Slater All Lines Insurance School

3717-196th Street SW, #214, Lynnwood, WA 98036

Phone 425.771.4870 Fax 425.771.5933

www.slaterinsuranceschool.com

Continuing Education

Health Insurance Principles

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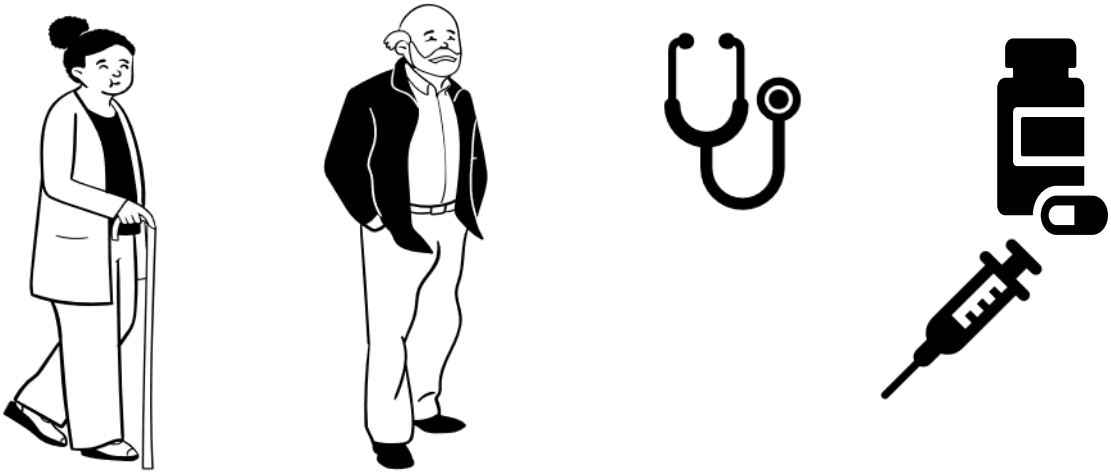

Contents

I. PART I: MEDICARE

A. CHAPTER 1: MEDICARE BASICS

1. MEDICARE IS A FEDERAL 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).
Individuals with ALS

2. THE DIFFERENT PARTS OF MEDICARE

The different parts of Medicare help cover specific services. Medicare has the following parts:

a) Part A: Hospital Insurance

Helps cover inpatient care in hospitals
Helps cover skilled nursing facilities, hospice, and home health care

b) Part B: Medical Insurance

Helps cover doctor's services, outpatient care, and home health care
Helps cover some preventive services to help maintain an individual's health and keep certain illnesses from getting worse.

c) Part C: Medicare Advantage Plans (HMO or PPO)

A health coverage option run by private insurance companies approved by and under contract with Medicare, includes Part A, Part B and usually other coverage like prescription drugs.

d) Part D: Medicare Prescription Drug coverage

A prescription drug option run by private insurance companies approved by and under contract with Medicare.

Helps cover the cost of prescription drugs.
May help lower prescription drug costs and help protect against higher costs in the future.

3. SUMMARY OF COVERAGE CHOICES

a) ORIGINAL MEDICARE

Run by the Federal government.
Provides Part A and/or B coverage.

Individuals can go to any doctor or hospital that accepts Medicare.
Individuals can join a Medicare Prescription Drug Plan to add drug coverage.
Individuals can buy a Medigap (Medicare Supplement Insurance) policy (sold by private insurance companies) to help fill the gaps in Part A and Part B.

b) Medicare Advantage Plans (like an HMO or PPO) Advantage Plans

are run by private insurance companies approved by and under contract with Medicare.

Provides Part A and Part B coverage but can charge different amounts for certain services. It may offer extra coverage and prescription drug coverage, sometimes for extra cost. Costs vary by plan.

If an individual wants drug coverage, they must get it through their plan.

An individual does not need and cannot use a Medigap policy with a Medicare Advantage Plan.

c) Other Medicare health plans

Plans that are not Medicare Advantage Plans but are still part of Medicare, include, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Most plans provide Part A and Part B coverage, and some also provide prescription drug coverage (Part D).

4. MEDICARE PART A

Medicare Part A: (Hospital Insurance)

helps cover inpatient care in hospitals, including critical access hospitals, and inpatient rehabilitation facilities and long term care hospitals (not custodial or long-term care). It also helps cover hospice care and some home health care. Inpatient care in a Religious Nonmedical
Health Care Institution, individuals must meet certain conditions to get these benefits.

a) 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.

b) Some people Need to sign up for Part A

In most cases, if an individual choose to **buy** Part A, they must also have Part B and pay monthly premiums for both. **If an individual has limited income and resources, their state may help them pay for Part A and/or Part B.**

If an individual gets benefits from Social Security or the Railroad Retirement Board (RRB), they automatically get Part A starting the first day of the month they turn age 65. If they are under age 65 and disabled, they automatically get Part A after they get disability benefits from Social Security or certain disability benefits from the RRB for 24 months. They will get their Medicare card in the mail 3 months before their 65th birthday or their 25th month of disability.

If an individual is receiving social security disability, they will be eligible for Medicare after 24 months.

If an individual has ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), they automatically get Part A the month their disability income benefits begin.

If an individual needs to sign up for Part A, they can sign up during the following times:

Initial Enrollment Period—When they are first eligible for Medicare. (This is a 7-month period that begins 3 months before the month they turn age 65, includes the month they turn age 65, and ends 3 months after the month they turn age 65.)

General Enrollment Period—Between January 1–March 31 each year. The coverage will begin July 1. Individuals may have to pay a higher premium for late enrollment. See below.

Special Enrollment Period—If the individual or their spouse (or family member if they are disabled) is currently working, and they are covered by a group health plan through the employer or union. Enrollment processed is discussed under Part B.

Special Enrollment Period for International Volunteers—If you are serving as a volunteer in a foreign country. Enrollment processed is discussed under Part B.

If an individual is not eligible for premium-free Part A, they may be able to buy it. However, if they don't buy Part A when they are first eligible, their monthly premium may go up 10%. They will have to pay the higher premium for twice the number of years they could have had Part A, but didn't join. For example, if they were eligible for Part A, but didn't join for 2 years, they will have to pay the higher premium for 4 years. They don't have to pay a penalty if they are eligible for a special enrollment period.

For more information on Part A, call Social Security, or visit www.socialsecurity.gov. If an individual gets benefits from the RRB, call 1-877-772-5772.

If an individual has End-Stage Renal Disease (ESRD), different rules apply. For more information, visit www.medicare.gov/Publications/Pubs/pdf/10128.pdf to view the booklet, "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services."

5. MEDICARE PART-A COVERED SERVICES:

a) Blood:

In most cases, the hospital gets blood from a blood bank at no charge, and the insured won't have to pay for it or replace it. If the hospital has to buy blood, the insured must either pay the hospital costs for the first 3 units of blood the insured gets in a calendar year or have the blood donated by someone.

b) Home Health Services

Limited to medically-necessary, part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor must order your care, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. You must be homebound, which means that leaving home is a major effort.

c) Hospice Care

Hospice is for people with a terminal illness. The doctor must certify that the insured is expected to live 6 months or less. Coverage includes drugs for pain relief and symptom management; medical, nursing, and social services; and other covered services as well as services Medicare usually doesn't cover, such as grief counseling. A Medicare-approved hospice usually gives hospice care in the home or other facility like a nursing home. Hospice care doesn't include room and board unless the hospice medical team determines that the insured needs short-term inpatient stays for pain and symptom management that can't be addressed in the home.
These stays must be in a Medicare-approved facility, such as a hospice facility, hospital, or skilled nursing facility. Medicare also covers inpatient respite care which is care given in a Medicare approved facility so that the usual caregiver can rest. An individual can stay up to 5 days each time they get respite care. Medicare will pay for covered services for health problems that aren't related to the terminal illness. An individual can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that the individual is terminally ill.

d) Hospital Stays (inpatient)

Hospital stays includes semi-private room, meals, general nursing, and drugs as part of the inpatient treatment, and other hospital services and supplies. Examples include inpatient care an individual gets in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and mental health care. This **doesn't** include private-duty nursing, a television or telephone in the room (if there is a separate charge for these items), or personal care items like razors or slipper socks. It also doesn't include a private room, unless medically necessary. If the individual has Part B, it covers the doctor's services they get while they are in a hospital.

e) Skilled Nursing Facility Care

Includes semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies after a 3-day minimum inpatient hospital stay for a related illness or injury. An inpatient stay begins the day the individual is formally admitted with a doctor's order to a hospital. To qualify for care in a skilled nursing facility, the doctor must certify that the individual needs daily skilled care like intravenous injections or physical therapy. Medicare doesn't cover long-term care or custodial care in this setting.

The beneficiary pays:

Days 1-20	$0
Days 21-100	$217 per day (2026)
Days 101 -	All the costs

6. 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: Most recipients pay the standard Medicare Part B premium each month. However, if an individual's modified adjusted gross income as reported on their IRS tax return from 2 years ago is above a certain amount may have to pay more. Social Security notifies any individual that may have to pay more than the standard premium. In some cases, this amount may be higher if the individual didn't sign up for Part B when they first became eligible.

a) How to Get Part B

If an individual gets benefits from Social Security or the Railroad Retirement Board (RRB), in most cases, they will automatically get Part B starting the first day of the month they turn age 65. If their birthday is on the first day of the month, their Part B will start the first day of the prior month. If they are under age 65 and disabled, they will automatically get Part B after they get disability benefits from Social Security or certain disability benefits from the RRB for 24 months. They will get your Medicare card in the mail about 3 months before their 65th birthday or their 25th month of disability. If they don't want Part B, they follow the instructions that come with the card, and send the card back. If they keep the card, they keep Part B and will pay Part B premiums.

If they have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease), they automatically get Part B the month their disability benefits begin.

b) When Can You Sign Up for Part B?

If an individual didn't sign up for Part B when they first became eligible, they may be able to sign up during one of these times:

General Enrollment Period —Between January 1–March 31 each year. Their coverage will begin on July 1. They may have to pay a late enrollment penalty.

Special Enrollment Period —If they wait to sign up for Part B because they or their spouse is currently working, and they are covered by a group health plan based on that work, or if they are disabled and they or a family member is working, and they are
covered by a group health plan based on that work. They can sign up for Part B anytime while they have group health plan coverage based on current employment or during the 8-month period that begins the month after the employment ends, or the group health plan coverage ends, whichever happens first. If they have COBRA coverage, they must enroll during the 8-month period that begins the month after the employment ends. This Special Enrollment Period doesn't apply to people with End-Stage Renal Disease (ESRD).

Special Enrollment Period for International Volunteers —If the individual waited to sign up for Part B because they had health insurance while volunteering outside of the U.S. for a tax exempt organization for at least a year. They can sign up during the 6-month period that begins the first month that any one of the following happens:
They are no longer volunteering outside the U.S.
The sponsoring organization is no longer tax exempt.
They no longer have health insurance coverage outside the U.S.

If an individual has Medicare because of End-Stage Renal Disease (ESRD), they can sign up for Part B when they sign up for Part A. If they delay signing up for Part B, they can only get it during the general enrollment period, and they may have to pay a late enrollment penalty.

If they live in Puerto Rico, and they want Part B, they will need to sign up for it. Contacting their local Social Security office for more information is the best process to follow..

If an individual is not getting Social Security or RRB benefits, and they want to get Part B, they will need to sign up for Part B during their initial enrollment period (the 7-month period that begins 3 months before the month they turn age 65, includes the month they turn age 65, and ends 3 months after the month they turn age 65).

If an individual doesn't sign up for Part B when they are first eligible, they may have to pay a late enrollment penalty for as long as they have Medicare. Their monthly premium for Part B may go up 10% for each full 12-month period that they could have had Part B, but didn't sign up for it. Usually, they don't pay a late enrollment penalty if they sign up for Part B during a special enrollment period.

NOTE: If they are age 65 or older, after they sign up for Part B, they have a 6-month Medigap open enrollment period which gives them a guaranteed right to buy a Medigap (Medicare Supplement Insurance) policy. Once this period starts, it can't be delayed or replaced.

c) Medicare and TRICARE Coverage

If an individual has Medicare Part A and TRICARE (coverage for active-duty military or retirees and their families), they must have Part B to keep their TRICARE coverage.

However, if they are an active - duty service member, or the spouse or dependent child of an active - duty service member, the following applies:

They don't have to enroll in Part B to keep their TRICARE coverage while the service member is on active duty.
When the active-duty service member retires, they must enroll in Part B to keep their TRICARE coverage. They can get Part B during a special enrollment period if they have Medicare because they are age 65 or older, or they are disabled.

7. MEDICARE PART B AND EMPLOYER OR UNION COVERAGE

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.

When the employment ends, three things happen:

1. An individual's health coverage through the employer's plan (in most cases for only 18 months) and probably at a higher cost to you.

2. They may get a special enrollment period to sign up for Part B without a penalty. This period will run for 8 months and begins the month after their employment ends. This period will run whether or not they elect COBRA. If they elect COBRA, they should not wait until their COBRA ends to enroll in Part B. If they enroll in Part B after the 8-month special enrollment period, they may have to pay a late enrollment penalty. When you sign up for Part B,

3. An individual has a 6-month Medigap open enrollment period which gives them a guaranteed right to buy a Medigap (Medicare Supplement Insurance) policy. Once this period starts, it can't be delayed or repeated.

8. MEDICARE PART B SERVICES

There are two kinds of Part B-covered services:
Medically-necessary services—Services or supplies that are needed to diagnose or treat a medical condition and that meet accepted standards of medical practice.
Preventive services—Health care to prevent illness or detect it at an early stage, when treatment is most likely to work best (for example, Pap tests, flu shots, and colorectal cancer screenings).

a) What You Pay

Costs for Part B services depend on whether the individual has Original Medicare or if they are in a Medicare Advantage health plan.

The following pages give general information about what an individual must pay if they have Original Medicare. For some services, there are no costs, but the individual may have to pay for the visit to the doctor. If the Part B deductible applies, an individual must pay all costs until they meet the yearly Part B deductible before Medicare begins to pay its share.

After the deductible is met, an individual typically pay 20% of the Medicare-approved amount of the service.

Abdominal Aortic Aneurysm Screening

This is a one-time screening ultrasound for people at risk. Medicare only covers this screening if an individual gets a referral for it as a result of their one-time "Welcome to Medicare" physical exam. Individual pays 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, the individual pays a copayment.

Ambulance Services

Emergency ground transportation when an individual needs to be transported to a hospital or skilled nursing facility for medically-necessary services, and transportation in any other vehicle could endanger the individual's health. Medicare will pay
for transportation in an airplane or helicopter.If an individual requires immediate and rapid ambulance transportation that ground transportation can't provide.

In some cases, Medicare may pay for limited non-emergency transportation if there is an order from the doctor. Medicare will only cover services to the nearest appropriate medical facility that is able to give the care needed. The individual pays 20% of the Medicare-approved amount, and the part b deductible applies.

Ambulatory Surgical Center

Facility fees for approved surgical procedures provided in an ambulatory surgical center (facility where surgical procedures are performed, and the patient is released within 24 hours). Individual pays 20% of the Medicare-approved amount (except for screening flexible sigmoidoscopies and screening colonoscopies, for which the individual pays 25%), and the Part B deductible applies. The individual pays all facility charges for procedures Medicare doesn't allow in ambulatory surgical centers.

Blood

In most cases, the provider gets blood from a blood bank at no charge, and the individual won't have to pay for it or replace it. However, they will pay a copayment for the blood processing and handling services for every unit of blood they get, and the Part B deductible applies. If the provider has to buy blood, the individual must either pay the provider costs for the first 3 units of blood in a calendar year or have the blood donated by the individual or someone else.

Individual pays a copayment for additional units of blood they get as an outpatient (after the first 3), and the Part B deductible applies.

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. Individual pays 20% and the Part B deductible applies.

Cardiac rehabilitation

Medicare covers comprehensive programs that include exercise, education, and counseling for patients who meet certain conditions with a doctor's referral. Medicare also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Individual pays 20% of the Medicare-approved amount if they get the services in a doctor's office. In a hospital outpatient setting, the individual pays a copayment.

Cardiovascular Screenings

Helps detect conditions that may lead to a heart attack or stroke. This service is covered every 5 years to test your cholesterol, lipid, and triglyceride levels. No cost for the test, Individual pays 20% and the Part B deductible applies.

Chiropractic Services (limited)

Helps correct a subluxation (when one or more of the bones of your spine move out of position) using manipulation of the spine. Individual pays 20% of the Medicare-approved amount, and the Part B deductible applies. Note: Individual pays all costs for any services or tests ordered by a chiropractor.

Clinical Laboratory Services:

Blood tests, urinalysis, some screening tests, and more. No Cost

Clinical research studies

Clinical research studies test different types of medical care, like how well a cancer drug works. They help doctors and researchers see if the new care works and if it's safe. Medicare covers some costs, like doctor visits and tests, in qualifying clinical research studies. Individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Colorectal Cancer Screenings

To help find precancerous growths and help prevent or find cancer early, when treatment is most effective. One or more of the following tests may be covered.

Fecal Occult Blood Test—Once every 12 months if age 50 or older. No cost for the test, but the individual generally has to pay 20% of the Medicare-approved amount for the doctor's visit.

Flexible Sigmoidoscopy—Generally, once every 48 months, if age 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk. Individual pays 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, individual pays a copayment.

Colonoscopy—Generally once every 120 months- (high risk-every 24 months) or 48 months after a previous flexible sigmoidoscopy. No minimum age. Individual pays 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, individual pays a copayment.

Barium Enema—Once every 48 months if age 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy. Individual pays 20% of the Medicare-approved amount for the doctor's services. In a hospital outpatient setting, individual pays a copayment.

NOTE: If an individual gets a screening flexible sigmoidoscopy or screening colonoscopy in an outpatient hospital setting or an ambulatory surgical center, individual pays 25% of the Medicare-approved amount.

Defibrillator (Implantable Automatic

For some people diagnosed with heart failure. Individual pays 20% of the Medicare-approved amount for the doctor's services. Individual pays a copayment but no more than the Part A hospital stay deductible. if an individual gets the device as a hospital outpatient. The Part B deductible applies.

Diabetes Screening

Medicare covers these screenings if an individual has any of the following risk factors:

High blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose).

