21st Century Long Term Care Partnership
This text is designed to provide accurate information in regard to the subject matter covered. The readers of this book understand that the author is not engaged in rendering legal or financial services. You should seek competent tax or legal advice with respect to any and all matters pertaining to the subject covered in this book.

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21st Century Long Term Care Partnership
Long Term Care Basics       SECTION 1

What is long-term care?

Long term care is different from traditional medical care. This service helps the insured live as he or she is presently. It is not designed to help to correct or improve medical impairments. Long-term care services may include help with activities of daily living, home health care, respite care, adult day care, care in a nursing home, in an assisted living facility and hospice care.
For example, there may come a time when a person needs help getting in and out of bed, eating or bathing. It also includes the kind of care that a person may need if he or she had a severe cognitive impairment like Alzheimer’s disease or dementia.

Long term care may also include care management services, which will evaluate the needs, monitor and coordinate the services. People with cognitive impairment usually need to be watched, supervised, protected or reminded to do daily activities.

The need for long term care usually arises from injury, disability, age or chronic illness. Approximately 60% of Americans who reach age 65 will need long term care before they die.

The need for long term care services can strike at any time. About 40% of people receiving long term care services are working age adults, between the age of 18 and 64.

Long term care is the type of care that people may need if they can no longer perform activities of daily living by themselves. The following is a list of examples of Activities of Daily Living.

Bathing:
• getting into a tub or shower; and
• getting out of a tub or shower; and
• washing your body in a tub, shower or by sponge both; and
• washing your hair in a tub, shower or sink

Dressing:
• putting on and taking off any necessary item of clothing,

Transferring:
• getting in and out of bed, wheelchair or chair

Toileting:
• getting to and from the toilet; and
• getting on and off the toilet; and
• performing associated personal hygiene.

Continence:
• maintaining control of bowel and bladder function; or
• when unable to maintain control of bowel or bladder function, performing associated personal hygiene

Eating:
• feeding yourself by getting food into your mouth from a container (such as a plate or cup), including use of utensils when appropriate (such as a spoon or fork); or
• when unable to feed yourself from a container, feeding yourself by a feeding tube or intravenously.

If the insured needs substantial assistance from another person to complete any one of these daily activities, he or she is considered to be dependent for Activities of Daily Living.
Cognitive Impairment

Many long term care insurance policies will pay benefits for “cognitive impairment” or mental inability. If you are unable to pass certain tests of mental function, the insurance policy will then start paying you benefits.

Cognitive impairment means a deterioration or loss in intellectual capacity (such as may occur with Alzheimer’s disease or dementia) that (a) places a person in jeopardy of harming him/herself or others and therefore the person requires substantial supervision by another person; and (b) is measured by clinical evidence and standardized tests which reliably measure impairment in: (1) short or long term memory; (2) orientation to people, places or time; and (3) deductive or abstract reasoning.

Most states do not allow long term care policies to limit benefits because the insured has a cognitive impairment, such as, Alzheimer’s disease.

Alzheimer’s disease is the # 1 reason for long term care claims – cancer, strokes, and accidents are some other reasons. Every day on average, 986 Americans are diagnosed with Alzheimer’s, and the decision to tell friends, relatives, employers is often an agonizing one. They fear they’ll be branded with a scarlet A. Alzheimer’s disease steals a person’s lucidity thought by thought. Since Alzheimer’s was identified in 1906, most families and patients have suffered silently until the symptoms were too noticeable for others to ignore or deny. But in recent years, emboldened by the examples of former President Ronald Reagan and actor Charleston Heston, more people with early-stage Alzheimer’s have chosen to speak for themselves while they still can. Approximately 5.4 million Americans and well over 35 million people worldwide have Alzheimer’s disease, by far the most common form of dementia.

About 75% of care for people with Alzheimer’s disease is provided for at home.
Long term care services can be received in a variety of settings, including your own home, assisted living facilities, adult day care centers or hospice facilities. The services can be covered completely or in part by long term care insurance. Many plans let you choose the amount of the coverage you want, as well as how and where you want to use your benefits. A comprehensive long term care policy includes benefits for all levels of care, custodial to skilled medical care.

