Personal Financial Planning Section

Free Excerpt

The adviser's guide to retirement and elder planning

Healthcare coverage planning

James Sullivan, CPA/PFS

5th edition

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For more information and education on many of the topics covered in this publication, visit the PFP Division.

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James Sullivan, CPA/PFS

Jim is a Medicare expert. He has worked with hundreds of clients over the years helping them secure the quality coverage that best meets their health care needs at affordable prices. He has also written over a hundred articles on issues relating to the financial impact of chronic and terminal disease on retirement plans. He is especially interested in Alzheimer's disease and other dementias. Jim works at Fairhaven Wealth Management located in suburban Chicago. Jim is a hospice volunteer.

AICPA PFP Executive Committee Elder Planning Task Force

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

Ralph Rolfe

Ted Sarenski, Chair

Michael Schulman, in his memory

Preface

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

How to use this guide

This guide is meant to be a practical resource that blends information and planning guidance in a way that, as it is read, allows the adviser to hear his or her clients ask related questions. Refer to the text boxes that include actual client concerns and the adviser's response to prepare for your clients' questions.

You will also find plainly stated information, with references to SSA publications for more details. Look for the following icons to help you use the information in this guide:

The light bulb icon indicates important planning tips.

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

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

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

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

In a February 2015 Bankrate.com retiree survey, 28 percent of the participants cited too high health care costs as their greatest concern. The number two concern at 23 percent was running out of money. In addition, younger clients may have elderly parents in need of planning for health care costs. Asking these clients about their parents' health can often open a discussion about their planning needs.

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

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

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

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

All seniors face higher health care costs

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

Clients reaching age 65 in good health can expect to face greater out-of-pocket health care costs than comparable unhealthy individuals. Although seemingly counterintuitive, the reason is obvious: unhealthy individuals will most likely die at younger ages using less in overall health care resources.

Healthy individuals will live longer but still face the costs of the inevitable decline in health that accompanies aging. According to a recent study, the present value of the cost of health care for a healthy couple is $265,000 after age 65; for a couple with one or both suffering from a chronic illness, the cost is $220,000.

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

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

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

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

How do people die?

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

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

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

Cause of Death	Comment	%
Frailty or dementia	The "slow dwindling" is represented by frailty and dementia (most likely, dementia of the Alzheimer's type). This can be the costliest illness due to the need for custodial care. It is also the least likely to be paid for by Medicare. More than 50% of those age 85 and older will develop Alzheimer's disease.	45%
Cancer	Cancer typically results in a relatively short period of decline. Death from cancer peaks at age 70.	22%

Cause of Death	Comment	%
Heart and lung failure	Heart and lung (and other major organ system failure) presents with intermittent exacerbations, meaning the patient will often rally for a time and get better. Death from this cause peaks at age 80.	16%
Sudden accident	—	7%
Other	—	9%
Source: Joanne Lynn, M.D., *Sick to Death and Not Going to Take It Anymore*.		

Planning for care

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

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

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

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

Chapter 2: An Overview of Medicare

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

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

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

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

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

As an alternative to choosing traditional Medicare, participants may elect a Medicare Advantage (MA) plan (also referred to as a Medicare Part C plan). MA offers a variety of plans, including managed care options (also referred to as coordinated care options). MA was added to allow private insurers, under the guidelines and authority of the CMS, to package equivalent or better benefits in various plans. As of 2018, Medpac reports that approximately 33 percent of all Medicare recipients use these plans, with significant regional variations (Report to Congress: Medicare Payment Policy March 2019 available at www.medpac.gov)

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

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

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

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

For more information on eligibility and enrollment on the Medicare website, go to www.medicare.gov. Click on Sign Up/Change Plans. Once there, click on Getting Started with Medicare. For information on a spouse's work record and eligibility for Medicare, go to www.ssa.gov. SSA Publication No. 05-10043, Medicare, has information on a divorced spouse's eligibility for each program

Basic benefit structure

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

Traditional Medicare is composed of three parts:

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

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

The Affordable Care Act and Medicare

Medicare is not a part of the health insurance marketplaces created under the Affordable Care Act (ACA) and seniors do not need to shop for coverage in these marketplaces.

Medicare is considered health insurance under the ACA, so people currently covered by Medicare Part A, or Part A and Part B, do not need to buy more health insurance. Those covered under Part B only are not considered to have the minimum essential coverage required under the ACA and without additional coverage may have to pay a penalty.

Medicare benefits under the ACA have expanded to include free preventative benefits, cancer screenings, and an annual wellness visit. In addition, Prescription Part D coverage is now subject to a similar sliding scale premium as Part B, causing those with higher incomes to pay more.

Clients with a Medicare Advantage Plan, known as Part C, may see reductions in their coverages. The ACA has changed the amounts paid to private insurers and, in response, they might be increasing participant cost or reducing some of their coverages.

The ACA also created Accountable Care Organizations (ACOs) to reduce costs by encouraging physicians, hospitals, and other providers to form networks to coordinate patient health care and thereby become eligible for bonuses when they demonstrate efficiencies. The primary care provider (PCP) physician is the lynchpin in this relationship and your clients might receive letters from their physicians as they start to join these ACOs.

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