AMI Benefit Plan Administrators Inc.
"A Fiduciary Plan Administrator"

AMI Newsletter, Fall 2019

Medicaid and Nursing Home Care

As you enter your 60s and 70s, health may become more of an issue than it once was, and your thoughts may turn to the future. Who will take care of you when you can no longer care for yourself? If you must enter a nursing home, how will you pay for it? By learning as much as you can about Medicaid right now and planning appropriately, you may be able to resolve these issues and create a more secure future.

Nursing homes provide different levels of long-term care

You may need to enter a nursing home if you become physically or mentally incapacitated and can no longer care for yourself properly. If the services of an in-home caregiver are inadequate or unavailable, or if you require around-the-clock care, entry into a nursing home on a long-term basis may be your only option.

A nursing home is a state-licensed facility that may provide skilled nursing care, intermediate care, and/or custodial care.

- Skilled care: This around-the-clock care, ordered by a physician and performed by skilled medical personnel, is designed to treat a medical condition.
- Intermediate care: This involves occasional nursing and rehabilitative care provided by registered nurses and certain other medical personnel under the supervision of a physician.
- Custodial care: This type of care is designed to help you perform the activities of daily living (e.g., bathing, eating, dressing). It can be provided by someone without professional medical skills but is supervised by a physician.

Medicaid can help you pay for nursing home care

Medicare (Part A), Medigap insurance, and Medicaid can each provide some assistance in paying for long-term care. However, Medicare and Medigap provide only short-term coverage for skilled care at nursing homes; only a certain number of days per year are covered. Also, they do not provide coverage for intermediate and custodial care in nursing homes.

In contrast, Medicaid (in most states) will pay for skilled care and intermediate care in nursing homes, and for custodial care at home. The bottom line is that most nursing home residents are left with only three alternatives for paying their nursing home bills: Medicaid, their own assets (e.g., cash, investments), and long-term care insurance (LTCI).

Although a LTCI policy may be an ideal solution, you may not be able to purchase such a policy later in life if you're uninsurable for health reasons, or if you find the premiums too high. If you don't want to spend your life savings on nursing home bills and can't afford LTCI premiums, qualifying for Medicaid may be your best bet. With proper planning, you may be able to qualify for Medicaid, protect your healthy spouse (if you have one), and even leave some assets to your loved ones after you're gone.

You must satisfy several requirements to qualify for Medicaid

Medicaid is a joint federal-state program that provides medical assistance to various low-income people, including those who are aged (i.e., 65 or older), disabled, or blind. It can pay for a number of costs, including hospital bills, physician services, and long-term care. Medicaid is the single largest payer of nursing home bills in America and is the last resort for people who have no other way to finance their long-term care. Although the eligibility rules vary from state to state, federal minimum standards and guidelines must be observed.

In addition to you meeting your state's medical and functional criteria for nursing home care, your assets and monthly income must each fall below certain limits if you are to qualify for Medicaid. However, several assets (which may include your family home) and a certain amount of income may be exempt or not counted.

Although many people are ineligible for Medicaid when they first enter a nursing home, several states allow elders to enter and then spend down their income and assets on nursing home bills to become eligible. This can be a great advantage. On the downside, though, you may have to kiss your life savings good-bye.

That's where Medicaid planning comes in. In determining your eligibility for Medicaid, a state may count only the income and assets that are legally available to you for paying bills. You can make assets unavailable by giving them away or by holding them in certain trusts. However, in some cases, such transfers may create a period of ineligibility before you can collect Medicaid. So, to engage in proper Medicaid planning, you should consult an experienced elder law attorney.

Choosing the right nursing home takes research

Because nursing homes have long waiting lists, you should research the nursing homes in your area before an emergency arises. If you plan on using Medicaid to pay for your nursing home care, make sure that the facility you select accepts Medicaid--not all nursing homes do. Many others restrict the number of Medicaid "beds" in the nursing home (some states, however, prohibit this). Also, be aware that if Medicaid will be paying for your nursing home care, you will not be entitled to a private room.

You should consider several factors when choosing a nursing home. These include:

- Level of medical care: Some homes provide mainly custodial care. If you think that you may need skilled nursing care in the future, don't choose a home that offers only custodial care.
- Cost of care: You will pay less at some facilities than at others. Compare the cost of each facility with the quality of care and the services provided.
- Recreational opportunities: Consider whether the nursing home organizes outside or in-house recreational activities for its residents.
- Appearance of grounds and facilities: The nursing home should be clean and well maintained. A bad smell is one sign of a poor-quality nursing home.
- Resident/staff ratio and interaction: Determine if the resident/staff ratio meets or exceeds state and federal requirements. Also, notice how staff members treat residents.

