

The Conversation



Talking With Your Aging
Parents About Medicare and
Other Health Care Issues



AFSCME Retiree Program



Medicare Rights Center

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Introduction to *The Conversation*

Health insurance coverage matters to people of all ages but is especially important as we grow older. Despite important breakthroughs in medical practice and advances in medical technology, the inescapable truth is that health problems, medical needs and health care expenses climb with age, making health coverage decisions critical for older Americans.

For most of us, whether we're seniors or not, decisions about health insurance are difficult because they affect the kind of care we get and our financial security. These decisions sometimes seem overwhelmingly complex, so parents and grandparents often turn to their adult children for advice.

The Conversation is intended to help you think through basic issues and provide information that should better equip you and your family to discuss these topics. It was prepared by the AFSCME Retiree Program in cooperation with the Medicare Rights Center.

The Medicare Rights Center is a national, not-for-profit consumer service organization that helps people understand Medicare rights, benefits and options. Through hotline counseling, education, and public policy programs, the Medicare Rights Center works to ensure that seniors and people with disabilities get the health care they need and the coverage they are due.



Know the Basics of Medicare

Medicare is the federal health insurance program for almost all Americans age 65 and older and for many adults with disabilities. You need to know the basics about Medicare so that you can help your parents—or yourself, if you are on Medicare—with health care planning.

WHAT MEDICARE COVERS

Medicare consists of Part A and Part B and, together, they provide coverage for basic medical services.

Americans age 65 and older are automatically entitled to benefits under Medicare Part A if they are eligible to receive Social Security. In addition to hospital inpatient care, Part A covers some skilled nursing facility (SNF), home health, and hospice care. For those who are entitled to Part A, there is no monthly or annual premium charge, but there is a deductible for each episode of hospital inpatient care, and daily coinsurance after a 60-day stay. Skilled-nursing facility-care coverage is limited to 100 days; people on Medicare do not pay coinsurance for the first 20 days but do pay coinsurance for each day thereafter. There is no coinsurance for Medicare home health services, or an absolute limit on the number of Medicare-covered home health visits. You must continue to meet specified eligibility requirements, however, as a condition of receiving home health services.

Part B pays for doctors' services, outpatient hospital care, and home health visits not covered under Part A. It also covers laboratory tests, for example, X-rays and blood work; medical equipment, such as wheelchairs and walkers; outpatient physical therapy; mental health care; and ambulance services. Part B has an annual \$100 deductible and, for most services, 20 percent coinsurance. People enrolled in Part B must pay a monthly premium (\$45.50 in 2000), which is typically deducted from their Social Security checks.

For a description of services covered under Medicare Part A and Part B, and how much people on Medicare must pay for each of these services, see the following table.

SUMMARY OF TRADITIONAL MEDICARE 2000

PART A Benefits

Beneficiary Pays

Inpatient hospital Days 1-60	Deductible of \$776 per benefit period*
Days 61-90	No coinsurance
60 lifetime reserve days	\$194 a day
	\$388 a day
Skilled nursing facility Days 1-20	No coinsurance
Days 21-100	\$97 a day
After 100 days	No benefits
Home health	No coinsurance
Hospice	Small payment for drugs and inpatient respite care

PART B Benefits

Beneficiary Pays

Deductible	\$100 a year
Physician and other medical services: MD accepts assignment	20% coinsurance
MD does not accept assignment	20% coinsurance plus up to 15% over Medicare-approved fee
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
X-rays: Durable medical equipment	20% coinsurance
Physical, speech and occupational therapy	20% coinsurance, maximum benefit of \$1,500 a year
Clinical diagnostic lab services	No coinsurance
Home health care	No coinsurance
Outpatient mental health services	50% coinsurance
Preventive services:	[The Part B deductible and 20% coinsurance are waived for certain preventive services.]
Flu shots; Pneumococcal vaccines; Colorectal cancer screenings; Digital rectal exams; Mammograms; Pap smears; Pelvic exams	
Bone-mass measurement and diabetes monitoring	20% coinsurance

* A benefit period begins when a person is admitted to a hospital and ends 60 days after discharge from a hospital or a skilled nursing facility.

WHAT MEDICARE DOES NOT COVER

You and your parents should be aware that the basic Medicare plan does not cover all health care expenses. It does not, for example, pay for outpatient prescription drugs (only in-hospital drugs), long-term custodial care at home or in a nursing home, eye exams, eyeglasses, hearing aids or dental care. Also, Medicare generally does not pay for care provided outside the United States. Medicare HMOs, however, often provide some degree of coverage of some of these services, most often prescriptions or dental, in addition to the basic benefits covered in the traditional Medicare package (see *Consider Your Parents' Medicare Options*).

