're in the donut hole, where you pay 100% of the next \$3,051.25. (Total drug costs at this point: \$5,451.25; total out-of-pocket: \$3,850.) Thereafter your plan will pay 95% of any further prescription costs.

Also for 2007, many plans provide significant coverage inside the donut hole—using generic drugs—for an additional premium. Clearly, you will want to choose a plan carefully, based upon your drug needs, the available formulary and your budget.

Means Testing

The legislation enacting drug coverage brought another revolutionary component to Medicare—means testing. The purpose of the new law is to attempt to equitably close the enormous funding gap faced by Medicare in the decades to come.

Beginning next year, high income beneficiaries will pay increased premiums for their Part B coverage. Current law pegs the premium to equal 25% of the estimated cost, with the government picking up the rest. In the future, individuals with Modified Adjusted Gross Income (MAGI) above \$80,000 (\$160,000 for spouses filing jointly) will pay an increased share; four brackets are indexed to inflation. Medicare will use tax returns from two years prior (with some exceptions) to determine applicability. In 2007, that means a premium of \$162.10/month for those with MAGI above \$200,000, who will pay 80% of the cost.

Many groups, including AARP, oppose means testing as a way to shore up Medicare: they feel the camel's nose is under the proverbial tent and income brackets will likely be reduced in the future.

Planning for Long Term Care

As challenging as planning for the payment of ordinary medical care may be, planning for the payment of long term care expenses is even more so. Longer life expectancies are increasing the likelihood that we each will one day require long term care. And, as with all health care, costs are rising at an alarming rate.

Long Term Care Likely—and Costly

- The U.S. Department of Health and Human Services estimates that 40% of people aged 65 or older have a 50% chance of entering a nursing home.
- The average stay is 2.4 years. (Alzheimer's and Parkinson's patients have much longer stays).
- The average cost of nursing home care is now \$65,000 per year. In some states costs can amount to \$100,000.

Except for limited circumstances, Medicare does not cover these costs. And, qualifying for Medicaid (see related article) for such coverage is becoming an untenable option for all but the poorest of Americans. Consequently, self funding or purchasing long term care insurance are now the vehicle of choice.

Many of us have an ostrich mentality when it comes to planning for long term care: that it will happen to someone else, but not to us—or the government will pay for it. In truth, long term care costs can rapidly deplete a lifetime's worth of savings and investments. There is no substitute in this regard for conducting a gap analysis to determine what the impact on savings—and the lifestyle of a well spouse—would be in the event we are required to self fund care under various scenarios.

It is critical, as well, not to underestimate the impact on care-giving family members when insurance is unavailable for long term care. Siblings can be torn apart and marriages destroyed by the financial and life pressures of caring for an aging or ailing parent.

Purchasing a long term care insurance policy is generally the last thing any of us wants to do. Why pay for something that is unlikely to be used? But that reasoning works with virtually any insurance policy: we should be *hoping* never to use it. Fortunately, long term care policies are now available with enormously flexible components and a policy can be designed to fit almost any budget to insure at least some of the risk. Plus, newer policies cover home care to the same degree as institutional care.

Among other items, policy holders can choose the dollar amount of coverage, inflation protection and the number of years of coverage. Policies can be designed to be shared between couples or among entire families, reducing the amount of premium compared to individual policies. And, there can be significant tax and other advantages to employers providing long term care insurance as an employee benefit.

The Step We Can't Afford to Skip

Health care costs incessantly rise due to drug development, technology and administrative bloat. The Centers for Medicare and Medicaid Services predict medical expenses will account for 20% of GDP by 2015, with out-of-pocket spending doubling to \$421 billion. It seems to be worth it. A study in the August 31 *New England Journal of Medicine* concluded that average life expectancies for newborns increased by almost seven years from 1960 to 2000; improved health care may be one reason for this outcome.

But cognizance of the magnitude of the financial challenges posed by health care may have profound influence on many of our fundamental financial planning priorities and assumptions. Will we put our kids through college? Should we downsize our homes at the earliest opportunity? Will leaving a financial legacy be possible for any family but the wealthiest?

Will there be the political will needed to change the system? Right now, we can't plan on it—so we must look after this need ourselves.