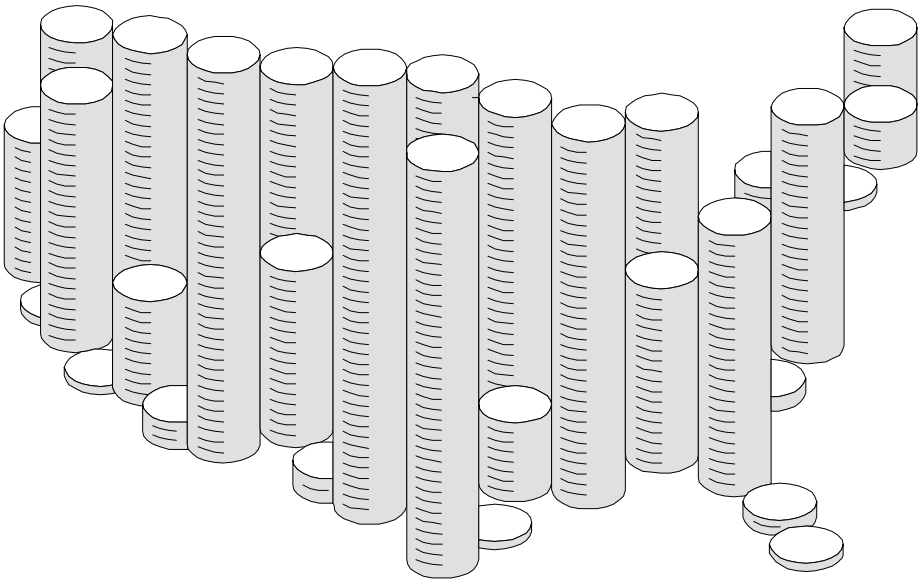
Overview of Payers for Long Term Care Services

Introduction

If you are like many older Americans who are thinking about their future health care needs, you might be uncertain about what the Medicare program covers and whether you need to look at purchasing any additional insurance.

While many of you may be aware of nursing homes as a source of health care for the elderly, you may not be aware of the full range of long term care options currently available to you or a family member.

This booklet will give you a better understanding of long term care and your Medicare benefits, identify the gaps in Medicare coverage, and provide tips on finding alternative sources of funding for any future long term care needs you or your family might have.



What Is Long Term Care?

Generally, “long term care” refers to a broad range of services needed by people for an extended period of time because of illness or disability.

Long term care includes medical services such as nursing care or therapies, and supportive services such as help in bathing, dressing, eating, taking medications, getting in and out of bed, and other activities of daily living. Long term care can be provided in a variety of settings including nursing homes, the person's home, adult day care centers, assisted living, and community-based residential facilities.

Nursing Home Care

Nursing home care has three basic levels:

- **Skilled Nursing Home Care**

  This care is ordered by a physician and requires the skills of professional personnel such licensed or registered nurses, physical and occupational therapists, and speech-language pathologists. Services are required daily and are provided by or under the direct supervision of various health care professionals.

- **Intermediate Nursing Care**

  This is basic care including physical, emotional, social, and other restorative services. This care also may involve skilled nursing or therapy services but not on a daily basis. Registered and licensed nurses are required to provide an initial physical assessment of the patient, develop the patient's care plan, and supervise unlicensed staff.

- **Custodial Care**

  This is care that can be performed by unlicensed staff under the medical supervision of registered/licensed nurses. This type of care is primarily for the purpose of meeting the personal needs of the resident such as assistance with one or more activities of daily living.

Home Health Care

Home health care includes:

- Skilled nursing services such as providing a treatment or administering medication by injection or through an IV;
- Home health aide services such as checking temperature, pulse, and blood pressure;
- Personal care for activities of daily living such as bathing, dressing, feeding, walking; and
- Physical, occupational, respiratory, or speech therapy.

Adult Day Care

Adult day care is provided in a nonresidential, community-based group program designed to meet the needs of functionally impaired adults. It is a structured, comprehensive program that provides the participant with a variety of health, social, and related support services during any part of the day.

Assisted Living

Assisted living is a combination of housing and personalized care designed to respond to the individual needs of people who need help with activities of daily living but who do not need the 24-hour skilled care of a nursing home.

