Financing Health Care in Later Life

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Financing Health Care in Later Life

V.L. Schmall and R. Stiehl

Because we are living longer than ever before, we are more likely to need health care, including long-term care for chronic health problems. Paying for such care can be financially devastating. Just as we plan for our children's education and our retirement, we need to plan for health care in later life and learn about available financial resources. Of all the financial hardships that can strike a family, few compare with the trauma of a prolonged, disabling illness.

The major resources for covering health-care costs are Medicare, Medicare supplement policies, Medicaid, and long-term care insurance. Coverage and eligibility for these resources are ever-changing; therefore, they will not be discussed in great detail. However, it's important to be informed about them, to know what they will and will not cover, and where you can obtain detailed, up-to-date information.

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Medicare

Medicare is a federal health insurance program for people 65 and older and certain people under 65 who are disabled. The most significant expansion of Medicare since its enactment in 1965 was the passage of the Medicare Catastrophic Coverage Act in 1988. It is designed to protect Medicare beneficiaries from overwhelming hospital, physician, and outpatient drug costs related to a serious illness or injury by placing a limit on a person's out-of-pocket expenses. While it helps with massive bills resulting from acute illnesses, it does not cover the enormous expenses for long-term care at home or in a nursing home. Provisions of the catastrophic health care bill will be phased in over the next several years.

Medicare has two separate parts: Hospital Insurance, which is usually called Part A, and Medical Insurance, called Part B. Neither A nor B offers complete coverage. You have to pay a deductible amount up-front and/or a co-payment in addition to what Medicare pays. And some expenses are not covered at all.

Hospital Insurance—“Part A”
Part A helps pay for medically necessary inpatient hospital care, skilled care in a nursing home, home health, and hospice care. Services covered include:

- **Hospital.** After you pay an annual deductible ($560 in 1989), Medicare pays 100 percent of "reasonable and medically necessary" care, regardless of cost, length of stay, or number of times you are admitted to the hospital during the year. A Peer Review Organization (an organization of physicians) for each hospital or a Utilization Review Committee in skilled care for nursing homes helps Medicare determine if care is "reasonable and necessary."

  Hospitals now receive a flat fee from Medicare for a particular diagnosis or surgical procedure, whether a person received care for 5 or 15 days. Thus, the hospital has an economic incentive to discharge patients as soon as possible.

- **Skilled care in a nursing home.** Medicare provides 150 days a year of skilled care in a nursing home. You must pay a co-payment for the first 8 days of care ($25.50 per day in 1989). Coverage ends, however, if skilled nursing care is no longer needed daily, sufficient progress is not made in therapy, or the services could be provided in the home or on an outpatient basis.

- **Home health.** Medicare covers all medically necessary home health visits, and part-time services of a visiting nurse or physical or speech therapist from a Medicare-certified home health agency. Starting January 1, 1990, Medicare patients who need intermittent skilled home-health care up to 6 days per week will be entitled to coverage without any time limitations for as long as the doctor prescribes the care. Those who need care 7 days a week will be covered up to 38 consecutive days. This 38-day limit can be extended under special circumstances.

- **Hospice.** Hospice coverage is provided for 210 days. However, unlimited hospice care is provided to persons who are recertified as terminally ill after 210 days in a hospice program.
• Psychiatric hospital care.
There is a 190-day lifetime limit on inpatient psychiatric hospital services.
Part A does not pay for a doctor's services even while a person is in the hospital. It also does not pay for private-duty nursing or the cost of a private room unless they are medically necessary.

Eligibility. You are automatically covered by Part A if you are receiving Social Security or Railroad Retirement checks at age 65 or after you have been entitled to Social Security disability benefits for 2 years. If you are not receiving such benefit checks at age 65, if you plan to continue working past age 65, or if you are eligible for Medicare on the basis of federal employment, you should apply to Social Security 3 months before your 65th birthday so that coverage starts the month you turn 65. Have your birth certificate or baptismal certificate (if recorded before age 5) available. You should call Social Security at 1-800-234-5772 to make an appointment to file an application. You will be called at the designated time and your application will be taken by telephone.

Cost. People who are automatically eligible for Part A do not pay a monthly premium. People age 65 and older who are not automatically eligible for Part A may enroll by paying a monthly premium.

