Peter (00:00:00):

And then part D is Prescription Drug coverage. The one thing that's not listed as one of those parts is Medicare Supplement plans are Supplements to what original Medicare part A and B doesn't cover. The part A portion of the policy, as long as you put in 40 quarters of employment in your lifetime, or the equivalent of 10 years where you're paying your Medicare taxes or Social Security tax, then there won't be any cost to you when you turn 65 for part A coverage.

Peter (00:00:34):

Part B, is going to be based on the income in the household during the two previous years. Like in this case, if somebody is going to enroll in part B now because they turned 65, then they look back to 2017 and look at the household income at that point to see how much the cost for part B will be. But just offhand, I believe it's $170,000 of a joint income. Currently, there would be a charge for part B of $135.50 per month for that one member to have part B coverage.

Peter (00:01:12):

Part C, the Advantage plans. Those plans are funded by the government primarily because what happens is that you have to have the part B coverage in order to get a Medicare Advantage plan, so you can't avoid paying that even if you take an Advantage plan, you still have to pay part B, which is doctor services, which like I said if it's under 170,000 joined, will be 135.50 a month, which is subject to change each year and it's not going to be going down. So it certainly goes up, but it tends to be a small percentage each year. And-

Jonathan Harrington (00:01:53):

So Peter, you mentioned the part B premium and that's a good segue into the cost. So even if you take a Medicare Advantage plan and we'll talk more about the specifics of those plans later, you still have to pay the part B premium?

Peter (00:02:09):

Yes you do.

Jonathan Harrington (00:02:10):

Okay.

Peter (00:02:10):

Yup. And the part D which is the Prescription Drug plan that is not subject to age or neither is an Advantage plan as far as the premium goes, it's strictly based on the benefits that you're looking for, which the plans are subject to change each year. With the Medicare plan, you got a Supplements to Medicare, those plans don't change year to year, you'll be grandfathered in once you accept the plan and stay with it. So you know that five years from now, or even 10 years from now, you'll know what your cost is going to be out of pocket, because the benefits don't change on those plans where the subject change year to year on an Advantage plan.

Peter (00:02:53):

And the one other thing I just wanted to note. With an Advantage plan, the reason why a lot of the plans are zero cost to the consumer is because the government is paying the insurance companies around

$850 per month to take care of all of your insurance claims. So anything that's paid up by an Advantage plan while you have that is entirely on the private insurance company because everything has been shifted responsibility-wise from the government to the private insurance carrier, because of the amount that they're paying the carrier.

Peter (00:03:26):

And primarily when you see an increase in premiums with the Advantage plans, yes, you can buy a plan with a slightly reduced out of pocket instead of a maximum of 6,700, maybe it'll be $5,400. But there's not a lot of change in benefits. It's really primarily better drug coverage is why you might be paying more from one plan to another. Or maybe a network in HMO versus a PPO.

Jonathan Harrington (00:03:51):

Okay. So as far as the other costs are concerned, there's with the basic Medicare part A and part B, for part A there's no premium, is that correct?

Peter (00:04:04):

Well, there's no premium as long as you put in the 40 quarters. And let's say that we have one person in the household that put in the 40 quarters and the other person in the household will stay at home working not actually submitting their wages to Social Security, our FICA, they would still be entitled to the same as their spouse once they turned 65 and not have to pay for part A coverage.

Jonathan Harrington (00:04:30):

Okay. So it's like Social Security, if your spouse isn't working.

Peter (00:04:35):

Yup. Yes.

Jonathan Harrington (00:04:35):

You get part of your... Okay.

Peter (00:04:35):

Correct. Where you get what 50%?

Jonathan Harrington (00:04:38):

50% of your spouse's benefits.

Peter (00:04:40):

Yes.

Jonathan Harrington (00:04:41):

Great. But there is deductibles for anyone that is using part A coverage.

Peter (00:04:49):

Currently the hospital deductible is $1,364 on part A. So the only time that would be really addressed is if you chose a Supplement Plan. The Supplement plans most offered all cover that deductible or any out of pocket at all on part A coverage. So there would be no out of pocket on part A with certain limits, for instance, a skilled nursing care. If someone is regulated to a nursing home like my father had Alzheimer's and dementia and he's not going to come out and he didn't. Then in that type of situation, there are caps. The cap is a hundred days of coverage between Medicare and for instance, a plan G on a Supplements where it becomes private pay after that. In which case, if you're concerned about assets, then you'd have to take steps because of the five year look back period with Medicaid, either through some sort of perhaps a revocable trust or shifting assets, but that's something left best to an estate attorney.

Jonathan Harrington (00:05:55):

Sure, okay. And most people are going to select Advantage or a Supplemental plan. No one would just say, "I'm not going to get either of those two things."

Peter (00:06:08):

It's very rare where I'd see somebody who would elect to do nothing. Very, very rare. And primarily if somebody makes that choice, it's really because they don't understand the benefits of Medicare and they never took time to research what their out of pocket could be. And then by the time they have medical bills, of course, at that point it can be too late.

Jonathan Harrington (00:06:29):

They didn't read all the flyers that they got in the mail.

Peter (00:06:31):

Yeah, unfortunately. Those are really complicated and I feel so bad for anyone I meet in the office about these things, because they're presented in such a confusing manner and my goal is to make it simple. I just want my clients to know when they leave the office, what their expectations are as far as what's coming out of pocket to them. It's not necessarily important, what's being covered here, what's being covered there. What's really important is what's it going to cost them at the end of the year for any of the services that they want or expect. And that's where we set proper expectations because it's functions much like typical medical insurance. For instance, it's not covering cosmetic surgery, although we probably we all like in our later years, Medicare is not going to cover that.

Jonathan Harrington (00:07:17):

Yeah. That's a shame.

Peter (00:07:19):

Or bunions either, but that's another story.

Jonathan Harrington (00:07:22):

Really?

Peter (00:07:22):

No.

Jonathan Harrington (00:07:25):

So we talked about part B with the deductible there and the monthly premium, which could change depending on your income. What is part D? What is the donut hole? That graphic up on the slide. How do you explain that? Because you hear that in the media, but I don't really understand what it is.

Peter (00:07:47):

Well, to try to keep the program, initially what the government did was they would set up these plans where initially you would have perhaps a deductible if you chose a plan that had a deductible, and then after that you would have copayment benefits, which did not go on forever. So initially what they do is they put in a donut hole gap, I believe, that when it first started in 2006, once you reach the full cost of the medication at $2,800 between the plan and what you're paying out, then the plan reached a point where there would be no coverage at all up until an additional limit was reached, which I think back then was $2,200. And then after that, you went into catastrophic coverage where you would pay 5% of the cost of the drug.

Peter (00:08:42):

Now, of course there were many people that were unhappy with this gap, what they call the donut hole and so there were ongoing efforts to improve the benefit. For instance, one of the first improvements was that generic drugs would be covered while you were still with a copay, while you're still in the donut hole. Of course, generics are lower cost to begin with. So the brand still was a big issue when you reached that donut hole. So then later on, what they developed was a percentage where it was 10% off a brand drug, 25% off a brand drug, then 50% off a brand drug, where now, I've been looking at some plans for some folks, and I've actually seen some plans that when they're entering the donut hole, now these are not super expensive medications, but the cost potentially even being less than the donut hole, than in their first part of coverage after they've met their deductible.