Tests are also covered if two or more of the following situations apply:

V Age 65 or older
V Overweight
V A family history of diabetes (parents, siblings)
V A history of gestational diabetes (diabetes during pregnancy) or delivering 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. No cost for the test, but the individual generally has to pay 20% of the Medicare-approved amount for the doctor's visit.

Diabetes self-management training

For people with diabetes-doctor or other health care provider must provide a written order. Individual pays 20% of the Medicare-approved amount, and the Part B deductible applies

Diabetes Supplies

Including blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions, and therapeutic shoes (in some cases). Insulin is covered only if used with an insulin pump. Individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

NOTE: Insulin and certain medical supplies used to inject insulin, such as syringes, may be covered by Medicare prescription drug coverage (Part D).

Doctor Services

Services that are medically necessary (includes outpatient and some doctor services that individuals get when they are a hospital inpatient) or covered preventive services.

This doesn't cover routine physicals except for the one-time "Welcome to Medicare" physical exam. Individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Durable Medical Equipment (like walkers)

This category includes Items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds which are ordered by the doctor for use in the home. Individuals pay 20% of the Medicare-approved amount, and the Part B deductible applies. Individuals must get their covered equipment or supplies from a supplier enrolled in Medicare. Individuals should also check if the supplier is a participating supplier. Participating suppliers must accept assignment and the individual's out-of-pocket costs may be less.

EKG Screening

Medicare covers a one-time screening EKG if you get a referral for it as a result of your one-time "Welcome to Medicare" physical exam. See "Physical Exam." You pay 20% of the Medicare-approved amount, and the Part B deductible applies. An EKG is also covered as a diagnostic test. See page 37.

Emergency Department Services

When an individual believes their health is in serious danger or may have a bad injury, a sudden illness, or an illness that quickly gets much worse. The individual pays a specified copayment for the hospital emergency department visit, and also pay 20% of the Medicare-approved amount for the doctor's services. The Part B deductible applies.

Eye Exams for People with Diabetes

Checks for diabetic retinopathy once every 12 months by an eye doctor who is legally allowed by the state to do the test. Individual pays 20% of the Medicare-approved amount for the doctor's services, and the Part B deductible applies. In a hospital outpatient setting, the individual pays a copayment.

Eyeglasses (limited)

One pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. Individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Federally- Qualified Health Center Services

This category includes many outpatient primary care and preventive services an individual get s through certain

community-based organizations. Individual pays 20% of the Medicare-approved amount.

Flu Shots

Helps prevent influenza or flu virus and is covered once per flu season in the fall or winter. Each individual needs a flu shot for the current virus each year. No cost for the flu shot if the doctor accepts assignment for giving the shot.

Foot Exams and Treatment

If an individual has diabetes-related nerve damage and/or meet certain conditions. Individual pays 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, the individual pays a copayment.

Glaucoma Tests

Helps find the eye disease glaucoma and is covered once every 12 months for people at high risk for glaucoma. An individual is considered high risk for glaucoma if they have diabetes, a family history of glaucoma, are African-American and age 50 or older, or are Hispanic and age 65 or older. An eye doctor who is legally authorized by the state must do the tests.

Individual pays 20% of the Medicare-approved amount, and the Part B deductible applies for the doctor's visit. In a hospital outpatient setting, individual pays a copayment.

Hearing and Balance Exams

If ordered by the doctor to see if an individual needs medical treatment. Individual pays 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, individual pays a copayment.

NOTE: Medicare doesn't cover hearing aids and exams for fitting hearing aids.

Hepatitis B Shots

Helps protect people from getting Hepatitis B. This is covered for people at high or medium risk for Hepatitis B. An individual's risk for Hepatitis B increases if they have hemophilia, End-Stage Renal Disease (ESRD), or a condition that increases their risk for infection. Other factors may increase their risk for Hepatitis B, so they should check with their doctor. Individual pays 20% of the Medicare-approved amount for shots given in a doctor's office, and the Part B deductible applies. Individual pays a copayment for a Hepatitis B shot given in a hospital outpatient setting.

HIV Screening

Medicare covers HIV screening for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to 3 times during a pregnancy. There is no cost for the test, but the individual generally has to pay 20% of the Medicare-approved amount for the doctor's visit.

Home Health Services

Home health services are limited to medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor must order it, and a Medicare-certified home health agency must provide it. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home.

An individual must be homebound, which means that leaving home is a major effort. No cost to the individual for home health services. For Medicare-covered durable medical equipment, the individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Kidney Dialysis Services and Supplies

Kidney Dialysis Services and Supplies are covered for people with End-Stage Renal Disease (ESRD). Medicare covers dialysis either in a facility or at home when the doctor orders it. The individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Medicare may cover kidney disease education services if the individual has kidney disease, and their doctor refers them for the service. The individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Mammograms (screening)

A type of X-ray to check women for breast cancer before they or their doctor may be able to find it. Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35–39. The individual pays 20% of the Medicare-approved amount.

Medical Nutrition Therapy Services

Medicare may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, or you have had a kidney transplant in the last 36 months, and your doctor refers you for the service. You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Mental Health Care (outpatient)

Mental health care is used to get help with mental health conditions such as depression, anxiety, or substance abuse, and includes services generally given outside a hospital or in a hospital outpatient setting, including visits with a doctor, psychiatrist, clinical psychologist, or clinical social worker, and lab tests. Certain limits and conditions apply.

What the individual pays will depend on whether they are being diagnosed and monitored or whether they are getting treatment.

For visits to a doctor or other health care provider to diagnose the condition, or to monitor or change prescriptions, an individual pays 20% of the Medicare-approved amount.

The individual pays 45%, in 2010, of the Medicare-approved amount for outpatient treatment of their condition (such as counseling or psychotherapy). This coinsurance amount will continue to decrease over the next 4 years. In a hospital outpatient setting, the individual pays a copayment.
The Part B deductible applies for both visits to diagnose or monitor their condition as well as treatment.

NOTE: Inpatient mental health care is covered under Part A hospital stays.

Non-doctor Services
Medicare covers services provided by non-doctors, such as physician assistants and nurse practitioners. Individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Occupational Therapy
This category includes evaluation and treatment to help an individual return to usual activities (such as dressing or bathing) after an illness or accident when their doctor certifies they need it. There may be limits on physical therapy, occupational therapy, and speech-language pathology services and exceptions to these limits. Individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Outpatient Hospital Services
Services an individual gets as an outpatient as part of a doctor's care. The individual pays 20% of the Medicare-approved amount for the doctor's services. The individual may pay more for a doctor's care in a hospital outpatient setting than they will pay for the same care in a doctor's office. The individual pays a specified copayment for each service they get in an outpatient hospital setting. The copayment can't be more than the Part A hospital stay deductible. The Part B deductible applies.

Outpatient Medical and Surgical Services and Supplies
For approved procedures (like X-rays, a cast, or stitches). You pay 20% of the Medicare-approved amount for the doctor's services. You pay a copayment for each service you get in an outpatient hospital setting. For each service, this amount can't be more than the Part A hospital stay deductible. See page 120. The Part B deductible applies, and you pay all charges for items or services that Medicare doesn't cover.

Pap Tests and Pelvic Exams (includes clinical breast exam)
Checks for cervical, vaginal, and breast cancers. Medicare covers these screening tests once every 24 months, or once every 12 months for women at high risk, and for women of childbearing age who have had an exam that indicated cancer or other abnormalities in the past 3 years. No cost to the individual for the Pap lab test. Individual pays 20% of the Medicare-approved amount for Pap test specimen collection, and pelvic and breast exams. If the pelvic exam was provided in a hospital outpatient setting, you pay a copayment.

Physical Exam (one-time "Welcome to Medicare" exam)
Coverage is a one-time review of the individual's health, and education and counseling about preventive services, including certain screenings, shots, and referrals for other care if needed. Medicare will cover this exam if the individual gets it within the first 12 months that they have Part B. Individual pays 20% of the Medicare-approved amount. In a hospital outpatient setting, Individual pays a copayment.

Physical Therapy
When their doctor certifies the need it, this category covers an evaluation and treatment for injuries and diseases that change the individual's ability to function.

There may be limits on these services and exceptions to these limits. The individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Pneumococcal Shot
Helps prevent pneumococcal infections (like certain types of pneumonia). Most people only need this preventive shot once in their lifetime. No cost if the doctor or supplier accepts assignment for giving the shot.

Prescription Drugs (limited)
Includes a limited number of drugs such as injections an individual gets in a doctor's office, certain oral cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or infusion pump) and under very limited circumstances, certain drugs an individual gets in a hospital outpatient setting.
The individual pays 20% of the Medicare-approved amount for these covered drugs. If the covered drugs an individual gets in a hospital outpatient setting are part of the service they get, they pay the copayment for the services. However, if they get other types of drugs in a hospital outpatient setting, what the individual pays depends on whether they have Part D or other prescription drug coverage, whether their drug plan covers the drug, and whether the hospital is in their drug plan's network

The individual should contact their prescription drug plan to find out what the individual pays for drugs they get in a hospital outpatient setting. Keep in mind that under Part B, an individual pays 100% for most prescription drugs, unless they have Part D or other drug coverage.

Prostate Cancer Screenings

Helps detect 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. The individual pays 20% of the Medicare-approved amount, and the Part B deductible applies for the doctor's visit. In a hospital outpatient setting, the individual pays a copayment. The individual pays nothing for the PSA test.

Prosthetic/ Orthotic Items

Including arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); some types of breast prostheses (after mastectomy); and prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy) when the individual's doctor orders it.

For Medicare to cover prosthetic or orthotic, an individual must go to a supplier that is enrolled in Medicare. The individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Pulmonary Rehabilitation

Medicare covers a comprehensive program of pulmonary rehabilitation if the individual has moderate to very severe chronic obstructive pulmonary disease (COPD) and has a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease. The individual pays 20% of the Medicare-approved amount if they get the service in a doctor's office. They pay a copayment per session if they get the service in a hospital outpatient setting.

Rural Health Clinic Services

Includes many outpatient primary care services. The individual pays 20% of the amount charged, and the Part B deductible applies.

Second Surgical Opinions

Second surgical opinions are sometimes covered in some cases for surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. The individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Smoking Cessation (counseling to stop smoking) Includes up to 8 face-to-face visits in a 12-month period if the individual is diagnosed with an illness caused or complicated by tobacco use, or they take a medicine that is affected by tobacco. The individual pays 20% of the Medicare-approved amount, and the Part B deductible applies. In a hospital outpatient setting, the individual pays a copayment.

Speech-Language Pathology Services

Speech-language pathology covers an evaluation and treatment
given to regain and strengthen speech and language skills including cognitive and swallowing skills when their doctor certifies their need for it. There may be limits on these services and exceptions to these limits. The individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Surgical Dressing Services

Surgical dressing services are for treatment of a surgical or surgically-treated wound. The individual pays 20% of the Medicare-approved amount for the doctor's services. The individual pays a fixed copayment for these services when they get them in a hospital outpatient setting. The individual pays nothing for the supplies. The Part B deductible applies.

Telehealth

Includes a limited number of medical or other health services, like office visits and consultations provided using an interactive two-way telecommunications system (like real-time audio and video) by an eligible provider who is at a location different from the patient's.

Available in some rural areas, under certain conditions, and only if the patient is located at one of the following places: a doctor's office, hospital, rural health clinic, federally-qualified health center, hospital-based dialysis facility, skilled nursing facility, or community mental health center. The patient pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Tests

Including X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests. Patient pays 20% of the Medicare-approved amount, and the Part B deductible applies.

If the patient gets the test at a hospital as an outpatient, the patient pays a copayment that may be more than 20% of the Medicare-approved amount, but it can't be more than the Part A hospital stay deductible.

Transplants and Immunosuppressive Drugs

This category also includes doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions and only in a Medicare-certified facility. Medicare covers bone marrow and cornea transplants under certain conditions.

Immunosuppressive drugs are covered if Medicare paid for the transplant, or an employer or union group health plan that was required to pay before Medicare paid for the transplant. The patient must have been entitled to Part A at the time of the transplant, and must be entitled to Part B at the time you get immunosuppressive drugs. Patient pays 20% of the Medicare-approved amount, and the Part B deductible applies.

If an individual is thinking about joining a Medicare Advantage Plan and is on a transplant waiting list or believe they need a transplant, they should check with the plan before they join to make sure their doctors and hospitals are in the plan's network. Also, check the plan's coverage rules for prior authorization.

NOTE: Medicare drug plans (Part D) may cover
immunosuppressive drugs, even if Medicare or an employer or union group health plan didn't pay for the transplant.

Travel

(Health care needed when traveling outside the United States) (Limited)

Medicare generally doesn't cover health care while an individual is traveling outside the U.S. (the "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa).

There are some exceptions including some cases where Medicare may pay for services that an individual gets while on board a ship within the territorial waters adjoining the land areas of the U.S. In rare cases, Medicare may pay for inpatient hospital, doctor, or ambulance services an individual gets in a foreign country in the following situations:

1. If an emergency arose within the U.S. and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition

2. If an individual is traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency
3. If an individual lives in the U.S. and the foreign hospital is closer to their home than the nearest U.S. hospital that can treat their medical condition, regardless of whether an emergency exists.

The individual pays 20% of the Medicare-approved amount, and the Part B deductible applies.

Urgently-Needed Care

To treat a sudden illness or injury that isn't a medical emergency. Individual pays 20% of the Medicare-approved amount for the doctor's services, and the Part B deductible applies.

What is not covered by Medicare Part A & B

Items and services that Medicare doesn't cover include, but aren't limited to, long-term care, routine dental care, dentures, cosmetic surgery, acupuncture, hearing aids, and exams for fitting hearing aids.

To find out if Medicare covers a service visit www.medicare.gov, and select "Find Out What Medicare Covers," or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

B. CHAPTER 2: MEDICARE CHOICES

Individuals can choose different ways to get their Medicare coverage. If they choose Original Medicare and they want drug coverage, they must join a Medicare Prescription Drug Plan (Part D).
If they choose to join a Medicare Advantage Plan, the plan may include Medicare prescription drug coverage. In most cases, if they don't make a choice, they will have Original Medicare. .
NOTE: If an individual has End-Stage Renal Disease (ESRD), they will usually get their health care through Original Medicare.

Each year individuals should review their health and prescription needs because their health, finances, or plan's coverage may have changed.

If an individual decides other coverage will better meet their needs, they can switch plans during certain times

There are Two Main Choices for How You Get Your Medicare

a) Choice One: Original Medicare

Part A (Hospital Insurance) and Part B (Medical Insurance)
V Medicare provides this coverage.
V Individuals have their choice of doctors, hospitals, and other providers.
Generally, the individual or their supplemental coverage pay deductibles and coinsurance.
V Individuals usually pay a monthly premium for Part B.
V Individuals must decide if they want Prescription Drug Coverage (Part D)
V These plans are run by private companies approved by Medicare
V An individual must also decide they want Supplemental Coverage
V If they want to get coverage that fills gaps in Original Medicare coverage:
V They can choose to buy a Medigap (Medicare Supplement Insurance) policy from a private company.
V Costs vary by policy and company.
V Employers/unions may offer similar coverage.

b) Choice Two: Medicare Advantage Plan (like an HMO or PPO)

Part C—Includes BOTH Part A (Hospital Insurance) and Part B (Medical Insurance)

Private insurance companies approved by Medicare provide this coverage.

In most plans, individuals need to use plan doctors, hospitals, and other providers, or they pay more or all of the costs. The individual usually pays a monthly premium (in addition to their Part B premium) and a copayment or coinsurance for covered services.

Costs, extra coverage, and rules vary by plan.
If an individual wants prescription drug coverage, and it's offered by their plan, in most cases they must get it through their plan.
If an individual's plan doesn't offer drug coverage, the individual can choose to join a Medicare Prescription Drug Plan.

c) Things to Consider When Choosing or Changing

Coverage
Coverage—Are the services needed covered?

Individual's other coverage—Does the individual have, or are they eligible for, other types of health or prescription drug coverage?

If so, the individual should read the materials they get from their insurer or plan, or call them to find out how the coverage works with, or is affected by, Medicare. If an individual has coverage through a former or current employer or union, or get their health care from an Indian Health or Tribal Health Program, they should talk to their benefits administrator, insurer, or plan before making any changes to their coverage.

Cost—How much are the premiums, deductibles, and other costs? How much does an individual have to pay for services like hospital stays or doctor visits? Is there a yearly limit on what the individual could pay out-of-pocket for medical services? An individual's costs may vary and may be different if they don't follow the coverage rules.

Doctor and hospital choice—Does the individual's doctors accept the coverage? Are the doctors they want to see accepting new patients? Do they have to choose their hospital and health care providers from a network? Do they need to get referrals?

Prescription drugs—What are the individual's drug needs? Do they need to join a Medicare drug plan? Do they already have creditable prescription drug coverage? Will they pay a penalty if they join a drug plan later? What will their prescription drugs cost under each plan? Are their drugs covered under the plan's formulary (drug list)?

Quality of care—The quality of care and services given by plans and other health care providers can vary. Medicare has information to help individuals compare plans and providers. See page

Convenience—Where are the doctors' offices? What are their hours? Which pharmacies can the individual use? Can they get their prescriptions by mail? Do the doctors use electronic health records or prescribe electronically?

Travel—Will the plan cover the individual while in another state? If an individual is in a Medicare plan, they should review the Evidence of Coverage (EOC) and Annual Notice of Change (ANOC) the plan sends individuals each year. The EOC gives details about what the plan covers, how much an individual pays, and more. The ANOC includes any changes in coverage, costs, or service area that will be effective in January.

C. CHAPTER 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.

a) 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".

b) 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." Whether the individual and their the doctor sign a private contract
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 them self.
Whether an individual has other health insurance coverage that works with Medicare.

Whether an individual has Medicaid or get state help paying their Medicare costs.
Whether an individual has a Medigap (Medicare Supplement Insurance) policy.
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 an individual wants to know the costs for a specific service, they should visit www.medicare.gov on the web for this information.

c) 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.

d) WHAT IS A PRIVATE CONTRACT?

A "private contract" is a written agreement between the patient and a doctor or other health care provider who has decided not to provide services to anyone through Medicare. The private contract only applies to the services provided by the doctor or other provider who asked an individual to sign it. Individuals don't have to sign a private contract. They can always go to another doctor who does provide services through Medicare. If an individual signs a private contract with your doctor or other provider, the following rules apply:

Medicare won't pay any amount for the services that an individual gets from this doctor or other provider.

