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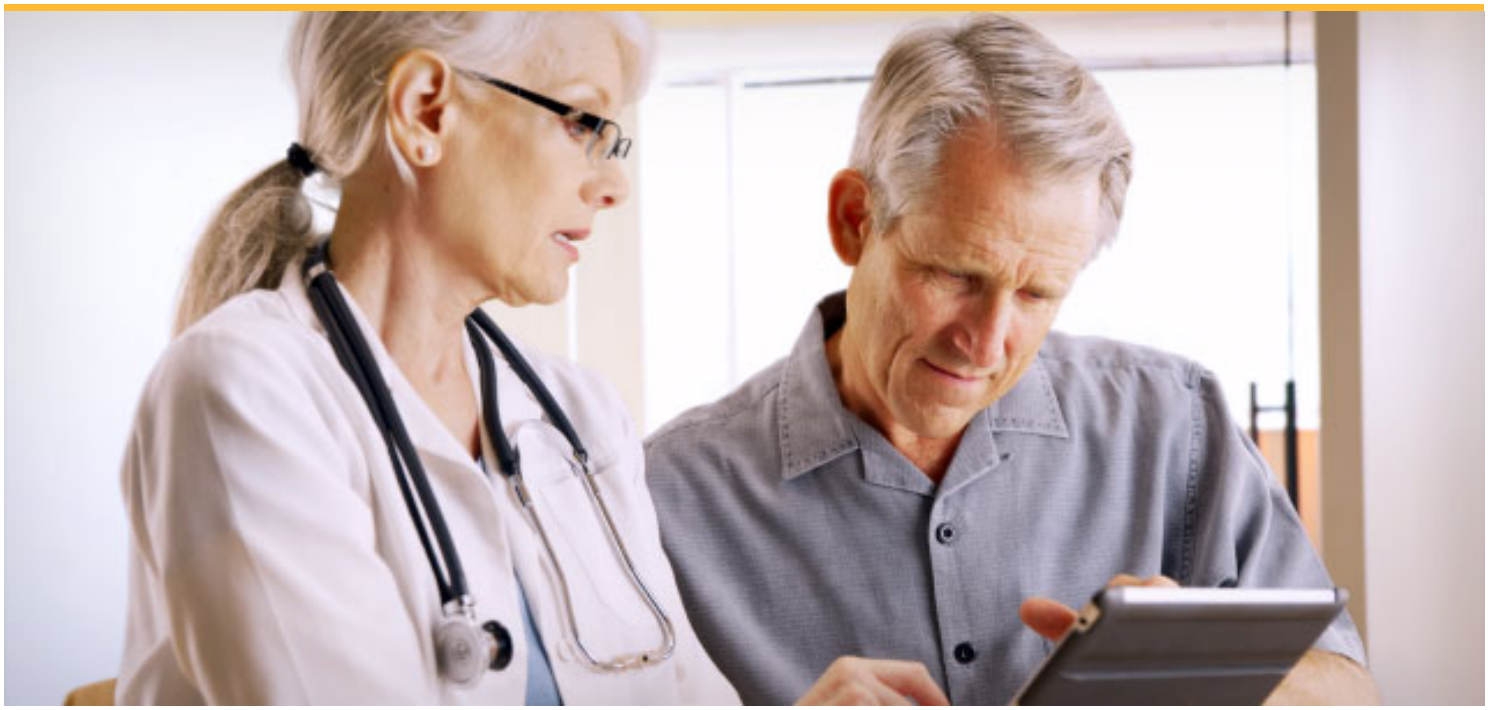

From the *Savvy Social Security Planning* newsletter – January 30, 2020

Pre-Medicare planning: 6 caveats to watch out for

Unlike Social Security, which people tend to think about many years before claiming, Medicare is almost an afterthought. As long as people are working and covered by an employer plan, they don't think very much about how their health insurance might change upon turning 65 or leaving employment. This leaves them open to all kinds of potential mistakes.

