Life & Health Insurance Advisor

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Retirement Planning for Women

Women generally live longer than men. Many leave work or reduce their working hours while raising children. And women still earn less, on average, than men. All these factors combine to make retirement planning a particular challenge for women.

Here are some questions to help you take charge of your financial future:

1 Does your employer offer a retirement plan?

If yes, join as soon as you can and contribute as much as the plan allows. Most employers with a 401(k) plan match 50 percent of employees' contributions, up to a maximum percentage of wages or salary, usually 6 percent. That's like getting free money!

2 Have you worked at the job long enough to be vested?

"Vesting" means you have earned the right to benefits from a savings or pension plan. If you leave before being vested, you may lose all or a portion of the benefits you have earned. Many plans require you to work for a minimum of five years before you are fully vested.

3 How will you handle retirement plan balances if you leave your job?

Rules for your plan are spelled out in the summary plan description (SPD). In some cases, an employer might require you to take your retirement benefits in a lump sum. Others may not permit you to receive funds until retirement.

If you take benefits in a lump sum, you will owe income taxes on those funds, and may owe a penalty tax. To avoid tax penalties and keep your retirement savings on track, you can reinvest your funds in another qualified retirement plan or an Individual Retirement Account (IRA) within 60 days.

If you receive the money directly, you will have to pay a 20 percent withholding tax and then file for a refund in the next year, providing proof that you have transferred the funds to an IRA. Instead, instruct the retirement plan to transfer your money directly to an IRA or another qualified retirement plan. This is easy to do using simple forms supplied by the new plan.

4 Are you tracking your Social Security earnings?

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This Just In…

The healthcare rate of inflation is slowing, according to Standard & Poor's. Between November 2009 and November 2010, the healthcare rate of inflation slowed to 6.27 percent, down from 6.68 percent in the 12-month period ending in October 2010.

S&P's healthcare indices estimate "…the per capita change in total allowed claim costs incurred each month by patients (through their co-payments) and their healthcare benefit programs for services rendered by hospitals and physicians."

David M. Blitzer, chairman of the Index Committee at S&P, noted that "…expenditures associated with commercial health insurance plans continue to significantly outpace expenditures for Medicare.… [and] growth rates for services provided under Medicare coverage are approaching or reaching new lows. The Medicare composite posted an annual growth rate of +3.74% in the 12-months ending in November."

The U.S. Census Bureau projected total healthcare expenses in the U.S. at $2.57 trillion for 2010. Of that, private expenditures accounted for $1.31 trillion and government expenditures (including Medicare and Medicaid) for $1.27 trillion.

Which Plan Type Meets Your Needs?

The type of health insurance plan you choose can make a big difference in your out-of-pocket costs and choice of providers. The following information can help you decide which type of plan best suits your situation.

Health plans fall into two broad categories: fee-for-service and managed care plans.

Fee-for-Service Plans

Fee-for-service, or indemnity, plans allow an insured to use any healthcare provider. After an insured meets the deductible, most fee-for-service plans pay a percentage, usually 80 percent, of the "usual and customary" (U&C) charge in your area for covered services. The insured pays the other 20 percent, which is known as coinsurance. If your provider charges more than the U&C rates, you will pay both the coinsurance and the difference.

Fee-for-service major medical plans are becoming less common than in years past, although some supplemental health policies use a fee-for-service model. You'll likely pay more in premiums and out-of-pocket costs with these plans, but you will have your choice of provider.

In 2009, deductibles for a fee-for-service major medical plan averaged $1,466 for single coverage and $3,566 for family coverage, according to a survey by America's Health Insurance Plans (AHIP), a health insurer trade organization.

Most fee-for-service plans cap out-of-pocket expenses. After your out-of-pocket expenses (deductibles and coinsurance) total a certain amount in a year or other specified period, the insurer will pay the full amount of covered claims. AHIP reported that in 2009, caps averaged $3,145 for single-only coverage and $4,913 for family coverage among plans that had caps.

Managed Care Plans

In contrast to fee-for-service plans, managed care plans have contracted with certain health care providers to offer services to plan members at reduced cost. To obtain the highest reimbursement rates, you must use a contracted (or in-network) provider. Most also have features to discourage unnecessary use of healthcare services, such as requiring a primary care physician's referral before the plan will pay for treatments by a specialist. In general, managed care plans involve less paperwork and lower out-of-pocket costs for members. A variety of managed care plan types exist:

Health maintenance organizations (HMOs). HMOs are the oldest form of managed care plan. They offer members a range of health benefits, including preventive care, for a set monthly fee. There are many kinds of HMOs. If doctors are employees of the health plan and practice at central medical offices or clinics, it is called a staff or group HMO. Other HMOs contract with physician groups or individual doctors with private offices. These are called individual practice associations (IPAs) or networks. Virtually all HMO plans cover only care provided by HMO providers, except for emergencies or when otherwise medically necessary.