All Medicare Part A recipients who pay $150 or more in federal taxes now pay a surtax, or income-based premium. This "supplementary premium" is to help cover the costs of added protection under the Catastrophic Coverage Act of 1988. It starts at 15 percent of federal income taxes for 1989, and will rise to 28 percent by 1993. There is a ceiling on the amount you must pay each year. For 1989, the ceiling is $800; in 1993, $1,050. The maximum is double for a married couple as long as both were eligible for Part A for more than 6 full months during the taxable year. After 1993, the rate will be adjusted on the basis of program costs.

There are special rules for federal government retirees to adjust for the fact that their government pensions are fully taxed while Social Security benefits are not. The "supplementary premium" is paid along with the federal income tax.

Medical Insurance—"Part B"
Part B is an optional, supplementary medical insurance for which you must pay a monthly fee. It helps pay for:
• doctors' services
• diagnostic and laboratory tests
• certain prosthetic devices
• rental or purchase of special medical equipment (e.g., wheelchairs and walkers)
• outpatient services (e.g., surgery and physical therapy)
• home health care

Part B will not pay for any services that Medicare does not consider "medically necessary."

Starting January 1, 1990, several additional benefits will be available under Part B. These will include the following products and services:
• Prescription drugs. Limited outpatient prescription drugs—intravenous drug therapy and immunosuppressant drugs for organ transplants—will be covered after you pay a deductible. Beginning January 1, 1991, Medicare will begin paying a percentage of all outpatient prescription drugs exceeding an annual deductible. In 1991, Medicare will pay 50 percent of outpatient prescription drugs after you pay a $600 annual deductible. In 1992, Medicare will pay 60 percent. In 1993 and thereafter, Medicare will pay 80 percent of allowable drug charges in excess of the deductible, if the catastrophic coverage premiums have been sufficient to cover program costs.
- **Respite care.** Medicare will pay up to 80 hours annually for a home health aide to provide relief for an individual caring for a Medicare patient at home. However, to qualify for respite care, the Medicare patient must be chronically dependent (needs assistance with at least two activities of daily living—eating, bathing, dressing, toileting, or transferring in and out of bed or in and out of a chair) and have met either the limit on out-of-pocket expenses for a doctor’s care or the annual deductible for outpatient prescription drugs.

- **Mammography.** For women age 65 and older, up to $50 will be paid by Medicare every other year for mammogram screenings for breast cancer.

**Eligibility.** Anyone 65 or over is eligible for Part B. When you enroll for Part A you are automatically signed up for Part B, unless you specifically reject it.

**Cost.** Enrollees in Part B pay a monthly premium ($31.90 in 1989). This premium is deducted from Social Security, Railroad Retirement, and civil service retirement checks. If you do not receive monthly checks from these sources, you are billed quarterly by Medicare.

Part B has a deductible ($75 in 1989). Once the deductible is satisfied, Medicare Part B pays 80 percent of Medicare-approved charges. The one exception is home health care, for which Medicare pays 100 percent of the approved rate for care. The amounts approved by Medicare are generally lower than the actual charge made by the doctor or supplier. You are responsible for paying 20 percent of the Medicare-approved fee and all charges higher than the amount approved by Medicare.

For example: If your doctor’s bill is $75, and the Medicare-approved charge is $50, then Medicare would pay 80 percent of the $50, which equals $40. You would be responsible for the additional 20 percent of the Medicare-approved charge ($10) plus the $25 charge above the Medicare-approved fee.

As of January 1, 1990, a limit will be placed on the annual amount individuals must pay out-of-pocket for Medicare-approved physician and medical services ($1,370 in 1990). It doesn’t matter whether these expenses are paid directly by you or by your private supplemental policy. Once this limit is reached, Medicare will pay 100 percent of its approved charges for the remainder of the calendar year. Only the deductible and your 20 percent co-payment count toward the Part B limit on expenses.
Charges not allowed by Medicare—such as a doctor’s fees in excess of Medicare-approved charges or costs of non-covered services (for example, routine physical examinations)—do not count toward this limit and continue to be the responsibility of the individual. The limit will be adjusted annually.

**Medicare assignment.** One way to reduce medical costs is to select physicians and other health care providers who will accept payment on “assignment.” Accepting “assignment” means the doctor or other provider will accept the amount approved by Medicare as the total charge for covered services and supplies, even if his or her usual fee for the services or supplies is higher. You must still pay the annual deductible, the 20 percent of the Medicare-approved amount, and the cost of any services not covered by Medicare. A doctor who does not accept Medicare assignment can charge any amount.

