

MEDICARE

TALKING ABOUT MEDICARE & HEALTH COVERAGE

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Welcome

Medicare is a critically important source of health insurance for 41 million Americans. Health insurance coverage matters to people of all ages, but it is especially important for those with permanent disabilities and those with health care diseases and conditions associated with aging. Despite important breakthroughs in medical practice and advances in medical technology, the inescapable truth is that health problems, medical needs, and health care expenses are major concerns -- making health coverage decisions critical for those covered by

Medicare. For most of us -- whether we're on Medicare or not -- decisions about health insurance are often difficult because they affect the kind of care we get and our financial security.

Talking about Medicare is intended to help you think through basic health care issues and provide information that should better equip you and your family to discuss these topics. Beginning in 2006, people on Medicare will face additional choices when the new Medicare drug benefit takes effect. This guide helps you understand how the drug benefit works, how to choose a drug plan that meets your needs, and how to get additional help with drug costs if you are on a limited income.

In addition, a state-by-state list of key agencies that can answer your specific questions about Medicare, Medicaid, supplemental health insurance, the new prescription drug benefit, and long-term care is included under **Additional Resources** in this guide. We hope this guide will be a useful tool for you.

About This Guide

Whether you are already on Medicare or the family member or friend of someone on Medicare, this guide will help answer your questions about Medicare, prescription drug coverage, and long-term care, including:

- What does Medicare cover? Do people who have basic protection under Medicare need additional insurance?
- What does the new Medicare drug law mean for you?
- What about joining a Medicare private plan? How do you choose among plans in your area?
- Should you buy a long-term care policy? How can you tell a good policy from a bad one?

Medicare at a Glance

- Know the Basics about Medicare
- Medicare Eligibility
- What Medicare Covers
- Other Upcoming Changes
- What Medicare Does Not Cover
- Plan for Medicare Enrollment

Tip

If you and your spouse are different ages, you won't be able to go on Medicare at the same time. For example, if your husband turns 65 and becomes eligible for Medicare when you are 63, he can enroll in Medicare. You will have to wait two years until you turn 65 before you can enroll.

Know the Basics about Medicare



Medicare is the federal health insurance program for almost all Americans age 65 and older and for many adults with permanent disabilities. Knowing the basics about Medicare can help you make good decisions about your health coverage and care.

Medicare Eligibility

You are eligible for Medicare if you are a U.S. citizen or have been a permanent legal resident for five continuous years, and:

- You are 65 years or older and eligible to receive Social Security; or
- You are under 65, permanently disabled, and have received Social Security disability insurance payments for at least 2 years; or
- You get continuing dialysis for permanent kidney failure or need a kidney transplant; or
- You have Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's disease).

What Medicare Covers

Three parts of Medicare – Part A, Part B, and, beginning in 2006, Part D – provide coverage for basic medical services and prescription drugs.

Part A: – Hospital Insurance: In addition to hospital inpatient care, Part A covers some skilled nursing facility (SNF), home health, and hospice care. If you are entitled to Part A, there is no monthly or annual premium charge, but there is a charge for most health care services. There are also specific requirements you must meet before you can receive coverage for some services, such as home health care, skilled nursing facility care, and hospice care.

Part A	
BENEFITS	INDIVIDUAL PAYS (in 2005)
Inpatient hospital Days 1-60 Days 61-90 Days 90-150 After 150 Days	Deductible of \$912 per benefit period* No coinsurance** \$228 a day \$456 a day No benefits
Skilled nursing facility Days 1-20 Days 21-100 After 100 days	No coinsurance \$114 a day No benefits
Home health	No deductible or coinsurance
Hospice	Copayment of up to \$5 for outpatient drugs and 5% coinsurance for inpatient respite care
<p>*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.</p> <p>**Coinsurance – portion of a health care fee that must be paid by an insured patient</p>	

Part B: – Medical Insurance: Part B pays for doctors' services, outpatient hospital care, and home health visits not covered under Part A. It also covers laboratory tests, such as X-rays and blood work; medical equipment, such as wheelchairs and walkers; preventive services, such as mammograms and prostate cancer screenings; outpatient physical therapy; mental health care; and ambulance services. Part B has an annual \$110 deductible (2005) and, for most services, 20% coinsurance. If enrolled in Part B, you must pay a monthly premium (\$78.20 in 2005), which is typically deducted from your Social Security check.

Part B	
BENEFITS	INDIVIDUAL PAYS (in 2005)
Premium	\$78.20 per month
Deductible	\$110 a year
Physician and other medical services MD accepts assignment* MD does not accept assignment	20% coinsurance 20% coinsurance plus up to 15% over Medicare-approved fee ¹
Outpatient hospital care	20% coinsurance
Ambulatory surgical services	20% coinsurance
X-rays; durable medical equipment	20% coinsurance
Physical, speech, and occupational therapy	20% coinsurance ²
Clinical diagnostic laboratory services	No coinsurance
Home health care	No coinsurance
Outpatient mental health services	50% coinsurance
Preventive services - Flu shots; pneumococcal vaccines; colorectal cancer screenings; prostate cancer screenings; mammograms; Pap smears; pelvic exams - Bone mass measurement; diabetes monitoring; glaucoma screening	Part B deductible and 20% coinsurance waived for certain preventive services 20% coinsurance
<p>¹ Referred to as the Medicare Limiting Charge Law, the limit on the percentage above the Medicare-approved amount that a physician can charge is less than 15% in some states.</p> <p>² There is currently no coverage limit on Medicare outpatient therapy services. A \$1,590 limit per year for occupational therapy services, and \$1,590 limit per year for physical and speech-language therapy services combined is set to begin on January 1, 2006.</p> <p>* Assignment – physicians agree to accept the Medicare’s predetermined fee as payment-in-full; patients are responsible for 20% copayment but no more.</p> <p>SOURCE: "HHS Announces Medicare Premium, Deductibles for 2005," press release, U.S. Department of Health and Human Services, September 3, 2004</p>	

Part D – Prescription Drug Insurance: Part D will begin to cover outpatient prescription drugs in 2006. For more details on Part D, see the **Prescription Drug Costs and Medicare**.

Other Upcoming Changes

Starting on January 1, 2005, Medicare will begin covering some additional preventive services:

- One initial physical exam within six months of when a person first enrolls in Medicare Part B;
- Screening blood tests for cardiovascular (heart) diseases; and
- Diabetes screening tests for people at risk for diabetes.

The Part B deductible, which has been set at \$100 since 1991, increases to \$110 in 2005 and will increase every year after that to keep up with the costs of Part B spending.

The Part B premium is currently the same for all people on Medicare (\$78.20 per month in 2005). Beginning in 2007, it will be higher for people with incomes over \$80,000 (\$160,000 per couple).

What Medicare Does *Not* Cover

You should be aware that Medicare does not cover all health care expenses -- for example, it does not pay for long-term personal care services at home or in a nursing home but does cover short-term skilled nursing care. Medicare does not cover eye exams, eyeglasses, hearing aids, dental care, or care provided outside the United States.

Medicare does not currently include coverage for most prescription drugs, unless they are provided as part of a Medicare-covered hospital or short-term skilled nursing home stay. See **Prescriptions Drug Costs and Medicare** for more information about the prescription drug benefit that will begin in 2006.

Medicare private plans -- now called Medicare Advantage plans -- often provide some coverage of supplemental benefits, such as prescription drugs, in addition to the benefits covered in the traditional Medicare program. See **Talking About Medicare Advantage and Private Plans** for additional information.

Plan for Medicare Enrollment

As a senior, eligibility for Medicare begins upon turning 65, even if your eligibility for full Social Security benefits does not begin until later. Choosing to start receiving Social Security early does not affect when you become eligible for Medicare, but it may affect the enrollment process.

- **If you are already receiving Social Security benefits when you turn 65**, you will automatically be enrolled in both Parts A and B of Medicare, effective on the first day of the month that you turn 65. A Medicare card will arrive in the mail about three months before your birthday. You can choose to decline Part B coverage, but you should take it if you want to have full Medicare benefits and avoid paying a Part B premium penalty later on (unless you have health care coverage through your or your spouse's current employer).



- **If you are not receiving Social Security benefits when you turn 65, you must apply for Medicare.** You will not be enrolled automatically. You may apply at any Social Security office during the *initial enrollment period*, which begins three months before you turn 65 and ends three months after your birthday. Contact information for making an appointment with your local social security office is available in the **Additional Resources** section of this guide for contact information.

If you do not enroll in Medicare during the initial enrollment period, you must enroll during a general enrollment period, which is January 1st through March 31st of every year. Your coverage will begin on July 1st of the year you sign up. If you wait until after your initial enrollment period, you may have to pay a penalty for each year you delayed enrollment. This penalty will be added permanently to your Part B premium.

If you or your spouse are still working when you turn 65, and you have health coverage through your employer, you may be able to delay enrolling in Part B without paying a late enrollment penalty. This will allow you to avoid duplicating Part B coverage and paying the Part B monthly premium. To avoid a late enrollment penalty you must enroll in Part B within 8 months of the time that you or your spouse stop working or you lose your employer-sponsored health insurance, (called your *Special Enrollment Period*). Your coverage will begin the month after you enroll. You should check with your local Social Security office before declining Part B to be sure you will not have to pay a penalty for late enrollment. Information on contacting your local Social Security office is available in the **Additional Resources** section of this guide.

If you have continuation health care coverage from a former employer, sometimes called COBRA, you should still enroll in Medicare Parts A and B during your initial enrollment period. Your health insurance under COBRA typically ends as soon as you are eligible for Medicare.

If you are a citizen or permanent resident, but not entitled to Medicare (for example, because you did not work enough years to qualify), you may still voluntarily enroll in Medicare. However, you must pay a monthly premium for Part A benefits (in 2004, \$189 if you worked 30 or more quarters; \$343 if you worked fewer than 30 quarters).