Peter (00:09:37):

But in essence, you can still expect to pay more while you're in that gap or donut hole of coverage. Then once you get out of that gap or donut hole, then again, it's 5% of the cost. I think it's $5 or 5% of the cost of the drug, whichever is greater, after the gap has been met. So they're slowly closing the donut hole.

Jonathan Harrington (00:09:59):

It sounds like it.

Peter (00:10:00):

Yes.

Jonathan Harrington (00:10:01):

Becoming less of a hole.

Peter (00:10:02):

It's become less of an issue, although consumed, it's happening slowly. But yes, I've surprised a few clients during this open enrollment saying that it actually is going to, in some cases, draw for some of these clients in the gap coverage simply because the negotiated discount and the gap coverage that the

government has on some of these drugs is less than the copay that they had initially on their plan for a drug that could be expensive.

Jonathan Harrington (00:10:30):

That's interesting. And do any of the Prescription Drug plans cover the entire donut hole?

Peter (00:10:38):

No, they can't. There was the government regulation of how these plans are structured and the government sets the rules, the insurance companies submit the plans for approval by CMS which is the Medicaid services who runs these plans, the health plans for the government. And they have to approve the plans. So they are structured by the government and then the players have to abide by the rules, just like the Supplement Plans or the Advantage plans for that matter.

Jonathan Harrington (00:11:12):

All right. So let's talk about our topic today, Medicare open enrollment. So the way I understand it is Medicare open enrollment is a two month period currently, October 15th to December 7th every year, when people who are on Medicare have the option of switching their plans. And like I have on the slide here, it's only Medicare Advantage and Prescription Drug coverage, it's not the Supplemental plans.

Peter (00:11:42):

Correct.

Jonathan Harrington (00:11:42):

Is that correct?

Peter (00:11:43):

Yes.

Jonathan Harrington (00:11:44):

Okay.

Peter (00:11:45):

Yeah. So the Advantage plans, we have an open enrollment period each year where you can either go on to a plan, switch plans or drop coverage altogether. The part D standalone drug plans. Again, the same thing there, you can add, switch or drop. Medicare Supplement plans or Medigap plans, as they're also referred to. Those plans are not subject to an open enrollment, those plans can be possibly switched any time from one Supplements to another type of plan, either for saving money or gaining benefit most any time of the year. However, the caveat is that there is an open enrollment for the Supplement plans, which is seven months when you're turning 65. It's three months prior to your birth month, it's your birth month, and then it's three months after your birth month.

Jonathan Harrington (00:12:40):

So that would be that initial enrollment period-

Peter (00:12:42):

Yes.

Jonathan Harrington (00:12:43):

...on the slide there. Okay.

Peter (00:12:45):

Yes, which also works for the Advantage plans as well. The initial enrollment period or IEP, since we like these acronyms. And after that open enrollment period then the insurance companies as far as the Supplements go, those plans are medically underwritten. So if you either went to an Advantage plans, and then you wanted to go back to a Supplement at some point, or you're in a Supplement, and you want to change plans after open enrollment period, it would be medically underwritten and you could be denied coverage. This has nothing to do with Obamacare. This is after age 65, not prior to age 65.

Peter (00:13:24):

There is one carrier out of all the carriers that are offering Supplements in New Hampshire that currently is not doing any medical underwriting. So if I have a client who comes to me and they want to switch, the rate is competitive. It's not the best rate, but it is competitive. And it's a well known carrier, we'll try to place them with the lead carrier first, as far as stability and rates are and if they can't make it due to a medical situation or medications they're taking, which is indicative of being treated for a medical situation, then we can always place them with this one carrier who currently is not doing medical underwriting.

Peter (00:14:05):

However, one thing that's important to know is that New Hampshire is an age in state. So the age you start one of these Supplements at, is the age they're going to hold you at for renewal for as long as you stay with the plan. So our goal in our office is to find a client, a large stable carrier who does not make big rate changes year to year buying market share, by lowering their rates and then increasing the rates the next. We're looking for a stable market for our clients, so they don't have to switch plans, so they keep a renewal at age 65 instead of getting a new business rate for every year they get older.

Peter (00:14:46):

So yes, we don't want to switch people around. They're better off staying and we would prefer that somebody take a look at their option for the health plan when they turn 65 as a forever plan, not one that they're jumping around on. Unfortunately, it's different with the Advantage plans. That's not to say that there's a problem with the Advantage plans. It's different in the sense that the Advantage plans are by nature plans that you would research or look at them from year to year because the benefits change and the premiums change as well as the networks possibly changing as well. So those are year to year. They are not based on age and once you're on that side of the field, the advantage part of the plans, if that's what you're in, then it's not based on age and it would be wise to look at your plans. Certainly you should have somebody look at those plans for you, one year to the next.

Peter (00:15:42):

And this also goes for the drug plans, the part D plans, those are not based on age, it's based strictly on medications. So the networks, the negotiated prices for pharmacies, negotiated prices for the

pharmaceutical companies, the benefit managers, all play a role in what the plans are going to cost year to year. So those we do look to offer advice with our clients from year to year, to see if they're in the best plan for them on Prescription Drug side.

Jonathan Harrington (00:16:12):

Given what you just said, how would you switch from a Medicare Advantage Plan to a Medigap plan? How would that work?

Peter (00:16:20):

Yeah, they'd have to notify the carrier during open enrollment that they're dropping, and they'd have to re-enroll with Medicare which is just notifying Social Security that you're switching back to a Medicare coverage plan with a Supplements. So they know that they're not mailing a check to the carrier anymore. And then just enroll for a Supplement plan. Right now it's easy in the sense that we try to give a client the best option, but if that's not available, we fall in the second best because there are no medical questions. So at this time we can still switch somebody. Absolutely no problem.

Peter (00:17:00):

But this carrier has also indicated that they're going to start to medical underwrite in the future, we don't know if it's next June or next year or the year after. We don't know when, but they realize they're losing money because they're taking anyone at any time for any reason, while the other insurance companies, their competition, is not. And so eventually that will catch up with them from an underwriting standpoint where it's adverse selection, meaning that they're adversely getting a higher risk compared to their competition, which is going to impact their rates.

Peter (00:17:34):

So that's why they've realized that they have to close that door and then in which case they truly will be forever plans that you won't be able to switch around. I just had somebody who notified me today that they'd like to switch plans and go from Advantage plan now at their age 75, back to a Supplement where they were at three years ago. And the problem that we ran into was the spouse was just diagnosed with Parkinson's a year ago and that makes an automatic decline with any of the insurance companies on Supplement side, which they want to enroll into, except that one carrier still has an open door policy.

Peter (00:18:14):

So I can place them but once that door closes, then they would have to stay in Advantage plan. And if they have medical issues, then they could be subject to the maximum out of pocket each year, which could be $5,400 or $6,700, whatever the plans are calling for. So that obviously can get expensive.

Jonathan Harrington (00:18:33):

Can you do the medical underwriting while you're still on an Advantage plan? So you know that once you drop it, you have...

Peter (00:18:42):

Oh, yeah. We can request an effective date, which would be in line with when they're going to drop like January 1st.

Jonathan Harrington (00:18:48):

Like January 1st. Okay.

Peter (00:18:48):

Yeah, so that's not a problem.