Doctors and other providers who agree not to charge more than the Medicare-approved amount for all Medicare-approved services and supplies are called Medicare-participating physicians and suppliers. Physicians who don’t participate may accept assignment at their discretion or refuse to ask physicians and other providers—such as suppliers of medical equipment, therapists, and home health care agencies—if they accept assignment of Medicare benefits.

A listing of doctors and providers who accept assignment are available from offices of Social Security, Area Agencies on Aging, or the state’s Medicare insurance carrier. Because of changes, call listed physicians and providers you are interested in to verify that they still accept Medicare assignment. Doctors and other providers who accept assignment submit their bills directly to Medicare for payment. Medicare pays 80 percent of approved charges directly to the provider, and sends you an “Explanation of Medicare Benefits” form to explain how much Medicare paid and how much is still your responsibility to pay. If the doctor or provider does not accept assignment you may have to submit the claim forms to Medicare.

The services provided under Medicare, and the amounts of the deductibles are subject to change. For full details about what is and is not currently covered, contact your local Social Security office and ask for a free copy of publication #05-10043, Medicare.

The following are some of the most common myths about Medicare. It’s important that you know the facts.

**Myth:** Medicare pays all of an older person’s health care expenses.

**Fact:** Medicare was never designed to cover all health care costs of older people. In general, it covers only about 40 percent of health care expenses. Services not covered by Medicare include routine physical checkups; hearing and eye examinations and the cost of eyeglasses and hearing aids; dental care and dentures; foot care; and outpatient prescription drugs (although some coverage will begin January 1, 1990).

Medicare also does not pay for care of individuals who primarily require custodial care—supervision or help with walking, getting in and out of bed, bathing, eating, dressing, or taking medication—even if it is provided by a hospital, skilled care nursing home, or home health agency.

**Myth:** After payment of deductibles, Medicare pays the rest.

**Fact:** There are limits on some services for which Medicare will pay and limits on how much it will pay for each service. This is particularly true for Medicare Part B coverage.
Myths About Medicare

**Myth:** Medicare covers most long-term nursing home and in-home care costs.

**Fact:** Medicare’s coverage for nursing home care is minimal. It pays for less than 2 percent of nursing home costs. Older adults and their families pay over 50 percent of costs; Medicaid over 40 percent.

Medicare has limits on the amount of time and circumstances under which it pays for nursing home care. The person must require skilled care in a nursing home on a daily basis. The term “skilled” is very important. It means the person needs a level of nursing care comparable to what he or she would receive in the hospital. Most older people living in nursing homes need primarily intermediate or custodial care.

Four fairly strict conditions must be met before Medicare will pay for home health-care visits:
1. A person must be homebound and only able to leave his or her home with great difficulty.
2. A doctor must plan the care and certify that the services are needed.
3. The person must require either intermittent skilled nursing care, physical therapy, or speech therapy.
4. The agency must be Medicare-certified.

The emphasis on the need for skilled nursing care and being homebound means people usually qualify for a short period of time.

**Myth:** Medicare covers medical expenses for beneficiaries when they are traveling in other countries.

**Fact:** Medicare does not cover hospital or medical costs abroad, except under very restrictive conditions and only in Canada and Mexico:
1. You are in the United States when an emergency occurs and the nearest hospital is in Mexico or Canada.
2. Your home is in the United States and is closer to a hospital in Canada or Mexico than one in the United States.
3. You are traveling from Alaska by the most direct route to another state and encounter an emergency, requiring care in a Canadian hospital.

Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Northern Mariana Islands are considered part of the United States.

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Medicare Supplement Policies

Medicare is a tremendous help to older people. Without it, many more would face serious financial problems about their medical care. However, a person can still have large “gaps” in coverage of medical bills after payment by Medicare. The three important areas Medicare does not cover are:

1. Medicare deductibles and copayments.
2. Non-covered items and services.
3. Provider charges exceeding the Medicare-approved amounts.

Private supplemental health insurance policies, often called “Medigap” policies, can help cover these gaps in Medicare. However, no Medicare supplement policy covers all of the gaps. The goal is to select a policy that fills as many of the important gaps as possible and is within your budget.

Medigap policies and costs vary greatly. Typically, a policy will pay some or all of Medicare’s deductibles and copayments. They usually follow Medicare’s guidelines, reimbursing the “allowable” expenses that Medicare does not pay.

