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1. INTRODUCTION: A BRUISED U.S. HEALTH SYSTEM

OLDER AMERICANS INCREASINGLY FACE A SYSTEM COMING APART

“Soaring Health Premiums Creating More Uninsured”; “Despite Efforts, Medical Errors Go on Killing”; “Half of Doctors Plan to Limit Medicare Patients They Treat.”

As the headlines these days make all too clear, sometimes is wrong with the U.S. health care system. On some level everyone knows that – whether it’s a drug you can’t afford, or medical mistake that injured a relative or finding a doctor who will take your Medicare card. It has been coming apart for decades only to be stitched back together by temporary fixes and, for some people, by HMOs.

Hit by the backlash against managed care, relentlessly rising costs and waves of new technology, the system once again threatens to destruct. What ails U.S. health care these days is deep and fundamental, many experts believe. “The heart of the problem is the basic nature of the system – the way insurance is paid and the way doctors are paid,” says the former editor of the New England Journal of Medicine. “The system is fragmented, providers are paid on a piecework basis, and there’s no overall accountability.”

The system seems to work for people who stay insured and never have medical problems, but once they need care or leave a job, they often bump into the barriers that prevent them from receiving care. No wonder the Commonwealth Fund, a New York-based research organization, found that Americans are more dissatisfied with their system than citizens in Australia, Canada, New Zealand and the United Kingdom.

Discontented as some people may be, “there’s no consensus that we need a whole new system,” says a professor of health policy at the Harvard School of Public Health. “People can be quite unhappy and disturbed, but that doesn’t translate into a major political movement.”

And so the system staggers along with little agreement on how to repair it. Just look at the political stalemate over a prescription drug benefit for Medicare beneficiaries. In short, says the new president of the Institute of Medicine, “We are drastically underperforming on access, we are extravagant in costs” – and, he adds, the country is just beginning to focus on quality. Americans confronting the realities of growing old know what he means.

The New Uninsured

Some 41 million people have no health insurance – a statistic that many people pay scant attention to. Middle-class Americans “have other things to worry about,” says a professor of health policy at Brandeis University. “The uninsured are them, not us.”

Increasingly, the uninsured are us as employers cut back on coverage for active workers, those retiring early and workers already retired. Americans too young for Medicare but no longer insured through their employers are finding themselves without health insurance for the first time in their lives.

Uninsured people have few affordable options. Existing medical conditions make it hard to buy a policy in the individual health insurance market, and state programs designed to help the uninsured aid a limited number of low-income individuals.

State high-risk pools offer coverage to people who are uninsurable in the regular market. But premiums are high.

Extravagant Spending

It is no secret that the United States spends more of its gross domestic product on health care than any other country. It spends 14.1 percent of GDP on medical care, while the Canadians spend 9 percent, and
the Germans spend nearly 11 percent. Both Canada and Germany insure all their citizens and have lower prices for prescription drugs.

Making matters worse, cuts in Medicare mandated by Congress in 1997 are beginning to squeeze the incomes and profits of providers and HMOs. As a result, some HMOs no longer cover Medicare patients and have cut back on drug coverage. And some physicians are turning away Medicare patients altogether.

“Additional cuts in Medicare physicians payments of the magnitude expected over the next few years are likely to increase beneficiaries’ access problems,” says the president of the Center for Studying Health System Change, a nonprofit policy research group in Washington.

Throughout the 1990s managed care tried to engineer changes in the system by paying doctors to care for a group of patients and limiting the use of services. Through selective contracting with physicians and hospitals, HMOs drove down the cost of care.

“We economists are convinced that savings went straight into the paychecks of workers,” says an economics professor at Princeton University. “Managed care was the best home for getting high-quality, affordable care short of having a single-player system. But doctors unleashed a huge political backlash.” Moreover, some people with valid complaints have come to view managed care as menacing.

With managed care no longer generating hoped-for savings, patients are being forced to shoulder more of the country’s rising health care costs. And while evidence mounts that shifting costs to patients could prevent some people from getting care, that shift is occurring anyway.

The Kaiser Family Foundation recently reported that premiums shot up nearly 13 percent last year, the highest increase since 1990.

**The Paradox of Quality**

The latest gee-whiz technology is almost instantly available whether or not it has been proven effective. Yet many Americans fail to get basic preventive care like Pap smears or cholesterol screening. Twenty percent of women over age 18 have not received a Pap test in a three-year period, and about half of all adults with diabetes have not received annual eye, foot and blood pressure tests.

Even when people get the care they need, there often are problems. Eight million households have experienced a medical error that caused serious health problems, reports the Commonwealth Fund.

And while errors occur throughout the system, many occur when medicines are given in a hospital. “The system is massively dysfunctional when it comes to communication about medicines,” says a vice president at the Institute for Healthcare Improvement, a nonprofit group in Boston.

There are glimpses of improvement on the quality front. The National Committee for Quality Assurance, a nonprofit group that accredits managed care plans, recently noted that HMOs had demonstrated slow but steady improvement in the quality of care they deliver. Thirteen health plans, for instance, reported that 100 percent of patients who had suffered a heart attack received life-saving beta blocker treatment.

Still, many studies of health care quality find huge gaps between the care patients need and the care they get. Quality varies by location. Doctors are paid the same whether they give poor or excellent care.

Many experts believe the way to fix this problem is to encourage doctors and hospitals to invest in systems to help them track what they are doing and give them information to improve the quality of care they provide. Redesigning payment policies also would offer incentives to provide better care.

Equally important, Americans have yet to decide two basic issues:

- Is health care a right? Or is it a privilege for those lucky enough to have private insurance or to qualify for government programs?
• Should insurance cover everything or should it be reserved for those catastrophic health events that few can pay for out of pocket?

Until Americans reach consensus, the system will continue to push to the brink, only to fall back again leaving unhappy people, many unable to get care, along the way.

FILING HEALTH INSURANCE CLAIMS

Sorting Out Health Insurance Coverage

Most people are confused about their health insurance coverage in that they are never really certain as to what they are entitled to collect.

For the most part insurance policies are difficult to read and understand. We have had many people tell us that they are not certain that they are collecting all that they are entitled to.

It is estimated that over 40% of the people that incur costs for health care do not receive what they are entitled to or don’t attempt to file a claim. Perhaps this chapter can eliminate confusion regarding health claims.

1.1.1.1. First – Determining The Type Of Policy Someone Has And If Benefits Are Coordinated.

Millions of people have more than one insurance policy; therefore, it is necessary to file claims in proper order. In order to avoid lengthy claims processing and delays, or worse yet, have legitimate claims denied. Here are some tips on this procedure:

PRIMARY HEALTH INSURANCE POLICIES

The primary policy is the one that is responsible for paying first. Should individuals have more than one policy, they need to determine which one is primary.

SECONDARY OR SUPPLEMENTAL POLICIES

In the event that their primary policy does not pay 100%, a secondary or supplemental policy is designed to reimburse them for a portion, and in some cases, all of the difference. This is called “coordinating benefits” with the primary policy.

Individuals must provide the supplemental or secondary insurance company with evidence of what their primary policy has paid. That evidence is the EXPLANATION OF BENEFITS, (EOB) received from the primary insurance company.

It is important to understand the order in which policies coordinate benefits. Claims should NEVER be sent to the supplemental or secondary insurance plan until having received the explanation of benefits from the primary plan.

1.1.1.2. Still Uncertain Of The Difference Between Primary And Secondary Coverage?

Here are some guidelines:

• Employed and Medicare Eligible. When an individual or married couple is over age 65, enrolled in Medicare, working full-time and enrolled in an employer's group plan (where there are more than 20 in the work force).
• The employer's group plan will provide primary coverage.
• Medicare will provide secondary coverage. That means the Explanation of Benefits from the employer's plans must be submitted to Medicare before Medicare will process the claim.
Two income households. When both husband and wife are employed, both have medical insurance supplied by each of their respective employers and both are dependents under each other’s policy.

The husband’s plan is primary for him and secondary for her. The wife’s plan is primary for her and secondary for him.

If children are covered under both policies, a “birthday” rule applies. The policy of the parent with the earlier birthday (month and day of the calendar year) will be primary for the children.

CATASTROPHIC HEALTH POLICIES
Catastrophic health policies usually provide secondary or supplemental coverage and provide benefits after a high deductible is met.

FIXED-COST POLICIES
Indemnity plans usually pay a fixed amount per day or week for a given illness when an individual is hospitalized or disabled and does not have coordination of benefits clauses.

Most indemnity polices allow individuals to file claims when they are incurred for covered expenses.

1.1.1.3. Confirming Coverage And Benefits By Phone

There is no reason at all for anyone to get confused over trying to understand all their health insurance coverage.

Individuals can call the insurance company’s claims department to confirm their coverage and learn how to file their medical insurance claims.

TO SAVE TIME:

- If an individual has Medicare, hospitals, clinics, physicians, and other health care providers are required by Medicare to file the claim directly.
- Individuals should be prepared to discuss their current or anticipated medical condition and their insurance deductible, policy provisions, coverage areas and file requirements with the claims representative.

1.1.1.4. Making Sure Of Deductibles

Individuals should always confirm how a deductible is calculated. Make notes concerning the specified amount of certain costs that are their responsibility before they can expect to receive any reimbursements.

Remember that deductibles are based on what is considered by the company to be “reasonable and customary”. Eligible expenses can be different from actual expenses. For example, if an individual incurs a $300 bill, the insurance company may only consider $150 of that bill to be reasonable and customary. As a result $150, not $300 is applied to your deductible.

If there is more than one policy, each may have a different way of figuring its deductible.

1.1.1.5. Renewal Periods For The Deductible

Most policies require that a deductible amount be met each calendar year before claims will be paid. Since there are variations as to the length of time a benefit period runs once a deductible has been met always confirm your deductible renewal periods with your insurance company claims representative. Remember to record this information for future reference.

1.1.1.6. Preparing A Master Claim Form Will Save Time
Once an individual has confirmed their coverage and recorded what they need to know on each of their health insurance policies, they will save considerable time when filing future claims by preparing a Master Claims form for each of their policies.

To prepare a Master Claims form, they can take a blank insurance company claims form and fill in the following information in the appropriate boxes:

- The policy number, name, address and Social Security number of the insured.
- Any additional health insurance coverage that the family of the insured carries.
- The signature of the insured.

Then, whenever they need to file a claim simply make a copy of the Master Claim's form and fill in the information on their copy that pertains to the bills that they are submitting.
HOW TO ELIMINATE PAPERWORK
The mounds of insurance paperwork can quickly baffle anyone with more than one bill from a doctor, hospital clinic or laboratory. This chapter will review the steps that will help avoid this confusion.

ORGANIZE AND KEEP TRACK OF MEDICAL EXPENSES
Each individual is responsible for all of their medical bills!

Whether the individual or their hospital physician or other medical provider files the health insurance claims, they will need to keep track of all expenses. They should keep a different set of records for each family member since insurance companies pay claims on each individual insured.

Most people who are filing claims will already have accumulated more than one bill from a physician, hospital pharmacy, laboratory, clinic, ambulance, or other health care providers. They must begin by sorting all the bills and other paperwork such as receipts in date order by when medical services were received.

Then make a record of these bills in date order. It will then be easy to identify insurance reimbursements and provider payments for specific bills when they arrive.

The insured should keep a record all of their bills, even if the doctor, hospital or other providers are filing them directly to with the insurance company.

- First, record the date or dates of service for each charge. This may be a single date or multiple dates if the provider's bill is for more than one charge.
- Fill in the name of the physician, hospital laboratory, pharmacy, medical supply company, ambulance, dentist, or physical therapist.
- List all of the individual charges itemized on the provider's bill.
- Attach any doctor's NOTE OF MEDICAL NECESSITY for medical equipment; physical speech and occupational therapy, private-duty nursing care and private hospital room. The note must be written by the ordering physician and must include diagnosis and, when applicable, frequency and duration of treatment.
- Make a photocopy of each bill claims form and any supporting material before sending anything to the insurance company.

UNTANGLING WHAT IS OWED & REIMBURSEMENTS
Most people are confused and even overwhelmed when the insurance company Explanation of Benefits begins to arrive.

That is because it is difficult to keep track of problems such as these:

- Which insurance claims have been paid. (This is especially difficult when an Explanation of Benefits statement does not include the name of the provider or when cumulative reimbursements for multiple charges of multiple service dates are combined).
- Whether those who have provided medical services have been directly paid by the insurance company.
- How to recognize an underpaid or denied claim. (This is particularly confusing when special messages are computer coded, making it difficult to know why a claim has been denied or underpaid.)

To overcome the preceding problems quickly and easily, dates and the amounts on each Explanation of Benefits statement should be matched to the statements received from the provider of the services.

- In one column, record the amount that the insurance company paid corresponding to the specific bill you recorded earlier in the first column.
In the next column, record the date the reimbursement check was issued. This date can be taken from the check or from the date on the Explanation of Benefits.

In the next two columns, check who received payment from the insurance company.

Indicate "me" if the insured received payment.

Indicate "provider" if the provider received a check directly from the insurance company.

Never endorse an insurance check to a hospital physician or other provider. Individuals should issue their own personal check or bank charge so they have a record of payment if there is an error in crediting their account.
2. UNDERSTANDING MEDICARE CLAIMS

Medicare is a health insurance program for
- Individuals age 65 or older,
- Individuals under age 65 with certain disabilities, and
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

2.1.1.1.1. Medicare Part A

Hospital Insurance - Most people don’t pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.

2.1.1.1.2. Medicare Part B

Medical Insurance - Most people pay a monthly premium for Part B.
Prescription Drug Coverage - Most people will pay a monthly premium for this coverage.

2.1.1.1.3. Medicare Plans

Today’s Medicare brings more choices in how to get health care:
- The Original Medicare Plan
- Medicare Advantage Plans
- Medicare Health Maintenance Organization (HMO) Plans
- Medicare Preferred Provider Organization (PPO) Plans.
- Medicare Special Needs Plans.
- Medicare Private Fee-for-Service (PFFS) Plans.
- Other Medicare Health Plans (that aren’t Medicare Advantage Plans).
- Medicare Cost Plans
- Demonstrations
- PACE
- Medicare Prescription Drug Plans.

MEDICARE PART A

Medicare Part A: (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Individuals must meet certain conditions to get these benefits.

2.1.1.1.4. Cost

Most people don’t have to pay a monthly payment, called a premium, for Part A. This is because they or a spouse paid Medicare taxes while working.

For those who don’t get premium-free Part A, they may be able to buy it.

Individuals who must pay a premium for Part A include:
- Individual (or their spouse) who aren’t entitled to Social Security, because they didn’t work or didn’t pay enough Medicare taxes while they worked and are age 65 or older, or
- Individuals who are disabled but no longer get free part because they have returned to work.

2.1.1.1.5. What Hospital Insurance Protection Does Medicare Provide?
Persons protected have benefits paid for certain hospital and related health care services when they incur expenses for such services.

A person entitled to social security monthly benefits or a qualified railroad retirement beneficiary is automatically entitled to Hospital Insurance protection beginning with the first day of the month of attainment of age 65. An individual who is insured for monthly benefits need not actually file to receive benefits. However, benefits are usually not paid for services furnished outside the United States.

Medicare does not pay for services covered under automobile medical, no-fault, or liability insurance. It also does not pay for services covered under an employer’s group health plan if an employed individual (and his spouse) decide to be covered by the employer’s plan while entitled to Medicare Hospital Insurance protection. In these cases, the employer’s plan, or the automobile medical, no-fault, or liability insurance, pays its benefits first. Medicare may then pay for any services not covered in whole or in part by the insurance or the employer’s plan.

Medicare Part A Helps Cover Medically Necessary:

2.1.1.6. Hospital Stays:
Include semiprivate room, meals, general nursing, and other hospital service and supplies, inpatient care in critical access hospitals and mental health care.

This does not include:
- Private duty nursing, or a television or telephone in the room.
- A private room, unless medically necessary.

Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

2.1.1.7. Skilled Nursing Facility Care:
Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (only after a related three-day inpatient hospital stay).

2.1.1.8. Home Health Care:
Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language services that are ordered by the doctor and provided by a Medicare-certified home health agency. Also includes medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice Care
For people with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare (like grief counseling).

Hospice care is usually given in the home (which may include a nursing facility if this is your home). However, Medicare covers some short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest).

2.1.1.9. Blood:
Pints of blood you get at a hospital or skilled nursing facility during a covered stay.

Costs for these services vary, depending on the plan choose
MEDICARE PART B
Medicare Part B (Medical Insurance) helps cover doctors’ services and outpatient care. It also covers some other medical services that Part A doesn’t cover, such as some of the services of physical and occupational therapists, and some home health care.

Part B helps pay for these covered services and supplies when they are medically necessary.

Cost: The recipient pays the Medicare Part B premium each month. In some cases, this amount may be higher if the individual didn’t sign up for Part B when they first became eligible.

Caution: If an individual does not take Part B when they are first eligible, the cost of Part B will go up 10% for each full 12-month period that they could have had Part B but didn’t sign up for it, except in special cases (see employer or union coverage information on page in another segment of this book). This penalty will have to be paid as long the individual has Part B coverage.

Individuals will also pay a Part B deductible each year before Medicare starts to pay its share. Individuals may be able to get help from their state to pay this premium and deductible.

Medicare deductible and premium rates may change every year in January.

PART B & GROUP HEALTH COVERAGE FROM AN EMPLOYER OR UNION
It’s important that an individual understands how their Part B enrollment rights can be affected if they or their spouses are still working, and they have coverage through an employer or union, or under COBRA.

The decision about when to sign up for Part B can also affect the rights to buy a Medigap policy.

MEDICARE PART B HELPS COVER MEDICALLY NECESSARY:

2.1.1.10. Medical and Other Services:
Doctors’ services (not routine physical exams except for a “Welcome to Medicare” one-time physical exam within the first six months an individual has Part B).

Outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers).

It also covers a second, and sometimes a third, surgical opinion for surgery that isn’t an emergency (in some cases), outpatient mental health care, and outpatient occupational and physical therapy, including speech-language services. (These services are also covered for long-term nursing home residents.)

2.1.1.11. Clinical Laboratory Services:
Blood tests, urinalysis, some screening tests, and more.

2.1.1.12. Home Health Care:
Limited to reasonable and necessary part-time or intermittent skilled nursing care and home health aide services as well as physical therapy, occupational therapy, and speech-language therapy that are ordered by the doctor and provided by a Medicare-certified home health agency.

Also includes medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

2.1.1.13. Outpatient Hospital Services:
Hospital services and supplies received as an outpatient as part of a doctor’s care.
2.1.1.14. Blood:
Pints of blood an individual gets as an outpatient or as part of a Part B-covered service. Costs for these services vary, depending on the plan chosen.

PREVENTIVE SERVICES COVERED BY MEDICARE PART B

2.1.1.15. Bone Mass Measurements
These measurements help determine if an individual is at risk for broken bones. Medicare covers these measurements once every 24 months (more often if medically necessary) for people with Medicare at risk for osteoporosis.

2.1.1.16. Cardiovascular Screenings
To prevent a heart attack or stroke, Medicare covers screening tests for cholesterol, lipid, and triglyceride levels every five years.

2.1.1.17. Colorectal Cancer Screening
These tests help find pre-cancerous growths so they can be removed and prevent cancer. They also help find colorectal cancer early, when treatment is most effective.
For individuals age 50 or older, or those who are at high risk for colorectal cancer, one or more of the following tests are covered:
- Fecal Occult Blood Test, Flexible Sigmoidoscopy,
- Screening Colonoscopy, and/or Barium Enema.

How often Medicare pays for these tests depends on the test an individual and their doctor decide are best and the individual's level of risk for this cancer.

2.1.1.18. Diabetes Screenings
Medicare covers tests to check for diabetes. These tests are available for individuals who have any of the following risk factors:
- high blood pressure,
- dyslipidemia (history of abnormal cholesterol and triglyceride levels,
- obesity, or a history of high blood sugar.

Medicare also covers these tests if an individual has two or more of the following characteristics:
- Age 65 or older,
- Overweight,
- Family history of diabetes (parents, brothers, sisters), and
- A history of gestational diabetes (diabetes during pregnancy), or
- Delivery of a baby weighing more than 9 pounds.

Based on the results of these tests, an individual may be eligible for up to two diabetes screenings every year.

2.1.1.19. Flu Shots
These shots help prevent influenza, or flu virus. Medicare covers these shots once a flu season in the fall or winter for all people with Medicare.

2.1.1.20. Glaucoma Tests
These tests help find the eye diseases glaucoma. Medicare covers these tests once every 12 months for people with Medicare at high risk of glaucoma.

2.1.1.21. **Hepatitis B Shots**

These three shots help protect people from getting Hepatitis B. Medicare covers these shots for people with Medicare at high or medium risk for Hepatitis B.

2.1.1.22. **Pap Test and Pelvic Exam (includes clinical breast exam)**

This shot helps prevent pneumococcal. These exams check for cervical and vaginal cancers. Medicare covers these exams every 24 months for all women with Medicare and once every 12 months for women with Medicare at high risk.

2.1.1.23. **Pneumococcal Shot**

This shot helps prevent pneumococcal infections. Medicare covers this shot for all people with Medicare. Most people only need this shot once in their lifetime.

2.1.1.24. **Prostate Cancer Screening**

These tests help find prostate cancer. Medicare covers a digital rectal exam and Prostate Specific Antigen (PSA) test once every 12 months for all men with Medicare over age 50.

2.1.1.25. **Screening Mammograms**

These tests check for breast cancer before an individual or their doctor may be able to feel it. Medicare covers mammograms once every 12 months for all women with Medicare age 40 and older.

2.1.1.26. **“Welcome to Medicare” Physical Exam”**

(A one time exam) Medicare covers a one-time review of an individual’s health, as well as education and counseling about the preventive services they may need, including certain screenings and shots. Referrals for other care are also covered.

An individual must have the physical exam within the first six months that they have Medicare Part B.

**MEDICARE COVERED ITEMS AND SERVICES**

Below is a list of common items and services Medicare covers if they are medically necessary. If an item or service an individual needs isn’t listed, they should call 1-800-MEDICARE (1-800-633-4227) and ask about it. TTY users should call 1-877-486-2048. This information is also available at www.medicare.gov on the web.

- Ambulance services—when it’s medically necessary to be transported to a hospital or skilled nursing facility, and transportation in any other vehicle would endanger the individual’s health.
- Chiropractic services—manipulation of the spine to correct a subluxation (when one or more of the bones of the spine moves out of position).
- Clinical trials — routine costs if an individual takes part in a qualifying clinical trial (doesn’t cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial).
- Diabetic Self-Management Training—for certain people with Medicare at risk for complications from diabetes. The doctor or other health care provider must request this service.
- Diabetic supplies —glucose testing monitors, blood glucose test strips, lancet devices and lancets, glucose control solutions, and therapeutic shoes (in some cases) Syringes and insulin
aren't covered (unless used with an insulin pump) unless the individual joins a Medicare Prescription Drug Plan.

• Durable medical equipment—items such as oxygen, wheelchairs, walkers, and hospital beds needed for use in the home.

• Emergency room services—when the individual believes their health is in serious danger, when every second counts. An individual may have a bad injury, sudden illness, or an illness quickly getting much worse.

• Eyeglasses—one pair of eyeglasses with standard frames after cataract surgery that includes implanting an intraocular.

• Foot exams and treatment—if an individual has diabetes-related nerve damage and meets certain conditions.

• Hearing and balance exams—if the doctor orders them to see if medical treatment is needed (hearing aids and exams for fitting hearing aids aren’t covered).

• Kidney dialysis services —kidney dialysis, and services and supplies, either in a facility or at home.

• Long-term care —only skilled care given in a certified skilled nursing facility or in your home (not custodial care).

• Medical nutrition therapy services—for people who have diabetes, or for people who have kidney disease (unless they are on dialysis) with a doctor’s referral for three years after a kidney transplant.

• Mental health care —inpatient or outpatient; certain limits and conditions apply.

• Practitioner services —such as those provided by clinical social workers, physician assistants, and nurse practitioners.

• Prescription drugs—Medicare Part B covers limited prescription drugs, like certain injectable cancer drugs. For information about more complete prescription drug coverage, see that section in this book.

• Prosthetic/orthotic items—arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); breast prostheses (after mastectomy); prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy).

• Second surgical opinions—covered in some cases.

• Smoking cessation counseling—inpatient or outpatient services, up to eight face-to-face visits during a 12-month period if an individual is diagnosed with a smoking-related illness.

• Surgical dressings—if required for treatment of a surgical or surgically treated wound.

• Telemedicine—services in some rural areas.

• Tests —X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests if medically necessary.

• Transplant services —heart, lung, kidney, pancreas, intestine, and liver transplants (under certain conditions and in a Medicare-certified facility only), and bone marrow and cornea transplants (under certain conditions); immunosuppressive drugs if the transplant was paid for by Medicare,
or paid by an employer group health plan that was required to pay before Medicare (the individual must have been entitled to Part A at the time of the transplant and entitled to Part B at the time they got immunosuppressive drugs, and the transplant must have been performed in a Medicare-certified facility).

- Travel (outside the United States) — services provided in Canada when an individual travels between Alaska and another state. Medicare also covers hospital, ambulance, and doctor services if the individual is in the United States, but the nearest hospital that can treat the individual isn’t in the United States. (The “United States” means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and for services that you received while on board a ship, the territorial waters adjoining the land areas of the United States.)

- Urgently needed care—care an individual needs for a sudden illness or injury that isn’t a medical emergency.

**Important:** These items and services are covered no matter what kind of Medicare plan an individual has chosen. The amount Medicare pays for these items and services depends on the type of plan the individual selected.

**WHAT IS NOT COVERED BY MEDICARE PART A & B**
Medicare doesn’t cover everything. Items and services that aren’t covered include, but aren’t limited to:

- Acupuncture.
- Deductibles, coinsurance, or co-payments when an individual gets health care services.
- Dental care and dentures (with only a few exceptions).
- Cosmetic surgery.
- Custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home.
- Eye refractions.
- Health care an individual gets while traveling outside of the United States (except as listed elsewhere in this booklet).
- Hearing aids and hearing exams for the purpose of fitting a hearing aid.
- Hearing tests (other than for fitting a hearing aid) that haven’t been ordered by a doctor.
- Long-term care, such as custodial care in a nursing home.
- Orthopedic shoes (with only a few exceptions).
- Prescription drugs—most prescription drugs aren’t covered routine foot care such as cutting of corns or calluses (with only a few exceptions).
- Routine eye care and most eyeglasses.
- Routine or yearly physical exams. (Medicare will cover a one-time physical exam within the first six months an individual has Part B.)
• Screening tests and screening laboratory tests except those listed elsewhere in this book.

• Shots (vaccinations) except those listed elsewhere in this book.

• Some diabetic supplies (like syringes or insulin unless the insulin is used with an insulin pump or the individual joins a Medicare Prescription Drug Plan).

Some of these services may be covered if an individual joins a Medicare Advantage Plan or other Medicare Plan.

2.1.1.27. Who Is Permitted to Provide Services & Supplies Under Medicare?

Health care organizations and professionals providing services to Medicare beneficiaries must meet all licensing requirements of state or local health authorities. The organizations and persons listed below also must meet additional Medicare requirements before payments can be made for their services:

• Hospitals
• Skilled Nursing facilities
• Home Health agencies
• Hospice programs
• Independent diagnostic laboratories and organizations providing X-ray services
• Organizations providing outpatient physical therapy and speech pathology services
• Facilities providing outpatient rehabilitation facilities
• Ambulance firms
• Chiropractors
• Independent physical therapists (those who furnish services in the patient’s home or in their offices)
• Facilities providing kidney dialysis or transplant service
• Rural health clinics

All hospitals, skilled nursing facilities, and home health care agencies participating in the Medicare program must comply with title VI of the Civil Rights Act, which prohibits discrimination because of race, color, or national origin.

Medicare does not pay for care received from a hospital, skilled nursing facility, home health agency, or hospice that is not certified to participate in the program. Such providers are referred to as non-participating. But Hospital Insurance can help pay for care in a qualified non-participating hospital if:

• The patient is admitted to the non-participating hospital for emergency treatment, and
• The non-participating hospital is the closest one that is equipped to handle the emergency. Under Medicare, emergency treatment means treatment that is immediately necessary to prevent death or serious impairment to health.

If the non-participating hospital elects to submit the claim for Medicare payment, Medicare will pay the hospital directly except for any deductible or coinsurance amounts. If the hospital does not submit the claim, the patient may submit and receive payment. In this case, the patient would reimburse the hospital.

WHAT IS MEDICARE PRESCRIPTION DRUG COVERAGE?

Medicare prescription drug coverage helps cover an individual’s prescription drug costs. Each individual must choose a plan to get this coverage.

The individual will pay a monthly premium. If an individual has limited income and resources, they may get this coverage for little or no cost.

An individual can choose to take advantage of this coverage by joining a Medicare Prescription Drug Plan that covers prescription drugs only, and keep the rest of the Medicare coverage just the way it is.

They may also join a Medicare Advantage or other Medicare Health Plan that covers their doctor and hospital care as well as prescriptions. Important: If someone has prescription drug coverage through an employer or union, they should check with their benefits administrator to discuss their options.

How much will drug insurance cost?

Individual costs will vary depending on individual financial situations and which drug plan is chosen.

Individuals should check with the drug plans in their area to compare their costs and what they cover.

Standard coverage is described in detail in another section of this book. Plans may offer more coverage and have different premiums and cost sharing.

Drug Coverage when someone has Employer or Union Plan Coverage?

Medicare will help employers and unions continue to provide retiree drug coverage that meets Medicare’s standards. If someone currently has prescription drug coverage through an employer or union that is, on average, at least as good as the minimum standard Medicare prescription drug coverage, they can keep it as long as it is still offered by their employer or union.

The employer can let the individual know if the current coverage, on average, is at least as good as the standard Medicare prescription drug coverage. Individuals will have a Special Enrollment Period to sign up for a drug plan if their employer or union stops offering this coverage.

When Is A Medicare Card Issued?

A Medicare card is issued to a person after he becomes eligible for Medicare benefits. The card shows the person’s coverage (Hospital Insurance, Supplementary Medical Insurance and Catastrophic Drug Insurance, or both) and the date protection started. The card also shows the person’s health insurance claim number.

The claim number has nine digits and a letter. On some cards, there will be another number after the letter. The full claim number must always be included on all Medicare claims and correspondence. When a husband and wife both have Medicare, they will receive separate cards and different claim numbers. Each spouse must use the exact name and claim number shown on his card.

Important Points to Remember:
The patient should always show his Medicare card when receiving services that Medicare can help pay for.

