LNP 310
Planning for Retirement and Your Healthcare Needs
Robert Klein

Kelly: Hi and welcome back to the Legal Nurse Podcast. This is your co-host, Kelly Campbell. Today we have a guest, Robert Klein. He's the healthcare cost in retirement and income planner with a concern about aging in place. He is a partner with Jester Financial. His two concerns are planning for mandatory and likely healthcare costs and longevity. Welcome, Robert, thanks for joining us.

Robert: Hi, Kelly, and thank you for having me this morning.

Kelly: I have a lot of questions. So, before I get started, what's your number one thing that you think we should know?

Robert: That healthcare costs are mandatory in retirement and most people are not aware of it.

Kelly: You know, as also a life care planner, not a legal nurse consultant, I couldn't agree more. So, aging in place is something that I'm starting to think about with my aging. Let's start by defining what you mean, "aging in place."

Robert: Well, that's going to have different meaning for different people, but the way I interpret aging in place is about being comfortable staying in a home or some type of situation. Maybe it's living with family, where you're not in a care home. You're with family, or you're taking care of yourself and maybe have somebody from the outside coming in. So, in other words, something that's not a nursing home, not assisted living. You're in your own home or in your family's home.

Kelly: Okay. All right, thanks for that clarification. Medicare and Social Security: We see a lot of advertisements for that, and they are two separate programs. So, why must we think about them together when planning for retirement?

Robert: The dirty little secret, if you will, is that even though they're technically two separate programs, one obviously handles retirement income, the other one is your third-party payer for health costs or for
most health costs anyway in retirement. They really are one in the same program and people say, "Well, how's that possible?" I said, "All you have to do is go back in time and look at the changes starting in 1993."

Back in 1993, Social Security changed their program operating manual to state the following, "If you want your Social Security benefit in retirement, you must enroll in Medicare when you're eligible." Now for a lot of people that didn't mean much because back then people still had health costs in health care, or I should say health insurance was paid for by their employer, or they were part of the VA. So, it didn't really make much of a difference to them. But over time, as we see, many employers got out of health care, or shall I say health insurance in retirement, and now it's started becoming a big deal.

In 2003, there was the Medicare Modernization Act, which was the largest expansion of Medicare. It created what we call the Medicare Advantage Plans today, the Medicare Part D, the prescription drug plans. Everybody who was for this legislation said, "Wow, this is great. We're going to have all these new options. Now it will be more affordable and we're helping seniors," but nobody read the fine print. And the fine print said, "In order to pay for all of this starting in 2007, we're going to charge higher income earners more money."

And that was called the IRMAA, Income-Related Monthly Adjustment Amounts. And, of course, those who did bring up that said, "Well it's only 5 percent of the population, who cares?" Well, back in 2003-2007, you didn't have all the baby boomers of 65 yet, so they weren't retired. So, of course, nobody was paying attention to what the numbers really meant.

**Kelly:** Right, so the question I asked and the way I asked it was completely wrong. Medicare and Social Security are not necessarily two separate things. They are one program.

**Robert:** Right and I'll go even further. There was a big court challenge against it. If you look up the legislation, it was called "Hall v. Sebelius," and I think there were dozens if not tens of plaintiffs who sued Kathleen Sebelius and one of the big litigants involved in it was Dick Armey, a former Congressman. And they basically said, "Look, we don't want
Medicare in retirement. We want to opt out of it. We don't want these two together."

And it made its way through the federal courts and finally the deciding opinion, and I think it was in the D.C. Circuit court, was Justice Rosemary Collyer who basically ruled against him. And it was an interesting ruling because in the early parts of the litigation it almost sounded like she was sympathetic to their cause. But in the end, she decided, or she ruled that, "No, the intent was that the systems are the same."

The Supreme Court declined to hear it on appeal, so it stands that they're two together. And in her opinion the intent was that they were really the same. That's something not everybody realizes. When you retire and you're on Social Security, at minimum, your part B is what pays the providers, or people call it the doctor reimbursement amount. That is deducted from Social Security. That's mandatory once you're collecting the benefit.

And the other issue is you're subject to any of those higher income surcharges that are also deducted from the Social Security benefit. And it goes further. In 2010, when the Affordable Care Act became law, a lot of people said, "Well, it doesn't really affect Medicare." Yes, it does because it added the IRMAA surcharges to prescription drug Part D, so now your drug costs go up. Well, I should say your insurance for the drugs go up.

**Kelly:** And is that a surcharge?

**Robert:** If you have a prescription drug plan and you're on Medicare, your premiums will have a surcharge if you earn a higher income, so it's going to affect your retirees. So, even though the original intent of the Affordable Care Act was for insurance for the pre-age 65 population, it does have a little teeth in the 65 and above crowd.

