RETIREMENT INSIGHTS

Health care costs in retirement

April 2016

IN BRIEF

- As health care costs are rising faster than overall inflation, many Americans contemplating retirement are reasonably concerned about planning for their medical expenses.
- The ratio of covered workers to Medicare beneficiaries, a key measure of the program's fiscal health, is deteriorating. If no action is taken, the Medicare Trust Fund, which is used for Part A inpatient hospital benefits, is projected to be depleted by 2030.
- A prudent approach to retirement planning should anticipate increases in U.S. health care costs at the long-term historical average of about 5% per year. Because retirees tend to consume more health care as they get older, it is appropriate to assume 7% annual cost increases during retirement.

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GROWTH IN HEALTH CARE COSTS IN THE U.S. HAS SIGNIFICANTLY OUTPACED OVERALL INFLATION: From 1982 to 2014, spending on health care grew at an average of 5.0%, faster than all spending categories other than higher education.[1] In the past few years, however, the pace of health care spending increases has slowed. In 2014, health care spending rose 3.0%, which is still higher than the 0.8% increase in the overall Consumer Price Index.

The recent decline, while welcome, does not solve three fundamental problems facing Americans as they plan for retirement:

- While difficult to predict, health care cost increases may revert to historical averages of 5% per year
- People tend to use significantly more care as they get older
- Budget pressures may result in increased future costs for Medicare beneficiaries

A sound retirement strategy must plan for increasing health care expenses. While managing and investing for current income, an effective retirement strategy must also include sufficient growth investments to cope with the added health care costs.

This paper will:

- Analyze the forces driving health care spending growth
- Assess the pressure points and sustainability of the current Medicare system
- Consider options for future retiree health care coverage

[1] BLS, Consumer Price Index, J.P. Morgan Asset Management. Data represents annual percentage increase from December 1982 through December 2014.

MEDICARE AND MEDICARE ADVANTAGE

A discussion of U.S. health care trends begins with the Baby Boomers, the 76 million Americans born between 1946 and 1964, whose ranks far eclipse the Silent Generation that preceded them. Many of the oldest Baby Boomers are already Medicare beneficiaries, and there are millions more turning 65 every year, putting greater pressure on the system.

Traditional Medicare has several components:

- Part A, funded by payroll taxes, covers inpatient hospital expenses
- Part B covers doctors, tests and outpatient procedures
- Part D covers prescription drugs (these plans are sold by private companies)

Parts B and D are funded by Treasury revenues and beneficiary premiums, with the government picking up about 75% of the premium costs for most beneficiaries. Because there are significant gaps in Medicare coverage (including co-pays and deductibles), most people buy a Medigap policy, a standardized plan sold by private companies, to fill in the holes. The most popular Medigap plan is the most comprehensive option available.

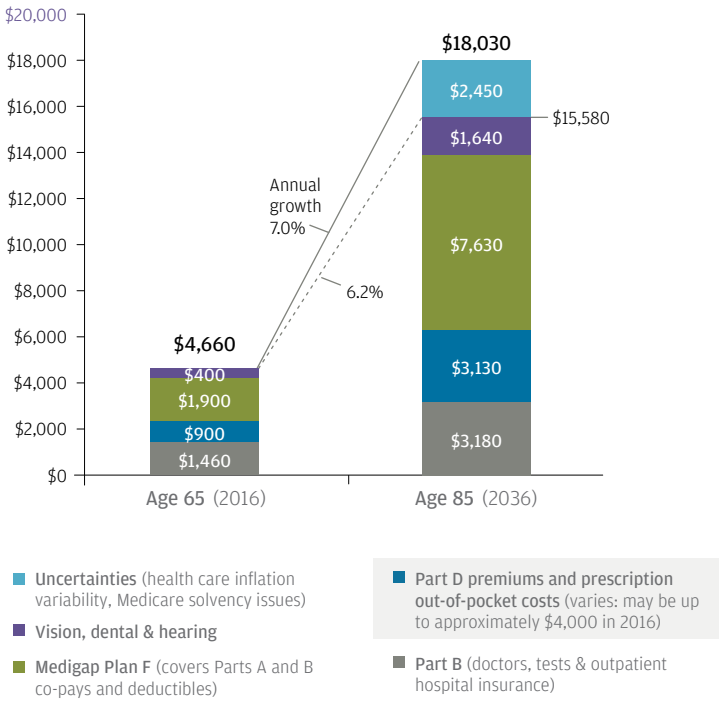
For current beneficiaries, it completely fills in the holes affecting co-pays and deductibles except for prescription drugs. However, some costs are not covered at all, including most vision, dental and long-term care.

For traditional Medicare with prescription drug coverage, a comprehensive Medigap policy, plus typical vision, dental and hearing expenses, median health care costs for a 65-year-old total about $4,660 a year. These costs may more than triple from age 65 to age 85, using an average inflation rate of 7%. This includes increases in Medigap premiums due to age—since in most states insurers charge higher premiums for older policy holders. It also includes about 1% per year inflation over government estimates due to the unpredictability of health care cost increases and the possibility of some changes to the Medicare system in the future.

