Welcome to InFRE's January 2021 Issue of Retirement Insight and Trends

Retirement InSight and Trends is the quarterly newsletter for the International Foundation for Retirement Education's Certified Retirement Counselors® (CRC®s) to help retirement professionals with the practical application of new retirement readiness, counseling, planning and income management concepts for the mid-market. Find out more about the CRC® and InFRE here.

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January, 2021 InFRE Update: Welcome to Our New CRC® Board of Standards and Policy Development Members!

The International Foundation for Retirement Education® (InFRE) is a non-profit 501(c)(3) organization founded in 1997.

InFRE's *Certified Retirement Counselor® (CRC®)* certification was created to advance recognition among retirement planning professionals of the need for a retirement specific certification program that demonstrates a mastery of subject matter, a commitment to the retirement planning profession, and adherence to a code of ethics and continuing education requirements.

The purpose of the *CRC®* Board of Standards and Policy Development (BOS) is to establish the governing rules and regulations related to *CRC®* certification, make determinations regarding eligibility and all essential certification decisions, and provide mediation and interpretations for the *CRC®* program as needed by staff and other volunteer committees.

Three new individuals were recently elected to serve on the BOS beginning in January 2021. We extend our congratulations and sincere thanks to

- George Arroyos, CRC©, RPA, Vice Present, Enterprise Retirement Solutions
- Russell M. Look, CRC©, Athene Financial, and
- Carolyn Palka, CEP, BLS, ACLS, University of Michigan, public member

for agreeing to serve on InFRE's Board of Standards. We also extend a sincere thank you and appreciation to Donna Richards and Kenneth White who both recently completed their term on the BOS.

Here are the current members of the InFRE Board of Standards:

- Sherry Keegan, Keegan Wealth Management & Retirement Strategies, LLC
- Leigh Donohue
- Justin Price (Chair), AIM Advisory Group
- John Barker, COPERA
- Kathryn Berkenpas (Co-Chair), ICMA-RC
- Andy Fass, Hilltop Securities
- Russell Look, Athene
- George Arroyos, Enterprise Retirement Solutions
- Carolyn Palka, Public Member, University of Michigan Medicine

As explained in the CRC® Program Policies Manual, the term of a BOS member is three years or until his/her successor has been elected and qualified. The BOS Chair and Co-Chair will approve and nominate Candidates for any election or for any vacancy on the BOS. Candidates shall be presented to the entire BOS and elected to office by the affirmative vote of a majority of members then in office. A BOS member's term may be renewed by the BOS for one additional three (3) year term. Former members of the BOS may be reappointed after a period of not less than three (3) years from the date of his/her most recent term on the BOS ended.

21st Century Medicare Planning to Protect Your Client's Healthcare Rights and Retirement Savings

Emily Gang, Owner of The Medicare Coach

Editor's note: This article is an adaptation of the live webinar delivered by Emily Gang in 2020. Her comments have been edited for clarity and length.

You can read the summary article here as part of the 4th Qtr 2020 Retirement InSight and Trends Newsletter, worth 1.0 CE when read in its entirety (after passing the online quiz.)

You may also choose to take the full length course 21st Century Medicare Planning to Protect Your Client's Healthcare Rights and Retirement Savings for 1.0 hour continuing education (CE) credit.

*By **Emily Gang, Owner of The Medicare Coach***

Medicare is delivered in a very confusing way in our country. Unfortunately, the way the government and the insurance companies have set up Medicare, people are very likely to make the wrong decision if they don't fully understand what's going on. Making the wrong decision means jeopardizing people's retirement savings and not being able to see preferred doctors.

Medicare can be fantastic when people ultimately do what's right for them. It's usually cheaper than employer plans with lower deductibles, lower max out-of-pockets, and it can continue to cover most people's preferred doctors.

I happen to have a degree in finance. I went to New York to work for Goldman Sachs for seven years to help the bank and its clients manage risk. I thought that I knew everything when it came to investing and retirement planning.

When my dad was 64, I learned about his Medicare woes. I was shocked at how confusing the system was, despite it being a critical part of retirement. I knew it would take me weeks to understand the parts of Medicare, the rules, the companies, and everything else about Medicare.

What is Medicare?

Let's start with the two main parts of Medicare: Medicare Part A and Medicare Part B. Medicare Part A covers your hospital visits, skilled nursing, mental health, Hospice, etc.

If your client or spouse has worked 40 quarters, which is ten years, and they've paid their FICA taxes during that 40-quarter requirement, they don't pay anything extra for Medicare Part A premium. They prepay those premiums through their FICA payroll taxes. But if they have not met that requirement, Part A can cost over $400 a month.

Medicare Part B covers most of what people need when it comes to their healthcare. Part B covers doctors' visits, lab tests, therapy, durable medical equipment, etc. In 2020, most pay $144.60 a month for Medicare Part B. It can be less if your client is on Medicaid, but it can also be more if your client has a higher income.

If your client had a modified adjusted gross income in 2020 – the premium is based on their taxes – of $87,000 or more as an individual, or $174,000 or more as a couple, they will pay more for Medicare Part B. The more they make, the more they pay. That said, there are ways to appeal income surcharges. I think it's vital as an advisor to understand how these income surcharges work because the way you recommend retirement distributions can impact how much Medicare costs them.

Medicare usually only covers 80 percent of healthcare expenses, and individuals are responsible for the remaining 20 percent – Medicare doesn't pay 100 percent of their healthcare costs. There are some exceptions, including the fact that Medicare will cover 100 percent of preventative services approved through the Affordable Care Act. However, everything else is essentially covered by the 80/20 rule.

Medicare Supplements and Medicare Advantage Plans

For that reason, we have both Medicare supplements and Medicare Advantage Plans. Those are the plans that come in to help cover that 20 percent that Medicare does not cover to reduce your clients' healthcare risk once on Medicare. This is where I think Medicare gets confusing.

What most people don't know is that there are two different Medicare program choices. People get to decide which program they want to provide their Part A and their Part B services. The first program is called Original Medicare, also known as traditional Medicare. The second program is called Medicare Advantage, also called Medicare Part C. To understand the differences between the two programs, let's talk about how each one works.

The federal government administers Original Medicare and negotiates prices with the doctors and the hospitals. It includes both Medicare Part A and Medicare Part B. Under Original Medicare, you can see any doctor or hospital across the entire country that accepts Original Medicare.

Studies show that about 95 percent of doctors in our country accept Original Medicare. When people are on Original Medicare, they can see any doctor across the entire country who accepts Original Medicare. Now Original Medicare generally does not include coverage for prescription drugs. But there is one exception.

Medications that must be administered by a medical professional, such as chemo at the doctor's office, other injections, must be covered by Medicare Part B. But all other prescriptions that people get from their pharmacy are not covered by Medicare Part A or B, but instead covered by Medicare Part D drug plans, which are standalone plans offered by independent insurance companies. Also, as I mentioned before, when you're on Original Medicare, it only covers 80 percent usually of medical services, and people are required to pay the remaining 20 percent if they only have Part A and B.

However, this is where supplement, also called Medigap, insurance comes in. Most people on Original Medicare will get a Medicare Supplement plan to cover nearly most of the 20 percent that Medicare does not cover. Medicare Supplement plans only go with Original Medicare. They never go with Medicare Advantage.

What is Medicare Advantage?

Now let's talk about Medicare Advantage. One of the critical differences between Original Medicare and Medicare Advantage is that Medicare Advantage is administered by private insurance companies approved by Medicare to offer the benefits. It's the Blue Cross Blue Shield, Humana, United, Aetna; all those companies out there have Medicare Advantage plans.

These private companies are the ones negotiating prices with the doctors and the hospitals. While Medicare Advantage plans must offer all the same coverage as Original Medicare, they can determine which doctors and hospitals you can see since they are the ones negotiating prices. Most Advantage plans work like HMOs or PPOs.

Advantage plans might offer extra benefits, like drug coverage, free gym membership, extra vision, or dental services. Please also note that Medicare Advantage plans have co-pays and co-insurance, and they can also have max out-of-pocket costs, which in 2020 can be up to $6,700 a year for in-network providers.

There's another critical thing that you should be aware of when it comes to these programs. One of the main reasons people regret their decision is that they didn't fully understand this difference. I can't go into all of the differences, but let's go into one in a bit more detail. It has to do with the doctors that you can or cannot see through each program.

The Differences Between Medicare Supplement Insurance (Medigap) and Medicare Advantage Plans

As I mentioned earlier, with Original Medicare, people can see any doctor or hospital that accepts Original Medicare. In contrast, with Medicare Advantage, people can usually only see doctors in their network. Depending on the doctors your client currently sees, or they want to see in the future, they should easily fit best into one program or the other.

But here is what usually happens, which is why people regret their decision. Usually, an insurance company will come to your client, or they'll see them on the television. Most of the time, they encourage people to send out for a Medicare Advantage plan first. And they do this because it makes insurance companies a lot of money, which they openly share in their financial reports. Since Medicare Advantage plans are very profitable for insurance companies, they spend more on advertising. They put more perks in it to entice people to join. But the reality is they don't always share the full story. They don't always share the co-pays, the high max out-of-pockets, and they don't always share the doctors you can or cannot see, which is the most important thing.

