

UNDERSTANDING MEDICARE

Costs and
Coverage Options

Preview
Enrollment
Guidelines

Out-of-Pocket
Health-Care Costs

What the **Future**
Might Hold



Foreword

Since it was established in 1965, Medicare has provided a “safety net” to help Americans age 65 and older pay their medical expenses. In the ensuing years, the Medicare program has expanded to include many disabled people younger than 65 and to offer a wider variety of benefits and coverage options. These benefits can be valuable, although understanding them and obtaining the benefits appropriate for your situation may take some effort.

If you anticipate becoming eligible for Medicare in the not-too-distant future, the information presented here should help you understand what to expect, and it will examine some decisions you may have to make when the time comes to enroll. If you already participate in Medicare, you may find facts, ideas, and options that you had not previously considered.

This booklet focuses on Medicare benefits based on age rather than disability, and it reflects the current state of the program. There may be changes down the road, but it would be wise to take some time to understand how the program works today and keep an eye on future developments. More detailed information is available through your local Social Security office or at www.medicare.gov.

Most of the information in this booklet comes from the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, 2016, unless otherwise indicated.

IRS Circular 230 Disclosure:

To comply with requirements imposed by the Internal Revenue Service, any tax advice contained in this communication is not intended to be used, and cannot be used, for the purpose of avoiding penalties imposed under the Internal Revenue Code or promoting, marketing, or recommending to another party any tax-related matter addressed herein.

Medicare History

President Lyndon B. Johnson signed two amendments to the Social Security Act of 1935 — establishing Medicare and Medicaid — on July 30, 1965. He chose to sign these programs into law at the Truman Library in Independence, Missouri, to honor former President Harry S. Truman, the first president to propose national health insurance legislation. Truman, who was then 81 years old, received the first Medicare card.

The Medicare program officially began 11 months later on July 1, 1966. About 19 million Americans age 65 and older enrolled.

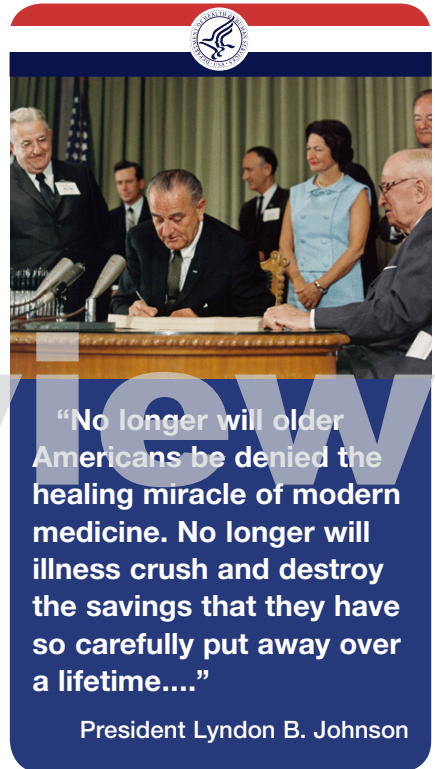
In 1972, President Richard M. Nixon extended Medicare coverage to include individuals under age 65 with long-term disabilities and individuals with end-stage renal disease.

The next big change came when President George W. Bush signed into law the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which added more benefits, including outpatient prescription drug coverage (effective in 2006).

The Patient Protection and Affordable Care Act of 2010 added some free preventive services to Medicare and made prescription drugs more affordable for seniors in the coverage gap (donut hole).

In 2015, Medicare provided coverage for about 55 million people, and spending totaled about \$648 billion.¹

1) Medicare Trustees Report, 2016



Medicare Basics and Choices

The Original Medicare Plan is divided into hospital insurance (Part A) and medical insurance (Part B), which are run by the federal government. Medicare Parts C and D are provided by private, Medicare-approved insurance companies.

