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Health care

White paper

NATIONWIDE RETIREMENT INSTITUTE®

Make health care part of today's retirement planning process

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The importance of planning for health care costs in retirement

Few people would argue against optimal health and financial stability being the foundations for a successful retirement. Unfortunately, with recent health care cost increases and the changes to Medicare and Social Security, and rising health care cost inflation,[1] fewer Americans are likely to reach this mark.

With the birth of Medicare in 1965, Lyndon Johnson's Great Society Act attempted to simplify health coverage for retirees age 65 years and older. The legislation provided hospital insurance under the Social Security Act, with a supplementary medical benefits program and an extension of medical assistance for the aged.

But times have changed. What was once a modest plan intended to cover about 12 million beneficiaries with shorter life expectancies has grown to 55 million subscribers, and many of them are living well into their eighties and nineties.

Because baby boomers *— who are projected to live longer —* are retiring at a rate of 10,000 per day,[2] *health care costs and benefits, especially those specifically related to Medicare, are expected to change drastically in the future.*

People will pay more money for fewer services, and supplemental insurance will be needed to fill in the gaps. Financial and health-related stability in retirement, a luxury that most Americans enjoyed over the past five decades, will be replaced by a universal obligation for all citizens to put health care costs at the forefront of their retirement planning.

[1] The Facts on Medicare Spending and Financing, Kaiser Family Foundation, 2018.
[2] Baby Boomers Retire," Pew Research Center (Dec. 29, 2010).

Reading this paper may be an important early step in the planning process. It provides simplified information about health care costs in retirement, including:

- Medicare Parts A, B and D
- Supplemental coverage
- Out-of-pocket costs

A key step in today's retirement planning is to be prepared for covering health care costs in retirement. Creating a portfolio to pay for medication is not nearly as glamorous as saving for a European cruise. It's important to understand that, unlike buying a less expensive car or downsizing their home, individuals entering retirement cannot eliminate their medications or cut back on necessary health services. For those who want a fulfilling retirement, reducing access to quality health care is not an option.

Key points

This paper highlights five key points about the importance of planning for retirement health care costs, including:

1. Medicare is not free, and it does not cover all services; premiums, surcharges, supplemental insurance, copays and deductibles, which can grow to hundreds—and even thousands—of dollars a month, must be considered
2. Social Security Cost of Living Adjustments (COLAs) may not keep up with retirement health care cost inflation, as evidenced by the last several years[3]
3. Medicare means testing, which levies income-based surcharges, will impact more retirees because the income brackets are not indexed to inflation
4. Longer life expectancies and long-term care costs, especially for women, could slowly erode retirement savings in the final years of life
5. Individuals with chronic conditions can reduce costs through proper behavior management and potentially increase retirement income through a consistent investment strategy

A few assumptions

It's important to understand that these points are based on the following assumptions:

- HealthView Services, a separate and non-affiliated company contracted by Nationwide, draws information from 70 million health care cases, as well as actuarial and government data, to project retirement health care costs; the firm's rigorous bottom-up approach integrates specific variables that will drive future health care expenses, including health status, age, sex, income and state of residence; the final calculations draw upon and are consistent with government health care inflation forecasts
- Retirement health care cost projections include Medicare Parts B and D, supplemental insurance premiums and out-of-pocket costs related to hospitalization, doctor visits, tests and prescription drugs; it is assumed that most Americans paid Medicare taxes while employed and will not be responsible for Medicare Part A; national averages are used for cost projections unless otherwise indicated
- Calculations assume actuarial longevity for different health conditions, sexes and ages
- The report relies on future dollar estimates unless otherwise indicated
- Long-term care expenses are not factored into cost estimates unless specifically indicated
- Actual costs for individuals may vary from these averages, just as it is with any aspect of retirement planning

HealthView Services contributed technical content and scenarios to illustrate the topics discussed in this white paper.

[3] Centers for Medicare & Medicaid Services, cms.gov.

A breakdown of Medicare coverage

Most people spend the bulk of their working lives subsidized by employer-sponsored programs, so they only think about health care when they are sick or lose coverage. Many also live under the false assumption that Medicare will take over where their employer coverage left off. They mistakenly believe it will be equivalent to the insurance they enjoyed throughout their working lives.

Keep in mind that individuals who are eligible for Medicare at age 65 have a seven-month sign-up period. This includes the three months before their birth month until the end of the three months after their birth month. Clients who are late to enroll may have to pay a higher premium throughout retirement.

