FINANCIAL PLANNING

Health Insurance in Retirement: Medicare and Beyond

The risk of high medical bills during retirement calls for a well-thought-out plan, especially at age 65, when you're eligible for universal medical coverage under Medicare. Many crucial aspects of health insurance have the potential to save you a lot of money—or cost a lot if you aren't paying attention.

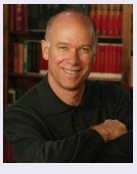
BY STEVE VERNON

Are you concerned about large medical bills that could wipe out your savings in retirement? If so, you're not alone—this is a common fear that I hear expressed quite often.

The fact is, there's a good reason to be concerned: If you're like most people, the cost of health care is one item in your budget that will most likely increase substantially after you retire. Here's why: According to the U.S. Department of Labor, on average, employers subsidize about 80% of the cost of medical insurance for their active employees and about two-thirds of the cost for families. But for most people, these subsidies will disappear when they retire. This represents a game-changing challenge that you need to address.

By making smart choices and putting plans in place to tackle your concerns, you can help alleviate your fears and feel better about your retirement years. The first step is to make sure you've developed well-thought-out, solid strategies for your income and expenses so you can make the magic formula for retirement income security work for you.

But that's not enough: When it comes to your medical expenses, there's more planning to do. High medical expenses can blow up your well-laid plans for managing your income and expenses. As a result, you'll want to take some additional steps to protect yourself—and your spouse if you're married—against the risk of high medical expenses.



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APRIL IS: Financial Literacy Month

Understand Your Basic Medicare Options

Once you reach age 65, you are eligible for Medicare and you can't be denied coverage for pre-existing conditions. Despite these benefits, managing your insurance coverage can still be complicated, and you'll need to plan carefully to make every dollar count. It will be essential for you to make some key, informed choices as you approach your 65th birthday.

First, you'll want to understand the four parts of Medicare:

» Part A covers inpatient care in hospitals, skilled nursing facility care, hospice care and some home health care services.

» Part B covers services from doctors and other qualified health care providers, outpatient care, some home health care services, durable medical equipment and many preventative services.

» Part C, also known as Medicare Advantage, is like an HMO or PPO that combines Parts A and B in one network of health care providers. Medicare Advantage plans typically also include costs for prescription drugs that are covered under Part D (described next); they might also include extra coverage for services like vision care, dental care, hearing aids and/or wellness services.

» Part D helps pay for the cost of prescription drugs, run by Medicare-approved private insurance companies that follow rules set by Medicare. But if you enroll in a Medicare Advantage plan, you most likely won't need to buy a separate policy for Part D benefits.

Medicare doesn't cover services for dental or vision care, unless it's the result of a trauma or accident. Also, Medicare doesn't cover the cost of hearing aids. You'll want to make plans for paying these costs out of pocket or purchasing a policy that covers these expenses.

Learn About Original Medicare

You can elect Original Medicare, where you enroll in

Medicare Parts A and B and purchase a separate prescription drug plan under Part D. Here are a few key details:

» Most retirees receive Part A without paying a monthly premium (see below for details).
» You'll need to pay a monthly premium for Part B, which is $135.50 per month for most new retirees in 2019. Retirees with high incomes may pay a higher premium, as discussed later.
» Part D, which covers prescription drugs, will also require a separate premium. For 2019, the national average monthly premium for Part D coverage is $33.19, according to the National Council on Aging; however, actual costs vary significantly depending on the plan you choose and where you live.

There are gaps in Medicare coverage due to the significant deductibles and copayments, which can amount to thousands of dollars. As a result, most people who elect Original Medicare also buy a separate Medicare Supplement Insurance plan, also known as a Medigap plan, that pays for many of the expenses not covered by Medicare. You'll pay a monthly premium for a Medigap plan, in addition to the Medicare Part B premium listed above. In 2017, costs for a separate Medigap plan ranged from $126 to $464 per month for men age 65, and from $118 to $464 for women of the same age, according to the National Medicare Supplement Price lndex.

One critical advantage of Original Medicare, when it's supplemented by a Medigap plan, is that you can self-refer to health care providers who accept Medicare reimbursement. This gives you some degree of freedom when choosing your providers that you may not have with a Medicare Advantage plan. This might be important if you want to have the broadest possible access to medical professionals and specialists.

Shop for a Medigap Plan

Medigap plans work alongside Medicare Parts A and B, paying for much of Medicare's substantial deductibles and copayments. There are 10 standardized Medigap plans sold in most states, labeled with letters A through N. (Massachusetts, Minnesota and Wisconsin have a different standardization model.) Plan F provides the most comprehensive coverage, and as a result, it's the most popular plan, selected by almost two-thirds of people who buy Medigap plans.