How Medicare Insurability Rules Work

Many people approach their Medicare decision, and they say, "You know what? I'm just going to pick the cheapest plan. I'm healthy," or, "I'll get the plan with the gym memberships, or dental and vision coverage. And when I need something different, I'm just going to change plans later."

The fact is that Medicare rules don't let people just change plans whenever they want. It is crucial to understand how these insurability rules work because it impacts how your clients pick their program.

If your client needs to switch programs in the future, it is easier if you first join Original Medicare, and then you can more easily go into Medicare Advantage later. It is much harder, if not impossible if you first join Medicare Advantage and go back into Original Medicare.

Here is why. When it comes to Medicare Advantage plans, they really can't turn anyone away. If your client applies for a Medicare Advantage plan during an approved period, and they don't have, say, end-stage renal disease, they have to accept you. While technically, Original Medicare can't turn people away either, supplement – also called Medigap – insurance companies can turn people away.

Remember how I said Original Medicare only covers 80 percent of most expenses, and either the individual or the supplement plan pays the remaining 20 percent? Well, this is where it gets tricky. When people first join Medicare, they have a six-month window where they are automatically eligible to join any supplement plan of their choice. They can join these plans, whether they are healthy or sick.

They can have Stage IV cancer, diabetes, lung issues, heart issues, autoimmune issues, be on depression medicine, and the Medigap insurance companies are required to accept them during this six-month window. Medigap insurance companies cannot charge them more for any of the pre-existing conditions. However, once this six-month window expires, these guaranteed-issue rights expire also.

So, after the six-month window, in most states, to switch letters, join a new plan, switch companies, any of those things, the company can and will ask for the individual's health history. They can deny coverage if they're unhealthy or if they don't want to cover them for any reason. Therefore, it's hard, if not impossible, to switch programs after someone first joined Medicare.

Most people don't realize that they're in the wrong plan until they're sick, and once they're sick, it's usually too late to switch. So, again, what I'm saying here is that if your client first joins Medicare Advantage and they later decide they'd rather be in Original Medicare, they may not be able to switch.

The only way people can easily switch is if they're completely healthy and insurable. Suppose they're not healthy, while they can still join Original Medicare, they likely will not be approved for a Medicare Supplement plan. So they are now responsible for 20 percent of their medical bills, which can quickly bankrupt them.

How to Help Your Client Decide Which Medicare Program Best Fits Their Needs

For your client to decide which program fits them best, they should look at:

1. What Medicare their current doctors accept
2. If they were to get sick, who their future doctors might be
3. What Medicare future doctors might accept

4. If your client is traveling or living in multiple states and how that might impact the program they pick
5. Look at the costs and the risks of each plan to see which one ultimately best fits your client.

If your client ends up going down the Medicare Advantage route where they talk to their doctors, they all accept Medicare Advantage, they're completely fine with that, there are four things that they should be doing to identify the right Medicare Advantage program.

1. First, find out which doctors they can see on that plan. Kaiser is unique, where you can usually only see doctors inside of the Kaiser network. But other plans can have exceptions.
2. Look at all the costs: the premiums, the deductibles, the co-pays, the max out-of-pocket, both in-network and out of network.
3. Look to see how well that plan covers your client's medications. There can be thousands and thousands of dollars in medication cost differences through different plans.
4. And then also look at the fine print of the document.

Each plan has about a two- to three-hundred-page "Evidence-of-Coverage" document, where they will outline particular fine print, as they'll only cover 20 percent of the cost of chemo until they reach their out of pocket limit. There are little things that should be looked at before finalizing any Medicare Advantage plan.

That said, most people in our country are on Original Medicare. Original Medicare is more work upfront. In my opinion, when our clients' doctors accept Original Medicare, it's worth it because they can see their doctor. I think of Original Medicare as an all ala carte menu. There are Medicare Part D plans and Medicare Supplement plans, also called Medigap plans, to choose from.

With Original Medicare, people can customize a plan to fit them best, the coverage they want, and at the cost they want. Original Medicare includes Medicare Part A and B and does not include prescription drug coverage. Once your client confirms they want to be on Original Medicare, the next step is to pick out a Medicare Part D drug plan.

When you first look at these prescription plans, they all look very much the same. But prescription plans have little details that make a huge difference in cost. For this reason, it is incredibly important for people to get the right Part D drug plan.

Here is how Medicare Part D drug plans work. First, Medicare determines the types of medications that every plan must cover. Now some plans will include extra medications, but they're not required to do so. Now once this list is released, insurance companies go to the drug companies to negotiate prices. Depending on how good a deal the insurance companies get, it will put the drugs in different tiers. There are usually five different tiers, with the first being the cheapest and the fifth being the most expensive.

So the right plan for your client depends on many factors, including the medications they take, the tier their medication falls into, the premiums, the deductible, their preferred pharmacy, and whether or not your client hits a donut hole or even catastrophic coverage levels.

This is a high-level overview of Medicare Part D. There are three other things that I want to share with you that most people are not aware of, and it can be hard to find out on your own.

1. Medicare Part D drug plans have prescription penalties. Medicare rules say by the time you turn 65, you must have a creditable prescription drug plan, and if not, you'll face penalties.

   Most people are on medications, so it's usually a no-brainer to just get a Part D drug plan. But there are quite a few people out there these days that don't take any medications. If your client is in that boat where they don't take any medications, be aware that if they don't have a creditable drug plan, either for a Part D plan or included in their Medicare Advantage plan, they will be penalized. The penalty isn't huge, but it's still a penalty that applies for the rest of your life.
2. Medicare Part D plans also have high-income IRMAA (income-related monthly adjustment amounts) surcharges. So, IRMAA surcharges mainly impact what your client pays for Medicare Part B, but it will also impact what they pay for their drug coverage as well.
3. Part D plans change every single year. These plans do not have insurability rules so that everyone can change plans every single year. Your client must review his or her plan every single year during open enrollment.
4. Here's how it works. By October 1st of every year, every single Part D plan must announce the new plan details for the upcoming year. Your client then has from October 15th through December 7th to review those plans and change plans for the upcoming year. This is the only time that most people can change Part D drug plans during a year, so it's essential to get this right. During this time, you can change things like premiums, add or drop medications, add or drop pharmacies, or change the tiering of the medications' price. We are currently in this process right now of doing our clients' annual reviews for them. Our average savings every year per client are between $800 and $900.

People often ask me, "Well, Emily, which is the right Medicare Part D drug plan?" It's like a giant game of cups. There is no good plan; there is no bad plan. But there is a plan that will fit you best. It's just all about finding that red ball every single year. Most couples will be on different medication plans because they have different medications. Again, it's all about finding out what ultimately fits you best.

Picking Out a Medicare Supplement Plan

A Medicare Supplement Plan is sometimes called a Medigap plan because these plans fill the 20 percent gap that Medicare does not cover. These supplem
only go with people who are on Original Medicare. If your clients have chosen to go the Medicare Advantage route, they will not have one of these plans.

I highly recommend that people on Original Medicare pick a supplement plan out when they first join Medicare. Supplement plans are critical to reducing what someone pays out of pocket for their healthcare. Original Medicare pays 80 percent. If someone does not have a Medicare Supplement plan, they are paying more or less 20 percent of their health care cost. None of us know what the future holds. For that reason, I highly recommend that people plan for all scenarios and choose a plan when they first join Medicare that they're comfortable having when if they were to have health issues.

A few weeks ago, we received a call from Kate, a 30-year-old teacher, and she was calling on behalf of her dad, who's on Medicare. He was recently diagnosed with end-stage renal disease, which is luckily covered by Medicare, and the treatment includes dialysis and possibly a kidney transplant. While it's great that Medicare covers the treatments, it is not great that her dad did not get a Supplement insurance policy when he first joined Medicare.

Kate called to see if there's any way that we could help them get financial coverage of some nature because she knew that 20 percent of the cost of his dialysis would quickly go through all of his savings. Based on the government rules, the government won't step in for extra help until he has no money left to his name.

However, it's too late to get a Medicare Supplement plan. He missed that chance. But, there are still some options that are a bit more complicated because he does have end-stage renal disease. If he simply would have gotten a supplement plan when he first joined Medicare, he could have avoided this huge financial risk now and the stress it's causing on both him and his family.

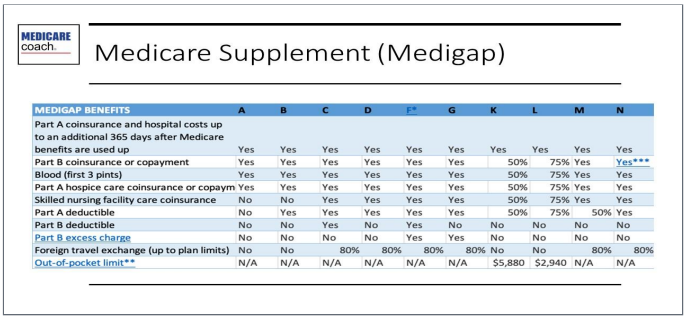
Again, if your client goes down Original Medicare route, please encourage them to pick a supplement plan out when they first join Medicare. These are the plans that have the insurability rules. When someone first joins Medicare, they have a six-month window where they're automatically insurable, and the companies must accept them no matter what their health conditions are.

