

Aging and Retirement

Securing Medicare and Other Health Insurance for the Retirement Journey

MANAGING RETIREMENT DECISIONS SERIES



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Introduction

PEOPLE ARE LIVING LONGER in retirement than ever. Maintaining good health will help make those years vibrant. So will access to affordable medical care and to medical insurance to help pay for that care. This Decision Brief looks at some of the key health insurance decisions that retirees need to make.

The decision process is like planning a long road trip: first studying where to go and then figuring out how to make it happen. Most people who are not yet eligible for Medicare will find many health care plan options available, but these are often at costs much higher than expected. Once eligible for Medicare, people are often relieved to find they now have more affordable choices. Sometimes, however, the new choices can be difficult to navigate or understand, and some may entail implications or complications that are not readily apparent at first glance.

The bottom line: Just as when planning that long-awaited road trip, it pays to explore the route before settling on the direction to take. It also helps to review the route periodically in case changes become necessary. This Decision Brief is designed to help people do those things.

A Frank Look at Costs

WE START WITH A DISCUSSION of the cost for health care and health insurance, because such costs are a major financial consideration for people when they retire. Experts project that health care costs will continue to rise more than general inflation in the coming years.¹ This makes it increasingly necessary to have health insurance to help pay for these expenses while working and also when retired.

The cost of health care insurance is the “premium” charged for a policy. Many people don’t realize that while they are working the employer usually subsidizes a large portion of the premium for workers who are covered by their group health insurance plan. The employer subsidy is significant; it averages about 80% of total premium for employees with single coverage and 70% for family coverage.²

An important reminder when purchasing health care insurance—whether you are covered by Medicare or not—is to consider both the monthly premium and an estimate of your out-of-pocket costs for the year. Out-of-pocket costs include the deductibles, coinsurance and copays that you will have to pay. It is often helpful to look back over the past year to see what kind of health care you received and what the doctors and hospitals charged you. Think about what you expect to pay in the upcoming year to determine what your out-of-pocket costs might be. It may also be helpful to think what might happen if you end up having some large expenses (e.g., a hospitalization) to ensure you have enough savings to pay for these unexpected costs.

Before age 65, people without employer coverage may purchase individual health care coverage through the insurance exchanges that operate under the Affordable Care Act, often referred to as “the marketplace.” There are subsidies for those at lower income levels who are buying from the insurance exchanges that help with the monthly premiums and may also offer better benefits than individual health care plans.

FOOTNOTES

1 2016–17 Medicare Technical Panel, *Review of Assumptions and Methods of the Medicare Trustees’ Financial Projections*, September 2017.

2 Kaiser/HRET, *Survey of Employer-Sponsored Health Benefits*, September 2019.

Securing Medicare and Other Health Insurance for the Retirement Journey

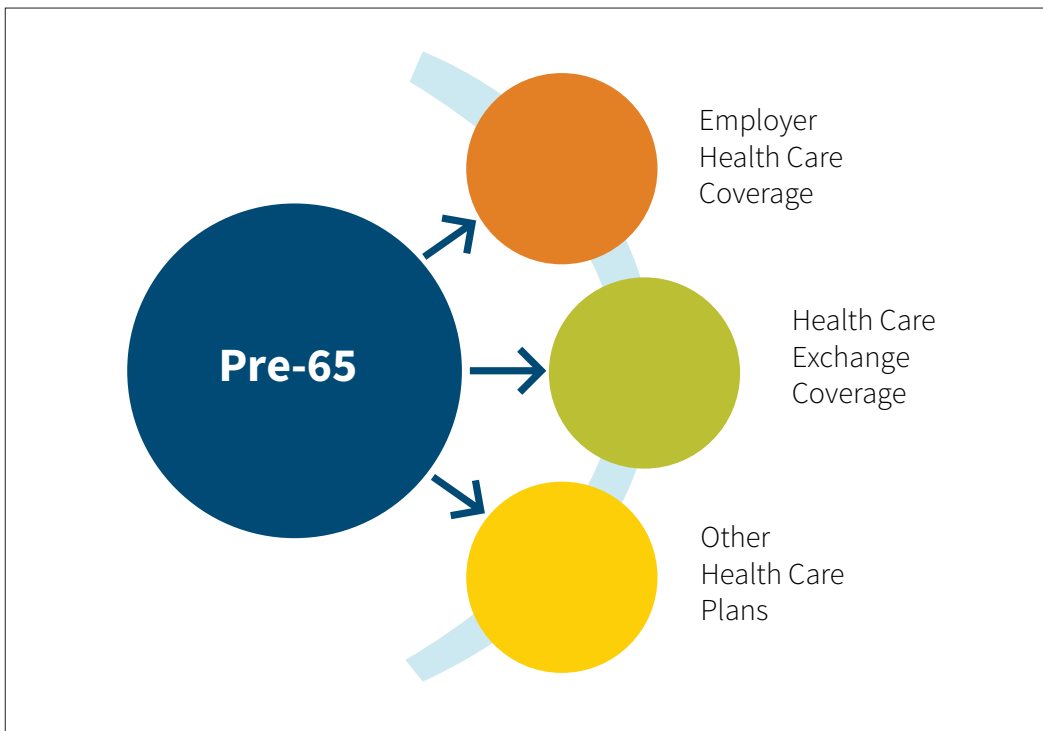
People wanting to retire before age 65 may encounter sticker shock related to the cost of their new health insurance plan. That is because the cost of comparable coverage they now will purchase most likely will be higher than what they had paid during their working years. One reason for the increase in cost is that the employer subsidy no longer applies. Another reason is that the premium charged is now based on the individual's age, not on the average premium for all employees of their former workplace.

Fortunately, people do have several choices for health care insurance, whether they are retiring before they become eligible for Medicare at age 65 or after that. However, these choices may have different effects on the overall cost for their health care coverage. Thus, it is very important for people to review their health care needs, research their health care insurance coverage options and related costs available to them and make an informed decision on their health care insurance before retiring at any age.

Health Care Coverage Before Age 65

UNTIL AGE 65, most people with health care coverage are used to the health care plans they currently have. The health care decisions that people make before age 65 entail three major health care insurance systems:

Major Health Care Choices Pre-65



1. The health care plan offered by an employer
2. The individual health care purchased on the health care exchanges (both public and private) and
3. Other health care plans purchased through an insurance agent, a membership association, a social welfare arrangement or other unique circumstance.