The individual will have to pay the full amount of whatever this doctor charges.

If an individual has a Medigap (Medicare Supplement Insurance) policy, it won't pay anything for the services they get.

The doctor must tell the individual if the service is one that Medicare would pay for if the individual got it from another doctor who accepts Medicare.

A doctor must tell you if he or she has been excluded from Medicare.

Individuals cannot be asked to sign a private contract for emergency or urgent care.

e) ADDING MEDICARE DRUG COVERAGE PART D

In Original Medicare, if an individual doesn't already have creditable prescription drug coverage and they would like prescription drug coverage, they must join a Medicare Prescription Drug Plan.
These plans are available through private companies approved by and under contract with Medicare. If an individual currently does not a creditable prescription drug coverage, they should think about joining a Medicare Prescription Drug Plan as soon as they are eligible. If an individual doesn't join a Medicare

Prescription Drug Plan when they are first eligible and they decide to join later, they may have to pay a late enrollment penalty.
If an individual has a creditable prescription drug coverage, they should call their employer or union's benefits administrator before they make any changes to their coverage. If an individual drops their employer or union coverage, they may not be able to get it back.

f) Extra Help Paying for Drug Coverage

People with limited income and resources may qualify for Extra Help paying their Medicare prescription drug coverage costs.

D. CHAPTER 4: MEDICARE ADVANTAGE-PART C

1. MEDICARE ADVANTAGE PLANS

A Medicare Advantage Plan (like an HMO or PPO) is another health coverage choice individual may have as part of Medicare.

Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare.

If an individual joins a Medicare Advantage Plan, the plan will provide all of Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. In all plan types, an individual is always covered for emergency and urgent care. Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care.

Original Medicare covers hospice care even if the individual is in a Medicare Advantage Plan. Medicare Advantage Plans aren't considered supplemental coverage.

Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage. In addition to Part B premium, an individual usually pay one monthly premium for the services provided.

Medicare pays a fixed amount for their care every month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how to get services (like whether an individual needs a referral to see a specialist or if they have to go to only doctors, facilities, or suppliers that belong to the plan).

2. MEDICARE ADVANTAGE PLANS I Medicare Advantage Plans include the following:

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.

a) There are other less common types of Medicare Advantage Plans that may be available:

Point of Service (POS) Plans—Similar to HMOs, but an individual may be able to get some services out-of-network for a higher cost.
Provider Sponsored Organizations (PSOs)—Plans run by a provider or group of providers. In a PSO, individuals usually get their health care from the providers who are part of the plan.

Not all Medicare Advantage Plans work the same way.

b) More about Medicare Advantage Plans

As with Original Medicare, individuals still have Medicare rights and protections, including the right to appeal.

Individuals should check with the plan before they get a service to find out whether they will cover the service and what your costs may be.

Individuals must follow plan rules, like getting a referral to see a specialist or getting prior approval for certain procedures to avoid higher costs. Check with the plan.

Individuals can join a Medicare Advantage Plan even if they have a pre-existing condition, except for End-Stage Renal Disease.

Individuals can only join a plan at certain times during the year. In most cases, individuals are enrolled in a plan for a year.

If an individual goes to a doctor, facility, or supplier that doesn't belong to the plan, their services may not be covered, or their costs could be higher, depending on the type of Medicare Advantage Plan.

If the plan decides to stop participating in Medicare, the individual will have to join another Medicare health plan or return to Original Medicare.

Individuals usually get prescription drug coverage (Part D) through the plan. If they are in a Medicare Advantage Plan that includes prescription drug coverage and they join a Medicare Prescription Drug Plan, the individual will be disenrolled from their Medicare Advantage Plan and returned to Original Medicare.

Individuals don't need to buy (and can't be sold) a Medigap (Medicare Supplement Insurance) policy while they are in a Medicare Advantage Plan. It won't cover their Medicare Advantage Plan deductibles, copayment, or coinsurance.

c) Who Can Join a Medicare Advantage Plan?

An individual can generally join a Medicare Advantage Plan if
they meet these conditions:
They have Part A and Part B.
They live in the service area of the plan.

If an individual has other coverage the individual should talk their employer, union, or Indian or Tribal Health Program benefits administrator about their rules before they join a Medicare Advantage Plan. In some cases, joining a Medicare Advantage Plan might cause the individual to lose employer or union coverage. In other cases, if they join a Medicare Advantage Plan, they may still be able to use their employer or union coverage along with the plan they join. Individuals must keep in mind that if they drop their employer or union coverage, they may not be able to get it back.
If an individual has a Medigap (Medicare Supplement Insurance) Policy the he or she cannot use it to pay for any expenses they have under a Medicare Advantage Plan.

If they drop their Medigap policy to join a Medicare Advantage Plan, in most cases, they won't be able to get it back.

3. End-Stage Renal Disease (ESRD)

End-Stage Renal Disease (ESRD) is when you have permanent kidney failure that requires a regular course of dialysis or a kidney transplant. Get specific information for children with ESRD.

a) Am I eligible for Medicare?

If you have ESRD, you can get Medicare no matter how old you are if all of these apply:

Your kidneys no longer work

You need regular dialysis or have had a kidney transplant

One of these applies to you:

You've worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a government employee

You're already getting or are eligible for Social Security or Railroad Retirement benefits

You're the spouse or dependent child of a person who meets either of the requirements listed above

b) How do I get Medicare?

If you're eligible for Medicare because of ESRD and you qualify for Part A, you can also get Part B. Signing up for Medicare is your choice. But, you'll need both Part A and Part B to get the full benefits available under Medicare to cover certain dialysis and kidney transplant services. You can sign up for Part A and Part B by contacting your local Social Security office or by calling Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

If you apply for Medicare and you're approved because of ESRD, you can sign up for Part B without paying a late enrollment penalty. If you already have Medicare because of age or disability, and you currently pay a Part B late enrollment penalty, you'll need to sign up again for Medicare (because of ESRD) to stop paying the penalty. Contact your local Social Security office to sign up for Medicare because of ESRD.

c) When will my coverage start?

Eligibility for Medicare coverage based on ESRD works differently than other types of Medicare eligibility. If you're eligible for Medicare based on ESRD and don't sign up right away, your coverage could start up to 12 months before the month you apply.

If you become eligible for Medicare based on ESRD in February, but don't sign up for Medicare until November, your Medicare coverage will start in February (this is called retroactive coverage).

d) If you're on dialysis:

Medicare coverage usually starts on the first day of the fourth month of your dialysis treatments. This 4-month waiting period will start even if you haven't signed up for Medicare.

If you start dialysis on July 1, your coverage will begin on October 1, even if you don't sign up for Medicare until December 1.

If you're covered by an employer group health plan, your Medicare coverage will still start the fourth month of dialysis treatments. Your group health plan may pay the first 3 months of dialysis.

Medicare coverage can begin as early as the first month of a regular course of dialysis treatments if you meet all of these conditions:

You participate in a home dialysis training program offered by a Medicare-certified training facility during the first 3 months of your regular course of dialysis.

Your doctor expects you to finish training and be able to do your own dialysis treatments at home.

You maintain a regular course of dialysis throughout the waiting period that would otherwise apply.

Medicare won't cover surgery or other services needed to prepare for dialysis (like surgery for a blood access (fistula)) before Medicare coverage begins. However, if you complete home dialysis training, your Medicare coverage will start the month you begin regular dialysis, and these services could be covered.

If you're already getting Medicare due to age or disability, Medicare will cover physician-ordered fistula placement or other preparatory services before dialysis begins.

e) If you're getting a kidney transplant:

Medicare coverage can begin the month you're admitted to a Medicare-certified hospital for a kidney transplant (or for health care services that you need before your transplant) if your transplant takes place in that same month or within the next 2 months.

Mr. Green will be admitted to the hospital on March 11 for his kidney transplant. His Medicare coverage will begin in March. If his transplant is delayed until April or May, his Medicare coverage will still begin in March.

If your transplant is delayed more than 2 months after you're admitted to the hospital (for the transplant or for health care services you need before your transplant), Medicare coverage can begin 2 months before your transplant.

Mrs. Perkins was admitted to the hospital on May 25 for some tests she needed before her kidney transplant. She was supposed to get her transplant on June 15. However, her transplant was delayed until September 17. Therefore, Mrs. Perkins' Medicare coverage will start in July — 2 months before the month of her transplant.

f) When will my Medicare coverage end?

If you have Medicare only because of permanent kidney failure, Medicare coverage will end:

- 12 months after the month you stop dialysis treatments.
- 36 months after the month you have a kidney transplant.

Your Medicare coverage will resume if:

- You start dialysis again, or you get a kidney transplant within 12 months after the month you stopped getting dialysis.
- You start dialysis or get another kidney transplant within 36 months after the month you get a kidney transplant.

g) What are my coverage options?

People with ESRD can choose either Original Medicare or a Medicare Advantage Plan for their Medicare coverage.

Original Medicare Medicare Advantage Plan

Original Medicare includes Part A and Part B.

You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).

You can use any doctor or hospital that takes Medicare, anywhere in the U.S.

A Medicare Advantage Plan is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D.

Some Medicare Advantage Plans also offer extra coverage, like vision, hearing and dental coverage.

In many cases, you'll need to use health care providers who participate in the plan's network and service area. Before you join a plan, you may want to check with your providers and the plan you're considering to make sure the providers you currently see (like your dialysis facility or kidney doctor), or want to see in the future (like a transplant specialist), are in the plan's network. Contact your plan for specific information.

Compare Original Medicare and Medicare Advantage side-by-side.

h) How does coverage for prescription drugs work?

Once you become eligible for Medicare based on ESRD, your first chance to join a Medicare drug plan will be during the 7-month period that begins 3 months before the month you're eligible for Medicare and ends 3 months after the first month you're eligible for Medicare.

Your prescription drug coverage will start the same time your Medicare coverage begins, or the first month after you make your request, whichever is later.

Medicare Part B covers transplant drugs after a covered transplant, and most of the drugs you get for dialysis. However, Part B doesn't cover prescription drugs for other health conditions you may have, like high blood pressure. Medicare offers prescription drug coverage (Part D) to help you with the costs of your drugs not covered by Part B.

i) How does other coverage work with Medicare?

There are other kinds of health coverage that may help pay for services and treatment related to ESRD, like:

- Employee or retiree coverage from an employer or union
- Medicare Supplement Insurance (Medigap)
- Medicaid
- Veterans' Administration benefits

If you're eligible for Medicare only because of permanent kidney failure, your Medicare coverage usually can't start until the fourth month of dialysis (also known as a "waiting period"). This means if you have coverage under an employer or union group health plan, that plan will be the only payer for the first 3 months of dialysis (unless you have other coverage).

Once you become eligible for Medicare because of permanent kidney failure, there will still be a period of time, called a "coordination period," when your employer or union group health plan will continue to pay your health care bills.

If your plan doesn't pay 100% of your health care bills, Medicare may pay some of the remaining costs. This is called "coordination of benefits," under which your plan "pays first" and Medicare "pays second." During this time, Medicare is called the secondary payer (the insurance policy, plan, or program that pays second on a claim for medical care). This coordination period lasts for 30 months.

Tell your health care provider if you have employer or union group health plan coverage so they bill your services correctly. At the end of the 30-month coordination period, Medicare will pay first for all Medicare-covered services. Your employer or union group health plan coverage may still pay for services that Medicare doesn't cover. Check with your plan's benefits administrator for more information.

j) Can there be more than 1 coordination period?

There's a separate 30-month coordination period each time you sign up for Medicare based on permanent kidney failure.

For example, if you get a kidney transplant that continues to work for 36 months, your Medicare coverage will end after 36 months (unless you have Medicare based on your age or disability). If (after 36 months) you sign up for Medicare again because you start dialysis or get another transplant, your Medicare coverage will start right away. You won't have to wait 3 months before Medicare begins to pay. However, you'll have a new 30-month coordination period if you have employer or union group health plan coverage.

k) What happens if I have COBRA or TRICARE coverage?

If you're currently working and have COBRA coverage through your job when you sign up for Medicare, your COBRA will probably end. If you become eligible for COBRA coverage after you're already signed up for Medicare, you must be allowed to take the COBRA coverage. It will always be secondary to Medicare (unless you have ESRD).

If you have TRICARE and are an active duty service member with ESRD, you should sign up for Part A and Part B when you're first eligible.

Do I have to get Medicare if I already have an employer or union group health plan?

No, but think carefully about this decision. Here are some things to consider:

Medicare only covers immunosuppressive drugs in specific circumstances. If you get a kidney transplant, you'll need to take immunosuppressive drugs for the rest of your life, so it's important to know if you'll have coverage.

If your group health plan coverage has a yearly deductible, copayment, or coinsurance, signing up for Medicare could help pay those costs during the coordination period. If your group health plan coverage will pay for most or all of your health care costs (for example, if it doesn't have a yearly deductible), you may want to delay signing up for Medicare until the 30-month coordination period is over.

If you delay signing up, you won't have to pay the Part B premium for coverage you don't need yet. After the 30-month coordination period, you should sign up for Medicare. Your Part B premium won't be higher because you delayed when you signed up in this situation. If your group health plan benefits are decreased or end during this period, you should sign up for Medicare as soon as possible.

For more information about how employer or union group health plan coverage works with Medicare:

Get a copy of your plan's benefits booklet.

Call your benefits administrator, and ask how the plan pays when you have Medicare.

l) How does the Health Insurance Marketplace® work with Medicare?

You aren't required to sign up for Medicare. If you don't have Medicare, you might be able get a Marketplace plan. You may be eligible for tax credits and lower cost-sharing through the Marketplace.

You generally can't drop Medicare coverage to choose a Marketplace plan. You can choose to withdraw your original Medicare application, but if you do, you'll have to repay all costs that Medicare covered, pay any outstanding balances, and refund any benefits you got from Social Security or the Railroad Retirement Board. Once you've made all of these repayments, your withdrawal will be processed.

If you have Original Medicare, your ESRD Network can help you:

Get your dialysis treatments

Find out who to contact for your supplies, drugs, transportation to dialysis services, and emergency financial help if you need it

Call your ESRD Network for more information. You can also call us at 1-800-MEDICARE (1-800-633-4227) to get: Your ESRD Network's contact information

More information about getting dialysis in a disaster or emergency

If you have a Medicare Advantage Plan or other Medicare health plan:

Contact your plan for help finding a dialysis facility and to find out what rules change during a disaster or emergency.

Learn more about getting care & drugs in disasters or emergencies.

m) How does dialysis work if I'm traveling?

You can still travel within the United States if you need dialysis. Your facility can help you plan your treatment along the route of your trip before you travel. Find out about Medicare's coverage when you travel outside the U.S.

While you're traveling you may need to pay your co-pay when you get your dialysis. Check with the social worker at your dialysis facility to learn more.

n) What's the Immunosuppressive Drug benefit?

If you only have Medicare because of End-Stage Renal Disease (ESRD), your Medicare coverage, including immunosuppressive drug coverage, ends 36 months after a successful kidney transplant.

Medicare offers a benefit to help you pay for your immunosuppressive drugs beyond 36 months. You may be eligible if:

You had Medicare because of ESRD at the time of your kidney transplant.

You don't have or expect to get certain types of other health coverage (like a group or individual health plan, TRICARE, or Medicaid that covers immunosuppressive drugs).

This benefit only covers your immunosuppressive drugs and no other items or services. It isn't a substitute for full health coverage. If you sign up for the immunosuppressive drug benefit, but get other health coverage later, you must notify Social Security within 60 days of enrolling in the new coverage.

o) When can I sign up?

You can sign up for this benefit at any time. To sign up, call Social Security at 1-877-465-0355. This is a special phone number just for this benefit. TTY users can call our general line at 1-800-325-0778. YWhat will I pay for this benefit?

You'll pay a monthly premium and an annual deductible.

The monthly premium for this benefit is $110.40 (or higher based on your income) in 2025 ($121.60 in 2026) . Who pays a higher premium because of income?

The annual deductible is $257 in 2025 ($283 in 2026). Once you've met the deductible, you'll pay 20% of the Medicare-approved amount for your immunosuppressive drugs.

Can I get help with these costs?

If you have limited income and resources, you may be able to get help paying for this benefit through one of these Medicare Savings Programs:

For questions or complaints about kidney dialysis services, call the local ESRD Network Organization. An ESRD Network Organization is a group of kidney care experts paid by the Federal government to check and improve the care given to Medicare patients who get dialysis treatments for kidney care. Call 1-800-MEDICARE (1-800-633-4227) to get the telephone number. TTY users should call 1-877-486-2048.

For more information about ESRD, visit

- www.medicare.gov/Publications/Pubs/pdf/10128.pdf to view the booklet, "Medicare Coverage of Kidney Dialysis and Kidney Transplant Services."

p) Costs for Medicare advantage plans

The out-of-pocket costs in a Medicare Advantage Plan depend on the following:

Whether the plan charges a monthly premium in addition to the Part B premium.
Whether the plan pays any of the monthly Part B premium. Some plans offer this option, usually for an extra cost. Whether the plan has a yearly deductible or any additional deductibles.
How much an individual pays for each visit or service (copayments).
The type of health care services an individual needs and how often they get them.
Whether the individual follows the plan's rules, like using network providers.
Whether the individual needs extra coverage and what the plan charges for it.
Whether the plan has a yearly limit on out-of-pocket costs for all medical services.
To learn more about individual costs in specific Medicare Advantage Plans, the individual should contact the plans they are interested in to get more details.

Visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227).

q) 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.

r) 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 them self. 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 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).

s) 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.

There are two types of PPOs— Regional PPOs and Local PPOs. Regional PPOs serve one of 26 regions set by Medicare. Local PPOs serve the counties the PPO Plan chooses to include in its service area.

t) 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.

PFFS Plans aren't the same as Original Medicare or Medigap. The plan decides how much an individual must pay for services.

Doctors, hospitals, and other providers may decide on a case-by-case basis not to treat an individual even if they've seen them before.

For each service an individual gets they should check to make sure their doctors, hospitals, and other providers will agree to treat them under the plan, and that they will accept the PFFS Plan's payment terms.

In an emergency, doctors, hospitals, and other providers must agree to treat you.

u) Medical savings account

Individuals can go to any Medicare-approved doctor or hospital that accepts the terms of the plan's payment.

An individual must join a Medicare Prescription Drug Plan to get drug coverage.
Medicare MSA Plans have two parts -a high deductible health plan and a bank account.

