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Medicare

White paper

NATIONWIDE RETIREMENT INSTITUTE®

Preparing clients for health care expenses

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Tim O'Mara is dedicated to educating financial professionals, clients, plan sponsors and plan participants about the latest in retirement income trends. He implements practical and comprehensive retirement income solutions. Tim is a graduate of Mercyhurst University, where he majored in Business Management. He is FINRA Series 63, 66 and 7 licensed. His areas of focus include retirement income planning, Medicare, Social Security and long-term care.

Introduction

Many people enter their later years unaware that health care costs in retirement can be burdensome. What's more, the many Medicare options available to individuals who are about to turn 65 can be daunting. To provide valuable assistance, you don't need to be an expert — but you do need to be prepared. This paper outlines the basics of Medicare, explains the enrollment process and discusses the Medicare surcharges your more affluent clients may face, as well as uncovered costs.

As a financial professional, knowing the health care costs your clients could face in retirement may affect the strategies you devise for them. Understanding how Medicare fits into their long-term retirement income plan allows you to provide extra value.

The looming costs of health care

Many older clients may be under the impression that once they turn 65, Medicare will cover their health care costs. Unfortunately, that's not entirely true. Medicare is not free, even if the client paid the Medicare payroll tax throughout their entire career. These clients may be surprised to learn that Medicare premiums may be deducted from their Social Security checks.

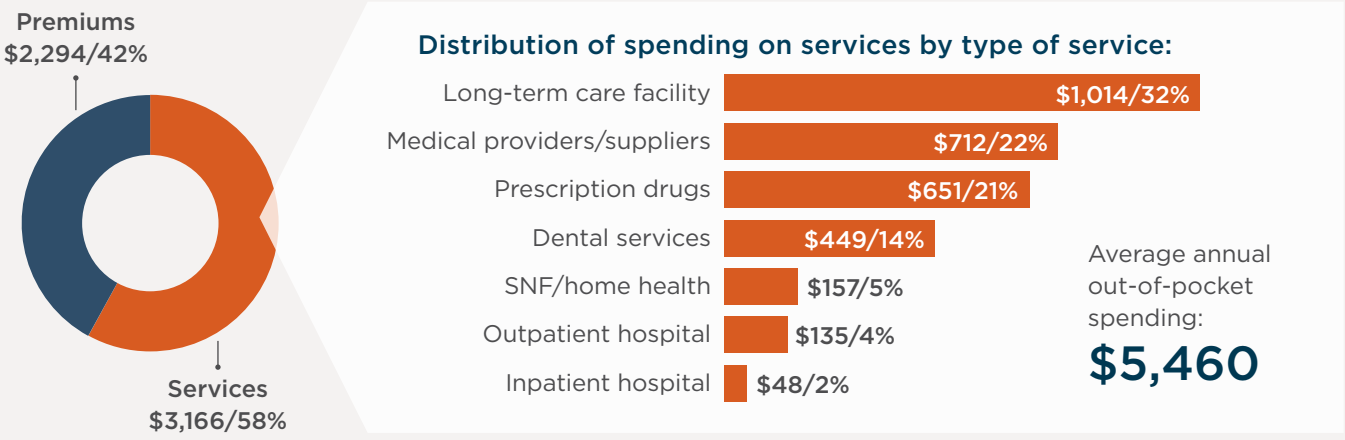
Out-of-pocket costs could be larger than expected

For those with Original Medicare, there will be required deductibles, co-insurance and co-payments, and many retirees will also pay for supplemental insurance (Medigap) and prescription drug coverage. Original Medicare imposes no cap on out-of-pocket expenses, though a Medigap plan would cover those — but only on Medicare-approved services. Some services, such as vision, hearing and dental care, are not approved, and Medigap would not cover those out-of-pocket costs.

The uncovered portion could be a significant percentage of a retiree's total health care costs. Analysis conducted by the Henry Kaiser Family Foundation found that Medicare beneficiaries are shouldering 58% of their total health care costs.[1]

Additionally, inflation could take a toll over time. Premiums inevitably rise, as does the need for health care as we age. Considering that longevity is increasing the length of time that many people are on Medicare, the costs could be substantial.