But once that six-month window expires, in most states, the companies can and do ask for their health history whenever they apply for a new plan, a different letter, a different company, any of those things. Therefore, it's so important to get it right.

Now with Medicare, there are always exceptions. New York State allows people to move between Medicare Advantage and supplement plans without any medical underwriting. And so, if you have a client in New York State, these rules are different. You will see that the plans in New York State are much more expensive than any other state.

Washington State has a rule where you can move between certain supplement letters without underwriting. So, there are some states like that. There are about five or six states that have rules like that. But most states have standard insurability rules.

The first step to picking the right supplement plan is choosing a letter. On this chart is the current letters that are offered in most states across the country. Please know that if your client lives in Wisconsin, Minnesota, or Massachusetts, they have their supplement plans, so they won't have these options. But the other 47 states and territories will have these letters.



MEDIGAP BENEFITS	A	B	C	D	F*	G	K	L	M	N
Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Part B coinsurance or copayment	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes***
Blood (first 3 pints)	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A hospice care coinsurance or copaym	Yes	Yes	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Skilled nursing facility care coinsurance	No	No	Yes	Yes	Yes	Yes	50%	75%	Yes	Yes
Part A deductible	No	Yes	Yes	Yes	Yes	Yes	50%	75%	50%	Yes
Part B deductible	No	No	Yes	No	Yes	No	No	No	No	No
Part B excess charge	No	No	No	No	Yes	Yes	No	No	No	No
Foreign travel exchange (up to plan limits)	No	No	80%	80%	80%	80%	No	No	80%	80%
Out-of-pocket limit**	N/A	N/A	N/A	N/A	N/A	N/A	$5,880	$2,940	N/A	N/A

There are lots of letters when it comes to Medicare. There is Medicare Part A, which is hospital insurance. There is Medicare Part B, which is medical insurance. There is Medicare Part C, which is Medicare Advantage. Medicare Part D is a drug plan.

Please don't confuse those parts, letters, with these above supplement letters. Medicare Part A and Supplement Plan A are two very different things. Supplement plans differ based on what they cover, and they also differ based on their premium. Premiums range anywhere from about $30 a month to over $200 a month.

A woman came to me a few weeks ago and said, "Now, Emily, I did my own Supplement research, so I don't need your help there. I just picked the most expensive Supplement plan because I assumed that that was best." It literally made me cringe because the plan she picked was not the best. It's expensive because no one's in it. It will cost her a lot of money, and she already missed her six-month window, so I can't undo that.

So your clients must get that right letter when they first join Medicare. People often ask me, "Emily, which letter is best?" It depends. Most of the married couples that I work with end up on different letters because they have different health issues; they have different doctors; they have different health concerns; they're different people. Medicare is a very individual decision.

Some supplemental plan companies are adding extra perks like gym memberships, or extra vision and dental, which can be valuable. I don't recommend people decide when it comes to Medicare on those factors, but it can be a factor to be aware of when adding extra coverage for your client at a lower cost.

Once people decide which letter fits them best, they need to determine which company they want to provide them in that plan. When looking at companies to purchase a plan through, look at things like the history of the rate hikes, how contracts are priced, the company's financial stability, the customer service, and things like that. We capture these things in our Medicare Supplements Scorecard to be able to compare companies against companies easily.

You can't always tell from their name or from their public image which really is the best. There are dozens of companies in each state who offer Supplemen

What You Can Expect in Medicare Costs

What your client ultimately pays will be based on where they live, their income, their health conditions, their doctor considerations, etc.

With Original Medicare, most of your clients will pay nothing for Medicare Part A. At least for 2020, most of your clients will pay $144.60 a month for Part B. Again, if they have a higher income, they are also subject to IRMAA surcharges.

In most states,

Medicare Part D drug plans have a premium from about $6 a month to $150 a month. These plans also have co-pays, so what your client pays for drug coverage will depend on their medications, their pharmacy, their plan, all of those good things.

The final cost of Original Medicare is supplement coverage. In 2020, these ranged anywhere from $23 a month to around $250 a month. The maximum out of pocket on most of those plans is around $2,340 a year. This will give you an idea of what you should be planning for when it comes to the Original Medicare route based on how the current environment looks.

The second path is to use Medicare Advantage plans. You'll have the same, likely zero, cost for Part A. You will likely have the $144.60 a month for Part B and then the Medicare Advantage plan, where their premiums go anywhere from zero a month to a couple hundred a month. Medicare Advantage has a vast range of premiums. The critical thing to look at is they do have co-pays. They have a maximum out-of-pocket of up to $6,700 for in-network doctors, and they usually include drug coverage.

Strategies to Help Your Clients Prepare for Medicare

There are a few things that you can be doing with your client as early as 60 to help them prepare for Medicare.

1. Identify your clients who are over age 60 or if they haven't retired yet and are not on Medicare today. Help them think about the doctors they'll want to see; how it will impact the Medicare program that they pick, whether they are with that doctor now or might be in the future. This could be a Mayo Clinic, an MD Anderson, or a EuroMed. One of our good family friends had Stage IV lung cancer, and he went to a Euromed facility. He's now completely cured of cancer. But Medicare is not accepted at all there. So, if your client says, "I want to go to a place like Euromed" that doesn't accept any Medicare, then that could be an extra planning line for their retirement. But having those conversations now can help you understand what you're planning for in the future.

   Also, ask your client early on:

   1. If they have any other health insurance we should be looking at
   2. Whether they are working past 65 and still have an employer plan
   3. Whether they came from a corporation or a union which has a retiree plan
   4. Whether they have VA benefits, TRICARE for Life, or ChampVA.

   Understanding the healthcare options that your client has outside of Medicare is essential to consider before you assume that they're going on Medicare.

2. How might the retirement distributions that you're recommending impact what they pay for Medicare? Medicare premiums change every single year based on the previous two years' income. If your client plans to take a lump sum of money out for a new home or a child's wedding or something of that nature, understand how the Medicare rules work. I'm not saying you should make a recommendation based on these income requirements. I am saying that it's good to be aware of Medicare's income limits so you can at least make informed recommendations.

3. Talk to your clients about whether they should be delaying Medicare. Different factors go into deciding whether your client joins Medicare at 65 or whether they delay it. I know that this sounds silly because people assume that you must join Medicare at 65. But that's not the case. And if your client incorrectly joins Medicare at 65, it can be a huge waste of money.

   The Medicare rules say that when you turn 65, you either must be on Medicare or covered under an acceptable health insurance plan that meets Medicare rules. Now, if you don't meet one of these two requirements, you will face lifetime penalties. For your retired clients, if there's no other form of health insurance past age 65, then, yes, they should be joining Medicare. But most people today are working past 65, have some health insurance, or their spouse is working past age 65.

   There are specific rules that a plan must meet to delay Medicare without penalties. It's important to understand that this rule does exist and decide what makes sense. For most employer plans to meet Medicare rules, they must meet all three of these requirements.

   A. The first one is, do you have health insurance of some type through a company? Obamacare does not meet this rule. COBRA does not meet this rule. Medi-Share plans don't meet this rule. VA makes you join Medicare. TRICARE for Life or ChampVA requires Part A and B. There are some nuances. My point is just because they have a plan, it does not mean that it meets Medicare rules. So be aware of this.

   B. The employer providing health insurance must have 20 employees or more, and if your client is disabled, the employer must have 100 employees or more. If the employer providing health insurance does not meet this rule, then your client must join Medicare.

   C. Does the employer plan have creditable prescription drug coverage? Creditable means the plan, on average, covers prescriptions as well as or better than Medicare. The company's benefits person is legally required to confirm this every single year for your client.

   If your client meets all of these requirements, they can delay Medicare.

I would say that before you finalize that decision, compare the employer plan vs. Medicare. A client of mine was going to work until at least age 70. But we found that she could save $16,000 by leaving her employer plan and joining Medicare instead. I have other clients, especially with high incomes, who were better off on their employer plan for as long as they possibly can. Again, just know that there are different situations where you're better off on Medicare, and others where you're better off on your employer.

4. Find out if your client's spouse is working past 65. If they have a retiree health plan, evaluate how good the retiree plan is, or are they better off on Medicare? Usually, the tipping point is that if a retiree or employer plan has a premium, monthly premium of $250 a month or more, you're almost always better off on Medicare. It can depend, though, but that's about where the tipping point is.

   Just because your client or spouse has an employer plan or a retiree plan, it does not mean that that one is truly best for them. I have seen some really bad plans out there offered by employers, by retiree plans, and people just assume that they should take that coveted employer or retiree plan because they've worked their whole lives for it; but it's not always best for them. It's a stern message to deliver, but it's an important one to talk about before your client finalizes anything.

Key Takeaways

1. Most of the changes and decisions happen when your client first joins Medicare. If your client is already on Medicare, please recommend that they review their options every year during Medicare's annual election period. There can be huge changes, especially in Part D drug plan, so this is another reason to meet with your clients every September. Remind them that the Medicare enrollment period is coming up to make sure they take advantage of it.

2. Please look to see if the income distributions you recommend create temporary increases in your client's income that might result in them paying more for Medicare.

3. Help your client think of the doctors they want to see once on Medicare, or after age 65, and the corresponding Medicare program and cost implications that will impact their retirement planning. Remind your clients of Medicare insurability rules.

