

Medicare & Medicaid: What's the difference?

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By David A. Cutner



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This is the second in a series of articles about Elder Law. ([Read the first in this series](#))

Medicare and Medicaid are two government-sponsored medical and health programs for seniors and disabled persons. Perhaps because their names are so similar, these programs are often confused with each other. In fact, they are quite different.

In this article, we will take a look at the scope and eligibility requirements for each. In future articles, we will explore how you can obtain valuable benefits that may seem unavailable or unattainable.

Let's start with the basics:

Medicare is medical insurance for acute medical care needed for an illness or injury. Within limits, it covers hospitals, doctors, skilled nursing, and hospice. Medicare does not cover long-term, custodial care needed after a patient has recovered from an illness or has been rehabilitated from an injury. Almost everyone is eligible (regardless of assets or income), and you pay for it through payroll deductions and premium payments.

Medicaid is for elderly or disabled persons who have problems with the "activities of daily living" (for example, bathing, toileting, dressing, eating), and who need long-term, custodial care. Alzheimer's disease, arthritis, dementia, Parkinson's disease, or stroke, are typical situations where long-term care is needed, but there are obviously many others. Unlike Medicare, Medicaid has strict eligibility requirements, and benefits are available only to those with extremely limited financial resources. (Those who plan properly may be able to obtain benefits and preserve their assets or income. Medicaid planning will be discussed in future articles in this series.)

With this overview in mind, now let's take a closer look at these programs.

Medicare
Who is eligible?

Almost everyone, age 65 or over. You are eligible if you receive or are eligible for Social Security or Railroad Retirement benefits, or if you or your spouse had Medicare-covered government employment. If you are under age 65, you may be eligible if you have received Social Security or Railroad Retirement disability benefits for 24 months, or if you have end-stage renal disease.

What is covered and what does it cost?

Most people do not have to pay for Part A, which covers hospitals, skilled nursing facilities (for rehabilitation), hospice, and limited home health care (again, for rehabilitation). Those who are eligible have already made contributions to Medicare through payroll deductions.

Most people pay a premium towards Part B, which covers doctors, physical and occupational therapists, some home health care, and other "medically necessary" services and supplies. The 2008 premium for Part B is \$96.40 per month, but may be higher for individuals who earn more than \$82,000 (\$164,000 for couples filing jointly). If you do not sign up for Part B when you are eligible at age 65, Medicare will increase your premium by 10% for each year that you could have had Part B, and you will continue to pay a higher

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premium for as long as you have Part B. However, you can delay your Part B enrollment after age 65 without having to pay a higher premium if you or your spouse are working and one of you has a group health plan with an employer or union. If you wish to avoid the higher Part B premium, you should enroll within 8 months following the month when the employer or union health plan ends, or employment ends, whichever is first.

There are a variety of Prescription Drug (Part D) plans that are offered by insurance companies and other private companies approved by Medicare.

These plans require the payment of a premium. Unfortunately, it requires a bit of investigation to determine the best plan for you. You will want to consider whether the drugs you are taking are covered by the plan (the “formulary”), the amount of the deductible, and the required co-payments. Medicare drug plans sometimes have a gap in coverage (the “donut hole”), which means that, after a certain amount has been spent by you and your plan for covered drugs (no more than \$2,510), you will have to pay the full amount yourself while you are in the gap (which could be as much as \$3,216).

What about Tier 4 drugs? Approximately 86% of Medicare drug plans (and an increasing number of private health insurance plans) now incorporate a co-pay system that requires those who take a particularly expensive drug to pay a percentage of the drug’s cost (typically 20% to 33%), rather than the fixed co-pay amount they pay for other drugs (usually \$20 to \$40). Unfortunately, this relatively recent change severely impacts people with serious diseases such as cancer, multiple sclerosis, and rheumatoid arthritis.

What are “Medigap” supplemental insurance policies?

