HOW TO AVOID THE TOP 7 MEDICARE MISTAKES

I have been helping seniors with insurance and financial decisions since 2015. During that period, I talked with many, many seniors of all ages. I have spoken to those who are new to Medicare as well as those who have had Medicare for many years. I have seen, read, and heard from clients and colleagues about every Medicare Horror Tale you could imagine. All of the stories are heart-wrenching and for the most part, these sad endings could have been avoided quite easily. The truth is that far too many people make decisions based on what a friend or relative may have told them without bothering to see if the advice they received was accurate or not. That is the reason I have written this guide for those entering Medicare for the first time. I truly hope that the benefit of my experience and the knowledge I have accumulated over the years will be an asset to you.

Reality is frighteningly real. The first taste of reality for many folks when they turn 64 is the sheer volume of mail and propaganda you begin receiving in the mail every day is mind-blowing. The second thing most people learn is that Medicare is not FREE! We pay for Medicare and Social Security throughout our working career, but rarely do we know anything of substance about what we have to do or how many options we have when we turn 65.

MEDICARE MISTAKE #1 (ENROLLMENT INTO MEDICARE)

Don't assume you are automatically enrolled in Medicare when you turn 65. The honest fact is that if you have not received income or benefits from Social Security before turning 65 you must enroll. You can enroll through the Social Security office or online at www.ssa.gov. It is recommended that you Enroll in Medicare Part A three months before you turn 65. You will receive your Medicare Number and your Medicare Card. Then, when you are ready to enroll in Medicare Part B it is a much faster process.

More than 10,000 people are turning 65 every day in the United States. In some parts of the country, there are so many people turning 65 that there is a three-month waiting list for an appointment at the Social Security office. In addition, do not assume that just because you visited the Social Security office and completed the required paperwork your enrollment is "a done deal". I have seen many, many cases of people having to visit the Social Security office three or more times before their paperwork is processed and they show up in the Medicare system. If you assume that everything is OK and don't check up on your status, you may

find yourself without Medicare coverage. If the error is not discovered soon enough, you can go for as long as a full year without Medicare health insurance and have to pay a penalty to boot.

You can only enroll in Medicare through the Social Security Administration, Medicare is a Department of Health and Human Services, but they are not permitted to enroll individuals into Medicare.

If you are continuing to work and your Employer employs more than 20 people your Employer-sponsored healthcare is considered credible. If your employer has less than 20 employees. You will need to enroll in Part B at age 65 because your employer coverage is not considered credible. And COBRA is not considered Credible Coverage.

MEDICARE MISTAKE #2 (MISSING YOUR INITIAL ENROLLMENT WINDOW)

Your initial enrollment "right" to enroll in the Medicare Supplement plan of your choosing is predicated entirely on your Medicare Part B start date. You can get any Medicare Supplement plan you want and your acceptance into the Medicare Supplement plan is 100% guaranteed as long as you enroll within 6 months of your Medicare Part B Effective Date.

If you miss this, you can still apply for a Medicare Supplement plan any day of the year, however; your acceptance will no longer be guaranteed, and you will have to answer Medical questions and you will be subject to Medical Underwriting.

If you have both Medicare Part A & Medicare Part B but use your employer group health coverage, you may lose your enrollment right into a Medicare Supplement when you decide to switch away from group coverage unless you lose your employer health coverage involuntarily.

The bottom line is this, if you will be using creditable employer health coverage after age 65, delay enrolling in Medicare Part B until you decide to stop working and receiving employer health benefits. If you don't and are in poor health, you may find yourself with very few Medicare health insurance options that will cost you more over your lifetime and provide lower-quality care.

MEDICARE MISTAKE #3 (NOT CHOOSING A MEDICARE SUPPLEMENT PLAN)

When you start Medicare, the most important decision you make will be deciding between keeping your Medicare Part A and Part B and adding a supplement or replacing Medicare Part A and Part B with a Medicare Advantage plan. Here is what you need to know.