For example, let’s assume you had an operation and Medicare approves $500 for the operation, but your doctor charges $700. Medicare will pay 80 percent of the $500, which is $400. If your supplemental policy will pay only the Medicare-approved amount that Medicare did not pay, it will pay the 20 percent, i.e., $100. You would have to pay the remaining $600. Some policies cover more of the total costs of health services not covered by Medicare. (For example, a very good policy would pay for the remaining $600 as well).

Medigap policies usually exclude from coverage the same services excluded by Medicare, for example, routine physical examinations and custodial nursing home care. Advertisements that imply that a Medicare supplement policy covers “all medical costs not covered by Medicare” are usually misleading.

Federal and state laws require that policies advertised and sold as Medicare supplement policies meet minimum standards. For example, the waiting period for pre-existing conditions cannot be longer than 6 months in such a policy, and only conditions treated during the 6 months before application may be considered. Insurance companies are also prohibited from offering Medigap policies which duplicate Medicare benefits.

Some older people, fearful about the costs of long-term care, purchase several policies, feeling that the more policies they have, the better they are covered. In most cases, multiple policies are a waste of money.

A common belief is that after Medicare pays its share of approved medical expenses, the insurance company which sold the supplemental insurance policy is automatically informed. This is usually not true. The “Explanation of Medicare Benefits” form received from Medicare must be sent to the insurance company with the insurer’s name, policy number, and claim form, if required.

You may not need to purchase a Medicare supplement policy if:

- You can afford to cover the gaps in Medicare yourself.
- You have adequate health care coverage through an employer after retirement. If you are currently employed and have a group health insurance, find out before you retire if it can be
continued or converted to a suitable Medicare supplement policy when you retire. Check costs and benefits, including benefits for a spouse. An advantage is that usually there are no waiting periods or exclusions for pre-existing conditions. If you are covered by your spouse’s employer’s plan, find out your options in case of divorce or widowhood. • You are enrolled in a Health Maintenance Organization (HMO). The HMO becomes your supplementary coverage. • You are eligible for Medicaid. Medicaid is a federal program that acts as a Medicare supplement for the poor and for those who become impoverished as a result of medical expenses.

Buying a Medicare Supplement Policy: Questions to Ask

A carefully chosen policy can close some or most of the gaps in Medicare coverage. Before buying a supplemental policy, shop and compare, analyze the provisions of each policy, and carefully weigh your options. The differences in payments for the same benefits between policies can be substantial. Answering the following questions about each policy will help you to compare policies and determine which one is best.

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<tr>
<th>Policy A</th>
<th>Policy B</th>
<th>Policy C</th>
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<td>What is the annual premium?</td>
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<td>Does the premium increase with age?</td>
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<td>Does the policy cover all of Medicare’s deductibles and co-payments?</td>
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<td>Does the policy automatically cover increases in Medicare’s deductibles and co-payments?</td>
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<td>Does the policy provide benefits which cover actual costs or only the Medicare-approved charge?</td>
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<td>What health care services does the policy cover which Medicare does not?</td>
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<td>What are the policy’s exclusions or restrictions?</td>
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<td>What is the waiting period for pre-existing conditions?</td>
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<td>Is the policy guaranteed renewable?</td>
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<td>Does the policy provide coverage for medical care outside the United States?</td>
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Some states publish comparisons of policies to help you make a sound decision. To determine the availability of such information in your state, contact your state insurance department, state office on aging, or local area agency on aging. For more information on selecting a Medicare supplement policy, contact any Social Security Office and ask for the free pamphlet, Guide to Health Insurance for People with Medicare and fact sheet, Should You Buy A Supplement to Medicare?