When you're first eligible for Medicare Part B, you can't be excluded from buying a Medigap plan for pre-existing conditions or be charged a higher premium. As long as you continue the coverage by paying the premiums, your policy is guaranteed renewable for the rest of your life.

If you want to change plans after you're first eligible for Medicare, however, then insurance companies are allowed to apply medical underwriting. This means they can either exclude you altogether because of pre-existing conditions or charge you a higher premium if they deem you to be unhealthy. As a result, when you're first eligible for Medicare, you'll want to carefully consider the Medigap plan that will best suit your needs for the rest of your life. You may not get a "do-over" and be able to upgrade to a more generous policy in future years.

The cost of the premiums you'll pay for a Medigap plan depend on the insurance company you select, your age, gender and where you live. There's a very wide spread between the lowest and highest premium amounts, so it's a good use of your time to shop around for the best plan.

Remember that Medicare doesn't cover routine dental and vision care services. Medicare *might* pay for such services if you have an emergency or injury from a trauma. It also might pay for certain glaucoma screenings and cataract surgery.

Some insurance companies offer special coverage options to their Medigap plan members for routine dental and vision care, or they may offer insured members a discount program to help them save money on routine dental and vision care. You'll want to investigate whether your Medigap plan covers these items. If it doesn't, you may need to pay for these items out of pocket or look for standalone dental insurance or vision plans.

Medicare and Medigap plans might also cover hearing diagnostic tests if they're medically necessary, but they won't pay for the cost of hearing aids.

See the Helpful Resources box in the online version of this article for links where you can learn more about Medigap plans.

Shop for a Part D Plan

Medicare Part D is a separate policy that pays for some or all of your costs for prescription drugs—these costs aren't covered by Medicare's other parts. Medicare mandates the features that must be offered in a basic Part D plan, although you can buy a policy with more generous features than the basic plan. Most, but not all, Medicare Advantage plans also cover prescription drug benefits, so if you participate in a Medicare Advantage plan, you'll want to find out if you need to purchase a separate Part D plan.

Note that you can change your Part D plan in future years without needing to satisfy medical underwriting, if you want to upgrade to a more generous plan.

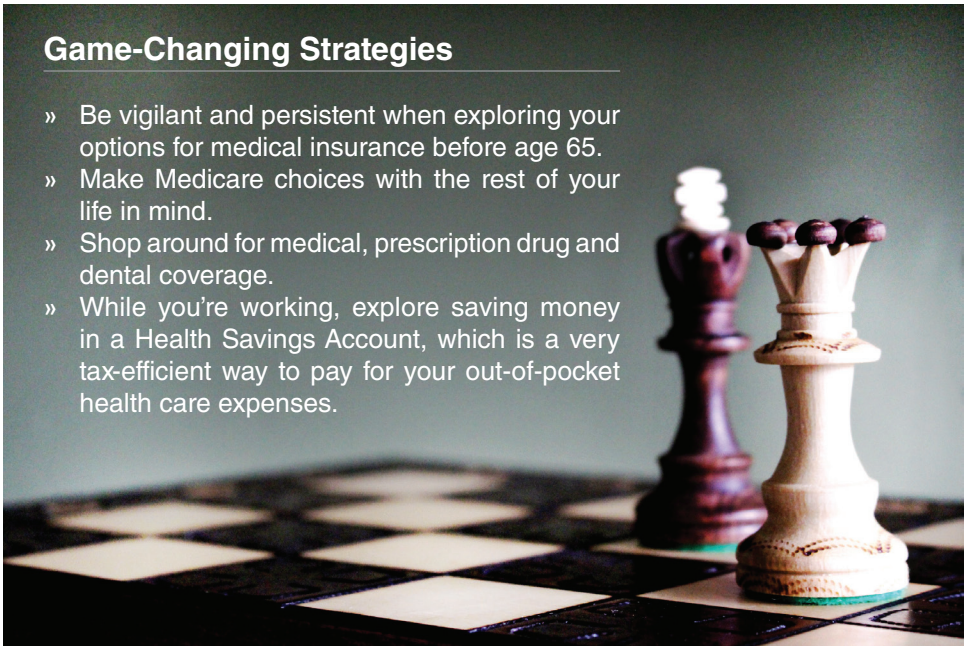
What follows are the features of a basic Part D

prescription drug plan. Note that all figures are 2019 numbers.

