RETIREMENT MANAGEMENT JOURNAL

A reprinted article from Volume 9, Number 1, 2020

Understanding the True Cost of Health Care in Retirement

By Nick Halen, RICP®, Kelli Faust, FSA, MAAA, and Todd Taylor, FSA

INVESTMENTS & WEALTH INSTITUTE®

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SUMMARY

After years of working hard and diligently saving to prepare for retirement, many individuals expect they'll finally be able to slow down, pursue hobbies, and enjoy the next phase of their lives. However, the truth facing retirees today is that numerous financial risks and uncertainties threaten their ability to spend their hard-earned money and maintain the quality of life they desire. Perhaps the greatest worry for those in, or near, retirement is whether they will be able to afford rising healthcare costs, particularly unplanned out-of-pocket expenses. This fear looms large for many retirees who are afraid that a poor medical diagnosis threatening their health also could jeopardize their financial wellness. Yet rather than trying to ease these fears by attempting to estimate what these expenses potentially could be and constructing formal plans for how to reduce and fund them, many individuals are instead self-insuring their retirements by constraining spending and continuing to save in retirement.

Retirees' concerns around health care are not without merit, yet a closer look reveals a different picture. Our research concludes that healthcare expenses for many retirees are a small percentage of total spending and are far less variable than most people think, making them easier to plan for properly than conventional wisdom suggests. The financial impact and likelihood of experiencing a spending shock associated with a health event are low, suggesting the perception of healthcare spending is far worse than the reality. Consequently, many retirees are unnecessarily living below their means to fund outsized healthcare expenses that are unlikely to be incurred.

Our research uncovered two healthcare-related risks that increase spending variability in retirement dramatically: long-term care (LTC) events and longevity. LTC events can derail retirement plans because the cost of care can be steep, and living meaningfully past life expectancy will increase lifetime healthcare costs and exacerbate other risks, such as investment and inflation risk. Longevity also increases the probability of experiencing an LTC-related health event. We found these risks and associated expenses to be more concerning for a retiree's financial well-being than all other healthcare costs because they are less known in terms of when or if costs will be incurred, what these costs will be, and over what period retirees will have to fund them.

An appropriate strategy for managing healthcare expenses in retirement is to plan for known or diversifiable risks and insure the unknown or undiversifiable risks. Basic healthcare expenses can be budgeted and planned for effectively because the variability of spending is manageable, particularly for retirees with supplementary coverages. However, this approach becomes more difficult and inefficient for LTC and longevity risks because they significantly increase spending variability in tail scenarios. Rather than self-insuring these risks through budgeting and setting aside potentially hundreds of thousands of dollars to cover unexpected costs, it is far more efficient to pool these risks with other retirees through the purchase of insurance. Our research shows that retirees who insure these two important risks with LTC insurance and income annuities are generally happier, more confident, and have an overall higher quality of life because doing so affords them the ability to spend more freely than those who don't.

This study has three primary goals. First, to assess and quantify the variability of out-of-pocket healthcare costs to determine whether retiree concerns around funding these expenses are warranted. Second, to identify what factors drive variability in spending and quantify their potential financial impact. Third, to identify solutions financial professionals can utilize with clients to reduce spending variability and achieve better outcomes in retirement.

LITERATURE REVIEW

The literature on healthcare spending in retirement can be broken down broadly into two areas of focus: (1) the cumulative costs of health care through life expectancy, and (2) the likelihood and potential financial impact of healthcare-related spending shocks. Numerous studies have been conducted to quantify these costs and—in some cases—attempt to explain what is driving them and how they vary based on certain factors. Although the

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findings from this wide body of literature are sometimes conflicting, the overarching takeaway is that healthcare expenditures must be considered within the context of a broader financial plan in retirement.

Estimates of cumulative healthcare expenses tend to vary based on the methodology. Fidelity (2020) found that the average sixty-five-year-old couple in 2020 may need approximately $295,000 in after-tax savings to cover healthcare expenses in retirement (Fidelity 2020). Fronstin and VanDerhei (2020) estimate some retired couples will need up to $325,000 to cover healthcare expenses. Using dynamic models of health, mortality, and out-of-pocket medical spending, Jones et al. (2018) estimate that at age seventy, households will on average incur $122,000 in medical spending, including Medicaid payments, over their remaining lives. Vanguard and Mercer Health and Benefits (Guyton et al. 2018)—who proposed a planning framework that considers annual healthcare spending rather than cumulative—project that annual healthcare expenses for a typical sixty-five-year-old woman will be $5,200 per year.

Intensifying the concerns around healthcare spending is the fact that it is expected to account for a higher percentage of total retirement income, particularly Social Security. Cubanski et al. (2018) found that Medicare beneficiaries' average out-of-pocket healthcare spending as a share of average per capita Social Security income is projected to rise from 41 percent in 2013 to 50 percent in 2030. McInerney et al. (2017) found that in 2014, average retirees had 65.7 percent of their Social Security benefits remaining after out-of-pocket spending and 82.2 percent of total income.

Other research has concluded that healthcare expenditures must be effectively planned for because they could be back-loaded and peak when retirees are older and have fewer assets. Banerjee (2015) found that usage and expenses of non-recurring healthcare services increase with age, driven largely by costs associated with nursing home stays. Alemayehu and Warner (2004) found that the distribution of healthcare costs is strongly age dependent because individuals age eighty-five and older consume three times as much health care per person as those sixty-five to seventy-four, and twice as much as those seventy-five to eighty-four. In fact, for survivors to age eighty-five, more than one-third of their lifetime healthcare expenditures will accrue in their remaining years.

