

HEALTH CARE COVERAGE

To access to health care today, a person should have health care coverage. Options for health care coverage discussed here are:

- *Medicaid*
- *Medicare*
- *Private Health Insurance*

MEDICAID

Through the New Hampshire Department of Health and Human Services, New Hampshire offers Medical Assistance (Medicaid) to adults through several programs— Old Age Assistance (OAA), Aid to the Needy Blind (ANB), Aid to the Permanently and Totally Disabled (APTD) and Qualified Medicare Beneficiary (QMB) programs. (See the section, *Medicare*, for more information on QMB and related programs.) Medicaid provides medical care coverage to individuals with insufficient income and resources. A person may apply for assistance under any of these categories and if eligible for more than one, must choose one. If the person with a disability meets the requirements for OAA, ANB or APTD, he or she may receive benefits for special living arrangements (see below)— the residential care facility, the community residence, a home- and community-based care (HCBC) program or a nursing facility.

Special Living Arrangement	Services
Residential Care Facility	Personal and social care to adults who are elderly or physically disabled who cannot live alone but do not require institutionalization.
Community Residence	Personal and social care to individuals with a mental illness or a developmental disability who cannot live alone but do not require institutionalization.
HCBC — Elderly or Chronically Ill, Developmentally Disabled, or Acquired Brain Injury	Home- and community-based services that an individual needs in order to prevent institutionalization.
Nursing Facility	Health-related care and services on a daily in-patient basis.

WHAT DOES THE MEDICAID PROGRAM COVER?

The New Hampshire Medicaid program provides financial coverage for medical services and items. For example, the New Hampshire Medicaid program provides coverage for medically necessary—

- Inpatient and outpatient hospital services;
- Prenatal care;
- Physician services;
- Nursing homes and intermediate care facilities for the mentally retarded;
- Family planning services and supplies;
- Home health care;
- Laboratory and x-ray services;
- Personal care services;
- Medical equipment;
- Prescribed drugs; and
- Rehabilitation and physical therapy services.

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR MEDICAID?

To be eligible for Medicaid, a person must meet: (1) the general eligibility requirements, (2) the categorical eligibility requirements, and (3) the financial eligibility requirements.

General Eligibility Requirements

There are several general eligibility requirements for the New Hampshire Medicaid program, including residency and citizenship requirements. Areas of special interest to persons with disabilities and those who support them are the requirements that a person with a disability develop all potential sources of income and public assistance reimbursement requirements. (For more on reimbursement requirements, see *Reimbursement of Public Assistance Payments* under *Public Benefit Considerations*.)

Categorical Eligibility Requirements

The basic categorical eligibility requirements for the New Hampshire Medicaid program are listed below. If a person qualifies under OAA, ANB, or APTD, the person may also apply for assistance in a special living arrangement (a residential care facility, community residence, home- and community-based care program, or nursing facility), if the level of care in the living arrangement is appropriate.

OAA Categorical Requirements

1. 65 years of age or older.

ANB Categorical Requirements

1. Central visual acuity of $\leq 20/200$ in the better eye, with correction; *or*
2. Field of vision limitation so that the widest diameter of visual field is under a 20° angular distance; *or*
3. Vision so defective as to prevent the performance of ordinary activities for which functional eyesight is essential.

APTD Categorical Requirements

1. Ages 18 through 64; *and*
2. Physical or mental disability that is likely to result in death or expected to last for a continuous period of not less than 48 months.

Financial Eligibility Requirements

To meet financial eligibility requirements, a person must be both income- and resource-eligible. The financial eligibility criteria are important to consider when planning for a person with a disability.

Income Eligibility – The income-eligible person has a countable income that falls at or below the Medicaid income limits. The State looks at all of the income that is available to the person. As required by law, the State excludes some income (See examples of income, excluded income and income deductibles on page 51) and makes deductions from the income that remains. Countable income is income left after the exclusions and deductions. If the person's countable income is at or below the State's income limit, he or she is income-eligible.