- The patient should always write his health insurance claim number (including the letter) on any bills he sends in and on any correspondence about Medicare. The patient should have the Medicare card available when making a telephone inquiry.

- The patient should carry the card whenever away from home. If it is lost, immediately ask a representative at any Social Security office for a new card.

The patient should use his Medicare card only after the effective date shown on the card.

- Medicare cards made of metal or plastic, which are sold by some manufacturers, are not substitute for the officially issued Medicare card.

- Never permit someone else to use your card.

**Protect Yourself from Identity Theft and Fraud**

Identity theft means someone uses someone else’s personal information, like name; Social Security, Medicare, or credit card number; or other personal information, without consent in order to commit fraud or other crimes.

This information should be kept safe. It should not given to anyone who comes to your home (or calls you) uninvited selling Medicare-related products.

Personal information should be given only to doctors or other providers that are approved by Medicare and to people in the community who work with Medicare like State Health Insurance Assistance Programs or the Social Security Administration.

To verify if a provider is approve by Medicare Call 1-800-MEDICARE.

If a Medicare card is lost or stolen, a new Social Security number is needed, go to www.socialsecurity.gov on the web, or call the Social Security Administration at 1-800-772-1213.

If an individual gets benefits from the Railroad Retirement Board (RRB), they can call their local RRB office or 1-800-808-0772, or visit www.rrb.gov on the web.

If someone thinks that someone is using their personal information, they can call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, or

- the Fraud Hotline of the HHS Office of the Inspector General at 1-800-447-8477. TTY users should call 1-800-377-4950, or


For more information about identity theft, visit www.consumer.gov/idtheft on the web.

**MEDICARE COVERAGE OPTIONS**

Medicare covers many of health care needs. Today’s Medicare is working with private companies to bring new options to meet both health care and prescription drug needs.

An individual’s decisions are important because they affect things like how much they pay and what is covered.
Individuals can get their Medicare health care and prescription drug coverage in different ways:

**THE ORIGINAL MEDICARE PLAN**
This is a fee-for-service plan that covers many health care services and certain drugs. An individual can go to any doctor or hospital that accepts Medicare.

A later chapter describes the Original Medicare Plan, including how it works, what costs are involved, and how an individual can buy a Medigap (Medicare Supplement Insurance) policy and join a Medicare Prescription Drug Plan to cover costs not covered in Original Medicare.

**MEDICARE ADVANTAGE PLANS AND OTHER MEDICARE HEALTH PLANS**
These plans, which include HMOs, PPOs, and PFFS plans, may cover more services and have lower out-of-pocket costs than the Original Medicare Plan.

However, in some plans, like HMOs, individuals may only be able to see certain doctors or go to certain hospitals.

A later chapter describes Medicare Advantage Plans and Other Medicare Health Plans, including what they are, how they work, how individuals can get a Medicare health plan that includes prescription drug coverage, and the costs involved.

**MEDICARE DRUG PLANS**
Medicare prescription drug coverage started January 1, 2006. Individuals can get prescription drug coverage no matter how they get their Medicare health care.

A later chapter describes Medicare prescription drug coverage and explains how individuals can add this important coverage by joining a Medicare Prescription Drug Plan. It also explains how this new prescription drug coverage may affect any prescription drug coverage they may already have.

**THE FRAUD AND ABUSE HOTLINE**
If a person has reason to believe that a doctor, hospital or other provider of health care services is performing unnecessary or inappropriate services, or is billing Medicare for services he did not receive, he can report evidence of fraud, waste or abuse to the Health Care Financing Administration by using a toll-free Hot Line.

The toll-free number is 1-800-368-5779. In Maryland, call 1-800-638-3986. A person can send his complaints in writing to HHS; OIG, Hot Line, P.O. Box 17303, Baltimore, Maryland 21203-7303.

**CONSIDERATIONS WHEN CHOOSING MEDICARE COVERAGE**

2.1.1.28. **Cost**
What will be paid out-of-pocket, including premiums?

2.1.1.29. **Benefits**
- Are extra benefits and services, like additional drug coverage, eye exams or hearing aids covered? These may be covered by some plans.
- Doctor and hospital choices
- Can an individual see the doctor(s) they want to see?
- Do they need a referral to see a specialist?
- Can they go to the hospital they want?
2.1.1.30. Convenience

- Where are the doctors’ offices?
- What are their hours?
- Is there paperwork?
- Are they accepting new patients?
- Do you spend part of each year in another state?

2.1.1.31. Prescription drugs

- Are they covered?
- Are their prescription drugs on the plan’s list of covered drugs (formulary)?

2.1.1.32. Pharmacy choice

- Can individuals use the pharmacy they want?
- Are the pharmacies convenient?

2.1.1.33. Quality of care

- How is the quality of the plans in their area?

Information about quality is available at www.medicare.gov on the web.

Focus Points

1. Medicare is a federal health insurance program for persons 65 or older, persons of any age with permanent kidney failure, and certain disabled persons.

2. Medicare consists of hospital insurance protection (Part A) and medical insurance (Part B).

3. The Department of Health and Human Services contracts with private insurance companies for the processing of payments to patients and health care providers.

4. Under Part B, the private insurance companies are called carriers.

5. Providers who are not certified to participate in the program are called non-participating.

6. Under the Basic Hospital Plan, care in a psychiatric hospital is subject to a lifetime limit of 190 days.

7. Medicare does not cover custodial care or care that is not “reasonable and necessary” for the diagnosis or treatment of an illness injury.

8. Care is considered custodial when it is primary for the purpose or meeting personal needs and could be provided by persons with out profession skills or training.

9. Waiver or Beneficiary Liability is the provision in which an individual will not be held responsible for paying for care if he could not reasonably be expected to know Medicare did not cover it.
3. THE ORIGINAL MEDICARE

The Original Medicare Plan is one of the health plan choices as part of the Medicare Program. Individuals stay in the Original Medicare Plan unless they choose to join a Medicare Advantage Plan or other Medicare Health Plan.

How does the Original Medicare Plan work?

The Original Medicare Plan is a fee-for-service plan that is managed by the Federal Government. The rules for how the Original Medicare Plan works are below.

- Individuals use their red, white, and blue Medicare card when they get health care.
- Individuals that have Medicare Part A, get all the Part A-covered services.
- Individuals that have Medicare Part B, get all the Part B-covered services. They usually pay a monthly premium for Part B.
- Individuals can go to any doctor or supplier that accepts Medicare and is accepting new Medicare patients, or to any hospital or other facility.
- Individuals pay a set amount for their health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and the individual pays their share (coinsurance or co-payment) for covered services and supplies (unless they have a Medigap policy).
- Monthly, after getting a health care service, the individual gets a Medicare Summary Notice (MSN) in the mail.

The notices are sent by companies that handle bills for Medicare.

The notice lists the details of the services received and the amount that an individual may be billed.

For more information about the Medicare Summary Notice, visit www.medicare.gov on the web and select "Medicare Billing."

Individuals getting Medicare Part B drugs (like certain cancer drugs) during their doctor’s visit may get two Medicare Summary Notices.

One notice will be for their doctor’s visit. The second notice will have the name and address of the company where their doctor ordered the drug. This notice will let the individual know if the claim for the doctor administered drug is approved or denied. If an individual disagree with the information on the MSNs or with any bill they receive, they can file an appeal.

Individuals can get will information from their doctor on how to ask for an appeal. This information is also on the MSN.

COSTS IN THE ORIGINAL MEDICARE PLAN

What an individual pays out-of-pocket depends on:

- Whether an individual has Part A and/or Part B (most people have both).
- Whether the doctor or supplier accepts “assignment.”
- How often an individual needs health care.
• What type of health care is needed.

• Whether an individual chooses to get services or supplies not covered by Medicare. In this case, an individual would pay all the costs for these services themselves.

• Whether an individual has other health insurance coverage that works with Medicare.

If an individual has Medicare Part A and/or Part B, they will have to pay a part of the services they get. These costs can change each year. If you want to know the costs for a specific service, visit www.medicare.gov on the web for this information.

WHAT IS “ASSIGNMENT” IN THE ORIGINAL MEDICARE PLAN
Assignment is an agreement between people with Medicare, their doctors and other providers, and Medicare.

The person with Medicare agrees to let the doctor or other provider request direct payment from Medicare for covered Part B services, items, and supplies. Doctors or providers who agree to (or must by law) accept assignment from Medicare can’t try to collect more than the Medicare deductible and coinsurance amounts from the person with Medicare, their other insurance, or anyone else.

If assignment isn’t accepted, doctors and providers may charge individuals more than the Medicare-approved amount. For most services, there is a limit on the amount over the Medicare-approved amount the doctors and providers can bill the patient.

The highest amount of money a patient can be charged for a Medicare covered service by doctors and other providers who don’t accept assignment is called the limiting charge.

The limiting charge is 15% over Medicare’s approved amount. The limiting charge applies only to certain services and doesn’t apply to supplies and items. In addition, a patient may have to pay the entire charge at the time of service.

Medicare will send the patient its share of the charge when the claim is processed.

In some cases, the health care providers and suppliers must accept assignment.

For example, if an individual gets Medicare Part B-covered prescription drugs and biologicals from a pharmacy or supplier that is enrolled in the Medicare Program, the pharmacy or supplier must accept assignment.

Caution: If an individual gets their Medicare Part B-covered prescription drugs or supplies from a supplier or pharmacy not enrolled in the Medicare Program, the individual may have to file their own claim for Medicare to pay.

Doctors and other providers generally have to submit the claim to Medicare. For glucose test strips, all enrolled pharmacies and suppliers must submit the claim and can’t charge for this service.

To get more information about assignment, get a free copy of “Does your doctor or supplier accept assignment? ” (CMS Pub. No. 10134) or to find doctors and suppliers who participate in Medicare, visit www.medicare.gov on the web. Select “Search Tools” at the top of the page. You can also call 1-800-MEDICARE (1-800-633-4227) for this information.
PLANS THAT SUPPLEMENT THE ORIGINAL MEDICARE PLAN

MEDIGAP (MEDICARE SUPPLEMENT INSURANCE) POLICIES

The Original Medicare Plan pays for many health care services and supplies, but it doesn’t pay all of the health care costs or cover prescription drugs.

To help cover extra health care costs, individuals might want to get a Medigap policy.

WHAT IS A MEDIGAP POLICY?
A Medigap policy is a health insurance policy sold by private insurance companies.

They must follow federal and state laws. The front of the Medigap policy must clearly identify it as “Medicare Supplement Insurance.”

Costs that individuals must pay, like coinsurance, copayments, and deductibles, are called “gaps” in Original Medicare Plan coverage.

Individuals might want to consider buying a Medigap policy to cover these gaps in Original Medicare coverage.

Some Medigap policies also cover benefits that the Original Medicare Plan doesn’t cover, like emergency health care while traveling outside the United States.

A Medigap policy may help save on out-of-pocket costs.

In all states except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of 12 standardized policies (Plans A-L) so that an individual can compare them easily.

Each plan has a different set of benefits. Plans K and L are new policies that help limit high out-of-pocket costs for doctor’s services and hospital care.

They will likely have a lower premium than other Medigap policies. However, unlike Plans A-J, individuals will pay more of Medicare’s coinsurance and deductibles before the policy pays its share of these costs.

Two of the standardized policies (Plans F and J) may have a high-deductible option.

In addition, any standardized policy may be sold as a “Medicare SELECT” policy.

Medicare SELECT policies usually cost less because individuals must use specific hospitals and, in some cases, specific doctors to get full insurance benefits from the policy. In an emergency, individuals may use any doctor or hospital.

MEDICARE IN CONJUNCTION WITH A MEDIGAP POLICY?
Individuals may go to any doctor, specialist, or hospital (unless they buy a Medicare SELECT policy). Medicare pays its share, and then the Medigap policy pays its share. What the Medigap policy covers depends on which plan (Plan A-L) the individual buys. However, Medigap policies generally cover Medicare’s coinsurance, co-payments, and deductibles.

- Individuals pay their monthly Medicare Part B premium, and they pay the insurance company a monthly premium for their Medigap policy.

www.dynastyschool.com
• After an individual gets a health care service, in most cases each month the individual will get a Medicare Summary Notice in the mail and their Medigap insurance company will send them information on what it paid on their behalf.

**MEDICARE PRESCRIPTION DRUG PLANS**

How does the Original Medicare Plan work with a Medicare Prescription Drug Plan?

• Individuals pay a separate monthly premium for their prescription drug plan.

• Individuals pay a co-payment or coinsurance, and deductible for their prescription drugs.

• Individuals get a prescription card from their Medicare Prescription Drug Plan. They show it when they get their prescriptions filled.

• Individuals must go to pharmacies that belong to (are in the network of) the Medicare Prescription Drug Plan that they join.

• If they go to a pharmacy that isn’t part of the plan they join, in most cases, their drug won’t be covered and they will have to pay the full cost of the drug.

• Each Medicare Prescription Drug Plan has a list of covered prescription drugs which may vary from plan to plan. In most cases, only drugs on this list will be covered.

What if someone has a limited income and can’t afford a Medicare Prescription Drug Plan?

People with Medicare and Medicaid, and other people with limited income and resources can qualify for help paying their Medicare Prescription Drug Plan costs.

**HOW BILLS GET PAID IF AN INDIVIDUAL HAS OTHER INSURANCE**

**Health Insurance**

Sometimes the other insurance pays the health care bills first and the Original Medicare Plan pays second.

Other insurance that may pay first includes the following:

• Employer group health plan coverage when coverage is based on their or a family member’s current employment, no-fault insurance, liability insurance, black lung benefits, and workers’ compensation. In most cases, these types of insurance must pay first.

It’s important to tell the doctor and hospital that there is other insurance so they will know how to handle the bills correctly.

In some cases, if the insurance that is supposed to pay first doesn’t pay promptly, the Original Medicare Plan may make a “conditional” payment.

The Medicare payment is conditional because it must be repaid to Medicare when the insurance that is supposed to pay first makes a payment.

**MEDICARE ADVANTAGE PLANS?**

Medicare Advantage Plans are health plan options that are part of the Medicare Program.

If an individual joins one of these plans, they generally get all their Medicare-covered health care through that plan.
This coverage can include prescription drug coverage.

Medicare pays a set amount of money for an individual's care every month to these private health plans whether or not the services are used.

In most of these plans, generally there are extra benefits and lower co-payments than in the Original Medicare Plan.

However, individuals may have to see doctors that belong to the plan or go to certain hospitals to get services.

Medicare Advantage Plans include Medicare HMOs, Medicare PPOs, Medicare Special Needs Plans, and Medicare Private Fee-for-Service.

**WHAT ARE THE OTHER MEDICARE HEALTH PLANS?**

There are some types of Medicare Health Plans that are not part of Medicare Advantage. However, they are still part of the Medicare Program.

In some of these plans, individuals generally get all their Medicare-covered health care from that plan.

This coverage can include prescription drug coverage.

Medicare pays a set amount of money for an individual's care every month to these private health plans.

These other types of Medicare Health Plans include Medicare Cost Plans, Demonstrations, and PACE (Programs of All-inclusive Care for the Elderly.)
4. ADVANTAGE & OTHER PLANS

MEDICARE ADVANTAGE PLANS

MEDICARE HEALTH MAINTENANCE ORGANIZATION (HMOs) PLANS
Individuals generally must get their care from primary care doctors, specialists, or hospitals on the plan’s list (network) except in an emergency.

MEDICARE PREFERRED PROVIDER ORGANIZATION (PPOs) PLANS
In most of these plans, individuals pay less if they use primary care doctors, specialists, and hospitals on the plan’s list (network). Individuals can go to any doctor, specialist, or hospital not on the plan’s list, but it will usually cost extra.

MEDICARE SPECIAL NEEDS PLANS
These plans provide health care coverage designed for specific groups of people.

MEDICARE PRIVATE FEE-FOR-SERVICE (PFFS) PLANS
If individuals join one of these plans, they can go to any primary care doctor, specialist, or hospital that accepts the terms of the plan’s payment.

The private company, rather than the Medicare Program, decides how much it will pay and how much the individual pays for the services they get.

OTHER MEDICARE HEALTH PLANS

MEDICARE COST PLANS
In these plans, individuals can use primary care doctors, specialists, and hospitals on the plan’s list (network).

However, unlike Medicare Advantage Plans, if an individual gets services from a non-network provider, they are covered under the Original Medicare Plan.

Coverage in Medicare Cost Plans can include prescription drug coverage. These plans don’t provide free additional benefits or savings on the Medicare Part B or prescription drug coverage premiums.

Note: There are a limited number of Medicare Cost Plans.

DEMONSTRATIONS
These plans are special projects that test possible future improvements in Medicare coverage, costs, and quality of care.

PACE (PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY)
PACE combines medical, social, and long-term care services for frail elderly people.

If an individual joins a Medicare Advantage Plan or Other Medicare Health Plan

• they are still in the Medicare Program.
• they still have Medicare rights and protections (see Section 10).
• they still get all their regular Medicare-covered services.
• they may be able to get prescription drug coverage through the plan.
If individuals are in most Medicare Advantage Plans and other Medicare Health Plans, they must get their Medicare prescription drug coverage from the plan if it’s offered.

If they have a Medicare Private Fee-for-Service Plan that doesn’t offer Medicare prescription drug coverage, or if they have a Medicare Cost Plan, they can join a Medicare Prescription Drug Plan.

Individuals may be able to get extra benefits, such as coverage for vision, hearing, dental and/or health and wellness programs. However, they may have to see doctors that belong to the plan to get these services.

What an individual pays out-of-pocket in addition to the Part B premium depends on the plan’s monthly premium amount. Medicare Advantage Plans and other Medicare Health Plans will have one premium that includes coverage for Part A and Part B benefits, prescription drug coverage (if offered), and any extra benefits (if offered).

Individuals will have to pay other costs (such as co-payments or coinsurance) for the services they get. Generally, their out-of-pocket costs in these plans are lower than in the Original Medicare Plan.

**MEDICARE HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS**
These are the general rules for how Medicare HMOs work. For some of these rules, plans may differ slightly, so it’s important to read plan materials carefully.

- In most Medicare HMOs, there are doctors and hospitals that join the plan (called the plan’s “network”). Individuals generally must get their care and services from the plan’s network. Call or get a list from the plan to see which doctors and hospitals are in the plan’s network.

- When individuals join a plan, they may be asked to choose a primary care doctor.

- The primary care doctor is the doctor they see first for most health problems. In many HMOs, an individual must see their primary care doctor before they can see any other health care provider.

- If an individual wants to keep seeing their current doctor, they can call and ask if he or she is in the Medicare HMO and can continue to see the doctor.

- If an individual wants to change their primary care doctor, they can ask their plan coordinator for the names of other plan doctors in the area.

- Doctors can join or leave Medicare HMOs.

- If an individual’s primary care doctor should leave their plan, the plan will notify the individual in advance and give them a chance to pick a new doctor.

- If an individual gets health care outside of the plan’s network, they may have to pay for these services themselves. In some cases, neither the Medicare HMO nor the Original Medicare Plan will pay for these services.

- The service area is where the plan accepts members and where plan services are provided. Individuals are covered if they need emergency or urgently needed care and they aren’t in their HMO’s service area.

- Individuals usually need a referral to see a specialist (such as a cardiologist). A referral is a written OK from the primary care doctor for the individual to see a specialist or get certain services.
• There are special rules for certain services. If the individual is a woman, they can go once a year, without a referral for a screening mammogram. They can go every other year to a specialist in the network for Medicare-covered routine and preventive women’s care services. If the type of specialist needed isn’t available the plan will arrange for care outside the network.

Some Medicare HMOs offer a Point-of-Service option. This allows an individual to go to other doctors and hospitals who aren’t a part of the plan (“out-of-network”), but the individual may pay more.

If the Medicare HMO includes prescription drug coverage, the individual will pay a copayment or coinsurance for each covered prescription (unless they have Medicare and Medicaid, and are in an institution like a nursing home).

**MEDICARE PREFERRED PROVIDER ORGANIZATION (PPO) PLANS**

Medicare PPOs use many of the same rules as Medicare HMOs listed above and elsewhere in this book.

However, generally in a PPO individuals can see any doctor or provider that accepts Medicare.

Individuals don’t need a referral to see a specialist or any provider out-of-network. If they go to doctors, hospitals, or other providers who aren’t part of the plan (“out-of-network” or “non-preferred”), they will usually pay more.

Individuals may want to contact the plan before they get services to find out how much they will have to pay and to determine if the service they want is covered.

Generally, individuals will get more benefits for lower costs than the Original Medicare Plan.

Every PPO plan must pay for all covered services the individual gets out-of-network, but every plan is different in what the individual must pay.

Starting in 2006, regional PPOs became available in most areas of the country to give choices for Medicare health care coverage.

Also, local PPOs are now available in more areas of the country. Unlike local PPOs, which serve individual counties, regional PPOs will serve an entire region, which may be a single state or multi-state area.

This will help bring more plan options to people with Medicare.

Just like local PPOs, regional PPO members also will be able to get their Medicare prescription drug coverage from the PPO plan. In a regional PPO, members will have an added protection for Medicare Part A and Part B benefits. There will be an annual limit on their out-of-pocket costs. This limit will vary depending on the plan.

**MEDICARE SPECIAL NEEDS PLANS**

In 2005, Medicare Health Plans started to offer “Special Needs” Plans.

These plans may limit all or most of their membership to people

• in certain long-term care facilities (like a nursing home),
• eligible for both Medicare and Medicaid, or
• who have certain chronic or disabling conditions.

Special Needs Plans are available in limited areas.
The Special Needs Plan must be designed to provide Medicare health care and services to people who can benefit the most from things like special expertise of the plan’s providers, and focused care management. Special Needs Plans also must provide Medicare prescription drug coverage.

In most of these plans, generally there are extra benefits and lower co-payments than in the Original Medicare Plan.

For example, a Special Needs Plan for people with diabetes might have additional providers with experience caring for conditions related to diabetes, have focused special education or counseling, and/or nutrition and exercise programs designed to help control the condition. A Special Needs Plan for people with both Medicare and Medicaid might help members access community resources and coordinate many of their Medicare and Medicaid services.

To find out if any Medicare Special Needs Plans are available in your area:

- visit www.medicare.gov on the web. Select “Search Tools” at the top of the page.
- call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**MEDICARE PRIVATE FEE-FOR-SERVICE (PFFS) PLANS**

Medicare Private Fee-for-Service Plans are fee-for-service plans offered by private companies.

The general rules for how Medicare Private Fee-for-Service Plans work are below:

- Individuals can go to any Medicare-approved doctor or hospital that accepts the terms of the plan’s payment.
- Individuals may get extra benefits not covered under the Original Medicare Plan, such as extra days in the hospital.
- The private company, rather than the Medicare Program, decides how much it will pay and what the individual will pay for the services they get.
- Individuals in a Medicare Private Fee-for-Service Plan can get their Medicare prescription drug coverage from the plan if it’s offered, or they can join a separate Medicare Prescription Drug Plan to add prescription drug coverage if drug coverage isn’t offered by the plan.

**MEDICARE COST PLANS**

These are the general rules for how Medicare Cost Plans work. For some of these rules, plans may differ slightly, so it’s important to read plan materials carefully.

- Medicare Cost Plans are available in limited areas of the country.
- Medicare Cost Plans use many of the same rules as Medicare HMOs. However, in a Medicare Cost Plan
  - if an individual goes to a non-network provider, the services are covered under the Original Medicare Plan. Individuals would pay the Medicare Part A and Part B coinsurance and deductibles.
  - Individuals can join a Medicare Cost Plan anytime it is accepting new members.
  - Individuals can leave a Medicare Cost Plan at any time and return to the Original Medicare Plan.
Individuals can either get their Medicare prescription drug coverage from the plan if it’s offered, or they can buy a separate Medicare Prescription Drug Plan to add prescription drug coverage.

**DEMONSTRATIONS**
Demonstrations are special projects that test possible future improvements in Medicare coverage, costs, and quality of care. Demonstrations are usually for a specific group of people and/or are offered only in specific areas.

The results of demonstrations have helped shape many of the changes in Medicare over the years.

To find more information about demonstrations that individuals can join, visit [www.medicare.gov](http://www.medicare.gov) on the web or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**PACE (Programs of All-inclusive Care for the Elderly)**

PACE plans are offered in some states as an option under Medicaid.
COSTS OF ADVANTAGE & OTHER MEDICARE HEALTH PLANS
What an individual pays out-of-pocket each year depends on:

- Whether the plan charges a monthly premium in addition to their monthly Part B premium. Medicare Advantage Plans and other Medicare Health Plans will have one premium that includes coverage for Part A and Part B benefits, prescription drug coverage (if offered), and extra benefits (if offered).

- Whether the plan reduces the monthly Medicare Part B premium.

- How much the individual will pay for each visit or service.

- Type of health care needed and how often used.

- Types of extra benefits needed and whether the plan covers them, and whether they charge an additional premium.

SAVING ON MEDICARE PART B PREMIUM
Some Medicare Advantage Plans may pay all or part of Medicare Part B premium. If an individual joins a plan that offers this benefit, it may save them money. They would still get all Medicare Part A and Part B-covered services.

MEDICARE ADVANTAGE PLANS WITH PRESCRIPTION DRUG COVERAGE
Most Medicare Advantage Plans provide for options for coverage for prescription drugs. Individuals can take their current coverage, switch to another provider or return to the Original Medicare Plan and join a Medicare Prescription Drug Plan.

Note: Medicare prescription drug coverage is voluntary. In some cases, Medicare Advantage Plans or other Medicare Health Plans don’t offer prescription drug coverage and, in those cases, individuals can keep their current coverage or switch to the Original Medicare Plan if the individual does not want prescription drug coverage.

SAVING ON YOUR PRESCRIPTION DRUG COVERAGE PREMIUM
Individuals may have to pay a premium for Medicare prescription drug coverage, like they pay for Medicare Part B.

Some Medicare Advantage Plans and other Medicare Health Plans may pay all or part of the prescription drug coverage premium.

If an individual joins a plan that offers this benefit, it may save them money.

Individuals should read the plan materials carefully before joining to see if the Medicare Advantage Plan or other Medicare Health Plan they are interested in offer lower prescription drug coverage premiums.

Plans decide each year if they will reduce part or all of the prescription drug coverage premium.

HOW BILLS GET PAID IF ONE HAS OTHER HEALTH INSURANCE
Sometimes the other insurance pays the health care bills first and Medicare Advantage Plan or other Medicare Health Plan pays second.
Other insurance that may pay first includes employer group health plan coverage (when coverage is based on an individual’s or a family member’s current employment), no-fault insurance, liability insurance, black lung benefits, and workers’ compensation.

**MEDICARE PRESCRIPTION DRUG COVERAGE?**

Medicare Prescription Drug Coverage is insurance.

Private companies provide the coverage.

Individuals choose the drug plan and pay a monthly premium.

Like other insurance, if an individual decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

There are two types of Medicare plans that provide insurance coverage for prescription drugs.

There is prescription drug coverage that is a part of Medicare Advantage Plans and Medicare Health Plans.

Individuals get all of their Medicare health care through these plans.

There is also Medicare prescription drug coverage that adds coverage to the Medicare Plan, and some Medicare Cost Plans and Medicare Private Fee-for-Service Plans.

These plans are offered by insurance companies, and other private companies approved by Medicare. Both types of plans are referred to as drug plans in this section.

Like other insurance, Medicare drug coverage has a monthly premium. Individuals who have limited income and resources, may get extra help to cover prescription drugs for little or no cost.

The amount of the monthly premium is not affected by health status or how many prescriptions are needed.

Individuals will also pay a share of the cost of their prescriptions. All drug plans will have to provide coverage at least as good as the standard coverage, which Medicare has set. However, some plans might also offer more coverage and additional drugs for a higher monthly premium.

Individuals who have limited income and resources, may be able to get help with drug plan costs.

If an individual’s employer or other union offers drug coverage, they might not need to join a Original Medicare drug plan.

The prescription drug coverage option that an individual chooses affects:

4.1.1.1. Coverage

Medicare drug plans will cover generic and brand-name drugs. Plans may have rules about what drugs are covered in different drug categories. This makes sure people with different medical conditions can get the treatment they need.

Most plans have a formulary, which is a list of drugs covered by the plan.

This list must always meet Medicare’s requirements, but it can change when plans get new information. An individual’s plan must let them know at least 60 days before a drug they use is removed from the list or if the costs are changing.
If an individual’s doctor thinks they need a drug that isn’t on the list, or if one of the drugs is being removed from the list, the individual or their doctor can apply for an exception or appeal the decision.

4.1.1.2. Cost

Monthly premiums and an individual’s share of the cost of their prescriptions will vary depending on which plan they choose. Individuals who have limited income or resources, may qualify for extra help paying for their drug plan costs.

4.1.1.3. Convenience

Drug plans must contract with pharmacies in their area. Individuals should check with the plan to make sure the pharmacies in the plan are convenient to them. Some plans also allow individuals to get their prescriptions through the mail.

LIMITED INCOME AID PROGRAM?
If individuals have limited income and resources, they may qualify for extra help paying their prescription drug costs.

If an individual qualifies, they will get help paying for their drug plan’s monthly premium, yearly deductible, and prescription co-payments.

HOW DOES ONE QUALIFY FOR THIS PROGRAM?
The amount of extra help an individual receives will be based on their income and resources (including their savings and stocks, but not counting their home or car).

Based on 2005 figures, single individuals with resources of less than $11,500 and married individuals living with their spouses with resources of less than $23,000 would qualify for assistance.

IF AN INDIVIDUAL QUALIFIES FOR EXTRA HELP
An Individual must apply and choose and join a Medicare Prescription Drug Plan.

INDIVIDUALS AUTOMATICALLY QUALIFY
Individuals automatically qualify and not have to apply if they get supplemental security income, or help from a state Medicaid program paying their Medicare premium (belong to a Medicare Savings Program).

WHAT IS MEDICAID?
Medicaid is a joint Federal and State program that helps pay medical costs for some people with limited incomes and resources.

Most of an individual’s costs are covered if they have Medicare and Medicaid. Medicaid programs vary from state to state. People with Medicaid may get coverage for services such as nursing home and home health care that aren’t fully covered by Medicare.

The income limits for Medicaid vary from state to state. Individuals should contact their medical assistance office to see if they qualify.

MEDICARE SAVINGS PROGRAMS
States have programs for people with limited income and resources that pay Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance. These programs help millions of people with Medicare save money each year.
HOW DOES AN INDIVIDUAL QUALIFY FOR THIS PROGRAM?

- Individuals must have Medicare Part A. (If they are paying a premium for Medicare Part A, the Medicare Savings Program may pay the Medicare Part A premium for the individual.)

- Individuals must be an individual with resources of $4,000 or less, or a married couple with resources of $6,000 or less. Resources include things like money in a checking or savings account, stocks, and bonds.