Another concern for retirees is whether they will experience a healthcare-related spending shock that will deplete their assets. Although the definition of what should be considered a shock varies, the literature generally concludes that the probability of most retirees incurring one is both low and manageable from a cost standpoint. Banerjee (2020) found that very few retirees experience a castastrophic shock tied to a health event and few of those who do experience spending shocks face permament increases as a result (i.e., they tend to be one-time events). Blanchett (2018) found that health shocks may require less planning and saving than we think because they are rarely financially cataclysmic and retirees tend to respond to them by reducing future spending. Thus, although health shocks may impact retiree utility and overall quality of life negatively, they are seldom situations that lead to destitution.

This study expands upon the existing body of research by quantifying the annual variability of out-of-pocket healthcare spending when accounting for various factors, assessing the impact other healthcare-related risks have on spending variability, and proposing practical solutions financial professsionals can utilize to reduce spending variability and provide better outcomes for retirees.

MANY RETIREES SELF-INSURE HEALTHCARE COSTS RATHER THAN PLAN FOR THEM

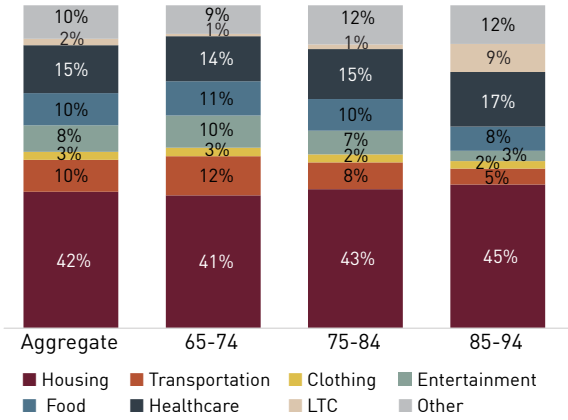
Being able to retire after years of hard work is an accomplishment that brings joy to many Americans. However, making the leap from employed to retired also can bring uncertainty and a wide range of concerns about the future. One worry is the cost of health care. Findings made available in the *2019 Insured Retirement Institute (IRI) Fact Book* show that the cost of health care is a top concern for many retirees and it ranks higher than the health of themselves and their families (Insured Retirement Institute 2019).

The American Psychological Association (2019, 2) found that more than half of adults (55 percent) worry they will not be able to pay for the healthcare services they may need in the future. This is driven largely by two factors: (1) healthcare inflation, which has exceeded general inflation in the United States historically by a wide margin, is expected to drive costs—particularly premiums—higher for the foreseeable future, and (2) the uncertainty around what future healthcare-related services will be needed and the extent to which they will be covered by Medicare or other insurance coverages.

Despite this, most individuals are not constructing formal plans for how to reduce and fund these retirement expenses. The Employee Benefit Research Institute (2019, 15) found that only 29 percent of workers and 40 percent of retirees have calculated how much money they likely will need to cover healthcare expenses in retirement (EBRI 2019). Financial professionals are partly responsible for this disconnect because many do not offer healthcare planning services. Findings from the Greenwald & Associates Retiree Insights 2018 study show that one-third of financial advisors admit to not offering planning services for healthcare costs despite their clients wanting and needing them.[1] Offering such services provides a substantial opportunity for advisors to provide much needed counsel to existing clients and can serve as a key differentiator in attempting to attract new ones.

Figure 1

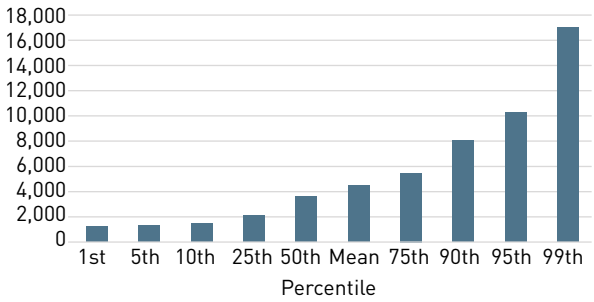
SHARE OF ANNUAL SPENDING BY CATEGORY AND AGE



Source: HRS and CAMS Survey Data, New York Life Research

Figure 2

DISTRIBUTION OF TOTAL HEALTHCARE EXPENSES



Source: HRS and CAMS Survey Data, New York Life Research

Many individuals appear to be self-insuring their retirements by constraining spending and continuing to accumulate assets. Steverman (2019) found that, "… even very rich clients often have a crippling reluctance to fully enjoy their money." Similarly, Clark (2016) stated: "Most retirees of modest means, as well as those who are affluent, don't even spend all of their income from Social Security, pensions, and investment earnings, much less draw down the principal in their nest egg. Their assets either stay about the same or grow over their lifetime." We contend that the uncertainties and fears around healthcare costs are an important driver of the underspending behavior we are seeing among many—particularly mass affluent and affluent—retirees.

Healthcare expenses in retirement are not as high, or volatile, as expected. To determine if these concerns are warranted, we conducted research on healthcare spending patterns of thousands of retirees in the United States to better understand (1) what average annual healthcare expenses are for retirees, considering both premiums and other out-of-pocket (OOP) costs, and (2) the variability of these expenses, particularly OOP.[2] To do this, we utilized the latest data available from the Health and Retirement Study (HRS) and the Consumption and Activities Mail Survey (CAMS).[3] Our analysis considered a wide range of retiree healthcare expenditures (e.g., insurance premiums,[4] OOP costs for care, prescription drugs) to determine how overall healthcare spending varies by respondents' age, gender, income, wealth, health status, and insurance coverage type. Insurance type was split into three distinct categories: Original Medicare, Medicare Advantage, and Original Medicare plus supplementary coverages. LTC-related expenses (e.g., nursing homes, home health services, special facilities) were excluded in the base analysis but discussed later, to focus on basic healthcare and medical expenditures.

Healthcare spending is a small portion of total retirement expenses. Average annual healthcare expenses for all retirees, excluding LTC costs, are roughly $4,500, or 15 percent of total spending. This is not materially different than what they will spend, on average, for food and transportation and significantly less than what they will pay for housing (see figure 1), yet studies have shown these expenses are less concerning for retirees. A 2019 survey conducted by the financial firm Hearts & Wallets found that most pre-retirees underestimate what they will spend on housing in retirement and overestimate healthcare spending (Eisenberg 2019). This misguided optimism toward housing, which accounts for a large percentage of spending, and pessimism toward health care, which is a small percentage of spending, typifies why working with an advisor to construct a fact-based financial strategy for retirement is paramount.

