2013

CPA's Guide to Financing Retirement Healthcare

American Institute of Certified Public Accountants. Personal Financial Planning Section

AICPA® Personal Financial Planning Section

The CPA's Guide to **Financing Retirement Healthcare**

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For more information and education on many of the topics covered in this publication, visit the PFP Web seminar archive, Forefield Advisor, Advanced PFP Conference recordings, and the AICPA PFP Section homepage (www.aicpa.org/pfp).

Acknowledgments

The AICPA Personal Financial Planning (PFP) Division would like to take this opportunity to acknowledge the individuals and organizations that provided their expertise to make *The CPA Adviser's Guide to Financing Retirement Healthcare* a beneficial tool for all practitioners.

James Sullivan, CPA/PFS

Jim has been a personal financial planner and investment manager for almost 30 years. He spent 20 years at Arthur Andersen before beginning his own practice. His practice focuses primarily on seniors – those about to retire or already retired. Jim provides investment management services through *Core Capital Solutions, LLC*. His special emphasis is on planning for health care costs after age 65. He has written over 50 articles on a variety of retirement planning topics. He also writes a monthly column on aging for the AICPA newsletter, CPA *Insider.* Jim serves on the Board of ESSE, a not for profit organization that provides adult day care services for Alzheimer Disease patients in the suburbs of Chicago. He is also on the Executive Board of Consumer Debt Counselors, Inc., a not for profit debt counseling agency. His three children (Emmy, Danny and Becca), his wife Janet and a Beagle named Molly keep him busy. By the way, special thanks to Janet for her critical reading of all his first drafts – she improves everything he does.

AICPA PFP Executive Committee Elder Planning Task Force

The Elder Planning Task Force provided the technical review of this guide. The task force is committed to identifying and educating CPA financial planners on the issues and decisions that face the public as it gets older. A special thanks goes to the following task force members:

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Preface

This guide is designed by CPAs for CPAs. The intent of this guide is to provide an overview of the resources available to clients as they consider how they will pay for their healthcare costs during retirement. Although many resources are available that provide Medicare facts or advice, including those from the Social Security Administration (SSA), few are oriented toward professionals seeking to offer guidance to clients. The CPA trusted adviser is in a unique position to assist his or her clients with the financial decisions relating to healthcare choices because of his or her unique understanding of a range of personal financial planning concerns, including taxation. Many clients of the Baby Boom generation will be retiring in the next 20 years and will be looking to CPAs to assist them in optimizing their healthcare financing during retirement. The authors of this guide hope you will find this handbook a valuable tool to use in giving advice on Medicare benefits and issues that arise with healthcare-related decisions.

How to Use This Guide

This guide is meant to be a practical resource that blends information and planning guidance in a way that, as it is read, allows the adviser to "hear" his or her clients asking related questions. Refer to the text boxes that include actual client concerns and the adviser's response to prepare for your clients' questions. You will also find plainly stated information, with references to SSA publications for more details. Look for the following icons to help you use the information in this guide:

 The light bulb icon indicates important planning tips.

 The search icon alerts you to information on where to find for additional information on the topic being discussed.

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Chapter 1
The Scope of the Problem and Extent of the Opportunity

From the day a client turns age 65 to the date of his or her death, he or she will incur significant health care costs. This guide will focus on how to plan for and finance these costs.

CPA planners must understand how to assist clients with meeting the challenge of paying for health care costs after age 65. This valuable service represents a significant business opportunity for CPA planners, as on average, 10,000 baby boomers turn age 65 each day.

In a March 2011 study[1], two of the four issues identified as threatening even the best-prepared retiree were the impact of access to health care coverage on retirement decisions and the impact of long-term care costs.

For these reasons, advisers must work closely with clients to identify how they will finance their health care needs after age 65.

The opportunity for CPA planners, however, is not just with those clients ages 65 and over. Younger clients, still years away from Medicare eligibility and retirement, also need to plan carefully to meet these costs.

CPA planners can use age 65 as a starting point, because it is the age at which the vast majority of individuals become eligible for Medicare. The topic, however, is much broader than just Medicare because health care costs for those ages 65 and older are paid for from a variety of sources. Medicare was never designed to be an all-encompassing health insurance plan for beneficiaries. In addition, the growing number of individuals delaying their retirement to after age 65 has made the topic more complex. The CPA planner must understand how the primary and secondary payer rules apply to a Medicare beneficiary who still participates in an employer provided health plan.

Health care costs incurred after age 65 will vary tremendously from client to client. Much of this variation will be due to the client's health. As discussed subsequently, a client with good health does not necessarily mean that he or she will have lower health care costs. Another contributing factor is the cause of death. Modern medicine has extended life expectancy, but the added years often come at a high cost and most of these costs are not paid for by Medicare. It is important to understand how the health care decisions clients face directly affect the planning process.

[1] Scripps Gerontology Center, Miami [Ohio] University, and the MetLife Mature Market Institute, *Best-Case Strategies for a Flexible Retirement*, February 2011

All Seniors Face Higher Health Care Costs

For most people, aging brings declining health and higher health care costs. A recent Urban Institute Study estimates that "the share of adults age 65 and older spending more than a fifth of their household income on health care—a common measure of burdensome costs—will increase from 18 percent in 2010 to 35 percent in 2030 and 45 percent in 2040. Recently, Medicare premium increases have outpaced Social Security cost-of-living increases"[2]. These increases make it especially tough on seniors living on a fixed income. Recall, however, that Medicare represents only one component of health care coverage for seniors. Medicare does not cover the costs of vision or hearing care or the custodial costs of long-term care and, surprisingly, good health does not translate into health care cost savings.

Clients reaching age 65 in good health can expect to face *greater* out of pocket health care costs than comparable unhealthy individuals. Although seemingly counterintuitive, the reason is obvious: unhealthy individuals will most likely die at younger ages using less in overall health care resources. Healthy individuals will live longer but still face the costs of the inevitable decline in health that accompanies aging. According to a recent study, the present value of the cost of health care for a healthy couple is $265,000 after age 65; for a couple with one or both suffering from a chronic illness, the cost is $220,000.

For women, the urgency of planning for post–age 65 health care costs is even greater than for men because a woman's lifetime health care expenditures are much higher than for a man. This difference is primarily due to a woman's longer life expectancy. In addition, women are particularly affected by the cost of long-term care because they

1. are often the caregiver, which imposes both physical and financial costs.
2. live longer than men.
3. are more likely to die single after providing care to their husband.

For women, the average long-term care costs are $124,000; for men, $44,000[3].

A CPA planner will have to carefully consider rising health care costs when meeting with his or her clients. To better understand the health care costs that individuals can incur, the following paragraphs will consider various causes of death.

How Do People Die?

How do people die? This brings up a topic that few CPAs want to think about, but the question has a purpose. By understanding how your clients may die, you can better educate them on what to expect in terms of the health care costs they may incur.

[2] Urban Institute, *Will Health Care Costs Bankrupt Aging Boomers?*, 2010
[3] Scripps Gerontology Center, Miami [Ohio] University, and the Mature Market Institute, *Women, Retirement, and the Extra-Long Life*, September 2011

For many clients, the increase in life expectancy that began in the early 1900s means an extended period of illness and frailty—the costs of which can be very high. In his book, *My Mother, Your Mother,* Dennis McCullough, M.D., a geriatrician, writes, "Diseases that once ended lives relatively quickly have been changed into chronic illness, chronic debilitation, and extended years of decline."

Although people hope to die peacefully in our sleep at an advanced age, this rarely happens. The following table summarizes causes of death:

Cause of Death	***Comment***	***%***
Frailty or dementia	The "slow dwindling" is represented by frailty and dementia (most likely, dementia of the Alzheimer's type). This can be the costliest illness due to the need for custodial care. It is also the least likely to be paid for by Medicare. More than 50% of those age 85 and older will develop Alzheimer's disease.	45%
Cancer	Cancer typically results in a relatively short period of decline. Death from cancer peaks at age 70.	22%
Heart and lung failure	Heart and lung (and other major organ system failure) presents with intermittent exacerbations, meaning the patient will often rally for a time and get better. Death from this cause peaks at age 80.	16%
Sudden accident	-	7%
Other	-	9%

Source: Joanne Lynn, M.D., *Sick to Death and Not Going to Take It Anymore.*

Planning for Care

As mentioned previously, this guide focuses on how CPA planners can advise clients to plan and pay for health care costs after age 65, in particular which plan pays for which costs and how much of the costs may have to be paid for out of pocket. In reality, the demarcation lines of payment between the various plans are not so clear, in part due of the nature of the U.S. health care system. Because care is often cobbled together from many different health care providers with little (if any) coordination of care, complicated cases can lead to a seemingly insurmountable and confusing mountain of paperwork.

Imagine how much more difficult it is for the elderly, who sometimes can be too frail or cognitively impaired, to navigate the health care system unless they have a knowledgeable spouse or other family member willing to provide assistance. Even with the assistance of well-meaning family members, it is difficult to properly plan for the costs of acute or chronic illness. Many family members simply become overwhelmed trying to find suitable care for their loved one and simultaneously trying to manage their

family member's finances. Mistakes are made, planning opportunities are lost, and the caregivers become more overburdened.

Increasingly, many individuals and families will seek out the assistance of a financial planning professional. CPA planners can provide assistance in planning for health care costs of and understanding how these costs are paid. This represents tremendous value to clients and their children as their client's age. With this knowledge, CPA planners can meet the needs of an aging population and expand their client base by establishing relationships with children of clients and health care providers.

The official Medicare website, www.medicare.gov, contains useful information for CPAs and their clients. For example, at www.medicare.gov/Publications/Search/SearchCriteria.asp, clients can select a specific publication or may click on "View all Publications" for a comprehensive list of publications.

Chapter 2
An Overview of Medicare

Traditional, or original, Medicare is a program of health insurance provided for those age 65 and older or, if younger, those entitled to Social Security disability benefits. Medicare is a federal government program administered through the Centers for Medicare and Medicaid Services (CMS). It is funded through a combination of payroll taxes and general revenues of the Federal government.

Older, as well as disabled, Americans are eligible for Medicare coverage regardless of income or assets.

Traditional Medicare is a *basic* program of health insurance. It includes annual deductibles and copayments, as well as benefit limits on certain types of health care procedures and equipment.

Medicare was never designed to pay all the health care costs incurred by participants. For example, Medicare is prohibited by statute from paying for custodial care except for hospice services. Services covered must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Traditional Medicare also does not cover routine vision and hearing care.

Another major shortcoming of Medicare is that it has no annual out-of-pocket limits. In other words, no limit exists on the amount of the participant's share of the cost he or she may be required to pay during the year. These and other "gaps" in Medicare coverage can be filled with *Medicare Supplement* or "Medigap" plans sold by private insurance companies but regulated by CMS and the states in which they are sold.

As an alternative to choosing traditional Medicare, participants may elect a Medicare Advantage (MA) plan (also referred to as a Medicare Part C plan). MA offers a variety of plans, including managed care options (also referred to as coordinated care options). MA was added to allow private insurers, under the guidelines and authority of CMS, to package equivalent or better benefits in various plans. As of 2012, approximately 27 percent of all Medicare recipients use these plans, with significant regional variations.

Medicare coverage begins on the first day of the month the applicant turns age 65. For an applicant born on the first of the month, coverage will begin the month prior to the month in which he or she turns age 65. Unlike the Social Security program, which offers a reduced early benefit at age 62, there is no early Medicare benefit unless the applicant is disabled.

Eligibility for Medicare is tied to an individual's eligibility for Social Security benefits—40 quarters of work credits are required to be fully insured. Those without 40 quarters of work credit, however, may be fully insured based on their spouse's work history. If an individual is not eligible for Social Security, he or she is not eligible for Medicare. For that reason go to www.ssa.gov for more information on eligibility especially as it relates to eligibility for both programs based on the work record of a spouse. Divorced spouses can qualify for both Social Security and Medicare based on the work record of their ex-spouse.

PLANNING TIP: A client may qualify for both Social Security benefits and Medicare based on his or her spouse's work record even though he or she never worked in a job covered by the Social Security program. For example, many teachers were not covered by the Social Security program during their careers. Upon retirement, they did not have sufficient quarters of work history to qualify for Medicare. They may, however, qualify based on their spouse's work history.

PLANNING TIP: If a client is considering making an election to choose the reduced Social Security benefit at age 62, be sure to discuss his or her need for health insurance until he or she qualifies for Medicare at age 65.

For more information on eligibility and enrollment on the Medicare website, see www.medicare.gov/navigation/medicare-basics/eligibility-and-enrollment.aspx. For information on a spouse's work record and eligibility for Medicare, go to www.ssa.gov. SSA Publication No. 05-10043, *Medicare*, has information on a divorced spouse's eligibility for each program.

Basic Benefit Structure

Traditional Medicare is a *fee for service* plan; that is, as long as a health care provider accepts Medicare, the participant may use its services. Unlike a managed care plan, participants do not need "pre-approval" before setting an appointment nor do they need to worry whether or not the health care provider is part of a "network."

Traditional Medicare is composed of three parts:

Part	***What It Covers***
Medicare Part A: Hospital Insurance	Inpatient care in a hospital, skilled nursing facility, hospice, and home health care.
Medicare Part B: Medical Insurance	Covers doctor services and outpatient care, some preventive services, and medical equipment (wheel chairs, walkers, and so on)
Medicare Part D: Prescription Drug Insurance	Prescription drug programs offered through private insurance companies. Plans must be approved by the Centers for Medicare and Medicaid Services.

Medicare Part C plans, or MA plans, offer a variety of plans, including managed care options. Private insurers and health care organizations contract with CMS to offer the plans. Plans offered include health maintenance organizations and preferred provider organizations. Also available are Special Needs Plans for the chronically ill and a private fee for service option. Participants electing MA plans are still enrolled in Medicare and pay the Medicare Part B premium (and Medicare Part A if there is not a sufficient work history). The health care services are provided through the private plan, while the MA plan company is paid a fee from CMS for providing coverage. MA plan participants do not need to purchase a Medigap plan. Many, but not all, MA plans offer a prescription drug feature (known as MA-PD plans), which makes it unnecessary for the participant to choose a Medicare Part D plan. MA plans vary in their popularity around the country.

Chapter 3
Traditional Medicare Enrollment

Enrollment in Medicare is administered through the Social Security Administration (SSA). There is no local Medicare office to go to; rather, if issues regarding coverage or enrollment come up, a participant may need to go to his or her local Social Security office for resolution.

An *eligible* individual becomes *entitled* to coverage after the application process is complete. An application for coverage may be filed as early as the third month before the month in which the applicant turns age 65 (for example, if the individual's birth month is May, he or she may file as early as February 1). In the past, when the full retirement age (FRA) for the Social Security program was 65, application for Social Security benefits and enrollment in Medicare took place simultaneously. Now, with the FRA at age 66 for those born on January 2,1943, through January 1, 1955, and waiting to apply for their full Social Security benefits, they must remember to enroll in Medicare the year before when they had turned age 65.

Clients can apply for Medicare coverage online rather than by going to a local Social Security office. See www.medicare.gov and SSA Publication No. 05-10530, *Apply Online For Medicare—Even If You Are Not Ready to Retire*, available at www.ssa.gov/pubs/10530.html, for more information. Enrollment via phone is also available by calling 1.800.772.1213.

Traditional Medicare consists of Part A (hospital insurance) and Part B (medical insurance). Together they provide participants with basic protection against high health care costs. There are, however, several differences between the two parts, as provided in the following table.

Category	**Medicare *Part A* *(Hospital Insurance)***	**Medicare *Part B* *(Medical Insurance)***
Enrollment	Enrollment is mandatory if an individual is receiving Social Security payments. An individual cannot decline Medicare Part A coverage unless he or she gives up Social Security benefits. This mandatory coverage is being challenged in the courts (see *Hall v. Sebelius*).	Enrollment is voluntary.

Category	**Medicare *Part A*** ***(Hospital Insurance)***	**Medicare *Part B*** ***(Medical Insurance)***
Cost	There is no cost, regardless of income or assets, for individuals with sufficient work credit or those who are eligible due to a spouse's work history. If an individual has no quarters of coverage and is not covered by a spouse's work history, he or she will pay $441 per month in 2013 for coverage under Medicare Part A. For those with some work history, but less than 40 quarters, the monthly premium is reduced.	For new enrollees, the monthly premium in 2013 is $104.90, but it increases if the individual's or couple's income is higher than certain thresholds. A penalty is added if the individual delays enrollment beyond his or her initial enrollment period.
Funding	Medicare Part A is financed solely through a payroll tax on employers and employees.	Medicare Part B is financed through the monthly premiums paid by participants and from general revenues of the federal government.

ACTUAL CLIENT CONCERN: I will become eligible for Medicare in 2 months when I turn age 65. I'll be retiring and will lose my group health insurance coverage. My spouse is 58 1/2. I know that she will be eligible for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage and may remain on the group plan for 18 months. But at that time, she will be just under 60 years old. What alternatives will she have for health insurance coverage after COBRA coverage ends?

ADVISER RESPONSE: She may apply for an individual health care insurance plan. In many states, however, the insurance companies may refuse to issue a policy due to a pre-existing condition. (Some states require insurance companies doing business in their states to offer *guarantee issue policies*, but such policies can be very expensive.) If your wife cannot find coverage, she will want to determine if a high risk pool insurance plan is available in your state. Such plans will issue policies to individuals unable to find coverage. For more information, see http://nahu.org/consumer/HRPGuide.cfm. The Patient Protection and Affordable Care Act created the Pre-Existing Condition Insurance Plan for individuals who are unable to find health care insurance due to a pre-existing health condition. Unfortunately, it requires an applicant to have been without health insurance coverage for 6 months prior to applying in addition to having a pre-existing condition or having been previously turned down for health insurance.
For more information, see www.healthcare.gov/law/features/choices/pre-existing-condition-insurance-plan/index.html.

ACTUAL CLIENT CONCERN: If my wife has never worked outside our home, and she turns 65 before I do, can she get Medicare at age 65? Or, does she have to wait until I turn age 65 and am on Medicare?

ADVISOR RESPONSE: If you are *at least age 62* and have worked for at least 10 years in Medicare-covered employment, your spouse can get Medicare Parts A and B at age 65. If you have worked at least 10 years in Medicare-covered employment but are not yet age 62 when your spouse turns age 65, he or she will not be eligible for premium-free Medicare Part A until your 62nd birthday. In this case, your spouse should still apply for Medicare Part B at age 65 so that he/she can avoid paying a higher Part B premium. However, if you are still working and your spouse is covered under your group health plan, she could delay enrollment in Part B without paying higher premiums.

(Adapted from Frequently Asked Questions at www.medicare.gov).