In the United States today, Medicare is the health care system for individuals 65 and older (and disabled individuals who have received Social Security disability benefits for 24 months). As comfortable as people may be with their pre-65 insurance, they need to know that many things will change once they turn 65 or leave employment.

Pre-Medicare planning should begin no later than age 64—earlier, if you are doing tax planning to reduce the IRMAA, or at least a year before leaving employment for clients who work past age 65. You and your clients will need this much time to get ready for the day they transition to a whole new health care system.

These Medicare minefields are not well known. If you are a member of our Savvy Medicare Planning program, you've been briefed on these issues, so consider this a review and a reminder to do your pre-Medicare planning and alert clients to these issues. If you are not a member, consider becoming one so you will understand the rules underlying these caveats. Also consider attending one of our Social Security/Medicare workshops in February or March for a deeper dive and a better understanding of how you can help clients avoid seriously expensive Medicare mistakes.

Caveat #1: Your doctor may not accept Medicare

Now, let it be known that most doctors do accept Medicare. But if a client chooses to go into a Medicare Advantage plan as opposed to original Medicare, their doctor may not be in that plan's network. Clients who have strong feelings about keeping their doctor will need to understand this. Before signing up for a Medicare Advantage plan they'll need to check the plan's

network and make sure their doctor is in it (and hope the doctors stays in it). Even if they are going with Original Medicare they should check to be sure their doctor accepts Medicare.

Clients who will not be going into a Medicare Advantage plan and who do not have an established relationship with a doctor may have trouble finding a doctor who accepts new Medicare patients. Because most doctors will accept Medicare for patients with whom they already have a relationship, part of pre-Medicare planning involves developing a relationship with a Medicare doctor prior to signing up for Medicare.

Caveat #2: Once you go onto Medicare you can no longer contribute to an HSA

This issue is coming up more frequently these days as more employers switch to high-deductible health plans with health savings accounts. Once a person enrolls in any part of Medicare, no contributions can be made to an HSA, beginning with the first month of enrollment. Some clients are caught by surprise, not learning about this rule until many months after enrollment. For example, a client applies for Social Security at age 68 not realizing that he was automatically enrolled in Medicare Part A and that it was made six months retroactive. If HSA contributions were made for any of those months, they will need to be backed out. If they are not, the money will be taxable and the client will be subject to a 6% overcontribution penalty every year the contributions, and the investment earnings thereon, remain in the account.

Part of your pre-Medicare planning will involve asking clients about their current health plan and determining if it is an HSA. If they voluntarily enroll in Medicare, or if they start Social Security and are mandatorily enrolled in Medicare (they must take Part A if they want to receive Social Security), they will need to stop those HSA contributions. If the client is still working and wants to maintain employer health insurance, they can ask the employer for a different type of plan; if the employer is making the HSA contributions ask for that money in the form of salary or other benefit.

Caveat #3: High-income people pay more for Medicare

Don't forget about the income-related monthly adjustment amount (IRMAA). Many people who have not yet entered the world of Medicare don't know that monthly premiums for Part B and Part D are higher for individuals with income over $87,000 and couples with income over $174,000. Warn your clients of these extra charges well in advance of going onto Medicare. Indeed, the IRMAA itself may help inform the decision to stay on an employer plan or go off the plan and onto Medicare; if they are still working and earn a high salary, the IRMAA may tip the scale in favor of staying on the employer plan as long as possible.

But at some point everyone goes onto Medicare—once they stop working if not before. And that's when the IRMAA could kick in for clients who have not previously managed their assets and income to avoid it. This is why savvy Medicare planning should start early, in time to get those Roth conversions done in the most tax-advantageous manner so that RMDs starting at age 72 won't trigger the IRMAA (or at least keep it to a lower tier). Ideally (and in the absence of otherwise adverse tax consequences), Roth conversions should be done more than two years before Medicare starts. That way, the taxable IRA distribution that's taken for the Roth conversion won't figure into the IRMAA. Age 60 is not too early to start talking about Medicare and IRMAA management.

