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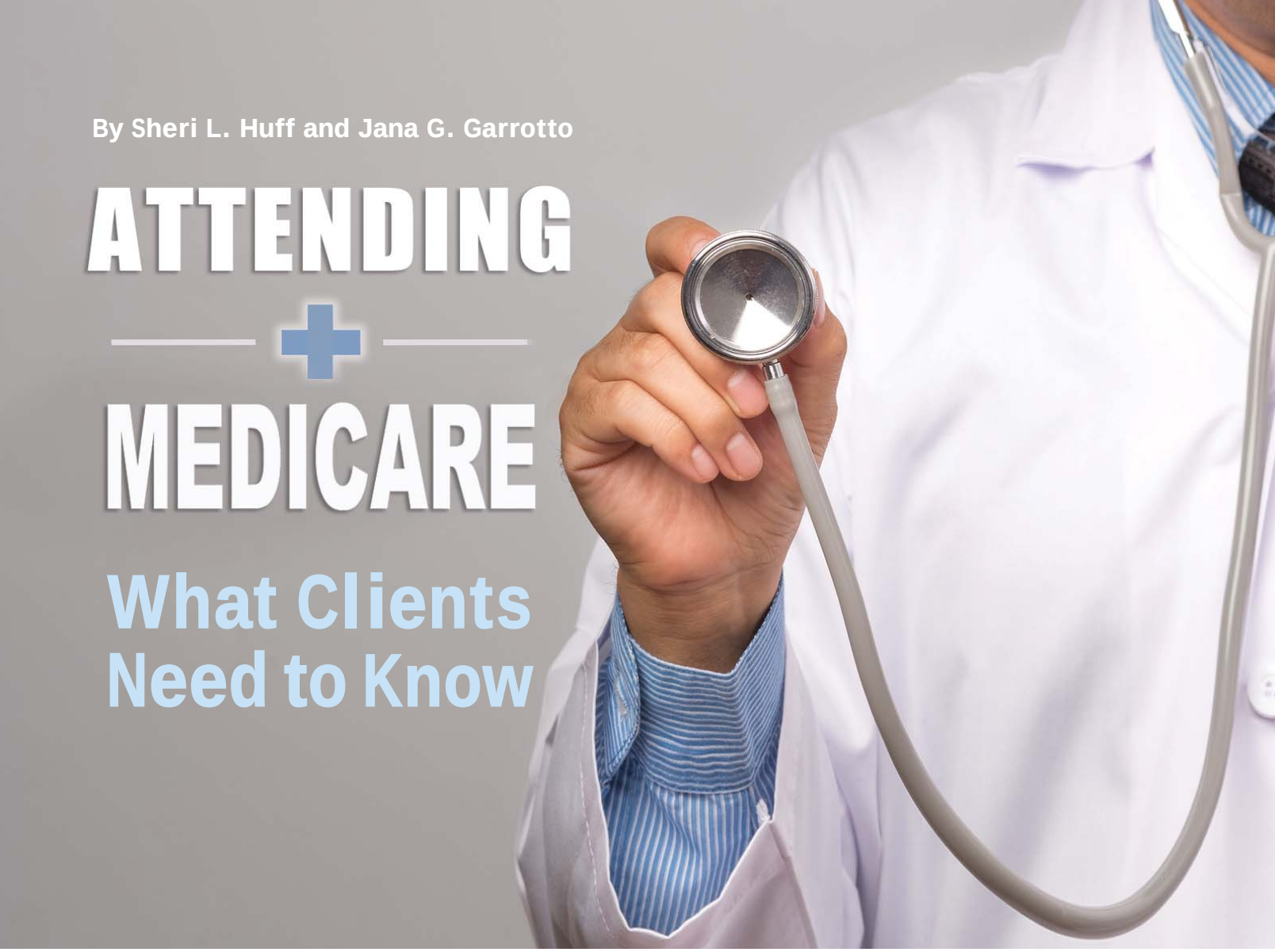
ATTENDING + MEDICARE

What Clients Need to Know



ACCORDING TO THE CENSUS Bureau, by 2030, for the first time, the United States will have more 65-and-older residents than children with all boomers and 1-in-5 American residents having reached the traditional retirement age of 65.