PLAN FOR MEDICARE ENROLLMENT

If your parents are **receiving Social Security benefits** when they turn 65, they are entitled to Medicare Part A and Part B, and will automatically be enrolled in both A and B on the first day of the month that they turn 65. A Medicare card will arrive in the mail about three months before their birthday. Your parents can choose to decline Part B coverage, but they should take it if they want full Medicare benefits (98% of seniors buy Part B because it represents such good value for the monthly premium cost).

If your parents are **still working at age 65**, and believe that they may not need Part B because they have health coverage under an employer plan, they should check with their local Social Security office before declining Part B to be sure they will not have to pay a penalty for late enrollment. Your parents may elect to delay Part B enrollment at age 65 if either of them is still working for an employer with 20 or more employees and has health coverage under an employer plan. They will then avoid duplicating Part B coverage and paying the Part B monthly premium. Your parents will not incur any premium penalties for waiting to enroll in Part B, as long as they do so before they lose coverage under their employer plan or within eight months after losing their employer coverage.

If your parents are citizens or permanent residents, but **not entitled to Medicare** (because for example, they did not work enough years to qualify), they may still voluntarily enroll in Medicare. They must pay a monthly premium, however, for Part A benefits (\$301 in 2000).

If your parents are **entitled to, but not receiving**, Social Security benefits, they must apply for Medicare, because they will not be enrolled automatically. They may apply at any Social Security office during the initial enrollment period, which begins three months before they turn 65, includes the month of their birthday, and the three months after.

If your parents have continuation health care coverage from a former employer, known as COBRA, they should still enroll in Medicare Parts A and B during their initial enrollment period, because their **health insurance under COBRA** ends as soon as they are eligible for Medicare.

If your parents do not enroll in Medicare during the initial enrollment period, they must enroll during a **general enrollment period**, which is January 1st through March 31st of every year. Their coverage will begin on July 1st of the year they sign up. If they wait until the general enrollment period, they will incur a penalty for each year they delayed enrollment.



Consider Your Parents' Medicare Options

More than 33 million people are covered under the traditional Medicare program, which has been available since 1966. Another six million belong to health maintenance organizations (HMOs), which have been available under Medicare since the mid-1980s. Your parents may also be able to choose other Medicare private health plan options because of a new program called Medicare+Choice.

To make an informed decision, first you and your parents need to understand how these health plans work and how they differ, then discuss which option is best.

Here is a brief description of each of the Medicare options.

TRADITIONAL MEDICARE

If your parents choose coverage under the traditional fee-for-service program, they can get care from any doctor or hospital they want and receive coverage for their care anywhere in the country. Nearly 85 percent of older people still choose the traditional program, largely because of its flexibility. Medicare, however, does have high cost-sharing requirements and does not cover certain benefits, such as outpatient prescription drugs. To help pay for uncovered benefits, and to help with Medicare's cost-sharing requirements, many people in traditional Medicare have supplemental insurance (see *Understand Private Medicare-Supplement Insurance*).

OTHER MEDICARE OPTIONS

HMOs: Medicare HMOs cover the same doctor and hospital services as the traditional Medicare program. HMOs appeal to some people on Medicare because they often provide additional benefits, such as prescription drugs and eyeglasses, which are not covered by the traditional Medicare program. If your parents choose an HMO, they may be able to get these additional benefits at no cost or at low cost and will not need supplemental insurance.

Your parents should be aware that Medicare HMO enrollees generally can use only the doctors, hospitals and other providers in their HMO's network. For an additional fee, some HMOs offer point-of-service (POS) benefits that partially cover care received outside the network. But neither Medicare nor the HMO will pay for unauthorized visits to specialists in the plan, or to providers outside the HMO's network, or for non-emergency care outside the HMO's service area.

If your parents join a Medicare HMO, they will select a primary care doctor who is responsible for deciding when they should see a plan specialist and which specialist they should see.

Other Non-Traditional Plans: There are four additional private plan options that may be available in the future under a new program called Medicare+Choice. These include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans, and medical savings accounts coupled with high-deductible insurance plans. At present, only a few such plans exist anywhere in the nation. For additional information about these non-traditional options, or to see if any operate in your area, call 1-800-Medicare, or log onto the Medicare Compare Web site at <http://www.medicare.gov/comparison/>.

KNOW WHAT YOUR PARENTS WANT FROM A MEDICARE PLAN

To help your parents decide what type of Medicare plan to choose, discuss with them whether traditional Medicare, a Medicare HMO, or another Medicare plan will meet their needs. Consider how needs can change: a person can be healthy today and sick tomorrow. Learn what's most important to them when it comes to health care by discussing their specific needs and circumstances. Here are some basic topics to cover:

Receiving care from the doctor and hospital of their choice: Under traditional Medicare, your parents can use whatever specialists and hospitals they choose, whenever they need them, and without a referral from another doctor. Other options could limit your parents' ability to get care from the doctor or hospital of their choice, or may charge a fee for out-of-network care.

