

INSURANCE AND YOUR FUTURE HEALTH CARE

by

William Nietmann

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Introduction. Although this article was expressly developed for NAU retirees, it may have application for retirees and about to retire who are also employed by the state universities. The subjects covered in this article present various facets and stages of your involvement with Medicare. Discussions range from the period of time when you enter Medicare and a little bit on your involvement with Social Security. It addresses the sign-up period, the Medicare options you will face *each* year, something about the cost of various Medicare options, a segment which considers dropping health insurance plans offered by the Arizona State Retirement System (ASRS), and finally it addresses some questions people often ask about health care. Thus, there is a logical progression to the segments of this discussion: (1) the beginning, (2) the middle, and (3) the conclusion, the progression of the stages of involvement with Medicare.

1. Entering Traditional Medicare.

Since everyone has to do it, you'd think enrolling in Medicare would be easy. At first, it is; but then reality sets in. Because Medicare is an incomplete insurance coverage, issues begin. This presentation won't resolve issues by making choices for you, but it will lead you up to those choices. Choosing is your job. Though the context for this presentation is that of Northern Arizona University employees, were someone outside the university system to use this presentation, be aware that there are parts of Medicare which lie outside of the large, intuitional setting which would apply different rules to some of the choices. For example, different rules apply to people who work for employers with fewer than 20 people on the payroll. So if your spouse should work for such an employer who provides health care insurance, upon retirement s/he would make a modest enrollment adjustment to what is presented here. First, then, some general information . . .

The initial Medicare enrollment is done through the Social Security Administration. In this initial enrollment period you will make your choices respecting how you design your Medicare insurance, and you can do it at the Social Security office or online--Medicare.gov. When Medicare actually becomes your primary health insurer will depend on when you in fact are no longer employed by the State of Arizona. Only then does Medicare become your primary insurer, this for the rest of your life. Any other supplemental health care policy you buy will be a secondary insurance to Medicare.¹ As I will develop in this presentation, this supplemental insurance could be a continuation of the state insurance policy you are likely to have now, an offering by ASRS, or a Medigap insurance policy. Privately sponsored Medicare programs, called Advantage plans (Plan C in Medicare jargon), can be substituted for the traditional

¹ A relatively few people already have qualified for Medicare before age 65 because of specific diseases or disabilities for which Social Security granted them Medicare support. There are other people who fall short of the minimum number of Medicare pre-payments (a part of the Social Security deduction) required to qualify for Medicare, Part A. These people have to sign up for additional payments to gain access to Part A insurance. (These exceptions are likely to apply to very few university retirees.)

Medicare plans. However, all of these possibilities require enrollment in traditional Medicare as the underlying beginning point.² Each will be explained as we go.

What is Medicare insurance? Traditional Medicare is divided into three types of insurances and only pays 80% of the costs for two of them—these are: Part A (hospitals) and Part B (doctors/medical care people). The third part is Part D, the drug plans, all of which are bought on the private market. Medicare only exercises oversight to Plan Ds. The particulars of what services and procedures are covered by Medicare Parts A and B are extensive. Consult the current *Medicare & You, 2017* handbook for details.

So far, so good? Is it smooth sailing? Not quite! You will need to keep track of when you are to do what. Medicare is somewhat bureaucratically entwined with Social Security. For example: you have to sign up for both, but the sign-up times for Medicare and Social Security are on different time schedules. Everyone is eligible for Medicare at 65 (some because of end-stage renal disease or disability before that). However, it is unlikely that you will be eligible for Social Security income until around age 66 (and you may want to wait until an even later date).³ Thus, a couple of scenes unfold because of this difference.

To meet Medicare rules, you *will* sign up for Part A (hospital-related care) of Medicare at age 65.⁴ However, if you continue to work for the university and if you continue its health insurance plan, you are allowed by Medicare to seek a delay in initiating Part B (physician-related care) of Medicare because your job provides equivalent or better insurance to that provided by Medicare, but you *must* indicate at the time you are enrolling in Medicare's Plan A that you are delaying entry into Part B for employment insurance reasons. You will need a letter of equivalence from the Human Resources Department stating this equivalence.

At the other end of the timeline, when you finally do retire, your entry into Medicare Part B awaits. **Failure to sign up for Medicare at this point in time will result in financial penalties—10% per year for each year you were not enrolled, this penalty a permanent increase (life-long) to your Medicare bill.**⁵ Best idea: follow directions. Three months prior to your severance date is a good time to arrange for Medicare Part B to start on the first day of the month in which you retire. That way, there will be no lapse of time when you are not covered by health insurance.

You shouldn't need further prompting to sign up for Medicare during the prescribed time, but consider this: don't be sucked in by the fact that you have a seven month sign up window for Part B following your severance—three months before you retire, the month of your retirement, and three months after you retire). Failure to begin your full entry into Medicare Parts B and D

² Note: even if you continue your current insurance policy or elect to enter a supplemental program sponsored by the Arizona Retirement System (ASRS), all presuppose Medicare as the primary insurer. This means the Medicare pays first and then your additional (supplemental) plan is billed for the difference.

³ There are financial advisors who for some people suggest waiting until up to age 70½ to start Social Security payments because of, roughly, an up to one third increase (8% per year for each year you wait) in income to your check. There is a “break-even” point, however, which should enter into your thinking—topic for a different venue than this one. It centers on life-expectancy or investment return calculations.

⁴ The “parts” of Medicare are explained in greater detail below. Most people have already paid for Part A throughout their working life when Social Security/Medicare deductions are taken from their pay checks, so there are no further Part A premiums to pay.

⁵ For limited income people, these penalties are waived. Recent figures are these: in 2016, a monthly income of less than \$1,458 for an individual (\$1,966 for a couple) and assets of less than \$13,440 for an individual (\$26,860 for a couple). These figures for “poverty” can change. The forms necessary are called Limited Income Subsidy (LIS) forms. They require detailed information to prove the necessity of a subsidy for people at this income level.