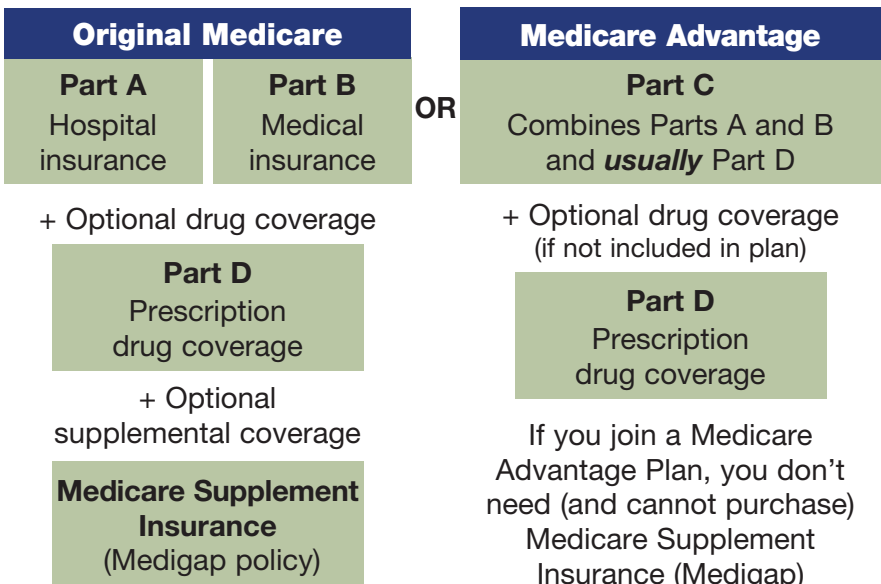
Part A (hospital insurance) helps cover inpatient care in a hospital (but not physicians' fees), a limited amount of post-hospital care in a skilled nursing facility, hospice care, and some home health care.

Part B (medical insurance) helps cover physicians' services, inpatient and outpatient medical services, outpatient hospital care, and diagnostic tests.

Part C (Medicare Advantage) plans provide benefits and services covered under Parts A and B and may offer additional coverage such as vision, hearing, dental, and/or health and wellness programs. Many plans include prescription drug coverage.

Part D (prescription drug coverage) plans help cover the cost of prescription drugs and are available for an additional premium.

When you become eligible for Medicare, you can choose the following ways to receive benefits:



Enrollment Periods for Parts A and B

If you are receiving Social Security or Railroad Retirement Board (RRB) benefits when you turn 65, you will be enrolled automatically in Medicare Parts A and B.

- If you do not want to enroll in Parts A or B, you should decline coverage by following the instructions on your Medicare card.
- About 99% of Medicare beneficiaries receive premium-free Part A hospital insurance. If you are among this group, there is probably no reason to decline Part A coverage.
- Part B requires premium payments that vary based on income (see page 5). If you don't decline coverage, the Part B premium will be deducted automatically from your Social Security or RRB benefit.

If you are not yet receiving Social Security or RRB benefits when you turn 65, you have to enroll in Medicare if you want coverage. There are three enrollment periods for Medicare Parts A and B.

Initial Enrollment Period

To avoid penalties, you should enroll during your initial enrollment period, which starts three months before the month you turn 65 and ends three months after the month you turn 65. Depending on when you enroll, coverage will start on the first day of the month indicated in this chart.

If you enroll during the...	Coverage starts the...
Three months before the month you turn 65	Month you turn 65*
Month you turn 65	First month after enrollment
First month after you turn 65	Second month after enrollment
Second or third month after you turn 65	Third month after enrollment

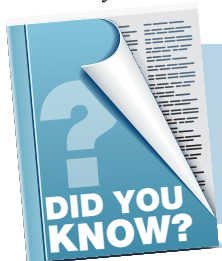
*If your birthday is the first day of the month, coverage will begin on the first day of the month before you turn 65.

General Enrollment Period

If you didn't sign up for Part A and/or Part B when you were first eligible, you can sign up between January 1 and March 31 each year. Your coverage would begin on July 1. However, you may have to pay a higher premium for late enrollment.

Late Enrollment Penalties

- **Part A.** If you are not eligible for premium-free Part A and didn't sign up when you were first eligible, your monthly premium may go up 10%. You will have to pay the higher premium for *twice the number of years* you could have had Part A but didn't sign up.
- **Part B.** If you did not sign up for Part B when you were first eligible, you may have to pay a late enrollment penalty for *as long as you have Medicare*. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B but didn't sign up for it.



In 2015, Medicare spent an average of \$12,744 for each Medicare beneficiary.

Special Enrollment — Employment-Based Coverage

If you didn't sign up for Medicare Part A and/or Part B when you were first eligible because you were covered under a group health plan based on your current employment (or your spouse's), you can enroll at any time you have coverage or as described below, usually without paying a penalty.

- During the eight-month period that begins the month after the employment ends or the group health plan insurance coverage ends, whichever happens first.

Open Enrollment

In the fall of each year during Medicare Open Enrollment (October 15 to December 7), you can change from Original Medicare to a Medicare Advantage plan. The new coverage would begin the following year.