Assisted living residences may be known under many names: residential care facilities, adult congregate living facilities, personal care homes, retirement homes, homes for adults, rest homes, residential health care facilities, and assisted living residences.

Hospice

Hospice care is a program that provides medical and social services primarily designed for pain relief, symptom management, and support services to the terminally ill person and his or her family. Services may include physician's visits, skilled

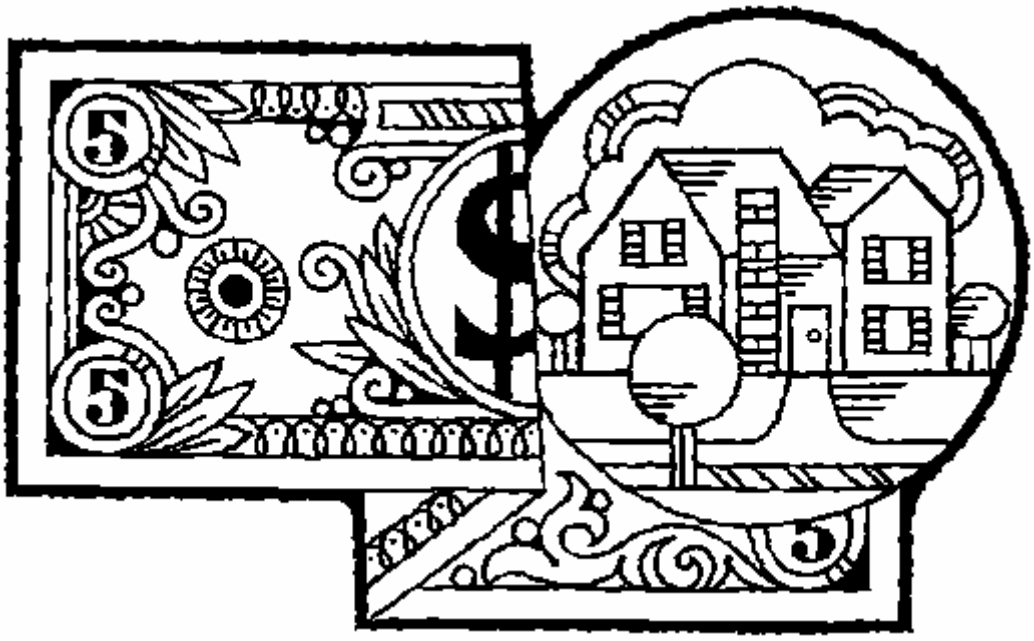
nursing care, medical equipment/supplies, drugs for pain, counseling, home health aides and, if necessary, inpatient care.

Summary

Whether or not a person requires long term care depends on his or her level of disability. The chances of needing long term care usually increase as a person ages, but long term care may be needed at any age. In Wisconsin, three percent of all people age 65 to 84 reside in a nursing home. That number increases to more than 25 percent for people over the age of 85.

It's true that the longer a person lives, the more likely he or she will need long term care. Many more people will have acute illnesses or injuries and may need nursing home or home health care for a short period until recovery is complete. For example, many patients recovering from hip or knee replacement surgery are admitted to a nursing home for a short period of rehabilitation and then go home.