Getting coverage of additional benefits, such as prescription drugs: If your parents choose coverage under traditional Medicare, a supplemental health plan will help fill in Medicare's gaps and may also pay for additional benefits, such as prescription drugs (see *Understand Private Medicare-Supplement Insurance*). If your parents choose a Medicare HMO, the plan may provide some coverage of benefits not covered under traditional Medicare. It is important to review the scope and limits of additional benefits when choosing among available plans.

Reducing out-of-pocket medical costs: If your parents are on a tight budget and are willing to limit their choice of doctors and hospitals, they may be able to reduce their health care expenses and get more benefits through an HMO. If provider choice is a priority, they should consider traditional Medicare with added protection from a Medicare supplemental insurance policy, sometimes known as "Medigap".

Maintaining health care coverage while away from home: Under traditional Medicare, your parents will be covered for care anywhere in the United States. While HMOs cover emergency care for enrollees outside the plan area, most do not cover other health care services. This could be a problem if your parents spend part of the year in Florida, for example, or if you live in another part of the country and might want your parent to stay with you in the event of a serious illness.

Keeping supplemental coverage from a former employer or union: If your parents are considering joining one of the newer Medicare health plans and are entitled to coverage through a former employer, they should talk to the employer to be sure they won't lose valuable retiree health benefits if they do so (employer coverage is often limited to specific plans).

Coordinating with Medicaid benefits: If your parents' income and assets are quite modest, they may qualify for Medicaid or other special programs that will cover some of their health care costs. If they are already covered by both Medicaid and Medicare, they should find out what, if anything, they must pay out-of-pocket if they join an HMO. They should also check to see if they qualify for a program that requires Medicaid to cover their Medicare plan copayments.

THEIR RIGHTS UNDER MEDICARE

If your parents enroll in an HMO or other Medicare+Choice plan, and the plan decides to stop covering people on Medicare (as several have done in the last few years), the law will permit their return to traditional fee-for-service, or they can select another participating HMO. Through December 2001, your parents will be able to enroll in or disenroll from a Medicare HMO at any time. Beginning in 2002, Medicare will phase in an annual enrollment period which will limit your parents' ability to switch plans.

No matter which plan your parents choose—traditional Medicare, a Medicare HMO, or another plan—they need to understand their rights as patients and consumers. If your parents believe they have been unfairly denied any Medicare-covered benefits, they have the right to appeal. Check with Medicare to find out the necessary steps. Also, try to get a letter from your parents' doctor that explains why the denied service was required.



COMPARE PLANS AVAILABLE WHERE YOUR PARENTS LIVE

Once you understand how the traditional Medicare plan differs from the other Medicare plans, you need to determine which plans are actually offered where your parents live. Though traditional Medicare is available everywhere, the other plans may not be. For a list of plans in your parents' area and a copy of the Medicare handbook, *Medicare & You*, call Medicare at **1-800-Medicare** or visit Medicare's Web site at www.medicare.gov. For free help in understanding differences among Medicare plans, you or your parents can call their State Health Insurance Assistance Program (SHIP). Phone numbers for SHIPs can be found in the *Medicare & You* handbook.

If your parents decide on a type of Medicare plan other than the traditional program, they will have to find a company that offers it in their area. If they want to join a Medicare HMO, several plans may be offered and they will need to compare and choose among them. You and your parents should consider and discuss four important factors before signing on to a non-traditional plan:

- 1. Accessibility of doctors and hospitals:** Can your parents continue to see the doctors they know if they join a certain plan? Their doctor or specialist might be in one plan's network, but not in another's. Even if their doctor is in an HMO's network, the doctor can leave that network at any time.
- 2. Extra Benefits:** The supplemental benefits offered by most HMOs and other Medicare+Choice plans vary widely; be aware that they may change every year. If your parents want to join a plan because of the prescription drug benefit (a common reason for joining non-traditional plans), make sure that the plan covers the drugs they need, and that you understand any limits that apply (plans often cap benefits at a specific amount).
- 3. Cost:** How much are the premiums and copayments? Is there a deductible? Keep in mind that costs can change each calendar year.
- 4. Quality and reputation:** All health plans are different. Besides reviewing the plan's written information, try to talk to plan members about their experiences. For objective information on quality and performance, visit Medicare's Web site at www.medicare.gov. Once you are at the site, go to the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans (CAHPS) for comparative plan information.