Selecting a Medicare Supplement Policy: Ten Things To Do

1. Know what Medicare covers and does not cover. Make sure that any policy you consider is a genuine Medicare supplement policy. 
2. Deal with reputable insurance companies and licensed agents. Agents must carry proof of state licensing. If the agent cannot show you such proof, do not buy from that person. A business card is not a license. Don't buy from an advertisement, unsolicited door-to-door salesperson, or agent who claims he or she represents a government agency or program. Medicare supplement insurance is not sold, financed, or sponsored by the government, Social Security, or Medicare. To determine the status of each insurance company for which you have a policy prospectus, consult the most recent issue of Best's Insurance Reports: Life and Health. The reference librarian in your local library can direct you to Best's Reports.
3. Take your time. Do not let a short-term enrollment period pressure you into buying. Professional insurance agents will not rush you into a decision.
4. Select the best policy. Buying the most comprehensive policy you can afford is better than several policies with overlapping or duplicate coverage.
5. Choose a policy that pays for services. Policies that pay a flat rate per day (indemnity policies) or pay only if you have a specific disease like cancer are not Medigap policies.
6. Choose a policy that is renewable and non cancellable. Beware of policies which are "renewable at company option." Such a policy gives the company the right to refuse renewal on an individual basis. If a policy is "conditionally renewable," the company cannot drop an individual policy holder, but can elect not to renew that policy in a given geographic area. A "guaranteed renewable" policy is best. This means the company cannot cancel the policy as long as premiums are paid. However, the company can raise the premium for an entire group of policies.
7. Check for exclusions for pre-existing conditions that may reduce or eliminate coverage for pre-existing health problems. Don't be misled by the phrase, "no medical examination required." Pre-existing condition clauses make it unnecessary to require a medical examination.
8. Ask questions. The time to ask questions is before you buy a policy—not when making a claim. Discuss coverage experience with family and friends who have Medigap policies.
9. Get a written outline of coverage of each policy's benefits, limitations, and exclusions and how they relate to Medicare before giving serious consideration to any one policy.
10. Be careful when replacing existing coverage. Keep an existing policy until waiting periods have been met on a new policy. Remember, with a new policy, the limitations on pre-existing conditions begin again.
After You Have Decided on a Policy:
Seven Things To Do

1. Read the entire insurance policy carefully, particularly the fine print, to make sure it offers the benefits you expected.

2. Answer all questions honestly and completely on the insurance application. An insurance company can refuse coverage, deny a claim, or cancel a policy on the basis of false information.

3. Pay only by check, money order, or bank draft made payable to the insurance company, not to the agent. Never pay with cash.

4. Take advantage of "free look" provisions. You have a right to return the policy within 10 days and receive a full refund if you are not satisfied. If the policy was purchased through the mail, you have 30 days. Your state may have time frames longer than these. Know exactly how long your "free look" lasts.

5. Keep copies of the application and all payments and correspondence.

6. Keep health insurance policies in a single place that is readily accessible and tell someone close to you about the location.

7. Make a list of policy numbers and companies that issued them in case the original policies are misplaced or lost. Keep this list in a different place than the policies.

If you have problems: Contact the state insurance department or its consumer affairs division if you have concerns about a policy you are considering, the agent, or the company he or she represents, if an agent used unfair or dishonest sales practices, or if there are problems with refunds or payment of benefits. The department cannot make a purchase decision for you, but it can tell you if a company is reputable and if the policy is licensed to be sold in your state.

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Medicaid

Medicaid (called Medi-Cal in California), a program financed jointly by the federal and state governments, assists low-income people of all ages who have exhausted their own funds and cannot pay for health care.

In some states, if you are eligible for Supplemental Security Income (SSI)—a cash assistance program for older and disabled people with very low incomes and very limited assets—you are automatically eligible for Medicaid. However, you may still need to complete an application for Medicaid.

Medicaid eligibility and benefits vary from state to state, but a recipient must have a limited income and limited assets or "resources." Eligibility is determined by a person's income and assets, including real estate, automobiles, bank accounts, life insurance, stocks, and bonds. To be eligible for benefits, a person's assets may first need to be spent down to a maximum level allowed. However, if assets are transferred out of the name of the impaired person 30 months or more before applying for Medicaid, they might not be counted.

Certain assets, such as a home, are exempt from the resource limitation. People whose incomes are above Medicaid income guidelines sometimes still qualify for Medicaid benefits (in some states) on the basis of being "medically needy.”

If you are eligible for Medicaid, you do not need private health insurance. Medicaid provides much more comprehensive coverage than Medicare. It covers many health care services not covered by Medicare, such as prescription drugs, dental work, hearing aids, glasses, and custodial nursing home care.

The specific services available through Medicaid vary by state. Some states also require prior authorization before Medicaid will cover certain medical services.

In some states, if you are entitled to Medicare and eligible for Medicaid, the Medicaid program will pay your Medicare premiums for Part B Medical Insurance, the deductibles, and copayments. However, in order for Medicaid to pay these charges, the doctor or other provider of services must agree to "accept assignment.”

If Medicaid pays your health care bills, you may only use those providers who have agreed to accept Medicaid payment rates. Payments are made directly by Medicaid to service providers. A provider, however, may bill you for services not covered by Medicaid. Payment of these costs is your responsibility.