When you find a nursing home that you like, you should find out if a bed will be available for you, or if you can add your name to a waiting list. And remember, Medicaid planning should be done well before the need for a nursing home arises.

For more information on how to evaluate a nursing home, contact your state department of elder services.

Medicare

Medicare is a federal program that provides health insurance to retired individuals, regardless of their medical condition, and certain younger people with disabilities or end-stage renal disease. Here are some basic facts about Medicare that you should know.

What does Medicare cover?

Medicare coverage consists of two main parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance). These parts together are known as Original Medicare. A third part, Medicare Part C (Medicare Advantage), covers all Part A and Part B services, and may provide additional services. A fourth part, Medicare Part D, offers prescription drug coverage that can help you handle the rising costs of prescriptions.

Medicare Part A (hospital insurance)

Generally known as hospital insurance, Part A covers services associated with inpatient hospital care. These are the costs associated with an overnight stay in a hospital, skilled nursing facility, or psychiatric hospital, including charges for the hospital room, meals, and nursing services. Part A also covers hospice care and home health care.

Medicare Part B (medical insurance)

Generally known as medical insurance, Part B covers other medical care. Physician care — whether you received it as an inpatient at a hospital, as an outpatient at a hospital or other health-care facility, or at a doctor's office — is covered under Part B. Laboratory tests, physical therapy or rehabilitation services, and ambulance service are also covered. Medicare Part B also covers 100% of the cost of many preventative services and an annual wellness visit.

Medicare Part C (Medicare Advantage)

A Medicare Advantage plan is a private health-care plan that contracts with Medicare to provide Part A and Part B benefits. A Medicare Advantage plan covers all of the services that Original Medicare covers except hospice care. Some plans offer extra coverage for expenses not covered by Original Medicare such as vision, hearing, dental, and other health expenses. Most also offer prescription drug (Part D) coverage. Several types of Medicare Advantage plans may be available, including health maintenance organization (HMO) plans, preferred provider organization (PPO) plans, private fee-for-service (PFFS) plans, and special needs plans (SNPs). You can choose to enroll in either Original Medicare or a Medicare Advantage plan. If you enroll in a Medicare Advantage plan, you'll generally pay a monthly premium for it, in addition to your Part B premium.

Medicare Part D (prescription drug coverage)

All Medicare beneficiaries are eligible to join a Medicare prescription drug plan offered by private companies or insurers that have been approved by Medicare. Although these plans vary in price and benefits, they all cover a broad number of brand name and generic drugs available at local pharmacies or through the mail. Medicare prescription drug coverage is voluntary, but if you

decide to join a plan, keep in mind that some plans cover more drugs or offer a wider selection of pharmacies (for a higher premium) than others. You can get information and help with comparing plans on the Medicare website, medicare.gov, or by calling a Medicare counselor at 1-800-Medicare.

What is not covered by Medicare Parts A and B?

Some medical expenses are not covered by either Part A or B. These expenses include:

- Your Part B premium
- Deductibles, coinsurance, or co-payments that apply
- Most prescription drugs
- Dental care
- Hearing aids
- Eye care
- Custodial care at home or in a nursing home

Medicare Part C may cover some of these expenses, or if you're enrolled in Original Medicare you can purchase a supplemental Medigap insurance policy that will help cover what Medicare does not.

Are you eligible for Medicare?

Most people age 65 or older who are citizens or permanent residents of the United States are eligible for Medicare Part A (hospital insurance) without paying a monthly premium. You are eligible at age 65 if:

- You receive or are eligible to receive Social Security or Railroad Retirement Board benefits based on your own work record or on someone else's work record (as a spouse, divorced spouse, widow, widower, divorced widow, divorced widower, or parent), or
- You or your spouse worked long enough in a government job where Medicare taxes were paid

In addition, if you are under age 65, you can get Part A without paying a monthly premium if you have received Social Security or Railroad Retirement Board disability benefits for 24 months, or if you are on kidney dialysis or are a kidney transplant patient.

Even if you're not eligible for free Part A coverage, you may still be able to purchase it by paying a premium. Call the Social Security Administration (SSA) at (800) 772-1213 for more information.

Although Medicare Part B (medical insurance) is optional, most people sign up for it. If you want to join a Medicare managed care plan or a Medicare private fee-for-service plan, you'll need to enroll in both Parts A and B. And Medicare Part B is never free — you'll pay a monthly premium for it, even if you are eligible for premium-free Medicare Part A.