Jonathan Harrington (00:18:50):

Gotcha.

Peter (00:18:51):

So they would know well in advance what their options are.

Jonathan Harrington (00:18:56):

All right. So we talked general open enrollment is during this period here, and these are all the different things that you can do, and I think you've pretty much covered all of these already. How do you work with clients? I mean, you must be rather busy this time of year. Are all these decisions made during these two months for all your clients? Do you have every client that is working with the Advantage or Supplement or Prescription Drug plan coming to see you during these two months?

Peter (00:19:34):

Well, we actually start making appointments with our clients. We start in June. So we start talking about some of these things, what their concerns are, what they're happy about their plans or possibly what they don't like about their plans. So we can talk about what our goal would be when open enrollment was getting near. We can't enroll anybody before open enrollment obviously, we can only do it once the door opens, but for instance, with ACA, which is under 65 plans, which there are certainly plenty of people out there that still need that, open enrollment is November 1st to December 15th. But we can do window shopping right now. We have a software where we can go in and we can compare plans for 2020 and networks even though we can't enroll somebody yet.

Peter (00:20:22):

So it's nice to have a preview of what's happening so we can discuss this with our clients that have concerns if they want access to a famous Boston hospital, and they don't have that now. We can talk about that now and the cost. Because open enrollment is such a short time period, we have to be somewhat innovative and when we're discussion and what we're discussing with our clients in order to try to take care of everybody that would like to review their plans.

Peter (00:20:54):

Again, if somebody is in a Supplement, we do not encourage them to move. The idea is a forever plan to stay there because moving around plans is going to cost them just more money because they come to me at age 75. Now it's their age locking in is 75 and the renewals are based on age 75 versus I'm staying at 65. Because once somebody is in a plan for five years or possibly even three years, we can't even move them to another carrier because every carrier's rates going to be higher than what the renewal rates are going to be, which is the good thing. That's the whole point of locking in age is keeping their rates lower.

Peter (00:21:33):

I had a client who we started on a plan F, which was the Cadillac plan, gosh, 15 years ago. And their rate for plan F, a hundred percent plan. So if you had that plan and whether you had a $5,000 bill, a $50,000 bill, or a $500,000 bill, from a medical standpoint, what was covered under Medicare, you had no out of pocket on that plan at all, which is why it was referred to as the Cadillac plan. Well, that plan had started off from that person 15 years ago, 136 a month. And now his premiums are up to 188.

Peter (00:22:06):

At this time, this was three years ago, he's now 77 years old and he wants to see while it's been creeping up on me, can we take a look and see what other carriers can offer for a plan F and I already know, since I'm looking at this every day, but the least expensive plan at age 75 for a plan F, three years ago, was $239 a month. And some of the carriers went as high as $400 a month. So when I gave him the rates going through the carriers, he was like, "Wow, I guess I should stick with what I have. I have something really good here, 188."

Peter (00:22:40):

And that's the advantage of staying with the plan over the long term. And of course, when you're going through retirement years, those fixed costs especially on healthcare are really, really, really important because it can get tremendously expensive if you have a plan, that's more open-ended on cost. So that's why we encourage to stick with a plan once you're in it, if you're in an Advantage Plan, then you've got to take a look at it year to year really to be in your best interest.

Jonathan Harrington (00:23:09):

Can you just talk in more detail about how that works getting into a plan at your age 65 pricing versus if you try to change it later on. Why is there that difference?

Peter (00:23:24):

Well, because New Hampshire passed a law that in our state we're entry age, and there are a lot of other states in the country that are also entry age, it behooves you to stay in a plan and they try to make it more attractive for you to stay in the plan by holding you at a renewal rate. And the fact is that with an insurance company, the higher their retention is, the less expensive it is to keep a client. So they can offer a lower rate on renewal than a new business rate, because the retention is better for somebody that stays with them. It's less expensive than the constantly rewrite new people. So it's reflected in their premium payments as long as they stay with them.

Jonathan Harrington (00:24:07):

So you're being rewarded for [crosstalk 00:24:09].

Peter (00:24:09):

So our consumers are rewarded for being loyal to a carrier, which is why we look for a carrier that has a great reputation, that has a large customer base because the law of large numbers. Sharing the cost will help control those premiums. We've had some carriers that have come into the state and we would call it buying business, where they would offer a lower rate than what we consider the top tier companies. And we would consider these companies really secondary tier. They're not really well known for being in

the market. And they would come in with a drop dead rate that was lower than everybody, perhaps by, five or 10%. And it was not sustainable, we knew that.

Peter (00:24:54):

They would come into the state and then all of a sudden the next year or a second year, their rates would jump up 15% or 20% and then we'd have somebody that would be very unhappy. And then they be quiet for a few years, they'd be dormant and then they would come back again. Then they would drop a bomb like that with the lowest rates. And then we shy away from them because what happens if we can't move that client because their health has changed?

Jonathan Harrington (00:25:20):

Right.

Peter (00:25:21):

And we see that all the time. So, we can't risk that with someone or if somebody wants... It just so happens that the top carriers last year, the year before, and this coming 2020 have the best rates for 2020 anyways. So that's great. But three years ago I guess, we had a carrier that was buying business, we switched some clients over to see how it would go and we were like, we heard in the wind that there was a possibility that they were buying business because they had a relatively good name overall as far as historically in the marketplace. But we were somewhat cautious because where I've said, they've done this before, they've bought business before, and we don't know if they're buying again or if they're truly dedicated.

Peter (00:26:15):

And then we found that they weren't dedicated in that, they were buying business. And I was fortunate enough to be able to move all these people to these other carriers that are more stable but I can't risk that anymore because I don't want somebody to get in a situation and they're locked in with a carrier because of a change in their health history.

Peter (00:26:38):

So the only ones that I've ever tried with those carriers were people that wanted the rock bottom rate, they were okay with the name of the carrier and we certainly were too, that was not the issue and they had exceptionally good health at that time. Actuarial studies show that really good health potentially can last over a large group of a cross-section of a number of insurers that typically last for about three years. So we were able to move some of those clients, but we really want to stay away from carriers that are just buying business and it's best for the consumer that way. And their rate will be extremely competitive anyways.

Jonathan Harrington (00:27:24):

Are there limits on what an insurer can raise the rates?

Peter (00:27:29):

No, they just have to prove it when they make their filings that the losses that they've had, that they have to justify the rate increase. The rate increase can be denied, but as long as it's justifiable, then they can ask for the rate increase and probably be granted.

Jonathan Harrington (00:27:51):

Even though they were trying to [crosstalk 00:27:55].

Peter (00:27:55):

If a low rate comes into the market, typically the insurance department is not going to say no. They want the consumer to have the best options. But if they come back and say, "Well, geez, we had these losses, we really have to increase at this percentage." Then, if they can prove it, then it'll be approved.

Jonathan Harrington (00:28:15):

Okay. What is the Medicare Advantage open enrollment second period of January through March? How does that work?

Peter (00:28:27):

The secondary period, which is January 1st, the initial open enrollment period is December, I'm sorry, October 7th through December 7th. And then the second period, which is January 1st through March 31st, that allows people to change their plan from the plan that they were in or didn't change during the initial open enrollment period. They're still allowed to change but at that time you can only switch to a Medicare Advantage plan that has five stars. There are some plans that don't have that rating. So you can't just switch to just any plan. It's only a highly rated plan.