Once a client retires and income drops, be sure to help them appeal the IRMAA based on work stoppage.

Caveat #4: COBRA at 65+ messes up Medicare

Let's say a client retires before age 65. They want to continue with their employer-sponsored health insurance and are willing to pay the premiums themselves. So they go onto COBRA. This is all well and good as long as they enroll in Medicare at 65. At that point the COBRA would stop and they can find supplemental insurance (Medigap) or enroll in a Medicare Advantage plan to have comprehensive coverage.

But what if someone retires after age 65 and wants COBRA? Well, in addition to probably paying too much for health insurance, they run the risk of not dropping the COBRA in time to take advantage of their special enrollment period, which ends eight months after their employer insurance stops. If they go onto COBRA for the full 18 months, when they come off the COBRA they will be outside their special enrollment period and will have to wait until the next general enrollment period (Jan. 1–March 31) and coverage won't start until July 1. Meanwhile, they won't have health insurance.

So if your 65+ clients are offered COBRA when they retire, tell them not to take it. They'll be enrolling in Medicare instead and will get a Medigap policy or Medicare Advantage plan in order to have complete coverage.

Caveat #5: Retiree plans pay secondary to Medicare

Let's say a client retires before age 65 and is lucky enough to have retiree insurance. (In this age of shrinking retiree plans, many people are forced to work until Medicare age in order to have health insurance.) As long as the client is under 65, the retiree plan is the sole payer, and everything works pretty much as it did before. The client incurs a medical bill, the bill is submitted to the retiree insurance company, and the insurer pays the bill.

Everything changes the month the client turns 65. Now that the client is Medicare-eligible, the retiree plan pays secondary to Medicare—but only if the client is enrolled in Medicare. If the client isn't enrolled in Medicare, Medicare won't pay and the plan won't pay either.

Pre-Medicare planning with pre-65 retirees will involve informing them that: 1) they must enroll in Medicare at 65, and 2) they must contact their insurance company to find out how their plan will change. Some retiree plans offer good supplemental coverage, but only if the client is enrolled in Medicare. If the plan offers creditable prescription drug coverage, they may not have to enroll in Part D. They should take direction from the plan regarding whether or not to enroll in Part D.

Caveat #6: The Medigap guaranteed-issue period only lasts six months

One great thing about Medicare is that this government program is open to all American citizens and legal residents age 65 and over regardless of health status. Part A is free if you've paid into Medicare for ten years, and Part B costs a reasonable $144.60 per month (plus the IRMAA if applicable). People who had trouble getting reasonably priced insurance prior to turning 65 will be elated to go onto Medicare.

The problem is that Medicare doesn't pay the full cost. There is a hefty Part A deductible ($1,408 in 2020) for hospital visits, and only 80% of doctor bills and procedures are covered. This is why most people get private insurance to go with their Medicare. Medicare Advantage plans also take everyone regardless of health status, but these plans may not be the best for some clients because you have to get your care close to home, within the specific provider network. For clients who travel, have multiple homes, or simply like the stability of a plan that doesn't change from year to year, a Medigap policy is the best form of supplemental insurance. But in most states Medigap insurers do NOT have to take everyone unless they are within their Medigap open enrollment period, which is the six-month period after enrolling in Part B. After that, they the person is subject to underwriting and may not qualify for a policy.

This is another pre-Medicare planning consideration. Everyone getting ready to enroll in Medicare should be informed of the six-month Medigap guaranteed-issue period so they'll know that if they don't take advantage of it, they may never be able to get a Medigap policy. There are a few exceptions, such as the one-year Medicare Advantage trial period, and some states hold Medigap insurers to a stricter standard. But this is one of the things many people aren't informed of until it's too late: they go into a Medicare Advantage plan when they first become eligible for Medicare and after a few years decide they want original Medicare; at that point they may not be able to get a policy. Or maybe they're still working and keeping their employer insurance but they sign up for Parts A and B to get supplemental coverage. They need to know that six months after enrolling Part B that Medigap guaranteed-issue period ends. Clients who are keeping employer coverage after age 65 should not enroll in

Part B until they are ready to leave the employer plan. At that time they will arrange to have their Medicare and their Medigap policy start immediately after the employer insurance ends and will have no trouble qualifying because they'll be within the Medigap guaranteed-issue period.

