Paying for Long Term Care

When it comes to long term health care, many Americans incorrectly assume that Medicare, supplemental policies or standard health insurance policies will cover the expenses. Consequently, many people do not plan ahead financially to provide for their care in the event of infirmity or extended illness. Costs of services provided by a nursing facility can exceed $50,000 annually, or more than $4,000 per month. Costs for residing in an assisted living facility average $24,000 annually, but can cost much more in urban settings or if a resident needs a high level of services.

As these figures show, paying for long term care calls for financial planning for your health needs, especially as you approach retirement. The following information is designed to give you a better sense of the financial programs and options available, as well as the benefits you can expect.

Long Term Care Insurance

Long term care insurance can protect personal assets and inheritance for the family, provide greater choice in the selection of long term care settings (nursing and assisted living facilities) and generally provide for financial security. Recently enacted federal health insurance legislation has helped make private long term care insurance a more viable option for paying for long term care costs while preserving personal savings, choice and dignity.

The recently enacted Health Insurance Reform Act includes consumer protections for purchasers of long term care insurance as well as clarifications that make treatment of private long term care insurance identical to that of health insurance coverage. Starting January 1, 1997, individuals are able to include out-of-pocket expenses for long term care and long term care insurance premiums with their other itemized medical expenses on their annual tax returns. Long term care and other medical expenses are deductible, to the extent that they exceed the federal government's 7.5 percent threshold of adjusted gross income. Also, the insurance benefits consumers receive, for the most part, will not be taxable as income.

Long term care insurance policy premiums are set based on several factors: age, health, length of deductible period, amount paid and duration of benefits. Higher daily benefits and optional features, such as inflation protection and nonforfeiture benefits, increase the premium. According to the Health Insurance Association of America, the annual premium for a low-option policy for a person at age 50 is about $850; at 65, that same policy costs about $1,800; and at 79, about $5,500. (You should consult with your insurance or financial advisor on current costs.)

Contact your state insurance commissioner's office for a list of companies authorized to sell long term care insurance in your state. For more information on long term care insurance, see the American Health Care Association's and the National Center for Assisted Living's brochure "Understanding Long Term Care Insurance."

Medicare

Medicare is a federal health insurance program for people 65 and over and certain disabled people under 65. It does not provide a comprehensive long term care component and generally does not cover assisted living costs but may pay for short term services (e.g. physical and other therapies) contracted through a home health care agency and provided to the resident at the assisted living facility. Medicare covers only those skilled nursing facility services rendered to help a beneficiary recover from an acute illness or injury. Medicare is administered by the federal government's Centers for Medicare and Medicaid Services (CMS) and is divided into two parts: Hospital Insurance (Part A); and Medical Insurance (Part B).

Eligibility

Nursing facility coverage falls under Part A of Medicare and is very limited. If certain conditions are met, Medicare only pays fully for the first 20 days of care in a skilled nursing facility (SNF).
For the 21st through the 100th day, the patient must share, or co-pay, for the cost of care by paying a daily coinsurance rate, which changes yearly. In 2002 the coinsurance payment is just over $101 per day.

Medicare Pays for Nursing Facility Care Only Under the Following Conditions:

1. The nursing home is a skilled nursing facility (SNF). SNFs provide 24-hour nursing care to convalescent patients.
2. Continuous skilled nursing care or skilled rehabilitation services (as defined by the federal government) are required on a daily basis.
3. The patient has spent at least three consecutive days in a hospital and if the admission to the SNF occurs within 30 days after discharge from the hospital.
4. A physician certifies that SNF services are needed for the same or related illness for which the person was hospitalized.

Services Covered by Medicare

- A semi-private room
- Meals, including special diets
- Regular nursing services
- Rehabilitation services
- Drugs furnished by the facility
- Medical supplies

Services Not Covered by Medicare

- Personal convenience items
- Private duty nurses
- Extra charges for a private room

Medicare Part B may help pay for covered services you receive from your doctor in a SNF, if you choose to participate in the Part B medical insurance program. If you have used up your Part A coverage for a spell of illness, Part B also covers a portion of services received in a SNF, such as physical and occupational therapy.
Under the Part B program, you must pay an annual premium and a deductible for all Part B services, including physician services, after which Medicare pays 80 percent of the reasonable charges for covered services.

