Nine Costliest Mistakes You Can Make When New To Medicare

I have been helping seniors with insurance and financial decisions since 1984. In that time I have spoken with seniors of all ages; both new to Medicare and people who have had Medicare of some form for many years before I came into their life. I have witnessed or been privy to just about every Medicare horror story you can imagine. All of the stories are heartbreaking and, in many cases, preventable. In this article I will present the costliest mistakes you can make when new to Medicare, based on my experience.

The most frustrating point from my perspective is that many, if not most of the heartbreaking occurrences I have seen or heard could have been avoided with proper guidance and decision making early on. If people knew the risks and potential pitfalls of their decision ahead of time, they may have chosen a Medicare different path. Unfortunately, too many people don't make the effort to research or understand Medicare and then talk over their choices with a person who is both experienced and knowledgeable. Too many people make decisions about their Medicare / healthcare without being fully informed of their all their options. My goal, with the free educational videos on my website and the articles I write is help you make an informed decision about your Medicare. Because of my experience, I can provide insight you may not have even considered. I hope the articles and videos I provide are helpful and educational.

When you are just starting out with Medicare you have some important decisions to make. These decisions and the amount of effort you put in to making the right decision for your needs and your budget will set the stage for the quality of healthcare you receive for the rest of your life.

My company motto is to "Help you to make an informed decision." An informed decision about which Medicare plan is right for your needs and your budget is critical. There is no true right or wrong as long as you are informed ahead of time about the pros and cons of each decision. No one likes surprises when it comes to their healthcare.

To help you make an informed decision I have produced a full library of educational videos on Medicare. These are offered free and without obligation. You can find them here: https://medigapseminars.org/on-demand-webinar/ All the videos linked in this article can be found on that page.

In addition, here are the Nine Costliest Mistakes you can make when new to Medicare (in no special order). Yes, this is a long article. Print it out if you must. This is important information that can save you both money and heartache.

1. Don't assume you are automatically enrolled in Medicare when you turn 65. In fact, unless you are already on Social Security income before you turn 65, you must enroll. You can enroll through the Social Security office or (in some cases) online. As I write this article there are more than 10,000 people 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. Start the enrollment process three months before the month you turn 65. You'll be glad you did.

2. In addition, do not assume that just because you visited the Social Security office and completed the required paperwork that your enrollment is "in-the-bag". In 2014 our country started producing over 10,000 new 65-year olds every day. It has been overwhelming for some departments of our government that do not respond quickly to changes in demographics. I have seen many, many cases of people having to visit the Social Security office three or more times before their paperwork is actually 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.
3. You do not need to start both Medicare Part A & B at the same time. In fact, if you will be continuing with employer sponsored creditable health insurance coverage you should delay starting your Medicare Part B and can do so indefinitely.

COBRA is NOT Creditable Coverage

Your initial enrollment "right" to enroll in Medicare Supplement plan of your choosing is predicated entirely on your Medicare Part B start date. You can get any Medicare Supplement plan guaranteed within 6-months of starting Medicare Part B. After 6-months you lose your guarantee. After that 6-month period, depending on your health you may not be able to get a Medicare Supplement. That is why it is very important to delay your enrolling in Medicare Part B if you have employer coverage. Some states have specific laws addressing this issue.

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.

Bottom line; 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.

For more information see: Introduction to Medicare

4. 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 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 a MAPD plan before first reviewing your Medicare supplement costs and options, then the odds are that 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.

   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. Be wary.

   See these two videos for more: About Medicare Advantage Plans, Medicare Supplement Webinar

5. If you purchase a Medicare supplement (aka Medigap plan) when you are age 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.

   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 exact same plan. The exact same insurance coverage. In fact 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 age 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 insurance 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 premium by thousands of dollars per year. In fact, the most I ever save 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 exact same plan and within 30-minutes saved him more than $300 per month in insurance premiums. This was the exact same plan with the exact same benefits. Most people save between $500 and $1,200 per year.

   For more information on this subject see: Overpriced Medigap Plans.

6. 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 giving the healthcare provider the right to bill you if Medicare does not cover the procedure. You are often signing away your Medicare rights.

   Medicare strives to cover all that is medically necessary. However, your doctor can requests 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.

For more details, including a look at the ABN form and what to do when you get it, watch this video; Avoid Surprise Medicare Bills

7. 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. 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 are 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".

8. Part D Prescription Drug Plans is where most people make their costliest mistakes. Unlike Medicare supplement plans, every Part D plan is different. They have 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 your plan using their internet program that considers your specific prescriptions. See this video for a step-by-step guide on How to Shop for a Part D Prescription Drug Plan.

   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 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.

Because Medicare Part D plans have a lot of moving parts, watch this video to learn what you need to know about Part D; Medicare Part D Explained.

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 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 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 prior to this event he decided not to get Part D coverage. Now he has to pay for his medication out-of-pocket or go without. See this video for more details on the true penalty for not enrolling in Part D.

9. Last, but by no means least, we need to address Medicare's biggest weakness; Medicare and the Cost of Cancer Treatment. Medical treatments for cancer have advanced significantly in just the past 15-years. More and more people are surviving cancer. Much of the increased success is due to new drugs, many of which target specific cancer cells rather than trying to kill everything and hope the patient survives longer than the cancer. But these new drugs come at a very high price to the consumer. Without insurance, the average cancer drug cost $10,000 per month with treatment lasting a year or more, sometimes for life. Consider that $10,000 per month is just the average. There is no ceiling for how much you might pay out-of-pocket.

   When you have Medicare Part D prescription drug coverage, Medicare pays for 95% of the prescription cost after you have paid a certain amount out-of-pocket. The numbers change every year, but you can expect to pay 5% of the drug cost after you first pay about $5,000 out-of-pocket. Medicare Part D has no maximum out-of-pocket limit. Plus treatment can continue for years with additional out-of-pocket expenses of $3,000 to $4,000 per year.

   Here are the statistics:

   - Men starting Medicare today have a 50% probability of contracting cancer before death.
   - Women starting Medicare today have a 33% probability of contracting cancer before death.
   - These are high probabilities. Think of all your friends; half of all men and one-in-three women will battle cancer before they die.
   - The average person on Medicare that survives cancer has out-of-pocket expenses of $26,800 after their first year. Half have even more expenses. Keep in mind that cancer treatments now span many years, with patients paying $3,000 to $4,000 in yearly out-of-pocket expenses.

- A large percentage of all Medicare beneficiaries who survive cancer either have to return to work to pay medical bills or declare bankruptcy.

If you can absorb the extra expenses of cancer treatment, awesome. If not and the expenses we outlined above would have a negative impact on the quality of your life, you should seriously consider Cancer Protection insurance.

Cancer protection insurance is very affordable and provides you a tax-free lump sum of cash when first diagnosed with cancer. The money is yours to spend as you need and help you battle cancer without taking on high debt.

For more details please see; Medicare & the Cost of Cancer Treatment

Matthew Claassen, CMT
Managing Partner & Independent Agent

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