Medicare Part A

- Free for most Americans; recipient or spouse must have 40 quarters of substantial career earnings
- Covers most, but not all, hospital care, as well as one wellness physical per year with no vitals or bloodwork; coverage includes inpatient care, skilled nursing facilities and Hospice care

Medicare Part B

- Although this is supplementary, all enrollees must pay based on income
- Coverage includes most other necessary medical services, such as doctor visits, physical therapy and medical equipment
- Most people pay a monthly premium of $134,[4] although income-based surcharges may apply
- Additional penalties can be incurred for late sign-up

Medicare Part D

- For prescription drug coverage, including most or all of six main prescription drug categories, although specific drug coverage and cost can vary and may be complex
- Premiums are based on terms and conditions set by private insurance companies
- Everyone is eligible, but the annual open enrollment period and the only time when plans can be changed is October 15 to December 7
- Both income and state of residency can impact premiums

Supplemental insurance (Medigap)

- A form of insurance that helps fill in the gaps of Medicare Part A and B coverage, such as co-pays and deductibles for medical services
- Premiums are based on terms and conditions set by private insurance companies that administer each plan, and have been approved by Medicare
- State of residency can impact premiums
- Income-based surcharges may apply

Other out-of-pocket costs

- Medicare does not cover everything or pay the total cost for most services or supplies that are covered[4]
- Dental, vision and hearing, which are often in demand as people age, are some of the services and equipment that Medicare does not cover
- All individuals—even those with supplemental insurance—will need to cover these expenses with their own money throughout retirement

[4] Medicare 2018 costs-at-a-glance, Medicare.gov.

Factors that impact the cost of health care

Inflation

Retirement health care inflation is the primary driver of rising costs, and it is projected to increase between 5% and 6% for the foreseeable future.[5] Keep in mind that this is a weighted metric that measures multiple inflation rates for different forms of coverage.

The following table provides anticipated inflation rates for Medicare Parts B, D and supplemental insurance premiums. All projections are based on HealthView Services data, unless otherwise noted.

Projected inflation rates per category[5]

Service	Projected inflation rate (through 2025)
Premiums	
Medicare Part B	7.025%
Medicare Part D	8.000%
Supplemental insurance	3.800%
Out-of-Pocket Costs	
Hospitals	3.000%
Doctors and tests	3.400%
Prescription drugs	3.660%

Based on the latest projections from the Medicare Board of Trustees, Part B premiums are expected to rise by an average of 7.025% through 2026, culminating with a $190.20 premium in 2026.[6]

It is anticipated that Part D premiums will grow at a rate of 8% annually,[5] which is more than 2.5 times an average U.S. inflation rate of approximately 2.1% (over the past 20 years).[7] According to the Congressional Budget Office (CBO), spending on Part D benefits represented 15.6% of net Medicare outlays.[8] Driven by this higher inflation rate, prescription drugs will occupy a larger portion of health-related expenditures in retirement.

Two distinct variables influence supplemental insurance policies, also known as Medigap: inflation and a year-to-year, age-based cost adjustment.

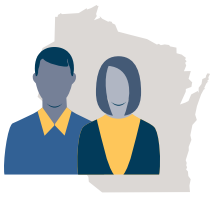
Most out-of-pocket costs stem from hospitals, doctors and tests, and prescription drugs. The costs are projected to increase between 3% and 3.66%.[5] These rates remain relatively low and appear to be more aligned with historic U.S. inflation rates. Dental, hearing and vision costs are projected to increase by 5%.[5]

Social Security COLAs aren't keeping pace. They were 0% in 2016, 0.3% in 2017 and 2.0% in 2018, which is far below the historical average of 3.8% and current inflation rates. COLAs are expected to rise at an annual level of 2.6% for the foreseeable future,[9] or less than half the expected retirement health care cost inflation of 5.47%.[5]

State of residence

Many retirees are surprised to learn that significant portions of their health care expenses vary in cost depending on the state in which they live. While it's true that Medicare is a federal program, individual states charge different amounts for Medicare Part D coverage, although the cost difference does not affect coverage. The same is true for supplemental insurance.

The following examples illustrate some of these differences:



Example 1:
Medicare Part D is **33% more expensive** in Wisconsin than in New Mexico.[10]

A healthy 55-year-old couple retiring in Wisconsin in 10 years will spend $75,844 more for Part D premiums than a similar couple living in New Mexico.[10]

Example 2:
Supplemental insurance (Plan F) is **49% more expensive** in Massachusetts than in Hawaii.[10]

A healthy 55-year-old couple retiring in Massachusetts in 10 years will spend $113,255 more for supplemental insurance premiums than a similar couple living in Hawaii.[10]

When planning where to retire, most Americans probably consider weather, housing costs, tax rates, proximity to family and other personal matters — not the difference in health care expenses from one state to another. But based on the data, crossing state borders could significantly impact future costs.