Examples of Income, Excluded Income and Income Deductions

Income	Excluded Income	Income Deductions
Salary or wages	Earned income tax credits	Income the person allocates to a dependent or spouse
Tips or commissions	Scholarships	Court-ordered alimony or child support
SSI payments	Federal fuel assistance	Wage garnishments
Pension benefits	Food Stamps	Training expenses
Insurance benefits	Loans	
Contributions	Plan for Achieving Self-Support	
Dividends	Tax Refunds	
Savings account interest	VA Aid & Attendance Allowance	
	VISTA payments	

There are two sets of income limits under the Medicaid program— *categorically needy* and *medically needy*. The *categorically needy* income limits are the same as the income limits under the New Hampshire Financial Assistance program. The *medically needy* income limits are for individuals who have too much income to qualify for categorically needy assistance but have medical expenses that offset the excess income. Through payment of medical expenses, individuals in the medically needy category *spend down* their income to the medically needy income limit in order to become Medicaid eligible. In 2001, for example, an individual may not have more than \$544 (\$797 for a couple) of income in a month to meet categorically needy eligibility, although income limits in special living arrangements may be slightly higher. The 2001 spend down limit for the medically needy program is \$544.

Resource Eligibility -- A person is resource-eligible for Medicaid if the total value of his or her countable resources is at or below:

- \$1,500 for Medicaid for the categorically needy, or
- \$2,500 for Medicaid for the medically needy (\$4,000 for assistance group of 2; \$4,100 for assistance group of 3).

Resources are the personal property and real estate of the person. Some resources are excluded by law (See example on below). If at any time a person's countable resources exceed a value of \$1,500 (\$2,500 for medically needy), the person becomes ineligible for Medicaid and must spend down resources to become eligible again.

Countable Resources - Examples

Bank Accounts
 Individual Retirement Account
 Keogh Plan (established by individual)
 Stocks and bonds
 Revocable Trusts

Excluded Resources - Examples

Home
 Household Items
 Life Estate
 Life Insurance (if no cash surrender value)
 Loans
 Plan for Achieving Self Support
 Vehicle

If a person lives in an institution and has a spouse who lives in the community, a resource that is usually countable may be a protected resource, a resource set aside for the use of the community spouse and not countable in the person's resource assessment. (See below.)

The Protected Resource for the Community Spouse

The spousal share is one-half of the combined resources of the individual and the individual's community spouse at the time of the individual's institutionalization.

The protected resource amount for the community spouse is the higher of the:

- Spousal share, up to a maximum of \$87,000;
- The minimum spousal resource standard of \$17,400;
- Amount transferred to community spouse by a court support order; or
- The amount determined by a State Appeals Unit.

If a person *transfers assets* to become eligible for Medicaid and the person receives less than a fair market value for the asset, he or she may become ineligible for benefits for a period of time. The rules on asset transfers are discussed in *Transfer of Assets* under *Public Benefit Considerations*. This is important if the person receives or is expected to receive Medicaid coverage for institutional care, such as care in a nursing home, or for HCBC services.

HOW MUCH MUST THE PERSON WITH A DISABILITY CONTRIBUTE TO THE COST OF CARE?

If the person receives Medicaid for care at an institutional level of care, such as in a nursing home, or under a HCBC program, he or she will be expected to contribute to the cost of that care. The contribution will come from income that the person receives. To determine how much income the person must contribute, the State basically looks at all of his or her income, except income excluded by law, and from that income:

- Deducts SSI benefits;
- Deducts a personal allowance (ranging from \$50 to \$90 per month for one person)
- Deducts a maintenance allowance for HCBC recipients;
- Deducts medical costs not covered by Medicaid; and
- Deducts a VA Aid and Attendance allowance, if received.

The income that remains goes towards the cost of care.

WHAT IS MEDICAID IN AND OUT?

Medicaid In and Out is available to a person whose income is insufficient to meet medical costs or who has unpaid prior medical debt. The person eligible for Medicaid In and Out meets all eligibility requirements except that his or her income exceeds the medically needy income limit.

If a person is eligible for Medicaid In and Out, he or she must choose a one-month or six-month spend-down period and applications are good for no more than a six-month consecutive period. The spend-down amount is the difference between the medically needy income limit and the person's net income. Assistance begins on the day that the person meets the spend-down. The person is responsible to notify the State of that spend-down status.