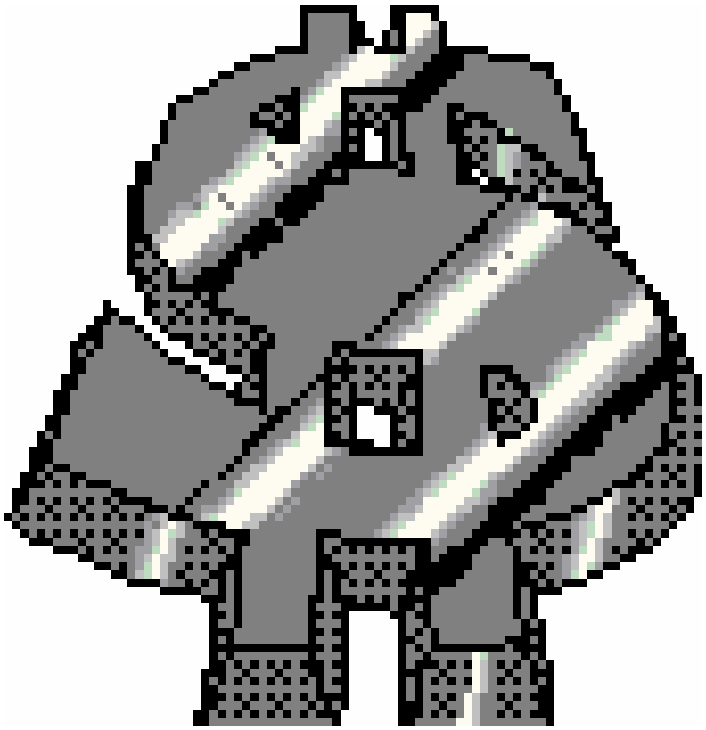
While we don't like to think of growing older or our health failing, it is important to realize that, at some time in our lives, we or a loved one may need long term care, and we should start to consider how we are going to pay for it.



What Is the Cost of Long Term Care?

The cost of long term care depends on the services provided. The average cost for a day in a nursing home for a private pay patient was approximately $212. This does not include any additional services such as therapy. A home health nurse has additional charges, depending on the length of the visit.

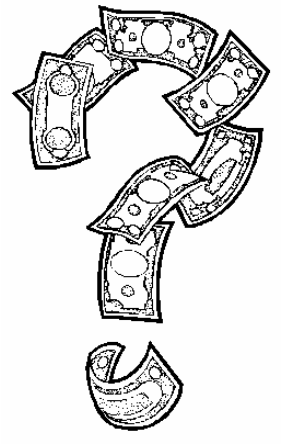
A basic assisted living fee may cover all services, or the resident may be required to pay extra if he or she requires more care. An example would be that the facility may charge an additional fee if the resident needs assistance with feeding, rather than just providing a meal.



Who Pays for Long Term Care?

Many people must pay for the cost of long term care themselves either in whole or in part. There are several ways you can defray all or part of the cost. Let's review the many options available. They are:

- Medicare Part A and B
- Veteran's Administration
- Medicaid Program/Title 19/Medical Assistance
- Medicare Supplement Insurance
- Long Term Care Insurance



Medicare

Medicare is a federal health insurance program for people 65 or older and people of any age with certain permanent disabilities or end-stage renal disease.

Medicare has two parts, Hospital Insurance (Part A) and Medical Insurance (Part B). Part A is available free of charge to anyone who qualifies for benefits either under the Social Security or Railroad Retirement programs or worked a sufficient period of time in federal, state, or local government to be insured. If you do not qualify for premium-free Part A benefits, you may purchase the coverage if you meet certain criteria. If you need more information, contact the Social Security Administration.

Part B is optional and is available to all beneficiaries when they become eligible for Part A. It also may be purchased by most people over 65 who do not qualify for Part A. The premium for Part B coverage is automatically deducted from your Social Security check each month.

Benefits

Medicare Part A will help pay for medically necessary inpatient care in a hospital, skilled nursing facility**,** psychiatric hospital, or hospice unit. Part A also will pay the cost of “medically necessary” home health care and 80 percent of durable medical equipment covered under the home health benefit.

Skilled Nursing Facility Care

A skilled nursing facility (SNF) is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility, such as a nursing home or hospital.

Medicare Benefits Are Payable Only Under the Following Circumstances:

- You are enrolled in Medicare Part A,
- You must have had a three-day qualifying hospital stay,
- You must be transferred into a Medicare certified bed within 30 days after the qualifying stay, and
- A physician certifies that you require daily skilled care.

Medicare Part A will help pay for **up to 100 days of skilled nursing and rehabilitation care. The first 20 days are covered in full and days 21-100 are coinsurance days**. This means that you will have to pay a daily coinsurance amount ($119 in 2006) out of pocket.

Medicare will pay nothing after day 100. Only about seven to 15 percent of all nursing home days are covered by Medicare. This is because Medicare defines **skilled care** in a very restrictive way and because only about 75 percent of the nursing homes in Wisconsin participate in the Medicare program.