Because a portion of annual healthcare costs is unknown in advance and will depend on utilization of services, among other things, it is also important to understand the variability of spending, i.e., the total distribution of expenses and how high they might reach in worst-case scenarios (see figure 2).[5] In observing variability, it is worth noting that we are viewing healthcare spending in two categories of expenditures: premiums and other OOP costs (e.g., deductibles, copayments, coinsurance, services not covered through insurance). Premiums, which on average account for 64 percent of total healthcare spending across all retirees, likely will be known in advance with a relatively high degree of certainty. Future premiums undoubtedly will rise with healthcare inflation; however, these increases likely will be steady and occur over time rather than cause a significant spending increase in a given year.

On the other hand, OOP costs—which account for 36 percent of total healthcare spending—are truly variable and more difficult to predict. To determine variability, we analyzed the distribution of annual healthcare spending across thousands of retirees. Our findings show that overall variability of annual OOP healthcare spending is relatively low and predictable in all but the tail scenarios.[6] Annual retiree healthcare spending does not increase meaningfully until the 90th percentile of results, which is where OOP expenses approach $3,700 (see figure 3).

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Figure 4 shows that more than two-thirds of retirees (70 percent) incur expenses below the population average. Further, retirees who experience a healthcare-related spending shock, which we have defined as the average of the 90th percentile of outcomes and above, will incur OOP costs 4.6 times the population average. Thus, a spending shock will result in total healthcare spending (including premiums) being approximately 2.3 times the population average.

Given healthcare costs typically represent a small percentage of overall spending for retirees—even at the 90th percentile healthcare expenses account for 24 percent of spending—and the risk of experiencing a spending shock more than four times the average is low, the perception of healthcare spending appears far worse than the reality. As a result, many retirees are reserving or stockpiling cash for an outsized healthcare expenditure that may never materialize.

VARIABILITY IN OOP EXPENSES RELATES TO AGE, HEALTH STATUS, AND INSURANCE COVERAGE TYPE

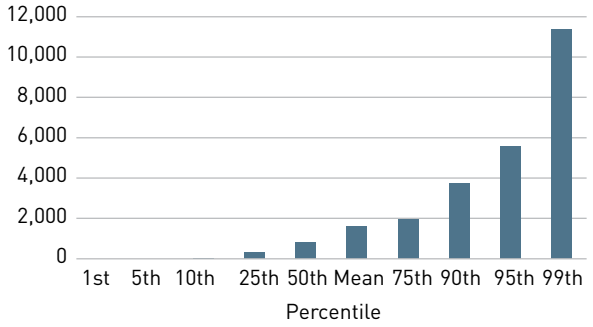
To better understand what drives variability in tail scenarios, we analyzed how OOP healthcare spending varies based on certain factors—age, gender, health status, insurance coverage type, income, and wealth. Doing so helped us see if the overall variability of the distribution differs for certain segments of the population. We assessed variability by looking at the range between the median and 99th percentile of results to focus solely on the right tail of the distribution (i.e., a wider range indicates more variability). Our findings show the difference in healthcare spending variability experienced by retirees varies based on age, how healthy they are, and the type of insurance coverage they have (see table 1). However, no clear relationships exist between spending variability and gender, income, or wealth.

The amount and variability of healthcare expenditures increase with age. Healthcare spending typically increases as retirees age. This is driven largely by the fact that retirees are more likely to take prescription drugs and incur costs associated with hospital stays as they get older. Our research shows that 94 percent of retirees age eighty-five to ninety-four take prescription drugs (versus 89 percent of those age sixty-five to seventy-four) and 42 percent go to the hospital (versus 25 percent of those age sixty-five to seventy-four). Further, the average number of annual doctor visits increases with age (fourteen times for those age eighty-five to ninety-four versus twelve times for those age sixty-five to seventy-four).

Unhealthy retirees see more variability in healthcare expenses. The health status of retirees was measured by the number of chronic conditions they have.[7] Figure 5 shows that average healthcare expenditures, and the variability of those expenses, increase with the number of conditions retirees have. Retirees with 2–3 conditions spent 41 percent more and retirees with 4+ conditions spent 77 percent more on health care in 2016