Average out-of-pocket spending on services and premiums among traditional Medicare beneficiaries[1]



Notes: SNF is "skilled nursing facility." Analysis includes beneficiaries living in the community and long-term care facility residents; it excludes beneficiaries with Part A only or Part B only for most of the year or Medicare as a Secondary Payer and beneficiaries in Medicare Advantage.

Few retirees will be able to escape these costs. Eventually, most will experience health difficulties during some portion of their retirement. And for many, long-term care is inevitable (see the box on p.7).

For most retirees, health care expenses will be a significant part of their budget, and the use of Medicare coverage will be substantial. In fact, for a single man turning 65 in 2020, the cumulative Medicare benefit could amount to $229,000 over his life (net of premiums).[2]

Those enrolling in Medicare should pay careful attention to choosing an appropriate plan. And your clients should be informed that individuals who fail to enroll in Medicare during their Initial Enrollment Period may have to pay a lifelong penalty once they do enroll. The penalty is an additional 10% added to the Part B premium for every full year of delay.

Planning for Medicare and related health care costs should be a serious consideration for all older adults and their financial professionals.

[1] KFF analysis of Centers for Medicare & Medicaid Services 2016 Medicare Current Beneficiary Survey (2019 update).
[2] "Social Security and Medicare Lifetime Benefits," Urban Institute (2018 update).

Understanding Medicare

Enrollment if living overseas

While there is no requirement to do so, Americans living abroad should sign up for Part A because it's usually premium-free. Although doctor and hospital costs incurred in foreign countries are *not* reimbursed, enrollees will receive Part A coverage if they visit the United States or move back permanently.

Those who plan to move back to the U.S. at some point should consider the timing of their plans and do the math. For example, someone who plans to be gone for only two years may choose a 20% late enrollment penalty over paying for Part B for the 24 months they're away. Someone else, who plans to be away for 10 years or more, would be facing a 100% penalty for late enrollment — doubling their Part B premium.

There may also be concerns about trying to obtain a Medigap policy at a later date, when there is no guaranteed issue right. Learn more about Medigap on p.6.

Who's eligible?

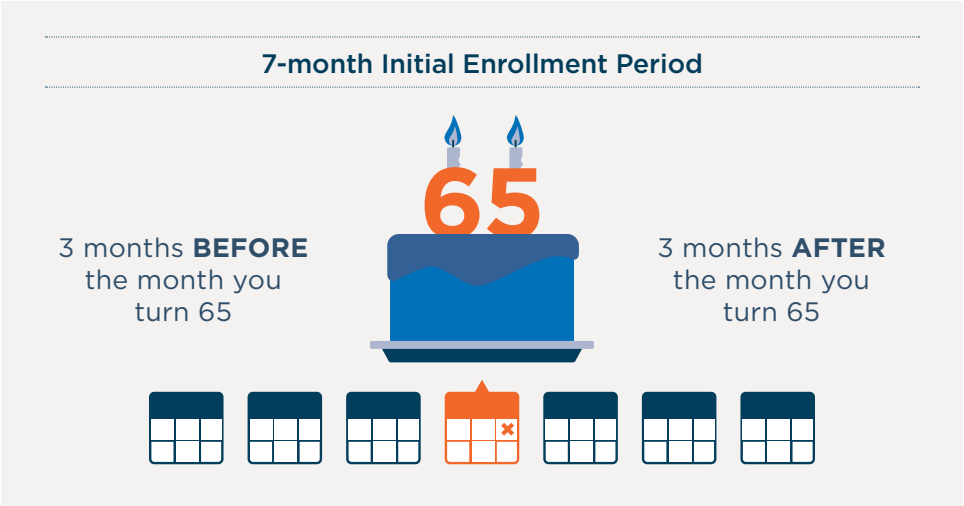
Generally speaking, individuals age 65 or older may enroll in Medicare if they have qualified to collect Social Security benefits, are a citizen, or have been a permanent resident for at least five years. And even though they may not receive Social Security benefits, public sector employees also qualify, though the rules may be somewhat different in terms of enrollment and payment, depending on the amount of time they worked in a governmental job.

