SECTION 5
HEALTH INSURANCE PROGRAMS

Health Insurance and Counseling .................. 98
Long-term Care Planning .......................... 100
Medicare Basics ...................................... 102
How Medicare Works ............................... 103
Medicare Health Plan Options ..................... 105
Medicare Savings Programs ....................... 107
Medicare Prescription Drug Coverage .......... 108
Medicare – Health Screenings and Tests .......... 110
Medicaid Basics ...................................... 111
Medicaid Waiver and SSI-Related Programs .... 112
Other Insurance Programs ......................... 116
HEALTH INSURANCE AND COUNSELING

Over the past several decades health insurance, and the way we access it, has evolved. As coverage options expand in an environment of managed care and cost containment, it is vitally important to understand your options. For seniors who have retired or, for individuals with disabilities using Medicare as their primary source of insurance, this understanding takes on a special significance.

Medicare covers a variety of services to help you stay healthy. However, as with all insurance, there are some things that may not be covered or that change, and it can be more complicated than ever to understand all the choices you face. To help you better understand how your Medicare health and prescription insurance works, the Department of Elder Affairs provides free, unbiased health insurance counseling for seniors and individuals with disabilities through the SHINE Program.

SHINE, or Serving Health Insurance Needs of Elders, is funded through the federal Administration for Community Living (ACL). SHINE volunteers offer free Medicare and health insurance counseling to all Medicare beneficiaries, their caregivers, and their families, regardless of income.

QUESTION 1:
My medications have changed over this past year and I need to re-evaluate my plan choices, who should I contact during the Annual Enrollment Period?

QUESTION 2:
I just received a notice from CMS stating that I am now eligible to apply for Medicare. Where do I begin?

ANSWER:
Contact your Aging and Disability Resource Center and ask for a SHINE counselor for more information about health insurance coverage, enrollment, and plan options available in your area.
**SHINE Volunteers Can:**

- Inform you of your rights and options,
- Review your Medicare insurance forms,
- Interpret your health insurance coverage, and
- Provide educational presentations on Medicare-related topics.

For additional information on SHINE, visit [floridashine.org](http://floridashine.org), contact your Aging and Disability Resource Center, or call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337).

**QUICK FACT:**

In addition to Medicare counseling, volunteers offer information on Medicaid, prescription drug options, long-term care insurance, and managed care programs.
LONG-TERM CARE PLANNING

The phrase long-term care encompasses a range of medical, personal, and social services that are available to individuals who suffer from prolonged illness, dementia, or disability. These services are offered by a variety of providers, including home health care agencies, adult day care centers, assisted living facilities, continuing care retirement communities, traditional nursing homes, and even family members.

Regardless of age, many individuals require periods of long-term care at some point in their lives – for example, while recovering from a stroke or heart attack. The aging process may, however, increase the need for long-term care services to help with activities of daily living, such as getting dressed or taking a bath.

The Department of Elder Affairs encourages individuals to plan ahead for their long-term care needs by learning about long-term care options and discussing them with a family member, doctor, financial advisor, or close friend. Planning ahead enables individuals to choose the type of care they want and how to receive that care. It provides time for them to talk with a doctor about future health issues and the care needed to maintain their independence, and to let loved ones know of their desires and concerns. Including family members in the planning process may be helpful in figuring costs and how to pay for long-term care needs.

Long-term care can be very expensive and could cause financial stress on families that are unprepared. Options to help pay for long-term care include:

- Personal or family resources,
- Long-term care insurance,
- Assistance from federal or state programs,
- Home equity programs, or
- Family members.

Individuals turning 65 today have a 70 percent chance of needing some type of long-term care service and support in their remaining years. Regardless of your age, it is wise to understand and plan for the possible need for long-term care. If Medicare is an important element in your long-term plan, remember Medicare only pays for short stays in skilled nursing facilities following a hospital stay. Also keep in mind that Medicaid (for assistance with nursing home costs) is only available for individuals with low-incomes or disabilities.
For more information about long-term care planning and insurance, contact the SHINE (Serving Health Insurance Needs of Elders) program by calling the Elder Helpline at 1-800-96-ELDER (1-800-963-5337). SHINE provides free, unbiased counseling on long-term care planning, Medicare, and other health insurance-related issues.
MEDICARE BASICS

Medicare is a nationwide federal health insurance program established by Congress in 1965. Eligibility is determined by the Social Security Administration for individuals age 65 and older, as well as individuals under age 65 with certain disabilities. Medicare is administered by the Centers for Medicare & Medicaid Services (CMS).