Figure 3

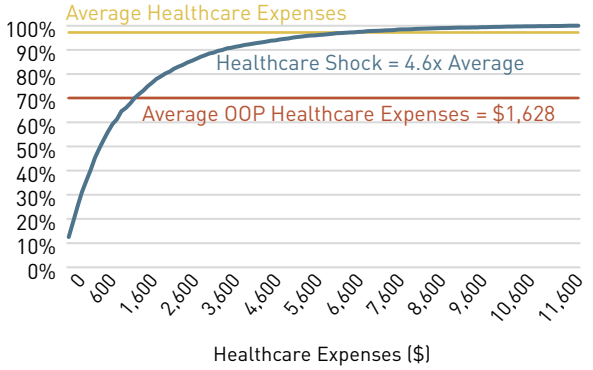
DISTRIBUTION OF OUT-OF-POCKET HEALTHCARE EXPENSES



Source: HRS and CAMS Survey Data, New York Life Research

Figure 4

MOST RETIREES HAVE BELOW-AVERAGE HEALTHCARE EXPENSES



Source: HRS and CAMS Survey Data, New York Life Research

Table 1

ANNUAL OUT-OF-POCKET HEALTHCARE SPENDING AND VARIABILITY BY VARIOUS FACTORS

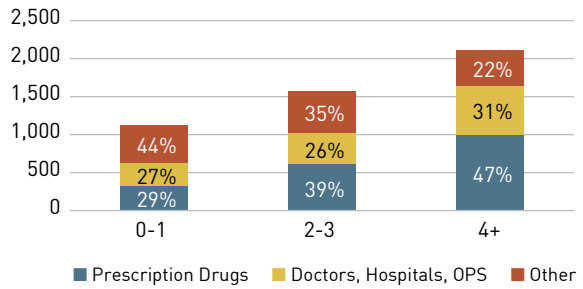
Split		Average OOP Spending	Range between Median and 99th Percentile
Aggregate		**$1,628**	**$10,528**
Age Group	65–74	$1,482	$8,720
	75–84	$1,629	$11,265
	85–94	$2,174	$14,628
Health Status	0–1 condition	$1,120	$8,895
	2–3 conditions	$1,574	$10,243
	4+ conditions	$2,113	$12,900
Coverage Type	Original Medicare	$1,584	$11,270
	Medicare Advantage	$1,647	$10,198
	Medigap	$1,637	$10,574

Source: HRS and CAMS Survey Data, New York Life Research

than retirees with 0–1 condition. Further, spending shocks were 29 percent and 66 percent higher for those with 2–3 and 4+ conditions, respectively, relative to those with 0–1 condition. Breaking down utilization and OOP costs by health status, figure 5 shows the largest spending categories for retirees with 4+ conditions are prescription drugs (47 percent of total OOP spending), followed by doctors, hospitals, and outpatient surgeries (31 percent of total OOP spending), whereas the largest spending category for retirees with 0–1 condition is "other" services—which includes the dentist, special food, equipment, visits by health professionals, or other undefined costs (44 percent of total OOP spending). This explains why healthcare spending for unhealthy retirees is significantly higher and more volatile than healthy retirees—they are faced with recurring expenses associated with refilling prescriptions, they need to visit the doctor frequently, and they are much more likely to end up in the hospital. Almost half (46 percent) of retirees with 4+ conditions went to the hospital in the past two years, versus 14 percent with 0–1 condition. Additionally, the average number of times a retiree goes to the hospital increases with the number of conditions. Those with 4+ conditions went to the hospital an average of 1.0 times over the past two years, versus 0.2 times for those with 0–1 condition.

Figure 5

SHARE OF OUT-OF-POCKET SPENDING BY EXPENSE TYPE AND HEALTH CONDITIONS



Source: HRS and CAMS Survey Data, New York Life Research

Insurance reduces variability and creates more predictability. In evaluating the impact different insurance coverage can have on retiree healthcare spending, we split insurance type into three distinct categories: Original Medicare, Medicare Advantage, and Original Medicare plus supplementary coverages. The Original Medicare plus supplementary coverages category consists primarily of Medicare Supplemental Insurance policies (Medigap), but it also includes coverages from former employers, insurance companies, and other coverages that offer benefits that fill in some of Medicare's coverage gaps. For the remainder of this paper we will refer to this broad category of coverages as "Medigap" when presenting the findings of our analysis. We also considered the impact of prescription drug costs, which typically are covered by Medicare Part D. Table 2 provides a brief overview of the three Medicare coverage types. Figure 6 shows that as expected, Medigap and to a lesser extent Medicare Advantage shift a greater percentage of expenses to predictable premiums. There are Medigap plans that afford retirees the ability to eliminate most OOP costs if they are willing to pay additional premiums, meaning many retirees experience little to no healthcare spending variability for covered services.

Table 2

OVERVIEW OF MEDICARE COVERAGES

	Original Medicare	Medicare Advantage	Medigap
Description	Federally provided insurance program that covers hospital stays (Part A) and certain medical services (Part B)	Private health plan that provides Part A & B benefits directly in place of Original Medicare	Private supplemental coverage that pays all or most Part A & B out-of-pocket costs
Premiums	Part B only. $144.60 to $491.60 per month depending on income	$0 to more than $100 per month depending on the plan. All plan enrollees pay the same regardless of age or health	Average about $150 to $200 per month, but will vary by age and health
Out-of-pocket costs	High/No limit	In-network medical deductibles and copays of up to $3,400 to $6,700 a year, depending on the plan. $10,000 cap for PPO plans	Low to none
Part D prescription drug coverage	Not included	Included with most plans	Not included
Long-term care coverage	Not included	Not included	Not included
Vision, dental, and hearing coverage	Not included	Coverage varies by plan	Not included
Choice of doctors and hospitals	Any that participate in Medicare	HMOs: Plan providers only PPOs: Any provider, but out-of-network providers cost more	Any that participate in Medicare

Note: The out-of-pocket limits shown for Medicare Advantage are only for Medicare-covered services. Services not usually covered by Medicare, such as prescription drug, vision, dental, hearing, and non-emergency transportation are not counted in the limit, and limits can change every year. Source: New York Life Research

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To further evaluate the impact of different insurance coverages, we focused only on services that are at least partly covered by Medicare Parts A and B, for which all three categories provide some level of coverage. We did this to isolate the impact insurance has on healthcare spending and to make it a more direct comparison. Variability for each category was then determined by studying the OOP costs incurred for these services, which consisted of those associated with doctor visits, inpatient hospital stays, and outpatient surgeries (OPS). These costs are represented by the orange bars in figure 6.

Average OOP spending on these expenses is 28 percent lower for retirees with Medigap than those relying solely on Original Medicare. OOP spending on services normally covered by Parts A and B tend to be lower for retirees with Medigap than other coverages because in exchange for higher premiums recipients receive a better insurance benefit. Overall, the impact of a healthcare-related spending shock (i.e., the average of the 90th percentile of outcomes and above) for those with Medigap is 20 percent lower than those with Original Medicare.