**Kelly:** Okay, so that leads to my next question. When does one enroll in Medicare? It's a twofold question. How much does Medicare cost and what are people receiving from Social Security? I guess that's a threefold question.

**Robert:** Not a problem, we'll answer it in order.
Kelly: Okay.

Robert: So, the first thing is, "When does somebody enroll?"

Some people think like you must enroll at age 65. That's not entirely true. The first thing you must look at is, "Do I have credible health insurance through my employer or if I'm married, does my spouse have credible health insurance?"

And credible, the definition of that means it must be 20 or more people. So obviously if you're working for a major Fortune 500 company and you plan on working until you're 70, you don't necessarily have to opt into Medicare. There are some people who are in that situation, or if their spouse has coverage, say their spouse works for General Electric or something like that, they say, "Well, I'll go on his or her plan."

Now there are some that will say, "We'll enroll in Part A anyway because why forget to enroll in it? It will work along with your employer coverage." The reason not to do that is if you or your spouse are participating in a health savings account under current rule, current law, you can't contribute to a health savings account if you're enrolled in Medicare, even Medicare A. So that's just a little nuance.

Now not everybody has a health savings account and high deductible plan, so for some people it's no big deal. Whether you are working or not working, if you no longer have credible coverage at age 65, you must enroll in Medicare, at least Medicare Part A. And you're given a seven-month window, basically the month that you turn 65, the three months before and the three months after. You also want to enroll as quickly as possible if you do not have credible coverage in Part B because there's a late enrollment penalty. Part B, the average premium, which is someone enrolling in Medicare today, is going to be $135.50 a month.

Kelly: Okay.

Robert: Okay.

Robert: Correct, and it's what people call the "Hospital Plan." For most people, Medicare A is going to be free, and the reason why it's free is because you paid for it with your payroll deductions or if you were self-employed, you know your self-employment taxes. You covered your Medicare costs. So, if you meet the definition for Social Security, if you're eligible to have a Social Security benefit, which is usually your 40 quarters, your Medicare A is not going to have a premium cost. There's still a deductible, but there's no premium for it.

Kelly: Right. Medicare B is your doctor's visits and Medicare D is your prescriptions.

Robert: Right, your prescription drug plan. And the average cost of a prescription drug plan in the United States is $33.19 a month. And that's going to vary depending upon your zip code and what kind of drugs you're taking. Obviously, if you need a comprehensive plan because you're on a lot of medication, that cost is going to be higher. But original Medicare, which is Part A and Part B, has deductibles and cost sharing.

So, for the hospital deductibles over $1,300 for Part A, and unlike non-Medicare insurance such as your private health insurance, it's not an annual deductible. It goes by benefit periods and their benefit periods are 60 days, and it must be for the same incident. So, an example is if I'm 65 years old and I go into the hospital with chest pains. It turns out I have a heart attack and they wind up admitting me. I'm in there and that's one benefit period.

And if I've got to go back to the hospitals within the 60 days for something cardiac-related, it's not going to trigger another deductible most likely. But if after I'm discharged and within the 60 days I trip and fall in my house and break a hip and then I get admitted for that, that's a new benefit period even though it's within the 60 days because it's a hip issue, not cardiac.

Kelly: Right, a different diagnosis.

Robert: Correct, so it can get very pricey and that's a little nuance in there. With Part B, you have $185 annual deductible and generally for most people that's not going to be a problem, but it's 80/20 cost sharing with no limit. So, unlike regular health insurance, eventually you have
a maximum out-of-pocket amount. With Medicare, it can continue and on.

So, how do you solve that?

You must go to the supplement plan market and get something like a Medigap plan. The most comprehensive one right now is Plan G. Plan F is being phased out and Plan G covers pretty much everything except for the $185 deductible. Although, let me clarify everything.

Medicare does not cover vision. It doesn't cover dental, and it does not cover hearing aids, so.

Kelly: Plan G.

Robert: Plan G. Some people are still in Plan F. Plan F is really the top tier one. The problem is, is that it's being phased out. And those who continue to be in there, you're going to have an ever-shrinking pool of people, most likely getting older, most likely using more health costs, you know and health services, so the premiums will rise. So, generally the recommendation is G.

Kelly: Okay.

Robert: Now there are some people that may say, "Well, Plan G is too expensive" because the average cost of a Plan G is $290. They may opt for a Medicare Advantage Plan, which can have a prescription drug plan. Some Medicare Advantage Plans offer additional services that are not covered by Medicare and not covered by the Medicare supplement plan. Although, you know “buyer beware” with those plans because you are limited to a network. You are limited and the network can change mid-year. And it's very possible the doctor who you liked before you were switched over to a Medicare Advantage Plan doesn't take it. You’re also affected if you travel, if you're a snowbird.

