

Medicare Myths Unraveled

■ Medicare is often misunderstood. Helping seniors plan appropriately for their future medical needs entails informing them about the realities of Medicare coverage—in particular, helping them understand that Medicare does not cover long-term care.

BY NANCY A. DYKEMAN, CSA, CLTC

Last month, I received a call from my friend Grace. Her mother, Irene, was in the hospital with a broken hip. It was the fifth day of her hospital stay, and she was ready to be discharged. Irene needed to move from the hospital to a skilled nursing facility for a month or two of rehabilitation on her hip. Grace called me with a question: “The social worker at the hospital told us Mom would need to recover in a nursing home, and that Medicare would pay the costs. Is this right?” She was also confused and concerned about the options for ongoing care once Irene left the nursing home.

As a professional who works closely with seniors, you may have been asked similar questions yourself. When seniors require rehabilitation and recovery, their family members are frequently left to figure out what Medicare will pay for and what they need to do to make sure their loved ones receive the available benefits. Whether these questions arise in our personal or our professional lives, as Certified Senior Advisors (CSAs), we need to be prepared to educate others about what Medicare covers, and under what circumstances.

Misconceptions about Medicare

Medicare was created in 1965 to pay for skilled care in a hospital and for skilled services

outside of a hospital. The program is designed to facilitate recovery or complex treatment for people under age 65 who are disabled and for people over age 65 who qualify for Social Security. But many people misunderstand Medicare, and misconceptions about the program abound. At workshops and in client meetings, people often ask me: What has to happen in order to have Medicare cover the costs of skilled care? What happens when a patient doesn't show improvement? What if the patient can't continue with therapies due to exhaustion or the inability to participate in daily rehabilitation or skilled care? And perhaps the most common question of all: What do you mean Medicare doesn't pay for long-term care?

As seniors consider the possibility that they might have an accident, an extended illness, or loss of mental capacity, they often



believe that Medicare will cover all their health care needs after age 65. What many people don't understand is that Medicare does not pay for ongoing, non-skilled care at home or in a nursing facility. This is the number-one misconception about Medicare, and it's critical for professional service providers such as CSAs to set the record straight.

What Medicare pays for—and doesn't pay for

Medicare pays for medically necessary skilled nursing facility or home health care as long as the patient meets certain criteria. The patient must stay in the hospital for at least 72 consecutive hours before discharge and must require skilled rehabilitation or treatment under the care of a Medicare-approved health-care provider. The hospital's discharging physician determines whether the care is medically necessary. Because hospitals are paid on a Prospective Payment System for specific health care services rendered, they have an incentive to discharge patients as quickly as possible. This means that some patients who need rehabilitation are discharged from the hospital before the end of the 72-hour window, which renders them ineligible for Medicare to pay for skilled care, including rehabilitation after discharge. My friend Grace is fortunate because her mother fulfilled the requirement of staying at least 72 consecutive hours in the hospital; Irene was eligible to continue receiving care through her Medicare benefits once she entered the Medicare-approved skilled nursing facility. However, this doesn't mean all of her expenses would be paid, nor does it mean that Medicare would continue to pay indefinitely.

Medicare expects every patient to recover within 100 days, or else to no longer require skilled care after that time. For the first 20 days of rehabilitation, Medicare pays for 100 percent of the costs. After the first 20 days, the patient must show improvement

in order for Medicare to continue to pay. It is up to the nurses providing the skilled care and the rehabilitation therapists to document improvement or to register the patient's inability to continue to improve based on the outcome of daily skilled care. Many times, a patient cannot handle the rehab program, and if the patient reaches a plateau, he or she may not be able to continue receiving Medicare reimbursement. Medicare also requires a daily co-pay after the first 20 days of rehabilitation. In 2011, the daily co-pay amount is \$141.50 per day. The limit of Medicare skilled care following a hospitalization is 100 days. Beneficiaries rarely use all 100 days because they generally stop improving before the end of that time period. At that point, the facility and therapists stop receiving Medicare dollars, so they may discharge the patient from the recovery program. This scenario is more common than the case of a patient who continues to improve through intensive recovery for the 100 days allowed.

What many people don't understand is that Medicare does not pay for ongoing, non-skilled care at home or in a nursing facility.

Medicare doesn't pay for non-medical long-term care

Most long-term care is designed to assist people with the activities of daily living, including bathing, dressing, eating, using the toilet, moving between bed and chair, and dealing with incontinence. It may also include health checks that most healthy people are able to perform on themselves, such as diabetes monitoring.

It's critical to note that Medicare doesn't pay for any of these types of "custodial care" services for patients who are not receiving

skilled care through a Medicare-approved skilled-care program. During the first 20 days of Medicare-covered services within a skilled nursing facility, Medicare will pay for both skilled and non-skilled services associated with recovery. However, Medicare does not pay for supervision for a patient who is suffering from cognitive impairment or memory loss. A senior who has dementia, [Alzheimer's disease](#), or Parkinson's disease might need constant companionship in order to remain safe, but Medicare will not pay for that service.