(or to an Advantage plan) results in not only the unpleasant consequence the above mentioned fine, but if you should miss the seven-month window, you will have to wait until a sign up period between January and March of the following year. Even then, your coverage won't start until July 1. You might find an insurer who would cover you for injury or illness during this waiting period, but because of typically high cost, it is more likely that you will go without health insurance—not the best idea.⁶

Finally, there's this detail about paying the bill for Medicare Part B. Usually the payment for Medicare Part B is deducted from your monthly Social Security check. However, for those people who want to delay the start of their Social Security income until age 70½,⁷ the Part B Medicare premium payment comes out of your pocket each month. In the interim when your future Social Security is building in value, the various options of paying for Part B are the same as the options you have when paying your utility bills. If you are on any part of Medicare while you are working for the university, your primary insurer remains its insurance plan (presuming that you have it). Medicare is your secondary insurer. This means that the institution's plan pays the bills first, and if there are costs they didn't pay (not too likely), then Medicare may step in. However, should you continue to stay with the institution's plan *after* you retire, Medicare Parts A, B, and D become your primary insurers, and the institution's plan is your secondary insurer. In other words, the institution's plan works like a Medigap plan which has added Medicare Part D, which will be your drug plan. More on Part D in a bit.⁸ So, let's review:

The month of your 65th birthday determines when your obligations to become enrolled in Medicare begin. **Sometime during the seven month period beginning three months before your 65th birth month, the month of your birthdate, and following three months after your birth month—in total, a seven month period—you *must* sign into Medicare.**⁹

You can apply at a Social Office in your area, or you can apply on-line. The website, <http://ssa.gov/pubs/EN-05-10043.pdf>, will have the necessary forms. If you are going to the Social Security office, you can fill these out before you get there and take them with you. The

⁶There are some circumstances in which persons have an eight-month window in which to enroll in Medicare. Called "Special Enrollment Periods" (SEP to Medicare bureaucrats), this possibility kicks in when you (or your spouse whose policy covers you as well) continue working past your 65th birthday and continue the health insurance coverage offered by the institution. When the relationship with the insuring employer is finally severed, you have a Special Enrollment Period of up eight months following termination to initiate Parts A and Part B of Medicare. Should you continue your institution's insurance plan, you will likely pay for it at a cost which is a bit reduced from its full (unsubsidized) cost? Thus, if you or your spouse (or family member, if you're disabled) is working, and you have family coverage through the group health plan provided at that work. Once you are retired, Medicare becomes your health insurance policy.

Note: once retired or laid off employment, COBRA is *not* considered coverage based on current employment. You're *not* eligible for a Special Enrollment Period when that coverage ends. This Special Enrollment Period also doesn't apply to people with [End-Stage Renal Disease \(ESRD\)](#) inasmuch as they are eligible for Medicare at the onset of their disease.

⁷ At age 70 ½ it's mandatory that one begin receiving Social Security.

⁸ Social Security and Medicare rules play the decisive role in determining qualifications and requirement for Medicare payments for people in same sex marriages or domestic partnerships. See <https://www.medicare.gov/sign-up-change-plans/same-sex-marriage.html> for relevant information.

⁹If you are 65 and your spouse is 60, can your spouse get Medicare, too? No. Your spouse cannot get Medicare based on your eligibility. To qualify for Medicare a person must be 65, or have received Social Security Disability Insurance (SSDI) for the prior 24 months to application for Medicare, or have End-Stage Renal Disease (ESRD), or have ALS (Lou Gehrig's disease).

online address is [ssa.gov](http://www.ssa.gov). Click on “Apply for Retirement.” A bit more information can be found at <http://www.socialsecurity.gov/medicare/apply.html#&a0>

Advice: Sign up! Don't fool around with Medicare deadlines.

So what does traditional Medicare cost? Note the word “traditional.” It is “traditional” in that it is government run. Traditional Medicare competes with private insurance companies’ healthcare plans which are called “Advantage Plans.” These plans can be substituted for Traditional Medicare. In Medicare parlance, they are called “Plan Cs.” A Plan C is likely to add “bells and whistles” as incentive to sign into them. An example of this is a “Silver Sneaker” gym program. So first, I’ll go through the costs tied to Traditional Medicare and then turn to Medicare “Plan C,” the Advantage Plans which have no intrinsic ties with traditional Medicare.

Medicare Costs

Basic Costs for Part A. Medicare covers 80% of most costs associated with being in a Medicare-accepting hospital. (Not all hospitals accept Medicare insurance. You have to check to find out.) Everyone qualifying for Social Security income has prepaid this premium over the years as part of one’s regular Social Security deduction from one’s paycheck. Upon enrollment in Medicare, Part A is free of further charges.

If you don’t qualify for Social Security income, you will still enroll in Medicare and then be charged a monthly Plan A premium. This can change year by year. For example, in 2015, the premium would have been \$407/month for Plan A, in 2016 the cost was \$411 per month. I should be a bit more in 2017.

Costs for Part B. Part B pays 80% of the doctors’ bills. However, the monthly premium for Part B is variable according to one’s income. Usually the premium is taken out of one’s monthly social security check; but if you delay starting your social security income, you pay the monthly premium out of your own pocket. The premium for **people already in Medicare in 2015** will remain the same in 2016, \$104.90 per month. For **those new to Medicare in 2016**, your Part B premium will be \$121.80/month.¹⁰ Should you be a **high income participant** (in 2016 above \$107,000 for an individual, double that for a couple) you saw a rise in your premium to \$233 per month, up from the then current \$145.90. Individuals with an income of more than \$214,000 (double that for couples) will paid \$509.30, up from \$335.70 in 2015.¹¹ At this writing, what the premiums were to be in 2017 were yet to be determined.

