



Bulletin

Extension

Estate Planning Considerations for Ohio Families

Section 2

Retirement Planning and Medical Insurance

by Warren Lee and Richard Duvick

One of the more important objectives of estate planning for most families is to provide adequate income during retirement. Retirement planning can be approached in three steps:

1. Recognize the planning period,
2. Estimate living costs during retirement, and
3. Design an investment program to try to cover these living costs.

The Planning Horizon

Estimating the planning horizon is illustrated for the “Joneses” who plan to retire when the husband is 65 and his wife is 60 years old. Based on average life expectancies, the husband can expect to live for another 15 years and his wife about 22 years. However, mean life expectancies are not a reliable basis for retirement planning. A survey of the obituary section of a daily newspaper will quickly reveal that many men live beyond age 80 and many women live beyond age 82. If the Joneses are willing to assume a 30 percent chance of living beyond their planning horizon, they should plan on another 20 years for the husband and 30 years or more for his spouse. A life expectancy calculator that incorporates your age, general health and lifestyle can be found at <http://www.ces.purdue.edu/retirement/> under the topic “Are You Ready to Retire?”

A realistic estimate of the planning horizon is important because over a 30-year period, living costs will increase significantly due to inflation. If the average inflation rate is 3 percent per year, it will take \$2.43 after 30 years to buy what \$1.00 will buy today. A 5 percent inflation rate will increase that amount to \$4.32. Table 1 provides some sample inflation calculations.

Effects of Inflation

Years	3%	4%	5%	6%
5	1.16	1.22	1.28	1.34
10	1.34	1.48	1.63	1.79
15	1.56	1.80	2.08	2.40
20	1.81	2.19	2.65	3.21
30	2.43	3.24	4.32	5.74

The “Rule of 72” is a useful rule of thumb that will estimate how fast income needs will double due to inflation. The rule of 72 is as follows: “Divide the interest (inflation) rate into 72 to estimate the number of years it will take for living costs to double.” For example, if the inflation rate is expected to be 4 percent per year, living costs will double approximately every 18 years ($72/4$). The “Rule of 115” can be used to estimate how long it will take for living costs to triple.

Estimating Living Costs

A general rule of thumb is that living costs during retirement will be 75 to 80 percent of present living costs. Some expenses such as clothing and commuting to work may decline; however, other expenses such as medical care will likely increase. Families who plan on an active living style during retirement should plan on 100 or more percent of present living costs. For retirement income calculators, please refer to “How Much Will Your Expenses Be in Retirement?” at <http://www.ces.purdue.edu/retirement/>.

Designing an Investment Program

Social Security and employer pensions are the base for retirement income planning. These are sources of cash flow over which we have little control once we retire. We are no longer paying in after payments start and terms are set once payments begin. Generally they provide a fixed income for our lifetime and for the surviving spouse. Amounts received may or may not keep up with inflation. For a good overview of Social Security and pensions, please refer to “All about Money: Retirement Planning” at <http://ohioline.osu.edu/mm-fact/index.html>.

The rest of our retirement income must come from resources over which we have some control. These include IRAs and other tax deferred accounts, securities, our home, life insurance, liquid savings, and other investments such as real estate, collectibles, a business, etc. The primary criteria for selecting and managing the investment portfolio over time are returns, risk, and liquidity.

Returns and risks over the period 1926-99 for a sample of investment alternatives are summarized in Table 2. These examples represent distinct, broad classes of investments—equities (stocks), real assets (real estate), fixed income (government bonds), and money market (treasury bills). Average annual total returns, the sum of capital gains plus interest, rent or dividends, ranges from over 13 percent to less than 4 percent.

Table 2. Average Annual Returns and Risk, 1926-99

Asset	Mean	Standard Deviation	“Two-thirds Range”
Common Stocks	13.3%	20.1%	-6.8% to 33.4%
Farm Real Estate	10.5%	8.5%	2.0% to 19.0%
Government Bonds	5.5%	9.3%	-3.8% to 14.8%
U.S. Treasury Bills	3.8%	3.2%	0.6% to 7.0%
Inflation	3.3%	4.5%	-1.2% to 7.8%

The standard deviation is a common statistical measure of risk. It can be interpreted as follows: In two out of three years, the actual return was within one standard deviation of the mean. The actual return on common stocks for example was within 13.3% (+/-) 20.1% giving a “Two-thirds Range” of -6.8% to 33.4%. An additional interpretation is that 95% of the time, the actual return was within two standard deviations of the mean. The data in Table 2 illustrate a fundamental rule of investing: The higher the return, the greater the risk. Common stocks have historically offered high returns, but one must be prepared for the inevitable downturns.