- Individuals must be an individual with a monthly income of less than $1,097, or a married couple with a monthly income of less than $1,464. Income limits will change slightly in 2006. For individual living in Alaska or Hawaii, income limits are slightly higher.

SUPPLEMENTAL SECURITY INCOME BENEFITS

Supplemental Security Income (SSI) is a monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 or older.

SSI benefits provide cash to meet basic needs for food, clothing, and shelter. SSI benefits aren’t the same as Social Security benefits.

Individuals can make an appointment to apply for SSI benefits on the telephone or in person at their local Social Security office.

To qualify for SSI, individuals must have limited income and resources, and be disabled, blind, or age 65 or older. They also must be a resident of the United States, not be absent from the country for more than 30 days, and be either a U.S. citizen or national, or in one of certain categories of eligible non-citizens.

THE PACE PROGRAM

Pace combines medical, social, and long term care services for frail people. Some PACE programs may also provide Medicare prescription drug overage. Pace might be a better choice instead of a nursing home. Pace is only available in states that have chosen to offer it under Medicaid.

The qualifications for PACE vary from state to state.

OTHER PROGRAMS

There are programs for people with limited income and resources who live in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. Programs and qualifications vary in these areas.

JOINING AND SWITCHING PLANS

Sometimes people with Medicare decide to join a plan or switch to another plan. For example, a person who has the Original Medicare Plan might decide to switch to a Medicare HMO, or a person who has a Medicare PPO might decide to switch to the Original Medicare Plan. This section gives the information required about joining a Medicare Advantage Plan, or switching to another plan.

JOINING A MEDICARE ADVANTAGE OR OTHER MEDICARE PLAN?

Individuals can generally join if:

- They live in the service area of the plan that they want to join. The service area is where they must live for the plan to accept them as its member. In the case of a Medicare HMO, it also is usually where they get services from the plan. The plan can give them more information about its service area.
• They have Medicare Part A and Part B (except for Medicare Cost Plans where they may join one with only Part B.) However, if they are already in a Medicare Health Plan and have only Part B, they may stay in your plan.

• They don’t have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

WHO CAN JOIN A MEDICARE PRESCRIPTION DRUG PLAN?
Everyone with the Original Medicare Plan, a Medicare Private Fee-for-Service Plan that doesn’t offer prescription drug coverage, or a Medicare Cost Plan can join a Medicare Prescription Drug Plan in his or her area.

WHEN CAN ONE JOIN ONE OF THESE PLANS?
Individuals can join any Medicare Advantage Plan or other Medicare Health Plan, or Medicare Prescription Drug Plan available in their area:

1. When an individual first becomes eligible for Medicare, during the period that starts three months before the month they turn 65 and ends three months after the month they turn 65. If they get Medicare due to a disability, they can join three months before and after their 24th month of cash disability benefits.

2. Enrollment is November 15 to December 31st of each year. Enrollment is generally for the following calendar year.

4.1.1.4. How Does One Join A Medicare Advantage Plan Or Other Medicare Health Plan, Or Medicare Prescription Drug Plan?

Compare the Medicare Advantage Plans, other Medicare Health Plans, and Medicare Prescription Drug Plans available in the area. Once an individual has decided which plan they want, they should contact the plan that they are interested in for enrollment information.

For example, some plans will send them an enrollment form. They should fill out the form and mail it to the plan, or give it to the plan representative. They can get help filling out this form. They will get a letter from the plan telling you when their coverage begins.

RULES FOR PEOPLE WITH END-STAGE RENAL DISEASE:

Individuals having End-Stage Renal Disease (ESRD) and are in the Original Medicare Plan, may join a Medicare Prescription Drug Plan, but they usually can't join a Medicare Advantage Plan or other Medicare Health Plan.

However, if they are already in such a plan, they can stay in it or join another plan offered by the same company in the same state.

If they have had a successful kidney transplant, they may be able to join a Medicare Advantage Plan or other Medicare Health Plan.

Visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease, and Medicare Advantage Plans and other Medicare Health Plans. TTY users should call 1-877-486-2048.
HEALTH INSURANCE PRINCIPLES

If they have ESRD and are in a Medicare Advantage Plan or other Medicare Health Plan and the plan leaves Medicare or no longer provides coverage in their area, they have a one-time right to join another Medicare Advantage Plan or other Medicare Health Plan.

They don’t have to use their one-time right to join a new plan immediately. If they change directly to the Original Medicare Plan after their plan leaves or stops providing coverage, they will still have a one-time right to join a Medicare Advantage Plan or other Medicare Health Plan at a later date as long as the plan is accepting new members.

They may also be able to join a Medicare Special Needs Plan for people with ESRD if one is available in their area.

4.1.1.5. Can An Individual Keep Medigap (Medicare Supplement Insurance) Policy If They Join A Medicare Advantage Plan Or Other Medicare Health Plan?

Yes, they can keep it. However, they will have to keep paying their premiums and they may get a little or no benefit from it while they are in a Medicare Advantage Plan or other Medicare Health Plan.

If they join a Medicare Advantage Plan or other Medicare Health Plan, they will have to pay copayments and deductibles. Also, if their plan covers prescription drugs and they have a Medigap policy that covers prescription drugs, the drug coverage must be removed from the Medigap policy, and the premium changed. They can call their state Health Insurance Assistance Program if they need help deciding whether to keep their Medigap policy.

If they drop their Medigap policy, they may not be able to get it back, except in certain situations. If they join Medicare Advantage Plan or other Medicare Health Plan when they first become eligible for Medicare at age 65, or if this is the first time they have joined a Medicare Advantage Plan or other Medicare Health Plan, or a Medicare SELECT Policy, they may have special Medigap protections that gives them a right to get their old Medigap policy back or buy a new one later if they choose to leave their Medicare Prescription Drug Plan.

For more information on Medigap policies and protections, visit www.Medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) and get a free copy of “Choosing a Medigap Policy: A Guide to Health Insurance For People With Medicare”.

4.1.1.6. Can Someone Join A Medicare Advantage Plan Or Other Medicare Health Plan If They Have Employer Or Union Coverage?

If you join a Medicare Advantage Plan or other Medicare Health Plan and also have employer or union coverage, you may, in some cases, still be able to use this coverage along with your plan coverage. Talk to your employer or union benefits administrator about rules that apply. Remember, if you drop your employer or union coverage, you may not be able to rejoin it later.

SWITCHING A MEDICARE PLAN

4.1.1.7. When Can An Individual Switch Their Plan?

Generally, someone joining a Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan, can only change plans under certain circumstances.

They can choose to switch their current plan from November 15 through December 31 of every year. Enrollment is generally for the calendar year.
In certain cases, such as if they move or enter a nursing home, they can switch their plan at other times. After they request to switch, their plan will let them know, in writing, the date the coverage ends. If they don’t get a letter, they should call the plan and ask for the date.

4.1.1.1.8. How Is A Plan Switched?

Medicare plans can be switched in one of three ways:

1. Join another Medicare plan
2. Write or call the plan
3. Call 1-800-MEDICARE (1-800-633-4227)

After January 1, 2006, Medigap policies that includes prescription drug coverage are no longer available. In some cases, they may not be able to buy any Medigap policy.

4.1.1.1.9. What If Someone Moves Out Of The Plan's Service Area?

They may have to switch to another plan. However, they can call the plan to see if they can stay in the plan. If they must switch to another plan, they must follow the instructions for switching a Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan.

They can choose to join another Medicare Advantage Plan or other Medicare Health Plan if one is available in their new area, or join another Medicare Prescription Drug Plan.

They can join the Original Medicare Plan, because they moved out of the plan service area and they will then have the right to buy a Medigap policy.

4.1.1.1.10. What Can Someone Do If Their Plan Leaves The Medicare Program?

At the end of the year, their plan may decide to leave the Medicare Program. If their plan leaves the Medicare Program, the plan will send them a letter to notify them. The letter will tell them about their options.

4.1.1.1.11. Special Rules if a Medicare Advantage Plan or other Medicare Health Plan leaves the Medicare Program.

The individual will be automatically returned to the Original Medicare Advantage Plan or other Medicare Health Plan. They will have the right to buy a Medigap policy. In this case, they should learn as much as they can about their choices before making a decision. No matter what they choose, they are still in the Medicare Program and will get all Medicare-covered services.

If their plan covers prescription drugs and they want to keep getting prescription drug coverage, they need to join another plan that offers this coverage. If they decide to return to the Original Medicare Plan and want to continue to have drug coverage, they will have to join a Medicare Prescription Drug Plan.

4.1.1.1.12. What Can I Do If I Have To Leave My Medicare Advantage Plan Or Other Medicare Health Plan Because My Plan Reduces Its Service Area?
At the end of the year, an individual’s plan may decide not to provide services in all counties or ZIP codes in an area. If the plan reduces its service area and there are no other plans in the area, an individual may be able to keep their coverage with that plan. If the plan offers this option, an individual must agree to travel to the plan’s service area to get all their services (except for emergency and urgently needed care).

If the plan doesn’t offer this option, the individual will automatically return to the Original Medicare Plan on January 1. In this case, they will have the right to buy a Medigap policy.

**Caution:** Generally, individuals can only join one plan at a time. If they currently have a Medicare Advantage Plan, other Medicare Health Plan or Medicare Prescription Drug Plan and you enroll in another Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan, they will be disenrolled from the plan they have today when their enrollment in the new plan begins. People in some Private Fee-for-Service Plans and people in Medicare Cost Plans may also join a Medicare Prescription Drug Plan and be in both plans at the same time.

**Caution:** Individuals can’t call a Medicare Advantage Plan or other Medicare Health Plan to join over the telephone, unless they are switching to another plan offered by the same company, and the company offers that option. Also, if an individual joins a Medicare Prescription Drug Plan using the web, the plan must send them a bill. The plan can’t ask for payment at that time they join.

**OTHER INSURANCE**

Now is a good time for an individual to review all their health care coverage. In addition to Medicare, they may already have or are eligible for other health care coverage such as an employer or retiree coverage.

They also might be able to lower their out-of-pocket costs by buying other supplemental health coverage.

The coverage they have will affect how much they pay, what benefits they may have, which doctors they can see, and other things that maybe important to them. Other insurance and ways to pay health care costs include

1. Employer and Union health coverage.
2. Veteran’s Benefits.
4. Federal Employee Health Benefits Program (FEHB).
5. Paying for Long-Term Care.

**EMPLOYER OR UNION HEALTH COVERAGE**

Individuals should call the benefits administrator at their, their spouse’s or other family member’s current or former employer or union. Ask if they have or can get health care coverage based on their, their spouse’s, or other family member’s past or current employment.

When they have coverage from an employer or union, this coverage is voluntary. The employer or union generally has the right to change benefits and premiums, or stop offering coverage.

Medicare will help employers or unions continue to provide retiree drug coverage that meets Medicare’s standard. If an individual has prescription drug coverage based on their current or previous employment, their employer or union will notify them how their drug plan will work with the new Medicare Prescription Drug Plans. In some cases, if someone joins a Medicare Prescription Drug Plan, it can limit or end their employer or union coverage. Before an individual join a Medicare Prescription Drug Plan, they should call the employer’s or union’s benefit administrator.
Caution: If an individual drops their employer or union group health coverage, they may not be able to rejoin it later. They also may not be able to drop drug coverage without also dropping all their health coverage.

Veteran’s Benefits
If an individual is a veteran or has had any U.S. military service, they should call the U.S. Department of Veteran’s Affairs at 1-800-827-1000 or visit www.va.gov on the web for information about veterans’ benefits and services available in their area. Depending on how close they live to VA facility, they may be able to get their prescription drugs through the VA program.

Military Retiree Benefits
TRICARE is a health care program for active duty and retired uniformed services members and their families. It includes TRICARE Prime, TRICARE Extra, and TRICARE Standard. Medicare-eligible uniformed services retirees age 65 or older, and certain family members have access to expanded medical coverage known as TRICARE for Life (TFL). You must have Medicare Part A and Part B to get TFL benefits.

In general, Medicare pays first for Medicare-covered services. If Medicare doesn’t pay all of the bill, TRICARE might pay some of the costs as a second payer. TRICARE will also pay the Medicare deductible and coinsurance amounts, and for any services not covered by the Original Medicare Plan that TRICARE covers. TRICARE also covers prescription drugs.

For most information about the TRICARE programs, call 1-888-363-5433 or visit www.tricare.osd.mil on the web.

Federal Employee Health Benefits Program (FEHB)
The FEHB Program offers health coverage for current and retired Federal employees and covered family members. Generally, plans under the FEHB Program help pay for the same kind of expenses as Medicare. FEHB plans also provide coverage for prescription drugs, routine physicals, emergency care outside of the United States and some preventive services that Medicare doesn’t cover. Some FEHB plans also provide coverage for dental and vision care.

Pay for Long-Term Care
Long-term care can be very expensive. Since Medicare generally doesn’t cover this care, it’s very important to plan ahead before a crisis occurs. Individuals should think about how to get and pay for long-term care services before they need that type of care. Some options they may want to consider are explained below.

Long-Term Care Insurance
Long-term care insurance is sold by private insurance companies and usually covers medical care and non-medical care to help individuals with their personal care needs, such as bathing, dressing, using the bathroom, and eating.

For more information about long-term care insurance, get a copy of “A Shopper’s Guide to Long-Term Care Insurance” from either the State Insurance Department (call 1-800-MEDICARE to get the telephone number for a specific State Insurance Department), or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600. Or, call the State Health Insurance Assistance Program.
REVERSE MORTGAGE
An option for homeowners is a “reverse mortgage.” It allows some people to use the equity they have in their home as a source of income, without losing ownership. It is a type of loan. Talk to a lawyer or financial advisor about the benefits and risks of a reverse mortgage. Individuals can also look at www.medicare.gov on the web for more information. Select “Search Tools” at the top of the page.

LIFE INSURANCE
Some insurance companies let individuals use their life insurance policy to pay for long-term care.

PERSONAL RESOURCES
Individuals can use their savings to pay for long-term care. Once they have spent most of their resources, they may qualify for Medicaid.

For more information about long-term, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), to get a free copy of “Choosing Long-Term Care: A Guide for People with Medicare” (CMS Pub. N0. 02223).
5. MEDICARE RIGHTS

THE RIGHT TO APPEAL DENIED SERVICES
Individuals having Medicare, have certain guaranteed rights. One of these is the right to a fair, efficient, and timely process for appealing decisions about health care payment or services. **No matter what kind of Medicare plan an individual has, they always have the right to appeal.** Some of the reasons they may appeal include:

- A service or item they received isn’t covered, and they think it should be.
- A service or item is denied, and they think it should be paid.
- They question the amount that Medicare paid.

Information on how to file an appeal is on the Medicare Summary Notice (if they are in the Original Medicare Plan), in the health plan materials (if someone is in a Medicare Advantage Plan or other Medicare Health Plan), or in their drug plan materials (if they are in Medicare Prescription Drug Plan). If someone decides to file an appeal, they should ask their doctor or provider for any information that may help their case.

If an individual is in the Original Medicare Plan, they are protected from unexpected bills. A doctor or supplier may give them a notice that says Medicare probably (or certainly) won’t pay for a service. If they still want to get the service, they will be asked to sign an agreement that they will pay for the service themself if Medicare doesn’t pay for it. This is called an Advanced Beneficiary Notice.

Advance Beneficiary Notices are used in the Original Medicare Plan. Medicare Advantage Plans, other Medicare Health Plans, and Medicare Prescription Drug Plans have other ways of providing this information.

If someone isn’t sure if Medicare was billed for the services that they got, they should write to the health care provider and ask for an itemized statement. This statement will list each Medicare item or service they got from that provider.

The service recipient should get it within 30 days. They can also check their Medicare Summary Notice to see if the service was billed to Medicare. If the service was not billed to Medicare they can request a “Demand Bill”.

If an individual is in a Medicare Advantage Plan, other Medicare Health Plan, or Medicare Prescription Drug Plan, they can call their plan to find out if a service or item will be covered. The plan must tell them if they ask.

**FAST-TRACK APPEALS**
If an individual is enrolled in the Original Medicare Plan, they have the right to a fast appeal when their provider services are ending.

This fast appeal is called an expedited review. They can get an expedited review whenever they are discharged (or services are stopped) from an inpatient hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice. They will get a notice from their provider that will tell them how to ask for an appeal if they believe that their services are ending too soon.

They will be able to get an expedited review of this decision, with independent doctors looking at their case to decide if their services need to continue. If they decide to file an appeal, they should ask their doctor for any information that may help their case.
Individuals may have other appeal rights if they miss the timeframe for filing a fast-track appeal.

Anyone enrolled in a Medicare Advantage Plan or other Medicare Health Plan, has a right to a fast-track appeals process. They can get a quick review whenever they are discharged (or services are stopped) from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility, or getting inpatient hospital care.

They will get a notice from their provider or plan that will tell them how to ask for an appeal if they believe that their services are ending too soon.

They will be able to obtain a quick review of this decision, with independent doctors looking at their case and deciding if their services need to continue. Individuals may have other appeal rights if they miss the timeframe for filing a fast-track appeal.

APPELLING MEDICARE PRESCRIPTION PLAN’S DECISIONS

Individuals have the right to get a written explanation from their Medicare Prescription Drug Plan. Some reasons they might ask for a written explanation are if the pharmacist tells them that their drug plan won’t cover a prescription or they are asked to pay more than they think they are required to pay. They also have the right to ask their drug plan for an exception if they and their doctor believe they need a drug that isn’t on their drug plan’s list of covered drug.

If they disagree with the information provided by a pharmacist, they can contact their drug plan to ask for a coverage determination. The pharmacy will give them or show them a notice that explains how to contact their drug plan. Once their drug plan receives their request for a coverage determination, the drug plan has 72 hours (for standard request) or 24 hours (for an expedited request) to make a decision. If they disagree with that decision, they will have the right to appeal.

The appeal must be requested within 60 calendar days from the date of the decision.

A standard request must be made in writing unless the plan accepts requests by phone.

Individuals can call their plan or write to them for an expedited request. Once their plan receives their request for an appeal, the plan has 7 days (for a standard request for coverage or to pay you back) or 72 hours (for an expedited request for coverage) to make its decision.

When an individual enrolls in a Medicare Prescription Drug Plan, the plan will send them information about the plan’s appeal procedures.

For more information about appeal rights, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) and say “Publications” to get a free copy of “Your Guide to Medicare Prescription Drug Coverage” (CMS Pub. No. 11109).

OTHER MEDICARE RIGHTS

In addition, individuals have rights to

- Get information
- Get emergency room services
- See doctors; specialists, including women’s health specialists; and go to Medicare-certified hospitals
- Participate in treatment decisions
- Know their treatment choices
• Get information in a culturally competent manner in certain circumstances (for example, get information in languages other than English from Medicare, and its providers and contractors)

• File complaints

• Nondiscrimination

• Have their personal and health information kept private

For more information about rights and protections, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), and say “Publications” to get a free copy of “Your Medicare Rights and Protections” (CMS Pub. No. 10112).

MEDICARE NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT INDIVIDUALS MAY BE USED AND DISCLOSED AND HOW INDIVIDUALS CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

By law, Medicare is required to protect the privacy of your personal medical information. Medicare is also required to give you this notice to tell you how Medicare may use and give out (“disclose”) your personal medical information held by Medicare.

Medicare must use and give out your personal medical information to provide information

• To you or someone who has the legal right to act for you (your personal representative),

• To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and

• Where required by law.

Medicare has the right to use and give out your personal medical information to pay for your health care and operate the Medicare Program. For example:

• Medicare Carriers use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), or to prepare your Medicare Summary Notice.

• Medicare may use your personal medical information to make sure you and other Medicare beneficiaries get quality health care, to provide customer services to you, to resolve any complaints you have, or to contact you about research studies.

Medicare may use or give out your personal medical information for the following purposes under limited circumstances

• To state and other Federal agencies that have the legal right to receive Medicare data (such as to make sure Medicare is making proper payments and to assist Federal/State Medicaid programs).

• For public health activities (such as reporting disease outbreaks),

• For government health care oversight activities (such as fraud and abuse investigations),

• For judicial and administrative proceedings (such as in response to a court order).
• For law enforcement purposes (such as providing limited information to locate a missing person),

• For research studies, including surveys, that meet all privacy law requirements (such as research related to the prevention of disease or disability),

• To avoid a serious and imminent threat to health or safety,

• To contact you about new or changed benefits under Medicare, and

• To create a collection of information that can no longer be traced back to you.

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn’t set out in this notice. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

By law, you have the right to

• See and get a copy of your personal medical information held by Medicare.

• Have your personal medical information amended if you believe that it is wrong or if information is missing, and Medicare agrees. If Medicare disagrees, you may have a statement of your disagreement added to your personal medical information.

• Get a listing of those getting your personal medical information from Medicare. The listing won’t cover your personal medical information that was given to you or your personal representative, that was given out to pay for your health care or for Medicare operations, or that was given out for law enforcement purposes.

• Ask Medicare to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O Box instead of your home address).

• As Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare Program. Please note that Medicare may not be able to agree to your request.

• Get a separate paper copy of this notice.

Visit www.medicare.gov on the web for more information on

• Exercising your rights set out in this notice.

• Filing a complaint, if you believe the Original Medicare Plan has violated these privacy rights. Filing a complaint won’t affect your benefits under Medicare.

You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. Ask to speak to a customer service representative about Medicare’s privacy notice. TTY users should call 1-877-486-2048.

You may file a complaint with the Secretary of the Department of Health and Human Services. Visit www.hhs.gov/ocr/hipaa on the web or call the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

By law, Medicare is required to follow the terms in this privacy notice. Medicare has the right to change the way your personal medical information is used and given out. If Medicare makes any changes to the way your personal medical information is used and given out, you will get a new notice by mail within 60 days of the change.


www.dynastyschool.com
PROTECT YOURSELF AND MEDICARE FROM BILLING FRAUD

Most doctors, health care providers, plans, and pharmacies who work with Medicare are honest. There are a few who aren’t honest. Medicare is working very hard with other government agencies to protect you and the Medicare Program.

Medicare fraud happens when Medicare is billed for services you never got. Medicare fraud takes a lot money every year from the Medicare Program. You pay for it with higher premiums. A fraud scheme can be carried out by individuals, companies or groups of individuals.

If you suspect billing fraud, you can

1. Call your health care provider to be sure the billing is correct, or
2. Call 1-800-MEDICARE (1-800-633-4227; TTY users should call 1-877-486-2048) or

When you get health care in the Original Medicare Plan, you get a Medicare Summary Notice from a company that handles bills for Medicare. It shows what services or supplies were charged and how much Medicare paid.

You should check the notice for mistakes. Make sure that Medicare wasn’t charged for any services or supplies that you didn’t get. If you see a charge on your bill that may wrong, call the health care provider and ask about it. The bill may be correct, and the person you speak to may help you to better understand the services or supplies you got. Or, you may have discovered an error in billing that needs to be corrected. If you aren’t satisfied after speaking with your provider, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

YOU ARE PROTECTED FROM DISCRIMINATION

Every company or agency that works with Medicare must obey the law. You can’t be treated differently because of your race, color, national origin, disability, age, religion, or sex under certain conditions. Also, your rights to health information privacy are protected. If you think that you haven’t been treated fairly for any of these reasons, call the Office for Civil Rights in your state or call toll-free 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr on the web for more information.

SOURCES FOR INFORMATION

5.1.1.1.1. www.medicare.gov on the web

5.1.1.1.2. Go To The Official Medicare Website For Quick Answers And Information.

Here are some things that can be found on the website:

- Find a Medicare Prescription Drug Plan
- Compare health plan options in a specific area
- Find a doctor
- Find out if you are eligible for Medicare and when you can enroll
- Find out what Medicare covers
• Get information on the quality of care provided by nursing homes, hospitals, home health agencies and dialysis facilities.

5.1.1.1.3. My.Medicare.Gov

My.Medicare.gov provides individuals with direct Internet access to their Medicare benefits, eligibility, and preventive health information—24 hours a day, 7 days a week.

Individuals can visit the site, sign up, and Medicare will mail them a password to allow them access to their personal Medicare information.

Later in 2006, My.Medicare.gov will also include access to information on their Medicare claims. (This feature is already available to residents of Indiana.)

5.1.1.1.4. 1-800-Medicare Helpline

The 1-800-MEDICARE (1-800-633-4227) helpline has replaced the touch-tone system with a speech-automated system to make it easier for individuals to get the information they need 24 hours a day, including weekends.

The system will ask the caller questions that they answer with their voice to direct their call automatically.

Remember to

• Speak clearly,
• Call from a quiet area, and
• Have the red, white, and blue Medicare card in front of you.

To get to the right customer service representative faster if use the chart below to direct your call. If you need help at any time, you can always say “Agent.”

5.1.1.1.5. If you are calling about ……..

Just Say ………..

<table>
<thead>
<tr>
<th>Medicare prescription drug coverage</th>
<th>“Drug Coverage”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor’s bills, x-rays, or outpatient doctor’s care</td>
<td>“Doctor’s Service”</td>
</tr>
<tr>
<td>Inpatient or outpatient hospital visit or emergency room care</td>
<td>“Hospital Stay”</td>
</tr>
<tr>
<td>Oxygen, wheelchairs, walkers, eyeglasses, diabetic supplies, or Medicare-covered prescription drugs</td>
<td>“Medical Supply”</td>
</tr>
<tr>
<td>Plan choices under Medicare, including Medicare Advantage</td>
<td>“Plan Choices”</td>
</tr>
<tr>
<td>Ordering Medicare publications (including the ones listed in this handbook)</td>
<td>“Publications”</td>
</tr>
</tbody>
</table>

MEDICARE PUBLICATIONS

Below is a list of detailed booklets covering some of the topics discussed in this book.

Booklets on other topics are also available. Many of these booklets are available in English, Spanish, Audiotape (English and Spanish), Braille, and Large Print (English and Spanish). To get copies of these booklets or to see what’s available, visit www.medicare.gov on the web. Select “Search Tools” at the top of the page. You can also call 1-800-MEDICARE (1-800-633-4227) and say “Publications” for a free copy. TTY users should call 1-877-486-2048.
INFORMATION ABOUT THE ORIGINAL MEDICARE PLAN

- “Your Medicare Benefits” (CMS Pub. No. 10116)
- “Enrolling in Medicare” (CMS Pub. No. 11036)
- “Guide to Medicare’s Preventive Services” (CMS Pub. No. 10110)
- “Your Medicare Rights and Protections” (CMS Pub. No. 10112)
- “Choosing a Medigap Policy: Guide to Health Insurance For People With Medicare” (CMS Pub. No. 02110)

5.1.1.6. Information About Medicare Advantage Plans And Other Medicare Health Plans

- “Quick Facts About Medicare’s New Coverage for Prescription Drugs for people with a Medicare Health Plan, with prescription drug coverage” (CMS Pub. No. 11135)

5.1.1.7. Information About Medicare Prescription Drug Coverage

- “Your Guide to Medicare Prescription Drug Coverage” (CMS Pub. No. 11109)
- “Introducing Medicare’s New Coverage for Prescription Drugs” (CMS Pub. No. 11103)
- “Quick Facts about Medicare’s New Coverage for Prescription Drugs” (CMS Pub. No. 11102)

5.1.1.8. Other Important Contacts

Telephone numbers for important contacts are listed for organizations that provide nationwide services. These numbers were correct at the time of printing. Sometimes these number change. To get the most up-to-date telephone numbers, visit www.medicare.gov on the web. Select “Search Tools” at the top of the page. Or call 1-800-MEDICARE (1-800-633-4227)

<table>
<thead>
<tr>
<th>Telephone Numbers</th>
<th>TTY Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-800-MEDICARE Helpline</td>
<td>1-800-633-4227</td>
</tr>
<tr>
<td>Social Security Administration</td>
<td>1-800-772-1213</td>
</tr>
<tr>
<td>Coordination of Benefits Contractor</td>
<td>1-800-999-1118</td>
</tr>
<tr>
<td>Department of Defense/TRICARE</td>
<td>1-888-363-5433</td>
</tr>
<tr>
<td>Department of Health and Human Services, Office of the Inspector General</td>
<td>1-800-447-8477</td>
</tr>
<tr>
<td>Office for Civil Rights</td>
<td>1-800-827-1000</td>
</tr>
<tr>
<td>Department of Veteran’s Affairs</td>
<td>1-800-368-1019</td>
</tr>
</tbody>
</table>
For these local organizations, you can visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your state.

State Insurance Department---Call with general questions.

State Medicare Assistance Office---Call with questions about programs (including Medicaid) to help people with limited incomes and resources pay medical bills.

Quality Improvement Organization---
Call with complaints about the quality of Medicare-covered services.

Call 1-800-MEDICARE to be connected with the following organization in your state.

Say "Medical Supplies" to be connected to your Durable Medicare Equipment Regional Carrier---
Call with questions about durable medical equipment like prosthetics, orthotics and other supplies.

Say "Doctor’s Services" to be connected to your Medicare Carrier---
Call with questions about Medicare Part B (Medical Insurance) services and bills. (Railroad Retirement beneficiaries should call 1-800-833-4455).

Say “Nursing home,” “Home Health Care,” or “Hospice Facility” to be connected to your Regional Home Health Intermediary---
Call with questions about home health bills.
TTY users should call 1-877-486-2048.
6. MEDICARE COSTS

PREMIUM COSTS IN 2006

6.1.1.1. No matter what type of medicare plan an individual has

- $88.50 Medicare Part B monthly premium
- $393 Medicare Part A monthly premium (if an individual has less than 30 quarters of coverage and doesn't get premium-free Part A).

6.1.1.2. Original Medicare plan costs in 2006

If an individual has Medicare Part A and/or Part B, they will have to pay a part of the services they get. Below is a list of some of the costs they may have to pay. These costs are for 2006 and they might change January 1, 2007. Anyone wanting to know the costs for a specific service. They should visit www.medicare.gov on the web for this information. They can also call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of “Your Medicare Benefits” (CMS Pub. No. 10116).

- $124 Medicare Part B deductible
- $952 for a hospital stay of 1-60 days each benefit period
- $238 per day for days 61-90 of a hospital stay each benefit period
- $476 per day for days 91-150 of a hospital stay each benefit period
- All costs for each day of a hospital stay over 150 days
- $0 for the first 20 days of a skilled nursing facility stay each benefit period
- $119 per day for days 21-100 of a skilled nursing facility stay each benefit period
- All costs for each day of a skilled nursing facility stay after day 100 in the benefit period
- 20% of the Medicare-approved amount for most doctor services, outpatient therapy, preventive services, and durable medical equipment
- $0 for Medicare-approved home health services
- $0 for Medicare-approved clinical laboratory services
- 50% for most outpatient mental health services
- All costs for the first three pints of blood an individual gets as part of an inpatient hospital stay (unless they or someone else donates blood to replace what they use)
- All cost for the first three pints on blood an individual gets as an outpatient, then 20% of the Medicare-approved amount for additional pints of blood (unless they or someone else donates blood to replace what you use)
- Co-payments and coinsurance amounts for other services

Note: In 2006, there may be limits on physical therapy, occupational therapy, and speech-language services. For more information, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
COLLECTING DENIED & UNDERPAID CLAIMS

REASONS CLAIMS ARE DENIED OR UNDERPAID
Basically, there are four reasons that a Medicare claim can be denied or underpaid.