Making Up the 20% Shortfall for Medicare Parts A and B

Supplemental/Medigap Insurance. That traditional Medicare pays 80% of the costs of Parts A and B is certainly welcomed; and if the costs of hospitalization and the care of physicians “maxed out” in the neighborhood of \$20,000 or \$30,000, one might think that it would be better to pay the \$4,000 to \$6,000 difference out of pocket for the remainder of the bills than to buy supplemental insurance to help pay those bills. However, when you learn of hospital

¹⁰ This increase for new enrollees is connected to Medicare attempts to keep it solvent into the foreseeable future. I suppose they figure newer retirees (on average) to be better able to pay than those whose retirement incomes were established decades ago.

¹¹ Gleaned from information provided in the 11/15 issue of *Kiplinger’s Personal Finance*.

and physician costs pushing beyond \$100,000 to possibly hundreds of thousands for the sorts of modern medical procedures now employed, the 20% Medicare *doesn't* pay gets your attention!

That's why there are **Medigap plans**, also called **Medicare supplemental insurance**, to cover the remaining costs of Medicare Parts A and B. Wanting to create health-care-plan backers, legislators accommodated the insurance industry with a slice of the pie. The 20% left out of original Medicare A and B payments provided an opportunity for insurance companies to profit—hence Medigap plans which pick up some portion of the 20% remaining in the hospitalization and physician related expenses. With the evolution of buying online, you can go to the www.Medicare.gov website which enables you to peruse and choose a Medigap plan which suits your budget. In assessing costs, pay attention to co-pays and deductibles.¹² The higher your premium, the lower your co-pays and deductions will be. A place to familiarizing yourself with supplemental insurance is Section 6 in the 2017 *Medicare & You* handbook¹³ and going to the Medicare site itself to read specifics about plans you might be interested in. There are guidelines there; and you may find the following information helpful in your transition from the university to “the real world.”

Buying Supplemental Insurance. Upon retirement you confidently decide to leave the state plan offered through ASRA and buy a Medigap/supplemental plan to address the 20% problem. You turn to the Medigap market at the following address: <https://www.medicare.gov/supplement-other-insurance/compare-medigap/compare-medigap.html>. Feel a measure of frustration? You're not sure what buttons to push to get into the material you want to read—there are a lot of buttons! I advise patience. Nearly everything about Medicare is discussed on the Medicare website. The problem is that of locating where it is.

There are some structural things you might take note of before getting started. For example, there are different approaches to the way(s) an insurance company prices its Medigap policies. Choose the tab, “Supplements & Other Insurance.” The left hand column lists the various areas people commonly think about. Find the one about pricing strategies under: “How to Compare Medigap Policies.” Here you will note the three different ways insurance companies use to set prices. (1) The “Community-rated” plans are group plans which charge the same premium to all members, regardless of age. Be aware that there are reasons for changing premium pricing, but with the “community rating” strategy, age isn't one of them. (2) Issue-age-related policies keep the age at which you entered the policy as the basis for pricing future premiums based on factors which are not age related. (3) Attained-age-related policies are based on your current age. The older you get the more you are likely to pay, and to this is added the other, non-age related factors for increasing premiums. The “community rating” strategy and the “issue-age” policy are likely to charge higher premiums at first than an “age-related” policy, but over the long run the reverse may hold. One more thing: buying a Medigap policy **as soon as you left the university** to sign up for Part B relieves you of being screened by the insurance company to ascertain whether or not you would be too risky for them to insure you. If you wait

¹² A “copay” is (usually) a small amount of money you pay out of pocket for utilizing the service your there for. You go to a pharmacy and pay (say) \$8.00 on the pills you ordered and notice that the remaining \$50.00 was paid by your Plan D of Medicare. The “deductible” is a larger amount of money you have to pay before any of the insurance kicks in. Recall that the 2015 deductible on Medicare Part A was \$147—it changes! In 2017 you'll pay something more before to the hospital before Medicare starts picking up its 80% of your bill, or you go to the Emergency Room at the hospital and are charged, say, \$200 before your insurance company starts paying. (They do this as a way of getting you to think about using an urgent care facility first before using the Emergency Room.)

¹³ I wish the handbook were *more* helpful.

to buy a Medigap policy, you will likely requirement have to fill out a screening questionnaire about your health. Each company may present its own rendering, so one “turn-down” may not be decisive. Other companies may find you an acceptable risk. However, being turned down doesn’t leave you without solutions. There are three alternatives. One is “community related” plans which are available, there are the Medicare Part C Advantage Plans, and there may remain state sponsored plans offered through the Arizona State Retirement System. I will comment on these possibilities in turn.

Medigap plans are sold only to individuals. Some insurance companies will offer a slight discount (maybe 5%) if both senior members of a family sign up with that company, but before you accept this bait, check out to see whether one or the other of you would be better off, cost-wise, buying two individual plans from perhaps two different companies.

For those who don’t do business on computers or who prefer doing business with a person sitting there in front of them, go to a local insurance agency which has someone knowledgeable about Medicare insurance on its staff. This person can help you find a suitable plan. Here I would emphasize finding an agent who knows the Medicare territory well. Be sure the agent has attended training sessions in Medicare procedures, has a good knowledge of the insurance companies offering plans in your ZIP code area *and knows where to find a insuring company’s rating*. Some companies are better than others. Finally, find an agent who is more interested in your well-being than their own.