Prescription Drug Costs and Medicare



- Decide Whether a Discount Card Will Help You in 2004 and 2005
- Know How Your Current Drug Coverage May Be Affected by Discount Cards
- Learn About the Upcoming Drug Benefit (Part D)
- Know How Your Current Drug Coverage May Be Affected by Part D

The cost of prescription drugs has been going up rapidly year after year. People who rely on prescription drugs to maintain their health have been under increasing financial pressure, especially if they do not have insurance that helps cover the cost of their medicines.

In December 2003, a new law was passed to help people with Medicare pay for prescription drugs – the Medicare Prescription Drug, Improvement, and Modernization Act. The law created a prescription drug benefit that begins in 2006. As an interim measure before the drug benefit begins, people with Medicare can purchase Medicare-approved drug discount cards that may help lower the cost of some prescriptions in years 2004 and 2005.

This section describes these programs and how they may affect you. It also includes some more general tips on lowering your prescription drug costs.

Decide Whether a Discount Card Will Help You in 2004 and 2005

The Medicare-approved drug discount card program is intended to help people with Medicare with drug costs before the new benefit becomes available in 2006. Medicare-approved discount cards can charge up to \$30 per year to enroll. In exchange, card sponsors will offer discounts on the cost of specific prescription drugs – both brand and generic – through retail pharmacies and in some cases, mail order. Anyone with Medicare, except those with drug coverage through Medicaid, are eligible to enroll. In addition, people whose incomes are below \$1,047 a month (\$12,569 per year in 2004), if single, and \$1,405 a month (\$16,862 per year in 2004), if married (incomes limits will be slightly higher in 2005), may be eligible for up to \$1,200 towards the cost of their drugs (\$600 in calendar year 2004 and another \$600 in 2005). Any savings you have are not counted as part of your income in qualifying for the \$600.

Drug discount cards aren't insurance. Discount cards do not provide coverage for your prescription drug needs, but they do offer a discount off the full retail price of some drugs. Drug card sponsors negotiate discounts with pharmacies and drug

Tip

If you are married, you and your spouse must each apply for your own card. You may not share or use each other's cards. If you use different prescription drugs, you may find that it makes sense to enroll in different card programs. Or you may find that a card makes sense for one of you but not for the other.



manufacturers and are expected to pass savings along to card program enrollees. Discount cards may not provide as much cost relief as insurance coverage for prescription drugs, but they are likely to provide savings for those without any drug coverage, compared to the full retail price they would otherwise pay.

You can enroll right away. If you decide to enroll in a discount card, you must enroll directly with the company offering the card – not through Medicare. Some companies may allow you to apply by phone or on the Internet. Other companies may ask you to mail in a form. Each company may charge an enrollment fee ranging from \$0 to \$30 per year. Once you enroll in a card program, you are not allowed to switch cards until the end of 2004; at which time, you may select a different card, which you will have for all of 2005. The discount card program ends at the end of 2005.

You can enroll in only one Medicare-approved card program at a time. And, once you enroll in a Medicare-approved prescription drug discount card, you cannot change to another Medicare-approved card until the open enrollment period in November and December 2004, at which time, you can select the same or a different card for all of 2005.

The drugs that are included and the levels of discounts will vary. Discounts offered by various cards will vary and there are no guaranteed minimum discounts. How much you save will depend on which card you choose, the specific drugs you take, your willingness to shift to lower-cost generics or cheaper, equivalent drugs and your willingness to change pharmacies and/or use mail order.

Discounted drugs and the level of discounts available with any card may change. Any discount card sponsor can change its list of discounted drugs, and the level of discounts, as often as once a week. Card sponsors are not required to tell you about these changes unless you ask. However, the company must make current drug prices available on its website and by phone. You can ask about the discount list at any time. Medicare also makes this information available through the Medicare website (www.medicare.gov) and the toll-free phone number, 1-800-MEDICARE.

You don't have to enroll in a Medicare discount card at all. You may find that there are better ways for you to get cost savings for your drugs (see **Tips for Consumers**) and need not sign up for a discount card at all. Or, you can wait and enroll later, after you have had sufficient time to look into the cards available in your area. You may sign up for a card anytime up until the prescription drug benefit starts in 2006.

Things to consider: There are many Medicare-approved prescription drug discount cards offered nationwide. These are some questions that may help you decide whether any of them would help you.

What discounts can you expect to get on the drugs you take? The size of the discounts will vary from card to card. Start by making a list of the medicines you currently take, including the dosages (for example, whether a pill is 10 ml or 25 ml), how often you take the medications, and how much you pay for each one. Then gather information on the discounts that cards offer on those drugs at the various pharmacies in your local area.

To get discount information, you can call 1-800-MEDICARE. Medicare operators can give you some information over the phone and mail you information about the discounts available on the drugs you take at the pharmacies in your area. If you or someone you know has access to the Internet, you can find the same information at www.medicare.gov/AssistancePrograms. Another option is to talk with a counselor at your State Health Insurance Assistance Program (SHIP) (see **Additional Resources**). You can also contact card sponsors directly to ask about their discounts for specific drugs. Card sponsor contact information is available through the Medicare website or phone number.

What is the maximum annual enrollment fee? The annual fee ranges from \$0 to \$30. You pay the full annual enrollment fee, if you choose to enroll, whether or not you purchase any prescription drugs using the discount card.

Is there a particular pharmacy you want to go to? Some cards may offer discounts only at certain pharmacy chains. Some may offer discounts in only one state. You should find out what a card's pharmacy rules are before you sign up, and make sure you will be able to use the card where you want to use it.

Are there other ways to save money? Before spending money to enroll in a Medicare-approved discount card, make sure it will save you money in addition to your other options. For example, you may be able to enroll in a free discount card that is not participating in the "Medicare-approved" program or purchase discounted drugs from companies that offer mail-order services to the general public. You can only use one card at a time – you may not combine more than one discount on a single prescription. See the **Tips for Consumers** section for more ideas that could save you money or the **Additional Resources** section for assistance programs in your state.

Do you already have insurance coverage for prescription drugs? Whether you should get a Medicare-approved discount card depends on what type of coverage you have, and how it would interact with a discount card. See **Know How Your Current Drug Coverage May Be Affected by Discount Cards** for more information.

Shop around.

You may find that you can save money by shopping around from pharmacy to pharmacy. Some pharmacies offer seniors a discount or have special prices for certain drugs.

You might be able to save by using a mail-order pharmacy. The websites and phone numbers of many other mail-order pharmacies are posted at www.medicarerights.org/rxchart3.html.

Tips for Low-Income People Eligible for the \$600 Subsidy

Apply for the \$600 subsidy if your income is low

If your income in 2004 is below \$1,047 a month (\$12,569 per year) and you are single, or if your income is below \$1,405 per month (\$16,862 per year) and you are married (income levels will be slightly higher in 2005), then you may be eligible for a \$600 annual credit to help you with your drug costs. In addition, you will not have to pay an enrollment fee for your discount card. Unlike some other programs to help people on Medicare with limited incomes, any savings you have is not counted as part of your income for this program.

To receive the \$600 credit, you cannot have drug coverage through any group health insurance policy, Medicaid, or military or veterans' benefits. However, you can have drug coverage through a state pharmacy assistance program, if your state has an assistance program. Contact your state pharmacy assistance program for more information (see **Additional Resources**).

Your card will come with a \$600 credit for 2004. You will still have to pay 5% to 10% of the cost of each prescription. The \$600 credit will cover the rest of the price of each medicine, until you have used it up for the year. If you don't use up the entire credit in 2004, any remaining funds will rollover to 2005.

In January 2005, you will get an additional \$600 credit. You do not need to reapply for 2005. You may use any remaining 2004 funds along with the new 2005 annual credit during the 2005 calendar year.

The discount card program and \$600 credit will end in 2006, when the Medicare Part D drug benefit begins. However, you may be eligible for additional assistance with the cost of drugs through the Part D drug benefit program. See **Learn About the Upcoming Drug Benefit (Part D)** for more details.

First, check whether you are eligible for other programs like full Medicaid benefits or state pharmacy assistance programs. In general, programs like full Medicaid or state pharmacy assistance will provide even greater help with drug costs than the \$600 credit would. Your eligibility for Medicaid or a state pharmacy assistance program will depend on the specific rules in your state. See the **Additional Resources** section of this guide for contact information for programs in your state.

If not, choose a discount card that best suits your needs. You can get the \$600 credit toward the purchase of your drugs through any of the Medicare-approved discount card sponsors, so choose the company that best suits your drug needs. The card that you choose may have a significant impact on your savings. The previous section raises some questions you may want to consider when choosing a card.

Fill out a separate application for the credit along with your enrollment form for the discount card. The application will ask about your income, family size, and whether you have any other prescription drug coverage. There is very little paperwork or documentation required; you simply certify that your answers are true by signing the application. Find out when you should expect to receive the \$600 credit after sending in your application to the card sponsor.

If your drug costs are high, get more information. If you are likely to use up your \$600 credit before the end of the year, you could benefit by doing some additional research. Some drug manufacturers are working with Medicare-approved



discount drug card sponsors to offer additional discounts on their drugs after you use up your \$600. If possible, you may want to choose a card that has this kind of arrangement with the manufacturer of one or more of your drugs. For more information, ask when you call 1-800-MEDICARE or look up the list of these agreements on the Internet: <http://www.cms.hhs.gov/medicarereform/drugcard/mfragreements.asp>.

Know How Your Current Drug Coverage May Be Affected by Discount Cards

For those who currently have prescription drug coverage, it is important to understand how the new law will affect it and what steps to take to make sure you achieve the greatest savings on the purchase of your medications.