Automatic Enrollment and the Initial Enrollment Period

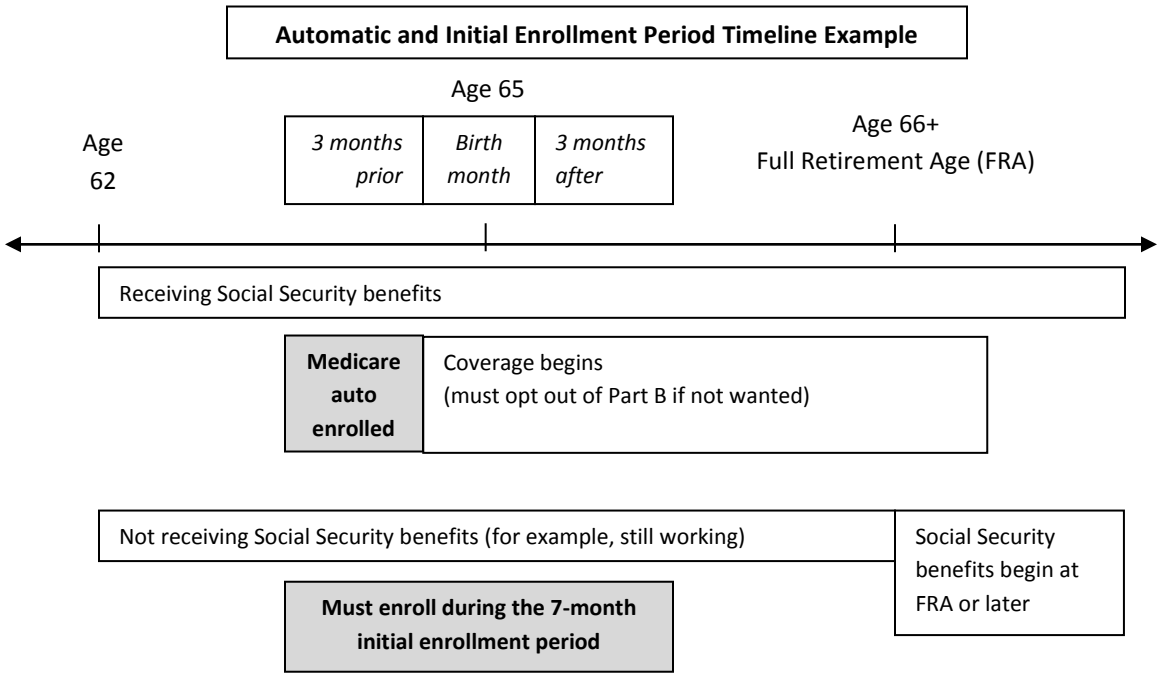
If an individual is already receiving Social Security retirement payments or disability benefits, he or she is automatically enrolled in Parts A and B. This also applies to a widow(er) receiving survivor benefits. According to Medicare, individuals will receive their Medicare information (including the claim number) in the third month prior to their birth month. The information, however, has been known to arrive in the month just prior to the birth month. This automatic enrollment occurs even though Medicare Part B is voluntary.

PLANNING TIP: As a precaution, alert clients under the age of 65 who are receiving Social Security benefits to check their mail for Medicare information from the SSA 1–3 months prior to their 65th birthday.

PLANNING TIP: If a client wishes to decline Medicare Part B, he or she must sign and return the form that will be included in the material mailed to them.

The FRA at which a Social Security participant is entitled to his or her full monthly benefit has been slowly increasing over the years. It is now age 66 for those born between January 1, 1943, and January 2, 1955. This means many Medicare eligible individuals will not be receiving Social Security payments when they turn age 65 and will not be automatically enrolled in Medicare Part A or Part B. These individuals will have to proactively enroll in Medicare during the initial enrollment period (IEP).

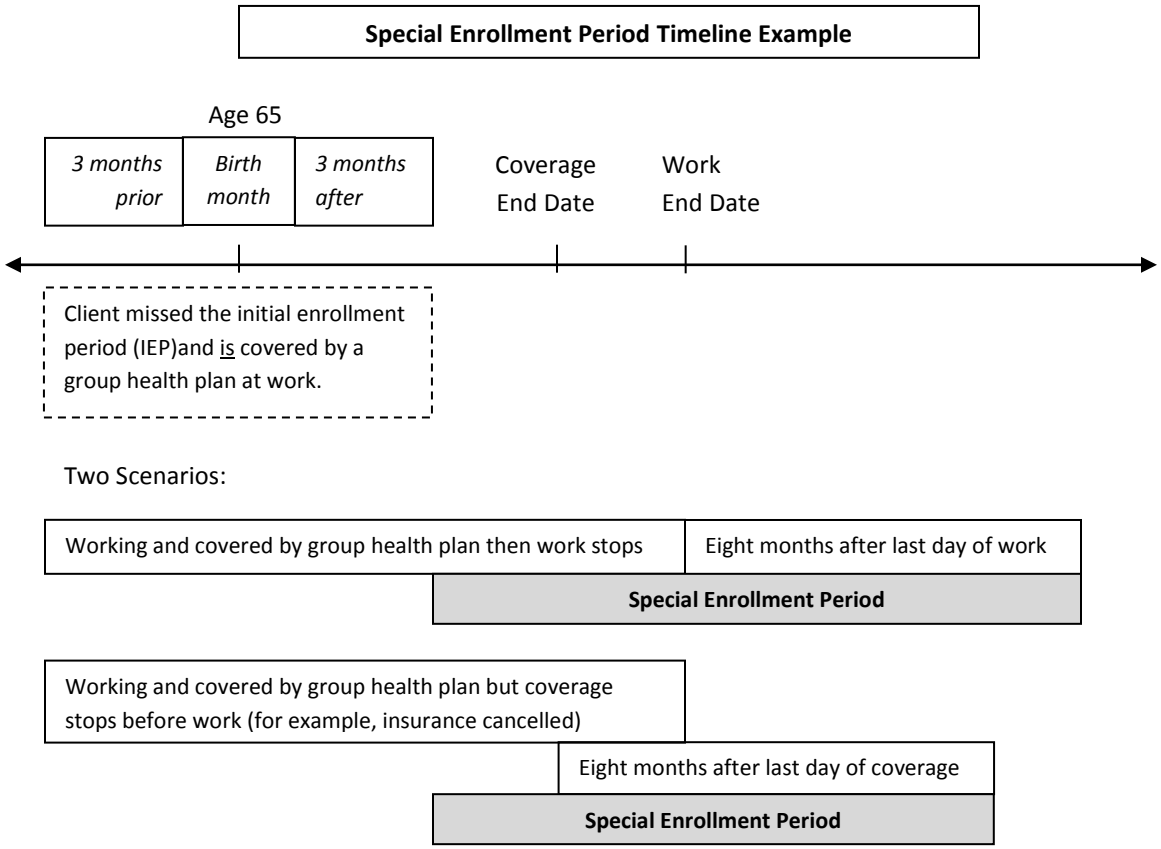
PLANNING TIP: The IEP is 7 months long and must not be missed. It begins the third month before the month in which a client turns age 65, includes the birth month, and extends to the end of the third month following the birth month.



Other Enrollment Periods

If an individual is not eligible for automatic enrollment and fails to sign up during the IEP, three alternative enrollment options are available: the special enrollment period (SEP), the general enrollment period (GEP), and a period for international volunteers. Note that if the individual has delayed enrollment in Medicare Part B without having other coverage and therefore must use the GEP, a penalty will be added to his or her monthly premium.

1. The SEP is available if an individual did not enroll during the IEP because he or she was covered by a group health plan at work. The individual may sign up for Part A, Part B, or both anytime that he or she or his or her spouse (or a family member, if the individual is disabled) is working and the individual is covered by a group health plan through his or her employer or union based on that employment. Alternatively, the individual may sign up during the eight-month period that begins the month after his or her employment ends or his or her group health plan coverage ends, whichever is first. If the individual signs up for Medicare Part A, Part B, or both while covered under a group health plan, that plan may be the *primary payer* of the individual's covered health care expenses with Medicare as the *secondary payer*.



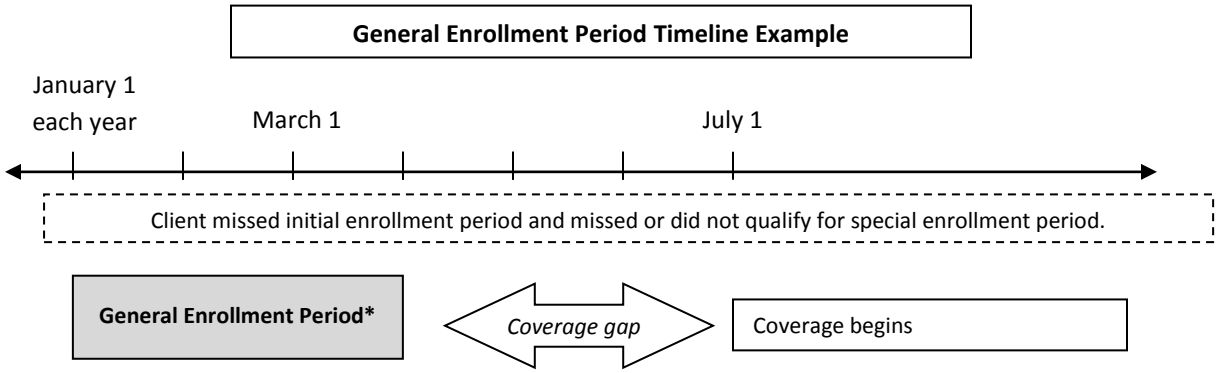
ACTUAL CLIENT CONCERN: I am 70 years old, currently working and covered by my company's healthcare plan. I have decided to work part-time rather than full-time beginning on May 1. That means my husband (he is age 71) and I will lose my employer's health care coverage at the end of next month, April 30. When should I enroll in Medicare Part B?

ADVISER RESPONSE: You can enroll now and delay the start date until the first day of any of the following 3 months. In this case, you can indicate that you want coverage to begin on May 1.

PLANNING TIP: Note that "group health plan at work" does *not* include COBRA coverage, which is *not*, by definition, coverage based on current employment. If a client is covered by COBRA, he or she should sign up during his or her IEP and not wait until the COBRA coverage period ends.

If a client with COBRA coverage does not enroll during the IEP, he or she must wait until the GEP. This may create a gap in coverage. If COBRA coverage ends in November and the IEP has past, the client will have to use the GEP to sign up for Medicare Part B. Although the GEP runs from January 1 through March 31, coverage does not begin until July 1. This leaves 7 months (December of the prior year through June of the current year) in which the client will have no Medicare Part B coverage. A few insurance companies sell insurance for this type of "gap" period, but it can be expensive, provides limited coverage, and is not guarantee issue, so the client must answer health questions during the application process and can be turned down for coverage.

2. The GEP runs from January 1 through March 31 each year. Coverage begins July 1. Unless an individual qualifies for the SEP, the cost of the Medicare Part B premium will go up 10 percent for each full 12 month period he or she could have but chose not to enroll during the IEP. The penalty lasts as long as the individual continues coverage under Medicare Part B.



**There is a 10 percent penalty for each full year after initial enrollment period, if not qualified for special enrollment period.*

PLANNING TIP: The 10 percent penalty is calculated based on the monthly Medicare Part B premium charged during the client's IEP. For example if George failed to enroll when he was first eligible late November 2012 and waited until 2015 (2 full years), the penalty that would be added to his base premium would be $20.98 (10 percent of his 2012 base premium of $99.90 = $9.99 each for the 2 years he delayed).
If by 2015 the base premium has gone up to $115.00, George will pay $115.00 + $9.99 + $9.99 or $134.98, per month.

3. Finally, there is special enrollment period for international volunteers, that is, those volunteering outside the United States who are covered by health insurance. If an individual delays coverage under these circumstances under Medicare Part B, he or she may sign up anytime during the six months following the month in which he or she stopped volunteering outside the United States.

Summary for Client Planning

If the client is…	Adviser Recommendation for Medicare Enrollment
Receiving a Social Security benefit	Automatic enrollment in Medicare Part A and Part B If Medicare Part B not desired, he or she must opt out
Not covered by a group plan	Enroll during the initial enrollment period (IEP) If he or she misses the IEP, use the general enrollment period (GEP) and pay the 10% penalty and potentially have a gap in coverage
Working and covered by a group plan	Enroll during the IEP and delay coverage start, or If he or she misses the IEP, use the special enrollment period (SEP): any time while he or she is still working and covered by group health plan within 8 months of either stopping work or losing coverage, whichever happens first If he or she misses the SEP, use the GEP, pay the 10% penalty, and potentially have a gap in coverage

Chapter 4
Traditional Medicare Covered Healthcare Expenses

A health care service, procedure, or equipment must be a *covered expense* under the Medicare rules before all or a portion of the cost will be paid. Some health care expenses are not recognized as covered and will not be paid for by Medicare.

The Medicare Act provides that payment will be made for "services and items" that

- are reasonable and necessary for the diagnosis or treatment of illness or injury or
- will improve the functioning of a malformed body member.

PLANNING TIP: Remind clients to ask their medical providers if the procedures being discussed are Medicare-covered procedures so they can understand in advance what their out-of-pocket expense will be. Medical expenses can escalate quickly, and unexpected expenses can affect their financial plan.

Before discussing what Medicare Parts A and B cover, it is just as important to understand what is not covered so Medicare participants understand what other health care costs they will have to budget for. Medicare Parts A and B *will not* cover the following items:

- Custodial or long-term care (see subsequent discussion)
- Routine dental, hearing, or vision care
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids
- Exams for fitted hearing aids

Of these expenses, the lack of coverage for all but a limited amount of custodial care can result in the largest cost to a Medicare participant. The act specifically prohibits payment "where such expenses are for custodial care (except, in the case of hospice care, as is otherwise permitted…)." For most Medicare participants, some form of custodial care will be needed before their death (see the discussion in chapter 1, "The Scope of the Problem and Extent of the Opportunity," of this guide). It is important for clients to understand that this expense is not covered by Medicare. While *custodial care* is not defined in the statute, it is defined at www.medicare.gov as helping meet "personal needs" such as activities of daily living such as dressing, bathing, and using the bathroom (see www.medicare.gov/LongTermCare/Static/Home.asp).

Preventive Services

In the past, Medicare covered very few preventive services. Many critics viewed this as short sighted, arguing that paying a small amount for preventive services potentially saved the program a large amount of money later on. This has changed in recent years, as Medicare has been expanding its covered preventative services. For example, a routine physical exam was not covered by Medicare until the introduction of the "Welcome to Medicare" exam in 2005. Even so, there were restrictions: the one-time exam had to take place within 6 months of the individual's date of coverage under Medicare Part B. Effective in 2009, this time frame was changed to 12 months from the date of initial coverage. Finally, beginning on January 1, 2011, beneficiaries are entitled to an annual wellness visit in addition to the "Welcome to Medicare" physical exam. Many other preventive services are now provided at no out of pocket expense to the participant.

For additional information on preventive services, see www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-overview.aspx.

PLANNING TIP: Opening an online Medicare account at www.medicare.gov is an excellent way for a client to keep track of the preventive services to which he or she is entitled. In the upper right hand corner of the website, the client can click on "Sign In to My Medicare.gov." On the landing page, he or she can create an account. Once the account is set up, a list of the preventive services for which he or she is eligible is provided.

Medicare Part A (Hospital Insurance) Covered Expenses

Services	Comment (Unless otherwise noted, publications in this table can be found at www.medicare.gov.)
Inpatient hospital	Includes a semi-private room, meals, general nursing, drugs that are part of the inpatient treatment, and other hospital services and supplies. The participant must be an inpatient; he or she may be admitted to an overnight stay at a hospital as an outpatient in which case the stay will be paid under Medicare Part B. This will affect the participant's out of pocket costs. Refer to Centers for Medicare and Medicaid Services (CMS) Product No. 11435, Are You a Hospital Inpatient or Outpatient? If You Have Medicare–Ask!, available at http://go.usa.gov/im9.
Home health	Limited to medically necessary part-time or intermittent skilled nursing care or physical, speech, or occupational therapy. Coverage is available for only 100 visits per "spell of illness" and only if the services are provided within 14 days of a prior hospital stay or stay in a skilled nursing facility (SNF). The spell of illness begins with the first day in which the participant receives home health services. It ends after the 60th consecutive day in which the participant is neither in a hospital nor a skilled nursing facility patient. See the subsequent discussion.
Hospice care	Available for participants with a terminal illness as certified by a doctor. The participant must have a life expectancy of 6 months or less. Medicare does not cover cost of the stay at a facility unless it is determined to be necessary for pain and symptom management that cannot be addressed at home. See CMS Product No. 02154, Medicare Hospice Benefits, available at www.medicare.gov/Publications/Pubs/pdf/02154.pdf.
Skilled nursing facility care	Covered if medically necessary following a 3-day minimum inpatient hospital stay for a related illness or injury (see previous discussion regarding inpatient hospital services).
Religious nonmedical health care institution	Applicable to those whose religious beliefs do not include medical care but who otherwise qualify under Medicare for a hospital or SNF stay. Medicare will pay for only the nonmedical, nonreligious health care items and services (such as room and board).

Skilled care includes rehabilitation services by a therapist or skilled nursing care. Skilled care does not include custodial care (that is, assistance with –activities of daily living; refer to chapter 10, "Long-Term Care" of this guide for further discussion). Skilled nursing care by definition cannot be performed by untrained employees but must be performed by licensed professionals and includes activities such as giving injections; administering medicines, treatments, or both; monitoring vital signs; and so on. In addition, for a stay in a skilled nursing facility (SNF) to be a covered expense by Medicare, the following requirements must be met:

- The stay must be preceded by a minimum of 3 consecutive days (not counting the day of discharge) in the hospital as an *inpatient*. If the participant is admitted to the hospital for "observation status," he or she is not treated as having been an inpatient but as an outpatient. The cost of observation status is treated as a Medicare Part B service and is subject to the annual deductible and the 20 percent coinsurance. Any subsequent stay at a SNF after a hospital stay as an outpatient for observation status—even if it is overnight—will not be paid for by Medicare.
- The stay must begin with 30 days of discharge from the hospital.
- A doctor must certify that the participant requires daily skilled nursing care or skilled rehabilitative services.

Hospice care is paid for by Medicare Part A even though it consists primarily of custodial care. Hospice focuses on comfort during a terminal illness, not on curing the illness. It is generally provided wherever the participant calls home. This can be a family home, assisted living facility, or a nursing home.

In order to be entitled to hospice care, a participant's life expectancy must be six months or less. (Of course, the participant is not required to die in six months. Hospice services can be extended.). The participant must sign a statement selecting hospice care rather than other Medicare covered services to treat the illness. During hospice, normal Medicare rules will pay for any other health care benefits received for health care problems unrelated to the terminal illness.

Medicare Part B (Medical Insurance) Covered Expenses

In general, Medicare Part B covers medically necessary services, such as doctors' services, tests, outpatient care, home health services (but see the previous section regarding home health care services), durable medical equipment (for example, wheelchairs or walkers), and a number of other medical services.

