James Wessels, CPA/PFS, CFA
4140 Grand Ave
Des Moines, IA 50312
515-453-2222
j.wessels@vfghelps.com
www.VFGhelps.com

Healthcare in Retirement

Healthcare in Retirement

What health care benefits are available in retirement?

Health care in retirement is available from many sources. Government programs (such as Medicaid and Medicare) offer numerous health care benefits. However, you may need to purchase supplemental health insurance or Medigap, as well. Most Americans are eligible to begin receiving Medicare benefits at age 65, but qualifying for Medicaid may require some planning on your part. In addition to these resources, you may also be entitled to military health care benefits if you are a veteran, retired servicemember, or the spouse or widow of a veteran or retired servicemember. Continuing care retirement communities and nursing homes also offer health care services for older individuals. Depending on your specific needs and circumstances, you may use any number of these resources during your retirement years.

Medicare

In general

Medicare is a federal health insurance program created in 1965. Medicare primarily assists those who are 65 or older, but if you are disabled or have kidney disease, you may be eligible for Medicare coverage no matter what your age. Medicare currently consists of Part A (hospital insurance), Part B (medical insurance), Part C (which allows private insurance companies to offer Medicare benefits), and Part D (which covers the costs of prescription drugs), with each part having its own eligibility requirements. You may qualify for one or more parts, or you may choose to accept or decline coverage if you are eligible. Many health policies limit coverage for Medicare-eligible individuals regardless of whether they have accepted Medicare coverage.

Medicare benefits for disabled individuals

Under certain conditions, the disabled are eligible to enroll in Medicare before age 65. If you have been receiving (or have been entitled to receive) Social Security disability benefits for at least 24 months (not necessarily consecutively), you may be eligible to enroll in Medicare. To enroll, you must be entitled to benefits in one of the following categories:

- A disabled individual of any age receiving worker's disability benefits
- A disabled widow or widower age 50 or older
- A disabled beneficiary who is older than age 18 and receives benefits based on a disability that occurred before age 22

In addition, Medicare may be available at any age if you are disabled as a result of chronic kidney failure requiring dialysis or a kidney transplant.

Qualified Medicare Beneficiary program

If you have limited means, you may be eligible for the Qualified Medicare Beneficiary (QMB) program. Here, your state's Medicaid program may pay for your Medicare Part B premium, Part A and Part B deductibles, and coinsurance requirements. Eligibility rules may vary from state to state, but in general, you must meet the following three criteria:

- You must be entitled to Medicare Part A
- Your income must be at or below the national poverty level
- The value of your assets must be below a certain level

There are also other related programs that have somewhat less restrictive eligibility requirements.

Medigap

In general

Medigap is supplemental insurance specifically designed to cover some of the gaps in Medicare coverage. Although the name might lead you to believe otherwise, Medigap is provided by private health insurance companies, not the government. However, Medigap is strictly regulated by the federal government.

There are 10 standard Medigap policies available (Plans E, H, I, and J are no longer available for sale, however, if you already have one of these plans you can keep that plan). All plans may not be offered in your state, yet all are standardized and certified by the U.S. Department of Health and Human Services so that each plan provides exactly the same kind of coverage no matter what state you live in (except for Massachusetts, Minnesota, and Wisconsin, which have their own standardized plans). Every Medigap policy offers certain basic core benefits, such as coverage of certain Medicare Part A and B coinsurance and co-payments. Other plans offer additional benefits, such as coverage of Medicare Part A and B deductibles, and charges that result when a provider bills more than the Medicare-approved amount for a service.

Medicaid

In general

Medicaid provides medical assistance to aged, disabled, or blind individuals, or to needy, dependent children who could not otherwise afford the necessary medical care. Medicaid pays for a number of medical costs, including hospital bills, physician services, home health care, and long-term nursing home care. Each state administers its own Medicaid programs based on broad federal guidelines and regulations. Within these guidelines, each state performs the following: (1) determines its own eligibility requirements; (2) prescribes the amount, duration, and types of services; (3) chooses the rate of reimbursement for services; and (4) oversees its own program.