Medicare Part B Covers Many Medical Costs Such As:

- Physician's Services
- Physical, Occupational, and Speech Therapy
- Diagnostic Tests
- Durable Medical Equipment
- Home Health Care
- Outpatient Hospital Treatment

After a $100 annual deductible, Medicare Part B pays 80 percent of Medicare-approved charges for covered services. Medicare does not always approve the charges in full and, unless your provider accepts assignment of benefits from Medicare, the charges could exceed the Medicare approved amount by as much as 15 percent. You would have to pay this out-of-pocket as well as the 20 percent coinsurance not paid by Medicare.

Home Health Care

Medicare covers only those home health visits that Medicare considers to be medically necessary. Medically necessary is defined quite narrowly and you must meet certain other criteria before Medicare will pay for the care. To qualify you must meet the following conditions:

- The care must include part-time skilled nursing care, physical therapy, or speech therapy;
- The patient must be confined to the home;
- Your physician must set up a home health plan; and
- The agency providing the care must be Medicare certified.

Adult Day Care

Medicare does not cover the cost of adult day care.

Assisted Living

Medicare does not cover charges from assisted living facilities.

Hospice

Medicare beneficiaries who have been certified by their physicians as terminally ill may choose to receive hospice rather than regular Medicare benefits for their terminal illness. Part A can pay for two 90-day hospice benefit periods, a subsequent period of 30 days, and a subsequent extension of unlimited duration. Medicare's Part A and B deductibles do not apply to hospice benefits. If you require outpatient drugs or inpatient respite care, you will have to pay a portion of the charges.

Medicaid/Medical Assistance/Title 19

How Do You Qualify?

Medicaid, also known as Medical Assistance or Title 19, is a government health care program paid for by the state and federal governments. To be eligible for Medicaid:

- You must be 65 or over, disabled, or in a family with dependent children; and
- You must have low income and few assets; or
- You must be paying so much for health care that you have very little income left.

For eligible persons, Medicaid pays for most health care costs, including nursing home and community-based care.

Benefits

Nursing Home

Medical assistance is a major source of payment for nursing home care. About 75 percent of all nursing home residents in Wisconsin receive help with their nursing home costs. To qualify for Medicaid nursing home benefits, an eligible nursing home resident must require medical, nursing, and/or therapeutic care on a daily basis, and be under a doctor's plan of treatment. Even after a person becomes eligible for Medicaid, most of his or her income must be used to pay nursing home bills, with Medical Assistance paying the remaining costs.

Many residents of nursing homes who receive Medical Assistance are able to pay for all their care themselves when they first enter the nursing home. Over the course of a long nursing home stay, many people spend most of their savings paying for their care, and then become eligible for Medical Assistance.

Home Health Care

Home health care can, in some cases, substitute for care provided in hospitals and nursing homes. Medical assistance pays for these home health visits and personal care services for eligible persons who have medical needs and are under a doctor's plan of treatment. The services must be provided by a home health agency certified by the Medicaid program.

Personal Care

Medical Assistance also pays for some personal care such as assistance with bathing and dressing, eating, or getting in and out of bed. To be covered under

Medical Assistance, services must be received by eligible persons under a doctor's plan of care and provided by a Medicaid certified agency.

- **Assisted Living**

  In Wisconsin, the Community Options Program provides community-based, long term care services to some qualified people. All or part of the cost of care is paid by Medicaid for those with limited income and assets. A wide range of services can be provided to eligible persons under this program including, personal care, transportation, adult day care, respite care, and assisted living.

  Please contact your local county social service agency or the benefit specialist at your county aging agency for more information about the Community Options Program.

Spousal Impoverishment Protection

The law permits a person whose spouse is receiving long term care in a nursing home to keep a certain amount of monthly income and assets (in addition to the family home and other non-counted assets) even though the spouse's long term care costs are being paid by Medical Assistance. For more details on this protection, contact your county aging agency.