Understand Private Medicare-Supplement Insurance

If your parents want to stay in traditional Medicare, you should discuss options for supplemental coverage with them. Without such coverage, their out-of-pocket costs could be high. Supplemental insurance helps pay the deductibles and coinsurance costs that traditional Medicare does not cover. In some cases, it also covers extra benefits, such as outpatient prescription drugs.

Your parents may be able to get supplemental insurance from a former employer or union (retiree coverage). If not, they can buy Medicare-supplement insurance (Medigap) directly from an insurance company. Depending on their income and assets, they may also qualify for Medicaid.

RETIREE HEALTH COVERAGE

As a rule of thumb, if your parents can get retiree coverage from a former employer or union, they should take it. Retiree policies are often more generous than Medigap, in terms of such benefits as prescription drugs. They also may be cheaper than Medigap policies, since employers tend to pay part of the cost. The union or the employer's personnel office will be able to tell you if coverage is offered and, if they do offer coverage, explain how the benefits coordinate with Medicare.

MEDIGAP

If your parents want to buy a private Medicare-supplement insurance policy, known as Medigap, they must decide which benefit package to buy and which insurer to use. Before making a decision, they should clearly understand what benefits are covered and how to compare plans.

Some Medigap policies provide only basic benefits, while others offer such extras as coverage for routine checkups and some prescription drugs. But no policy covers unlimited prescription drugs, long-term custodial care at home or in a nursing facility, vision and dental care, hearing aids, or private-duty nursing.

Compare Medigap Plans: Premiums for Medigap plans average about \$100 a month, but vary dramatically. You and your parents can easily compare the premiums and benefits offered by Medigap insurers because, by law, Medigap insurers can offer only 10 standardized Medigap plans (Plans A, B, C, D, E, F, G, H, I, J). As shown in the table below, each plan has a different set of benefits, and, regardless of the insurer, the benefits in a given plan are the same. For example, wherever it's sold, Plan H always covers up to \$2,500 in annual prescription costs, with 50 percent coinsurance and a \$250 deductible.

MEDIGAP PLANS AT A GLANCE

Benefits Covered	Plans	A	B	C	D	E	F	G	H	I	J
basic benefits: pays coinsurance for 61-150 days in-hospital payment in full for 365 additional days; 20% coinsurance for physician and other Part B services, first three pints of blood		■	■	■	■	■	■	■	■	■	■
hospital deductible: pays \$776 in 2000			■	■	■	■	■	■	■	■	■
skilled-nursing facility: pays coinsurance of \$97 for 21-100 days				■	■	■	■	■	■	■	■
Part B deductible: pays \$100 in 2000				■			■				■
Part B excess charges: pays up to 115% of Medicare's approved amount (plan G pays 80% of excess; others 100%)							■	■		■	■
emergency care outside the United States: pays 80% during the first two months of the trip with \$250 deductible; up to \$50,000 over lifetime				■	■	■	■	■	■	■	■
annual at-home recovery benefit: pays up to \$40 a visit for 40 visits						■		■		■	■
preventive services: pays up to 120% a year if ordered by doctor				■	■						
prescription drugs: pays up to 50% of \$2,500, after annual \$250 deductible									■	■	
prescription drugs: up to 50% of \$6,000, after annual \$250 deductible											■

■ indicates plan covers this benefit

At this time, no insurance policy fills gaps in coverage for Medicare HMOs or any of the new Medicare+Choice plans. Should your parents select an HMO, PPO, or other type of plan, they should budget for any costs the plan doesn't cover.

DO YOUR MEDIGAP HOMEWORK

After your parents have chosen a Medigap plan, they must select an insurance company that sells it. The following four steps will help them decide wisely.

- 1.** Call the insurance department in the state where your parents live for a list of companies that offer Medigap. Compare the premiums; they may vary a lot and may rise at different rates each year.
- 2.** Understand how premiums are calculated, since that could affect your parents' decision. Policies that base their annual premium on age may seem like a good deal when your parents are 65, but may be far costlier than other policies by the time they turn 75.
- 3.** Determine whether the Medigap insurer has arranged for Medicare to file Medigap claims automatically. Automatic-claims filing can save time and headaches.
- 4.** Check the insurer's reputation with your parents' state insurance department. Generally, companies rated "A" or better are reputable.

PLAN FOR MEDIGAP ENROLLMENT

Once your parents turn 65, they can sign up for any of the 10 Medigap plans during a six-month open-enrollment period. No plan can reject them or charge them higher rates due to pre-existing health conditions. If your parents enroll during the six-month period, the Medigap insurer must renew their policy for life, as long as premiums are paid. Missing a premium payment may jeopardize coverage.