Nursing Home Care

When a person needs nursing home care and does not have the financial resources to pay the costs, an application can be made to Medicaid for assistance. If the application is approved, the nursing home resident must contribute his or her monthly income, except for a small "personal needs allowance" and income allowed for the community spouse. But then, Medicaid will pay the balance.
Because the rates Medicaid pays for nursing home care are lower than those paid by Medicare or private-pay patients, many nursing homes do not accept Medicaid patients, or they place a limit on the number of beds available for individuals on Medicaid.

Starting September 30, 1989, federal law provides protection against "spousal impoverishment." Spouses of nursing home residents no longer will be forced to lose everything to pay for a mate's care before Medicaid can be used. But if the spouse is unaware of the law and spends everything for care, the impoverishment will not be reversed by the government.

Under this law, states are required to allow the spouse residing in the community to retain a minimum monthly income. He or she will receive part of the institutionalized spouse's income, if necessary, to pay excess housing expenses. The amount of income protected will be 122 percent of the Federal poverty level effective September 30, 1989 ($786 a month in 1989). It will rise to 133 percent of the poverty level on July 1, 1991; and to 150 percent effective July 1, 1992. However, if the court orders a higher income for the community spouse, the court order will prevail.

In addition to retaining the home, the community spouse also will be able to keep combined assets of $12,000 or half the couple's combined assets, whichever is greater, but not more than $60,000. None of this amount can be counted as available to help pay for nursing home care covered by Medicaid. States may raise the minimum asset level from $12,000 to as much as $60,000. Beginning in 1990, this figure will be raised each year to account for inflation. The following table shows how the formula will affect people at different levels of assets.

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<th>If total assets are:</th>
<th>Community spouse can keep:</th>
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<tr>
<td>Less than $12,000</td>
<td>all assets</td>
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<tr>
<td>$12,000 — $24,000</td>
<td>$12,000 in assets</td>
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<tr>
<td>$24,000 — $120,000</td>
<td>one-half of assets</td>
</tr>
<tr>
<td>Over $120,000</td>
<td>$60,000 in assets</td>
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Giving Away Assets

If the state Medicaid agency determines a person's assets were given away solely to become eligible for Medicaid, benefits can be denied. Federal law states that if a person has given away assets in the 30 months prior to applying for Medicaid, he or she becomes ineligible.

Your home may be transferred without penalty to your spouse, a child under 21, or an adult child who is blind or permanently disabled. Federal law also allows you to transfer your home to a child if the child has lived in the home and provided necessary care to you for at least 2 years, forestalling nursing-home placement. Your home may also be transferred to a brother or sister if they already own an interest in the home and have lived there for at least a year.

Do not transfer assets without first obtaining advice from an attorney or legal assistance program familiar with both federal and state Medicaid laws.

For more information. To learn more about the specific requirements to qualify for Medicaid or to complete an application, contact your local department of social services or welfare office.
Common Questions About Medicaid

If my parent is on Medicaid, am I required to provide financial support?

Children are not legally required to contribute to the support of a parent for the parent to be eligible for Medicaid.

My parent lives with me. Will my income and assets count toward my parent's eligibility for Medicaid?

Whether or not your parent qualifies for Medicaid depends essentially on his or her income and assets, even if your parent lives with you. However, if you contribute to your parent's support, how you do it can affect Medicaid eligibility. Inquire about this from your local Medicaid office.

The state in which I live pays higher Medicaid benefits. Should my Medicaid-eligible parent move to where I live?

Although there is no period of state residency required for Medicaid, your parent may be asked for a statement of intent regarding the move. He or she should be prepared to explain and document that the move was for reasons other than to receive Medicaid. Your parent may be required to show proof of residency and proof that residency in the other state has been given up. He or she cannot maintain a residence in one state and travel to a second state for treatment and care and claim benefits in the second state.

How long does Medicaid coverage last?

The length of time Medicaid coverage lasts depends on a person's financial situation and medical costs. Medicaid eligibility is reviewed periodically. If a person's financial situation changes, for example an inheritance is received, Medicaid should be informed.
Long-Term Care Insurance

Long-term care is help provided over a prolonged period of time, either in the community or in a nursing home, to people who are no longer able to care for themselves. The need for such care can result from a chronic illness or disability, or from a sudden accident or stroke. Most commonly, long-term illnesses require personal or custodial care—assistance with activities of daily living such as walking, bathing, preparing meals, taking medications, and performing basic household chores.

Long-term care can be expensive. The average cost of nursing home care is $2,000 a month. Living at home and having family, friends, and/or community services help can be less expensive, but requires planning.