Premiums for Parts A and B

Part A Premiums

Medicare Part A is generally premium-free if you or your spouse paid Medicare payroll taxes for at least 10 years (40 fiscal quarters). If not, the following monthly premiums apply in 2017:

- **\$227** — If you or your spouse paid payroll taxes for at least 7.5 years (30 fiscal quarters) but not 10 years.
- **\$413** — If neither you nor your spouse paid payroll taxes for at least 7.5 years.

Part B Premiums

Medicare Part B premium payments are based on adjusted gross income (AGI). In 2017, the following monthly premiums apply, based on the AGI on your 2015 tax return.

AGI for Single Filers	AGI for Joint Filers	Monthly Premium
\$85,000 or less	\$170,000 or less	\$109.00* or \$134.00
Over \$85,000 up to \$107,000	Over \$170,000 up to \$214,000	\$187.50
Over \$107,000 up to \$160,000	Over \$214,000 up to \$320,000	\$267.90
Over \$160,000 up to \$214,000	Over \$320,000 up to \$428,000	\$348.30
Over \$214,000	Over \$428,000	\$428.60

*Because the Medicare Part B premium increased more than the Social Security COLA for 2017, some beneficiaries protected by the hold-harmless provision will pay less (\$109, on average) for Part B.

How Premiums Are Paid

- **Part A.** If you pay premiums for Medicare Part A, you will receive a bill.
- **Part B.** Part B premiums are deducted automatically from benefits for Social Security, Railroad Retirement Board (RRB), or civil service. If you are not receiving any of these benefits, you will receive a bill.

Medicare Advantage (Part C)

Medicare Advantage (also called Part C) is a privately run Medicare alternative. Medicare Advantage plans are offered by private insurance companies approved by Medicare. They provide the benefits and services covered under both Parts A and B, and some may offer additional coverage.

You usually pay a monthly premium for Medicare Advantage in addition to your Part B premium, as well as copayments or coinsurance for covered services.

- Most Medicare Advantage plans include prescription drug coverage that replaces Medicare Part D. These plans may also offer extra coverage that is not provided under Original Medicare, such as vision, hearing, dental, and/or health and wellness programs.

Medicare sets rules for Medicare Advantage plans and pays a fixed amount each month to the company offering the plan. Each plan can charge different premiums and out-of-pocket costs, and each plan may have different rules for obtaining services. The plan administrator may change the rules each year.

The most common types of Medicare Advantage plans are:

- Health maintenance organization (HMO) plans
- Preferred provider organization (PPO) plans
- Private fee-for-service (PFFS) plans
- Special needs plans (SNP)

Limitations on Medicare Advantage and Other Coverage

If you want prescription drug coverage and your Medicare Advantage plan offers such coverage, you generally must obtain coverage through the plan. If the Medicare Advantage plan doesn't offer prescription drug coverage, you may obtain it by joining a Medicare Prescription Drug plan.

If you have a Medicare Advantage plan, you don't need (and cannot obtain) Medigap insurance. (*Medigap is described on page 9.*)

Prescription Drug Coverage (Part D)

If you are covered under Original Medicare and want prescription drug coverage, you might purchase a Part D plan and pay an additional premium. Like Medicare Advantage plans, Part D plans are offered by private insurance companies approved by Medicare. Premiums, covered drugs, and out-of-pocket costs — including deductibles, coinsurance, and copays — vary by plan.

- If you are in a higher income tax bracket, you may have to pay an extra charge above your plan's regular premium. The income brackets for calculating these charges are the same as the brackets for Part B premiums (see page 5). In 2017, the extra charges range from \$13.30 to \$76.20 per month.

Typically, you will receive a bill from the provider for your Part D premium. You may also request that premiums be deducted from your Social Security benefit. If you are already receiving Social Security, the premium will usually be deducted automatically.

Coverage Gap (Donut Hole)

Most Part D plans have a coverage gap (often called a “donut hole”) that occurs when a participant's annual prescription drug costs reach a certain threshold and Medicare stops paying for them until another threshold is reached.* As a result of health-care reform, there are discounts to help participants pay for drugs while in the coverage gap. In 2017, there is a 60% manufacturer's discount on covered brand-name drugs, and the government provides a 49% discount for covered generic drugs.

The following expenditures count toward getting out of the coverage gap:

- Your annual deductible, coinsurance, and copayments
- The discount on brand-name drugs in the coverage gap
- What you pay in the coverage gap

The Part D premium and the cost for drugs that aren't covered do not count toward getting you out of the coverage gap.