Despite a common misconception, Medicare is not a universal health insurance program for elders. The program is available if you are age 65 or older and have contributed to the Social Security system for a minimum of 10 years, if you have survivor benefits or railroad retirement benefits, or if you bought into Medicare. Individuals younger than 65 are also eligible for Medicare benefits if they are entitled to Social Security, railroad retirement disability benefits, or end-stage renal disease benefits.

Medicare is neither a comprehensive health care plan nor is it free of cost. In fact, Medicare only provides you with basic health insurance coverage. As a beneficiary, you are responsible for premiums, deductibles, copays, and coinsurance for services that are not covered. To help control escalating medical costs, the program has established a national fee schedule for medical procedures. Medicare will only cover medically necessary services for illnesses and injuries.

QUESTION:
Who determines if you are eligible for Medicare?

ANSWER:
The Social Security Administration is responsible for making eligibility determinations. You must meet age or disability requirements and residency standards. If you are age 65 or older, or are applying on the basis of a disability or end-stage renal (kidney) disease, then eligibility is a matter of verifying your identity and age.

You may file for Medicare benefits three months before reaching age 65. If you are entitled to cash benefits (Social Security or railroad retirement), you will automatically be entitled to Medicare without submitting an additional application.

For more information on Medicare and related eligibility requirements, contact your Aging and Disability Resource Center and ask...
for a SHINE (Serving Health Insurance Needs of Elders) counselor. Other information sources include the Social Security Administration, which you can reach at 1-800-772-1213 or online at ssa.gov, or at the Medicare website medicare.gov.

**How Medicare Works**

Medicare was enacted to provide a safety net of health-care coverage for qualifying individuals. Medicare is made up Part A, which provides hospital insurance protection; Part B, which provides medical insurance protection; Part C, which is a managed care option; and Part D, which provides coverage for prescription medications.

**Part A**

Medicare Part A pays for inpatient hospital care, post-hospital skilled nursing care, home health care, and hospice care. If you receive services under Part A, you generally will not have to pay anything other than the deductible, since you have already paid through Federal Insurance Contributions Act (FICA) payroll tax withholdings. If you need to go back to the hospital after at least 60 days from your last discharge date, you will pay another deductible. Medicare Part A covers up to 90 days of hospital services in each “benefit period” and an additional 60 lifetime days. Part A also pays for care in a skilled nursing facility under certain circumstances.

**Part B**

Medicare Part B medical insurance covers doctors’ fees, lab fees, home health care services, hospital outpatient services, and other medical services or items not covered under Part A. If you apply for Part A, you are automatically enrolled in Part B. However, under certain circumstances you do have the option to turn down Part B by notifying the Social Security Administration. If you decide to turn down Part B, you may incur a penalty if you decide to enroll in Part B at a later date. Monthly premiums are automatically deducted from your Social Security check unless the Social Security Administration (SSA) has been informed otherwise.

**Part C**

There are two ways Medicare beneficiaries can access services. The first way is Original Medicare, a traditional fee-for-service delivery system in which you visit a doctor or hospital of your choice and pay a fee or co-insurance amount for each service you receive. The second way to receive health care is to join a Medicare Advantage Plan (Part C). These plans are private managed care organizations – such as a health maintenance organization (HMO) or preferred

---

**Services Covered Under Medicare**

**Part A**
- Inpatient hospitalization care
- Limited post-hospital skilled nursing care
- Home health care
- Hospice care

**Part B**
- Doctors’ services
- Outpatient hospital care
- Occupational, physical and speech therapy
- Medical supplies and equipment
- Ambulance transportation (limited)
- Chiropractic services (limited)
- X-rays/lab tests
provider organization (PPO) – that have a contract with Medicare. The services Medicare covers are the same under both systems. However, there will be differences in the delivery of benefits, the method of payment, and the amount of your out-of-pocket expenses. Most people use Original Medicare. Fee-for-service users usually supplement their Medicare plans with Medigap insurance, or with retiree coverage from their employers or unions.

The number of people electing to receive Medicare benefits through Medicare Advantage plans, which generally require less out-of-pocket expense than Original Medicare, is on the rise. If you are approaching the eligibility age for Medicare, you should give careful consideration to the different Medicare service delivery options. Your choice may be influenced by several factors, including any retiree coverage you may have from previous employment, military benefits, your financial situation, future lifestyle and retirement plans, and other personal factors.