- Errors caused by omission of information.
- Insurance coverage disputes.
- Errors made by clerical personnel
- Failure to follow the carrier's regulations.

ERRORS CAUSED BY OMISSION OF INFORMATION
Here are some pitfalls to be aware of. Make certain your claims contain the following information.

- Be certain the proper diagnostic code appears on the claim.
- Be certain the claim shows an itemized bill not just the balance due.
- Be certain the bill contains your provider's number.
- Be certain that the diagnostic code is correct, (it's possible to obtain a list of these codes from your doctor).
- Should your claim contain any special equipment or other out of the ordinary expenses, a physician's "Note of medical necessity", must be submitted.

INSURANCE COVERAGE DISPUTES
The following are areas in which insurance coverage disputes can occur.

- The service is not covered by the plan purchased from the insurance carrier.
- The amount charged is more than what is considered "usual reasonable and customary" for the geographic area.
- A service considered the carrier to be routine, but in fact, is not routine.

ERRORS MADE BY CLERICAL PERSONNEL
Human’s process claims, and humans make errors. When you consider that hundreds of thousands of claims are processed each month, you have to expect that information can be either:

- Keypunched incorrectly.
- Numbers inadvertently reversed.
- Misplaced paperwork.
- Paperwork that cannot be identified as yours.

FAILURE TO FOLLOW THE CARRIER’S REGULATIONS
Often, the fact that by not carefully reading the carrier’s regulations concerning claims can pose major problems.

A couple of examples are as follows:

- Some hospital admissions require that an individual obtain a pre-certification from their carrier. (Except in emergencies, of course). A telephone call to the carrier can help solve this problem.
Health Insurance Principles

- Should the insured require an operation, some carriers require a second opinion. Failure to do so could cause a denial of claim.

**IF UNCERTAINTY ENTERS THE PICTURE**
Should an individual be confused or uncertain as to why a claim was denied or not paid, often, a call to the claims department can settle the issue. Before calling, have the following information available:

- Policy number.
- Date of disputed service.
- Amount of underpaid claim.
- Amount actually paid.
- Amount you feel is incorrect.
- Reason you feel claim is incorrect.

**AFTER KNOWING THE REASON FOR DENIAL OR UNDERPAYMENT**
The following remedies are available:

- Dispute over coverage. Call the carrier and ask for a letter that explains why the claim in question were either not routine, or not usual reasonable, and customary.
- Clerical errors, again call the carrier and provide them with the information that proves that a clerical error has been made and often, the correction can be made right on the phone.
- Omission errors, if made by the physician or other provider, can be corrected by simply requesting that a corrected statement be sent.
- Again, be certain that all pertinent information previously discussed, diagnostic code, provider's name, etc. is contained on the corrected bill.

### 6.1.1.1.3. SENDING LETTERS TO THE INSURANCE CARRIER

Although this may sound elementary, the contents of a letter will be directly related to the response and satisfaction you desire.

Therefore the letter should contain the following:

- Be certain to have the correct address of the insurance company.
- Be certain the name and address for return correspondence is in the letter.
- The policy number.
- The claim number.
- Directed to the attention of a specific department if possible.
- Better yet directed to an individuals name if possible.

The body of the letter should contain the following information concerning the inquiry.

- Who
- What
- Where
• How
• Why
• When

Finally, be certain the letter is signed and include the current phone number and after a reasonable length of time has passed, (10 days or so) a follow up inquiry may be necessary.

FINAL MEASURES
If after all else has failed to resolve the dispute, a final step is contact the State Department of Insurance.

RECONCILING WITH THE PROVIDER

UNPAID MEDICAL BILLS
Providers such as physicians, clinics or hospitals expect to receive payment for services rendered upon the completion of the service.

Claims typically take four to six weeks to process assuming that the claims are SUBMITTED CORRECTLY. Many providers have taken on the task of assisting in claims filing to enable them to receive their payment in a more timely fashion.

For example, some providers use two systems:

• Super bills that are pre-designed to provide the carrier with all needed information.
• Filing claims on behalf of the insured directly with the insurance carrier and eliminating the middleman.

SERIOUS ILLNESSES
Often, a serious illness runs up an expensive hospital bill. Most health providers are sensitive to these expenses and the financial devastation they can wreak on the insured and family.

BE UP FRONT WITH YOUR FINANCIAL HARDSHIP
Most people who have money due them have stated that they are more than willing to work with the debtor. The number one complaint from people who have money due them is that the debtor refuses to answer calls, letters or attempts to work out a fair payment agreement.

Often, an understanding provider will accept what the insurance carrier has paid them as payment in full. Others have been willing to reduce their fees to help the situation.

HOSPITAL BILLING ERRORS
We know that studying a hospital bill can be very difficult and time consuming, however, reviewing the hospital bill for errors is always a good idea.

Things to watch for include:

• Supplies never given to the patient.
• Services not received.
• Discrepancies in private vs. semi-private rooms
• X-rays never taken.
• Medication not prescribed.
EXCESSIVE CHARGES
Should a claim be denied because the carrier feels that the charge was excessive and did not fall within the "usual reasonable and customary" fee, contacting the physician or health provider that is involved in the excessive charge is very important. Often, the fee is fair and reasonable and since the carrier has not been given all the facts, the claim is paid for a lesser amount.

Here is what to do should this happen:

- Was there a service given above the norm? In other words, was the carrier explained the additional service in detail to justify the additional charge.
- Often, a letter from the physician can clarify the reason for an excessive charge.
- It is important that the diagnostic and procedure code on the claim matches the actual service received.

For the most part insurance carriers want to pay fairly and promptly for reasonable and legitimate medical care.

In closing, the major causes for differences of opinion in health insurance claims are as follows:

- Lack of information. Most claims do not have enough.
- Knowing what the policy pays and does not pay.
- Knowing the proper language to use is important

FOR EXAMPLE:
If a business owner wants to close for the Easter holidays, including Good Friday, so that he can have a three-day weekend, he must be careful how he tells his customers that he will be closed. For example, putting a sign on the building that say's "Closed for Good Friday" maybe misunderstood. Think about it!
7. LONG TERM CARE POLICIES

THE NEED FOR LONG TERM CARE

WHO NEEDS LONG TERM CARE
For the most part we feel that long term care is only for the elderly. Quite the contrary. In 2000, there were approximately 8 million Americans, 65 or older, who required long term care. And by the year 2036 that figure will be 19 million plus!

HISTORY OF LONG TERM CARE
Long term care is not a now concept or idea. They first appeared on the scene in the early 1980's, but were very primitive in nature and had numerous stipulations, requirements and exclusions that put them into the "Hit by a cow on the third of the month providing there was a full moon" category.

Insurance companies were reluctant to get into this market simply because there was not previous claims experience that they could follow. Actuarial science could not be applied and there were no records on who went into long term care facilities, when, for what and how long. Needless to say, this posed major obstacles in the pricing of the product.

WHAT TO LOOK FOR IN LONG TERM CARE
The most important feature to consider is what type of benefits the policy provides. The four most common long-term care benefits are as follows:

- Skilled nursing care.
- Intermediate care.
- Custodial care.
- Home health care.

Let's review each of these so that you completely understand the differences.

SKILLED NURSING CARE
Skilled nursing care is the most expensive. It requires a prescription from a qualified licensed physician. The care must be continuous on a 24 hour a day basis and you are to be cared for by a Registered Nurse.

INTERMEDIATE CARE
Although a doctor's prescription is not necessary for this level of care, it does require medical care under the supervision of medical personnel it must be administered by a Registered Nurse, Licensed Practical Nurse, or a Physical Therapist.

CUSTODIAL CARE
Custodial care assists the patient in meeting "Activities of daily living", also referred to as "ADL's". ADL's are as follows:

- Mobility
- Dressing
- Personal Hygiene
- Eating
HOME HEALTH CARE
Under this care, the patient is not confined to a nursing home and is usually able to care for him or herself. Usually a non-medical type person assists in shopping, meal preparation and some physical therapy.

OPTIONAL BENEFITS
Two of the more common optional benefits are:

- Hospice
- Adult Day care
- Inflation Protection
- Waiver of premium

HOSPICE
This provides the terminally ill with comfort in their last days and does not prolong treatment or employ life saving devices. Typically a hospital bed is set up in the patient's home to keep them in familiar surroundings with family members their last days. Depending on the severity of pain or medical needs, home visits are made by Registered Nurses as well as Social Workers. This is a wonderful organization that provides care to the rich and poor and truly does make the last days as comfortable as possible.

ADULT DAY CARE
This care is usually given at a center that caters to those that are mentally or physically impaired. A typical day at the center provides social activity, medical care, meals and transportation to and from their home.

INFLATION PROTECTION
An important option is inflation protection it provides for future increases in the daily benefit. Most policies offer a 5 percent increase in the daily benefit each year. Long term care is not immune to inflation and it is a safe assumption that nursing home care is going to do nothing but go up.

WAIVER OF PREMIUM
While optional most companies include waiver of premium as a standard provision. Typically, once the company has confined you.

HOW LONG WILL BENEFITS BE PAID
This depends entirely on the type of policy the insured purchased. The cost factor enters into this question also. Most companies offer benefits of from one to five years, some even for lifetime.

PRE-EXISTING CONDITIONS
Most policies make provisions for pre-existing conditions. Most pre-existing conditions are measured by excluding any condition for which you were treated or given medical advise for the period of six months prior to the effective date of coverage. Additionally, the pre-existing clause continues for six months following the effective date of the policy. So in reality, you are looking at a year.

EXCLUSIONS
You must be aware of the exclusions that long-term care policies contain. Claim time is not when you want to find out. In the early long term care policies, they would exclude Alzheimer's disease by saying that "the policy excludes diseases of an organic nature" which was their way of excluding Alzheimer's without mentioning the disease by name. This has since been rectified because Alzheimer's disease and other organic diseases are now covered in most policies that we have seen.
Here are some of the more common exclusions:

- Care given in a Veteran's hospice
- Losses that Workers' Compensation provides for.
- Mental psychoneurotic, or personality disorders that are not the result of organic or physical disease.
- War.
- Self inflicted injuries that are intentional

LONG TERM CARE POLICY RIDERS
It is now possible to purchase a life insurance policy or a disability income policy and add long term care as a rider. The rider is very much like the standard long-term care policy in that it affords you the same elimination periods, benefits periods and levels of care.

LIVING BENEFIT LONG TERM CARE RIDER
This rider permits terminally ill patients to use life insurance proceeds in advance to cover expenses connected with their illness. Typically, this option will make available to the insured 70 to 80% of the death benefit they are entitled to cover the cost of nursing home care. Another option in this category is receiving 90 to 95% of the death benefit they are entitled to because they are terminally ill.

7.1.1.1. FOCUS POINTS

- Long term care concept was first introduced in the early 1980's
- Insurance companies were first reluctant to get in this field because there was no previous claims experience
- The lack of actuarial science in this field made it difficult to price.
- The four most common long-term care benefits are skilled nursing care, intermediate care, custodial care, and home health care.
- Skilled nursing care is the most expensive form of care.
- Skilled Nursing care requires the aid of a Registered Nurse.
- Intermediate Care requires the supervision of medical personnel and administered by a Registered Nurse, Licensed Practical Nurse, or a Physical Therapist.
- Custodial Care assists the patient in mobility, dressing, personal hygiene and eating.
- Home Health Care uses a non-medical type person to assist with shopping, meal preparation, and some physical therapy.
- Hospice care provides terminally ill with comfort in their last days and does not prolong treatment or employ life savings devices.
- Adult Day Care is usually given at a center that caters to those that are mentally or physically impaired.
- How long benefits are paid depends on the policy.
- Most policies make provisions for pre-existing conditions.
- Long Term Care policies have exclusion clauses.
HEALTH INSURANCE PRINCIPLES

- Long Term Care policies can be added as riders to some life insurance policies
- Living Benefit Long Term Care Policies permit terminally ill patients to use life insurance proceeds in advance to cover expenses connected with their illness.

UNDERWRITING & LONG TERM CARE POLICIES

SOURCES OF INFORMATION
The underwriting process employs four important sources of information.

- The application.
- The agent.
- Verification reports.
- Medical records and history.

THE APPLICATION
Obviously, the application provides the company with the basis upon which they will make the decision to issue a contract. Questions need to be answered in full with honesty and integrity.

THE AGENT
Years ago, you were permitted to take applications by mail or phone so long as they were signed by the applicant. Today, however, companies want to know that the agent actually sees the applicant and assists in the field underwriting. You will be able to make observations unavailable to the home office underwriter.

VERIFICATION REPORTS
The verification reports provide investigative information to verify statements made by the applicant. These reports also sometimes produce additional information or problems that may not have been listed on the application.

MEDICAL RECORDS AND HISTORY
Often times, companies employ the Medical Information Bureau (MIB) as well as Attending Physician's Reports, (APR's) in verifying medical records and history. Obviously, this information is extremely important in the underwriting process.

SUBSTANDARD UNDERWRITING
Not all applications are approved as submitted or issued standard. Often, the applicant is required to pay more than the standard premium in order for the company to absorb certain hazard or risks.

Factors that directly affect whether the policy will be issued standard or substandard are:

- Pre-existing conditions
- Age
- Occupation (if applicable)
- Moral issues
- Current, past and possible future medical conditions

7.1.1.1.2. FOCUS POINTS
Underwriting applies four sources the application, the agent, verification reports and medical records and history.

The application provides the basis for the insurer to make the decision to issue the policy.

The agent assists the underwriting process by field observation.

The verification reports provide investigative information to verify statements made by the applicant.

The Medical Information Bureau is often used to verify medical records and history.

Policies are issued as either standard or substandard.

Factors effecting the level of policy include pre-existing conditions, age, occupation, moral issues, medical conditions.

GUIDE TO LONG-TERM CARE
The following information was reprinted from A Shopper’s Guide to Long-Term Care, developed by the National Association of Insurance Commissioners (NAIC) to aid in the purchase of long-term care insurance.

These guides are developed to give the potential client sufficient information about his or her options concerning long-term care insurance.

A SHOPPER’S GUIDE TO LONG-TERM CARE
I. What is Long-Term Care?
Long-term care involves a wide variety of services for people with a prolonged physical illness, disability or cognitive disorder (such as Alzheimer’s disease). Long-term care is not one service, but many different services aimed at helping people with chronic conditions compensate for limitations in their ability to function independently.

Long-term care differs from traditional medical care as it is designed to assist a person to maintain his or her level of functioning, as opposed to care or services that are designed to rehabilitate or correct certain medical problems. Long-term care services may include, but are not limited to, help with daily activities at home, such as bathing and dressing, respite care, home health care, adult day care, and care in a nursing home.

Persons with physical illnesses or disabilities often need hands-on assistance with activities of daily living. Persons with cognitive impairments generally need supervision, protection or verbal reminders to accomplish everyday activities.

The delivery mechanisms for long-term care services are changing very rapidly; however, skilled care and personal care remain the most common terms used to describe long-term care and the level of care a person may need.

Skilled care is generally needed for medical conditions that require care by skilled medical personnel, such as registered nurses or professional therapists. This care is usually provided 24 hours a day, is ordered by a physician, and involves a treatment plan. Skilled care is generally provided in a nursing home, but may also be provided in other settings such as the patient’s home, with help from visiting nurses or therapists.

Note: Medicare and Medicaid have their own definitions of skilled care. Please refer to The Guide to Health Insurance for People With Medicare or The Medicare Handbook to find out how Medicare defines skilled care. Contact your local social services office for questions regarding the Medicaid definition of skilled care.
Personal care (also known as custodial care) helps a person perform activities of daily living, which include assistance with bathing, eating, dressing, toileting, continence and transferring. It is less intensive or complicated than skilled care, and can be provided in many settings, including nursing homes, adult day care centers or at home.

There are different types of providers of long-term care and places where you can receive this care. State laws governing the providers of long-term care vary widely as do terms used to describe these providers. As you begin your evaluation of the need for long-term care insurance, you will hear about nursing homes, adult day care centers, assisted living facilities and home care agencies as some of the many types of long-term care providers.

II. How Much Does Long-Term Care Cost?
Long-term care can be expensive, depending on the amount and type of care needed and on the setting in which it is provided. According to the NAIC, in 1996 the cost of a year in a nursing home averaged about $38,000. (This cost is only an average and varies widely across the country.) If you received skilled nursing care in your own home and were visited by a nurse three times a week for two hours per visit for the entire year, the bill would have come to about $12,300. If you received personal care in your home from a home health aide three times a week for a year, with each visit lasting two hours, the bill would have amounted to about $8,400.

III. Who Pays for Long-Term Care?
The NAIC reports that nationally, one-third of all nursing home expenses are paid out-of-pocket by individuals and their families, and about half are paid by state Medicaid programs.

Long-term care expenses are generally not paid for by Medicare, Medicare supplement insurance or the major medical health insurance provided by most employers. Medicare will cover the cost of some skilled care in approved nursing homes or in your home, but only in certain situations.

Further, Medicare’s skilled nursing facility (SNF) benefit does not cover general "nursing home" care. The SNF benefit is a "post hospital" benefit which only covers a relatively intensive level of skilled care furnished during a brief convalescent period after an acute care stay in a hospital. Medicare does not cover homemaker services.

Medicare does not pay for custodial care provided by home health aides unless the individual is also receiving skilled care such as nursing or therapy and the custodial care is related to the treatment of the illness or injury. However, there are limits on the number of days and hours of care an individual can receive in any week.

Medicare supplement insurance is private insurance designed to help pay for some of the gaps in Medicare coverage such as hospital deductibles and excess physicians’ charges. These policies do not cover long-term care expenses. However, of the standardized Medicare supplement policies, Plans D, G, I and J do contain an at-home recovery benefit that may pay up to $1,600 per year for short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

Medicaid pays for nearly half of all nursing home care. Medicaid may also pay for some community-based services. To receive Medicaid assistance, you must meet federal poverty guidelines for income and assets, and may have to "spend down" or use up most of your assets on health care. (Some assets, such as your home, may not be counted when determining Medicaid eligibility.) When you have spent down your assets, you will then be eligible for Medicaid. Many people begin paying for nursing home care out of their own pockets and spend down their financial resources until they become eligible for Medicaid. They then turn to Medicaid to pay part or all of their nursing home expenses.

State laws differ on how much money and assets you are allowed to keep once you become eligible for Medicaid. Contact your state Medicaid office, office on aging, state department of social services or local Social Security office to learn about the rules in your state. In most states, the health insurance counseling and assistance program also may provide some Medicaid information.
IV. Should You Buy Long-Term Care Insurance?

Not everyone should buy a long-term care insurance policy. For some, a long-term care policy is an affordable and attractive form of insurance. For others the cost is too great and the benefits they can afford are insufficient. You should not buy a long-term care policy if it will cause a financial hardship and make you forego other more pressing financial needs. Each person should carefully examine his or her needs and resources to decide whether long-term care insurance is appropriate. It is also a good idea to discuss such a purchase with your family.

The need for long-term care can arise gradually as a person needs more and more assistance with activities of daily living or the need can surface suddenly following a major illness such as a stroke or a heart attack.

Some people who have acute illnesses may need nursing home or home health care for only short periods of time. Others may need these services for many months or years.

It is difficult to predict who will need long-term care, but there are studies that help shed some light on the likelihood of needing such care. For example, one national study projects that 43 percent of those who turned age 65 in 1990 will enter a nursing home at some time during their lives. The same study reported that among all persons who live to age 65, only 1 in 3 will spend three months or more in a nursing home; about 1 in 4 will spend one year or more in a nursing home; and only about 1 in 11 will spend five years or more in a nursing home.

In other words, 2 out of 3 people who turned 65 in 1990 will either never spend any time in a nursing home or will spend less than three months in one.

Also according to the NAIC, the risk of needing nursing home care is greater for women than men; 13 percent of the women in this study, compared to 4 percent of the men, are projected to spend five or more years in a nursing home. The risk of needing nursing home care also increases with age.

The chances of needing home health care are substantially greater than needing nursing home care.

Once you have assessed your odds of needing coverage, you should take a hard look at the reasons you want a policy and your ability to pay for it.

Whether you should buy a policy will depend on your age, health status, overall retirement objectives and income. For instance, if your only source of income is a Social Security benefit or Supplemental Security Income (SSI), you should probably not purchase long-term care insurance. Also, if you have trouble stretching your income to meet other financial obligations, such as paying for utilities, food or medicine, you should probably not purchase a long-term care insurance policy.

On the other hand, people with significant assets may wish to buy a long-term care policy if they want to save these assets. Many people buy a long-term care insurance policy because they want to pay for their own care and not burden their children with nursing home bills. However, you should not buy a policy if you can’t afford the premiums or cannot reasonably predict that you will be able to pay the premium for the rest of your life.

If you have existing health problems that are likely to result in the need for long-term care (Alzheimer’s disease or Parkinson’s disease, for example), you will probably not be able to buy a policy. Insurance companies have medical underwriting standards in place to keep the cost of long-term care insurance affordable. In the absence of such provisions, most people would not buy coverage until they needed long-term care services.

V. Who Sells Long-Term Care Insurance?

Private insurance companies sell long-term care insurance policies. They may sell them to individuals through agents or sometimes through the mail without using agents. Some companies sell coverage through senior citizen organizations, fraternal societies, and other groups or associations. Many
employers now make long-term care insurance policies available to their employees, their employees’ parents and their retirees.

Insurance companies must be licensed in your state to sell long-term care insurance. Be certain that you are dealing with a company that you know. If you decide to purchase long-term care insurance, be sure that the company and the agent, if one is involved, are licensed in your state. If you are not sure, contact your state insurance department.

You may also be able to purchase a long-term care insurance policy through a continuing care retirement community (CCRC). A CCRC is a retirement complex that provides a broad range of services. If you are a resident or are on the waiting list of a CCRC, you may be offered the opportunity to enroll in a group long-term care insurance policy.

The coverage provided by the long-term care insurance policy is similar to other group or individual policies and is usually designed to complement the fee structure of the continuing care retirement community. Individual medical screening, or underwriting, is often required when a resident applies for this type of long-term care insurance coverage.

VI. What Kind of Policies Can You Buy?

Today, long-term care insurance policies are not standardized like Medicare supplement insurance. There are several companies selling policies with multiple combinations of benefits and coverage. There are also several ways to acquire a policy. You may do so individually, through your employer or your spouse’s employer (and in some cases, your children’s employers), through membership in an association, and even through a life insurance policy.

A.) Individual Policies — Most of the policies sold today are sold to individuals. Many of these policies are sold through insurance agents, but some are also sold through mail solicitations or direct telemarketing. Individual policies offer a wide variety of coverage; however, not all companies offer the same coverage. You may have to shop among companies and agents to get the coverage that best fits your needs.

B.) Policies From Your Employer — Your employer may provide you with an opportunity to enroll in a group long-term care insurance plan. The coverage provided by these employer-group policies is similar to what you could buy in an individual policy from an agent or through direct mail solicitation. Insurers may allow you to keep your coverage after you leave your employer. They do this by offering continuation of coverage or conversion options. Many employers also allow retirees, spouses and parents-in-law to buy coverage. Typically, employees’ spouses, parents and parents-in-law must pass the company’s medical screening to qualify for coverage. Employees may not have to pass any medical requirements. If an employer offers such coverage, be sure to consider it carefully. An employer group policy may offer options you won’t find if you try to buy a policy on your own.

C.) Association Policies — Many associations allow insurance companies and agents to offer long-term care insurance to their members. These policies are quite similar to other types of long-term care insurance policies. Like policies that employers offer, association policies usually give their members a choice of benefit periods, maximum payments and elimination periods. Association policies may offer nonforfeiture benefits and inflation protection. In most states, association policies must allow members to keep their coverage after they leave the association. You should be cautious about joining an association for the sole purpose of purchasing any insurance coverage, especially long-term care coverage.

Life Insurance Policies — Some life insurance companies offer access to the life insurance death benefit and cash value under certain specified conditions prior to death, such as terminal illness, permanent confinement in a nursing home, or for long-term care. This is often referred to as an "accelerated benefit" provision. Long-term care benefits can be offered as a feature of an individual or group life insurance policy. Under these arrangements, a portion of the policy’s death benefit is paid on a periodic basis when the insured needs long-term care services. Policies may pay up to 100 percent of the death benefit for long-term care, and some companies offer the option to purchase additional long-term care coverage beyond the death benefit amount.
It is important to remember that the amounts used under this type of coverage reduce the amount of death benefit the beneficiary will receive, as well as the cash value of the life policy. For example, if you purchase a policy with a $100,000 death benefit and use $60,000 for long-term care, the death benefit of your policy will be reduced to $40,000. If you purchase life insurance to provide a benefit upon your death for a specific need, and you use this option for long-term care needs, the benefit upon your death may not cover this original need. If you never use the long-term care benefit, the full death benefit stated in your life insurance policy will be paid to your beneficiary.

Partnership Programs — Some states have programs designed to assist persons with the financial consequences of spending down to Medicaid eligibility standards. These programs, generally called "partnerships," allow persons to purchase certain qualified long-term care insurance policies from insurance companies and receive full or partial protection against the normal Medicaid spend down of assets. Please keep in mind that "partnership" programs are specific to that particular state, and that you must be a resident of that state once the policy benefits are exhausted and you are ready to apply for Medicaid assistance.

VII. How Policies Work

7.1.1.1.3. A, What's Covered?

If you buy a long-term care policy, it is critical that you understand the coverage for the variety of long-term care services available. Some policies cover only stays in nursing homes. Others cover only care in your home. Still others cover both nursing home and home care. In addition, many policies also cover services provided in adult day care centers or other community facilities.

Many long-term care policies will only pay for care provided in licensed nursing facilities. Most policies on the market today do not distinguish among the types of nursing home care or level of care that is provided. They will pay for any care you need, provided, of course, you need long-term care and meet other eligibility requirements contained in the policy, which are explained later in this guide.

Home care coverage varies. Some policies pay home care benefits only for home care performed in your home by registered nurses; licensed practical nurses; and occupational, speech or physical therapists. Many policies offer a more broad range of home care benefits coverage. For instance, the services of home health aides employed by licensed home care agencies may be covered. These aides have less training than nurses who perform skilled care, and they generally help patients with personal care. You may find a policy that pays for homemaker or choreworker services. This type of policy, though rare, would pay for someone to come to your home and cook meals and run errands. Generally speaking, adding home care benefits to the policy will raise the cost.

Note: Most policies don’t pay benefits to family members who may perform home-care services.

7.1.1.1.4. B. How Are Benefits Paid?

Insurance companies generally pay benefits in two different methods: the expense-incurred method and the indemnity method.

In the expense-incurred method, once you have been determined to be eligible for benefits and you submit claims, the insurance company either pays you or the provider up to the limits contained in the policy. Your policy or certificate will pay benefits only when eligible services are received.

The second type of benefit payment is the indemnity method. Under this method, once you have been determined to be eligible for benefits, the insurance company will pay benefits to you directly in the amount specified in the policy, without regard to the specific services received.

It is important to read the literature that accompanies your policy or certificate. Most of the policies purchased currently pay benefits by the expense-incurred method. The difference between the two types of polices lies in the way benefits are paid. Expense-incurred policies pay benefits either to you or to the
provider, while indemnity polices normally pay benefits directly to you only. (Expense-incurred policies tend to be less expensive, but also tend to provide benefits for a longer period of time.)

7.1.1.5. C. Where Is Service Covered?

With a long-term care policy, it is not enough to know what services are covered. You also need to know where services are covered. If you are not in the right type of facility, the insurance company can refuse to pay. Some policies provide for care in any state-licensed facility.

Others may limit the kinds of facilities where you can receive care. For example, many will not cover personal care unless it is provided in a licensed nursing facility. Others list by name the kinds of facilities where you will not be covered. These often include homes for the aged, rest homes, personal care homes and assisted living facilities, although many states license these facilities to provide custodial care. Some policies may explicitly define the kinds of facilities that they will cover.

Some will say the facility must care for a certain number of patients or require a certain kind of nursing supervision. It is important to check these requirements very carefully and pay particular attention to the types of facilities that provide services in your area. It is important that you contact your insurance company before entering the health care facility to determine if the stay will be covered.

7.1.1.6. D. What’s Not Covered?

Generally insurance companies do not pay benefits if services are needed for a person who has:

- a mental or nervous disorder or disease, other than Alzheimer’s disease;
- an alcohol or drug addiction;
- an illness or injury caused by an act of war;
- had treatment already paid for by the government, or;
- attempted suicide or intentionally self-inflicted injuries.

Note: Insurance carriers cannot exclude coverage for Alzheimer’s disease in states that have adopted the National Association of Insurance Commissioners’ Long-Term Care Insurance Model Regulation. Virtually all policies specifically say they will cover Alzheimer’s disease. You should also be aware of the connection between Alzheimer’s disease and eligibility for benefits.

7.1.1.7. E. How Much Coverage Will You Have?

The amount of coverage provided by your policy or certificate is expressed in different ways. Be sure you understand the amount of coverage you have in your policy or certificate. Also, keep in mind that the type of service received will dictate the amount of coverage, and that the amount of coverage may vary depending upon the type of service you receive.

When you buy a policy, you will also be asked to choose a benefit period—that is, how long you want your benefits to last. Benefit periods may run for one year, two years, four years, six years, ten years and sometimes for the rest of a policyholder’s life.

7.1.1.7.1. 1.) Lifetime Maximum Benefits —

Most plans have a total maximum benefit they will pay out over the length of the policy’s duration. The maximum benefit limit is generally expressed in language similar to: “total lifetime benefit,” "maximum lifetime benefit" or “total plan benefit.” When you are examining a policy or certificate, be sure you carefully consider the total amount of coverage you will have available. A few plans offer unlimited lifetime
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benefits. Often, these benefits are expressed in the marketing materials as benefit periods of one, two, three or more years, or total dollar amount available. Which is better — a longer or a shorter benefit period? Most nursing home stays are short — three months or less — but some illnesses can go on for several years, necessitating very long stays. You will have to decide whether you want to be protected for such catastrophic events, bearing in mind that policies with longer benefit periods tend to cost more.