People under age 65 can apply for Medicare if they have a qualifying disability or one of two diseases: ALS, also known as Lou Gehrig's disease, or end-stage renal disease.

When should your clients enroll?

If the individual is collecting Social Security benefits, they will automatically be enrolled in Medicare Parts A and B starting the first day of the month they turn 65 — unless their birthday *is* the first of the month, in which case, their Medicare coverage will begin on the first day of the *previous* month. These auto-enrolled people will receive a "Welcome to Medicare" packet three months before they turn 65, and it will have information about additional steps they need take.

If the person is not collecting Social Security benefits when they become eligible for Medicare, they have a seven-month period to sign up, known as the **Initial Enrollment Period.**



Those who miss the Initial Enrollment Period may have to pay a permanent, lifelong penalty in addition to their Part B premium. The penalty is 10% of the premium for each full year of delay.

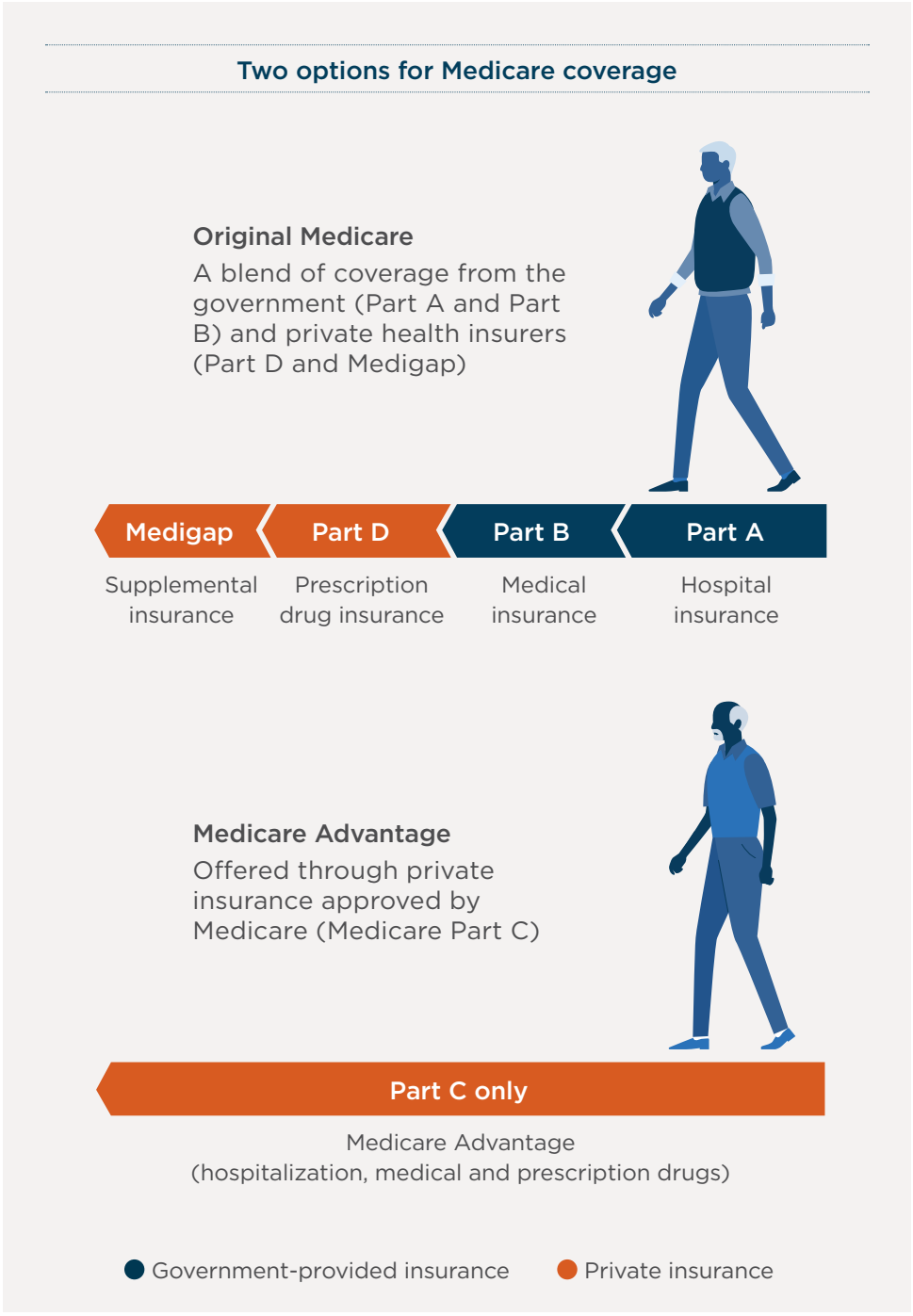
There is an exception to the penalty, if an individual is still working and covered by their employer plan when they turn 65. When that person (or their spouse, if it was the spouse's coverage) retires, is laid off or leaves their employer, a **Special Enrollment Period** (SEP) goes into effect after employee coverage stops. Applicants have eight months to enroll in Original Medicare or two months to enroll in a Medicare Advantage plan.