Allowable medical expenses for the spend-down are medical expenses remaining after third-party payments (such as health insurance payments) are made. Allowable medical expenses include: current medical expenses; health insurance premiums; over-the-counter medications that are part of a treatment plan supervised by a physician; medical transportation; adult day care; and medical debt. Allowable medical expenses also include medical costs not covered under the Medicaid program.

MEDICARE

Medicare is a health insurance program for people who are elderly or for people with a disability or end-stage renal (kidney) disease. The Medicare program is divided into two parts — *Part A*, a hospital insurance program, and *Part B*, a supplementary insurance program.

Most people find that Medicare coverage alone is insufficient to meet their needs. This is especially true if a person requires long-term care. Medicare coverage is primarily for short-term episodes of illness with limited long-term care coverage. For the person who requires long-term care services, including services provided through a home- and community-based service system or through an institutional setting, the Medicare program provides very limited coverage. Private supplementary insurance coverage, often referred to as Medi-Gap coverage, may bridge some of the coverage gaps. Long-term care insurance coverage is also beneficial. If someone has substantial long-term care needs and minimal financial resources, the Medicaid program may be the best choice for a “Medi-Gap” type of insurance.

WHO IS ELIGIBLE FOR MEDICARE?

Medicare Part A Without a Monthly Premium

A person entitled to Medicare Part A receives coverage without paying an insurance premium. To be entitled, a person must fall under one of these three categories.

Category One — The person is:

- Age 65 or older; and
- Eligible for benefits under the Social Security, Railroad Retirement, or Medicare-covered government employment programs.

Category One Exception: Eligibility for Social Security retirement benefits requires “40 hours” of Medicare-covered employment. However, an individual with 30 to 39 hours of Medicare-covered employment may also be *entitled* to Medicare coverage and receive that coverage at a reduced premium. (For example, the premium in 2002 is \$175.)

Category Two — The person:

- Is under age 65; and
- For at least 24 months, has been entitled to disability benefits under the Social Security (including Medicare-covered government employment) or Railroad Retirement programs.

Category Three — The person:

- Does not meet the criteria of Category One or Category Two; and
- Has end-stage renal disease.

Medicare Part A as a Premium Hospital Insurance

By paying a premium, Medicare Part A coverage is also available to those who do not fall under the categories listed above. In 2002, for example, the Part A premium is \$319 per month. A person is eligible for Part A as a premium insurance if he or she falls under one of these two categories—

Category Four — The person:

- Is age 65 or over;
- Is a resident of the United States and a citizen or an alien meeting certain requirements; and
- Is entitled to Medicare Part B or is eligible for and has enrolled for Medicare Part B.

Category Five — The person:

- Is under age 65;
- Is entitled to Medicare Part A on the basis of entitlement to Social Security disability benefits;
- Continues to have a disability;
- Loses entitlement to disability benefits solely because of excess earnings (relating to substantial gainful activity); and
- Is not otherwise entitled to Medicare Part A.

To receive Medicare Part A coverage as a premium insurance, a person must enroll during specified enrollment periods.

Medicare Part B

Medicare Part B is a voluntary medical insurance program for people who are aged or have a disability and who choose to participate in the program and pay premiums for the coverage.

The person eligible for Part B is:

1. Entitled to Part A benefits, Categories One, Two or Three); or
2. Is 65 years of age or older, a resident and a citizen of the United States or an alien meeting certain requirements.

The person may or may not be required to actually enroll in Medicare Part B. The person who is entitled to Medicare Part A (See Categories One, Two or Three on the previous page) is automatically enrolled in Part B. In all other circumstances, the eligible individual must actually enroll during a specified enrollment period or be enrolled by the State as part of a buy-in agreement. If the individual enrolls after the initial enrollment period or re-enrolls after termination of coverage, the premium is increased by ten percent for every full twelve-month period of missed enrollment. In 2002, for example, the standard monthly premium for Medicare Part B is \$54 per month.

WHAT ARE THE MEDICARE BENEFITS?

Medicare Part A (hospital insurance) provides coverage for medically necessary inpatient hospital services, related after-hospital services, home health services and hospice care. As with private insurance, there are limitations on the number of days of coverage, conditions on service coverage, and deductibles and coinsurance costs.

Medicare Part B provides supplemental medical coverage to Medicare Part A. Each is described on the following pages.