Advice: you might look for a helpful agent, but keep in mind that their income is derived from their commissions—selling it. How will you tell if that becomes an incentive for some agents to push one policy rather than another?¹⁴ Other than asking your friends, I have no advice to put in this forum. What buying Medigap insurance involves is that you (a) begin with your own research (use the Medigap Search tool at www.medicare.gov) to get your issues and questions ready, then (b) go to an agent. It’s not impossible that after perusing that site you may even end up trusting your own instincts to buy on line. What Consumers Reports suggests is to “go to www.ncqa.org/ratings to get details on specific plans. For Medicare Advantage plans, you can also go to medicare.gov, which gives the government’s star ratings provided by participant feedback on that health plan’s quality. Look for a plan with 4 stars or more” (p. 50).¹⁵

Bottom line—choose an insurance company which is stable (meaning they are unlikely to fold under economic pressures), is efficiently run (meaning they expedite their payouts to the hospitals and doctors in a timely way, have better customer relations, and the like). When it comes to pricing, businesses in the medical field seem to price not so much in terms of what things cost as what can they get. This is true of insurance, too. Pricing insurance is shaped by policies which aim to protect "margins" (profits). They are likely to trade on their reputation, hence the heavy advertising aimed at creating an image. Like people who buy Aleve (naproxen sodium) for pain relief rather than Walmart’s Equate (naproxen sodium), so people might buy a

¹⁴ Originally, the framers of Medicare thought that competition among insurance companies would drive prices downward . . . didn’t happen. Competition is the enemy of business, so over time only a few major insurers dominated the supplemental insurance and Advantage plan markets—all the more reason to seek a trustworthy agent.

¹⁵ I didn’t find the National Committee for Quality Assurance (ncqa) all that helpful, maybe because (surprise) the most highly rated plans are not sold in Arizona.

more expensive AARP-backed product (viz., United Health Care insurance) rather than an Omaha Insurance Company product. After all, it's AARP backed! Since pricing is *the only* difference between the specific categories of any Medigap insurance (see next paragraph), aim to get the most in coverage and service for the least amount of money.

For detailed information about the levels of Medigap coverage, go to www.Medicare.gov and click on "Supplements and Other Insurance." Here you will find Supplemental plans, each given an alphabetic designation, A through N (omitting H, I, J). What the plan covers and its estimated annual costs are provided in a chart you'll find there.¹⁶ Keep in mind that within each grouping, all policies listed within group "A" are identical, the same with "B," and so on through N. If 72 companies offered Medigap Plan F, the most complete of all the Supplemental policies, each Plan F is the same all other Plan Fs.¹⁷ *Only the premiums charged by each company differ.* Within any single grouping, being higher priced doesn't make it better.

Plan F picks up what Medicare doesn't pay. You will have to determine whether any specific ASRS plan will pay for more types of medical procedures than those approved by Medicare. For example, a state plan might cover more physical therapy sessions than would Medicare. State plans are reshaped regularly (yearly), so you have to check on their most recent iterations. Still, it is the ultimate cost differential that counts. If you paid out of pocket for these additional therapy sessions, would your bill still be less than if you paid for a year of state-offered health insurance premiums? The answer to that question is only something you can determine. (Be sure to read through footnote 16.)

There is another wrinkle in the Medigap Plan F. Medigap Plan G is Plan F with lower premiums—it covers the exact same expenses, but with Plan G there is an initial deductible to pay before the insurance company picks up the bill(s). If you price out the difference between Plan F and Plan G, you will note that the total outlay with Plan G is still less than the total premium cost of Plan F. Of all the Medigap Plans A to N, more Plan Fs are sold, by a significant percentage.

There are very few reasons for dropping or buying a Medigap *outside* the "open enrollment" period (October 15 to December 7). Most common is that of people who are in an Advantage plan and want to reenroll in traditional Medicare. People have other sorts of questions: for example, is there any coordination between Tricare or Veterans Hospitals and Medicare. Answer: no, there is none. Other health care questions swirling around access to

¹⁶ Once you've fiddled around on the Medicare.gov screen, "choosing a Medigap plan," you'll come to a page which contains an estimate of yearly medical costs. The figures are listed on the left side of the screen. This estimate by Medicare includes *all* medical costs per year. The figure includes dentists, for example, and Medicare has nothing available for dental coverage.

For those in ASRS, Delta dental insurance is the one to choose. Why? if you jump out of a state-sponsored plan, at NAU you cannot jump back into its Blue Cross/Blue Shield plan. So, keep Delta Dental for two reasons. First, the premium may be covered by the very modest amount of money ASRS retirees are provided to help defray medical costs. This amount depends on an ASRS formula which includes how long you worked for the state and at what income level. (Note: professors who chose an optional retirement plan [not available to staff] and are not in ASRS get to subsidy and must pay out of pocket for dental insurance.) Second, should you jump out of a state plan and at some future date and want to jump back in, the *only* way this is possible is if you keep active at least one insurance policy offered by the state. I suggest that Delta dental insurance be that one. It's widely accepted by dentists.

¹⁷Gasp! Plan F is being phased out! Why? Plan G is the same as Plan F except for the initial deductible charges, so it the insurance companies determined that their margins could be increased by forcing people into their Plan G. Plan F will continue a bit longer, and as matters now stand one who is reasonably healthy will save money by buying a Plan G over paying the monthly higher premiums of Plan F.

Medicare can be found in the *Medicare & You 2017* handbook. It sketches out some of the answers but will point you to more detailed explanations and expansions. I'll say nothing more here than to mention it. In any case, the "open-enrollment" period is the best time to make adjustments (buy/drop plans, etc.) in Medigap and drug plan policies. But be warned: there are a plethora of rules which govern what you can do and not do outside the open enrollment period.

Suppose: You Jump Out of a State Sponsored Plan. I will take my own experience as a case study. I was among those considerable number of people who stayed with the NAU Blue Cross/Blue Shield (BCBS) after retirement. I did so, having no idea of what health insurance really costs. Moreover, it was no consolation to discover that were one to price similar non-Medicare policies on the national market, they would cost even more than NAU BCBS depending on one's health, likely \$16,000 and upward into the mid-\$20,000s. Paying the \$1,000 a month when I retired took a huge chunk out of our retirement income. After a couple of years of this, I wondered why it cost so much when Medicare was paying 80% of my bills.

If you are in this boat, with me you, too, will think about jumping out of the a plan that sucks up your income. Is there something more affordable? That's how my involvement with Medicare and health insurance got started and why I write about health care insurance.