Jonathan Harrington (00:29:03):

That's it. Why do you think they have it set up that way?

Peter (00:29:07):

One is that, they try to find ways to encourage the companies that offer Advantage plans incentive. The rating system is derived from consumers. So a consumer can go in on these websites, these comparative sites from the government, and they can rate the carrier for instance, as far as customer service, billing options, networks, and so on, and letting a carrier participate during the secondary enrollment period, where they can pick up more big business is going to be a reward and they're not going to reward a company that has a lower star rating. So they want to give that reward only to a carrier that has the highest star ratings.

Peter (00:29:51):

Now, if there are three carriers that have five star ratings, then great, they have three carriers to choose from. In the past year, 2019 in New Hampshire we had just one carrier that was offering plans during that January through March 31st enrollment period.

Jonathan Harrington (00:30:06):

That doesn't say a lot about the quality of plans in New Hampshire.

Peter (00:30:11):

Well, it's difficult to maintain that higher rating. The problem with the carrier that was being offered in that period primarily was in New Hampshire. They're serving several states, but in New Hampshire their

network was very small. So there was not a lot of activity for them in New Hampshire at least during that period.

Jonathan Harrington (00:30:31):

Okay, thank you. We've talked before about the notion that when people are looking for Medicare, either Advantage or Medigap plans, they should focus on predictability, simplicity and cost. Would you agree with that?

Peter (00:30:54):

Yes. It's easy when you're younger and things are clear and easier to understand when you're younger and you want to take a chance, meaning that the chance is simple. You can either save money by going with an Advantage plan because you don't anticipate, or you don't in fact have a lot of out of pocket expenses or you take the risk that you're going to self-insure and have a potential of five, six, $7,000 out of pocket on your expenses. And that's an easier choice until you get older because what I find is that I'm meeting with people that are entering their 70s now or in their mid 70s, and they don't want to be in these plans anymore because they've been burnt on their out of pocket cost because it doesn't take much to run up a hospital bill.

Peter (00:31:54):

One is, the out of pocket cost become unpredictable and costly. The other one, which is huge for most clients actually is the network. Because with an Advantage plan, you're going to have a narrow network plan. You might have, for instance, in just New Hampshire, just whatever state you're in. And then have limited access to some of the best hospitals in the world at a higher out of pocket cost, perhaps 10,000 whereas with, for instance, the Supplement, there is no network.

Peter (00:32:30):

So Supplements are easy to understand where you don't have to check to see if your doctor is in the network. Any hospital in the country that is a public hospital, has to accept Medicare, that's it. And the Supplements, that means your Supplement plan is good in any hospital that is a public hospital. Private, if you're in the Mayo Clinic and they choose not to accept Medicare patients at all, you can't go there, but the other Mayo Clinics that are around the country still do. There's plenty of access to some of the world's greatest hospitals with Medicare that's not an issue.

Peter (00:33:06):

And with Medicare because there is no network, there are also no referrals, which is huge. So from the standpoint of simplicity, the Medigap plans, so the Medicare Supplements are easy to understand network wise. It's not a matter of if my doctor is in the network, it's really, I can go see anybody I want, as long as they take Medicare. It doesn't even have to mean that they take Medicare assignment, as long as they take a Medicare patient at all. And the difference between taking Medicare assignment and not is that, with Medicare if they take assignment, that means they accept all billing with Medicare as a final cost. They won't balance bill you. And if somebody does not take Medicare assignment, which you'll see with some specialists out there like heart surgeons, or I just saw one last week, which was a dermatologist, all that means is they're allowed by law to charge an extra 15% above Medicare's reimbursement rate.

Peter (00:34:09):

And what happens when they do that is that Medicare will not cover that extra 15%. But if you're in the right Supplement plan, that's called an excess charge. It'll cover that for you. So whether you'd see a doctor that takes Medicare assignment or doesn't, it makes no difference to you if you're in the right plan, because that plan will cover that portion of the bill for you. So you don't have to be concerned whether or not they accept Medicare.

Peter (00:34:34):

So the predictability is that you have a network with millions of doctors and hospitals, no referrals because there is no network and I shouldn't have said network of a million doctors in hospitals. You can just see anyone in the country virtually that'll see you and your plan, if you have the right one will pay all the out of pocket costs that aren't covered by Medicare if they do not take Medicare assignment, because your plan, if you chose the right one, will cover those excess charges. So in predictability of the network, there is not a predictable network with the Advantage plans. The networks will change year to year. Your doctor can drop out midway through the year. They're not beholding to stay in until the end of the year.

Peter (00:35:23):

And the smaller network just means you may not have access to the best care possible. And an example I can give is that my mother had Parkinson's disease. We went to a local hospital, their neurological specialist treated 200 different conditions and felt after dealing with my mother for two years, that she probably had Parkinson's, they were not certain. So we chose at that point to go to Mass General in Boston. And when we went down there, I was shocked to find that they had eight doctors who specialized in Parkinson's. Nevermind a doctor that specialized in 200 different neurological conditions. They had her diagnosed in 45 minutes because of their experience and treated her appropriately. And we used their followup care for the rest of her life and certainly their recommendations.

Peter (00:36:18):

At the time, because they're also a teaching hospital. They had a program going on where they were testing a new medication that they were hoping would slow down the onset of the Parkinson's disease and the progression. And of course in that situation, they have people that are taking this medication. But then you also have people that are taking medication that is not part of the treatment program that the medication that they're taking would have no effect on them whatsoever. But we didn't want to risk that with my mother. It was for two years, either she takes something that will not have any effect on her at all, or could possibly differ the advancement of the Parkinson's and we wanted the treatment now that would increase the quality of her lifestyle instead of taking the risk of not. But at least the options are there with a teaching hospital.

Jonathan Harrington (00:37:20):

Right.

Peter (00:37:20):

Versus being with a local hospital, that's much smaller and doesn't have a specialty like that.

Jonathan Harrington (00:37:25):

So were all the Advantage plans, HMO plans?

Peter (00:37:29):

No. Some were PPOs, but again, the network on the PPO side are limited networks.

Jonathan Harrington (00:37:34):

It's limited networks.

Peter (00:37:35):

They're not national networks.

Jonathan Harrington (00:37:37):

So there's no Advantage plans that offer the broader network?

Peter (00:37:42):

No, not that broad. Some will cover New England, some might have a two tiered where it's going to be more expensive to access some hospitals within that network. But for instance, if I have somebody that's going to Florida and they're snowbirds, no doubt the best plan by far, the only one they should consider is a Supplements, because if they're going to be spending three or six months here, and six months down there, since they have a Supplement with a Prescription Drug plan, there's absolutely no concern on their point about whether they can get treatment down in Florida regardless of where they are. They can get treatment, it will fall under their plan benefits, period. Where the Advantage plan that can be an issue or even a big issue.

Jonathan Harrington (00:38:31):

So somebody that is a snowbird and they're traveling to Florida, Arizona, wherever, when they're down there, what if they have a medical condition and they're in a Medicare Advantage plan that's covering the Massachusetts [crosstalk 00:38:45].

Peter (00:38:45):

Well, if it's an emergency, then they'll get coverage in the event of emergency. But if it's an illness, that's not an emergency, then they wouldn't have coverage outside of the network.