If you have drug coverage from a former or current employer: In most cases, employer coverage will offer far more generous assistance with drug costs than a Medicare-approved discount card, so you will want to stick with your employer coverage, if that is the case. Contact your local SHIP with any questions (see **Additional Resources**).

If you are in a Medicare Advantage plan with drug coverage: Ask your managed care plan whether you can use a Medicare-approved discount card along with your current coverage. Many plans are offering their own discount cards to their enrollees.

If you have a Medigap policy that covers drugs (plan H, I, or J): Until 2006, you may use both a Medicare-approved discount card and your Medigap coverage (although they cannot be used simultaneously to purchase a prescription).

If you have drug coverage through Medicaid: Until 2006, nothing changes. By law, you will keep your drug coverage through the Medicaid program, as long as you remain eligible for the program. You are not eligible to sign up for a Medicare-approved discount card because your coverage is already better than the help you would get from a discount card. Contact your state's Medicaid program with any questions about your Medicaid coverage (see **Additional Resources**).

If you are enrolled in a state pharmacy assistance program: For now, contact your state program about whether you should enroll in a Medicare discount card in 2004 and 2005. See the **Additional Resources** section for contact information for the state pharmacy assistance program in your state, if one exists.

Learn About the Upcoming Drug Benefit (Part D)

On January 1, 2006, a new drug benefit will begin as “Part D” (as in “Drug”) of Medicare. Drug benefits, not just discounts, will be provided through private plans. Starting November 15, 2005, beneficiaries can begin signing up for Part D coverage. Those who want to remain in original Medicare (the traditional fee-for-service program) for their Medicare benefits will be able to sign up for drug coverage under stand-alone, private prescription drug plans (PDPs). Others may choose to get all Medicare benefits, including new prescription drug benefits, from health plans like HMOs or PPOs, called Medicare Advantage plans. Each plan will set its own premium and benefits, within certain guidelines established by Medicare. Like the prescription drug discount cards, each plan may limit coverage to a specific list of drugs, and the list may change during the year.

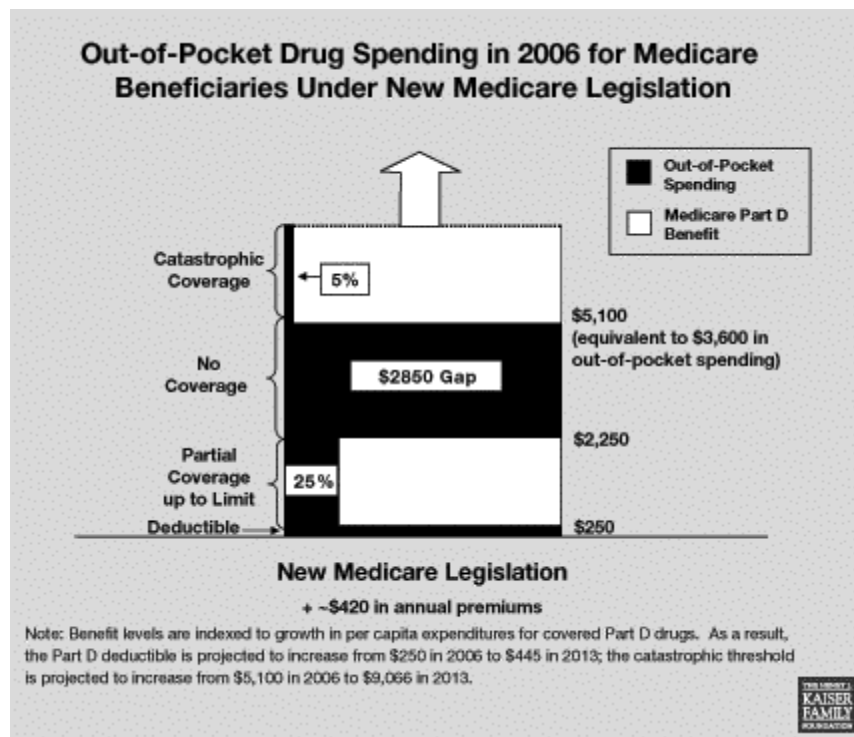
The law describes a standard benefit package that is an example of how plans may structure their benefits during the course of a year.

In 2006, under the standard benefit:

- You pay a monthly premium, set by the plan. The monthly premium is not defined by law, but is estimated to be about \$35 per month in 2006.
- You pay the first \$250 of your drug costs each year (the drug plan deductible).
- After meeting your deductible, you pay 25% of the cost of each covered prescription, up to an initial benefit limit (\$2,250 in total costs for covered drugs or \$750 in out-of-pocket costs for covered drugs). If you use drugs that are not on the plan’s list of covered drugs, you will have to pay for the entire cost yourself.
- After reaching the initial benefit limit, you pay 100% of the cost of your prescriptions until you reach the catastrophic limit.
- You reach the catastrophic limit for the year when you have paid \$3,600 out-of-pocket for covered drugs. Above this catastrophic limit, you pay for the remainder of the year 5% of the cost of covered drugs or a copay of \$2 for covered generics and \$5 for covered brand-name drugs—whichever is greater.

Tip

A 75-year-old woman with \$700 in prescription drug costs a year has no drug coverage, only a drug discount card to help pay her drug costs. She has heard of the upcoming Medicare drug benefit program but is not aware of the penalty for late enrollment. She opts not to join a Part D plan in 2006. Three years later, her drug expenses increase substantially and she decides to join a plan, only to learn that she will have to pay a penalty of 1% a month for every month she delayed enrollment. This amounts to a 36% higher premium each month for as long as she gets drug benefits through Part D.



Some people may want to supplement the Medicare Part D drug benefit with additional coverage. You will be able to buy supplemental drug coverage from the same company that provides your basic drug benefit.

Signing up

The new drug benefit is voluntary, but if you don't enroll when you first become eligible, you may have to pay a late-enrollment penalty if you choose to sign up at a later date. This penalty will be added to your premium each month for the whole time you are enrolled in Medicare Part D. The longer you delay your Part D enrollment, the higher the penalty. However, you won't have to pay this penalty if you have other drug coverage that is at least as comprehensive as Part D coverage. The first chance to enroll will be in November 2005.

Look for extra assistance for people with limited incomes

As part of the new benefit that begins in 2006, extra assistance will be available through Medicare Part D for individuals with incomes below about \$14,000 (about \$18,800 for a couple) and savings below \$10,000 (\$20,000 for a

Facts

- More than one in five seniors say they did not fill a prescription or skipped doses of a prescription medicine due to cost. - *Kaiser/Commonwealth/Tufts-New England Medical Center 2001 Survey of Seniors in Eight States, 2002*
- About one in three Medicare beneficiaries will qualify for low-income assistance under the new Part D benefit (including people who are already enrolled in Medicaid). - *Congressional Budget Office, 2003*
- Generic drugs typically cost 30% to 60% less than the brand-name drugs they replace. Generics use the same active ingredients, have the same medical effect, and meet the same quality standards as brand-name drugs, according to the FDA. - *Congressional Budget Office, 1998*

couple). The exact income limits will be set in 2005. In addition, many state pharmacy assistance programs are still deciding how they will supplement the Part D benefit. Starting July 1, 2005, if you think you could qualify, you can apply for extra assistance at your local Social Security office. Contact information for Social Security offices is in the **Additional Resources** section of this guide.

If you are enrolled in Medicaid as well as Medicare, a major transition occurs starting in 2006: you will begin to receive drug benefits under Medicare, rather than Medicaid. You will need to select and enroll in a private plan for your Medicare drug benefit by January 1, 2006. If you do not enroll by that date, you will be randomly assigned to a Part D plan. Your copay for each prescription could range from \$1 to \$5, depending on your income and whether your medicine is a brand-name or generic drug. You will pay no premium or deductible.

If your income is below about \$12,600 per year (\$16,900 for a couple) and your savings are under \$6,000 (\$9,000 for a couple), you will pay \$2 for each generic prescription and \$5 for each brand-name prescription. You will pay no premium or deductible.

If your income is between about \$12,600 and \$14,000 (\$16,900 and \$18,800 for a couple) and your savings are under \$10,000 (\$20,000 for a couple), you will pay 15% of the cost of each prescription after you meet a \$50 deductible. If you spend more than \$3,600 of your own money on medicines in one year, then you will pay only \$2 to \$5 copays for the rest of the year. You will have to pay a monthly premium, but it will be lower than the full Part D premium.

Know How Your Current Drug Coverage May Be Affected by Part D

This section offers some help in understanding how the new law will affect sources of drug coverage for those who currently have drug benefits.

If you have drug coverage from a former or current employer: Many employers are expected to continue providing drug coverage exactly as they had before the Part D benefit goes into effect. Others may opt to wrap around the Medicare drug benefit and/or pay the monthly premium for Medicare drug coverage. Prior to 2006, ask your employer what to expect when the Medicare Part D benefit goes into effect.

If you are in a Medicare Advantage plan with drug coverage: In 2006, all Medicare Advantage organizations will offer a plan with a prescription drug benefit under Medicare Part D. This benefit package may be different from the one you have now. If you want to enroll in Part D, you may choose the prescription drug plan offered by your managed care plan, switch to a different Medicare Advantage plan, or choose to be in traditional Medicare and enroll in a PDP, a private plan that offers the drug benefit. Because the program is voluntary, you can choose not to enroll in Part D, but if at a later date, you decide you want Part D coverage, you will be charged a delayed enrollment fee for every month you did not sign up for Part D coverage.

If you have a Medigap policy that covers drugs (plan H, I, or J): Leading up to 2006, you will need to decide whether to keep your Medigap coverage for prescription drugs or enroll in Medicare Part D. You cannot have both. If you keep your Medigap drug coverage but decide later that you want to enroll in Part D, you

may have to pay a late enrollment penalty. If you choose to enroll in Part D, you can switch to another Medigap plan that does not include drug coverage. You can seek advice on this decision from your local State Health Insurance Assistance Program (SHIP) (see **Additional Resources**).

