

Dialogues » WEALTH STRATEGIES FOR DISCUSSION



Top Concerns of Wealthy Investors*

- | | |
|-------------------------------------|-----|
| 1. Rising cost of health care | 57% |
| 2. Protecting current wealth..... | 55% |
| 3. Increased energy prices..... | 48% |
| 4. Minimizing taxes..... | 45% |
| 5. Terrorism | 36% |

THIRD QUARTER
2009

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Health Care Planning for a Confident Life

Practical Considerations for America's New Longevity

» Americans today are living longer, more vital lives—and that's good news. The bad news, however, is that these additional years likely translate to more dollars spent on health care; the worse news is that the price tag is shifting increasingly to individuals and families. And with many adults now becoming responsible for aging parents, you may end up footing the bill not just for your own health and long-term care, but that of your parents or spouse's parents as well. Even wealthy individuals view the cost of health care as a major threat to their family's financial well being.

But it doesn't have to be.

Careful, advanced planning can mean the difference between a retirement filled with enjoyment and one filled with anxiety. We can help. ■

*Data Source: Phoenix Affluent Marketing Service Tracking Program as of June 2007. Issues related to savings and investments for investors with \$1 million+ in investable assets.

By Morgan Stanley Smith Barney LLC.

How Much Will You Need?

Having the right amount of funding begins with understanding how much you'll need to save—and what your options are for saving.

» The cost of medical care has outpaced inflation for the past 20 years and shows no sign of slowing down. Assuming Medicare benefits remain at current levels, a couple that reaches average life expectancy will need approximately \$300,000 to cover health-insurance premiums and extra expenses and as much as \$550,000 if they reach age 95, according to the Employee Benefit Research Institute.

And then there's long-term care. This refers to any services beyond medical care, such as home health aides or nursing-home stays required for people with disabilities or chronic illness. While health insurance and

Medicare typically cover routine visits to the doctor and emergency medical situations sufficiently, ongoing long-term health care isn't covered. And it is long-term care that can be financially devastating for older Americans, quickly depleting even substantial retirement savings and wiping out any potential inheritance for heirs or charity.

According to AARP, 60% of people over age 65 will need some type of long-term care. Of course, unlike other large expenses such as a home purchase or college tuition, health care costs could come at any time. Wise planning now can make a great difference in how financially prepared you will be to handle those costs when they come. ■

“The cost of medical care has outpaced inflation for the past 20 years and shows no sign of slowing down.”

Finding Insurance Coverage

» There are three types of health care insurance: employer-provided insurance, government insurance and private insurance. Employer-provided insurance should be the first line of defense. If you're working and belong to a group health plan, regardless of your age or health, keep it. The premiums, deductibles, prescription-drug and co-pay charges available through a group health plan are a bargain compared to individual health insurance. In fact, the cost savings may be so attractive that you might consider delaying retirement, particularly if you have a known health condition.

“If you're working and belong to a group health plan, regardless of your age or health, keep it.”

If you are changing employers, sign up for your new employer's plan as soon as you join the company (generally within the first 30 days). Many large plans will have

no limitations on preexisting conditions, but that only may apply if you sign up immediately upon becoming an employee. If you wait for the annual enrollment period and do not have proof of existing coverage from another source, additional charges or limitations may apply.

The government's COBRA legislation (Consolidated Omnibus Budget Reconciliation Act of 1986) instituted a variety of safeguards for some workers and their immediate family members to maintain health care coverage for a minimum of 18 months after working. If you have the option to remain on your employer's plan through COBRA, sign up. You will be responsible for paying out of pocket for the premiums, but the cost likely will still be cheaper than buying comparable private insurance. If you have COBRA, you should still enroll in Medicare Parts A and B because your health insurance under COBRA typically ends as soon as you are eligible for Medicare.