**QUESTION:**
What are some of the advantages and disadvantages of joining a Medicare Advantage plan such as an HMO?

**ANSWER:**
A key advantage of belonging to an HMO is that the HMO itself may provide benefits beyond those that Medicare will pay. These may include coverage for dental care, eyeglasses, and hearing aids. A possible disadvantage of belonging to an HMO is that most will limit your access to specialists and services within their networks. If you need to see a specialist, you are generally required to first get a referral from your primary care physician (see the Medicare Health Plan Options section for more details).

**Part D**
Medicare Part D is a voluntary prescription drug benefit available to individuals entitled to Part A, and/or enrolled in Part B, who select a Medicare-approved prescription drug plan from those available in their service area. Your prescriptions may be covered through either a Medicare Advantage plan or a stand-alone prescription drug plan.

For additional information on Medicare, contact a counselor with Florida's SHINE program by calling the Elder Helpline at 1-800-96-ELDER (1-800-963-5337), or visit the SHINE website at [floridashine.org](http://floridashine.org).
Medicare Health Plan Options
Since Medicare was designed to provide basic health insurance coverage for seniors, it does not pay all medical expenses. To fill gaps in coverage, beneficiaries are required to contribute through co-payments and deductibles, and/or through the purchase of supplemental policies. Once you become eligible for Medicare, you must choose the type of plan that best meets your health care needs. Several health plan options are described below.

**Original Medicare**  Covers medical expenses up to 80 percent of approved services under Medicare Part B, leaving you to pay the remainder. Depending on the nature of your illness, the remaining portion can be very costly. Because of the possibility of these additional costs, you may want to consider other options, such as a Medicare Advantage Plan (health maintenance organization, preferred provider organization, etc.), an employers’ group plan, or a Medicare Supplement Insurance (Medigap) policy.

**Supplement Insurance (Medigap)**  Private insurers offer 10 different plans to fill some of the “gaps” not covered by Medicare. Each plan covers specific costs and services that are not already covered under Original Medicare. For example, Medigap insurance may cover your co-insurance out-of-pocket costs for skilled nursing care after 20 days and up to 100 days at $157.50 per day (2015). Plans may also cover the amount of your Part A and Part B deductibles, at-home recovery needs, foreign travel, and other benefits.

**Medicare Advantage Plans**  Medicare Advantage organizations offer several plan options to beneficiaries: a coordinated care plan or managed care organization or a Private Fee-for-Service plan.

Here is a brief description of each of these managed care options:

**Coordinated Care Plans**  You must have both Medicare Part A and Part B in order to enroll in a coordinated care plan. These managed care plans may provide benefits that original Medicare does not, such as dental, vision, or hearing coverage. Most plans also cover prescription drugs. Individuals receive services through a designated network of providers and suppliers and must live within the plan’s service area. Plan options include health maintenance organizations (HMOs), provider-sponsored
organizations, regional or local preferred provider organizations (PPOs), and special needs plans (SNPs) for individuals who are institutionalized, eligible for Medicaid or have a severe or disabling chronic condition.

_Private Fee-for-Service Plan (PFSS)_ This type of plan reimburses providers at a rate determined by the plan on a fee-for-service basis, without putting the provider at risk. Some PFSS Plans contract with a network of providers. So before enrolling in a private fee-for-service plan, you may want to check with your doctors to see if they will accept the plan. If your PFSS does not offer prescription drug coverage, you will need to enroll in a separate prescription drug plan.

_Employer Group Plans_ If you are currently enrolled in a group plan, you may want to check with your benefits administrator to learn your continued coverage or supplemental options once Medicare becomes your primary insurance. On the other hand, if you are still working and plan to keep your employer’s group plan as your primary insurance carrier, you may want to delay signing up for Part B of Medicare until you retire. You may also enroll in a Medicare HMO if you are disabled, fulfilled a 24-month requirement, and have Medicare Part A and Part B.

_NOTE:_ Upon retirement, seniors have an eight-month special enrollment period in which to sign up for Medicare Part B. However, if you are eligible but do not sign up for Medicare Part B during this special enrollment period (SEP), you will be able to sign up only during the general enrollment period (GEP) held from January to March each year. The cost of your Part B coverage may also go up. In addition, when you sign up for Medicare Part B, you automatically begin your Medigap open enrollment or guarantee issue period, which, once started, cannot be changed or restarted.