The following are considered preventive services:

- Abdominal aortic aneurysm screening
- Bone mass measurement
- Cardiovascular screenings
- Colorectal cancer screenings
- Diabetes screening and self-management training

- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV screening
- Mammograms screening
- Medical nutrition therapy services
- Pap tests and pelvic exams (includes clinical breast exam)
- Physical exams (one-time "Welcome to Medicare" exam and annual wellness exam)
- Pneumococcal shot
- Prostate cancer screenings
- Smoking cessation counseling

For additional information on preventive services, see www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-overview.aspx. Clients can use the Medicare's online resource locator page, www.medicare.gov/navigation/resource-locator/resource-locator-overview.aspx to, among other things, determine whether Medicare will cover their desired tests, services, or items. You can also direct clients to the Centers for Medicare and Medicaid Services (CMS) Publication No. 10110, *Your Guide to Medicare's Preventive Services*, available at www.medicare.gov/Publications/Pubs/pdf/10110.pdf and CMS Publication No. 11420, *Are You Up-To-Date on Your Preventive Services?*, available at www.medicare.gov/Publications/Pubs/pdf/11420.pdf.

Other Medicare Part B covered services (nonpreventative) are listed in chapter 5, "Traditional Medicare Payment and Premium Structure," of this guide.

To find out if and how a particular procedure is covered by Medicare, clients can go to www.medicare.gov/coverage/your-medicare-coverage.html and select the procedure(s) they are interested in.

For example, a client who selects chemotherapy will learn the following information in 2013:

Coverage under Medicare: *Medicare covers chemotherapy for patients who are hospital inpatients, outpatients, or patients in a doctor's office or freestanding clinics. Medicare Part A covers the cost for hospital inpatients. In a hospital outpatient setting, freestanding facility, or doctor's office, Part B covers chemotherapy.*

The amount you need to pay: *You pay 20% of the Medicare-approved amount. You pay a copayment in the hospital outpatient setting.*

> *Important notes:*
> *You must pay an annual $147 (in 2013) deductible for Part B services and supplies before Medicare begins to pay its share.*
> *Actual amounts you must pay may be higher if a doctor, health care provider, or supplier does not accept assignment.*

Home Health Care

Home health care as covered by Medicare has received growing interest in the past few years. The vast majority of participants would prefer to stay at home and receive needed care rather than enter a SNF. The Medicare and Medicaid programs save money when a participant elects to stay home rather than request placement in a nursing home. Several Medicare and Medicaid demonstration programs are under way around the country that are focused on keeping participants in the community for as long as possible.

Note that home health care is *not* the same as custodial services performed in the home. The latter are not covered by Medicare, however, most long-term care insurance policies do cover such custodial care expenses.

The home health care benefit is provided under both Medicare Parts A and B. Most participants rely on Medicare Part A for payment of these expenses; however, participants who do not qualify for coverage under Medicare Part A due to not meeting the 14-day stay requirement (see the “Medicare Part A (Hospital Insurance) Covered Expenses” section in this chapter) may have expenses paid under Medicare Part B.

When Medicare Part A covers the cost of home health care, in addition to meeting the 14-day stay requirement, all of the following requirements must be met:

1. The doctor decides the participant needs medical care in his or her home and makes a plan for the delivery of care at home.
2. The participant needs at least one of the following: intermittent (and not full-time) skilled nursing care, physical therapy or speech language pathology services, or a continued need for occupational therapy.
3. The participant is homebound. This means he or she is normally unable to leave home and that leaving home is a major effort. When he or she leaves home, it must be infrequent and for a short time. The participant may attend religious services and leave the house to receive medical treatment, including therapeutic or psychosocial care. He or she can also receive care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.
4. The home health agency caring for the participant must be approved by the Medicare program.

Coverage under Medicare Part B is available for services that are not covered under Medicare Part A. In addition, coverage under Medicare Part B is available for the same services covered under Medicare Part B for those participants who do not meet the 14-day requirement and those who have reached the maximum 100 visits under Medicare Part A. Generally, Medicare pays all the costs of home health care although the participant may be charged the 20 percent coinsurance for the Medicare-approved amount on such items as wheelchairs, walkers, and oxygen equipment.

Clients can learn more about home health care by reading CMS Product No. 10969, *Medicare and Home Health Care*, available at www.medicare.gov/publications/pubs/pdf/10969.pdf.

To find a client's local Medicare certified home health care provider, go to www.medicare.gov/homehealthcompare/search.aspx. Providers can be located based on zip code. The website also provides qualitative information on home health care providers.

Durable Medical Equipment

Coverage is available under Medicare Part B for *durable medical equipment* (DME) *prosthetics, orthotics, and supplies*. DME includes wheelchairs, hospital beds, walkers, canes, oxygen systems, and dialysis systems. The equipment may be rented, purchased, or leased. DME is subject to the 20 percent participant copayment. In general, a physician must order the equipment in order for the DME to be a Medicare covered expense.

Guidelines have been established about whether a piece of DME should be rented, leased, or purchased. Clients can learn more information at www.cms.hhs.gov/center/dme.asp.

Beginning in 2011, Medicare introduced a new competitive bidding program that rolled out in certain parts of the country and will eventually cover the entire United States. In order for Medicare to pay its share of the cost, the participant will almost always have to use a *Medicare contract supplier*. A Medicare contract supplier must meet Medicare quality and financial standards and made a successful bid to participate. Certain suppliers may participate in the program as a "grandfathered" supplier (participants who began renting from the supplier before the new program took effect may continue to rent from a grandfathered supplier). Otherwise, the participant will have to pay the full price when not using a Medicare contract supplier in areas in which the program has been rolled out.

To find DME suppliers in a client's area or request a list of suppliers within a certain radius, see www.medicare.gov/Supplier/home.asp. Also, clients may refer to CMS Product No. 11307, *What You Should Know if You Need Medicare-covered Equipment or Supplies*, available at www.medicare.gov/publications/pubs/pdf/11307.pdf.

Chapter 5
Traditional Medicare Payment and Premium Structure

The previous chapter described what health care costs are covered by Medicare. A participant's healthcare costs *covered* by Medicare, however, are not all fully *paid for* by Medicare. The cost is shared with the participant through the imposition of *deductibles, coinsurance*, and *copayments*.

Traditional Medicare Parts A and B each have their own separate payment structure. Any amount paid out of pocket by a participant for a covered Medicare Part A health care expense does not apply toward, for example, the Medicare Part B annual deductible. Each participant qualifies individually for Medicare and pays his or her own deductibles, coinsurance, and copayments; there is no family coverage as there is under group health plans provided through an employer.

In addition, Medicare Part A and B each have their own premium structure. Most participants pay no monthly premium for Medicare Part A coverage, but Medicare Part B requires all participants to pay a monthly premium. High-income participants pay a higher monthly premium, and lower income participants receive assistance paying the premium.

Medicare has no *out of pocket* limitations. Absent a Medicare Supplement plan, participants are at risk for having to pay high coinsurance and copayment amounts for covered health care expenses. Medicare Supplement plans, discussed in detail in chapter 6, "Medicare Supplement Policies," of this guide provide some protection.

Defining Terms

CPA planners should understand the following Medicare terms:

Assignment. A provider will accept Medicare approved amounts as being paid in full. Most health care providers accept assignment.

Coinsurance. A percentage of the amount a participant must pay toward the cost of a covered expense. Medicare Part B has both an annual deductible ($147 in 2013) and coinsurance. After the annual deductible is paid by the participant, he or she, must, in general, pay 20 percent of the cost of any covered expense incurred (certain exceptions apply for certain preventive services).

Copayment. A fixed dollar amount a participant is responsible for paying toward the cost of a covered expense. After the 60th day, Medicare Part A requires a copayment of $296 per day (in 2013) for days 61–90 (or a total of $8,880).

Deductible. The amount paid by a participant before a covered expense is paid by Medicare. For example, Medicare Part A includes a deductible of $1,184 (in 2013) for an inpatient hospital stay. After the participant pays the first $1,184, Medicare pays 100 percent of the covered expense for a stay of up to 60 days in the hospital for each benefit period (explained previously).

Medicare approved amount. The amount set by Centers for Medicare and Medicaid (CMS) that it will pay for a service, procedure, or medical equipment.

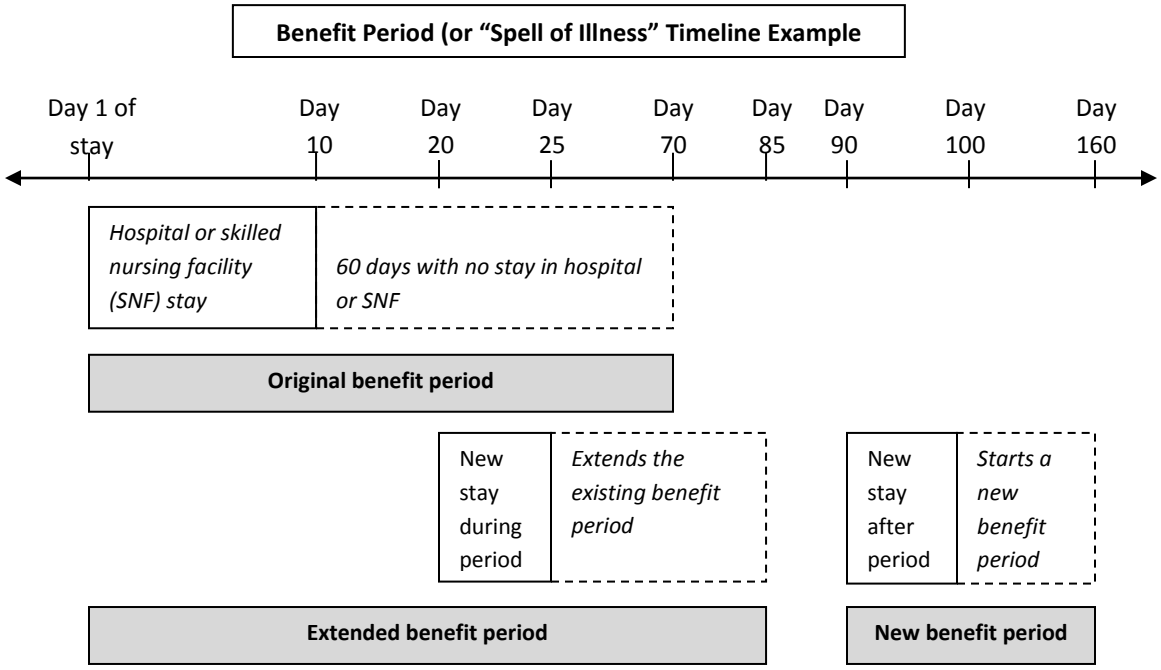
Medicare Part B excess charge. The additional amount charged that can be passed on to a participant if a provider does not accept assignment. The excess charge, however, is limited to no more than 15 percent of the Medicare-approved amount.

ACTUAL CLIENT CONCERN: I recently incurred a $400 expense for a service provided under Medicare Part B. How much will my part of the bill be?

ADVISER RESPONSE: If the Medicare approved amount is $400 for a service provided under Medicare Part B, you will pay 20 percent of the bill, or $80; Medicare will pay the balance, or $320 ($400 −$80). If the $147 (in 2013) annual deductible has not been met, you will pay $147 plus 20 percent of $253 ($400 −$147), or $51. Medicare will pay $400 −$147 −$51.00, or $202.

Benefit Periods

Note that the deductibles for an inpatient hospital stay and a stay at a skilled nursing facility (SNF) apply to each *benefit period*. In other words, the deductible is not based on a time period (for example, an *annual* deductible) but, rather, the timing of the services received. Another term for "benefit period" is "spell of illness." The benefit period is defined the same for both the inpatient hospital stay and the stay at a SNF. A benefit period begins on the first day of the stay. It ends after 60 consecutive days in which the participant has not received inpatient care at a hospital or skilled care in a SNF.



It is possible for a participant to remain in a SNF and have those days counted toward the 60 days in a row in which no skilled care is received. If he or she received only custodial care during that time, the days do not count as a covered stay in a SNF.

Each new benefit period carries with it new deductibles. Still, it may be more beneficial for a participant to have 2 benefit periods rather than 1. In the case of a participant with an extended stay in a hospital (more than 60 days) during the benefit period, he or she will pay $296 per day (the copayment in 2013) should it be necessary to reenter the hospital *before* the beginning of a new benefit period. On the other hand, although the new benefit period will carry with it a "toll charge" in the form of the Medicare Part A $1,184 deductible, there will be no copayments due until day 61. Any subsequent stay of more than 4 days in the new benefit period will offset the cost of the new deductible of $1,184 ($296 × 4). In that case, it may make sense for the participant to delay reentering the hospital, if possible, through use of home care. Of course, this should be done only after consultation with a doctor.

ACTUAL CLIENT CONCERN: My mother spent 5 days in the hospital in January due to a broken leg. She had a stroke in August and is back in the hospital for an extended stay. Will she have to pay the Medicare Part A deductible of $1,156 again?

ADVISER'S RESPONSE: Yes. Because your mother was out of the hospital for more than 60 days, her readmittance counts as a new "benefit period." She will have to pay the deductible again. On the other hand, the 60-day benefit period during which the hospital costs are fully paid by Medicare will not be affected by her 5-day stay in January. For the new benefit period, she is entitled to the full 60 days.

A Medicare Summary Notice (MSN) is mailed to participants every three months. It shows all the services or supplies that were billed Medicare during each three-month period and details the services provided, amounts charged, and how costs are shared between Medicare and the participant. Clients should go to www.medicare.gov/navigation/medicare-basics/understanding-claims/understanding-claims-overview.aspx for an explanation of the claims and payments process and a guide to reading MSNs.

Medicare Part A Hospital Insurance

Payment Structure

Inpatient hospital stays

The following table provides the deductibles and copayments that apply to inpatient hospital stays.

Days in Hospital	Deductibles and Copayments (In 2013)
1st through 60th	$1,184 deductible each benefit period, which is increased each year (*Note*: It is possible for a participant to have multiple benefit periods during a 12-month period. See the subsequent discussion.)
61st through 90th	$296 per day copayment (0.25 × $1,184) each benefit period
90th +	$592 copayment per day (0.5 × $1,184) using "lifetime reserve" days (Each participant has up to 60 lifetime reserve days.)
After all lifetime reserve days used	All costs are paid by participants. Each Medicare Part A beneficiary is entitled to up to 60 lifetime reserve days when a hospital stay goes beyond 150 days. Once used, they are no longer available. By purchasing a Medicare Supplement plan, beneficiaries can add another 365 days of hospital stay coverage.

ACTUAL CLIENT CONCERN: My spouse spent 200 days in a hospital. How much of that cost will we have to pay? She used up her 60 lifetime reserve days during a previous stay several years ago.

ADVISER RESPONSE: Your share of the cost, using 2013 figures, will be:

Days	You will pay	
1–60	the annual deductible	$1,184
61–90	$296 per day times 30 days	$8,880
91–150	$592 per day for 60 days	$35,520
151–200	the hospital daily charge of $1,100	$55,000

The total you will pay equals $100,584 ($1,184 + $8,880 + $35,520 + $55,000).

Note: Most Medicare Supplement plans will cover these costs plus provide coverage for an additional 365 days in the hospital. See chapter 6 of this guide for more information.

Inpatient mental health care in a *psychiatric* hospital is limited to 190 days in a lifetime.

Skilled Nursing Facilities

The following table provides co-payments that apply to SNFs.

Days in Skilled Nursing Facility	Copayments (In 2013)
1st through 20th*	$0 each benefit period
21st through 100th	$148.00 per day for each benefit period or a maximum of $11,560.
101st +	All costs (participant pays entire amount)

**If the participant leaves the skilled nursing facility after coverage begins but is readmitted within 30 days, the second period will also be covered.*

Clients can learn more about hospice care by reading CMS Product No. 02154, *Medicare Hospice Benefits*, available at www.medicare.gov/Publications/Pubs/pdf/02154.pdf.

Hospice Care

In general, there are no deductibles or copayments for hospice care. However, the participant is responsible for copayments and coinsurance as follows:

- A copayment of up to $5 per outpatient prescription drugs for pain and symptom management
- Coinsurance of 5 percent of the Medicare-approved amount for inpatient respite care (Respite care gives a caregiver "time off" to get some rest while a patient receives care from a paid caregiver.)

Medicare pays for the services provided by the hospice team of health care professionals; it does not pay for room and board for the participant except under limited circumstances. For example, the medical team may decide that the participant needs short-term inpatient care or a stay is needed in a facility for respite care.

Hospice services are paid for whether the participant is in traditional Medicare or a Medicare Advantage (MA) plan.

Other Medicare **Part A Copayments and Coinsurance**

Miscellaneous Medicare Part A copayments and coinsurance include the following:

- A participant must pay the hospital for the first 3 units of blood received.
- For home care, a participant pays $0 for the services and 20 percent of the cost for durable medical equipment (DME).

For quality information on hospitals in a client's geographic area, go to www.hospitalcompare.hhs.gov/hospital-search.aspx.

Premium Structure

Participants with sufficient work history (at least 40 quarters of Medicare covered employment) do not pay a monthly premium for coverage. If participant does not have a sufficient work history, he or she may pay for coverage if he or she is age 65 or older. In addition, the participant must meet citizenship or residency requirements. Special rules apply for those who are under age 65 and disabled. The 2013 monthly premium is $441 (approximately $242 for individuals with 30–39 quarters of coverage).

Medicare Part B Medical Insurance

Payment Structure

Medicare Part B has both an annual deductible ($147 in 2013) and coinsurance (20 percent of covered expenses) that apply to covered expenses. Covered expenses include the following:

- Ambulance services
- Ambulatory surgical centers (Participant pays all facility fees Medicare does not allow in an ambulatory surgical center.)
- Cardiac rehabilitation
- Chiropractic services (limited)
- Clinical lab services (Participant pays nothing for test itself, must pay 20 percent of Medicare-approved amount for doctor office visit.)
- Diabetes supplies (Some limits apply.)
- Doctor services
- DME
- EKG screening
- Emergency department
- Eyeglasses after cataract surgery
- Foot exams and treatments
- Hearing and balance exams
- Home health services (Services must be medically necessary, and the participant must be homebound. Limitations and other rules apply.)
- Kidney dialysis
- Kidney disease education
- Mental health care (Outpatient only and special payment requirements apply.)
- Non-doctor services (Those provided by, for example, physician assistants or nurse practitioners.)
- Occupational therapy
- Outpatient medical and surgical services and supplies
- Physical therapy
- Prescription drugs (These are limited, for example, to injections received in a doctor's office; otherwise, prescription drugs covered by Medicare Part D.)
- Prosthetic or orthotic items
- Pulmonary rehabilitation
- Second surgical opinions
- Speech-language pathology services
- Surgical dressing services (There is a fixed copay for services received in an hospital outpatient setting. Participants pay nothing for supplies; the Medicare Part B deductible does apply.)
- Telehealth

- Miscellaneous lab tests (These include, for example, x-rays, MRIs, CT scans, EKGs, and so on; special payment rules apply if test is performed while participant is in the hospital as an outpatient.)
- Transplants and immunosuppressive drugs
- Urgently needed care

PLANNING TIP: Remind clients that, for the most part, costs of medical care while traveling in a foreign country are not Medicare covered expenses. However, some Medicare Supplement plans do provide coverage for specific expenses. See CMS Publication No. 11037, *Medicare Coverage Outside the United States*, available at www.medicare.gov/publications/pubs/pdf/11037.pdf.