The main variation in costs for someone with traditional Medicare including a Medigap policy is co-pays and deductibles for prescriptions. Prescription costs vary widely and may be as high as approximately $4,000 a year for individuals who need particularly expensive treatments. (**EXHIBIT 1**).

Given the variability of health care costs, it may be prudent to assume an inflation rate of 7.0%.

EXHIBIT 1: ESTIMATED TRADITIONAL MEDICARE COSTS FOR THOSE WITH MEDIAN AND HIGH PRESCRIPTION DRUG EXPENSES



An increasingly popular alternative to traditional Medicare is Medicare Advantage. When compared to traditional Medicare, these private market plans, sold with a government subsidy, may provide additional benefits such as vision and dental coverage. About 31% of current beneficiaries have Medicare Advantage coverage,[2] although premiums vary, they tend to be much lower than premiums for traditional Medicare coverage.

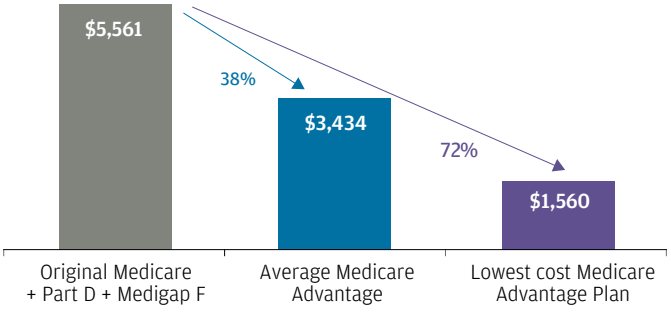
Note: In most states, older individuals have higher Medigap premiums. Exceptions: AR, CT, MA, ME, MN, NY, VT and WA have the same Medigap premiums for all ages. Most Medigap policies in AZ, FL, ID and MO will have the same premium for all those who first purchased Medigap at the same age of first purchase. Analysis includes Medigap Plan F (the most comprehensive plan). Parts B and D premiums are calculated from federal tax returns 2 years prior; individuals may file for an exception if they reduce or stop work. Age 85 estimated total median cost in 2016 is $7,490 (includes more prescription expense and higher Medigap premiums based on age). Modified Adjusted Gross Income (MAGI) is calculated by taking Adjusted Gross Income (AGI) and adding back certain deductions such as foreign earned income, tax-exempt interest, taxable IRA contributions and Social Security payments.

Source: Employee Benefit Research Institute (EBRI) data as of December 31, 2015; SelectQuote data as of December 31, 2015; J.P. Morgan analysis.

In some parts of the country (Florida, for example), where Part D and Medigap premiums are particularly expensive at younger ages, some Medicare Advantage providers offer much greater efficiencies by working to keep policy holders healthy and out of the hospital. Providers may encourage healthier patient behavior and/or make certain treatments free or less expensive if they are likely to help prevent major medical issues at a later date. As an illustration of the variation in plans, in Miami the average Medicare Advantage plan premium is 38% less expensive than traditional Medicare with a comprehensive Medigap policy and the cost of the least expensive policy is more than 70% lower (**EXHIBIT 2**).

In Miami, the average Medicare Advantage plan premium is 38% less expensive than traditional Medicare with a comprehensive Medigap policy

EXHIBIT 2: A COMPARISON OF MEDICARE AND MEDICARE ADVANTAGE PLAN PREMIUMS IN MIAMI



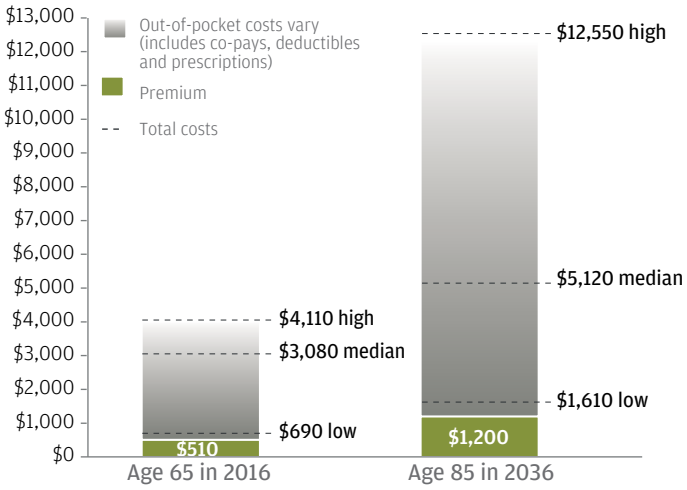
Note: This is an illustrative example. There are over 2,000 different plans nationwide to choose from, which will each provide different costs and coverage. Not enrollment weighted.

Source: MedPac, CMS, Leerink Swann Research.