Considerations for those who do not have employer-provided health insurance prior to age 65 are discussed further in this Decision Brief.

Medicare at Age 65

MUCH HEALTH CARE FUNDING AT THE OLDER

AGES is built upon Medicare. Because of that, people should start researching their Medicare options well before turning age 65. This Decision Brief provides insight on topics to review, and it points to various independent resources to check out for more information.

Reminder

The normal retirement age for Social Security has increased to between ages 65 and 67 for those born after 1937. However, eligibility for Medicare is still at age 65.

Enrolling in Medicare is a major milestone. Although most people expect to be covered by Medicare, many do not know how to get started, what options are available or how to project Medicare costs within their overall retirement plan. Here are some thoughts on these points.

Who Is Eligible for Medicare?

Those who paid Medicare taxes while working, generally for at least 10 years, are eligible when they reach age 65; nonworking spouses³ of such individuals are also eligible when they reach 65. Those who are under 65 and have been a disabled beneficiary under Social Security or Railroad Retirement for more than 24 months are also eligible. Even people who never paid Medicare taxes may be eligible if they pay a Medicare premium for the benefits.

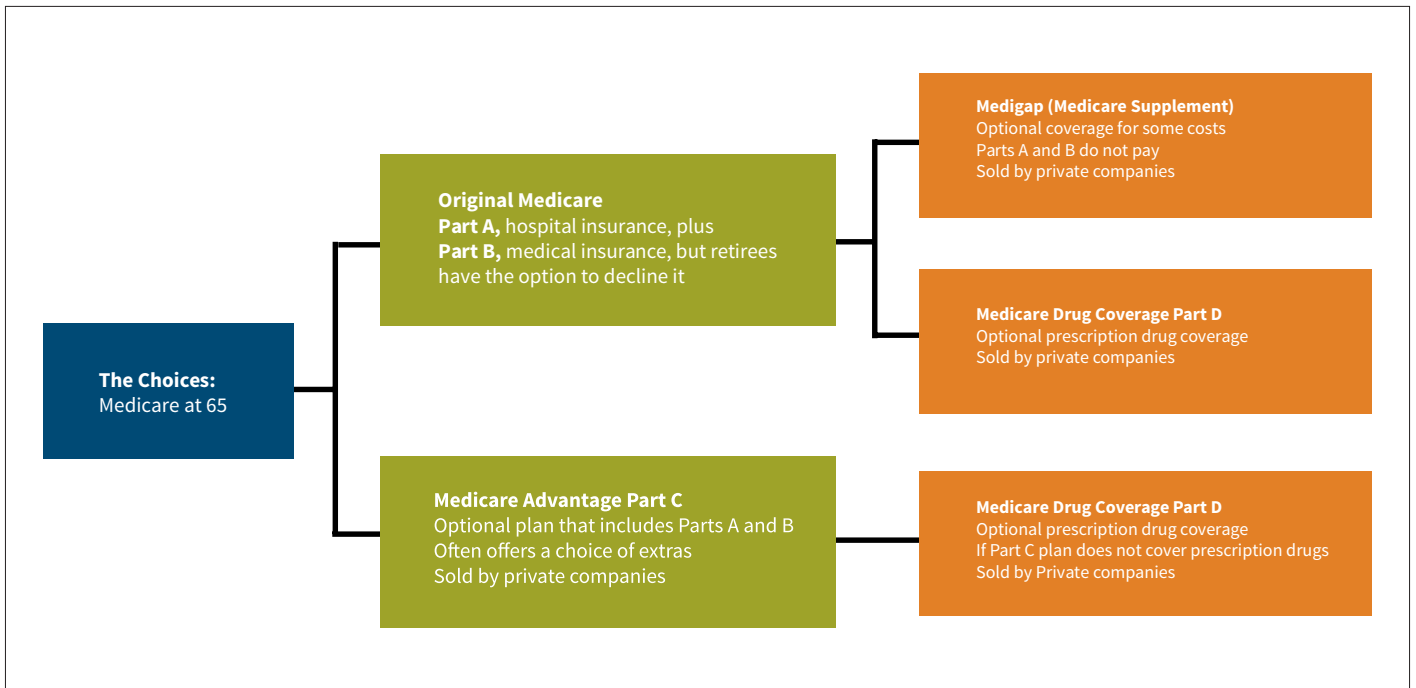
What Benefits Does Medicare Provide?

Medicare provides coverage for health care benefits in four “Parts.” Three of those Parts are optional, meaning people can elect them or not. The Medicare Choices chart below shows the breakdown, followed by a brief summary of each Part. Note that the choices present two different paths—take Original Medicare and its optional components if desired, or take Medicare Advantage Part C and its optional component if desired.

FOOTNOTE

³ “Spouses” are used throughout this brief and may include domestic partners in Medicare and employer plans.

Medicare Choices at Age 65



Medicare Choices at Age 65

- **Part A:** This is hospital insurance. It helps pay for hospital, home health, skilled nursing facility costs (on an extremely limited basis) and hospice care for the aged and disabled. Enrollment is automatic for most people at age 65.
- **Part B:** This is medical insurance. This coverage helps pay for physician, outpatient care and home health (in the rare instance when a person does not have Part A coverage). It also pays for other medical services for the aged and disabled who voluntarily enroll in Part B and pay its premiums. While enrollment in Part B is automatic at age 65, coverage in Part B is optional since you can decline Part B coverage. Premiums for Part B increase with increasing income, but people with lower incomes may be eligible for financial assistance from state programs for paying their premiums.

