PEOPLE ARE LIVING LONGER in retirement than ever. Maintaining good health will help make those years vibrant. So will access to affordable medical care and to medical insurance to help pay for that care. This Decision Brief looks at some of the key health insurance decisions that retirees need to make.

The decision process is similar to planning a long road trip: first studying where to go, how to get there and what to do, and then making adjustments if conditions and needs change.

When it comes to health insurance, those who are not yet eligible for Medicare may face major challenges finding suitable and affordable coverage. Those who are eligible for Medicare may encounter the opposite; they often find plenty of choice, but the sheer volume of choices may be overwhelming.

Either way, people will need to do research to determine which way to go on this particular journey, and then consider making changes as the years move on.

Important: Some people reach the point where they need assistance with activities such as dressing, walking, eating and using toilet facilities. Such assistance can be very costly. Health insurance policies do not cover such long-term care expenses. To provide insurance coverage for these types of expenses it is necessary to purchase separate long-term care insurance.

A Frank Look at Costs
Experts are projecting that health care costs will continue rising in the coming years. This makes it increasingly necessary to have health insurance to help pay for these costs.

For instance, a 65-year-old couple retiring in 2011 will need an estimated $230,000 to pay for medical expenses throughout retirement, not including nursing-home care (Fidelity Benefits Consulting, March 2011).

Special Issues for Early Retirees
In 2011, early retirees—those who retire before the Medicare age of 65—
may find it virtually impossible to get individual coverage if they or their family members have health problems. If they do find coverage, it is typically very expensive, so they will likely face some extremely difficult decisions.

If they forgo coverage, health care costs can dominate their retirement spending. This is especially so if they need significant care for catastrophic illness.

If they purchase coverage, that will ease worry about paying for care, particularly if major health issues surface. However, the monthly premium, co-pays and other costs may severely curtail the family budget.

Therefore, when deciding whether to retire early, the need for adequate and affordable health insurance should be a factor. Employees should also explore how they will manage if they later develop unanticipated chronic conditions with catastrophic out-of-pocket costs.

Solutions and Options
The solutions and options available to those who want to preserve precious retirement resources will generally depend on age and health status.

Such options may include employer health insurance, Medicare and Medigap (supplemental health insurance that covers many costs not paid for by Medicare). Additional coverages include dental, vision insurance and long-term care insurance.

Prospective retirees will need to be well-informed about each option. Health care reform, enacted in 2010, will probably change the options and decisions as the law is implemented.

Major provisions of health care reform (such as the new health exchange options available to individuals) will not be in place until 2014. Those who are weighing options in the interim will need to expect a gradual phasing in of changes and plan to make adjustments accordingly.

The table on page 4 separates out the key health insurance decisions, arranged according to age and year. This illustrates how health care decisions at retirement will be affected not only by when the person retires but also by health care reform and its full implementation in 2014.
### Key Health Plan Decisions and Actions at Retirement

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<tr>
<th>Situation</th>
<th>Year</th>
<th>Key Decisions And Considerations</th>
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| Pre-65 with employer retiree health care | Before 2014           | • Which option to take within employer offerings  
• If not choosing employer option, whether to find a private market option or be covered by spouse’s plan  
• Whether to cover spouse and family members  
• Whether retiree coverage (from the employer) is affordable  
(Note: If employer coverage is not affordable, then the individual probably cannot afford to retire.) |
| Post-65 with pre-65 spouse and with retiree health provided | Before 2014           | • For the spouse, the issues are the same as for pre-65 retirees (above).  
• For the retiree, the issues are the same as for other Medicare-eligible retirees.  
(Note: Those who are approaching age 65 will need to make health plan decisions for their post-65 years. Options totally change at age 65.) |
| Pre-65 or spouse who is pre-65 w/o employer retiree health care | Before 2014           | • Whether the person can afford to retire and can secure affordable coverage in the broad marketplace.  
• Whether to purchase the employer’s group coverage for a limited period under terms of federal law (COBRA). |
| Pre-65 or spouse who is pre-65 w/o employer retiree health care | After 2014            | • State health insurance exchanges (government-administered marketplaces for health insurance) will be in operation, so retirees may need to decide whether/how to use the exchanges.  
• People will still need to decide whether retirement is affordable. |
| Post-65 (with no pre-65 family members) | Before and after 2014 | • Enroll in Medicare.  
• Make Medicare choices (for example, traditional Medicare or Medicare Advantage).  
• Decide whether to buy a Medicare supplement policy. |

