

Welcome to InFRE's October 2019 Issue of Retirement Insight and Trends

 retirement-insight.com/welcome-to-infres-October-2019-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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October, 2019 InFRE Update: CRC® Program Maintains NCCA Accreditation Status

 retirement-insight.com/october-2019-infre-update

From Kevin Seibert
Managing Director, InFRE

Every five years InFRE is required to reapply for CRC® certification accreditation by the National Commission for Certifying Agencies (NCCA). Our most recent application was submitted in April and I'm pleased to announce that the CRC® has been approved for accreditation status through July of 2024.

Preparing to submit and complete the NCCA accreditation application is a time consuming and labor-intensive process. I would like to thank the members of the InFRE Board of Standards and Policy Development and the more than 30 CRC® Certificants who volunteered countless hours over the past year to help with updating the CRC® Practice Analysis, writing new exam questions, creating a new exam form, and conducting an exam pass point study. All of these activities are critical to meeting NCCA accreditation standards and allows the CRC® to continue to meet the highest standard of certification program credibility.

Since 1977, the NCCA has been accrediting certifying programs that meet rigorous standards related to governance of the program, exam development and implementation processes, and recertification requirements. Although there are more than 315 accredited programs in a wide range of professions, the CRC® program is part of a small and unique group of only ten financial related designation programs that have received and maintained independent accreditation status.

Meeting accreditation standards is an ongoing process and we rely heavily on CRC® volunteers to ensure we keep the CRC® program up-to-date and relevant in a constantly changing retirement plan and planning environment. I'd like to invite all those interested in volunteering their time and expertise to [complete a volunteer application form](#).

Thank you.

Medicare Advantage vs. Medigap: Which plan is right for your clients?

retirement-insight.com/medicare-advantage-vs-medigap-which-plan-is-right-for-your-clients

By Joanne Giardini-Russell, Owner, Boomer Health Group and Cameron Giardini, Boomer Health Group

There are the two choices that every 65-year-old is going to face when it's time to think about what they're going to do when it comes to Medicare: do they go with a Medicare Advantage Plan or Medigap?

There have been a lot of headlines with the Affordable Care Act over the last ten years, how no one wants to take away insurance for people with health conditions, and that you can't be denied coverage. That's not the case with Medicare, which is probably the biggest issue of which your clients should be aware.

Financial advisors should start talking to clients in their early 60s about what it's going to cost them when they go on Medicare. Medicare costs are determined by IRMAA (Medicare's income-related monthly adjustment amount (IRMAA)). IRMAA is a higher premium charged by Medicare Part B and Medicare Part D to individuals with higher incomes, so if you have higher-net-worth clients, they will pay more for Medicare when the time comes. If you can lower their modified adjusted gross income early enough, then you can prevent higher premiums when they turn 65. They will be forever grateful. I have higher-net-worth clients that say, "Well, no one told me about this," and I have to break the news to them.

The other important age is 64½. We try to have a conversation with every single client when they're 64½ because, at age 65, most people know that you have to do something with Medicare.

Parts A, B, C and D of Medicare



[Joanne Giardini-Russell, Owner, Boomer Health Group and Cameron Giardini Boomer Health Group](#)

Editor's note: This article is an adaptation of the live webinar delivered by Joanne Giardini-Russell and Cameron Giardini in 2019. Their comments have been edited for clarity and length.

You can read the summary article here as part of the [3rd Qtr 2019 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 "[Medicare Advantage vs. Medigap: Which plan is right for your clients?](#) for 1.0 hour continuing education (CE) credit.

We don't want to get too far into the specifics of Medicare because it all changes depending on which product you have, whether it's Medigap or Medicare Advantage.

Medicare Part A covers people at the hospital and generally has no cost to enrollee. As long as you worked 40 quarters or ten years and paid your taxes, you don't pay for Part A.

Medicare Part A does not cover long-term care expenses. Please talk to your clients and tell them Medicare is not going to solve their long-term care needs. It's an excellent opportunity for you to bring up this topic. Many people have asked me, "Well, everything's covered, right?" I have to say, "No, if you're in a nursing home, you're not going to get coverage through Medicare beyond a certain number of days." Medicare not covering long-term care is a huge shock to many people.

Medicare Part B is for when you go to the doctor, have surgery, or have outpatient procedures. It's pretty straightforward. Medicare pays for 80 percent of procedures, and the enrollees are responsible for the other 20 percent.

There are two IRMAA surcharges, one for Part B and one for Part D, which is drug coverage. Check out the charts below. You can see that for a client within a joint spousal household that is taking in \$300,000 in modified adjusted gross income, their Medicare Part B is going to cost them \$352 each per month versus the typical \$135, so this is a big deal for many people. People that make more money get mad about this.

Examples of mental biases include:

Income-Related Monthly Adjustment Amount (IRMAA)

Individual Tax Filers	Joint Return Filers	Married Couples Filing Separately	2019 Medicare Part B Premium
\$85,001-\$107,000	\$170,001-\$214,000	N/A	\$189.60
\$107,001-\$133,500	\$214,001-\$267,000	N/A	\$270.90
\$133,501-\$160,000	\$267,001-\$320,000	N/A	\$352.20
\$160,001-\$499,999	\$320,001-\$749,999	\$85,001-\$414,999	\$433.40
\$500,000 and above	\$750,000 and above	\$415,000 and above	\$460.50

DATA SOURCE: WWW.MEDICARE.GOV

There are two different situations where IRMAA or modified adjusted gross income comes into play. Below you can see that for drug coverage, that same couple that's making \$300,000 would be paying an additional \$51 for Medicare Part D.

***Plus Part D
IRMAA**

Beneficiaries who file individual tax returns with income that is:	Beneficiaries who file joint tax returns with income that is:	Medicare Part D Income Related Monthly Adjustment Amount			
		2019	2018	\$ Increase	% Increase
Less than or equal to \$85,000	Less than or equal to \$170,000	\$0.00	\$0.00	\$0.00	0%
Greater than \$85,000 and less than or equal to \$107,000	Greater than \$170,000 and less than or equal to \$214,000	\$12.40	\$13.00	-\$0.60	-4.62%
Greater than \$107,000 and less than or equal to \$133,500	Greater than \$214,000 and less than or equal to \$267,000	\$31.90	\$33.60	-\$1.70	-5.06%
Greater than \$133,500 and less than or equal to \$160,000	Greater than \$267,000 and less than or equal to \$320,000	\$51.40	\$54.20	\$2.80	-5.17%
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$320,000 and less than or equal to \$428,000	\$70.90	\$74.80	-\$3.90	-5.21%
Greater than \$214,000 and less than or equal to \$500,000	Greater than \$428,000 and less than or equal to \$750,000	\$70.90	\$74.80	-\$3.90	-5.21%
Greater than \$500,000	Greater than \$750,000	\$77.40	\$74.80	\$2.60	3.48%

Medicare Options

Everyone gets the “Medicare & You” handbook when they turn 65. It boils down to two choices. Clients can choose from Original Medicare where you pair Medicare with a drug plan and the Medigap plan, or they can choose a Medicare Advantage plan. There are still some employer-sponsored retiree coverages available today. However, for most people, Original Medicare and Medicare Advantage are going to be their options.

Medigap

Medigap is often called “Medicare supplement.” Private insurance companies are the ones that provide Medigap, so they simply pay secondary to Medicare. It’s something where if you have a Medigap policy, it’s great for people that travel – snowbirds – because you can go to any facility around the country, as long as they take Medicare.

These products are pretty straightforward. They’re just designed to pay what’s leftover from Medicare. So, if Medicare pays 80 percent, this plan will pay 20 percent, and your client walks out with no hospital bills when they have procedures done. You do have to have separate drug coverage with Part D. That is also by private insurance, and that pairs with Medigap.

There are standardized plans with Medicare: A, B, all the way to N, and they’re all standardized, so if you have a Plan G with one company, like Blue Cross, it’s going to be the same as a Plan G with a company like Aetna, so it actually makes the comparison very easy. Again, Medigap pays after Medicare, so you have to find a facility that takes Medicare, and you’re good to go.

Here is a chart that we show that talks about the benefits of Medigap. Plan G and Plan N are the way to go when it comes to Medigap. If you have clients with any other plan, that should raise a red flag to at least look at their options.