Medicare Advantage plans tend to have narrower provider networks, and government rules prohibit the sale of these plans with a Medigap policy to fill in co-pays and deductibles. As a result, costs vary significantly by use of care. For beneficiaries of all ages, premiums average about $510 a year. For someone with low use of the health care system and inexpensive prescription drugs, total costs may be less than $700 a year. Median total costs for those age 65—are $3,080 per year, which is less expensive than traditional Medicare. However, for those with high use of the health care system and those with high prescription costs, co-pays and deductibles, out-of-pocket costs may total more than $10,000 a year (**EXHIBIT 3**).[3] This is partly because insurers reacted to

Dramatic differences in costs depending on health

EXHIBIT 3: ANNUAL MEDICARE ADVANTAGE COSTS



Note: Total costs = annual premium + out-of-pocket costs for those with relatively low costs (those in the lowest third of the cost distribution), median costs and high costs (those in the highest third of the cost distribution).

Since plans are sold by private companies, premiums will vary based on geography and plan characteristics. Out-of-pocket expenses include co-pays and deductibles for Medicare Parts A & B, plus out-of-pocket prescription drug costs. By law, 2016 out-of-pocket costs may not exceed $6,700, but that does not include prescriptions. Those with high incomes pay higher premiums (above $85,000 single or $170,000 filing jointly). Age 85 estimated median cost in 2016 is $3,920. Cost estimates at age 85 in 2036 are adjusted for inflation and increased use of medical care at older ages.

Employee Benefit Research Institute (EBRI) data as of December 31, 2015; SelectQuote data as of December 31, 2015; J.P. Morgan analysis.

decreased government subsidies by increasing out-of-pocket maximums for Medicare Advantage policies. In 2016, 54% of Medicare Advantage plans carried maximum out-of-pocket spending limits of $5,001-$6,700, up from just 23% of plans in 2012. These limits do not include prescription drugs (**EXHIBIT 4**, next page). A retiree or pre-retiree weighing various coverage options should consider premium levels, deductibles and out-of-pocket limits, among other factors.

FORCES DRIVING GROWTH IN HEALTH CARE SPENDING

Like all medical insurance plans, Medicare confronts the reality of rising health care costs. In 2011, health care expenditures accounted for 17.2% of GDP, up from 13.8% in 2000 and far more than the 5.2% level that prevailed in 1960.[4] There are many drivers of the growth in health care spending, but one of the key contributors is new medical technology (including new treatment options and prescription drugs as well as new diag-

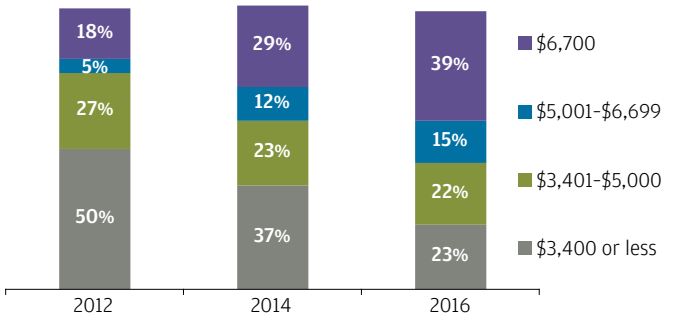
[2] Kaiser Family Foundation Medicare Advantage 2016 Data Spotlight: Overview of Plan Changes, December 2015.

[3] J.P. Morgan analysis of data provided by SelectQuote, 2015. Data excludes Alaska and Hawaii.

[4] National Center for Health Statistics, Hyattsville, MD, 2013.

Medicare Advantage: Out-of-pocket spending limits

EXHIBIT 4: DISTRIBUTION OF MEDICARE ADVANTAGE PLANS' OUT-OF-POCKET SPENDING LIMITS (EXCLUDING PRESCRIPTION DRUGS)



Source: "Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes," Kaiser Family Foundation, December 2014.

Note: Excludes SNPs, employer-sponsored (i.e., group) plans, demonstrations, HCPPs, PACE plans, MSAs and plans for special populations. Percentages are unweighted by enrollment. All Medicare Advantage plans have been required to limit out-of-pocket expenses to no more than $6,700 since 2011. Data may not add to 100% due to rounding. Data from MPRI / KFF analysis of CSM's landscape files for 2013-2015.

nostic tests and medical devices) (**EXHIBIT 5**). For example, when it was first introduced, Solvadi, a drug for Hepatitis C from Gilead, cost between $80,000 and $100,000 per patient in the U.S. Solvadi and Gilead's newer drug for Hepatitis C, Harvoni, now face competition from a new, though slightly inferior drug. Since the disease progresses slowly, this resulted in pharmacy managers demanding a price cut or they would only approve the alternative drug. In the future, drugs that have the potential to cure specific forms of cancer or other deadly diseases may be more difficult to deny to patients, which may have significant cost implications for the health care system.