Applying for benefits

To apply for Medicaid, you must use a written application on a form prescribed by your state and signed under penalties of perjury. Give the application to your state Medicaid office. Typically, you will need to provide proof of age, marital status, residence, and citizenship, along with your Social Security number, verification of receipt of government benefits, and verification of your income and assets. A responsible individual can complete the application on behalf of an incompetent or incapacitated individual.

Eligibility

To qualify for Medicaid, you must meet two basic eligibility requirements. First, you must be considered categorically needy because of blindness, disability, old age, or by virtue of being the parent of a minor child. Next, you must be financially needy, which is determined by income and asset limitation tests. States have much discretion in determining which groups their Medicaid programs will cover, but as participants in Medicaid, they must provide coverage for all residents who are considered categorically needy.

Caution: *State and federal rules regarding Medicaid eligibility change frequently.*

Transfer of assets

Because Medicaid eligibility is based on your income and other resources, state Medicaid authorities are interested in knowing whether you have tried to transfer assets out of your name in order to qualify for Medicaid. When you apply for Medicaid, the state has the right to examine your finances and those of your spouse as far back as 60 months from the date you are eligible for medical assistance under the State plan. Only certain transfers are prohibited. Fair market transactions will typically be considered legitimate, but if you transfer assets for less than fair market value around the time you apply for Medicaid, the state will presume that the transfer was made solely to help you qualify for Medicaid.

Planning goals and strategies

As mentioned earlier, the state has the right to look into your financial transactions to determine whether you have transferred assets solely to qualify for Medicaid. However, the state may count only the income and assets that are legally available to you for paying your bills. Consequently, several methods have been developed to help you shelter your assets from the state and facilitate Medicaid qualification. Proper planning can help you to qualify for Medicaid, shelter "countable" assets, preserve assets (including the family home) for loved ones, and protect the healthy spouse (if any).

Medicaid qualifying trusts

To qualify for Medicaid, both your income and the value of your other assets must fall below certain limits (which vary from state to state). A trust helps you to qualify for Medicaid because it can shelter your income and assets, making them unavailable to you. The state Medicaid authorities cannot consider assets that are truly inaccessible to the Medicaid applicant. Therefore, anything

that stays in an irrevocable trust will lie outside of your financial picture for Medicaid eligibility purposes. If you are looking for a strategy to shelter your resources, one of the following may be appropriate: (1) an irrevocable income-only trust, (2) an irrevocable trust in which the creator of the trust is not a beneficiary, (3) a Miller trust, or (4) a special needs trust.

Protection of principal residence

In certain cases, the state may be entitled to seek reimbursement for Medicaid payments by forcing the sale of your principal residence if you are a Medicaid recipient. Medicaid planning tools have been devised to protect your home, but their effectiveness varies. Therefore, it is important to weigh the costs and benefits of each device carefully. If you are looking for a strategy to preserve your home for loved ones, one of the following four methods may be appropriate: (1) an outright transfer or gift of the home, (2) a transfer subject to life estate, (3) a transfer subject to special power of appointment, or (4) a transfer in trust.

Medicaid and long-term care insurance

Long-term care (LTC) insurance can be useful as part of your Medicaid planning strategy. Your LTC policy can subsidize your nursing home bills during the Medicaid ineligibility period caused by your transfer of assets to third parties. Thus, it may be possible for you to give your assets away to loved ones, have the security of paid nursing home bills during the ineligibility period, and qualify for Medicaid when the LTC policy runs out.

