Your Retiring Clients' Biggest Fear

Special Report: Healthcare & Retirement

By David E. Adler

April 1, 2008

Healthcare costs increased 8% last year, as they did the year before and the year before that. The cost of the average family's health insurance premiums rose 80% from 2000 to 2006. During that same period, the consumer price index increased by only 17%. These statistics, from the Kaiser Family Foundation, indicate that the cost of healthcare trends at 2.5% above the general inflation rate. The U.S. now spends 16% of its GDP on healthcare, double the average of other industrialized countries. Not surprisingly, how to pay for healthcare is "the single biggest concern that people have approaching retirement," says Ellen Breslau, who is managing director, global wealth planning at Citigroup Wealth Advisory Services. "It has to be at the forefront of financial planning; that's what clients are worried about. And it is important for planners: How to pay for health insurance for themselves, their employees and their families is an issue they must confront in their own lives and practices."

We get relatively little for all the money we spend. Americans do not have a particularly long life expectancy by Western standards, and any increase in life spans has been much less than that enjoyed by citizens of other developed countries. Says Gerard Anderson, a professor of health policy at Johns Hopkins, "The bottom line is, for the dollars we are spending—twice that of other countries—our outcomes are not as you would anticipate." Worse, the U.S. is in the middle or bottom of most basic healthcare quality rankings. According to data assembled by the Commonwealth Fund, a healthcare research foundation, there are only a handful of bright spots: The U.S. ranks No. 1 in measles vaccinations, for instance. But it does relatively poorly on mammography screening rates. And it has the Western world's highest rate of mortality from asthma, a disease that should not be a cause of death.

Advisors face a challenge of how to help their clients, and themselves, deal with America's dysfunctional health system and plan for future health costs. To say this isn't easy is an understatement: Anderson, who formerly was on the Centers for Medicare and Medicaid forecasting unit, says, "It's not knowable how fast healthcare costs will rise. I cannot give you a number a planner should use for estimates."

This is in part because the outcome of current policy arguments about how to reform healthcare is uncertain. Planners therefore need to be on top of the healthcare debate and proposed policy solutions, in addition to understanding insurance options. What is clear: The debate is intensely politicized. Robert Blendon, who runs the Harvard program, Public Opinion and Health and Social Policy, explains the distinction in terms of the upcoming presidential election. Democrats, he says, want the government to find a way to provide more coverage, whereas Republicans want more choices. Similarly, Democrats largely think employers and the government should pay for care, while Republicans think individuals should be able to buy policies tailored to their needs. Hence the word "reform" has a different meaning to each group, with Republicans focused on introducing more competition and Democrats focused on expanding coverage.

With all eyes on the election and discussions of health reform in the air, understanding the big-picture policy debates can make for a more sophisticated conversation with clients. Planners still need to know the brass tacks of how to plan for rising costs and find the right insurance policies in this uncertain climate. Here are some of the most influential policy ideas from U.S. health economists and researchers.

Healthcare Reform — The Main Proposals

Any discussion of rising health prices in the U.S. should start with at least one important insight: that as much as people complain about U.S. healthcare, the benefits—in increased productivity and longevity—outweigh the costs. Harvard economist David Cutler is the main academic voicing this finding. (He is also an advisor to Barack Obama.) "Comparing the change in health...with the increase in medical spending, we estimate that, for most plausible assumptions, increased medical technology has been worth its cost," he wrote recently. Cutler contrasts successful treatments for cardiac disease today, such as statins, to the recommended treatment in the 1950s, which was bed rest. Similarly, doctors in the 1950s could set bones, but they couldn't routinely replace deteriorated hips or knees. Overall, disability is decreasing rather than increasing for the elderly. Would patients really want to go back to the not-so-good, but cheap old days?

This argument points to technology as the main driver of the rise in healthcare spending. But these increases can't continue indefinitely. What then do the experts propose?