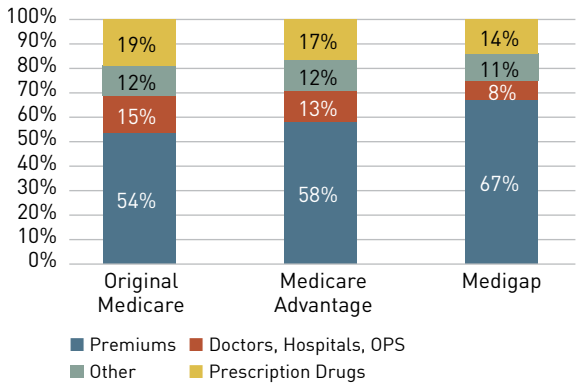
Another noteworthy finding is the value of Medicare Advantage relative to Original Medicare does not become apparent until the 90th percentile of results (see figure 7). This is likely associated with tail scenarios where recipients experience a health event and reach the OOP limits of their policy, a benefit Original Medicare does not provide. This, along with the fact that Medigap results do not exhibit significant variability until the 99th percentile, highlights the value of insurance in reducing spending variability and shows that most retirees with additional coverages will not experience financial distress tied to a health event.

We then analyzed the impact prescription drug costs have on spending given they are more ubiquitous than other OOP costs. Seventy-four percent of retirees reported having incurred at least some OOP costs associated with prescription drugs. Also, overall prescription drug costs, which include annual deductibles, copayments, coinsurance, and OOP payments for needed medications, account for nearly half of all OOP costs for retirees. Our analysis shows that average prescription drug costs for those with and without prescription drug coverage (through Part D, Medicare Advantage, or private insurance) are similar and the variability of spending (defined as the range between the median and 99th percentile) for those without prescription drug coverage is only higher for unhealthy retirees. Table 3 shows that retirees with 0–1 condition and drug coverage experience 17-percent higher variability than those without coverage, whereas retirees with 4+ conditions experience 10-percent lower variability if they have coverage. On the aggregate, retirees with prescription drug coverage experience 1-percent lower variability than those without coverage.[8]

Retirees have no control over their age and modest control over their health; however, they do have full control over which

Figure 6

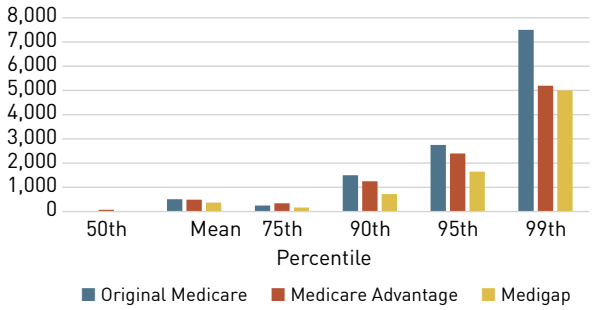
SHARE OF OUT-OF-POCKET HEALTHCARE SPENDING BY INSURANCE TYPE



Source: HRS and CAMS Survey Data, New York Life Research

Figure 7

DISTRIBUTION OF DOCTOR, HOSPITAL, AND OUTPATIENT SURGERY EXPENSES BY COVERAGE TYPE



Source: HRS and CAMS Survey Data, New York Life Research

Table 3

DRUG EXPENDITURE VOLATILITY BY NUMBER OF CONDITIONS

Number of Conditions	Aggregate Spending	Spending With Prescription Drug Coverage	Spending Without Prescription Drug Coverage	Spending With vs. Without Coverage
0–1	$3,528	$3,504	$3,000	+17%
2–3	$4,512	$4,500	$4,560	–1%
4+	$5,460	$5,460	$6,098	–10%
Average				–1%

Source: HRS and CAMS Survey Data, New York Life Research

insurance coverage they choose. This is important because our research shows that even though individuals may be in segments that typically have higher healthcare spending variability (i.e., older age with multiple health conditions), being properly insured can reduce spending variability greatly. Relative to the aggregate population, retirees experience a 17-percent increase in spending variability if they are age eighty-five to ninety-four and have 4+ conditions. However, if these individuals select Medigap, their variability is reduced significantly (39 percent)—so much so that their overall healthcare spending variability is less than the aggregate population.

LONG-TERM CARE AND LONGEVITY ARE RISKS THAT ARE MORE VOLATILE AND DIFFICULT TO PLAN FOR

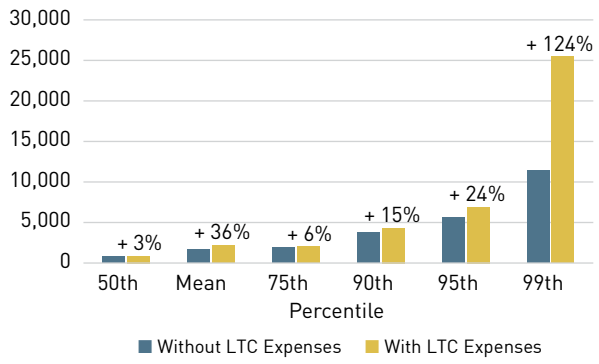
Our findings thus far have shown that the variability of healthcare expenses exists only in tail scenarios and the costs associated with spending shocks are reasonable. However, we have identified other healthcare-related expenses that are far more variable, costly, and thus difficult for retirees to plan for properly. These include expenses associated with LTC events and longevity.

An important risk that increases the variability of healthcare—and thus total—spending is related to LTC events. The National Institute on Aging defines LTC as "a variety of services designed to meet a person's health or personal care needs during a short or long period of time. These services help people live as independently and safely as possible when they can no longer perform everyday activities on their own."[9] The most common type of LTC is personal care—help with everyday activities, also called activities of daily living. These services often are needed when retirees have a serious, ongoing health condition or disability and care typically is administered in the patient's home (by a family member or qualified care provider), a nursing home, or an assisted living facility.

LTC events are disconcerting for retirees because there is a high likelihood they will need LTC-related care at some point and the costs associated with this type of care are high if obtained through a qualified care provider. The U.S. Department of Health and Human Services stated someone turning age sixty-five today has almost a 70-percent chance of needing some type of LTC service and support in their remaining years and 20 percent will need care for longer than five years.[10] Genworth (2018) found that more than one-third of retirees will spend time in a nursing home, where the average annual cost of a private room is now more than $100,000.[11] Additionally, a study by Vanguard Research and Mercer Health and Benefits found that 15 percent of retirees will incur more than $250,000 in cumulative LTC costs (Guyton et al. 2018).