- Each year, you'll pay for 100% of your drug costs before you reach the prescription drug deductible, which is $415.
- After you meet the deductible ceiling, a basic Part D plan will pay for 75% of all your drug costs and you'll pay 25%, until both you and your plan have paid $3,820 for prescription drugs.
- At that point, you're then in a coverage gap, or "donut hole," and the amount you'll pay depends on whether you are using generic or brand-name drugs. In 2019, you can realize a 75% discount on brand-name drugs and a 63% discount for generic drugs. The coverage gap will be eliminated in 2020.
- Once you've spent $5,100 out-of-pocket for prescription drugs in 2019, you're out of the coverage gap. After that, you're eligible for the catastrophic coverage, and you'll spend no more than 5% of the cost of drugs for the remainder of the year when you're eligible for catastrophic coverage.

Some drug plans may offer higher reimbursements if you use a network pharmacy; they may even require that you use a network pharmacy, so it's important to find out if your favorite pharmacy is a preferred provider under the plan you buy.

Note that a Part D plan can provide more generous features than the basic plan described above, but you'll spend more on monthly premiums. If you're interested in expanded coverage, you'll want to decide if the additional benefits would justify the extra premiums.



Game-Changing Strategies

- Be vigilant and persistent when exploring your options for medical insurance before age 65.
- Make Medicare choices with the rest of your life in mind.
- Shop around for medical, prescription drug and dental coverage.
- While you're working, explore saving money in a Health Savings Account, which is a very tax-efficient way to pay for your out-of-pocket health care expenses.

Learn About Medicare Advantage Plans

Medicare Part C, or Medicare Advantage, is an alternative to Original Medicare. Medicare Advantage plans are more like a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO), and they combine Parts A and B in order to provide you with integrated hospital, physician and outpatient coverage. Medicare Advantage plans have their own deductible and coinsurance schedules, so you don't need to buy a separate Medigap policy, as you would with Original Medicare. By law, Medicare Advantage plans must provide the same services as Medicare Parts A and B, but these plans are in charge of how they'll deliver medical services.

Medicare Advantage plans also usually cover Part D prescription drug benefits, and they may include extra coverage for special items such as vision care, dental care, hearing aids and/or wellness services. One goal of Medicare Advantage plans is to simplify your life by bundling health care services in a managed care environment. However, be aware that if you choose a Medicare Advantage plan, you might not be able to switch to a Medigap plan in the future, if your health or circumstances change.

In addition to your Part B premium, you'll usually pay a monthly premium for the Medicare Advantage plan. In some instances, however, there's no additional premium for so-called "zero premium plans." In this case, you only need to pay your usual Part B premium.

For tips on choosing between a Medigap plan and a Medicare Advantage plan, see the online version of this article.

Medicare Advantage plans typically restrict or encourage you to use the medical providers in the plan's network. Here are the two most common types of Medicare Advantage plans:

- HMO plans usually restrict care to providers within their network. If you choose otherwise, you'll pay the full cost for providers outside the network, except possibly in the case of a medical emergency. In most cases, you'll need to select a primary care doctor, and you'll need a referral from that physician in order to see a specialist each time you need one.
- PPO plans offer the best coverage and costs for in-network services, but they also allow physician choice by covering out-of-network care. However, you'll pay higher out-of-pocket costs for out-of-network services. In most cases, you don't need to select a primary care doctor, and you don't need a referral to see a specialist.

In either case, you'll want to check whether your doctors and specialists are in the network of the Medicare Advantage plan you're considering. And you may want to consider possible future needs for specialists. You'll also want to review and understand the plan's premium amounts, deductibles and copayments and determine whether your Medicare Advantage plan pays for such items as dental care, vision care, hearing aids and wellness programs.

For more details regarding the various circumstances under which you can switch plans, see the links in the Helpful Resources box in the online version of this article.

Check Your Eligibility for Medicare Part A

Whether you elect Original Medicare or a Medicare Advantage plan, you'll want to make sure either you or your spouse have paid FICA taxes for at least 40 calendar quarters (10 years). This qualifies both of you for free Medicare Part A coverage.

If neither of you has paid FICA taxes for 40 quarters, you can still purchase Medicare Part A, but it will be costly. The premium in 2019 is $240 per month per person if you paid FICA taxes for 30 to 39 calendar quarters, and $437 per month per person if you paid FICA taxes for fewer than 30 quarters. If you're close to these thresholds, you might consider continuing to work and paying FICA taxes until you reach these thresholds to either reduce or eliminate your Medicare Part A premiums.