Medigap Plans A-N										
Medicare Supplement Insurance Plans	A	B	C	D	F ¹	G	K ²	L ²	M	N
Basic Benefits*	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part B Coinsurance	✓	✓	✓	✓	✓	✓	50%	75%	✓	Copay ³
Skilled Nursing			✓	✓	✓	✓	50%	75%	✓	✓
Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Part B Deductible			✓		✓					
Part B Excess					100%	100%				
Foreign Travel Emergency			✓	✓	✓	✓			✓	✓
Preventive Care Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Pros of Medigap plans

The biggest one is the freedom to choose doctors. There's no network. Many times, people ask, "Do you take Blue Cross? Do you take United Healthcare?" With Medigap, it's as simple as saying, "Do you take Medicare?"

You can go anywhere you want. You can go to the Mayo Clinic if you wish to receive specialty treatment. If you're going to go to MD Anderson for your specific cancer, you can travel from Michigan down to Texas and get the care you need with no questions asked. So, that's a huge one, especially for people who have a lot more saved in retirement and want to travel or just want the best care possible. Who doesn't want the best care possible?

Also, going back to the best care, you get the best coverage. Your costs are going to be the lowest with Medigap as far as your out-of-pocket expenses go when you go to the doctor. You usually only spend up to \$185 per year when you have medical procedures, and this makes budgeting easier. I always say Medigap is like leasing a car. You pay a little more upfront, but you know what's coming as far as payments and as far as maintenance.

Medigap has guaranteed renewable contracts. As long as you pay your premium, you keep the plan. If you don't want your doctors changing in and out of network, or you don't want your benefits changing, you get a Medigap plan when you're 65. You keep paying the premium until you're 95, so that plan is not going to change for you. The price can go up, but the benefits are not going to change, so this is huge for people. The only way it can change is if your company goes out of business, which I've only seen happen once. It gives you security.

Medigap gives you more of an a la carte-style feel, and that means you can pick a drug plan that's perfect for you to go with the best Medigap plan, so it's not all a bundled package because your Medical needs might not fit your prescription needs. You may have many prescriptions and not go to the doctor a lot, or you may go to the doctor all the time, but you're only taking low-cost, generic medications.

So, this makes it able to customize. You can pick from 30 different plans out there, find the best plan for you every single year, and then you're good to go. It does not change your medical coverage in any way if you want to change your drug coverage.

Cons to Medigap Plans

The first one is probably the most straightforward, which is there are higher premiums. It's no secret that Medigap is typically a higher monthly premium than Medicare Advantage plans.

Higher Premiums

- It is no secret that Medigap typically costs more in monthly premium than most Medicare Advantage plans.

\$114.80 /mo	AARP Medicare Supplement Plans, Insured By Unitedhealthcare	🌐	📄	✕	➤
\$116.08 /mo	Mclaren Health Plan Inc	🌐	📄	✕	➤
\$119.45 /mo	Health Alliance Plan Of Michigan	🌐	📄	✕	➤
\$120.30 /mo	Humana Benefit Plan Of Illinois, Inc.	🌐	📄	✕	➤
\$127.30 /mo	Transamerica Premier Life Insurance Company	🌐	📄	✕	➤
\$130.06 /mo	Blue Cross Blue Shield Of Michigan Mutual Insurance Company	🌐	📄	✕	➤
\$131.00 /mo	Priority Health	🌐	📄	✕	➤

The higher premium comes with Medigap, where you can see here the baseline plan. These are rates in Michigan for a 65-year-old. You're looking at about \$115 minimum per month when it comes to Medigap, whereas Medicare Advantage can go all the way down to zero. You have probably seen the advertisements on TV – "Call us now to talk about a zero-premium plan." Those ads are talking about Medicare Advantage. Medigap premiums start in the hundreds of dollars, and it changes based on your location, your age, and your gender.

Another con to Medigap is that you must purchase separate drug coverage. You see it when people feel overwhelmed by everything that comes with Medicare. We tell them you have to go to Social Security, sign up for Part A, get Part B, then you need Medigap, then you need a drug plan, and then you need dental coverage. Sometimes, people want the one-size-fits-all package. It doesn't exist, but they think that's the package they're getting with Medicare Advantage, whereas with Medigap, they don't want to look at a new drug plan every year and have a different medical card for the pharmacy.

So, this is something that comes up. I always tell people, whether they're an advisor or client, that they shouldn't make healthcare decisions based on having an extra card in their wallet, but at least know that it can be a struggle for people.

There are also no additional benefits when it comes to Medigap. Generally, Medigap policies never cover long-term care. There is not going to be a policy that somehow combines Medigap coverage with long-term care.

Compared to Medicare Advantage plans, Medigap doesn't cover vision and dental. So, your routine vision and dental when you go to get your glasses, your eyes checked, your contacts, or if you go to get your teeth cleaned – that is not going to be covered by Medicare, and because Medicare does not cover it, it's not going to be covered by Medigap either.

The biggest reason people stray away from Medigap aside from just the price, is they're not going to get YMCA for free and can't get their teeth cleaning paid. Frequently, this comes as a shock to people, so they'll just say, "Well, this Plan Zero covers all of that, so I'm just going to go with it."

Medicare Advantage

Medicare Advantage plans are, without a doubt, the more heavily marketed plan, and there are a couple of reasons.

The government pays insurance companies to offer Medicare Advantage plans. The government doesn't want the risk on their books of having people on Original Medicare, so instead, they tell the insurance companies they'll give them a lump sum or monthly payment to offer Medicare Advantage plans, so they don't have to deal with the fluctuations of health and healthcare costs. Medicare Advantage plans love it because they know what's coming in and know what benefits they can provide for that price. It tends to be the more lucrative option when it comes to insurance companies and their revenue.

We have talked to COOs and CEOs of large insurance companies, and we've even had one say, "Medigap is better coverage, better for the client, but Medicare Advantage pays the bills."

So, what is Medicare Advantage (MA)? It's usually called "Part C." This is just a marketing thing. It's not a part of Medicare in any way. It just fits in with the A, B, C, and D, but really, what happens with Part C is that you are no longer enrolled in Original Medicare. Instead, your Advantage plan takes over your medical coverage and drug coverage. It wraps it all into one package.

MA plans are an all-in-one or bundled alternative to Original Medicare. They are offered by private insurance companies, and members must reside in the plan's service area. So, these plans are more of the HMO/PPO variety that most people are used to, and coverage will be where you live. For example, metro Detroit has specific plans where you can't go outside of metro Detroit. It's a smaller HMO plan. It gives you richer benefits for the sacrifice of the larger network, but know that again, it works similarly to under-65 health insurance, so it feels comfortable for people.

If you're coming from a Ford plan as an employee, and you have a deductible, copays, coinsurance, and you can go to see a physical therapist, and then you go to Medicare Advantage and have the same copay at the doctor, max out-of-pocket, and deductible, it's structured a lot like under-65 insurance. Again, it bundles everything into one, so they do include drug coverage, even at the zero-premium price, and then they offer the additional benefits beyond Original Medicare that we talked about, like dental, vision, hearing, and gym membership. Who knows what will be added next?

A quick story on that – I saw one yesterday doing training for next year, and the company is going to do a service called PAPA, where they send college students to elderly enrollees' homes, and they just cook for them, clean for them, and do whatever, so they're really doing everything at this point to try to differentiate their plans. I thought that was interesting – sending college kids to hang out with the elderly. We'll see how that goes.

Pros of Medicare Advantage Plans

There are lower premiums with Medicare Advantage plans. The average is \$30 per month. You can compare that to premiums in the hundreds for Medigap, but for many plans, most of the marketing is geared toward zero-premium plans. These do include prescription coverage, so you can pay zero per month and get drug coverage included. I've even seen some plans that have a much narrower network and scope, and they'll be a zero-premium plan that comes with drug coverage, and they give you a rebate toward Part B. You can even pay \$30-40 less for Part B in addition to having a no-cost plan to go with it.

So, the lower premium is by far the most significant enticement. Going back to the complexity and the simplicity, Medicare Advantage plans come with one card. I've talked to insurance agents who say, "Well, you've got to agree that it's better just to have one card in your wallet." It's a convenience thing, but don't make your healthcare choices based on one card, two cards, or three cards. Just know that it is something out there that people hear that is enticing.

Medicare Advantage also makes it easier for payments, so you don't have a bunch of payments coming from a drug company or a Medigap company. It is all wrapped into one.