Covered *preventive services* vary in how much of the cost the participant must pay, as provided in the following table.

Service	Amount Paid by Participants
Abdominal aortic aneurysm screening	Nothing if doctor accepts assignment
Bone mass measurement	Nothing if doctor accepts assignment
Cardiovascular screenings	Nothing for the tests, but 20% of the Medicare-approved amount for the doctor's visit
Colorectal cancer screenings	20% of the Medicare-approved amount for the doctor's services; if hospital outpatient, the hospital receives a co-payment
Diabetes screening and self-management training	For screening, nothing for the test, but 20% of the Medicare-approved amount for the doctor's visit For training, 20% of the Medicare-approved amount, and the Medicare Part B deductible applies
Flu shots	Nothing if doctor accepts assignment
Glaucoma tests	Doctor receives 20% of the Medicare-approved amount, and Medicare Part B deductible applies for the doctor office visit; if hospital outpatient, hospital receives a co-payment

Service	Amount Paid by Participants
Hepatitis B shots	Nothing if doctor accepts assignment
HIV screening	Nothing for the test, doctor receives 20% of the Medicare-approved amount
Mammograms screening	Nothing if doctor accepts assignment
Medical nutrition therapy services	Nothing if doctor accepts assignment
Pap tests and pelvic exams (includes clinical breast exam)	Nothing for the pap test specimen collection, the test, or pelvic and breast exams if doctor accepts assignment
Physical exams (one time "Welcome to Medicare" exam and annual wellness exam)	Nothing for the "Welcome to Medicare" exam if taken within the first 12 months participant has Medicare Part B and doctor accepts assignment. Nothing for the annual wellness exam if doctor accepts assignment.
Pneumococcal shot	Nothing if doctor or supplier accepts assignment for giving the shot
Prostate cancer screenings	Doctor receives 20% of the Medicare-approved amount, and Medicare Part B deductible applies to the doctor office visit; if hospital outpatient, co-payment is required
Smoking cessation counseling	Doctor receives 20% of the Medicare-approved amount, Medicare Part B annual deductible applies; if hospital outpatient, co-payment is required
Pneumococcal shot	Nothing if doctor or supplier accepts assignment for giving the shot

Premium Structure

Medicare Part B premiums are means tested, meaning higher income participants will pay more for their monthly premium. In 2013 the premiums are as provided in the following table.

Annual Income*			Income-related monthly adjustment amount (IRMAA)	Total Monthly Premium Amount
Single, Head of Household, Qualified Widow(er)	Married Filing Joint	Married Filing Separate		
$85,000 or less	$170,000 or less	$85,000 or less	$0.00	$104.96
$85,001 to $107,000	$170,001 to $214,000	n/a	$40.00	$146.90
$107,001 to $160,000	$214,001 to $320,000	n/a	$99.90	$209.80
$160,001 to $214,000	$320,001 to $428,000	$85,001 to $129,000	$159.80	$272.70
>$214,000	>$428,000	>$129,000	$219.80	$335.70

*****AGI plus tax-exempt interest and exclusions for Series EE bond interest and foreign earned income and housing. *Note*: Income brackets are not adjusted for inflation.

To determine your IRMAA (income-related monthly adjustment amount) the SSA uses the most recent Federal tax return that the IRS provides. For example, to determine the 2013 IRMAA, the SSA uses the return filed in 2012 for the 2011 tax year. The IRS may, however, may only provide information for a return filed in 2010 for the 2009 tax year. In such cases, that information is used to determine IRMAA in 2013. If a more recent return is available, the beneficiary will want to contact the SSA. *(Source: Medicare Premiums: Rules for Higher-Income Beneficiaries (SSA Publication No. 05-10535; 2012). Page 6.)*

The participant can request a redetermination to review and reconsider the adjustment due to if his or her income goes down due to the following circumstances:

- Marriage, divorce, or death of a spouse
- Participant or spouse stopped working or reduced worked hours
- Participant or spouse lost income producing property due to a disaster or other event beyond the participant's control
- Participant or spouse experienced a scheduled cessation, termination, or reorganization or an employer's pension plan
- Participant or spouse received a settlement from an employer or former employer because of the employer's closure, bankruptcy, or reorganization

To determine whether a doctor accepts assignment, see www.medicare.gov/find-a-doctor/provider-search.aspx. The search allows a client to narrow results to only show providers who accept Medicare approved amount as payment in full.

PLANNING TIP: Often clients have their highest income in the year of retirement due to payouts of deferred compensation, accrued unused vacation, or sick pay, and they are put in a much higher tax bracket than normal. This may create an opportunity for clients to appeal to CMS and have the income taken into account by Medicare in determining that their Medicare Part B premium should be reduced. For additional details, see Social Security Administration Publication No. 05-10536, *Medicare Premiums: Rules for Higher Income Beneficiaries*, available at www.ssa.gov/pubs/10536.html .

Penalty for Late Enrollment

To encourage Medicare eligible individuals to enroll in Medicare Part B, there is a 10 percent penalty added to the premium for each full year of late enrollment (no penalty is applied if the delay is less than 12 months). This is discussed in more detail in chapter 3, "Traditional Medicare Enrollment," of this guide.

For more information on the penalty for late enrollment, clients can go to www.medicare.gov/navigation/medicare-basics/eligibility-and-enrollment.aspx and use the Medicare Part B Late-Enrollment Calculator.

No Out of Pocket Limitation

Neither Medicare Part A nor Medicare Part B has out of pocket limitations. Unlike Medicare, private insurance policies provide an annual out of pocket limit on how much a participant will have to pay toward covered medical expenses in a given year.

ACTUAL CLIENT CONCERN: How does the Medicare out of pocket limit differ from the out of pocket limit for a typical group health insurance plan?

ADVISER'S RESPONSE: Your former employer's group health plan provided an annual deductible of $1,000 and an out of pocket limit of $3,000. That meant you would spend no more than $4,000 out of pocket for the year (the deductible does not apply toward the out of pocket limit). As a Medicare participant, you are at risk for high out of pocket costs unless you purchase a Medicare Supplement (Medigap) policy. All Medicare Supplement plans (even the least expensive, most basic policy, Medigap Plan A) provide some protection to you from unlimited out of pocket costs. Many Medicare participants drop their Medicare Supplement policy due to high monthly premiums not realizing that that puts them at risk for high out of pocket costs. MA plans typically provide for annual out of pocket limitations.

Chapter 6
Medicare Supplement Policies

In chapter 1, "The Scope of the Problem and Extent of the Opportunity," of this guide, the need for Medicare Supplement (also referred to as Medigap) policies was introduced. Medicare participants may (but are not required to) purchase 1 of 10 different Medigap plan types from private insurance companies. Because Medigap policies are standardized, individuals often believe little difference exists between plans. In reality a big difference exists in the monthly premium. For example, Medigap Plan A offered by different companies in the same geographic area may be priced much differently. In one part of the country, the monthly premium range is $58–$241!

Pricing Differences

Part of the difference in pricing is due to a number of factors, including the type of pricing methodology used by the insurance company issuing the policy. Pricing differences also arise due to the geographic area covered by the plan; whether the issuing company offers guarantee issue policies outside of the guarantee issue period (discussed subsequently); and if the company does not offer guarantee issue polices other than when required by law, the underwriting standards the company uses.

Pricing methodologies are described in the following table.

Pricing Methodology	**Description**	**Impact on the Participant** *(All policies will go up due to inflation and other factors regardless of age.)*
Community-rated	Same price for all policyholders regardless of age	Best pricing as policy holder ages
Issue age rated	Premium based on the age of policyholder when policy is purchased	Premiums are lower for younger buyers; will not go up as policyholder ages
Attained age rated	Premium based on policyholder's current age	Premiums are lower for younger buyers but increase as the policyholder ages

In addition to the monthly Medicare Part B premium (and the Medicare Part A premium if the participant does not have sufficient Medicare covered work history), traditional Medicare shares costs with the participant through the imposition of deductibles, copayments, and coinsurance. In addition, Medicare limits its coverage for certain services. For example, a hospital stay covered under Medicare Part A includes an initial deductible and copayments. These deductibles, copayments, and coinsurance can be filled through the purchase of a Medigap policy.

Medigap policies are regulated by the Centers for Medicare and Medicaid Services (CMS) through a certification process.

PLANNING TIP: A CPA can assist his or her clients with selecting and purchasing a Medigap policy. In the past, clients would purchase a policy at age 65 and hold on to the policy until death. With the increasing costs of health care, a better approach is to reassess annually whether it would make sense to move to a different plan with a different company.

Comparison Shopping Made Easier

To make policy comparison for consumers easier, the policies were standardized in 1992. A participant who purchased a nonstandard policy purchased before July 31, 1992, was allowed to continue that policy. Standardization of policies is different in three states: Minnesota, Wisconsin, and Massachusetts.

Each Medigap policy type is designated by a letter indicating which benefits it provides. Currently, 10 types of plans are offered: A, B, C, D, F, G, K, L, M, and N. Medigap Plan F offers a high deductible ($2,110 in 2013 option in addition to its standard plan. Medigap Plans M and N were introduced on June 1, 2010, and Medigap plans E, H, I, and J can no longer be sold after that date but remain available for existing policyholders.

Insurance companies offering Medigap policies for sale are required by CMS to offer Medigap Plan A. Companies are not required to offer any of the other plans. If the company does offer any other Medigap plans they must offer either Medigap Plan C or Plan F. Generally, companies offer only a limited number of plans because not all plans attract many enrollees. Bringing a plan to market is not economical if it attracts few enrollees.

To locate companies that sell Medigap policies in a client's area, see www.medicare.gov/find-a-plan/questions/medigap-home.aspx and enter the requested information (ZIP code, health status [optional], and whether the client has a Medigap policy). The results page will allow the client to view policies by company.

Medicare SELECT is a Medigap policy that requires the policyholder to use specific hospitals, and in some cases specific doctors, for full coverage. In exchange, the monthly premium may be lower than the comparable standard plan. Not all insurance companies offer a Medicare SELECT option.

The following table compares the benefits offered by the Medigap plans that may be sold currently. All plans must offer the core benefits found in Medigap Plan A. The remaining plans differ in their mix of other benefits offered beyond the core benefits. Medigap plans, in general, only pay for Medicare *covered expenses*. In other words, if Medicare does not pay for a service, procedure, or medical equipment, neither will the Medigap plan. The exception is the additional 365 days of hospital inpatient coverage that must be provided.

Medigap Benefits	**A**	***B***	***C***	***D***	***F*** *(1)*	***G***	***K*** *(2)*	***L*** *(3)*	***M***	***N*** *(4)*
Core benefit—Medicare Part A copayments for days 61–90 of hospital stay ($296 per day in 2013)	X	X	X	X	X	X	X	X	X	X
Core benefit—Medicare Part A lifetime reserve copayments days 91–150 ($592 per day in (2013)	X	X	X	X	X	X	X	X	X	X
Core benefit—Up to 365 additional days in the hospital beyond Medicare coverage	X	X	X	X	X	X	X	X	X	X
Core benefit—Medicare Part B coinsurance (except for preventive services)	X	X	X	X	X	X	50 %	75 %	X	X
Core benefit—Blood (first 3 pints)	X	X	X	X	X	X	50 %	75 %	X	X
Skilled nursing facility care copayment for days 21–100 ($148 for 2013)			X	X	X	X	50 %	75 %	X	X

Medigap Benefits	A	*B*	*C*	*D*	*F* *(1)*	*G*	*K* *(2)*	*L* *(3)*	*M*	*N* *(4)*
Medicare Part A hospital deductible ($1,184 in 2013)		X	X	X	X	X	50 %	75 %	X	X
Medicare Part B annual deductible ($147 in 2013)			X		X					
Medicare Part B excess charges					X	X				
Foreign travel emergency (up to respective plan limits)			X	X	X	X			X	X

(1) Medigap Plan F offers both standard and high annual deductible ($2,110 in 2013) alternatives.
(2) There is an annual out of pocket limit $4,800.
(3) There is an annual out of pocket limit of $2,400.
(4) Medigap Plan N pays 100 percent of the Medicare Part B coinsurance of up to $20 for certain doctor office visits and a $50 copayment for emergency room visit that does not result in admittance.

Clients and their advisers should pay particular attention to the benefits offered by each Medigap plan and select the one that best meets their needs. For example, participants who travel abroad frequently, Medigap Plans C, D, F, G, M, and N offer additional coverage for foreign travel.

Despite the differences among the various Medigap plans, actual enrollment is clustered around just a few plans:

- Medigap Plan F with the standard deductible attracts 41 percent of all Medigap enrollees.
- Medigap Plan C attracts 16 percent.
- Medigap Plans A, B, and G collectively attract 11 percent.

Despite the likely economic benefits of electing Medigap Plan F with the high deductible or Medigap Plan G (as described subsequently in the case study), very few participants elect those plans.

For additional information, clients should refer to CMS Product No. 02110, *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*, available at www.medicare.gov/Publications/Pubs/pdf/02110.pdf. Also, Medicare provides a Medigap policy comparison tool at www.medicare.gov/find-a-plan/questions/medigap-home.aspx.

PLANNING TIP: Under the right circumstances, a high deductible Medigap Plan F may offer savings even if a client spends the $2,000 annual deductible. For example, for a healthy male, age 75, the monthly premium for standard Medigap Plan F is $269; the monthly premium for the high deductible Medigap Plan F is $86. With a monthly difference of $183, the annual savings is $2,196, or more than the annual deductible. In this case, the company offers guarantee issue policies so the client may move into the high deductible plan the month after the application is submitted. He can also move back to the standard plan should his health care expenses increase. This monthly price difference tends to widen as the client gets older. If the company does not offer guarantee issue, the client will have to submit an application and respond to the health questions—in which case a policy may not be issued.

Guarantee Issue

Medicare rules require that during certain periods, a participant has the right to the *guarantee issue* of a Medigap policy. Guarantee issue means that a policy must be issued regardless of the applicant's health. Outside of those designated periods, the insurance company may impose medical underwriting on the applicant. If the applicant has health problems, he or she may be denied a policy.

Medical underwriting can restrict a participant's ability to move to another policy with the same company or may restrict the participant from moving to a different Medigap issuer. Some companies, however, offer only guarantee issue policies. Other companies may impose underwriting (health) standards that are more or less restrictive than their competitors. These differences offer participants planning opportunities in selecting a policy or moving from one policy to another. Companies that issue only guarantee issue policies tend to have higher premiums than other companies who require medical underwriting because the policyholder pool used to price the product will tend to be less healthy. An example is provided in the subsequent case study.

Medigap policies can vary slightly from state to state because of the role the various state insurance commissioners and The National Association of Insurance Commissioners (NAIC) play in the regulatory process. NAIC works closely with CMS on the certification, regulation, and monitoring of the policies. For this reason, some differences may exist in Medigap policy rules and regulations from state to state. For example, a state may require all Medigap polices be available as guarantee issue whether or not the applicant is in his or her open enrollment period.

Medicare participants have guarantee issue rights. These rights are limited to certain periods (such as during their initial enrollment in Medicare) or certain events (the issuing company goes bankrupt). The guarantee issue rights are described in the following table.

Period or Event	Description
Medigap open enrollment period	Begins on the first day of the month in which the applicant is age 65 or older and enrolled in Medicare Part B and lasts for 6 months
Medicare Advantage (MA) disenrollment	Participant enrolled in MA after first becoming eligible for Medicare but decides to disenroll and enroll in traditional Medicare within 12 months. He or she is guaranteed issuance of any Medigap policy offered for sale in his or her state (may be extended for another 12 months under certain circumstances). Participant dropped Medigap policy to enroll in a MA for the first time but decides to disenroll within 12 months. He or she is guaranteed issuance of the same Medigap policy from the same company if that policy is still for sale. If not, guarantee issuance of Medigap plans A, B, C, or F (may be extended for another 12 months under certain circumstances).
Any of the following other events: • Participant moves out of area serviced by plan • Issuer terminates plan service in participant's area • Issuer declared bankruptcy • Issuer misrepresented the plan • Issuer violates marketing restrictions Rights also apply to participants whose employer terminates employee or retiree health care insurance, or when Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends.	Guarantee issuance of plans A, B, C, or F. All other plans are not guarantee issue.

Once a Medigap policy is purchased, it is guaranteed renewable unless the participant stops paying the premium or made a material misrepresentation. In other words, the policyholder cannot be dropped due to poor health.

Preexisting Conditions

A preexisting health condition is one that existed prior to coverage by a new health insurance policy. Insurance companies can sell Medigap policies excluding coverage of any preexisting condition for up to 6 months. *This applies even during the open enrollment period* with one exception: federal law prohibits such exclusion if the applicant applies for a Medigap policy during the open enrollment period and had at least 6 months of *creditable coverage*. Further, if the applicant had a break in creditable coverage of more than 63 days, at any time, only the period of creditable coverage after the break may be counted.

Creditable coverage includes a group health plan; Medicare Part A or Part B; Medicaid; the Federal Employees Health Benefit Plan; a public health plan; a health plan under the Peace Corps Act; a state health benefits high risk pool.

If permitted, the insurance company can refuse to cover the policyholder's out of pocket costs for preexisting conditions for up to six months (the preexisting condition waiting period). Note that Medicare does pay the costs for any preexisting condition care; the waiting period applies only to the Medigap policy.

Planning Opportunities

Planning for coverage under a Medicare Supplement plan (Medigap) is often overlooked. Eligible beneficiaries typically enroll in traditional Medicare at age 65 and purchase a Medigap policy from the closest available insurance agent. Little comparison shopping is done. But careful planning and comparison shopping by the client can save hundreds of dollars—or more—a year. A CPA planner can provide clients a valuable service by educating them about the choices available among Medigap plans and comparing premiums.

Monthly Medigap premiums have risen steadily over the years, and participants are finding the plans less affordable. Although many participants consider dropping the coverage altogether, a CPA planner can provide a valuable service by explaining why Medigap coverage is necessary, the risks of not owning a policy, and that more affordable plans may be available—either by switching plans or by switching insurance companies. In the subsequent case study, a CPA helps an elderly couple better understand the risks of going without coverage and learn that a little planning can help them secure the coverage they need at a more reasonable cost.

PLANNING TIP: Laws protect consumers from the unnecessary switching of Medigap policies. A client should never drop a current policy before he or she secures coverage under a new policy. New policies have a "free look period," meaning the client can decide whether or not to keep the policy during that time. Recommend that clients continue to pay their premiums on their old policies until they decide whether to purchase a new policy.

Case Study: Fred and Lois

Fred and Lois live on a modest retirement income. Their monthly income includes Social Security benefits and a modest withdrawal from their $500,000 retirement nest egg. Fred is 85; Lois is 78. Each owned a Medigap Plan F standard policy issued by a large, nationally known insurance company. For Fred, the monthly premium was $281; Lois' monthly policy cost was $261 for a combined cost of $542.

When the monthly cost of their Medigap policy was added to their Medicare Part B and Part D premiums, they were spending well over $700 a month on their health care coverage. Both are relatively healthy and have modest health care expenses.