If you have drug coverage through Medicaid: In 2006, your drug coverage will change from Medicaid to Medicare, and you must enroll in a private drug plan under Medicare Part D in order to have drug coverage. You will pay up to \$1 for generic prescriptions and up to \$5 for brand-name prescriptions, depending on your income. The drug coverage provided under Medicare Part D will not necessarily be the same as what you currently receive under Medicaid. It is important that you choose your plan carefully so you can select the best plan available to meet your needs by January 1, 2006. If you don't sign up by that date, you will be assigned to a plan. You will be able to switch plans one time after you are assigned. Contact your state Medicaid office with questions (see **Additional Resources**).

If you are enrolled in a state pharmacy assistance program: Leading up to 2006, you should ask for information about how your program will work with the Part D benefit when it goes into effect in 2006. Many states are working out the details about how their prescription drug assistance programs will coordinate with the Part D benefit. Contact your state's assistance program, if one exists, for more information see Additional Resources.

Talk to your doctor.

- Ask your doctor to review all of your prescriptions with you. There may be a cheaper option for some of the drugs you take – such as a generic version or an older brand-name drug that would do the job just as well. In some cases, there may even be an over-the-counter medication that could help you. This is also a good opportunity to double-check for interactions between the drugs you're taking, especially if different doctors prescribed them.
- If you have a discount card or insurance plan that only covers a certain list of drugs (a "formulary"), share that list with your doctor so you can take advantage of those savings. If you need a specific drug that isn't on your insurance company's formulary, find out if your doctor can ask for an exception.

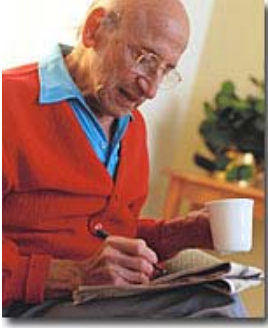
Tips for Medicare Beneficiaries

Find out whether the drugs you take are covered. The array of drugs covered will vary from plan to plan. Before you enroll in a plan, it is important to find out whether it covers the specific drugs that you take. But you should note that plans have fairly broad flexibility and may change their list of covered drugs during the course of the year.

Know your appeals rights for coverage of a non-covered drug. All Part D enrollees will have the right to ask their plan to reconsider a decision to deny coverage for a particular drug or to obtain a non-preferred drug for a lower copayment amount.

Make sure you take advantage of the programs available to you. Your local Area Agency on Aging or State Health Insurance Assistance Program (see **Additional Resources**) can help you look into many of the following options:

- State pharmacy assistance programs and Medicaid programs provide coverage for prescription drugs. Income limits vary from state to state. You can find contact information for the programs in your state in the last section of this guide (**Additional Resources**).
- If your income is low but you don't qualify for Medicaid or a state assistance program, you may qualify for free or low-cost prescriptions from a pharmaceutical manufacturer. Your doctor may need to fill out the application. You can find more information about these and other programs on the Internet at www.medicare.gov, www.helpingpatients.org, or www.accesstobenefits.org, or call (800) 762-4636. Many manufacturers also offer discounts to people with moderate incomes. You can sign up for these free discount cards in addition to or instead of a Medicare-approved discount card.



Medicare Advantage Plans

- Consider Your Medicare Options
- Know What You Want from a Medicare Plan
- Compare Medicare Plans Offered Where You Live

Consider Your Medicare Options

More than 41 million people are covered by the Medicare program. People with Medicare can get their coverage through original Medicare (the traditional fee-for-service program) or from Medicare private plans (the Medicare Advantage program). Today, fewer than five million people with Medicare are enrolled in a Medicare private plan (HMO, PPO or PFFS). Most people with Medicare who have joined a Medicare private plan are in health maintenance organizations (HMOs), which have been available under Medicare since the mid-1980s.

To make an informed decision, you need to first understand how these health plans work and how they differ, then decide which option is best for you. Here is a brief description of each of the Medicare options.

Original Medicare

If you choose coverage under the traditional fee-for-service Medicare program, you can generally get care from any doctor or hospital you want and receive coverage for your care anywhere in the country. However, traditional Medicare has high cost-sharing requirements and does not currently cover the costs of certain benefits, such as outpatient prescription drugs (drug coverage will begin in 2006; see **Learn About the Upcoming Drug Benefit (Part D)**). To help pay for uncovered benefits, and to help with Medicare's cost-sharing requirements, many people on Medicare have supplemental insurance (see **Health Insurance to Supplement Medicare**).

Medicare Private Plans

Medicare HMOs

Medicare HMOs cover the same doctor and hospital services as the original Medicare program, but out-of-pocket costs for these services are usually different. HMOs appeal to some people with Medicare because they may provide additional benefits, such as prescription drugs and eyeglasses, which are not covered by the traditional Medicare program. If you choose an HMO, you may be able to get some help with these additional benefits. Typically, Medicare HMOs charge a premium that you would need to pay in addition to the Part B monthly premium.

Facts

- Nearly seven out of ten Medicare HMO enrollees are in a plan that offers prescription drug benefits under their “basic” option, but the level of drug coverage offered by Medicare HMOs varies from plan to plan. – *Achman and Gold, Mathematica Policy Institute, 2003*
- Most people with Medicare – about 60% – live in an area with at least one Medicare HMO or PPO plan. Yet only 11% of people with Medicare are now enrolled in a Medicare private plan. – *MedPAC, 2004*

You should be aware that Medicare HMO enrollees generally can only use doctors, hospitals, and other providers in the HMO's network. For an additional fee, some HMOs offer point-of-service (POS) benefits that partially cover care received outside the network. If you join a Medicare HMO, you will usually have to select a primary care doctor who is responsible for deciding when you should see a specialist, and which specialist you should see. 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.

Medicare PPOs

Medicare PPOs or "Preferred Provider Organizations" are private health plans, much like Medicare HMOs. HMOs and PPOs differ in three key ways:

1. Medicare PPOs will cover some of the costs of your care if you use doctors and hospitals outside the network.
2. Medicare PPOs will generally charge higher monthly premiums than Medicare HMOs.
3. Medicare PPOs generally do not require that you see a primary care physician before going to a specialist.

Other Medicare Advantage Plans

There are three additional private plan options that may be available under the Medicare Advantage program. These include provider-sponsored organizations (PSOs), private fee-for-service (PFFS) plans, and medical savings accounts (MSAs) coupled with high-deductible insurance plans. Not all Medicare private plan options are available everywhere. To date, HMOs remain the primary alternative to traditional Medicare. For additional information about Medicare Advantage plans, call 1-800-MEDICARE, or get information about Medicare options in your area on the Medicare Personal Plan Finder website, <http://www.medicare.gov/MPPF/home.asp>.

Know What You Want from a Medicare Plan

Whether original Medicare, a Medicare HMO, or another private Medicare plan is right for you will depend on your unique needs and circumstances. Think about what is most important to you when you are healthy and when you are sick. Here are some topics to consider:

Receiving care from the doctor and hospital of your choice

Under original Medicare, you can use whatever specialists and hospitals you choose, whenever you need, and without a referral from another doctor. Medicare private plan options could limit your ability to get care from the doctor or hospital of your choice, or there may be extra charges for out-of-network care. If provider choice is a priority, you should consider original Medicare with added protection from a Medicare supplemental insurance policy, sometimes known as Medigap, or from an employer-sponsored or union retiree health plan, if one is offered to you (see **Health Insurance to Supplement Medicare**).

Getting coverage of additional benefits to reduce your medical costs

If you are on a tight budget and are willing to limit your choice of doctors and hospitals, you may be able to reduce your health care expenses and get coverage of additional benefits through a Medicare Advantage plan. It is important to review the scope and limits of additional benefits when choosing among available plans. It is also important to look at how much your out-of-



pocket costs will be if you get sick. For example, some Medicare private plans charge a deductible every time you enter the hospital, while original Medicare only charges a deductible once per benefit period, even if you have multiple hospitalizations.

Starting in 2006, coverage for prescription drugs will be available to beneficiaries in original Medicare who enroll in a private drug plan and those who enroll in Medicare Advantage plans that provide drug coverage (see **Prescription Drug Costs and Medicare**).

Maintaining health care coverage while away from home

Under original Medicare, you will be covered for care anywhere in the United States. While private plans must cover emergency care for members outside the plan area, most do not cover other health care services while away from home. For example, Medicare HMOs have more restrictive networks of doctors and hospitals that limit coverage away from home.

Keeping supplemental coverage from a former employer or union

If you are considering joining a Medicare private plan, you should talk to your employer or former employer to be sure you won't lose valuable retiree health benefits. Many employers offer retiree health coverage as a supplement to traditional Medicare; some also offer coverage through Medicare HMOs and other private plan options.

Coordinating with Medicaid benefits

If your income and assets are quite modest, you may qualify for Medicaid benefits or other special programs that will help pay some of your health care costs. For those who qualify, Medicaid often pays for valuable benefits, such as prescription drugs and nursing home care, and also pays Medicare's premiums. If you are already covered by Medicaid and Medicare, you should find out what you must pay to join a Medicare private plan and whether Medicaid will cover the plan's copayments. Contact information for your state Medicaid office can be found in the **Additional Resources** section of this guide.

Changing your mind

Currently, you can enroll in a Medicare private plan at any time when the plan is accepting new members. You may also disenroll or change plans at any time for any reason. Beginning in 2006, you will only be able to change your enrollment once a year – only during the first six months of the year. In later years, this “open enrollment” period will be limited to just the first three months of the year. If you enroll in a Medicare private plan that later stops serving people with Medicare, you can always return to original Medicare, the traditional fee-for-service program, or you can enroll in another Medicare Advantage plan.