**QUESTION:**
If I enroll during the general enrollment period, will Medicare coverage start immediately?

**ANSWER:**
No, if you enroll during the general enrollment period, your Medicare coverage will begin on July 1st of that year.
For assistance with information on Medicare choices, call your Aging and Disability Resource Center and ask for a counselor with Florida’s SHINE program, or call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337).

**Medicare Savings Programs**

State-administered programs are available to help people with Medicare save money each year. These programs are available through the state Medicaid program to help pay Medicare costs for low-income Medicare beneficiaries with modest means. Most state programs pay some or all of Medicare's premiums, deductibles and co-insurance for those who qualify.

In Florida, if you are a Florida resident, qualify for Medicare Part A, have an income below a certain amount, and your financial resources (bank accounts, stocks, and bonds) amount to no more than $7,280, you may qualify for assistance as:

- a Qualified Medicare Beneficiary (QMB),
- a Special Low-Income Medicare Beneficiary (SLMB), or
- a participant in a Qualifying Individual (QI-1) program.

**NOTE:** Your “resources” do not include your home, car, furniture, life insurance up to $2,500, or burial fund up to $2,500.

- **QMB** Benefits include coverage of your Medicare premiums (Part A and Part B), deductibles, and co-insurance within certain limits.

- **SLMB** Benefits include coverage of your Medicare premiums for Part B.

- **QI-1** Benefits include coverage for your Medicare premiums for Part B. Funding for this program is limited each year based on state and federal allocations, so you may want to apply early in the year.

If you think you may qualify for any of these savings programs, it is very important that you call for more information. Call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337) and ask to speak with a SHINE counselor for information and to see if you qualify for these programs.
Medicare Prescription Drug Coverage

Medicare Prescription Drug Coverage, commonly known as Medicare Part D, is a prescription drug benefit available to Medicare beneficiaries who are entitled to Part A hospital insurance and/or are enrolled in Part B medical insurance. Your prescriptions may be covered through either a Medicare Advantage Plan or a stand-alone prescription drug plan. There are two ways to get Medicare prescription drug coverage.

Original Medicare and a Prescription Drug Plan

Individuals with original Medicare (Part A and/or Part B) may enroll in a stand-alone prescription drug plan that adds drug benefits to their regular Medicare coverage.

Medicare Advantage Plan with Prescription Drug Coverage

These plans will provide an integrated benefit covering hospital, physician, and drug costs. These are managed care organizations that have contracted with Medicare to serve beneficiaries in a specific geographic area. To qualify for a Medicare Advantage plan with prescription drug coverage, a beneficiary must be entitled to Part A and enrolled in Part B.

Enrollment in these plan options is voluntary, and there are specific enrollment periods during which interested consumers must enroll in order to receive benefits. The following enrollment periods allow individuals the opportunity to participate in this coverage:

Initial Open Enrollment

Occurs when an individual is first eligible for Medicare benefits, running from three months before to three months after the person turns 65. Individuals with disabilities may enroll from three months before to three months after their 25th month of disability. Individuals may owe a Part D late enrollment penalty if they go without Part D or creditable prescription drug coverage for any continuous period of 63 days or more after their initial enrollment period is over.

Annual Enrollment Period

Occurs every year from October 15 – December 7. Even if you already have coverage you like, it is important to review your coverage each year to determine whether the plan you selected continues to meet your needs. If you want to change plans, the Annual Enrollment Period is the time when this change can be made.
Special Enrollment Period  Occurs when an individual has a special qualifying circumstance that allows him or her to enroll during this period, such as a change of residence.

Costs Under Medicare Part D  Your actual drug plan costs under Medicare Part D will vary depending on the medications you use, the plan you chose, whether your pharmacy is in the plan’s network, and whether you qualify for “extra help” paying for Part D costs (see below). Most drug plans charge a monthly premium (in addition to the Part B premium), an annual deductible, and co-payments or co-insurance charged for prescriptions after the deductible is met. In addition, Medicare drug plans have a coverage gap (or Donut Hole) – after you and the drug plan have spent a certain amount of money for covered drugs, you must pay an out-of-pocket percentage of brand name and generic drug costs up to a set limit. The percentage you pay for generic drugs will decrease each year until it reaches 25% in 2024. Some Medicare drug plans provide limited coverage during this gap period. Once you pay the out-of-pocket maximum, you reach what is called catastrophic coverage, when you only pay a small co-payment for prescribed drugs for the rest of the plan year.