Along with new medical technology, other forces propelling growth in health care spending include:

- Increases in provider fees
- An aging population that consumes more health care and suffers from more chronic conditions:
  - Americans over the age of 75 consume almost twice as much health care as they did between ages 65 and 74[5]
  - In 2010, 67% of Medicare beneficiaries had two or more chronic conditions and 14% had six or more[6]
- Lack of cost sharing
- Poor care coordination

[5] Meara, White and Cutler, "Trends in Health Spending by Age." Represents combination of household surveys and total spending data to analyze trends in medical spending from 1963-2000.

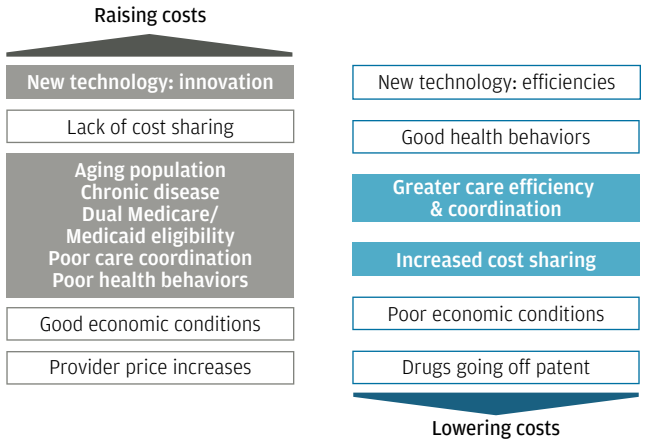
[6] Centers for Medicare and Medicaid Services. Chronic Conditions among Medicare Beneficiaries, Chartbook, 2012 Edition. Baltimore, MD, 2012.

This last point speaks to a fundamental characteristic of U.S. health care—it is basically a fee-for-service system. Most doctors and hospitals essentially get paid for each increment of health care they deliver and are thus incentivized to provide more services, receive more fees and drive up overall health care costs.

FORCES RESTRAINING GROWTH IN HEALTH CARE SPENDING

Some forces are slowing the growth in health care spending. Increased cost shifting onto patients may result in a reduction in the use of health care. Poor economic conditions also tend to decrease demand for health care. New technology can reduce expenses by introducing new efficiencies and techniques. For example, the development of surgical techniques and tools that enable minimally invasive surgeries can reduce the length of time required to perform a procedure and, crucially, reduce the number of days patients spend in a hospital. On balance, though, new technology does more to drive up costs than it does to reduce them.

EXHIBIT 5: MAIN DRIVERS OF GROWTH IN HEALTH CARE SPENDING



Source: Containing the Growth of Spending in the U.S. Health System, Health Policy Center, Urban Institute, October 2011. Health care spending and the Medicare Program, Medicare Payment Advisory Commission, June 2013 Databook. Center for Medicare and Medicaid Services, Medicare and Medicaid Research Review, 2013, Vol 3, No 3. Kaiser Family Foundation, Medicare's Role for Dual Beneficiaries, April 2012. J.P. Morgan Asset Management analysis.

HEALTH CARE COSTS BEFORE AGE 65

For Baby Boomers under 65 who retire early or work without employer-provided coverage, health care costs are often a source of concern. The ACA will make early retirement easier for the following reasons:

- There are no increased costs for those with pre-existing conditions
- There are subsidies for those with lower incomes
- Insurers are not allowed to charge older individuals more than three times the amount they charge younger individuals*

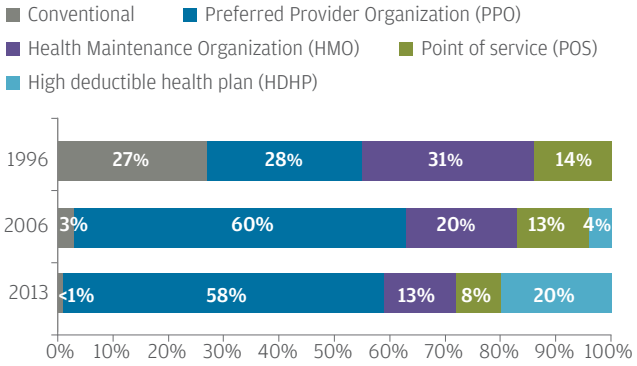
However, if someone does not qualify for a subsidy, costs under the ACA will be significantly higher than they would be under Medicare. According to the online Kaiser Family Foundation subsidy calculator, as of April 2016, premiums for a 64-year-old non-smoker with an ACA Silver Plan and no subsidy will average about $8,420 per year, with maximum out-of-pocket costs of $6,600 a year, excluding prescription drugs. As noted earlier, for traditional Medicare with prescription drug coverage and a comprehensive Medigap policy, the median national health care costs for a 65-year-old would total about $4,200 or $4,660 with typical vision, dental and hearing costs included.

For those with employer-provided coverage, the recent trend has been to shift away from conventional coverage with low deductibles and toward Preferred Provider Organizations (PPOs) and high deductible plans. In PPOs, costs for policy holders are higher out of network, and high deductible plans tend to have lower premiums but higher costs for those who use more care (**EXHIBIT 6**). We expect this trend of cost shifting to employees to continue. Younger individuals should also prepare for higher and more variable costs depending on health care use. In addition, they should consider directing automated savings into an account to help fund unexpected health costs. Certain high deductible plans may also allow for savings into special health savings accounts.

