

CHAPTER FOUR

How Am I Going To Pay For This? Financial Considerations

Medicare

The Medicare program was established by Congress in 1965 and is a federal healthcare insurance for those ages 65 and over, and certain disabled people under age 65. The Medicare program is administered by the Health Care Financing Administration (HCFA); Medicare applications are accepted at local Social Security Administration offices.

Medicare covers approximately 97 percent of Americans over age 65 and is expected to pay out more than \$303 billion annually by the year 2000.

Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Medicare Part A covers the following:

- Inpatient hospital care
- Skilled nursing care
- Hospice care
- Home health care
- Respite care
- Daily inpatient rehabilitation services

Medicare Part B covers the following:

- Outpatient services

In addition, Medicare Part D was recently added to provide prescription medication coverage.

For specific information please reference www.medicare.gov
or call 1-800-MEDICARE

Medicaid

Medicaid is often confused with Medicare. Both Medicaid and Medicare are federally funded programs; however, there are several important differences:

- Medicaid is a joint federal/state program which means it receives funds from both federal and state sources
- Medicaid is state operated, so benefits differ from state to state
- Medicaid is designed for low-income individuals
- Medicaid is for all ages (In 1994, one in five Medicaid recipients was 65 or older.)

Qualified Medicare Beneficiary (QMB) Benefit: Medicaid may pay for a person's Medicare premiums, deductibles and coinsurance costs. Application for QMB is through the local social services office. (The social services office is listed in the Blue Pages of the telephone book.)

For a better understanding of what your state Medicaid program offers, contact the local public assistance office or the state's Department of Public Welfare for more information and eligibility requirements. (These offices are listed in the Blue Pages of the telephone book.)

Long-term Care Insurance

Long-term care insurance is designed specifically to pay for the long-term care services that are not covered by Medicare. Like any insurance policy, there are many companies which sell a variety of policies. Some pay a percentage of the cost of services while others pay up to a specified dollar amount; however, most are indemnity policies – which pay a fixed dollar amount for each day a person receives care.

Cost: The premiums are generally determined by a person's age, health status, the amount of coverage desired, and the length of the benefits.

Things to be aware of:

Policies that . . .

- **cover only skilled nursing care**
(most nursing home residents receive custodial care)
- **require a nursing home stay to be “medically necessary”**
- **do not cover residential care settings** (e.g. assisted living, personal care homes, etc.)
- **require prior institutionalization** (sets limitations on home health care)
- **do not provide care outside a local area**
- **exclude Alzheimer's disease** or other organize mental disorders
- **do not have an inflation benefit** (this is important if purchasing a policy when young)
- **raise premiums as policyholders age**
- **are not guaranteed renewable** (a policy should guarantee the right of continuation of coverage)
- **do not contain a “waiver of premiums”** (this waiver allows a person who has entered a nursing home to receive insurance benefits and no longer pay premiums)

Note: Never buy a policy without thoroughly understanding its provisions and benefits and comparing it to at least two other policies.

Private Pay

“Private Pay” simple means your health care services are not being paid by Medicare, Medicaid, or private insurance. Since only 1 percent of the senior population carries long-term care insurance, most people fall into this category.