*In 2017, the coverage gap starts when the plan participant and the plan have paid \$3,700 for drugs, and it ends when the participant has paid \$4,950 out-of-pocket for covered medications since the start of the year.

Parts C and D Enrollment Periods

Initial Enrollment Period

You can join a Part C Medicare Advantage plan or a Part D Prescription Drug plan during your initial enrollment period (*see page 3*).

Open Enrollment Period

There is a general enrollment period for Parts C and D during the fall of each year (October 15 to December 7), with coverage changes effective January 1 of the following year. During this period, you may:

- Change from Original Medicare to a Medicare Advantage plan, or vice versa
- Switch from one Medicare Advantage (Part C) plan to another Medicare Advantage plan
- Join a Part D Prescription Drug plan, switch between Part D plans, or drop prescription drug coverage completely

Five-Star Special Enrollment Period

Private Medicare providers are rated from one to five stars based on performance feedback. You can switch to a five-star Medicare Advantage plan and/or Prescription Drug plan at any time during the year. However, you can switch to a five-star plan only once each year.

Note that there are other, more limited Part C and D enrollment periods that apply to various circumstances.

Late Enrollment Penalties

- **Part C.** There is no penalty if you do not join a Medicare Advantage plan during your initial enrollment period (unlike the case with Medicare Part A and Part B late enrollment).
- **Part D.** If you did not join a Medicare drug plan when you first became eligible, a late enrollment penalty may apply if you go 63 or more consecutive days without having a Medicare drug plan or other *creditable prescription drug coverage* (such as that from an employer). You may have to pay the penalty for as long as you have a Medicare Part D plan.

Medicare Supplement Insurance (Medigap)

If you are enrolled in Medicare Parts A and B, you have the option of purchasing Medicare Supplement Insurance, or Medigap, which is sold by private insurers approved by Medicare. Medigap policies are designed to help cover the deductibles and copayments that the Original Medicare program doesn't cover (thus, "filling the gaps"), but it will not pay for procedures that are not covered by Medicare.

Medigap policies are regulated by federal and state laws. There are 10 standardized plans, typically identified by the letters A through N based on the benefits they provide. (Plans E, H, I, and J can no longer be sold.) *Although each standardized plan is identical from insurer to insurer, the monthly premiums may differ. All plans may not be available in every state.*

Note: A Medigap policy will not pay any Medicare Advantage plan premiums, copayments, or deductibles. If you switch from Original Medicare to a Medicare Advantage plan, you may want to drop your Medigap coverage.



A Medigap policy covers only one person. Spouses must have separate policies.

Medigap Enrollment Period

The best time to buy a Medigap policy is during the six-month period that begins on the first day of the month in which you are 65 or older *and* enrolled in Medicare Part B. If you obtain coverage after this period, your choices may be limited and/or your premium may be higher.

- If you did not enroll in Medicare Part B when first eligible because you had employer-based health coverage, your Medigap open enrollment period would begin on the first day of the month that you sign up for Part B.

Out-of-Pocket Costs with Original Medicare

In addition to the monthly premiums (which are adjusted annually for inflation), you should consider Medicare deductibles, coinsurance, and copays. Although these costs have been relatively stable, that could change in the future. The following costs are effective in 2017. (See page 5 for monthly premium costs.)

Part A Hospital Insurance

For each benefit period, you would be responsible for:

- A deductible of \$1,316 and no copayment for days 1 to 60
- \$329 per day for days 61 through 90
- \$658 per “lifetime reserve day” after day 90 (up to a 60-day lifetime maximum)
- All costs for each day after the lifetime reserve days

A benefit period begins on the day you are admitted as an inpatient in a hospital, and it ends when you haven’t received any inpatient care for 60 consecutive days. There is no limit on the number of benefit periods.

Skilled Nursing Facility Care

If treatment is ordered by a physician and admission to a skilled nursing facility occurs within 30 days of a three-day hospital stay, Medicare will pay covered services for the first 20 days (for each benefit period). From days 21 through 100, Medicare will cover all but a daily \$164.50 copayment. After 100 days, Medicare does not offer any further assistance. *Medicare and most health insurance plans (including Medigap) do **not** pay for long-term care in an intermediate or custodial nursing home.*

Part B Medical Insurance

- Annual deductible: \$183
- Coinsurance (after meeting deductible): For most services, you would pay 20% of the Medicare-approved amount if the physician or other health-care provider accepts *assignment* (an agreement to accept Medicare-approved payments and bill you only for the Medicare deductible and coinsurance).
- There is no annual limit for out-of-pocket expenses.