Most investors will approach the markets through mutual funds, IRAs or other tax deferred accounts; however, a basic understanding of the inherent risks associated with the investment classes in Table 2 is still important because mutual funds are merely a mix of these types of investments. See “Start With Mutual Funds” at <http://ohioline.osu.edu/mm-fact/index.html>.

Equities. Investors in common stocks become part owners of the companies whose shares they hold. Both dividends and capital appreciation of the common stock depend on business risk—the profit performance and outlook for the company. Stocks are also subject to market risk—the tendency for all stock prices to rise and fall together. For an excellent discussion of investing in common stocks, please refer to “Investing in Stocks” at <http://ohioline.osu.edu/mm-fact/index.html>.

Fixed Income Securities. Investors in fixed income securities such as bonds are lenders to the issuers of the securities. Other examples of fixed income investments include loans to individuals, for example, a sale of property on an installment contract. The primary source of risk is interest rate risk—the inverse relationship between the value of a bond and changes in market rates of interest. U.S. Government bonds have no default risk, but bonds issued by corporations and loans to other borrowers also involve varying amounts of default risk in addition to interest rate risk. The U.S. Government bonds in Table 2 have shown more year-to-year variability than one might normally associate with a “fixed income” investment. Factors to consider when investing in bonds or other fixed income securities are discussed in “Investing in Bonds” at <http://ohioline.osu.edu/mm-fact/index.html>.

Real Assets. Investments in real assets such as real estate, commodities, collectibles, etc., offer a wide range of expected returns and risks. Investing in farm real estate has offered reasonably high returns and low risk compared to common stocks, as illustrated in Table 2. Like the stock market, investing in real assets is subject to business risk—returns are heavily influenced by profit history and prospects for future growth. Moreover, some investments in real assets lack liquidity. Common stocks can be liquidated by simply calling your broker. Selling a parcel of real estate or a restaurant usually involves more time, expense, and effort and these kinds of assets usually cannot be sold in small units.

Money Markets. The U.S. Treasury Bills in Table 2 illustrate the risks and returns from investing in short-term money market instruments such as T-Bills, certificates of deposit, commercial paper, and other short-term, fixed income securities. These investments involve minimal default risk but their returns have

barely kept up with inflation. Some cash is needed to meet liquidity needs and provide flexibility, but money market instruments generally should not make up a large share of the total portfolio.

Personal Residence. For many families, their home is their largest single investment. The home represents a large amount of capital that is essentially “locked in” as long as you continue to live there. Selling the present home and moving to a smaller, less expensive one is an option that may free up some funds. Sale of the personal residence will generally be tax-free. For a review of housing choices, see <http://ohioline.osu.edu/ss-fact/0144.html>.

Other options for “unlocking” funds tied up in the home are home equity loans and reverse mortgages. Home equity loans and reverse mortgages involve appraisal fees and closing costs. Money borrowed on a home equity loan must be repaid. Interest on a home equity loan may be tax-deductible if you itemize deductions. A reverse mortgage allows senior homeowners to convert the equity in their home to cash—either a lump sum or monthly income. The loan is repaid when the home is sold or the homeowner dies. Details on reverse mortgages can be found at <http://ohioline.osu.edu/ss-fact/>.

Life Insurance. Some financial planners recommend cashing in policies and investing the proceeds elsewhere. However, some life insurance is needed to provide for financially dependent survivors and to provide liquidity to pay debts and estate settlement costs. One way to free up some cash is to stop paying premiums if the cash value will keep the policies in force. Some policies allow for proceeds to be used before death in the event of a terminal illness. For a more complete discussion of life insurance, see Life Insurance.

Other Investments. Investments in real estate, a business, etc., can be converted to cash, but the time frame to convert is longer. The maximum tax rate on most capital gains is 15 percent (28 percent on collectibles). Cash generated from the sale of these types of investments can be put into equities, fixed income, or money market securities for future appreciation and ease of converting back to cash.