The other big thing is the additional benefits. It's prevalent for dental, vision, hearing, and gym memberships to be covered with Medicare Advantage plans. Many people think, "Okay, I can go to the dentist, I can have crowns, fillings – Whatever it may be, I'm going to be covered if something happens to my teeth." That's really not the case. Routine dental and vision are covered, so you can typically get one or two cleanings, one or two x-rays, and maybe a filling for the year, and then, for vision, you usually get a free exam, and you might get \$100 toward glasses or contacts.

In Medicare and Medicare advertising, you might see “coverage” or “covered by this plan.” All “coverage” means is that it has some form of coverage. It doesn’t mean it’s completely covered. If you tell me something is covered, like dental, in my mind, I say, “Okay, great, it’s totally covered,” but really, it just means you’re giving me some form of coverage. So, you have to dive deep into these plans and understand what “coverage” means.

I’ve had other HMO plans where they have a limited, narrow network, and the sales rep is saying, “Well, you have nationwide coverage. It’s an HMO, but you can go anywhere.” And then, you look down at the asterisk, and it says, “If you go out of network, you pay 50 percent of the cost.” So you have coverage everywhere, but what kind of coverage is that? If you have a client that has to get the premier treatment at MD Anderson, 50 percent of a \$50,000 bill – it’s coverage, but it’s not good coverage.

There’s also limited discrimination for pre-existing conditions. You can be denied Medigap coverage based on having pre-existing conditions. With Medicare Advantage plans, you can simply switch every year, and you can do that without the potential of being denied as long as you don’t have end-stage renal disease (kidney failure).

Pre-existing conditions are the big thing for people if they already have a Medicare Advantage plan. If they have a lot of pre-existing conditions, it’s important every year to look at the new options out there and see which plan will fit best. You can have cancer and switch Medicare Advantage plans. You cannot switch to Medigap, but you can switch from one Medicare Advantage to another Medicare Advantage.

Cons of Medicare Advantage

The biggest con is limited networks. They are HMO/PPO-style plans. They are becoming a little bit broader, where some of the PPO plans will give you almost identical coverage outside of the network compared to inside the network, but there is cost-sharing involved. There is a difference between the actual out-of-pocket spending when it comes to Medicare Advantage plans versus Medigap.

Medicare Advantage Plans are yearly contracts with insurance companies, so consumers have to agree to see medical providers in their insurance plan in an approved network. Insurance companies offer that “At this reduced price, we will give you medical coverage and additional benefits. You have to agree to see our doctors.” It’s really that simple as to what Medicare Advantage plans are.

Medicare Advantage Plans leave you exposed to HMO plans. If you have to go out of network, it can be hard to coordinate as well for people who travel outside the service area. There are now some snowbird-specific plans, but just because you’re a snowbird doesn’t

mean you're only going from Michigan to Florida. You may take a trip elsewhere that is not part of a specific plan, so if you have somebody committed to traveling, that's a big reason to stray away from the Medicare Advantage side.

These are yearly contracts, so they're not guaranteed contracts like Medigap. It's not where you pay your premium, and you get to keep your plan forever. You have to go year to year with your decision, whereas with Medigap, you have the budgeting and planning picked out for decades instead of the year-to-year decision.

Another disadvantage is that physicians and hospitals can and do terminate agreements in the middle of the year. I've seen plenty of headlines in July or August that the so-and-so healthcare system is no longer taking so-and-so's Medicare Advantage plan. I saw one in Florida that no longer takes United Healthcare plan, and if you have that United Healthcare plan, you have to pick a new doctor for the rest of the year. You can't change your plan just because your doctor is no longer in-network, so that's a big thing about which people don't technically think.

Again, government funding is tied to Medicare Advantage plans. If Republicans are in office, it's usually funded more. If they're not, it's funded less, so you never know what's going to happen with year-to-year funding.

Medicare Advantage plans own the right to tell you where you can and cannot receive care (managed care). If your doctor says you have to have a procedure done at a specific clinic, your Medicare Advantage plan has every right to say, "How about you try this first?"

If it's a top-of-the-line procedure with an endoscope that's going to be minimally invasive, your Medicare Advantage plan can say, "Yes, that's great, but we want you to try this option first, where it's more exploratory, and we need actually to open you up." So, it's not always up to you as the consumer or end-user where you can or cannot seek care because your Medicare Advantage plan may not allow it.

We commonly find people who are on a Medicare Advantage plan and have been healthy for two years. Then, they need a knee replacement, and they get that knee replacement done with their Medicare Advantage plan, and they do not understand at the time that all of a sudden, they're going to start paying \$40 per session for physical therapy. That's problem No. 1 – they're not prepared for one month costing \$500 – but No. 2, the carrier can come back, and they often will and do cap how many treatments that person can have for physical therapy. So, with a knee replacement, they might give you seven sessions because that's managed care – they can tell you you're stopping at seven – whereas if you're back with Original Medicare and Medigap, you might have 22 sessions.

There are also higher out-of-pocket costs. With Medicare Advantage plans, instead of the \$185 deductible and cap, you're looking at up to \$6,700 as the max out-of-pocket with a Medicare Advantage plan, and this does not include prescriptions. Many people think prescriptions are covered in the \$6,700. You could have a bunch of procedures, rack up bills for \$6,700 for the year, and also have another \$5,000 in prescription costs.

The exposure to the high deductible of Medicare Advantage plans is huge for people. Usually, I will say most plans are about \$5,000. They don't go to the max – \$6,700 – but just know that is possible, and that's just for 2019. We don't know what it is for 2020 yet. It makes budgeting difficult, like getting a lower-cost car and hoping that nothing terrible happens.

There's less flexibility with coverage options, so again, you do get the bundled approach, where it has the drug coverage and the medical coverage built-in, but what people don't realize is that you can have the same doctor forever, but your medications are rarely ever going to stay the same for your whole retirement. If you have a medication that is no longer covered by your plan, you have to switch to a different Medicare Advantage plan.

When you do that, you also have to change your doctors and your network because again, it's a bundled approach that includes everything, so your medications could determine what plan is covered by your doctor, or your doctor could leave your plan, and you may want to follow your doctor, and then the new plan may not cover your prescriptions as well. So, again, you can't customize it. You have to find what's best for you, but you're not going to see the highly customizable option that you would with Medigap and separate coverage.

Comparing Medigap and Medicare Advantage

Here's the pricing for a Medigap plan, Plan G, and a Medicare Advantage plan using metro Detroit in Michigan as an example. It's a pretty good example of what is available nationwide.

Example for 65 Year old in Zip Code 48167

Procedure	Medigap (Plan G)	Medicare Advantage (PPO)
Monthly Premium	\$115/month	\$14/month
Deductible	\$185	\$80
Max out of pocket (MOOP)	\$185	\$6000/\$8100
PCP/Specialist Visit	\$0/\$0	\$20/\$50
Hospitalization (Inpatient)	\$0	\$260/day (days 1-6)
Hospitalization (Outpatient)	\$0	\$175
Emergency Care	\$0	\$80
Skilled Nursing (days 20-100)	\$0*	*\$160/day
Physical Therapy	\$0	\$40/visit
Dental Coverage	None	\$0 co-pay for 1 exam and 1 cleaning per year. 50% the cost of 1 bitewing x-ray
Vision Coverage	None	\$50/visit
Cost of Adding drug plan	Approx. \$20/month	\$0/month

You can see that Medigap is \$115 a month, and Medicare Advantage is \$14 a month. The big difference is the out-of-pocket spending with Medicare Advantage plans where the max out-of-pocket is \$6,000. If you have to go to physical therapy, it costs you \$40 every visit. There are a bunch of various copays, even if you're hospitalized. If you're hospitalized for six days, you're paying north of \$1,200 with Medicare Advantage, whereas Medigap covers everything once you meet the deductible of \$185.

Here is another chart that compares the differences between coverage of Medigap and Medicare Advantage plans.

	 Medicare supplement insurance plans	 Medicare Advantage plans
 Doctors and hospitals	You can select your doctors and hospitals as long as they accept Medicare patients.	You may be required to use doctors and hospitals in the plan network.
 Referrals	You can see specialists without referrals.	You may need referrals and may be required to use network specialists.
 Network	No network restrictions. Coverage goes with you across the United States.	You may have network restrictions. Emergency care is covered for travel within the United States and sometimes abroad.
 Enrolling	You can apply to buy a Medicare supplement insurance plan any time after you turn 65 and join Medicare Part B.	Generally, there are specific periods during the year when you can enroll or switch to another Medicare Advantage plan.
 Costs	You pay a monthly plan premium in addition to your Part B premium. When you use services, your out-of-pocket costs are limited.	Generally, you pay a low or \$0 monthly plan premium in addition to your Part B premium. When you use services, you pay co-pays, co-insurance and deductibles.
 Prescription drug coverage	Prescription drug coverage is not included. Consider also purchasing a Medicare Part D plan.	Prescription drug coverage is included with most plans.