Figure 8

DISTRIBUTION OF OUT-OF-POCKET HEALTHCARE COSTS WITH AND WITHOUT LTC-RELATED EXPENSES



Source: HRS and CAMS Survey Data, New York Life Research

When we expanded our initial analysis to account for the impact of LTC-related expenses, we found that overall variability increased significantly. When focusing exclusively on OOP expenses, we found a similar impact on the overall distribution (see figure 8). Additionally, when adding in LTC expenses, a spending shock event will have a much larger impact on retirees. Those in the top 10 percent of the distribution, on average, will have expenses 5.7 times more than the average of the total distribution, which is significantly more than the 4.6 times we observed earlier when excluding LTC expenses.

Another healthcare-related risk and potential financial shock many retirees face is related to longevity (i.e., living meaningfully past one's life expectancy). Doing so lengthens the planning period for retirees and has a multiplier effect on other retirement costs and risks, such as investment and inflation risk. Increases in life expectancy are generally a good thing; however, it also brings uncertainty around what additional costs will be incurred the longer one lives and the ability to support a certain lifestyle later in retirement. Manageable costs early in retirement can become unmanageable if they need to be funded for longer than originally planned, especially when considering the effects of inflation.

To assess the financial impacts of longevity, we analyzed how OOP healthcare spending (inclusive of LTC costs) varies based on how long retirees live. We did this for both males and females to account for the fact that they have different life expectancies. In both cases, living to the 95th percentile of life expectancy (roughly an extra twelve years for males and fourteen years for females) will result in higher expenses than paying the 95th percentile of expenses through life expectancy (see figure 9).[12] Further, these results show that longevity risk has a multiplier effect on cumulative spending in retirement greater than the impact of higher costs themselves. For example, females who live to life expectancy and incur costs in the 95th percentile will spend 3.3 times the average. Living to the 95th percentile of life expectancy (age ninety-nine) and incurring costs in the 95th percentile drives cost to 6.3 times living to age ninety-nine and incurring average costs.

In addition, living beyond life expectancy appears to also increase the likelihood of experiencing an LTC-related spending shock.

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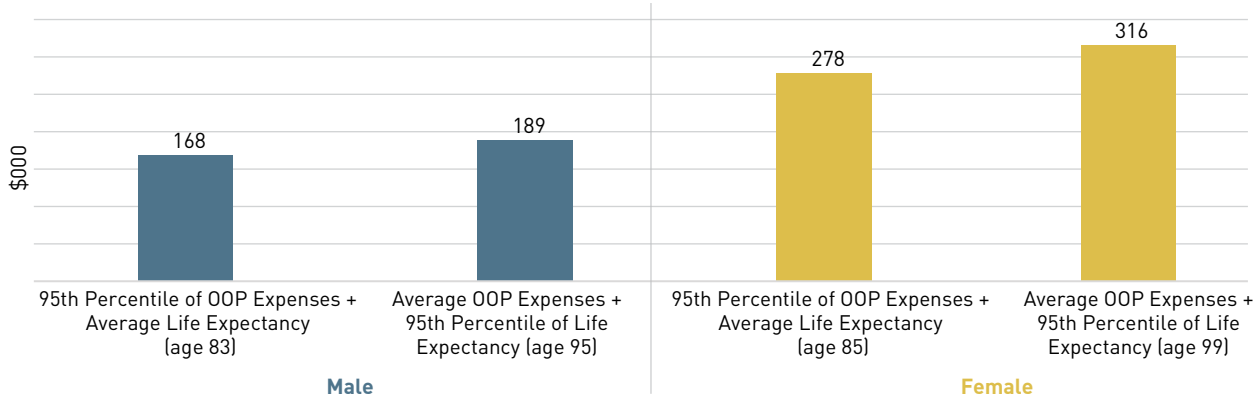
Figure 9

CUMULATIVE OUT-OF-POCKET HEALTHCARE EXPENSES BY LIFE EXPECTANCIES

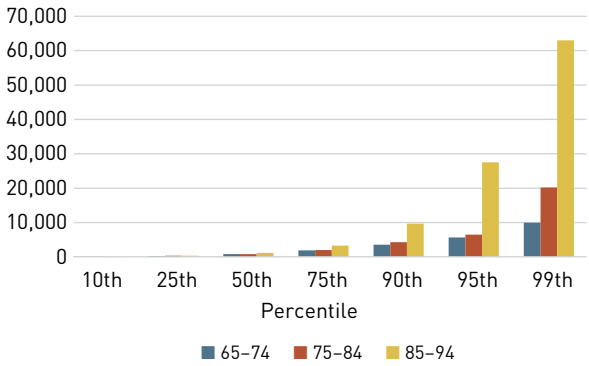


Source: HRS and CAMS Survey Data, New York Life Research

Figure 10 shows that the distribution of healthcare expenditures (inclusive of LTC-related costs) is steady until age eighty-five. At age eighty-five and older, the variability of expenditures increases significantly at the 95th and 99th percentiles. This was not the case when we excluded LTC, which shows retirees who live beyond life expectancy are more susceptible to an LTC-related spending shock than one associated with basic health care.

Figure 10

DISTRIBUTION OF OUT-OF-POCKET HEALTHCARE EXPENSES (BASIC AND LTC) BY AGE BANDS



Source: HRS and CAMS Survey Data, New York Life Research

HOW CAN AMERICANS BETTER PREPARE TO MEET HEALTHCARE COSTS IN RETIREMENT?

