



Government health care fundamentals

When it comes to preparing for your financial future, it's natural to focus on planning for the retirement lifestyle we each envision for ourselves and for our loved ones. But don't overlook the importance of retirement health care planning.

As people age, they tend to need more medications and doctor visits to continue leading healthy, active lives. Furthermore, with people now living longer, on average, than previous generations — and with health care costs generally increasing faster than inflation — many Americans need to be prepared to spend more on health care than our parents.

These are good reasons to understand the fundamentals of the government health care program you will someday depend upon. Your RBC Wealth Management® financial advisor and other knowledgeable professionals with specialized expertise can help you start planning for retirement health care.

Taking appropriate action today will help you see your financial life

with new clarity. It will also help you proceed with confidence toward the tomorrow you envision.

Medicare essentials

Medicare is a federal government-sponsored health insurance program intended to help people 65 or older pay their medical bills. (People younger than 65 who have certain disabilities may also be eligible.) The program covers some, but not all, medical expenses; and it is important to know that Medicare does not cover most long-term care costs.

Medicare is a “pay as you go” system similar to Social Security that is financed by a 2.9% payroll tax, half (1.45%) paid by workers and half by their employers, as well as by monthly premiums deducted from Social Security checks.

Unlike Social Security, however, there is no upper income limit above which earnings are not taxed for Medicare.

While you apply for Medicare through the Social Security Administration, it is run by the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services. As a beneficiary, however, you deal mostly with the private insurance companies that actually handle the claims at your local level.

The amount Medicare pays is based on the average “reasonable and necessary” cost for the specific care you need — in the area of the country where you receive it. So Medicare benefits are not based on your financial resources or ability to pay.

Medicare Part A (Hospital insurance)

Part A helps you pay for the services associated with inpatient care — such as meals, hospital room and nursing services — received at a hospital, skilled nursing facility or psychiatric hospital. Some home health care and hospice care may also be covered. Insurance companies that handle Part A claims are called “fiscal intermediaries.”

It is important to know that not all hospital services are covered by Part A. For example, private duty nursing, a television or telephone and a private room (unless medically necessary) are not covered under Part A.

There is no premium for Medicare Part A if you are age 65 or older and you are eligible for Social Security benefits. People with certain disabilities who are younger than 65, as well as dependents and some survivors of a person who is entitled to Social Security retirement benefits, may also qualify for free Medicare Part A. If you are 65, but not eligible for Social Security, you may still buy Medicare Part A.

The portion of hospitalization costs Medicare Part A pays for depends on the length of your hospital stay and there is a deductible for each hospitalization. For details on Part A costs, as well as its coverage, limits and gaps, please refer to our *Medicare Key Numbers* guide.

Medicare Part B (Medical insurance)

Part B helps you pay for other medical care — including physician care, regardless of where it is received — and other medical services and supplies not covered by hospital insurance, such as ambulance service, laboratory tests and physical therapy or rehabilitation services. Insurance companies that handle Part B claims are called “Medicare carriers.”

It is important to know that not all medical services and supplies are covered by Part B. For example, hearing aids, eye glasses and most annual physical exams are not covered under Part B.

Anyone who is eligible for Medicare Part A can enroll in Part B by paying a monthly premium and an annual deductible for medical care received. Citizens of the United States and certain long-term lawfully admitted non-citizens who are not eligible for free Medicare Part A can buy Part B medical insurance without having to buy Part A.

For details on Part B costs, as well as its coverage, limits and gaps, please refer to our *Medicare Key Numbers* guide. If you are a high income retiree who may be subject to higher Part B premiums resulting from means-testing, please refer to our *Medicare: Planning for Income Related Monthly Adjustment Amount* guide for more information about what you may pay and strategies to help mitigate this risk.

Medicare Part C (Private insurance options)

Part C combines Parts A & B and is offered by private companies approved by the Federal government but not regulated under Medicare.

In many areas, private health care plans like managed care plans, preferred provider organizations, medical savings accounts and private fee-for-service plans are authorized to offer Medicare benefits. People with Medicare Parts A & B may choose to receive all their health care services through one of these plans using Medicare Part C.