Medicare gives the plan an amount each year for an individual's health care, and the plan deposits a portion of this money into their account. The amount deposited is less than their deductible amount, so they will have to pay out-of-pocket before their coverage begins. Money spent for Medicare -covered Part A and Part B services counts toward their plan's deductible. After they reach their out-of-pocket limit, their plan will cover their Medicare-covered services in full. Any money left in their account at the end of the year remains in their account, along with the deposit for next year.

In 2010 Medicare MSA Plans are only available in Pennsylvania

v) Medicare Special Needs Plans

An individual 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 (except emergency care, out-of-area urgent care, or out-of-area dialysis. Plans typically have specialists for the diseases or condition that effect their members.

Individuals, generally, need to have a primary care doctor.

Individuals need a referral to see a specialist. Yearly screening mammograms and in-network Pap test and pelvic exam don't require a referral.

A plan must limit plan membership to people in one of the following groups:

- People who live in certain institutions (like a nursing home) or who require nursing care at home, or
- People who are eligible for both Medicare and Medicaid, or
- People who have one or more specific chronic or disabling conditions (like diabetes, congestive heart failure, a mental health condition, or HIV/AIDS).

Plans may further limit membership within these groups.

Plans should coordinate the services and providers an individual needs to help them stay healthy and follow their doctor's orders.

- If an individual has Medicare and Medicaid, their plan should make sure that all of the plan doctors or other health care providers accept Medicaid.
- If an individual lives in an institution, they need to make sure that plan doctors or other health care providers serve people where they live.

4. An Individual Can Join, Switch, Or Drop A Medicare Advantage Plan At These Times

When an individual first become eligible for Medicare (the 7- month period that begins 3 months before the month an individual turns age 65, includes the month they turn age 65, and ends 3 months after the month they turn age 65).

If an individual gets Medicare due to a disability, they can join during the 3 months before to 3 months after their 25th month of disability. They will have another chance to join 3 months before the month they turn age 65 to 3 months after the month they turn age 65.

Between November 15–December 31 each year. Their coverage will begin on January 1 of the following year, as long as the plan gets their enrollment request by December 31.

Between January 1–March 31 of each year. Their coverage will begin the first day of the month after the plan gets their enrollment form.

During this period, they can't do the following:
Join or switch to a plan with prescription drug coverage unless they already have Medicare prescription drug coverage (Part D).
Drop a plan with prescription drug coverage.
Join, switch, or drop a Medicare Medical Savings Account Plan.
In most cases, the individual must stay enrolled for that calendar year starting the date their coverage begins. However, in certain situations, they may be able to join, switch, or drop a Medicare Advantage Plan at other times.

Some of these situations include the following:
If the individual moves out of their plan's service area
If they have both Medicare and Medicaid
If they qualify for Extra Help to pay for their prescription drug costs
If they live in an institution (like a nursing home)
Individuals can call their State Health Insurance Assistance Program (SHIP) for more information.

i) How to Join

If an individual chooses to join a Medicare Advantage Plan, they can join by completing a paper application, calling the plan, or enrolling on the plan's Web site or on www.medicare.gov. They can also enroll by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

When an individual join a Medicare Advantage Plan, they will have to provide their Medicare number and the date their Part A and/or Part B coverage started. This information is on their Medicare card.

ii) How to Switch

If an individual is already in a Medicare Advantage Plan and wants to switch, this is what they need to do:
To switch to a new Medicare Advantage Plan, simply join the plan they choose. They will be disenrolled automatically from their old plan when their new plan's coverage begins.

To switch to Original Medicare, they can contact their current plan, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. They will also need to decide about Medicare prescription drug coverage (Part D).

If an individual's Plan Decides Not to Participate in Medicare The plan will send the individual a letter about their options. Generally, the individual will automatically be returned to Original Medicare if they don't choose to join another Medicare Advantage Plan. The individual will also have the right to buy certain Medigap policies.
If the Plan Stops Providing Service in the Area an individual may be able to keep their coverage with that plan if there are no other Medicare Advantage Plans in their area.

If their plan offers this option, the 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 individual's plan doesn't have this option, they will automatically return to Original Medicare.

In this case they will have the right to buy a Medigap policy. If the individual decides to return to Original Medicare and they want drug coverage, they will need to join a Medicare Prescription Drug Plan.

b) Other Medicare Health Plans

Some types of Medicare health plans that provide health care coverage aren't Medicare Advantage Plans but are still part of Medicare. Some of these plans provide Part A (Hospital Insurance) and/or Part B (Medical Insurance) coverage, and some also provide Part D (Medicare prescription drug coverage). These plans have some of the same rules as Medicare Advantage Plans. Some of these rules are explained briefly below. However, each type of plan has special rules and exceptions, so the individual should contact any plans they're interested in to get more details.

c) 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.

There is another type of Medicare Cost Plan that only provides coverage for Part B services. These plans never include Part D. Part A services are covered through Original Medicare. These plans are either sponsored by employer or union group health plans or offered by companies that don't provide Part A services.

d) Demonstrations/Pilot Programs

Demonstrations and pilot programs, sometimes called "research studies," are special projects that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time for a specific group of people and/or are offered only in specific areas. Check with the demonstration or pilot program for more information about how it works.

For more information about current Medicare demonstrations and pilot programs, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227), and say "Agent." TTY users should call 1-877-486-2048.
Programs of All-Inclusive Care for the Elderly (PACE) PACE combines medical, social, and long-term care services, and prescription drug coverage for frail elderly and disabled people. This program provides community-based care and services to people who otherwise need a nursing home-level of care.

To qualify for PACE, an individual must meet the following conditions:
Be age 55 or older.
Live in the service area of a PACE organization.
Be certified by their state as meeting the need for a nursing home-level of care.
At the time they join, to be able to live safely in the

community with the help of PACE services.

PACE uses Medicare and Medicaid funds to cover all of their medically necessary care and services.

The individual can have either Medicare or Medicaid or both to join PACE.

Individuals should call their State Medical Assistance (Medicaid) office to find out if they are eligible and if there is a PACE site near them.

For more information, you can also visit

e) www.medicare.gov/Publications/Pubs/pdf/11341.pdf to view the fact sheet, "Quick Facts about Programs of All-inclusive Care for the Elderly (PACE)."

E. MEDICARE PRESCRIPTION DRUG COVERAGE (PART D)

Medicare offers prescription drug coverage (Part D) to everyone with Medicare. To get Medicare drug coverage, the individual must join a plan run by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered.

There are two ways to get Medicare prescription drug coverage:

- **Medicare Prescription Drug Plans.**
  These plans (sometimes called "PDPs") add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.

- **Medicare Advantage Plans** (like an HMO or PPO) or other Medicare health plans that offer Medicare prescription drug coverage.

Individuals get all of their Part A and Part B coverage, and prescription drug coverage (Part D), through these plans. Medicare Advantage Plans with prescription drug coverage are sometimes called "MA-PDs."

Both types of plans are called "Medicare drug plans" in this section.

a) Why Join a Medicare Drug Plan?

Even if an individual doesn't take a lot of prescription drugs now, they should still consider joining a Medicare drug plan. If an individual decides not to join a Medicare drug plan when they are first eligible, and they don't have other creditable prescription drug coverage (also called creditable coverage), they will likely pay a late enrollment penalty (higher premiums) if they join later.

NOTE: Discount cards, doctor samples, free clinics, drug discount Web sites, and manufacturer's pharmacy assistance programs aren't considered prescription drug coverage and aren't creditable coverage.

b) Who Can Get Medicare Drug Coverage?

To join a Medicare Prescription Drug Plan, an individual must have Medicare Part A and/or Part B. If an individual would like to get prescription drug coverage through a Medicare Advantage Plan, they must have Part A and Part B. An individual must also live in the service area of the Medicare drug plan they want to join.

If an individual has employer or union coverage, they need to call their benefits administrator before they make any changes, or before they sign up for any other coverage. If an individual drops their employer or union coverage, they may not be able to get it back. They also may not be able to drop their employer or union drug coverage without also dropping their employer or union health (doctor and hospital) coverage. If an individual drops their coverage, they may also have to drop coverage for their spouse and dependants.

c) When Can an individual Join, Switch, or Drop a Medicare Drug Plan?

An individual can join, switch, or drop a Medicare drug plan at these times:

- When they are first eligible for Medicare (the 7-month period that begins 3 months before the month they turn age 65, includes the month they turn age 65, and ends 3 months after the month they turn age 65).

- If an individual gets Medicare due to a disability, they can join during the 3 months before to 3 months after their 25th month of disability. They will have another chance to join 3 months before the month they turn age 65 to 3 months after the month they turn age 65.

- Between November 15 – December 31 each year. Their coverage will begin on January 1 of the following year, as long as the plan gets their enrollment request by December 31.

- Anytime, if an individual qualifies for Extra Help or if they have both Medicare and Medicaid.

In most cases, they must stay enrolled for that calendar year starting the date their coverage begins. However, in certain situations, they may be able to join, switch, or drop Medicare drug plans during a special enrollment period (like if they move out of the service area, lose other creditable prescription drug coverage, or live in an institution).

d) How Do You Join?

Once an individual chooses a Medicare drug plan, they may be able to join by completing a paper application, calling the plan, or enrolling on the plan's Web site or on www.medicare.gov. They can also enroll by calling 1-800-MEDICARE. Medicare drug plans aren't allowed to call an individual to enroll them in a plan.

When an individual joins a Medicare drug plan, they will have to provide their Medicare number and the date their Part A or Part B coverage started.

e) How to Switch?

Depending on the circumstances, an individual can switch to a new Medicare drug plan simply by joining another drug plan during one the enrollment periods. An individual does not need to cancel their old Medicare drug plan or send them anything. Their old Medicare drug plan coverage will end when their new drug plan begins. They should get a letter from their new Medicare drug plan telling them when their coverage begins. After they join a Medicare drug plan, the plan will mail them membership materials, including a card to use when they get their prescriptions filled.

f) What You Pay

Exact coverage and costs are different for each Medicare drug plan, but all plans must provide at least a standard level of coverage set by Medicare. Actual drug plan costs will vary depending on the prescriptions used, the plan an individual chooses, whether an individual goes to a pharmacy in their plan's network, whether their drugs are on their plan's formulary, and whether an individual qualifies for Extra Help paying for their Part D costs.

Monthly premium—Most drug plans charge a monthly fee that varies by plan. An individual pays this in addition to the Part B premium. If they belong to a Medicare Advantage Plan (like an HMO or PPO) or a Medicare Cost Plan that includes Medicare prescription drug coverage, the monthly premium may include an amount for prescription drug coverage.

Yearly deductible—Amount an individual pays for their prescriptions before their plan begins to pay. Some drug plans don't have a deductible.

Copayments or coinsurance—Amounts an individual pays at the pharmacy for their covered prescriptions after the deductible. The individual pays their share, and their drug plan pays its share for covered drugs.

Coverage gap—Most Medicare drug plans have a coverage gap. This means that after the individual and their drug plan have spent a certain amount of money for covered drugs, the individual has to pay all costs out-of-pocket for their prescriptions up to a yearly limit. Their yearly deductible, their coinsurance or copayments, and what an individual pays in the coverage gap all count toward this out-of-pocket limit. The limit doesn't include the drug plan's premium or what an individual pays for drugs that aren't on their plan's formulary.

There are plans that offer some coverage during the gap, like for generic drugs. However, plans with gap coverage may charge a higher monthly premium. An individual needs to check with the drug plan first to see if their drugs would be covered during the gap.

Catastrophic coverage—Once an individual reaches their plan's out-of-pocket limit during the coverage gap, they automatically get "catastrophic coverage." Catastrophic coverage assures that once an individual has spent up to their plan's out-of-pocket limit for covered drugs, they only pay a small coinsurance amount or copayment for the drug for the rest of the year.

g) What is the Part D Late Enrollment Penalty?

The late enrollment penalty is an amount that is added to an individual's Part D premium. An individual may owe a late enrollment penalty if one of the following is true:

The individual didn't join a Medicare drug plan when they were first eligible for Medicare, and they didn't have other creditable prescription drug coverage.
The individual had a break in their Medicare prescription drug coverage or other creditable coverage of at least 63 days in a row.

NOTE: If an individual gets Extra Help, they don't pay a late enrollment penalty.

Here are a few ways to avoid paying a penalty:

- Join a Medicare drug plan when you're first eligible.

- Don't go for more than 63 days in a row without a Medicare drug plan or other creditable coverage. Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, or the Department of Veterans Affairs. An individual's plan will tell them each year if their drug coverage is creditable coverage. An individual should keep this information, because they may need it if they join a Medicare drug plan later.

- Don't go 63 days or more in a row without letting your Medicare drug plan know if you had other creditable coverage. When an individual joins a plan, they may get a letter asking if they have creditable coverage. They should complete the form. If an individual doesn't tell the plan about their creditable coverage, they may have to pay a penalty.

h) How much more will an individual pay?

When an individual joins a Medicare drug plan, the plan will tell them if they owe a penalty, and what their premium will be. To estimate the penalty amount, an individual can count the number of full months that they didn't have creditable coverage after they were eligible to join a Medicare drug plan.

If the number of months is multiplied by the "1% penalty calculation" which is $.32 in 2010, an individual can estimate the amount that will be added each month to their Medicare drug plan's premium for the current year. This penalty amount may increase every year.

If an individual doesn't agree with their late enrollment penalty, they may be able to ask Medicare for a review or reconsideration. They will need to fill out a reconsideration request form, and the individual will have the chance to provide proof that supports their case such as information about previous prescription drug coverage.

i) Important Drug Coverage Rules

The following information can help answer common questions as
an individual begins to use your coverage.

To Fill a Prescription Prior to the Membership Card is received within 2 weeks after the plan gets the completed application, the individual will get a letter from the plan letting them know they got their information. The individual should get a welcome package with their membership card within 5 weeks or sooner. If an individual needs to go to the pharmacy before their membership card arrives, they can use any of the following as proof of membership to the Medicare drug plan:

- A letter from the plan
- An enrollment confirmation number that the individual got from the plan,
- The plan name, and telephone number
- The individual should also bring their Medicare and/or Medicaid card, proof of any other prescription drug coverage, and a photo ID.

Once the individual has considered their options and chosen a plan, they should join early to give the plan time to mail their membership card, acknowledgement letter, and welcome package before their coverage becomes effective.

Plans may have the following coverage rules:

- **Prior authorization**—The individual and/or their prescriber (their doctor or other health care provider who is legally allowed to write prescriptions) must contact the drug plan before they can fill certain prescriptions. Their prescriber may need to show that the drug is medically necessary for the plan to cover it.

- **Quantity limits**—Limits on how much medication an individual can get at a time.

- **Step therapy**—The individual must try one or more similar, lower cost drugs before the plan will cover the prescribed drug.

j) What Are "Tiers"?

Many Medicare drug plans place drugs into different "tiers." Drugs in each tier have a different cost. For example, a drug in a lower tier will cost less than a drug in a higher tier. In some cases, if the drug is on a higher tier and the prescriber thinks the individual needs that drug instead of a similar drug on a lower tier, they can file an exception and ask their plan for a lower copayment.

NOTE: Medicare drug plans must cover all commercially-available vaccines (like the shingles vaccine) when medically necessary to prevent illness except for vaccines covered under Part B. Information about a plan's list of covered drugs (called a formulary) isn't included in this book because each plan has its own formulary. Formularies can change.

In most cases the prescription drugs an individual gets in an outpatient setting like an emergency department (sometimes called "self-administered drugs") aren't covered by Part B.

The individual's Medicare drug plan may cover these drugs under certain circumstances. They will likely need to pay out-of-pocket for these drugs and submit a claim to their drug plan for a refund.

k) Ways to Pay the Premium

Depending on their plan and their situation, an individual may be able to pay their Medicare drug plan premium in one of four ways:

- Deducted from their checking or savings account.
- Charged to a credit or debit card.
- Billed to you each month directly by the plan. Some plans bill in advance for coverage the next month. Payment should be paid directly to the plan (not Medicare).
- Deducted from an individual's monthly Social Security payment.

The individual should contact their drug plan (not Social Security) to ask for this payment option. With this option, the first deductions usually take 3 months to start, and 3 months of premiums will likely be collected at one time. Individuals may also see a delay in premiums being withheld if they switch or leave plans.

For more information about a specific Medicare drug plan premium or ways to pay for it, an individual should contact their drug plan.

l) Other Private Insurance

Employer or Union Health Coverage — Health coverage from the spouse or other family member's current or former employer or union. If an individual has prescription drug coverage based on their current or previous employment, their employer or union will notify the individual each year to let them know

Employer or Union Health Coverage—Health coverage from your spouse's, or other family member's current or former employer or union. If you have prescription drug coverage based on your current or previous employment, your employer or union will notify you each year to let you know if your drug coverage is creditable. Keep the information you get. Call your benefits administrator for more information before making any changes to your coverage.

COBRA—A Federal law that may allow an individual to temporarily keep employer or union health coverage after the employment ends or after the individual loses coverage as a dependent of the covered employee. There may be reasons why an individual should take Part B instead of COBRA. However, if they take COBRA and it includes creditable prescription drug coverage, they will have a special enrollment period to join a Medicare drug plan without paying a penalty when the COBRA coverage ends.

Medigap (Medicare Supplement Insurance) Policy with Prescription Drug Coverage—Medigap policies can no longer be sold with prescription drug coverage, but if an individual has drug coverage under a current Medigap policy, they can keep it.

However, it may be to their advantage to join a Medicare drug plan because most Medigap drug coverage isn't creditable. If an individual join a Medicare drug plan, their Medigap insurance company must remove the prescription drug coverage under their Medigap policy and adjust their premiums.

Federal Employee Health Benefits Program (FEHBP)—Health coverage for current and retired Federal employees and covered family members. If an individual joins a Medicare drug plan, they can keep their FEHBP plan, and their plan will let them know who pays first.

Veterans' Benefits—Health coverage for veterans and people who have served in the U.S. military. The individual may be able to get prescription drug coverage through the U.S. Department of Veterans Affairs (VA) program. You may join a Medicare drug plan, but if they do, they can't use both types of coverage for the same prescription.

TRICARE (Military Health Benefits)—Health care plan for active-duty service members, retirees, and their families. Most people with TRICARE who are entitled to Part A must have Part B to keep TRICARE prescription drug benefits. If an individual has TRICARE, they aren't required to join a Medicare Prescription Drug Plan. If they do, their Medicare drug plan pays first, and TRICARE pays second. If they join a Medicare Advantage Plan with prescription drug coverage, TRICARE won't pay for their prescription drugs.