4. Finally, if your client is already on Medicare, make sure they review their plan every year.

For anyone who'd like to know more about the Medicare Coach, have us help your clients. Our signature offering is a Medicare Enrollment Concierge Service. It's a done-for-you service that includes a four-part process that will take your client from the very beginning, no matter where they are. It could be simple; it could be complex. It takes them through the entire process to ensure that they're making the right decision, the right timing, the company, the right plan, and all of those details to truly ensure they're protecting their healthcare rights and retirement savings. This is where we use our expertise – when it comes to Medicare with both the rules, the insurance companies, all unique things to guide your client to help them save money and save time.

Ideally, clients start our concierge six months before they ever join Medicare, so there's time to be thoughtful and thorough with this important decision. Most of the clients who join our service save time, hassle and ultimately gain peace of mind that they're doing the right thing regarding Medicare.

21st Century Medicare Planning to Protect Your Client's Healthcare Rights and Retirement Savings – Emily Gang

About Emily Gang, Owner of The Medicare Coach

Over the past four years, Emily has changed the way people make their Medicare decision. She has helped thousands of people navigate Medicare rules and insurance company confusion to help them make their right Medicare decision to protect their healthcare rights and retirement savings.

Emily has combined her seven-year experience managing risk for Goldman Sachs and her passion for helping people, to revolutionize the way people make a Medicare decision to save people time and money.

Emily Gang provides independent, unbiased advice to Americans approaching their Medicare decision. Her mission is to help people navigate Medicare rules and insurance company confusion to help them make the right decision for their unique situation. Her goal is to:

- Educate Americans on Medicare to help them make the right decision to protect their healthcare rights and retirement savings.
- Create strategy to leverage technology and social media to easily reach individuals looking for guidance on Medicare and retirement.
- Develop systems to leverage intellectual capital in order to help more Americans.
- Partner with other organizations helping Americans 65+ years to provide a group of trusted advisors to guide them through the new opportunities in retirement.

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Guaranteed Income: The Forgotten Household Asset

David Blanchett, CFA, CFP®, AIFA – Head of Retirement Research, Morningstar

Editor's note: This article is an adaptation of the live webinar delivered by David Blanchett in 2020. His comments have been edited for clarity and length.

You can read the summary article here as part of the 4th Qtr 2020 Retirement InSight and Trends Newsletter, worth 1.0 CE when read in its entirety (after passing the online quiz.)

You may also choose to take the full length course Guaranteed Income: The Forgotten Household Asset for 1.0 hour continuing education (CE) credit.

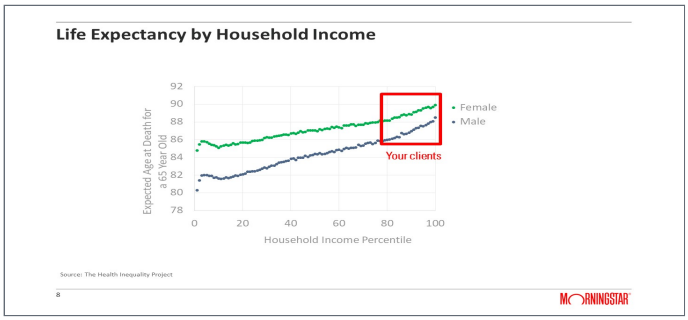
By David M. Blanchett, PhD, CFA, CFP®, Head of Retirement Research, Morningstar Investment Management

Of all the risks that people face, longevity risk is the oddest because risks are usually a bad thing. Living a long time, in theory, should be a good thing, right? When we retire, we want to have a long and active retirement. The problem though is that the longer your retirement lasts, the more expensive it becomes. If you live a really, really long time, there's a decent chance that you outlive your savings, and that's not how most people want things to go.

If you look at public surveys about retirement fears, usually the thing that people are most afraid of is healthcare costs. That's interesting because healthcare is only one aspect of overall consumption. You often see estimates that healthcare will cost a quarter of a million or more in retirement for a couple. You could do those same estimates for food and housing and entertainment, and they would be significant numbers too, right? What this speaks to – what healthcare costs speak to – is this fear of going broke.

People are more afraid of outliving their money than dying. This gets to the heart of longevity risk. It's that at some point in the future – I don't know when – I could go broke. This possibility of going broke or the implications of living to say age 100 have changed considerably.

Life expectancy is defined as the average number of years remaining for a given cohort. Below are how life expectancies vary for households based upon their income. It includes males and females.



Life expectancy at birth is irrelevant for you and your clients for two reasons. First, when it comes to life expectancy, what matters is how long you're going to live when you retire starting at age 65. Second, many life expectancy numbers are based upon US population averages. The most common mortality table that includes information about the odds of people dying is the Social Security Administration's Periodic Life Table that includes all Americans.

What it doesn't factor in is who your clients are. Individuals who use financial planners are overwhelmingly wealthier than average. They tend to be in the top two income deciles between the 80th and 100th percentiles in this analysis. And why that's so critical is if you look at that group, they have life expectancies that are three to five years longer than the average American. This requires thinking about funding retirement differently than if you're focused on the "average American."

How Do We Measure Retirement Success Today?

How do you determine what a good outcome is for a financial plan? You can do it via success rates; you can do what I would call a deterministic projection, which is like a time value of money; but how do we define good and bad? Along these lines, there's this question of "What would you define is a safe asset?" Again, this is kind of a trick question because you can define safety in different ways.

Here's an example of defining different outcomes. If you want to fund income from a portfolio, by definition, the odds of that portfolio failing – of it not being able to accomplish that income goal – is greater than zero percent. At some point, bad things could happen, and that portfolio might no longer fund that lifestyle. With guaranteed income, it's approximately zero percent.

"Well, the annuity company can fail." There are the State Guaranty Associations that insure consumers in the unlikely event that their insurance companies fail, so it's really, really unlikely. If annuity companies start failing, there's going to be nowhere safe to hide. But again, there's the perception of, "Well, which is safer – something that has a non-zero chance of failing or one that has a zero percent chance?"

A different lens to think about this is combining this idea of asset volatility and retirement outcomes. If you were to ask you what a safe asset is – people would often say, "Cash." T-bills are an incredibly safe asset in that there's a very high likelihood you'll get your money back. Here's the thing. If you overlay that safety with a retirement outcome, they become incredibly risky. If you buy an asset today with a zero percent return before fees, inflation, and taxes – if taxes really matter – then that will not last more than say 20 or 25 years in retirement. The odds of that portfolio failing if there's a reasonable withdrawal rate over, say, 30 years is almost 100 percent.

So, treasury bills are a safe asset from an asset volatility perspective. They aren't necessarily a safe asset when it comes to funding retirement. Guaranteed income, though – as maybe Social Security or private pension annuity – is a safe asset from a volatility perspective. You have that cash flow that's effectively guaranteed, like the coupon from a bond, but it's also going to lead to a safer retirement outcome. The key is thinking about the definition of safety across different dimensions. Safety for a retiree just isn't asset volatility. It's everything that impacts how that person experiences that retirement outcome.

Why that matters is because "Well, how do we define retirement success?" If you run a Monte Carlo projection, you might say, "Oh, Mr. and Mrs. Client, you have a 60 percent chance of accomplishing your retirement goals," or it could be a 30 percent chance or a 90 percent chance. I think that is somewhat useful information, but it can be totally off base many times.

Here's an example that I think applies well to retirement. Let's just say that you have an income goal of $10,000 a year for ten years. In the 10th year of the goal, you fall $1,000 short. And so, by definition, you have failed to accomplish your goal. If this is a traditional Monte Carlo simulation – and let's say that this always happens – you would have a zero percent chance of success. However, if you were to ask me, "David, has this person accomplished their goal?" I'd respond, "Yeah, they pretty much did. They got 90 percent of the way there."

The problem with success rates is that it ignores the magnitude of failure. If you extend this kind of analysis out 30 or 40 years, what you often see happen for retirement is that the portfolio "fails" in the last three years of retirement. But even when it fails, you still have income sources like Social Security and pension, so it's not giving you a fair perspective on what the actual likelihood of "failure" is.

Along these same lines, we essentially don't even estimate failure correctly. What is the truly bad outcome for a retiree? A good outcome it's not going broke over 30 years, right? The bad outcome for a retiree is being broke and being alive, and that's important. It's not just about not having any money over a 30-year time horizon, it's you need to be still alive, and you must be broke, right? And we don't capture that almost ever in Monte Carlo projections. We pick a fixed period like 30 years, and then we estimate the likelihood of you accomplishing that income goal over that time horizon.

If you change your Monte Carlo approach to say, "I'm going to incorporate mortality, and I'm going to incorporate the impact or the probability of you or both of you passing away at ages 70 and 80 and 90," this gives you a much more realistic perspective on failure. If you do that, safe withdrawal rates can go up significantly. Now when you look at retirement research, it doesn't tend to use success rates. I still do sometimes because success rates are the language of retirement. If you are an advisor and go online and use online tools, you're probably using a Monte Carlo projection and using the success rate.

That's not how academics think about retirement outcomes. The biggest reason is that it ignores the magnitude of failure. If you run a Monte Carlo projection, each run is effectively a binary outcome. Did you fail, or did you succeed? It doesn't provide context as to the magnitude of failure.

