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MEDICARE vs. MEDICAID: What's the difference?

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One of the confusing aspects of planning for elderly clients is that some very important terms sound a lot alike. The similarity of such terms can often be frustrating for clients seeking to understand the different rules and restrictions that apply to them as they struggle to find the best ways to meet their or their family member's anticipated long-term care needs.

Two such terms are **Medicare** and **Medicaid**. Clients and even certain professional often confuse one with the other, and yet the terms refer to types of benefits that are radically different.

What are they? How are they different? And why do they matter? Medicare and Medicaid are alike in that they are both forms of government benefits and they both involve payment for health care needs. However, that is where their similarities end.

Medicare

Medicare is an "entitlement" program, meaning that Medicare is a benefit that is "earned" based on an individual's employment history. It is therefore broadly available to members of the public provided that they meet the applicable requirements.

Medicare is in essence health insurance for the elderly: it is designed to meet the everyday health care needs of the elderly. It is not designed to underwrite extended forms of care that are needed on an ongoing basis, such as skilled nursing care.

Medicare is "earned" by an individual based on their previous periods of employment. A qualifying individual must work for at least a required number of quarters, and they must attain the requisite age – currently sixty-

five (65) years of age.

Finally, an individual must apply for Medicare. Note: Applying for Medicare in timely fashion is an issue of critical importance but is beyond the scope of this article.

If an individual meets these requirements, they will qualify for Medicare and will be able to use it upon retirement, when they are no longer covered through any employer-provided insurance.

Medicaid

Medicaid, on the other hand, is a “welfare” program, meaning that is a needs-based program available to those who are deemed unable to provide for their own needs. Prior work history is for the most part irrelevant to Medicaid.

The requirements for Medicaid eligibility vary, depending on particular basis for which Medicaid eligibility is sought. However, if Medicaid is sought to pay for skilled nursing care costs, then the applicant must have a demonstrated medical and financial need.

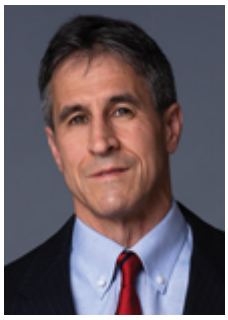
In order to be medically eligible for Medicaid, it must be established that the applicant needs skilled nursing care. That determination must be made by a qualified health care professional, and usually the determination is made regarding the applicant’s ability or inability to meet standard activities of daily living (ADLs) – eating, bathing, dressing, transferring, and toileting.

Financial need is determined based on the sources and amounts of the applicant’s resources (assets) and income. To qualify, an applicant can only have a very modest amount of countable resources and almost no income. Certain assets are not counted toward an applicant’s eligibility for Medicaid, but countable assets generally include not just those of the applicant but also those of their spouse. If an applicant receives institutional care, then the costs of institutional care will often exceed and offset income, thereby enabling them to meet the income threshold.

Because it would otherwise be easy to meet the resource limitations by transferring otherwise countable assets at the last minute, there are detailed restrictions on the transfer of assets.

In general, an uncompensated transfer of assets within five years prior to applying for Medicaid will cause an applicant to be ineligible for Medicaid for a period of time that is determined by formula. The formula divides the total value of uncompensated transfers during the five year period by the average cost of skilled nursing care statewide (per day) to arrive at the number of days that the applicant is ineligible to receive Medicaid. The period of ineligibility commences once the applicant’s resources are otherwise at the level required to qualify for Medicaid. As with Medicare and most government benefits, an application must be completed and filed in order to qualify for Medicaid.

If you have questions about Medicare or Medicaid, or have other Elder Law or Estate Planning concerns, please contact one of our Elder Law Attorneys or call 814-459-2800.



Jeff Scibetta focuses his practice on elder law planning, complex estate planning and administration, business planning, succession planning, tax planning, and real estate. He has spoken to a variety of groups

and professionals about elder law matters.

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