When it comes to healthcare and other healthcare-related expenses in retirement, financial advisors should work with clients to plan for known or diversifiable risks and insure the unknown or undiversifiable risks. Our research has shown that most retirees should have a good sense of what health care will cost them, especially if they are young, relatively healthy, and do not rely solely on Original Medicare. It follows that financial advisors work with their clients to understand their healthcare needs and ensure they have the best coverage for those specific needs. Given that most healthcare costs will consist of premium payments, financial advisors can put a plan in place to ensure clients can appropriately fund these predictable costs as they increase with inflation, while also maintaining reserves to cover OOP expenses. Possible investments and solutions include tax-advantaged vehicles such as health savings accounts (HSAs), guaranteed income annuities with an annual increase feature, and effectively managing modified adjusted gross income (MAGI) to reduce Medicare premiums, to name a few.

HSAs are personal savings accounts that offer greater tax benefits than other types of retirement savings plans. Individuals who open an HSA through an employer—and are enrolled in a high-deductible health insurance policy—can do so with pre-tax contributions, with interest and investment earnings within the account accruing tax-free. That money eventually can be taken out of the HSA tax-free if used to fund qualified medical expenses, which include deductibles, copayments, coinsurance, vision, dental care, and other OOP medical costs. Funds also can be used to pay for certain medical premiums, including Medicare and LTC insurance.

Guaranteed income annuities with an annual increase feature provide a source of guaranteed income that will increase each year by a percentage determined at purchase. For example, a fifty-five-year-old male who purchased a $100,000 deferred income annuity with a 3-percent annual increase option would receive roughly $5,100 of annual income at age sixty-five. However, that amount would increase to $6,900 at age seventy-five and $9,300 at age eighty-five,[13] making it a funding source to help with rising insurance premiums.

In addition to planning for which assets will be used to fund expenses, it is also important to consider ways in which to keep down the liability side of the equation. Financial advisors must work with clients to incorporate tax-efficient distribution strategies to keep MAGI below certain thresholds, which will help keep Medicare Parts B and D costs down. This is particularly important

for high-income taxpayers who are required to pay additional premiums (known as the income-related monthly adjustment amount) once MAGI reaches $88,000, and $176,000 for married couples (in 2021). Crossing the first threshold increases the cost of Medicare Parts B and D by 48 percent and surpassing the highest threshold increases costs by nearly 300 percent.[14] Income from HSAs, Roth IRAs, Roth 401(k)s, life insurance policies, nonqualified annuities, longevity insurance, and reverse mortgages is not included in the MAGI calculation.

RISK POOLING IS AN EFFECTIVE WAY OF MANAGING LTC-RELATED AND LONGEVITY RISKS

LTC events and longevity can be planned for effectively through risk pooling. The variability of these expenses is significantly higher and overall costs are unknown. Rather than self-insuring or relying on family assistance for an unforeseen LTC event, it can be more efficient to insure these risks in conjunction with a comprehensive financial plan. In other words, replace unknown—likely large—costs with smaller, more manageable costs that can be included as a part of a retiree's overall spending plan.

Most people do not take LTC risks as seriously as they should, which is driven at least partly by a lack of education on the subject. The Center for a Secure Retirement found that nearly 80 percent of baby boomers have nothing saved for LTC and, perhaps even more worrisome, more than half mistakenly believe LTC will be covered through Medicare (2019, 15).[15]

Purchasing LTC insurance (LTCI) helps cover the costs of eligible services that typically are not covered by regular health insurance, which include assistance with routine activities of daily living such as bathing, dressing, and transferring into and out of a bed, chair, or wheelchair; or require substantial supervision to protect from threats to health and safety due to severe cognitive impairment. Most policies reimburse for eligible care provided in a variety of places, such as one's home, nursing facilities, assisted living facilities, and adult day care centers, and the benefits paid through LTCI generally are not taxed as income. It is important to consider buying LTCI prior to reaching retirement age because waiting reduces the likelihood of qualifying for coverage and increases the cost. Hybrid or linked-benefit life and annuity products are additional options for clients looking to obtain protection against future LTC events.

Research shows that individuals who have LTCI tend to be more confident, be happier, and generally spend more than those who do not have this type of insurance. Our assessment of retirement satisfaction scores in the 2016 HRS study found that, holding for wealth, a higher percentage of retirees (more than 8 percent) with LTCI are very satisfied with retirement relative to their counterparts without LTCI. Further, Banerjee (2012, 13) found that having LTCI had a significant effect on spending by retired households. The analysis concluded that in 2009, people with LTCI had median total household spending of roughly $47,000, whereas those without LTCI spent only $32,000 (48 percent more). These findings held even when running a regression controlling for income and wealth.

As with LTC, longevity risk is concerning because, if not properly managed, it could lead to retirees becoming dependent upon others to maintain their lifestyle or, even worse, descending into financial distress. Although most retirees will never actually run out of money because of the Social Security benefits they receive, relying entirely on that source of income is insufficient because retiree spending typically exceeds the income received from Social Security by a wide margin. The Social Security Administration estimates that Social Security retirement benefits will replace only about 40 percent of pre-retirement income for individuals with average earnings, and the percentage is even lower for people in the upper income brackets.[16] As fewer and fewer individuals reach retirement with the crutch of a defined benefit pension plan and the future of Social Security becomes more uncertain, having additional sources of guaranteed lifetime income to offset the risk of living meaningfully beyond life expectancy becomes paramount.

Many financial assets and strategies can generate income; however, only annuities can provide the guaranteed lifetime income many retirees need. Insurance companies, much like defined benefit plan providers and the Social Security Administration, can do this by pooling longevity risk among large cohorts of individuals. In addition to lifetime income, single-premium immediate and deferred-income annuities typically provide more income than similarly rated fixed income investments because the income amounts include mortality credits (i.e., the income provided to individuals who live beyond life expectancy is subsidized by those who pass prior to life expectancy).