If, like me, you see yourself leaving a state plan some years after retirement, here is what you face. You are likely to be screened if you choose one of the age-based options, yet these policies initially will save you a great deal of money. Of course the company may not accept you as a client. This means you have to be psychologically prepared with a backup plan should the insurance company think you are potentially more expensive to insure than the company is willing to pay. A likely candidate for a backup plan might be a "community rated" plan. These tend to be more expensive, but the "half-a-loaf-better-than-none" principle comes into play here. They are not age-based, and your objective is to beat what you now are paying. The chances are that you will pay less than the cost of the state plan.

Yet for me, jumping out of NAU BCBS approached with trepidation. It's a good plan. So I pause for a moment to point out my main reason for jumping. Cut costs! True, as a retiree I was eligible to continue the NAU BCBS insurance program (or any of the other state-sponsored programs). It is a good plan. I wouldn't have to fiddle around with Medigap, drug plans, or Advantage plans—but for several thousand dollars more in costs? The principal reason I would move out of NAU BCBS is that in spite of the burden thrown on a person by entering the private market, I could cut medical costs by a significant amount. I might be able to put a dent in the widely quoted study Fidelity Investments which suggested that the *average* cost of health care during retirement years is \$245,000 (but see footnote ¹⁸ below).

Relatively few people are ready for or expect to shoot so much of retirement income up on insurance and its shortfalls. I think the situation may be much worse that Fidelity projects. For the sake of the hypothesis, say a couple lives for 25 more years and die at age 90. Nowadays that's not an impossible thought. If the BCBS premiums averaged out to \$15,000 a year over that length of time (realistic? no! grossly understated) it would cost \$375,000 for insurance. Now,

¹⁸See <https://www.fidelity.com/about-fidelity/employer-services/health-care-costs-for-couples-retirement-rise>. Another online report I consulted (https://www.hvsfinancial.com/PublicFiles/Data_Release.pdf) suggested that "The average lifetime retirement health care premium costs for a 65-year-old healthy couple retiring this year and covered by Medicare Parts B, D, and a supplemental insurance policy will be \$266,589. (It is assumed in this report that Medicare subscribers paid Medicare taxes while employed, and therefore will not be responsible for Medicare Part A premiums.) If we were to include the couple's total health care (dental, vision, co-pays, and all out-of-pockets), their costs would rise to \$394,954."

suppose the two of you for the next 25 years were to buy Medigap insurance from the private market paying half of what BCBS charges—\$7,500 a year/couple (remember, this is hypothetical figure though at present the dollar figure is close enough)—for a total of \$187,500. The reality is that our retirements incomes (for some from ASRS, for others [professors] from private optional plans) will remain relatively constant, while the health insurance premiums will move alarmingly upward.¹⁹ I hope you have investments independent of your required retirement savings (e.g., 401k, personal savings) to bolster your income in your really old age.) It would be this sort of thinking about the future which motivates jumping. It's not the lesser but the cheaper of the two evils one takes.

My reality: For 2016 the NAU BCBS pricing for a person on Medicare who retires from NAU is set for \$594.94/month (\$7,139.28 per year for the single NAU retiree). Add a spouse *who also is on Medicare* (the premiums are higher for a person not on Medicare) and the BCBS premium doubles to \$1,190.02 per couple (\$14,280.24 per year.) Even as other Medigap plans increase their premium pricing, NAU's, remained about the same as last year; but they are significantly more expensive than competing Medigap policies on the private market.

Added costs beyond the initial premium are typical with Medicare supplemental insurance plans and Advantage plans, too. It's like paying extra for bringing luggage aboard most airlines. With the exception of Medigap Plan F, there are copays and deductibles to pay in most other Medigap plans, a lot with some plans, not so much with others. The less you pay for the plan, the higher the cost of copays and deductibles will be.

Buying Part D of Medicare—Drug Insurance. In Traditional Medicare there's one thing left to look at (and for me, it is the most difficult part to assess). We turn to Part D of Medicare, drug plans. Before getting into choosing a plan and Part D of Medicare, there are some procedural things which you need to know.

If you decide to insure with traditional Medicare you *must* enroll in a Medicare Plan D drug insurance plan along with your enrollment in Part B. Part D drug insurance is sold on the private market. You choose a drug plan and typically pay monthly premiums directly to the insurance company, although you can have your premium deducted from your monthly Social Security check. Inform *your drug insurance company* to bill Social Security directly, if this is your wish. Otherwise you pay monthly, out-of-pocket. One easy way of paying is to let the insurance company bill your credit card or an automatic bank withdrawal.

As with high income participants in Part B, you will pay an additional high income premium surcharge to Medicare itself for your Part D coverage. "High income" earning levels are the same as for Part B. The surcharge amount will be between \$12.60 and \$70.80 per month and is taken directly out of your Social Security check.

Medicare oversees/regulates prescription policy, and though there is no connection between Medicare and the Affordable Care Act (ACA or "Obamacare"), this is one place where there is spill over. All Plan Ds have the infamous "doughnut hole," less graphically, called "the coverage gap." It will eventually close in 2020 according the ACA legislation, if all this goes

¹⁹There is no cost of living adjustments built into the Arizona State Retirement System, although you may recall something about the Permanent Benefit Increase or PBI. This (hoped for) increase depends on the health of the stock market over a several year period of time. If the average return at present exceeds that of the actuarially determined amount of money needed for a sound continuing payout of future retirement benefits, then that profit is divvied us between ASRS members as a permanent benefit. At last word, the ASRS fund had yet to recover from the last recession, so as yet there is no profit to share with the members. People in the optional retirement plans are subject to the vicissitudes of stock and bond market gyrations.

according to plan. Should you be one of the few people in 2016 whose drug costs hit the \$3,310 mark (minus the cost of premiums), you drop into the hole. What happens then is that you will pay 45% of the plan's cost for the brand name drugs on their formulary (that is, the list of drugs they're willing to pay on) and 58% of the cost of the generic drugs on their list for the next \$1,540. Then, when the total cost of your outlay the first of the year reaches the \$4,850 point (called the "catastrophic level"), your Medicare Plan D reverts to a very low copayment the rest of the year. Then, next year, it starts all over again.