If a person wants to sign up after the open-enrollment period closes, federal law allows Medigap insurers to refuse to offer them certain Medigap plans because of their age or health status. This can be a problem if a person leaves a Medigap plan to join an HMO and then wants to drop the HMO and return to traditional coverage. Re-entry into traditional Medicare would be assured, but not re-entry into a supplemental Medigap plan. You and your parents should consider these restrictions before disenrolling from a Medigap plan.

State laws on Medigap consumer protections differ; your parents should check with their state's insurance department about Medigap rights.



Learn About Programs for People With Low Incomes

Like millions of America's elderly, your parents may be living on a limited income, unable to afford supplemental insurance. If so, they may be able to get help from *Medicaid* to fill the gaps in *Medicare* coverage. Medicaid is a jointly sponsored federal and state program that helps low-income families and individuals pay their health care bills.

If they qualify, Medicaid will cover many—if not all—of their out-of-pocket Medicare costs, as well as such additional benefits as prescription drugs and long-term care. To qualify for Medicaid, your parents must meet income and asset limits, which vary by state.

FULL MEDICAID BENEFITS TO SUPPLEMENT MEDICARE

If your parents receive cash assistance under the Supplemental Security Income (SSI) program, they probably are eligible for *full* Medicaid benefits. To receive SSI in 1999, an older person's income could not have exceeded \$520 a month (\$771 per couple), and assets had to be less than \$2,000 (\$3,000 per couple). Even if income or assets exceed the limits, however, large medical and long-term care expenses can make a person eligible for full Medicaid benefits (see *Assess Long-Term Needs and Options*).

QUALIFIED MEDICARE BENEFICIARY PROGRAM

The Qualified Medicare Beneficiary program (QMB) is for people whose income is at or below 100 percent of poverty (up to \$707 a month for singles and \$942 a month for couples in 1999) and whose assets are limited (up to \$4,000 for singles and \$6,000 for couples in 1999). For those who qualify, the state will pay Medicare premiums, and some or all of the deductibles, and coinsurance.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM

The Specified Low-Income Medicare Beneficiary (SLMB) program pays Medicare's Part B premiums for people whose income is between 100 percent and 120 percent of poverty (up to \$844 a month for singles and \$1,126 a month for couples in 1999) and whose assets are limited. If your parents' income is slightly higher, they may be eligible for additional assistance through two new programs, called QI-1 and QI-2, administered by the states.

To apply for any of these programs, contact the state agency that administers Medicaid, often the state welfare office or the department of social services.

PRESCRIPTION-DRUG ASSISTANCE

Even if your parents' income and assets are not low enough to qualify them for Medicaid benefits, they may still qualify for a state-run prescription-drug assistance program for low-income seniors. Check with your Area Agency on Aging or local social service department to see if your parents' state operates one of these programs.





Assess Long-Term Care Needs and Options

The idea of shouldering the cost of nursing-home care, choosing between your kids' education and your parents' long-term care, or seeing your savings consumed by long-term care costs is daunting. The very possibility may already have prompted talks between you and your parents about long-term care coverage.

Long-term care may include care in a nursing home and medical and personal care at home. Medicare covers only a fraction of long-term care costs and, even then, only in certain situations. As a result, you and your parents must understand Medicare's benefits and limits, and plan ahead for whatever expenses they may incur. You also need to discuss who will care for your folks when they need help, what kind of care they want, and where they will live as they age.

DETERMINE THE LEVEL OF NEEDED CARE

When your parents are no longer able to live independently and appear to need some help taking care of themselves, the first step is to determine the type of care they need. Evaluating care options is easier once you know the range and extent of services they require. Often, you and other family members are best equipped to make this assessment, since you know your parents' situation and how much day-to-day help they really need. If you prefer, you can hire a geriatric care manager, nurse, or social worker for a professional evaluation. If your parents are eligible for Medicaid, a state social worker sometimes will do this assessment without charge.

EXPLORE LONG-TERM CARE OPTIONS

There are a number of different ways to meet your aging parents' long-term care needs, ranging from a few hours of personal assistance in the home to skilled, round-the-clock care in a nursing home. Depending on your parents' needs and preferences, there are several home-, community-, and institution-based services available to them. You may especially want to discuss whether your parents would want to stay in their own home or whether they would feel comfortable in an outside facility.

Home-based care

Many older people prefer to remain in their own homes rather than move into a supervised facility when they need long-term care. If your parents elect to stay at home, you, and they, may need to consider how much care they will require. For example, will they require someone nearby 24-hours a day or a few hours of personal assistance a few days each week? You may need to put together a “patchwork” of formal and informal caregivers and services. Formal services may include visiting nurse services, home health aides, and such social service programs as “Meals on Wheels.” You can look for services in your parents’ community by calling the local **Area Agency on Aging**. If you don’t know how to get in touch with the AAA, find out how by calling the Eldercare Locator at 1-800-677-1116.