Medigap policies are offered by insurance companies to cover the deductible and co-pay amounts under Part A and Part B, and the “donut hole” under Part D drug plans. These policies currently cost approximately \$200 to \$300 per month.

What are “Medicare Advantage” plans?

Private insurance companies sponsor a variety of Medicare Advantage Plans (like an HMO or a PPO) that are approved and paid for by Medicare. These plans provide all your Part A, Part B, and often Part D coverage, for the same or a similar premium that you would pay under the Original Medicare plan.

Typically, the Medicare Advantage plans have more benefits and lower co-payments than the Original Medicare plan. However, you may be limited to the doctors and hospitals that are in your particular plan. In most cases, you will not need or want a Medigap policy.

You can compare Medicare’s health plans, drug plans, and Medigap policies on the Internet at www.medicare.gov. On the Home page, look under “Search Tools.” You may also want to consult your pharmacist on which drug plan is best for you.

Medicaid

Medicaid addresses a different need for a more discrete population – individuals who need long-term care (in the community, at home, or in a nursing home) and who lack the means to pay for these services. Medicaid is also the “payer of last resort” of the medical expenses incurred by individuals in this program. Individuals on Medicaid who also have Medicare normally keep those benefits and have access to more doctors, but there is no longer any need for supplemental insurance as Medicaid will cover deductibles, co-pays, and “donut holes.”

Medicaid is a joint federal, state, and local program, and, as a result, the benefits and rules differ from state to state, and even from county to county. New Yorkers are fortunate to have some of the most generous benefits and rules in the country, particularly for community Medicaid and home care. In addition, because New York State and New York City provide generous financial support for their elderly and disabled populations, there are a great many programs and facilities available that cannot even be found in other states.

Medicaid is available to applicants who have limited resources and monthly income. “Resources” include assets of all kinds, including checking and savings accounts, CD’s, savings bonds, securities accounts, IRA’s and retirement plans, and the cash value of insurance policies. Owning a home (including a condo or co-op apartment) that is worth less than \$750,000 will not prevent you from receiving Medicaid if you are otherwise qualified. In certain cases, Medicaid may be entitled to place a lien against your home to secure re-payment of the value of the benefits it provided during your lifetime, but only if you or your spouse no longer live in the home. “Income” includes income from virtually any source, including Social Security, pensions, and IRA distributions.

In 2008, the resource limit for individuals is \$4,350, and for couples is \$6,400. For those seeking community Medicaid or home care, the income level for individuals is \$745 per month, and for couples is \$1,087 per month. Those who receive Medicaid benefits in a nursing home are permitted to keep only \$50 per month, and the balance of their income must be contributed to the nursing home.

When one spouse is in a nursing home and the other remains at home, the “community spouse” is subject to a maximum federal “Community Spouse Resource Allowance” of \$104,400. Any excess amount is subject to a claim by Medicaid, because the community spouse has a legal obligation of support towards the spouse in the nursing home. Similarly, the community spouse is subject to a “Minimum Monthly Maintenance Needs Allowance” of \$2,610, and a portion of any excess is also subject to a claim by Medicaid.

What to do?

Individuals and families who need, or who have considered, long-term care know that the costs involved are “ruinously expensive” (to quote New York’s highest court). Currently, in New York City, someone who needs 12 hours of home care should expect to pay in the neighborhood of \$5,000 per month, and someone who needs nursing home care could pay up to \$15,000 per month.

Many families that consider Medicaid’s eligibility standards believe that they cannot qualify for benefits, and resign themselves to “spending down” their life’s savings until there is virtually nothing left.

However, it is not necessary to do so. In future articles in this series, we will explore available planning options to qualify for Medicaid without spending down all of your assets or income, or putting your home at risk. You may be surprised to learn that it is not too late to plan, even if a family member is about to be admitted to a nursing home, or is already in a nursing home.

David A. Cutner is a founding partner of Lamson & Cutner, P.C. (www.lamson-cutner.com), a New York City law firm that is devoted solely to the practice of Elder Law and protecting the rights of the elderly and disabled.

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