*Kaiser Family Foundation Summary of the Affordable Care Act, last modified April 23, 2013.

Plan mix has changed as employers looked to control costs

EXHIBIT 6: DISTRIBUTION OF HEALTH PLAN ENROLLMENT FOR COVERED WORKERS, BY PLAN TYPE



Source: Kaiser Family Foundation, Employer Health Benefits Annual Survey, 2015.

New payment models are moving from payments for quantity of care delivered and toward payments for outcomes, or value of care delivered. It's a recent shift, and one that is gaining traction. A growing contingent of providers has developed sophisticated tools to help lower costs without compromising the quality of care. For example, CareMore, a Wellpoint-owned chronic care program for dual eligible (Medicare and Medicaid) patients, has made notable progress in reducing the length of hospital stays and hospital admissions for end-stage renal diseases, among other measures (**EXHIBIT 7**, next page).

In recent years, many drugs have gone off patent, replaced by cheaper generics, and this has helped reduce costs overall. However, the health care sector has already received most of the benefits from patent expiration, and promising new bio-tech drugs will likely spark new growth in drug costs. (For a look at the investment implications of changes in health care spending, see "Dynamic investing prospects," page 9.)

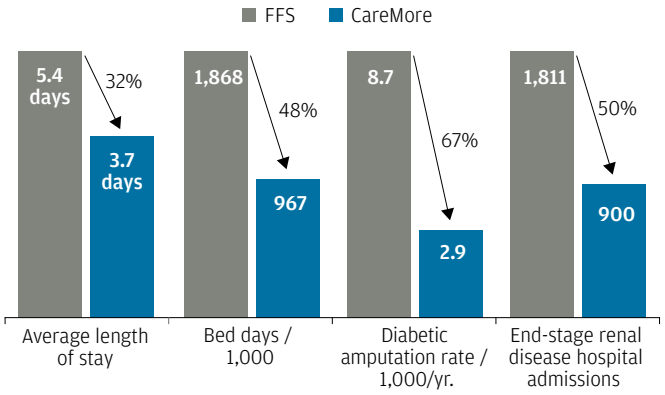
PROJECTING COSTS, FEDERAL BUDGET BURDENS

When projecting future health care expenses, it is reasonable to assume a 7% annual rise in health care costs that begins when a person starts Medicare. In retirement, individuals will need a balance of current income to pay for lifestyle expenses and some growth to cover general inflation and rising health care costs. (Planning for potential long-term care expenses is outside the scope of this paper.)

Whatever the pace of health care spending growth, the federal government will be paying a large share of the total bill. In recent decades, the government's role in the health care

Sophisticated tools can lower costs without compromising care

EXHIBIT 7: A COMPARISON OF FEE-FOR-SERVICE (FFS) COVERAGE FROM MEDICARE AND COVERAGE FROM CAREMORE, A CHRONIC CARE PROGRAM FOR DUAL ELIGIBLE (MEDICARE AND MEDICAID) PATIENTS



Note: CareMore is a chronic care program for dual eligible Medicare patients.

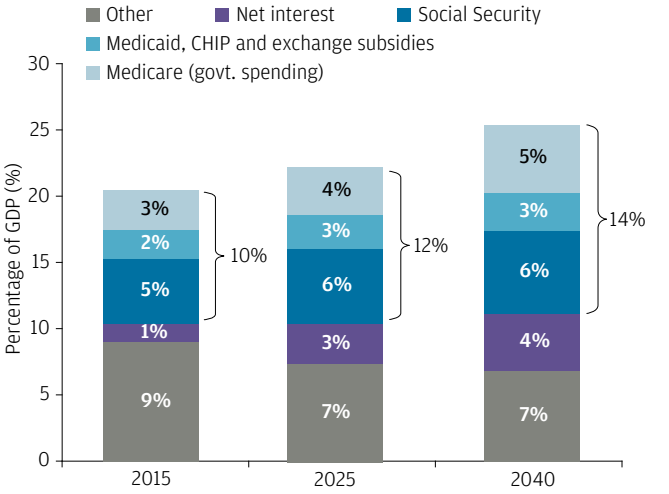
Source: Data represents CareMore 2013 hospital metrics. Admissions and days are rates per 1,000 beneficiaries. Inpatient length of stay in days. Readmissions are 30-day acute hospital readmissions. Medicare averages from most recent data available, 2011 HHS Health Information Warehouse (www.healthindicators.gov).

sector has grown substantially. In 2013, 43% of all health care spending was directly funded by the government, up from 32% in 1987 (**EXHIBIT 8**).