Estate Recovery Program

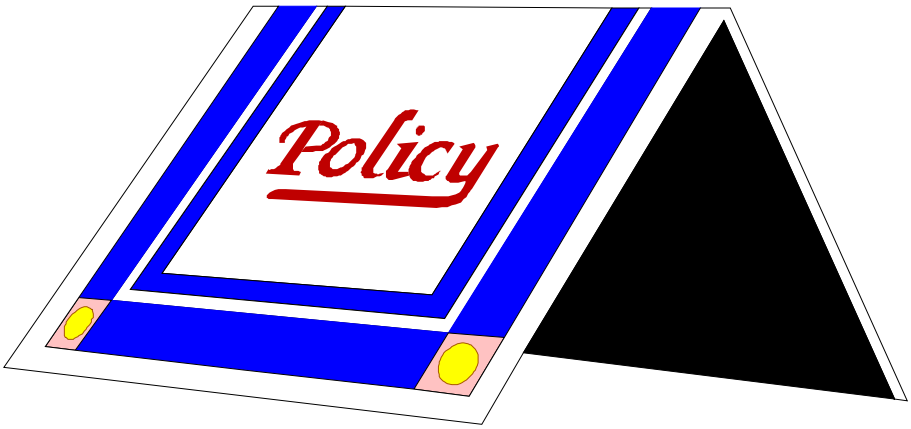
Wisconsin has an estate recovery program through which the state seeks **repayment of Medical Assistance** payments for nursing home care. The recovery is made from the estate of a recipient or the estate of the spouse. An estate includes **all assets** owned by a person at the time of death.

Medicare Supplement Insurance

If you are like most Americans covered by Medicare, you may be uncertain about what Medicare covers and how much it pays toward your Medical expenses. Like many other beneficiaries, you may want to know what, if any, other insurance you should buy. As this booklet has already pointed out, Medicare does not cover all your potential health care costs. For example, you are responsible for the deductible and coinsurance under Medicare Part B. Few people can afford to pay all of these expenses out of their own funds, so they rely on supplemental insurance to cover some of the costs.

Note: Anyone eligible for Medical Assistance (Medicaid) does not need to buy private health insurance. If you bought a Medigap policy after November 5, 1991, and then became eligible for Medical assistance, the law permits you to suspend your Medigap insurance for up to 24 months while you are enrolled in Medical Assistance. If you would lose your Medical Assistance eligibility any time within those 24 months, the law permits you to reinstate your Medigap insurance.

You will find that there are three basic ways of "supplementing" Medicare benefits: (1) through the purchase of Medicare supplement insurance, which is also called "Medigap" insurance; (2) by enrolling in a Health Maintenance Organization (HMO) that has a contract to serve Medicare benefits (This is called a "Medicare Select" or "Medicare Risk" plan.); and (3) by continuing coverage under an employee group health plan.



Medigap

Medigap insurance is regulated by state and federal law and must be clearly identified as Medicare supplement insurance. It is designed specifically to complement Medicare's benefits by filling in some of the gaps in Medicare coverage. Medigaps pay most, if not all, coinsurance amounts and **may** provide coverage for Medicare's deductibles. Some policies also may pay for services not covered by Medicare, such as outpatient prescription drugs.

Basic Benefits

All **Medigap** policies offered by traditional insurers provide the following long term care related benefits:

- Copayment for 21st to 100th day of skilled nursing care in a skilled nursing facility ($119 in 2006),
- Forty home health visits in addition to the number covered by Medicare,
- Twenty percent of the Medicare covered Part B services, and
- Coverage for 20 days of non-Medicare covered "skilled nursing care" -- no prior hospitalization required. (Medigap insurers generally follow Medicare guidelines when defining what is "skilled care.")

Insurers may offer the following **optional,** long term care related benefits in a separate benefit for an additional premium:

- Part A Medicare deductible,
- Part B Medicare deductible,
- Additional home health care (up to 365 visits per year).

Medicare Select

Medicare Select, which is offered by insurance companies and HMOs, is the same as a standard Medigap policy in nearly all respects. The only difference between Medicare Select and standard Medigap insurance is that Medicare Select policies will pay only supplemental benefits if covered services are provided through specified health care providers.

The specified health care providers, called "preferred providers," are selected by the insurance company or HMO. Each issuer of Medicare Select policies makes arrangements with it's own network of preferred providers.