Medicare covers only short-term, acute care, not long-term care services. In fact, Medicare and Medicare supplement insurance policies combined pay less than 3 percent of the total nursing home costs in the United States. Most long-term care is financed by individuals and families, or Medicaid.

Long-term care can quickly deplete life savings and other financial resources, even of individuals and families who thought they were financially secure. For example, half of all private paying patients eventually spend enough of their income and resources in nursing home care to become eligible for Medicaid.

Although you may feel uncomfortable thinking about yourself or another family member needing long-term care, the reality is that about 40 percent of people over 65 will eventually need some long-term care services. Approximately 20 percent of older adults will spend some time in a nursing home. For every person in a nursing home, at least another two people living in the community have an equivalent level of functional impairment.

The likelihood of chronic illness and disability and the risk of needing long-term care increases with advancing age. Although relatively few people in their sixties require nursing home care, at any given time, 22 percent of people age 85 and older are in a nursing home.

Several insurance companies are now offering long-term care insurance policies. Many policies, however, are relatively expensive. They also have restrictions on eligibility, and limit how much, and under what circumstances, they will pay claims. And, they do not cover all long-term care expenses.

Beware of any policy or salesperson promising coverage to a person who has a medical diagnosis which means nursing home care likely will be needed. It’s too late to insure!

Long-term care policies are improving. As of 1989, 80 percent of long-term care policies no longer require prior hospitalization to obtain benefits. Many states require that policies provide at least two types of care.

Services covered and costs vary substantially from one long-term care policy to another. Four major factors affect cost:

Age. Generally, the younger you are when purchasing a policy, the lower the premium. The average premium for a person at 75 purchasing a policy is likely to be two to three times higher than for a 65-year-old.
Elimination or deductible (waiting) period. Usually the longer the elimination or deductible period—the number of home health visits or days in a nursing home you must pay for before your benefits begin—the lower the premium.

Amount and duration of benefits. The longer the benefit period and the more the policy will pay, the higher the premium.

Services covered. The more services a policy covers in addition to nursing home care—such as home care, adult day care, and adult foster home care—the higher the premium.

Almost all long-term care policies are “indemnity policies.” They pay a fixed amount per day rather than covering the actual costs or a percentage of the costs. Individuals are responsible for the remaining charges. Policies have limits on the maximum number of days or total dollars that will be covered.

A limitation of the fixed daily benefit is that an amount which is sufficient today may not be adequate in the future—in 10, 15, or 20 years—when you may need long-term care. Most policies do not automatically adjust for inflation; however, some offer an “inflation rider” for a higher premium that adjusts the benefit annually.

When services are needed, the person often must meet certain conditions before receiving benefits, for example, determination of need for care by a physician, deductible periods, and pre-existing condition waiting periods. Deductible periods may range from 20 to 100 days before coverage begins. You may have a choice of a shorter deductible period with a higher premium.

Policies generally do not cover all levels of long-term care. Benefits also vary according to the level of care and service provided. No policy provides unlimited nursing home or home care coverage. In selecting a long-term care policy, it’s important to remember that custodial and intermediate care are the most common types of long-term care needed. If only skilled care in a nursing home is covered, the policy may do nothing more than a Medicare supplement policy would do. Pay particular attention to the conditions and exclusions that significantly restrict nursing home coverage.

Avoid a policy paying only for skilled nursing care or paying for intermediate or custodial care only preceded by hospital stays or skilled nursing home care. This can pose problems. Most individuals who need such care do not first require skilled nursing care. For instance, many individuals with Alzheimer’s disease or Parkinson’s disease need long-term care, but not skilled nursing care. Some of these patients go directly to the nursing home, but then cannot get benefits.

Make sure a policy you are considering will cover care in the type of facility you expect to use. Some policies pay benefits only if you are in a Medicare-approved facility. Some pay for a variety of levels of care, but only in a skilled nursing facility. Still others will pay for care in any facility licensed by the state.

Carefully investigate and compare policies to decide what is best for your situation. Be sure you understand the terms and conditions of a policy. Know the restrictions—what a policy will not cover. Many policies will not cover individuals with certain conditions, for example mental health problems or Alzheimer’s disease, or for health problems that existed prior to the purchase of a policy.

The best policy is one which is guaranteed renewable. When a policy is guaranteed renewable, it cannot be cancelled for any cause other than non-payment of premiums.