7.1.1.7.2. 2.) Daily/Monthly Benefit Amounts

Benefits are often payable on a daily, weekly, monthly, annual or other basis. For example, in an expense-incurred plan, a nursing home benefit might be paid on a daily basis in an amount up to $100 per day, while a home care benefit might be paid on a weekly basis of up to $350 per week for approved home care services. Some policies include single event benefits, such as a single payment for installation of a home medical alert system. Insurance companies offer you a choice of periodic benefit amounts (usually $50 to $250 a day, or $1,500 up to $7,500 a month) for care in nursing homes. It is important to know how much nursing facilities in your area charge before you select a benefit amount for your policy. If home care is a covered benefit included in your policy, the benefit for those services is normally half or some other percentage of the benefit for nursing home care.

Note: For home care coverage, the benefit period may be different from the benefits for nursing home stays, though in some policies it may be the same or longer.

7.1.1.8. F. When Are You Eligible for Benefits? (Benefit Triggers)

All policies contain provisions that determine if and when benefits are payable. The provisions that companies use to determine benefits, sometimes called, "benefit triggers," are generally contained in a section of the policy and outline of coverage entitled, "Eligibility for the Payment of Benefits" or simply, "Eligibility for Benefits." The manner in which a company determines when benefits are payable is an important feature of a long-term care policy and one you should pay careful attention to as you shop. There might be a wide variation among policies when it comes to these provisions. Some policies use more than one provision to determine when benefits are payable. Some states have specific benefit trigger requirements. Check with your state insurance department to find out what is required in your state.

7.1.1.8.1. 1.) Activities of Daily Living

The most common method for determining when benefits are payable is based upon the insured’s inability to perform activities of daily living, commonly knows as ADLs. Generally speaking, the most common ADLs used by insurance companies are bathing, continence, dressing, eating, toileting and transferring. Typically, benefits are payable when a person is unable to perform a certain number of the ADLs, such as three of the six or two of the six.

Note: The six ADLs have been developed through years of research. This research also has shown that bathing is usually the first ADL that a person is unable to perform. If a policy only uses five ADLs and bathing is not included, it may be more difficult to qualify for benefits through that policy than through a policy that includes the bathing ADL.

7.1.1.8.2. 2.) Cognitive Impairments

Many policies also have a provision for "cognitive impairment" or mental incapacity. This type of provision generally provides benefits if the insured is unable to pass certain tests assessing his or her mental function. This provision is especially important if a person has Alzheimer’s disease. Most states prohibit policies from containing an exclusion for Alzheimer’s disease.

However, a policyholder who has Alzheimer’s disease may not qualify for benefits if he or she is physically able to perform the activities of daily living specified unless the policy has a provision for
cognitive impairment or mental incapacity. If the policy uses only an ADL benefit trigger, those with Alzheimer’s disease may not qualify for benefits. But if a policy also has a benefit trigger for cognitive impairment or mental incapacity, an insured with the disease is more likely to receive benefits.

7.1.1.8.3. 3.) Doctor Certification of Medical Necessity

Under some policies, you’ll qualify for benefits if your doctor orders or certifies that the care is medically necessary. If you need personal care in a nursing home, but are not sick or injured, you may not qualify for benefits under a medical necessity requirement, depending on how the policy defines medical necessity.

7.1.1.8.4. 4.) Prior Hospitalization

Some policies sold several years ago required the insured to have a prior hospital stay of at least three days before qualifying for benefits. This requirement is very restrictive and can severely limit your ability to receive any benefits from your policy. This type of provision is prohibited in the current NAIC model law. Most states now prohibit policies from requiring a prior hospitalization. However, a few states still permit insurance companies to use this benefit trigger.

Note: The provisions for benefits that companies use for home care coverage may be different from those it uses for nursing home care.

7.1.1.9. G. When Do Benefits Begin? (Elimination Period)

With many policies, your benefits won’t begin the first day you enter a nursing home or begin using home care. Most policies include an elimination period (sometimes called a deductible or a waiting period). That means benefits begin 20, 30, 60, 90 or 100 days after you enter a nursing home depending on the elimination period you pick when you buy your policy. You might be able to choose a policy with a zero-day elimination period, but these also tend to cost more.

Some companies may not give you the option of selecting such an elimination period. Of course, during the elimination period, you’ll have to cover the cost of long-term care services yourself. Elimination periods may be shorter for home care benefits.

In choosing an elimination period, you’ll have to weigh the trade-off between paying a higher premium for a shorter elimination period. If a nursing home in your area costs $80 a day, a policy with a 30-day elimination period will require you to pay $2,400 out of pocket, a policy with a 60-day period will require $4,800 of your own money, and a policy with a 90-day elimination period will cost $7,200 of your own money.

If your stay is short and you have a policy with a long elimination period, you may not receive any benefits from your policy. On the other hand, if you can afford to pay for a short stay, a longer elimination period might be in order. In this manner, you’ll be protected if you have a prolonged nursing home stay, and at the same time keep the cost of your insurance down.

You may also want to consider how the policy pays if you have a repeat stay in a nursing home. Some policies require you to be out of a facility for a certain period of time before you can receive benefits for a second stay. Others will consider the second stay as part of the first one as long as you are released and then readmitted within 30, 90 or 180 days. You need to find out if the insurance company requires the elimination period to run again for a second stay. Keep in mind that repeat nursing home stays are not typical, so you may not want to put a lot of emphasis on this feature as you do your shopping.

7.1.1.10. H. What Happens When Long-Term Care Costs Rise? (Inflation Protection)
Inflation protection can be one of the most important additions you can make to a long-term care policy. However, inflation protection adds to the cost of the policy. Unless your policy provides inflation for your daily benefit to increase over time, years from now you may find yourself owning a policy whose benefit has not kept pace with the increasing costs of long-term care. A nursing home that costs $86 a day now will cost $228 in 20 years, assuming an inflation rate of 5 percent a year. Obviously, the younger you are when you purchase a policy, the more important it is for you to consider adding inflation protection.

There are two ways that inflation protection is most commonly offered. The first automatically increases your benefits each year. The second allows you the option to increase your benefits on a periodic basis, such as every three years. Be sure you understand the implications of accepting or rejecting an opportunity to increase the inflation protection benefits of your policy.

There are also two types of increases that are generally made available — simple and compounded rate increases. Under both, the daily benefit increases annually by a fixed percentage, usually 5 percent, for a certain period, usually 10 or 20 years. Even though the automatic increases are a fixed percentage amount, the dollar amount of the increases from year to year will differ, depending on whether the inflation adjustment is "simple" or "compounded."

If the inflation adjustment is simple, the dollar amount of the increase added to the benefit stays the same every year; but if the adjustment is compounded, the benefit increases by an increasing dollar amount from one year to the next. For example, an $80 daily benefit that increases by a simple 5 percent a year will provide $160 a day in 20 years, but if it’s compounded, it will provide $212 a day. It is desirable to choose a policy with automatic increases that are compounded, but some policies do not provide for that. Some states now require that inflation increases be compounded. Compounding can make a large difference in the size of your benefit.

Note: The NAIC model regulation requires companies to make an offer of inflation protection, leaving it up to you to decide whether to buy the coverage. Most states have adopted this provision. If you decline, you will be asked to sign a statement saying you don’t want the inflation protection. Be sure you understand what you are signing.

Other options may be available. These optional features may add to the cost of the policy. Ask your insurer what features add to the cost of the policy.

1. Third Party Notification

This benefit allows you to name a third party who would be notified by the insurance company if the policy is about to lapse because of the non-payment of the premium. The third party can be a relative, friend or a professional (a lawyer or an accountant, for example). This third party, after he or she has been notified, would then have a period of time to pay the overdue premium. Individuals with cognitive impairments who have forgotten to pay the premium have had their policy lapse when they have needed it the most. If you select this provision, a lapse can be prevented. You can generally designate a third party at no additional cost to you. Some states now require that the insurance company provide you with the opportunity to name a third party and may even require that you sign a waiver if you elect not to name anyone to be notified in the event that the policy is about to lapse.

2. Waiver of Premium

This provision allows you to stop paying premiums once you are in a nursing home or you are receiving care at home and the insurance company has started to pay benefits. Some companies waive the premium as soon as they make the first benefit payment, others wait 60 to 90 days. Waiver of premium may not apply if you are receiving care in your home.
7.1.1.11.3. 3. Restoration of Benefits

This benefit provides for the maximum amount of your original benefit to be restored, even if you have previously received benefits through your policy. Generally, if you receive long-term care benefits, and then go for a stated period of time without receiving long-term care services, the amount of your benefit reverts back to the amount you originally purchased. For example, if you used $5,000 of long-term care benefits that were paid for by your policy (out of a maximum available amount of $75,000), and thereafter used no long-term care services for a specified period of time, the $5,000 would be restored back to the maximum amount of benefit you would have available. Instead of having only $70,000 of benefits remaining, you would have the original $75,000 benefit available.

7.1.1.11.4. 4. Nonforfeiture Benefits

This benefit returns to you some of the investment (through the premiums paid) in the policy if you drop your coverage. Without this type of benefit, you receive nothing if you drop the policy 10 or 20 years later.

Some states may require the offer of nonforfeiture benefits. There are several types of nonforfeiture benefits and each has a different premium associated with it. A company may offer a nonforfeiture benefit by giving you a reduced paid-up policy.

This coverage generally provides the same daily benefit purchased for a reduced period of time based on the number of years the policy was in premium paying status. Other carriers may offer a "return of premium" benefit under which they return all or a portion of the premiums after a certain number of years if you drop your policy. This is generally the most expensive type of benefit.

A nonforfeiture benefit can add roughly 10 to 100 percent to a policy's cost, depending on such things as your age at the time of purchase, the type of nonforfeiture benefit offered, and whether the policy provides for inflation protection.

7.1.1.11.5. 5. Premium Refund Upon Death

This benefit refunds to your estate any premiums paid minus any benefits the company paid. To receive a refund at death, you must have paid premiums a certain number of years. In some policies, death benefits are payable only if the policyholder dies before a certain age, usually 65 or 70. Death benefits may also add to the cost of a policy.

VIII. Will Your Health Affect Your Ability to Buy a Policy?

Companies selling long-term care insurance "underwrite" their coverage. That means they look at your health and health history before they will issue a policy. Some companies do what is known as "short-form" underwriting. On the application for coverage, they will ask you to answer a few questions about your health; for example, they may want to know if you have been hospitalized in the last 12 months or are confined to a wheelchair.

Some companies conduct more extensive underwriting. They may examine your current medical records and ask for a statement about your health from your doctor. These companies may be more selective about whom they'll insure. Having certain conditions that are likely to require a nursing home stay in the near future (Parkinson's disease, for example) probably will disqualify you for coverage at these companies. In either case, you must answer certain questions that the company uses to determine if it is going to issue the coverage. Some group policies, especially those available through an employer, may be available without any underwriting requirements.

No matter what kind of underwriting a company uses, it is very important to answer all health questions truthfully. If a company later learns you did not fully disclose your health status on the application, and the company relied on the misstatement to grant coverage, it can rescind, or cancel, your policy and return the premiums you've paid. It usually can do this within two years after you buy the policy.

Sometimes companies do not investigate your medical record until you file a claim, and then they may attempt to deny benefits based on inconsistencies. This practice is called "post-claims underwriting" and...
is illegal in many states. Companies that thoroughly check on your health before issuing a policy are not as likely to engage in post-claims underwriting.

Most states require the insurance company to provide you with a copy of the application you completed when you applied for coverage. You should review the application and be certain that you have answered all health questions truthfully and the information you provided to the company is accurate.

What Happens if You Have Preexisting Conditions?

Many companies will usually issue a policy to people who have relatively minor health problems. The company may not pay benefits for conditions related to these minor health problems, or preexisting conditions, for a period of time after the effective date of the policy, usually six months. Some companies have longer preexisting conditions periods; others have none. A preexisting condition is normally defined in the policy as one for which you sought medical advice or treatment or had symptoms within a certain period before applying for the policy.

Companies also vary in the length of time they will look back at your health status, and you will want to consider these variations as well. If the company discovers you have not disclosed a preexisting condition on your application, it may refuse to pay for treatment related to that condition and perhaps terminate your coverage.

IX. Can You Renew Your Coverage?

In most states, the laws require policies currently sold to be guaranteed renewable. When a policy is guaranteed renewable it means that the insurance company guarantees that it will offer you the opportunity to renew the policy and maintain the coverage. It does not mean that you are guaranteed the opportunity of renewing at the same premium.

Premiums may rise over time as companies pay claims in greater amounts and frequency. However, once you buy a policy the premiums won’t rise just because you get older. Keep in mind that insurance companies cannot raise the premiums on any individual policy. They must raise the premiums on all policies of the same class in your state. If you have purchased this policy in a group setting and you leave the group, you may be able to convert your coverage from the group policy to an individual policy, or continue your coverage under the group policy.

X. What Do Policies Cost?

A long-term care policy can be expensive, and you might want to be sure you can pay the premium for it as well as premiums for your other health insurance which you also consider to be important. The annual premium for long-term care policies with inflation protection can run as much as $2,000 for someone age 65. Obviously the premium will be lower for those who are younger and more for those who are older.

If you purchase a policy at age 75, the premium will generally be two- and one-half times greater than if you had bought the policy at age 65. It will be six times higher than if you bought it at age 55. It’s not unusual for a couple aged 65 to spend around $7,500 for all their health insurance coverage. If you buy a policy with a large daily benefit or a longer benefit period, it will also cost you more. Inflation protection can add 25 to 40 percent to the premium. Nonforfeiture benefits can add 10 to 100 percent to the premium.

When buying a long-term care policy you must consider not only whether you can continue to pay the premium now, but also if you will be able to continue to pay the premiums in the future, when they most likely will be higher. Premiums on these policies may increase. Insurance companies can raise the premiums on their policies, but only if they increase the premiums on all policies of that class in that state. No individual can be singled out for a rate increase, regardless of the amount of claims that they have incurred. Some states have rate increase restriction laws.

Consider how much income you have and how much you could afford to spend on a long-term care policy now. Also try to project what your income is likely to be in the future, what your living expenses will be, and how much you can pay for long-term care insurance premiums. If you don’t expect your income
to increase, it probably would not be wise to purchase a policy now with a premium that is at the upper limit of what you think you can afford.

Note: Don’t be misled by the term "level premiums." Some persons or entities marketing long-term care insurance might tell you that your premium is level and imply that it will never rise. With the exception of "whole life" insurance policies, companies cannot guarantee their premiums will never increase. The NAIC model prohibits insurance companies from using the word "level" in connection with a sale of guaranteed renewable policies. Many states have adopted this provision. New rules require companies to tell prospective customers that the premiums on their policies may go up.

XI. If You Already Own a Policy, Should You Switch Plans or Upgrade Existing Coverage?

Before you buy a new policy, make sure it is better than the one you already have. Even if your agent has switched companies, carefully consider any changes. If you decide to switch, make sure your new application is accepted and the policy is issued before you cancel the old policy.

If you cancel a policy in the middle of its term, most companies will not return any premiums you have paid. If you switch policies, new restrictions on preexisting conditions may apply, and you may not have coverage for certain conditions for a specific period of time. Some states do not allow a new preexisting condition waiting period for similar benefits if you switch policies. The new waiting period will apply for new benefits only.

It may be appropriate to switch, however, if you have an old policy with requirements for a prior hospital stay or for prior levels of care, and you are in good health and can qualify for another policy. If you have a good policy you bought when you were younger, you might ask if the insurance carrier can enhance the policy, for example, by adding inflation protection or removing the pre-hospitalization requirement. It might be cheaper to keep the policy you have and improve it rather than buy a new one.

XII. What Shopping Tips Should You Keep in Mind?

Here are some points to keep in mind as you shop:

7.1.1.1.12. A) Ask questions.

If you have questions about the agent, the insurance company or the policies, contact your state insurance department or senior counseling program.

7.1.1.1.13. B) Check with several companies and agents.

It is wise to contact several companies (and agents) before you buy. Be sure to compare benefits, the types of facilities you have to be in to receive coverage, the limitations of coverage, the exclusions, and, of course, the premiums. (Policies that provide identical coverage and benefits may not necessarily cost the same).

7.1.1.1.14. C) Take your time and compare outlines of coverage.

Never let anyone pressure or scare you into making a quick decision. Don’t buy a policy the first time an agent comes calling. Ask the agent to give you an outline of coverage. The outline of coverage summarizes the policy’s benefits and highlights important features. Compare outlines of coverage for several policies. Most states require the producer to leave an outline of coverage at the time the agent initially contacts you. If the agent does not give you an outline or tells you he or she will provide it later, do not deal with that agent.

7.1.1.1.15. D) Understand the policies.
Make sure you know what the policy covers and what it does not. If you have any questions, ask the agent or call the insurance company's home office before you buy. If the agent gives you answers that are vague or differ from information in the company literature, or if you have doubts about the policy, tell the agent you will get back to him or her later and don’t hesitate to call or write to the company and ask your questions. Beware of sales solicitation that claims the policy can be offered only once.

Some companies may sell their policies through the mail, bypassing agents entirely. If you decide to buy a policy through the mail, contact the company if you don’t understand how the policy works.

Discuss the policy with a friend or relative. You may also want to contact your state insurance department or your state’s insurance counseling program.

7.1.1.16. E.) Don’t be misled by advertising.

Don’t be misled by the endorsements of celebrities. Most of these people are professional actors who are paid to advertise. They are not insurance experts. Neither Medicare nor any other federal agency endorses or sells long-term care policies. Be skeptical of any advertising that suggests the federal government is involved with this type of insurance.

Be wary of cards received in the mail that look as if they were sent by the federal government. They may actually have been sent by insurance companies or agents trying to find potential buyers. Be skeptical if you are asked questions over the phone about Medicare or your insurance. Any information you give may be sold to persons or entities marketing long-term care insurance who might call you, come to your home, or solicit you by mail.

7.1.1.17. F.) Don’t buy multiple policies.

It is not necessary to purchase several policies to get enough coverage. One good policy is enough.

7.1.1.18. G.) Don’t be misled by marketers of long-term care insurance who say your medical history is not important.

Disclosing your medical history is very important. Make sure you fill out the application completely and accurately. If an agent fills out the application for you, don’t sign it unless you have read it and made sure that all of the medical information is correct. If information about the state of your health is wrong, and the company relied on it in granting coverage, the company can refuse to pay your claims and can even cancel your policy.


Use a check or money order made payable to the insurance company.

7.1.1.20. I.) Be sure to get the name, address and telephone number of the agent and company.

Obtain a local or toll-free number (if the company has one).

7.1.1.21. J.) If you don’t receive your policy within 60 days, contact the company or agent.

When you receive your policy, keep it in a convenient place where you can find it, and tell a trusted friend or relative where it is.
7.1.1.22. **K.) Be sure you review your policy during the free-look period.**

If you decide you do not want the policy after you purchase it, you can cancel the policy and get your money back if you notify the company within a certain number of days after the policy is delivered. This is called the "free-look" period. Some states require that the insurance company disclose information about the free-look period on the cover page of the policy.

Most states allow policyholders to cancel within 30 days, but some may have a shorter free-look period.

If you want to cancel, do the following:

Keep the envelope the policy was mailed in, or insist your agent give you a signed delivery receipt when he or she hands you the policy.

If you decide to return the policy, send it to the insurance company along with a brief letter asking for a refund.

Send both the policy and letter by certified mail and obtain a mailing receipt.

Keep a copy of all correspondence.

The refund process usually takes four to six weeks.

7.1.1.23. **L.) Read the policy again and make sure it provides the coverage you want.**

Reread the application you signed. It becomes part of the policy. If it's not filled out correctly, notify the insurance company right away.

7.1.1.24. **M.) It may be a good idea to have premiums automatically deducted from your bank account.**

That way, if an illness causes you to forget to pay them, your coverage won't lapse. If you decide to not renew your policy, be sure you contact the bank and stop the automatic withdrawal.

7.1.1.25. **N.) Check on the financial stability of the company you're considering.**

Several private companies or rating agencies conduct financial analyses of insurance companies and grade them. These ratings carry no guarantee of accuracy but can provide you with information on how some analysts view the health of particular insurance companies. Different agencies use different rating scales, so be sure to find how the agency labels its highest ratings as well as the ratings for the companies you are considering.

Ratings from some agencies are available at most public libraries or you can call the agencies directly at the numbers listed below. (Note that there will be an extra charge on your telephone bill for calls to a "900" number.)

- A. M. Best Company (900) 420-0400
- Duff & Phelps, Inc. (312) 368-3157
- Fitch Investors Service, Inc. (212) 908-0500
WHO SHOULD BUY LTC INSURANCE?

Of course, not everyone has an urgent need for long-term care insurance. Thus, not everyone should buy a policy. An important aspect to consider before purchasing long-term care insurance is whether or not it can be afforded. Long-term care insurance should not make an individual undergo financial troubles simply to have a plan in case of future need.

An individual considering the purchase of long-term care insurance should look seriously at his or her assets to determine if a long-term care policy purchase is a wise investment at the present time. The individual should consider his or her age, health condition, future plans and current financial status. If an individual is suffering from an existing condition, it will most likely be rather difficult to obtain a long-term care insurance policy.

But having some form of long-term health care coverage is very appropriate for those people reaching senior adulthood. People without insurance may be forced to enter a facility not right for their needs or a facility they would not normally choose due to the fact that, because of their economic position, they simply cannot afford the costs associated with extended care.

Because of this, a very important reason one should obtain a long-term care insurance policy is so their assets are protected from the above situation. Because so many people depend on their accumulation of assets after they retire, ensuring that the money they worked so hard for all their lives will be there when they need it and will not be wiped out due to an extended illness, is a definite necessity.

People with low incomes and few (or no) assets are sometimes apt to purchase long-term care insurance. The premiums are frequently rather expensive and, of course, there is no guarantee that this coverage will ever be used. Thus, many people with low incomes cannot afford long-term care insurance. Sometimes, the people in this situation already qualify for Medicaid, which takes care of any long-term care.

Essentially, long-term care insurance policies are not ideal for people with low income and asset levels.

People who are classified as being in the upper- or middle economic classes are those most likely to obtain long-term care insurance. Members of these classes earn adequate salaries, and most often are also entitled to insurance and retirement benefits. Due to the fact that they can afford long-term care insurance, it is a good idea for them to have this form of coverage. If an uninsured person happened to suddenly need a form of long-term care, then he or she could be headed for financial devastation because of the costs associated with the uninsured care.

Long-term care insurance would definitely be appropriate for a person in this type of situation. If it were not for the insurance coverage, the person would most likely be financially ruined in a short period of time.

Of course, a long-term care policy does not have to cover every exposure for the policyholder to benefit from having the coverage. Lower amounts of coverage may help to reduce the premium payments and, in the process, make the coverage more affordable for the insured.

Individuals with the most to lose from not having long-term care insurance are the most ideal candidates for coverage. As stated previously, if an uninsured individual suddenly faces lengthy medical care illness or injury, he or she could go broke struggling to pay for all the costs associated with long-term care.
This also works in reverse situations. If a person has a large amount of income and/or assets which would not be affected by being uninsured and in need of some type of long-term health care, then long-term care insurance may not be an urgent necessity. Successful entertainers fall into this category. These people more than likely would not be financially ruined if they had to have long-term care and did not have the insurance to cover it. These individuals have the economic means to afford almost anything they might encounter.

Of course, long-term care policies could be purchased by individuals with high incomes solely for the protection of their assets. They may not only want themselves to be financially well-off or secure, but want their children and the remaining members of their family to be secure as well.

Having long-term care insurance could enable the individual to retain the family assets for the beneficiaries.
8. POLICY PROVISIONS

Years ago, the National Association of Insurance Commissioners developed a model Uniform Policy Provision Law. They established 23 policy provisions of two types. 12 that are required to appear in all policies and 11 that are option and may be used at the discretion of the insurance companies to better customize their policies. One rule that is strictly enforced is that no substitute language may be used in any provision unless the substitute language is in favor of the insured.

REQUIRED POLICY PROVISIONS
- Entire Contract
- Time limit on certain defenses.
- Reinstatement
- Claim forms.
- Grace period.
- Notice of claims.
- Time payment of claims.
- Proof of loss.
- Claimant payment.
- Autopsy or physical exam.
- Change of beneficiary.
- Legal Action.

ENTIRE CONTRACT
A policy including all attached papers constitutes the entire contract Riders, endorsements and changes must be approved in writing and executed by an officer of the company. The agent does not have permission to change or waive any policy provision.

TIME LIMIT FOR CERTAIN DEFENSES
This provision is more commonly referred to as the "period of incontestability". It is usually two years in length. Should an application contain any fraudulent statements, the policy’s period of contestability shall be extended to the life of the contract. The only exception is a “guaranteed renewable policy” in that once the period has expired, the policy cannot be contested even if fraudulent statements were made on the application.

REINSTATEMENT
A policy that has lapsed may be reinstated under certain conditions providing the proper procedure is followed. Some companies require an application for reinstatement, which may or may not be approved.

CLAIM FORMS
Companies are required to supply you with a claim form within 15 days after receiving a claim. Should they not meet this requirement, you may submit proof of loss on any form you choose.

GRACE PERIOD
Normally, 31 days this is the time the company gives you to make a delayed payment without penalty and with the policy remaining in force. Should payment not be made by the end of the grace period, the policy will lapse and for terminate.

NOTICE OF CLAIM
You are required to notify the company within 20 days or as soon thereafter as is reasonably possible.

TIME PAYMENT OF CLAIMS
This provision stipulates that "the company must pay the claim immediately". Usually payment of claim is made within 60 days.
PROOF OF LOSS
You are given 90 days in which to submit proof of loss. Should you be unable to meet this 90 days deadline, your claim will not be affected if it was reasonably possible for you to do so.

CLAIM PAYMENT
Payment for losses of life would be made to the designated beneficiary. Should a beneficiary not be made payment will go to the insurer’s estate. Also the insured has a right to request a payment be made directly to the hospital or physician that rendered services.

AUTOPSY OR PHYSICAL EXAM
The company can request at its own expense, physical exams. So long as law does not forbid it, the company has a right to request an autopsy on the body of the insured.

CHANGE OF BENEFICIARY
The insured has a right to change the beneficiary at any time except if an irrevocable beneficiary has been designated.

LEGAL ACTIONS
Should the insured have a dispute with the company in regards to a claim they must wait at least 60 days and no longer than 5 years to take legal action.

OPTIONAL POLICY PROVISIONS
- Misstatement of age.
- Unpaid premiums.
- Insurance with other insurer.
- Cancellation.
- Change of occupation.
- Other insurance in this insurer.
- Conformity with state statutes.
- Relation of earnings to insurance.
- Illegal occupation.
- Intoxicants and narcotics.
- Insurance with other insurers.

MISSTATEMENT OF AGE
If an applicant misstates his / her age at the time they are applying for coverage, any benefit due them will be adjusted to reflect what would have been purchased had the correct age been stated in the first place.

UNPAID PREMIUMS
Should a claim become due and payable while a premium remains unpaid, the premium due will be subtracted from the claim amount due and the difference will be sent to the insured or beneficiary.

INSURANCE WITH OTHER INSURER
So as to avoid over insurance and if the company finds that there was other existing coverage for the same risk, the excess premiums will be refunded to the policy owner.

CANCELLATION
The company has the right to cancel the policy with 20 days written notice to the insured and the insured may cancel the policy following the expiration of the policy’s original term.

CHANGE OF OCCUPATION
After a policy has been issued should the insured change to a more hazardous occupation that would require an increase in premium and the insurance company is not notified and a loss occurs, the benefit paid will be reduced. Should the opposite occur, and a loss occurs, a refund will be made to the insured for the excess premium.
OTHER INSURANCE IN THIS INSURER
To avoid over insurance and limit a company's risk coverage written on one person is restricted to a maximum amount no matter how many separate policies the insured has. Premiums that have been applied to the excess coverage will be refunded to the insured or to their estate.

CONFORMITY WITH STATE STATUTES
Should any part of a policy conflict with state statutes in the state where the insured resides, the policy shall automatically amend itself to conform to statutory requirements.

RELATIONS OF EARNINGS TO INSURANCE
If at time of disability, monthly benefit amounts due exceed the insured’s monthly earnings or the average of his earnings for the previous two years, the company is only liable for the amount that is proportionate to the insured's earnings under all such coverage.

ILLEGAL OCCUPATION
Policy benefits are not payable if the insured has a loss while committing a felony or being connected with a felony or participation in any illegal occupation.

INTOXICANTS AND NARCOTICS
Should the insured be under the influence of narcotics or intoxicated, unless such were administered on the advice of a physician the company is not liable for any losses.

NON-FORFEITURE OPTIONS FOR LTC
As the popularity of long term care polices grow, the insured is going to have to be afforded non-forfeiture options that protects their policy values and benefits and protects them from forfeiting same. Life Insurance policies currently contain these three non-forfeiture options, but, the wording of these non-forfeiture options will be different for long term care policies.

The three non-forfeiture options are:

CASH VALUE
This would provide a guaranteed amount to be paid to the insured should the policy be surrendered or lapsed.

REDUCED PAID UP
This would provide that the daily benefit be reduced for the policy's benefit period and that the insured not be required to continue payment of premiums.

EXTENDED TERM
Extension of coverage for the full amounts that the policy would have ordinarily paid without any future payments of premiums for a limited extension of time.

Another type of non-forfeiture option that has come upon the long-term care scene is a cash back feature. Under this provision, an insured might typically receive 50, 60, 70, or 80% of total premiums paid upon discontinuing the policy either by surrender or having the policy lapse. Of course, as is the case in most cash back features, claims paid are deducted from the amount of returned premiums.
9. THE BASICS OF DISABILITY INCOME

UNDERSTANDING THE IMPORTANCE OF DISABILITY INCOME
If you had a machine that produced 25 crisp $100.00 bills each month, how would you take care of it?

- Would you cover it?
- Would you oil it?
- Would you insure it?

Of course you would!

Each individual is that money machine.

They are the one that produces an income each month.

Disability income insurance is one of the most undersold and overlooked markets in the insurance business.

Surveys taken tell us that 85%, yes, 85% of workers surveyed in companies, that employ 3 to 50 employees, have NO SHORT TERM OR LONG TERM DISABILITY.

It has been said that 97 out of 100 American families would be bankrupt if they missed just THREE PAYCHECKS!

If someone went to their doctor today and the doctor said, "Well, the tests have come back and you need to go home and get in bed and stay flat on your back for 7 months because the illness you have requires this."

Would they have a problem paying their bills?

Some may say "I have money in the bank" or "I have sick pay at work" or "My friends will support me" (That's the best of all of them. Well the truth is that the majority of us would be in serious financial trouble. The light company, phone company, Mortgage Company, and auto finance company could care less.