If you have a Medicare Select policy, each time you receive covered services from a preferred provider, Medicare will pay its share of the approved charges and the insurer will pay the full supplemental benefit provided in the policy.

In general, Medicare Select policies deny payment or pay less than the full benefit if you go outside the network for services. Medicare, however, will still pay its share of the approved charges.

All **Medicare Select** plans offered by HMOs must provide the following long term care related benefits:

- Copayment for the 21st to the 100th day of skilled nursing care in a skilled nursing facility,
- Part B deductible,
- Part B 20 percent copayment on Medicare-approved charges,
- Forty additional home health visits, and
- Coverage for up to 20 days of Non-Medicare, skilled nursing facility care, no prior hospital stay required.

Medicare Risk Plans

A Medicare Risk Plan is a special arrangement between the federal Health Care Financing Administration (HCFA) and certain HMOs. Under this arrangement, the federal government pays the HMO a set amount for each Medicare enrollee. The HMO agrees to provide all Medicare benefits. The HMO will provide some additional benefits at an additional cost. These are sometimes referred to as "Medicare Replacement Plans."

Anyone who enrolls in a Medicare Risk HMO is **locked in**. This means that, except for emergency or urgent care situations away from home, enrollees must receive all services **including Medicare services**, from HMO providers. If you were to be admitted into a nursing home without the authorization of your HMO physician, you would be responsible for the entire cost of the services received. The HMO also may provide supplemental benefits for an additional fee paid by the insured.

Remember: If you buy a policy from the HMO, you must use only their approved providers. You will not have to file claims. Except for out-of-area claims, the HMO takes care of all paperwork. You also do not have to worry about having to pay for any charges in excess of Medicare's approved charge.

Employer Group Insurance for Retirees

Many people, upon reaching age 65, have private insurance, often purchased through their or their spouse's current employer or through union membership. If you have such coverage, find out if it can be continued when you or your spouse retires. Group health insurance that is continued after retirement has the advantage of having no waiting period or exclusions for preexisting conditions, and the coverage is usually based on group premium rates, which may be lower than individually purchased policies.

Caution: If you have a spouse under 65 who was covered under the prior policy, make sure you know what effect your continued coverage will have on his or her insurance. Furthermore, since employer group insurance policies do not have to comply with the federal standards for Medigap policies, it is important to determine the benefits your specific benefit plan provides. While it may not provide the same benefits as a Medigap plan, it may offer other benefits such as a prescription drug plan or routine eye care. If you are over 65 and you or your spouse work, Medicare may be the secondary payer to your employer group health plan.

Contact your employer for more information.

Tips for Purchasing Medigap Insurance

- ✪ **Shop carefully before you buy.** Policies differ as to coverage and cost. Companies differ as to service. Contact several agents and compare prices before you buy.

- ✪ **Don't buy more policies than you'll need**. Duplicate coverage is expensive and unnecessary. A single comprehensive policy is better than several policies with overlapping coverage.

- ✪ **Consider your alternatives**. Depending on your needs and finances, you may want to consider continuing the group coverage you had at work, joining an HMO, or buying a Medigap policy.

- ✪ **Take your time.** Do not be pressured into buying a policy. If you are not sure a policy is good, ask the salesperson to explain it to a friend or family member.

- ✪ **Do not pay cash.** Pay by check, money order, or bank draft made payable to the insurance company, not to the agent or anyone else.

Cost of Policies

Anyone buying a Medigap policy should find out exactly what the premium will be. A few companies charge everyone the same amount. Most companies charge different rates based on the age of the person applying for coverage. Several companies also charge different rates for men and women and a few have different rates in different parts of the state.

You also should find out what happens to your premium as you get older. Be sure to ask the agent for any company you are considering what approach is used. The general approaches are described below:

- **Attained Age**. In addition to medical inflation and increased Medicare deductibles and copayments, your premium also will increase as you age. This is due to the increase in medical services as people age.

- **Issue Age**. Your premium will increase due to medical inflation and increased Medicare deductible and copayments. It will not increase due to your age. Your initial premium will be somewhat higher than under Attained Age. As a result, the premium you will pay in later years should be somewhat less than under the Attained Age method.