Part D Prescription Drugs

Deductibles, coinsurance, and copays vary among prescription drug plans. The amount you pay will typically depend on the types of drugs you use and whether you use a pharmacy in your plan's network.

Potential Health-Care Costs in Retirement

Many people underestimate the potential cost of health care in retirement — even with Medicare, which typically covers only a little more than half of the average subscriber's health-care costs. It's estimated that a man, woman, or couple who retired at age 65 in 2015 might need the following amounts to cover their health expenses in retirement.



Source: Employee Benefit Research Institute, 2015



At least 70% of people over age 65 will need long-term-care services at some point in their lives. This type of custodial care is *not* covered by Medicare.

How Medicare Works with Other Insurance

If you have Medicare *and* group health insurance coverage (such as that from your employer or your spouse's employer), there are different rules regarding whether Medicare would be the *primary* or *secondary* payer. If the group health plan is with a current employer that has fewer than 20 employees, Medicare would pay first. If the group plan coverage is with an employer that has 20 or more employees, the group health insurer would pay first.

The Future of Medicare

Medicare Taxes

Like Social Security, Medicare is funded primarily by payroll tax revenues (these funds go toward Medicare Part A hospital services). Since 1986, the Medicare payroll tax has been 2.9%, which is split evenly between the employer and the employee. Medicare funding for Parts B and D comes from premiums paid by beneficiaries as well as from general revenues.

Since 2013, high-income taxpayers have been subject to additional taxes as a result of the Patient Protection and Affordable Care Act.

- A 0.9% Medicare hospital insurance tax is assessed on *earned income* (wages and salaries) above \$200,000 (\$250,000 for joint filers).
- A 3.8% net investment income tax (*unearned income* Medicare contribution tax) is assessed on net investment income (capital gains, dividends, interest, royalties, rents, and passive income) for taxpayers whose modified adjusted gross income exceeds \$200,000 (\$250,000 for joint filers).

Fiscal Challenges

Funding shortfalls, lower birth rates, a graying nation, and rising health-care costs have continued to strain the system. In 1965, there were 4.5 workers for each Medicare beneficiary. By 2015, the ratio of workers for each beneficiary had fallen to about 3.1, and it is projected to be 2.4 by 2030.

Since 2008, Medicare has paid out more in benefits than it received in revenues. The program's trustees project that there will be slight surpluses from 2016 to 2020, after which deficits will return. Bonds redeemed from the Medicare Hospital Insurance trust fund have been used to help pay current obligations, but the fund is expected to be depleted by 2028.

Although there is widespread support for Medicare, there is growing pressure to control entitlement spending. Given the fiscal challenges facing our nation, you can probably expect future changes to the Medicare program.

Preparing for Higher Medical Expenses

Many people could pay substantial out-of-pocket health-care expenses in retirement, even with current Medicare benefits. Although the future of Medicare is uncertain, it seems likely that any changes to the program might lead to greater cost sharing with potentially higher expenses for enrollees.

Considering the challenges facing Medicare and the rising cost of health-care services, it would be wise to factor these potential expenses into your retirement preparation and spending.

Of course, your own approach should reflect your personal situation, including your health, age, and financial resources. Your financial professional can help you estimate the savings you may need and work with you to develop an appropriate strategy.

Preview

This material was written and prepared by Broadridge Advisor Solutions.

Copyright © 2017 by Broadridge Investor Communication Solutions, Inc. All rights reserved. No part of this publication may be copied or distributed, transmitted, transcribed, stored in a retrieval system, transferred in any form or by any means — electronic, mechanical, magnetic, manual, or otherwise — or disclosed to third parties without the express written permission of Broadridge Advisor Solutions, 15050 Avenue of Science, Suite 200, San Diego, CA 92128-3419, U.S.A.

The information contained in this booklet is not written or intended as tax or legal advice, and it may not be relied on for the purpose of avoiding any federal tax penalties. You are encouraged to seek advice from your own tax or legal counsel. The content is derived from sources believed to be accurate. Neither the information presented nor any opinion expressed constitutes a solicitation for the purchase or sale of any security.

Broadridge assumes no responsibility for statements made in this publication including, but not limited to, typographical errors or omissions, or statements regarding legal, tax, securities, and financial matters. Qualified legal, tax, securities, and financial advisors should always be consulted before acting on any information concerning these fields.