Guaranteed Income and Retirement Spending

A critical point here that is totally ignored in research is the impact that guaranteed income has on safe withdrawal rates.

Think about Bill Bengen's seminal research that came out 20 plus years ago. The idea of having a safe withdrawal rate is incredibly valuable. Researchers have made improvements on it over time. However, almost all research that addresses safe withdrawal rates ignores the magnitude of failure. It assumes that if your portfolio fails, it's the end of the world.

However, let's assume you're a retiree who gets 80 percent of his or her or their income from Social Security, and that portfolio is funding 20 percent. You can take a lot more from that portfolio than you could if Social Security was only 20 percent of your income because if that portfolio fails, you still get 80 percent. The magnitude of failure should impact the definition of safe withdrawal rates. I've researched this. Lots of folks have.

I find the optimal safe withdrawal rate changes dramatically based upon effectively the magnitude of failure. If you're a retiree that gets most of your income from Social Security or guaranteed income or pension, you can be more aggressive. If you're a retiree, though who gets most of their income from a portfolio and you don't have any flexibility at all – two percent could honestly be your safe withdrawal rate – and that's super low, but that's just reality. Also, a client's ability to change their spending significantly impacts what a safe withdrawal rate is. It's not often captured in our projections when we do financial plans or research exploring safe withdrawal rates.

People don't like to spend down their money. This is the behavioral aspect of funding retirement, and the markets have been incredibly volatile lately. How d
about dealing with volatility every year for the next 30 years? How do you feel about having to go in every month, every quarter, or every year and pull money

account that has to fund retirement? You don't know how long retirement is going to last, right? That's painful. We're so used to spending income when we work. It's great. You get a paycheck every week, every month, every whatever it is. You earn income. You can spend it.

Creating income in retirement is not as automated and creates all these different pain points. You must pull money out at some interval to fund your consumption. You don't know how long you're going to live. There's been research on this idea of how much people enjoy retirement more the more they annuitize their money. We find that the more someone converts assets into annuities, the happier they tend to be in retirement. There's a host of reasons for this but just think about the radical simplification.

I know that everyone doesn't need more annuities. Many folks are just fine without them. But as opposed to having to worry about, "Well, how much can I take out? How long am I going to live? What if I go broke? What if the markets go down? What about these low rates?" Instead, it's, "Hey, I have a paycheck that the insurance company sends me. I can spend it going forward." Guaranteed income can make things easier.

This calls into question much past research that utilized this idea of living off just the yield. Up to about a few years ago, you actually could live off the yield of your portfolio pretty easily. You could live off the income from your bonds and dividends from the equities. That's not really an option today. The dividend yield today on equities is only around two percent.

You can allocate more wealth to guaranteed income in lots of ways. You can delay claiming Social Security. You can buy a private annuity. If you work, maybe you can somehow get a larger pension benefit. The key here, again, is who benefits more from more guaranteed income?

Annuities are only one type of guaranteed income, but they create this interesting, often negative, reaction among most planners. The key is that annuities, as a product, have been around for thousands of years. There are some good ones, there are some bad ones, but we just can't dismiss them because there are some bad ones out there.

It is important how we frame information about guaranteed income to retirees. Who would you rather be? A retiree with a half-million dollars and $75,000 a year of pension benefits or someone who has assets of $750,000 and $25,000 a year in pension benefits? Which retiree is worth more? The person with $75,000 a year in pension benefits, as they are easily worth another half-million dollars.

What is the largest asset of retirees when it comes to the household balance sheet? Social Security. In my experience, when advisors create a financial statement, they will include the value of the home, the value of a portfolio, they'll even include furniture, but they don't include any estimate about the value of Social Security.

You might say, "Well, David, why would I include the value of Social Security? It's just an income source." Here's the thing: If you do a financial plan, you treat the 401(k) or the IRA as both an asset and an income source. It's going to show up on your balance sheet. We're also going to use that asset to fund your retirement. With respect to guaranteed income, it is also assumed to be an income source. However, in general, today, it's not included as an asset. I think that's wrong. What we need to do as an industry is do a better job at having someone understand what all their assets are.

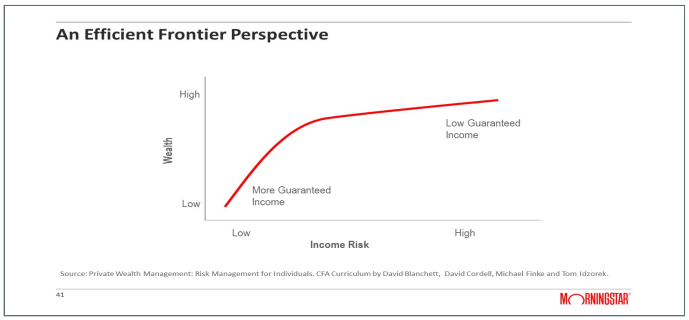
Who Should Allocate More of Their Total Wealth to Guaranteed Income?

There are four ways to manage risks. You can reduce, retain, avoid, and transfer risk.

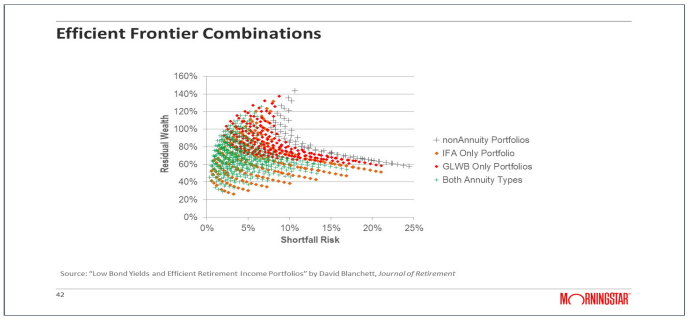
Most economists say annuities hedge the most dangerous kinds of risks, and that's why you transfer it. It is a very severe risk if you go broke when you're old, but it also doesn't happen all that often. Risk transfer is most efficient for risks that are severe and low frequency. So, people think, "Well, should I allocate more to guaranteed income?" It makes a lot more sense than, say, buying products like that warranty from Best Buy because – if that bad thing happens, which is your portfolio goes empty – the implications are a lot more.

Now one of the most common approaches people talk about when it comes to, "Should you buy more guaranteed income?" is this idea of a retirement income efficient frontier. It lends itself to the original efficient frontier we use for investments. People have created papers on this for at least two decades. The idea is, "Who benefits from guaranteed income across different risk levels and return or wealth levels?"

What you see here is you've got income risk on the horizontal axis and wealth on the vertical axis. That red line is the most efficient combination of an annuity and a portfolio.



If I'm okay with less wealth and want low-income risk, I should buy more guaranteed income. If I am less concerned about income risk and want to maximize my wealth, I should have less of my overall wealth in guaranteed income. Now you can run projections – and I've done this countless times – looking at how you combine a non-annuity portfolio – i.e., a regular stock/bond portfolio – with different types of products. This is how you create a retirement income efficient frontier.



How does combining products with different attributes affect what someone should do, given that combination of how they feel about shortfall risks or income risks and residual wealth? The traditional retirement income efficient frontier focuses on your preference for income stability and your preference for bequests – your residual wealth. Other things matter too.

For example, that entire graph is going to shift based upon how much guaranteed income you have, how prepared you are for retirement, the quality of the annuity you're considering, and how long you're going to live. Long story short, all this matters, and to truly figure out whether you should annuitize is really, really complicated. One of the best frameworks is honestly the simplest. It's asking someone, "How much income do you want to have locked in for as long as you're alive?" and if that's less than what they have locked in today, think about at least annuitizing that amount or possibly more.

I commented earlier that the term "annuities" is somewhat of a loaded term. We must acknowledge this whenever we talk about guaranteed income. There has been somewhat of a shift in the potential reception to annuities or guaranteed income over the last several years. There are better terms to call them. I like the phrase "personal pensions" because that's because the word "annuity" has lots of baggage associated with it. Often people will say, "Well, I never recommend annuities to my clients." I really have a problem with that.

Tongue in cheek, I have this thing that I call the mutual fund puzzle. There are mutual funds out there that are incredibly expensive. They have expense ratios of over four percent a year. There is overwhelming evidence that most mutual funds underperform their benchmarks, and most of the time today, advisors who recommend or sell them aren't fiduciaries. The problem is that people will take this exact same logic and say, "Well, I would never recommend an annuity,"; but that's ridiculous. We all recommend annuities for the most part because it's not the fact that there are some bad ones out there. It's the vehicle itself.

Many annuities do have high fees, and they aren't very good. There are probably more bad annuities than bad mutual funds, but there are some great ones out there. Part of the problem people when think about annuities is, they don't always apply the right framework.

Annuities are like an investment. A lot of them have investment-like attributes. But the fundamental purpose of an annuity is insurance. Advisors view the value of guaranteed income annuities from an investment lens. Again, some have investment attributes, but the key benefit is protection, not necessarily growth.

Interestingly, we see that people who don't own annuities don't often have positive impressions of them. However, after they buy one, it becomes a lot more positive. There's probably some selection bias here. People who buy them tend to like them, but this is the behavioral part of it that I think is so hard for people like me to quantify.