When seniors need long-term care

This is exactly where the confusion lies. Prior to needing care, many seniors think Medicare will pay for all of their care. A recent poll conducted by the Robert Wood Johnson Foundation and Harvard School of Public Health found that 68 percent of people who are retired or near retirement believe that they will have trouble paying for long-term care, and 39 percent would expect Medicare to pay most of the costs should they ever need care in a nursing home for three months or more. See [Poll Highlights Mistaken Expectations](#) at right.

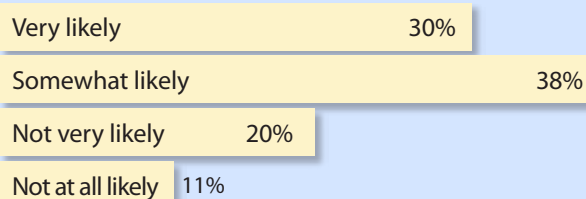
Something to keep in mind is that for people suffering from cognitive impairment, remaining at home will likely require the services of family, friends, or professionals to provide non-skilled care. Many people want to recover at home, and in my experience, many who have medical insurance—whether individual plans or through their employers—think that their insurance plan and/or Medicare will pay for them to hire someone who is a non-medical professional or for a friend or family member to provide care. However, most health plans are designed to cover only the cost of services that are so inherently complex that they must be delivered by licensed professionals such as physicians; nurses; or physical, speech, or occupational therapists.

If a senior's family members can provide a

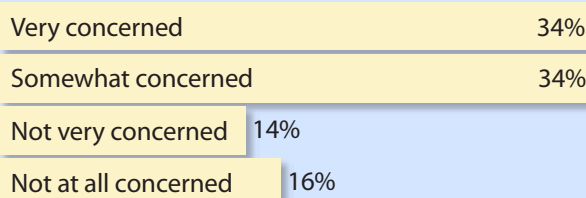
» Poll Highlights Mistaken Expectations

In a [recent survey](#) conducted by the Robert Wood Johnson Foundation and Harvard School of Public Health, 1,164 respondents ages 50 and older revealed a great deal of both confusion and concern about how they will pay for long-term care if they ever need it.

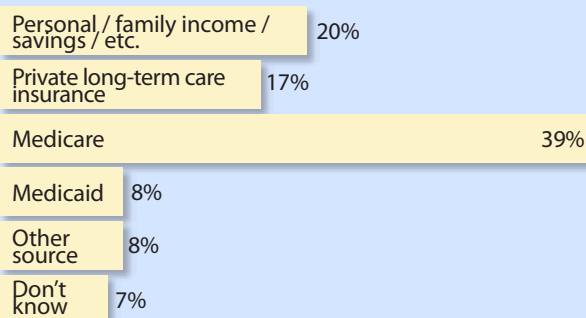
How likely is it that you will have trouble paying for long-term care, such as care in a nursing home, assisted living, or home care, if you (or your spouse/or your partner) need it during retirement?



How concerned are you about being able to afford nursing home care during your retirement if you (or your spouse/or your partner) need it?



If you (or your spouse/or your partner) were to need care in a nursing home for three months or more, how would the majority of the costs be paid?



Source: Harvard Opinion Research Program. September 2011. "Poll: Retirement and Health." Boston: Harvard School of Public Health.

service, it is unlikely to be covered by Medicare or a private health-insurance policy. Health plans, including Medicare, are designed to make patients well and enable them to recover fully. Long-term care is what they need when they don't. And in all practicality, few seniors have family members who are capable of providing long-term care, strong enough to do the necessary heavy lifting, and available 24x7.

Once my friend Grace understood that Medicare would pay for her mother's skilled care during her recovery, she asked me what would happen when the rehabilitation was over. Irene doesn't have long-term care insurance, and her ability to pay for ongoing care at home is limited. Her hard-earned nest egg of \$450,000 will take her through only the next four to six years with a home health-care aide, at which time she won't have the funds to meet her ever-increasing care needs, or even to cover her basic food and shelter needs, which the nest egg was intended to fund. Even if Grace spent a good deal of time caring for Irene, she would need help so that she could continue to work and maintain something of an independent lifestyle. Virtually no one can care for another person 24 hours a day, 7 days a week.

Consider another, hypothetical example: You work with a senior named Dan who has a debilitating lower-back condition. He is in so much pain that he can hardly breathe. Dan goes to the emergency room, asking for pain relief. He is admitted to the hospital for pain control, therapies, and management of his disability under a doctor's care. The hospital stay is considered skilled care because the treatment Dan receives is complex. He doesn't require surgery, but it will take him several months to get back to normal. Medicare covers Dan's nine-night hospital stay. He is discharged with a plan of care that involves a stay in a skilled nursing facility; Medicare will pay most of this facility's costs as well.