Aside from guaranteed income, and much like LTCI, owning annuities also can provide behavioral benefits and give individuals confidence in their ability to live a long, meaningful life in retirement. Greenwald & Associates and CANNEX (2019) found that nearly 90 percent of annuity owners worry less about retirement and 75 percent said they can use more of their money for discretionary spending because they own annuities. When bifurcating the retirement satisfaction scores captured in the HRS survey by those with and without annuity income, we found of those retirees with an annuity, 8 percent more feel very satisfied with retirement relative to those without an annuity. We also found that on average—and holding wealth constant—retirees receiving annuity income spend 8 percent more than retirees without.[17]

CONCLUSION

Retirees are worried about the affordability of health care, particularly out-of-pocket expenses that may arise unexpectedly in the future. Those in, or nearing, retirement may find comfort in the knowledge that non-LTC healthcare expenses for many retirees are a small percentage of total spending and are far less variable

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than most people think, making them easier to plan for properly. The financial impact and likelihood of experiencing a significant spending shock associated with a health event is low, suggesting the perception of healthcare spending is far worse than the reality. Thus, many retirees are unnecessarily living below their means to fund outsized expenses that are unlikely to occur.

LTC events and longevity are two healthcare-related risks that have the potential to increase spending variability dramatically in retirement. We found these risks and associated expenses to be more concerning for a retiree's financial well-being than all other healthcare costs because they are less predictable in terms of when or if costs will be incurred, what these costs will be, and over what period retirees will have to fund them.

An appropriate strategy for managing healthcare expenses in retirement is to plan for known or diversifiable risks and insure the unknown or undiversifiable risks. Basic healthcare expenses can be budgeted and planned for effectively because the variability of spending is manageable. However, this approach becomes more difficult and inefficient for LTC and longevity risks because they significantly increase spending variability in tail scenarios. Rather than self-insuring these risks through budgeting and setting aside potentially hundreds of thousands of dollars to cover unexpected costs, it is more efficient to pool these risks with other retirees through the purchase of insurance. Research shows that retirees who insure these two important risks with LTCI and annuities are generally happier, more confident, and have an overall higher quality of life because doing so affords them the ability to spend more freely than those who choose to self-insure these risks.

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ENDNOTES

1. Greenwald & Associates and The Diversified Services Group. 2018. Retiree Insights 2018.
2. Our findings are focused primarily on variability of out-of-pocket expenses rather than total expenses because premiums are likely known in advance and are less volatile.
3. The Health and Retirement Study (HRS) provides income information on thousands of U.S. citizens older than age fifty and the Consumption and Activities Mail Survey (CAMS), which is a supplement of the HRS, contains detailed spending information on durable and non-durable expenses. We utilized 2016 HRS data and the 2017 CAMS to conduct our analysis. To analyze healthcare spending behaviors in retirement, we included only respondents who (a) considered themselves fully retired, (b) were between the ages of sixty-five and ninety-four, (c) stated they had wealth greater than $0, and (d) have annual income greater than $10,000. Households with health insurance provided by unions and those with Medicaid were removed from the analysis. Only those respondents where 2016 was their first interview or they were also interviewed in 2014 were included so that the reference period for all included respondents was a two-year period. Respondent-level weights applied for this analysis.
4. Medicare Part B premiums, which are based primarily on modified adjusted gross income (MAGI), were not provided in the survey because they often are deducted directly from Social Security. Thus, we calculated Part B premiums using household taxable income as a proxy for MAGI. Household taxable income was calculated as household total income plus household individual retirement account withdrawals. Any additional premiums (e.g., prescription drug coverage, supplemental coverage, Medicare Advantage) were captured in the survey.
5. Focusing on average healthcare expenditures is not entirely relevant given that certain coverages are regulated at the state level (e.g., prescription drug and supplemental policies). This means the insurance carriers, policies, and—most importantly—the costs of coverage can vary greatly depending on where someone lives. Plus, planning for retirement based solely on nationwide averages is not a recommended approach.
6. Throughout this paper the terms "tail scenario" or "tail risk" refer to the 90th, 95th, or 99th percentile of expenses across the entire population analyzed.
7. Health status was measured by quantifying how many of the following conditions respondents have: high blood pressure, diabetes, cancer, lung disease, heart disease, stroke, psychiatric problems, and arthritis.
8. It is important to consider that only 11 percent of survey respondents stated that they did not have prescription drug coverage versus 89 percent who said they did (i.e., the sample sizes are substantially different and may be skewing the results shown).
9. See https://www.nia.nih.gov/health/what-long-term-care.
10. See https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html.
11. See Long-Term Care Group (LTCG) Cost of Care Survey (2018), https://www.newyorklife.com/NYLInternet/products/ltc-national-averages.
12. This analysis applies average total out-of-pocket healthcare expenses of each age group, to each age within that group. It uses the average from the 85–94 age group for all ages 95+. It assumes annual inflation of 4.22 percent, which is an estimate of projected healthcare expense inflation provided by HealthView Services. https://hvsfinancial.com/download-2018-retirement-health-care-costs-data-report/.
13. The annual income shown reflects Life Only payout rates for males as of December 9, 2020. The product referred to is a deferred income annuity with a 3-percent annual increase option, and the amounts shown reflect average payouts across thirteen different annuity carriers.
14. See https://www.medicare.gov/Pubs/pdf/11579-medicare-costs.pdf.
15. The Center for a Secure Retirement is Bankers Life's dedicated research and consumer education program. The Center's studies and consumer awareness campaigns provide insight and practical advice to help everyday Americans achieve financial security in retirement.
16. Social Security Administration. Benefits Planner: Retirement, https://www.ssa.gov/planners/retire/r&m6.html.
17. This analysis merges the dataset used in prior analyses with the RAND CAMS dataset and includes only those who appear in both. We grouped singles and couples into deciles by wealth and took the average spending of each group with and without an annuity. Eight percent is the average of these groups. The story becomes even stronger (20-percent more spending) when looking at those with various types of guaranteed income (annuitized income and/or pension income) versus those without guaranteed income.

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