Due to the expense of their Medigap policies, they are considering dropping their policies. They mentioned it to their son, who called his CPA. Although he understands his parents live on a tight budget, he is worried that dropping the Medigap policy would leave them vulnerable should either of them have a serious illness and need to spend time in a hospital or skilled nursing facility. He asked his CPA's opinion and for any alternatives.

The CPA told the son that he was right to be concerned. In addition to the deductibles and copayments that Medicare participants are responsible for, there is no limit on the amount of Medicare cost-sharing expenses a beneficiary could incur. Unlike private health insurance policies, Medicare does not have a maximum out of pocket limit for a participant's cost.

The CPA recommends that Fred and Lois look at alternative Medigap policies with their current company as well as consider pricing plans from an alternative company (Newco). They might want to consider Medigap Plan G, a high deductible version of Medigap Plan F, or one of the newer plans, Medigap Plan M or Plan N.

The CPA constructed the following chart comparing the monthly premiums.

Period or Event	Monthly Premium			
	Current Company		Newco Company	
	Fred	Lois	Fred	Lois
Plan A	$142	$123	$127	$108
Plan F Standard	$281	$261	$250	$197
Plan F High Deductible	$90	$81	n/a	n/a
Plan G	$266	$235	$205	$162
Plan M	$197	$183	n/a	n/a
Plan N	n/a	n/a	$195	$154

At a meeting with Fred and Lois, the CPA points out that the high deductible Medigap Plan F from their current company (Newco does not offer high deductible Medigap Plan F in their state) costs $191 less per month for Fred and $180 less per month for Lois, representing annual premium savings of $2,292 and $2,160, respectively. The high deductible Medigap Plan F is similar to the standard Medigap Plan F except the participant must pay $2,000 of covered health care expenses before Medicare or the Medigap policy plan will pay. Although this may seem to be a significant risk, the CPA points out that the savings in annual premiums *exceeds* the potential out of pocket annual costs for both Fred and Lois. In addition, the high deductible Medigap Plan F will provide the same protection should either, or both, incur high covered health care expenses during the year.

Medigap Plan N also offers a lower monthly premium, saving Fred $84 per month and Lois $78 per month. There are four differences between standard Medigap Plan F and Medigap Plan N. Under Medigap Plan N

- there is a $20 co-pay for each doctor office visit.
- the plan does not pay the annual Medicare Part B deductible ($147 in 2013).
- there is a $50 copayment due for a visit to the emergency room (waived if the participant is admitted to the hospital).
- the plan does not pay for a doctor's "excess charges" that can be charged by doctors who do not accept Medicare assignment.

Medigap Plan M is similar to Medigap Plan N except it pays only 50 percent of the Medicare Part A deductible and does not impose a $20 doctor office visit copayment.

Medigap Plan G is similar to Medigap Plan F with one difference: Medigap Plan G does not cover the Medicare Part B deductible ($147 in 2013). Notice a move to Medigap Plan G with the same company will save both a few dollars— and more than the cost of the Medicare Part B deductible (a net savings of just $40 for Fred; $172 for Lois). However, a move to Medigap Plan G with Newco would provide a much greater annual net savings to Fred of $772; to Lois $1,048.

Because Fred and Lois are in good health, they both opt for high deductible Medigap Plan F. Their current company does not require medical underwriting to purchase a policy—all policies are guarantee issue. The couple knows they can switch back to standard Medigap Plan F if their health worsens (assuming no change to the guarantee issue policy of the insurance company). Newco, on the other hand, requires medical underwriting outside of an open enrollment period, which is part of why Newco's pricing is so attractive compared to their current company.

Fred and Lois also have a personal preference staying with their current company. They are nervous about moving to Newco.

PLANNING TIP: As Medigap insurance premiums and out of pocket health care expenses increase, older adults are struggling with paying for their health care including premiums. CPAs can assist their clients by understanding how Medigap policies work, the risks they cover, and how a little comparison shopping can make the policies more affordable.

For more information on Medicare Supplement policies, see CMS Publication No. 02110.

Chapter 7
Medicare Part D Prescription Drug Coverage

For its first 40 years, Medicare provided little in the way of prescription drug coverage. What little coverage was provided through traditional Medicare was supplemented through Medigap plans. This changed in 2006 with the introduction of Medicare Part D. Although the plans are offered through private insurance companies, they must first be approved by the Centers for Medicare and Medicaid Services (CMS). Some critics argue that Medicare Part D coverage is too limited pointing to, among other factors, the infamous "donut" hole (discussed subsequently).

Prescription Drug Coverage Outside of Medicare Part D

Options	Comments
Traditional Medicare Part A	Very limited coverage. While a participant is a hospital inpatient, the cost of drugs and biologicals will be paid if the hospital • typically provides such drugs and • the drugs and biologicals present a cost to the hospital.
Traditional Medicare Part B	Very limited coverage. Drugs and biologicals that cannot be self-administered and are incidental to a physician's services are covered. For example, injected drugs or drugs given intravenously are not self-administered.
Medigap Plans	After the introduction of Medicare Part D, Medigap plans were no longer allowed to offer a prescription drug benefit.
Medicare Advantage (MA) Plans	Some MA plans, referred to as MA-PD plans, do offer a prescription drug feature. Participants enrolled in a MA-PD plan need not enroll in a Medicare Part D plan.

Basic Introduction

Participants electing Medicare Part D coverage can meet most of their prescription drug needs despite the plan's limitations.

To understand Medicare Part D, it helps to compare it to a similar plan, Medicare Part B. Both plans

- are voluntary.
- have a monthly premium.
- add a penalty to a participant's monthly premium, unless an exception applies, if the participant delays enrollment beyond his or her original eligibility date at age 65.
- have means-tested premiums; that is, higher income participants will pay a higher monthly premium.

Unlike Medicare Part B, however, Medicare Part D is not part of traditional Medicare. Rather, Medicare Part D *adds* prescription drug coverage to traditional Medicare.

To learn the basics of Medicare Part D, see Medicare's Part D benefits page at www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx.

Enrollment Periods

Medicare participants can enroll in Part D during the following enrollment periods:

1) *When first eligible for Medicare*. This is a 7-month period that begins 3 months before the individual turns age 65 and ends the 3 months after the month after the individual turns age 65.
2) *Open enrollment.* Everyone can join during the annual open enrollment period that runs from October 15 through December 7. During the annual open enrollment, current Medicare Part D participants may change their plan for the following year. This is done without medical underwriting. See the "Open Enrollment: Finding the Best Plan," section in this chapter.

In general, Medicare Part D participants cannot change plans during the year. If they drop their plan during the year, they must wait to enroll in a new plan until the annual open enrollment period. However, a change may be made in the following circumstances:

1) When a participant becomes a resident of a long-term care facility (this includes skilled nursing facilities, rehabilitation, psychiatric, long-term care hospitals [and hospital units], and intermediate care facilities), he or she may drop the current plan and join another plan at any time. (This is in part because the long-term care facility will contract with an outside pharmacy

to fill resident prescriptions, and the pharmacy may not be a network provider of the plan the participant had when he or she entered the facility.)

2) Starting on December 8, 2011, participants can switch to a 5-star (referring to the quality rating system established by CMS) drug program at any time during the year (see www.medicare.gov/find-a-plan) however, there are some exceptions:
    a. A 5-star plan must be available in the participant's area.
    b. The participant can switch to a 5-star plan only one time annually.
3) The participant moves out of the plan's service area.
4) The participant loses other creditable prescription drug coverage.

Standard Plan Design

Each plan has its own formulary. A plan is not required to have all drugs on its formulary. Rather, a general rule requires that for each medical condition, at least 2 drugs that treat that condition must be offered. If a drug is not included on the formulary, the plan will not pay for it. Prices and the formulary itself can change during the year. Plans must give participants 60 days' notice before they remove a drug from their formulary.

PLANNING TIP: Clients often focus purchasing the Medicare Part D plan with the lowest monthly premium. This is a mistake. The monthly premium is only one component of cost. More important to the total cost of the plan is the client's current regimen of prescription drugs and whether the drugs are listed on the formulary. A client's prescription drugs may change annually or his or her current plan may make changes to its formulary. This makes it important to review a client's plan choice each year during the open enrollment period described subsequently.

Plans put each drug in a tier. Lower tier drugs (usually generics) cost the participant less than those in a higher tier (usually brand-name drugs). The tier design encourages use of lower cost drugs. If a drug is in a higher tier and a participant's doctor believes he or she needs that drug instead of a drug in a lower tier, the participant or the doctor may ask the plan for an exception to obtain a lower cost.

Insurance companies can offer plans that differ from the standard design as long as the plan offered is actuarially equivalent. For example, many plans do not have an annual deductible, and others may provide some coverage during the donut hole (but this coverage is typically limited to generic drugs).

Each plan also has its own drug plan coverage rules, including the following, regarding certain drugs on its formulary:

1. *Generic substitution*. The plan provides the generic version of a brand-name drug.

2. *Prior authorization.* A participant or a pharmacy must contact the drug plan before a prescription can be filled.
3. *Quantity limits.* The plan places limits on how much medication a participant may receive at any time. For example, some very expensive drugs may be limited to a 30-day prescription. If the need for the prescription drugs ends between renewals, there are fewer pills remaining than if a 90-day supply were prescribed.
4. *Step therapy.* A participant must try less costly (but similar) drugs before the plan will cover more expensive drugs.

PLANNING TIP: When selecting a plan, the plan's drug coverage rules should be reviewed carefully along with the formulary. Some plans may place greater restrictions on a participant's particular drug than do others.

Open Enrollment: Finding the Best Plan

During the seven-month period of initial Medicare eligibility or the open enrollment period, participants may select a new Medicare Part D prescription drug plan. Unfortunately, many Medicare beneficiaries focus too much on the monthly premium. It is the *total cost* of the plan that participants should focus on. Often the plan with the lowest monthly premium is selected even though the overall cost of the plan is much higher than other available plans.

Shortly before the annual open enrollment period, participants will receive their Annual Notice of Change. This will explain changes being made to the plan in the next plan year. There may be changes to pricing, utilization controls, the formulary, or the payment structure. The participant may find one of his or her most expensive drugs is no longer in the formulary, requiring a change.

Which plan offers the lowest total cost depends on a number of factors including the individual's drug regimen. Two individuals of the same age living in the same geographic area but taking different prescriptions drugs may each come up with different plans offering the lowest total annual cost. Much of the price difference depends on the plan's *formulary*, that is which drugs are covered, how each drug is reimbursed by the plan, and how much of the cost must be paid for by the participant. In many cases, an individual may find the total cost of the highest cost plan given his or her drug regimen is twice as expensive as the lowest price plan. .

Fortunately, the Medicare website provides a total cost analysis tool at www.medicare.gov/find-a-plan/questions/home.aspx. A general search can be done quickly by entering a client's ZIP code and following a four-step process.

PLANNING TIP: The total cost analysis tool will ask a participant to select the local pharmacy at which his or her medications are purchased. Although this is not required, it is strongly recommended to compare and test plan results with and without a pharmacy selected. For example, a search performed without selecting a pharmacy resulted in the least expensive plan having an annual cost of $1,795. Doing the same search after selecting a local pharmacy added almost $400 to the annual cost the plan ($2,226). The plan then dropped from the least expensive to the 18th least expensive plan when a retail pharmacy was used.

Access to this type of analysis is essential. The CMS estimates that there are 1,041 different drug plans offered nationally. In each geographic region, there is an average of 31 plans to choose from. Many Medicare participants take 8 or more prescription drugs. This wide range of choice can be overwhelming and confusing even with the comparison tool offered at the Medicare site.

PLANNING TIP: The following are some planning tips on prescription drugs to consider:

- ✓ When logging the client's prescription medicines, have a complete list available, including name, dosage, and so on. Ideally, have the medicine bottles handy.
- ✓ List the retail pharmacy the client uses when prompted. It will make a difference to the final results because price differences exist between and among pharmacies even if they are listed as in the plan's network.
- ✓ List plan results not only by retail cost but by mail order cost. Sometimes the least expensive plan based on purchasing the medicines at the local pharmacy is not the least expensive if purchased through mail order.
- ✓ Encourage the client to at least consider mail order purchasing.
- ✓ Suggest that the client ask his or her pharmacy will offer to match the best price of its competitors.
- ✓ Do not overlook the big "box stores" when it comes to price comparisons.

If a current participant selects a new plan for the following year, he or she will be dropped automatically from his or her current plan on December 31. With few exceptions, the participant cannot drop his or her Medicare Part D plan during the year without risking the premium penalty should he or she rejoin at a later date.

Payment Structure

The cost of a Medicare Part D plan includes

- the monthly premium;
- the annual deductible;
- copayments and coinsurance;
- payments in the "donut" hole; and
- if applicable, the late enrollment penalty.

The *monthly premium* is established by the company offering the plan. According to the CMS, the lowest monthly premium is $15, with the highest being $132. The monthly premium covers only a portion of the total cost of Medicare Part D; the balance of the cost is paid by U.S. taxpayers from general revenues of the federal government.

The *annual deductible* in 2013 is $325. The annual deductible increases annually as the overall cost of Medicare Part D increases. Some plans have no or a lower annual deductible.

The following table describes the four stages to the Medicare Part D *copayment and coinsurance* payment structure.

Stage	Payment Structure*
1) Annual deductible	The participant pays the first $325 (in 2013) in covered costs. Not all plans have an annual deductible.
2) Copayment (up to the initial coverage limit)	After the deductible, the participant pays 25% of the cost of his or her medications; the plan pays 75%. This continues until the participant and the plan together have paid $2,970, the initial coverage limit, including the deductible. The participant will have paid $661.25 ([$2,970 − 325] x 0.25) in total copayments out of pocket when this limit is reached, or a total of $986.25 including the deductible.
3) Coverage gap (donut hole)	At this stage, there is a gap in coverage until the participant has paid total out of pocket expenses of $4,750 (in 2013). In the gap, the participant pays 79% of the generic cost and 47.5% of the cost of brand-name drugs (drug companies pay the balance). The $4,750 in total expenses to get out of the coverage gap includes any deductibles, copayments, coinsurance, or other payments but not including premiums. It also includes the discounted portion of the retail cost that the drug companies paid (see the subsequent actual client concern for an example).

Stage	Payment Structure*
4) Catastrophic coverage	At this stage, the participant is only responsible for copayments on generic drugs $2.65 in 2013 and $6.60 on brand-name and other drugs (these amounts are also adjusted annually). There is no maximum.

*Note that any amounts paid for drugs that are not covered by the plan or drugs purchased from other countries are not counted toward the annual deductible, copayment, or coverage gap.

ACTUAL CLIENT CONCERN: My husband Tom and I (Janet) have many prescriptions. The total retail cost of my prescriptions is $2,500 per year (all generic drugs), and my husband's retail costs are $7,500 per year (all brand-name drugs). How much of those costs are we going to have to pay ourselves?

ADVISER'S RESPONSE: Because your Medicare Part D prescription drug plan does have an annual deductible, your costs will be as follows:

Type of expense	**Tom's costs**	**Janet's costs**
1) Annual deductible (first $325)	$325.00	$325.00
2) 25% copayments (next $2,645)	$661.25 (25% of $2645)	$545.00 (25% of $2,180)
3) Coverage gap	$1,787.78 (47.5% of $3,763.75*)	n/a
4) Catastrophic coverage	$6.60 copay	n/a
Total actual out of pocket cost	**$2,774.03 plus $6.60 copays**	**$865.00**

So, between Tom and yourself, your total prescription out of pocket expense should be $3,701 with Tom continuing to pay a $6.50 copay for his brand-name drug prescriptions after that.

*The coverage gap is met when a total of $4,700 has been paid by the participant and the drug company discount during the coverage gap period. Because Tom had already paid $972.50 for the deductible and copayments, he has $3,727.50 remaining to reach the $4,700 out of pocket threshold. Although he only pays 50 percent of the drug cost ($1,863.50), the entire cost applies toward the $4,700 threshold.

Out of Pocket Costs

These costs include

- what the participant pays to fill or refill a prescription for a covered Medicare Part D drug.

- payments made on behalf of the participant by certain programs or organizations (for example, Extra Help, the federal program for low-income).

Out of pocket costs do *not* include the following:

- Premium payments
- Drugs not covered by the plan
- Drugs paid for through Medicare Part A or B (such as drugs given or administered during a hospital stay)
- Drugs purchased at a nonnetwork pharmacy that does not meet the insurance company's out of network pharmacy access policy
- Payments for drugs made by certain government funded programs including TRICARE and the Veteran's Administration, worker's compensation, and so on

Total drug costs is the total of all payments made for covered Medicare Part D drugs including what the plan pays, what the participant pays, and what any other program or organization has paid for the participant's drugs.

Premium Structure

As with Medicare Part B premiums, Medicare Part D premiums are means tested based on modified adjusted gross income as shown in the following table.

Annual Income*			**Total Monthly Premium Amount including IRMAA**
Single, Head of Household, Qualified Widow(er)	**Married Filing Joint**	**Married Filing Separate**	
$85,000 or less	$170,000 or less	$85,000 or less	Plan premium
$85,001 to $107,000	$170,001 to $214,000	n/a	Plan premium + $11.60
$107,001 to $160,000	$214,001 to $320,000	n/a	Plan premium + $29.90
$160,001 to $214,000	$320,001 to $428,000	$85,001 to $129,000	Plan premium + $48.30
>$214,000	>$428,000	>$129,000	Plan premium + $66.60

*****AGI plus tax-exempt interest and exclusions for Series EE bond interest and foreign earned income and housing. *Note*: Income brackets are not adjusted for inflation.

PLANNING TIP: The monthly Medicare Part D premium can be automatically deducted from a participant's monthly Social Security payment. To do so, the drug plan must be notified, not the Social Security program.

To determine your IRMAA (income-related monthly adjustment amount) the SSA uses the most recent Federal tax return that the IRS provides. For example, to determine the 2013 IRMAA, the SSA uses the return filed in 2012 for the 2011 tax year. The IRS may, however, may only provide information for a return filed in 2010 for the 2009 tax year. In such cases, that information is used to determine IRMAA in 2013. If a more recent return is available, the beneficiary will want to contact the SSA. *(Source: Medicare Premiums: Rules for Higher-Income Beneficiaries (SSA Publication No. 05-10535; 2012). Page 6.)*

The participant can request a redetermination to review and reconsider the adjustment due to if his or her income goes down due to the following circumstances:

- Marriage, divorce, or death of a spouse
- Participant or spouse stopped working or reduced worked hours
- Participant or spouse lost income producing property due to a disaster or other event beyond the participant's control
- Participant or spouse experienced a scheduled cessation, termination, or reorganization or an employer's pension plan
- Participant or spouse received a settlement from an employer or former employer because of the employer's closure, bankruptcy, or reorganization

Often participants have their highest income in the year of retirement due to payouts of deferred compensation, accrued unused vacation, or sick pay and are put in a much higher tax bracket than otherwise. This may create an opportunity to have the adjustment changed. If the participant does not agree with the adjustment for some other reason, he or she can appeal.