People who don't sign up for Medicare Parts A and/or B when first eligible, and who do not have a Special Enrollment Period, can enroll in any later year during the **general enrollment period**, January 1 through March 31.

There's also an **annual enrollment period,** in which a person can change their Medicare health or prescription drug coverage, from October 15 through December 7 each year.

Two coverage choices

Enrollees must choose one of two major options for Medicare coverage, and then they must make additional selections. Both of the options offer coverage for the same core services, and both come with monthly premiums, deductibles, and co-payments and/or co-insurance.



Option 1 is Original Medicare

It consists of two parts administered by the government:

Part A covers hospitalization (inpatient care)

Part B is for doctor visits (outpatient care)

Often added are two elective parts that are purchased from private health insurers:

Part D provides prescription drug coverage

Medigap supplemental insurance pays for the out-of-pocket costs on Medicare-approved services

With the Original Medicare option, Medicare beneficiaries may visit any doctor or facility in the United States that accepts Medicare patients.

Option 2 is Medicare Advantage

This is also known as Part C. This choice is offered by private health insurance providers who are approved by the government. These are usually health maintenance organizations (HMOs) or preferred provider organizations (PPOs). As such, they usually have a list of in-network doctors, and the coverage may be limited to a specific geographic region.

To choose Medicare Advantage, an individual first has to enroll in Original Medicare to obtain their Medicare number. Then they can initiate the switch.

Original Medicare coverage and costs — Part A

Original Medicare has clearly defined benefits. Part A covers inpatient services, which are:

- Inpatient care at a hospital
- Skilled nursing facility care for up to 100 days following a three-night (or longer) admittance to a hospital
- Hospice care
- Home health care — but only when certain conditions are met and certified by a physician; otherwise, Medicare typically will not cover the expense of long-term care in the home

Part A may require a premium if the enrollee has not worked for long enough (Medicare taxes are deducted from paychecks). While people file for Medicare as individuals, when it comes to Part A premiums, a spouse's work history may be used to determine the price.

In 2021, Part A is:

- **Premium-free** for those who worked 40 calendar quarters or more (10+ years)
- **$259 per month** if they worked 30 to 39 quarters (7.5 to 10 years)
- **$471 per month** if they worked fewer than 30 quarters (7.5 years)

Part A also has a deductible and co-payments (per benefit period):

- Hospital deductible: $1,484
- Daily hospital co-payments:
  - $0 for first 60 days of inpatient care
  - $371 per day for days 61 – 90
  - $742 per lifetime reserve day after day 90
- Daily skilled nursing facility co-payments:
  - $0 for first 20 days of inpatient care
  - $185.50 per day for days 21 – 100

Key terms

Benefit period: The period of time that starts the day a beneficiary begins getting inpatient care and ends when they have not received inpatient hospital or skilled nursing facility care for 60 days in a row.