Dan wants to go home. If he does, Medicare will pay for home-based physical

therapy three days a week and a nurse's visit once a week for the purpose of medical monitoring. However, Dan will still have pain and limited mobility. If Dan doesn't leave his house for any purposes other than intermittent doctor visits or attendance of religious services, Medicare will pay for the majority of his costs. However, as Dan recovers and becomes more mobile, his care professionals will determine how long he can continue to use Medicare to pay for his skilled care. From the time of his hospital discharge, the majority of Dan's care is not medical; it's the type of help he could receive from his wife, family members, neighbors, or friends. Although these services would be provided by a skilled nursing facility, and Medicare would pay most of the cost of the nursing facility during Dan's rehabilitation, Medicare will not cover the cost of custodial care once Dan is home and is no longer homebound or once his care providers determine that he can perform personal care services for himself. Just keep in mind that Medicare is skilled care; custodial care is non-skilled.

Medicare vs. Medicaid vs. private options

As a CSA providing professional guidance to Dan, you need to help him understand that if he decides to recuperate at home, he's going to either rely on his family to care for him day-to-day, or else he's going to pay out of pocket for caregivers (or for people to relieve his primary, volunteer caregiver). The whole ordeal will likely cost him thousands of dollars.

What should Dan's plan be? How can he pay for his non-medical care as his back condition improves? He may be under the impression that some government program will pay for his non-skilled care. If he were destitute, he would be able to turn to Medicaid for long-term care funding. However, Medicaid is health insurance for people who cannot afford to pay for care, and qualifying

is difficult. Eligibility requires low assets and low income. Don't confuse Medicaid with Medicare. Medicare does not pay for long-term care. Period. No seniors can rely on this government program to pay for their care outside of short periods of recovery from a specific illness or injury, and it is the CSA's responsibility to make sure senior clients understand this fact.

For those who are eligible, long-term care insurance is an option—although in Dan's case, having a debilitating back condition will disqualify him from coverage. If he improves and can qualify, based on no longer needing care, a new policy may be available. Often, a senior and his or her family fully understand the benefits of long-term care insurance only after the senior already needs care, at which point he or she cannot qualify for coverage. To provide professional guidance to clients who are interested in exploring this option, see *Who Should Buy Long-Term Care Insurance?* at right.

If a client qualifies to purchase long-term care insurance, be aware that there are specific requirements to meet when care is needed. Long-term care insurance pays for non-skilled, custodial care if a person is deficient in at least two of the six activities of daily living, or needs supervision due to a loss of memory or reasoning, and assistance is expected to last 90 days or more. Think of this coverage as the first liquid asset that a client might have access to when a claim is approved. He or she wouldn't need to call a banker, real estate agent, or financial advisor to find the money. As long as your client qualifies for benefits, the insurance company will pay toward his or her care. Some policies require that caregivers be professionals in order to reimburse them, but others pay friends or neighbors to provide care at home. If admitted to an assisted living community or nursing home, a long-term care policy will pay benefits based on the individual's qualifications. Most long-term care is custodial care, not skilled care.

» Who Should Buy Long-Term Care Insurance?

Individuals should consider buying long-term care coverage if:

- They have significant assets and income, so they won't qualify for Medicaid coverage.
- They want to protect some of their assets and income in the event of expensive long-term care.
- They can afford to pay premiums, including possible premium increases, without financial difficulty.
- They want to stay independent of the support of others, not relying on family, neighbors, and friends if they become unable to care for themselves.
- They never want to require their spouse or children to take care of them full-time.
- They want to have the flexibility of choosing care in the setting they prefer (nursing facility, rehabilitation hospital, or their own home), or to select the setting in which they will be most comfortable.

To ensure that you're always providing the best information for senior clients and their families, I suggest you frequently review the annually updated [Medicare & You](#) government handbook to familiarize yourself with the current state of Medicare benefits and the limits on benefits, which may change annually. In addition, if you have questions about Medicare and the funding of long-term care, there is a wonderful explanation of Medicare in [A Shopper's Guide to Long-Term Care Insurance](#) by the National Association of Insurance Commissioners. As this guide says, "you should not rely on Medicare to pay for

your long-term care needs.” This is advice that every senior-focused professional should be ready to dispense, and to explain in detail. ■



Nancy A. Dykeman, CSA, CLTC, is the president of Long-term Care Planning Consultants, LLC, and founder/principal of LTCares, an education and planning company.

She is an insurance professional, faculty member for SCSA, core instructor for The Corporation for Long-Term Care Certification, and director of the CLTC Board of Standards. Over the past 30 years, she was a licensed nursing home administrator and also served as a caregiver for her mother, father, step-daughter, and husband. You can reach her at Nancy@tc-planning-consultants.com.

References

Centers for Medicare & Medicaid Services. 2012. [Medicare & You](#). Baltimore.

National Association of Insurance Commissioners. 2010. [A Shopper's Guide to Long-Term Care Insurance](#). Washington, D.C.