Market-Driven Solutions

Suppose you have an MRI. Its true cost is $10,000. You are billed for only a portion, a co-pay of $100. Financially speaking, this means you are more likely to go ahead with it than you would be if you had to pay full freight. Says Mark Pauly, an economist at the University of Pennsylvania, "Insurance makes expensive things look cheap." And so people use too much of them, driving up overall expenditures. His solution is simple, theoretically: "Change insurance so that prices are closer to their true cost, which will reduce spending." Charging patients the true $10,000 cost of their MRI, in this case, will dramatically cut down the number of patients who undergo MRIs.

Pauly, the godfather of most market-based healthcare solutions, is quick to point out that his insight only holds for upper-income patients and truly discretionary procedures. Catastrophic insurance still plays a necessary role. But Pauly also argues that making patients pay the full cost of their initial care will reduce the amount of low value, high-cost care, such as needless MRIs or CAT scans where an X-ray would suffice. In the industry this is known as making patients put "skin in the game." If patients have to pay for it, they will be more careful about what care they use. This goes beyond reducing unnecessary procedures: It's a way of driving consumers to hospitals that offer more value, reducing expenses and improving the quality of the healthcare system.

Rather than damaging health, Pauly argues that a market-based approach could actually improve outcomes. "If you had to pay more, you might become more engaged in your healthcare and change your lifestyle," he says.

Many proponents of market-based solutions use Pauly's work, acknowledged or not, as their starting point. This school of thought argues that if we brought greater market freedom to healthcare it would solve both cost and quality problems through competition. Well-known thought leaders promoting this viewpoint include Regina Herzlinger and Michael Porter, both of Harvard Business School. Porter argues that unlike other industries, which compete on the basis of providing superior value at lower cost, the healthcare industry is engaged in a zero-sum competition to shift costs or reduce choices. The healthcare industry needs to shift its focus to value-based competition, which he defines as when "providers and health plans compete to achieve the best medical outcomes for patients."

For planners and clients, a market-based solution might include consumer-driven health plans (CDHPs) featuring health savings accounts, because they foster greater consumerism and more prudent purchasing (to say nothing of their tax advantages and cheaper, albeit thinner, coverage). Consumers who are responsible for their own accounts would then reward the best providers with their business, driving the health system toward improvement. Although he doesn't think we are there yet, Pauly says, "A true open market could potentially lead to all sorts of innovations."

The Top-Down Approach

Another school of thought involves policy changes at the federal level, including increased coverage of the uninsured. The Commonwealth Fund, a prominent foundation in New York, lays out these ideas in its influential new report on health spending, Bending the Curve. Anthony Shih, M.D., assistant vice president for quality improvement at Commonwealth and an author of the report, says it offers four broad target areas where the U.S. could achieve savings while improving value:

- Produce and use better information for healthcare decision-making. This would include better health IT (much of the healthcare industry is still paper based).
- Promote health and enhance disease prevention efforts. This would include efforts to reduce obesity, such as a proposed tax on on sweetened soft drinks and other products that contribute to the obesity epidemic.
- Align financial incentives with quality and efficiency of care.
- Correct price signals and improve efficiency in healthcare markets by offering one unified rate system instead of the one now in which providers get reimbursed differently by payers.

Take one of these ideas, misaligned incentives. Currently hospitals are paid for the amount of care they give, rather than the quality of care: The sicker the patient, the more days spent in the hospital, the more revenue for the hospital. This could be corrected by paying the hospital by episode of care (e.g., bundling a heart attack patient's hospital stay and outpatient care as one episode) rather than fee-for-service, a change that is already under way in Medicare. According to Shih, paying hospitals by episode will encourage greater collaboration with outpatient care givers and provide greater funding to manage patient transitions, leading to a a less-fragmented health system. Ultimately, explains Shih, these proposed targets could save the U.S. health system as much as $1.5 trillion dollars over the next decade. That should be more than enough to pay for improved coverage of the uninsured—who are often forced to get basic care from emergency rooms, at great cost.

It is critical that financial advisors recognize that healthcare costs will keep spiraling upward if no systematic changes are made, Shih says, adding that the overall employer-based insurance system is unstable. The only long-term solution, he says, is for "individual stakeholders—insurers, providers, employers and doctors—to put aside their own interests and serve the interest of the population of the whole."