Medicare Part A – In-Patient Hospital Coverage

Coverage is available for each day of in-patient hospital care, up to a maximum coverage of 90 days per “spell of illness”; if the hospital stay exceeds 90 days, the individual may also use days from a 60-day lifetime reserve. (This does not include inpatient psychiatric care for which there is a 190-day lifetime maximum limit.)

<p>In-Patient Hospital Benefits Include:</p> <ul style="list-style-type: none"> Semi-private hospital room accommodations; Nursing and related services, not including private duty nursing services; Inpatient hospital services; Medical social services; Drugs and biologicals; Certain diagnostic and therapeutic services; Supplies, appliances and equipment; and Transportation services, including ambulance services

For in-patient hospital care, the individual has deductible and coinsurance costs. There is a deductible for the first 60 days of in-patient services, a coinsurance charge for days 61 through 90, and a doubled coinsurance charge for lifetime reserve days. The 2002 Medicare Part A deductible and coinsurance costs for hospitalization are listed below as an example.

MEDICARE PART A DEDUCTIBLES AND COINSURANCE	
Year 2002	
Inpatient hospital deductible	\$812 per benefit period*
Coinsurance - days 61 through 90 of hospitalization	\$203 per day
- lifetime reserve days	\$406 per day
- days 21 through 100 of extended care in a skilled nursing facility . . .	\$101.50 per day

* A “benefit period” begins the day of admission to a hospital or skilled nursing facility. The benefit period ends after 60 consecutive days of no hospital or skilled nursing care. There is no limit on the number of benefit periods a beneficiary may have.

Medicare Part A – After-Hospital Skilled Nursing Facility Coverage

Coverage for after-hospital nursing home care is available to a person hospitalized for at least three days and who was admitted to the nursing home usually within 30 days of discharge from the hospital. To receive this coverage, a person must require skilled nursing care or other skilled rehabilitation services on a daily basis.

Coverage extends to up to 100 days per *spell of illness*. Medicare pays for all covered services in the first 20 days of nursing home care and there is a coinsurance charge for days 21 through 100.

After-Hospital Nursing Home Benefits Include:
Supervised nursing care;
Semi-private room accommodations;
Physical, occupational or speech therapy;
Medical social services;
Drugs;
Supplies, appliances and equipment;
Some hospital services; and
Other services generally provided by a skilled nursing facility.

Medicare Part A – Home Health and Hospice Coverage

Home health service coverage is available under Part A or Part B. Home health services are for a person who is:

- Confined to the home;
- Under the care of a physician;
- Periodically in need of skilled services, including nursing care, physical therapy, speech-language therapy and occupational therapy;
- Under a plan of care; and
- Receiving services from a Medicare-qualified home health agency.

Medicare provides coverage for an unlimited number of home health service visits, although there are limitations on the coverage of durable medical equipment. There is no coinsurance charge.

Under certain conditions, Medicare Part A may also provide coverage for hospice care during two periods of 90 days each and an unlimited number of subsequent 60 day periods. There are coinsurance and co-payment costs associated with hospice care.

Home Health & Hospice Benefits Include:
Nursing services
Physical, occupational and speech therapies
Medical social services
Home health aide services
Medical supplies (not drugs)

Medicare Part B

The Medicare Part B program provides supplemental medical insurance coverage to Medicare Part A. Part B coverage includes payment for:

- Physician services;
- Home health services;
- Outpatient physical therapy and occupational therapy;
- Outpatient rehabilitation facility services;
- Ambulatory surgical center services;
- Prosthetic devices and orthotics and prosthetics; and
- Partial hospitalization services provided by a community mental health center.

There is a \$100 annual Part B deductible. Generally, the Medicare beneficiary must also pay 20% of the service charge and there are some required co-payments. There is no charge to the beneficiary, however, for home health services (not including durable medical equipment) and clinical laboratory services.

HOW CAN YOU GET HELP TO PAY MEDICARE COSTS? — THE QMB, QDWI, SLMB, SLMB135, SLMB175 PROGRAMS

There are several Medicaid programs that provide assistance to those unable to meet Medicare costs, including premiums, deductibles and coinsurance costs. The assistance available under these programs is listed below.