Diversification. The investment portfolio should contain a mix of investments that are not highly correlated. Over time, fixed income securities such as bonds have been negatively correlated with stocks—when returns from stocks have been declining, there has been a tendency for returns from bonds to increase, and vice versa. So, it makes sense to put our eggs in different baskets. Here are some sample investment portfolios and expected returns based on past performance:

Lower Risk: 55% Cash, 20% Fixed Income, 25% Stocks—Average Return = 6%.

Medium Risk: 20% Cash, 35% Fixed Income, 45% Stocks—Average Return = 8%.

Higher Risk: 0% Cash, 35% Fixed Income, 65% Stocks—Average Return = 10%.

As asset values change, it may be necessary to periodically *rebalance* to keep the asset mix in the desired proportions. After a period of time when stocks have increased by 30% and bonds have declined by 10%, rebalancing would involve selling some of the stocks and investing the proceeds in bonds. Rebalancing sometimes takes discipline and there are tax consequences to consider, but it is necessary to keep your risk within your goals.

Management. Are you going to do it yourself or hire a professional? A “financial planner” or “financial advisor” can guide us through the complexities of investing. If the individual is in the business of giving advice on the selection of securities, that person is considered to be an “investment advisor” under state law. In addition to legal and professional qualifications, the person’s general attitude and personality are important. For guidance on selecting an advisor, please see <http://www.securities.state.oh.us/>.

A Case Study in Retirement Planning

The Joneses have estimated that they will need \$40,000 per year during retirement. They estimate that their income from Social Security and pensions will be \$30,000 per year, so they will need to generate \$10,000 per year from their investments. They have a “medium risk” investment portfolio that may earn 8 percent per annum; however, they expect that the average annual inflation rate will be 3 percent, so the *real* rate of return on their investments will be 5 percent.

In order to generate an annual income of \$10,000 from earnings alone with a 5 percent real rate of return, they will need a retirement nest egg of \$200,000 ($\$10,000/0.05$). They can generate an income of \$10,000 from a somewhat smaller nest egg if they plan to gradually liquidate their investment portfolio during retirement. A portfolio of approximately \$153,700 earning 5 percent real return will generate \$10,000 per year if the principal is used up over a 30-year period. Table 3 illustrates the size of nest egg needed to generate \$10,000 per year at different real rates of return.

Years	3%	5%	7%	9%
5	\$45,788	\$43,296	\$41,002	\$38,897
10	85,324	77,220	70,235	64,177
15	119,332	100,371	91,083	83,126
20	148,809	124,626	105,943	91,283
25	174,216	140,944	116,537	98,222
30	196,078	153,728	124,085	102,733
35	215,053	163,747	129,483	105,663

This case illustrates the need to 1) estimate the period of time over which retirement income will be needed, 2) project retirement living expenses, and 3) design an investment portfolio that will help meet these goals. Clearly, retirement planning should begin well before age 65!

Long-Term Care Insurance

by Warren Lee

The purpose of long-term care insurance is to pay for services such as nursing homes, adult day care, home care, or assisted living that are generally not covered by medical insurance or Medicare. Nursing home care services are expensive, as much as \$50,000 per year or more, depending on where you live. Custodial care in your home will cost about half as much as nursing-home care.

As with all types of insurance, the purpose of long-term care insurance is to protect your income stream and wealth against the financial consequences of adversity—in this case, an extended need for long-term care. Long-term care coverage is a relatively new insurance product; it is expensive and it is not for everyone.

Sizing Up the Risks

The Ohio Department of Insurance estimates that on average, there is about a 50-50 chance that you will

spend some time in a nursing home after you reach the age of 65. However about half of the people entering a nursing home stay 3 months or less; almost 80% stay one year or less; and fewer than 10% stay in a nursing home longer than 5 years.

So, the odds that long-term care expenses will result in a financial catastrophe appear to be low. But insurance decisions should not be based on the odds. The probability of having one's home destroyed by fire is very low, but most people carry casualty insurance and hope they never have a claim. Long-term care insurance should be viewed as protection against the unlikely event that one would need months or years of care that could cost \$50,000 per year or more.

Is It For You?

If you have significant assets and income to protect and you want to remain independent and pay for your own care, you should consider buying long-term care insurance.