- **No Age Rating**. Under this method, the premium is the same for all customers regardless of age.

Exclusions

Medicare excludes certain types of medical expenses. So do many Medicare Supplement, Medicare Select, and Medicare Replacement policies. Some items frequently excluded from these policies are:

- custodial care in nursing homes
- private duty nursing
- routine check-ups
- eye glasses
- hearing aids
- dental work
- cosmetic surgery
- outpatient prescription drugs

There are two other exclusions.

1. Medicare pays only for charges that are medically necessary. If Medicare denies a service, most likely your Medigap plan will also. Medicare only pays its portion of "approved charges." Your Medigap plan typically will pay the difference between what Medicare "approved" and what Medicare "paid." If you have the Medicare Part B Excess Rider, the policy will pay the difference between the doctor's charge and what Medicare approved.

2. Medicare pays for skilled nursing care in a Medicare certified skilled nursing facility. There are **no benefits for custodial care**. Skilled care is defined quite narrowly.

Limitations

Many insurance policies have waiting periods before coverage begins. If the policy excludes preexisting conditions for a limited time, that must be stated clearly in the contract.

Remember: For the first six months after people first enroll in Part B Medicare, insurers **must accept them regardless of their health.**

Guaranteed Renewable

Be sure to ask the agent or company about the renewability of the policy. All Medigap policies sold today must be guaranteed renewable for life. This means that you can keep the policy for life as long as you continue to pay the premium.

Long Term Care Insurance

Long term care insurance is available to cover custodial care in a nursing home as well as certain kinds of care in the home. Policies also are available to pay for skilled nursing facility care after your Medicare benefits run out. If you are considering purchasing long term care insurance, be sure you know which types of nursing homes and services are covered.

Remember: custodial care is **not** covered by Medicare or most Medigap insurance policies.

There are now three types of insurance policies sold in Wisconsin to cover long term care expenses. They are:

1. **Long Term Care Insurance Policies:** These policies cover both nursing home care and home health care.

2. **Nursing Home Insurance Policies:** These policies cover only nursing home care.

3. **Home Health Care Insurance Policies:** These policies cover only care received in the community (home-health care or other community-based services).

The state of Wisconsin has established minimum standards for each of the three types of policies.

All three types of policies must:

- Provide at least one year of benefits.

- Provide benefits based on the level of care only if the lowest limit of daily care is not less than 50 percent of the highest limit for daily care. For example, benefits provided for custodial care would have to be at least 50 percent of those provided for skilled care.

- Offer a choice of elimination periods. If the policy offers you the option of an elimination period of 180 days or less, then the policy also must offer you the option of an elimination period of more than 180 days. An elimination period is like a deductible. It is the number of days you would have to be eligible for benefits before the policy would make payments. In no event should policies have an elimination period longer than one year.

- Provide benefits even if not medically necessary.

- Pay benefits to a person without requiring a prior hospital stay.

- Pay benefits for a person with "irreversible dementia" (such as Alzheimer's disease) provided they need the type of care covered by the policy.

- Offer inflation protection as an option.

Policies that include home health care benefits must pay for care:

- Even if the person is not receiving care from a nurse or licensed therapist.
- Regardless of whether the person has an acute medical problem.
- Even if the services are not provided by a Medicare-certified home health agency.
- Even if the person was not previously in a hospital or nursing home.

Life Insurance Policies

Another way to cover long term care services is through a rider attached to a life insurance policy. Long term care riders differ from long term care policies in several respects. Monthly benefits for a nursing home stay are typically based on a percentage of the life insurance amount. For example, on a $100,000 policy, a two percent benefit would provide you $2,000 a month. A monthly benefit for home health care when covered is usually 50 percent of the nursing home benefit.

Benefits are tied directly to the amount of life insurance in force. Benefits are reduced by any loans against the policy. Using the long term care benefit will reduce the life insurance coverage.

What Should I Look for When Comparing Policies?