They want their money and NOW!

POLICY ELIMINATION PERIOD
An important factor to consider here is how long would an individual be able to continue their present standard of living in the event of a total disability.

That is how long they can afford to wait before the company begins paying them benefits? This is called the policy elimination period.

The following elimination periods are available:

- 14 day (very rare and hard to find)
- 30 day
- 60 day
- 90 day
- 180 day
- 365 day

Obviously the policy elimination period has a great deal to do with the premium the insured will pay. The longer the elimination period, the less it costs. The shorter the elimination period, the more it will cost.
The following factors should be considered in determining the policy elimination period:

- How much liquidity of assets or savings does an individual have?
- Does the individual have a short-term disability policy at work?
- Does the individual have sick days accumulated holidays or bonus days at work that they may use?
- Do they have vacation time coming?
- Does the spouse have an income they can depend on?
- Does the individual have sources of unearned income from rentals, investments, dividends, interest and the like?

The individual should very carefully make a list of their fixed expenses and know exactly how long the above four factors can provide them with an income.

Now the individual can intelligently determine the proper policy elimination period.

**BENEFIT PERIOD**

Another factor that affects the cost of the disability income policy is its benefit period.

This is the period of time that benefits will be paid to the insured for total disability.

Typical benefit periods are as follows:

- One year
- Two years
- Five years
- Age 65
- Lifetime

The average disability lasts 9 to 18 months. However, depending on the occupation and the definition of the occupation, the benefit period is a major consideration.

For example, if the individual is a plastic surgeon, losing a hand is a major disability and they certainly would want to have an age 65 or lifetime benefit period.

If however, the individual is a tow truck driver, a one or two years benefit period might be just fine.

**HOW IS A DISABILITY POLICY RENEWABLE?**

There are two types of renewal provisions in disability plans:

- Non-cancelable.
- Guaranteed Renewable.

**DEFINITION OF NON-CANCELABLE**

This type is the most favorable to an individual and the one that the underwriters look at the closest. As long as they pay their premiums on time to a pre-determined date, usually age 65, the company **CANNOT:**

- Cancel the policy.
- Change any provisions.
- Add any riders that restrict coverage.
- Add any changes to the policy.
- Raise the premiums.
DEFINITION OF GUARANTEED RENEWABLE
A disability policy may be Guaranteed Renewable Only.

This means that the company CANNOT do any of the above five EXCEPT number 5. The company CAN raise the premiums but an individual insured cannot be singled out.

The company must raise the premium for all that are either in that class or that type of policy contract.

AT AGE 65?
In order to keep the policy beyond age 65, the insured must:

- Be employed full-time under the insurers’ definition.
- Pay the premiums on time.

HOW IMPORTANT IS THE DEFINITION OF TOTAL DISABILITY
This definition determines if the individual gets paid or not when a claim is filed. It is very important.

Basically, the definition of TOTAL DISABILITY IS AS FOLLOWS:

- The INDIVIDUAL CANNOT OR IS UNABLE TO WORK AT ONE OR MORE OF THE IMPORTANT DUTIES OF THEIR REGULAR JOB.
- THE INSURED IS UNDER THE CARE OF A QUALIFIED AND LICENSED PHYSICIAN.

OCCUPATIONS
One of the most important considerations in issuing a disability policy is the insured's occupation.

The more hazardous the job, the higher the premium will be due to the inherent risk factors.

Therefore, companies take a close look at the following categories regarding the occupation:

- Does the individual travel a lot in their job?
- What kinds of materials, machines, or tools does the individual use?
- What industry is the company engaged in?
- Does the individual manage others?
- Is the job seasonal in nature?
- Is the individual prone to being laid off or having their hours shortened?

OCCUPATIONAL CLASSIFICATIONS
Disability policies can use a class grouping or an alphabetical grouping for occupations.

The five most common are:

- Class One or AAAA.
- Class Two or AAA.
- Class Three or AA.
- Class Four or A
- Class Five or B.
CLAS ONE OR AAAA.
Occupations commonly found here are the ones with favorable claims experience such as CPA’s, Dentists, Doctors, Vets, etc.

CLASS TWO OR AAA.
Occupations in this group are typically managerial technical professional and executive types who’s duties are generally restricted to the office.

CLASS THREE OR AA.
Occupations here are comprised of supervisors of performing employees but not those that do the actual operations. Merchants, Salespeople, Store Managers are a few examples.

CLASS FOUR OR A.
Here you will find skilled labor type of occupations such as home construction and small construction machines to name a few.

CLASS FIVE OR B.
Here we find the most hazardous of the occupational classifications and the most difficult to insure. A Motorcycle Police Officer, Bricklayer, or Welder is prime examples.

INCOME REQUIREMENT
This area is one that is very strictly underwritten in that companies do not want to permit an individual to earn more income while disabled than they would while working.

Obviously, this situation would cultivate false claims and malingering disabilities.

Therefore, companies place a percentage of monthly benefits to your monthly-earned income. Typically, companies will issue a monthly benefit equal to from 40 to 70% of the individual’s earned income. For example, if the individual earn $3,000 per month, they can expect an insurer to give them a monthly benefit of from $1,200 (40% of $3,000) to $2,100 (70% of $3,000) or any amount in between.

Companies are looking for "earned income" which can best be defined as income for which an individual must sweat. Companies also look at "unearned income" such as rental income, royalties, investments, or dividends. Since this is income that would normally continue even if the individual were disabled it is generally not considered in the percentage formula and in some cases, it may even reduce the amount the company is willing to issue as benefit.

WHAT TYPES OF OCCUPATION DEFINITIONS ARE THERE?
- Your regular occupation.
- A limited regular occupation.
- Your regular occupation (Not working).
- Non-occupation

YOUR REGULAR OCCUPATION
This definition is the best of the choices. However, it usually applies only to insured's that are in highly professional positions such as dentists, lawyers and doctors. This definition covers the insured's "usual work" and a claim will be paid when the insured satisfies this stipulation.

A LIMITED REGULAR OCCUPATION
This is the second best of the choices. The major difference is that the insured would not be considered disabled for the full benefit period. For example if the benefit period were 5 years, the policy may cover you for 3 of those years under the regular occupation definition.
HEALTH INSURANCE PRINCIPLES

However, after the 3 years definition has been satisfied the policy would contain an additional condition the last 2 years of the benefit period and it may then say:

Coverage will continue if the insured is not working in a reasonable occupation or if the insured is unable to work in a reasonable occupation

YOUR REGULAR OCCUPATION (NOT WORKING)
In order to qualify for disability benefits under this definition the individual must be unable to do the substantial and material duties of their job AND not work in reasonable occupation.

NON-OCCUPATION
Rather than specially address an occupation, this definition says that they are totally disabled if,

You are unable to work at any job for which you are reasonably suited for by training, education or experience.

WAIVER OF PREMIUM
This provision is usually part of all disability contracts. It states that if the insured is disabled more that 6 months (some may be 90 days) the premiums are waived until the insured goes back to work and no longer disabled or the benefit period expires.

Some policies also refund the premiums paid during the 6-month (or 90 day) period while they were waiting for the waiver provision to start.

EXCLUSIONS
There are three that commonly appear in most disability policies. They are:
- Self inflicted injury.
- Pregnancy.
- War

Some companies have removed the pregnancy exclusion in order to be more attractive to the female market.

GRACE PERIOD
The grace period is defined as the period of time beyond the due date that the insured may pay the premium without the policy lapsing.

This is 31 days in most disability policies. During the grace period, the policy stays in force so long as the insured pays the premium that is due before the end of the 31st day.

CONTESTABILITY
Disability policies contain a period of contestability that is usually two years.

It should be noted that some policies exclude periods of disability during the two years.

During the period of contestability the insurance company is given time to determine if any misstatements were made so that they can have the option of either rewriting the policy, or canceling it.

After two years, there is nothing that can be done if misstatements are discovered.
DISABILITY POLICY OPTIONS

CUSTOMIZING YOUR POLICY
Flexibility is one of disability income's strong suits in that an individual is able to add a lot of bells and whistles or options to customize the disability policy.

For example, the following are common "options" that are available:

- Cost of living.
- Future increase of monthly benefit.
- Hospital confinement.
- Life extension.
- Social Security rider.
- Cash back option.

COST OF LIVING
This is an excellent option considering today's inflationary trend. This option permits the insured to increase his monthly income benefit based upon certain factors. The increase may be tied to the Consumer Price Index or it can be guaranteed to specific limits. Some can have a cap as to the maximum. Others have no cap and allow the individual to continue increasing their coverage until they reach age 65.

FUTURE INCREASE OF MONTHLY BENEFIT
This option allows an individual to increase their monthly benefit without evidence of insurability on specific future dates.

Examples of times in which the insured may increase their monthly benefit are:

- Every fourth policy year anniversary up to a specific number or amount.
- The birth of a child.
- Marriage.
- Purchasing a new home.

Typically, the policy states that when any of the above events take place, the insured may increase their monthly benefit a specific amount each time, such as $300 or $400 per month, up to a final monthly maximum.

HOSPITAL CONFINEMENT
This option permits an individual to purchase a specific daily benefit in addition to their regular monthly disability income benefit. This option requires that the insured is admitted to the hospital as an "Inpatient" and during that time, the policy pays a daily benefit of $25 to $200 for each day that they are in the hospital.

LIFE EXTENSION
This option is available when the basic policy has an age 65-benefit period. It extends the benefit period for total disability to the lifetime of the insured in ONE of the four following ways:

- Lifetime benefits are paid if total disability begins before age 50, 55, or 60.
- Lifetime benefits are paid if total disability before a specific age, but at a reduced percentage of the policies monthly income benefits.
An example of this might be that the insured is 60 years of age and becomes totally disabled, the full monthly benefit will be paid to him or her until they are 65, then at age 65, the lifetime extension is reduced to 50%.

Lifetime benefits are paid if an ACCIDENT causes total disability before age 65. This does not include illness and benefits would cease at age 65 with no lifetime extension. Lifetime benefits are paid if total disability occurs before age 65 and there are absolutely no other restrictions as to accident or sickness, age of onset of disability prior to age 65, or reduction in benefit. Obviously, this is the best of the four, and also the most expensive.

SOCIAL SECURITY RIDER
Here a benefit is paid to the insured if Social Security does not pay benefits. This is an excellent rider for the money in that Social Security is the most difficult disability income benefit to qualify for. Social Security has been known to deny in excess of 65% of all claims for benefits.

Basically this rider stipulates that the insured will receive an additional monthly benefit above and beyond their basic monthly benefit if Social Security benefits are denied. If however, Social Security does approve benefits, then the insurance company will not pay this additional monthly benefit.

Another way in which this option works is that the basic monthly benefit WELL BE REDUCED by any amount Social Security pays.

CASH BACK OPTION
Many people feel that this option is expensive and impractical. One of their major complaints is that their money does not earn any interest. An insurance company charges an additional premium, which can be very substantial for the cash back option.

The two most common cash back options are as follows:

- The company will return to the insured at age 65 all premiums paid less any benefits received. In the event benefits received exceed the premiums they have paid to age 65, there is no return of the premium.

- Some companies will permit the insured to drop the cash back option and reduce their premium accordingly, should the insured ever reach the point that benefits paid exceed their premiums. However, most companies continue charging the insured the additional premiums for the cash back option even when benefits paid exceed their premiums collected.

- The company will review the policy every ten years (rather than waiting to age 65) and return 80% of all premiums paid, less any benefits received. The insured can then use this return or premium to pay future premiums. Obviously most people will find other uses for the money.

BUSINESS OVERHEAD POLICY
If an individual owns a business, one of the major disasters they could face is the owner not being on the premises to run the business. A business overhead policy can help keep the business open until the owner is able to return to work. Many businesses are dependent upon the owner's knowledge, skilled profession, or just plain good within dealing with customers or bank connections. Obviously, their absence could pose big problems in these areas. This is especially true when the owner is the key employee or major factor in the success of the business.

Conversely, there are business owners that do not play major roles in the operation of their business but depend on others to do what is necessary to produce income for the company.
ELIMINATION PERIODS
Common elimination periods for business overhead policies are as follows:

- 30 day
- 60 day
- 90 day

The most common of the elimination periods is the 30-day in those business owners do not have sufficient funds to cover business expenses for a long period of time.

BENEFIT PERIOD
Common benefit periods for business overhead policies are as follows:

- 12 months
- 15 months
- 18 months
- 24 months

 Typically, it must be realized that if the business owner does not return because of a total disability after 24 months their return at all is certainly doubtful.

MONTHLY BENEFIT
Monthly benefit considerations made here are:

- The type of business.
- Owner's occupation.
- Insured's portion of the work.
- Employee's portion of the work.
- Amount of loss of income.
- The company's current expenses.

COVERED EXPENSES
There are many expenses in running a business and not all can be covered with a business overhead expense policy.

The following are some of the more common of the covered expenses:

- Rent
- Utilities such as Water, Heat, Electricity, Telephone, Telephone Answering Service
- Employee's salaries
- Employee fringe benefits
- Payroll Taxes
- FICA (Social Security & Medicare)
- FUTA (Federal Unemployment Tax Act)
- SUTA (State Unemployment Tax Act)
- Professional or Association Dues
- Accounting fees
- Premiums for business insurance
EXPENSES NOT COVERED
It is very important that the policy owner understands WHAT IS NOT COVERED so that there are no misunderstandings or disputes at the time of claim.

The following are usually NOT COVERED:

- Purchases of equipment or furniture.
- Salaries, draws, commissions, fees, or any other monies due the owner. (The owner covers these expenses with a personal disability income plan).
- Payments made towards debts.

DISABILITY INSURANCE FOR A KEY EMPLOYEE
Often times an employee of the company is a key ingredient to its success. Should he/she become sick or hurt, the financial consequences to the company could be severe. A disability insurance plan for this key employee is the answer. The company purchases the disability policy and the company becomes its beneficiary. Should the key employee become disabled, the company is then reimbursed for the expected income loss caused by his/her absence. As a rule, the benefit period is for 6, 12, or 18 months.

TAXES & DISABILITY INSURANCE
Everyone has heard two things are certain; death and taxes. The role of thumb for Uncle Sam is pay him now or pay him later.

When writing disability income in the business market the tax laws depend upon the type of business involved. You should therefore be familiar with the following types of businesses:

CORPORATION
This is an entity granted a legal charter for a body of persons that are recognized as separate entities authorized by law. All business matters are done in the name of the corporation and the corporations, not the stockholders, are responsible for any liabilities or obligations.

SOLE PROPRIETORSHIP
The business is fully owned by one person and is not incorporated. In most cases, this person is the owner or manager and they are personally responsible for liabilities and obligations for both business and personal assets.

PARTNERSHIP
Here there are usually two or more people who join together as principals of a legal association. Each of the partners is responsible and personally liable for the obligations of the partnership with personal assets as well as their investment.

TAXES ON PERSONAL DISABILITY INCOME PLANS
Premiums paid for personal disability income plans are not tax deducted. The good news is that regardless of how much you receive while totally disabled under a personal disability plan, all income is received 100% tax-free.
A business owner for example, could insure himself / herself under a "Tax-favored sick-pay plan" and have it construed to be personally purchased. Here again the benefits are completely tax free because the business owner is not considered an employee and the premiums cannot be tax deducted.

**SICK-PAY PLAN FOR KEY EMPLOYEES**

The premiums are completely tax deductible as a necessary business expense for disability purchased on key employees. As a business owner, you are faced with the possibility of continuing a key person’s salary when they are disabled. This plan solves that problem.

**TAXES ON BONUSES FOR EXECUTIVES**

Executive Bonus is a simple way to insure tax-free benefits. The bonus can be deductible to the business owner as compensation to the executive. The business owner merely pays a bonus to the executive equal to the amount of the premium and writes it off as a business expense. The executive must report this bonus as ordinary income and pay the appropriate income tax disability benefits to the executive are received tax-free.

**TAXES ON OVERHEAD EXPENSE POLICIES**

Since the business owns the policy and the premiums are deducted as a business expense, the income from the policy, when paid to a disabled owner, are taxable. Since, however, the benefits are being used to pay business expenses there is obviously an offset.

**DISABILITY UNDERWRITING**

Contrary to popular belief, the "underwriter" is not just a home office position. Many companies place a lot of responsibility on the good judgment of the agent in the field when it comes to insureing a disability risk.

As an agent in the field, you have the upper hand in that you are not merely dealing with the information contained on the application, but are in fact, seeing and talking to the potential insured.

Underwriters use the following details to determine the risk factors in writing a disability policy.

- Date of birth.
- Occupational rating.
- Address.
- Gender.
- Earned Income.
- Net Worth.
- Expenses.
- Unearned Income.
- Benefits applied for.
- Current coverage.
- Medical History.
- Family History.
- Present physical condition.
- Hobbies.
- Moral Character.

**DEFINITION OF UNDERWRITING**

Underwriters can be compared to judges in that they gather "all the evidence" so to speak, concerning an individual and try to judge or determine to issue that individual a disability income plan.
Disability underwriting and life underwriting have many different concerns. There are many conditions a potential insured can have that are not life threatening but are certainly possible disability income claims.

For example, bad knee or back or shoulder injury while not life threatening, certainly become future disability claims.

**DEFINITION OF MEDICAL UNDERWRITING**
Medical underwriting is done two ways:
- First, in the field with the agent and,
- Second, with questions on the application.

The following areas are studied very carefully in the medical underwriting process
- Parts of the body that is affected.
- Symptoms.
- Date of onset.
- Severity of symptoms.
- Frequency.
- Duration.
- Cause.
- Time off work.
- Diagnostics.
- Kind of treatment.
- Names of all medical practitioners consulted.

**IMPORTANCE OF MEDICAL EXAMINATIONS**
The companies print and publish what are referred to as non-medical limits”. In other words, there are certain points at which a medical exam is required.

The following factors are taken into consideration and the company determines whether or not they want a physical exam or other test.
- Occupational classification.
- Age of applicant.
- Amount applied for.
- Benefit period applied for.

**FOR EXAMPLE -**
If an individual has a non-hazardous occupational class, are over age 60, and request a long benefit period, they will probably exceed the non-medical limit. Conversely, an individual could have a hazardous occupation with a short benefit period and not be required to take an exam.

**UNDERWRITING SUBSTANDARD POLICIES**
Not every applicant can be given a standard policy. There are many factors that cause an applicant to be considered substandard.

Some of them are:
- Current status of health.
- Age.
- Occupational rating.
- Pre-existing conditions.
- Sports or hobbies.
Rather than completely deny coverage, some companies are willing to make adjustments and issue a substandard policy.

Examples of these are as follows:

- Shorten the benefit period.
- Lengthen the elimination period.
- Issue a rider that excludes or limits coverage in certain areas.
- Charge an extra premium above and beyond the standard premium.
- Issue an exclusion rider for a qualified condition.

FINANCIAL UNDERWRITING OF DISABILITY PLANS
Before a company is willing to offer a specific amount of coverage, they will need to know all sources of the applicant's income.

This financial picture is very important some of the factors considered are as follows:

- Insured adjusted gross income.
- Existing disability policies.
- Unearned Income.
- New worth.

DISABILITY CLAIMS
Any time a company sells disability income insurance; it knows that part of the premium dollars taken in are going to be paid out in claims. Most companies make every effort to pay claims fairly and promptly. However, they also know that it is the company's obligation to be certain that unjust claims are not paid.

You should be aware of exactly what method your company uses in claims processing.

FOR EXAMPLE:
Some companies underwrite the application.

Some companies underwrite the claim.

When the client becomes disabled and has a loss of income and needs that money to pay his / her obligations, they have a very short attention span when it comes to claims.

Companies that underwrite the application certainly have the advantage over those that underwrite the claim. Most agents prefer companies that underwrite the application so that there are no problems or misunderstandings at time of claim.

Obviously, the claim form is very important as an agent, your role is to bring the form to the insured and assist them in completing it Caution is given here in that you should only assist the insured and you should never complete the form yourself.

The claim form will give the company the information necessary to process the claim. Remember, the quicker the claim begins, the quicker the claim can be paid.

OTHER FACTORS FOR CLAIMS
Some confusion lies as to when one can apply for benefits, if the disability income policy contains a 30 day waiting period. The insured is eligible for benefits on the 31st day.
However the agent must realize that his client may not see the first check for over 60 days. Companies pay claims only as earned.

In other words, they will not accept estimates that a client may be off work for six months and therefore, send a check for six months in the future.

As a rule, if an insured is in fact, not going to return to work for a period of six or eight months, according to the physician's estimates, the insured must submit an up to date claim form every 30 days.

Remember one of the primary requirements of the insurance company for continuation of benefits is that the insured be currently under the care of a qualified licensed physician.

The company also reserves the right to request periodic physical examinations on the insured to ascertain whether or not the condition that has caused total disability still applies. In most cases, the company pays for the physical examination and in almost all cases, the company, not the insured, picks the doctor to do the examination.

In conclusion, disability income is one of the most important policies you can have because it protects your most valuable asset the ability to earn an income for your family.
10. THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

INTRODUCTION

Federal and state laws provide important consumer protections for those who have pre-existing medical conditions and move from one job to another.

The federal law, officially called the "Health Insurance Portability and Accountability Act of 1996" (HIPAA), also referred to as the "Kassebaum-Kennedy Act", was enacted by President Clinton on August 21, 1996.

This chapter is designed to provide a general overview of the HIPAA law and how it interacts with existing state laws.

We hope this document will also help correct a few misconceptions about the laws.

You may have heard that individuals will be able "to take their medical coverage with them." This is only partially true.

They do not actually take their exact plan of health benefits with them, but they do get to "take the credit" for the time they’ve served under their former plan to their new employer’s plan.

In general, the laws require employer group health plans to cover pre-existing conditions sooner by giving them credit for coverage under their former health plan.

The law applies to most health plans. The "portability" or take it with you concept does not apply if individuals are changing from one individual health plan to another individual health plan.

Pre-existing conditions limits will still apply.

The laws do not affect all health insurance policies in exactly the same way.

Group policies have different rules than policies purchased by individuals.

As a consumer, individuals need to know what kind of plan they have and which laws apply to their plan.

In general, most of the laws cover group health plans only. Very few changes were made to individual health plans.

Tax changes were also made to long-term care plans and medical savings accounts.

GROUP HEALTH PLANS

Employer provided group health plans are either fully insured or self-insured.

Fully insured group health plans are divided into two categories:

- Small employer plans for groups with 2-50 employees or
- Large employer plans for groups with 51 or more employees.

Under any fully insured plan, the employer purchases coverage from an insurance company. The insurance company assumes the risk to pay all health claims.
Self-insured group health plans (or self-funded plans) are set-up by employers to pay the health claims of its employees.

The employer assumes the risk of providing the benefits and is obligated to pay all the claims.

Sometimes self-insured plans are confused with fully insured plans because employers often hire an insurance company or third party administrator to pay the claims. If an individual doesn’t know what kind of plan they have, they should ask their employer or plan administrator.

**HIGHLIGHTS OF CHANGES TO GROUP HEALTH PLANS**

Federal and state laws make a number of changes that apply to all group health plans.

The health insurance changes required by the new laws include the following:

- Defines pre-existing medical conditions and limits how long plans may exclude these conditions for benefits.
- Pregnancies cannot be considered a pre-existing condition.
- Requires plans to treat all eligible individuals equally.
- For example, plans may not discriminate against individuals with an unfavorable medical history.
- Requires insurance companies to automatically renew group coverage each year.
- Mandates insurance companies selling coverage to small employers to make all products available to all small employers who apply.
- Small employer is now defined as 2-50 employees.
- Requires plans to offer special enrollment period for all new dependents due to marriage, birth, adoption or placement for adoption.
- Requires plans to have the same dollar limits on mental conditions as on physical conditions.

**PRE-EXISTING MEDICAL CONDITIONS**

The main reason so many consumers have had difficulty changing from one insurance plan to another is because of prior or ongoing health conditions commonly called "pre-existing medical conditions."

Historically, health plans would not cover pre-existing conditions, or limited coverage when someone joined the plan, or even refused to give them health insurance.

The these laws:

- Define what conditions are considered pre-existing;
- Limit how long coverage may be excluded; and
- Require plans to give individuals credit for time served under their former health plan.

A pre-existing medical condition is defined as a physical or mental condition for which medical advice, diagnosis, care or treatment is recommended or received prior to their date of hire, or the date their coverage begins (depending on the plan).

The pre-existing condition limits vary depending on the type of group health plan that an individual has.
PRE-EXISTING EXCLUSION PERIODS:
A fully insured small employer plan (2 to 50 employees) can exclude coverage for pre-existing conditions for up to 9 months.

The individual’s pre-existing condition must meet the new definition and must have occurred within six-months prior to their effective date of coverage.

A fully insured large employer plan (51 or more employees) can exclude coverage for pre-existing conditions for up to 12 months.

The pre-existing condition must meet the new definition and must have occurred within 6 months prior to their effective date of coverage.

A self-insured plan can exclude coverage for their pre-existing conditions for up to 12 months. The pre-existing condition must meet the new definition and must have occurred within six months prior to their hire date.

CONDITIONS WHICH MAY NOT BE CONSIDERED "PRE-EXISTING"
Pregnancy is no longer a pre-existing condition in fully insured plans and self-insured plans. In other words, if the individual is pregnant when they join their new health plan their pregnancy must be covered.

Genetic information may not be considered a pre-existing condition if there is no specific diagnosis of a current disease or medical problem related to the genetic test.

PORTABILITY: MOVING FROM PLAN TO PLAN

GROUP TO GROUP
The laws add another very important provision to help make it easier when changing health plans. Individuals get credit for their time served under the former health plan.

This credit is "portable," that is, you take it with you as you move from plan to plan.

If the new group health plan has limits on coverage for pre-existing medical conditions, they must give the individual credit for any prior health coverage that they had. The law calls this credit "prior creditable coverage."

For example, let’s assume the new group health plan has a 6 months pre-existing condition exclusion period. The new plan must give the individual credit for time served under their prior health plan.

If their prior coverage was for at least 6 months, the plan must give them full credit which means all pre-existing conditions would be covered under their new plan.

If their prior coverage was for 60 days, the plan can only impose a 120 day exclusion for pre-existing conditions.

QUALIFYING FOR PRIOR COVERAGE
To qualify for prior coverage credit:

The individual must not have a gap of more than 62 days between the prior coverage and their new group health plan. (The new coverage must be in place on the 63rd day to avoid a gap in coverage.) AND the individual must have had coverage under a qualified health plan which includes fully insured employer health plans, individual health insurance, government health plans such as Medicaid and Medicare; state
and federal government employee health plans; coverage through state "high-risk" pools; and the Indian Health Service.

Plans that do not qualify for "prior creditable coverage"

The individual cannot get credit for coverage under non-medical coverages such as dental or vision plans; specified disease policies such as cancer or disability insurance; or workers compensation coverage.

**Portability: Moving from Plan to Plan Group to Individual State "High Risk " Pool**

Individuals can move from a group plan to the state "high risk pool" without pre-existing conditions being applied if:

- They were covered by one or more group health insurance plans (group, church, or employer plan) for at least 18 months before seeking individual coverage AND
- They have exhausted their COBRA or their state continuation benefits and join the pool within 63 days of losing prior coverage AND
- The plan they were covered under did not terminate for non-payment of premium or for fraud, AND
- They are not covered under Medicare or Medicaid
- They have not obtained new group coverage.

If an individual fulfills these requirements, they are considered a "federally eligible individual."

A federally eligible individual qualifies for a guaranteed issue policy without pre-existing condition exclusions.

The risk pool plan must offer enrollees a choice of at least three (3) deductibles and co-payment plans. Lifetime benefit maximums are unlimited. The plan allows dependent coverage.

**EMPLOYEE RIGHTS**

When an individual leaves a plan all group health plans must give them a certificate that shows how many months of coverage they had under their plan.

This certificate of "prior creditable coverage" must be provided to the employee when:

- They leave their job or
- They exhaust their COBRA benefits or
- They ask for it within 24 months after leaving the plan.

When they enroll in a new plan:

- All group health plans must tell individuals about any pre-existing condition limits in their plan.
- They must tell them what will be required to show proof of prior coverage.

After receiving proof of prior coverage, the plan must advise the individual...
if any conditions they have will be excluded as a pre-existing condition.

**DISCRIMINATION BASED ON MEDICAL HISTORY PROHIBITED**

The laws prohibit all group health plans from discriminating against the individual based on their health status. In other words, the plan cannot treat an individual any differently from other individuals covered under their plan because they have a medical condition (such as cancer or a disability) or have a history of filing medical claims.

**EMPLOYER (OR PLAN) RESPONSIBILITIES**

**Prior Coverage Certification**

All group health employer plans must provide written certification of prior coverage to all individuals losing coverage after June 1, 1997.

The certificate must identify the covered person, period of coverage, and waiting periods (if any). It should be sent by first class mail to the employee’s last known address.

The plan must also provide specific benefit information upon request to another employer’s plan.

**Notice of Pre-existing Condition Exclusion**

Certain information must be included in the Summary Plan Description (SPD) employee booklet to notify of their right to:

- Receive notice of the pre-existing condition exclusion.
- Receive credit for prior coverage.
- Request certificates of coverage from previous plan.
- The notice also must say the plan will help the participants get their certificates, if necessary.

**SPECIAL ENROLLMENT PERIODS**

Plans must provide a special enrollment period:

- For individuals who become dependents by marriage, birth or adoption. At that time, the employee or spouse may also elect coverage, if not already covered.

- For employees/dependents who initially decline your plan coverage because they were covered under another plan. (For example, the employee is covered through their spouse and then loses that coverage.)

**Disclosure Requirements (for self-insured plans only)**

Plans must provide notice of material reduction in benefits or services within 60 days.

The Summary Plan Description must include information about the third-party administrators of the plan.

**Employer Rights**
The laws also grant employers certain rights. Some important examples:

- Guaranteed renewability for all fully insured group plans.
- Insurance companies are required to automatically renew the group coverage each year.

Guaranteed availability for small employers.

- Health insurers in this market must make all their health plans available to all small employer groups that apply.
- Upon written request, the insurance company must provide the employer a written outline of all group health plans offered.

Mental Health Coverage

Large employer and self-funded health plans are prohibited from imposing different annual or lifetime dollar limits on benefits provided for mental health conditions than for medical and surgical coverage.

In other words, if their plan has a $50,000 annual limit on benefits for medical conditions, it must have the same annual limit for mental health coverage. There is an exception to this rule.

A plan can opt out, i.e. not provide this coverage, if they can show that their plan costs would increase by 1%.

48-Hour Coverage for Maternity

All group health plans are required to pay for minimum hospital stays for mother and her newborn child after delivery.