Most families with low to moderate income and wealth should probably not buy long-term care insurance. They may have difficulty paying the premiums, and if the policy lapses due to nonpayment of a premium, coverage will not be there when it is needed. A better strategy may be to spend down assets and allow Medicaid to pick up the cost of long-term care.

Rules governing Medicaid eligibility are strict. As a general rule, you must use up most of your own resources before Medicaid will pay. Transfers of assets within 36 months of application will be closely scrutinized and may result in restricted Medicaid eligibility.

What to Look for in a Policy

As with all new products, long-term care insurance is changing as the market grows and providers gain experience. One common feature is that benefits are triggered only when the insured is unable to perform some activities of daily living or suffers from mental impairment. Be sure to carefully check the benefit trigger provisions of the policy.

The cost of the policy will depend on a large number of features, but four of the more important variables are the daily benefit (for example, \$100 per day), the length of time benefits are paid (2 years, 4 years, lifetime), inflation protection, and the waiting period or deductible.

A 65-year-old can expect to pay from \$600 to \$900 per year for a policy that provides a \$100 daily benefit for 2 years after a 90-100 day deductible with no inflation protection. Expect to pay twice as much for a \$100 daily benefit for 4 years after a 0-20 day deductible with inflation protection.

Of course premiums for any given policy increase with the age at which it is purchased. On average, yearly premiums are about one-third less if the coverage is purchased at age 60 instead of 65. The cost of coverage purchased at age 70 is about 55% higher than the same coverage purchased at age 65. Tax qualified plans are available, but in most cases the tax savings will be small and they typically have more restrictive benefit triggers.

Beware of emotional sale presentations. Long-term care insurance is an expensive product that deserves careful research before buying.

Some excellent references are:

The Ohio Department of Aging
<http://www.state.oh.us/age/tc/index.html>

Ohio Shoppers Guide to Long-Term Care Insurance

Ohio Department of Insurance

<http://www.ohioinsurance.gov/consumserv/ocs/LTCareGuide/LTCShoppersGuide.htm>

A Shoppers Guide to Long-Term Care Insurance

National Association of Insurance Commissioners

[http://www.naic.org/pubcat/consumer.htm#A Shopperís Guide to Long-Term Care Insurance](http://www.naic.org/pubcat/consumer.htm#A%20Shopper%27s%20Guide%20to%20Long-Term%20Care%20Insurance)

What About Medicaid to Pay Nursing Home Bills?

by Jim Skeeles

Medicaid is a government program for the indigent over 65. Most of us never want to depend on the government to pay our bills because we have no money and/or assets left, but nearly two-thirds of residents currently in nursing homes are in that very situation. They do not have sufficient income and have spent their savings so Medicaid pays the nursing home bill. Keep in mind that half of us will never enter a nursing home and most who do enter a nursing home stay only a short time, so the likelihood of spending our savings and then being on Medicaid is low.

Why not give the money or assets away before entering a nursing home to preserve those assets? It is against the law! Criminal penalties may be imposed on those who have transferred assets to heirs with the aim of qualifying for Medicaid and protecting the transferred assets from being claimed by Medicaid. Even if assets are transferred without the aim of qualifying for Medicaid, Medicaid can claim a portion of those assets if transferred too close to making application for Medicaid. Gifts to other people must be transferred three years prior to Medicaid application for Medicaid to not claim a portion of the value of that gift. Gifts to trusts must be made five years prior to Medicaid application for Medicaid to not claim a portion of the gift. However, if the grantor retains any control of assets placed in the trust or if the trust is revocable (the grantor may regain control of assets), assets are considered by Medicaid, or for that matter by probate courts, to still be owned by the grantor.

Medicaid Income Limits

Let's consider first the income limitation. A single person in a nursing home may keep only \$40 of unearned monthly income, plus dollars used to pay medical insurance. All other unearned income must be used to pay the nursing home, and medical or prescription bills. If income is earned, the nursing home resident may keep \$105 per month, plus dollars used for medical insurance.

If one spouse of a married couple is in a nursing home, Medicaid calls that spouse the "institutionalized" spouse, and the spouse at home is called the "community" spouse. If, and only if, the couple meets Medicaid's income and resource limits for a couple, the spouse in the nursing home is eligible for Medicaid benefits. Once one qualifies for Medicaid, Medicaid allows the institutionalized spouse to keep only \$40 per month (plus dollars used for medical insurance). However the community spouse may keep all of his or her income.