- **Part C (also called Medicare Advantage or MA plans):** These are private health insurance plans that people buy from insurance companies. To offer these plans, the insurers contract with Medicare to provide coverage that is at least equal to Medicare Parts A and B. The plans typically offer additional benefits and access to “network providers” (doctors and health care facilities), as well, but particular benefits vary from plan to plan and can change.
- **Part D:** Part D plans provide insurance for prescription drugs. Private insurance companies sell Part D plans to people who have Medicare. The plans differ between insurers and can change annually, so consumers need to compare plan costs, features, providers, plan tiers (levels of drug coverage) and formularies (list of approved drugs covered by the plan). Premiums increase with increasing income, but people with income below a specified amount may qualify for Extra Help, a Medicare program that helps pay prescription drug costs, or other subsidy programs.
- **Medicare supplement policies (also called Medigap policies):** These are standardized health insurance policies sold by private companies that pay some costs that Original Medicare does not pay, thus wrapping around Original Medicare Parts A and B. They may also provide coverage for certain other health care costs. Insurers can sell these policies in 10 approved plan designs, currently identified by letters A, B, C, D, F, G and K through N.⁴

More about Part C

Part C is optional because people can choose to enroll in Part C or not. If they do, they will need to compare features such as premiums, copays, network providers and coverages (such as for prescription drugs) that insurers may offer in addition to Medicare Parts A and B coverage. Such features vary between companies and can change annually. Note: Not all health insurers offer Part C plans, and not all offer Part C in all states or locales.

Some people confuse Part C with Plan C, but the two terms have nothing to do with one another. As noted previously, Part C refers to Medicare Advantage plans, whereas Plan C is one of the 10 plan designs allowed for use in Medigap policies. The same is true with Part D (Medicare prescription drug plans) and Plan D.

FOOTNOTE

⁴ Note that three states (Massachusetts, Minnesota and Wisconsin) standardize their plans in a different way set by state law.

To Simplify Terminology

The remainder of this discussion uses the following terms:

- **Medicare Advantage** when referencing Part C or MA plans
- **Medigap** when referencing Medicare supplement policies

Table 1 summarizes highlights from each of the plan categories mentioned above. The information appears in table form to help break out some of the key factors to consider when evaluating and choosing plan options. This table is followed by a discussion of key points to keep in mind when selecting a plan and enrolling in Medicare.

Table 1
Summary of Original Medicare, Medicare Advantage, Medigap and Medicare Prescription Drug Plans

Issue	Original Medicare (Parts A and B)	Medicare Advantage (Part C)	Medigap (Supplement Plans)	Prescription Drug (Part D)
Benefits defined	In Medicare law, includes defined deductibles and copayments	Plans must offer benefits that are at least equal to Original Medicare, there may be major differences in benefits, and they may provide extra benefits.	A number of plan designs with standard coverage features regulated by law	A standard plan design is set by law, but plans may offer designs that are equivalent or better, and may set rules on prior authorization, quantity, drug formulary and other matters, and they must follow rules set by Medicare.
Providers that can be used	Any provider that has contracted with Medicare	Network doctors and facilities used by plan, but consumers should be careful because providers may drop out of network. For people in some locations, the network is very limited and is a major problem. In the event of major illness, you may still be limited to providers in plan.	Any provider that has contracted with Medicare	Each plan has its own drug formulary. Each may have its own pharmacy relationships (which specify drug stores available under the plan and their reimbursement levels).

Securing Medicare and Other Health Insurance for the Retirement Journey

Issue	Original Medicare (Parts A and B)	Medicare Advantage (Part C)	Medigap (Supplement Plans)	Prescription Drug (Part D)
Suitable for people who live in multiple locations (e.g., “snowbirds”)	Yes, but coverage only within the U.S.	Generally not; network usually limited to specific locations	Yes, with limited coverage by some plans for foreign travel	Yes, but some plans have better national coverage of preferred pharmacies; each plan should be checked for how this coverage works.
Annual re-enrollment required	No	Generally no, but people may change plans annually only during the open enrollment period (often referred to as “open season”).	No, but people may change plans annually to some extent (may face underwriting).	Once eligible for Medicare, people can join, switch or drop each year or during special enrollment periods.
Premiums	For Part B only, defined by law and vary by income. Premiums may be automatically deducted from Social Security and Railroad Retirement benefits.	Set by the individual plan. Must still pay Part B premium.	Set by individual plan. Beneficiary must still pay Part B premium.	Set by individual plan.
Copays and deductibles	Defined by Medicare. If you have a supplement, it may cover many of these deductibles and copays.	Defined by the plan, within parameters negotiated with Medicare.	Defined by the plan within parameters set by Medicare and state insurance departments. National standard is found in most states (MN, WI and MA have different standardized designs).	Yes, yearly deductible, copays or coinsurance. Note that the coverage gap or “donut hole” is gone in 2020.
Fee levels permitted	Set by Medicare. Some physicians may charge more than the Medicare allowance.	Set by plan. Providers generally not allowed to bill additional amount.	Set by Medicare with some plans covering amounts above the Medicare allowance.	Set by plan.
Includes drug coverage	No, you must also buy Medicare Part D.	Maybe—some plans include drug coverage.	No, consumers must also buy Medicare Part D.	Part D often included in Medicare Advantage plans and purchased separately with Original Medicare and Medigap plans

Securing Medicare and Other Health Insurance for the Retirement Journey

Issue	Original Medicare (Parts A and B)	Medicare Advantage (Part C)	Medigap (Supplement Plans)	Prescription Drug (Part D)
Includes extended coverage	No overall out-of-pocket limit. Can have very large costs if there are major uncovered items and hospital stays of more than 60 days.	Depends on plan.	Some plans cover all amounts not paid by Medicare, and some plans have maximum out-of-pocket limits.	No overall out-of-pocket limit, but once costs reach a certain limit, Medicare will pay most of the prescription costs.
Includes dental, vision or hearing coverage	No	Some may have limited dental, vision and hearing benefits.	No	No

Starting Medicare: The Basics

PEOPLE WHO ARE ALREADY RECEIVING SOCIAL SECURITY BENEFITS will, upon turning age 65, start receiving Medicare Part A and Part B automatically.

But there is an option here: As noted above, people may reject Part B coverage when turning 65. That makes part B optional. If they reject the coverage, they will not have to pay the monthly premiums for it.

However, if they decide to sign up later (beyond the initial enrollment period), their Part B premium may be subject to a late enrollment penalty.

Initial enrollment window: Those who have not started their Social Security benefit payments by age 65 will need to sign up for Medicare during a seven-month enrollment window. This period starts three months before the month of turning 65, includes the age 65 birthday month and closes three months after turning 65.

During the enrollment period, Medigap coverage is issued without any “underwriting.” This means that, during the first seven months of Medicare eligibility, insurers must issue coverage to all who meet the very minimal eligibility requirements, regardless of their health conditions. After that window closes, people who want to purchase this coverage may need to submit proof of insurability and may need to pay a higher rate than otherwise would be the case.