[5] Data provided by HealthView Services.
[6] "2017 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," Centers for Medicare and Medicaid Services (July 13, 2017).
[7] "Historical Inflation Rates: 1914-2018," US Inflation Calculator (2018).
[8] "March 2016 Medicare Baseline," Congressional Budget Office, cbo.gov/sites/default/files/ recurringdata/51302-2016-03-medicare.pdf (March 24, 2016).
[9] "Cost-of-Living Adjustments," Social Security Administration, ssa.gov/oact/cola/colaseries.html (2018).
[10] Data shown in all examples is provided by HealthView Services and assumes a male-female couple living to ages 87 and 89, respectively. Specifically for examples 1 and 2, additional costs are based on ages 65 through 87 for the male, and ages 65 through 89 for the female. Ages 87 and 89 are, respectively, the actuarial life expectancy projections for a health 55-year-old male and female.

Medicare means testing

The Medicare Modernization Act of 2003 included substantial changes, such as the introduction of Part D, which established prescription drug coverage. Another important-but-sometimes-overlooked provision was Medicare means testing, which essentially requires individuals with a high Modified Adjusted Gross Income (MAGI) in retirement to pay more for Medicare.

Medicare levies surcharges by measuring MAGI. These extra payments begin at $85,000 for an individual or $170,000 for a married couple. Initially, these figures may seem high, but since the baseline values are not expected to change over time, more retirees—whose incomes will rise with inflation—will be subject to the surcharges.

Implemented on January 1, 2007, the original proposal divided MAGI into five brackets. The top four were surcharged, and Part D surcharges were added four years later. This marked the first time Medicare recipients had to pay extra for Part B and Part D because of their income.

Medicare means testing thresholds[11]

Individuals	Couples	Average change in cost
<$85,000	<$170,000	—
$85,001-$107,000	$170,001-$214,000	37%
$107,001-$133,500	$214,001-$267,000	93%
$133,501-$160,000	$267,001-$320,000	149%
$160,000+	$320,000+	204%

Crossing the first threshold can increase Medicare Parts B and D costs by approximately 37%, and surpassing the highest bracket can inflate costs by more than 200%.[11] The combination of surcharges and health care cost inflation may place a considerable financial burden on retirees, validating their concerns about being able to afford quality health care in retirement.

Congress lowered these brackets in the Medicare "doc fix" legislation of 2015, which primarily focused on how physicians would be paid when accepting Medicare patients—not how lowering income thresholds would affect current and future retirees. The legislation also contained a two-year look-back policy, which meant that surcharges would be assessed on an individual's 2016 income rather than 2018.

In the 15 years since the law was established, Medicare has not adjusted the brackets for inflation. This was supposed to change in 2020, as originally proposed in the 2003 Act; however, the 2018 Budget Act indicates that Medicare will now begin indexing the brackets for inflation in 2028 instead of 2020.[12] Medicare essentially delayed the index for eight more years, which means that as incomes grow over time, more Americans will eventually face means testing.

Given the continued pressure on the Medicare Trust Fund, it's likely that indexing may be postponed even further because the reduction in revenue would presumably lead to reduced coverage, higher premiums or both.

As more baby boomers turn 65, Medicare enrollment will reach 64 million in 2020 and 81 million in 2030.[13] Many of them will be surprised to see their Social Security checks shrink due to Medicare premiums and surcharges, which will reduce monthly income and may also strain household budgets.

Health management

As of 2012, about half of all adults in the U.S. had one or more chronic health conditions, and one in four adults had two or more.[14] The leading causes are tobacco use, poor nutrition, lack of physical activity and excessive alcohol use. Even something as simple as getting people to properly follow their prescription drug protocol can be a difficult task. Recent surveys reveal that 50% of Americans diagnosed with a chronic condition do not take their prescribed medication after six months.[15] Treatments cost approximately $2.9 trillion annually, which amounts to roughly 86% of the nation's annual health-related expenditures.[16]

Although health care costs increase and patient lives could be shortened as a result, getting people to change their behavior is not always easy. Money can be a powerful motivator, but rewards must be substantial enough to drive change. In the past, doctors have not been able to immediately provide their patients with actuarial evidence that health management can lead to substantial annual savings and a longer life. That may change as new applications emerge.