You may not need long-term care insurance if:

- You have adequate financial resources to cover the costs of long-term care.
- You live in a Continuing Care Retirement Community where long-term care is provided at no additional cost.
- You have limited income and assets and would qualify for Medicaid.
Long-Term Care Insurance: Questions to Ask

Policies vary considerably in cost and benefits. Shopping around and comparing can help you compare policies and make an informed decision.

<table>
<thead>
<tr>
<th>What types of care does the policy cover?</th>
<th>Policy A</th>
<th>Policy B</th>
<th>Policy C</th>
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</thead>
<tbody>
<tr>
<td>Skilled nursing home care</td>
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<td></td>
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<tr>
<td>Intermediate nursing home care</td>
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<td>Custodial nursing home care</td>
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<tr>
<td>Home care</td>
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<tr>
<td>Other community-based care (e.g. adult day care)</td>
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</table>

What is the policy’s definition of various types of care?

<table>
<thead>
<tr>
<th>Skilled care</th>
<th>Intermediate care</th>
<th>Custodial care</th>
<th>Home care</th>
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</table>

What are the daily benefits for each type of care?

<table>
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<tr>
<th>Skilled nursing home care</th>
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<th>Custodial nursing home care</th>
<th>Home care</th>
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</table>

How long are benefits paid for each type of care?

<table>
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<tr>
<th>Skilled nursing home care</th>
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<th>Home care</th>
</tr>
</thead>
</table>

What are the requirements for each type of covered care?

<table>
<thead>
<tr>
<th>Skilled nursing home care</th>
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<th>Home care</th>
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<tr>
<th>Long-Term Care Insurance: Questions to Ask (continued)</th>
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<tbody>
<tr>
<td><strong>What is the deductible period for each type of care, i.e. how many days must you receive care at your own expense before coverage begins?</strong></td>
</tr>
<tr>
<td><strong>Policy A</strong></td>
</tr>
<tr>
<td>Skilled nursing home care</td>
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<tr>
<td>Custodial nursing home care</td>
</tr>
<tr>
<td>Home care</td>
</tr>
<tr>
<td><strong>Does the policy require a minimum number of days of skilled care in a nursing home before it will cover intermediate or custodial care?</strong></td>
</tr>
<tr>
<td><strong>Does the policy require hospitalization or nursing home care before it will pay home care benefits?</strong></td>
</tr>
<tr>
<td>If home care is provided, does the policy pay for non-medical care (e.g. housekeeper services, assistance with dressing, adult day care) as well as medical care?</td>
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<tr>
<td><strong>What is the premium?</strong></td>
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<tr>
<td>Is the premium fixed at the age of purchase?</td>
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<tr>
<td>Does the policy adjust for inflation?</td>
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<tr>
<td>Is the policy “guaranteed renewable”?</td>
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<tr>
<td>After purchasing the policy, what is the waiting period before coverage begins?</td>
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<tr>
<td>Does the policy have a “waiver of premium”?</td>
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<tr>
<td>If the policy has a waiver of premium, when does it begin?</td>
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<tr>
<td><strong>How are pre-existing conditions defined?</strong></td>
</tr>
<tr>
<td>Will your current health problems be covered by the policy?</td>
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<tr>
<td>If so, how long is the waiting period?</td>
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<tr>
<td>Does the policy cover care for mental or nervous disorders?</td>
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<tr>
<td>Will the policy cover care for Alzheimer’s disease and other dementias?</td>
</tr>
<tr>
<td>If so, what are the restrictions?</td>
</tr>
<tr>
<td>What other illnesses or conditions are specifically excluded from coverage?</td>
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</tbody>
</table>

If the answers you get are vague or contradict the sales literature, ask for a specimen policy. It will tell you exactly what is and is not covered. If an insurance agent is reluctant to give you a specimen policy, write to the insurance company. If the company doesn’t give you what you need, look at another company for your insurance needs.
A Final Note

If you have an older family member who has become increasingly frail, it may be wise to check regularly that his or her health insurance premiums are being paid, or assume the task yourself. One 82-year-old woman in the early stages of Alzheimer’s disease failed to pay the premiums for her Medicare supplemental insurance policy. The family learned this after she fell and broke her hip. A 78-year-old man quit paying premiums because “I’m never sick” and he falsely believed Medicare would pay all medical bills.

Many older adults and their families find out too late about services not covered by Medicare and other health insurance policies. It’s best to know what coverage you do and do not have before the need arises.

The sooner you begin planning for a time when you or a relative may require long-term care, the better prepared you will be if a need arises. A crisis is most likely to develop or problems compound if you have not planned.

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