Quite often **informal caregivers**—family members and friends—end up providing a large share of assistance. To supplement caregiving in the home, some families use community-based services such as adult daycare and senior centers. Call the local Area Agency on Aging to find out about available services in your parents’ neighborhood.

If home-based care is the most appropriate solution to your parents’ long-term care needs, you should consider **simple adaptations to the home** to make it a safe and comfortable environment. Improvements may include appropriate lighting, railings, well-secured carpeting, and quick access to emergency response if needed.

If it becomes too difficult or too expensive to provide long-term care at home, a supervised living facility, such as an assisted living facility or nursing home, may be an option.

Continuing-care retirement communities

These facilities offer long-term contracts that usually provide lifelong shelter and access to specified health care services. To be admitted, large advance payments often are required. Eligibility for new residents is generally based on age, financial assets, income level, and physical health and mobility. Residents usually are expected to move into a continuing-care community while they are still independent and able to care for themselves. If your parents are considering one of these, find out what happens when a person becomes sick or frail and can no longer live independently. Does the retirement community have a nursing facility on the premises? What if the nursing facility is full when your parent requires that level of care? Be sure to get a complete explanation of all costs, at all stages of life in the community.

Assisted-living facilities

These facilities (also called “board and care” or “adult care”) are usually in a residential or home-like setting. Most provide meals, housekeeping, and some assistance with activities of daily living such as dressing and bathing. Some of these facilities care for people who require skilled nursing and 24-hour attentive supervi-

sion. Find out where your parents will get their health care, whether they will continue to see their doctors, and how they will get to their appointments. Health care services may be delivered at the facility itself, or elsewhere through an arrangement with another provider such as a hospital. Ask what happens (both in terms of services and price) if your parents' condition declines after they enter an assisted living facility. Some facilities may discharge your parents if their health care needs increase considerably.

Nursing homes

These facilities provide custodial and skilled care prescribed by doctors and delivered by registered nurses, licensed practical nurses, and certified nurse assistants. If you or your parents are considering one of these facilities, find out whether they can get physical, occupational, and other therapy, and whether Medicare or Medicaid will pick up the cost. Costs and quality of care can vary considerably. Be sure to ask if the nursing home meets Medicare and Medicaid quality standards. Information on every Medicare and Medicaid-certified nursing home in the U.S. is available on the Health Care Financing Administration's Nursing Home Database, at Web site www.medicare.gov/nursing/home.asp.

DISCUSS WAYS TO PAY FOR LONG-TERM CARE

The price tag for long-term care can be astronomical, beyond the resources of most families. At best, Medicare pays only a fraction of these costs. Extended nursing home stays can easily cost \$4,000 a month, although fees vary widely. Although home care is generally cheaper (in part because it does not include housing and food costs, which are factored into nursing homes' rates), it too can be very expensive to patients and their families. Costs may depend on the level of care needed, the number of hours of care per week, and your parents' geographic location.

Before the need for long-term care becomes a reality, you and your parents should consider very carefully how to pay for it: through Medicaid, if they qualify; with private long-term care insurance; or out-of-pocket. Here are some fundamentals to help guide this tough decision.

Be Aware of Medicare's Limits

While Medicare covers some home health, skilled nursing, and hospice care, it is not a long-term care program. For example, although Medicare covers relatively short-term, medically necessary home health care, it does not pay for custodial care services such as cleaning or cooking at home. Nor does the program pay for prolonged care in a nursing home.

Home Health Care: Home health care is covered for homebound people who need the services of a skilled nurse or a skilled physical, speech, or occupational therapist. In these cases, Medicare will also cover home health aide services to help with bathing, toileting, feeding, other personal care, and medical social services. Home health benefits are only covered if your parents meet certain requirements: the visits must be prescribed by a doctor, and your parents must need intermittent or part-time skilled nursing care or therapy

services and generally must be homebound. There is no copayment for home health services under Medicare, and no limit to the number of covered visits, as long as your parents continue to meet these criteria.

Skilled Nursing Facility Care: Medicare covers up to 100 days of nursing home care, but only in limited situations. To qualify for this benefit, your parents must need daily skilled care (seven days a week of nursing care or five days a week of rehabilitative care). Moreover, they must have been hospitalized for at least three days within the 30 days preceding admission to the skilled nursing facility, or Medicare will not pay for their care. In addition, a copayment (\$97 in 2000) is required of every patient for the 21st through the 100th day of their care.

Medical Equipment: Medicare also helps cover some durable medical equipment for use at home, whether it is rented or purchased. These items include walkers, canes, and commodes that will assist your parents with their long-term care needs.