Jonathan Harrington (00:38:54):

So that has to either come back or-

Peter (00:38:57):

Right.

Jonathan Harrington (00:38:57):

...pay for it out of pocket or in the out of network rate?

Peter (00:39:00):

Yes. Or if they have like a PPO plan that'll cover being out of network, but then it could be subject to a much higher out of pocket like $10,000.

Jonathan Harrington (00:39:12):

Okay.

Peter (00:39:13):

Yeah, so I can only suggest at that point. And what's really nice about these Supplements, we talked about the age in and locking in the rate is that your Supplement is portable, the Advantage plans aren't. So I had somebody call me the other day, they're moving to Maryland and they were asking, "Do I have to change my plan?" Because they have a Supplements moving out of Maryland. No, absolutely not. They can keep their plan at the age in rate that they started at 65. And now they're 72 moving down to Maryland in a senior community and keep the locked in age and keep the full benefit, in which case they have plan F and that's grandfather, even though we can't offer it now to enrollees, but that's the other great thing about Supplements is that as far as the plan that you get, those plans are always grandfathered.

Peter (00:40:05):

We used to offer plan J before F and J was the Cadillac plan before F and I still have clients that are still on J from many, many, many years ago. But yeah, the Medigap plans are portable. If you move from one part of the country to another part of the country, then you have to change your Medicare Advantage plan. You would notify the plan at that point, they would notify you with the address change you submitted that they'll give you 60 days to move to another Advantage plan in your area. So again, make sure you have the proper network.

Jonathan Harrington (00:40:41):

But you couldn't do that every time you go down to Florida?

Peter (00:40:46):

No, it's going to be a permanent address change.

Jonathan Harrington (00:40:50):

Okay.

Peter (00:40:51):

Wherever you're declaring residency. But if you declare residency in Arizona and you have Supplement plan, that plan goes with you, there's no issue.

Jonathan Harrington (00:40:59):

Right. So the Supplements. I think you were moving on to the next slide there. I think you've pretty much covered a lot of what's here about the Supplemental plans. One thing to talk about is all the letters. Now you mentioned that F is no longer available and C is no longer available for new enrollees. There's eight different options for people to choose from. How do you wade through those different options with people, or do you just focus on one of the different plans or letters?

Peter (00:41:36):

Well, you're going to find that if you were to actually see all the offerings from different carriers, no carrier offers all the plans because some plans are not even purchased and some are purchased in such few numbers that it's not worth the while the carrier. The major plans for 2019 have been F, G and N. Those have been sold more than any other plan. And F cannot be offered anymore. So there will be for new enrollees after January 1st, there'll be plan G. There eventually we'll start seeing a high deductible plan G and then plan N are going to be the most popular plans.

Peter (00:42:23):

The point of view that I take with a client is that when they purchase insurance, if it's not protecting you financially, and if it's not protecting society morally, then you don't have the right kind of insurance and that goes for any kind of insurance. So in the event that when you and I look at plans, G is the number one plan now, that's the Cadillac plan. It's because the only thing it doesn't cover in care is just the deductible for Medicare part B, which for this year is currently $185. After that you have a hundred percent coverage across the board on medical bills.

Peter (00:43:04):

And then plan N is different than G in that there are three additional things that are out of pocket on plan N. Plan N used to be more popular before G came along three years ago. It's not as popular now and I'll tell you why, but the difference is plan N has the $185 deductible for doctor services on part B of Medicare, just like G does. Plan N has up to $20 copay for office visit, up to $50 copay for emergency room, but that is waived if you're admitted and the big reason why we don't really recommend N now is because it does not cover excess charges.

Peter (00:43:51):

So if you see a doctor or a surgeon who does not take Medicare assignment, and you're in the hospital and you're going to have surgery, although the facility might be covered a hundred percent because it's a public facility. That surgeon comes in, doesn't take Medicare, and you have plan N, then they can charge you personally up to 15% more for their services, because plan N does not cover excess charges. And frankly, there are doctors out there that are looking to make more money and certainly education expenses has a lot to do with it. It's getting so incredibly expensive to become a surgeon now through school that their priorities is also paying their bills. So they certainly can't be faulted for trying to find another way and you'll find more and more, I believe, in the next several years, doctors who will opt out of taking Medicare as a Medicare assignment, so they can charge the extra 15% more.

Peter (00:44:54):

N is a good option. People say, "Well, I'll just make sure that whatever doctor's treating me is going to be taking Medicare assignments so they avoid that. And then when I mentioned that office visits were up to $20, it's because sometimes the negotiated rate with Medicare is actually less than 20 for an office visit. My mother-in-law had an office visit with her primary care doctor as a followup. And the bill was $13.63 she got billed.

Jonathan Harrington (00:45:26):

That's incredible.

Peter (00:45:26):

And then I have some clients that say that they don't get bills at all because perhaps the visit is so low that the office doesn't feel it's worth even billing out for it, they just take whatever Medicare pays on the visit above the copay that's allowed. But the biggest issue though with N is, you just have to keep in mind with N is that it doesn't cover excess charges. I still have some clients that elect it, but I would say at this time, probably 90 to 95% of my clients are electing G because they want the excess charges covered.

Jonathan Harrington (00:45:59):

So with that said, that 95% of your clients are electing G, can you give us a ballpark numbers for what those premiums would be for a new enrollee? If they're getting it at 65?

Peter (00:46:12):

Sure, I would say that for a male at 65, it's around $154. For a female, maybe around $124 for a female. There are also discounts for spousal if we have a husband and wife that are going in. So if we just do one or the other now and then a spouse gets to age 65 and chooses the same carrier even if it's a different plan, they'll still get the spousal discount, which can run as high as 7% on the premiums that they're paying.

Jonathan Harrington (00:46:47):

All right. Given what you just said and actually the numbers mirror what your estimate was. If you take the part G or plan G Supplemental plan, you're not paying for part A, your part B costs would be 135 a month under the current rates, plus the 185 deductible.

Peter (00:47:15):

Correct.

Jonathan Harrington (00:47:15):

So that would be 1811 a year. And then if your G premium is 150 a month, that's 1800 a year. And potentially if you blow through the Prescription Drug coverage or deductible, that's 415 plus maybe $20 a month for that premium. So you're out of pocket for the year were limited to 4,266, adding in those altogether, unless you have a significant prescription drug cost.

Peter (00:47:49):

Yup.

Jonathan Harrington (00:47:49):

Does that make sense?

Peter (00:47:50):

That is correct.

Jonathan Harrington (00:47:52):

So that's the predictability piece of it.

Peter (00:47:55):

Yeah. And if you wanted a true dental plan, there was one carrier that's the premier dental plan in the state, which is Northeast Delta Dental. They really just don't have competition here. You can get a true dental plan with different levels of coverage if you want. Other than what you get with a typical Advantage plan, you'll get typically just cleanings on an Advantage plan. You don't get anything else. And then if you've got a true dental plan, you'll get, the cleanings and x-rays too, but you'll also get extractions for teeth fillings, periodontal maintenance, crown lengthening, emergency treatment. And then you can also get an option to get better coverage for major restorative work which could be onlays, implants, crowns, root canal therapy, and those types of treatments, if you elect to pay more to get that benefit. So you can get a much better benefit with a separate dental plan than what they'll advertise on TV. They'll advertise on Advantage plan, dental benefits, but it's just cleanings.