Compare Medicare Advantage Plans Offered Where You Live

If you are happy with your original Medicare coverage you can stick with it. You can keep your coverage through your Medicare private plan if the plan continues operating in your area from year to year. If you think you may want to change, the next step is to find out which plans are offered where you live. While original Medicare is available in all parts of the U.S., private plans may not be. In some areas of the U.S., no private options are available today, while in other areas, people with Medicare have multiple Medicare private plans from which to choose.

For a list of plans in your area and a copy of the Medicare handbook, *Medicare & You*, call Medicare at 1-800-MEDICARE or visit Medicare's website at www.medicare.gov. For free help in understanding differences among Medicare plans, you can call your State Health Insurance Assistance Program (SHIP). Contact information for your state's SHIP is in the Medicare handbook and in this guide under **Additional Resources**.

You should consider four important factors before signing up for a plan:

- 1. Accessibility of doctors and hospitals**
Can you continue to see the doctors you know and trust if you join a certain plan? Your doctor or specialist might be in one plan's network, but not in another's. Even if your doctor is in a plan's network, he or she can leave that network at any time. What about your choice of hospital?
- 2. Extra benefits**
The supplemental benefits offered by Medicare private plans vary widely and may change every year. If you want to join a plan because of the prescription drug benefit, make sure that the plan covers the drugs you need and you understand any limits that may apply. You may need to evaluate your options again in 2006 when a prescription drug benefit becomes available to those in original Medicare who sign up for stand-alone private drug plans.
- 3. Cost**
How much are the monthly premiums and copayments associated with different health care services? Is there a deductible? Keep in mind that costs generally change each calendar year.
- 4. Quality and reputation**
All Medicare private plans are not the same. Review each plan's written information and try to talk to plan members about their experiences. For information on quality and performance, visit Medicare's website at <http://www.medicare.gov/MPPF/home.asp>.

Know your rights

No matter which plan you choose – original Medicare, a Medicare HMO, or another Medicare private plan – you need to understand your rights as a patient and a consumer. If you believe you have been unfairly denied any Medicare-covered benefits, you have the right to appeal. You should send a copy of the denial notice and, if possible, a letter from your doctor explaining your need for the denied service and a letter requesting a review to the company that issued the denial.



Insurance to Supplement Medicare

- Understand Supplemental Health Insurance
- Learn About Programs for People with Low Incomes

Understand Supplemental Health Insurance

If you want to stay in original Medicare, you may want to look into your options for supplemental coverage. Without such coverage, your out-of-pocket costs could be high if you require medical care. Supplemental insurance helps pay the deductibles and coinsurance costs that original Medicare does not cover. In some cases, it also covers extra benefits, such as outpatient prescription drugs. You may be able to get supplemental insurance from a former employer or union (retiree coverage). If not, you can buy Medicare supplemental insurance (Medigap) directly from an insurance company. Depending on your income and savings, you may also qualify for Medicaid.

Retiree Health Coverage

As a rule of thumb, if you can get supplemental retiree coverage from a former employer or union, you should. Retiree policies are often more generous than Medigap. They also may be cheaper than Medigap policies, since employers tend to pay at least part of the cost. If you are not yet on Medicare, find out what benefits you may be eligible for from your employer when you go on Medicare and ask how these benefits coordinate with Medicare.

Medigap

If you want to buy a Medicare supplemental insurance policy, known as Medigap, you must decide which benefit package to buy and which insurer to use. Before making a decision, you should clearly understand what benefits are covered and how to compare plans. There are 10 different standardized Medigap plans, labeled A-J (except in Massachusetts, Minnesota and Wisconsin). Not all plans are available in all areas. Each Medigap plan pays for a particular set of benefits. Plan A offers the fewest benefits and is usually the least expensive. Plans H, I, and J are typically the most expensive, but include some prescription drug coverage (H, I and J will no longer be sold after 2006 when Medicare prescription drug coverage begins). The most popular Medigap plans are C and F, because they cover major benefits and are less expensive than other plans. No Medigap plan covers unlimited prescription drugs,

Facts

- Nine out of ten people on Medicare rely on some form of insurance – retiree health coverage, Medigap, Medicaid – to supplement Medicare. Find out what options are available to help fill gaps in coverage. – *Laschober for Kaiser Family Foundation, 2004*
- Medicaid makes Medicare coverage affordable for seven million low-income people on Medicare. To qualify for Medicaid assistance, you must meet specific income and savings limits. – *Kaiser Commission on Medicaid and the Uninsured, 2004*

long-term custodial care at home or in a nursing facility, vision and dental care, hearing aids, or private duty nursing.

The cost of your Medigap policy depends on the type of Medigap plan you choose and the company from which you buy it. When you have chosen the type of plan you want (A - J), it pays to shop around. Plans with the same letter name offer the same benefits, but the premiums vary from company to company. If you buy your Medigap policy during your open enrollment period or other federally mandated times, your premium cannot vary based on your health status.

For free assistance with understanding your options, contact your local SHIP (see **Additional Resources**). More information about Medigap plans can be found at: www.medicare.gov/mgcompare/home.asp.

No insurance policy fills gaps in coverage for Medicare HMOs or any of the Medicare private plan. Should you select an HMO, PPO, or other type of plan, you should budget for any costs that the plan doesn't cover.

Medigap Plans at a Glance 2004

Medigap Benefits	A	B	C	D	E	F	G	H	I	J
Basic benefits: Coinsurance for hospital days 61-150 and payment in full for 365 additional days; 20% coinsurance for physician and other Part B services after Part B deductible has been met; first three pints of blood.	★	★	★	★	★	★	★	★	★	★
Hospital deductible: \$876 in 2004		★	★	★	★	★	★	★	★	★
Skilled nursing facility: Coinsurance of \$109.50 for days 21-100			★	★	★	★	★	★	★	★
Part B deductible: \$100 in 2004			★			★				★
Part B excess charges: Part B excess charges up to 115% of Medicare's approved amount						★ 100%	★ 80%		★ 100%	★ 100%
Emergency care outside the United States: 80% during the first two months of the trip, with \$250 deductible and lifetime up to \$50,000			★	★	★	★	★	★	★	★
Annual at-home recovery benefit: Up to \$40 a visit for 40 visits — \$16,000 per year			★				★		★	★
Preventative services: Up to \$120 a year if ordered by doctor				★						★
Prescription drug costs: Up to 50% of \$2,500, after a yearly \$250 deductible (up to \$1,250)								★	★	
Prescription drug costs: Up to 50% of \$6,000, after a yearly \$250 deductible (up to \$3,000)										★

Upcoming Changes

The Medicare prescription drug bill passed in 2003 included new rules for Medigap plans. Starting in January 2006, plans H, I, and J (the plans that include some drug coverage) will not be sold to any new customers. People who have plan H, I, or J will have to make a choice: they can have prescription drug coverage either through Medigap or through Medicare, but not both. If you are enrolled in Plan H, I, or J and you decide to enroll in Medicare's Part D drug benefit, you can keep your Medigap policy – but you must ask your insurance company to change your policy so it doesn't include prescription drug coverage, which should lower your premiums. You may also want to consider switching to a different Medigap policy.

If you elect to continue getting your prescription drug benefits through H, I, or J, you should be aware that you will be subject to a monthly premium penalty if you elect Part D drug coverage at a later date. The penalty may be as high as 12% a year (1% for every month you delay enrollment). Since drug coverage through H, I and J is very limited, benefits are capped and the premiums are generally high, you may be better off enrolling in Medicare Part D. Contact your local SHIP for help choosing whether to stay in Medigap for drug coverage or opting for Part D. Contact information for your state's SHIP program are listed in the **Additional Resources** section of this guide.

In addition, two high deductible Medigap plans will be added (K and L). Compared to current Medigap options, these new plans are designed to provide more protection when you are very sick and include less coverage of your initial expenses. For example, neither plan will cover the Part B deductible and both will cover all hospital inpatient costs. The first plan will cover 50% of anything else you owe under Medicare Part A or Part B, and it will pay for everything after you reach an annual out-of-pocket limit of \$4,000. The second is similar, but covers 75% of your cost-sharing and everything after you spend \$2,000 in one year. In exchange for paying a high deductible, your monthly premium should be lower.

Do Your Medigap Homework

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

1. Call the insurance department in the state where you 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 and how they will change as you get older. Policies that base their annual premium on age (attained age policies) may seem like a good deal when you are 65 but may be far costlier than other policies by the time you 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 state insurance department. Generally, companies rated "A" or better are reputable.



Plan for Medigap Enrollment

Once you turn 65, you can sign up for any of the 10 Medigap plans during a six-month open enrollment period. Once you are enrolled, the Medigap insurer must renew your policy for life, as long as you pay your premiums. If you miss a premium payment, you may risk losing your coverage.

Under federal law, once your open enrollment period ends, Medigap insurers can refuse to offer you a Medigap plan because of your age or health status. However, you may have special protections if you want to buy Medigap because you or your employer drops coverage. State laws on Medigap consumer protections differ. For example, some states give you the right to buy a Medigap policy at any time, regardless of your health or age. You should check with your state's insurance department about your Medigap rights and protections.

Learn About Programs for People with Low Incomes

Like millions of seniors, you may be living on a limited income and unable to afford supplemental insurance. If so, you may be able to get assistance from Medicaid or a Medicare Savings Program. If you qualify, you could save hundreds of dollars on your monthly Medicare Part B premiums. You might be able to save even more if you qualify for additional Medicaid benefits such as long-term care and prescription drugs (note: prescription drug coverage only available under Medicaid through 2005 – see **Learn About the Upcoming Drug Benefit (Part D)**).