Long term care isn’t the type of care that people receive in the hospital or their doctor’s office. It isn’t the medical care they need to get well from a sickness or an injury. It isn’t short-term rehabilitation from an accident or recuperation from surgery. Surprisingly, long term is not always administered in a nursing home. In fact, more than 80% of all people receiving long care benefits and assistance are not in nursing homes.

NURSING HOMES  SECTION 2

What is a Nursing Home?

A nursing home is a residence that provides room, meals, help with activities of daily living, recreational activities, protective supervision, and monitoring of residents. Typically, nursing home residents have mental and physical impairments which keep them from living independently at home. Nursing homes are certified to provide different levels of care, from custodial to skilled nursing. They are designed to meet the needs of acute or chronically ill patients. People who require less than skilled care, or who require skilled care for a brief or long period of time, should consider a nursing home. For some, a nursing home may be a viable alternative to home health care, especially if the person has a chronic or acute illness that requires a level of care that cannot be easily provided at home.

Nursing Homes & Rehabilitation Centers
A visit to a nursing home will provide an opportunity for the caregiver and patient to talk to nursing home staff, and observe the people who live and receive care at that facility. Visitors will also be given the opportunity to examine the nursing home’s most recent survey report. By law, this report must be posted in the nursing home in an area that is accessible to visitors and residents.

Each resident is evaluated by the medical and professional team – Physicians, Nurses, Psychiatrist, Physical Therapist, Social Service Workers, and Recreation Coordinators.

**What is a Survey report?**

All nursing homes that are certified to participate in the Medicare or Medicaid programs are visited by a team of trained State surveyors approximately once a year. These surveyors examine the nursing home for several days. They will inspect the performance of the nursing home in numerous areas—including the quality of life and quality of care. At the conclusion of the survey, the team reports its findings to the Medicare or Medicaid Administration. Nursing homes that receive a deficiency report are subject to fines and other penalties if they are not corrected in a specified period of time.

**Rights of nursing home residents**

Over the last decade, different laws and regulations have been enacted to raise the standards of nursing home care, particularly with respect to quality of life. **The law currently requires that residents receive the necessary care and services that will enable them to reach and maintain their highest practicable level of physical, mental and social will-being.** In addition, civil rights law ensures equal access in all nursing homes regardless of race, color, or national origin.

Nursing Home and Rehabilitation Centers will usually accept the following insurances for payment:

- Social Security
Assisted Living facilities provide a variety of services that emphasize both comfort, and convenience. The following is a list of the typical things that are offered to all residents:

- A choice of apartments complete with full bath and kitchenettes
- Senior-focused features like: showers with seats, grab bars in the bathroom, night lights, raised electrical outlets.
- Individually controlled heating and air conditioning
- Personal emergency response system
- Periodic housekeeping and linen service
- Attractive community areas, including:
  1. Dining room
  2. Library & activity rooms
  3. Main living room for socializing
- Beautifully landscaped courtyard and walking paths
- Fire alarms and sprinkler systems
- Washers & dryers available for personal use
- Full-service beauty/barber shop (usually for an additional fee)
Standard services for residents include:

- Three meals daily
- Between-meal snacks
- Access to trained staff 24 hours a day
- Licensed nurses
- Daily physical fitness, creative, social, learning, and spiritual activities and programs
- Resident-sponsored clubs for a variety of interested persons
- Scheduled group trips
- Scheduled transportation for errands and medical appointments
- Social and educational programs for families
Custodial and medical services

- Personal hygiene
- Bathing and showering
- Dressing and undressing
- Nighttime care
- Mobility and transferring
- Continence
- Orientation (i.e. ability to recognize people, places, things)
- Communication
- Socialization and activities
- Monitoring of safety
- Eating
- Medications
- Treatments, monitoring and responding to health needs
- Alzheimer’s Care

According to a 2001 survey by the National Center for Assisted Living, about two-thirds of assisted-living residents pay for their stay out of pocket. Most long-term care insurance contracts provide coverage for assisted living, but Medicare does not.
The Cold Facts

There are numerous myths about long term care. Some people think that only senior citizens need to worry about long term care so they put off preparing for the possibility. The cold fact is that unforeseen accidents or illnesses can strike at any age. While 60% of people who will need long term care are 65 or older, 40% are working age adults between the ages of 18 and 64.