Indian Health Services—Health care for people who are American Indian/Alaska Native through an Indian health care provider. If an individual gets prescription drugs through an Indian health pharmacy, they pay nothing and their coverage won't be interrupted. Joining a Medicare drug plan may help their Indian health provider with costs, because the drug plan pays part of the cost of their prescriptions.

Who Pays First When You Have Other Insurance? When an individual has other insurance (like employer group health coverage), there are rules that decide whether Medicare or their other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage.

If your other coverage is from an employer or union group health plan, these rules apply:
If an individual is retired, Medicare pays first.
If the individual's group health plan coverage is based on their or a family member's current employment, who pays first depends on the individual's age, the size of the employer, and whether the individual has Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
If the individual is under age 65 and disabled, their plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.

If the individual is over age 65 and still working, their plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.

If the individual has Medicare because they have ESRD, their plan pays first for the first 30 months they have Medicare.

The following types of coverage usually pay first:
No - fault insurance (including automobile insurance)
Liability (including automobile insurance)
Black lung benefits
Workers' compensation
Medicaid and TRICARE never pay first. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

2. MEDIGAP (MEDICARE SUPPLEMENT INSURANCE) POLICIES

Original Medicare pays for many, but not all, health care services and supplies. A Medigap policy, sold by private insurance companies, can help pay some of the health care costs ("gaps") that Original Medicare doesn't cover, like copayments, coinsurance, and deductibles.
Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when an individual travels outside the U.S. If an individual has Original Medicare and they buy a Medigap policy, both plans will pay their share of Medicare-approved amounts for covered health care costs. Medicare doesn't pay any of the costs for a Medigap policy.

Every Medigap policy must follow Federal and state laws designed to protect consumers, and it must be clearly identified as "Medicare Supplement Insurance." Medigap insurance companies can sell only a "standardized" Medigap policy identified in most states by letters, Plans A through N. All plans offer the same basic benefits but some offer additional benefits, so you can choose which one meets your needs.

NOTE: In Massachusetts, Minnesota, and Wisconsin, Medigap policies are standardized in a different way.

NEW: Starting June 1, 2010, the types of Medigap Plans that an individual can buy have changed:

- There are two new Medigap Plans offered—Plans M and N. Plans E, H, I, and J will no longer be available to buy. If an individual already had Plan E, H, I, or J before June 1, 2010, they can keep that plan.
- Insurance companies may charge different premiums for exactly the same Medigap coverage. Individuals should be sure they are comparing the same Medigap policy (for example, compare Plan A from one company with Plan A from another company).
- In some states, an individual may be able to buy another type of Medigap policy called Medicare SELECT (a Medigap policy that requires the individual to use specific hospitals and, in some cases, specific doctors to get full coverage).

a) Buying a Medigap Policy

Generally, an individual must have Part A and Part B to buy a Medigap policy.

Individuals pay a monthly premium for their Medigap policy to the private insurer, and they pay their monthly Part B premium.

A Medigap policy only covers one person. If an individual and their spouse both want Medigap coverage, they must each buy separate policies.

It's important to compare Medigap policies since the costs can vary and may go up as an individual gets older. Some states limit Medigap costs.

The best time to buy a Medigap policy is during the 6-month period that begins on the first day of the month in which the individual is both age 65 or older and enrolled in Part B. (Some states have additional open enrollment periods.) After this initial enrollment period, an individual's option to buy a Medigap policy may be limited.

If an individual is under age 65, they may have additional rights to buy a Medigap policy, depending on the laws in their state.

If an individual has a Medigap policy and join a Medicare Advantage Plan (like an HMO or PPO),they may want to consider dropping their Medigap policy. They can continue to pay their Medigap premium, but their policy can't be used to pay their Medicare Advantage Plan copayments and deductibles.

If an individual wants to drop their Medigap policy, they must contact their insurance company to cancel the policy.

If an individual already has a Medicare Advantage Plan, it's illegal for anyone to sell them a Medigap policy unless they are switching back to Original Medicare.
If an individual joins a Medicare health plan for the first time, and they aren't happy with the plan, they will have special rights to buy a Medigap policy if they return to Original Medicare within 12 months of joining.

- If an individual had a Medigap policy before they joined, they may be able to get the same plan back if the company still sells it.
- The Medigap policy can no longer have prescription drug coverage even if the individual had it before, but they may be able to join a Medicare Prescription Drug Plan.
- If an individual joined a Medicare health plan when they were first eligible for Medicare, they can choose from any policy.

If an individual buys a Medicare SELECT policy they also have rights to change their mind within 12 months and switch to a standard Medigap policy.
An individual can't have drug coverage in both their Medigap policy and a Medicare drug plan.

To find and compare Medigap policies Visit www.medicare.gov, and select "Compare Medicare Health Plans and Medigap Policies in Your Area." Call 1-800-MEDICARE. Call the individual State Health Insurance Assistance Program (SHIP).

F. CHAPTER 5:PROGRAMS FOR LIMITED INCOME

There are Federal and state programs available for people with limited income and resources. These programs may help an individual save on their health care and prescription drug costs or provide extra income.

a) Extra Help Paying for Medicare Prescription Drug Coverage (Part D)

Individuals may qualify for Extra Help, also called the low-income subsidy (LIS) from Medicare to pay prescription drug costs if an individual's yearly income and resources are below the following limits in 2009:
Single person — Income less than $16,245 and resources less than $12,510
Married person living with a spouse and no other dependents — Income less than $21,855 and resources less than $25,010

These amounts may change in 2010. Individuals may qualify even if they have a higher income (like if they still work, or if they live in Alaska or Hawaii, or have dependents living with them). Resources include money in a checking or savings account, stocks, and bonds. Resources don't include an individual's home, car, household items, burial plot, up to $1,500 for burial expenses (per person), or life insurance policies.

If an individual qualifies for Extra Help and join a Medicare drug plan, they will get the following:
Help paying their Medicare drug plan's monthly premium. Depending on their income and resources and their drug plan's premium, they may pay a reduced premium or no premium for a basic plan. For an enhanced drug plan (a plan that may cover more drugs and generally has a higher monthly premium), they must pay more for the extra coverage.

Help paying any yearly deductible.

Help paying coinsurance and copayments for prescription drugs that are on their plan's formulary (list of covered drugs). An individual generally pays all costs for drugs that aren't on their plan's formulary unless they are granted an exception.

No coverage gap.

No late enrollment penalty.

An individual **automatically** qualifies for Extra Help if they have Medicare and meet one of these conditions:
They have full Medicaid coverage.

They get help from their state Medicaid program paying their Part B premiums (belong to a Medicare Savings Program). They get Supplemental Security Income (SSI) benefits.

Medicare will mail the individual a purple letter to let them know they automatically qualify for Extra Help. Individuals don't need to apply for Extra Help if they get this letter.

- If an individual isn't already in a plan, they must join a Medicare drug plan to get this Extra Help.

- If an individual doesn't join a drug plan, Medicare may enroll them in one. If Medicare enrolls them in a plan, Medicare will send them a yellow or green letter letting them know when their coverage begins.

Different plans cover different drugs. An individual should check to see if the plan they are enrolled in covers the drugs they use and if they can go to the pharmacies they want.

If an individual is getting Extra Help, they can switch to another Medicare drug plan anytime. Their coverage will be effective the first day of the next month. In most cases, they will pay only a small amount for each covered prescription.

If an individual has Medicaid, Medicare will provide them with prescription drug coverage instead of Medicaid. Medicaid may still cover some drugs that Medicare prescription drug coverage doesn't cover. Medicaid may still cover other care that Medicare doesn't cover.

If an individual has Medicaid and lives in certain institutions (like a nursing home), they pay nothing for their covered prescription drugs.

If an individual automatically qualifies for Extra Help, they can apply by:
Calling Social Security at 1-800-772-1213 to apply by phone or to get a paper application.
Visiting www.socialsecurity.gov to apply online.
Apply at the State Medical Assistance (Medicaid) office.
Call 1-800-MEDICARE, and say "Medicaid" to get the telephone number, or visit www.medicare.gov.

NOTE: An individual can apply for Extra Help at any time. To get answers to questions about Extra Help, call the State Health Insurance Assistance Program (SHIP) or call 1-800-MEDICARE.

Medicare gets data from the state or Social Security that tells them whether an individual qualifies for Extra Help

b) Paying the Right Amount

If an individual automatically qualified, they can show their drug plan the purple letter and the yellow or green letter they got from Medicare as proof that they qualify. If they applied for Extra Help, they can show their "Notice of Award" from Social Security as proof that they qualify.

An individual can also give their plan any of the following documents (also called "Best Available Evidence") as proof that they qualify for Extra Help. The plan must accept these documents.

c) Other Proof That an individual Has Medicaid

A copy of the Medicaid card
A copy of a state document that shows the individual has
A print-out from a state electronic enrollment file or screen print from the state's Medicaid systems that shows the individual has Medicaid
Any other document from the state that shows the individual has Medicaid

Proof That an Individual Has Medicaid & Lives in an Institution

A bill from the institution (like a nursing home) or a copy of a state document showing Medicaid payment to the institution for at least a month

A screen prints from the state's Medicaid systems showing that the individual lived in the institution for at least a month.

2. MEDICAID

Medicaid is a joint Federal and state program that helps pay medical costs if an individual has limited income and resources and meet other eligibility requirements. Some people qualify for both Medicare and Medicaid (these people are also called "dual-eligibles").

If an individual has Medicare and full Medicaid coverage, most of the individual's health care costs are covered. An individual has the option of Original Medicare or a Medicare Advantage Plan (like an HMO or PPO).

Medicaid programs vary from state to state. They may also be called by different names, such as "Medical Assistance" or "Medi-Cal."

People with Medicaid may get coverage for services that Medicare doesn't fully cover, such as nursing home and home health care.

Each state has different Medicaid eligibility income and resource limits and other eligibility requirements.

In some states, an individual may need to apply for Medicare to be eligible for Medicaid.

a) State Pharmacy Assistance Programs (SPAPs)

Many states have State Pharmacy Assistance Programs (SPAPs) that help certain people pay for prescription drugs based on financial need, age, or medical condition.

Each SPAP makes its own rules about how to provide drug coverage to its members. Depending on your state, the SPAP will help in different ways. To find out about the SPAP in your state, call your State Health Insurance Assistance Program (SHIP).

b) Programs of All-Inclusive Care for the Elderly (PACE)

PACE combines medical, social, and long-term care services, and prescription drug coverage for frail elderly and disabled people.

This program allows people who need a nursing home-level of care to remain in the community.

c) Medicare Savings Programs (Help With Medicare Costs)

States have programs that pay Medicare premiums and, in some cases, may also pay Part A and Part B deductibles and coinsurance. These programs help people with Medicare save money each year.

To qualify for a Medicare Savings Program, an individual must meet all of these conditions:
Have Part A
Single person—Have monthly income less than $1,239 and resources less than $8,100
Married and living together—Have monthly income less than $1,660 and resources less than $12,910
NOTE: These amounts may change each year. Many states figure the income and resources differently or may not have limits at all, so an individual may qualify in their state even if their income is higher. Resources include money in a checking or savings account, stocks, and bonds. Resources don't include the individual's home, car, burial plot, up to $1,500 for burial expenses (per person), furniture, or other household items.

d) Supplemental Security Income (SSI) Benefits

SSI is a monthly amount paid by Social Security 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. To get SSI benefits, an individual must also meet these conditions:
Be a resident of the U.S. (includes the Northern Mariana Islands, but not the territories listed below).

Not be out of the country for a full calendar month or more than 30 consecutive days.

Be either a U.S. citizen or national, or in one of certain categories of eligible non–citizens. People who live in Puerto Rico, the Virgin Islands, Guam, or American Samoa generally can't get SSI.

An individual can visit www.socialsecurity.gov, and use the "Benefit Eligibility Screening Tool" to find out if they may be eligible for SSI or other benefits. Call Social Security at 1-800772-1213, or contact the local Social Security office for more information. TTY users should call 1-800-325-0778.

e) Programs for People Who Live in the U.S. Territories

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Information is available by calling the local Medical Assistance (Medicaid) office to find out more about their rules, or call 1-800-MEDICARE (1-800-633-4227) and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov.

f) Children's Health Insurance Program

Do you have children or grandchildren who need health insurance?

A new bill signed into law in 2009 extends health insurance coverage to millions of uninsured children.

Each state has its own program, with its own eligibility rules.

In many states, uninsured children 18 years old and younger, whose families earn up to $44,500 a year (for a family of four) are eligible for free or low-cost health insurance that pays for doctor visits, dental care, prescription drugs, hospitalizations, and much more.

Call 1-877-KIDS-NOW (1-877-543-7669), or visit www.insurekidsnow.gov for more information about the Children's Health Insurance Program.

II. CHAPTER 6: MEDICARE RIGHTS

No matter what type of Medicare coverage an individual has, they have certain guaranteed rights. As a person with Medicare, they have the right to all of the following:

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Have access to doctors, specialists, and hospitals
- Have questions about Medicare answered

- Learn about all of the treatment choices and participate in treatment decisions
- Get information in a way you understand from Medicare, health care providers, and, under certain circumstances, contractors
- Get emergency care when and where you need it
- Get a decision about health care payment or services, or prescription drug coverage
- Get a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage
- File complaints (sometimes called grievances), including complaints about the quality of care
- Have personal and health information kept private

What Is an Appeal?

An appeal is the action an individual can take if they disagree with a coverage or payment decision made by Medicare or their Medicare plan.

An individual can appeal if Medicare or their plan denies one of the following:

- A request for a health care service, supply, or prescription that you think you should be able to get
- A request for payment for health care services or supplies or a prescription drug you already got that was denied
- A request to change the amount you must pay for a prescription drug
- An individual can also appeal if Medicare or their plan stops providing or paying for all or part of an item or service they think they still need.
- If an individual decides to file an appeal, they should ask their doctor or other health care provider or supplier for any information that may help your case.

How to File an Appeal

How an individual files an appeal depends on the type of Medicare coverage they have:
If an individual has a Medicare Health Plan or A Medicare Prescription Drug Plans they need to look at their plan materials to learn how to file an appeal.

If an individual has the Original Medicare, do the following to file an appeal:
Get the Medicare Summary Notice (MSN) that shows the item or service you are appealing. The MSN is the statement an individual gets every 3 months that lists all the services billed to Medicare and tells the individual if Medicare paid for the services.

Circle the item(s) you disagree with on the MSN, and write an explanation on the MSN of why you disagree.

Sign, write your telephone number, and provide your Medicare number on the MSN.

Keep a copy for your records.

Send the MSN, or a copy, to the Medicare contractor's address listed on the MSN. An individual can also send any additional information they may have about their appeal.

An individual must file the appeal within 120 days of the date they get the MSN. If they want to file an appeal, they should make sure they read their MSN carefully, and follow the instructions. An individual can also use CMS Form 20027, and file it with the Medicare contractor at the address listed on the MSN. To view or print this form, visit
www.cms.hhs.gov/cmsforms/downloads/CMS20027.pdf.

An individual should do the following to find out what was billed:
Ask their health care provider or supplier for an itemized statement. They should give this to you within 30 days.

Check your MSN if you have Original Medicare to see if the service was billed to Medicare. If you are in a Medicare plan, check with your plan.

The Right to a Fast Appeal

If an individual is getting Medicare services from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and they think their Medicare-covered services are ending too soon, they have the right to a fast appeal (also called an "expedited review" or an "immediate appeal"). The provider will give the patient a notice at least 2 days before their services end that will tell them how to ask for a fast appeal. If an individual doesn't get this notice, they need to ask the provider for it. With a fast appeal,

an independent reviewer, called a Quality Improvement Organization (QIO), will decide if the services should continue.

The individual must call their local QIO to request a fast appeal no later than noon on the day before their notice says their coverage will end.
If an individual misses the deadline, they still have appeal rights:
If they have Original Medicare, call the local QIO.
If they are in a Medicare health plan, call their plan. Look in their plan materials to get the telephone number.
An individual can contact their State Health Insurance Assistance Program (SHIP) if they need help filing an appeal.

Advance Beneficiary Notice (ABN)

If an individual has Original Medicare, their health care provider or supplier may give them a notice called an "Advance Beneficiary Notice" (ABN).

This notice says Medicare probably (or certainly) won't pay for some services in certain situations.
The individual will be asked to choose whether to get the items or services listed on the ABN. If an individual choose to get the items or services listed on the ABN, they will have to pay if Medicare doesn't.

The individual will be asked to sign the ABN to say that they have read and understood the notice.
An ABN isn't an official denial of coverage by Medicare.

An individual could choose to get the items listed on the ABN and still ask their health care provider or supplier to submit the bill to Medicare or another insurer. If Medicare denies payment, they can still file an appeal. However, they will have to pay for the items or services on appeal if Medicare determines that the items or services aren't covered (and no other insurer is responsible for payment).

An individual may also get an ABN for other reasons, such as when their doctor or health care provider reduces the home health care.

If an individual should have received an ABN but didn't, in most cases their provider should refund them for what they paid for the item or service. However, the individual must still must pay any copayments and/or deductibles that apply.

Appealing Medicare Drug Plan's Decisions

If an individual has Medicare prescription drug coverage (Part D), they have the right to do all of the following (even before they buy a particular drug):
Get a written explanation (called a "coverage determination") from their Medicare drug plan. A coverage determination is the first decision made by their Medicare drug plan (not the pharmacy) about their prescription drug benefits, including whether a particular drug is covered, whether they have met all the requirements for getting a requested drug, how much they're required to pay for a drug, and whether to make an exception to a plan rule when they request it.

An individual can ask their drug plan for an exception if the individual or their prescriber (their doctor or other health care provider who is legally allowed to write prescriptions) believes they need a drug that isn't on their drug plan's list of covered drugs.

An individual can ask for an exception if they or their prescriber believes that a coverage rule (such as prior authorization) should be waived.

An individual can ask for an exception if they think they should pay less for a higher tier drug because they or their prescriber believes they can't take any of the lower tier drugs for the same condition.

An individual or their prescriber must contact their plan to ask for a coverage determination or an exception.
If an individual's network pharmacy can't fill a prescription as written, the pharmacist will show them a notice that explains how to contact their Medicare drug plan so they can make their request. If the pharmacist doesn't show the individual this notice, they should ask to see it.