### Health Care

It is important to remember that health plans change every year, so regular plan evaluation is essential. Fortunately, many good resources exist; these can provide assistance with assessing health care trends as well as plans and plan options.
Before age 65, people are generally not eligible for Medicare coverage. (Note: Those receiving Social Security disability benefits for 24 months or more can qualify early.) Some employers offer a retiree health plan, so workers should check out the details. Another factor to consider is whether the employer plan offers insurance options for the spouse, if pre-65.

**Proceed with caution:** Even if pre-65 retirees are in good health, they may find that individual health policies are extremely expensive and/or difficult to get in certain parts of the country.

When evaluating employer-based coverage, older workers will want to consider the following:

- The premiums may increase when the employee switches from active to retired status.
- Premium rates will depend on whether the employee chooses individual coverage or the more expensive family coverage (spouse and dependents in addition to self). Understanding how the employer determines the employees’ contribution rate can help in assessing this aspect.
- Under the new health care reform law, young adults can stay on the parent’s plan up to age 26.
- The employer may have the right to change (or cancel) coverage at any time.

Even those who already have health insurance in place will need to plan for other health-care-related costs. These include certain cost-sharing and plan deductibles. However, certain provisions in the new health care law will help to keep personal health costs down.\(^1\)

What if the employer does not offer retiree health care coverage? Retiring workers may want to check to see if they are eligible for Medicaid, which is subject to very strict income and other requirements. Another option is to purchase private health insurance until Medicare kicks in at age 65.

If a private insurance company rejects the person or offers coverage only with a premium surcharge, the person might be eligible for state-guaranteed health insurance from a state high-risk pool.

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\(^1\) These provisions include a) restrictions on insurers from dropping health coverage due to illness, from denying coverage due to a preexisting condition and from placing annual or lifetime dollar limits on health coverage; and b) reductions in out-of-pocket costs for certain preventive care services.
Keep in mind: The employer may terminate its retiree health coverage plan. If that happens, retirees may have continuation rights under a federal law called COBRA for as long as 18 months.

The Big Decision: Medicare
Entering Medicare is a major turning point for the large majority of older citizens. But although most people expect to be Medicare-covered, many do not know how to get started, what options are available or how to project Medicare costs into their overall retirement plan. Here are some thoughts on these points.

Who is eligible for Medicare? Those who paid Medicare taxes while working are eligible upon reaching age 65; non-working spouses of such individuals are also eligible at age 65. Those who are under 65 and have been a disabled beneficiary under Social Security or Railroad Retirement Board for more than 24 months are also eligible. Even citizens who never paid Medicare taxes may be eligible if they pay a Medicare premium for the benefits.

What benefits does Medicare provide? The benefits are provided in different “Parts” as follows:

- **Part A.** This is hospital insurance. It helps pay for hospital, home health, skilled nursing facility costs (on an extremely limited basis) and hospice care for the aged and disabled.
- **Part B.** This is medical insurance. It helps pay for physician, outpatient care and home health (in the rare instance when a person does not have Part A coverage). It also pays for other medical services for the aged and disabled who have voluntarily enrolled and pay Part B premiums.
- **Part C.** “Medicare Advantage” plans are private health plans offered as an alternative to Medicare Parts A and B. These plans contract with Medicare to provide coverage that is at least equal to Medicare A and B. People will need to decide whether to enroll in such a plan, and, if so, which one. This choice may involve many comparisons—between premiums, co-pays, network providers, coverages offered in addition to basic Medicare, etc. Making comparisons again at annual reenrollment time may be helpful, too, since plan features do change. Options vary a great deal by geographic area.
- **Part D.** Offered by private insurers, these plans provide voluntary insurance for prescription drugs for all beneficiaries, and premium and cost-
sharing subsidies for low-income enrollees. (Voluntary means people can choose whether to buy Plan D or not.) In many areas, insurers offer many competing plans, so choosing a Part D plan will involve comparisons between plan costs, features, providers and other factors. At annual reenrollment time, new plans and options may be available and the relative costs may have changed, so new plan comparisons may be in order.

**How does a person start Medicare coverage?** Those who are already getting Social Security benefits will, upon turning 65, start receiving Part A automatically. Those who are not getting Social Security will need to sign up for Medicare during the three months before and after turning 65, even if they are not ready to retire.

There are other ways to start Medicare, as well. One example is if a person meets strict qualifications for disability.

Enrollment for Part B is automatic like Part A, unless a person rejects Part B. The Part B premium may be subject to a late enrollment penalty if the person does not sign up when first eligible.

Enrollment in Part D is optional. The person pays a monthly premium for this coverage plus co-pays (cost-sharing) on certain prescription purchases. As with Part B, there is a Part D late enrollment penalty.

**What are “out-of-pocket” costs for Medicare services?** These are costs that people who have Medicare will pay in addition to their monthly Medicare premiums. These costs change every year, so it is important to monitor them at the start of each plan year.

How it works: Under Part A, for hospital stays, people who have Medicare will pay cost-sharing factors—called a deductible and coinsurance—during each benefit period. In 2011, the deductible is $1,132 and the coinsurance is $283 per day for stays of 61 to 90 days. (The daily coinsurance increases for longer stays.) Part B services are also subject to an annual deductible and coinsurance, with yearly updates.

**What are Medicare gaps?** Medicare does not cover everything. For instance, it does not pay for long-term care or custodial care. This is so, even though
Medicare does pay for medically necessary skilled nursing facility or home health care on a very limited basis. Medicare also does not cover such things as dental care, vision care or hearing devices.

To fill the gaps, many people buy so-called Medigap policies from insurance companies. These policies supplement Medicare coverage. Some also buy long-term care insurance, dental insurance and/or vision care insurance.

Another gap-filler is Part D coverage. As noted above, this helps Medicare beneficiaries cover the cost of prescription drugs, subject to an annual deductible and coinsurance. The federal government has set the requirements for Part D plans, but private insurance companies are the ones who sell and administer the coverage. Since this is voluntary insurance, consumers are free to buy Part D or not.

Medicare Advantage plans issued by private insurers deal with the gap issue by offering comprehensive coverage that is at least comparable to traditional Medicare Parts A and B (and Part D as an option). They typically offer additional benefits as well, and they contract with a network of providers to provide the care. If these plans permit out-of-network providers, the cost for this care will be significantly higher than for in-network care. Those who have a Medicare Advantage plan do not need a Medigap policy.

Areas to Explore

This discussion has looked at some major areas that people need to explore as they map out their health care decisions for the retirement years. It takes thoughtful research and careful planning to assess the many issues and options, but having a good plan in place will make the effort more than worthwhile.

Helpful Roadmaps

- DOL/EBSA. *Taking the Mystery out of Retirement Planning*.
The Society of Actuaries would like to acknowledge the work of its Committee on Post-Retirement Needs and Risks in producing this series.

The committee’s mission is to initiate and coordinate the development of educational materials, continuing education programs and research related to risks and needs during the post retirement period. Individuals interested in learning more about the committee’s activities are encouraged to contact the Society of Actuaries at 847-706-3500 for more information. Additional information and research reports may be found at http://www.soa.org.