People of any age can develop serious conditions that require assistance with routine daily activities for an extended period of time and such help could be very costly. Long term care insurance can help cover the cost of this care and protect one’s assets.

Some believe that once they are stricken with an accident or sickness, their family will take care of them. In today’s society, children may live across the country or around the globe. And many women are active in the workforce, with less time to fulfill their traditional caregiver role.

More cold facts:

- By 2030, Americans age 65 and older will double.
- Americans age 85 and older will triple by 2030
- The longer people live, the greater the chance of becoming ill.
- Approximately 43% of Americans 65 and older will need long term care before they die.
- The average stay in a nursing home is approximately 456 days.
- 30% of the elderly people who stay three months or longer in a nursing home would become impoverished.
- 80% would be impoverished with a stay of 104 weeks
- Over 25% of Americans households are providing traditional long term, approximately 22.5 million families.
• Women generally outlive men, and they face a 50% greater probability than men of entering a nursing home after age 65
• By 2015 approximately nine million Americans will need some kind of long-term care. By 2020, 12 million will need long-term care
• A study by the Dept. of Health and Human Services indicates that 10% of the people, age 65 and residing in a nursing home, will stay there five years of longer.
• The longer you live, the greater the chance that you will need some type of long-term care.

Since 1987, the number of Americans who’ve purchased a long term care policy has grown at an annual rate of 18%, according to the Health Insurance Association of America, but the vast majority of that growth has taken place in recent years. In 1999, more than 750,000 policies were purchased. This was a 40% increase from the previous year. More than seven million Americans have now purchased a Long Term Care Policy. Currently there are over 35 million Americans age 65, so the market is still enormous.

Cost of Long Term Care

The national average cost of a semi-private room in a nursing home is $75,000 annually. This depends upon where a person lives and the type of facility that the person prefers, costs can be considerably higher.
Medicaid

Medicaid is a jointly-funded, Federal-State health program for certain low-income and needy people. The federal Government funds 57% of the program and each state funds about 43%. In 2010, Medicaid covered approximately 50 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments.

Medicaid is designed to protect those with minimal assets or disabled. To qualify, many people have to spend down nearly all of their assets. Because spouses have a legal responsibility to support each other, both must spend down their assets before an ill spouse may qualify for medicaid benefits.

Medicaid eligibility

States have some discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for federal funds, States are required to provide Medicaid coverage for most individuals who receive federally assisted income maintenance payments, as well as for related groups not receiving cash payments. Some examples of the mandatory Medicaid eligibility groups are:

- Low income families with children;
- Supplemental Security income (SSI) recipients;
- Infants born to Medicaid-eligible pregnant women;
- Children under age 6 and pregnant women whose family income is at or below 133 percent of the Federal poverty level;
- Recipients of adoption assistance and foster care under the Social Security Act;
- Certain Medicare beneficiaries

**Medically Needy Eligibility**

The option to have a “medically needy” program allows States to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory provisions. **This option allows them to “spend down” to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State’s Medicaid plan.** States may also allow families to establish eligibility as medically needy by paying monthly premiums to the State in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the income eligibility standard.

**Amplification on Medicaid eligibility**

Coverage may start retroactive to any or all of the 3 months prior to application, if the individual would have been eligible during the retroactive period. Coverage generally stops at the end of the month in which a person’s circumstances change. Most States have additional “State-only” programs to provide medical assistance for specified poor persons who do not
qualify for the Medicaid program. No Federal funds are provided for those programs.

**Medicaid-Medicare Relationship**

Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical bills from their State Medicaid program. There are various benefits available to “dual eligibles” that are entitled to Medicare and are eligible for some type of Medicaid benefit.