Everyone's health can and will change. I always tell people to buy the plan that's going to fit them for 20 years, not what's going to fit them for two. We had a person earlier this year who was in perfect health, wanted Medicare Advantage, felt good about it, and wanted the extra benefits. After we talked to her, she realized that she would like to go with Medigap after all. Two months later, she had a heart attack and had other issues where she could have never been able to get a Medigap plan if she had gone with a Medicare Advantage plan from the start. So, things can and do change. You have to plan for the long term, not the short, just the same as with financial planning.

Remember, the government is funding the carrier to the tune of \$1,000 a month per person. The carrier wants to turn around and sell it to a bunch of people, thus the push with Silver Sneakers, the dental coverage, and all the related perks.

Healthy people want to buy a Medicare Advantage plan because it looks fantastic. For Medicare Advantage plans, be aware that agent compensation is double what we are paid for signing somebody up with the Medigap contract. So, in our state, if someone enrolls in a Medicare Advantage plan, we get \$482 from the carrier. If we put them with a Medigap policy from the same carrier, we get \$240 as our agent commission.

If it's good for the government to put people into Medicare Advantage, it's good for the carrier to get them to Medicare Advantage, and it's good for the agent to get them to Medicare Advantage, it typically is not good for the consumers. It's critical to understand that if you follow the money trail, you can understand better why it's portrayed the way it is and why many people walk away with Medicare Advantage.

Key Takeaways

The biggest key takeaway is to make an educated choice from the beginning. Again, this is also from Medicare.gov. Please read this and understand it for your clients, or have your clients read it. When you first start Part B of Medicare, whether you're 65 or when you retire, you have six months to take any product with no health questions. After that, you are not guaranteed to get a Medigap plan without health questions for the rest of the time you're on Medicare.

Make an EDUCATED Choice in the Beginning

The best time to buy a Medigap policy is during your Medigap Open Enrollment Period. This period lasts for 6 months and begins on the first day of the month in which you're both 65 or older and enrolled in Medicare Part B. Some states have additional Open Enrollment Periods including those for people under 65. During this period, an insurance company can't use medical underwriting. This means the insurance company can't do any of these because of your health conditions:

- Refuse to sell you any Medigap policy it offers;
- Charge you more for a Medigap policy than they charge someone with no health issues;
- Require you to wait for coverage to begin.

Source: Medicare.gov "choosing a Medigap

If you have cancer and you're being treated actively, and you start your Part B, you can get any plan without any questions asked. It's going to cover you entirely, you're going to have most of your out-of-pocket expenses covered, and you won't have to worry about those bills.

Now, on the flip side, if you get a Medicare Advantage plan because you are healthy and you don't really care about the out-of-pocket expenses, in two years, if something happens then, and you want a Medigap plan, you simply cannot get one. Many people don't realize this. They say, "I thought Obamacare did away with pre-existing conditions." It did, but not for Medicare, so you can and will be denied Medigap plans if you have certain pre-existing conditions, which can be as extreme as Alzheimer's or even as mild as mini-strokes or diabetes. If you take insulin, that can stop you from getting coverage from a lot of Medigap plans with different insurance companies.

All this is why we talk to people at 64½, so they know at least that pre-existing conditions are a vital consideration when it comes to choosing a Medicare plan when they turn 65 or when they start Part B. Consumers out there just aren't getting this information. How would you like to be the consumer coming back four years later after a cancer diagnosis, realizing that you never saw this from your agent four years ago? This is why we do this.

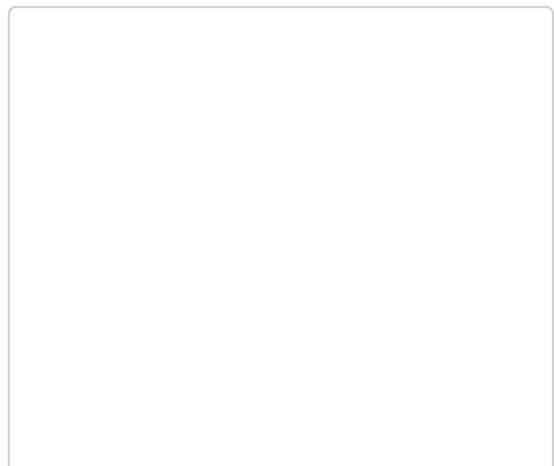
When you're talking about which is right for your clients – Medicare Advantage or Medigap – it is something that none of us can tell you or that even the client can tell you based on their needs. Medigap does provide very comprehensive coverage; there's no doubt about it, but it's just not going to fit everybody. Some people have a higher risk tolerance, whether it comes to financial investing or Medicare. People might want a lower payment, and they might want to take the chance with out-of-pocket spending, or they're fine having limited networks.

Bring up IRMAA. Please talk to your clients about how their modified adjusted gross income impacts their cost on Medicare. If your client does have a higher net worth and they're stuck with a higher IRMAA surcharge, know that it is appealable. If you retire and you have a life event that lowers your modified adjusted gross income, you can appeal your IRMAA surcharge, and many times, it is successful.

Find a broker that specializes in Medicare. Medicare agents and Medicare brokers have to go through rigorous training and testing to make sure they're certified to sell Medicare products. It's not just a standard health-licensed agent. You have to find somebody who knows what they're doing, understands the differences between the two products, and can talk to your clients, not only about the products, but also the penalties associated with Medicare and when and when not to sign up. It's not as simple as going to talk to somebody who can sell Medicare. So many people dabble in it; not many people focus on it. Very few agencies do only Medicare. It's just a gateway to talk about other products. A lot of Medicare agents out there get in the door with Medicare, and then move on to sell products that make other commissions.

About Joanne Giardini-Russell, Owner, Boomer Health Group

Joanne has been heard on WJR Radio, seen on WDIV's Live in the D, BenefitsPro Expo, PlanStronger TV and more. She routinely leads



Medicare classes for financial advisors, CPAs and the public. Joanne Giardini-Russell is a Medicare Guru and owner of Boomer Health Group, an independent provider of Medicare products nationally. Boomer currently has seven agents that work in Medicare-land each and every day.

Having spent years in the financial services and insurance industries, she recognized an enormous and unfilled niche. Namely, the lack of quality education and assistance in product selection in the extremely confusing space called Medicare.

In addition to holding client consultations daily, Joanne is often found teaching financial advisor firms, property and casualty agencies, group insurance providers and human resource professionals about the ins and outs of Medicare. She is also available for speaking engagements for organizations.

Joanne holds licenses in property, casualty, life and health in the State of Michigan. Additional health licenses are maintained in many states across the US. Joanne lives in Howell, MI with her five children and husband, Jeff.

About Cameron Giardini, Boomer Health Group

Cameron graduated from Central Michigan University with a biochemistry degree and the hopes of becoming a Doctor. After a long and grueling week of almost studying for the MCAT, he decided that ten more years of school and piles of insurance paperwork weren't for him.

So, naturally, instead of billing insurance, he decided to start selling it, right? This is when he entered the Medicare/senior market and quickly realized that so many people needed help and, more importantly, wanted help.

After several years in the industry he decided to join family members in launching Boomer Health Group. The company's mission is pretty simple: to educate consumers and stop the prevalent misinformation found throughout the market. It's maddening and avoidable.

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MEDICARE ADVANTAGE VS. MEDIGAP: WHAT PLAN IS RIGHT FOR YOU?

Joanne Russell-Giardini, Owner and
Cameron Giardini, Boomer Health Group

1 HR CE

Medicare Advantage vs. Medigap: Which plan is right for your clients? – Joanne Giardini-Russell and Cameron Giardini

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Heading Toward Social Security Reform

retirement-insight.com/heading-toward-social-security-reform

By Bruce D. Schobel, FSA, MAAA, CLU, CEBS, Consulting Actuary

Let's start with Social Security's financial status. There isn't any real news here. For more than 30 years, Social Security's Annual Trustees Reports have shown a very similar financial picture for the program. The funds have been building up over 36 years, and now they're going to be drawn down somewhat faster than that. They'll be exhausted around 2035.