For additional details, see Social Security Administration Publication No. 05-10536, Medicare Premiums: Rules for Higher-Income Beneficiaries, available at www.ssa.gov/pubs/10536.html.

Penalty for late enrollment

To encourage individuals to enroll in Medicare Part D as soon as they are eligible, there is a penalty added to the premium for each month of late enrollment. The penalty does not end once imposed. A late penalty may also be owed if *after* the initial enrollment, there is a period of 63 or more days in a

row when the participant does not have a Medicare Part D plan or other creditable prescription drug coverage.

Creditable coverage is prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. If a participant has this type of coverage when first eligible for Medicare Part D, he or she may remain in the plan without paying a late enrollment penalty should he or she drop that coverage and join Medicare Part D later. The plan providing the coverage will inform the participant if it is considered "creditable coverage."

The late enrollment penalty is calculated by multiplying 1 percent of the "national base beneficiary premium" ($31.17 in 2013) times the number of *full*, uncovered months the participant was eligible but did not join a Medicare Part D plan and was without creditable prescription drug coverage from another plan. The national base beneficiary premium typically increases annually, so the penalty amount may also increase.

After the participant joins a Medicare drug plan, the plan will tell him or her if a penalty is owed and what the premium will be. The penalty will have to be paid as long as the individual participates in Medicare Part D. If the participant was disabled and had to pay a Medicare Part D late enrollment penalty before turning 65, the penalty will be waived after he or she reaches age 65. The following example is taken from www.medicare.gov:

> Mrs. Jones did not join when she was first eligible on May 15, 2009. She joined a Medicare drug plan during the open annual enrollment period October 15–December 7, 2012, with an effective date of January 1, 2013. Because Mrs. Jones did not join when she was first eligible and went without other creditable drug coverage for 43 months (June 2009–December 2012), she is charged a monthly penalty of $13.40 ($31.17 [national base rate beneficiary premium] × 0.01 [penalty rate] × 43 [months]) in 2013. She pays this late enrollment penalty monthly in addition to her plan's monthly premium for as long as she is covered under a Medicare drug plan.

If a penalty is assessed and the participant does not agree, he or she can ask for reconsideration. A reconsideration form is available from the drug company.

Medication Therapy Management

Participants who have several chronic diseases and take multiple prescriptions may need assistance in managing their drug regimen. All drug programs must offer Medication therapy management (MTM) to assist a participant with managing his or her drugs and lower the cost of those drugs.

Although each drug plan has its own criteria for a participant to be enrolled in the program, the Medicare requirements provide that the participant

- has at least 3 chronic diseases,

- be taking 8 or more prescriptions, and
- incur more than $3,000 of Medicare Part D covered drugs annually.

Plan criteria for a participant's MTM program may be lower than the Medicare guidelines (for example, two chronic illnesses and five prescriptions). A comprehensive review will be done annually with a doctor or other health care professional.

Chapter 8
Medicare Advantage Plans

Medicare Advantage (MA) plans provide alternative coverage options to Medicare participants. The authority to offer these plans is found in Part C of the Medicare statute. That is why MA plans are often referred to as Medicare Part C plans. The plans are offered by private companies paid by Medicare to provide the coverage. In general, the plans offer a *managed care option* to Medicare participants. MA plans are not considered part of traditional Medicare.

When a participant joins an MA plan, he or she is still a Medicare participant. The participant may pay a monthly premium to join the plan and in most cases will still pay his or her Medicare Part B premium. Although participants no longer need a Medigap plan after joining, they may still need a Medicare Part D prescription drug plan if such coverage is not provided by the MA. MA plans that offer prescription drug coverage are referred to as MA-PD plans.

What Are the Advantages to Medicare Advantage?

Traditional Medicare provides participants the flexibility to select their own healthcare provider as long as the provider accepts Medicare payment. MA plans, on the other hand, typically restrict the choice of healthcare provider to their network or require a doctor's referral to see a specialist. What does the participant receive in exchange for these restrictions? The following are some of the advantages:

- *Additional services provided.* These services include vision, dental care, and hearing exams that are not covered by traditional Medicare. In some cases, however, the MA plan may offer these services only for an additional premium.
- *No need for Medigap insurance.* The monthly premiums for Medigap insurance can be well above $200. For many participants, the premium is not affordable.
- *Avoid unnecessary medical procedures and services.* MA plans are paid a flat rate to cover a participant. There is no incentive to order a procedure, for example, unless absolutely necessary. On the other hand, traditional Medicare only pays for procedures or services, so an incentive exists to order more, rather than fewer, services, even if they are unnecessary.
- *No or little paperwork.* If a participant uses an in network provider, there is no paperwork.
- *Greater emphasis on preventive care.* This advantage has diminished as traditional Medicare has added preventive services, some at no cost to the participant.

There are two broad categories of MA plans; within these categories are several types of plans as provided in the following table.

MA Category	Type	Restriction on Choice of Provider
Coordinated Care Plan	Health Maintenance Organization (HMO)	Must use doctors who belong to the plan or go to hospitals in the network for care. Participant may have to select a primary care physician (PCP) and may need a referral from the PCP to see a specialist.
Coordinated Care Plan	Point of Service (POS)	A type of HMO plan that allows use of health care providers outside the network for some services. Participant may have to pay more to go outside the network. Some POS plans do not require a referral to see specialist.
Coordinated Care Plan	Preferred Provider Organization (PPO)	More freedom than HMO and POS plans. Participant may not need referral to specialist and may go outside the network but at a higher cost.
Other	Special Needs Plans (SNP)	Care management plan for the chronically ill.
Other	Private Fee-For-Service (PFFS)	Participant may go to any provider who accepts Medicare but must make sure provider will accept payment from that particular plan.
Other	Medical Savings Account (MSA)	A MSA is a high deductible health plan. To offset that higher deductible, a contribution is made to the MSA by Medicare to a special account that participant owns.

Medicare *Dis*Advantage?

The greatest disadvantage and source of frustration to many participants is the company sponsoring an MA plan dropping coverage in an area. This is very unsettling and forces the participants to select another plan or return to traditional Medicare. Other disadvantages include the following:

- *Incentives to limit services.* The Centers for Medicare and Medicaid Services (CMS) pays a flat rate for each participant covered by the MA plan. The fewer services provided to the participant means greater profits. This may incent the company to limit access to needed services.

- *Requiring referrals to specialists.* Many plans require a primary care doctor to refer a participant to a specialist. Some critics believe that pressure placed on the doctors by the company may result in the doctor limiting referrals.
- *Network requirement. Most* plans (Private Fee-for-Service plans [PFFS] are one exception) require a participant to use in network providers. If a nonnetwork provider is used, the participant often must pay a higher premium or a larger portion of the cost. These limitations may reduce the number of service locations to which the participant must travel resulting in inconvenience and additional time.
- *Limitations.* Many plans place a limitation on what services may be accessed if a participant is outside the geographic area of service.
- *High copayments, coinsurance, and deductibles.* MA plans must cover everything Medicare covers but as long as the plan is *overall* actuarially equivalent to traditional Medicare, the plan is allowed to charge higher amounts for copayments, coinsurance, and deductibles on certain procedures and services.
- *Slow, inconvenient disenrollment.* Disenrollment may be slow and require a participant to follow certain rules, and computers tracking the disenrollment may not be updated quickly, resulting in claims being rejected after the participant returns to, for example, traditional Medicare.

Types of Medicare Advantage Plans

Approximately one out of every four Medicare participants is in an MA plan. Although MA plans are offered around the country, they are more popular in some states and regions than others. In areas in which MA plans are not popular, the provider networks may be weak or the companies may have a reputation for poor service or for coming in and out of the market.

PLANNING TIP: When a client evaluates whether to join an MA plan, he or she should first understand the type of plan it is (see subsequent discussion of plan types). The client should request a Summary of Benefits from the plan before making a decision.

Each plan type has its own particular rules regarding access to health care. The different types include four coordinated care plans:

1) Health maintenance organization (HMO) plans usually restrict the health care providers (including doctors and hospitals) that a participant may see, with exceptions for emergency care. The plan may also require that a primary care doctor make a referral before the participant may see a specialist.

2) Preferred provider organization plans provide participants with a financial incentive to use network health care providers. The network providers contract with the MA plan and accept payment at the agreed upon contractual rate. If the participant uses an out of network provider, he or she will have to pay more.
3) Provider-sponsored organizations are created by health care providers. These sponsoring organizations act as both provider and insurer for the participants.
4) HMO point of service plans are hybrid plans that allow participants to obtain some services from an out of network provider in return for a higher copayment or coinsurance.

Other MA plans that are not coordinated care plans include the following:

1) Special Needs Plans that target specific participants, including those with a chronic disease or needing specialized care, who are "dually eligible" on Medicare and Medicaid, or who live in a nursing home.
2) Private Fee-for-Service (PFFS) plans work much like traditional Medicare. A participant may go to any doctor, health care provider, or hospital as long as they accept the participant as a patient. The plan sets the reimbursement rates for health care providers.
3) Medical savings account (MSA) plans are similar to a health savings account combined with a high deductible health plan. For Medicare participants, a high deductible health plan is combined with a bank account. Medicare contributes a fixed amount to the plan to pay for health care expenditures.
4) Religious fraternal benefit societies may establish an MA plan that limits enrollment to affiliated members of the church, convention, or group.

The CMS must review and approve the MA plan benefit packages. According to the regulations, CMS must ensure that companies offering a MA plan do not offer benefits that discriminate against beneficiaries, promote discrimination, discourage or encourage enrollment or steer certain participants to or away from a plan, or inhibit access to services. In, some cases, despite a plan being deemed as "actuarially equivalent," there were significant differences in the cost sharing of certain procedures that participants were not aware when they selected the MA plan. These procedures included chemotherapy, renal dialysis, and skilled nursing care. Unaware of the increased cost sharing for chemotherapy, participants only found out about the provision once treatment started. To prevent this, beginning with the 2011 plan year, cost sharing (copayments, coinsurance, and deductibles) for these and any other procedures the Secretary of CMS deems appropriate can be no more than the cost sharing required in traditional Medicare. Participants should pay very close attention the cost sharing provisions of their MA plan and how they differ from traditional Medicare.

Payment Structure

MA plans may charge monthly premiums and impose an annual deductible, copayments, and coinsurance. What participants pay in the MA plan will differ by a number of factors. The payment structure factors include the following:

- The monthly premium (Some plans charge no monthly premium, but they must market themselves as offering a plan with a $0 premium rather a “no cost” plan.)
- Whether there is an annual deductible.
- How much the participant must pay for a visit to the doctor or for other services received (This is in the form of a copayment [a dollar amount] or coinsurance [a percentage of the cost].)
- Whether the participant must pay his or her Medicare Part B premium or the cost is paid by the MA plan
- Amounts paid by the participant if he or she goes out of network
- The annual limit on out of pocket costs for covered expenses
- The types of health service the participant needs
- Whether the health care provider accepts assignment

Searching for the Right MA Plan

The search for the right MA plan begins with understanding the coverage provided by traditional Medicare, which should be used as the basis of comparison. For example, the following table compares copayments for a hospital stay under traditional Medicare with a stay covered by a typical MA plan.

Traditional Medicare*		**Medicare Advantage Plan**
Days in Hospital	**Copayments (in 2013)**	
1st through 60th	$1,184 deductible each benefit period (*Note*: It is possible for a participant to have multiple benefit periods during a 12 month period. See the following discussion.). The deductible is increased each year.	• In network—The participant pays $225 copayment for days 1–7 for a total potential cost of $1,575 per benefit period. Next 53 days of the stay paid by plan. • Out of network—The participant pays $250 per day for the days 1–10 for a total potential cost of $2,500.
61st through 90th	$296 per day copayment (calculated as 25% of the $1,184 deductible) each benefit period	In network—$0 copayment for each additional hospital day after the 7th day. Out of network—$0 copayment for each day after the 10th day.

Traditional Medicare*		Medicare Advantage Plan
Days in Hospital	**Copayments (in 2013)**	
90th +	$592 copayment per day (calculated as 50% of the $1,184 deductible) using "lifetime reserve day" (each participant has up to 60 lifetime reserve days)	Other than as described previously in this table, no limit to the number of days covered by the plan each benefit period.
After all lifetime reserve days used	All costs are paid by participants	N/A—paid by plan.

*A Medicare Supplement plan may pay for most or all of the deductibles and copayments due under traditional Medicare.

Another difference is coverage provided for a stay in a skilled nursing facility. The MA covers up to 100 days each benefit period. Unlike traditional Medicare, the stay need not be preceded by a hospital stay. The MA plan pays for the first 20-day stay in a skilled nursing home without a copayment. Days 21–100 require a copayment of $141 for each skilled nursing home day, which is similar to traditional Medicare. If the participant goes to an out of network facility, however, he or she must pay 30 percent of the cost for each day in the facility. For a 60 day stay at $450 per day, the cost to the participant would be $8,100. Although the MA plan may still appeal to a participant, it is these differences that must be carefully analyzed.

PLANNING TIP: A client in poor health and subject to frequent, short stays in a hospital would probably be better off sticking with traditional Medicare and a Medigap policy. A client without an in network hospital nearby would find a 12 day stay in the hospital more than twice as expensive with the MA plan as it would be with traditional Medicare and a Medigap plan. Of course, other factors must be taken into consideration—the monthly premium for the MA plan is $70 versus the cost of a Medigap plan. In this case, the cost of the Medigap Plan N the participant owned was $172, or $102 more per month than the MA premium. Under Medigap Plan N, the participant paid the Medicare Part B annual deductible of $162 and was required to make a $20 copayment for each visit to the doctor's office.

To search for a MA plan in a client's particular area, go to www.medicare.gov/find-a-plan/questions/home.aspx, enter the client's zip code, and proceed to complete steps 1–4. If the client is not searching for a MA-PD plan, click on "I don't take any drugs" in step 2. If the search includes looking for a MA plan that provides drug coverage, click on "Enter Drugs" in step 2 and follow the instructions to enter drugs and dosages. Then, under "Summary of Your Search Results," limit the result to either Medicare health plans either with a prescription drug feature or without a prescription drug feature.

Enrollment

The enrollment periods for MA plans are similar to those of traditional Medicare with a few exceptions. For example, to encourage participants to try MA plans, there are rules that allow the plan to be dropped after what amounts to a trial period. There are also some special rules for MA-PD plans that participants should understand. The enrollment periods are provided in the following table:

Period	Rules
Initial eligibility for Medicare	An individual may join during the 3 months before the month in which he or she turns age 65, during that birth month, and during the 3 months afterward for a total of 7 months.
Annual open enrollment October 15–December 7th	Anyone can join, switch, or drop a MA plan. Coverage begins on January 1 of the next year. Medicare participants with end-stage renal disease may join a MA plan only under limited circumstances.*
January 1–February 14	If a participant elected a MA plan, he or she may leave the plan during this period and switch to traditional Medicare. During this period, the participant can also elect to participate in a Medicare Part D plan. The participant may not • switch from Original Medicare to a MA plan; • switch from one MA plan to another; • switch from one Part D plan to another; or • join, switch, or drop a Medicare MSA plan.
Special Enrollment Period (SEP)	In general, a participant must stay enrolled in the MA program during the year until the annual open enrollment period. The participant may be entitled to a SEP if during the year the participant • moves out of the plan's service area;

Period	Rules
	• qualifies for Medicaid; • qualifies for Extra Help paying for prescription drug coverage; or • moves into a skilled nursing facility or other institution.
The 5-Star exception	Beginning on December 8, 2011, a participant can switch to a 5-star MA plan at any time during the year. The 5-star description refers to the quality ranking set by Medicare based on a number of factors (see www.medicare.gov/publications and CMS Product No. 11226, *Use Medicare's Information on Quality to Help You Compare Plans*, available at www.medicare.gov/Publications/Pubs/pdf/11226.pdf).

*If a participant has end-stage renal disease (ESRD), he or she can only join a MA plan under certain conditions. The participant may be able to remain in the MA plan if already a member when he or she develops ESRD. See Centers for Medicare and Medicaid Services Publication No. 11360, *Medicare's Coverage of Dialysis and Kidney Transplant Benefits*, available at www.medicare.gov/Publications/Pubs/pdf/11360.pdf.

Chapter 9
Medicare: Special Tax Considerations

This chapter will discuss several health care income tax considerations for individuals ages 65 and older.

Itemized Deduction of Health Care Expenses

In general, those ages 65 or older are allowed to take as itemized deductions (subject to the current 7.5 percent limitation) the same medical expenses as those under age 65. Premiums paid for coverage under Medicare Part B and Part D are allowed as itemized deductions. Any premium paid under Medicare Part A is also deductible, and the premium paid for a Medigap plan may also be taken as an itemized deduction.

Increase in 7.5 Percent AGI Limitation

Taxpayers may deduct medical expenses only if they exceed 7.5 percent of their adjusted gross income (AGI). For taxpayers under age 65, this increases to 10 percent in tax years beginning after December 31, 2012. For taxpayers ages 65 and older and their spouses, the increase does not become effective until tax years beginning after December 31, 2016.

Premiums paid on qualified long-term care insurance policies can be taken as itemized deductions on the federal income tax return. The maximum amount deductible is based on the age of the filer. In 2013 an individual age 61 through 70 may deduct premiums of up to $3,640 for the year; those age 71 and up may deduct up to $4,550. Premium amounts in excess of these limitations may not be taken as an itemized deduction.

Amounts paid from *qualified* long-term care insurance policies (which are defined in the Internal Revenue Code [IRC]) for care are excluded from taxable income. Amounts paid from a nonqualified long-term insurance plan are reported on IRS Form 1099 but may be taken as an itemized deduction subject to the limitations.

Amounts paid out of pocket for qualified long-term care services may be included with other medical expenses that are taken as itemized deductions as long as they have not already been paid or reimbursed from an insurance policy. Qualified long-term care services may include “personal care services” (custodial care).

For additional information, see IRS Publication 502, *Medical and Dental Expenses (Including the Health Coverage Tax Credit)*, available at www.irs.gov/pub/irs-pdf/p502.pdf.

Health Savings Account

Once enrolled in Medicare, an individual is no longer eligible to *contribute* to a health savings account (HSA). HSAs are tax favored accounts that may be established by individuals who participate in a high deductible health plan. However, if the individual is the beneficiary of an *existing* HSA, he or she may still receive tax-free distributions to pay or be reimbursed for any qualified medical expenses. Premiums paid for coverage under Medicare Parts A, B, or D or Medicare Advantage (MA) plans may be paid from the HSA tax free. Note that premiums paid for a Medigap plan may *not* be paid from the HSA.

If the HSA beneficiary is ages 65 and older, distributions from the account for other than qualified medical expenses are subject to the regular income tax but not subject to the 20 percent excise tax imposed on such distributions made by beneficiaries under age 65.

All account beneficiaries should name a designated beneficiary. If a spouse is the designated beneficiary, after the account owner's death, the HSA will be treated as the spouse's HSA. If the spouse is not named as the designated beneficiary, at death the account is no longer a HSA. The fair market value is taxable to the nonspouse beneficiary in the year of the account owner's death. If the estate is the beneficiary, the value of the account is included in the decedent's final income tax return.