YOU MAY ENROLL IN COBRA ONLY IF A “QUALIFYING EVENT” OCCURS. THESE INCLUDE:

- » Death of the covered employee
- » Termination or reduction of hours due to resignation, discharge, layoff, strike or other cause
- » Divorce (which normally terminates an ex-spouse's eligibility)
- » A dependent child reaching an age or status for which coverage is excluded

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009. Included in the legislation is a government subsidy of 65% of the cost of COBRA coverage for qualified beneficiaries who've lost their health insurance coverage due to involuntary termination of employment. While this provision reduces the employee's cost of COBRA insurance to 35% of the total premium, including the 2% administrative fee if applicable, it requires the employer to initially cover the remaining 65% of the COBRA premium. ■

The ABC's of Medicare

MEDICARE: FEDERAL CORNERSTONE OF HEALTH CARE

Individuals are typically eligible for Medicare if they or their spouses worked for a minimum of ten years in Medicare-taxed employment (including self-employment), are 65 years of age or older and are citizens or permanent residents of the U.S. But as a tidal wave of baby boomers prepares to enter retirement, the program is facing cost pressures, causing many to question its long-term solvency. If you and your spouse are different ages, you won't be able to go on Medicare at the same time. If you have other insurance, it will complement your Medicare coverage and further reduce your out-of-pocket costs.

PARTS A AND B

Medicare consists of several parts. Part A helps pay for care in hospitals as well as some skilled nursing facilities, hospices and some home-health care. If you or your spouse paid Medicare taxes while working, there are no monthly premiums for Part A. However, there are monthly premiums for Part B, which help cover doctors' fees, outpatient hospital care and some other medical services such as physical and occupational therapists. As of January 1, 2009, the basic monthly premium is \$96; the premiums paid by higher-income individuals can range up to \$308.

If you're already receiving Social Security when you turn 65, you are enrolled automatically in Medicare Parts A and B even if you have employer-sponsored or private health insurance. If you are not receiving Social Security benefits when you turn 65,

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you will not be enrolled automatically in Medicare. You may apply during the initial enrollment period, which begins three months before you turn 65 and ends three months after. If you do not enroll, you must register during a general enrollment period, which is Jan. 1 to March 31 each year. Your coverage will then begin July 1 of that year. Waiting until after the initial enrollment period could subject you to a penalty, which will be added to your Part B premium.

PARTS C AND D

Medicare Part C, added in 1997, gives Medicare beneficiaries the option to receive their Medicare benefits through private health-insurance plans. Part D, introduced in 2006, adds general coverage options for many prescription drugs.

Private companies are responsible for setting up Part D plans, so each one will be slightly different. Part D is not automatic; you must choose to enroll in one of the many prescription drug plans. Like Part B, if you wait until after your initial enrollment period you will likely face a penalty, which will be added to your Part D premium. These plans vary widely in cost structures and drugs covered, and there is a gap in

coverage—known as the “donut hole”—that could prove burdensome. To make your selection easier, Medicare has an interactive online tool called the Prescription Drug Plan Finder, which lets you view and compare program structures and costs in your geographic area. You should also compare the Medicare D plans to drug-coverage costs offered under some Medigap policies.

If you or your spouse is still working when you turn 65 and you have health coverage through your employer, you may be able to delay enrolling in Parts B and D without paying an enrollment penalty. This will allow you to avoid duplicate coverage and having to pay monthly Part B and D premiums. ■

Medicare Prescription Drug Plan Finder

Find and compare plans that cover drugs:

» Medicare Prescription Drug Plans

» Medicare Health Plans

Go to: www.medicare.gov and click “Prescription Drug Plan”.

“For many people, the health-insurance coverage employers provide is almost as valuable as the salary they pay, or sometimes more so. But amid the inflation in health care expenses, many employers are reevaluating whether they will offer the same level of retiree health insurance as they have in the past.”

MEDIGAP: COVERING HOLES IN MEDICARE COVERAGE

Out-of-pocket expenses for Medicare can be substantial. For example, Part A has an annual deductible of nearly \$1,100 for a hospital stay from one to 60 days, as well as substantial copays for longer stays. After paying for 20 days of nursing-home care, Medicare charges a copay and limits total coverage to 100 days in any particular year. For Part B, on top of the yearly deductible, beneficiaries also pay 20% of the Medicare-approved amount for any covered services.