All insurance companies price their Part D drug plans by a Tier ranking. Generics have no co-pay or low co-pays since they generic, low cost drugs in the first place. The Tier pricing marches up to "what-it-costs" scale in accord with the price of the drug. However, where the drugs are placed in the Tier can be changed from year to year, and thus the pricing with them.

Though drug insurance companies are required by Medicare to cover all commonly prescribed drugs, often what this means that if there is a lower-cost generic equivalent for an otherwise expensive drug, you may have to justify using the more expensive name brand, and your doctor will have to offer a rationale for doing so. It's a hassle. There is "step management," that is you can't go beyond payment for the generic drug until you actually use it. If it is not as effective as the newer drug, then you may try the newer drug in the tier above it. All this requires doctor verification. These maneuvers are common practice, however, why? because drug companies will remanufacture the same old thing with some slight, patentable variation, heavily advertise it to create a market, and get rich! Insurance companies are not amused because by are picking up the tab, they cut into their margins—and then there is us (ugh!) who ultimately pay the bill. See footnote ²⁰ below.

Not a lot of people reach the coverage gap, but with those needing very high cost drugs, the \$3,310 mark comes all too quickly. The real problems arise when the drug is not in the formulary. New drugs (and some of the old ones re-patented with a slight variation, for example, treating a different problem not in the original patent) by which the pharmaceutical industry is allowed by law to maximize their profits (charge whatever they can get) are the ones most disturbing to the consumer.²¹ It is these which get the consumer into deep financial trouble. Though one can appeal the drug company for price reductions, this is a time-consuming process requiring doctor cooperation and, even then, could have uncertain results.

Medicare helps low income people with a program called "Extra Help." People qualifying for Extra Help do not enter the coverage gap. See Section 8 of the "Medicare and You—2017" handbook for further information. Though every other industrial country has pharmaceutical cost controls in place, the U.S. legislative bodies have seen fit to let the "free" market take its course. However, there is a measure of cost and quality control by Medicare. For example, all formularies must include drugs normally prescribed by the medical profession, but what this means can become a matter of judgment.

²⁰ You may have read about the New York-based Turing Pharmaceuticals buying an old medication (Daraprim) and raising its price from \$13.50 per pill to \$750. Here are some other examples: doxycycline hyclate, a common antibiotic from 4¢ per tablet to \$3.70 (up 8,281%), or albuterol sulfate used to treat asthma, 11¢ per tablet to \$4.34 (4,014%), glycopyrrolate used to treat irregular heartbeats, \$6.50 to \$127.70 per vial (2,728%), digoxin used to treat irregular heartbeats and heart failure, 11¢ per tablet to \$1.10 (884%), divalproex sodium er used to prevent migraines and certain seizures, 39¢ per tablet to 2.93 per tablet (736%), pravastatin sodium used to treat high cholesterol and prevent heart disease 5¢ per tablet to 39¢ (573%). There seems no end to citations.

²¹ This is an item for a different venue. The standard rationalization is that high prices are needed to recoup research costs. True? Then why does the rest of the world pay lower prices for new drugs than do people in the U.S., and why are drug companies' advertising budgets higher than research budgets?

There are insurance agents who will take an inventory of your needs and suggest plans with prices which will meet your needs. Since Plan Ds are sold only to individuals (not to couples) it could be that you and your spouse end up with different insurers/policies. Choose well. Once you have signed up for a prescription plan, with some exception, it's yours for the ensuing year. The *webmd* website cited below²² offers some help in getting ready to make a choice. I quote a part of it:

Keep these things in mind so that you can choose the plan that meets your needs:

Make sure the drugs you need are on the plan's drug list, called its formulary. A drug plan won't help pay for medicines that aren't on its list. Be thorough and check the details. Even if a drug is on the formulary, look closely to make sure it's covered at the dose and quantity you need. Also look to see if the plan requires you to get prior approval from your doctor for the medicine before they help pay for it.

If drugs you need aren't listed, talk to your doctor before you enroll in a plan. Your doctor may be able to prescribe different medicines that will work as well.

Compare the costs. The deductibles, premiums, and copays or coinsurance for Medicare prescription drug plans will differ.

Check the pharmacies. Some plans will only work with certain pharmacies. Make sure that the pharmacy that you use, or another one nearby, is on the list. If you like to have your medicines delivered by mail, check for that, too.

After you make your choice, call the specific plan to find out how to enroll. You will probably receive a form in the mail that you can fill out and return. You can also enroll online.

So . . . a click by click run-through might help.

1. Go to Medicare.gov and click on the tab labeled Drug Coverage (Part D).

2. There's a listing of sub-topics. (You may want to peruse). Click the top listing, "How to get drug coverage." Scroll down the page past "2 ways to get drug coverage. There's a link titled "Find a Medicare drug plan." Click! Now go down to "Personalized Search" and enter the information asked for: ZIP code, Medicare Number, Last Name, Effective Date for entry into Part A, and Birthdate.

3. Click on "Find Plans." Wait a few seconds. Now an entry page pops up with the heading "Type the name of your drug:" Get your prescriptions bottles out, but before you begin, here is why you do this: I typed in a listing of some of the **very most expensive** drugs available to date: Alimta, Erbitux, Fortes, Gleevec, Herceptin, Kadcyla, Keytruda, Lugron, Opdivo, Prolia Revlimid, Symbicort, Velcade, Viagra, Yervoy—none of which has a generic equivalent—and clicked on "My Drug List is Complete."

To get an idea of what all the drugs listed would cost/year without insurance, Medicare provided the figure of \$701,140 for the year. With insurance, the figure ranged between \$37,606 and \$58,720. This would include co-pays, deductibles and the insurance itself. It's a fantasy to put all these drugs in one, year, but all of this amounts to saying is that insurance helps. In one or another of the 22 plans scanned, all or almost all of the outrageously expensive drugs were

²² www.webmd.com/health-insurance/insurance-basics/medicare-part-d-prescription-drug-plans

available (with “prior authorization”)—except highly advertised Viagra (at more or less \$35/pill absolutely **no one** wanted to mess with that!) and one “Not on formulary” for the other highly advertised, Symbicort, an inhaler.