I live in the New York City area. We've got a lot of people who go down to Florida in the winter. If you have a Medicare Advantage Plan in the New York City area, it most likely will not work in Florida.

Kelly: Right and you know with aging, you cannot predict what's going to happen.
Robert: I mean, for emergencies you'll be fine. The problem is if it's something that's not deemed you know a life-threatening emergency. You know you're just not feeling so well and go to the doctor and you know you're down snowbirding in Florida, you're going to pay that bill.

Smart Money Management
Before I continue with the show, let’s talk about one point: You know that controlling expenses and keeping good track of your income is vital for your business. In my online training presented by an accountant, you will discover what you should be doing from this skilled accountant. Learn simple and straightforward ways to manage and understand your money so that you can use that information to grow and better manage your business. You won’t want to miss this.

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Kelly: Right. So, how does Medicare affect your Social Security check?

Robert: Right, so the Social Security (and you asked, and I forgot to answer). The average Social Security monthly benefit is $1,461. That's the average. Now obviously people who were higher income earners, they're going to see it well over $2,000.

So, what happens is that once you're enrolled in Part B and you're collecting Social Security, the $135.50 will be deducted from Social Security right off the bat. If you are deemed a higher income earner, and a higher income earner means if you're married filing jointly and you have a $170,000, more than $170,000 of modified adjusted gross income, you're going to wind up paying more money for Medicare.

And what is more money?

The premium penalty, it's called the IRMAA, which I mentioned before, the Income-Related Monthly Adjustment Amount, starts at 40-percent of a surcharge and goes well over 200-percent and that's per person.

Kelly: My goodness.

Robert: Yeah, so it can get very pricey, and that must be deducted. The IRMAA penalty must come out of the Social Security check. So, and if you're single, it's $85,000. It's the first dollar over $85,000 starts the IRMAA.

And again, you know some people say, "Well, how am I going to trigger that? I'm not making that right now." Well, I was very clear to have mentioned that it's modified adjusted gross income, which means if you look at the new IRS 1040 form that's line seven and line 2a. So, that includes almost everything. That includes your pension, IRA withdrawals even if they're mandatory withdrawals, mandatory 401k withdrawals because you're over 70-1/2 dividends, capital gains, rental income, wages if you're still earning, taxable interest, tax
exempt interest, taxable dividends, tax exempt income, so and then any other type of outside income.

There are exceptions that don't trigger the IRMAA, which gets into a lot of the planning work that I do. And the funny thing about those is some of those things that don't trigger the Medicare means testing or you know the IRMAA surcharge. They're some of the solutions that the gurus tell you to avoid. I always find that funny.

**Kelly:** Such as?

**Robert:** So, there are five things that, or I believe it is five, that are excluded from the Medicare means testing calculation. First one is the health savings account. That is gaining popularity, so I shouldn't say that the gurus tell you not to use it. As more people understand that if you have a high deductible health plan at work, you can contribute money to this kind of like a medical IRA. You get a tax deduction going in, the money can grow tax deferred and if it's used for qualified medical expenses, it's tax-free. So those who understand how these programs work, now you've got a nice little cache of money where you can withdraw and use it for health expenses.

**Kelly:** A nice little nest egg.

**Robert:** A nice little nest egg. And I say possibly because some people still treat health savings accounts as flexible spending, and they'll withdraw out of it to use for things that they really could be paying for out of pocket. But I guess the logic is like, "Well, it's in there. I might as well use it already." I mean, to each their own but that's why I say possibly you know see some growth. Because if you're going to take it out every year to use on expenses even though it's not taxable, it's not going to grow, obviously.

If you own a small business, and usually like a closely held family business, you can do an enhanced version of the HSA and it's called the 401H Plan. I don't talk about that that much because it has very limited application. It's nondiscriminatory, so you'll never see it in a large company because that means you must have everybody participate in it. But if people own their own business and you know that the business is going to pass on to the next generation, then it might be something to look at.
Another thing is the cash values from life insurance. You have a lot of people that over the years, these financial gurus on the radio, on television and print, they tell you to buy term insurance and invest the difference. Okay, but if those who still have whole life or universal life type of life insurance policies, the cash value in there, if there is cash value in it, maybe you may be able to borrow it against the policy. Not only is that not taxable, but it doesn't trigger the means testing for Medicare. So, for some people there could be some money in there.

Certain annuities, when you tell the insurance company, "Pay me like a pension," it's called "Annuitization." If it's done with after-tax dollars, in other words, you set up the annuity with after-tax dollars, the amount that is considered return-of-principal is not taxable. And it does not create a problem for Medicare.