I've had many advisors tell me, "David, I have run the numbers, and annuities don't make any sense at all." Remember, annuities are insurance. They shouldn't necessarily make you money. How are you running the analysis? Many advisors use historical long-term averages and compare them to an annuity quote today. That's ridiculous. The average historical yield on US government bonds is close to five percent. That yield today is less than one percent. You can't compare historical long-term average equity and bond returns to annuity prices today. When you equalize the return assumptions, annuities can become a lot more attractive.

Along those same lines, what about fees? Too often, advisors will run a projection that doesn't include fees to the portfolio, and they'll compare it against an incredibly high-cost annuity. It needs to be apples to apples. If you compare a high fee annuity to a low fee portfolio, of course, the portfolio is going to win. If you compare a high fee portfolio to a low fee annuity, of course, the annuity is going to win. The key is making it realistic and relative.

People will often say that annuities are expensive. Let's just say that you're going to pay a six percent commission today on an annuity purchase, or whatever it is. That is a lot, but so is paying a one percent management fee every year forever. I'm not trying to dismiss the value of advice here at all. I've done research talking about advisor value, but the key to all this is context. It's how we all think about and internalize the value of different products and approaches.

Key Takeaways

What are some key takeaways?

1. How do you think about guaranteed income? This is a serious question, and I think ahead in the sand perspective is honestly how most advisors view it. They say, "Well, I looked at it three or four years ago, and they didn't look very good," or "Annuities are very expensive. I don't recommend them."

   So much has changed in the product space and the fee-only space in the last three to five years. I think you've got to be continually looking at how these can help you improve your practice and your clients' retirement. For those advisors who are adamantly against annuities, I get that. Still, there are products like deferred income annuities or longevity insurance that aren't very expensive that can help someone hedge away their longevity risk.

2. Maybe your client doesn't like them or know that they want them. If I'm an advisor, I want to have as many arrows in my quiver as possible. To just dism
   for all your clients outright is a clear breach of fiduciary duty. There's no way that some of your clients would not benefit from having more of their wea

guaranteed income. For every single one of them, that could be higher Social Security benefits. That could be a pension from work. But I think we've got to think more about guaranteed income as part of a retirement plan, and to me, it is the cornerstone of a retirement income plan.

3. Guaranteed income is the cornerstone of people's retirement because it is the guarantee. It is that thing that we know will be there for as long as the person's alive, and a portfolio can't do that. Now it's not necessarily as fun or as sexy to talk about annuities or Social Security or pensions as it is to talk about investment alpha. Still, they are so important to someone's overall financial wealth – to how they invest their portfolio – that we simply can consider them at every part of a financial plan and give them their due. Now you might ask, "Well, how do I figure out what to do?"

   The key with annuities – like almost everything else in this profession – is blending the art and the science. The art is your experience. It's how you have seen clients respond to different environments. This is the behavioral stuff. I think the behavioral stuff is the most important out there. It's funny that almost all the research is on the science of guaranteed income. It's how they can improve someone's utility or portfolio efficiency or their outcome.

   Where annuities make the most sense is the behavioral side of things. It's giving someone that automated paycheck that you can't get from a portfolio.

   It's incumbent upon all advisors to understand the science, read journals like the Journal of Financial Planning, the Retirement Management Journal, the Journal of Personal Finance, or whatever it is, and understand what the academics that review these products think about them and where they think they fit.

   Every client is different, and every situation is different. Unless you understand how people like me and others think about them and talk about them, it's going to be hard for you to help clients make the best decisions, especially if you ignore guaranteed income as part of your overall retirement income strategy.

Guaranteed Income: The Forgotten Household Asset

About David M. Blanchett, PhD, CFA, CFP®, Head of Retirement Research, Morningstar Investment Management

David Blanchett, CFA, CFP®, AIFA, is the head of retirement research for Morningstar Investment Management. He works to enhance the group's consulting and investment services. David conducts research primarily in the areas of financial planning, tax planning, annuities, and retirement plans and he serves as the Chairman of the Advice Methodologies Investment subcommittee.

David's research has been published in a variety of academic and industry journals and has been featured in a variety of media publications. In 2014 Money Magazine named him one of the five brightest minds in retirement and in 2014 Investment News included him in their inaugural 40 under 40 list as a "visionary" for the financial planning industry.

He is part of group of retirement thought leaders – truly a breath of fresh air – along with Wade Pfau, Michael Finke and others, who challenge us to go beyond targeting 80% replacement rates, traditional retirement portfolio asset allocations, inflation-adjusted systematic withdrawals of 4% and probabilities of success or failure.

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Advisor's Guide to Health Savings Accounts: Differentiate Yourself

Kelley Long, CPA/PFS, CFP®

Editor's note: This article is an adaptation of the live webinar delivered by Kelley Long in 2020. Her comments have been edited for clarity and length.

You can read the summary article here as part of the 4th Qtr 2020 Retirement InSight and Trends Newsletter, worth 1.0 CE when read in its entirety (after passing the online quiz.)

You may also choose to take the full length course Advisor's Guide to Health Savings Accounts: Differentiate Yourself for 1.0 hour continuing education (CE) credit.

*By **Kelley Long, CPA/PFS, CFP®***

You might have heard the health savings account (HSA) referred to as the "new" 401(k). Thirty years ago, when the 401(k) first came out, it was thought of as something for just executives and higher income or more savvy planners, and now it's the everyman's retirement savings vehicle. The HSA is quickly becoming the second to that, but it's not going to take 30 years for people to realize the value. A recent report shows $17 billion already invested in HSAs, and that's a 32 percent increase year-over-year from 2019 to summer of 2020. The average balance of accounts is $15,000.

While this doesn't sound like much money in terms of the typical financial advisory world, there's a huge opportunity here because only about five percent of the accounts currently hold investments. As HSA-eligible healthcare plans become more and more available, we're just going to see that number balloon.

Over three-quarters of HSA assets are employer-related – meaning that people have their HSA through their employer plan, and so in their mind, it's paired with their healthcare plan.

A Review of the Basics of Health Savings Accounts (HSAs)

The S in HSA stands for savings.

Most of us grew up in the time of flexible spending accounts (FSA), where you made an educated guess as to what your out-of-pocket expenses were going to be, but you didn't want to overshoot it because you had to use it or lose it. However, an HSA is money that's yours. So, I like to try to frame it as more of a 401(k). Once you put money in, it's yours forever whether you switch out the plan, whether you leave the company, whether you need it, it's there.

Emphasizing the S is the key to framing health savings accounts that even many healthcare providers still need to figure out. I went for my annual visit a couple of weeks ago, and even my doctor said, "Well, you can use your HSA to buy a spinning bike." I said, "Maybe, but why would I do that?" She said, "Well, you have to use it up before the end of the year." I responded, "No, that's your FSA."

The one thing that really trips people up, and one of the most frustrating things for me as a practitioner, is that HSAs are complex, and the IRS has not done a good job of making them less complicated. Some of the rules are just really annoying and frustrating. I am a founding member of the Plan Sponsor Council of America's (PSCA) HSA committee. We advocate very strongly to make HSAs simpler, but for now, to deposit money into a health savings account, you must be enrolled in a high deductible healthcare plan (HDHP). This is the most confusing for people because they think of the HSA as paired with HDHP. When they roll off the HDHP, they feel like they must spend their HSA assets down. I did this very thing until I learned more about the HSA. I piddled away some savings that could have been there in the future when I ended up having some significant health expenses in my 40s.

Once you enroll in Medicare, you're no longer eligible to make deposits to an HSA. So, that can come in as a useful planning tool for clients who are planning to retire or maybe even are working past the age of 65 and thinking, "Oh, I should just go ahead and enroll in Medicare Part A just to make sure I don't screw anything up." The caveat is that if you want to keep funding your HSA, you can't have any other coverage. This often confuses people because you can have money in an HSA, and you can spend it at any time no matter what your coverage is, but you just can't put more money in unless you qualify.

We all know that HSAs are triple tax-free, but what that really means is that you can even make lump sum contributions to your HSA up until the tax filing deadline. Many people will set their HSA deposit amounts at open enrollment, not realizing that they can switch it or add more to it after-the-fact. It's more like an IRA in that regard, but the biggest thing is that it's a deduction. While it's in there, it grows tax-free, so it's like a traditional IRA or a traditional 401(k). And upon withdrawal – if it's for qualified medical expenses – it's also tax-free.

For 2021, the contribution limits are $3,600 for individual coverage and $7,200 for family coverage. If you're 55 or older – not 50 – you get an additional $1,000 catchup contribution per person. The big thing to know here is that if you are two spouses over age 55 on the same plan, the second spouse needs to open their own HSA to contribute $1,000.

Advanced Facts and Health Savings Account (HSA) Strategies

You can use your HSA to pay long-term care insurance premiums for the rest of your life. If nothing else, over funding the HSA up to the maximum amount and letting that money build up to provide long-term care insurance might be enough of an incentive to offer your clients.

Another asset retention opportunity is that most clients and retirees tend to be withdrawing money from their IRAs to pay for retirement healthcare. If they h… – even if you are not holding it – they can use their HSA to pay for these things and keep their money in their IRA with you.