4. I typed in the various generic drugs which I use and came up with one drug plan out of the 22 listed which cost \$18.40 per month with a \$360 deductible, \$1-\$4 co-pays for Tier 1 drugs, and 20%-35% coinsurance. The most expensive plan was \$109.70/month, no annual deductible and coinsurance of \$2-\$10 or 20%-45%. Which would you take? \$580.80 including the deductible plus co-pays and co-insurance, or \$1,316.40, no deductible but co-insurances. I think the odds stand with the former.

Summary. Here is Medicare’s summary of Plan D. “Each Medicare Prescription Drug Plan has its own list of covered drugs (called a formulary). Many Medicare drug plans place drugs into different “tiers” on their formularies. Drugs in each tier have a different cost. A drug in a lower tier will generally cost you less than a drug in a higher tier. In some cases, if your drug is on a higher tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you or your prescriber can ask your plan for an [exception](#) [a click here on the Medicare website will bring up a new screen] to get a lower copayment. A Medicare drug plan can make some changes to its formulary during the year within guidelines set by Medicare. If the change involves a drug you’re currently taking, your plan must do one of these:

Provide written notice to you at least 60 days prior to the date the change becomes effective.

At the time you request a refill, provide written notice of the change and a 60-day supply of the drug under the same plan rules as before the change.

Now comes the irritating part: when you choose a Plan D, you likely do so with the current medications as the screening tool for what plan would best suit you. Then, mid-year, a new malady comes into your life and the cure is not in the formulary of the drug plan you chose. It is then when a lot of “we wish we could help you, but ...” flows from the lips of druggists, doctors, insurance companies, and drug companies. To be sure, appeals can be made and are sometimes successful. None the less, it is at best an irritating hassle and at worst a devastating lament.

Each year you must review the offerings by Plan D providers to (1) investigate whether the company you choose offers coverage on the prescription drugs you use/need or might need and (2) is charging a price you are willing to pay. Companies can change both formularies and insurance premium prices every year. This is a perpetual case of “buyers beware”! There are still co-pays and deductibles in addition to the insurance premium built into any plan you buy. Go to <https://www.medicare.gov/find-a-plan/questions/home.aspx> to do your research, or go to a trusted (that is, a person interested in your well-being rather than their own. The best of them have plan/cost data at their computer’s “finger tips.”

Part C of Medicare, Private Market Plans, or—Advantage Plans

As it turns out, roughly speaking Advantage plans and Medigap plans are priced in the same neighborhoods for more or less equivalent plans and services. The Advantage Plan is

convenient, but there are differences. For example, supplemental plans allow for national coverage and a more tailored selection process. Advantage plans are regional and only emergency care is covered in the area outside of where the plan is issued. (You couldn't go to a Rochester, Minnesota Mayo clinic with an Arizona area Advantage Plan, for example.) One advantage of Advantage plans is that Medicare Parts A, B, and D are bundled together. It's Plan C. However, the drawback is that you have to check with each of your providers to find out if that provider accepts your particular Advantage insurance plan and to be absolutely sure, whether your insurance plan accepts your provider. There are cases of cross-signals.

Other health care needs are sometimes bundled into an Advantage plan—eye glasses, dentistry, gym membership, for example. These are enticements to buy, but you want to make sure that overall the plan will meet or beat Traditional Medicare. As with Traditional Medicare, one has to be aware of what one is buying. I quote the following from the September issue of an AARP newsletter.

Medicare Advantage Plans may not be the best deal. More than 30 percent of Medicare beneficiaries are enrolled in private Advantage Plans from insurers like Humana and Aetna, rather than in the government's Original Medicare. Typically Advantage Plans feature low premiums, all-in-one medical and drug coverage and extras like gym memberships and 24-hour nurse lines, which make them quite popular. But many Advantage Plans have limited provider networks concentrated in one geographic area—and reserve the right to shed doctors and hospitals after you've signed up.

"It can be like paying for a car and getting a bicycle," says Judith Stein at the Center for Medicare Advocacy. You may pay higher premiums for Original Medicare than you would for an Advantage Plan, she says, but you'd be covered at virtually every hospital and at about 90 percent of doctors nationwide.

This said, the *Medicare and You 2017*, Section 5 (pp. 67ff.) is on Plan C, and the handbook has some scattered information on Advantage plans that you can search for using the index in the front of the booklet. Where you live makes a difference in which insurance company you would want to use. Some people live in cities with Health Maintenance Organizations (HMOs), others in cities with Preferred Provider Organizations (Flagstaff is a PPO city; it has no HMOs). This means that your doctors, other health care providers, and hospitals you may go to have to be vetted by your Advantage plan insurance provider (in other words, in the "network" of that insurance company), to be covered. You can "go out of network" and pay the difference. The handbook advises: "Check with the plan for more information."

To investigate what an Advantage plan does, go to <https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html> for a quick overview of Advantage plans.

After getting a lay-of-the-land in the description of Advantage plans, next look at <https://www.medicare.gov/your-medicare-costs/medicare-health-plan-costs/costs-for-medicare-advantage-plans.html> for an overview and protocols concerning Advantage Plan sales tactics.

The thing you want to know, 'Who offers what at what price?', is hidden from scrutiny—at least I haven't found anything in Medicare.com nor in Google searches, EXCEPT commercial sites willing to help you find exactly what fits you, as they say. This means that a sales person ultimately will get involved. It's at that point I recoil. If one Googles "Medicare Advantage Plans 2017," a long page comes up with "let us schedule you an appointment" or a "fill-in-the-blanks

with your name and phone number,” I tend to worry about insurance companies looking for my business. Here is a quotation from one source I used: “By entering my contact information and clicking ‘View plans,’ I consent to receive e-mails, telephone calls, text messages and artificial or pre-recorded messages from (name of organization and other service providers) regarding health insurance products and services . . . [even] using an automated telephone dialing system.” Just what I needed!