What about people who are still working when they turn 65 and are enrolled in an employer health insurance plan? Such individuals may stay in the employer’s plan. If they later lose the employer coverage (e.g., due to going part-time or retiring), they may then sign up for Medicare. If

Helpful Tool

The www.medicare.gov website is the official Medicare website of the U.S. government. It provides extensive information to help consumers learn about Medicare, make comparisons and locate many useful resources.

Worth noting: The website includes a software tool that helps identify Medicare Advantage and Part D plans available by location. Titled *Find Health & Drug Plans*, this tool enables website visitors to find health plans and costs, Part D information and other information.

they provide proof of the previous employer health insurance coverage to Medicare, they will not be subject to the penalty premiums for late enrollment in Part B or Part D plans.

Spouses of those working past age 65 have a choice if they are not employed. They may continue on their spouse's employer coverage and sign up for Medicare when the spouse retires. Or they may sign up for Medicare if they are eligible under their own work record.

Note that for those working for an employer with fewer than 20 employees or who are self-employed, Medicare is the primary plan, meaning Medicare pays claims first. Any such employer coverage is secondary, meaning it pays after Medicare pays on a claim. The message for workers at these employers is to sign up for Medicare at age 65 even though still working.

There are other ways to qualify for Medicare as well. Those who meet strict qualifications for disability, end-stage renal disease or ALS (Lou Gehrig's disease) will qualify even if under age 65.

What about Part D? As noted above, enrollment in Part D is optional. Individuals who choose one of these prescription drug plans must pay a monthly premium for the coverage plus copays (cost sharing) on certain prescription purchases. As with the Part B late enrollment penalty, those who delay enrolling in Part D will generally need to pay a late enrollment penalty.

Higher-income beneficiaries are subject to higher premiums for both Parts B and D. For example, in 2020, individuals with a modified adjusted gross income greater than \$87,000 (\$174,000 if married filing jointly) in 2018 (based on the income tax return two years prior) were subject to higher premiums. The income threshold is indexed for inflation (CPI-U) after 2019.

The Cost of Late Enrollment

In general, those who apply for Part B after the initial seven-month application window closes may see their monthly premium increased by 10% for each year they are not covered by Part B.

For Part D, the late enrollment penalty is based on the national average premium for the basic Part D benefit. The penalty is equal to 1% times the national average times the number of months that the person did not have Part D coverage.

Paying Medicare Premiums

- **Medicare Part B:** People can pay these premiums in any of four ways:
 1. Have the premium deducted from their Social Security check
 2. Have Medicare Easy Pay debit the person's checking account
 3. Mail a check for each payment due
 4. Pay by credit card
- **Medicare Advantage, Medicare Part D and Medigap plans:** People can pay these premiums by check, automatic debit or credit card.

Reminder: People do not pay for Medicare Part A coverage if they (or their covered spouse) have worked for at least 40 quarters and paid Medicare taxes while doing so. However, those who did not pay Medicare taxes during some or all of their 40 quarters of work will be charged a Medicare premium; this premium will be deducted automatically from their Social Security checks.

The Role of Health Savings Accounts

Those who have a Health Savings Account (HSA) can make withdrawals from it to help pay for health care expenses not covered by Medicare, Medigap, Medicare Advantage or other noninsured health costs. The HSA can also be used to pay Medicare premiums but cannot be used to pay Medigap plan premiums. However, no one can continue making new contributions to their HSA once enrolled in Medicare.

One important tip is that if a person enrolls in Medicare after age 65, that person may be retroactively enrolled in Medicare for up to six months. To avoid tax penalties, people typically stop making HSA contributions by the later of age 65 or six months before enrollment in Medicare.

Employer-Provided Retiree Health Insurance

SOME EMPLOYERS continue to provide health insurance to their retirees. Usually, the retiree must meet certain eligibility rules. The specific rules vary, but a common requirement is 10 years of working service and leaving the company after turning age 55.

Many employers require enrollment in the retiree health insurance plan immediately after retirement, and the offer of coverage is not available at a later time. Coverage may be for the lifetime of the retiree and their dependents (such as the spouse), or it may be limited to a fixed number of years. Often coverage is only while the retiree is under age 65.

The health insurance coverage provided is usually the same as that provided to active employees until the retiree becomes eligible for Medicare. After becoming Medicare-eligible, the retiree is generally required to enroll in both Medicare Parts A and B with the employer plan being “secondary” (i.e., it pays claims second, after Medicare has paid).

Employer plans vary in the premium rates they require. For instance, employers may apply a higher premium rate for retirees than for active employees to account for the higher cost, whereas others may vary the rate depending on age or service at retirement. Other variations exist, so retirees need to review their options carefully and ask detailed questions.

Health Care Insurance Considerations

WHEN DECIDING WHEN TO RETIRE, the need for adequate and affordable health insurance is a critical factor. Good planning also entails exploring how to manage if unanticipated and costly chronic conditions occur or if desired health plan coverages and costs change in unexpected ways. These risk factors make it essential for retirees to do a yearly evaluation of their health plan choices. Following are some factors to consider in that review.

Considerations Before Age 65 and Becoming Eligible for Medicare

Before age 65, people are generally not eligible for Medicare coverage unless they qualify due to disability.

The principal options for health coverage prior to Medicare eligibility are employer-sponsored coverage including retiree coverage and the Consolidated Omnibus Budget Reconciliation Act (COBRA),⁵ individually secured coverage through the health insurance exchanges established under the Affordable Care Act, government programs for veterans and military personnel, and Medicaid.

Employer-sponsored coverage and options: When evaluating employer-based coverage, older workers will want to consider the following:

- The premium is usually shared between employer and retiree. However, the premiums will usually increase when the employee switches from active to retired status. Sometimes these increases are substantial.
- Premiums will depend on whether the plan covers only the employee (in an individual plan) or spouse and dependents as well (in a family plan). Understanding the employees' "contribution rate" (the portion the employees pay) can help in assessing this aspect.
- Young adults can stay on the parent's plan up to age 26.

FOOTNOTE

⁵ The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 is a federal law that provides for continuing employer group health insurance coverage for some employees and their families after a job loss or other qualifying event.