For additional information see IRS Publication 969, *Health Savings Accounts and Other Tax-Favored Health Plans*, available at www.irs.gov/pub/irs-pdf/p969.pdf.

Miscellaneous

High Earnings Additional Payroll Tax

Beginning in 2013, the employee portion only of the Medicare payroll tax will be increased to 2.35 percent from 1.45 percent. This additional 0.09 percent tax applies to wages, salaries, and net income from self-employment received in excess of the figures presented in the following table.

Filing Status	Wages, Salaries, and Net Income From Self-Employment
Married filing jointly	$250,000
Married filing separate	$125,000
Individual	$200,000

The dollar amounts provided in the table are not indexed to inflation. The additional 0.09 percent tax will not be eligible for the 50 percent of self-employment tax now allowed as a deduction in calculating AGI.

PLANNING TIP: For married filing joint taxpayers, the additional payroll tax is calculated based not on their separate income but on their combined wages, salaries, and self-employment net income. For a couple each earning $180,000, the tax will apply even though separately neither earns over $200,000. The additional tax will be $990 ([($180,000 + $180,000) − $250,000] × 0.009). It is not the employer's responsibility to collect this tax. The employer is responsible only to collect the additional tax on an employee's income in excess of $200,000. The spouse's income may be disregarded by the employer.

New Investment Income Tax

Beginning in 2013, a new tax on investment income will be collected in order to help finance Medicare. A new 3.8 percent rate applies to investment income. The rate combines the payroll tax paid by the employer and employee for Medicare (2.9 percent) with the new additional tax on high wage, salary, and net self-employment income of 0.009 percent.

The tax applies to the *lesser of*

1) net investment income or
2) the excess amount of "modified" AGI over the applicable threshold. "Modified" AGI is AGI increased by certain amounts of foreign earned income otherwise excluded from the taxpayer's gross income.

The tax only applies to investment income in excess of the thresholds provided in the following table.

Filing Status	Thresholds
Married filing jointly	$250,000
Married filing separate	$125,000
Individual	$200,000

For example, Bob and Sindi are married. Sindi earns $500,000 per year as an executive at a large corporation. Bob receives $100,000 in dividends each year. Their combined AGI is $600,000. The first step in the calculation is to determine the excess amount of their AGI over the applicable threshold: $600,000 −$250,000 = $350,000. The tax will apply to the lesser of

1) net investment income of $100,000 or
2) the excess amount of AGI over the applicable threshold of $350,000.

The lesser amount is $100,000. Therefore, Bob and Sindi's income investment tax is $3,800 (0.038 × $100,000).

Net investment income includes

- Interest income.
- Dividends.
- Net capital gains (not including the home sale exclusion).
- Rents from a "passive activity".
- Income from annuities, *except* annuities from tax favored retirement plans (employer sponsored plans, individual retirement accounts [IRAs]) or other distributions from these types of retirement plans. The income from annuities and other qualified plan distributions do, however, figure into the calculation of the tax, boosting AGI unless the distribution is from a Roth IRA. As a practical matter, income from a tax favored retirement plan—even if it is a required minimum distribution—may result in a couple ages 65 or older being subject to the tax.
- Certain trading activity.
- Certain dispositions of property.

Chapter 10
Long-Term Care

Understanding the need for financing health care costs after age 65 begins with understanding the health care challenges of aging.

We all hear stories of "lucky" elders dying in their sleep. Many wish for such an uncomplicated passing, but fewer than one in ten elders are spared a longer decline.

—*My Mother, Your Mother* by Dr. Dennis McCullough

As McCullough writes, the elderly face death by exhaustion. During those years, Medicare covers *acute* health care needs (for example, a bout of pneumonia) as well as many of the symptoms of *chronic* disease (for example, diabetes). But with age and chronic disease, comes frailty, and frailty requires hands-on care giving. And no advance in technology will replace the need for hands on care. Assistance needed with the daily tasks of living is referred to as *custodial care*—assistance that Medicare does not pay for. Often the elderly and their families learn this too late.

Just assume that whatever it is you need, Medicare won't pay for it.

—*A Bittersweet Season* by Jane Gross

Alzheimer's disease (AD) is an example of a disease that Medicare does not cover adequately. A patient with AD needs nontherapeutic, hands-on, custodial care. AD is a progressive disease that robs individuals of cognitive and eventually physical skills. Custodial care is needed whether at home, an adult day care, an assisted living facility, or a skilled nursing home, all of which are expensive and none of which are covered by Medicare. Medicare will pay some expenses, such as medication management, neuropsychological testing, PET scans, and various medications that slow the progression of the disease. A hospice benefit is available for AD patients but only near the end of their life.

For more information on AD, see the Alzheimer's Association website at www.alz.org. Clients can refer to www.alz.org/living_with_alzheimers_medicare_and_medicaid.asp for specific information about Medicare and Medicaid coverage for those with AD.

Private insurance companies offer long-term care insurance (LTCI) to cover the cost of custodial care but few Americans have purchased the product due to its expense, the lack of understanding of the need, or the erroneous belief that Medicare will pay for custodial care. Also, recent premium increases have kept the issuance of new policies low. Recently, hybrid products (combining life insurance or annuities with long-term care insurance) have grown in popularity. These products offset the fear that some potential purchasers have of paying policy premiums for years and then never needing the benefits.

But the fact is that the majority of the elderly will need, at one time or another, custodial care. In many cases, the need may be for a limited period of time with the care provided at home by a nonpaid family member or friend. In fact, the need for long-term care is very broad but not necessarily very deep. LTCI provides protection for extended stays at a nursing home or for paid care at home. The marketing of long-term care policies often exaggerates the potential future expense of long-term care, but it does not exaggerate the need for some protection—even if the protection is limited.

LTCI pays for custodial care that is for assistance with the *activities of daily living* (ADLs). There are, however, several different types of ADLs, as shown in the following table.

Advanced Activities of Daily Living	Incidental Activities of Daily Living	Activities of Daily Living*
Participating successfully as a member of a group	Maintaining and updating household budget; writing checks; balancing checkbook; and so on	Bathing
Ability to leave home to meet social needs	Navigating home safely, including the ability to walk up and down stairs	Dressing
Ability to use public and private transportation	Make and receive telephone calls	Continence
Shopping (beyond basic grocery shopping)	Making the bed and cleaning the home	Toileting, that is the physical ability to use the toilet
Ability to follow an exercise routine outside the home	Cooking	Transferring, for example, assistance moving from a bed to a wheelchair
Recognizing the need for repair and maintenance of the home or car and the ability to coordinate the repair or maintenance activities		Eating

*Used by most long-term care insurance policies to determine whether the benefit under the policy is triggered. See *A Shopper's Guide to Long-Term Care Insurance* published by the National Association of Insurance Commissioners (www.naic.org) Advanced activities of daily living and incidental activities of daily living are used to assess an individual's ability to, for example, live independently, need at-home assistance, or need to consider a different housing arrangement.

Paying for Custodial Care

The following table describes several potential sources of payment for custodial care.

Source of Payment	Description
Private pay	Payment is made by the individual needing care or by his or her family.
Medicare	Under limited circumstances, Medicare will pay for the custodial care needed in a skilled nursing facility (SNF) (see the subsequent discussion).
Medicare Supplement insurance (Medigap)	Plan will pay for Medicare covered procedures or items not fully paid for by Medicare (for example, some policies will pay for the copayment required for a stay in a SNF from days 21–100).
Medicaid	Program will pay for custodial care for individuals who meet the income and asset tests.
Programs of All-inclusive Care for the Elderly (PACE)	This Medicare and Medicaid program is offered in many states for individuals age 55 and older. An individual need not be covered by Medicaid to qualify. PACE is designed to allow individuals who need nursing home-level of care to remain in the community. For more information see Centers for Medicare and Medicaid Services Product No. 11341, *Quick Facts about Programs of All-Inclusive Care for the Elderly (PACE)*, available at www.medicare.gov/publications/pubs/pdf/11341.pdf.
Long-term health care insurance	Purchased through private insurers, the policy offers benefits when "triggered" as described by its terms.

Private Pay

Private payment may come from the income and assets of an individual, his or her family, or other sources. The cost of custodial care whether received at home, in an assisted living facility, or a skilled nursing facility (SNF) is expensive. The vast majority of elderly do not have the financial resources available for an extended period of time.

PLANNING TIP: In reality, much of the real cost of care is provided by unpaid family members and friends. It is estimated that the annual value of unpaid care in 2009 was $450 billion (see AARP Public Policy Institute, *Valuing the Invaluable: 2011 Update The Growing Contributions and the Costs of Family Caregiving*, available at www.aarp.org) To put this figure in context, it was more than all of Medicaid spending and almost as much as Medicare, $309 billion and $509 billion, respectively, in 2009.

Several large long-term-care insurance carriers publish periodic surveys on the annual cost of a nursing home stay. For example, Genworth's *2011 Cost of Care Survey* puts the median monthly rate in the United States for a semiprivate room at $5,790. Depending on the level of care needed, the monthly cost may be much higher. If the individual is in the Alzheimer's unit of the nursing home, the cost is higher.

What does a nursing home's regular monthly fee cover? The surveys offer only a general description. Genworth states that the charge "usually includes services beyond rent such as three meals a day, laundry, sundries, basic nurse supervision, and generic, nonprescription pharmaceuticals."

PLANNING TIP: Although these surveys and the service descriptions are helpful and a good starting point for families, they fail to take into account all the monthly nursing home costs. Clients, their families, and their CPA planners must shop carefully and understand which costs are included in the basic monthly fee and which costs are not. For example, if a client needs to be brought to the dining room by a nurse's aide, his or her facility may charge an additional $5–$10 per meal. For three meals, that adds up to an extra $15–$30 per day or $450–$900 per month.

Planning for the costs of care requires an understanding of what is included in the monthly fee and what is excluded.

For example, many facilities base their monthly fee on the assumption that only one caregiver will be needed to move a resident from his or her bed to his or her wheelchair. If the patient is too heavy or too frail for one caregiver to safely move, a second will have to be used. This results in an added daily cost that can add significantly to the monthly bill. Other examples of additional charges include escorting the patient to meals or other activities, assistance with feeding, incontinence supplies, and use of oxygen equipment (in some cases, the expense may be paid by Medicare).

Finally, a nursing facility's pharmacy may not be on the list of approved providers on a new resident's Medicare Part D prescription drug plan. Many facilities require that prescription drugs be purchased through their pharmacy. Until a change can be made under the special enrollment period rules, the cost of prescription drugs may be substantially higher.

For the elderly, assisted living facilities (ALFs) and continuing care retirement communities (CCRCs) are available housing options. ALFs provide a variety of care levels depending on the service contract that fall short of skilled care but may include a meal plan, housekeeping, laundry, and regularly checking in on the resident. The median monthly rate for a one bedroom apartment at an assisted living facility is $3,261, depending on the service contract (for example, if 3 meals a day are included, if there is laundry service, and so on.).

CCRCs are designed to offer everything from independent living to assisted living to skilled care on one campus. The contracts are complex, and they often require a large "buy in" by the resident that may be several hundreds of thousands of dollars plus a monthly payment.

According to Genworth, if care is received at home, the average cost of homemaker services is $18 per hour, a home health aide is $19 per hour, and one day in an adult day care health center is $60.

The cost of care—no matter where received—can quickly deplete financial resources. Some public programs pay for custodial care but always under limited circumstances or only after meeting certain rules and regulations.

Planning for private pay requires an understanding of the client's disease and the progression of care. In some cases, such as AD, the progression of care needed is known and is terminal. But the timing of each phase of the *progression of care* needed is not well known and how long the patient will live with the disease varies widely from 5 years to as many as 20. Other diseases, such as Parkinson's, present differently in each patient. Some patients may need very little care while others may need extensive care.

Medicare, Medigap, and Long-Term Care

By law, Medicare cannot pay for custodial care. This runs contrary to what most participants think. Polls taken over the years show that when asked how they will meet any long-term care cost, respondents cite Medicare as picking up the tab.

Medicare will cover the cost of a stay in a Medicare-certified SNF under the following limited circumstances:

1) The stay must follow a 3-day minimum medically necessary *inpatient* hospital stay for a *related* illness or injury (note some MA plans waive this requirement).
2) Admittance to the SNF must be within 30 calendar days of hospital discharge.
3) A doctor must certify that the participant needs daily skilled care such as intravenous injections or physical therapy.
4) The participant must need skilled care or skilled therapy on a daily basis.
5) The only place the participant can receive the services are in the facility.
6) Services must be reasonable and necessary to treat the medical condition.

See Medicare's Nursing Home Compare tool, www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteriaNEW.asp; the National Clearinghouse for Long Term Care Information, www.longtermcare.gov/LTC/Main_Site/index.aspx, and Centers for Medicare and Medicaid Services Product No. 02174, *Guide to Choosing a Nursing Home*, available at www.medicare.gov/Publications/Pubs/pdf/02174.pdf.

PLANNING TIP: Medicare pays 100 percent of the cost of a covered stay in a SNF for days 1–20. For days 21–100, a participant must pay a $148.00 (in 2013) daily copayment. Some Medigap plans will cover the copayment. After the 100th day, neither Medicare nor Medigap will pay the cost of the stay even if the participant is receiving skilled nursing care. These limits are imposed during each "benefit period." A new benefit period begins once the beneficiary has not received skilled nursing care for 60 days. This is the same "benefit period" definition that covers the Medicare Part A stay in a hospital.

Medicaid

Medicaid is a joint program of each state and the federal government. Unlike Medicare, Medicaid will pay for custodial care. Participation is based on meeting the income and asset limitations; it is not based on age. If a Medicare participant meets the Medicaid requirements, he or she becomes "dually eligible" participating in both plans.

Because these asset and income limitations are low, elder law attorneys will often assist the elderly to qualify for Medicaid through careful planning. This can be especially important if the extended care needs of a spouse will likely lead to the impoverishment of the community, or well, spouse. The specific rules vary from state to state, so hiring an experienced elder law attorney licensed in the state of the patient's residence is crucial.

Some individuals and couples will attempt to purposely "impoverish" themselves in order to qualify for Medicaid. Any attempt to hide assets or income for this purpose is a violation of federal law. Medicaid was designed as a safety net for individuals with limited income and assets. Changes to Medicaid law in recent years were also designed to protect the community spouse from becoming impoverished due to the costs of care received by their spouse at a SNF. Before legislation was passed, spouses often had to divorce in order for one of them to qualify for Medicaid. The federal and state laws are of sufficient

complexity that an experienced elder law attorney can be of real assistance. He or she can help clients understand the laws, avoid potential penalties and often qualify them for Medicaid sooner than otherwise would be the case.

Program of All Inclusive Care for the Elderly

An alternative to nursing home care, the Program of All Inclusive Care for the Elderly (PACE) is designed to reduce the increasing costs of skilled nursing home care and allow a participant to remain in his or her community. It is a Medicaid run program, but the participant need not be receiving Medicaid in order to qualify. Unfortunately, the program is not yet available in all states and in those states in which it is available, it is not necessarily available in all areas.

To qualify for PACE, a participant must be age 55 or older and

- live in the service area of a PACE organization;
- be certified as needing nursing home care; and
- at the time of joining, be able to live safely in the community with the assistance of PACE services.

The program provides coverage for the following:

- Prescription drugs
- Doctor or other health care provider visits
- Transportation
- Home care
- Hospital visits
- Nursing home stays when necessary

There is a monthly premium for the long-term care portion of the PACE benefit. Medicaid beneficiaries do not pay the premium; those with Medicare but *not* Medicaid pay the premium. PACE does not have a deductible or copayment for drugs, services, or care if approved by the PACE team.

Go to http://www.medicare.gov/nursing/alternatives/pace.asp for more information on the PACE program.

Medicare also provides a Compare Nursing Homes tool, www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteriaNEW.asp, for information on nursing homes in a specified area and a Home Health Compare search, www.medicare.gov/homehealthcompare/search.aspx, for information on nearby home health agencies.

Long-Term Care Insurance

LTCI policies work best for middle and upper middle income households. Elderly individuals with little income or assets are candidates for Medicaid because they cannot afford a policy and do not have the assets needed to protect themselves from the costs of long-term care. Wealthy elderly individuals, on the other hand, can fully or partly self-fund the risk of needing long term care with a LTCI policy. They also need to consider protecting their assets from the cost of long term care.

In general, long-term care insurance comes in a variety of alternative types, including the following:

- Traditional policies range from the earliest policies issued in the 1970s, which paid only for costs incurred in a nursing home, to policies issued since that time that cover the costs of care whether received at home, in an assisted living facility, or in a nursing home.
- Combination policies combine life insurance or an annuity with a long term care rider.

Traditional Policies

The range of benefits offered under traditional LTCI policies range from nonmedical and medical care received at home to adult day care, respite care (which allows a nonpaid caregiver a few days off), care received in an ALF or a SNF. Although earlier policies provided for coverage only in a nursing home, the range of care settings has expanded too much to exclude care received at home or in different facilities.

Applicants for LTCI

Traditional, accelerated payment, and combination (described in the following section) policies must undergo *medical underwriting*. This involves an applicant answering a variety of health related questions and providing health care records to the insurance company. The insurance company can, based on the answers, refuse to issue a policy. Once a policy is issued, they are *guaranteed renewable*, that is, as long as the premiums are paid and there were no misrepresentations by the applicant at the time of purchase, the policy must continue in force.

Traditional policies are sold based on the amount per day of the benefit and the number of days of coverage (for example, 2 years of coverage at $200 per day, or $146,000, of protection). Thus, if a patient needs only $100 per day from the policy, the policy will last 4 years. There is a difference, as well, between a $200 per day policy and a $6,000 per month policy. Both will have a “pot” worth $146,000, but the amount available on a daily basis will differ. As an extreme example, if the beneficiary incurred $6,000 in covered care costs in 1 day, the $200 per day policy would pay no more than $200. The $6,000 per month policy would pay $6,000 but nothing more for the remainder of the month. This approach to pricing is somewhat of an anachronism; current policies create a “pool” of benefits that are paid regardless of where care is received. Inflation protection can be (and should be for younger purchasers) added to the per day coverage amount, but it adds considerably to the premium.

Before shopping for a policy, the following questions should be considered:

- Can the applicant pass underwriting? Ultimately, money does not buy long term care insurance—good health and the ability to pass the underwriting does.
- How much of the cost of care is the applicant willing to self-insure?
- The flip side of the first question—how much protection does the applicant desire?
- How much protection is affordable? The applicant should consider that if he or she purchases a policy while still working, what is affordable at age 55 may not be affordable on his or her retirement income.
- Who will provide the care the applicant needs should he or she deplete the benefit pool? This is a very practical question not always asked. Does the applicant expect his or her spouse to provide the care? What if the spouse is unable to provide care? Does the applicant expect his or her children to provide care?
- Given the same premium, would the applicant prefer a policy that pays rich daily or monthly benefits for a short period of time or a policy that pays more modest benefits for a longer period of time?
- Should a return of premium traditional policy be purchased?