Tip

Find out about programs for low-income people on Medicare. Many low-income people on Medicare are eligible for financial assistance under Medicaid, but they do not apply.

Below are some of the basic rules for programs that exist for people on Medicare with low incomes. To get additional information about whether you may qualify for full Medicaid benefits or one of the Medicare Savings Programs in your state, contact your state Medicaid program (see **Additional Resources**). Another option is to use the online tool provided by the National Council on Aging (www.benefitscheckup.org).

Medicaid Benefits to Supplement Medicare

Medicaid is a federal and state program that covers medical care for people with low incomes. The Medicaid program varies a great deal from state to state. Each state has its own way of determining eligibility depending on your age, family size, medical condition and financial situation.

If you receive cash assistance under the Supplemental Security Income (SSI) program, you are eligible for full Medicaid benefits. To receive SSI, your income cannot exceed \$564 a month in 2004 (\$846 per couple), and your assets must be less than \$2,000 (\$3,000 per couple). Some states allow people with Medicare to have higher monthly incomes to be eligible for Medicaid (up to \$775/individual and \$1,040/couple in 2004).

If you have a higher income, but fairly high medical or long-term care expenses, you may qualify for Medicaid if your state has a "spend-down" program. For more information, contact your state Medicaid program (see **Additional Resources**).

Medicare Savings Programs: Qualified Medicare Beneficiary Program

Called QMB for short, this program is for people whose income is at or below 100% of poverty (up to \$796 a month for singles, and \$1,061 a month for couples in 2004) and whose savings are limited (up to \$4,000 for singles, \$6,000 for couples). For those who qualify, the state will pay Medicare premiums and may pay some or all of the deductibles and coinsurance.

Medicare Savings Programs: 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% and 120% of poverty (up to \$951 a month for singles, \$1,269 a month for couples in 2004) and whose savings are limited.

Qualifying Individual Program (QI-1)

The QI-1 program pays Medicare's Part B premiums for people whose income is between 120% and 135% of poverty (up to \$1,068 a month for singles, \$1,426 a month for couples in 2004) and whose assets are limited (some states do not have an asset test for QI-1).

To learn more about these programs or to apply, contact your local Medicaid office (see **Additional Resources**).



Long-Term Care

- Assess Long-Term Care Needs and Options
- Consider Ways to Pay for Long-Term Care

Assess Long-Term Care Needs and Options

The idea of shouldering the cost of nursing home care and seeing your savings consumed by long-term care costs is daunting. The very possibility may already have prompted you to consider how you would like to receive and pay for long-term care should you need it in the future.

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 must understand Medicare's benefits and limits and plan ahead for whatever expenses you may incur. You also need to consider who will care for you when you need help, what kind of care you want, and where you will live as you age.

Determine the Level of Care Needed. When you are no longer able to live independently and appear to need some help taking care of yourself, the first step is to determine the type of care you need. Evaluating care options is easier once you know the range and extent of services required. Often, you and your family members are best equipped to make this assessment, since you know your situation and how much day-to-day help you really need. If you prefer, you can hire a geriatric care manager, nurse, or social worker for a professional evaluation. If you 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 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 needs and preferences, there are several home-, community-, and institutionally-based services available. You may especially want to discuss with family members whether you want to stay in your own home or whether you would feel comfortable in an outside facility.

Tips for Choosing a Living Facility

If you think that you may need to move into a facility of some type, consider the following tips for choosing among facilities:

- Visit the facility unannounced at various times, including at mealtime and on the weekends to see how the residents are treated. Is the staff respectful of the residents' wishes and privacy? Are the residents properly dressed and assisted with activities? Is the environment pleasant for residents? Is it somewhere you could picture yourself living?
- Talk to residents and their family members. Most facilities have both a residents' council and a family council that may be helpful.
- Ask to see the most recent survey of the facility made by the state licensing and regulatory agency. The survey spells out the facility's deficiencies. Contact a long-term care ombudsman to discuss any concerns he or she may have about the long-term care facility. Every facility must post the ombudsman program's phone number in a visible place. Required by law, an ombudsman acts as an advocate for residents and helps resolve complaints. See **Additional Resources** for contact information.



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 you elect to stay at home, you may need to consider how much care you will require. For example, will you need help in the middle of the night, or a few hours of personal assistance several days each week? You may be best suited by a "patchwork" of formal and informal caregivers and services. Formal services may include visiting nursing services, home health aides, and such social service programs as "Meals on Wheels." Services in your community may be found by calling the local Area Agency on Aging or 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 your local Area Agency on Aging to find out about available services in your neighborhood.

If home-based care is the most appropriate solution to your long-term care needs, you may need help making simple adaptations to your 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 receive 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. Find out what happens when people become 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 they require that level of care? What happens if a person runs out of money?

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

Fact

Women are more likely than men to use long-term care services. Nearly three out of four nursing home residents age 65 and older are women. – *Centers for Disease Control/National Center for Health Statistics, National Nursing Home Survey, 1999*

these facilities care for people who require skilled nursing and 24-hour attentive supervision. Find out where you would get your health care, whether you will continue to see your own doctors, and how you will get to medical 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 condition declines after you enter an assisted living facility. Ask if the facility takes responsibility for making sure residents take their medicines properly. Some facilities may discharge you if your 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. Find out whether you 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 Centers for Medicare and Medicaid Services' Nursing Home Database website (www.medicare.gov/nhcompare/home.asp).

Consider 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 for an individual requiring skilled care can easily cost in excess of \$5,000 a month, although fees vary widely. Although home care is generally far 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 where you live.

Before the need for long-term care becomes a reality, you should consider very carefully how to pay for it: through Medicaid, if you qualify, with private long-term care insurance, or out-of-pocket. Often, the decision is about money. 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 you meet certain requirements: the visits must be prescribed by a doctor, and you 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 you 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, you must need daily skilled care (seven days a week of nursing care or five days a week of rehabilitative care). Moreover, for Medicare to cover your SNF stay, you must have been hospitalized for at least three days within the 30 days preceding admission to a Medicare-certified skilled nursing facility. In addition, you will have to pay a daily copayment (\$109.50 in 2004) 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, wheelchairs, and commodes that could assist with 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 some prescription drugs, respite care, and continuous nursing services for medical emergencies.

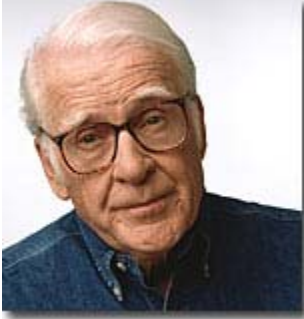
Hospice care is designed to help with pain management and other symptoms, so that patients can make the most of the time that remains. In addition, it can provide emotional and spiritual support to you and your family members.

Medicaid Coverage of Long-Term Care. Medicaid is the country's largest public payer for long-term care. If you qualify for Medicaid, it will pay for nursing home care, prescription drugs (until 2006 when Medicare begins to cover those with Medicare and Medicaid), 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 you can qualify for Medicaid. If you receive Supplemental Security Income (SSI), you are likely to qualify for Medicaid automatically. If you don't have SSI, but have extremely limited income and assets, you may be able to qualify for Medicaid anyway. The exact income eligibility levels for Medicaid vary by state, so check Medicaid rules where you live. Medicaid also looks at assets such as savings accounts when determining eligibility, although assets generally don't include homes, cars, household furnishings, or burial plots. If your income is higher than the state's Medicaid eligibility level, you 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. Generally, states let nursing home residents covered by Medicaid keep \$2,000 in assets and an income of about \$30 per month.

Medicaid rules vary by state. If you or family members have questions about Medicaid, contact the state Medicaid office or long-term care ombudsman in your area (see **Additional Resources**).



Long-Term Care Insurance. Long-term care insurance covers some of the costs of long-term care and may help you preserve a portion of your assets. Today, more than 100 insurance companies sell private long-term care insurance that covers nursing home and home care, but only a small share of people on Medicare 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 for four years of comprehensive coverage; at 79, they average \$5,900 a year. And people with Alzheimer's or other serious health problems may not even 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 you already qualify for Medicaid or would quickly spend down your assets to qualify, long-term care insurance might not be sensible. Nor is it a prudent investment if you can't afford to pay the premium for the rest of your life. Even if you can, long-term care insurance may not be a wise choice if you can pay for your care out-of-pocket.

Do Your Long-Term Care Insurance Homework

No two long-term care insurance policies are alike. Before you 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 home, or in a community setting? Some policies will pay cash once you meet eligibility requirements and will allow you to spend the money for care in the location of your choice. Others will pay for care only in a specifically defined location. Be sure the policy covers the type of care you want.

Be sure you can afford the premiums

Check to see if, and by how much, the premiums will rise over time, and consider whether you 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% 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. Individuals must pay for their own care during that time. The longer the elimination period, the lower the premium. Whatever you decide, be sure you can afford the out-of-pocket costs you will incur before your 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 you may need. Bear in mind that the cost of care will rise with inflation.

Individuals need coverage that keeps up with the rising cost of long-term care. Otherwise, a policy they buy today to cover 80% of these costs may cover only 40% later on, when they need such care. 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. 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 don't 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 need to think about how much care may cost over an extended period of time and as you 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 area. Then, calculate how much money you would need for a four-year stay. If you can set aside enough to cover four years of residential care, you should consider simply paying for it yourself. But realize that actual costs can't be predicted. Individuals who suffer from Alzheimer's or other forms of dementia 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 your area. Such services, along with home adaptations, can help you stay in your own home.

Don't wait until you need long-term care to begin discussing it with your family members. Talking about your preferences and needs now can help you plan how to pay for care. Depending on the decisions you make together with your family, purchasing a long-term care insurance policy, relying on savings, or using Medicaid may be right for you.