Consider a 55-year-old man with high blood pressure. Data shows that he can save more than $17,000 in cumulative pre-retirement out-of-pocket health expenses by following simple health management tactics, such as taking medications, limiting salt intake and exercising. In retirement, this same individual would also be able to save an average of $910 in health costs each year.[17] Individuals who suffer from conditions such as Type 2 diabetes could also benefit from similar lifestyle changes.

Motivating individuals with chronic conditions can go a long way in reducing medical expenses. Disease management programs, virtual care and consistent follow-up can make a difference in patient wellness.[18]

[11] Nationwide Health Care Cost Assessment powered by HealthView Services.
[12] U.S. House of Representatives H.R. 1892, congress.gov/bill/115th-congress/housebill/1892/text (Feb. 9, 2018).
[13] "Who Relies on Medicare? A Profile of the Medicare Population," AARP (November 2017).
[14] "Multiple chronic conditions among US adults: a 2012 update," Preventing Chronic Disease (April 2014).
[15] Mercy Health Research.
[16] "At a Glance 2015: National Center for Chronic Disease Prevention and Health Promotion," Centers for Disease Control (2015).
[17] Data provided by HealthyCapital.
[18] "Do Workplace Wellness Programs Save Employers Money?" Rand Corporation (2014).

End-of-life costs

Increased lifespans

While it's true that Americans are living longer, the longevity comes at a price. According to data from HealthView Services, an average, healthy 65-year-old couple who lives two years beyond their projected life expectancy will incur an additional $91,496 in total retirement health care costs (future value).[19]

But looking at large populations masks the considerable variations in individual health conditions and treatment costs. At one end of the spectrum, a retiree may live to 90 and never visit the doctor, while another may live to the same age but require intensive medical treatment at a substantial expense.

When planning, it's important to make decisions based on the best available information. Individual longevity, which is largely based on health conditions, will be a significant determiner of health care costs, and it needs to be factored into the retirement planning process.

Challenges for women

Not so long ago, many retired Americans — most of whom were married — enjoyed pensions, employer- or union-sponsored health insurance plans that included prescription drug coverage and Social Security benefits with somewhat substantial COLAs. But as health care costs escalate, life expectancies increase, pensions dwindle, divorce rates increase and health care inflation outpaces Social Security COLAs, future retirees — especially women — may be challenged to create lasting retirement income.

Data from HealthView Services shows the magnitude of the financial challenges women will probably face during retirement. The average expected health care costs for Medicare Parts B and D and a supplemental insurance policy for a healthy 65-year-old woman living to age 89 and retiring this year are projected to be $258,758. A 65-year-old man living to age 87 will need $219,597. After out-of-pocket costs for hospitalization, doctor visits, tests and prescription drugs are added, those outlays increase to $293,008 for women, which is 18% more than the $248,524 for men.[11] The primary driver of this cost variance is the two additional years of longevity. During this time, the woman is paying the highest annual amount for her health care costs due to compounding health care inflation.

Out-of-pocket expenses

In the last two years of life, retirees need to plan for additional out-of-pocket expenses for more frequent doctor visits, greater use of services and prescription drugs. Here is an example of what this means for a 65-year-old couple in 2018.

Additional end-of-life cost projections[20]

	Life expectancy	Baseline cost: final two years of life	Additional cost: hospitalization	Additional cost: doctors and tests	Additional cost: prescription drugs	Total additional cost: final two years of life	Difference (%)
Male	87	$3,827	$1,162	$2,854	$5,457	$9,473	$5,646 (148%)
Female	89	$4,180	$1,344	$2,600	$6,354	$6,119	$6,119 (146%)
Total		**$8,006**	**$2,505**	**$5,455**	**$11,811**	**$19,771**	**$11,765 (147%)**

Because this couple will visit doctors, use health services and require prescription drugs more frequently during their final two years of life, they will incur an additional $11,765 in out-of-pocket expenses. Prescription drugs will account for nearly 60% of total additional end-of-life expenses — more than hospitalization, doctor visits and tests combined.

These additional expenses may be relatively small compared to total lifetime costs, but they will occur when assets may be dwindled and aging retirees are most financially vulnerable.

[19] Data has been provided by Nationwide Health Care Cost Assessment powered by HealthView Services. Examples assume the national average cost for Part B, Part D, Supplemental Insurance Plan F and out-of-pocket costs for hospitalization, doctors, tests and prescription drugs. Life expectancy increases reflect men living two years past expected age 87 to age 89 and women living two years past expected age 89 to age 91.