Medicare Advantage Prescription Drug Plans (MAPD plans) are the highest commission product in Medicare and are the right choice for less than one in three Medicare enrollees. An MAPD can pay the agent up to five times the income of a Medicare supplement. In many cases, when you meet with an insurance agent inevitably the first thing they do is pull out a MAPD plan and proceed to focus on the low or zero-dollar premium rather than compare the benefits to a Medicare supplement. If an agent presents you with a Medicare Advantage plan before first reviewing your Medicare supplement costs and options, then the odds are that the agent is concerned more with the commissions they will earn than with finding the right plan for your needs.

First research and compare the price and benefits of the various Medicare supplement (aka Medigap) plans before considering any MAPD plan. Medicare supplements enhance your insurance coverage over the basic Medicare Part A and Medicare Part B. They allow you to see any doctor or hospital in the country that accepts. Medicare. You maintain complete control over your choice of healthcare providers. Plus, you can lower your out-of-pocket expense for medical costs down to zero or just a couple hundred dollars per year. As long as a Medicare supplement can fit into your budget you will have greater insurance coverage and flexibility vs. a Medicare Advantage plan.

If you must choose a MAPD plan due to economic reasons and your ability to manage a monthly premium, try to avoid HMOs where possible. From my experience, MAPD plans, in general, are the greatest source of consumer dissatisfaction with Medicare. HMOs are the source of most dissatisfaction within MAPD plans. HMOs have a limited network, no insurance for care outside the network and you must get permission from your Primary Care Physician to seek the help of a Specialist.

A new study from the Employee Benefit Research Institute shows that a couple without employer-sponsored retiree coverage can expect to need anywhere from $194,000 to $635,000 to cover healthcare premiums and out-of-pocket costs during retirement.

To arrive at their figures, researchers developed a model that took into account numerous mortality and investment risk scenarios, different sources of healthcare coverage, and different healthcare needs.

Because they live longer, women can always expect to need more savings to cover their costs than men. So, for example, a typical 65-year-old woman with

average drug expenses during retirement might expect to need $108,000 for her Medicare and Medigap premiums and out-of-pocket expenses, whereas a similarly situated man would need $79,000. People with higher drug expenses? The same woman would need $217,000 if her drug costs were at the top of the range, while the man would need $156,000.

I have found that the best exercise is to estimate what your 20% share of your medical expenses is. Then compare that amount with what a Medicare Supplement Plan G or Plan N premium would be. I say this. Your only real out-of-pocket expenses with a Medicare Supplement will be your premium because your plan will pay you your 20% share of all Medicare-approved expenses. And remember that there are no deductibles and no MOOP expenses with a Medicare Supplement. And any year that you reach your MOOP with a MAPD or MA plan, you could have paid for 3-5 years' worth of Medicare Supplement premiums.

I have seen cases where had serious medical needs but were denied coverage or denied their request to see a specialist simply as a cost-saving measure for the HMO. So, the adage "Buyer Beware" definitely comes into play.

MEDICARE MISTAKE #4 (NOT CHOPPING PRICES ON YOUR MEDICARE SUPPLEMENT PLAN)

If you purchase a Medicare supplement (aka Medigap plan) when you are aged 65 to 67, you should re-shop your Medicare supplement plan when age 71 to 74, or whenever you have an annual price increase of 8% or more. This can save you thousands of dollars in insurance premiums over your retirement years.

All Medigap plans have benefits standardized by Medicare. That means that all Medigap Plan F's are the same, all Plan G's are the same, and so on. However, your monthly premium is not regulated at all. Different insurance companies charge vastly different prices for the same plan. The same insurance coverage. The difference in price between the best-priced Medigap plan of any category and the highest-priced Medigap plan is often 100% or more.

Each insurance company has a different pricing strategy. Often, the insurance company that tries hardest to compete for your business when you are aged 65 to 67 is not the most competitively priced company when you are in your young 70s. Because people new to Medicare do not undergo any medical underwriting, the company that competes for your "new to Medicare" business absorbs more people with ongoing health issues that have high medical expenses. That adds up over time and forces the insurance company to raise prices at a higher rate than those companies who avoided the age 65 to 67 market.

I have helped people lower their monthly premiums by thousands of dollars per year. The most I ever saved a person was $3,700+ per year. The person was 74 years of age and all I did was shop his plan. I found the same plan and within 30 minutes saved him more than $300 per month in insurance premiums. This was the same plan with the same benefits. Most people save between $500 and $1,200 per year.