The 2019 Trustees Report came out on April 22, 2019, and mostly looks just like the last 30 reports. Trust Fund assets are very near their peak of three trillion dollars. For Social Security, it's not so much because the program pays out almost a trillion dollars a year.

Starting in 2020, the Trust Fund assets will begin declining because the outgo will exceed the income. It is estimated that the Trust Fund will be exhausted in the year 2035; it could be 2034 or 2036, but it's around 15 years from now. That's really not so far away in the context of retirement planning.



[Bruce D. Schobel, FSA, MAAA, CLU, CEBS, Consulting Actuary](#)

Editor's note: This article is an adaptation of the live webinar delivered by Bruce Schobel in 2019. His comments have been edited for clarity and length. You can read the summary article here as part of the [3rd Qtr 2019 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 "[Heading Toward Social Security Reform](#)" for 1.0 hour continuing education (CE) credit.

What Happens When the Trust Fund Is Exhausted?

Do they get a turn out the lights and lock the door and walk away?

If there's no money in the Trust Fund to act as a contingency reserve, then the government will be unable to pay full benefits on time. The Social Security program will continue to operate and take in tax income that will be sufficient to cover only about 80% of the benefits to be paid. The 80% funding of benefits will decline gradually over time because the outgo will continue to grow faster than the income. A couple of years later, benefits will be 79% funded, then 78%, 77%, and so on.

Congress will need to either raise revenue or lower the outgo. There really aren't any other options. Something needs to be done before 2035 if they want to pay full benefits on time. It's cliché, but it's actually true in this case, that if they act sooner, they have a lot of options available that aren't available if they wait until the last second. For example, raising the normal retirement age, which was last done in 1983. It took effect in the year 2000, so there was a 17-year notice. They won't raise the normal retirement age for people who are about to retire the next day or the next year.

If Congress waits until 2034, the only options available will be raising taxes or changing benefits for people in payment status. These are not something that has ever been done before, with a minor exception of changes to college student benefits in 1981.

Historical Reform Efforts

The last major legislation affecting Social Security was the Social Security Amendments of 1983 Public Law 98-21, signed by President Reagan on April 20 of that year.

The Trust Funds were about to run out of money on July 1 of that year, so they passed this law with ten weeks to spare. That's sort of like driving right up to the edge of the cliff and not going over.

There aren't many examples of legislation that has worked for 36 years without a need for significant Amendment, but the Social Security Amendments of 1983 actually did that. That legislation produced a financial build-up and drawdown that we have been watching for 36 years, and we're now basically at the peak, so the build-up is over, and the drawdown is about to begin, which will take about 15 years.

In 2005, President Bush made Social Security reform his highest domestic priority after he was re-elected. He spent 2005 traveling the country talking about Social Security and how it needed some reform. The reform that he advocated was establishing individual accounts that would be invested in the private sector equities.

It didn't really gain any traction. Probably the worst moment for the proposal was in September 2005 when President Bush was asked by a reporter if diverting payroll tax money from the Social Security Trust Funds into individual accounts would make matters worse for Social Security. He admitted that that would make matters worse and that the bankruptcy year would actually occur sooner. At that point, a lot of the political support for the proposal disappeared. Then we had the Great Recession of 2007-2009, and individual account plans lost all momentum. There aren't many people anymore who want to divert payroll tax money into the equity markets because of the risk involved. People are more comfortable just getting a guaranteed check from the government. So that's kind of where we are now. Nothing really has happened since 2005.

There has been Social Security legislation, notably the Bipartisan Budget Act of 2015, which made a bunch of technical changes in Social Security involving the ability to claim spousal benefits. These things were very technical, and nobody would refer to them as reform legislation. They were much more minor than that.

Now over the years, many members of Congress have proposed ways to solve the problems. We have 535 members of Congress, and a lot of those members have introduced Bills over the years. All of them lacked broad support and went nowhere.

Recent Social Security Reform Efforts

All of that seems to have changed in the year 2019 because the Democrats retook control of the House of Representatives. They seemed to have a more activist position on reforming Social Security than the Republicans have had, at least since 2005.

On January 30, 2019, Representative John Larson, who is the new chair of the Social Security Subcommittee of House Ways and Means Committee, reintroduced his Social Security 2100 Bill, and it was designated HR 861. I say reintroduced because he has been working on this proposal since at least 2014, but nobody cared about it until 2019 when he became the chair of the Social Security subcommittee and could move the Bill forward. It's not all that different from the 2014 version or the 2015 version or the 2017 version, but now it may go somewhere.

This Bill has 211 co-sponsors at last count. If it receives 218 votes, then it passes the House of Representatives. If the House leadership wanted this Bill to pass, they could make it pass any time.

The Bill is designed to carry the program through to the year 2100 without any reductions in current or future benefits. That's a very bold and striking goal. According to the Social Security Administration's actuaries, this Bill does it.

I think we need to be a little bit humble as actuaries. It's sort of hard to say what will work for 81 years, but at least the current projections based on the current actuarial assumptions show that result. We could have changes in actuarial assumptions. We can have changes in actual experience. We could have recessions or depressions or wars, or all kinds of things could happen. That would affect the projections. But right now, it looks a little like this Bill could succeed.

Now the Bill has a bunch of technical provisions that aren't very important, such as it combines the two Social Security Trust Funds that exist now into a single Trust Fund. So instead of the Old-Age and Survivors Insurance Trust Fund and the Disability Insurance Trust Fund, there would be one Social Security Trust Fund. Most people don't care which Trust Fund is paying their benefit, but seven provisions are substantive and consequential.

Provision One: An across-the-board benefit increase

This provision has been described in the news media as a 2% benefit increase, but that's not very accurate. That's just news media shorthand. What the Bill does is it raises the first percentage in Social Security's weighted-benefit formula from 90% to 93%. It would increase the benefits for everybody, but not by 2% of their Social Security benefit.

The Primary Insurance Amount (PIA) is the basic building block of all Social Security benefits. It is used to calculate the worker's own benefit and any spousal benefits or children's benefits that are payable on that worker's earnings record.

Social Security has a weighted benefit formula where the first \$926 of average lifetime earnings, after indexing and a bunch of other complicated stuff, gets a 90% weighting toward the benefit received. If you have lifetime average earnings of only about \$10,000 a year, Social Security will pay you 90% of what you used to earn. That makes sense because you probably were not able to save very much if you had lifetime earnings of \$10,000 a year.

As your earnings rise, Social Security replaces less. For the next \$45,000 of lifetime average earnings, Social Security replaces 32%, and for earnings above about \$60,000 a year, they replace only fifteen percent. This is a weighted benefit formula. The Social Security 2100 Bill would take the 90% replacement that's currently hard-coded into the law for that first band of your average earnings and raise it to 93%.

If you exceed earnings of \$926 a month, the contribution of the first band will go from \$833 a month to \$866 for a \$28 a month increase in the PIA. That's about 2% of the average monthly benefit under Social Security, which is \$1,400 a month now.

Provision Two: Revised COLA calculation

Social Security's cost of living adjustments (COLA) are based on the Consumer Price Index for Urban Wage Earners and Clerical Workers or the CPI-W. The CPI that they talk about generally on the news media is the CPI-U, which is the CPI for all Urban Consumers. You might think that the CPI-U is more appropriate for calculating Social Security's cost of living adjustment, and you're probably right. At the time this was enacted into law back in 1973, there only was one CPI. That subsequently became the CPI-W, and that's how we got to where we are. The cost of living adjustment for Social Security beneficiaries/retirees is based on the CPI-W. This has bothered people for a long time to some degree.

There are a lot of CPI's out there. There's also a CPI-E for elderly consumers. The CPI-E is relatively new, and it's not used for any purposes under the law today, but the Social Security 2100 Bill would substitute the CPI-E as the appropriate CPI to use for calculating Social Security cost-of-living adjustments.

Substituting the CPI as the Social Security 2100 Bill would do is expected to increase COLAs by about two-tenths of one percent a year. It's not a dramatic change, but it's a little bit of an increase.

Provision Three: A special-minimum benefit increase

Here's a fairly obscure one: Social Security used to have a minimum benefit for everybody of a \$122 a month. That was repealed in 1981. There is no longer a minimum. Some people receive very tiny benefits such as \$10 or \$20 a month if they had very little connection to the paid labor force. These tiny benefits are very rare.