Jonathan Harrington (00:49:04):

Okay. What about the vision coverage? Is that-

Peter (00:49:08):

And then the vision coverage typically on the Advantage plans is an eye exam and the dental plan through Northeast Delta Dental, that plan has a vision benefit, it's not designed to cover an eye exam, so that would be out of pocket. But it does have significant benefits typically up to 50% off the cost of glasses with their fixed pricing that they have through a company called EyeMed.

Jonathan Harrington (00:49:39):

Okay, cool. All right, so moving on to [crosstalk 00:49:47].

Peter (00:49:46):

And then just one quick thing, and I don't know if this is coming up, but if you wanted to compare that total potential out of cost with an Advantage plan, it's granted some of the premiums can be zero on an Advantage plan. You still have to pay for part A, which is at 135.50 per month currently.

Jonathan Harrington (00:50:06):

Part B.

Peter (00:50:07):

I'm sorry, part B, because A is already paid for, which is the 135.50 per month. But you'd also have the potential max out of pocket you'd have to consider, which currently I believe the max out of pocket is $6,700. So if you add those two together...

Jonathan Harrington (00:50:24):

You're looking at eight to 9000.

Peter (00:50:26):

You're looking at close to $9,000 potential out of pocket versus 4,200 potential out of pocket. So as we get older, knowing fixed costs become more and more important, especially since we're going to be more up to use services.

Jonathan Harrington (00:50:41):

So you have one serious medical event with an Advantage plan you're getting.

Peter (00:50:45):

Well, and that's why I have people pushing over now, they're in their 70s, even in their late 60s, back to a Supplement if they're on an Advantage plan is because they've experienced the max out of pocket and they realize that moving in the future, that they'd be better off with knowing a fixed cost because they have principally fixed income benefits. And they'd rather deal with it that way then the potential of saving money, but also the potential of spending twice as much than if they had a Supplement for drug plan.

Jonathan Harrington (00:51:19):

Okay. So, Advantage plans, I think you've covered most of the talking points here. Can we just briefly talk about the Advantage. If you're a consumer, you have an Advantage plan in 2019, should you assume that that Advantage plan is going to look the same in 2020 as it did in 2019?

Peter (00:51:48):

Absolutely not. It could be, and it may not. The deductibles could change, the premium could change just like the Prescription Drug plans do every year. Out of pocket spending limits will change or could change, copays could change, providers can change. Yeah. So all the benefits in the plan are subject to change for the next year. There's nothing guaranteed that it won't change. And certainly the premiums are subject to change as well. And of course, just like the part D Prescription Drug plans, the drug benefits can also change.

Peter (00:52:25):

With an Advantage plan, you can get a better quality drug plan when they're offering a higher premium on a plan. Like there's one company out there, which is called the carrier plus choice plan and they have different levels of coverage. Right now, I think it's four different Advantage plans for 2020 and the differences between the plans primarily, is the drug benefits and the out of pocket maximum. For instance, the lowest out of pocket maximum next year is $5,400, so highest is $6,700. So really the big difference between the plans is really going to be the drug benefit on the Advantage plans. You see some difference on the medical side, but you'll see a bigger difference on the drug benefit side.

Peter (00:53:18):

What's nice about the part D plans is that, for instance in our state New Hampshire, there's 26 plans that are available for the consumer to choose from and anyone can go onto medicare.gov and plug in their information and find out which plan is the least expensive, although you may want to consult with a broker because they should be able to show you very quickly and easily how to find the best pricing and explain how the program works. But you can certainly go in and as consumer and do that.

Peter (00:53:53):

And one of the things that we can do is tailor a plan based on your medication versus a buckshot plan on an Advantage plan where we can't really tailor a plan, we can give you the best that a carrier may offer and it may work great with your meds. Or possibly a D plan on its own would work better. We don't know unless we take a look at it but at least I know that I had somebody that I dealt with today and they

were taking three medications and through a couple of pharmacies, there was no out of pocket cost for them for the entire year, they were just paying for the plan each month, which was $16 a month. So that's subject to varying.

Peter (00:54:38):

One of the things I can do also, which is neat that I can do for a consumer is sometimes we find a medication that's not covered by Medicare, for whatever reason, it's not covered by Medicare. And with that plan, we have other ways of covering that through a discount plan, there's some really good discount plans out there that somebody maybe familiar with, then they're advertised on TV. And instead of going through the part D plan to try to cover it, instead, what we'll do is take a look and see if we're going to do better on the discount plan. And sometimes we find that there are medications that are better on the discount plan. So we just leave them off the list for the part D to get them a better plan.

Jonathan Harrington (00:55:17):

Okay. So with both of these, part D and Advantage plans the consumer has to really spend the time every year during this open enrollment period to review the plan and make sure that it matches what their expectations-

Peter (00:55:34):

Well, they should, the plan is going to change whether they look or not. And so I would strongly suggest they have somebody that's looking out for their best interest to review it for them each year. And they may or may not get hurt by that kind of thing. I had somebody who didn't look at their part D Prescription Drug coverage over a 10 year period. They thought they were all set. They were still working in real estate up to age 77, they were making money but they both had serious health issues and their drug costs were escalating. And when I sat down with them 10 years after the first time I sat down with them, we found that the current amount out of pocket they were paying was $7,700 for their medication on a part D plan. And after going through everything in their expensive medications, we found that we could put them on a plan for $3,400 total out of pocket for the same medications.

Peter (00:56:28):

Well, needless to say, one spouse says to the other spouse, "I wish we should have reviewed this sooner. I told you we should." And the of spouse said, "Well, I thought we were all set." Blah, blah. And it just goes to show you how it can get away from you, especially if you have cashflow in their case they did, but that was a big difference each month. We saved them over $4,000 by reviewing it.

Jonathan Harrington (00:56:48):

That's huge.

Peter (00:56:49):

Yeah. Very big, same meds.

Jonathan Harrington (00:56:57):

Do you have other tips with regard to medication and-

Peter (00:57:02):

Yup.

Jonathan Harrington (00:57:04):

I know we talked about generics.

Peter (00:57:06):

Sometimes we find that a client comes in and we're looking at a drug plan and they just started taking something for cholesterol and perhaps it's Crestor. And we find that that drug is two, three, $400. And so I'll ask them, why are they on that? Not questioning the doctor's decision. My goodness never do that but just asking if there was a reason and they don't know, they said, "Well, the doctor had it on hand and gave it to me."

Peter (00:57:33):

And then by using some websites that we have available to us, it tells us what common and popular alternatives there are to perhaps a brand name drug that can be had for that same patient for $10. And I said, can you please ask your doctor if there's any reason why you can't be on Atorvastatin versus Crestor. And she checks with the doctor and doctor says, "No, absolutely not. Atorvastatin is just fine for you." And it's $10. Well, that makes a big difference in a decision of what she's buying for a drug plan.

Jonathan Harrington (00:58:03):

And that's information that a consumer can find, or are you-

Peter (00:58:09):

It's available to a consumer but I check for all my clients to see if there's a better way to help them out in the selection of medications. Again, it's not questioning a doctor. Doctors are extremely busy. Oftentimes when they hand out samples, it's something that was given to them by a rep that stopped by, but it may not be the best option for the client because the doctors are not in tune with how much the patients are actually paying for a prescription. What they're in tune with is what's effective for a client. And sometimes the generic isn't effective for our client and it's best to be on a brand. But my job is to help educate consumer on the possibilities of what their options are. That's what my job is because nobody else is the advocate for the consumer on that side of costs than somebody who's offering to cover these things and help them find the best plan.