Securing Medicare and Other Health Insurance for the Retirement Journey

- If coverage continues after the retiree and spouse become eligible for Medicare, employers typically require the couple to enroll in Medicare, with the employer plan being secondary to Medicare.
- The employer may have the right to change (or cancel) coverage at any time.
- Even those who already have health insurance in place will need to plan for other health-care-related costs. These include certain cost-sharing and plan deductibles and expenses not covered by the plan. However, certain legal provisions can help keep personal health costs down.⁶
- Typically, if a retiree opts out of the employer plan when first eligible, the person will not be able to enroll later. Some plans may allow later enrollment under special circumstances (e.g., covered under an active employee health plan of the spouse and spouse retires later), but the retiree will want to understand the rules before deciding whether to accept or decline employer plan enrollment.

Individual coverage and options: What if the employer does not offer retiree health care coverage? Under COBRA, coverage is generally available for 18 months. However, premiums will usually increase when the employee switches to COBRA coverage.

Another option may be for the worker to purchase private health insurance under the Affordable Care Act marketplace until reaching Medicare eligibility at age 65. An individual should compare their COBRA option with a plan on the Affordable Care Act marketplace.

The Affordable Care Act marketplaces (also called exchanges) offer several insurance coverage options to individuals who are not eligible for Medicare. Most of these plans offer access to care provided by networks of preferred physicians and hospitals.

A Word about COBRA and Other Insurance

A person who has COBRA continuation coverage, retiree health insurance or individual health insurance would not qualify as having been “covered” by an employer health insurance plan for the waiver of Medicare’s late enrollment penalty.

Under Medicare rules, currently employed persons who are enrolled in the employer health plan are treated as covered.

FOOTNOTE

⁶ These provisions include (a) restrictions on insurers from dropping health coverage due to illness, from denying coverage due to a preexisting condition and from placing annual or lifetime dollar limits on health coverage and b) reductions in out-of-pocket costs for certain preventive care services.

Smart move: Before enrolling in any new plan, it is wise to check with the insurance company of the prospective new plan to ensure that the retiree's valued physicians or hospital groups are included in the provider network. (A provider network is the group of health care professionals and facilities that contract with the plan to deliver care to patients.)

Retiring workers may also want to check to see if they are eligible for Medicaid, which is subject to very strict income and other requirements that vary by state.

Military retirees and their spouses may also be eligible for TRICARE, the health care coverage program for uniformed service members, retirees and families.

Employers may terminate the company's retiree health coverage plan at any time. If that happens, retirees may have COBRA coverage available for as long as 18 months, although the cost may be higher. Knowing that, retirees may want to build additional health care expenses into their long-term retirement financial plans to ensure funds would be available.

Summary of health care options: People who are under age 65, not eligible for health insurance based on a current job and not eligible for Medicare have some options too. The main options are the following:

- Health insurance based on a spouse's job
- Health insurance based on retiree coverage provided by a former employer (or spouse's former employer)
- Health insurance obtained through the exchanges established under the Affordable Care Act
- Health insurance obtained through a professional association in some cases
- Health services provided by the Veterans Administration for veterans
- Health insurance for military retirees under the TRICARE program
- Health services obtained through Medicaid for those with low income and few assets
- Being uninsured—a highly risky option.

Considerations About Health Insurance After Age 65

An important consideration is what Medicare costs in terms of monthly premiums and out-of-pocket costs. As is probably evident from the forgoing discussion of choices, the answer to the question about cost is “that depends.” Following are some key points to keep in mind.

Monthly premiums: Part A coverage is paid for with payroll taxes during a person's working years. Part B coverage, which as noted earlier is optional, is paid in part by the government and in part by the retiree. Specifically, the government pays about 75% of the Part B premium costs, and the retiree pays the other 25%. In 2020, the retiree's monthly premium for Part B coverage is \$144.60 (or higher, depending on income).⁷

Securing Medicare and Other Health Insurance for the Retirement Journey

These premiums adjust in relationship to program costs. During the last 10 years, health care cost increases have been relatively stable, averaging about 3.5% per year. By comparison, the average increase in the Consumer Price Index over the same period was about 1.8% per year.

“Out-of-pocket” costs: These are costs that people who have Medicare will pay in addition to their monthly Medicare premiums. These costs change every year, so it is important to monitor them at the start of each plan year.

How it works: Under Part A, for hospital stays, people who have Medicare will pay cost-sharing factors—called a deductible and coinsurance—during each benefit period. In 2020 the deductible is \$1,408 and the coinsurance is \$352 per day for stays of 61 to 90 days (The daily coinsurance increases for longer stays). Part B services are also subject to an annual deductible (\$198 in 2020) and 20% coinsurance, which is the retiree’s share of cost of Medicare-approved covered services. The dollar amounts are updated annually.

Covering Medicare gaps: Medicare does not cover everything. Besides the coinsurance and deductibles mentioned above, some health care providers may charge an amount greater than that covered by Medicare, resulting in an “excess charge” not paid for by Medicare. Such providers are ones that do not agree to accept Medicare-approved amounts as full payment. You can use “Physician Compare” on the Medicare.gov site to make sure a provider has agreed to accept Medicare-approved amounts as payment in full.

There are also services that are not provided or provided on only a limited basis. For instance, Medicare does not pay for most long-term care or custodial care. However, Medicare does pay for a medically necessary skilled nursing facility or home health care on a very limited basis. Some physicians do not accept Medicare patients, and their services may not be covered. Medicare also does not cover such things as routine dental care, vision care or hearing devices.

To fill such cost-sharing gaps in Medicare covered services, retirees with employer coverage may be covered by a plan that coordinates its coverage with Medicare. Retirees who do not have such employer coverage may buy a Medigap policy from a private insurer to help fill the gaps.

FOOTNOTE

- 7 In 2020, for individuals earning \$87,000 and less in 2018 (two years prior), the standard monthly premium rate is \$144.60. For those earning more than \$87,000 the monthly premium rate ranges from \$202.40 to \$491.60 for the highest earners. Note that this adjusted premium rate is based on the income tax return from two years prior. For newly retired persons who will have lower income in retirement, it is worth seeking a review of premium determination based on supplied evidence of their now lower income.