MEDICAID ASSISTANCE PROVIDED IN THE QMB, QDWI, SLMB, SLMB135, SLMB175	
Assistance Program:	Assistance in the payment of Medicare:
Qualified Medicare Beneficiary (QMB)	Part A and Part B premiums Premium penalties for late enrollment Deductibles Coinsurance costs
Qualified and Working Individual (QDWI)	Part A premium for individuals with disabilities who lost Medicare due to earnings.
Specified Low-Income Medicare Beneficiary (SLMB, SLMB135, SLMB 175)	Part B premiums <ul style="list-style-type: none"> • SLMB and SLMB135 – Full premium payment • SLMB175 - Payment of the home health service portion of the Part B premium. Premium penalties for late enrollment

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR QMB, QDWI, SLMB, SLMB135, AND SLMB175?

As with other State assistance programs, eligibility requirements for these programs vary somewhat with the assistance group size and with the person’s living arrangement (independent living, residential care, etc.). Key requirements are presented here.

Reimbursement Requirements

A person who is 55-years-old or older and receives QMB, QDWI, SLMB, SLMB135, or SLMB175 Medicaid must reimburse the State for the payments made under the Medicaid program. To find out more about reimbursement requirements, see the section, *Reimbursement of Public Assistance Payments* under *Public Benefit Considerations*.

Categorical Eligibility Requirements

The categorical eligibility requirements for the QMB, QDWI and SLMB programs are listed below.

<p align="center">NEW HAMPSHIRE QMB, QDWI AND SLMB PROGRAMS CATEGORICAL ELIGIBILITY REQUIREMENTS</p>		
<p>Qualified Medicare Beneficiary (QMB)</p>	<p>Qualified Disabled and Working Individual (QDWI)</p>	<p>Specified Low-Income Medicare Beneficiary (SLMB)</p>
<p>Entitled to and enrolled in Medicare Part A.</p>	<p>1. Entitled to enroll in Medicare Part A; 2. Disabled and working; 3. Lost Medicare coverage due to earnings; and 4. Not eligible for other Medicaid programs.</p>	<p>1. Entitled to Medicare Part B; and 2. For SLMB135 and SLMB175- individual may not be eligible for other Medicaid programs.</p>

Financial Eligibility Requirements

To be eligible for the QMB, QDWI and SLMB programs, a person must be both income-eligible and resource-eligible.

Income Eligibility – A person is income-eligible if his or her countable income falls below the program income limits. The State looks at all of the income that is available to the person. By law, the State excludes some income and makes certain deductions from the income that remains. Countable income is income left after the exclusions and deductions. If a person’s countable income is at or below the State’s income limit (see 2001 limits listed below), he or she is income-eligible.

Income Limits for QMB, SLMB & QDWI (2001)		
Medicare Assistance Status	Income Limit Individual	Income Limit Couple
QMB	\$716	\$968
SLMB	\$859	\$1,161
SLMB135	\$967	\$1,307
SLMB175	\$1,253	\$1,694
QDWI	\$1,432	\$1,935

Resource Eligibility -- A person is resource-eligible if his or her countable resources have a value of no more than \$4,000 for an individual and \$6,000 for a couple.

PRIVATE HEALTH INSURANCE

Due to the high cost of health care today, some form of health care coverage is essential. For those able to meet the cost, individual private health insurance policies are available in New Hampshire. However, few insurance companies sell individual health insurance plans in New Hampshire. The Consumer Services division at the New Hampshire Department of Insurance can give you the latest information on the companies that sell individual plans.

An individual health insurance plan works much like the plan that many have through an employer. For a monthly premium and after an annual deductible, the plan pays for medical services and supplies in and out of the hospital. The services and items covered will vary with the plan. You should carefully examine the available policies to make sure that the coverage fits your needs.

Costs for an individual plan will vary significantly. The annual deductible may range from \$1,000 to \$10,000. Premiums may range, for example, from \$170 to \$370 per month. Premium costs vary with age, the individual's health status and the amount of the annual deductible (the higher the deductible, the lower the premium). There are preferred premiums and standard premiums, with the standard premium being higher. The lower preferred premium is for someone who is a non-smoker, not overweight, not regularly on medications and generally healthy. There may also be co-payment fees or other fees.