As health care draws on more and more of the federal budget, it risks crowding out spending on other important federal programs, including education, defense and infrastructure. The Congressional Budget Office forecasts that spending on Medicare, Medicaid and Social Security will increase from 10% of GDP in 2015 to 14% in 2040 (**EXHIBIT 9**). Along with increased interest payments to service the national debt, and absent any Congressional action to change the finances of Medicare, Medicaid and Social Security, this spending is predicted to reduce budgets for other discretionary programs from 9% of GDP in 2015 to 7% in 2040. This would amount to a 24% reduction in other spending, putting enormous pressure on the government's discretionary budget.

Will government-paid health care crowd out spending on other federal programs?

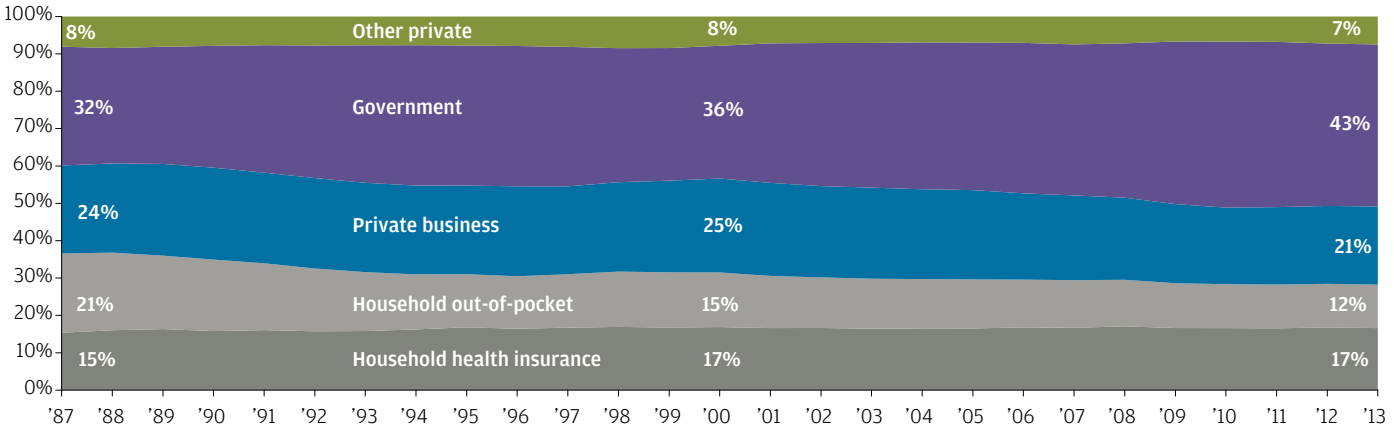
EXHIBIT 9: PROJECTED FEDERAL SPENDING, PERCENTAGE OF GDP



Source: The 2015 Long Term Budget Outlook, CBO, July 2015.

The government is picking up a growing share of the health care tab

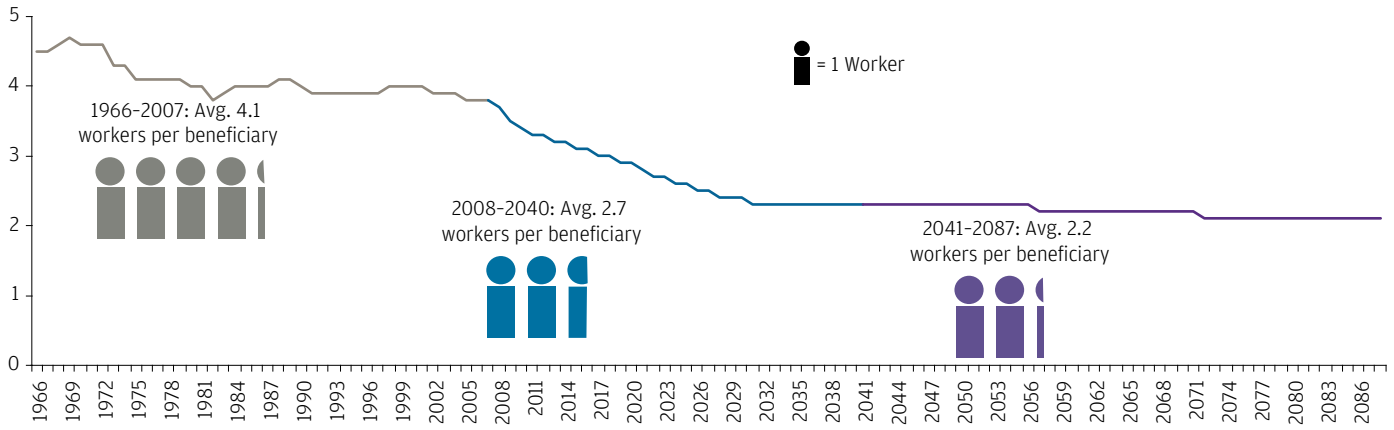
EXHIBIT 8: PERCENT DISTRIBUTION OF NATIONAL HEALTH EXPENDITURES



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. Numbers may not add to 100% due to rounding.