They must provide coverage for at least 48 hours in the hospital after a normal delivery and 96 hours after a cesarean section delivery.

Individual Health Plans

Individual health insurance policies must be guaranteed renewable. However, policies still may be canceled for non-payment of premiums or fraud.

Tax Benefits Long-term Care Insurance

The federal law (HIPAA) provides for favorable tax treatment for "qualified long-term care plans."

In the case of a qualified plan:

- You may deduct all or part of the premium as a medical expense.
- Benefits paid out by the policy will generally not be taxable as income.

Long-term care policies sold before January 1, 1997, are "grandfathered" as tax qualified.

All policies sold after January 1, 1997, must be identified as either tax qualified or non-tax qualified in the policy contract.

Individuals should consult with their attorney, accountant, or tax advisor regarding the tax implications of purchasing long-term care insurance.
Medical Savings Accounts- Health Savings Accounts

HIPAA also establishes a program tax exempt medical savings accounts (MSAs).

MSAs/HSAs are savings accounts set up to pay for medical expenses such as health insurance premiums and the cost of doctor visits.

The MSA must be set up to pay for medical expenses such as health insurance premiums and the cost of doctor visits.

The MSA must be set-up in connection with the purchase of a high deductible health insurance policy approved by the State Department of Insurance.

**WHO ENFORCES THE LAW?**

Most of the provisions in the law are the same whether they come under the federal HIPAA or are covered by State law.

The main difference is in who will enforce the law.

**Fully insured Group Health Plans**

Fully insured group health plans are subject to state laws and compliance is enforced by the State Department of Insurance.

**Self-insured Group Health plans**

Self-insured group health are not governed by state laws, but by a federal law called the Employee Retirement Income Security Act (ERISA).

If the plan is self-insured, it must follow federal laws (HIPAA). The U.S. Department of Labor (Pension and Welfare Benefits Administration) is enforcing these rules.

Self-insured plans not complying with the guidelines may be subject to an excise tax imposed by the Internal Revenue Service of $100 per day per violation.

Non-compliance also means the possibility of lawsuits from plan participants or the U.S. Department of Labor.

If anyone should have questions regarding any of these laws they will need to contact the U.S. Department of Labor.

**Individual Health Plans**

If someone has an individual health plan, their plan is governed by state law and is enforced by the State Insurance Department.

**Medical Savings Accounts**

HIPAA makes changes to federal tax laws to provide a tax exemption when a medical savings account is set-up in connection with the purchase of a high deductible health insurance plan.

The Internal Revenue Service enforces this portion of the law.

**Long-term Care Insurance**

HIPAA provides for favorable tax treatment for "qualified long-term care plans." Any questions regarding the tax qualification of a long-term care policy are determined by the Internal Revenue Service.
SUMMARY OF THE HIPAA PRIVACY RULE

INTRODUCTION
The Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") established, for the first time, a set of national standards for the protection of certain health information.

The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The Privacy Rule standards address the use and disclosure of individuals’ health information—called “protected health information” by organizations subject to the Privacy Rule — called “covered entities,” as well as standards for individuals’ privacy rights to understand and control how their health information is used.

Within HHS, the Office for Civil Rights ("OCR") has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties.

A major goal of the Privacy Rule is to assure that individuals’ health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public’s health and well being.

The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

This is a summary of key elements of the Privacy Rule and not a complete or comprehensive guide to compliance. Entities regulated by the Rule are obligated to comply with all of its applicable requirements and should not rely on this summary as a source of legal information or advice.

To make it easier for entities to review the complete requirements of the Rule, provisions of the Rule referenced in this summary are cited in notes at the end of this document. To view the entire Rule, and for other additional helpful information about how it applies, see the OCR website:
http://www.hhs.gov/ocr/hipaa

Links to the OCR Guidance Document are provided throughout this paper. Provisions of the Rule referenced in this summary are cited in endnotes at the end of this document. To review the entire Rule itself, and for other additional helpful information about how it applies, see the OCR website:

STATUTORY & REGULATORY
The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of HHS to publicize standards for the electronic exchange, privacy and security of health information.

Collectively these are known as the Administrative Simplification provisions.

HIPAA required the Secretary to issue privacy regulations governing individually identifiable health information, if Congress did not enact privacy legislation within three years of the passage of HIPAA. Because Congress did not enact privacy legislation, HHS developed a proposed rule and released it for public comment on November 3, 1999. The Department received over 52,000 public comments. The final regulation, the Privacy Rule, was published December 28, 2000.
BACKGROUND
In March 2002, the Department proposed and released for public comment modifications to the Privacy
Rule. The Department received over 11,000 comments. The final modifications were published in final
form on August 14, 2002. A text combining the final regulation and the modifications can be found at 45

The Privacy Rule, as well as all the Administrative Simplification rules apply to:

- Health plans,
- Health care clearinghouses, and
- Any health care provider who transmits health information in electronic form in connection with
transactions for which the Secretary of HHS has adopted standards under HIPAA (the “covered
entities”).

For help in determining who is covered, use the decision tool at:

WHO IS COVERED BY THE PRIVACY RULE

HEALTH PLANS.
Individual and group plans that provide or pay the cost of medical care are covered entities.

Health plans include health, dental, vision, and prescription drug insurers, health maintenance
organizations (“HMOs”), Medicare, Medicaid, Medicare+Choice and Medicare supplement insurers, and
long-term care insurers (excluding nursing home fixed-indemnity policies).

Health plans also include employer-sponsored group health plans, government and church-sponsored
health plans, and multi-employer health plans.

There are exceptions—a group health plan with less than 50 participants that is administered solely by
the employer that established and maintains the plan is not a covered entity.

Two types of government-funded programs are not health plans:

1. those whose principal purpose is not providing or paying the cost of health care, such as the food
   stamps program; and

2. those programs whose principal activity is directly providing health care, such as a community
   health center, or the making of grants to fund the direct provision of health care.

3. Certain types of insurance entities are also not health plans, including entities providing only
   workers’ compensation, automobile insurance, and property and casualty insurance.

HEALTH CARE PROVIDERS.
Every health care provider, regardless of size, who electronically transmits health information in
connection with certain transactions, is a covered entity.

These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other
transactions for which HHS has established standards under the HIPAA Transactions Rule.

Using electronic technology, such as email, does not mean a health care provider is a covered entity; the
transmission must be in connection with a standard transaction.

The Privacy Rule covers a health care provider whether it electronically transmits these transactions
directly or uses a billing service or other third party to do so on its behalf.
Health care providers include all “providers of services” (e.g., institutional providers such as hospitals) and “providers of medical or health services” (e.g., non-institutional providers such as physicians, dentists and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care.

**HEALTH CARE CLEARINGHOUSES.**

*Health care clearinghouses* are entities that process nonstandard information they receive from another entity into a standard (i.e., standard format or data content), or vice versa.

In most instances, health care clearinghouses will receive individually identifiable health information only when they are providing these processing services to a health plan or health care provider as a business associate. In such instances, only certain provisions of the Privacy Rule are applicable to the health care clearinghouse’s uses and disclosures of protected health information.iv

Health care clearinghouses include billing services, re-pricing companies, community health management information systems, and value-added networks and switches if these entities perform clearinghouse functions.

**BUSINESS ASSOCIATES**

**BUSINESS ASSOCIATE DEFINED**

In general, a business associate is a person or organization, other than a member of a covered entity’s workforce, that performs certain functions or activities on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of individually identifiable health information.

Business associate functions or activities on behalf of a covered entity include claims processing, data analysis, utilization review, and billing.

Business associate services to a covered entity are limited to legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services.

However, persons or organizations are not considered business associates if their functions or services do not involve the use or disclosure of protected health information, and where any access to protected health information by such persons would be incidental, if at all.

A covered entity can be the business associate of another covered entity.

**BUSINESS ASSOCIATE CONTRACT**

When a covered entity uses a contractor or other non-workforce member to perform “business associate” services or activities, the Rule requires that the covered entity include certain protections for the information in a business associate agreement (in certain circumstances governmental entities may use alternative means to achieve the same protections).

In the business associate contract, a covered entity must impose specified written safeguards on the individually identifiable health information used or disclosed by its business associates.v Moreover, a covered entity may not contractually authorize its business associate to make any use or disclosure of protected health information that would violate the Rule.

Covered entities that have an existing written contract or agreement with business associates prior to October 15, 2002, which is not renewed or modified prior to April 14, 2003, are permitted to continue to operate under that contract until they renew the contract or April 14, 2004, whichever is first.vi

Sample business associate contract language is available on the OCR website at: http://www.hhs.gov/ocr/hipaa/contractprov.html. Also see OCR “Business Associate” Guidance.
**PROTECTED HEALTH INFORMATION**

The Privacy Rule protects all “individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information “protected health information (PHI).”

“Individually identifiable health information” is information, including demographic data, that relates to:

- The individual’s past, present or future physical or mental health or condition, the provision of health care to the individual, or
- The past, present, or future payment for the provision of health care to the individual, and
- That identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.

Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

**DE-IDENTIFIED HEALTH INFORMATION**

There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information; either:

1) A formal determination by a qualified statistician; or

2) The removal of specified identifiers of the individual and of the individual’s relatives, household members, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.

**BASIC PRINCIPLE**

A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual’s protected health information may be used or disclosed by covered entities.

A covered entity may not use or disclose protected health information, except either:

(1) As the Privacy Rule permits or requires; or

(2) As the individual who is the subject of the information (or the individual’s personal representative) authorizes in writing.

**REQUIRED DISCLOSURES**

A covered entity must disclose protected health information in only two situations:

(a) To individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and

(b) To HHS when it is undertaking a compliance investigation or review or enforcement action. See OCR “Government Access” Guidance.

**PERMITTED USES AND DISCLOSURES**

A covered entity is permitted, but not required, to use and disclose protected health information, without an individual’s authorization, for the following purposes or situations:

(1) To the Individual (unless required for access or accounting of disclosures);
(2) Treatment, Payment, and Health Care Operations;

(3) Opportunity to Agree or Object;

(4) Incident to an otherwise permitted use and disclosure;

(5) Public Interest and Benefit Activities; and

(6) Limited Data set for the purposes of research, public health or health care operations.

Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

(1) To the Individual. A covered entity may disclose protected health information to the individual who is the subject of the information.

(2) Treatment, Payment, Health Care Operations. A covered entity may use and disclose protected health information for its own treatment, payment, and health care operations activities.

A covered entity also may disclose protected health information for the treatment activities of any health care provider, the payment activities of another covered entity and of any health care provider, or the health care operations of another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities, if both covered entities have or had a relationship with the individual and the protected health information pertains to the relationship.

See OCR “Treatment, Payment, Health Care Operations” Guidance.

Treatment is the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another.

Payment encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, and furnish or obtain reimbursement for health care delivered to an individual and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual.

Health care operations are any of the following activities:

(a) Quality assessment and improvement activities, including case management and care coordination;

(b) Competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation;

(c) Conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs;

(d) Specified insurance functions, such as underwriting, risk rating, and reinsuring risk;

(e) Business planning, development, management, and administration; and

(f) Business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity.

Most uses and disclosures of psychotherapy notes for treatment, payment, and health care operations purposes require an authorization as described below.
Obtaining “consent” (written permission from individuals to use and disclose their protected health information for treatment, payment, and health care operations) is optional under the Privacy Rule for all covered entities. The content of a consent form, and the process for obtaining consent, are at the discretion of the covered entity electing to seek consent.

(3) Uses and Disclosures with Opportunity to Agree or Object. Informal permission may be obtained by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce, or object.

Where the individual is incapacitated, in an emergency situation, or not available, covered entities generally may make such uses and disclosures, if in the exercise of their professional judgment, the use or disclosure is determined to be in the best interests of the individual.

Facility Directories. It is a common practice in many health care facilities, such as hospitals, to maintain a directory of patient contact information. A covered health care provider may rely on an individual’s informal permission to list in its facility directory the individual’s name, general condition, religious affiliation, and location in the provider’s facility. The provider may then disclose the individual’s condition and location in the facility to anyone asking for the individual by name, and also may disclose religious affiliation to clergy. Members of the clergy are not required to ask for the individual by name when inquiring about patient religious affiliation.

For Notification and Other Purposes. A covered entity also may rely on an individual’s informal permission to disclose to the individual’s family, relatives, or friends, or to other persons whom the individual identifies, protected health information directly relevant to that person’s involvement in the individual’s care or payment for care. This provision, for example, allows a pharmacist to dispense filled prescriptions to a person acting on behalf of the patient.

Similarly, a covered entity may rely on an individual’s informal permission to use or disclose protected health information for the purpose of notifying (including identifying or locating) family members, personal representatives, or others responsible for the individual’s care of the individual’s location, general condition, or death. In addition, protected health information may be disclosed for notification purposes to public or private entities authorized by law or charter to assist in disaster relief efforts.

(4) Incidental Use and Disclosure. The Privacy Rule does not require that every risk of an incidental use or disclosure of protected health information be eliminated. A use or disclosure of this information that occurs as a result of, or as "incident to," an otherwise permitted use or disclosure is permitted as long as the covered entity has adopted reasonable safeguards as required by the Privacy Rule, and the information being shared was limited to the “minimum necessary,” as required by the Privacy Rule.

See OCR “Incidental Uses and Disclosures” Guidance.

(5) Public Interest and Benefit Activities. The Privacy Rule permits use and disclosure of protected health information, without an individual’s authorization or permission, for 12 national priority purposes. These disclosures are permitted, although not required, by the Rule in recognition of the important uses made of health information outside of the health care context. Specific conditions or limitations apply to each public interest purpose, striking the balance between the individual privacy interest and the public interest need for this information.

REQUIRED BY LAW
Covered entities may use and disclose protected health information without individual authorization as required by law (including by statute, regulation, or court orders).
PUBLIC HEALTH ACTIVITIES
Covered entities may disclose protected health information to:

(1) Public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability and to public health or other government authorities authorized to receive reports of child abuse and neglect;

(2) Entities subject to FDA regulation regarding FDA regulated products or activities for purposes such as adverse event reporting, tracking of products, product recalls, and post-marketing surveillance;

(3) Individuals who may have contracted or been exposed to a communicable disease when notification is authorized by law; and

(4) Employers, regarding employees, when requested by employers, for information concerning a work-related illness or injury or workplace related medical surveillance, because such information is needed by the employer to comply with the Occupational Safety and Health Administration (OHSA), the Mine Safety and Health Administration (MHSA), or similar state law.

(5) See OCR “Public Health” Guidance; CDC Public Health and HIPAA Guidance.

VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE
In certain circumstances, covered entities may disclose protected health information to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.xv

HEALTH OVERSIGHT ACTIVITIES.
Covered entities may disclose protected health information to health oversight agencies (as defined in the Rule) for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS.
Covered entities may disclose protected health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.xvi

LAW ENFORCEMENT PURPOSES.
Covered entities may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions:

(1) As required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests;

(2) To identify or locate a suspect, fugitive, material witness, or missing person;

(3) In response to a law enforcement official’s request for information about a victim or suspected victim of a crime;

(4) To alert law enforcement of a person’s death, if the covered entity suspects that criminal activity caused the death;

(5) When a covered entity believes that protected health information is evidence of a crime that occurred on its premises; and

(6) By a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.
**HEALTH INSURANCE PRINCIPLES**

**DECEDENTS.**
Covered entities may disclose protected health information to funeral directors as needed, and to coroners or medical examiners to identify a deceased person, determine the cause of death, and perform other functions authorized by law.xvii

**CADAVERIC ORGAN, EYE, OR TISSUE DONATION.**
Covered entities may use or disclose protected health information to facilitate the donation and transplantation of cadaveric organs, eyes, and tissue.

**RESEARCH.**
“Research” is any systematic investigation designed to develop or contribute to generalizable knowledge.xviii The Privacy Rule permits a covered entity to use and disclose protected health information for research purposes, without an individual’s authorization, provided the covered entity obtains either:

1. Documentation that an alteration or waiver of individuals’ authorization for the use or disclosure of protected health information about them for research purposes has been approved by an Institutional Review Board or Privacy Board;

2. Representations from the researcher that the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purpose preparatory to research, that the researcher will not remove any protected health information from the covered entity, and that protected health information for which access is sought is necessary for the research; or

3. Representations from the researcher that the use or disclosure sought is solely for research on the protected health information of decedents, that the protected health information sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the individuals about whom information is sought.

A covered entity also may use or disclose, without an individuals’ authorization, a limited data set of protected health information for research purposes (see discussion below).

See OCR “Research” Guidance; NIH Protecting PHI in Research.

**SERIOUS THREAT TO HEALTH OR SAFETY.**
Covered entities may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat). Covered entities may also disclose to law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.

**ESSENTIAL GOVERNMENT FUNCTIONS.**
An authorization is not required to use or disclose protected health information for certain essential government functions.

Such functions include:

- Assuring proper execution of a military mission,
- Conducting intelligence and national security activities that are authorized by law, providing protective services to the President,
- Making medical suitability determinations for U.S. State Department employees,
- Protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.xix

**WORKERS’ COMPENSATION.**
Covered entities may disclose protected health information as authorized by, and to comply with, workers’ compensation laws and other similar programs providing benefits for work-related injuries or illnesses.
See OCR “Workers’ Compensation” Guidance.

**LIMITED DATA SET.**
A limited data set is protected health information from which certain specified direct identifiers of individuals and their relatives, household members, and employers have been removed.

A limited data set may be used and disclosed for research, health care operations, and public health purposes, provided the recipient enters into a data use agreement promising specified safeguards for the protected health information within the limited data set.

**Authorization.** A covered entity must obtain the individual’s written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule.

A covered entity may not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an authorization, except in limited circumstances.

An authorization must be written in specific terms. It may allow use and disclosure of protected health information by the covered entity seeking the authorization, or by a third party.

Examples of disclosures that would require an individual’s authorization include disclosures to a life insurer for coverage purposes, disclosures to an employer of the results of a pre-employment physical or lab test, or disclosures to a pharmaceutical firm for their own marketing purposes.

All authorizations must be in plain language, and contain specific information regarding the information to be disclosed or used, the person(s) disclosing and receiving the information, expiration, right to revoke in writing, and other data. The Privacy Rule contains transition provisions applicable to authorizations and other express legal permissions obtained prior to April 14, 2003.

Psychotherapy Notes. A covered entity must obtain an individual’s authorization to use or disclose psychotherapy notes with the following exceptions:

The covered entity who originated the notes may use them for treatment.

A covered entity may use or disclose, without an individual’s authorization, the psychotherapy notes, for its own training, and to defend itself in legal proceedings brought by the individual, for HHS to investigate or determine the covered entity’s compliance with the Privacy Rules, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight of the originator of the psychotherapy notes, for the lawful activities of a coroner or medical examiner or as required by law.

Marketing. Marketing is any communication about a product or service that encourages recipients to purchase or use the product or service. The Privacy Rule carves out the following health-related activities from this definition of marketing:

Communications to describe health-related products or services, or payment for them, provided by or included in a benefit plan of the covered entity making the communication;

Communications about participating providers in a provider or health plan network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan’s enrollees that add value to, but are not part of, the benefits plan;

**COMMUNICATIONS FOR TREATMENT OF THE INDIVIDUAL**
Communications for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or care settings to the individual.
Marketing also is an arrangement between a covered entity and any other entity whereby the covered entity discloses protected health information, in exchange for direct or indirect remuneration, for the other entity to communicate about its own products or services encouraging the use or purchase of those products or services.

A covered entity must obtain an authorization to use or disclose protected health information for marketing, except for face-to-face marketing communications between a covered entity and an individual, and for a covered entity's provision of promotional gifts of nominal value. No authorization is needed, however, to make a communication that falls within one of the exceptions to the marketing definition. An authorization for marketing that involves the covered entity's receipt of direct or indirect remuneration from a third party must reveal that fact.

See OCR “Marketing” Guidance.

**MINIMUM NECESSARY.**

A central aspect of the Privacy Rule is the principle of “minimum necessary” use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request.

A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

See OCR “Minimum Necessary” Guidance.

The minimum necessary requirement is not imposed in any of the following circumstances:

(a) Disclosure to or a request by a health care provider for treatment;

(b) Disclosure to an individual who is the subject of the information, or the individual's personal representative;

(c) Use or disclosure made pursuant to an authorization;

(d) Disclosure to HHS for complaint investigation, compliance review or enforcement;

(e) Use or disclosure that is required by law; or

(f) Use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules.

**ACCESS AND USES.**

For internal uses, a covered entity must develop and implement policies and procedures that restrict access and uses of protected health information based on the specific roles of the members of their workforce.

These policies and procedures must identify the persons, or classes of persons, in the workforce who need access to protected health information to carry out their duties, the categories of protected health information to which access is needed, and any conditions under which they need the information to do their jobs.

**DISCLOSURES AND REQUESTS FOR DISCLOSURES.**

Covered entities must establish and implement policies and procedures (which may be standard protocols) for routine, recurring disclosures, or requests for disclosures, that limits the protected health
information disclosed to that which is the minimum amount reasonably necessary to achieve the purpose of the disclosure.

Individual review of each disclosure is not required. For non-routine, non-recurring disclosures, or requests for disclosures that it makes, covered entities must develop criteria designed to limit disclosures to the information reasonably necessary to accomplish the purpose of the disclosure and review each of these requests individually in accordance with the established criteria.

**Reasonable Reliance.**
If another covered entity makes a request for protected health information, a covered entity may rely, if reasonable under the circumstances, on the request as complying with this minimum necessary standard.

Similarly, a covered entity may rely upon requests as being the minimum necessary protected health information from:

(a) A public official,

(b) A professional (such as an attorney or accountant) who is the covered entity’s business associate, seeking the information to provide services to or for the covered entity; or

(c) A researcher who provides the documentation or representation required by the Privacy Rule for research.

**Privacy Practices Notice.**
Each covered entity, with certain exceptions, must provide a notice of its privacy practices. The Privacy Rule requires that the notice contain certain elements. The notice must describe the ways in which the covered entity may use and disclose protected health information.

The notice must state the covered entity’s duties to protect privacy, provide a notice of privacy practices, and abide by the terms of the current notice. The notice must describe individuals’ rights, including the right to complain to HHS and to the covered entity if they believe their privacy rights have been violated.

The notice must include a point of contact for further information and for making complaints to the covered entity. Covered entities must act in accordance with their notices. The Rule also contains specific distribution requirements for direct treatment providers, all other health care providers, and health plans.

See OCR “Notice” Guidance.

**Notice Distribution.**
A covered health care provider with a direct treatment relationship with individuals must deliver a privacy practices notice to patients starting April 14, 2003 as follows:

- Not later than the first service encounter by personal delivery (for patient visits), by automatic and contemporaneous electronic response (for electronic service delivery), and by prompt mailing (for telephonic service delivery);

- By posting the notice at each service delivery site in a clear and prominent place where people seeking service may reasonably be expected to be able to read the notice; and

- In emergency treatment situations, the provider must furnish its notice as soon as practicable after the emergency abates.
COVERED ENTITIES,
Whether direct treatment providers or indirect treatment providers (such as laboratories) or health plans must supply notice to anyone on request.xxii

A covered entity must also make its notice electronically available on any website it maintains for customer service or benefits information.

The covered entities in an organized health care arrangement may use a joint privacy practices notice, as long as each agrees to abide by the notice content with respect to the protected health information created or received in connection with participation in the arrangement.xxiii

Distribution of a joint notice by any covered entity participating in the organized health care arrangement at the first point that an OHCA member has an obligation to provide notice satisfies the distribution obligation of the other participants in the organized health care arrangement.

A health plan must distribute its privacy practices notice to each of its enrollees by its Privacy Rule compliance date. Thereafter, the health plan must give its notice to each new enrollee at enrollment, and send a reminder to every enrollee at least once every three years that the notice is available upon request.

A health plan satisfies its distribution obligation by furnishing the notice to the “named insured,” that is, the subscriber for coverage that also applies to spouses and dependents.

ACKNOWLEDGEMENT OF NOTICE RECEIPT.
A covered health care provider with a direct treatment relationship with individuals must make a good faith effort to obtain written acknowledgement from patients of receipt of the privacy practices notice.xxiv

The Privacy Rule does not prescribe any particular content for the acknowledgement. The provider must document the reason for any failure to obtain the patient’s written acknowledgement. The provider is relieved of the need to request acknowledgement in an emergency treatment situation.

ACCESS.
Except in certain circumstances, individuals have the right to review and obtain a copy of their protected health information in a covered entity’s designated record set.xxv

The “designated record set” is that group of records maintained by or for a covered entity that is used, in whole or part, to make decisions about individuals, or that is a provider's medical and billing records about individuals or a health plan’s enrollment, payment, claims adjudication, and case or medical management record systems.xxvi

The Rule excepts from the right of access the following protected health information: psychotherapy notes,

- Information compiled for legal proceedings,
- Laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or
- Information held by certain research laboratories.

For information included within the right of access, covered entities may deny an individual access in certain specified situations, such as when a health care professional believes access could cause harm to the individual or another.

In such situations, the individual must be given the right to have such denials reviewed by a licensed health care professional for a second opinion.xxvii

Covered entities may impose reasonable, cost-based fees for the cost of copying and postage.
AMENDMENT.
The Rule gives individuals the right to have covered entities amend their protected health information in a designated record set when that information is inaccurate or incomplete. xxviii

If a covered entity accepts an amendment request, it must make reasonable efforts to provide the amendment to persons that the individual has identified as needing it, and to persons that the covered entity knows might rely on the information to the individual’s detriment.

If the request is denied, covered entities must provide the individual with a written denial and allow the individual to submit a statement of disagreement for inclusion in the record. The Rule specifies processes for requesting and responding to a request for amendment.

A covered entity must amend protected health information in its designated record set upon receipt of notice to amend from another covered entity.

DISCLOSURE ACCOUNTING.
Individuals have a right to an accounting of the disclosures of their protected health information by a covered entity or the covered entity’s business associates.xxix

The maximum disclosure accounting period is the six years immediately preceding the accounting request, except a covered entity is not obligated to account for any disclosure made before its Privacy Rule compliance date.

The Privacy Rule does not require accounting for disclosures:

(a) For treatment, payment, or health care operations;

(b) To the individual or the individual’s personal representative;

(c) For notification of or to persons involved in an individual’s health care or payment for health care, for disaster relief, or for facility directories;

(d) Pursuant to an authorization;

(e) Of a limited data set;

(f) For national security or intelligence purposes;

(g) To correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or

(h) Incident to otherwise permitted or required uses or disclosures.

Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

RESTRICTION REQUEST.
Individuals have the right to request that a covered entity restrict use or disclosure of protected health information for treatment, payment or health care operations, disclosure to persons involved in the individual’s health care or payment for health care, or disclosure to notify family members or others about the individual’s general condition, location, or death.

A covered entity is under no obligation to agree to requests for restrictions. A covered entity that does agree must comply with the agreed restrictions, except for purposes of treating the individual in a medical emergency.
CONFIDENTIAL COMMUNICATIONS REQUIREMENTS.
Health plans and covered health care providers must permit individuals to request an alternative means or location for receiving communications of protected health information by means other than those that the covered entity typically employs.

For example, an individual may request that the provider communicate with the individual through a designated address or phone number. Similarly, an individual may request that the provider send communications in a closed envelope rather than a post card.

Health plans must accommodate reasonable requests if the individual indicates that the disclosure of all or part of the protected health information could endanger the individual. The health plan may not question the individual’s statement of endangerment.

Any covered entity may condition compliance with a confidential communication request on the individual specifying an alternative address or method of contact and explaining how any payment will be handled.

HHS recognizes that covered entities range from the smallest provider to the largest, multi-state health plan. Therefore the flexibility and scalability of the Rule are intended to allow covered entities to analyze their own needs and implement solutions appropriate for their own environment.

What is appropriate for a particular covered entity will depend on the nature of the covered entity’s business, as well as the covered entity’s size and resources.

ADMINISTRATIVE REQUIREMENTS

PRIVACY POLICIES AND PROCEDURES.
A covered entity must develop and implement written privacy policies and procedures that are consistent with the Privacy Rule.

PRIVACY PERSONNEL.
A covered entity must designate a privacy official responsible for developing and implementing its privacy policies and procedures, and a contact person or contact office responsible for receiving complaints and providing individuals with information on the covered entity’s privacy practices.

WORKFORCE TRAINING AND MANAGEMENT.
Workforce members include employees, volunteers, trainees, and may also include other persons whose conduct is under the direct control of the entity (whether or not they are paid by the entity).

A covered entity must train all workforce members on its privacy policies and procedures, as necessary and appropriate for them to carry out their functions.

A covered entity must have and apply appropriate sanctions against workforce members who violate its privacy policies and procedures or the Privacy Rule. litigation.
A covered entity must mitigate, to the extent practicable, any harmful effect it learns was caused by use or disclosure of protected health information by its workforce or its business associates in violation of its privacy policies and procedures or the Privacy Rule.

DATA SAFEGUARDS.
A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure.xxx
For example, such safeguards might include shredding documents containing protected health information before discarding them, securing medical records with lock and key or pass code, and limiting access to keys or pass codes.

See OCR “Incidental Uses and Disclosures” Guidance.

COMPLAINTS.
A covered entity must have procedures for individuals to complain about its compliance with its privacy policies and procedures and the Privacy Rule.xxxi The covered entity must explain those procedures in its privacy practices notice.

Among other things, the covered entity must identify to whom individuals can submit complaints to at the covered entity and advise that complaints also can be submitted to the Secretary of HHS.

RETALIATION AND WAIVER.
A covered entity may not retaliate against a person for exercising rights provided by the Privacy Rule, for assisting in an investigation by HHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the Privacy Rule.

A covered entity may not require an individual to waive any right under the Privacy Rule as a condition for obtaining treatment, payment, and enrollment or benefits eligibility.

DOCUMENTATION AND RECORD RETENTION.
A covered entity must maintain, until six years after the later of the date of their creation or last effective date, its privacy policies and procedures, its privacy practices notices, disposition of complaints, and other actions, activities, and designations that the Privacy Rule requires to be documented.

Fully-Insured Group Health Plan Exception.
The only administrative obligations with which a fully-insured group health plan that has no more than enrollment data and summary health information is required to comply are the:

(1) Ban on retaliatory acts and waiver of individual rights, and

(2) Documentation requirements with respect to plan documents if such documents are amended to provide for the disclosure of protected health information to the plan sponsor by a health insurance issuer or HMO that services the group health plan.xxxii

The Rule contains provisions that address a variety of organizational issues that may affect the operation of the privacy protections.