There's also a special minimum benefit that is also very old but was not repealed in 1981. This minimum benefit provides a benefit larger than the regular formula for people who have low earnings for a very long time and the special minimum benefit. This benefit applies to only about fifty thousand beneficiaries out of Social Security's 62 million beneficiaries. If you have 30 years of coverage you would be guaranteed a 125% of the federal poverty level. This is pretty expensive, but it doesn't apply to that many people.

Provision Four: Increase the thresholds for benefit taxation

Social Security benefits used to be tax-free until 1984. Starting in 1984, up to half of the benefit became subject to tax. If you had an income of a \$25,000 for single filers and \$32,000 for married couples filing jointly in 1984, that was a fairly high income for a retiree, but it's not so high anymore. Those numbers have been frozen since they were enacted into law in 1983 and first effective in 1984. Originally only about ten percent of beneficiaries had to pay tax on their benefits. It's now up to about 40% because many retirees earn more than those thresholds.

Now, here's something most people don't know. The revenue from the taxation of benefits is actually transferred by the Treasury into the Social Security and Medicare Trust Funds so that tax helps support the programs. The Social Security 2100 Bill would raise the thresholds to \$50,000 for single filers and a \$100,000 in income for married couples filing jointly.

The thresholds would again stay frozen like they are today but at a much higher level. This will reduce the number of beneficiaries subject to benefit taxation and the amount of income tax revenue transferred to the Trust Fund. This would have an indirect effect of raising benefits for people by not taxing them as much on their benefits. It would also lower the amount of tax revenue that Social Security would receive.

Provision Five: Impose payroll tax on high earnings

This is a new payroll tax that would be imposed on high earnings. Social Security has a maximum taxable amount every year. In 2019 the earnings limit is \$132,900, and in 2020, it is \$137,700. Earnings above that amount are not subject to Social Security tax; they are subject to the Medicare tax because the Medicare tax has no maximum.

So, if you make one hundred million dollars, you pay Medicare tax on that whole amount, but you don't pay Social Security taxes above \$132,900 in 2019. The 2100 Bill would introduce a so-called doughnut hole Social Security taxation. It would end at the current law maximum of \$137,700 for 2020, but it would start again at \$400,000 in earnings and continue to infinity, just like the Medicare tax. About four-tenths of 1% of workers earn over \$400,000 a year. The 400,000 would be frozen, so a larger percentage of workers would be affected every year.

Provision Six: Benefits on newly taxed earnings

If all of these earnings that are taxed, will those earners gain additional benefits? Yes – Social Security has always provided earnings-related benefits. That's a principle that is really important to many people. Some proposals over the years would have taxed additional earnings without providing any additional benefits, and many people were offended by that. Having benefits based on your lifetime taxable earnings is a valuable principle worth retaining, and it provides much public support for the program, so they didn't want to drop that.

However, this was done for the Medicare program. Medicare is an on/off switch; either you have it, or you don't have it. No one gets more Medicare than anyone else. Social Security, on the other hand, doesn't have a flat benefit. It's not an on/off switch. It has benefits that are based on your earnings.

So people who have low earnings get a smaller benefit than people who have higher earnings, and if you're going to start taxing earnings above \$400,000, then you might want to provide some additional benefit based on those earnings, and the Bill does. Social Security's weighted benefit formula has three bands where the lowest band receives 90 percent credit. The second band, which is the biggest one, gets 32% credit, and the highest band gets only 15%. The new super-high band for earnings over \$400,000 would get just a 2% credit. It's not a good deal for the highest-earning people, which is not a surprise. It raises lots of taxes, and it pays out only a little in benefits. It's also time-shifted because you get the taxes right away, and the additional benefits aren't paid for a long time.

Provision Seven: Higher payroll-tax rate

Also, the Social Security payroll tax has been 6.2% on employees and employers each since 1990. The Social Security payroll tax had gone up periodically since the program began in 1937. It started at 1% and then it went to 1.5%. It went up about 20 or 23 times over the

years until it hit 6.2% in 1990. Then it just sat there. It didn't move, and it's been there now for 30 years. The Social Security 2100 Bill would raise the payroll tax by .05 percentage points per year starting in 2020 and ending in 2043 when it would top out at 7.40%. It is the second most financially significant provision of this Bill. It is really important and would affect everyone.

Where is the Social Security 2100 Bill Going?

Unlike prior proposals, this Bill has a powerful subcommittee chair as its sponsor and has more than 200 co-sponsors.

It could certainly pass the House of Representatives whenever the leadership chooses to bring it to a vote. The Bill has no Republican co-sponsors at this time. No one knows what the president would do with the legislation. He hasn't said anything about it. He did say when he was campaigning in 2016 that he's the only Republican who would not cut Social Security. Who knows whether that's still his position, but this Bill would be consistent with that campaign promise because it doesn't cut anyone's benefits. It raises benefits. It also raises taxes, which the Republicans are generally less comfortable with, which is why it has no Republican co-sponsors.

What amendments might we see to this Bill? Well, the 1983 law, which I worked on, contained a nearly equal balance between tax increases and reductions in future benefits that were not in payment status yet. Nobody wants to cut the benefits of people who are receiving them currently, and instead cut benefits for people who aren't yet receiving them.

We might see further increases in the full retirement age, which went up under the 1983 legislation from age 65 gradually to age 67 over about 20 years. It still isn't even age 67 quite yet; it'll be age 67 for people born in 1960 and later and people born in 1960 are only 59 this year, so they're not eligible to receive benefits yet as retired workers, but that will be possible in the year 2022 when they turn 62.

The number 67 is not a magic number. It didn't come down from the mountain top on stone tablets. Congress raised the number from 65 to 67, and they could increase it further if they wanted to age 68 or 69. People start to get a little uncomfortable when you see a retirement age of 70, but there are many people who retire at age 70. It's not an unknown number.

As a retirement age, people are working longer and longer, and they're also living longer and longer, so it's not unreasonable to raise the retirement age further in Congress. They did it in 1983, and they survived. It isn't like they all got voted out of office.

Conclusion

We may be seeing the emerging outlines of future Social Security reform for the first time in a long time in the Social Security 2100 Bill. It is not going to sail through the legislative process, but a lot of it is likely to survive the House.

The Senate might pass something very different. When the house and the Senate go to conference to work out the differences between their Bills, who knows which side will come out on top.

This Bill has much support, and it does accomplish the mission of restoring the Social Security program to close Actuarial balance. Something has to be done between now and 2035, and this might be it, so this Bill is worth watching closely and what we might see enacted into law.

**About Bruce D. Schobel, FSA, MAAA, CLU, CEBS,
Consulting Actuary**

Bruce D. Schobel retired in 2012 as vice president and actuary of New York Life Insurance Company, which he joined in 1990. Before that, he was a principal of William M. Mercer, Inc., an actuarial consulting firm. During 1979-88, he was with the U.S. Social Security Administration in various actuarial and policy-development positions, including senior policy advisor to the Commissioner and staff actuary to the National Commission on Social Security Reform (the "Greenspan Commission").

A frequent speaker and writer on tax and Social Security issues, Mr. Schobel's papers and articles have appeared in *The Wall Street Journal*, *Policy Review*, *The Journal of International Taxation* and numerous actuarial publications.

A graduate of Massachusetts Institute of Technology, Mr. Schobel is a Fellow of the Society of Actuaries, a Member of the American Academy of Actuaries, a Chartered Life Underwriter, a Certified Employee Benefit Specialist and a Founding Member of the National Academy of Social Insurance. He was president of the Society of Actuaries during 2007-08 and has also served on the Boards of Directors of the American Academy of Actuaries and the Conference of Consulting Actuaries. For more than a decade, he chaired the Social Security Committee of the American Council of Life Insurers.

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Reverse Mortgage for Purchase: Helping Seniors Buy a Right-Size Home with the Right Tool

retirement-insight.com/reverse-mortgage-for-purchase-helping-seniors-buy-a-right-size-home-with-the-right-

By Allen Chao, Senior Account Executive at Longbridge Financial

The reverse mortgage program is a multi-faceted tool. As a lender is, we qualify your clients for the most amount of money that they can get. For a traditional reverse mortgage you can divide that money up such as a credit line that you can tap into down the road, you can take it out as a lump sum to pay off a mortgage or pay off credit card debt, or we can annuitize it almost into monthly income options.