With one of these plans, you do not need a Medigap policy (a special supplemental insurance policy designed to help cover deductibles, coinsurance and other “gaps” in your Medicare coverage). Your managed care plan will likely charge a monthly premium, along with associated costs. What you pay may vary, depending on the scope of coverage you choose.

It is extremely important when considering Medicare Advantage plans to make sure your current providers and facilities are included in the plan’s network.

Medicare Part D (Prescription drug program)

Part D helps you pay for medications doctors prescribe for treatment. Participation is voluntary. Anyone who has Medicare Parts A and B or Medicare Part C is eligible. You will be charged an additional monthly premium for the benefit, and what you pay may vary, depending on your financial situation and the scope of coverage you choose.

Medicare Part D pays a variable amount, depending on your total annual prescription costs. There is also a “donut hole” in coverage where Medicare Part D pays nothing, although this donut hole is currently scheduled to phase out by 2019.

If you currently do not have prescription drug coverage, enrolling in Part D may be a wise health care investment, even if you currently do not take many prescription drugs. If you have prescription drug coverage through a current or former employer or union — or through the Department of Veterans Affairs or the Federal Employees Health Benefits program — check with your benefits administrator to discuss your options before enrolling in Part D.

For details on Part D costs, as well as its coverage, limits and gaps, please refer to our *Medicare Key Numbers* guide. If you are a high income retiree who may be subject to higher Part D premiums resulting from means-testing, please refer to our *Medicare: Planning for Income Related Monthly Adjustment Amount* guide for more information about what you may pay and strategies to help mitigate this risk.

How can I protect myself against large out of pocket costs?

Medicare Supplement plans (also referred to as Medigap plans) are optional insurance policies from a private provider designed to fill in the coverage gaps in Part A and Part B coverage; and requires the beneficiary

to pay a monthly premium. These plans cover many of the deductibles and copays (or gaps) that occur with Medicare Parts A and B. Coverage and premium costs for Medicare Supplement Plans vary by local geographic area.

Medicare enrollment process

The initial enrollment period for Medicare Parts A, B, C and D begins three months before you turn 65, includes the month you turn 65 and ends three months after the month you turn 65. Should you fail to enroll during the initial enrollment period,

you can still apply for benefits. However, if you don't sign up for Part B when you are first eligible, your premium may increase 10 percent per year, unless you are covered by an employer's health insurance plan. If you miss your initial enrollment period for Medicare Part D, your premium may increase by 1 percent per month, unless you remain on your employer's health insurance and it is classified as "creditable coverage".

If you miss the initial enrollment period, change your mind about the Medicare coverage you wish to receive or your other health insurance circumstances change, there are general and special enrollment periods. However, some penalties may apply.

Please refer to our *Medicare Enrollment Considerations* guide for information to help with general and special enrollment, as well tips for evaluating your Medicare coverage annually thereafter.

For more information about your Medicare options or to order a free handbook, "Medicare & You" (Publication No. CMS- 10050), go to www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

Depending on the state where you live, your State Health Insurance Assistance Program (SHIP) and/or Statewide Health Insurance Benefit Advisors (SHIBA) can answer questions about Medicare health plan choices, Medigap policies, Medicare rights and protections and long-term care insurance.

Department of Veterans Affairs health care benefits essentials

The United States Department of Veterans Affairs provides eligible

military veterans and certain survivors or dependents with a standard health benefits plan that emphasizes preventive and primary care. This standard plan also offers a full range of outpatient and inpatient services within the Veterans Affairs health care system. Disability benefits and long-term care benefits are available for qualifying veterans.

Eligibility for most veterans' health care benefits is based on active military service in the Army, Navy, Air Force, Marines, or Coast Guard (or Merchant Marines during World War II) with discharge under other than dishonorable conditions. Health care eligibility is not only for combat veterans.

It's important to know that not all health care services are available. For example, drugs or medical devices not approved by the Federal Drug Administration are not covered by Veterans Affairs.

To prevent demand for services from outstripping the resources available — thus preserving the quality of medical care and treatment provided — a priority system helps ensure that veterans with service-connected disabilities and those below a certain income level are able to be enrolled in the Veterans Affairs health care system.