Many HMOs offer an indemnity-type option known as a point of service (POS) plan. The primary care doctors in a POS plan usually make referrals to other providers in the plan. But in a POS plan, members can refer themselves outside the plan and still get some coverage. If the doctor makes a referral out of the network, the plan pays all or most of the bill. If the employee refers herself to a provider outside the network and the service is covered by the plan, the insured will have to pay coinsurance.

Your co-payments in an HMO plan might vary from none at all to amounts rivaling those in fee-for-service plans. In 2009, out-of-pocket maximums averaged $2,645 for single coverage and $5,091 for family coverage.

Preferred provider organizations (PPOs). PPOs are currently the most common type of health insurance policy in both the individual and employer markets. Like all managed care plans, a PPO has established agreements with doctors, hospitals and other care providers to accept lower fees for their services. PPOs also share some characteristics with fee-for-service plans because patients can, for an additional cost, go outside the network of providers if needed. As a result, your costs generally stay lower but you have

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If you work and pay Social Security taxes, you earn credit toward a monthly benefit at retirement. These earnings can also provide monthly disability or survivor benefits in certain instances. You may also be eligible for Social Security benefits through your husband's work, and can receive benefits when he retires or upon his disability or death. Special rules apply if you and your husband have been employed and both have paid into Social Security. Special rules also apply if you are divorced or if you have a government retirement plan.

To estimate your benefits, see www.socialsecurity.gov.

5 Are you entitled to a portion of your spouse's retirement benefit if you divorce?

As part of a divorce or legal separation, you may be able to obtain a portion of your spouse's retirement benefit (or he may be able to obtain a portion of yours). In most private-sector plans, this is done using a qualified domestic relations order (QDRO) issued by the court. You or your attorney should consult your spouse's plan administrator to determine what requirements the QDRO must meet.

6 Do you know the rules that govern your retirement plan and that of your spouse if either of you dies?

If you or your spouse belong to a defined benefit plan (a traditional pension plan), the surviving spouse may be entitled to a survivor benefit when the enrolled employee dies. This survivor benefit is automatic unless both spouses agree, in writing, to forfeit the benefit. You will need to check the SPD or consult with the plan administrator regarding survivor annuities or other death benefits.

The rules may differ for defined contribution plans (such as a 401(k) plan). Consult the plan administrator for details about spousal rights.

7 What retirement account options exist for those who don't have access to an employer-sponsored plan?

Anyone receiving compensation or married to someone receiving compensation can contribute to an IRA. In addition, if you are self-employed, you can start a Simplified Employment Plan (SEP) or a Savings Incentive Match Plan for Employees of Small Employers (SIMPLE). As with other retirement savings plans, there may be tax consequences, and possibly penalties, if you withdraw your savings early.

All plans specifically designed for retirement savings have annual contribution limits. If you are in a higher income bracket, relying on these plans alone might not allow you to save enough to continue your lifestyle in retirement. Other savings vehicles, including life insurance and annuities, can help you augment your retirement savings.

For more information on retirement planning, please contact us. ■

(Adapted from a document by the U.S. Department of Labor)

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flexibility of choice. If a plan member chooses to go outside the network, he or she will have to meet the deductible and pay coinsurance based on higher charges. In addition, members may have to pay the difference between what the provider charges and what the plan will pay.

High-Deductible Health Plans and Health Savings Accounts

A high-deductible health plan (HDHP) can be an HMO, PPO or indemnity plan, as long as it meets IRS requirements. For calendar year 2011, a high-deductible health plan must have an annual deductible that is not less than $1,200 for self-only coverage or $2,400 for family coverage, and the annual out-of-pocket expenses (deductibles, copayments, and other amounts, but not premiums) do not exceed $5,950 for self-only coverage or $11,900 for family coverage.

Having a qualifying HDHP and no other medical insurance (including a flexible savings account, or FSA, and health reimbursement arrangement, or HRA) allows you to open a health savings account (HSA). You and/or an employer can contribute up to a maximum of $3,050 for self-only coverage or $6,150 for family coverage to your HSA for 2011. Individuals can make pre-tax contributions; employer contributions do not count toward taxable income. Further, your funds grow tax-free and you can withdraw them free of taxes, as long as you use them for qualified medical expenses.