There are common uses of home equity that we consistently see as a lender.

1. The most popular is to pay off the forward mortgage or to consolidate debt; around 50% to 60% of all reverse mortgages are used to pay off a traditional mortgage and refinance it over to us.
2. Take the funds out to remodel the home. For many clients, it makes sense for them to take the money out of their home equity and use it to remodel or renovate their homes.
3. Another option that is becoming more popular is to maintain a credit line that grows. When Wade Pfau published research on setting up the credit line as soon as possible and letting that grow over time, it sparked a lot of financial advisers to learn more about it.

This article will cover purchasing a brand-new home without any mortgage payments, which is probably one of the better uses of the reverse mortgage. Not many advisors or consumers know about it. There are a couple of reasons for that.

One of them is just that the realtor market doesn't know about the HECM (Home Equity Conversion Mortgage) for purchase product at all. Many still think about traditional mortgages or traditional financing. Many are already affiliated with lenders or mortgage



[Allen Chao, Senior Account Executive at Longbridge Financial](#)

Editor's note: This article is an adaptation of the live webinar delivered by Allen Chao in 2019. His comments have been edited for clarity and length.

You can read the summary article here as part of the [3rd Qtr 2019 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 "[Reverse Mortgage for Purchase: Helping Seniors Buy a Right-Size Home with the Right Tool](#)" for 1.0 hour continuing education (CE) credit.

brokers that they have worked within the past and don't have affiliate relationships with reverse mortgage companies. It can be a compelling way of allowing clients to right-size into their new home with no future mortgage payments.

What Changes Have Been Made in the Reverse Mortgage Market?

In 2010 it was very much of a wild west in the reverse mortgage world. The program has always been well-intentioned by the government to support American's retirement, such as Social Security for retirement income and Medicare for medical coverage. The reverse mortgage is the government's way of supplementing and tapping into additional assets for homeowners that they can borrow later on down the road for retirement.

The problem is that when the government first created the reverse mortgage back in 2010, there were minimal rules: if you were 62 and over and you lived in a home, you would qualify for the reverse mortgage. Unfortunately, this attracted a lot of bad actors from all sorts of spectrums. Homeowners, loan officers, and lenders abused the program. The government stepped in and implemented strong protections in 2013, 2015, and 2017. They also strengthened the underwriting process of the program.

What Is Different Today?

Now it's a **lower cost, lower risk tool** to provide additional access and control of financial resources

Past products	Today's product
High initial and ongoing costs with no flexibility	Capped initial costs, lower ongoing costs and fees, flexible options
No financial underwriting	Financial Assessment raises profile, limiting distressed clients
Spouses not on the title had no repayment protection at borrower's death	New protections allow eligible "non-borrowing" spouses to continue deferral and remain in the home
Full draw often taken at closing accumulated interest faster	First year draw limits slow depletion of equity

Past Prejudices and Misperceptions Remain Challenging

If you could imagine back in 2010, out of all mortgage products in the market, HECMs were the only ones that had no underwriting guidelines for any income and credit. Clients were applying for the program when they had a bankruptcy the day before, or they were in foreclosure. Those kinds of clients would be extremely high-risk for any mortgage product out. One of the legacy issues we have is that if you read stories about the reverse mortgage program about people being foreclosed, a lot of those clients were very, very high-risk and probably should not have been associated with a mortgage product at all. Unfortunately, back then, we had to allow all clients into the program, so it attracted many subprime households who probably shouldn't have been in the program.

In the past, the HECM had a high initial and ongoing cost with no flexibility. It was a fixed rate lump sum distribution where all the money was accessed right away. That led to an interesting behavioral issue. For many sub-prime borrowers, it was almost like winning the lottery. What do you read about lottery winners? They win a million dollars, and then two years later, they go broke.

The same sort of thing happened in the reverse mortgage world where many of these people were already sub-prime. They were very tight on their cash flow. They got the reverse mortgage for a very short-term band-aid, but they didn't have a sustainable plan in place. One of the most significant changes was in 2015 when the government implemented very common-sense guidelines to turn the program into a long-term sustainable tool. If you were to go through the underwriting process with me or any other reverse mortgage company, one of the key things you will hear is whether or not this reverse mortgage is sustainable for the client.

We do evaluate and implement income and credit guidelines that allow the borrower to demonstrate and prove that they have a long-term plan in place. In the past, we had no financial underwriting. For today's product, we do have a financial underwrite that assesses their income and credit. It just raises the overall credit profile of clients.

It's still a very lenient program. It's never been the intention of the government to make people not qualify. But it does remove the bottom 10% who probably need to find alternative forms of housing or assistance to get them through retirement. The reverse mortgage would only be a temporary band-aid.

Another past issue was that spouses that were not on the title of the home or the reverse mortgage and had no repayment protection, and this led to some very tragic circumstances. Sometimes this was self-imposed by the borrower where they voluntarily remove the younger spouse. With reverse mortgages, we use the ages of the borrowers to determine how much they qualify. Guess what happened? When the older spouse passed away, the younger spouse was not on the title and didn't have access to any of the funds in the reverse mortgage program. They were literally and metaphorically kicked out to the curbside.

In 2013 HUD made sweeping changes to the program to implement spousal protections across the board. We now have to include spouses in the computation of the program. The younger spouse can continue to live in the home over their lifetime as long as they keep up with the other terms like living in the house, payment of property taxes, and homeowner's insurance. HUD (Housing and Urban Development, a federal agency) also did a good thing by extending those protections to grandfather in all those who wrongly experienced these situations. We shouldn't see these legacy issues anymore when it comes to these particular situations.

Finally, the old HECM product required full draws of the loan at a fixed interest rate of around 5% so that they would amortize pretty quickly. With today's product, we more often recommend the variable rate, which allows more flexibility in taking the funds out. Many clients are offered the credit line option, which leaves all the funds in the credit line until the borrower taps into it.

One thing that we have seen with our analysis here at Longbridge Financial is that the more money clients take out at the time of closing, the more they accelerate their draws in the next two years. It turns out that if clients take out just \$10,000 right away, they tend to burn through all their cash within the next two to three years. A client who leaves their funds in the credit line tends to have those funds last for a longer period of time. The credit line option or even the monthly income option is a better sustainable way of thinking about the reverse mortgage, especially for middle-income Americans who are looking at it for a longer-term planning tool.

Reasons to Consider Using a HECM for Purchase

Many retirees in America are carrying a lot of debt into retirement. Some are still carrying student loan debt that they acquired either from their children or grandchildren. Mortgage debt is usually the most significant source of debt that clients carry into retirement. For those ages 60 to 64, about 38% carry a mortgage. For those ages 65 to 74, about a quarter are still paying off a mortgage. Part of this is due to the effect of the Great Recession in 2008 that led to much refinancing in 2010 and 2011 after the stock market crashed and pushed interest rates very low. Pretty much everybody at that time refinanced if they could to lock in the lower interest rate.

However, they restructured the mortgage to a new 30-year term, so for a lot of people they have a mortgage that may outlive their own life. That means they're sort of beholden to that mortgage payment for as long as they live. The reverse mortgage gives these clients the flexibility to make that payment or not make that payment. At the heart of the reverse mortgage, and this is probably the simplest way that I can explain the program, is that it is just like any other mortgage with flexible payments, meaning that if you refinanced your existing mortgage over to a reverse mortgage, you could continue to make normal mortgage payments if you chose to do so. In addition, you can still write off the mortgage interest deduction like any other mortgage.

However, if a client gets into a bind and needs to skip the payment, they can with no penalty and just catch it up the next month or not at all. Whereas with a traditional mortgage, if you miss that payment the mortgage company will start to impose penalties or start the foreclosure proceeding. The very structure of the reverse mortgage gives flexibility to borrowers and reduces the foreclosure risk to seniors by not having a required payment for the mortgage interest and the mortgage principal. Clients can take money out of the

reverse mortgage, pay the mortgage down, take money out, and again pay it down. Behaviorally, we have discovered that 90% of clients, when given a choice, don't want to make any payments at all. But some clients do make payments on the reverse mortgage either as interest-only or a fully amortizing payment to pay down the balance.

The interest rates on reverse mortgages are in line with the broader mortgage market. Also, academic research is showing the advantages of using a reverse mortgage in a responsible manner. Proper use can lead to more legacy wealth left over for the children, and it can substantially increase the success rate of clients getting through retirement. It is especially useful for clients in the middle America range that have less than one million dollars saved for retirement.