Planning For Your Care

It's important to think about your wishes concerning medical care and to put them in writing in the event that you become too ill to communicate. Having such instructions, called advance directives, will comfort you and save your family members from having to make difficult decisions without knowing what you want. It is important to put your wishes in writing and make sure family members know where you keep important documents, such as wills and advance directives. Keep in mind that, since advance directives are legal documents, you must write them while you are still mentally competent, so it is important to plan ahead.

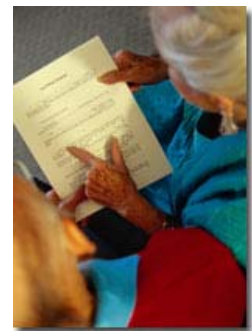
Although laws vary from state to state, there are basically two types of advance directives:

Health Care Proxies

A health care proxy is a legal document that allows you to appoint an agent to make medical decisions for you when you are unable to do so. You can select anyone you trust, such as a friend or family member. Generally, your agent may make health care decisions whenever you cannot speak for yourself.

Living Wills

A living will is a legal document that allows you to state your wishes about which medical treatments you do and don't want in the event that you are unable to communicate for yourself at the end of life. Typically, living wills direct health care personnel whether or not to prolong life if the patient is suffering from an incurable or irreversible condition. For example, your living will can have a "Do Not Resuscitate" order, which means that you will not be revived if your heartbeat and breathing stop. It can also state whether you want your organs donated.



Be sure your advance directives comply with laws of the state in which you live and that your doctors, lawyers, and other trusted persons have copies. Health personnel can follow the directions of the living will only if they have a copy of it. To obtain forms that are valid in your state, contact the state ombudsman program or a hospital or medical society in the area (see **Additional Resources**).

Fact

Thirty percent of adults say they do not know where their parent keeps important papers, such as their health insurance card, financial statements, or will.
- *Family Circle and Kaiser Family Foundation, 2000*



Additional Resources

- **Places to Start**
- **Additional Resources by State**

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

Places to Start

Get basic Medicare information by calling the National Medicare Hotline at 1-800-MEDICARE; TTY/TTD 1-877-486-2048 or visiting www.medicare.gov on the Internet.

You can also order *Medicare & You*, an overview of Medicare, by calling the hotline or by writing to Medicare Publications, Centers for Medicare and Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244-1850.

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.

Find out about Medicaid eligibility requirements and enrollment procedures at your 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 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 Advantage (MA) plans available in your area by calling the automated Medicare Special Information number at 1-800-MEDICARE (1-800-633-4227) or by visiting www.medicare.gov.

Additional Resources by State

A variety of state and local agencies can provide more specific information about Medicare, Medigap, and long-term care. The following state-by-state lists include some of these sources.

State Health Insurance Assistance Programs (SHIPs)

For information and free counseling related to Medicare, Medigap, MA plans, and long-term care, call your State Health Insurance Assistance Program. These are federally funded programs established to help beneficiaries with their health insurance choices.

State Medicaid Agencies

To answer questions about eligibility and enrollment in Medicaid, call your state Medicaid agency. It administers Medicaid benefits, including QMB, SLMB, and QI-1 programs.

Long-Term Care Ombudsmen

For questions about nursing homes and other long-term care facilities in your area, call this number. Your state long-term care ombudsman protects the rights of nursing home residents and responds to questions about facilities.

Social Security Offices

To find your local Social Security office, call 1-800-772-1213 or enter your zip code at this website: <http://s00dace.ssa.gov/pro/foi/foi-home.html>. State Social Security office websites are listed in the state-by-state table below.

State Pharmacy Assistance Programs

Many states have programs that help low-income Medicare beneficiaries who are not eligible for Medicaid pay for their prescription medications. To find out if there is a program in your state, see www.medicare.gov and follow the link for prescription drug assistance programs. See the table below for state websites and phone numbers.

	State Health Insurance Assistance Programs	State Medicaid Agencies	Long-Term Care Ombudsman	Social Security Office	State Pharmacy Assistance Programs
Alabama	800-243-5463 or 334-242-5743 http://www.adss.state.al.us/Ship.htm	800-362-1504 or 334-242-5000	877-425-2243 or 334-242-5743	http://www.ssa.gov/atlanta/southeast/al/alabama.htm	
Alaska	800-478-6065 or 907-269-3680 http://hss.state.ak.us/dsds/medicare.htm	800-211-7470 or 907-465-3030	800-730-6393 or 907-334-4480	http://www.ssa.gov/seattle/index.htm	907-269-3680 or 800-478-6065 http://health.hss.state.ak.us/dsds/seniorcaresio.htm
Arizona	800-432-4040 or 602-542-4446 http://www.de.state.az.us/aaa/programs/ship/default.asp	800-528-0142 or 602-417-5010	602-542-6454	http://www.ssa.gov/sf/offices/sf-arizona-offices.htm	
Arkansas	800-224-6330 or 501-371-2785 http://www.accessarkansas.org/insurance/srinsnetwork/seniorshlth_p1.html	800-482-8988 or 501-682-8292	501-682-8952	http://www.ssa.gov/dallas/state_ar.html	
California	800-434-0222 http://www.aging.ca.gov/html/programs/hicap.html	916-552-3492	800-231-4024 or 916-323-6681	http://www.ssa.gov/sf/offices/sf-california-offices.htm	
Colorado	888-696-7213 or 303-894-7552 http://www.dora.state.co.us/insurance/senior/senior.htm	800-221-3943 or 303-866-2993	800-288-1376 or 303-722-0720	http://www.ssa.gov/denver/colorado.htm	

	State Health Insurance Assistance Programs	State Medicaid Agencies	Long-Term Care Ombudsman	Social Security Office	State Pharmacy Assistance Programs
Connecticut	800-994-9422 http://www.ctelderlyservices.state.ct.us/choices.htm	800-842-1508 or 860-424-4908	866-388-1888 or 860-424-5200	http://www.ssa.gov/boston/CT.htm	800-423-5026 or 860-832-9265 http://www.connpace.com/
Delaware	800-336-9500 or 302-739-6266 http://www.state.de.us/inscom/eldindex.htm	302-255-9040	800-223-9074 or 302-453-3837	http://www.ssa.gov/phila/states/delaware.htm	800-996-9969 x17 http://www.state.de.us/dhss/dss/dpap.html
District of Columbia	202-739-0668 http://www.dcoa.dc.gov/dcoa/cwp/view,a,3,q,523610.asp	202-442-5988	202-434-2140	http://www.ssa.gov/phila/states/distofcolumbia.htm	
Florida	800-963-5337 or 850-414-2060 http://elderaffairs.state.fl.us/does/english/shine.html	888-419-3456	888-831-0404 or 850-414-2377	http://www.ssa.gov/atlanta/southeast/fl/florida.htm	888-419-3456 or 850-487-4441 http://www.floridahealthstat.com/silversaver.shtml
Georgia	800-669-8387 or 404-657-5347 http://www2.state.ga.us/departments/dhr/agingcares.html	866-322-4260 or 770-570-3300	888-454-5826 or 404-463-8384	http://www.ssa.gov/atlanta/southeast/ga/georgia.htm	
Hawaii	888-875-9229 or 808-586-7299 http://www2.state.hi.us/eoa/programs/sage_plus/	800-316-8005 or 808-524-3370	808-586-0100	http://www.ssa.gov/sf/offices/sf-pacific-offices.htm	
Idaho	800-247-4422 or 208-334-4350 http://www.doi.state.id.us/shiba/shibahealth.aspx	208-334-5500	877-471-2777 or 208-334-3833	http://www.ssa.gov/seattle/index.htm	

	State Health Insurance Assistance Programs	State Medicaid Agencies	Long-Term Care Ombudsman	Social Security Office	State Pharmacy Assistance Programs
Illinois	800-548-9034 or 217-785-9021 http://www.ins.state.il.us/Ship/ship_help.htm	800-226-0768 or 217-782-2570	800-252-8966 or 217-785-3143	http://www.ssa.gov/chicago/illinois.htm	866-226-0768 or 800-624-2459 http://www.seniorcareillinois.com/
Indiana	800-452-4800 or 317-233-3475 http://www.state.in.us/idoi/shiip/index.html	800-234-0225 or 317-233-4455	800-288-1376 or 800-622-4484 or 317-232-7000	http://www.ssa.gov/chicago/indiana.htm	866-267-4679 or 317-234-1381 http://www.in.gov/fssa/hoosierx/
Iowa	800-351-4664 or 515-281-6867 http://www.shiip.state.ia.us/	800-338-8366 or 515-327-5121	800-532-3213 or 515-242-3327	http://www.ssa.gov/kc/fos-ia.htm	
Kansas	800-860-5260 or 316-337-6010 http://www.agingkansas.org/shick/	800-792-4884 or 785-274-4200	877-662-8362 or 785-296-3017	http://www.ssa.gov/kc/fos-ks.htm	800-432-3535 or 785-296-1299 http://www.agingkansas.org/kdoa/programs/pharmassistprog.htm
Kentucky	877-293-7447 http://chs.ky.gov/Aging/programs/State%20Health%20Insurance%20Assistance.htm	800-635-2570 or 502-564-2687	800-327-2991 or 502-564-5497	http://www.ssa.gov/atlanta/southeast/ky/kentucky.htm	
Louisiana	800-259-5301 or 225-342-5301 http://www.lidi.state.la.us/office_index/Office_of_health.htm	255-342-9500	800-259-4990 or 225-342-6872	http://www.ssa.gov/dallas/state_la.html	
Maine	800-750-5353 or 207-623-1797 http://www.state.me.us/dhs/beas/hiap/welcome.htm	800-321-5557 or 207-287-3094	800-499-0229 or 207-621-1079	http://www.ssa.gov/boston/ME.htm	866-796-2463 or 800-423-4331 or 800-262-2232 http://www.state.me.us/dhs/beas/medbook.htm#lcd