The Centers for Medicare and Medicaid Services (CMS) in Woodlawn, Maryland, estimate there will be 81 million beneficiaries in 2030, or about a 33 percent increase compared to the present.

Medicare: Basics of A Most Challenging Law

Medicare alone currently serves 59 million people in the United States with the courts describing the Medicare Act as "among the most completely impenetrable texts within human experience," requiring "dense reading of the most tortuous kind."[1] [2]

Whether retired or still working, understanding the nuances of Medicare is critical when turning 65.

There are three major areas of confusion in the program to especially watch out for:

- If one does not enroll in Medicare on time, there will be a monthly penalty. Many baby boomers don't know if or when they are required to enroll in Medicare. But the timing rules are strict. Most health plans pay secondary to Medicare, but anyone covered by a retiree health plan, an individual policy, or small employer group plan must enroll in Medicare when they turn 65 or be subject to late-enrollment penalties.
- Clients who do not get the correct private insurance to

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go with Medicare are likely to pay too much in premiums and out-of-pocket costs. The need for private insurance to go with Medicare surprises most people. Most people think Medicare covers everything. But that is far from true. For prescription drug coverage and other out-of-pocket expenses, private insurance is essential.

- People who don't plan for higher health care costs in retirement can run out of money or not get the care they need. The probability of higher future health care costs must be factored into any retirement budget.

The only people exempt from enrolling in Medicare at age 65 are workers and spouses who are in an employer group plan that covers 20 or more employees. Their time comes later.

What Clients Need to Know About Medicare

Medicare was enacted in 1965 as a federal health insurance program primarily for those age 65 and older.[3]

It is also available to people under 65 with a qualifying disability or people of any age who are diagnosed with ALS (Lou Gehrig's disease) or end-stage renal disease.

The program has several parts—Parts A and B, which are known as Original Medicare.

Part A helps cover some hospitalization costs, while Part B helps cover some medical services expenses, such as doctor visits, procedures, and diagnostic tests.

Bills for Parts A and B go first to Medicare. The government pays the portion set by law, such as 80 percent of the doctor bill. The beneficiary is billed the deductible and any remaining amount.

Part D helps cover part of the cost of prescription drugs. It is offered through private insurers that contract with Medicare. There are many drug plans to choose from. Each has its own drug list and offers slightly different coverage at differing prices.

A key part to enrolling in Medicare is shopping for prescription drug plans and finding one that offers the medications needed at a cost one can afford.

An enrollee who doesn't take prescription drugs when they first sign-up for Medicare should still sign up for a Part D drug plan because if they delay drug coverage for very long, they could face a penalty when they finally do enroll.

How Much Medicare Costs

Many people think Medicare is free. It is not.

Part A may be free if the beneficiary or their spouse paid into Medicare for more than ten years. But "free" refers only to monthly premiums. If hospitalized, one pays a deductible before Medicare pays its share. If hospitalization exceeds 60 days, the beneficiary is accountable for all or part of the daily rate. Part B is not free for anyone, except those considered indigent.

Medicare charges a monthly premium that is deducted from one's monthly Social Security check. Anyone not receiving Social Security benefits receives a bill from Medicare, while individuals considered high-income pay an extra amount above the base premium.

An annual deductible that the beneficiary or their supplemental insurance must pay before Medicare pays its share is also levied in addition to the monthly premium. And because Medicare pays only part of the bill, the beneficiary or their insurance pays the rest.

The out-of-pocket expenses that one may be required to pay under Medicare are not limited. This is one reason why most people seek private supplemental insurance.

Medicare subsidizes drug coverage through payments to insurers offering Part D prescription drug plans. Still, one will likely have to pay a monthly premium to the drug plan insurer.

In addition to the monthly premium, annual deductibles and copayments or coinsurance are possible each time a prescription is filled. Terms and premiums vary among drug plans.

How Clients Enroll in Medicare

Contrary to conventional wisdom, Medicare enrollment is not automatic, unless an enrollee is receiving Social Security when they turn 65. Those not already receiving Social Security must proactively sign up for Medicare at least three months before their 65th birthday. The government does not send alerts or reminders.