[20] Data has been provided by HealthView Services. This table assumes that the national average couple experiences 52% out-of-pocket cost increase in the penultimate year of life and 238% out-of-pocket cost increase in final year of life.

Analyzing the data[21]

The following case studies, which cover a range of individuals, provide some data-driven insights into the impact of health care costs in retirement.

Condition Management

As health care delivery costs continue to increase dramatically, individuals, insurance companies, hospitals and self-insured firms are actively exploring cost-reduction strategies. One solution that offers the most hope involves motivating individuals with chronic conditions to adopt simple, healthy lifestyle changes. Here's a closer look at how that may help.

John and Mary are 55 years old and have both been diagnosed with a chronic condition. They may be able to improve their health by adopting the behaviors listed in the chart to the right.

Based on the data, if John and Mary follow their doctor's suggested treatments, they will not only increase their life expectancies by four and 11 years respectively, but they would also save about $4,400 per year in health-related expenditures.[17] If the couple decides to invest the savings, they will generate an additional $54,000[22] in savings by the time they are ready to retire in 10 years.

John

High cholesterol

Behavior modifications
Limiting salt intake
Choosing healthy fats
Taking medications
Losing a few pounds
Increasing physical activity

Life expectancy increase
82 to 86

Annual pre-retirement health care savings[21]
$2,974

Mary

Type II diabetes

Behavior modifications
Adopting diabetic diet
Taking medications
Losing a few pounds
Increasing physical activity

Life expectancy increase
76 to 87

Annual pre-retirement health care savings[21]
$1,318

Longevity

Life expectancy is a critical variable to consider when planning for retirement. As shown in the example to the right, an average couple living three years beyond their actuarial life-expectancy projections will accumulate tens of thousands of dollars in unplanned health care costs.

Michael and Ann are 65-year-old retirees with excellent health who believe they have saved enough for a comfortable retirement. While their lifestyles may translate to longer life spans, they are not prepared to pay for three extra years of health care costs.

Based on the latest estimates, if Michael and Ann live three years beyond their projected life expectancies, they will be responsible for an additional $141,015 in health care costs. This is a sizable outlay for a couple living on a fixed income.

Michael

65

Actuarial life expectancy projection
87

Lived to age
90

Three extra years of health care costs[21]
$66,736

Ann

65

Actuarial life expectancy projection
89

Lived to age
92

Three extra years of health care costs[21]
$74,279

[21] All case data is provided by Nationwide Health Care Cost Assessment powered by HealthView Services.
[22] This figure represents a 6% expected rate of return.

Concerns for Women

In heterosexual marriages, husbands are, on average, 2.3 years older than their wives,[23] and women tend to outlive men by an average of two years.[11] Consequently, the surviving female spouse could be solely responsible for all personal living expenses for more than four years after her husband passes. Although the average period is less than half a decade, the data shows that the distribution of survivorship years can be wide.

This may be an uncomfortable topic, but it's important to address longevity when it comes to retirement planning. This is especially true when the age gap between spouses is significant.

Jean is 55 years old and married to Robert, who is 62. They are both healthy—with no chronic conditions—and are projected to live well into their eighties.

Robert

62

Actuarial life expectancy projection
87

Jean

55

Actuarial life expectancy projection
89

Total health care expenses in nine years after Robert passes[21]
$270,031

Because Jean is seven years older than Robert—and projected to live two years longer as well—she will be responsible for her individual health care costs for nine years without her husband's income, except for Social Security survivor benefits. To afford quality medical care for the remainder of her life, Jean will need to save for more than $270,000 in health care costs.

The new retirement

For decades, millions of American retirees who enjoyed stable pensions and somewhat generous Social Security COLAs spent little time worrying about paying for health care in retirement. At the same time, lower life expectancies and population shifts made it possible for Medicare to manage subscriber costs. But looking ahead, longevity, high retirement health care inflation, increased Medicare means testing and relatively inconsequential Social Security COLAs may make it difficult for individuals to afford medical expenses in retirement.

There is some reason for optimism, including the prospect that 117 million Americans who suffer from one or more chronic conditions[24] can reduce their expenses—and even increase their retirement income—by following prescribed treatments. At the same time, many financial professionals are keenly aware that failing to account for health care could undermine retirement budgets, and they are now integrating these costs into the planning process.

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[23] America's Families and Living Arrangements: 2012," Current Population Survey (August 2014).
[24] Chronic Diseases: The Leading Causes of Death and Disability in the United States, Centers for Disease Control and Prevention, cdc.gov.

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