- It's possible to have more than one benefit period in a single calendar year
- There is no maximum out-of-pocket (MOOP) for these expenses, but a Medigap policy would cover them

Lifetime reserve days: 60 nonrenewable days that kick in after day 90 of a hospital stay.

- After the 60 days are used up, the beneficiary is 100% responsible for hospital expenses

Original Medicare coverage and costs — Part B

Part B covers outpatient care, which is:

- Doctor and physician services
- Ambulance services
- Durable medical equipment
- Outpatient services
- Preventive benefits:
  - Annual wellness visit
  - Mammograms
  - Bone mass testing
  - Screenings for cancer, cardiovascular disease and diabetes, among others

There are three categories of costs with Part B (2021 figures):

- Monthly premium: $148.50 (see Medicare surcharges, p.7)
- Annual deductible: $203
- Co-insurance: 20% of the Medicare-approved cost for covered services

As with Part A, there is no maximum on Part B out-of-pocket costs, but a Medigap plan would cover those.

Original Medicare add-on coverage and costs — Part D

Part D is an optional add-on to Original Medicare and is provided by private insurers. Part D covers prescription drugs, and the lists of approved drugs vary by plan. What an individual pays for Part D will depend on the plan they choose.

Plan premiums and formularies can change annually, so it's wise for beneficiaries to review them every year to ensure the Part D plan they've chosen is still the best one for them.

Those with large drug expenses may run into a Part D coverage gap, also known as the "donut hole." In 2021, the coverage gap begins once a person has spent $4,130 on covered drugs. During the gap, they pay no more than 25% of the cost for covered drugs until they've spent $6,550 out-of-pocket. At that point, they qualify for "catastrophic coverage," and there is only a small co-insurance amount or co-payment for the rest of the year.

Original Medicare add-on coverage and costs — Medigap

Medigap is private insurance that supplements Original Medicare and helps cover out-of-pocket costs, such as the deductibles, co-payments and co-insurance required under Parts A and B. Most Medigap policies will cover those out-of-pocket costs only if they were incurred on services approved by Parts A and B. Note that Medigap plans do not cover the Part D "donut hole" costs of prescription drugs.

There are 10 Medigap plans, though only eight are available to people new to Medicare. The various plans are offered by different insurance companies. Not every provider offers every plan, but the coverages are consistent from provider to provider. Medigap plans have letters for names but they should not be confused with Medicare Parts A, B, D or C.

There is a guaranteed issue right for six months after enrolling in Medicare, for 63 days after loss of other coverage, or within 12 months of trying out a Medicare Advantage plan. That means that even if an individual has pre-existing conditions, they cannot be denied Medigap coverage during these windows. If they wait longer, however, they could be charged more or denied altogether.

This chart shows what each plan covers. Monthly premiums will vary from company to company, so clients may want to shop around for providers after choosing the plan they want.

Medicare Supplement Insurance (Medigap) Plans

	A	B	C	D	F[3]	G[3]	K	L	M	N
Part A co-insurance and hospital costs	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Part B co-insurance or co-payment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%[4]
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care co-insurance or co-payment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care co-insurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
Out-of-pocket limit in 2021[5]	N/A	N/A	N/A	N/A	N/A	N/A	$6,220	$3,110	N/A	N/A

As of Jan. 1, 2020, Plans C and F are not available to people who are newly eligible for Medicare.

Note that clients who live in Massachusetts, Minnesota or Wisconsin will find that Medigap policies are standardized in different ways. A good resource for clarity in any state is the State Health Insurance Assistance Program (SHIP) office.

Medigap plan pricing

Medigap policies can be priced or "rated" in three ways:

1. **Community-rated** (or "no-age-rated"), which means that everyone enrolled in the same plan in the same area pays the same premium. Premiums may go up due to inflation but not due to age.