The community spouse may be able to keep all or a portion of the institutionalized spouse's income, depending on income of both spouses and household expenses. However, less than \$2,267 per month in 2003 (historically this limit goes up \$50 to \$150 each year) of the institutionalized spouse's income could go to the community spouse, with the rest used to offset nursing home and medical insurance costs. The County Department of Human Services administers Medicaid and determines eligibility and income to be kept by each spouse on an individual basis.

Medicaid Asset or Resource Limits

If a nursing home resident is single, all but \$1,500 of “counted” or “non-exempt” resources or assets must be used to pay nursing home bills. If both are in the nursing home, each may have \$1,500 in those counted assets that are not “exempt.” A home is “safe” for six months, only if Human Services determines the resident(s) may be able to return home sometime in the future. However, if Medicaid determines that resident(s) will never be able to return home, the home may have to be sold and the proceeds used to pay the nursing home bill until the proceeds are gone, unless there are dependents currently living in the home.

If married and only one spouse is in the nursing home or applying for Medicaid coverage, when application is made, all resources or assets are considered to be jointly owned by the couple, regardless of how owned or titled. The following assets may be retained by the community spouse:

1. the home;
2. the car if any one of the following:
 - it is titled to the community spouse,
 - if equipped for a disabled person,
 - if used for employment, or
 - if valued at \$4,500 or less;
3. wedding rings of both spouses;
4. furniture; and
5. certain other assets exempted by Medicaid.

In addition to the above assets, in 2003 the couple with one spouse in the nursing home could keep in entirety about \$20,000 additional assets. The community spouse could keep only half of the assets valued between \$20,000 and nearly about \$90,000 in 2003. All asset values of more than about \$90,000 would then have to be liquidated and spent before becoming eligible for Medicaid. Historically, these asset limits are increased every year, but seldom more than \$1,000 per year.

Even though certain assets such as a home are not counted in figuring Medicaid eligibility, Medicaid can still recoup their expenses, up to the amount of payments made on the homeowner’s behalf. If no spouse or dependent children are living in the home, after Medicaid has paid for nursing home bills for six months or they determine you will not be able to return to your home, the “uncounted” or “protected” assets may be sold and the cash used to pay nursing home bills. Also, upon the death of a nursing home resident whose bills are paid by Medicaid, if no spouse and/or dependents are living in the home, Medicaid will claim assets of the estate up to the amount paid for those 55 or older. Assets in an estate such as a home may have to be liquidated to cover the Medicaid claim.

In summary, a vacant home without a spouse or dependents living there is “protected” from Medicaid claim for only 6 months, even if there is a possibility the resident may be able to return home. If it is determined the resident will never be able to return home, the home is protected only as long as a spouse or dependents live there. A home (or other counted assets) is not protected from Medicaid claim for the purpose of passing it to heirs.

Medicaid will have a claim against an estate when both spouses have died, after all taxes, funeral expenses and other estate settlement costs have been paid. However, if your heirs can persuade probate court that Medicaid recovery would work an “undue hardship” on them, the Medicaid claim may not be allowed. For example, if the primary asset is a farm that the heirs operate, if Medicaid recovery would not allow the farming business to continue, the farm may be allowed to pass to heirs. Also, if the heirs are disabled or minors, the Medicaid claim may not be honored.

It is possible that Medicaid may not be able to recoup expenses from jointly owned property in the estate of a nursing home resident if that resident has a surviving community spouse or dependent(s) and that surviving spouse or dependent(s) do not also need to accept Medicaid assistance. However, the jointly owned assets must be held as follows: 1) The assets must be protected, such as a home. To be so protected the community spouse or dependent(s) must live in the home. 2) Prior to the Medicaid look back period (5 years if in trust but 3 years if otherwise, prior to entering a nursing home and applying for Medicaid to pay bill) the property must have been held in a manner that avoids probate, such as in joint tenants with right of survivorship (JTRS), so that it passes directly to the community spouse or dependent(s) and does not go through probate.

Medical Expense Assistance for Those with Low Income

If income and assets are low, help may be available not only for nursing home expenses, but also with medical expenses. Help for medical expenses for those with low income and assets may be obtained through the County Human Services Office, the same office that administers Medicaid.

