Planning for Health and Healthcare*

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While effort and thought (and money) is often devoted to retirement preparation and planning, comparatively little effort or thought is given to planning for health care in advance of reaching the age of 65 (which is the age at which many people become eligible for Medicare) or in advance of retirement. The exception to the relative dearth of planning for health care is Medicaid planning, which generally consists of asset disposition strategies in order to facilitate Medicaid eligibility for receipt of long-term care services which this article will not address.

Failure to plan for health care can be a significant problem, not only because health care needs are a significant issue for people as they age, but because health care costs are such a significant expenditure for people as they age, particularly for retired persons in proportion to other expenditures. Moreover, the ability to access health care as a Medicare beneficiary is another consideration because an increasing number of health care providers, particularly physicians, are not available to Medicare beneficiaries so evaluating access warrants advance consideration. Moreover, many services, such as eye exams and dental care, are not covered by Medicare. There can also be significant confusion regarding Medicare, Medicaid and other sources of third-party reimbursement for health care costs.

The Cost of Health Care in Retirement

A June 2018 analysis published by the National Bureau of Economic Research report (NBER Working Paper No. 24599) reported that the average person who is not a Medicaid beneficiary spends $122,000 for healthcare between the age of 70 and the time that they die. This is primarily for out-of-pocket health care costs such as copays and deductibles. Similarly, a January 2018 report by the Kaiser Family Foundation calculated that by 2030, retirees will spend half of their social security income on health care costs.

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Medicare and Medicaid

Generally, Medicaid is a health benefits program for the financially indigent although as part of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010), States were given financial incentives to expand coverage to individuals and families, including those with higher incomes and more assets than traditionally permitted for Medicaid eligibility. Medicaid is partially funded by the Federal government and partially funded by each State. Medicaid programs are administered by each State subject to certain Federal mandates.

Medicare is a health benefits program for individuals over 65 who have contributed to the Federal social security program and certain persons receiving social security disability benefits. Medicare also affords payment for certain services related to end stage renal disease, such as kidney dialysis.

The ABCs of Medicare

Medicare itself is divided into several different benefits.

Medicare Part A covers Medicare inpatient care, including care received while in a hospital, limited care in a skilled nursing facility, and, in limited circumstances, at home. There is no cost for Medicare Part A coverage for those individuals and eligible spouses who paid Medicare taxes for at least 40 quarters of work (10 years). In 2019, the monthly premium for individuals who paid Medicare taxes for less than 30 quarters will be $437 while the premium for those who paid Medicare taxes for 30 to 39 quarters will be $240 per month. However, an annual deductible is imposed for services covered under Part A which will be $1,364 in 2019. Depending upon the length of a facility stay, Medicare beneficiaries can also be responsible for daily co-insurance charges.

Medicare Part B covers certain professional services, such as the services of physicians on both an inpatient and outpatient basis, outpatient therapy, durable medical equipment and ambulance costs. A monthly premium is charged for Part B coverage. The amount of the premium is based upon whether the beneficiary is receiving social security benefits and also income. There is an annual deductible for Medicare Part B and all services are subject to 20% coinsurance which means that the patient must pay 20% of all costs.

Medicare Part C, also known as Medicare Advantage is managed Medicare. Under contract with the Federal government, Medicare Advantage contractors, which are health insurance companies, assume financial responsibility for both Part A and Part B services for those Medicare beneficiaries who opt for managed Medicare. Medicare Advantage Contractors frequently incentivize beneficiaries to enroll as members in Medicare Part C by reducing the deductibles and copays for which patients are responsible or by providing additional services that are not covered by traditional fee for service Medicare such as vision services or health club membership. However, the choice of providers, particularly

physicians, can be limited. Also, because Medicare Advantage contractors are insurance companies which must be licensed under State insurance laws, many Medicare Advantage contractors cover non-emergency health care services only in limited geographic areas. This creates challenges for beneficiaries who spent parts of the year in different locations. For example, certain Medicare Advantage contractors who do business in Florida do not do business in New Jersey and/or New York and vice versa.

Medicare Part D is an optional prescription drug plan. Coverage and premiums vary by plans and income. Some Medicare Advantage Plans also provide prescription drug coverage.

Because of the significant out of pocket costs associated with Medicare, many people who are not enrolled in Medicare Part C purchase Medicare supplemental coverage or "Medigap" insurance to cover these costs. Although premiums vary based on patient age, geography and extent of coverage, Medigap plan designs are standardized. Plans are labeled A through N (although there are presently no "E", "H", "I" or "J" plans) so the A plan offered by one insurance company in a State will provide the same benefits offered by a different insurance company in that State or in another State.

Timing Considerations for Medicare Enrollment

There are also timing considerations for Medicare enrollment. Although the usual age for Medicare eligibility is 65, the age to receive full social security benefits is 66 for individuals born in 1948 to 1954 and 67 for individuals born in 1955 or later. Therefore, an increasing number of people will become eligible for Medicare while they are still working. They will have to determine whether or not to enroll in Medicare Parts B and D, for which premiums must be paid, or continue with employer-sponsored health coverage, if it is available. Costs and coverage will have to be compared and evaluated. In many instances, failure to enroll in Medicare when first becoming eligible will result in financial penalties being permanently imposed. Therefore, as part of the evaluation of what to do, it is also necessary to determine whether there is qualification for a special enrollment period which will avoid late enrollment penalties.

Health Care Access Challenges

In addition to the cost of health care, access to health care can be a challenge for Medicare beneficiaries, even for those who do not enroll in a Medicare Advantage plan. One reason is that an increasing number of physicians and practitioners do not wish to enroll in the Medicare program because Medicare limits what enrolled providers may charge. When providers "opt-out" of Medicare, neither the provider nor the patient may submit a bill to Medicare for services rendered. Instead, the patient must personally pay the provider on an out-of-pocket basis and neither party is reimbursed by Medicare.

Another challenge is that some providers will only accept Medicare beneficiaries as patients if they were established patients before enrolling in Medicare. In many geographic areas, physicians have established “concierge” practices whereby a limited number of patients are accepted and accepted patients pay an annual fee simply to be able to be a patient of the provider; they then pay out-of-pocket for the actual clinical services received.

Finally, with extremely limited and quirky exceptions, Medicare does not provide coverage for health care services outside the United States even in emergencies.

Therefore, it is essential to identify providers and possibly establish relationships in advance of needing care. It is also advisable to purchase medical insurance in advance of traveling internationally.

Conclusion

It is prudent to plan for health care in advance of reaching age 65 and in advance of retirement. There are a myriad of financial and access issues to consider in order to avoid being unprepared or uncovered and prevent unnecessary expenditures.