

Financing Health and Long-Term Care for Elders Pat Faust, MGS, LNHA

The financing of the acute and long-term care needs of our elders has placed significant financial demands on individuals and their families, as well as federal and state governments. Because the costs of long-term care can be staggering, expectations for governmental assistance run high and often times these expectations are misplaced. A general misunderstanding of the Medicare and Medicaid system underlies the disappointment in service delivery and the ultimate decision making process involved in long-term care. The following paper will detail the Medicare and Medicaid program as well as the different components of the long-term care system.

Medicare is the federal health insurance program for persons age 65 and over. The program also covers certain disabled persons under age 65. If you meet eligibility requirements for Social Security (including disability benefits), you may apply for Medicare benefits.

<p>Medicare Part A: covers hospitalization, hospice care, some skilled nursing care, and some home health care from a Medicare-certified home health care agency</p> <ul style="list-style-type: none">• All costs for up to 20 days of skilled care in a skilled nursing facility after 3 consecutive days in a hospital (within 30 days of discharge) during a benefit period• All costs over the daily coinsurance amount for days 21 – 100 in a skilled nursing facility during a benefit period• Hospice care• Medically necessary home health visits from a Medicare-certified home health agency if you need intermittent skilled nursing care, physical therapy or speech therapy, if you are under a doctor's care, or are confined to your home• 80% of the Medicare approved amount for durable medical equipment <p>Medicare Part B: covers 80% of necessary medical services and equipment, including doctors' fees; physical, occupational, and speech therapies; durable medical equipment, X-rays and lab tests.</p>
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Medicare covers only a small portion of long-term care costs if you have a chronic illness or disability. **It will not cover 'personal or custodial' care or supportive services.** (Ohio Department of Aging, 2001)

Medicaid is a federal and state funded medical assistance program for low-income individuals of all ages. The services provided under the Medicaid program are free but there are strict financial eligibility requirements that must be met in to qualify for Medicaid programs. Individuals might find it necessary to reduce, or 'spend down' their assets, income and savings in order to reach eligibility levels. Different asset and income levels apply depending on whether care is being received in the recipient's home or in a nursing home.

Medicaid covers:

- All care provided in a Medicaid –certified nursing facility
- Home health care, including nursing care, physical therapy and related services
- Other home services, such as homemakers and chore services
- Hospital care
- Physician care, including podiatrist, psychologist, optometrist, chiropractor, dentist
- Hospice care
- Community mental health services
- Medical transportation
- Prescription drugs
- Assistive devices, including eyeglasses, dentures, and hearing aids
- The cost of some Medicare Part A and B premiums, deductibles, and co-payments, if you are financially eligible

Medicaid generally covers all long-term care expenses in a Medicaid-certified nursing facility or through PASSPORT's Home and Community Based Services if you are financially and medically eligible (Ohio Department of Aging, 2001).

Medicare and Medicaid are the two widely known insurance plans serving older adults. There are obvious gaps in service levels between these two programs and eligibility criteria for Medicaid strictly places it as a program for low-income individuals. The **Ohio Senior Health Insurance Information Program** sponsored by the Ohio Department of Insurance, provides free information and advice about long-term care and other health insurance options.

- **Medigap Insurance** (also called Medisup insurance): this is a supplement to Medicare insurance designed to fill in the 'gaps' in Medicare coverage, such as co-payments.
- **The Residential State Supplemental (RSS)**: this is an Ohio program that assists older persons and qualified persons with disabilities who do not qualify for nursing home placement, but who live in approved group home settings.
- **Long-term Care Insurance Policies**: these policies do not replace Medigap insurance. Instead they pay for long-term care services that Medicare and Medigap policies do not cover. Policies vary in what they cover.
- **Veterans' Affairs**: offers benefits to veterans and in some cases, their families. VA medical centers around the country offer nursing home care and hospital-based home care.

Source: Ohio Department of Aging, 2001

After much discussion about how to pay for long-term care, the question persists – How much does elder care cost? The following page contains a brief breakdown by category of long-term care housing, program and service needs. These are ranges of prices and are subject to variability due to geographic area, and type of service and quality.

Summary

The perception for most of the population is that Medicare will take care of long-term care needs when the occasion arises. Disillusion in the system is spawned when the reality that Medicare is not a long-term insurance program settles in. Medicaid can work if you meet the low-income eligibility requirements. Long-term care is expensive and it requires proper planning on the part of family members to sustain family assets and savings for the long run. Everyone needs to prepare for this contingency because it can affect everyone at some point throughout life. Being responsible for the long-term care of a parent or spouse can very likely happen to you.

- **Nursing Homes:** approximately \$115/day or \$50,000 annually
- **Assisted Living Facilities:** \$1000-\$5000/month; not covered by health insurance plans
- **Independent Living Facilities:** \$1000-\$5000/month; not covered by health insurance plans
- **Home Care and Home Health Care:** covered by Medicare and health insurance plans
If you pay privately - \$85/visit for home health care
Home care – most elders pay privately; \$20/hour for 24 hour care, an average of \$100/day
- **Adult Day Programs:** \$10-\$50/day Insurance plans and government benefits generally do not pay for this service
- **Senior Centers:** often a charge for lunch and transportation service is based on elder's ability to pay
- **Geriatric Care Managers:** \$40-\$100/hour and some charge for an initial assessment. This is usually paid for privately.
- **Emergency Response Service:** \$35-\$50/month. Some services also have a one time installation fee, approximately \$50-\$100.
- **Medication Reminder Service:** approximately \$20/month. Insurance plans do not cover this service.
- **Meal Delivery Programs:** each meal may cost between \$2-\$5 and often the program will bill monthly. Insurance does not cover this program but many local programs are subsidized with government grants.
- **Companion/Visitor Programs:** many communities offer free programs where volunteers visit seniors living alone
- **Transportation Services:** insurance policies, including Medicare, will pay for ambulance transportation to take an elder to an inpatient facility. Transportation to an outpatient facility is not covered. Average cost for ambulance service is \$800 for a one-way ride. Wheelchair vans run \$50-\$100/round trip with additional costs per mile. Many communities have paratransit services which provide services to elders and disabled people. This is often free or costs the elder several dollars per ride.