Jonathan Harrington (00:59:04):

Awesome. So what if people are working after 65, so they don't retire at 65, they have the option to go on Medicare part A and part B and buy Supplements or Advantage plans. What's your advice in that area? Should they do that? Or, what should they do?

Peter (00:59:28):

Well, they should look at their options, I mean. Sometimes employers will give an employee such an attractive option by how much they're paying for their plan that they want to stick on the work plan and that's fine. I've had people come to me for instance at age 72 and say, I'm finally going to stop working and getting my full benefit on the healthcare side. I've been paying, let's say nothing for my health insurance. My provider has been providing the full cost. By that deferral, if they look at a Supplement plan, how it cost them in terms of age, where now I might be looking at them at age 72, going into a

plan instead of 65 and then I've had clients say to me, "Well, then I should have done this when I was 65." Well, could be.

Peter (01:00:13):

Some people, if there's such a great portion of the benefit paid by the employer, maybe the amount of money that you saved because they were paying it more than offset the increase of paying in premium coming in later. By the same token, I've had plenty of people that come into a plan later and save money over what their plan costs them from the employer. They didn't realize it because they never looked into their options and now they're going to have to pay a higher rate in the Supplement anyways, because they didn't come in at a younger age.

Jonathan Harrington (01:00:47):

They don't have to do under [crosstalk 01:00:49].

Peter (01:00:49):

And the whole point of open enrollment is based on when you obtain part B of Medicare, it's not based on part A. Part A, you get automatically at 65 or when you're putting your-

Jonathan Harrington (01:01:00):

Social Security.

Peter (01:01:00):

...40 quarters under FICA. So if somebody comes in to be, I had somebody I talked to today, yes, I'm referring to a lot of things I've done lately because I talk to people constantly, all day long, forever it seems, about their options. And yeah, I have somebody that just came in and this person now is age 69 and they just started part B, September 1st. So they're in the window of open enrollment, which is three months before the month of their birth and three months after. So there's no medical underwriting, even if they're in perfect health, at least there's still no medical underwriting.

Peter (01:01:47):

But now he's of course paying a higher rate. But initially during the first five years frankly, with one of the carriers, the rates don't change all that much between 65 and 70, enter age rates, they only change by maybe a dollar or two a month. And maybe by the time they're 70 years old, if they come in at age 70, perhaps the rate coming in is maybe just $7 more per month or $8 more per month than what they would've done at age 65. But that's as of now in the future, that can change.

Jonathan Harrington (01:02:22):

Okay. And it's still maybe lower than what they're paying at work.

Peter (01:02:27):

Could be or else they could have something where it works. So I encourage anyone to check out their benefits at work and then sit down and compare and see what's in their best interest.

Jonathan Harrington (01:02:35):

Do they have also look to see if their Prescription Drug coverage at their work is considered creditable?

Peter (01:02:44):

Generally that's not an issue at all. If it is not credible coverage, then that is a major concern because for every month you do not have credible drug coverage. Once you turn 65, there is a penalty for not picking up a part D plan that is credible coverage and so if you haven't had a drug plan for two years, you can pay potentially up to 24% in penalties, meaning that whatever you pay for the drug plan itself on a premium basis, you'll have to pay the increase on that premium for the rest of your life. The government simply wants everybody to participate to help keep the pricing down for everyone. That's why the penalty exists.

Jonathan Harrington (01:03:29):

Okay. So people should verify, even though you said it's not an issue, people should verify whether or not.

Peter (01:03:36):

They should. And if a plan is not, the employer is supposed to send out a letter each year, indicating that the drug plan they have is not-

Jonathan Harrington (01:03:42):

Credible.

Peter (01:03:42):

...a credible coverage.

Jonathan Harrington (01:03:44):

Is there an exception for people that work for a company with fewer than 20 employees? Do they have to get on B once they turn 65?

Peter (01:03:55):

If you have fewer than 20 employees, when they turn 65 in a company, they can offer to their employers Medicomp coverage if they have a group plan and the Medicomp coverage, essentially instead of being over 65 health insurance plan is really, they take part A and B of Medicare and their plan through the group would be a Supplement, which typically includes drugs. There's no part D, the Medicomp plan includes drugs, which could be subject to a deductible.

Jonathan Harrington (01:04:29):

Okay. What about moving? I know you talked about this briefly before, but if you aren't in an Advantage plan or a Supplement or a Medigap plan and you move, how does that work?

Peter (01:04:45):

Well, with a Medicare Supplement or Medigap plan, they're portable. So you have no issue and whatever age you entered at is locked. And so if you have an F plan, which anybody, although we can't offer them to anybody new coming in at age 65 after January 1st, anybody has one, it is grandfather and

keep it. Portable anywhere in the country, but any of the Supplements are portable anywhere in the country if you choose to move.

Jonathan Harrington (01:05:15):

If you move, do you have a guaranteed issue, right? To go from an Advantage to a Supplement plan?

Peter (01:05:27):

Well, if it creates an open enrollment period, you can switch plans with Medicare Advantage because those are based on the service area that you're in.

Jonathan Harrington (01:05:38):

Okay. But you couldn't say, "Hey, I'm going to just move so I can switch from an Advantage to a Supplement."

Peter (01:05:44):

No, you can only do that during the initial enrollment period, which is October 15th through December 7th.

Jonathan Harrington (01:05:53):

Okay. So changes for 2020. You already mentioned that F and C are not going to be available any longer because they want the users to pay that part B deductible.

Peter (01:06:10):

Correct.

Jonathan Harrington (01:06:11):

What's the reason behind that? Do you know?

Peter (01:06:13):

Yes, the government wants to discourage a hundred percent coverage plans because it tends to encourage usage of the plan. So if you take a look at a cross-section of people who need health benefits, if someone has a deductible on a plan versus one that covers a hundred percent, the utilization rate is higher for a plan that offers a no out of pocket to consumer. There's nothing to hold a consumer back or think twice about seeking care because there's no out of pocket expense to them for that visit whatever it's for.

Peter (01:06:55):

So quite frankly, the government wants to steer away from the a hundred percent everything plan to a deductible plan to try to cut back because of the expenses on our healthcare system, especially for those Medicare benefits or Social Security benefits, they want to help try to contain costs in the plan. And one of them is no longer covering the deductible at a hundred percent.

Jonathan Harrington (01:07:22):

Even though it's only 185-

Peter (01:07:24):

Well, it's 185 now. But be rest assured those that have a plan F and if the cost is going up because of higher utilization, they're going to be paying in premium anyways. So although we can say it's a hundred percent, that'll be reflected in their premium if there is in fact higher utilization.

Jonathan Harrington (01:07:42):

And so realistically then the new F is the G with the [crosstalk 01:07:48].