Cost of Policy

The premium may vary according to various factors, including the benefits, your age, sex, and place of residence. Policies purchased at a younger age are generally less expensive than those bought at an older age. In most cases, your premium will not increase just because you get older.

Elimination Period

Policies frequently have elimination periods. The longest period allowed by Wisconsin law is 365 days. Usually the longer the elimination period, the lower the premium. The longer the elimination period, the less chance you will collect the benefits.

Inflation Protection

As health costs increase, you may find that you have a benefit that is too low by the time you need care. Some policies allow you to increase benefits over time. While it may add to the cost of the premium, it is an important safeguard against inflation.

Exclusions

Long term care policies may contain some exclusions. The most common are for mental and nervous disorders, preexisting conditions, care outside the United States, and care needed as a result of a self-inflicted injury.

Preexisting Conditions

Anyone who is sick or under a doctor's care for a particular condition when a policy is sold may **not** be eligible for benefits until a certain period of time has past. This is called a **preexisting condition waiting period**. The longest waiting permitted in Wisconsin is six months. This waiting period can be applied only to conditions that you have **not** been asked about on the application.

Type of Coverage

Policies pay in different ways. For example, some policies pay a fixed amount for each day you are confined to a nursing home or each day you receive home health care regardless of the actual cost of the care. Other policies pay according to the provider's actual charges up to a fixed amount or a percentage of the charges.

You also should examine the period of time the benefits are paid. Benefits may last for one year, several years, or for the rest of your life, depending on the policy. In general, costlier plans will provide payments longer and will have fewer restrictions.

When comparing policies, look at the type of coverage contained in the policies. Policies frequently limit benefits to specific types of services, provided by specific types of facilities or agencies. For example, services provided in the home may be limited to those provided by a licensed home health care agency. Nursing home coverage may be limited to certain levels of care. In other words, it is important to check out the policy to be sure you understand what services are covered.

Tips for Purchasing Long Term Care Insurance

- ✪ **Know With Whom You're Dealing.** A company must meet certain qualifications to do business in this state. Agents also must be licensed in the state. If the agent cannot verify that he or she is licensed, do not buy from that person. A business card is not a license.

- ✪ **If You Decide To Buy, Complete The Application Carefully.** Do not believe an insurance agent who tells you that the medical history on an application is not important. If you leave out any of the medical information requested, coverage could be refused for a period of time for any medical condition you neglected to mention.

- ✪ **Use The Free-Look Provision.** Insurance companies must give you at least 30 days to review a policy. If you decide you don't want it, send it back to the agent or company within 30 days and ask for a refund of all premiums paid.

- ✪ **Do Not Pay Cash.** Pay by check, money order, or bank draft made payable to the insurance company. Always get a receipt with the insurance company's name, address, and telephone number for your records.

What if I Have any Questions or a Complaint?

If you have any questions concerning or complaints about:

Medicare

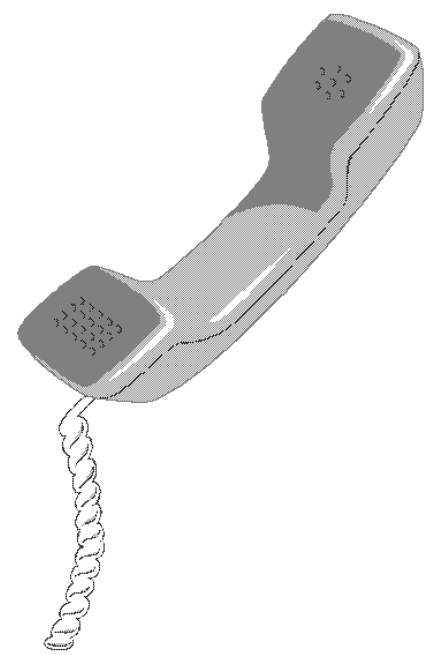
Contact your local Social Security office, your County Agency on Aging, or call toll-free 1-800-234-5772.

Medicaid

Contact the county Social Service Agency or the Recipient Hotline (800-888-7989). In Madison, the Recipient Hotline number is (608) 266-4279.

Insurance

Contact the agent or company involved. If you do not get satisfactory answers, contact the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI 53707-7873. Phone 1-800-236-8517.



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