2. **Issue-age-rated** (also called "entry-age-rated"), meaning that the price is determined by the client's age when they buy the policy. Premiums may go up due to inflation but not due to age.

3. **Attained-age-rated**, which means that premiums are low for younger buyers but go up as people age. For someone who lives a long time, these premiums can eventually become the most expensive. They are also subject to inflation increases.

[3] Plans F and G also offer a high-deductible plan in some states.
[4] Plan N pays 100% of the Part B co-insurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for some emergency room visits.
[5] Plans K and L have an out-of-pocket yearly limit.

Possible additional costs

Affluent people may have to pay surcharges on their Medicare Part B and D premiums. These are the Income-Related Monthly Adjustment Amounts (IRMAA), which are determined every year by a Medicare beneficiary's modified adjusted gross income (MAGI) from two years earlier. In 2021, a person's IRMAA is determined by their 2019 MAGI.

Income-Related Monthly Adjustment Amount (IRMAA)				
2019 individual income (MAGI)	Married income (MAGI)	Part B	Part D	Total monthly surcharges
$88,000 or less	$176,000 or less	$148.50	Plan premium	N/A
$88,001 – $111,000	$176,001 – $222,000	+ $59.40	+ $12.30	$71.70
$111,001 – $138,000	$222,001 – $276,000	+ $148.50	+ $31.80	$180.30
$138,001 – $165,000	$276,001 – $330,000	+ $237.60	+ $51.20	$288.80
$165,001 – $499,999	$330,001 – $749,999	+ $326.70	+ $70.70	$397.40
$500,000 and above	$750,000 and above	+ $356.40	+ $77.10	$433.50

Source: medicare.gov (November 2020).

For many, keeping MAGI down becomes and remains a goal starting when they approach age 63. (At the same time, there may be other considerations that diminish the importance of this issue.) For example, if a client is exceeding these IRMAA thresholds due to Roth conversions, they may want to discontinue that activity two years before Medicare eligibility. Also, future income boosts from Social Security benefits and required minimum distributions should be anticipated.

Note that the thresholds for single people are much lower. In the case of one member of a couple passing away, the ongoing income may push the remaining spouse into a higher Medicare surcharge.

What's not covered by Original Medicare

There are a number of important services that are not covered by Parts A and B:

- Most dental care
- Most vision care
- Routine hearing care, including hearing aids
- Most foot care
- Most long-term care
- Most alternative medicine
- Most care received outside the U.S.
- Most nonemergency transportation

Because these are not Medicare-approved services, a Medigap policy won't cover associated out-of-pocket expenses. These gaps in coverage are why many enrollees decide against Original Medicare and go with a Medicare Advantage plan instead — though doing so may only gain coverage for some of these services.

A closer look at long-term care

Long-term care provides assistance with the type of tasks that someone used to do on their own but now, due to frailty or dementia, cannot do without help. These activities of daily living are usually supported at first by family members or neighbors. If provided by professional caregivers, the costs can quickly add up and pose a risk to a client's portfolio.

Unfortunately, this type of custodial or long-term care is not covered by Original Medicare or Medigap. Some Medicare Advantage plans offer coverage for "in-home support services," but it's critical to read the fine print to understand the limitations of that coverage. It is typically not for comprehensive long-term care.

Medicare Advantage plans — Part C

An alternative to Original Medicare Parts A and B (plus Part D and Medigap, if chosen) is a Medicare Advantage plan (also called Part C). There are many Medicare Advantage plans in the marketplace, and they are required to cover everything that Original Medicare Parts A and B cover. Most also offer coverage for prescription drugs. Some plans cover additional services, such as hearing, vision, dental and more. Co-payments vary by service, and in many cases, these co-pays may be lower than the 20% co-insurance of Original Medicare. The premiums may be lower, too.

The Medicare Advantage option does put a lot of coverage into one plan, but there are lifestyle issues to consider — particularly travel plans in retirement. Medicare Advantage plans often have a limited network of approved medical providers (except for urgent or emergency care), and that network could have a limited geographical footprint.