Securing Medicare and Other Health Insurance for the Retirement Journey

As discussed earlier, Medigap policies are designed to supplement Medicare coverage. Health insurers are allowed to sell one or more of 10 standardized Medigap plans; in most states, these standardized plans are identified by letters (Plan A, Plan B etc.). The coverage available in each standardized plan, such as Plan A, will be the same among all insurers selling such policies. However, it pays to compare the same plan sold by different insurers, because Medigap premiums can and do differ between companies, and so do the “extras” that companies often offer, such as access to discounted fitness programs.

Keep in mind that Medigap coverage is issued without any “underwriting” during the first seven months of Medicare eligibility. This means that the Medigap insurers must issue coverage to all who meet the very minimal eligibility requirements, regardless of health conditions. After the window closes, people who want to purchase Medigap coverage may need to submit proof of insurability and may need to pay a higher rate than otherwise would be the case.

Exceptions: Massachusetts, Minnesota and Wisconsin have Medigap policies that are standardized in a different way. More information on this can be found on the Medicare.gov website and in the government’s Medicare and You handbook, which is mailed out each year and is available as a pdf download at www.Medicare.gov or from those states’ insurance departments.

Medicare Advantage: Alternatively, retirees can enroll in a Medicare Advantage plan as described above. Some employers sponsor special Medicare Advantage plans that are available only to their retirees (and dependents, if the plan is also available to dependents). Whether buying an employer Medicare Advantage plan or an individual Medicare Advantage plan, retirees must still pay Part B premiums and often an additional premium to the Medicare Advantage plan. A retiree cannot be enrolled in both a Medicare Advantage plan and a Medigap plan.

Part D plans: Finally, a Medicare retiree needs to assess whether the employer plan or Medicare Advantage plan they are considering covers prescription drugs. Medigap plans do not cover drugs. If a health plan does not cover drugs, most retirees consider buying a Part D prescription drug plan.

Change in 2020

Medigap plans that cover the Part B deductible will no longer be available to new enrollees starting January 1, 2020. This means Medigap Plans C and F will no longer be sold, but people who are already enrolled in either plan may continue with that coverage. Also, those who were eligible for Medicare prior to 2020 but not yet enrolled may be able to buy Medigap Plans C or F upon enrollment in Medicare.

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Snowbirds: For those who live in two geographic locations (e.g., summers in the north and winters in the south), Original Medicare plus a Medigap and Part D plan may be the best option. However, it is also a good idea to look at a Medicare Advantage plan because some of them offer out-of-network benefits and broader network coverage than just for emergencies.

Choices for couples: Since Medicare eligibility age is based on an individual's age, choices for couples become more complex depending on employment status and Medicare eligibility for each individual. Spouses can't always time their respective retirements to make best use of insurance resources, but learning more about what the couple needs to do can help formulate plans that will work for them. Even when to start certain medical treatments can be affected by when one or both spouses retire. See Table 3 for questions to consider.

Insurance Other than Medical

Many retirees should consider buying additional personal insurance coverage beyond basic insurance for medical care. Plans available in the private insurance market may include dental, vision, hearing and long-term care insurance. Since such plans typically have annual or lifetime dollar limits on coverage, it is important to understand what each plan covers. Following are some key points.

Out-of-Country care: Medicare generally does not provide coverage for medical care outside of the U.S., with the exception of three limited circumstances. Some Medigap plans do include limited coverage for this, as do some Medicare Advantage plans and some employer-sponsored plans. Individuals who plan to travel outside of the U.S. should check their existing medical coverage and decide what risks they are willing to assume and which ones to transfer to their travel insurance. See www.medicare.gov for more information.

For those needing insurance coverage for emergency medical care while traveling, options may be available through tour operators, travel agents or special travel policies. Emergency transport back to a desired location for medical care can be especially important. Worth noting: Some travel policies provide annual coverage.

Some individuals travel to purchase drugs, obtain surgery or secure other medical care outside of the US. Financing and insurance for these needs is beyond the scope of this Decision Brief. Some Americans choose to live all or part of the year outside of the country. Medical benefits for such individuals are also beyond the scope of this Decision Brief.

Dental, vision and hearing care: Few employers offer dental, vision or hearing care insurance to workers who retire. Individual plans are available in most locations. These plans will vary from offering discounts with certain providers to providing fixed benefits (e.g., \$150 for a dental exam, \$100 for frames for eyeglasses) with annual maximums. Those looking for these benefits should consider coverage provided through retiree organizations and affinity groups. In addition, some Medicare Advantage plans provide these coverages, ranging from primarily basic coverage but sometimes being more comprehensive. It is worth checking what is available in Medicare Advantage plans before purchasing additional insurance.

Long-term care: Some people reach the point where they need assistance with activities such as dressing, walking, eating and using toilet facilities (often referred to as “activities of daily living” or ADLs). Such assistance can be very costly. Health insurance policies typically do not cover such long-term care expenses or, if they do, for only a limited time. To secure insurance coverage for these types of expenses, it is necessary to purchase separate long-term care insurance.⁸

Medicaid with Medicare

Medicaid is a public assistance program for lower income individuals who meet both functional and financial eligibility criteria. People who have used up their personal assets for long-term care may turn to Medicaid for subsequent care. Medicaid may cover medical costs that Medicare does not cover or partially covers (such as nursing home care, personal care and home- and community-based services). Eligibility criteria and benefits vary greatly from state to state.

Noteworthy: People may be in both Medicaid and Medicare. For example, in 2019, there were about 60 million individuals on Medicare (40 million on Original Medicare and 20 million on Medicare Advantage) and 75 million individuals on Medicaid.⁹ Of those, 12 million were in both.

The term “dual eligible beneficiaries” refers to people who are eligible for both Medicare and Medicaid. Included are beneficiaries receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of the following Medicare Savings Program (MSP) categories:

FOOTNOTES

⁸ See the Society of Actuaries' [Financing Long-Term Care Needs](#) decision brief.

⁹ Centers for Medicare & Medicaid Services, *CMS Fast Facts*, January 2019.