Question of the week

Q: *Single female, DOB 6/17/1954, enrolled in Medicare Part A & B June 2019 and purchased a BCBS TX Supplemental Plan F; wasn't aware she did not have Rx coverage so did not purchase supplemental Rx Plan. Client takes no Rx and has been in breast cancer remission for many years, learned her breast cancer has returned. When tried to get Rx, learned she has no coverage so tried to purchase some. Talked to SSA who said her only option is to change to Medicare Advantage Plan effective 7/1/20 so she'll have Rx coverage. Client does not want to give up Plan F coverage she currently has. She called BCBS to see if they can enroll her in one of their Rx plans and was told no, she'd have to wait until fall Open Enrollment. Since enrollment in Medicare Adv Plan will disenroll her in Plan F, is there a way she can get Rx coverage now (or July 1)? Does Jan—March General Enrollment period (effective July 1) apply to supplemental coverage only (Medigap and/or Advantage Plans) and not Rx coverage also?*

A: This is terrible. These crazy enrollment periods are really messing with people's lives. I'm afraid I can't say anything different from what your client has already been told. The July 1 effective date would apply to the Medicare Advantage plan only—and yes, she would have to drop Plan F. If she wants to keep Plan F, she will have to enroll in a standalone prescription drug plan—but she can't do that until the October 15–December 7 enrollment period, with coverage starting January 1, 2021. To add insult to injury she'll probably be charged a penalty for going more than 63 days without creditable drug coverage. She might try calling the Medicare Rights Center to see if there's anything they can do.

Answering your questions

When posting a question, please include first names, ages, and PIAs of your clients, along with any other relevant information. This will help me target my answer to your client's situation.

Retirement news

SECURE To Ignite 'Huge Boom' In Annuities, But Not Immediately

"The reason you won't likely see a huge boost in 2020 is because plans still have to add annuities and do a review in order to get them into the plan as an investment option," said Hopkins, also an associate professor of taxation at The American College of Financial Services and director of the New York Life Center for Retirement Income.

Large-scale annuity inclusion in plans won't come immediately after the enactment of the expanded safe harbor for a related reason—there are three constituencies that need to be educated, according to Sri Reddy, Principal Financial Group's senior vice president in retirement and income solutions.

First, advisors need to learn about SECURE's nuances and how to be experts in this arena, Reddy said.

Second, recordkeepers need to learn about how annuities are different from mutual funds with age restrictions and contribution differences, and they also need to build technology to support annuity offerings and their proliferation.

The third group that needs to be educated, he said, are the plan sponsors." *(InsuranceNewsNet)*

Inspector General Warns Public About New Twist to Social Security Phone Scams

"The Inspector General of Social Security, Gail S. Ennis, is warning the public that telephone scammers may send faked documents by email to convince victims to comply with their demands. The Social Security Administration Office of the Inspector General (OIG) has received reports of victims who received emails with attached letters and reports that appeared to be from Social Security or Social Security OIG. The letters may use official letterhead and government 'jargon' to convince victims they are legitimate; they may also contain misspellings and grammar mistakes." *(Social Security Matters)*

Should Clients Take a Lump-Sum Social Security Payment?