You can use your HSA to reimburse yourself for Medicare Part B and Part D premiums, which many people don't realize. Medicare premiums – as you probably know – come out of your Social Security check. Still, you could make a $145 per month withdrawal from your HSA and use your Social Security check or your end of year tax form from the Social Security administration as your receipt to show that you're reimbursing yourself for that year's premiums.

Many people don't know this, but you can move your HSA even while you're actively contributing. When I discovered with a previous employer that my HSA was portable, I went to my HSA provider once a year and did an indirect rollover of my HSA to a better HSA provider. It's kind of like the IRA indirect 60-day rollover rule.

If you're helping your clients with portability of their HSAs, make sure you have them check into any fees. Not all providers work this way, but once a year, you can do a rollover to an investment account if the intent is to building investment funds.

The other thing to understand is you can spend your HSA dollars on any tax dependent. A married couple might be on different healthcare plans. The husband has an HSA; the wife does not. Let's say the wife works for a firm that has a great PPO plan with very few costs, so she stays on that plan. The husband uses the HSA and has the kids on his plan.

The husband can put $7,200 into the HSA for the family and even spend it on the wife, even though she's not on the plan. She is a tax dependent. This also includes parents. If any of you or your clients have elderly parents who have moved in with you and become taxable dependents, you can use your HSA to pay for their medical expenses if they're on your tax return.

There is a one-time IRA rollover provision. Every HSA holder has a once-in-a-lifetime opportunity to rollover IRA money into their HSA up to the annual limit to pay for an expense. This is only applicable if you had somebody who had an HSA that hadn't been funded. Maybe they put in $30 a paycheck. Then they end up with a considerable medical expense that they don't have any cash for anywhere else to cover it, and they're thinking about taking an early distribution from their IRA. It's better to roll it over to the HSA and then pay it out of the HSA for a tax-free distribution. You can only do this once, and you can only do it up to the annual limit, so it's not a huge opportunity, but just something to know.

The Super Health Savings Account (HSA)

How the Super HSA works is essentially it takes advantage of or addresses the fact that you must be a taxable dependent to use somebody else's HSA dollars.

For people who have college students who are over the age of 19, you probably know you can't claim them as a dependent anymore on your tax return. You may be able to get deductions for tuition you pay on their behalf, but you don't get that little tax deduction like you used to. But they can stay on your plan up until they're 26.

When I worked at Financial Finesse, I spoke with many early-career employees who opted to stay on their parents' plan just for simplicity. They didn't feel like figuring out open enrollment. They weren't sure about staying in-network. They were still transitioning into adulthood, so they stayed on their parents' plan. The issue is that they can't use their parents' HSA dollars.

The good news is that they can open their own HSA because they're enrolled in a high deductible healthcare plan. Families with children between the ages of 19 and 26 who are still enrolled on the healthcare plan can contribute an additional $3,600 (2021). If you have a client who may be looking for some tax planning opportunities from a family perspective, they have up until April 15, 2021, to fund an HSA using the 2020 limit of $3,550, and the child would get the tax deduction because the HSA is in their name.

This strategy is not as useful for parents, but at the end of the day, the family with parents that are over 55 and one child could save up to $12,800 in an HSA.

Another key planning strategy with HSAs is that there is no time limit for distribution reimbursements from your HSA. Suppose you have clients who have accumulated a lifetime of medical expense receipts, and they've kept that money in their HSA. In that case, it can be a powerful way to distribute money tax-free even without a lot of medical expenses in retirement. This is often an objection that people will put forth about overfunding an HSA. "Well, what if I'm super healthy? What if I don't need it in retirement?" You can still use it, and there are ways to do that.

In the HSA rules, the age of 65 is crucial. At that point, you can withdraw HSA money without penalty. This is where you can overcome that objection of "What if I don't need all this money?" You're talking to a 30-year-old who says, "I could have $600,000 in my HSA by the time I retire. What world am I going to live in that I'm going to need $600,000 for medical expenses?" At age 65, you can tap that money just like it's a 401(k), but if you happen to need it for things like long term care, medical expenses, or Medicare premiums, then it's tax-free. If you withdraw money from your HSA before 65 and you don't have a qualified medical expense to support it, then there's a 20 percent penalty. In that case, you're better off raiding your retirement savings account versus the HSA.

Examples of Different Coordination Strategies

Let's start with someone at the beginning of their career. Let's say they have the option to contribute to a 401(k) and make an HSA contribution.

The first dollar they contribute to these accounts should be the first year they're enrolled in an HSA. You need to put at least $1 in to start your eligibility to use it. People make a common mistake because they open their HSA, enroll in a high deductible healthcare plan, don't put any money in their HSA, and then have a medical expense. Technically speaking, they're thinking, "Oh, I'll just put the $150 of my medical bill in my HSA and reimburse myself." They're not eligible to use their HSA for medical expenses even if they're not on a high deductible healthcare plan in the future.

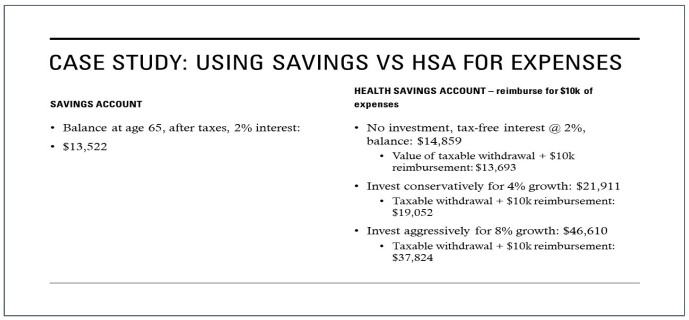
If people save more than their match in their 401(k) and not maxing out their HSA, without any change to cash flow and, in fact, an increase in cash flow, you need to dial back to just the match in the 401(k) and then max out your HSA. For example, if you're putting 10 percent into your 401(k) but you only get a match on the first five percent, shift that five percent of pay into your HSA. Not only is there no change in your cash flow, but you are going to see even an increase in your net pay

HSA money is a deduction from your FICA as well. A 401(k) is only a federal and state tax deduction. HSA money comes out before we even withhold for Social Security and Medicare.

Now, why does this make sense? First, the main reason people tap their 401(k)s and IRAs early and pay a 10 percent early penalty in taxes is because of medical expenses – unexpected, crippling medical expenses. Why not have that available in a tax-advantaged account versus a tax-deferred account where you have penalties for early withdrawal? This only makes sense if you can let your HSA dollars accumulate and invest most of your HSA money similarly to the 401(k).

Now once you're saving in your 401(k) to the match and you're maxing out your HSA, then if you have extra dollars, it makes sense to return to the 401(k) or – depending on the plan – fund an IRA or a Roth IRA. That will depend on the availability of different tax planning mechanisms through workplace plans.

For the example below, let's assume that a 45-year-old person is financially secure. They have emergency savings set aside, they're debt-free, they're at least getting their match in their 401(k), and they've got $10,000 in savings that is not earmarked for anything special. If these assumptions aren't met, and they are still paying off student loans or higher interest rate debt, it would make more sense to use their HSA for medical expenses. But we're assuming that they're able to super fund the HSA and let this money ride for 20 years. They're in a 24 percent tax bracket, and – throughout those 20 years – let's assume that they have $10,000 worth of medical expenses.



So, if they were to leave that $10,000 in their savings while using their HSA to cover their $10,000 worth of medical expenses throughout those 20 years of working, at the age of 65, they'd have $13,522 in their savings account after paying 24 percent taxes on the interest that account earns.

Let's say instead they spent their savings down and let that $10,000 stay in their HSA, and it earns, again, two percent. At the end of 20 years, they'd have $14,859 because they're not paying taxes on the interest. Let's say then at age 65, they want to take out the future dollars tax-free equivalent to reimburse themselves for the savings they spent on medical expenses. The remaining taxable $4,859 would be taxable, so they'll have $13,693.

A reasonable person who will keep $10,000 in their HSA is at least going to invest it conservatively at four percent growth. At age 65, they will net out $19,052 after withdrawing the equivalent reimbursement for the future value of the $10,000 of medical expenses. If they invest more aggressively at eight percent growth, they're looking at a net $37,000 of savings.

Here's another example of Ben and Shelby, both age 30. Ben is in the HSA eligible healthcare plan because he wants an affordable plan. In general, the HSA eligible plan – especially in workplace plans – is the cheapest premium. He's looking for the cheapest premium, and he's a pretty healthy guy. His goal is to balance his current costs with his long-term goal of having some money in his HSA.

On the other hand, Shelby is in the FIRE (financial independence, retire early) movement. She is looking for a way to retire early, and her HSA will support that goal. Her goal is to retire at 55. Why 55? Because at that point, she can withdraw from her 401(k) penalty-free, and she's got ten years to plug the gap for healthcare.

Ben saves to the match in his 401(k), then puts $2,000 a year in his HSA, which is his plan's deductible. He's funding just enough to make sure that he at least has enough for his deductible, and on average, he spends about $1,000 a year of that money. After a while, he decides to loosen his grip a little bit and invest in a balanced fund. He achieves four percent growth over his 35-year career. At retirement, he has about $74,000 in his HSA. Not bad for somebody who's buying the cheap premium plan, putting money in the HSA tax-deductible to fund his current medical expenses, and having $74,000 leftover to help with retirement medical expenses.