According to the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, national spending on health care was $2,809.0 billion in 2012. Spending in the Medicaid program was $165.9 billion in 2011.

**Cutbacks on Medicaid programs**

State governments typically provide half of the funds for Medicaid health insurance programs for the poor, with the federal government making up the difference. But when the economy sags, state budget cuts are unavoidable.

Medicaid consumes a large portion of each state’s budget, for example: Wyoming 7%, Texas, 7.3%, Illinois, 31%, and North Carolina 37% in 2010. Because of the growing cost of Medicaid, states are beginning to cut back on other services, such as education, social services, and law enforcement. Higher drug prices and greater use of Medicaid services are the main reasons for these enormous increases.
The State of Maryland Medicaid Program

In 2008, the State of Maryland had over 761,000 uninsured residents. Usually the State’s Medicaid Program places a limit on the number of hospital days it will pay for a Medicaid patient. Once that limit has been reached, hospitals are then forced to give more uncompensated care, which eventually leads to higher hospital rates to insured patients. This will eventually cause health insureds to pay higher insurance premiums. The Maryland Health Services Cost Review Commission sets hospital rates. When hospitals are forced by the State to provide more uncompensated health care services to uninsured patients, the hospitals will usually request for a rate increase. This will basically cause those insured patients who are hospitalized to pay for the uninsured and for shortfalls in the Medicaid Reimbursement Program. Each State has its own method of passing on these costs to its residents.

All State Medicaid Programs depend heavily on Federal assistance in areas such as prescriptions and hospital cost.

Producers who sell Long Term Care Policies should become very familiar with the State Medicaid Program in his / her area of business.
The State’s Medicaid Program for nursing home residents

To get Medicaid for nursing home care in many states, the applicant and his/her resources must be within limits set by law.

In counting the applicant’s income for a month, the State’s Dept. of Social and Health Services looks at what the applicant has on the first of the month that he already had in the previous month. Resources typically include such things as real estate, bank accounts, CDs, stocks and bonds.

A. Income

The applicant monthly income must be less than the following total:

The Medicaid rate for nursing home care plus the applicant’s regular monthly medical expenses. The Medicaid rate—the rate charged for Medicaid residents—is different for different nursing homes. The applicant would have to find out the rate for a particular nursing home by asking the nursing home or calling DSHS.

Example:

<table>
<thead>
<tr>
<th>ABC Nursing Home Medicaid monthly rate</th>
<th>$ 3,800.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>The applicant’s monthly pharmacy bill</td>
<td>95.00</td>
</tr>
<tr>
<td>Total</td>
<td>$ 3,895.00</td>
</tr>
</tbody>
</table>

If the applicant’s monthly income is less than $ 3,895.00, his income will be within the Medicaid eligibility limit for care at ABC Nursing Home.

Once the applicant is determined eligible for Medicaid nursing home coverage, he will be allowed to keep approximately $ 60 per month for his personal needs. The rest of his income will be used as follows:
(1) an amount for his spouse if he has one;

(2) an amount for any dependent family members living with his spouse;

(3) an amount to pay health insurance premiums;

(4) an amount to pay medical bills for services not covered by Medicaid, if the bills are still owed and not covered by any Insurance;

(5) an amount to cover certain miscellaneous items, such as guardianship fees that satisfy certain requirements.

Any remaining income must be paid to the nursing home for the applicant’s care. The part of the care that is paid by the applicant is called his “participation.” Medicaid covers the rest.

Once the person has been determined eligible for Medicaid nursing home coverage, the person will be allowed to keep $60 per month for his personal needs. The rest of your income will be used as follows:

(1) an amount for your spouse if you have one

(2) an amount for any dependent family members living with your spouse:

(3) for a single person or an institutionalized couple only, an amount (not more than $696) for the maintenance of a home for up to 6 months, but only if a physician has certified that the person or a member of the couple is likely to return to the home within the 6-month period: even without any physician’s certification, if there is rental income from a home to which a Medicaid recipient or spouse intends to return, that income may be used for payment of home
maintenance, taxes and insurance:

(4) an amount to pay health insurance premiums:

(5) an amount to pay medical bills for services not covered by Medicaid (usually services provided before you became eligible for Medicaid), if the bills are still owed and not covered by any insurance:

(6) an amount to cover certain miscellaneous items, such as guardianship fees that satisfy certain requirements.