Medicaid liens and estate recoveries

Federal law requires states to seek reimbursement from Medicaid recipients for Medicaid payments made on their behalf. Cost-recovery actions against the assets of Medicaid recipients may come in two forms: (1) real or personal property liens and (2) recovery from decedents' estates. A Medicaid lien makes it impossible for you to sell or refinance your house without the state's knowledge and ability to collect what it is owed. As for recovery from decedents' estates, states also can seek reimbursement from your probate estate after you die. States have the option to expand the definition of estate to include all nonprobate assets as well.

Divorce and Medicaid

From a purely financial perspective, divorce can be a practical move and may actually be used as a Medicaid planning tool. When a spouse enters a nursing home and applies for Medicaid, the couple's assets must be pooled together and totaled to determine what portion the healthy spouse may keep. After this Spousal Resource Allowance has been determined, the Medicaid applicant must transfer assets representing the amount of the allowance to the healthy spouse. The remaining assets must be spent on the institutionalized partner's medical care. A divorce court order can supersede the normal Spousal Resource Allowance rules prescribed under state Medicaid regulations. You should consult your legal advisor for further information.

Military benefits

Disability benefits, health-care benefits, and long-term care benefits are available through various military programs sponsored by the Department of Defense and the Department of Veterans Affairs (VA), formerly known as the Veterans Administration. Health care for veterans is typically available at VA hospitals and health-care facilities. In general, active service members, retirees, and veterans other than those who were dishonorably discharged are eligible for military benefits. Survivors of servicemembers and veterans are also generally eligible for some of the same benefits. However, the rules surrounding these benefits can be complex and may change frequently. It is best to check with your military personnel office or local VA office if you have questions about any of these benefits.

Choosing a continuing care retirement community

Continuing care retirement communities (CCRCs) are retirement facilities that offer housing, meals, activities, and health care to their residents. These communities appeal to people who are currently in good health but who worry that they may need nursing care later on. The CCRC and the resident sign a contract guaranteeing that the CCRC will provide housing and nursing home care throughout the resident's life and that, in return, the resident pays an entrance fee and a monthly fee. In choosing a CCRC, you should consider factors such as the entrance fee and monthly fees, insurance requirements, the financial stability of the CCRC, its facilities and activities, and the quality of medical care provided to residents.

Choosing a nursing home

A nursing home is a licensed facility that provides skilled nursing care, intermediate care, and custodial care. Although you may prefer in-home care, you may have to enter a nursing home if you need round-the-clock care, especially if you can't get help from family or an in-home caregiver. When choosing a nursing home, you should consider factors such as the cost of the home, the quality of medical care provided, the appearance and the safety of the facilities, the ratio of staff to residents, and recreational opportunities.

Paying for nursing home care

Nursing home care can be extremely expensive, and paying for this care is a problem that weighs heavily on the minds of older Americans and their families. There are several resources you can use in planning for this expense, including self-insurance, long-term care insurance, Medicare (limited benefits), Medicaid, and military benefits.

IMPORTANT DISCLOSURES Broadridge Investor Communication Solutions, Inc. does not provide investment, tax, legal, or retirement advice or recommendations. The information presented here is not specific to any individual's personal circumstances. To the extent that this material concerns tax matters, it is not intended or written to be used, and cannot be used, by a taxpayer for the purpose of avoiding penalties that may be imposed by law. Each taxpayer should seek independent advice from a tax professional based on his or her individual circumstances. These materials are provided for general information and educational purposes based upon publicly available information from sources believed to be reliable — we cannot assure the accuracy or completeness of these materials. The information in these materials may change at any time and without notice.

Registered Representative. Securities offered through Cambridge Investment Research, Inc., a broker-dealer, member FINRA/SIPC.

Investment Advisor Representative . Cambridge Investment Research Advisors, Inc., a Registered Investment Advisor. Cambridge and Vision Financial Group are not affiliated.

James Wessels, CPA/PFS, CFA
4140 Grand Ave
Des Moines, IA 50312
515-453-2222
j.wessels@vfghelps.com
www.VFGhelps.com

VISION FINANCIAL GROUP