Demographics have set Medicare on a long path of fewer workers per beneficiary

EXHIBIT 10: COVERED WORKERS PER PART A (INPATIENT HOSPITAL CARE) BENEFICIARY



Source: 2015 Medicare Trustees Report, J.P. Morgan analysis.

MEDICARE'S FISCAL STRAITS

How dire is the prognosis for Medicare? Central to its fiscal outlook is the covered worker ratio. Here's how it works: Medicare Part A is paid for by the Medicare Trust Fund, which is funded by a 2.9% payroll tax, shared equally by current workers and employers. Between 1996 and 2007, the ratio of current workers to beneficiaries, the covered worker ratio, was in a healthy balance—an average of 4.1 workers per beneficiary. That is no longer the case. Demographic forces have set Medicare on a long path of fewer workers per beneficiary. Unless the U.S. labor force sees a huge infusion of new workers, this ratio will likely deteriorate further as more Baby Boomers leave the workforce and sign up for Medicare (**EXHIBIT 10**).

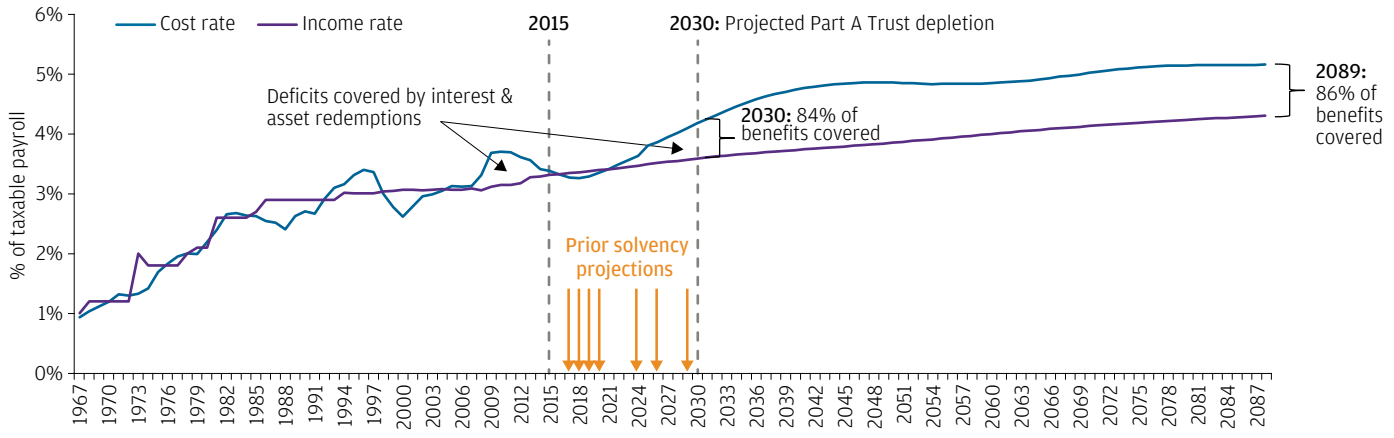
If Congress fails to act, the Medicare Trust Fund is projected to be depleted by 2030. That is, the Medicare trustees estimate that in 2030 only 84% of Part A coverage costs would be funded through payroll taxes collected at that time (**EXHIBIT 11**).

RECENT LEGISLATION

Two pieces of legislation, the Affordable Care Act of 2010 (ACA) and the Protecting Access to Medicare Act of 2014, have had a significant impact on Medicare. While the ACA sparked substantial debate and controversy, the Protecting Access to Medicare bill was a bipartisan effort that passed Congress with relatively little rancor. While the two laws changed the overall

If Congress fails to act, the Medicare Trust Fund is projected to be depleted by 2030

EXHIBIT 11: PART A (INPATIENT HOSPITAL CARE) TRUST COST VS. INCOME RATES



Source: 2015 Medicare Trustees Report Supplementary Tables.

U.S. health care system in different ways, the discussion below is limited to the provisions related to Medicare.

The Affordable Care Act made three significant changes to Medicare:

1. **Reduced payments to certain providers, including Medicare Advantage providers**

   Historically, the government provided higher subsidies for Medicare Advantage than traditional Medicare coverage. These higher subsidy levels have mostly been eliminated.

2. **Froze income thresholds for higher premiums**

   Part B and D premiums are higher for those with modified adjusted gross income (MAGI) of more than $85,000 for singles and $170,000 for joint filers. The ACA froze these income thresholds until 2019, rather than allowing them to increase with inflation.