Peter (01:07:48):

Yes. The best plan that can be purchased is the G. And something that should be said or spoken about is, I pulled up the history of the part B deductible, and the increase has been minimal. It's been perhaps, I think the average has been 7% a year over the last 15 years. When I looked at the history, I think it went back to 2005 and some years there's been no increase in the deductible. And that happens because as I mentioned earlier, there's a whole harmless agreement that if the government does not have an increase in Social Security benefits, then the government will not increase part B premium or the part B deductible. So there was a period where it was held for three years flat at 147 for a deductible. It went up in 2011 to $160 deductible. In the following year, it dropped down to $140 deductible and then it's been increasing since from the 140 to most recently the 185.

Peter (01:08:53):

And there's been one or two stalls in between where there was an increase in Social Security benefits. So they froze the premium for part B and the deductible of part B. One thing is for sure is that, certainly there'll be a day when it hits a $250 deductible where it's 185 now. Whether that's in five years or whenever it is, I don't know. But seniors will scream when it hits 250 because I have people that complain now about the 185. So there'll be a lot of pressure on Congress to help contain that deductible, but where it goes because of healthcare costs over the next 15, 20 years, who knows. But it doesn't matter what plan you buy, medical costs are going to impact an Advantage plan.

Peter (01:09:41):

When they talk about Congress is going to cut back on Medicare beneficiaries benefits, what they're talking about is they're cutting back on the increases that they're offering the plans. They're not talking about actually cutting a cost of something, they're cutting the increase, the projected increase that Congress is going to pay. So if Congress is, or if the government is currently reimbursing an Advantage Plan, $150 a month and the projected increases to 875, and then it's at 900 or whatever that progression is. When they talk about cutbacks, they talk about decreasing the increase or making them further apart. That's what they're talking about, but whatever impacts one plan is going to impact them all, because that's just the cost of healthcare.

Jonathan Harrington (01:10:26):

And that will get pushed on to the premium cost.

Peter (01:10:28):

Gets pushed onto the consumer, it always does. Not the insurance company. Nope.

Jonathan Harrington (01:10:34):

What is the high deductible plan G? That's a new option for 2020?

Peter (01:10:40):

Yeah. And the high deductible what's been confused about that has been very little information about a new high deductible plan. I see on your screen, you have $2,800 deductible.

Jonathan Harrington (01:10:50):

I get that from you.

Peter (01:10:52):

Right, because at one point plan F was high, but now I'm seeing G it could be 2300, but that's not even set in stone. So that seems to be a little bit fluid. And with plan G since there's $185 deductible, the 23 or $2,800 deductible, whatever it ends up being, because we don't see carriers offering that, any of the major carriers offering that this coming year. That the 185 deductible may or may not be separate. So we don't know if the findings include the 185 deductible because plan G has that deductible in part B, or once the deductible, whatever, ends up being is satisfied that you'd still have a 185 deductible on top of that.

Jonathan Harrington (01:11:34):

On top of that. I guess if no one's offering the plan, it's not worth talking about today.

Peter (01:11:41):

Well, yeah. At this time, it's because it's so new. I think we'll start seeing them next year on the market.

Jonathan Harrington (01:11:49):

Okay. So where can people go for help with their questions about Medicare?

Peter (01:11:56):

Well, they have-

Jonathan Harrington (01:11:56):

Should they read the big blue book?

Peter (01:11:58):

Yeah. They have the blue book. I think it's helpful to speak with somebody. Unfortunately, if somebody you speak with is not well versed or has a lot of experience in the market, they could possibly make it confusing. And I'm saying that goes for a broker as well as an agent, as well as ServiceLink. I mean, it's based on experience and helping consumers. ServiceLink is definitely a starting point for those that want to start exploring, but they're going to be speaking with people who are not licensed in healthcare and don't get the feedback from consumers on how the plan benefits work.

Peter (01:12:39):

mass.gov has details that can explain what's unique to Massachusetts. With medicare.gov. You can go in, you can see Advantage plans versus Prescription Drug part D plans. They don't help on the

Supplements though, which is a little bit of a dismay. They'll indicate there that you can look up the Supplemental plans there or the Medigap plans, but when they show you a G plan, they'll show you the range that they tend to fall in premium for someone age 65, but they don't spell out which carrier.

Peter (01:13:13):

So certainly a broker like myself, we can show you all the plans that are available. The insurance department in your state should have them listed as well. But what's important to know is the history of a plan. Just like if you're in an investment you maybe leery of a plan that has an attractive if it's some sort of fixed plan with some sort of fixed or locked interest rate, you might be attracted by the rate going in, but over the long haul, what will that rate do? Or what is the history of an investment? I don't sell investments. I used to be licensed for them many years ago, but something you always want to look at the history of anything that you're relying on financially, any financial instrument you want to know. So that's something that we're interested in too.

Peter (01:14:03):

My concern with my clients is that I want them happy. And I know that if I put them in a Supplement, they will be happy because they have access to whomever they want, whenever they want it. And the costs stay relatively predictable compared to some other types of plans. And that I'll go to bat for them. As far as the part D plans go every year, we can research and see what's the best for them there to work with. But yeah, it's tough doing it on your own. Out of a hundred clients, I have maybe five, that'll go through the Medicare & You book, read it cover to cover, really try to understand the plans.

Jonathan Harrington (01:14:44):

A long book, it's a big book.

Peter (01:14:47):

And some people are more analytical and they really want to understand it. And some people want to save the retirement for enjoyment. If you have a hard time falling asleep sometime, pick up the Medicare & You book, it'll put you right out.

Jonathan Harrington (01:15:02):

How do brokers and agents get compensated for their services they provide?

Peter (01:15:06):

We get paid for the plans that we sell. And so with the Supplements, they give us an initial commission, they give us a small trailing commission to service them through the lifetimes of the plans and same thing with the Advantage plans and the Prescription Drug. I've elected not to take commissions on the part D plans because of the regulations concerning those plans where they make it more difficult to offer to current clients about when somebody is offered a plan, how it's offered to them, whether it's initiated by the consumer, if it's initiated by the agent. All I have to do with those plans is just guide somebody through it because I've been doing it since they started back in 2006 and put them in any plan that services them best.

Jonathan Harrington (01:16:06):

Great. Well, Peter, thank you so much for joining us today. We've gone a little longer than I expected, but man, you provided a lot of information.

Peter (01:16:19):

Yeah. Well, my throat's a little dry. And I'm sorry to anybody out there, if this was monotonous and boring, it's tough to make it exciting. It's insurance.

Jonathan Harrington (01:16:30):

Yeah, a complicated insurance. So how can people get in touch with you if they want to get your assistance?

Peter (01:16:38):

Yeah. If anybody is looking for a little advice, if they want to feel us out and talk to us, please feel free to call us at our phone number at 603-647-1988 or visit us on our Facebook page and you'll see that we have an office dog, which is really, really, really friendly and you'll see him typically every Tuesday, we'll have a picture posted with some client with dogs on their lap. You don't have to be friendly with the dog. He will want to be friendly with you and just let us know in advance. But yeah. However, whether it's through email, my email is peterg@gosselan G-O-S-S-E-L-A-N-insurance.com or by phone or Facebook or however you'd like to best communicate with us-

Jonathan Harrington (01:17:33):

Great.

Peter (01:17:33):

...we're there.

Jonathan Harrington (01:17:35):

All right, and this webinar will be posted to Milestone Financial Planning website tomorrow, and we'll be sending it out to all participants and those that couldn't make it today so they can listen later on. Thank you for joining us. We appreciate it and we'll send out a message about the next webinar shortly.

Peter (01:17:57):

Thank you.