Determine When You Should Enroll in Medicare

There are many different rules and deadlines for enrolling in the various parts of Medicare, and enrollment dates can be different for each of Medicare's four parts. For instance, if you start your Social Security income benefits before age 65, you'll be automatically enrolled in Medicare Parts A and B to be effective at age 65, and you'll receive your Medicare card three months before your 65th birthday. At that point, you'll have the option to refuse Part B, since premiums are required, but that's usually a bad idea. The only time it makes sense to delay signing up for Part B is when you're getting coverage from another source, such as a health plan offered by your employer or your spouse's employer.

If you aren't covered by a medical plan at work and if you haven't started your Social Security benefits by age 65, then it's best if you enroll in Medicare Parts A, B and D no later than three months after your 65th birthday. *This is necessary even if you continue to delay the start of your Social Security income benefits.* If you don't sign up for coverage before this deadline, coverage can be delayed and late penalties may apply.

Warning: If you delay signing up for Medicare Part B or Part D after you're first eligible, Medicare applies a permanent penalty surcharge to your monthly premiums. The only exception is if you're eligible for a special exemption, such as coverage from the Department of Veterans Affairs.

If you decide you'd rather be covered by a Medicare Advantage plan than be covered separately by Medicare Parts A and B, you'll need to select and enroll in your Medicare Advantage plan *no later than three months after your 65th birthday,* though I always recommend doing it early so you don't forget. Once again, if you don't sign up for coverage before this deadline, coverage can be delayed and late penalties may apply. You can sign up as late as three months after your 65th birthday to avoid any penalties.

If you continue working beyond age 65 and are covered by your employer's medical plan as an active employee, make sure you understand how that plan coordinates with Medicare. The best way to do this is to consult with your HR department or benefits administrator. One key reason to look into this is that there are different rules for employers with fewer than 20 employees compared to employers with 20 or more employees. It's also important to note that many employer-sponsored plans require you to enroll in Medicare Part A but not Part B. You'll also want to determine whether your employer's plan covers prescription drugs; if so, you won't need to sign up for Medicare Part D while you're covered by your employer's plan.

If you don't enroll in Medicare Parts B and D because you're covered by your employer's plan while you're working, the late enrollment penalties mentioned here won't apply. To avoid a late penalty completely, however, you'll generally need to enroll in Medicare Part B no more than eight months after you eventually retire. You'll also need to buy a Medicare Part D plan within 63 days of your retirement date.

In most cases, you won't want to elect a Medicare Advantage plan while you're covered by your employer's medical plan as an active employee since you'll be duplicating coverage and wasting the premiums you'd have to pay for the Medicare Advantage plan.

Learn When You Can Switch Plans

Each year, during Medicare's open enrollment period (from October 15 to December 7), you can switch from:

» Original Medicare/Medigap to a Medicare Advantage plan;
» One Medicare Advantage plan to another Medicare

Advantage plan;
» A Medicare Advantage plan to Original Medicare (but not necessarily to a Medigap plan; see below); and
» Your Part D prescription drug plan to another Part D plan, if you're in Original Medicare.

The problem arises when you want to switch from a Medicare Advantage plan to a Medigap plan that supplements traditional Medicare, or from one Medigap plan to another Medigap plan. Most states allow insurance companies to apply medical underwriting in this situation (Connecticut, Massachusetts and New York are the exceptions). If the insurance company finds you to be in poor health, it can increase your premiums or even deny coverage outright.

In limited circumstances, you're sometimes allowed to switch out of a Medicare Advantage plan and into a Medigap plan without medical underwriting:
» If your Medicare Advantage plan no longer serves your area,
» If you move to an area not served by your Medicare Advantage plan, or
» If you enrolled in a Medicare Advantage plan for the first time and want to switch within the first 12 months.

In addition to Medicare's general open enrollment period in the fall of each year, there's also another limited open enrollment period that runs from January 1 through March 31 of each year. During this period, you can:
» Change from one Medicare Advantage plan to another Medicare Advantage plan,
» Opt out of your Medicare Advantage plan and switch to original Medicare, or
» Elect a stand-alone Part D prescription drug plan if you lose prescription drug coverage due to opting out of your Medicare Advantage plan.

For more details regarding the various circumstances under which you can switch plans, see the links in the Helpful Resources box in the online version of this article.

Action Steps

» If you or your spouse are retiring before age 65, investigate your options for obtaining health insurance until you're eligible for Medicare.
» Investigate your strategy for choosing Original Medicare or a Medicare Advantage plan when you reach age 65.
» If you decide to sign up for Original Medicare, shop for a Medigap plan and Part D prescription drug coverage.
» If you purchase Part D prescription drug coverage, understand how your plan's drug formulary treats your specific prescription drugs and whether your local pharmacy is a preferred pharmacy.
» Each year, determine whether to continue your Part D coverage or whether it would be advantageous for you to change your Part D plan.
» Prepare a budget of your costs for medical premiums and out-of-pocket expenses, such as deductibles, copayments and services not covered by Medicare. Don't forget dental expenses, eyeglasses and hearing aids.