These “leftover” costs can mount rapidly—Medigap was devised to “fill in the gaps” of coverage. Most states offer ten Medigap options, all of which must offer certain basic benefits: coinsurance for inpatient hospital care and 365 extra days of hospital care during your lifetime after Medicare coverage ends, Part B coinsurance and the first three pints of blood per year. Some of the more extensive Medigap plans may also pay such things as coinsurance for skilled nursing, Part A deductibles, preventive care or foreign-travel emergencies (only on grandfathered policies as of Jan. 1, 2006). Medigap does not cover long-term care or any other expenses not covered by Medicare.

MEDICAID: HEALTH CARE FOR THE DISADVANTAGED

Medicaid is a federal program administered by each state that provides medical

assistance to people with low incomes and limited assets and is also available to people eligible for public assistance (Supplementary Security Income). Medicaid covers all types of medical care including hospital care, doctor bills, nursing-home coverage, home care and prescriptions. Medicaid covers deductibles and many services not covered by Medicare.

In the past, some individuals transferred their assets to children and others in an attempt to qualify for Medicaid coverage of nursing homes and other long-term care. But as part of the Deficit Reduction Act of 2006, Congress cracked down on that practice by increasing the “look back” period, which refers to the period of time during which the financial transactions of a Medicaid applicant are subject to review in determining eligibility, as well as any penalty period when the applicant would not be eligible for Medicaid benefits. Before February 2006, the look-back period was only three years; now, however, the Department of Social Services looks back five years for any disposal of assets.

Another key provision of the 2006 Deficit Reduction Act is that, starting in 2011, a Medicaid applicant with more than \$500,000 in home equity will not be eligible for Medicaid (states have the option of increasing the cap to \$750,000). The only exceptions to the

rule are applicants who still have a spouse, a child under 21 or a disabled child still living in the house. The rule effectively could force an applicant to sell a home if he or she hopes to receive Medicaid.

PRIVATE INSURANCE

For many people, the health-insurance coverage employers provide is almost as valuable as the salary they pay, or sometimes more so. But amid the inflation in health care expenses, many employers are reevaluating whether they will offer the same level of retiree health insurance as they have in the past. That means you may find yourself without health insurance if you stop working before age 65, when you become eligible for Medicare. You also may have to scramble if you work for a small employer without coverage, start your own business or need to supplement for dental, vision and other services Medicare doesn't cover.

Private health insurance is available. If you're relatively healthy, it may be possible to find private health insurance that is not exorbitantly priced. Online sites are available to help you compare policies; you may also seek help from an insurance broker or talk to your Financial Advisor. But there are several caveats:

- » Monthly premiums (as well as copayments and deductibles) tend to be high, and the actual benefits are often less

generous than those typically offered by employer-sponsored group plans.

- » Unlike an employer-sponsored plan that must accept all employees regardless of their current state of health, private plans in most states can reject applicants or exclude coverage for a preexisting condition.
- » Whereas all employees pay the same price in a group plan, pricing for individual plans is based on age, health and other factors. Some states do require private insurers to offer coverage to every applicant regardless of age or health status. The result, however, usually is higher premiums for all—even young, healthy individuals.
- » In most states, private health-insurance plans increase premiums with age, consuming more of your retirement savings as you age (assuming you need private insurance to pay expenses Medicare does not cover).

LONG-TERM CARE INSURANCE

Long-term care insurance is designed to help you pay for nursing-home costs and other long-term care expenses, which can be expensive and last for years. By covering some of these costs, long-term care insurance can help protect your

“Long-term care insurance can help protect your retirement savings and any inheritance you hope to leave behind. It can also help reduce your dependence on family members and give you greater control over the services you receive.”

retirement savings and any inheritance you hope to leave behind. It can also help reduce your dependence on family members and give you greater control over the services you receive.