3. **Reduced expenses for those with relatively high prescription drug costs**

   Historically, after a certain dollar limit, Part D would provide no coverage for prescription drugs until a catastrophic level of costs was reached. This gap in coverage is commonly known as "the donut hole." The ACA is gradually increasing drug coverage through 2019 to fill in this gap in coverage.[7]

The Protecting Access to Medicare Act of 2014 is commonly called the "doc fix bill" because it eliminates payment reductions to doctors that had been put in place in the Balanced Budget Act of 1997. These payment reductions were continually deferred by Congress through this year so that most doctors would continue to accept Medicare patients. The annual deferral of cuts to doctors' pay usually resulted in a painful budget debate. The opportunity to avoid this debate going forward enticed legislators on both sides of the aisle to vote for the bill. Elements of the "doc fix" legislation that relate to Medicare:

- Starting in 2020, new retirees will be subject to the $147 annual Part B deductible, even if they have a Medigap policy. It is expected that Medigap premiums will decrease accordingly, and overall costs may be reduced since individuals will bear some out-of-pocket costs when they use medical services.
- Beginning in 2018, premiums will increase for Medicare Parts B and D for those with modified adjusted gross incomes over $133,500 filing single or $267,000 filing jointly. This will result in approximately $1,000 per year in additional premium costs for some individuals over what they would have paid before this law was passed. These thresholds will increase with inflation.
- The Act includes incentives to continue the gradual change in Medicare reimbursements to doctors and hospitals from a fee-for-service structure to structures that will link fee-for-service payments to quality measures or to alternative payment models. These models may include shared savings or risk sharing: Doctors and hospitals will have an incentive to meet quality of care outcomes, but at lower treatment costs. Another type of alternative payment model is known as disease management: Certain providers may be paid a fixed fee for the entire cost of treating a patient population with a particular ailment (for example, end-stage renal disease or congestive heart failure) rather than being paid for each increment of care delivered.

LEGISLATIVE OUTLOOK

The recently passed Protecting Access to Medicare Act of 2014 provides strong clues as to longer-term future of Medicare:

- It is feasible that Congress may further limit Medigap policies, which are currently designed to cover deductibles for Medicare Parts A and B.
- Budget pressures could eventually lead Congress to further decrease government subsidies for Parts B and D, particularly for middle- to higher-income beneficiaries.
- Moving to other types of payment models offers the possibility of improving patient care for less cost. These models are relatively new in the U.S. Designing and implementing payment rules is a complex endeavor. Longer-term results, while promising, are uncertain.

A voucher-style plan is favored by some Republican legislators for new Medicare enrollees. The objective is to increase competition and efficiency, and thus reduce costs, by allowing consumers to purchase private plans or buy into traditional Medicare. If this were put in place, limiting the growth of government subsidies for vouchers may shift more costs onto seniors over time.

[7] Kaiser Family Foundation: Medicare Spending Limits and Implications, March 2013.

Given the recent passage of the Protecting Access to Medicare Act of 2014, the voting strength of seniors and the partisan battles that have persisted in the wake of the ACA's passage, the politics of making significant changes to Medicare will be difficult. For that reason, we expect that the projected trust fund depletion will be the biggest impetus for changing the system. If the trustees' assumptions are roughly correct, Congress may feel pressure to make changes as we approach 2030.

CONCLUSION: REALISTIC SPENDING PROJECTIONS, SOUND RETIREMENT PLANS

While it is difficult to predict the forward path of U.S. health care costs, we believe that they will continue to increase at a pace faster than overall inflation. A host of powerful forces, led by an aging population and advances in medical technology, will propel that growth even as some innovative insurers are increasing efficiencies to alleviate some of the pressure. In addition, changes in employer-provided insurance and eventual changes to Medicare could shift more of the cost burden to individuals, particularly individuals who use more care or who use expensive types of care.

Taking all these factors into account, both younger and older individuals should be prepared to pay more for health care. Part of that preparation will involve the design of investment portfolios aimed at outpacing health care cost inflation and bolstering funds for unexpected health care expenses.

We can engage in healthier behavior that may lower our future health care bills. Still, we cannot know what medical issue we may confront or how long we will live. We do know that older people tend to use more health care than their younger counterparts. This makes it critical to plan for the likelihood of increasing health care costs and the investment growth needed as part of a well-constructed, long-term retirement plan.

J.P. MORGAN'S VIEW ON DYNAMIC INVESTING PROSPECTS

The shifts in health insurance and the countervailing forces driving health care costs both up and down—are but two examples of the many factors that make the health care sector so dynamic. As we construct our equity funds, we believe dynamic industries present especially compelling investment opportunities because they tend to create clear winners and losers. We identify two main categories of investment themes:

- **Medical cost solutions:** Companies may gain advantages with innovative solutions that can help reduce costs without significantly disrupting care. Companies in this category include the leading Medicare Advantage providers, sophisticated health insurance plans and best-in-class outpatient surgery centers. Investment prospects may also be found in retail pharmacies, which may benefit from increased prescription drug use by older Americans and pharmacies' increasing role as providers of relatively low-cost care.
- **Medical innovation:** We find attractive investment opportunities among companies using scientific innovation to address previously untreated diseases or develop improvements in existing treatments. In a competitive marketplace, some biotech companies and pharmaceutical companies appear well positioned for growth.

As we assess investment strategies for retirees and pre-retirees, current income is usually a primary concern since earnings from work will likely have stopped or dramatically declined in retirement. However, a combination of growth- and income-generating investments is required to cover increasing health care costs over the long term.

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