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- **Qualified Medicare Beneficiary (QMB) program:** Helps pay premiums, deductibles, coinsurance and copayments for Part A, Part B or both programs.
- **Specified Low-Income Medicare Beneficiary (SLMB) program:** Helps pay Part B premiums.
- **Qualifying Individual (QI) program:** Helps pay Part B premiums.
- **Qualified Disabled Working Individual (QDWI) program:** Pays the Part A premium for certain disabled and working beneficiaries. Medicare pays covered medical services first for dual eligible beneficiaries because Medicaid is generally the payer of last resort.¹⁰

FOOTNOTE

¹⁰ CMS, Dual Eligible Beneficiaries under Medicare and Medicaid, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf.

Use Caution

MOST EXPERTS AGREE that it is a good idea to think through the many decisions that people must make when establishing a retirement health care plan. Doing so will help avoid some unintended, and costly, mistakes. Here is a list of some common trouble spots worth circumventing:

- Forgetting that there is an initial enrollment deadline for Medicare Parts A, B, C and D, and forgetting about the annual reenrollment period for Parts C and D. An associated problem is not going to local community resources or appropriate government websites to learn about how and where to enroll.
- Not understanding what health care services are covered and not covered, and not making an effort to find out before making critical health care decisions.
- Not remembering that there is a late enrollment penalty for Medicare Parts B and D.
- Not realizing that products sold by insurance companies can and do differ in their designs, including the “extras” that plans might offer, and that these product designs can change over the years.
- Not knowing that Medigap plans, Medicare Advantage plans and Part D prescription drug plans vary in the premium rates they charge. The rates typically differ by location, too, and the rates often change from year to year.
- Not being aware that a person can be subject to an “evidence of insurability” requirement (review of health history), in specified circumstances. This can happen when, for example, an insured who has been covered by one supplemental plan for a specified period elects to leave that plan and enter another supplemental plan in the same community.
- Not evaluating a plan’s provider network (in plans that offer networks). This can create care problems, particularly in cases of serious illness, if, for example, an insured cannot find desired specialists in the network. The alternative—consulting an out-of-network specialist—can be very costly.

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- Not checking out the location of care providers that a plan makes available. People in rural areas may face almost impossible situations in accessing care, particularly if their plan requires use of a specific network that is far away.
- Not realizing that provider networks can change at any time. That could impact access to a valued provider or facility.
- Not noticing, until it is too late, that the selected prescription drug plan's drug formularies and "tiers" of coverage may not cover the prescriptions the person uses.
- Not understanding that premiums for health care coverage after early retirement are likely to be much greater than the employee's cost of coverage while working.
- Not understanding that people face different health care options before and after age 65 and that spouses of different ages and in different employment situations also may face different options.
- Not knowing that people in a Medicare Advantage plan (Part C) cannot buy or use a Medigap plan at the same time. Medicare requires that any such transfers be done at specific times and in a specific way so there is no overlap in coverage and no missing days of coverage.
- Not considering that health care plans will change (in availability, premiums, choices etc.) when a person moves to a new geographic location.
- Not understanding that some financial advisors, insurance agents and brokers have strong specialized expertise in health insurance and so can help people make better decisions regarding Medicare than by making choices without professional help.

Helpful Decision Tables

THE FOLLOWING THREE TABLES SUMMARIZE A FEW KEY POINTS about Medicare as viewed from different consumer positions. Included are additional cautionary notes.

- Table 2 reviews some key decisions that people need to make specifically regarding Medicare coverage.
- Table 3 spotlights a few key decisions that older people need to make if their employer does not offer health insurance coverage in retirement.
- Table 4 identifies some key health insurance decisions to make for those with available employer coverage.

Note that the decisions addressed in the tables focus on medical care insurance. When couples are mentioned, single retirees will want to focus on situations cited in the tables that depict cases where both retiree and spouse are in either the pre-65 or post-65 category.

The www.Medicare.gov website is an excellent resource for additional information. So are the other resources listed at the end of this brief.

Table 2
Decisions Needed When a Person Is on Medicare

Decision	Comments
When to sign up for Medicare	<ul style="list-style-type: none"> • Those who are entitled to Medicare are automatically enrolled in Parts A and B when turning 65 if receiving Social Security or Railroad Retirement benefits. Those who do not want Part B must decline coverage. • Those not receiving these government pension benefits may apply for Parts A and B between three months prior to the month of turning 65 to the three months after. Those still employed at age 65 should sign up for Medicare at age 65 if covered by a small employer health care plan. • Those covered by an employer plan beyond age 65 can sign up for Medicare three months before the expected retirement date.
Original Medicare (fee-for-service Medicare Parts A and B) or Medicare Advantage	<ul style="list-style-type: none"> • Original Medicare includes both Part A (hospital insurance) and Part B (optional medical insurance). Those wanting to have a Medigap plan need both. • No evidence of insurability is required if enrolling when first eligible for Medicare, typically at age 65. • Switching between plans of other insurance companies may be possible during the open enrollment period each year, but caution is advised because switching may make the retiree subject to underwriting.

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Decision	Comments
If Medicare Advantage, which plan?	<ul style="list-style-type: none"> • Each fall, an open enrollment period starts for enrollment in Medicare Advantage plans. Those new to Medicare can enroll, those already in a Medicare Advantage plan can switch to a new one, and people in Original Medicare can elect to enroll in Medicare Advantage plan at this time. • Considerations include premiums, cost-sharing requirements, coverage included and what doctors and hospitals are in the plan’s network. Such details change, so annual plan reviews are essential. • Medicare Advantage plans essentially package Medicare Parts A and B, but may also include extras such as prescription drug, vision and dental coverage as well as fitness or wellness benefits. They limit access to out-of-network doctors in different ways too. • Plan offerings vary, as do cost structures, so comparative analysis is important.
Do I want drug coverage under Part D?	<ul style="list-style-type: none"> • This prescription drug coverage is provided through private insurance companies. Purchase is optional, and there is a penalty for later enrollment. Note: Some Medicare Advantage plans incorporate Part D coverage if the insured elects to have it. • The Part D open enrollment period starts in the fall of each year. Consumers will want to compare premiums, cost-sharing, covered drugs and the pharmacy networks offered with each Part D policy. People in rural areas may need to compare distances to a covered pharmacy. • Assessing the plans on a yearly basis helps because plan features can and do change. • People who use expensive drugs, many drugs or drugs not covered by the chosen plan may face large out-of-pocket costs, and drugs that are covered often change year by year for each plan. Retirees will want to research this carefully.
Do I want a Medigap policy to supplement my Original Medicare Part A and Part B coverages?	<ul style="list-style-type: none"> • Medicare Parts A and B have deductibles and copayments and uncovered items. People covered by Original Medicare can buy supplemental coverage in the private market to increase their coverage. Insurance companies offering this coverage must follow federally required standard designs. • Premiums vary by insurance carrier, plan design, age and geographic location. • Those new to Medicare can purchase Medigap coverage without evidence of insurability for a limited period, making it important to choose a supplemental plan the retiree is likely to retain. • Specialized agents and services can help people compare and purchase this coverage.