Long-term care insurance typically covers the cost of in-home health aides, adult-day-care programs, assisted-living facilities and nursing-home care. Premiums can be relatively high, so it's important that you build them into your retirement-cash-flow planning. To lock in a lower premium and increase your chances of qualifying, a good time to buy a long-term care policy is usually in middle age, before age and health issues make the cost prohibitive. Though somewhat limited, there are federal tax deductions to help you pay long-term care premiums. Your Financial Advisor can give you information and assistance with several of the long-term care policies we offer. ■

Long-Term Care Tax Deductions

2009 Eligible Long-Term Care Insurance Premiums

Attained Age Before Close of Taxable Year & Max. Limit 40 or less: \$ 320

More than 40 but not more than 50 \$ 600

More than 50 but not more than 60 \$1,190

More than 60 but not more than 70 \$3,180

More than 70 \$3,980

Note: The limit on premiums is for each person. Also, you cannot include premiums for long-term care insurance if you elected to pay them with tax-free distributions from a qualified retirement plan made directly to the insurance provider and these distributions would otherwise have been included in income.

Data: www.irs.gov <<http://www.irs.gov>> , Publication 502.

Other Sources of Funding

» Because the costs of a sudden accident or illness can be catastrophic financially, the costs of insurance are preferable to the costs of paying out of pocket. But beyond insurance, there are other ways to supplement health care expenses.

HEALTH SAVINGS ACCOUNTS: A TAX-FAVORED STRATEGY FOR HEALTH CARE SAVINGS

As health-insurance costs have gone up, a new type of plan—the high-deductible health plan (HDHP)—has been designed for people who want insurance coverage but do not have a current need for frequent health care. Because the premiums are lower (15% to 45% lower than other plans), the plan carries relatively high deductibles. To help pay these deductibles, the federal government has created legislation that lets people establish a tax-advantaged account known as a Health Savings Account, or HSA. HSAs were created to encourage people to save for their current and future health care expenses and adopt HDHPs, which make clients more responsible for their own health care choices.

An HSA combines an individual's health-insurance plan with a tax-deductible savings account. HSAs offer significant advantages, particularly for clients in higher tax brackets—annual contributions are deductible; earnings on contributions grow tax-free; and withdrawals from the account for qualified medical expenses are also tax-free. HSAs are fully portable, meaning you can keep your account even if you change jobs or medical coverage, become unemployed, move to another state or change your marital status.

If you are not yet retired, you might consider establishing an HSA. To qualify, you need to have medical coverage under an IRS-approved HDHP. Check with your employer's insurance agent or benefits department to see if they offer such an alternative. If not, you can also contact your state insurance department to find insurance companies qualified to sell these plans in your state of residence. Small-business owners who offer a high-deductible plan as an employee benefit could also offer an HSA that provides for either employee or employer contributions, or both.

WE CAN HELP

As you approach retirement, pondering the cost of health care once you retire can be frightening. But we can help you find answers to your questions and strategies to address the issue. We can perform a personal retirement analysis that evaluates your current and future cash flow, including the potential impact of health care costs on your retirement assets. We can also help you explore your insurance needs and funding options to determine which ones may be right for you, along with answering any question you may have about postretirement medical benefits, Medicare, long-term care and employer-sponsored health and disability insurance.

Our primary focus is ensuring that your wealth works hard for you—and that your overall financial plan continues to work as your needs change. ■

“HSAs were created to encourage people to save for their current and future health care expenses.”

HSA Eligibility Checklist

- » Currently have (or will switch to) a High Deductible Health Plan (HDHP) that meets IRS requirements. Please understand that HDHPs may not be suitable for everyone.
- » Are not covered by other health insurance.
- » Are not enrolled in Medicare.
- » Are not claimed as a dependent on another person's tax return.

Ask us for details on the Citibank Health Savings.