- Should a tax qualified policy be purchased? Policies sold after January 1, 1997, as tax-qualified must meet certain federal standards. The vast majority of policies sold today are tax-qualified. The following table provides the differences between tax-qualified and non-tax qualified policies.

Federally Tax-Qualified Policies*	Federally Non-Tax Qualified Policies*
Premiums may be taken as an itemized deduction on the federal income tax return	Not clarified by federal government or U.S. Treasury
Benefits paid for covered long-term care expenses are generally not included as income for income tax return purposes	Not clarified by federal government or U.S. Treasury
Benefits may be triggered only if beneficiary is unable to do two activities of daily living without substantial assistance	Policy triggers differ from policy to policy
"Medical necessity" may not be used as a benefit trigger	"Medical necessity" may be used as a benefit trigger
Chronic illness or disability must be expected to last for 90 days or more	90 days requirement need not be included in policy
The cognitive impairment benefit trigger must require "substantial supervision."	"Substantial supervision" requirement need not be included in policy

*Adapted from *A Shopper's Guide to Long-Term Care Insurance* published by the National Association of Insurance Commissioners.

Ultimately, how much protection an individual or a couple should buy is a personal matter. A good CPA planner will provide guidance. When purchasing the LTCI policy, several factors will determine the amount of the premium and the amount of protection, including the following:

- The elimination period is the period that the policyholder must pay for any covered expenses incurred. Some policies will discard the elimination period for care received at home.
- The daily benefit can range from $50–$300 or more per day.
- The coverage period can be for as little as 2 years (few policies, if any, offer only a 1-year coverage period) to lifetime (although most companies have eliminated lifetime coverage). Typical coverage periods are 3, 5, and 10 years.
- Policies can be purchased by couples who share the available benefits.
- Discounts are available for purchases by a couple.
- Benefits may be expressed in terms of a daily benefit or monthly benefit (see the example on page 87.)

Combination Policies

The Pension Protection Act (PPA), signed into law in 2006 but not effective until 2010 improved the tax treatment of combination long-term care policies that combine a LTCI rider with a life insurance or annuity policy. Only the tax treatment of combination plans is new; the plans are not. Although the sale of traditional LTCI policies peaked in 2002 and has been declining since, combination policies have found a marketplace even before the tax benefits of the PPA became effective. Recently, first year premiums on combination contracts reached $650 million exceeding the $600 million for traditional stand-alone policies.

Combination plans, whether a life insurance or annuity contract, offer LTCI coverage through a policy rider. A rider is an optional benefit that can be added to the life insurance or annuity contract for an additional premium.

In a combination plan, the payment of the LTCI rider *charge* to pay for the coverage is from the cash value contained in the base policy, that is, the life insurance contract or the annuity. LTCI *benefits* paid under the terms of the rider come from two sources. The first source comes from the policy itself, either the cash value of the annuity or the accelerated payment of the death benefit from the life insurance policy. The second source is paid by the insurance company that is independent of payments made from the base policy.

ACTUAL CLIENT CONCERN: I'm confused between the life policy long-term care combination product and the annuity long-term care combination product. What is the difference?

ADVISER RESPONSE: A life and long-term care combination plan provides not only for the *accelerated payment* of death benefits to pay for long-term care expenses, but also provides for additional payments to be made by the insurance company. Two riders may be added to the policy contract. Under the first, payment of the death benefit (a portion of which is a pro-rata reduction to cash values) is accelerated to pay for covered long-term care expenses. A second rider may provide for *extended* benefits. This rider pays additional benefits after the entire stated amount of the death benefit has been paid out under the first rider. The insurance company is at risk for the extended benefits.

An annuity and long-term care combination plan provides for benefits to be paid from a combination of the cash value of the annuity and payments by the insurance company. Assume the rider provides for long-term care protection equal to 3 times the premium. A $100,000 premium provides $300,000 of long-term care protection. If the annuity beneficiary goes on claim and submits a reimbursable bill for $1,000, the payment is made from the cash value of the annuity until it is depleted. The remaining $200,000 of benefits will be paid by the insurance company; it is at risk for those payments.

Comprehensive combination life and long-term care insurance riders should be distinguished from life insurance riders that merely accelerate death benefits to pay for long-term care. An *accelerated death benefit* rider on a life insurance policy provides for the payment of some or all of the death benefit *prior* to the death of the insured if he or she is diagnosed as terminally or chronically ill. These accelerated payments are nontaxable pursuant to IRC Section 101(g).

The PPA changed, and in some cases clarified, the income tax treatment of combination plans. The tax law changes were effective January 1, 2010, for contracts issued after 1996.

Specifically, PPA addresses the following issues:

1) In 2009 and prior years, charges paid using cash values in the life or annuity combination policy were treated as distributions. Those distributions were reported as taxable income to the extent there are undistributed gains within the contract. In 2010, charges from within the policy will technically still be considered distributions by the IRS, but they will not be reported as taxable income.
2) The payment of charges will reduce the policy holder's basis in the contract (but not less than zero). This has the effect of potentially increasing the gain realized by the policy holder should the policy be surrendered or sold. CPAs may not treat the charges as paid first from any undistributed gain within the policy, although this would be the preferred approach.
3) Charges made from the insurance policy or annuity cash value are not deductible as an itemized deduction under IRC Section 213(a).
4) The tax law changes apply only if the LTCI policy offered through the rider is *qualified*. A qualified LTCI policy meets the requirements of IRC Section 7702B(b)(1). Benefits paid out of a qualified long-term care contract are tax free.

5) In 2010, life and annuity policies with qualified LTCI riders are eligible for tax free exchange under IRC Section 1035.
6) The tax benefits provided are not available for qualified annuities purchased through retirement plans.

Critics argue that due to the reduction of policy basis for charges paid on the LTCI rider and the inability to deduct the premium under IRC Section 213(a), the tax benefits may not offer much real benefit.

On the other hand, the reduction in basis issue is moot in those cases in which the entire base plan value is paid out as tax-free LTCI benefits. For annuity combinations, this represents the only way to harvest gains on a tax-free basis. The broadening of the IRC Section 1035 exchange definition also has significant value. Annuity and life insurance policyholders will be able to exchange existing policies, with earnings, into a combination product on a tax-deferred basis.

Riders can offer significant *nontax* benefits, such as more affordable LTCI coverage and less restrictive underwriting. The LTCI is more affordable because the combination plans include an element of self-funding.

Whether a traditional policy or combination policy is best often comes down to a personal preference. Traditional policies typically provide the most care for each dollar of premium—if care is needed. For many individuals, the attractiveness of the combination policy is that if no or little care is ever needed, their premiums are not "lost."

See the appendix of this guide for a client interview outline that is designed to help CPA planners gather important information from clients as well as to educate them about preparing for the cost of health care after age 65.

Appendix
The Client Interview

The purpose of the client interview is to educate the client regarding Medicare and other coverage options as well as gather information on the client's current coverage and health.

The interview consists of the following sections:

- Client's plans for retirement
- Current health insurance coverage and other available options (such as an employer plan, Veterans' Benefits, and so on)
- General health information and financial responsibility for anyone with a chronic disease
- Basic Medicare education
- Enrollment information

Why ask clients for basic health information? As Martin Shenkman, J.D., CPA/PFS points out, 26 percent of those ages 65–74 have their lives significantly impacted by chronic illness and 50 percent of those age 85 and older have cognitive impairment, such as Alzheimer's Disease. (*Estate Planning for People with a Chronic Condition or Disability*, 2009 Demos Medical Publishing, LLC) Which clients have a chronic disease is not always obvious, and clients often do not tell their advisers about their condition, believing there is nothing the adviser can do for them. It is also important for the adviser to know if the client is financially responsible for anyone with a chronic disease, whether it is a child, parent, sibling, or other relative. *Advisers need to ask these questions as part of the interview.*

The adviser needs to know when the client anticipates retiring and what other coverage he or she may have. If the client expects to continue working after age 65, the question becomes which plan will provide coverage and pay for any costs incurred, Medicare or his or her employer's plan? With more clients working beyond age 65, the *coordination of benefits* (what happens when 2 or more health plans share the costs) is growing in importance. When costs are incurred, one plan will be primarily responsible for payment. If any costs remain after the primary payer pays for costs, as outlined in the policy, the secondary payer will then pay any remaining unpaid covered costs.

The Medicare Secondary Payer (MSP) program was passed in 1980. It prohibits Medicare from paying for health services that are also covered by another plan, such as an employer group health plan. Both traditional Medicare and Medicare Advantage (MA) are subject to the MSP rules. Under the law, Medicare is the *secondary payer* to

1) an employer provided group health plan offered to current employees and their spouses. The employer must employ 20 or more full- or part-time employees.
2) coverage provided under automobile, liability, and workers' compensation policies.

If the client is not planning to work beyond age 65, he or she may have coverage available under his or her spouse's group health plan. Other sources of coverage may be based on being a veteran of the

armed forces, coverage earned from a former employer, and so on. With other coverage available, the client may opt out of enrolling in Medicare Part B until a later date.

A discussion of veteran health and long-term care benefits is beyond the scope of this guide. If a client is a veteran (or his or her spouse was a veteran), recommend they go to www.va.gov/healthbenefits for more information.

In addition, clients on Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage should be aware of the consequences of staying on COBRA beyond their initial Medicare enrollment period.

The adviser should be familiar with how the client enrolls in Medicare, that is, the *practical* aspects of enrollment. For example, clients do not go to a Medicare office to enroll. The Social Security Administration is responsible for enrolling individuals in Medicare. No matter, enrollment is primarily done online or by telephone. When clients do enroll, ask about their experience and any tips they might offer future enrollees. This includes knowing the Medigap market in the local area, including pricing structures, which companies offer plans, and so on. Few clients tend to actually shop for a policy and, as a result, end up overpaying for a policy.

Finally, for new and existing clients already age 65 or older, use the 2 questionnaires in this appendix to gather facts on the clients' current Medicare coverage, whether traditional Medicare or MA. Reviewing their current coverage can often yield benefits in terms of a less expensive plan with similar coverage or a plan that better fits their needs.

Medicare Discussion Outline

1. Initial questions
    a. What is the current status of your health insurance coverage?
        i. Your health
            (1) General overall description
            (2) Any chronic conditions
            (3) Any health conditions that may affect life expectancy
            (4) Any health conditions that may affect planning
            (5) Family health history
        ii. Your employment status
        iii. Your current plans for retirement
    b. Are you or your spouse or partner entitled to any post-retirement health benefits from a former employer?
    c. Do you plan to stay employed after age 65?
        i. Will that include health care coverage for you and your spouse or partner?
        ii. Have you discussed your plans with the human resources (HR) department?
    d. Do you or your spouse or partner have Consolidated Omnibus Budget Reconciliation Act coverage?
    e. Do you have an individual or family health care plan?
    f. Do you have coverage available under your spouse's or partner's health care plan?
        i. What happens after you turn age 65?
        ii. Have you or your spouse or partner discussed the situation with the HR department?
    g. Were you in the military?
        i. Are you receiving veterans' benefits?
    h. Have you thought about or planned for long-term care costs? (Refer to the last section in this outline.)
    i. Are you financially responsible for anyone (a child, parent, friend, sibling, or other relative) with a chronic disease?

2. Medicare Basics
    a. In general, you are eligible for enrollment in Medicare the month you reach age 65. (If your birthday is on the first of the month, you are eligible to enroll in the prior month.)
    b. Your *initial enrollment period* begins 3 months prior to the month in which you turn age 65 (your birth month) and continues for 3 months after you birth month for a total of 7 months.
    c. There are three parts to *traditional Medicare*:
        i. Part A—hospitalization
        ii. Part B—doctor bills

iii. Part D—prescription drugs

d. Under traditional Medicare, you can go to any doctor, hospital, or provider that accepts Medicare. It is a *fee for service* insurance plan.

i. Will your provider accept assignment?

ii. What happens if your provider does not accept assignment?

iii. What if your providers opt out of Medicare?

e. What is Medicare Advantage (MA)?

i. Made up of coordinated care plans (health maintenance organizations, preferred provider organization, and so on), Special Needs Plans for the chronically ill, a Private Fee-for-Service plan, and a Medicare medical savings account plan

ii. Offered by private insurance companies but participants are still enrolled in Medicare

f. Participants or their spouses with sufficient work history do not pay a premium for Medicare Part A coverage.

g. Medicare Part B and Part D are *voluntary*—a premium is charged.

i. If you elect *not* to participate in Medicare Part B, Part D, or both, you may end up paying a penalty if you elect to join later.

ii. The Medicare Part B *premium* is tied to your income—the higher your income the higher the premium you pay.

iii. Medicare Part D covers prescription drugs, and private insurance companies offer plans; in many areas, there may be 35 or more plans from which to choose.

(1) The Medicare Part D plan that is best for you depends on which medicines you take.

(2) If you are first eligible to participate in Medicare during the year, you can select a plan for the rest of the year.

(3) If you currently take no prescription medicines, consider selecting the plan with the lowest monthly premium in order to avoid a future penalty. If your circumstances change (for example, you went on a medicine for a chronic condition during the year), you can move to a new Medicare Part D plan during the October 15 to December 7 annual enrollment period. These plans are guarantee issue, meaning you will not have to respond to health questions.

(4) Near the end of each year, always evaluate your prescription drug plan to determine if it is the best plan for you.

h. For additional information on Medicare, go to www.medicare.gov to order or download a copy of the annually updated publication *Medicare & You*.

3. Medicare Supplement or "Medigap" Policies

a. You should know the following facts.

i. Medigap policies are offered through private insurance companies.

ii. The policy covers "gaps" in traditional Medicare. These plans help pay traditional Medicare coinsurances or copays, amounts you must pay out of pocket if you choose not to buy a Medigap policy.
    (1) *Example:* Under Medicare Part A, you pay a deductible when you stay at a hospital (in 2013) the deductible is $1,184. Certain Medigap plans will pay the deductible.
    (2) *Example*: Under Medicare Part B, there is an annual $147 deductible (in 2013). Certain Medigap plans pay the deductible.
    (3) *Example:* Under Medicare Part B, there is no maximum out-of-pocket expense. After you pay the deductible, you pay 20 percent of covered costs. Medigap plans will pay all or most of that coinsurance amount.

iii. You are not required to purchase a Medigap policy.

iv. Several different types of policies are offered.
    (1) To reduce confusion, Medigap policies have become standardized.
    (2) The standardized policies are each assigned a letter. Currently, plans A– L are offered.
    (3) In other words, there are no *coverage* differences between a Medigap Plan F offered by one company versus a Medigap Plan F offered by another company.
    (4) The difference comes in price, level of service, and financial strength of the insurance company.
    (5) The price may vary.
        (a) The monthly premium range among companies is very broad, despite offering the same plan, for several reasons:
            i. When you first enroll in Medicare (the open enrollment period), Medigap providers must accept you for enrollment (guarantee issue rights); in some circumstances, you may be made to wait for coverage of preexisting conditions (up to six months, *unless* you have creditable coverage). You cannot, however, be charged more for coverage during this time because of health problems.
            ii. Even during the initial enrollment period there will be significant price differences due to the way companies initially price their products.
            iii. Outside your open enrollment period and other specially designated periods, such as a special enrollment period, companies may refuse to issue you a policy due to an existing health condition.
            iv. Some companies, however, always offer guarantee issue policies.
            v. Companies that are more selective tend to have a healthier group of policyholders and lower overall claims, therefore, they can offer policies at lower cost.

vi. Because policies are standardized, consider shopping based on price during your open enrollment period but do not ignore service quality and the financial strength of the insurance company.

vii. Client pricing comparison

(6) Review standard Medigap insurance policy features.

(a) *Note*: Companies are not required to offer all policies.

(b) Medigap Plans C and F tend to be the favorites.

(c) Medigap Plan M and N are new as of June 1, 2010.

(d) Medigap Plans E, H, I, and J are no longer sold.

(e) *Discuss foreign travel*

(f) Discuss doctors' excess charges

4. Medicare Part D

a. You must sign up for it separately.

b. If you enroll in a MA plan, you do not need a separate prescription drug plan.

c. Monthly premium typically costs $30–$50.

d. The premium cost is just a small part of the overall cost—a cheaper plan for your needs may have a higher monthly premium.

e. There are various ways to enroll.

i. The best option is online at www.medicare.gov.

ii. By entering your medications, you can find the policy that is least expensive overall for the year. Do not focus only on the monthly premium. Total cost is also affected by copayments, coinsurance, deductibles, and the plan's *formulary.* Some of your drugs may not be covered or may be more expensive depending upon the plan.

5. Applications

a. You can enroll online (recommended).

b. You can call 1.800.772.1213 to initiate the enrollment process. (The representative may send you to the local Social Security office.)

c. Set up a My Medicare account at www.medicare.gov to track your Medicare claims. On the site, you can do the following:

- View claim status (excluding Medicare Part D claims)
- Order a duplicate Medicare Summary Notice or replacement Medicare card
- View eligibility, entitlement, and preventive services information
- View enrollment information, including prescription drug plans
- View or modify your drug list and pharmacy information
- View address of record with Medicare and Medicare Part B deductible status
- Access online forms, publications, and messages sent to you by the Centers for Medicare and Medicaid Services

6. Final thoughts—What Medicare Does Not Cover
    a. Vision
    b. Dental
    c. Long-term care
        i. Do you have a long-term care policy?
        ii. If so, please explain the type and terms of the policy
        iii. If not, have you thought about how long-term costs will be paid?

Traditional Medicare—Your Information

Basic Information

Your name: _____
Your birth date: _____
Home address: _____

Original Medicare

Original Medicare enrollment information (refer to your Medicare card):

Part A effective date: _____
Part B effective date: _____
My Part D drug plan (name of company): _____
Monthly premium: _____
Effective date of drug plan: _____

Medicare Supplement (Medigap) Coverage

Name of insurance company: _____
Company phone number: _____

Circle type of plan (refer to your policyholder card):

A	F – low deductible	J
B	F – high deductible	K
C	G	L
D	H	M
E	I	N

Monthly premium: _____

I have other supplemental health care insurance (check what applies):

As an employee from current employer _____
As a retired employee _____
Veterans' benefits _____
Other (describe) _____

Do you receive "Extra Help" with your Part D prescription drug coverage? _____

Are you eligible for Medicaid? _____

Medicare Advantage—Your Information

Basic Information

Your name: _____
Your birth date: _____
Home address: _____

Medicare Advantage

Original Medicare enrollment information (refer to your Medicare card):

Part A effective date: _____

Part B effective date: _____

Medicare Advantage effective date: _____

Name of plan: _____

Name of insurance company: _____

Plan phone number: _____

Plan ID number: _____

Monthly premium: _____

Type of plan: (HMO, PPO, PFFS, and so on): _____

Does the plan cover (circle covered benefits):

Dental Vision (eye exams or glasses) Hearing?

Does the plan provide prescription drug coverage? _____

If not, name of Part D prescription drug coverage: _____

I have other supplemental health care insurance (check what applies):

As an employee from current employer _____
As a retired employee _____
Veterans' benefits _____
Other (describe) _____

Do you receive "Extra Help" with your Part D prescription drug coverage? _____

Are you eligible for Medicaid? _____

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