Remember, Shelby wants to retire at age 55. She's maxing out her 401(k), $19,500 this year, and she also is putting in $3,550 (2020) into her HSA. She invests right away by rolling her money over to a provider that allows her to invest it in equities. At the age of 55, she has about $260,000 in her HSA to help her achieve her FIRE goal.

At age 55, Shelby uses her HSA to pay her COBRA premiums while she is unemployed. You can use your HSA to fund COBRA if you're on unemployment, but you cannot use your HSA to pay other healthcare premiums except for Medicare. Once her COBRA expires, she enrolls in critical care – so super cheap insurance that she has to pay out of pocket – but her HSA is there for actual medical costs. (We're assuming Shelby is healthy.) She doesn't have many medical costs, but if she were to fall and break her leg on one of her adventures in her late 50s, her HSA would swoop in and cover the cost because her medical insurance is anemic.

Then once she's 65, she uses it for Medicare premiums, and – because, during her 25 years of working, she did accumulate some medical expenses that she didn't use her HSA for – she can reimburse herself for prior year expenses. She uses it for some tax bracket planning. In other words, you might talk to your clients about filling up your tax bracket each year. Once she's at the top of her tax bracket, she uses her HSA to reimburse herself for previous expenses versus taxable withdrawals. Because she has a certain balance at the age of 65, she may even be able to forego buying long-term care insurance knowing that she can self-fund with her HSA.

Ben, on the other hand, because he uses his HSA throughout, only has enough to pay Medicare premiums, pay for his hearing aids, and the other costs that have as a retiree. He also uses his HSA to pay for long-term care insurance premiums.

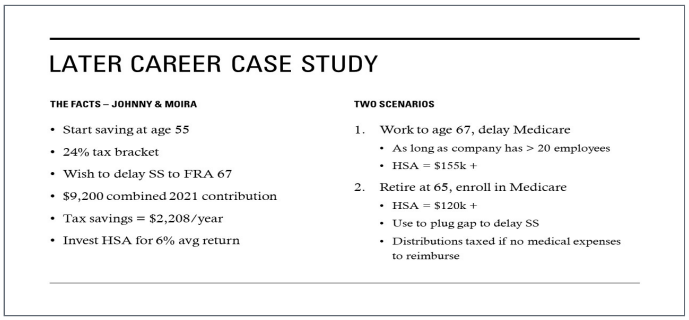
It's worth pointing out a few things here:

1. Be sure to your receipts to allow yourself those tax-free reimbursements in the future.
2. HSAs aren't just for co-pays or your standard medical bills.

Keeping good records is paramount if you're going to engage in these tax-free withdrawals for prior year expenses. Save those receipts when you buy eligible products and supplies. The way I manage it is I keep an app on my phone called DocScan. I take a picture of all of my receipts, keep them in a file labeled with the current year, and – when I'm ready to engage in this HSA reimbursement game – then I'll go year-by-year and add up all my 2020 receipts. Whatever that adds up to, I'll take that withdrawal out, and then – if the IRS ever asks me to justify it – I send them my 2020 file. The other thing to note is that it's on us – because these are consumer-driven healthcare plans – to retain and prove that we spent this money on HSA-eligible expenses even if it was 20 years prior.

One final example is a married couple, Johnny and Moira, who didn't care too much about money until later in life. They learned about their HSA from their advisor at the age of 55. They're in the 24 percent tax bracket, and their goal is to delay Social Security until their full retirement age, so $9,200 will be their 2021 maximum contribution.

Now, if Moira is on Johnny's plan, she would have to open her own HSA to make that extra $1,000 catchup, but Johnny would put the initial $8,200, which is the $7,200 family limit, plus the $1,000 catchup for him. Moira must do her $1,000 catchup into her own HSA. The good news is there are more and more consumer HSAs out there. At a $9,200 combined contribution with a 24% tax rate, they're saving $2,200 in taxes per year. They are going to invest their HSA at a 60-40 mix for 6% growth.



So, let's look at two scenarios. The first scenario is that they decide to work until they're 67, which means they will delay Medicare. Why is this a key fact? If you are on a work-based plan with an employer that has more than 20 employees, you can delay Medicare until you retire. Because Johnny and Moira want to continue to contribute to the HSA, they decide to do that. They keep funding the HSA up to age 67 while they're working, and then – the day they retire – they're enrolled in Medicare, with no lifetime penalties, no delays, and they've got over $155,000 in their HSA.

The other scenario is that they retire at age 65. So, they go ahead and enroll in Medicare, so they must give up a couple more years of contributing to their HSA than they would in scenario No. 1. But here, they can use the HSA to plug the gap for those two years before enrolling in Social Security. Even if their Social Security would be $30,000 a year, and they don't have medical expenses that they had incurred from 55 to 65 to justify a non-taxable withdrawal from the HSA, it would be a taxable distribution. They will not pay penalties because they're age 65. There would still be some money left in the HSA after-the-fact to cover other medical expenses later in life.

Retiree Benefits of the HSA

1. Use your HSA in retirement to pay a long-term care premium. You can use it for Medicare premiums.
2. You can use it for things like new hearing aids or adding a ramp to make your house a little bit more accessible to somebody who might be using a walker or a cane.
3. It allows for that tax diversification. Medicare premiums will go up once your income exceeds a certain amount, and it's based on a two-year rolling average, and it can help reduce taxation of your Social Security.
4. If you still have money in your HSA when you die and your spouse inherits it, they get to retain that tax-free quality and use it for their medical expenses just as if you're alive. However, anyone else that inherits your HSA – your kids, your grandkids, your next-door neighbor, your girlfriend – is going to have to take an immediate distribution and pay taxes on the money. If a client desires to leave a bequest to a nonprofit, they suggest that they put the nonprofit as the HSA beneficiary. If they end up exhausting their HSA, then they can redo their will to include the bequest in their will, but otherwise, that's a super tax-friendly way to pass along money to a charity.

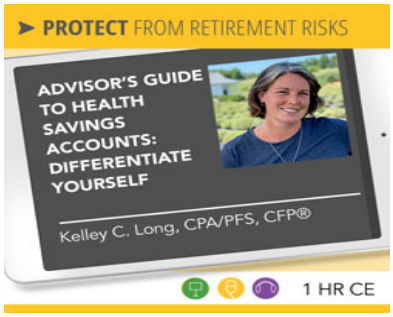
Key Takeaways

1. HSAs are fully portable, even if you're still actively contributing.
2. Contributions can be made via lump sum up to the April tax filing deadline and can typically be changed throughout the year via payroll deductions. Some employers have rules that may only allow you to increase your contributions. However, anytime I've had access to an HSA, I've been able to change my contributions throughout the year.

3. Medicare enrollment stops the ability to contribute, but not to spend. If somebody's over the age of 65 when they enroll in Medicare, remember there is a six-month lookback with Medicare where you cannot contribute to an HSA.

4. Discourage HSA spending during working years but save receipts for future tax planning. It's a savings account. If nothing else, it's there to fund big things in the future. If you've got college-age kids, help them fund an HSA that can be there for them when they've got kids going to college. It can fund things in the future.

I like to tease young people by saying, "You can save in your HSA to pay for the expenses of children you're going to have with somebody you haven't even met yet as long as they're a tax dependent." So, don't spend that money, but do save your receipts. Suppose you end up in a pickle in the future, and you have money in your HSA, and you've got receipts for previous expenses. In that case, you can always tap that to get you through, or ideally, in retirement, it will help with tax diversification and tax planning strategies.



Advisor's Guide to Health Savings Accounts: Differentiate Yourself – Kelley Long

About Kelley Long, CPA/PFS, CFP®

Kelley Long is a personal finance expert and financial wellness coach who is on a personal mission to empower all people to feel and be great with money. She is a CERTIFIED FINANCIAL PLANNER® professional as well as a Certified Public Accountant, and is frequently cited in the media, including the NY Times, Wall Street Journal, Washington Post and Reuters.

She lives by her personal definition of financial security, which is using money to get to a place where you are able to make decisions in your life for every reason except money. She overcame her own poor money habits that lead to climbing out of 5-figure debt not once, but twice, as an example of how and why addressing the psychological aspects of money is as important, if not more so, than providing just financial education and planning.

With over 20 years of various roles in the financial services industry, Kelley left her most recent full-time position as a Senior Financial Planner and Personal Financial Coach with Financial Finesse after five years of changing the financial lives of employees throughout the US. Financial Finesse is often credited with starting the financial wellness industry in 1999 and is still the leading provider of unbiased workplace financial wellness programs – her experience there informs her consulting and speaking work today.

Kelley is a noted expert on Health Savings Accounts and their related financial planning strategies, having served over three years as a founding member of PSCA (Plan Sponsor Council of America), HSA Committee, an American Retirement Association affiliated organization, committed to advocating for the enhancement and adoption of HSA-friendly education and legislation.

After coaching over 2,500 individuals on their money and presenting to employees at several different Fortune 100 companies, Kelley has a deep understanding of how the concepts of behavioral finance can be applied to change behavior. She's a sought-after content creator, specializing in written pieces that support financial decision-making without getting bogged down in the jargon that so often intimidates and confuses readers.

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