The Roth IRA could also be the Roth 401k for people working for hospitals and other organizations like that. They might have a 403b with a Roth option. Under current rules, the distributions in retirement are income tax-free. They're also not counted by Medicare and Social Security.

The final one is home equity and that's where you also get into aging in place. Because you could have seniors, and by seniors, I mean anyone age 62 or above, who may be sitting on a lot of home equity, and they may want to access that equity now or at some point in the future. And depending on their situation, that could be a huge funding source for healthcare costs, and it does not trigger the calculation for Medicare means testing.

Kelly: Okay, that's starting to make my mind roll a little bit and I have probably 15 more questions, and we're running out of time to see what that means. We're going to have to have a part two. But before we have part two, I do have a couple of simple questions because part two we're going to dive deep, and I'm telling you that right now. How early should one start planning?

Robert: That's a great question. You know a lot of people wake up when they are 65 or close to 65 and in my humble opinion that's too late. You really want to start as soon as you're out of school and in your first job, you really should start thinking about this.
Now I know a 20-something-year-old is not thinking about something that's happening possibly 40 years in advance, but the earlier you start and the decisions that you make when you're younger are important. And it's simply different decisions on where to save and how to save. That can mean the difference of a catastrophe later.

One of the biggest culprits that I see out there is that you talk to accountants and all they want is the tax deferral and the tax deduction today. I will argue with the new tax law and grant that tax laws can always change. But I will argue, especially for someone young starting out, you might be better off to say forget about increasing your tax deductions today. Use the standard deduction and look at doing things after-tax so that you will have tax-free later.

I don't buy into the belief that we're going to be in lower income tax situations later. There's a big cost to pay for all these programs. You have a lot of baby boomers, about 10,000 of them retire each day, and you got about another 10 more years until the youngest baby boomers turn 65. So, it's going to be costly.

Kelly: So very true, so very true. So, part two. Let's get the audience ready for part two when we dive deep into aging in place with Roth IRAs, with home equity, with saving. What else do we need to dive deep into before we close out for today?

Robert: Long term care, even though I don't like the term long term because when I say that to somebody, they automatically assume a nursing home. And that's why we started with aging in place. If you plan properly for long-term care, it could wind up becoming nursing home avoidance because you might be living in the comfort of your own home. Your home may need to be reconfigured a little bit differently. You may wind up putting on an addition to your kid's home. You may wind up building a granny pod or an accessory dwelling unit as they call it because your son or your daughter has a property large enough and the zoning allows it.

Kelly: And having an attendant care.

Robert: Right or planning for home care. So, those are things that you must do. You know it should be part of part two and kind of like the deep
dive because Medicare doesn't cover long-term care and that's a huge thing that people don't realize.

The final thing also to cover in another discussion is really the longevity because longevity is a risk multiplier. I think people underestimate how long they're going to live. And the longer you live, why, it's great. We want to see our children grow and get married and have their own kids. And we get to see your grandkids grow. And I know a good number of people who already have great-grandchildren, which is fantastic.

But the longer we live, the more our basic living costs are, the more we're going to pay a mandatory health costs and the greater our chances are of needing some form of long-term care. So, it's a double-edged sword or, as I like to call it, it's a risk multiplier.

Kelly: Yes. Yeah, a cost multiplier too.

Robert: That’s right.

Kelly: All right. Well, today was a great overview. Audience, get ready for a deep dive. And hey, I forgot to ask you will you come back and do a second podcast with us?

Robert: Absolutely, and...

Kelly: Sorry for putting you on the spot there, but in the meantime let's let our audience know how to get ahold of you before we get you back here.

Robert: All right, one of the… If you have access to the Internet, one of the great places to start is the Jester Financial website at Jester, like the court jester, (J-E-S-T-E-R) jesterfinancial.com, so that's all one word. And over there, you can dive a little bit into healthcare costs in retirement. I believe you can even still get a free report on how this… on how the costs look like over your retirement years.

[00:26:52]

You may also reach me toll free at (877) 259-2259. That's (877) 259-2259. Actually, I just realized that's my... I just gave my fax number by accident. It's...
So, you can also reach me at my email, which is, R-K-L-E-I-N, rklein@jesterfinancial.com. That's R-K-L-E-I-N, rklein@jesterfinancial.com and I'll correct the toll free number. It's (888) 383-2724. That's (888) 383-2724.

Kelly: Okay, great. All right audience, tune in next week. And thanks Robert, I can't wait to talk to you again.

Bye-bye.

Robert: Bye-bye and thank you, Kelly.

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