Table 3

Decisions Needed When Employer Coverage Is Not Available

Decision	Comments
Where can I get medical coverage?	<ul style="list-style-type: none"> • COBRA coverage available for 18 months after prior employer coverage terminates • Marketplace plans if retiree is under age 65 • Medicare plan options if age 65 or older
What should a pre-65 retiree with a pre-65 retired spouse consider?	<ul style="list-style-type: none"> • Compare cost and coverage of Affordable Care Act marketplace plan options • Plan selection may be different for spouse and family members • Begin planning for coverage after age 65 on 64th birthday
What should a pre-65 retiree/spouse with post-65 retiree/spouse consider?	<ul style="list-style-type: none"> • For the pre-65 retiree or spouse, the issues are the same as for pre-65 retirees (above) • For the post-65 retiree or spouse, the issues are the same as for other post-65 retirees (below).
What should a post-65 retiree with post-65 retired spouse (with no other pre-65 family members) consider?	<ul style="list-style-type: none"> • Enroll in Medicare. • Make Medicare choices: <ul style="list-style-type: none"> • Original Medicare • Original Medicare with Medigap plan • Original Medicare with Medigap plan and Part D drug plan • Medicare Advantage with separate Part D drug plan • Medicare Advantage including Part D (MA-PD)

Table 4

Decisions Needed When Employer Coverage Is Available

Decision	Comments
What plans are offered?	The employer may continue the same plans that are available to active employees or may offer different plans. The plans may change when a worker becomes eligible for Medicare.
How much will it cost?	The employer may pay a given percentage of the premium cost or may pay a set dollar amount of the premium that may or may not change in the future.
Will my spouse be covered?	Most employer plans will cover spouses, but the employer subsidy may be lower.
Will my children be covered?	Children must be covered until age 26, but the employer subsidy may be lower.
Would marketplace coverage be better than my employer plan?	Employer plans are generally better, but some marketplace plans could be better, especially if income is low, thus enabling access to marketplace premium subsidies and cost-sharing reductions.

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Will the plan change when I become eligible for Medicare?	Some employer plans will stop. Those that continue will coordinate with Medicare. Some employers will offer Medicare Advantage or Medigap plans. Retirees are usually required to enroll in Medicare Parts A and B.
What should a pre-65 retiree with pre-65 retired spouse consider?	<ul style="list-style-type: none"> • How does the cost and coverage compare to other available alternatives (marketplace, spouse's plan)? • Which option to take within employer offerings? • Does this cover spouse and family members? • Is the retiree coverage from the employer affordable? • Is alternative health insurance affordable if employer retiree coverage stops? • Does the employer coverage continue to provide appropriate plans after age 65 when the employee is approaching Medicare age, and is coverage of dependent children still eligible?
What should a pre-65 retiree/spouse with post-65 retiree/spouse consider?	<ul style="list-style-type: none"> • For the pre-65 retiree/spouse, the issues are the same as for pre-65 retirees (above). • For the post-65 retiree/spouse, the issues are the same as for other post-65 retirees (below).
What should a post-65 retiree with post-65 retired spouse (with no other pre-65 family members) consider?	<ul style="list-style-type: none"> • Which option to take within employer offerings • Does the employer plan require Medicare enrollment? Considerations: <ul style="list-style-type: none"> • Most plans that require Medicare enrollment will “impute” Medicare payment (i.e., estimate what Medicare would have paid) and adjust plan benefits, and the retiree is required to pay the balance to the health care provider. • Some federal and other public plans may not require Medicare enrollment and will not impute Medicare payment. • If not choosing employer option, whether to find a Medigap plan, Medicare Advantage plan or coverage by the spouse's employer's post-65 plan • Whether to cover spouse under retiree plan • What is the cost of employer-provided coverage versus alternatives? • Can the retiree afford another available health insurance plan if the employer discontinues retiree coverage?

Conclusion

A KEY RETIREMENT CONSIDERATION is the availability and cost of health care, including insurance. As you can see from this Decision Brief, there are important choices to make around health insurance at the time of and during retirement. Understanding these choices and how to find more information is critical in determining the impact of health care costs on your retirement financial plan.

Signing up for and using Medicare is not a one-time decision but should be reviewed annually in the fall when open season begins. This brief has pointed out repeatedly that people need to explore the Medicare territory carefully as they map out their health care decisions for the retirement years, and they need to continually reexamine their choices as their needs change and Medicare itself changes.

Thoughtful research will help surface answers to questions that come up and help sort through the many issues that the decision-making involves. All of this will take more than a minute or a day. However, the time and effort invested will help increase your confidence about the end result.

Useful Roadmaps

Centers for Medicare and Medicaid Services, *Medicare & You*, an annual publication provided to Medicare beneficiaries that describe the program that is also available online at www.medicare.gov.

Centers for Medicare and Medicaid Services, [Find 2020 Health & Drug Plans](http://www.medicare.gov) link on www.medicare.gov, provides an online resource that lists available plans: Original Medicare, Medicare Advantage, Medigap and Part D. Software tools available at this website can help individuals see what plans are available for their own situation, including their own geographic location.

State Health Insurance Assistance Programs (SHIP), www.shiptacenter.org, provides information and help to navigate the Medicare programs both online and reference to local help.

DOL/EBSA, *Taking the Mystery out of Retirement Planning*, <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/taking-the-mystery-out-of-retirement-planning.pdf>, is a helpful booklet of issues to consider regarding wealth management in retirement.



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DISCLAIMER

This Decision Brief does not provide advice for specific individual situations and should not be so construed. It is an information tool for general guidance. Individuals needing advice should seek the services of a qualified professional. Keep in mind that tax codes change, taxation of products and strategies vary, and personal tax needs and issues are unique. Consideration of tax issues is beyond the scope of this work.

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