Enrolling in Medicare through the Social Security Administration takes care only of Parts A and B, while enrollment for Part D requires that one must select a prescription drug plan and then enroll through their private insurer or through Medicare.

Clients who don't enroll in Medicare during the official enrollment period may face a late-enrollment penalty when they finally do enroll.

There are two main enrollment periods for Parts A and B. The initial enrollment period is for anyone when they turn 65 with the exception of everyone who is not remaining in a 20-or-more-employee group coverage plan.

The initial enrollment period starts three months before turning 65 and lasts for seven months.

The special enrollment period applies to those with an employer group plan that covers 20 or more employees that entitles them to sign up later. To avoid any coverage gaps, it is wise to enroll in Medicare before the group coverage ends. Part B late-enrollment penalties can be avoided by enrolling before the end of the seventh month after the group coverage ends.

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Clients who miss the initial or special enrollment period, may enroll in Medicare during the general enrollment period, which is January 1 to March 31 of each year. If they sign up in this period, their Medicare coverage starts July 1 and late enrollment penalties may be added.

For clients with a Health Savings Account (HSA) and High Deductible Health Plan (HDHP), enrolling in Medicare causes HSA contributions to cease. By law, contributions to an HSA may be made after age 65 only for those not enrolled in Medicare.

If an employer plan covers fewer than 20 employees, a client needs to enroll in Medicare at 65 and stop contributing to the HSA. If their plan covers 20 or more employees, they may wait to enroll in Medicare and keep contributing to the HSA. If they want to continue contributing to the HSA, they should not enroll in Medicare Part A or Part B.[4]

Regarding Part D, clients have several choices depending on their other insurance. If a retiree plan will serve as their supplemental insurance, and that plan includes creditable prescription drug coverage, they probably won't sign up for Part D during their initial or special enrollment period.

However, if that coverage ends, they must sign up for Part D within 63 days or pay a late-enrollment penalty. Clients should keep the annual statement from their insurance company saying their drug coverage is creditable. Medicare will ask for it, and if it cannot be provided, a late-enrollment penalty may be assessed.

How to Get Supplemental Insurance

So many out-of-pocket costs are associated with Medicare that the enrollment process should also incorporate a search for suitable private plans. This should be done well before the effective date so that coverage by both Medicare and the supplemental insurance start at the same time.

Medicare supplemental insurance, also known as Medigap, covers gaps in coverage that Medicare does not deal with such as some deductibles, co-payments, and coinsurance amounts for Medicare-approved services.

There are many choices. If signing up during the initial or special enrollment period, one cannot be denied coverage regardless of health status. Policies are standardized, with all policies

designated by the letters A through N offering the same benefits.

For example, Plan F is the most comprehensive and offers the same benefits no matter which insurance company is the provider. This makes price and service key issues when choosing supplemental insurance.

If an employer offers retiree coverage, the client may not need supplemental insurance. Their existing retiree plan may offer better coverage at a lower price, but the client may still need to enroll in Medicare Parts A and B.

Medicare Advantage Plans

These plans offered by private insurers provide another way to get Medicare. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), for example, made the biggest revisions to Medicare in the past 38 years.

Under the MMA, private health plans approved by Medicare became known as Medicare Advantage Plans. These are sometimes called Part C plans. Insurers offering Medicare Advantage plans contract with Medicare and receive a per-capita amount from Medicare. They are responsible to deliver all care under Parts A and B, while most also offer Part D prescription drug coverage.

An enrollee in a Medicare Advantage plan may get extra services such as vision or wellness programs in addition to their Medicare gap coverage. Clients must enroll in Parts A and B *and pay Part B premiums*, along with any premiums charged by the Medicare Advantage plan. Medicare Advantage plans are distinct from Medigap policies. A client who has a Medicare Advantage plan may not apply for Medigap coverage.

What About Long-term Care & Medicaid?

When considering Medicare, it is critical for clients to take the possibility of long-term care into consideration. The reason is simple. When it comes to long- term care, Medicare doesn't provide it and doesn't cover it.

Many people are surprised to find out that if they or their parents ever need help with the routine activities of daily living, like bathing and dressing, or if someone in their family needs supervision because of cognitive decline, Medicare will not pay for it.