A standard request for a coverage determination or exception must be made in writing unless the plan accepts requests by phone.

An individual or their prescriber can call or write their plan for an expedited (fast) request. The request will be expedited if the individual hasn't received the prescription and their plan determines, or their prescriber tells the plan, that their life or health may be at risk by waiting.

If an individual is requesting an exception, their prescriber must provide a statement explaining the medical reason why similar drugs covered by the plan won't work or may be harmful to the individual.

Once the Medicare drug plan gets the request for a coverage determination or the prescriber's statement, the Medicare drug plan has 72 hours (for a standard request) or 24 hours (for an expedited request) to notify the individual of its decision.

If the drug plan doesn't give a prompt decision, and the individual can show that the delay would affect the individual's health, the plan's failure to act is considered a coverage determination.

If an individual disagrees with the Medicare drug plan's coverage determination or exception decision, they can appeal. There are five levels of appeals available.

The first level is appealing through the plan.

Appealing the Drug Plan's Coverage Determination Decision

An individual, their representative, or their prescriber can appeal the drug plan's coverage determination decision.

The appeal request must be made within 60 days of the drug plan's decision.

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

An individual, their representative, or their prescriber can call or write their plan for an expedited request.

The Medicare drug plan has 7 days (for a standard request) or 72 hours (for an expedited request) from the date it gets the request to notify the individual of its decision. Individuals may have additional appeal rights if they don't agree with the plan's decision.

An individual can get help filing an appeal from their State Health Insurance Assistance Program (SHIP).

If the plan doesn't respond to the request for a coverage determination, an exception, or an appeal, an individual can file a complaint. Call the plan or 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

After an individual, appeals through their plan, they will get a notice explaining the next level of appeal. If they disagree with the plan's decision, they can ask for an independent review of their case.

For more information about rights and the different levels of appeals visit www.medicare.gov/Publications/Pubs/pdf/10112.pdf to view the booklet, "Your Medicare Rights and Protections."

How Medicare Uses Your Personal Information

Individuals have the right to have their personal and health information kept private. The following describe how the information may be used and given out and explains how the individual can get this information.

Notice of Privacy Practices for Original Medicare

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED AND HOW
YOU 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 the following:

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 where required by law Medicare has the right to use and give out your personal medical information to pay for your health care and to operate the Medicare Program. Examples include the following:

Companies that pay bills for Medicare 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 people with Medicare get quality health care, to provide customer service 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 coverage under Medicare

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 anytime, except to the extent that Medicare has already acted based on your permission.

By law, you have the right to take these actions:
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 listings 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).

Ask 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 for more information on the following:
Exercising your rights set out in this notice.

Filing a complaint, if you believe Original Medicare has violated these privacy rights.

Filing a complaint won't affect your coverage 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. Call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr/privacy.

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.

The Notice of Privacy Practices for Original Medicare became effective April 14, 2003.

Protect Yourself from Fraud and Identity Theft

Identity theft is a serious crime. Identity theft happens when someone uses another person's personal information without their consent to commit fraud or other crimes.
Personal information includes things like a person's name and Social Security, Medicare, or credit card numbers.

Individuals should only give personal information like their Medicare number to doctors, other health care providers, and plans approved by Medicare; any insurer who pays benefits on behalf of the insured; and to people in the community who work with Medicare, like a State Health Insurance Assistance Program (SHIP) or Social Security.

Medicare plans can't ask for credit card or banking information over the telephone, unless you are already a member of that plan. In most cases, Medicare plans can't call an individual to ask them to join a plan; instead, the individual must call them.

The SMP Program Can Help

The SMP (formerly known as the Senior Medicare Patrol) Program educates and empowers people with Medicare to take an active role in detecting and preventing health care fraud and abuse. There is an SMP Program in every state, the District of Columbia, Guam, the U.S. Virgin Islands, and Puerto Rico.

PROTECTION from Medicare from Billing Fraud

Most doctors, pharmacists, plans, and other health care providers who work with Medicare are honest. Unfortunately, there may be some who are dishonest. Medicare is working with other government agencies to protect the consumer and Medicare.

Medicare fraud happens when Medicare is billed for services or supplies the insured never got. Medicare fraud costs Medicare a lot of money each year.

Remember these tips to help prevent billing fraud:
Ask questions! The insured has the right to know everything about their health care including the costs billed to Medicare.
Educate yourself about Medicare. Know what a provider can and can't bill to Medicare.
Be wary of providers who tell you that the item or service isn't usually covered, but they "know how to bill Medicare" so Medicare will pay.
If an individual believes a Medicare plan or provider has used false information to mislead them they should call Medicare at, 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

When an individual gets health care services, they should record the dates on a calendar and save the receipts they get from providers. Use the calendar and receipts to check for mistakes on statements they get. These include the Medicare Summary Notice if they have Original Medicare, or similar statements that list the services they got or prescriptions they filled.

If an individual suspects billing fraud, here's what they can do:
Contact the health care provider to be sure the bill is correct. Call 1-800-MEDICARE.
Call the fraud hotline of the HHS Office of Inspector General at 1-800-HHS-TIPS (1-800-447-8477). TTY users should call 1-800-377-4950, or email HHSTips@oig.hhs.gov.
Call the Medicare Drug Integrity Contractor at 1-877-7SAFERX (1-877-772-3379) if the individual is in a Medicare Advantage Plan or a Medicare Prescription Drug Plan.

Fighting Fraud Can Pay

You may get a reward of up to $1,000 if you meet all these conditions:
You report suspected Medicare fraud.
The Inspector General's Office reviews your suspicion.

The suspected fraud you report isn't already being investigated.
Your report leads directly to the recovery of at least $100 of Medicare money.
For more information, call 1-800-MEDICARE (1-800-633-4227).
TTY users should call 1-877-486-2048.

NOTE: For their protection, the insured's full Medicare number is no longer printed on their Medicare Summary Notice. The first 5 digits of their number is replaced with "Xs."
How Medicare Protects You

Medicare works with other government agencies to protect Medicare from fraud and to protect individuals from identity theft. With help from honest health care providers, suppliers, law enforcement, and citizens, Medicare is improving its ability to prevent fraud and identity theft. Some dishonest health care providers have been removed from Medicare, and some have gone to jail. These actions are saving money for taxpayers and protecting Medicare for the future.

Protection from Discrimination

Every company or agency that works with Medicare must obey the law. Individuals can't be treated differently because of their race, color, national origin, disability, age, religion, or sex.

The Medicare Beneficiary Ombudsman

An "ombudsman" is a person who reviews issues and helps to resolve them. The Medicare Beneficiary Ombudsman shares information with the Secretary of Health and Human Services, Congress, and other organizations about what works well and what doesn't work well in Medicare. The Ombudsman helps improve the quality of the services and care you get from Medicare by reporting problems and making recommendations The Ombudsman makes sure information about the following is available to all people with Medicare:

An individual's Medicare coverage
Information to help individuals make good health care decisions
An individual's Medicare rights and protections
How individuals can get issues resolved

The Ombudsman reviews the concerns raised by people with Medicare through 1-800-MEDICARE (1-800-633-4227) and through the State Health Insurance Assistance Program (SHIP). TTY users should call 1-877-486-2048. For more information about the Medicare Beneficiary Ombudsman, visit www.medicare.gov, and select "Ombudsman."

A. CHAPTER 7: PLANNING AHEAD

LONG TERM CARE INSURANCE

Long-term care is a variety of services including medical and non-medical care for people who have a chronic illness or disability. Non-medical care includes non-skilled personal care assistance, such as help with everyday activities like dressing, bathing, and using the bathroom. Medicare and most health insurance plans, including Medigap (Medicare Supplement Insurance) policies don't pay for this type of care, also called "custodial care." Medicare only pays for medically-necessary skilled nursing facility or home health care if the individual meets certain conditions. Long-term care can be provided at home, in the community, in assisted living, or in a nursing home.

Paying for Long-Term Care

Long-term Care Insurance—This type of private insurance policy can help pay for many types of long-term care, including both skilled and non-skilled (custodial) care. Long-term care insurance can vary widely. Some policies may cover only nursing home care. Others may include coverage for a range of services like adult day care, assisted living, medical equipment, and informal home care.

Long-term care insurance doesn't replace Medicare coverage.
An individual's current or former employer or union may offer long-term care insurance. Current and retired Federal employees, active and retired members of the uniformed services, and their qualified relatives can apply for coverage under the Federal Long-term Care Insurance Program. Information is available at www.opm.gov/insure/ltc, or by calling the Office of Personnel Management at 1-800-582-3337.

Personal Resources—An individual can use their savings to pay for long - term care or perhaps their life insurance policy.

Medicaid—Medicaid is a joint Federal and state program that pays for certain health services for people with limited income and resources. If an individual qualifies, they may be able to get help to pay for nursing home care or other health care costs.

Home and Community-based Services Programs—If an individual is already eligible for Medicaid (or, in some states, would be eligible for Medicaid coverage in a nursing home), an individual may be able to get help with the costs of services that help them stay in their home instead of moving to a nursing home. Examples include homemaker services, personal care, and respite care. For more information, contact your State Medical Assistance (Medicaid) office. Call 1-800-MEDICARE (1800-633-4227), and say "Medicaid" to get the telephone number, or visit www.medicare.gov. TTY users should call 1-877-4862048.

Programs of All-inclusive Care for the Elderly (PACE)— PACE is a Medicare and Medicaid program that allows people who otherwise need a nursing home-level of care to remain in the community.

PACE provides all the care and services covered by Medicare and Medicaid, as authorized by a team of health professionals, as well as additional medically-necessary care and services not covered by Medicare and Medicaid. PACE provides coverage for prescription drugs, doctor visits, transportation, home care, check-ups, hospital visits, and even nursing home stays whenever necessary.

ADVANCE DIRECTIVES

Advance directives are legal documents that allow an individual to put in writing what kind of health care they would want if they were too ill to speak for themselves. Advance directives most often include the following:

A health care proxy (durable power of attorney)
A living will
After-death wishes

A health care proxy (sometimes called a durable power of attorney for health care) is used to name the person an individual wishes to make health care decisions for them if they aren't able to make them for themselves. Having a health care proxy is important because if an individual suddenly isn't able to make their own health care decisions, someone they trust will be able to make these decisions for them.

A living will is another way to make sure their voice is heard. It states which medical treatment they would accept or refuse if their life is threatened.

Dialysis for kidney failure, a breathing machine if they can't breathe on their own, CPR (cardiopulmonary resuscitation) if their heart and breathing stop, or tube feeding if they can no longer eat are examples of medical treatment they can choose to accept or refuse.

In some states, advance directives can also include after-death wishes. This may include choices such as organ and tissue donation.

Each state has its own laws for creating advance directives. For more information, contact your health care provider, an attorney, your local Area Agency on Aging, or your state health department.

Tips

Keep the original copies of your advance directives where they are easily found.
Give the person named as the health care proxy, and other concerned family members or friends, a copy of the advance directives.
Give the doctor a copy of the advance directives for the medical record.
Provide a copy to any hospital or nursing home providing care.
Carry a card in their wallet that states they have advance directives.

B. CHAPTER 8: MEDICARE TERMINOLOGY

Active Treatment
Therapy designed specifically for individuals to help resolve or improve their condition

Appeal
A special kind of complaint you make if you disagree with certain kinds of decisions made by Medicare or your health plan. You can appeal if you request a health care service, supply or prescription that you think you should be able to get, or you request payment for health care you already received, and Medicare or a health plan denies the request. You can also appeal if you are already receiving coverage and the plan stops paying. There is a specific process your Medicare Advantage Plan, other Medicare Health Plan, Medicare drug plan, or the Original Medicare plan must use when you ask for an appeal.

Assignment
In the Original Medicare Plan, this means a doctor or supplier agrees to accept the Medicare-approved amount as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.

Benefits
The money or services provide by an insurance policy. In a health plan, benefits take the form of health care.

Benefit Period
The way that the Original Medicare Plan measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to the hospital or skilled nursing facility. The benefit period ends when you haven't received any hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods an individual can have.

Coinsurance
The amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the deductible for Part A and/or Part B. In a Medicare Prescription Drug Plan, the coinsurance will vary depending on how much you have spent.

Copayment
In some Medicare health and prescription drug plans, the amount you pay for each medical service, like a doctor's visit, or prescription. A copayment is usually a set amount you pay. For example, this could be $10 or $20 for a doctor's visit or prescription. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Creditable Prescription Drug Coverage
Prescription drug coverage (like from an employer or union), that pays out, on average, as much as or more than Medicare's standard prescription drug coverage.

Critical Access Hospital — A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

Custodial Care—Non-skilled personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom.

It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible
The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan or other insurance begins to pay. For Example, in Original Medicare, you pay a new deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

End-Stage Renal Disease (ESRD)
Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.

Extra Help—A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Excess Charges
If you are in the Original Medicare Plan, this is the difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

Formulary
A list of certain kinds of prescription drugs that a Medicare drug plan will cover subject to limits and conditions.

Guaranteed Issue Rights (also called "Medigap Protections")
Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a policy, or place conditions on a policy, such as exclusions for preexisting conditions and can't charge you more for a policy because of past or present health problems.

Health Maintenance Organization Plan
A type of Medicare Advantage Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Your cost may be lower than in the Original Medicare Plan.

Hospice Care
A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver as well. Hospice care is covered under the Medicare Part A (Hospital Insurance).

Inpatient Rehabilitation Facility—A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

Institution
A facility that provides short-term or long-term care, such as a nursing home or skilled nursing facility (SNF) or rehabilitation hospital. Private residences. such as assisted or adult living facilities, or group home are considered institutions for this purpose.

Lifetime Reserve Days
In the Original Medicare Plan, a total of 60 extra days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. Once these 60 reserve days are used, you don't get any more extra days during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Long-Term Care Hospital
Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Medically Necessary—Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare-Approved Amount—In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the actual amount a doctor or supplier charges.

Medicare Health Plan—A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term is used throughout this handbook to include all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Plan—Refers to any way other than Original Medicare that you can get your Medicare health or prescription drug coverage. This term includes all Medicare health plans and Medicare Prescription Drug Plans.

Medical Underwriting
The process that an insurance company uses to decide, based on your medical history, whether or not to take your application for insurance, whether or not to add a waiting a period for the pre-existing conditions (if your state law allows it), and how much to charge you for that insurance.

Penalty
An amount added to your monthly premium for Medicare Part B, or for a Medicare drug plan, if you don't join when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions.

Premium
The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Primary Care Doctor—Your primary care doctor is the doctor you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider. Quality Improvement Organization (QIO)— A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to people with Medicare.

Referral—A written order from your primary care doctor for you to see a specialist or to get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Service Area—A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Facility (SNF) Care
A Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include, physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

State Insurance Department
A State agency that regulates insurance and can provide information about Medigap policies and other private insurance.

State Medical Assistance Office
A State agency that is in charge of the state's Medicaid program and can give information about programs that help pay medical bills for people with low income.

PART II: PATIENT PROTECTION AND AFFORDABLE CARE ACT 2010

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following summary of the new law, and changes made to the law by subsequent legislation, focuses on provisions to expand coverage, control health care costs, and improve health care delivery system.

OVERALL APPROACH TO EXPANDING ACCESS TO COVERAGE

Requires most U.S. citizens and legal residents to have health insurance. Creates state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost sharing credits available to individuals/families with income between 133-400% of the federal poverty level (the poverty level is $18,310 for a family of three in 2009) and create separate Exchanges through which small businesses can purchase coverage. Requires employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets. Expand s Medicaid to 133% of the federal poverty level.

INDIVIDUAL MANDATE-REQUIREMENT TO HAVE COVERAGE

Require U.S. citizens and legal residents to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment.

Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).

EMPLOYER REQUIREMENTS REQUIREMENT TO OFFER COVERAGE

Requirement to offer coverage

Assess employers with 50 or more employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees from the assessment. (Effective January 1, 2014)

Exempt employers with fewer than 50 employees from any of the above penalties.

Require employers that offer coverage to their employees to provide a free choice voucher to employees with incomes less than 400% FPL whose share of the premium exceeds 8% but is less than 9.8% of their income and who choose to enroll in a plan in the Exchange. The voucher amount is equal to what the employer would have paid to provide coverage to the employee under the employer's plan and will be used to offset the premium costs for the plan in which the employee is enrolled. Employers providing free choice vouchers will not be subject to penalties for employees that receive premium credits in the Exchange. (Effective January 1, 2014)

Other requirements

Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

EXPANSION OF PUBLIC PROGRAMS

Treatment of Medicaid

Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (as under current law and in the House and Senate-passed bills undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.

To finance the coverage for the newly eligible (those who were not previously eligible for at least benchmark equivalent coverage, those who were eligible for a capped program but were not enrolled, or those who were enrolled in state-funded programs), states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020 and later). States have the option to expand Medicaid eligibility to childless adults beginning on April 1, 2010, but will receive their regular FMAP until 2014. In addition, increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2014)

Treatment of CHIP

Require states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. CHIP benefit package and cost-sharing rules will continue as under current law. Provide states with the option to provide CHIP coverage to children of state employees who are eligible for health benefits if certain conditions are met. Beginning in

2015, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%. CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.

PREMIUM AND COST-SHARING SUBSIDIES TO INDIVIDUALS

Eligibility

Limit availability of premium credits and cost-sharing subsidies through the Exchanges to U.S. citizens and legal immigrants who meet income limits. Employees who are offered coverage by an employer are not eligible for premium credits unless the employer plan does not have an actuarial value of at least 60% or if the employee shared the premium exceeds 9.5% of income. Legal immigrants who are barred from enrolling in Medicaid during their first five years in the U.S. will be eligible for premium credits.

Premium credits

Provide refundable and advance-able premium credits to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges. The premium credits will be tied to the second lowest cost silver plan in the area and will be set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels:

Up to 133% FPL: 2% of income
133-150% FPL: 3 – 4% of income
150-200% FPL: 4 – 6.3% of income
200-250% FPL: 6.3 – 8.05% of income
250-300% FPL: 8.05 – 9.5% of income
300-400% FPL: 9.5% of income

Increase the premium contributions for those receiving subsidies annually to reflect the excess of the premium growth over the rate of income growth for 2014-2018. Beginning in 2019, further adjust the premium contributions to reflect the excess of premium growth over CPI if aggregate premiums and cost sharing subsidies exceed .54% of GDP.

Provisions related to the premium and cost-sharing subsidies are effective January 1, 2014.