There is no monthly premium for Veterans Affairs health care benefits. However, co-payments are required for non-service connected and zero % non-compensable veterans whose income is above the established threshold that is set annually by Veterans Affairs.

There are three ways to enroll:

1. In person at any Veterans Affairs Medical Center or Clinic
2. On-line at: www.va.gov/1010EZ.htm
3. By mailing completed Form 10-10EZ to the Veterans Affairs Medical Center of your choice

Once your application is processed, the Veterans Affairs Health Eligibility Center will send you a letter with your enrollment priority group assignment

and instructions to contact the local Veterans Affairs health care facility for an appointment. You should receive the appropriate enrollment letter within 7 to 14 days. If the Health Eligibility Center determines you are not eligible to enroll, the letter will give you instructions on how to appeal the decision if you do not agree with it.

If you are a military veteran, to learn more about your U.S. Department of Veterans Affairs health care benefits, go to www.va.gov or call 1-877-222-8387.

Medicaid essentials

Medicaid is a state-run program intended to provide medical treatment and health care services to people who may not otherwise be able to afford the essential care they need. There are broad federal guidelines. However, each state determines the amount, duration and types of benefits Medicaid will provide. Typical Medicaid programs cover inpatient and outpatient hospital services, physician and surgical services, diagnostic services, family planning services and prenatal/delivery services for pregnant women.

Unlike Medicare, which offers the beneficiary a higher degree of control over health care decisions, Medicaid is a social safety net designed to provide care for people who can demonstrate extreme financial need and may not be able to otherwise have the means to pay for essential care on their own.

As a result, not all health care services are available. For example, elective procedures (such as cosmetic surgery, orthodontics or surgical vision correction) not deemed a medical necessity generally are not covered. As a social safety net, Medicaid recipients also frequently have limited or no choice in the doctors, hospitals and nursing homes they go to for care.

You do not pay any premium for Medicaid coverage and Medicaid does not pay money to you. Instead, it sends payments directly to your health care providers. Depending on your state's rules, you may be required to make a nominal co-payment for some medical services.

Medicaid rules require an applicant's financial records to be reviewed as far as five years back to ensure his or her income and total net worth are lower than statutory maximum thresholds. Applicants must generally meet three fundamental definitions of neediness to receive Medicaid benefits.

1. Categorical need test — Applicants must meet one or more of the following conditions: age 65 or older, disabled or blind.

2. Income test — In "spend-down" states, the applicant must spend all of his or her monthly income (minus a very small personal needs allowance) on medical or nursing home expenses. In "income-cap" states, personal income greater than the generally low monthly income cap allowed by the state will disqualify the applicant from receiving Medicaid.

3. Asset test — The applicant is allowed to own only minimal assets (generally up to \$2,000 for an individual or \$3,000 for a married couple, if they are both applying).

While it is possible to plan for Medicaid by using tools such as trusts, transfers of the family home, purchase of exempt assets, purchase of long-term care insurance and other strategies, it is critical for you and your family to consult a knowledgeable elder law attorney before you take any steps toward trying to qualify for Medicaid.

You can apply for Medicaid benefits at your local Medicaid office. Most states have a toll-free number to help answer your questions. If you are not sure whether you qualify, you can apply for Medicaid and have a caseworker in your state evaluate your situation.

In many states, if you are eligible for Supplemental Security Income (SSI), you are automatically eligible for Medicaid. To get Medicaid benefits by applying for SSI, call the Social Security Administration at 1-800-772-1213.

If you do not believe you will have the income or assets in retirement to afford to pay for the health care services and medical treatments you need, go to www.cms.hhs.gov/home/medicaid.asp or call the toll free number for your state listed at www.cms.hhs.gov/apps/contacts/ (select "State Medical Assistance Office" for Organization Type) to learn about Medicaid. If you do not have internet access, look under "State Department of Human Services" in the government section of your phone book, call your local Social Security office or call Medicare at 1-800-633-4227 for a voice-automated system to help you find the number for the Medicaid office nearest you.

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