In 1965, Congress created Medicaid through Title XIX of the Social Security Act.[5]

Medicaid created a partnership between federal and state governments to provide healthcare and health related services for certain individuals and families with low incomes and, in some cases, limited resources. Each state sets its own Medicaid eligibility requirements based on federal guidelines. California's Medicaid program is known as Medi-Cal.[6]

Advance planning for long-term care needs can help avoid having to spend down assets in order to qualify for Medicaid.

It is important to remember that Medicaid is a state-run welfare program that pays for care for those who have little or no money. But that means an individual must spend down assets to less than $2,000 to qualify, essentially rendering oneself destitute.

Medicaid covers needed services that Medicare does not, such as long-term care in nursing homes and the community. Medicaid also helps make Medicare affordable by covering Medicare premiums and/or cost-sharing, which can be high for individuals with low or fixed incomes.

Dual Eligible Beneficiaries

Generally describing beneficiaries eligible for both Medicare and Medicaid, the term includes

beneficiaries enrolled in Medicare Part A and/or Part B and receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of the Medicare Savings Program (MSP) categories.

Medicare pays covered medical services first for dual eligible beneficiaries and, by law, is considered to be the payer of last resort. If another insurer or program has the responsibility to pay for medical costs incurred by a Medicaid-eligible individual, that entity is generally required to pay all or part of the cost of the claim prior to Medicaid making any payment. This is known as third party liability, or TPL.[7]

Third parties that may be liable to pay for services include private health insurance providers, Medicare, employer-sponsored health insurance programs, settlements from a liability insurer, workers' compensation, long-term care insurance, and other State and Federal programs, unless specifically excluded by Federal statute. Third-party payers are not responsible to reimburse Medicaid for services not covered under the Medicaid State plan.

Medicaid may cover medical costs that Medicare may not cover or partially covers. They may include nursing home care, personal care, and home- and community-based services.

Certain legal devices allow a public benefits recipient to maintain their personal assets without requiring them to be reduced to financial eligibility requirements.

A Special Needs Trust, sometimes called a Supplemental Needs Trust or SNT, is a legal arrangement in which a person or organization, Bank or Pooled Special Needs Trust manages assets for a person with a disability. The person with the disability is called the beneficiary and the person who is managing the assets is the trustee.

Many kinds of assets can be put in a trust, such as cash, stocks, bonds and real estate.

An SNT provides for those needs (goods and services) of a person with a disability that are not already provided by a public benefit program. The assets that are in the Special Needs Trust will not result in a reduction or loss of benefits from programs such as Supplemental Security Income (SSI), Medi-Cal, In-Home Support Services (IHSS) and HUD housing assistance. Assets in a Special Needs Trust won't be counted toward the SSI, Medi-Cal and IHSS eligibility limit of $2,000 per individual.

In general, there are two types of Special Needs Trust: a first party trust and a third party trust. The primary difference is whether the beneficiary owns or has a right to own the trust assets. There are also special rules that apply when the beneficiary dies and Medi-Cal exercises its claim to reimbursement from the trust's assets.

Since rules governing Special Needs Trusts are complicated, one should consult a professional regarding its use in any particular situation.

In short, clients who are informed about Medicare, know the rules and timing requirements for enrollment, understand how the program meshes with state programs and insurance, are best positioned to enjoy the range of benefits available through Medicare. By combining Medicare with supplemental insurance that is best tailored to their needs will help clients avoid unnecessary costs and anxiety.

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[1] CMS/Office of Enterprise Data & Analytics/Office of the Actuary, August 2018. *www.cms.gov/fastfacts/.*

[2] *E.g., Prime Healthcare Servs. v. Humana Ins.* 298 F.Supp.3d 1316 (C.D.Cal. 2018).

[3] 42 U.S.C. §§ 1395 et seq.

[4] www.irs.gov/publications/p969#en_US_2018_publink1000204063.

[5] 42 U.S.C. §§ 1396-1 et seq.

[6] *See e.g., Hunt v. Superior Court* (1999) 21 Cal.4th 984, 994 (Discussing history of the Medi-Cal program).

[7] *www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/downloads/tpl.pdf.*