What is the HECM for Purchase program?

Within the world of reverse mortgages, the purchase program is probably one of the hidden secrets. I was able to pull 2017 data from the top eight or nine states from HUD, which is the last full year's worth of available data. About one of every 20 reverse mortgages are a HECM for Purchase.

Reasons to consider a HECM for Purchase for your clients include:

1. When clients want to right-size their house.
2. You also want to be looking at the HECM approaches when a client doesn't want to pay all cash for their new home. This will also help them preserve their portfolio.
3. If clients may not have long-term care or they may not have enough assets to buffer through what I like to call 'shocks' such as their car breaking down, to home renovations, to medical expenses. Every client should have a couple hundred thousand dollars (depending upon where they live) to help absorb those shocks over their lifetime.
4. The client's estate does not necessarily need to live in the home, especially once the parents pass away. When the reverse mortgage gets triggered by the parents moving out or passing away, the children will have to make a decision on the debt at that time.

When not to look at the HECM approaches:

1. Just like any other mortgage, there are closing costs, mortgage interest, and HUD mortgage insurance that will eat up some in the home a little or a lot depending on how long the clients live. It can also make moving difficult because the equity has been reduced by the reverse mortgage, so they may not have a lot of equity rollover into another home.
2. Children may not be able to live in the home once the parents die because the children will have to decide how to pay off the debt, and they may not be able to refinance at that time, or they may not be able to pay off the mortgage on their own.

3. There are also ongoing obligations by property taxes, homeowner's insurance, and home maintenance.
4. There are property restrictions on condos and coops. More specifically, for condos, it does need to be FHA approved.

How to use a HECM for Purchase to create a sustainable living situation

The HECM purchase allows clients to right-size into a home in a single financing transaction. In the past, clients financed their retirement home using a traditional financing tool, with 20% down and 80% financed. Then a couple of months later, they financed into a reverse mortgage, experiencing two sets of closing costs when they could have used the HECM purchase directly to buy into the home. It also makes home equity more accessible.

Using a HECM for Purchase to Right-size

Here's a classic example of a HECM for Purchase. The Millers want to move to Florida for warmer weather and purchase a condo. They currently own a home that is worth \$350,000, owe \$50,000 on a HELOC, and are looking for a condo in the same price range of what they have today.

Their financial adviser wants to investigate the HECM for Purchase Program on their behalf to see how it might fit in their portfolio. He likes how the Millers can reduce their state tax burden by moving down to Florida (which has no state income tax), and to unlock equity for future long-term care and other needs. The adviser is looking five, 10, 15 years down the road and trying to preserve as much money in a portfolio as possible.

Case Study 1: Condo in Florida

🏠 DELAWARE Home		🏠 FLORIDA Condo		4% interest \$0 origination
Home Sale	\$350,000	Purchase	\$350,000	
HELOC Payoff	(\$50,000)	HECM Proceeds	(\$196,700)	
Seller Costs	(\$24,500)	HUD Insurance	\$7,000	
Net Cash	\$275,500	Transaction Costs	\$8,700	
		Down Payment	\$169,000	

 **NEW HOME**
  **NO PAYMENTS**
  **ASSETS**

* Longbridge Financial pricing as of August 2019. For illustrative purposes only.

Let's say the Millers sell their home for \$350,000 and pay off the \$50,000 HELOC. Seller costs total \$24,500, so the Millers net \$275,500 from this transaction. This means they won't have enough to pay cash for their new home, but they will have the ability to put in a

good amount equity.

If they were to a HECM for Purchase, they could purchase their new home for \$350,000. They qualify for a reverse mortgage of around \$196,700. HUD insurance is 2% of the home value, or \$7,000, and there are transaction costs of \$8,700, so the total down payment needed from the Millers is \$169,000.

This allows them to net over \$106,000 that they can take out while buying a brand-new home in Florida. Also, they will not have any future mortgage payments.

Using a HECM for Purchase with a Silver Divorce

We are starting to see more silver divorces where couples divorce after decades of marriage.

For example, Marianne, aged 68, is recently divorced. She is starting over at the age of 65. She is looking to buy a brand-new home for \$480,000 close to her children.

Her divorce decree entitles her to half the value of the \$500,000 home. However, the ex-husband wants to keep that home so that she will receive her half in cash. Marianne's CFP knows that even though Marianne is entitled to another large distribution from the ex-husband's business, one of the problems is that the business's proceeds are illiquid, so she probably won't see those funds for many years. Marianne, unfortunately, doesn't have many savings under her name beside a modest \$80,000 cash account, so she is looking to stretch that cash as far she can.

Case Study 2: Silver Divorce

 PENNSYLVANIA Home		 NEW JERSEY Home	<div style="border: 1px solid green; padding: 2px; display: inline-block;">3.8% interest \$0 origination</div>
Home Sale	\$500,000	Purchase	\$480,000
Marianne's Share	(50%)	HECM Proceeds	(\$255,300)
Net Cash	\$250,000	HUD Insurance	\$9,600
		Transaction Costs	\$7,200
		Down Payment	\$241,500
 NEW HOME	 NO PAYMENTS	 ASSETS	

* Longbridge Financial pricing as of August 2019. For illustrative purposes only.

On the Pennsylvania home, she's entitled to 50% of the \$500,000 value so that she will receive \$250,000 right away from the divorce. She found a home in New Jersey she'd like to purchase. At a 3.8% interest rate with no origination, a HECM for Purchase will qualify her for \$255,300 loan, less closing costs of 2% for HUD insurance, and transaction costs such as title fees, notary fees, documentation fees, of about \$7,200.

This means that she needs to put down \$241,500 to buy the home in New Jersey using a HECM for Purchase, close to what she can get from the equity of her former home. She will have no payments on this new home in New Jersey, and she's able to preserve the \$80,000 of cash that she has for everything else needs.

Key Takeaways

When to use the HECM for Purchase:

1. Clients want to move into their forever home and have a sustainable living situation. The HECM for Purchase is truly designed for the forever home where clients don't have to worry about payments or the interest rate, and then when they pass away, the remaining home equity pays off the loan. To use the HECM for Purchase, at least one of the spouses needs to be 62, and they do need to meet very minimal income credit standards.

Most clients tend to be in their sixties and seventies. That's usually the sweet spot where they can access 50% of home's value as a loan and 50% for the down payment for their retirement home.

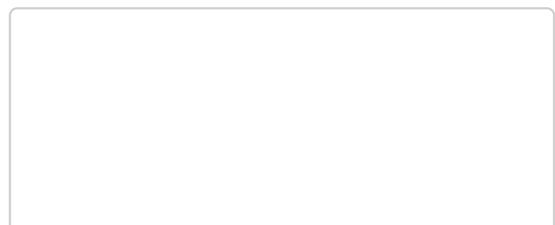
2. The HECM for Purchase helps preserve the retirement portfolio so it can stay invested where needed.

We do have a [website](#) available just for financial advisers. We have the best of class calculators that are free for financial advisers. There's no paywall for registration. One of them allows you to compute HECM proceeds, and it does incorporate jumbo reverse mortgages. The other one is a Monte Carlo simulation for financial modeling.

The reverse mortgage is a good long-term tool for middle America. These clients have less than one million dollars in assets, but they're looking for a little bit more to get them through retirement. These are smart clients, they are proactive, they've done a good job saving for retirement, but they also know through their forecast that they're not quite sure that everything that they have will get them through to the end. Americans are living longer than ever with good health and good medicine, so they need to plan for a minimum of 25 to 30 years through retirement. That's a long time to prepare for when you have so many uncertainties. The HECM for Purchase can help.

About Allen Chao, Senior Account Executive at Longbridge Financial

Allen Chao is a Senior Account Executive at Longbridge Financial with six years of reverse mortgage-specific experience in origination



activities, including management at a Top 3 reverse lender. He's presented at FPA, NAPFA, and Investment News on the reverse mortgage program and works directly with financial institutions and advisors to incorporate the tool into their offerings. He graduated as a Valedictorian B.B.A in Economics and B.B.A in Finance from Lamar University.

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REVERSE MORTGAGE FOR PURCHASE: HELPING SENIORS BUY A RIGHT-SIZE HOME WITH THE RIGHT TOOL

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Reverse Mortgage for Purchase: Helping Seniors Buy a Right-Size Home with the Right Tool – Allen Chao



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