Any remaining income must be paid to the nursing home for your care. The part of your care you pay for is called your “participation.” Medicaid covers the rest.

B. Resources

The limit for resources (assets, property, and savings) that a single person may have is $2,500. Certain “exempt” resources are not counted in determining whether you fall within this limit.

When a married person applies for Medicaid for nursing home care, his or her spouse is allowed to have substantially more resources.
The State of Virginia Medicaid Program

Resources that Medicaid applicant/recipient sets aside to pay for their burial expenses are excluded from countable assets. If the following guidelines are satisfied:

1. The burial expenses must not exceed $3,500 for the individual or spouse
2. The burial amount should be reduced by the face value of the life insurance on the individual /owner or his spouse

Cemetery plots and life rights to real estate are not counted as resources.

Reasonable efforts to sell the property

1. The property must not be listed at an amount that exceeds 150% of the current tax assessed value.
2. It is viewed that “a reasonable effort” has been made if the property is listed at current market value and the realtor verifies that the property is unlikely to sell within 90 days of listing.
3. The recipient is expected to continue to make a reasonable effort to sell the property if the property could not be sold when it was on the market.
4. If the property had not been sold after 12 months the Medicaid recipient is then allowed to sell the property between 75% to 100% of its tax assessed value.
5. Once it has been determined that the property is unsaleable, the property will no longer be regarded as part of the eligibility requirements.
Automobile rules

1. The applicant is allowed to keep one automobile and it will not affect his eligibility for Medicaid assistance.

Cash surrendered value of life, retirement and other types of insurance guidelines:

1. If the cash surrender value of the recipient’s life, retirement, and other types of insurance policies exceeds $1,500 then the cash surrender value of those policies are counted to determine eligibility.

Interest-bearing savings accounts

Individuals or family members applying for Medicaid Assistance may have one interest-bearing savings account or investment account per applicant. The amount in the account cannot exceed $5,000 and the recipient must designate the accounts for self-sufficiency purposes and use it as such.

Household goods and personal effects

The Commonwealth of Virginia will disregard the value of household goods and personal effects if they are used in connection with the maintenance, use and occupancy of the premise at the recipient’s home.

Medicaid applicants are determined eligible for Medicaid assistance if their countable resources are at or below Virginia’s resource standards.
The Medicare Program

Medicare is a health insurance program for:

- People age 65 or older.
- Some people under age 65 with disabilities
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare has Four parts

Part A  Hospital Insurance,
        Most people do not have to pay for Part A
Part B  Medical insurance
        Most people pay monthly for Part B
Part C  Medicare Advantage program
Part D  Prescription Drugs

Medicare Part A

Medicare Part A (hospital insurance) helps cover inpatient care in the hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care- certain conditions must be met.

Cost:  Most people do not have to pay a monthly payment,
       (Called a premium) for Part A. This is because they or their spouse paid Medicare taxes while they were working.

If a person did not pay Medicare taxes while they were working and they are age 65 older, they still may be able to buy Part A.
What does Medicare Part A covers?

**Hospital Stays:** Semiprivate room, meals, general nursing, and other hospital services and supplies. This includes inpatient care received in critical access hospitals and mental health care. This does not include private duty nursing or a television or telephone in room. It also does not include a private room, unless medically necessary. Inpatient mental health care in a psychiatric facility is limited to 190 days in a lifetime.

**Skilled Nursing Facility Care:** Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies. Person must have had a related 3-day inpatient hospital stay prior to entering a skilled nursing facility.