Some individuals will “automatically” qualify for Extra Help. Examples include someone who has full Medicaid benefits, is currently receiving Supplemental Security Income (SSI) benefits, is enrolled in a Medicare Savings Program (either QMB, SLMB, or QI-1), or who meets their share-of-cost through the Medically Needy Program.

Extra Help Prescription Savings Program  If you are on Medicare and have limited income and resources, you may be entitled to “extra help” paying your Medicare prescription drug costs. This prescription savings benefit program helps with the costs of Medicare drug plan premiums, deductibles, and co-payments, including coverage during the coverage gap.

To apply, call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337) and ask for a SHINE counselor.
Medicare – Health Screenings and Tests
To help elders live a healthier life, Medicare covers several preventive health services (with certain limitations, many are now free of charge), including:

- “Welcome to Medicare” exam,
- Annual wellness exam,
- Alcohol misuse screening and counseling,
- Abdominal aortic aneurism screening,
- Bone mass measurement tests (to help detect osteoporosis),
- Cardiovascular screenings,
- Cervical and vaginal cancer screening,
- Colorectal cancer screening tests,
- Depression screening,
- Diabetes screenings,
- Diabetes self-management services,
- EKG screening,
- Glaucoma screening tests,
- HIV screening,
- Lung cancer screening
- Mammograms (screening and diagnostic)
- Medical nutritional therapy services (for those with diabetes),
- Obesity screening and counseling,
- Prostate cancer screening tests,
- Sexually transmitted infections,
- Tobacco use cessation counseling, and
- Vaccinations (flu, pneumonia, and hepatitis B).

You can take a number of steps to lower your risk of disease and illness. Talk to your doctor about your risk of developing these health problems and your need for these preventive services.

For specific information on health screenings and tests covered by Medicare, call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337) and ask to speak to a SHINE counselor.
MEDICAID BASICS

Because of their similar names, Medicare and Medicaid may be confusing to some people. Both programs serve people age 65 or older, but Medicaid also covers a wide range of other categories, including individuals who are disabled, parents with minor children, pregnant women, children, and those who are medically needy.

While Medicare is available to seniors regardless of their income and resources, Medicaid is a need-based program and is only available to individuals who meet certain income and asset requirements. If your income is below the established Medicaid criteria but your assets are not, you can receive health care coverage only after you have “spent down” your countable assets. For Medicaid purposes, countable assets are those items that count toward the Medicaid asset limitation. Not all assets you own are included in the Medicaid eligibility determination process. Non-countable assets are exempt for Medicaid eligibility purposes. Medicaid allows applicants some flexibility in defining the assets that can be excluded under its non-countable assets provisions. These items are exempt and will not affect your eligibility to receive Medicaid benefits:

- A home (principal residence) - regardless of value.
- Household belongings, furnishings, personal effects and jewelry (some states limit value).
- A burial account of up to $2,500 (or $1,500 for SSI recipients).
- Burial plots for the individual or members of the family.
- Prepaid non-cancelable burial contracts.
- Cash value of life insurance policies (face value cannot exceed $2,500 or $1,500 for SSI recipients).
- Term life insurance policies (no face value limitation).
- One automobile for use by individual and family.
- Company pension funds, certain Keogh funds and certain trust funds.
- Certain income-producing property that is essential to the person’s self-support.
- Inaccessible assets of any value.
Medicaid is a medical assistance benefit program jointly funded by the federal and state governments. While programs may vary from state to state, many low-income elderly over the age of 65 and/or individuals with disabilities may be covered under both Medicaid and Medicare. Medicaid is now the single largest public source of funding for long-term care services. In 2015, approximately 3.8 million Florida residents were enrolled to receive Medicaid benefits.

You may also qualify for Medicaid if you are covered by Medicare and meet the required income and asset limits of the Supplemental Security Income (SSI) program. For those who qualify under these circumstances, Medicaid may cover the premiums, deductibles, and co-payments you have to pay under Medicare. Medicaid may also pay for your long-term nursing home care if you qualify under income and asset restrictions. If you have spent down your life savings on costly long-term care, Medicaid may cover you after you have exhausted your resources.

State Medicaid programs are required to pay for nursing home care for persons who qualify under federal and state criteria. Through waiver programs, states increasingly are using Medicaid funding to cover other types of care for Medicaid-eligible seniors and individuals with disabilities. This includes care provided at home or in other community-based settings for those who qualify.