MEDICARE MISTAKE #5 (NOT KNOWING WHAT AN ABN FORM IS)

As long as you have Medicare Part A and Part B and not a Medicare Advantage plan, a doctor or hospital cannot bill you directly or contact you regarding payment unless you have provided them with written permission to do so. Here is the scary part; that written permission is provided on a form called the ABN form (Advanced Beneficiary Notice). Many doctors and labs slip this form in with other paperwork. When you sign the form you can be given the health care provider the right to bill you if Medicare does not cover the procedure. You are often signing away with your Medicare rights.

Medicare strives to cover all that is medically necessary. However, your doctor can request preventive care tests in a time frame that Medicare does not consider medically necessary. (i.e. Preventive care blood tests that can be performed once every two years but your doctor requests you perform the test every year.) To make sure your doctor or the lab is paid, they slide in an ABN form for you to sign. Then, months later you get a bill for hundreds of dollars for a procedure you thought was covered by Medicare.

Avoid surprises and manage your preventive care by enrolling in your free My Medicare account at https://www.mymedicare.gov/. This is free and provided by Medicare so that you can manage your doctor and your healthcare.

MEDICARE MISTAKE #6 (NOT CALLING MEDICARE IF YOU EVER HAVE A PROBLEM)

If you ever have a dispute over healthcare coverage or premiums with an insurance company don't waste your time battling it out with the insurance company. Insurance companies have more ways of delaying decisions or manipulating the outcome than you can imagine, instead of fighting them alone, call Medicare.

Call **1-800-MEDICARE** (1-800-633-4227) and get them involved. Where possible, Medicare will act on your behalf as your advocate.

I have helped clients with disputes where insurance companies are insisting their case must go through internal arbitration or appeals. I usually get a call after the client has spent many hours arguing their case and is frustrated beyond words. When we call Medicare and get them involved, the insurance companies will often back down. In one instance, the day after getting Medicare involved, my client received not one but two telephone calls from the insurance company management apologizing to her for the "misunderstanding".

MEDICARE MISTAKE #7 IS NOT ESEARCHING YOUR MEDICATIONS BEFORE ENROLLING IN A PART D PRESCRIPTION DRUG PLAN & NOT RE-SHOPPING YOUR PLAN EVERY YEAR.

Part D Prescription Drug Plans is where most people make their costliest mistakes. Unlike Medicare supplement plans, every Part D plan is different. Every plan has different premiums, they charge different prices for the same prescription.

They have different deductibles and different copays. Most insurance companies have more than one plan, each with different pricing structures. Even more, these plans change every year. Just because your plan was the right one for you one year doesn't mean it will be right for you next year. It is your responsibility to shop your plan every year. Every year between October 15th and December 7th you have the opportunity to shop the next year's plans and decide if you wish to stay with the plan you have and its changes for the coming year.

Never take an agent or insurance broker's word for what is the best plan for you. Always go to Medicare.gov and shop for your plan using their internet program that considers your specific prescriptions.

Many people focus on the Part D plan monthly premium. Unless you have no or very few prescriptions, don't! Your biggest cost will be the price that the plan charges for your prescription, not the monthly premium. There may also be a plan deductible that you must pay before your Part D insurance kicks in. Shop plans by their total annual cost for all prescriptions, not just the premium.

Make sure you understand what the Preferred Pharmacies are with your particular plan. Each insurance company has a list of Preferred and Non-Preferred pharmacies. And even though you can have a prescription filled anywhere the

cost differences are mind-blowing between Preferred and Non-Preferred pharmacies.

If you have no prescriptions and are considering not enrolling in Medicare Part D right away, please reconsider. You are taking a huge risk that can cost you hundreds of thousands of dollars. It's not the penalty. It's the fact that once you miss your initial enrollment window you will not be able to enroll in a Part D plan except during specific times of the year. There are many conditions, including cancer, that have an average prescription cost of $10,000 or more per month without insurance. I have seen it happen; a gentleman was diagnosed with cancer in June. His doctor advised as part of his treatment a prescription drug that cost $12,000 per month. Because he was healthy before this event he decided not to get Part D coverage. Now he has to pay for his medication out-of-pocket or go without.