Planning And Paying For Long-Term Care (Part 2 In A Series: Medicare)

By Scott Alan Mitchell

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As discussed in Part 1 of this series, the U.S. Department of Health and Human Services estimates that at least 70% of people over age 65 will need long-term care services at some point in their lives – and over 40% will need care in a nursing home for some period of time. In Pennsylvania, the cost for nursing care is nearly $8,000 per month. Nursing care generally is paid either out of one's private assets, Medicare and private health insurance, long-term care insurance, or Medicaid/Medical Assistance. Medicare and private health insurance will be the focus of this Part 2. According to current statistics, approximately 20% of nursing care throughout the country is paid by Medicare. However, as will be explained below, that statistic is somewhat misleading in that Medicare coverage for nursing care is quite limited.

Many individuals mistakenly use the terms "Medicare" and "Medicaid" interchangeably, but they are entirely different programs. Medicare is a health insurance program generally for people age 65 and above. People under 65 with certain types of disabilities also can qualify for Medicare. Medicare generally has four "parts," but the most common parts are Part A (hospital insurance) and Part B (medical insurance). For most individuals 65 or older, if they receive or are eligible to receive Social Security benefits, they are entitled to Medicare Part A completely free of charge (and others may be able to "buy-in" to Part A). Anyone who is eligible for free Part A also may enroll in Medicare Part B by paying a monthly premium (currently $96.40 or $110.50 for most individuals).

Medicare Part A (hospital insurance) provides coverage for inpatient care in hospitals, skilled nursing facilities, hospice, and home health care. With respect to skilled nursing facilities, Medicare Part A only pays for skilled nursing care if the need for nursing care arises after an inpatient stay in a hospital for at least three days ("observation" status or time spent in the ER does not count; inpatient status is required). Thereafter, so long as the person is receiving rehabilitation in the nursing facility, Medicare Part A will pay for a maximum of 100 days of skilled nursing care. The first 20 days will be covered in full by Medicare. Days 21 through 100 will be covered partially by Medicare, subject to a daily co-payment (presently $141.50). The co-payment generally is paid by the individual's private/secondary health insurance. However, individuals without secondary health insurance must pay the daily co-payment out-of-pocket (over $4,000 per month).

As mentioned above, Medicare coverage will cover only up to 100 days – and that coverage only occurs so long as the person is receiving rehabilitation for the illness for which he or she was hospitalized. Thus, if an individual refuses therapy while in the nursing facility, Medicare will end coverage before the full 100 days. Also, if an individual's rehabilitation or improvement has ceased or reached a plateau while in the nursing facility, Medicare will end coverage before the full 100 days. When Medicare coverage ends, the individual's private health coverage usually also ends. Although many individuals mistakenly believe that the first 100 days of nursing care automatically are covered by Medicare, current statistics suggest that Medicare coverage typically ends after 25 to 30 days. When Medicare coverage is about to end, an advance "notice of non-coverage" generally will be provided, which the individual may appeal if he or she believes that Medicare coverage should continue.

Medicare will cover subsequent nursing facility stays so long as the individual is admitted to the nursing facility following a new 3-day inpatient hospital stay – and so long as the person previously has been out of a hospital or nursing facility for 60 days.

As can be seen above, Medicare certainly is beneficial for those needing a short-term nursing care stay after hospitalization. However, for those needing long-term care in a nursing facility, Medicare coverage is very limited – lasting only as long as the person is receiving rehabilitation, and up to a maximum of only 100 days. Thus, the individual generally will be left with payment options of private pay, long-term care insurance, and Medicaid/Medical Assistance. In Part 3, long-term care insurance will be discussed.