Services Not Included Under Medicare Part B

- Routine physical examinations and tests
- Routine foot care
- Eye or hearing exams for prescribing or fitting eyeglasses or hearing aids
- Immunizations other than for the flu or pneumonia

How to Apply for Medicare

Contact your nearest Social Security office to find out if you are automatically covered for Part A because of credits for the number of (calendar) quarters worked in your lifetime. Also, if you are interested in signing up for Medicare medical insurance (Part B), the Social Security office can assist you with that process. Keep in mind, though, that you can only sign up for the insurance in the first three months
of the calendar year.

Medicaid

Medicaid is a joint federal-state government program designed to provide health care assistance to low income people, and it has become the major payer of services for care in a nursing facility. In many states, Medicaid will pay for assisted living services, although in most cases such coverage is limited.

Eligibility

Medicaid will pay for nursing facility care for those persons who meet a state-determined poverty level and certain health related criteria, provided the nursing facility is certified, and meets a stringent set of government standards.

Benefits

Medicaid will pay for care in a nursing facility (NF). The amount paid is determined by each state, and covers room, board, nursing care and social activities.

How to Apply for Medicaid

Contact your local Department of Welfare or Department of Health for an application. Because Medicaid is based on financial need, you will be asked for extensive information such as residence, family composition, income, real and personal property, banking/investment transactions and medical expenses.

Risk of Impoverishment

Spouses of nursing facility residents are protected from what is termed "spousal impoverishment." This refers to the required depletion of an "at home" spouse's financial resources so that the spouse in a nursing facility can qualify for Medicaid. States are required to permit the at-home spouse to retain a "maintenance needs allowance" from the other spouse's income that is sufficient to bring the at-home spouse's income to 150 percent of the federal poverty level for a two-person household.

Special Care Programs

Assisted Living

Assisted living is a congregate, residential setting that provides or coordinates personal care services, 24-hour supervision, assistance (scheduled and unscheduled), activities and health-related services.

Assisted living is a largely private-pay setting. Most long term care insurance policies today also provide coverage for assisted living services. Although an increased amount of government funding is being made available for assisted living, the overall involvement is not yet substantial. Several government programs provide funds for qualifying individuals that may be used to pay for assisted living services. The most widespread of these programs is Supplemental Security Income (SSI). Individual states sometimes provide funding through Social Services Block Grants or other state-initiated programs. Historically, Medicaid has not been a factor in assisted living; but, as of 2002, 41 states had state plans, Home- and Community-Based Service (HCBS waivers), or Section 1115 waivers that allow at least some Medicaid funding for assisted living services. According to the National Academy for State Health Policy, a number of additional states are planning to offer Medicaid funding for assisted living services. Please inquire at your state Office on Aging for details.

Persons with Mental Retardation or with Developmental Disabilities (MR/DD)

Medicaid is the primary payer of MR/DD services for persons with mental retardation or developmental disabilities, although some clients are considered disabled children and may access their parents' Medicare and Social Security. Most individuals who receive MR/DD services have severe or profound mental retardation and other disabilities often associated with concurrent impairments in adaptive behavior.

Veteran's Programs

The Department of Veteran's Affairs (VA) provides care in its own facilities to veterans in need of skilled or intermediate nursing care. The VA also provides both skilled and intermediate care to veterans through contracts with community nursing homes. Beds are available to all veterans on a space-available basis. Contact your local VA office for more information.

A Final Note for Consumers

Be careful to find out exactly what costs are included in the monthly or daily charge given by a facility. Does this include everything - bed, board, nursing care, medicines, laundry? Or are there extra charges? Read all papers carefully before signing. Ask questions until you understand. A facility administrator and his or her staff want you to feel confident that the best possible care and attention will be provided.

About the American Health Care Association and the National Center For Assisted Living

The American Health Care Association and the National Center for Assisted Living represent nearly 12,000 non-profit and for-profit nursing facilities, assisted living residences, subacute centers and homes for persons with mental retardation or developmental disabilities. These facilities, residences, centers and homes provide care to more than one million elderly and disabled individuals nationally. Members of AHCA and NCAL are long term care providers who believe that the individuals they serve are entitled to a supportive environment in which professional and compassionate care is delivered in a safe and secure setting.

This belief compels AHCA and NCAL, their affiliates and member providers to advocate for persons who – because of social needs, disability, trauma, age or illness – require services provided in a long term care setting.

AHCA and NCAL are committed to principles that support quality care and quality of life, and are dedicated to professionalism and ethical marketing among all who provide long term care.

This booklet is intended to provide general information regarding paying for long term care. Seek advice on your specific situation from a facility, your state's Medicaid office, your state Office on Aging or from the Social Security Administration.