The Medicaid programs that provide services to the aged and disabled are called SSI-related programs. These programs provide a variety of benefits to both seniors and individuals with disabilities (see the segment on Medicaid Waiver/SSI Programs within this section for more details).

For more information on the Medicaid program or application process, contact the Department of Children and Families’ ACCESS (Automated Community Connection to Economic Self-Sufficiency) at 1-888-419-3456 or via the website at myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash. In addition, a variety of information is available by contacting your local Aging and Disability Resource Center (ADRC). ADRC Medicaid staff will assist with long-term care program education, while the CARES (Comprehensive Assessment and Review for Long-term Care Services) staff will assist with the Institutional Care Program (ICP) (nursing home Medicaid) process. Additionally SHINE (Serving Health Insurance Needs of Seniors) counselors may assist you
with the Medicare savings programs. You may also call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337).

**Medicaid Waiver and SSI-Related Programs**

During the implementation of Statewide Medicaid Managed Care (SMMC), payment for long-term care services was directed primarily to nursing home care. As caregivers and recipients began to request that the same kind of resources available for institutional care also be made available in the home and community-based settings, the government responded with waivers and Supplemental Security Income (SSI) programs. Today, Medicaid funds can be used to provide care in a variety of home and community-based settings.

To be eligible for these programs, you must meet certain age and eligibility criteria. A brief summary of the various Medicaid waiver and SSI-related Medicaid programs is provided below:

**Hospice Medicaid Program**  Helps maintain a terminally ill individual at home for as long as possible by providing in-home care and avoiding institutionalization whenever possible. Hospice is also available to individuals residing in nursing homes.

**Institutional Care Program (ICP)**  Helps people in nursing homes pay for the cost of their care. Unlike Medicare, Medicaid may pay for custodial care for an unlimited period of time.

**Medically Needy Program**  Provides Medicaid for persons with high medical bills and whose income is too high to qualify for traditional Medicaid programs. Individuals qualify for the Medically Needy program on a month-to-month basis by contributing an established monthly share of cost.

**Optional State Supplementation (OSS)**  A cash assistance program managed by the Department of Children and Families, OSS is designed to supplement a person's income to help pay costs in an assisted living facility, mental health residential treatment facility, or adult family care home. To qualify for OSS, individuals must need assistance with their activities of daily living due to physical and/or mental conditions. This is not a Medicaid program, and eligibility requirements may differ from those of Medicaid. The payment is made directly to the client and is based on the client’s income and the program’s current cost of care in the facility.
For more information about OSS, contact DCF’s Customer Call Center at 1-866-762-2237.

**Program of All-Inclusive Care for the Elderly (PACE)**  PACE is a community-based program, which integrates Medicare and Medicaid services. PACE addresses each participant’s acute and long-term care needs, including preventive care, and targets individuals who would otherwise qualify for nursing home placement, providing them with a comprehensive array of home and community-based services at a cost less than nursing home care. Services include but are not limited to primary care, social services, restorative therapies, personal care, supportive services, nutritional counseling, recreational therapy, transportation, and meals. Individuals who choose to enroll in PACE have both their medical and long-term care needs managed through a single provider.

PACE services are determined by an interdisciplinary team that may provide services in the adult day health center, the client’s home, and inpatient facilities as needed. PACE centers provide transportation to and from adult health care centers. PACE may also include coverage of over-the-counter medications when appropriate and approved.

The PACE team consists of a physician, registered nurse, masters level social worker, physical therapist, occupational therapist, recreational therapist, dietician, PACE Center Manager, home care coordinator, personal care attendant, and transportation specialist.
To be eligible, PACE recipients must:

- Be 55 years or older,
- Live within the defined service area of the PACE center,
- Meet the medical eligibility requirements,
- Be able to live safely within the community, and
- Be dually eligible for Medicare and Medicaid, or Medicaid only, or private pay.

For more information about PACE, contact your local Aging and Disability Resource Center or the Elder Helpline at 1-800-96-ELDER (1-800-963-5337).

**Project AIDS Care Waiver Program** – Provides home and community-based services to individuals diagnosed with AIDS. Recipients make informed choices between hospital or nursing home care and home and community-based services.