"But what do advisors tell clients who have delayed taking Social Security even after reaching full retirement age (FRA), and when they make the claim, the government offers them a lump-sum retroactive payment up to six months? Should they take it or not, and what's the downside, if there is one? We asked several financial advisors via email how they would advise clients on this choice. Keep in mind that the six-month, one-time lump sum offer isn't available to those who haven't reached FRA. Also, the lump sum retroactively resets the benefit amount. For example, after full retirement age, the Social Security benefit is increased by 2/3 of 1%, or .667% per month, and if the lump sum is taken, the monthly Social security payment would be set back by 4% of that payout…" *(BenefitsPRO)*

The Jimmo v. Sebelius Settlement Agreement: An Issue Brief for Medicare Providers

"Jimmo v. Sebelius, No. 5:11-CV17 (D. Vt., 1/24/2013), was a nationwide class-action lawsuit brought against the Centers for Medicare & Medicaid Services (CMS) on behalf of individuals with chronic conditions who had been denied Medicare coverage on the basis that they were not improving or did not demonstrate a potential for improvement. In 2013, a U.S. District Court approved the settlement agreement, which required CMS to confirm that Medicare coverage is determined by a beneficiary's need for skilled care, not on a beneficiary's potential for improvement… The Jimmo Settlement means that Medicare beneficiaries should not be denied maintenance nursing or therapy when skilled personnel must provide or supervise the care for it to be safe and effective. Medicare-covered skilled services include care that improves, maintains, or slows the decline of a patient's condition. Thus, Medicare coverage should not be denied solely because an individual has an underlying condition that will not get better (such as MS, ALS, Parkinson's disease, or paralysis)." *(Center for Medicare Advocacy)*

2020 Presidential Candidates' Views on Social Security

"The 2020 presidential candidates have proposed various changes to Social Security's retirement program. The Center has collected a list comparing these changes. The list will be updated on a regular basis throughout the campaign season. Download the comparison chart here." *(Center for Retirement Research at Boston College)*

Add This Often-Forgotten Task to Your 2020 Financial To-Do List

"You likely have already created your financial to-list for the year. And if you're like most people your list likely includes: pay down debt and save more for retirement. But there's a lesser-known but equally important task that you should add to your list: Check your Social Security Statement. To do, you'll have to sign in to your personal "My Social Security" account. There, you can review personal estimates of future Social Security benefits based on your real earnings and review your earnings history. What to look for? Well, it's especially important that you review your earnings record for missing years and mistakes. Missing years and/or mistakes may reduce your Social Security benefit. And you wouldn't want to receive less from Uncle Sam than what you are owed. So, if you discover errors and/or mistakes, contact Social Security." *(TheStreet)*

Ten Charts on Proposals to Lower Prescription Drug Costs

"Three in ten Americans say they haven't taken their medicine as prescribed due to costs. That's why three bills are in Congress looking to lower the cost of drugs for Medicare recipients. This slideshow looks at the proposals, how they would be financed, and what the effect could be." *(Kaiser Family Foundation)*

Examining the Nest Egg

"Retirement security is built on a foundation of secure income during retirement. For decades, researchers, financial advisors,

and others have encouraged working Americans to pursue the so-called "three-legged stool" of retirement savings: Social Security; a defined benefit pension; and individual savings, typically through a defined contribution plan. This report examines the actual sources of retirement income for older Americans to find out, in part, just how many older Americans actually achieve on the three-legged stool in retirement… Only a small percentage of older Americans, 6.8 percent, receive income from Social Security, a defined benefit pension, and a defined contribution plan (the three-legged stool). A plurality of older Americans, 40.2 percent, only receive income from Social Security in retirement. Roughly equal numbers of older Americans receive income from defined benefit pensions as from defined contribution plans. This is likely to change in the future as fewer private sector workers have access to defined benefit pensions now than in the past." *(National Institute on Retirement Security)*

How Democratic Presidential candidates Want to Change Health Care, Medicare

"Candidates asking for your vote in the presidential primaries are proposing health care overhauls that share a common goal: movement toward universal coverage for all Americans. But how they get there—and pay for it—has divided the candidates and fueled heated exchanges in televised debates. The dispute is largely centered on whether to upend the entire health care industry by creating a single-payer Medicare for All program, or build on the so-called Affordable Care Act by creating a 'public option' insurance plan that would compete with private insurers in an attempt to drive down consumer costs. Here's where the candidates stand." *(Bridge Michigan)*

As always, post your questions or write to me at socialsecurity@horsesmouth.com.

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