Determine If You'll Pay a Higher Premium for Medicare Part B

The usual Medicare Part B premium covers about one-fourth of the costs of that coverage; the U.S. government subsidizes the rest of the cost. The government imposes higher premiums for high-income retirees, however, as one method to improve Medicare's financing.

To determine if you'll pay higher premiums for an upcoming calendar year, the Social Security Administration (SSA) looks back at your most recent available federal tax return, which is usually the tax year that's two years before the year in which you're paying Medicare premiums. The SSA uses a sliding scale to calculate the additional premiums you'll pay, based on your modified adjusted gross income (MAGI). Your MAGI is your total adjusted gross income plus tax-exempt interest income.

Here are the basic guidelines: If you file taxes as married filing jointly and your MAGI is greater than $170,000, you'll pay higher premiums for your Part B and Medicare prescription drug coverage. Also, if you file your taxes using single or head of household status and your MAGI is greater than $85,000, then you'll also pay higher premiums.

Note that whether you'll pay higher premiums is determined each year based on the look-back rule. So, it's possible that you might pay higher premiums for a specific year but subsequently drop to the regular premium levels in the

(continued on page 15)

respectively. The Vanguard STAR fund had positive returns in 2000 and 2001, and a loss of just under 10% in 2002. Thus, it clearly matters WHAT we invest in. For nervous investors, the big takeaway is: diversify, diversify, diversify.

Now, to the issue of HOW we invest. In the 19-year period from 2000–2018, a lump-sum investment in the Vanguard 500 Index fund experienced the brunt of bad timing and finished with an annualized return of 4.75%. The Vanguard STAR fund fared better with an annualized return of 6.27%. Interestingly, if the investor had chosen to invest money each year (say, $3,000) into each fund, the internal rates of return for both funds were impressive: 7.12% for the Vanguard STAR fund and 8.48% for the Vanguard 500 Index fund. The idea of "bad" starting years doesn't really apply to systematic investors who plan to stay invested for at least 15 to 20 years.

The moral of the story is that systematic investing (annually, quarterly or monthly) markedly reduces timing risk. Whereas lump-sum investors are fully exposed to timing risk, investors who "get back into the markets" by making regular contributions (annually in this analysis) may actually benefit if markets decline during the first few years. And, if markets don't decline initially, that's okay too. Very simply, lump-sum investors can only feel good initially if their investments have positive returns. Systematic investors can feel good either way—if performance is initially bad, they accumulate more shares with their subsequent investments. If performance is good, well ... they can live with that.

So, to investors who are nervous about reentering equity investments, you may want to consider doing so gradually. It's kind of like marathon training: Don't start by running 26 miles.

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future, if your MAGI drops sufficiently.

If you end up having to pay a higher premium because of your high retirement income, you'll want to factor those costs into your budget for living expenses. In limited circumstances, you can apply for a waiver of these additional costs. The most common situation that might prompt you to apply for a waiver is if your current income has dropped substantially because you retired compared to the look-back year, although there are other circumstances that apply as well.

For details on these rules, including a table that summarizes the additional premiums, see the link in the Helpful Resources box in the online version of this article.

A Final Tip

Be sure to carefully consider your own specific health care needs. Don't blindly follow the advice of a well-intentioned family member or friend—their needs might be very different from yours. You might want to find experts who can help you sort through and choose the best option.

One good source is Medicare's Star Rating System, which measures the performance of Medicare Advantage and Part D prescription drug plans.

Another option is to work with an insurance salesperson or website such as eHealthInsurance.com. They'll earn a commission on the sale of insurance, which means they might be restricted in the plans they offer you, but they can help you pick the best plan for you among the plans they service.

You might also need to pay to hire a qualified, objective consultant to help you shop for a plan. This can not only help you save money, but it can help you choose the best plan for you. One note of caution: Make sure that any consultant you hire isn't paid commissions from an insurance company or by selling your personal information.

The Helpful Resources box online identifies an independent consulting firm that I respect, helpful resources on Medicare's website, as well as a website that contains a directory of Medigap insurance agents and two online health insurance agencies.

While it might be frustrating to spend this kind of time or money, remember: The medical procedures and drugs you'll be covered for under the right plan may be what will keep you alive and healthy.

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