A National Health Plan

The Commonwealth Fund's options for change are not far from many reforms embraced by the Democratic Party. More sweeping reforms call for the U.S. to drop its employer-based health insurance system in favor of the single-payer system found in most other Western countries.

Central to this line of thinking is the finding that the United States does not use more health resources, in terms of volume, than its competitors. By most standards, we use less. On a per-person basis, for instance, we have fewer physicians than France. Fewer nurses than Finland. Fewer hospital admissions than in Sweden. More startlingly, this holds true for high-tech medicine as well. Globally, the U.S. ranks only eighth in use of CT scanners, and ninth in terms of MRI use.

We just pay more for what we do use. An MRI in Germany is cheaper than it is here. A visit to a physician in France costs half as much. Prescription drugs or a day in a hospital here cost two-and-a-half times more than in other industrialized countries. U.S. healthcare is twice as expensive as in other countries, not because we deploy more technology, but because we pay double the prices for the same care. It's analogous to living in an expensive city like, say, London, where even a short trip on the subway now costs $8.00. Services aren't any better in the London Underground than they are in other cities; they are just more expensive.

Why is healthcare so expensive here? The answer, say single-payer advocates, has to do with bargaining clout. Hopkins' Gerard Anderson observes, "Everybody else has a single purchaser (usually the government) negotiating with doctors and hospitals. We have many different purchasers, and each one is less powerful." A single payer has the negotiating power to force down prices, salaries and industry profits. In the U.S. this is seen to some degree with Medicare; the private sector pays 25% more, on average, for comparable services.

The single-payer argument has support among many physicians. A leading advocate is Steffie Woolhandler of Harvard Medical School, who is co-founder of Physicians for a National Health Program. Says Woolhandler, "Every other industrialized country gives you some sense of financial security in the face of illness. Here, if you get sick and you lose your job, you may lose your coverage; and if you dont lose your job, you may still go bankrupt because so many services are uncovered."

Regardless of the outcome of proposed reforms, advisors still need to plan and budget for healthcare and its associated costs. Perhaps the most common method, at least conceptually, is to segment clients into age groups: The young, those approaching retirement and the already retired have substantially different health insurance options and needs.

Working Clients

The major action point is to start the conversation about health costs early on, even if retirement is decades in the future. Clients may mistakenly assume that Medicare covers all costs or that their medical benefits will continue into retirement. Discussions about long-term-care insurance also need to start sooner rather than later because of the jump in costs as the client ages.

Even so, "healthcare is a hard discussion to have," says Ellen Breslau of Citibank. The topic, unlike investing, isn't fun, and can become uncomfortably personal. Getting clients to focus on retirement is already hard; getting them to focus on health costs "is even harder," Breslau continues. Her tip is to get clients focused on different types of funding for possible future expenses.

The conversation doesn't have to focus only on health costs in retirement—current needs can be included as well. Some planners help clients sort through their current health insurance options. Kathy Longo, of Accredited Investors in Minneapolis, examines clients' benefits packages. If appropriate, Longo advises clients to max out on health savings accounts. Planning for all family members is important as well. According to Jim Barnash, national director of financial planning at Ameriprise, "We educate advisors about the best way to cover clients' children."

As retirement approaches, the issue of healthcare goes beyond the conversation stage and action becomes more urgent. Many advisors start implementing the purchase of long-term-care insurance. Advisors also establish concrete targets to cover healthcare costs, even if these are uncertain. At Accredited Investors, Longo says she conservatively plans for healthcare costs of $10,000 a year in addition to Medicare, with these numbers significantly adjusted upward each year—at a rate of 7%, versus 3% for non-medical expenses— to account for unaticipated costs like prescription drugs. "We accept the fact we don't see an end to medical costs increasing," she says.

When Advisors Need Advice

Even when clients are covered by Medicare, planner and client still face decisions on how best to plug the many gaps in coverage. Planners need to evaluate the pros and cons of Medicare Advantage, a type of Medicare plan in which a private insurer provides the benefits, versus supplemental coverage for the traditional, fee-for-service Medicare coverage. And within supplemental coverage, there are many plans to choose from as determined by the client's precise health condition and pharmacy needs. To add a layer of complexity, these decisions must be regularly revisited: A supplemental plan that was a good fit for a 65-year-old may not be right when the client is 75.