HDHPS generally have lower premiums than other, more comprehensive plans, but your deductible and other out-of-pocket expenses will be higher. This, plus the tax-advantaged savings offered by an HSA, can make these plans good choices for relatively healthy individuals who can budget for their healthcare expenses. They might not be the best choice for less-healthy individuals or for those who have limited savings for healthcare expenses.

For a comparison of different plan types available in your area, please contact us. ■

FRAUD— *continued from Page 4*

to bona fide association plans. HIPAA protects members of group plans by limiting exclusions for preexisting medical conditions; by allowing individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent; and by prohibiting discrimination in enrollment and in premiums based on health-related factors.

Agent/Broker Fraud

Sometimes insurance agents and brokers (or individuals posing as such) commit fraud. Victims of this type of fraud apply for coverage, often from a legitimate company, pay their premium, and think they're covered… only to discover they are uninsured after filing a claim.

We are always happy to discuss our services and qualifications with clients and prospective clients, and to provide references from other satisfied clients. For more information, please call us. ■

Protect Your Family from Health Insurance Fraud

Health and Human Services Secretary Kathleen Sibelius warned insurance commissioners last year that, "...scam artists and criminals may be using the passage of [the Patient Protection and Affordable Care Act healthcare reform law] as an opportunity to confuse and defraud the public." What should consumers watch for?

Phony policies

In her statement to insurance commissioners, Sibelius said, "...fraudsters have gone door to door selling phony insurance policies. Some have attempted to make dishonest profits by urging consumers to obtain coverage in a non-existent 'limited enrollment' period that they falsely claim was made possible by the new legislation."

Families USA, a nonprofit healthcare advocacy group, specifically warns against fake association health plans. "Consumers may be encouraged to join fake associations to buy health insurance so they have an illusion of coverage," it said in a special report. *("Buyer Beware: Unlicensed Insurance Plans Prey on Health Care Consumers," October 2010)*

Association Plan Caveats

Even legitimate association plans can pose problems. Association plans do not have to meet all the state rules and regulations that other health plans must meet. For example, they might not have to provide specific coverages mandated by state law or adhere to underwriting requirements that make health coverage more affordable for older or less-healthy individuals.

Those who enroll in association plans often think they are obtaining group coverage. However, insurers often underwrite association coverage as individual plans, so less-healthy individuals might be disqualified or have to pay higher rates.

COBRA and HIPAA, two important laws protecting members of group plans, do not apply to association plans. COBRA, the Consolidated Omnibus Budget Reconciliation Act, generally applies to plans covering 20 or more workers, and gives covered individuals the right to continue their group health benefits for 18 months or more after they lose coverage due to specified "qualifying events." These events include voluntary or involuntary job loss, reduction in the hours worked, death, divorce and other life events.

HIPAA, the Health Insurance Portability and Accountability Act, also does not apply

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To avoid insurance fraud, take the following steps:

1 Be suspicious of high-pressure sales tactics or "limited time only" offers. A professional agent will want to build a long-term relationship with you. He or she will take the time to explain a policy's provisions and help you compare features of different policies, rather than pushing just one.

2 Verify licensing for any new agent or broker who wants your business. Insurance agents and brokers must have a license issued by the insurance department of the state in which they are doing business. See www.naic.org/state_web_map.htm for links to state insurance regulators. To earn a license, agents and brokers must demonstrate their knowledge by passing a licensing exam, agree to adhere to a code of ethics, and sell only products within the scope of their license.

3 Ask your agent about his/her other credentials. This includes experience, professional designations and other continuing education classes. Continuing education and involvement in professional associations indicates a commitment to professionalism.

4 Don't go by name alone: many fraudulent companies have names that sound like legitimate ones. Make sure the insurer is licensed in your state. State regulators provide important consumer protections, including ensuring that insurers are financially solvent so they can pay claims.

Further, the National Association of Insurance Commissioners says, "Legitimate companies that are not licensed by the state to sell insurance might lead consumers to think they are selling 'insurance' while evading state insurance regulations. A company selling a health discount plan might call the plan insurance when it is really an unregulated, non-insurance product. If you question whether a product you are offered is insurance, contact your state insurance department."

5 Keep a copy of your policy application. Follow up if you do not receive insurance cards and a copy of your policy within a reasonable period. If you have concerns, contact the insurance company directly or call the state insurance department. ■