Hospice Care: Hospice care is available under Medicare for people with advanced illness and who are expected to live six months or less. It concentrates on improving quality of life, not on curing the condition. Medicare's hospice benefit covers a range of services, including care from doctors, nurses, therapists, and home health aides. It also covers services that Medicare usually does not, including many prescription drugs, respice care, and continuous nursing services for medical emergencies.

Hospice care is designed to help with pain management and other symptoms, so that you and your parents can make the most of the time that remains. In addition, it can provide emotional and spiritual support to you, your parents, and other family members.

Medicaid Coverage of Long-Term Care

Medicaid is the country's largest public payer for long-term care. If your parents qualify for Medicaid, it will pay for nursing home care, prescription drugs, and other costs that Medicare does not cover. Medicaid may also pay for some long-term care services provided at home.

There is more than one way your parents can qualify for long-term care under Medicaid. If they receive Supplemental Security Income (SSI) payments, they are likely to qualify for Medicaid automatically. If they do not have SSI, but have extremely limited income and assets, they may be able to qualify for Medicaid anyway. The exact income eligibility levels for Medicaid vary by state, so check Medicaid rules where your parents live. Medicaid also looks at assets such as savings accounts when determining eligibility, but assets generally do not include homes, cars, household furnishings, or burial plots.

If their income is higher than the state's Medicaid eligibility level, your parents may still be eligible for Medicaid coverage. In several states, people can qualify for Medicaid after spending their income and assets on nursing home and other health care expenses. This is called Medicaid "spend down".

Some people enter a nursing home as private-pay patients but become eligible for Medicaid over time because of the high cost of such care. Most states let nursing home residents covered by Medicaid keep between \$1,600 and \$2,000 in assets and an income of about \$30 per month.

Medicaid rules vary by state. If you or your parents have questions about Medicaid, contact the state Medicaid office or long-term care ombudsman in your area.

Long-Term Care Insurance

Long-term care insurance covers some of the costs of long-term care and may help your parents preserve a portion of their assets. Today, more than 400 insurance companies sell private long-term care insurance that covers nursing home and home care, but only a small share of older people have a long-term care policy.

While long-term care insurance can limit costs for some people, it is not a good option for everyone. Such insurance is expensive, and the older you are when you buy it, the higher the cost of the monthly premiums. Policies purchased at age 65 average \$1,800 a year and buy four years of comprehensive coverage; at 79, similar coverage costs an average of \$5,600 a year. And if your parents have Alzheimer's or other serious health problems, they may not be able to buy a policy at any price.

To Buy or Not to Buy? A major reason for purchasing long-term care insurance is to avoid depleting life savings with a prolonged nursing home stay and to preserve savings and other assets for children and grandchildren. Another is to help offset the cost of long-term care for couples whose assets are limited, but whose income is fairly high (over \$35,000 a year). But, if your parents already qualify for Medicaid or would quickly spend down their assets to qualify, long-term care insurance might not be sensible. Nor is it a prudent investment if they cannot afford to pay the premium for the rest of their lives. Even if they can, long-term care insurance may not be a wise choice if they can pay for their care out-of-pocket if necessary.

No two long-term care insurance policies are alike. Before your parents decide to buy a policy, consider these issues:

Find out what the policy covers: Does it provide for care in a nursing home, in your parents' home, or in a community setting? Some policies will pay cash once your parents meet eligibility requirements and will allow them to spend the money for care in the location of their choice. Others will pay for care only in a specifically defined location. Be sure the policy covers the type of care your parents want.

Be sure you and your parents can afford the premiums: Check to see if, and by how much, the premiums will rise over time, and consider whether you and your parents can afford premium hikes in the future. Premiums are also affected by the number of years covered under the policy. Four years of coverage is a good compromise between lifetime coverage (which can be quite expensive) and the risk of less coverage. Consider this: people between age 65 and 94 who enter a nursing home stay, on average, two and a half years, while 90 percent stay less than four years.

Examine the costs of elimination periods: Many long-term care insurance policies have elimination periods, which are waiting periods that act as deductibles. Your parents must pay for their own care during that time. The longer the elimination period, the lower the premium. Whatever they decide, be sure your parents can afford the out-of-pocket costs they will incur before their policy begins paying.

Consider the level of coverage you are buying: Choose a policy with a benefit that will cover a good portion of the daily cost of services your parents may need. Bear in mind that the cost of care will rise with inflation. Coverage should keep up with the rising cost of long-term care. Otherwise, a policy your parents buy today to cover 80 percent of these costs may cover only 40 percent later on, when the care is actually needed. Inflation protection is often sold as a “rider” to long-term care products.