**Statewide Medicaid Managed Care (SMMC)** – The Statewide Medicaid Managed Care Program (SMMC) has two key components: the Managed Medical Assistance Program (MMA) and the Long-term Care Program (LTC). An MMA recipient will receive comprehensive health care services (other than long-term care) provided by a managed care plan. MMA Plans cover services such as prescriptions, doctors’ visits, and hospital stays. The LTC is designed to provide home and community-based services to Medicaid recipients who are 65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability, and determined to require nursing home level of care. Created by the Florida Legislature in 2011, LTC provides long-term care services, including nursing home and in-home care services, in a managed care setting. Managed care is a term for the process of how health care organizations manage the way their enrollees receive health care services. Managed care organizations work with a variety of health care providers to offer quality health care services to ensure enrollees have access to the health care providers they need.
For additional information on the SMMC programs, visit the Agency for Health Care Administration web page [ahca.myflorida.com/Medicaid/statewide_mc](http://ahca.myflorida.com/Medicaid/statewide_mc).

For additional information to help you better understand the Medicaid program, contact your Aging and Disability Resource Center or call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337).
OTHER INSURANCE PROGRAMS

Early retirement, the loss of a job, termination of employer-sponsored coverage, or a reduction in work hours can all result in a change to health insurance coverage. For adults ages 50 to 64 who find themselves in this situation, the search for affordable replacement coverage can be extremely challenging.

The following information may help seniors find affordable health insurance benefits:

**ACA** The Affordable Care Act (ACA) requires most U.S. citizens and legal residents to have health insurance, either individually or through an employer. Through health benefit exchanges in each state, uninsured individuals and families can purchase coverage, with cost-sharing credits and subsidies available to eligible individuals, families, and small businesses. The ACA includes increasing cost-free preventive services, prohibits discrimination due to pre-existing conditions, and extends coverage to young adults on their parents’ plans up to age 26. Florida’s Health insurance Marketplace is open and available to assist citizens and small businesses purchase health insurance. If you do not have what is considered minimum essential coverage or do not have health insurance, you may be required to pay a penalty, and may also have to pay for all of your health care costs. For more information or for assistance with applying for coverage, Florida residents can access the trusted website [localhelp.healthcare.gov](http://localhelp.healthcare.gov) and enter your city and state or ZIP Code and answer a few questions, or call toll-free 1-800-318-2596, available 24 hours a day.

**COBRA** The Consolidated Omnibus Budget Reconciliation Act (COBRA) can be helpful in temporarily continuing group coverage. COBRA is designed for people who lose their jobs or have reduced working hours. This health coverage option offers more benefits than buying a private policy, but it can be expensive. Coverage lasts for either 18 or 36 months. For information on COBRA benefits, call the U.S. Department of Labor at 1-866-444-3272, or go online to [dol.gov/dol/topic/health-plans/cobra.htm](http://dol.gov/dol/topic/health-plans/cobra.htm).

**Group Health Plan** If you are currently covered by a group health plan and are about to be laid off, you should try to continue your health plan coverage for as long as possible. See your benefits administrator for options.
**HIPAA** The Health Insurance Portability and Accountability Act (HIPAA) helps protect people who switch jobs and want to keep their health insurance coverage. While you cannot take your old health coverage with you, HIPAA allows you to transition from one health plan to another, without being rejected for having a serious health condition. HIPAA guarantees access to health insurance and exempts you from exclusion periods for pre-existing conditions. For more information on HIPAA coverage, call the Department of Financial Services’ Consumer Helpline at 850-413-3100 (for in-state callers) or 1-800-342-2762 (out-of-state callers).

**Florida Discount Drug Program** The Florida Discount Drug Card was created to help lower the cost of prescription drugs for Florida residents who lack drug insurance coverage or are not currently enrolled in a Medicare prescription drug plan. Florida residents may participate regardless of age, income, or pre-existing conditions. To apply, call 1-866-341-8894 (TTY dial 711), or visit the Florida Discount Drug Card website at floridadiscountdrugcard.com.

**QUESTION:**
What if I need immediate medical care and have no health insurance?

**ANSWER:**
If you need immediate medical assistance and do not have insurance, you can go to a county health department clinic in your area. State health care providers in these facilities accept individuals who need medical assistance, regardless of whether they have insurance coverage. Health centers and clinics are staffed by board-certified doctors, and most offer on-site pharmacies, x-ray services, and other health related services.

For additional information on free or low-cost health care options in your area, contact your Aging and Disability Resource Center, or call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337) and ask to speak to a SHINE counselor.