If cost is not an issue, Original Medicare plus Medigap offers the *most flexibility*. But for those who don't intend to travel much or do want additional services, Medicare Advantage may be a *better value*.

Solutions for uncovered costs

By taking advantage of Medigap insurance and Medicare Part D (drug coverage) or by enrolling in Medicare Advantage, a retiree can cover the bulk of his or her health care costs. But as we have seen, some costs may still be uncovered. Fortunately, financial professionals can take steps to address this.

Permanent life insurance

To cover health care expenses, financial professionals may want to suggest a permanent life insurance policy. In addition to providing a death benefit, these policies accumulate a cash value that may be borrowed or withdrawn and used for any purpose.

Products that can lower MAGI

If a client pays surcharges on Parts B and D, lowering their MAGI could help reduce or eliminate those surcharges. Investment accounts that can lower MAGI include life insurance, nonqualified annuities, Roth IRAs, health savings accounts and longevity insurance.[6]

Long-term care coverage

As we noted above, long-term care is one of the biggest threats to their estate that many retirees will face. Unfortunately, the options for covering this expense are limited. Original Medicare offers some coverage for skilled nursing facility care, but not for the custodial services that constitute long-term care.

Note that Medicaid (a different government program) covers long-term care expenses for some people, but it is not a realistic solution for most individuals. To qualify, a retiree must spend down his or her assets to just $2,000 — and have an annual income near or below the federal poverty level. Alternatively, the retiree must have transferred his or her assets to an irrevocable trust five years earlier.

While long-term care coverage is an option for most retirees, thinking about potential long-term care costs can help retirees be better prepared. But it can be difficult to know where or how to estimate these costs. Nationwide's Health Care/Long-Term Care Cost Assessment can help you with this challenge.

[6] "Understanding the Impact of Modified Adjusted Gross Income on Retirement Health Care Costs," HealthView Insights, HealthView Services (2014).

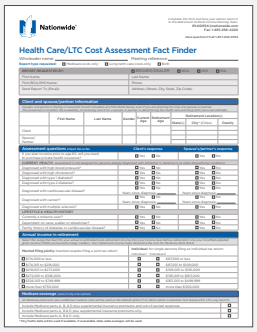
Next steps

Your younger clients may not be ready for a Medicare enrollment discussion, but it may still be a good time to introduce the topic of planning for health care expenses in retirement. For those closer to Medicare enrollment age, you can serve as their trusted source for guidance on Medicare.

Nationwide can assist by offering unbiased, user-friendly resources, allowing you to focus on enhancing your client relationships and further refining their holistic retirement income plans.

Clients in their 50s

1. Talk with your clients about expected health care expenses, and ask them to complete a Health Care/Long-Term Care Cost Assessment Fact Finder.
2. Use the results from your clients' personalized HC/LTC Cost Assessment report as a planning opportunity:
   - > Discuss reducing MAGI as they get closer to retirement
   - > Use Nationwide's Quick Quote tool to identify solutions that can help them cover health care and long-term care costs
   - > Gain an understanding of your clients' desired lifestyle in retirement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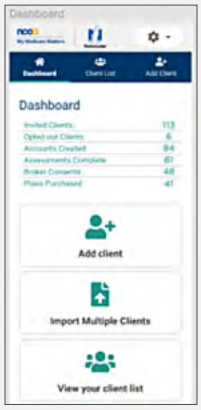
Health Care/LTC Cost Assessment Fact Finder

Clients approaching age 65

1. Discuss Medicare options and enrollment to assess client readiness.
2. Assess where your clients may need more detail, and offer Nationwide's client guides on various Medicare topics.
3. Provide a link to the National Council on Aging's My Medicare Matters® tool brought to you by Nationwide.
4. Share Nationwide's "Questions to ask before enrolling in Medicare" guide to have on hand when they talk with a Medicare broker.



For additional consultation, contact the Nationwide Retirement Institute Planning Team at **1-877-245-0763**.

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