The Qualified Medicare Beneficiary (QMB) Program

The Qualified Medicare Beneficiary (QMB) Program is like a free Medicare Supplement or Medigap policy, which will pay for all major medical expenses not paid by Part A of Medicare. In 2003, individuals with monthly income less than \$749 and counted total assets valued less than \$4,000 (couples with monthly income less than \$1,010 and counted total assets valued less than \$6,000) could qualify as a QMB.

The Specified Low Income Medicare Beneficiary Program (SLMB)

Those who do not qualify for the QMB may qualify for the Specified Low Income Medicare Beneficiary Program (SLMB). SLMB pays only for the Part B premium charged for Medicare (\$58.70 per month in 2003). It also pays the premium for the three months prior to qualifying. To qualify for SLMB an individual must have had monthly income of \$899 or less (\$1,212 for a couple) in 2003. Asset limits for SLMB are the same as for QMB—\$4,000 for an individual and \$6,000 for a couple. Income limits increase slightly every year, but asset limits have not changed recently for QMB and SLMB.

Medical Expenses in Autumn Years

by **Jim Skeeles**

Federal programs such as Medicare, Medicaid, and Social Security can provide some income and assist with expenses incurred in later life. The key word in the previous sentence is “assist.” These programs are not and have never been intended to be the sole source of income, medical care, or nursing home care for individuals in later life.

Medicare

Medicare pays a portion of medical expenses and is available to individuals 65 or older who qualify for Social Security benefits. Forty quarters of work credit are generally the minimum requirement for Social Security benefits.

Just as other medical insurance has two parts, Medicare has two parts, with Part A covering hospitalization and Part B covering major medical. Part A is free for those with 40 quarters credit. Part B costs \$58.70/month regardless of quarters credit, but is not available without Part A. Only one spouse need qualify and Social Security benefits continue after either spouse passes away.

If you have already been on Social Security when you turn 65, you get a card notifying you that you will be enrolled in Medicare and the premium for Part B will be deducted from your Social Security check. If you are eligible for Social Security but not enrolled, apply for Medicare two or three months before the month of your 65th birthday, at the Social Security Office. The government will not pay medical or hospital expenses incurred before enrollment, even if you were already 65 when in the hospital.

Most people not eligible for Social Security have had or currently have a medical payment plan, most often referred to as medical insurance. However, even if you have other health benefits, those eligible for Social Security benefits should apply for at least “Part A” of Medicare, if eligible, before you turn 65, as “Part A” is free.

Because Part B costs \$58.70 per month during 2003, check with your health benefit provider to see if you need to enroll in Part B before you turn 65. If you chose not apply for Part B because your employer’s benefit package has Part B benefits, but you then retire, check before you retire to see if you will need Part B, as most likely you will.

Part A

Part A covers part of your hospital bills or “hospitalization.” You pay the first \$840 (2003) every time you are admitted to the hospital in each “benefit period.” A benefit period begins when you are admitted and ends when you have been out of the hospital, skilled nursing facility, or rehabilitation facility for 60 days. It also ends even if you remain in a skilled nursing facility but don’t receive any skilled care there for 60 days in a row. If you enter a hospital again after 60 days, a new benefit period begins, you pay \$840 again, but you get a new “set” of benefits for the new benefit period. There is no limit to the number of benefit periods for hospital or skilled nursing facility care. For most people on Medicare, the \$840 “deductible” is all they pay for hospitalization. This is the case because most hospital stays are less than 60 days.

During each benefit period, the hospital room cost is covered for the first 60 days. After that, you pay \$210 (2003) of daily hospital room cost for the 61st through 90th day and Medicare pays the rest of hospitalization expenses. Hospital room cost is not covered beyond 90 days in any benefit period, except for an additional once in a lifetime allocation of 60 days (called lifetime reserve days). After you are in the hospital for more than 90 days, you may choose to begin using your allocation of 60 lifetime reserve days. Once used, those 60 days are gone and never renewed. You pay \$420 (2003) for each lifetime reserve day used and Medicare pays the rest of hospitalization expenses. Additional hospital expenses deemed to be unnecessary by Medicare (private room or private duty nurse if not doctor ordered, telephone and/or television in the room) are not covered by Medicare. Also, care outside the United States is generally not covered by Medicare.