2009 Medicare Services and Out-of-Pocket Costs

Parts of Medicare and Covered Services	Out-of-Pocket Costs
PART A	
<ul style="list-style-type: none"> » Inpatient hospital <ul style="list-style-type: none"> – Up to 90 days per year – Plus 60 “lifetime reserve days” » Skilled nursing facility (100 day per year) » Hospice care » Home health care 	<ul style="list-style-type: none"> » \$1,068 deductible per benefit period* <ul style="list-style-type: none"> – Days 1 – 60: \$0 – Days 61 – 90: \$267 per day – 60 “lifetime reserve days”: \$512 » Days 1 – 20: \$0 Days 21 – 100: \$133.50 » Copayment of up to \$5 for outpatient drugs and 5% coinsurance for inpatient respite care » No cost
PART B	
<ul style="list-style-type: none"> » Premium » Deductible » Clinical Laboratory Services » Home Health Services » Durable Medical Equipment » Medical and Other Services » Mental Health Services » Outpatient Hospital Services 	<ul style="list-style-type: none"> » \$96.40 – \$308.30 per month** » \$135 per year » No cost for Medicare-approved services » No cost for Medicare-approved services » 20% of Medicare-approved amount for durable medical equipment » 20% of Medicare-approved amount for most doctor services, outpatient therapy, most preventative services, and durable medical equipment » 50% for most outpatient mental health care » Coinsurance or copayment amount varies by service
PART D***	
<ul style="list-style-type: none"> » Premium » Deductible » Coinsurance 	<ul style="list-style-type: none"> » Average cost is \$30.36 per month (varies by insurance company, plan and location) » \$295 standard plan <ul style="list-style-type: none"> – 25% on costs from \$295 to \$2,700 – 100% from \$2,700 to \$6,154 – 5% above \$6,154

NOTES:

* A benefit period begins when a person is admitted to a hospital and ends 60 days after discharge from a hospital or a skilled nursing facility. The deductible is the amount an individual must pay before Medicare begins to pay for services.

** The Part B premium starts at \$96.40. For individuals with incomes above \$85,000 and for couples (married filing jointly) with incomes above \$170,000 premiums increase on a sliding scale up to a maximum of \$308.30 per month.

*** Varies depending on plan. Many plans do not charge a \$295 deductible and 25% coinsurance for each prescription filled. Many also do not have a coverage gap. If you enroll in a plan with a coverage gap and have more than \$2,700 in total drug costs (not counting the premium), you will pay the entire cost of your prescription drugs until you have spent \$4,350 for your prescriptions out-of-pocket, in addition to your monthly premiums.

Source: medicare.gov

Ten Steps to Selecting an Elder Care Attorney

Finding a Compassionate and Experienced Professional

» An elder care attorney can provide advice in a range of areas, including: disability issues, health care proxies, living wills, powers of attorney for health care and finances, plans in the event of incapacity, long-term care insurance, Social Security claims, guardianship issues, general life insurance, trusts and wills.

HERE ARE TEN STEPS TO GO ABOUT FINDING ONE:

1. Identify prospective attorneys. Talk to people who work with elder care attorneys. Consult the AARP, the local state bar association and the National Academy of Elder Law attorneys.

2. Schedule screening interviews. Find an elder care attorney with whom you feel comfortable working. Do they call you back promptly? How do they sound on the phone? What is their office like?

3. Determine if the attorney is qualified.

At the first interview, ask basic questions: What percentage of your practice is devoted to elder care law? What types of problems have you handled? Ask for references.

4. Understand the network of professionals. Elder care requires a holistic approach that involves a team of specialists; your attorney should not be the lone ranger.

5. Discuss fees. You want someone who is reasonably priced and has a fee schedule that is comfortable for you. The most expensive is not necessarily the best.

6. Contact references. Was the attorney proactive? Responsive? A good advocate? Any regrets or concerns?

7. Prepare for the second interview. Ask follow-up questions, and bring personal documents you wish to discuss, such as estate-planning instruments and insurance policies.

8. Get specific. Ask each attorney how he or she would address a particular situation; a proposed plan should make sense to you.

9. Select your elder care attorney. You want someone who is qualified, with whom you are comfortable, who has a network of people they work with and is reasonably priced.

10. Put it in writing. Having a written agreement (or a retainer agreement) can help ensure that your expectations are met. ■