Cost-sharing subsidies

Provide cost-sharing subsidies to eligible individuals and families. The cost-sharing credits reduce the cost sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level:

100-150% FPL: 94%
150-200% FPL: 87%
200-250% FPL: 73%
250-400% FPL: 70%

Verification

Require verification of both income and citizenship status in determining eligibility for the federal premium credits.

Subsidies and abortion coverage

Ensure that federal premium or cost-sharing subsidies are not used to purchase coverage for abortion if coverage extends beyond saving the life of the woman or cases of rape or incest (Hyde amendment).

If an individual who receives federal assistance purchases coverage in a plan that chooses to cover abortion services beyond those for which federal funds are permitted, those federal subsidy funds (for premiums or cost-sharing) must not be used for the purchase of the abortion coverage and must be segregated from private premium payments or state funds.

PREMIUM SUBSIDIES TO EMPLOYERS

Small business tax credits

Provide small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees with a tax credit.

- Phase I: For tax years 2010 through 2013, provide a tax credit of up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost or 50% of a benchmark premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 25% of the employer's contribution toward the employee's health insurance premium.

- Phase II: For tax years 2014 and later, for eligible small businesses that purchase coverage through the state Exchange, provide a tax credit of up to 50% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost. The credit will be available for two years. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000. The credit phases-out as firm size and average wage increases. Tax-exempt small businesses meeting these requirements are eligible for tax credits of up to 35% of the employer's contribution toward the employee's health insurance premium.

Reinsurance program

Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. Program will reimburse employers or insurers for 80% of retiree claims between $15,000 and $90,000. Payments from the reinsurance program will be used to lower the costs for enrollees in the employer plan. Appropriate $5 billion to finance the program.
(Effective 90 days following enactment through January 1, 2014)

TAX CHANGES RELATED TO HEALTH INSURANCE OR FINANCING HEALTH REFORM

Tax changes related to health insurance

- Impose a tax on individuals without qualifying coverage of the greater of $695 per year up to a maximum of three times that amount or 2.5% of household income to be phased-in beginning in 2014.

- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. (Effective January 1, 2011)

- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount. (Effective January 1, 2011)

- Limit the amount of contributions to a flexible spending account for medical expenses to $2,500 per year increased annually by the cost of living adjustment.
  (Effective January 1, 2013)

- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.
  (Effective January 1, 2013)

- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and impose a 3.8% tax on unearned income for higher-income taxpayers (thresholds are not indexed). (Effective January 1, 2013).

- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U) for years beginning in 2020).

The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,650 for individual coverage and $3,450 for family coverage. The threshold amounts may be adjusted upwards if health care costs rise more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers.

The tax is equal to 40% of the value of the plan that exceeds the threshold amounts and is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. The aggregate value of the health insurance plan includes reimbursements under

a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage, excluding dental and vision coverage. (Effective January 1, 2018)
Eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments. Summary of (Effective January 1, 2013)

COVERAGE PROVISIONS

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following summary explains key health coverage provisions in the new law and incorporates changes made to the law by subsequent legislation.

The legislation will do the following:

- Most individuals will be required to have health insurance beginning in 2014.
- Individuals who do not have access to affordable employer coverage will be able to purchase coverage through a health Insurance Exchange with premium and cost-sharing credits available to some people o make coverage more affordable. Small businesses will be able to purchase coverage through a separate Exchange.
- Employers will be required to pay penalties for employees who receive tax credits for health insurance through the Exchange, with exceptions for small employers.
- New regulations will be imposed on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender.
- Medicaid will be expanded to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) for all individuals under age 65.

The Congressional Budget Office estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 billion over ten years, while reducing the deficit by $124 billion during this time period.

Individual Mandate

All individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of $695 per person (up to a maximum of $2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016.

Exceptions will be given for financial hardship and religious objections; and to American Indians; people who have been uninsured for less than three months; those for whom the lowest cost health plan exceeds 8% of income; and if the individual has income below the tax filing threshold ($9,350 for an individual and $18,700 for a married couple in 2009).

Expansion of Public Programs

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) based on modified adjusted gross income.

This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a limitation of the program that prohibits most adults without dependent children from enrolling in the program today (though as under current law, undocumented immigrants will not be eligible for Medicaid). Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above 133% of the poverty level who do not have access to employer sponsored insurance will obtain coverage through the newly created state health insurance Exchanges.
The federal government will provide 100% federal funding for the costs of those who become newly eligible for Medicaid for years 2014 through 2016, 95% federal funding for 2017, 94% federal funding for 2018, 93% federal funding for 2019, and 90% federal funding for 2020 and subsequent years. States that have already expanded adult eligibility to 100% of the poverty level will receive a phased-in increase in the FMAP for non-pregnant childless adults.

Medicaid payments to primary care doctors for primary care services will be increased to 100% of Medicare payment rates in 2013 and 2014 with 100% federal financing.

American Health Benefit Exchanges

States will create American Health Benefit Exchanges where individuals can purchase insurance and separate exchanges for small employers to purchase insurance. These new marketplaces will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

Access to Exchanges will be limited to U.S. citizens and legal immigrants. Small businesses with up to 100 employees can purchase coverage through the Exchange.

Although there will not be a public plan option in the Exchanges, the Office of Personnel Management, which administers the Federal Employees Health Benefit Program, will contract with private insurers to offer at least two multi-state plans in each Exchange, including at least one offered by a non-profit entity.
In addition, funds will be made available to establish non-profit, member-run health insurance CO-OPs in each state.

Plans in the Exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan.

Premium subsidies will be provided to families with incomes between 100-400% of the poverty level ($29,327 to $88,200 for a family of four in 2009) to help them purchase insurance through the Exchanges.

These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income for those up to 133% of the poverty level and 9.5 % of income for those between 300-400% of the poverty level.

Cost-sharing subsidies will also be available to people with incomes between 100-400% of the poverty level to limit out-of-pocket spending.

Changes to Private Insurance

New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. These new rules will also require that all new health plans provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage.
Health plan premiums will be allowed to vary based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members.

Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.

Increases in health plan premiums will be subject to review.

Young adults will be allowed to remain on their parent's health insurance up to age 26.

States will be allowed to form health care choice compacts that enable insurers to sell policies in any state that participates in the compact.

Waiting periods for coverage will be limited to 90 days.

Existing individual and employer-sponsored insurance plans will be allowed to remain essentially the same, except that they will be required to extend dependent coverage to age 26, eliminate annual and lifetime limits on coverage, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days.

Employer Requirements

There is no employer mandate but employers with 50 or more employees will be assessed a fee of $2,000 per full-time employee (in excess of 30 employees) if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange. Employers with more than 50 employees that offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of $3,000 for each employee who receives a premium credit or $2,000 for each full-time employee (in excess of 30 employees).

Employers that offer coverage will be required to provide a voucher to employees with incomes below 400% of the poverty level if their share of the premium cost is between 8-9.8% of income to enable them to enroll in a plan in an Exchange. Employers that offer a free choice voucher will not be subject to the above penalty.

Large employers that offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage.

Coverage and Cost Estimates

The Congressional Budget Office (CBO) estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 billion over ten years.

According to CBO, by 2019, the legislation will result in 24 million people obtaining coverage in the newly created state health insurance Exchanges, including some who previously purchased coverage on their own in the individual market. In addition, 16 million more people would enroll in Medicaid and the Children's Health Insurance Program.

The cost of the legislation will be financed through a combination of savings from Medicaid and Medicare and new taxes and fees, including an excise tax on high-cost insurance. The Congressional Budget Office estimates the health care components of the legislation will reduce the deficit by $124 billion over ten years (the total reduction in the deficit including the health care and education components is estimated to be $143 billion over ten years).

Tax changes related to financing health reform

Impose new annual fees on the pharmaceutical manufacturing sector, according to the following schedule:
$2.8 billion in 2012-2013;
$3.0 billion in 2014-2016;
$4.0 billion in 2017;
$4.1 billion in 2018; and
$2.8 billion in 2019 and later.

Impose an annual fee on the health insurance sector, according to the following schedule:
$8 billion in 2014;
$11.3 billion in 2015-2016;
$13.9 billion in 2017;
$14.3 billion in 2018

For subsequent years, the fee shall be the amount from the previous year increased by the rate of premium growth.

For non-profit insurers, only 50% of net premiums are taken into account in calculating the fee.

Exemptions granted for non-profit plans that receive more than 80% of their income from government programs targeting low-income or elderly populations, or people with disabilities, and voluntary employees' beneficiary associations (VEBAs) not established by an employer. (Effective January 1, 2014)

- Impose an excise tax of 2.3% on the sale of any taxable medical device. (Effective for sales after December 31, 2012)
- Limit the deductibility of executive and employee compensation to $500,000 per applicable individual for health insurance providers. (Effective January 1, 2009)
- Impose a tax of 10% on the amount paid for indoor tanning services. (Effective July 1, 2010)
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit. (Effective January 1, 2010)
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance. (Effective upon enactment)

- **HEALTH INSURANCE EXCHANGES**

- ***Creation and structure of health insurance exchanges*** Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage. Permit states to allow businesses with more than 100 employees to purchase coverage in the SHOP Exchange beginning in 2017. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area. (Funding available to states to establish Exchanges within one year of enactment and until January 1, 2015)
- ***Eligibility to purchase in the exchanges'***
- Restrict access to coverage through the Exchanges to U.S.
- citizens and legal immigrants who are not incarcerated.
- ***Public plan option***

Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law. Each multi-state plan must be licensed in each state and must meet the qualifications of a qualified health plan. If a state has lower age rating requirements than 3:1, the state may require multi-state plans to meet the more protective age rating rules.

These multi-state plans will be offered separately from the Federal Employees Health Benefit Program and will have a separate risk pool.

Consumer Operated and Oriented Plan (CO-OP)

Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and District of Columbia to offer qualified health plans. To be eligible to receive funds, an organization must not be an existing health insurer or sponsored by a state or local government, substantially all of its activities must consist of the issuance of qualified health benefit plans in each state in which it is licensed, governance of the organization must be subject to a majority vote of its members, must operate with a strong consumer focus, and any profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members. (Appropriate $6 billion to finance the program and award loans and grants to establish CO-OPS by July 1, 2013-

Benefit Tiers

Create four benefit categories of plans plus a separate catastrophic plan to be offered through the Exchange, and in the individual and small group markets:
Bronze plan represents minimum creditable coverage and provides the essential health benefits, cover 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit ($5,950 for individuals and $11,900 for families in 2010);

Silver plan provides the essential health benefits, covers 70% of the benefit costs of the plan, with the HSA out-of-pocket limits;

Gold plan provides the essential health benefits, covers 80% of the benefit costs of the plan, with the HSA out-of-pocket limits;

Platinum plan provides the essential health benefits, covers 90% of the benefit costs of the plan, with the HSA out-of- pocket limits;

Catastrophic plan available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only with the coverage level set at the HAS current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible. This plan is only available in the individual market.

Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);
200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);
300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family).

These out-of-pocket reductions are applied within the actuarial limits of the plan and will not increase the actuarial value of the plan.

Insurance market and rating rules

Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchange.

Require risk adjustment in the individual and small group markets and in the Exchange. (Effective January 1, 2014)

Qualifications of participating health plans

Require qualified health plans participating in the Exchange to meet marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, use a uniform enrollment form and standard format to present plan information.

Require qualified health plans to report information on claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollee rights in plain language.

Requirement of the exchanges

Require the Exchanges to maintain a call center for customer service, and establish procedures for enrolling individuals and businesses and for determining eligibility for tax credits. Require states to develop a single form for applying for state health subsidy programs that can be filed online, in person, by mail or by phone. Permit Exchanges to contract with state Medicaid agencies to determine eligibility for tax credits in the Exchanges.

Require Exchanges to submit financial reports to the Secretary and comply with oversight investigations including a GAO study on the operation and administration of Exchanges.

Basic health plan

Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Exchange and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees.

States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchanges.

Abortion coverage

Permit states to prohibit plans participating in the Exchange from providing coverage for abortions.

Require plans that choose to offer coverage for abortions beyond those for which federal funds are permitted (to save the life of the woman and in cases of rape or incest) in states that allow such coverage to create allocation

accounts for segregating premium payments for coverage of abortion services from premium payments for coverage for all other services to ensure that no federal premium cost-sharing subsidies are used to pay for the abortion coverage. Plans must also estimate the actuarial value of covering abortions by taking into account the cost of the abortion benefit (valued at no less than $1 per enrollee per month) and cannot take into account any savings that might be reaped as a result of the abortions. Prohibit plans participating in the Exchanges from discriminating against any provider because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Effective dates

Unless otherwise noted, provisions relating to the American Health Benefit Exchanges are effective January 1, 2014.

BENEFIT DESIGN

Essential benefits package

Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits ($5,950/individual and $11,900/family in 2010), and is not more extensive than the typical employer plan. Require the Secretary to define and annually update the benefit package through a transparent and public process. (Effective January 1, 2014)

Require all qualified health benefits plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, except grandfathered individual and employer-sponsored plans, to offer at least the essential health benefits package. (Effective January 1, 2014)

Abortion coverage

Prohibit abortion coverage from being required as part of the

essential health benefits package.(Effective January 1, 2014)

CHANGES TO PRIVATE INSURANCE

Temporary high-risk pool

Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. U.S. citizens and legal immigrants who have a pre-existing medical condition and who have been uninsured for at least six months will be eligible to enroll in the high-risk pool and receive subsidized premiums. Premiums for the pool will be established for a standard population and may vary by no more than 4 to 1 due to age; maximum cost-sharing will be limited to the current law HSA limit ($5,950/individual and $11,900/family in 2010). Appropriate $5 billion to finance the program. (Effective within 90 days of enactment until January 1, 2014)

Medical loss ratio and premium rate reviews

Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)

Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plan should be excluded from the Exchange based on unjustified premium increases.
Provide grants to states to support efforts to review and
approve premium increases. (Effective beginning plan year
2010)
Administrative simplification

Adopt standards for financial and administrative transactions to promote administrative simplification. (Effective dates vary)

Dependent coverage

Provide dependent coverage for children up to age 26 for all individual and group policies. (Effective six months following enactment)

Insurance market rules

Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud. Prohibit pre-existing condition exclusions for children. (Effective six months following enactment) Beginning in January 2014, prohibit individual and group health plans from placing annual limits on the dollar value of coverage. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary.

Grandfather existing individual and group plans with respect to new benefit standards, but require these grandfathered plans to extend dependent coverage to adult children up to age 26, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days. Require grandfathered group plans to eliminate lifetime limits on coverage and beginning in 2014, eliminate annual limits on coverage. Prior to 2014, grandfathered group plans may only impose annual limits as determined by the Secretary. Require grandfathered group plans to eliminate pre-existing condition exclusions for children within six months of enactment and by 2014 for adults. (Effective six months following enactment, except where otherwise specified)

- Impose the same insurance market regulations relating to guarantee issue, premium rating, and prohibitions on preexisting condition exclusions in the individual market, in the Exchange, and in the small group market. (See new rating and market rules in Creation of insurance pooling mechanism.) (Effective January 1, 2014)

- Require all new policies (except stand-alone dental, vision, and long-term care insurance plans), including those offered through the Exchanges and those offered outside of the Exchanges, to comply with one of the four benefit categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards. (See description of benefit categories in Creation of insurance pooling mechanism.) (Effective January 1, 2014)

- Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. This deductible limit will not affect the actuarial value of any plans. (Effective January 1, 2014)

- Limit any waiting periods for coverage to 90 days. (Effective January 1, 2014)

- Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals. Finance the reinsurance program through mandatory contributions by health insurers totaling $25 billion over three years. (Effective January 1, 2014 through December 2016)

- Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)

Consumer protections

Establish an internet website to help residents identify health coverage options (effective July 1, 2010) and develop a standard format for presenting information on coverage options (effective 60 days following enactment).

Develop standards for insurers to use in providing information on benefits and coverage. (Standards developed within 12 months following enactment; insurer must comply with standards within 24 months following enactment)

Health care choice compacts and national plans

Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. Insurers selling policies through a compact would only be subject to the laws and regulations of the state where the policy is written or issued, except for rules pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. Compacts may only be approved if it is determined that the compact will provide coverage that is at least as comprehensive and affordable as coverage provided through the state Exchanges. (Regulations issued by July 1, 2013, compacts may not take effect before January 1, 2016)

Health Insurance Administration

Establish the Health Insurance Reform Implementation Fund within the Department of Health and Human Services and allocate $1 billion to implement health reform policies.

STATE ROLE

- Create an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange for individuals and small businesses and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, and to define rating areas.

- Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 (states have the option to expand enrollment beginning in 2011), coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program. Maintain current Medicaid and CHIP eligibility levels for children until 2019 and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational. A state will be exempt from the maintenance of effort requirement for non-disabled adults with incomes above 133% FPL for any year from January 2011 through December 31, 2013 if the state certifies that it is experiencing a budget deficit or will experience a deficit in the following year.
- Establish an office of health insurance consumer assistance or an ombudsman program to serve as an advocate for people with private coverage in the individual and small group markets. (Federal grants available beginning fiscal year 2010)

- Permit states to create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchanges. (Effective January 1, 2014) Permit states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit. (Effective January 1, 2017)

COST CONTAINMENT

Administrative simplification

Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than $1 per covered life. (Effective April 1, 2014)

Medicare

Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates, with higher payments for areas with low FFS rates and lower payments (95% of FFS) for areas with high FFS rates. Phase-in revised payments over 3 years beginning in 2011, for plans in most areas, with payments phased-in over longer periods (4 years and 6 years) for plans in other areas. Provide bonuses to plans receiving 4 or more stars, based on the current 5-star quality rating system for Medicare Advantage plans, beginning in 2012; qualifying plans in qualifying areas receive double bonuses. Modify rebate system with rebates allocated based on a plan's quality rating. Phase-in adjustments to plan payments for coding practices related to the health status of enrollees, with adjustments equaling 5.7% by 2019. Cap total payments, including bonuses, at current payment levels. Require Medicare Advantage plans to remit partial payments to the Secretary if the plan has a medical loss ratio of less than 85%, beginning 2014. Require the Secretary to suspend plan enrollment for 3 years if the medical loss ratio is less than 85% for 2 consecutive years and to terminate the plan contract if the medical loss ratio is less than 85% for 5 consecutive years.

- Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity. (Effective dates vary)

- Freeze the threshold for income-related Medicare Part B premiums for 2011 through 2019, and reduce the Medicare Part D premium subsidy for those with incomes above $85,000/individual and $170,000/couple.
  (Effective January 1, 2011)
- Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, require the Chief Actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the President and Congress for immediate consideration.

The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by January 1, 2015.

- Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided (Effective fiscal year 2014)

- Eliminate the Medicare Improvement Fund. (Effective upon enactment)

- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. (Shared savings program established January 1, 2012)

- Create an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that

improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs.
(Effective January 1, 2011)

- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.
(Effective October 1, 2012)

- Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)

Medicaid

Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price. (Effective January 1, 2010)

Extend the drug rebate to Medicaid managed care plans. (Effective upon enactment)

Reduce aggregate Medicaid DSH allotments by $.5 billion in 2014, $.6 billion in 2015, $.6 billion in 2016,$1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. Require the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for 1115 waivers. (Effective October 1, 2011)

Prohibit federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011)

Prescription drugs

Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed. (Effective upon enactment)

Waste, fraud, and abuse

Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, strengthen standards for community mental health centers and increase funding for anti-fraud activities. (Effective dates vary)

IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE

Comparative effectiveness research

Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning fiscal year 2010) Terminate the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act. (Effective upon enactment)

Medical Malpractice

Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.
Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year 2011)

Medicare

Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for

an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, develop a plan for expanding the pilot program. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016)

Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012)

Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012) Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. (Reports to Congress due January 1, 2011)

Dual Eligible

Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office, to more effectively integrate Medicare and Medicaid benefits and improve coordination between the federal government and states in order to improve access to and quality of care and services for dual eligibles. (Effective March 1, 2010)

Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for home health-related services, including care management, care coordination, and health promotion. (Effective January 1, 2011)

Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

Expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). ($11 million in additional funds appropriated for fiscal year 2010)

Primary care

Increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates. (Effective January 1, 2013)

Provide a 10% bonus payment to primary care physicians in Medicare from 2011 through 2015. (Effective for five years beginning January 1, 2011)

National quality strategy

Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011)

Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. (Funds appropriated for five years beginning in FY 2011)

Financial disclosure

Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Report due to Congress April 1, 2013)

Disparities

Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for

people with disabilities. Require the Secretary to analyze the data to monitor trends in disparities. (Effective two years following enactment)

PREVENTION/WELLNESS

National Strategy

Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment) Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010) Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-

Establish a Prevention and Public Health Fund for prevention, wellness, and public health activities including prevention research and health screenings, the Education and Outreach Campaign form preventive benefits, and immunization programs. Appropriate $7 billion in funding for fiscal years 2010 through 2015 and $2 billion for each fiscal year after 2015. (Effective fiscal year 2010)

Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas. (Funds appropriated for five years beginning in FY 2010)

Coverage of preventive services

- Eliminate cost-sharing for Medicare covered preventive services that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests. Authorize the Secretary to modify or eliminate Medicare coverage of preventive services, based on recommendations of the U.S. Preventive Services Task Force. (Effective January 1, 2011)

- Provide states that offer Medicaid coverage of and remove cost-sharing for preventive services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations with a one percentage point increase in the federal medical assistance percentage (FMAP) for these services. (Effective January 1, 2013)

- Authorize Medicare coverage of personalized prevention plan services, including a comprehensive health risk assessment, annually.

- Require the Secretary to publish guidelines for the health risk assessment no later than March 23, 2011, and a health risk assessment model by no later than September 29, 2011.

- Reimburse providers 100% of the physician fee schedule amount with no adjustment for deductible or coinsurance for personalized prevention plan services when these services are provided in an outpatient setting.
  (Effective January 1, 2011)

- Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. (Effective January 1, 2011 or when program criteria is developed, whichever is first)

- Require Medicaid coverage for tobacco cessation services for pregnant women. (Effective October 1, 2010)

- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. (Effective six months following enactment)

Wellness programs

- Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011)
- Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment)

- Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage

for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate. (Effective January 1, 2014)

- Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017 if effective. Require a report on the effectiveness and impact of wellness programs. (Report due three years following enactment)

Nutritional information

Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item. (Proposed regulations issued within one year of enactment)

LONG-TERM CARE

Class Act

Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase nonmedical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out.
(Effective January 1, 2011)

Medicaid

Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocate $10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014).

Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan. (Effective October 1, 2010)

Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years. (Effective October 1, 2011)

Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based longterm care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally based long-term services and supports. (Effective October 1, 2011 through September 30, 2015)

Skilled nursing facility requirements

Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. (Effective dates vary)

OTHER INVESTMENTS

Medicare

Make improvements to the Medicare program:

– Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 (Effective January 1, 2010);

– Phase down gradually the beneficiary coinsurance rate in the Medicare Part D coverage gap from 100% to 25% by 2020:

For brand-name drugs, require pharmaceutical manufacturers to provide a 50% discount on prescriptions filled in the Medicare Part D coverage gap beginning in 2011, in addition to federal subsidies of 25% of the brand-name drug cost by 2020 (phased in beginning in 2013)

For generic drugs, provide federal subsidies of 75% of the generic drug cost by 2020 form prescriptions filled in the Medicare Part D coverage gap (phased in beginning in 2011); Between 2014 and 2019, reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage;

- Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community based care services equal to the cost-sharing for those who receive institutional care (Effective no earlier than January 1, 2012);

- Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result (Effective upon enactment);

- Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015; and

- Provide payments totaling $400 million in fiscal years 2011 and 2012 to qualifying hospitals in counties with the lowest quartile Medicare spending; and

- Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. (Effective January 1, 2011)

Workforce

Improve workforce training and development:

Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy.

(Appointments made by September 30, 2010)

Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for payments for the expenses associated with operating primary care residency programs. (Funds appropriated for five years beginning fiscal year 2011)

Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010)

Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. (Initial appropriation in fiscal year 2010) Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. (Funds appropriated for five years beginning in fiscal year 2011)

Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)

Community Health Centers and School Based Health Centers

Improve access to care by increasing funding by $11 billion for community health centers and by $1.5 billion for the National Health Service Corps over five years (effective fiscal year 2011); establishing new programs to support school-based health centers (effective fiscal year 2010) and nurse-managed health clinics (effective fiscal year 2010).

Trauma care

Establish a new trauma center program to strengthen emergency department and trauma center capacity. Fund research on emergency medicine, including pediatric emergency medical research, and develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. (Funds appropriated beginning in fiscal year 2011)

Public health and disaster preparedness

Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency. (Funds appropriated for five years beginning in fiscal year 2010)

Requirements for non-profit hospitals

Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. (Effective for taxable years following enactment)

American Indians

Reauthorize and amend the Indian Health Care Improvement Act. (Effective upon enactment)

FINANCING

Coverage and financing The Congressional Budget Office (CBO) estimates the new health reform law will provide coverage to an additional 32 million when fully implemented in 2019 through a combination of the newly created Exchanges and the Medicaid expansion.

CBO estimates the cost of the coverage components of the new law to be $938 billion over ten years. These costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees, including an excise tax on high-cost insurance, which CBO estimates will raise $32 billion over ten years. CBO also estimates that the health reform law will reduce the deficit by $124 billion over ten years.

SOURCE NOTE

The information provided in this section is also available as a publication (#8061) on the Kaiser Family Foundation's website at www.kff.org. The Henry J. Kaiser Foundation is a non-profit private operating foundation dedicated to producing and communicating the best possible analysis and information on health issues.

SUMMARY OF COVERAGE PATIENT PROTECTION AND AFFORDABLE CARE ACT

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. The following summary explains key health coverage provisions in the new law and incorporates changes made to the law by subsequent legislation. The legislation will do the following:

- Most individuals will be required to have health insurance beginning in 2014.
- Individuals who do not have access to affordable employer coverage will be able to purchase coverage through a health Insurance Exchange with premium and cost-sharing credits available to some people to make coverage more affordable. Small businesses will be able to purchase coverage through a separate Exchange.
- Employers will be required to pay penalties for employees who receive tax credits for health insurance through the Exchange, with exceptions for small employers.
- New regulations will be imposed on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender.
- Medicaid will be expanded to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) for all individuals under age 65.

The Congressional Budget Office estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 billion over ten years, while reducing the deficit by $124 billion during this time period.

Individual Mandate
All individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of $695 per person (up to a maximum of $2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016.

Exceptions will be given for financial hardship and religious objections; and to American Indians; people who have been uninsured for less than three months; those for whom the lowest cost health plan exceeds 8% of income; and if the individual has income below the tax filing threshold ($9,350 for an individual and $18,700 for a married couple in 2009).

Expansion of Public Programs
Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) based on modified adjusted gross income.

This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a limitation of the program that prohibits most adults without dependent children from enrolling in the program today (though as under current law, undocumented immigrants will not be eligible for Medicaid). Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above 133% of the poverty level who do not have access to employer sponsored insurance will obtain coverage through the newly created state health insurance Exchanges.

- The federal government will provide 100% federal funding for the costs of those who become newly eligible for Medicaid for years 2014 through 2016, 95% federal funding for 2017, 94% federal funding for 2018, 93% federal funding for 2019, and 90% federal funding for 2020 and subsequent years. States that have already expanded adult eligibility to 100% of the poverty level will receive a phased-in increase in the FMAP for non-pregnant childless adults.
- Medicaid payments to primary care doctors for primary care services will be increased to 100% of Medicare payment rates in 2013 and 2014 with 100% federal financing.

American Health Benefit Exchanges
States will create American Health Benefit Exchanges where individuals can purchase insurance and separate exchanges for small employers to purchase insurance. These new marketplaces will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

- Access to Exchanges will be limited to U.S. citizens and legal immigrants. Small businesses with up to 100 employees can purchase coverage through the Exchange.

- Although there will not be a public plan option in the Exchanges, the Office of Personnel Management, which administers the Federal Employees Health Benefit Program, will contract with private insurers to offer at least two multistate plans in each Exchange, including at least one offered by a non-profit entity. In addition, funds will be made available to establish non-profit, member-run health insurance CO-OPs in each state.

- Plans in the Exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan.

- Premium subsidies will be provided to families with incomes between 100-400% of the poverty level ($29,327 to $88,200 for a family of four in 2009) to help them purchase insurance through the Exchanges.

These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income for those up to 133% of the poverty level and 9.5 % of income for those between 300-400% of the poverty level.

- Cost-sharing subsidies will also be available to people with incomes between 100-400% of the poverty level to limit out-of-pocket spending.

Changes to Private Insurance
New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. These new rules will also require that all new health plans provide comprehensive coverage that includes at

least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage.
Health plan premiums will be allowed to vary based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members.

Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.

Increases in health plan premiums will be subject to review.

Young adults will be allowed to remain on their parent's health insurance up to age 26.
States will be allowed to form health care choice compacts that enable insurers to sell policies in any state that participates in the compact.

Waiting periods for coverage will be limited to 90 days.

Existing individual and employer-sponsored insurance plans will be allowed to remain essentially the same, except that they will be required to extend dependent coverage to age 26, eliminate annual and lifetime limits on coverage, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days.

Employer Requirements
There is no employer mandate but employers with 50 or more employees will be assessed a fee of $2,000 per full-time employee (in excess of 30 employees) if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange. Employers with more than 50 employees that offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of $3,000 for each employee who receives a premium credit or $2,000 for each full-time employee (in excess of 30 employees).

- Employers that offer coverage will be required to provide a voucher to employees with incomes below 400% of the poverty level if their share of the premium cost is between 89.8% of income to enable them to enroll in a plan in an Exchange. Employers that offer a free choice voucher will not be subject to the above penalty.

- Large employers that offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage.

Coverage and Cost Estimates
The Congressional Budget Office (CBO) estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of $938 billion over ten years. According to CBO, by 2019, the legislation will result in 24 million people obtaining coverage in the newly created state health insurance Exchanges, including some who previously purchased coverage on their own in the individual market. In addition, 16 million more people would enroll in Medicaid and the Children's Health Insurance Program. The cost of the legislation will be financed through a combination of savings from Medicaid and Medicare and new taxes and fees, including an excise tax on high-cost insurance. The Congressional Budget Office estimates the health care components of the legislation will reduce the deficit by $124 billion over ten years (the total reduction in the deficit including the health care and education components is estimated to be $143 billion over ten years).

PART III: 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 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 preexisting 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 coverage 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" with-out pre-existing conditions being applied if:
V 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

V They have exhausted their COBRA or their state continuation benefits and join the pool within 63 days of losing prior coverage AND

V The plan they were covered under did not terminate for nonpayment of premium or for fraud, AND

V They are not covered under Medicare or Medicaid V 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:
- V They leave their job or
- V They exhaust their COBRA benefits or
- V They ask for it within 24 months after leaving the plan.

When they enroll in a new plan:
V All group health plans must tell individuals about any preexisting condition limits in their plan.

V 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 preexisting 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 can not 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:

- V Receive notice of the pre-existing condition exclusion.
- V Receive credit for prior coverage.
- V Request certificates of coverage from previous plan.
- V 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:

- V 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.
- V 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:

- V Guaranteed renewability for all fully insured group plans.
- V Insurance companies are required to automatically renew the group coverage each year.

Guaranteed availability for small employers.

- V Health insurers in this market must make all their health plans available to all small employer groups that apply.

- V 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 nonpayment 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 healthinsurance premiums and the cost of doctor visits.
The MSA must be set up to pay for medical expenses such as health insurancepremiums 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 longterm 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: http://www.hhs.gov/ocr/hipaa.

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 CFR Part 160 and Part 164, Subparts A and E on the OCR website: http://www.hhs.gov/ocr/hipaa.

The Privacy Rule, as well as all the Administrative Simplification rules applies 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: http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupp ort/default.asp.

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.

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, and 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. 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.

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'srelatives, 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 heath 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)

(2) To the Individual. A covered entity may disclose protected health information to the individual who is the subject of the information.

(3) 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.

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.

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.

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. 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.

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.

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.

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.

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. 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:

V Assuring proper execution of a military mission,
V Conducting intelligence and national security activities that are authorized by law, providing protective services to the President,
V Making medical suitability determinations for U.S. State Department employees,
V 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.

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 preemployment 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.

A covered entity must also make its notice electronically available on any web site 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.

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.
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*.

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.

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.

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.

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.

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.

For example, such safeguards might include shredding documents containing protected health information before discarding them, securing medical records with lock and key or passcode, 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. 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.

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 Sponsor.

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.

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.

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:
V Is necessary to prevent fraud and abuse related to the provision of or payment for health care,

V Is necessary to ensure appropriate State regulation of insurance and health plans to the extent expressly authorized by statute or regulation,

V Is necessary for State reporting on health care delivery or costs,

V 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

V 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.

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.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 website, http://www.hhs.gov/ocr/hipaa.

PART IV: 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 new 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:

- V Skilled nursing care.
- V Intermediate care.
- V Custodial care.
- V 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:

- V Mobility
- V Dressing
- V Personal Hygiene
- V 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 nonmedical type person assists in shopping, meal preparation and some physical therapy.

OPTIONAL BENEFITS
The most 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 hospital

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.

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.

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.

- V The application.
- V The agent.
- V Verification reports.
- V 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

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 longterm 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 longterm 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.

NOTE: By 2010 standards these figures have doubled and even tripled in some instances.

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 polices 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, parents 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 longterm care coverage.

D. 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 longterm 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

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.

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.)

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.

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 ofInsurance 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.

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.

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 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.

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.

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.

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 known 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.

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.

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.

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.

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.

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.

I. What Other Optional Policy Provisions May Be Available?

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.

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.

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.

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. I

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:

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.

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).

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.

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.

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.

F. Don't buy multiple policies.
It is not necessary to purchase several policies to get enough coverage. One good policy is enough.

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.

H. Never pay in cash.
Use a check or money order made payable to the insurance company.

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).

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.

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.

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.

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.

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.)

- M. Best Company (900) 420-0400
- Duff & Phelps, Inc. (312) 368-3157
- Fitch Investors Service, Inc. (212) 908-0500
- Moody's Investor Service, Inc. (212) 553-1653
- Standard & Poor's (212) 208-1527
- Weiss Research, Inc. (800) 289-9222
- For more information, contact the NAIC at 120 W. 12th St., Suite #1100 Kansas City, MO 641051925. (Phone (816) 842-3600.)

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.

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 CLAIMS

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.

Tax Treatment LTC Expenses & LTC Insurance
Health Insurance Portability & Accountability Act of 1996 (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. The1996 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 longterm 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:

V Eating
V Toileting
V Transferring
V Bathing
V Dressing
V 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 A0L'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 A0L'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:

V Guaranteed renew-ability or non-cancellability
V Prohibitions on exclusions and limitations
V Provisions relating to extension of benefits & conversions
V Replacement
V Unintentional lapse
V Post-claim underwriting
V Requirement to offer inflation protection & rejection by consumer
V Restrictions on preexisting conditions and probationary periods
V Disclosure
V 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.

Grandfathered 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 nonsmoker 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:

1. Medical Savings Accounts.
2. Individual deductibility.
3. Deductibility for the self-employed, owners of S-corporations, limited liability partnerships (LLP) & limited liability corporations (LLC).
4. 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:

- V **Under Age 40 $ 250**
- V **Ages 41 - 50 $ 470**
- V **Ages 51 - 60 $ 940**
- V **Ages 61 - 70 $2,510**
- V **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 longterm 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.

- V Amount Allowed For TQ-LTCi: $5,020
- V Medicare Supplement Premiums 3,600
- V Medicare Part B Premiums 1,400
- V Other Allowable Medical Expenses 2,000
- (Rx, eyeglasses, dental)

- ***Total $12,020***

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 longterm 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 longterm care insurance, legislators appear to see private insurance as an important tool of public policy.

PART V: 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 des 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. ***CLASS 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.

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
- Postage
- Stationary and Supplies
- Furniture and equipment depreciation

- Janitorial Service and maintenance
- Laundry

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.
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 insuring 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 nonmedical limits”. In other words, there are certain points at which a medical exam is required.

DISABILITY UNDERWRITING

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.

III. PART VI:FILING HEALTH INSURANCE CLAIMS

A. CHAPTER 1: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.

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 POLICES
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.

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.

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.

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 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.

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.

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.

CHAPTER 2: 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.

- 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.

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 individual's 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.

B. CHAPTER 3: RECONCILING THE BILLS

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 to them have stated that they are more than willing to work with the debtor. The number one complaint from people who have money due to 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 fail 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 says “Closed for Good Friday” may be misunderstood. Think about it!

END OF COURSE