Compare how companies determine eligibility for benefits: Long-term care policies have different ways of determining if and when someone is eligible for benefits. For example, under some plans, policyholders qualify for coverage when they cannot perform activities of daily living on their own. These may include eating, walking, moving from a bed to a chair, dressing, bathing, and using the toilet. Make sure bathing is mentioned specifically, since people with long-term care needs are likelier to require help with this task than with any other activity. Always read the fine print before purchasing a long-term care plan.

Paying for Long-Term Care Yourself

Because Medicare’s coverage is limited, and many do not qualify for Medicaid or are unable to afford a long-term care policy, often elderly people and their families must tap into savings to pay for care. You and your parents need to think about how much care may cost over an extended period of time, and as your parents become increasingly frail.

The cost of institutional care depends heavily on the amount of time it is used. Find out about nursing home care costs in your parents’ area. Then, calculate how much money they would need for a four-year stay. If they have sufficient savings to cover four years of residential care, they might consider simply paying for it themselves. But realize that actual costs can’t be predicted. If your parents suffer from Alzheimer’s or other forms of dementia, they may need care for many more years.

Home care often costs much less than residential care. Since people with long-term care needs often wish to continue living in their own homes, you may want to research the costs of home and community-based services in the area. Such services, along with home adaptations, can help your parents stay in their own home.

Do not wait until your parents need long-term care to begin discussing it. Talking about their preferences and needs now can help you plan how to pay for their care. The decisions you and your parents make together could determine whether purchasing a long-term care insurance policy, relying on savings, or depending on Medicaid is the best answer for your family.



Planning for Your Parents' Care When They Cannot

Advance directives are written instructions stating your parents' wishes about medical care if they cannot communicate because they are incapacitated. It is important to discuss advance directives now, because having such instructions can be very comforting to your parents should they become seriously ill. They can also save you and other family members from having to make difficult decisions without knowing what your parents want. There are two types of advance directives: health care proxies and living wills.

HEALTH CARE PROXIES

A health care proxy allows your parents to appoint someone they trust (called an agent) to make their medical decisions if they are too ill to make decisions for themselves. Generally, the agent may make health care decisions not only at the end of life, but whenever your parents cannot speak for themselves.

LIVING WILLS

Through a living will, your parents state in writing their wishes about which medical treatments they do and do not want should they become incapacitated at the end of life. Typically, living wills tell health care personnel whether or not to prolong life if the patient is suffering from an incurable or irreversible condition. Be sure your parents' living wills comply with laws of the state in which they live, and that their doctors, lawyers, and other trusted persons have copies. Health personnel can follow the directions of the living will only if they have it.

Your parents must execute advance directives while they are still mentally competent. To obtain forms that are valid in their state, contact the state ombudsman program or a hospital or medical society in the area.



More Information

There are a number of places to turn for information about Medicare and other health care coverage for your parents. Since different agencies supply different types of information, you might have to contact several before finding one that can help.

HERE ARE SOME PLACES TO START

Get **basic Medicare information** by calling the National Medicare Hotline at 1-800-Medicare; TTY for the hearing and speech impaired is 1-800-820-1202. You can also order *Medicare & You* (the Medicare handbook) and related brochures by calling the Hotline or by writing to Medicare Publications, Health Care Financing Administration, 7500 Security Blvd., Baltimore, MD 21244.

Get information on **Medicare enrollment and eligibility** by calling the National Social Security Hotline at 1-800-772-1213. Also call this number to report lost Medicare cards and a change of address.

Report cases of **fraud, waste, or abuse** by calling the Fraud Hotline of the Office of the Inspector General, Department of Health and Human Services at 1-800-HHS-TIPS (1-800-447-8477); TTY for the hearing and speech impaired 1-800-377-4950.

Find out about **Medicaid eligibility requirements** and enrollment procedures at your parents' state or local welfare office, social service, or Medicaid agency.

Get referrals for local agencies that can help you obtain information and services **in your parents' community** on issues including home health care, nursing home care, and long-term care insurance by calling the **Eldercare Locator** at 1-800-677-1116.

Request detailed information in English or Spanish about the **Medicare+Choice plans** available in your parents' area by calling the automated Medicare Special Information number at 1-800-Medicare (1-800-633-4227).



Ten Tips to Remember

When talking to your parents about their health care coverage:

- 1. Plan ahead.**
- 2. Find out how your parents want to manage their health care costs and address their health care needs.**
- 3. Understand that Medicare does not offer comprehensive coverage.**
- 4. Find out how much your parents can spend to cover additional costs.**
- 5. Think about how best to fill gaps in coverage, including copayments, prescription drugs, home care and nursing home care.**
- 6. Determine who will care for your parents when they need help.**
- 7. Discuss where they want to live as they grow old ...**
- 8. ... and how they want to die.**
- 9. Don't be afraid to raise these issues.**
- 10. Continue the conversation as your parents age.**



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