How much does Medicare cost?

Medicare deductible amounts and premiums change annually. Here's what you'll pay in 2019 if you're enrolled in Original Medicare:

	Premium	Deductible	Coinsurance
Part A (hospital)	None for most people, but noneligible individuals pay up to $437 per month (if they have 39 or fewer quarters of Medicare-covered employment)	$1,364 per benefit period	$341 a day for the 61st to 90th day each benefit period; $682 a day for the 91st to 150th day for each lifetime reserve day (total of 60 lifetime reserve days); $170.50 a day for the 21st to 100th day each benefit period for skilled nursing facility care
Part B (medical)	The standard Part B premium amount is $135.50 (subject to an income-based adjustment). However, some people who get Social Security benefits will pay less than this amount. See below for more information.	$185 per year	After satisfying a deductible if one applies, you normally pay 20% of the approved amount for medical expenses (20 to 40% for outpatient mental health services, 20% for hospital charges for outpatient hospital services, nothing for laboratory services)

If you have your premiums deducted from your Social Security benefits, and the increase in your benefits for 2019 will not be enough to cover the Medicare Part B increase, then you may pay less than the standard Part B premium. Otherwise, you may pay the standard Part B premium of $135.50. You'll also pay the standard Part B premium of $135.50 (or higher) if:

- You enroll in Part B for the first time in 2019.
- You don't get Social Security benefits.
- You're directly billed for your Part B premiums.
- You have Medicare and Medicaid, and Medicaid pays your premiums.
- Your modified adjusted gross income as reported on your federal income tax return from two years ago is above a certain amount.*

The table below shows what you'll pay if you're in this group.

If you file an individual income tax return with income that is:	If you file a joint income tax return with income that is:	If you file an income tax return as married filing separately with income that is:	Monthly premium in 2019:
$85,000 or less	$170,000 or less	$85,000 or less	$135.50
Above $85,000 up to $107,000	Above $170,000 up to $214,000	N/A	$189.60
Above $107,000 up to $133,500	Above $214,000 up to $267,000	N/A	$270.90
Above $133,500 up to $160,000	Above $267,000 up to $320,000	N/A	$352.20
Above $160,000 and less than $500,000	Above $320,000 and less than $750,000	Above $85,000 and less than $415,000	$433.40
$500,000 and above	$750,000 and above	$415,000 and above	$460.50

*Beneficiaries with higher incomes have paid higher Medicare Part B premiums since 2007. To determine if you're subject to income-related premiums, the SSA uses the most recent federal tax return provided by the IRS. Generally, the tax return you filed in 2018 (based on 2017 income) will be used to determine if you will pay an income-related premium in 2019. You can contact the SSA at (800) 772-1213 if you have new information to report that might change the determination and lower your premium.

Since Original Medicare doesn't cover every type of medical care, and you'll have to pay deductibles and coinsurance, you may want to buy a Medicare supplemental insurance (Medigap) policy.

If you're enrolled in a Medicare Advantage plan, you'll generally pay one monthly premium for that plan in addition to your Medicare Part B premium. Each Medicare Advantage plan has different premiums and costs for services, and coverage varies, so what you'll pay depends on the plan you have.

Who administers the Medicare program?

The Centers for Medicare & Medicaid Services (CMS) has overall responsibility for administering the Medicare program and sets standards and policies. The CMS also manages the official government website for Medicare, medicare.gov. But it's the SSA that processes Medicare applications and answers Medicare eligibility questions.

How do you sign up for Medicare?

You'll generally be automatically enrolled in Medicare when you turn 65 if you're already been receiving Social Security or Railroad Retirement Board benefits for at least four months before you turn 65. The SSA will notify you that you're being enrolled. If you're not automatically enrolled and are eligible for Medicare at age 65, you have a 7-month initial enrollment period to sign up for Part A and/or Part B.

Although there's no cost to enroll in Medicare Part A, you'll pay a premium to enroll in Medicare Part B. If you've been automatically enrolled in Part B, you'll be notified that you have a certain amount of time after your enrollment date to decline coverage. Even if you decide not to enroll in Medicare Part B during the initial enrollment period, you can enroll later during the annual general enrollment period that runs from January 1 to March 31 each year. However, you may pay a slightly higher premium as a result, depending on the circumstances

If you decide to postpone applying for Social Security past your 65th birthday, you can still enroll in Medicare when you turn 65. The SSA suggests that you call (800) 772-1213 three months before you turn 65 to discuss your options. The easiest way to apply for Medicare is online at socialsecurity.gov.

IMPORTANT DISCLOSURES

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