HYBRID ENTITY.
The Privacy Rule permits a covered entity that is a single legal entity and that conducts both covered and non-covered functions to elect to be a “hybrid entity.” (The activities that make a person or organization a covered entity are its “covered functions.”) To be a hybrid entity, the covered entity must designate in writing its operations that perform covered functions as one or more “health care components.” After making this designation, most of the requirements of the Privacy Rule will apply only to the health care components. A covered entity that does not make this designation is subject in its entirety to the Privacy Rule.

AFFILIATED COVERED ENTITY.
Legally separate covered entities that are affiliated by common ownership or control may designate themselves (including their health care components) as a single covered entity for Privacy Rule compliance.

The designation must be in writing. An affiliated covered entity that performs multiple covered functions must operate its different covered functions in compliance with the Privacy Rule provisions applicable to those covered functions.
ORGANIZED HEALTH CARE ARRANGEMENT.
The Privacy Rule identifies relationships in which participating covered entities share protected health information to manage and benefit their common enterprise as “organized health care arrangements.”

Covered entities in an organized health care arrangement can share protected health information with each other for the arrangement’s joint health care operations.

COVERED ENTITIES WITH MULTIPLE COVERED FUNCTIONS.
A covered entity that performs multiple covered functions must operate its different covered functions in compliance with the Privacy Rule provisions applicable to those covered functions.

The covered entity may not use or disclose the protected health information of an individual who receives services from one covered function (e.g., health care provider) for another covered function (e.g., health plan) if the individual is not involved with the other function.

GROUP HEALTH PLAN DISCLOSURES TO PLAN SPONSORS.
A group health plan and the health insurer or HMO offered by the plan may disclose the following protected health information to the “plan sponsor”—the employer, union, or other employee organization that sponsors and maintains the group health plan.

Enrollment or disenrollment information with respect to the group health plan or a health insurer or HMO offered by the plan.

If requested by the plan sponsor, summary health information for the plan sponsor to use to obtain premium bids for providing health insurance coverage through the group health plan, or to modify, amend, or terminate the group health plan.

“Summary health information” is information that summarizes claims history, claims expenses, or types of claims experience of the individuals for whom the plan sponsor has provided health benefits through the group health plan, and that is stripped of all individual identifiers other than five digit zip code (though it need not qualify as de-identified protected health information).

Protected health information of the group health plan’s enrollees for the plan sponsor to perform plan administration functions. The plan must receive certification from the plan sponsor that the group health plan document has been amended to impose restrictions on the plan sponsor’s use and disclosure of the protected health information.

These restrictions must include the representation that the plan sponsor will not use or disclose the protected health information for any employment-related action or decision or in connection with any other benefit plan.

PERSONAL REPRESENTATIVES.
The Privacy Rule requires a covered entity to treat a “personal representative” the same as the individual, with respect to uses and disclosures of the individual’s protected health information, as well as the individual’s rights under the Rule.

A personal representative is a person legally authorized to make health care decisions on an individual’s behalf or to act for a deceased individual or the estate. The Privacy Rule permits an exception when a covered entity has a reasonable belief that the personal representative may be abusing or neglecting the individual, or that treating the person as the personal representative could otherwise endanger the individual.

SPECIAL CASE: MINORS.
In most cases, parents are the personal representatives for their minor children. Therefore, in most cases, parents can exercise individual rights, such as access to the medical record, on behalf of their minor children. In certain exceptional cases, the parent is not considered the personal representative.
HEALTH INSURANCE PRINCIPLES

In these situations, the Privacy Rule defers to State and other law to determine the rights of parents to access and control the protected health information of their minor children. If State and other law is silent concerning parental access to the minor’s protected health information, a covered entity has discretion to provide or deny a parent access to the minor’s health information, provided the decision is made by a licensed health care professional in the exercise of professional judgment.

See OCR “Personal Representatives” Guidance.

PREEMPTION.
In general, State laws that are contrary to the Privacy Rule are preempted by the federal requirements, which means that the federal requirements will apply.

“Contrary” means that it would be impossible for a covered entity to comply with both the State and federal requirements, or that the provision of State law is an obstacle to accomplishing the full purposes and objectives of the Administrative Simplification provisions of HIPAA.xxxiii

The Privacy Rule provides exceptions to the general rule of federal preemption for contrary State laws that:

(1) Relate to the privacy of individually identifiable health information and provide greater privacy protections or privacy rights with respect to such information,

(2) Provide for the reporting of disease or injury, child abuse, birth, or death, or for public health surveillance, investigation, or intervention, or

(3) Require certain health plan reporting, such as for management or financial audits.

EXCEPTION DETERMINATION.
In addition, preemption of a contrary State law will not occur if HHS determines, in response to a request from a State or other entity or person, that the State law:

✓ Is necessary to prevent fraud and abuse related to the provision of or payment for health care,

✓ Is necessary to ensure appropriate State regulation of insurance and health plans to the extent expressly authorized by statute or regulation,

✓ Is necessary for State reporting on health care delivery or costs,

✓ Is necessary for purposes of serving a compelling public health, safety, or welfare need, and, if a Privacy Rule provision is at issue, if the Secretary determines that the intrusion into privacy is warranted when balanced against the need to be served; or

✓ Has as its principal purpose the regulation of the manufacture, registration, distribution, dispensing, or other control of any controlled substances (as defined in 21 U.S.C. 802), or that is deemed a controlled substance by State law.

COMPLIANCE.
Consistent with the principles for achieving compliance provided in the Rule, HHS will seek the cooperation of covered entities and may provide technical assistance to help them comply voluntarily with the Rule.

The Rule provides processes for persons to file complaints with HHS, describes the responsibilities of covered entities to provide records and compliance reports and to cooperate with, and permit access to information for, investigations and compliance reviews.

CIVIL MONEY PENALTIES.
HHS may impose civil money penalties on a covered entity of $100 per failure to comply with a Privacy Rule requirement. That penalty may not exceed $25,000 per year for multiple violations of the identical
Privacy Rule requirement in a calendar year. HHS may not impose a civil money penalty under specific circumstances, such as when a violation is due to reasonable cause and did not involve willful neglect and the covered entity corrected the violation within 30 days of when it knew or should have known of the violation.

**Criminal Penalties.**
A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of $50,000 and up to one-year imprisonment.xxxiv

The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm. Criminal sanctions will be enforced by the Department of Justice.

**Compliance Schedule.**
All covered entities, except “small health plans,” must be compliant with the Privacy Rule by April 14, 2003. Small health plans, however, have until April 14, 2004 to comply.

**Small Health Plans.**
A health plan with annual receipts of not more than $5 million is a small health plan.xxxv Health plans that file certain federal tax returns and report receipts on those returns should use the guidance provided by the Small Business Administration at 13 Code of Federal Regulations (CFR) 121.104 to calculate annual receipts.

Health plans that do not report receipts to the Internal Revenue Service (IRS), for example, group health plans regulated by the Employee Retirement Income Security Act 1974 (ERISA) that are exempt from filing income tax returns, should use proxy measures to determine their annual receipts.

The entire Privacy Rule, as well as guidance and additional materials, may be found on our website, http://www.hhs.gov/ocr/hipaa.
11. TAX TREATMENT LTC EXPENSES & LTC INSURANCE

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)
(Public Law 104-191, 110 Statutes 1936, 2054 & 2063)

Federal & state tax codes have a purpose beyond raising revenue. Public policy is often served by providing economic relief to taxpayers or motivation for particular behavior. The 1996 Health Insurance Portability & Accountability Act (HIPAA – Public Law 104-191, 110 Stat. 1936, 2054 & 2063) is one of the most far-reaching laws passed by Congress in the latter part of the 20th century.

The effects of HIPAA are so complex that federal and state governments continue to grapple with its legislative intent. HIPAA’s impact on the treatment of long-term care expenses and long-term care insurance is the focus of this section. Congress attempted to fulfill a number of different public policy objectives in taking on long-term care as a topic:

1. Classifying long-term care costs as a medical expense thus providing taxpayers with some economic relief;
2. Categorizing long-term care insurance as accident & health insurance thereby providing clarity as to the tax treatment of premiums and benefits; and
3. Providing the general public an incentive to purchase long-term care insurance.

The general categories in this section include:
- Tax treatment of long-term care expenses.
- Definition of a “chronically ill” individual
- General tax treatment of TQ & NTQ long-term care insurance
- Tax qualified long-term care insurance deductibility
- Current efforts to expand tax incentives for long-term care expenses and long-term care insurance

TAX TREATMENT OF LONG-TERM CARE EXPENSES
The Internal Revenue Code allows deductions for medical and dental expenses under certain circumstances (IRC Sec. 213d). Prior to the passage of HIPAA, a broad range of long-term care expenses were generally not deductible.

Part of Congress’ intent in enacting HIPAA was to provide tax relief to individuals and families that were incurring long-term care costs.

However, part of the challenge facing legislators was determining which expenses would qualify.

The broad and expanding nature of long-term care expenses made it difficult to stipulate a “laundry list” of qualified services.

The IRS defines “qualified long-term care services” as:

Necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative services and maintenance and personal care services required by a chronically ill individual pursuant to a plan of care prescribed by a licensed health care practitioner.

This overly broad universe of services could potentially be used by anyone at any time for services normally covered under healthcare insurance.
To control when the cost of long-term care services could receive favorable tax treatment, Congress established a trigger basis for initiating benefits by tying services to a state of disability defined as a chronically ill individual.

A chronically ill individual must be certified by a licensed health care practitioner within the previous 12 months as one of the following:

- The insured is unable, for at least 90 days, to perform at least two activities of daily living (ADL’s) without substantial assistance from another individual, due to loss of functional capacity. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence. (See IRS Notice 97-31, issued May 6, 1997 or CIC 10232.8(e1 – 6) for the definitions of the ADL’s.)
- The insured requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment.

This standardized definition of a chronically ill person cannot be altered in any way by state law, and it is the only definition allowed to receive the favorable tax treatment for the cost of long-term care services.

**LICENSED HEALTH CARE PRACTITIONER**

The Internal Revenue Service defines the licensed health care practitioner (LHP) in very general terms. They can include doctors, nurses, social workers, chiropractors, Christian Science practitioners, mental health professionals, and other licensed therapists.

IRS Publication 502 includes an extensive list of licensed health care practitioners.

Individual State Insurance Codes often define Health Care Practitioners in more specific terms.

Such as California Section 10232.8(c) narrows the list by specifying the role of the LHP in the certification, assessment, and plan of care of the insured for the purposes of the claims process. The LHP must be independent of the insurance company and “shall not be compensated in any manner that is linked to the outcome of the certification” (CIC 10232.8(c)).

Federal and State law requires the certification of the insured’s assessment be renewed annually.

**90-DAY CERTIFICATION FOR ACTIVITIES OF DAILY LIVING**

This component of the long-term care qualification may be the most misunderstood. A review of its impact as it applies to long-term care insurance is addressed later in this section. Its relevance to the deductibility of long-term care expenses is clear.

Congress intended to limit long-term care costs to those associated with chronic illness.

A clinical definition of chronic illness is one that is expected to last 90 days or more.

Some expenses for acute or short term illnesses were already deductible as a medical expense.

If policy makers had ignored the distinction between acute and chronic, it would have had the unintended consequence of allowing taxpayers to deduct all their expenses associated with short-term disabilities, due to the vague nature of the definition of a qualified long-term care service.

Therefore, a taxpayer who wishes to deduct qualified long-term care expenses using the ADL definition, must have a licensed health care practitioner certify that the insured is likely to need substantial assistance for at least 90 days.

Keep in mind, the requirement concerns the likelihood of needing care, not the actual receipt of care. In fact, there is no requirement that the person actually receives the full 90 days of care.
The insured must be re-certified at least annually.

Note: IRS Publication 502 stipulates that the 90-day certification period is not a deductible period for people who have long-term care insurance. Long-term care insurance can still pay benefits following the deductible period of the policy, if any, as long as the certification stipulates that the person is likely to need qualified long-term care services for at least 90 days.

The certification may also be done retroactively in the event a claim is not filed until after the deductible period in the policy has been met.

Substantial Assistance
For the purposes of the activities of daily living, IRS Notice 97-31 (1997) allows substantial assistance to be defined to mean both *hands-on assistance* and *standby assistance*.

• **Hands-On Assistance**: means the physical assistance of another person without which the individual would be unable to perform the ADL.

• **Stand-By Assistance**: means the presence of another person within arm’s reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL.

SEVERE COGNITIVE IMPAIRMENT & SUBSTANTIAL SUPERVISION
Notice 97-31 defines a *severe cognitive impairment* “as a loss or deterioration in intellectual capacity that is similar to Alzheimer’s disease and like forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in short-term and long-term memory, orientation to people, places or time and deductive or abstract reasoning.” The 90-day certification by a LHP is not a requirement for qualification under the cognitive impairment trigger. Similar to the ADL qualification however, the insured must be re-certified every 12 months to ensure that they still qualify for benefits.

Note: Taxpayers and tax preparers must document an ADL or cognitive impairment consistent with HIPAA rules in order to deduct long-term care expenses as a medical expense. Many tax preparers miss this point and it could be a critical matter during a tax audit.

TAX QUALIFIED LONG-TERM CARE INSURANCE
The Federal and state governments have recognized the impact of long-term care expenses on their state Medicaid budgets. Over the last 40 years the Medicaid program has become the primary source for long-term care expenses in the United States for the middle class population.

Congress is attempting to shift the Medicaid burden to the private sector by providing general tax incentives to purchase long-term care insurance in anticipation of the huge number of baby boomers who may need care in the future.

Prior to HIPAA, neither long-term care insurance premiums or benefits were addressed in the Federal tax code. There was uncertainty as to whether LTC insurance would be classified as(accident & health or disability) for the purposes of both the deductibility of premiums and the taxation of the benefits. However, the common belief was that as long as premiums were paid with after-tax dollars, benefits would be tax free. This was pre-HIPAA a rule of thumb for all insurance.

HIPAA stipulates that generally, long-term care insurance policies that use the definition of a chronically ill individual will be “qualified long-term care insurance” and that long-term care expenses incurred by a taxpayer who qualifies as a chronically ill individual will be deductible as a medical expense (HIPAA also requires certain consumer protection provisions that will be discussed later).
• Tax qualified long-term care insurance is treated the same as an accident & health insurance policy
• Benefits pass tax-free
• Per diem and cash method policy benefits received are subject to an annually adjusted amount -- $220/day in 2003 (indexed upwards annually by approximately 5%.
• Premiums are generally deductible

1. Limits apply to individuals, sole proprietors, owners of S-corporations, & LLP’s.

2. Premiums paid by an employer for an employee are 100% deductible.

3. Not counted as income to an employee.

4. Cannot currently include qualified long-term care insurance in a Section 125 Cafeteria plan or flexible spending arrangement.

Various deductibility scenarios will be explored later in this section.

Congress created a generalized structure to which qualified products must adhere.

For purposes of HIPAA, a qualified long-term care insurance product must pay benefits using no less than 5 or no more than 6 of the following activities of daily living:

• Eating
• Toileting
• Transferring
• Bathing
• Dressing
• Continence

Note: Qualified long-term care insurance policies may not use “medical necessity” as a benefit trigger and must coordinate benefit payment with Medicare.

This 5 – 6 ADL structure created concern in California because policies issued in California after January 1, 1993, that provided benefits for home care services, were required to use a benefit trigger of 7 ADL’s; the six listed above plus ambulating.

Generally, all qualified long-term care insurance policies issued nationwide utilize a 6 ADL structure requiring a loss of 2 or 3 ADL’s to qualify for benefits (subject to certification by a LHP that the impairment is likely to last for at least 90 days).

Qualified long-term care insurance policies are required to meet specific consumer protection guidelines of the 1993 National Association of Insurance Commissioners Model Act and Regulations for Long-term Care Insurance. Many of the consumer protections in the NAIC Models had already been adopted in California with the passage of State Senate Bill 1943, including:

• Guaranteed renew-ability or non-cancellability
• Prohibitions on exclusions and limitations
• Provisions relating to extension of benefits & conversions
• Replacement
• Unintentional lapse
• Post-claim underwriting
• Requirement to offer inflation protection & rejection by consumer
• Restrictions on preexisting conditions and probationary periods
• Disclosure
• Non-forfeiture provisions
HIPAA requires that long-term care insurance policies comply with its guidelines to be considered "qualified" long-term care insurance.

Policies that do not meet these requirements are considered to be non-qualified long-term care insurance policies. Premiums paid for a non-qualified policy are not presumed to be deductible as accident and health insurance.

However, HIPAA was silent as to the tax treatment of benefits received from non-qualified policies issued after January 1, 1997 causing confusion. To date, the Department of the Treasury has not issued an opinion on this conflict and Congress has not taken the matter up again leading to continued speculation about the tax implications of these benefits.

HIPAA also establishes a reporting mechanism for benefits received under all long-term care insurance policies. Similar to disability insurance, if a policyholder receives benefits from a long-term care insurance policy, they will receive an IRS 1099 LTC Form issued by the carrier.

Benefits reported on the 1099 must also be reported on IRS Form 8853. The 1099 form must identify the method of benefit payment (reimbursement or per diem) but does not need to determine the tax qualified status of the actual long-term care insurance policy from which the benefits were paid. Form 8853, which contains the medical savings and the IRS 1099 information, adds additional mystery to the taxation of non-qualified benefits conundrum because it provides a vehicle for these benefits to be taxed.

Despite continuing confusion neither the Department of the Treasury nor Congress seems anxious to clarify this matter.

Long-term care insurance benefits that are part of a life insurance or annuity contract may not receive the same tax favored status as benefits received from a tax qualified long-term care insurance policy. If the benefits constitute an advance payment of death benefit, then it is likely that they will not be taxed as income.

If, however, the benefits received are part of the accumulation value of the contract, taxes may be payable. In no case are the premiums paid for life insurance or annuity contracts, which include long-term care insurance benefits, deductible as tax qualified long-term care insurance premiums.

**Grandeathered Long-Term Care Insurance Policies**

Congress realized that there were many long-term care insurance policies issued prior to January 1, 1997, that would not comply with HIPAA. Either their benefit structures or payment mechanisms were inferior to its guidelines or, in the case of California, the benefit triggers were considered too generous.

Legislators left it to the Department of the Treasury to establish guidelines for “grandfathered” policies. In its interim directive on tax qualified long-term care insurance (Notice 97-31, May 1997), the Department of the Treasury indicated that long-term care insurance policies issued prior to January 1, 1997, meeting “long-term care insurance requirements of the State in which the contract was … issued” would be grandfathered for the purposes of tax qualification unless the policyholder made a “material change” to the policy. However, they did not define material change.

Final regulations issued in December 1998 identified criteria for which a material modification that would result in a policy losing its tax qualified status. Action that could be taken by the policyholder that is not material and would not jeopardize the policy’s grandfathered status includes the following:

- A change in the mode of premium payment.
• A class-wide increase or decrease in premiums for contracts that have been issued on a guaranteed renewable basis.

• A reduction in premiums due to the purchase of a long-term care insurance policy by a member of the policyholder’s family.

• A reduction in coverage (with correspondingly lower premium) made at the request of a policyholder.

• A reduction in premiums that occurs because the policyholder becomes entitled to a discount under the issuer’s pre-1997 premium rate structure (such as a group or association discount or change from smoker to non-smoker status).

• The addition without an increase in premiums of alternative forms of benefits that may be selected by the policyholder.

• The addition of a rider to increase benefits under a pre-1997 contract if the rider would constitute a qualified long-term care insurance contract if it were a separate contract.

• The deletion of a rider or provision of a contract (called an HHS – Health & Human Services – rider) that prohibited coordination of benefits with Medicare.

• The effectuation of a continuation or conversion of coverage right under a group contract following an individual’s ineligibility for continued coverage under the group contract.

• The substitution of one insurer for another in an assumption reinsurance transaction.

• Expansion of coverage under a group contract caused by corporate merger or acquisition.

• Extension of coverage to collectively bargained employees.

THE ADDITION OF FORMER EMPLOYEES
The Final Regulations suggest that the following practices will be treated as issuance of a new contract:

• A change in terms of a contract that alters the amount or timing of an item payable by either the policyholder, the insured or insurance company.

• A substitution of the insured under an individual contract.

• A change (other than an immaterial change) in the contractual terms or in the plan under which the contract was issued relating to eligibility for membership in the group covered under a group contract.

Note: The important message that should be grasped from this review is that anytime a consumer considers replacing a policy issued prior to January 1, 1997, great caution must be exercised.

A pre-HIPAA policy may contain provisions that might make it easier to qualify for benefits: for example, 2 out of 7 activities of daily living instead of the 2 out of 6 required by HIPAA; a medical necessity benefit trigger that is prohibited in HIPAA; no HIPAA 90 day certification requirement; the benefits of a pre-HIPAA policy do not require coordination with Medicare, which increases the amount available to pay for care.

TAX QUALIFIED LONG-TERM CARE INSURANCE PREMIUM DEDUCTIBILITY
The Health Insurance Portability & Accountability Act of 1996 and subsequent Department of the Treasury rulings have created a number of different premium deduction scenarios that benefit
consumers. The tax incentives that allow for premium deductibility help the self-employed and employees of companies that provide employer-paid long-term care insurance.

To a lesser extent, some individual taxpayers, who are not self-employed, will benefit from the premium deductibility allowed by HIPAA.

There are four primary deductibility scenarios for tax qualified long-term care insurance.

They are:

- Medical Savings Accounts.
- Individual deductibility.
- Deductibility for the self-employed, owners of S-corporations, limited liability partnerships (LLP) & limited liability corporations (LLC).
- Deductibility for employee/owners of C-corporations.

The intent of this next section is to provide students with broad-brush guidance pertaining to the tax deductibility of TQ long-term care insurance premiums. Most agents are not Certified Public Accountants (CPA’s) or tax preparers.

They should always refer clients to insured’s tax advisor for the final analysis as to whether premium deductibility makes sense for them.

**Medical Savings Accounts**

Medical Savings Accounts (MSA) were established under HIPAA. Their primary appeal is to consumers under age 65, who are willing to take on the responsibility of a relatively large medical insurance deductible in favor of lower premiums.

Simply stated, the consumer purchases a medical insurance plan with a high deductible that generally exceeds $4,000.

They are then allowed to take an above-the-line deduction on their taxes equal to a percentage of the deductible (65% for an individual, 75% for a couple or family). The amount of money deducted must be placed in an MSA account. The money placed in the MSA grows tax deferred, similar to an IRA or other qualified retirement plan. The funds accumulated can be used to pay for un-reimbursed medical expense (allowed by IRC Sec. 213(d)) deductibles and co-insurance.

The money in the MSA can also be used to pay the premiums on a tax qualified long-term care insurance policy. From a practical standpoint, this is the only way an individual, self-employed or otherwise, can garner the equivalent of an above-the-line deduction for a qualified long-term care insurance policy.

MSAs have achieved inconsistent acceptance since their introduction in 1997. Their applicability depends on the regional make-up of the medical care delivery system, the availability of medical insurance plans in an area, and the pricing disparity between conventional “low-deductible” plans and the “high-deductible” plans that qualify for the MSA program.

MSAs represent an opportunity for some consumers to tailor their medical insurance and long-term care insurance priorities in a cost and tax-efficient manner.

**Individual Deductibility**

This deductibility scenario for tax-qualified long-term care insurance is one of the most
misunderstood applications. It is true that only taxpayers who itemize their deductions can benefit from the deductibility of qualified long-term care insurance premiums.

It is also a fact that, based on the taxpayer’s age, only a portion of the long-term care insurance premium may be deducted. With this in mind, taxpayers and their advisors may be wise to step back and take a broader view of the opportunities.

Taxpayers over age 60 with above average income and assets are typically interested in long-term care insurance.

Often these individuals do itemize their deductions because they own property and the standard deduction is not in their best interest. In this situation, expenses for medical care and insurance premiums are deductible to the extent that they exceed 7.5% of adjusted gross income.

Prior to HIPAA, most taxpayers in this circumstance would not exceed 7.5% of their adjusted gross income in un-reimbursed medical expenses.

However, with the inclusion of qualified long-term care insurance as an accident and health insurance policy, some taxpayers may benefit.

HIPAA states that premiums for tax qualified long-term care insurance are deductible as an accident and health insurance policy.

However, unlike other accident and health insurance premiums, the amount of qualified long-term care insurance premiums is limited by a stipulated age to the amount that can be deducted.

In 2003, the age that “banded” amounts that may be applied towards the taxpayer’s un-reimbursed medical expenses are:

- Under Age 40 $ 250
- Ages 41 - 50 $ 470
- Ages 51 - 60 $ 940
- Ages 61 - 70 $2,510
- Ages 71 + $3,130

Note: These amounts allowable towards deductions are indexed upward annually by a factor of approximately 5%.

Individual taxpayers under age 61 who itemize their deductions, may not get much of a tax relief by including the allowable long-term care insurance premium amount in their Un-reimbursed medical expenses. However, someone age 61+ may do better.

To reiterate, individual taxpayers who itemize their deductions, may include the cost of tax qualified long-term care insurance as an accident and health insurance premium. The amount allowed is limited by the above-referenced, age-related amounts.

The following is a thumbnail example of how this may work for a hypothetical husband and wife, both age 65, who are considering purchasing a qualified long-term care insurance policy with a joint annual premium of $7,000.

Assume, for the purposes of this example, that this couple has an adjusted gross income of $100,000 therefore they must exceed $7,500 of un-reimbursed medical expenses before they receive any type of tax relief from these types of deductions.

- Amount Allowed For TQ-LTCi: $5,020
- Medicare Supplement Premiums 3,600
- Medicare Part B Premiums 1,400

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In this example, the taxpayers would be allowed to deduct $4,520 ($12,020 minus their $7,500 threshold) of un-reimbursed medical expenses. If they are in a combined federal and state income tax bracket of 35%, their tax savings would equal $1,582 ($4,520 x 35%).

This would amount to a 22% premiums savings ($1,520 ÷ $7,000). Clearly, anyone can create an example that works! But consider the facts in this case.

The deductible amount allowed for long-term care insurance premiums in and of itself is not enough to trigger a deduction for these taxpayers, nor are the stand-alone deductions for the other un-reimbursed medical expenses.

However, the combination of all of them does provide this hypothetical couple with a meaningful savings.

Most agents are not qualified tax advisors and as such need to be cautious and circumspect in their recommendations. However, an agent may spot an opportunity for a taxpayer that might go unnoticed by the client’s tax preparer.

Clearly, if the agent inquires as to the un-reimbursed expenses illustrated above they can spot a potential tax savings for the consumer and refer them to their tax advisor.

DEDUCTIBILITY FOR THE SELF-EMPLOYED

For the purposes of this discussion, self-employed individuals include sole proprietors, partners and owners of S-corporations, limited liability partnerships (“LLP”) and limited liability corporations (“LLC”).

An owner is defined as any individual who owns 2% or more of the business entity. While these types of business entities can have a separate tax identification number for the reporting of income, the tax return that is filed is informational in nature only.

The profit or loss from the business entity is passed through to the owners pursuant to their share of ownership.

Typically, in sole proprietorships and partnerships, spouses are not considered owners. If they are on the payroll, they would be considered employees.

Spouses of owners of S-corporations, LLP’s and LLC’s are considered owners regardless of their direct or indirect participation in the business’ activities. With respect to accident and health insurance coverage purchased by one of these entities for a non-owner employee, premiums are fully deductible, there is no imputed income to employee of premiums and the benefits pass tax free at time of claim.

The good news for owners of these entities is that beginning in 2003 premiums for accident and health insurance are 100% deductible. It is not necessary for these taxpayers to exceed 7.5% of adjusted gross income to benefit from the tax code for these expenses.

Tax qualified long-term care insurance, being accident and health insurance, falls into this general rule.

The bad news is that the amount allowable for deduction is limited by the previously discussed age-related schedule.

While this is not optimal, it can lead to savings. Consider a self-employed husband and wife, both age 55 who are considering purchasing a tax qualified long-term care insurance policy with a joint annual premium of $3,600 per year. They would be allowed to deduct $1,880 ($940 x 2). If they are in the
combined Federal & State tax bracket of 35% their tax savings would be $658 or approximately 18% of premium.

Additionally, they may save on their self-employment taxes because the premium amount paid by the business entity would be received not as income, but as an employee benefit. This may save this self-employed couple an additional 16% of the premium paid.

Individually or combined, these tax savings provides incentives to owners of these entities to purchase qualified long-term care insurance through their businesses.

Agents should be very cautious and understand their limitations of advising consumers about their insured’s specific tax situation and circumstances.

**DEDUCTIBILITY IN CLOSELY-HELD C-CORPORATIONS**
The fine difference between owners of business entities discussed in the previous section and employee owners of closely-held C-corporations is that for the purposes of paying taxes they are considered employees, not owners.

Therefore, premiums paid by the C-corporation for tax qualified long-term care insurance (a.k.a. accident and health insurance) for stockholder employees is deductible to the corporation: there is no imputed income to the employee stockholder for premiums paid; and the benefits will pass tax-free at time of claim.

Some believe that this tax treatment of accident and health insurance premiums and benefits means that every employee in the company must receive “like” benefits.

Others go to the other extreme and tell consumers that they can discriminate as to who receives such benefits.

Both are incorrect.

The Internal Revenue Code Sec. 105 clearly indicates that accident and health insurance specifically provided to stockholder employees on a selective basis, without creating a distinguishable class of employees who are eligible for the benefit, is not allowed.

The class must be based on employment status. It cannot be based on stock ownership. A class of employees such as “officer employees” can be created for the corporation who are eligible for a specific accident and health insurance benefit. However, they must be employees, not just officers or stockholders.

Court decisions on this matter go back to 1968. If the closely-held corporation cannot validate a clear class of employees who are eligible for the benefit then the premiums could be treated as dividends to the stockholder-employee and the premiums are not deductible to the corporation. It is therefore incumbent upon agents and their tax advisors to be judicious in establishing classes eligible for coverage.

It is also important for the corporation to establish the plan in their minutes and to clearly identify the classes of employees that are eligible for benefits.

Again, once a bona fide class of employees is established, tax qualified long-term care insurance premiums are deductible to the corporation; there is no income imputed to the employee and the benefits pass tax free at time of claim. This tax scenario is the best of all worlds for employees of any corporation and owner-employees of closely-held corporations.

**FINAL ITEMS ON TAX DEDUCTIBILITY**
Currently long-term care insurance may not be included in Section 125 Cafeteria Plans or Flexible Spending arrangements. However, for the past several sessions of Congress,
legislation has been introduced to allow for this.

Additionally, this legislation has attempted to expand individual deductibility and create tax credits for taxpayers who incur long-term care expenses.

Over the years there has also been legislation in California designed to expand premium deductibility for State income tax purposes and to provide credits for long-term care expenses. While this paper will not speculate on the outcome of these efforts to provide additional incentives to purchase qualified long-term care insurance, legislators appear to see private insurance as an important tool of public policy.