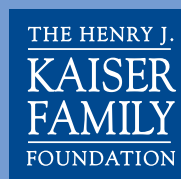
	State Health Insurance Assistance Programs	State Medicaid Agencies	Long-Term Care Ombudsman	Social Security Office	State Pharmacy Assistance Programs
Maryland	800-243-3425 or 410-767-1100 http://www.mdoa.state.md.us/Services/ship.html	800-492-5231 or 410-767-5800	800-243-3425 or 410-767-1100	http://www.ssa.gov/phila/states/maryland.htm	800-226-2142 or 800-972-4612 or 410-821-9262 http://www.dhmd.state.md.us/mma/mpap/
Massachusetts	800-243-4636 or 617-727-7750 http://www.800ageinfo.com/programs/shine.cfm	800-325-5231 or 617-628-4141	800-243-4636 or 617-727-7750	http://www.ssa.gov/boston/MA.htm	800-243-4636 or 617-727-7750 http://www.mass.gov/portal/index.jsp?pageID=elderstopic&L=3&sid=Elders&L0=Home&L1=Health+Care&L2=Prescription+Advantage
Michigan	800-803-7174 or 517-886-0899 http://www.mymmap.org/	800-642-3195 or 517-335-5001	866-485-9393 or 517-335-1560	http://www.ssa.gov/chicago/michigan.htm	866-747-5844 or 517-241-3424
Minnesota	800-333-2433 or 651-296-2770 http://www.mnaging.org/seniors/healthinsurance/SHIP.html	800-366-8930 or 651-297-3933	800-333-2433 or 651-296-0382	http://www.ssa.gov/chicago/minnesota.htm	651-296-8517 or 800-333-2433 http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/DHS_id_006258.hcsp
Mississippi	800-948-3090 or 601-359-4929 http://www.mdhs.state.ms.us/aas_info.html	800-421-2408 or 601-359-6050	800-948-3090 or 601-359-4929	http://www.ssa.gov/atlanta/southeast/ms/mississippi.htm	
Missouri	800-390-3330 or 573-893-7900 http://mpcrf.org/beneficiaries/medicare_help.asp	800-392-2161 or 573-751-4815	800-309-3282	http://www.ssa.gov/kc/fos-mo.htm	866-556-9316 http://www.dhss.mo.gov/MoSeniorRx/

	State Health Insurance Assistance Programs	State Medicaid Agencies	Long-Term Care Ombudsman	Social Security Office	State Pharmacy Assistance Programs
Montana	800-332-2272 or 406-444-4077 http://www.dphhs.state.mt.us/sltc/protective_legal/07.02.SHIP.CMS.htm	800-362-8312 or 406-444-5900	800-332-2272 or 406-444-4077	http://www.ssa.gov/denver/montana.htm	
Nebraska	800-234-7119 or 402-471-2201 http://www.state.ne.us/home/NDOI/nica/nica.htm	402-471-3121	800-942-7830 or 402-471-2307	http://www.ssa.gov/kc/fos-ne.htm	
Nevada	800-307-4444 or 702-486-3478 http://www.nvaging.net/ship/ship_main.htm	702-486-5000	775-688-2964	http://www.ssa.gov/sf/offices/sf-nevada-offices.htm	800-262-7726 http://www.nevadaseniorr.com/
New Hampshire	800-852-3388 http://www.nhhelpline.org/hiceas/hiceas/index.cfm	603-271-4238	800-442-5640 or 603-271-4375	http://www.ssa.gov/boston/NH.htm	888-580-8902 or 877-852-4060
New Jersey	800-792-8820 or 609-943-3437 http://www.state.nj.us/health/senior/ship.shtml	800-356-1561 or 609-588-2600	877-582-6995 or 609-943-4026	http://www.ssa.gov/ny/services-fo.htm	800-792-9745 or 609-588-7048 http://www.state.nj.us/health/seniorbenefits/paadapp.htm
New Mexico	800-432-2080 or 505-476-4799 http://www.nmaging.state.nm.us/benes.html	888-997-2583 or 505-827-3100	866-842-9230 or 505-255-0971	http://www.ssa.gov/dallas/state_nm.html	

	State Health Insurance Assistance Programs	State Medicaid Agencies	Long-Term Care Ombudsman	Social Security Office	State Pharmacy Assistance Programs
New York	800-333-4114 http://www.hiicap.state.ny.us/	800-541-2831 or 518-747-8887	800-342-9871 or 518-474-7329	http://www.ssa.gov/ny/services-fo.htm	800-332-3742 http://www.health.state.ny.us/nysdoh/epic/faq.htm
North Carolina	800-443-9354 or 919-733-0111 http://www.ncshqip.com/consumer/shqip/shqip.asp	800-662-7030 or 919-857-4011	919-733-8395	http://www.ssa.gov/atlanta/southeast/nc/north_carolina.htm	866-226-1388 http://www.ncseniorcare.com/index.htm
North Dakota	800-247-0560 or 701-328-2440 http://www.state.nd.us/ndins/consumer/details.asp?ID=58	800-755-2604 or 701-328-2332	800-451-8693 or 701-328-2310	http://www.ssa.gov/denver/ndakota.htm	
Ohio	800-686-1578 or 614-644-3999 http://www.ohioinsurance.gov/ConsumServ/Oshqip/WhatisOSHIIP.htm	800-324-8680 or 614-728-3288	800-282-1206 or 614-466-6190	http://www.ssa.gov/chicago/ohio.htm	
Oklahoma	800-763-2828 or 405-521-6628 http://www.oid.state.ok.us/consumer/shicp.html	800-522-0114 or 405-522-7300	800-211-2116 or 405-521-2327	http://www.ssa.gov/dallas/state_ok.html	
Oregon	503-947-7984 or 800-722-4134 http://oregonshiba.org	800-527-5772 or 503-945-5772	503-378-6533	http://www.ssa.gov/seattle/index.htm	
Pennsylvania	800-783-7067 http://www.aging.state.pa.us/aging/CWP/view.asp?A=282&QUESTION_ID=173806	800-692-7462	717-783-7247	http://www.ssa.gov/phila/states/pennsylvania.htm	800-225-7223 or 717-651-3600 http://www.aging.state.pa.us/aging/cwp/view.asp?A=293&Q=173876

	State Health Insurance Assistance Programs	State Medicaid Agencies	Long-Term Care Ombudsman	Social Security Office	State Pharmacy Assistance Programs
Rhode Island	401-464-4000 or 401-462-0508	401-462-5300	401-785-3340	http://www.ssa.gov/boston/RI.htm	800-322-2880 or 401-222-2858 http://www.dea.state.ri.us/socialservices.htm
South Carolina	800-868-9095 or 803-898-2850 http://www.caresouth-carolina.com/vantage.htm#icare	803-898-8206	800-868-9095 or 803-898-2850	http://www.ssa.gov/atlanta/southeast/sc/south_carolina.htm	877-239-5277 http://southcarolina.fhsc.com/Beneficiaries/silverxcard/documents.asp
South Dakota	800-536-8197 or 605-773-3656 http://www.state.sd.us/social/ASA/SHIINE/	605-773-3495 or 800-452-7691	866-854-5465 or 605-773-3656	http://www.ssa.gov/denver/sdakota.htm	
Tennessee	877-801-0044 or 615-741-2056 http://www.state.tn.us/comaging/ship.html	800-669-1851 or 615-741-0192	877-236-0013 or 615-741-2056	http://www.ssa.gov/atlanta/southeast/tn/tennessee.htm	
Texas	800-252-9240 http://www.tdoa.state.tx.us/benefitsbasics/benefitsbasichicap.htm	888-834-7406 or 512-424-6500	512-438-4356	http://www.ssa.gov/dallas/state_tx.html	
Utah	800-541-7735 or 801-538-3910 http://www.hsdaas.utah.gov/health_ins_info.htm	800-662-9651 or 801-538-6155	801-538-3910	http://www.ssa.gov/denver/utah.htm	
Vermont	800-642-5119 http://www.medicarehelpvt.net/	800-250-8427 or 802-241-2800	800-917-7787 or 802-863-2316	http://www.ssa.gov/boston/VT.htm	800-250-8427 or 802-241-2992 http://www.dsw.state.vt.us/districts/ovha/ovha8.htm

	State Health Insurance Assistance Programs	State Medicaid Agencies	Long-Term Care Ombudsman	Social Security Office	State Pharmacy Assistance Programs
Virginia	800-552-3402 or 804-662-9333 http://www.aging.state.va.us/vicap.htm	804-726-4231	804-565-1600	http://www.ssa.gov/phila/states/virginia.htm	
Washington	800-397-4422 http://www.insurance.wa.gov/consumers/shiba/default.asp	800-562-3022	800-562-6028	http://www.ssa.gov/seattle/index.htm	
West Virginia	877-987-4463 or 304-558-2241 http://www.state.wv.us/seniorservices/shine/	304-558-1700	304-558-3317 or 800-834-0598	http://www.ssa.gov/phila/states/westvirginia.htm	
Wisconsin	800-242-1060 or 608-267-3201 http://www.dhfs.state.wi.us/aging/Genage/BEN_SPECS.HTM	800-362-3002 or 608-221-5720	800-815-0015 or 608-246-7014	http://www.ssa.gov/chicago/wisconsin.htm	800-657-2038 http://dhfs.wisconsin.gov/seniorCare/
Wyoming	800-856-4398 or 307-856-6880 http://www.wyoming seniors.com/WSHIIP.htm	888-996-8678 or 307-772-7531	307-322-5553	http://www.ssa.gov/denver/wyoming.htm	



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