Part B

Part B of Medicare covers doctor bills and medical expenses other than the hospital room cost. You pay the first \$100 of Medicare approved charges and Medicare pays 80% of the remaining Medicare approved expenses. That leaves 20% of these “major medical” expenses that you need to pay, or make other arrangements to be paid. You may pay more than 20% if Medicare does not approve all major medical expenses.

This short description by no means gives all details and specifics of Medicare. For more information, see the Medicare website at www.medicare.gov. If you prefer telephone, order free publications or talk to a Medicare Customer Representative at 1-800-633-4227.

Other Medicare Coverage

Long Term Care

Medicare pays less than 2% of the U.S. total nursing home bill. The requirements for partial payment of nursing home bills by Medicare are:

1. hospitalized for at least four days in a row, counting the day of discharge,
2. enter a Medicare-approved, skilled nursing home within 30 days of leaving the hospital,
3. doctor ordered daily skilled care that can only be provided in a skilled nursing home facility,
4. admission into the nursing home for the same medical condition for which in hospital,
5. continue to require daily skilled care,
6. continue to make progress and respond to skilled care.

If the above qualifications are met, Medicare will pay the total bill for the first 20 days of care. For the 21st through 100th day, Medicare will pay only \$105 per day for skilled nursing home care. After 100 days, Medicare pays nothing.

Home Health Care

Medicare generally fully covers medically necessary home health visits if you are homebound, if they are part-time or intermittent skilled nursing services. However, full-time nursing care at home is not covered, nor are drugs or meals delivered to the home.

Hospice Care

Those certified as terminally ill are eligible for hospice benefits from Medicare. In general, hospice services provided in your home are fully covered, except for needed drugs. If medical care is needed, but not for a condition related to the terminal illness, regular Medicare benefits are available.

The following website contains information about individual nursing homes in most communities. It may help you select a nursing home: www.medicare.gov/NHCompare/home.asp

Medigap Insurance

Many purchase Medigap insurance, which is a medical insurance policy that pays all or a portion of those medical expenses not covered by Medicaid. The time to purchase Medigap insurance is a six-month period beginning the month of eligibility for Medicare Part B. This period of time is called the "Open Enrollment" period. During open enrollment, insurance companies must accept you for any Medigap policy it sells, at its lowest price for customers in your age group. In other words, during the open enrollment period a company cannot reject you or charge you a higher rate because of poor health.

If you have Medicare because you are disabled and you are not yet 65, your open enrollment period is the six-month period beginning the month of your 65th birthday. If you are going to purchase Medigap insurance and you have had a past history of health problems, make the purchase during the open enrollment period. However, with a pre-existing condition, there may be up to a six-month wait for coverage, even if the Medigap insurance is purchased during the open enrollment period.

It is illegal to sell duplicate Medigap policies to the same individual and only 10 different plans (lettered A through J) can be offered. Each plan with the same letter must offer the same benefits. When shopping for Medigap insurance remember that:

1. more than one plan is a waste of money,
2. purchase during the open enrollment period for Medicare,
3. don't pay cash—make checks out to a reputable insurance company (not to an individual),
4. don't purchase a policy if your employment or retirement plan does the same thing, and
5. there is a 30-day no-obligation period during which you can change your mind and get your money back.

Excellent materials as well as other assistance is available through the Ohio Senior Health Insurance Program (OSHIP) at <http://www.ohioinsurance.gov/ConsumServ/Oshiip/WhatisOSHIIP.htm>. You may also contact them by calling 1-800-686-1578 or 1-800-686-1526. OSHIP has volunteer counselors throughout Ohio as well as on the phone at the above toll-free numbers to assist you:

1. deal with and make sense of the medical bills and statements you receive,
2. make sure you get the benefits you are entitled to,
3. better understand medical and government assistance available to you, and
4. assist you with insurance decisions.

They will send you a shoppers guide for various types of insurance. Shoppers guides for medicare supplement insurance and long-term care insurance are on the web at: <http://www.ohioinsurance.gov/consumserv/ocs/MedGuide/MedicareShoppersGuide.htm> and <http://www.ohioinsurance.gov/consumserv/ocs/LTCareGuide/LTCShoppersGuide.htm>.

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