Eugene Scanzera, director of Medicare and pharmacy at AARP, counsels that the advisor communicate to the client that she understands what the client is going through, that the decisions aren't obvious and have to be revisited over time. "If you can't make it simple at least make it clear," he advises. Because of the complexity of Medicare gap coverage decisions, most planners rely on a benefits specialist familiar with all the nuances of the plans.

Outsourcing seems almost to be a necessity. "There are 177 providers of Medigap policies. I use a local healthcare specialist to wade through the specifics," says Pete Bush of Horizon Wealth Management in Baton Rouge. Bush oversees the financials in retirees' portfolios, including income and expense projections, but lets the specialist match each client's health needs with the best Medigap plan.

Perhaps the largest health-related issue for planners and their clients is the actual decision to retire. Advisors, clients and benefits specialists need to find a health insurance solution jointly if the client is determined to retire early. [For more on this important subject, see "Healthcare Without Medicare,"] But this assumes an affordable solution exists, which isn't always the case. "I've had clients who've ended up working longer than anticipated because of the need for healthcare," Bush says.

Practicing What Your Preach

As business owners, planners directly confront rising health costs for themselves and their employees. How are they applying their advice to clients to their own practices?

Using a healthcare agent is a good starting place. Accredited Investors used an agent to help find the best plan, which turned out to be a high-deductible plan coupled with health savings accounts. Accredited makes deposits directly into employees' accounts. "The balances of employees are really starting to grow," says Longo.

Overall, Accredited hasn't seen any gigantic increases in health insurance costs in recent years. Perhaps the HSAs are a factor but more important, according to Longo, "We think about wellness." Accredited's new, expanded headquarters features a new health club with elliptical trainers and yoga. Several independent broker-dealers have come up with their own answers to the conundrum, which are described in "Take Cover."

Ultimately, rising health costs and the so-so quality of American healthcare are not just issues for clients and planners. "Healthcare is a social challenge for the country right now and we need a long-term solution," Barnash says. Advisors can help by educating clients about gaps in coverage and the need to plan for health costs in the same way advisors have been discussing saving for retirement, an educational process that has taken years. But advisors can do more. Barnash argues that planners should be central to promoting change: The mere fact that consumers with the means to hire a planner are so concerned about health care shows the extent of the problem. "We see how desperate people are," he says. "The best proponent for a fix really is the financial planning community. We will be on the leading edge of pushing our senators and congressmen to get proactive."

-David E. Adler, a New York-based writer, is a regular contributor to Financial Planning.

The study consolidates information from several sources, including data from Tiburon's benchmarking tools, financial firms' websites, detailed news searches, analyst reports and interviews from financial industry participants.

As 78 million baby boomers look to retire over the next 20 years, they'll begin to liquefy their retirement, personal and illiquid assets. The expected buyers of these assets-Generation X-however, are already taking on large sums of debt, igniting concern that they will not be able to purchase these assets and provide the liquidity boomers need. A credit crunch could delay some boomers' retirement.

"When they retire over the next two decades, the boomers are going to look to sell their businesses and, for some, their homes. There has to be a market for this, which is their children-Generation X. But Generation Xers have taken on a great amount of debt much earlier-tens of thousands of dollars for expenses such as school. And so the question is how are they going to buy all these homes and businesses? It's assets transferring, but that generation has a lot of debt, which will put the boomers' liquefaction plans into question," says Chip Roame, managing principal at Tiburon Strategic Advisors.

One lifesaver many expect to get the boomers out of their sinking savings crisis is the trillions they are expected to inherit from the generation before them. But Tiburon's report doesn't offer much hope, finding that the median value of boomer's likely inheritance is just $48,000. Further, only 2% of boomers who have already received an inheritance got more than $100,000. In fact, only 15% of boomers expect any inheritance at all.