The only helpful information I found was near the bottom of a webpage article in U.S. News titled “Best Medicare Advantage Plans 2016.” I clicked on a summary informative link, and it listed CIGNA as the only five star (maximum) plan being sold in Arizona. I don’t know what 2017 brings in regard to “best plans in Arizona.”

I’m sorry I can’t do better for you regarding Advantage plans, but please know that several people in NAURA have voiced satisfaction with their Advantage plans to me over the years, so though I’m pleased with the path I’ve taken, sticking with Traditional Medicare, there is another way.

Conclusion. This introduction to health insurance and retirement was first created in the context of NAU employees whose health insurance is underwritten by Blue Shield/Blue Cross (NAUBCBS) which was legislatively allowed because there are no HMOs in Flagstaff. No other state institutions offer this policy. In retirement, NAU people have the option of remaining with NAUBCBS or joining a policy offered by ASRS. I modified this introduction with the hope that I’m in tune with what others in the state system face.

Two state agencies may send you health insurance information the year 2017. One will come from the Arizona State Retirement System (ASRS) and the other may come from the Arizona Department of Administration (ADOA). Though in general they overlap each other, they in fact are independent of one another. Each sought insurance bids and then negotiated the policies you read about in the brochures. There are minor differences including pricing and scope of coverage in the policies offered by the two agencies. Only ADOA offers the NAU health insurance policy. Along with the rest of the state employees you can also look at policies likely offered by companies other than NAUBCBS. Last year United Health Care (with trivial differences) has provided policies in both agencies. I advise NAU employees to stick with BCBS if they can afford it. Otherwise, jump. With HMOs in others parts of Arizona, one might look more closely before one jumps.

Since because my active life in the NAU Retirees Association, I decided to become a (certified) Medicare counselor. There’s a lot about Medicare which I still need the training manual in hand if I am to be helpful. Here are three of the common questions I’ve been asked along the way.

(1) I’m retiring from NAU prior to age 65, the eligibility date for Medicare. What options do I have concerning health insurance?

There remains the possibility that you may be able to join your spouse’s (or your partner’s) insurance plan if s/he is employed by an employer offering a family health insurance plan. Or perhaps you retired because of a disability covered under the “disability” part of the Social Security program. If you applied for and receive recognition from Social Security for disability payments, you are qualified for Medicare as well. However, if you simply retired at

age 62 and started Social Security payments, you won't be qualified for Medicare until you reach age 65.

The basic, underlying reality is that, if you do not qualify for Medicare and have no job-provided insurance, one way or another, you will pay 100% of the costs of your health care, this beginning with the fact that you are required by the Patient Protection and Affordable Care Act (i.e., the ACA or "Obamacare") to enroll in one of its insurance programs.

To give you an idea of ACA pricing, the 2015 premiums went something like the following: the high priced "Platinum PPO" plans had premium around \$755/month, a \$1,500 deductible, out of pocket maximum payments of \$2,500 with \$10 to \$30 copays. For a couple, both age 60 with an income of \$45,000, there was a tax credit toward premium of \$924. The lowest cost (with higher deductibles and copays) is called a "bronze" PPO, \$162/month premium, deductible of \$12,600 with a maximum out of pocket \$12,600 and no copays after the deductible is paid. What the year 2017 holds is not at all clear. I can't imagine that things will be better.

There are numerous web site offering help for pre-Medicare people, for instance: <http://HealthCare.gov>, <http://obamacarefacts.com/obamacare-facts/>, <http://obamacare-guide.org/arizona/>. You may enroll on-line or perhaps there is an insurance agent in town you trust who can help you. In one way or another, upon retiring you'll be joining an insurance plan offered by the "private market." The plans offered will price their policies in terms of how much of your medical costs you want them to pay. A policy which pays 80% of the costs charges considerably more than one which pays and pay "full freight" for your medical insurance. Depending on the conditions of your retirement from State of Arizona retirement, you may be able to continue with the NAU Blue Cross/Blue Shield plan (BCBS) or another State of Arizona health insurance plan offered by the Arizona State Retirement System (ASRS). But the pricing will be similar to or more than what you would pay when buying a policy on the open market. Whatever you decide, it will cost you.

(2) You reach age 65 when you are Medicare eligible but continue working at NAU. Does my health care insurance continue as it always did?

Yes—except note this well: though people continue employment with NAU past the age of 65, they still have to sign up for Part A of Medicare at age 65. About three months before your 65th birthday, you will receive a letter from Medicare asking you to go online and fill out your "Initial Enrollment Questionnaire." (There is also a phone service to help you do this: 1-855-797-2627.) As an employee, you (and perhaps family) continue to be covered by the NAU Blue Cross/Blue Shield (BCBS) health care program, but *everyone has to sign up for Part A of Medicare* at age 65. There's a seven-month window in which to do this, a period including the three months before the month of your birthday and three the months after. During this process of signing up, you will also indicate that you have equivalent or better coverage to anything offered by Medicare. NAU Human Resources is supposed to provide you a yearly letter indicating this equivalence. As long as you work at NAU, BCBS is your primary insurer and Medicare is your secondary insurer.

(3) I have a very modest retirement income. Is there any financial help connected with Medicare?

Yes, however, (in 2016) your assets cannot exceed \$13,640 for an individual or \$27,250 for a couple. These exclude your house and car. Your monthly income must be below \$1,485 for an individual and \$2,003 for a couple. The 2017 figures will be available shortly, but they will still be in the same neighborhood as the 2016 figures.

Likewise, there is help for a Medicare drug coverage plan for persons with a limited income called "Extra Help."

You can read about both in the Medicare handbook. Contact the State Health Insurance Assistance Program for the help you may need in filling out the necessary forms. Telephone 1-800-521-3500 for help.