**Home Health Care:** Part-time skilled nursing care, physical therapy, occupational therapy, speech-language, home health aide services medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

**Hospice Care:** For people with a terminal illness, includes drugs for symptom control and pain relief, medical and support services from a Medicare-approved hospice, and other services not otherwise covered by Medicare. Hospice care is usually given in the patient’s home. However, short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest) are covered when needed.

**Blood:** Pints of blood you get at a hospital or skilled nursing facility during a covered stay. Patient must pays for the first three pints of blood.
Medicare Part B

Medicare Part B (Medical Insurance) helps cover the patient’s doctor’s services, and outpatient hospital care. It also covers some other medical services that Part A does not 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: Person has to pay the Medicare Part B premium of $104.90 per month in 2013. In some cases, this amount may be higher for those who did not sign up for Part B when they first became eligible. The cost of Part B may go up 10% for each 12-month period that the person could have had Part B but did not sign up for it. The person will have to pay this extra amount as long as he or she has Part B, except in special cases.

Enrollment in Part B

Enrolling in Part B is optional. If a person is already getting Social Security or Railroad Retirement benefits, he or she are automatically enrolled in Part B starting the first day of the month they turn age 65. If they are under age 65 and disabled, they are automatically enrolled in Part B after they get Social Security or Railroad Retirement benefits for 24 months.

Premiums for Medicare Part B are taken out of the person’s monthly Social Security, Railroad Retirement, or Civil Service Retirement check. If a person does not get any of these payments, Medicare will send a bill for Part B premium every three months.
Important Telephone numbers:

* Social Security Administration 1-800-772-1213
* Railroad Retirement Board 1-800-808-0772

What Medicare Part B Covers:

Medical and other Services: Doctors’ services (including routine physical examinations), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers second surgical opinions, outpatient mental health care, and outpatient physical and occupational therapy, including speech-language therapy.

Clinical Laboratory Services: Blood tests, urinalysis, and more.

Home Health Care: Part-time skilled nursing care, physical therapy, occupational therapy, speech-language, home health aide services, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Outpatient Hospital Services: Hospital services and supplies received as an outpatient, as part of a doctor’s care.

Blood: Pints of blood received as an outpatient or as part of a Part B covered service.
Preventive Services:

Medicare Part B Covered Preventive Services

**Bone Mass Measurements:** Once every 24 months for qualified individuals and more frequently if medically necessary.

**Colorectal Cancer Screening:** Fecal Occult Blood Test – Once every 12 months.

**Flexible Sigmoidoscopy**- Once every 48 months

**Colonoscopy** – Once every 24 months if person is at high risk for colon cancer.

**Barium Enema:** Doctor can use this instead of a flexible sigmoidoscopy.

**Diabetes Services and Supplies:**
Coverage for glucose monitors, test strips, and lancets.

**Glaucoma Screening:** Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in the patient’s state.

Mammogram Screening: Once every 12 months.

**Medicare also covers new digital technologies for mammogram screening.**
Pap Test and Pelvic Examination
(includes a clinical breast exam): Once every 24 months. Once every 12 months if the person is at high risk for cervical or vaginal cancer, or if the person is of childbearing age and has had an abnormal Pap test in the past 36 months.

Prostate Cancer Screening: Digital Rectal Examination- Once every 12 months.

Shots (vaccinations):

Flu Shots – Once a year in the fall or winter.
Pneumococcal pneumonia Shot – One shot may be all a person may ever need.

Hepatitis B Shot

The Flu is a serious illness that can lead to pneumonia. It can be dangerous for people age 50 and older. People need a Flu shot each year because flu viruses are always changing. The shot is updated each year for the most current flu viruses. Also, the flu shot only provides protection from the flu for about one year.
Medicare Advantage Part C
(HMO, PPO or Fee – For – Service Plans)
(11.5 million participants)

When you enroll in a Medicare Advantage, you are simply receiving your Medicare Parts A and B health insurance through private insurance companies. The insurance companies’ contracts with Medicare are from January 1st through December 31st. Medicare Advantage was added to the Medicare Program in 1997.

Under the contract, Medicare pays the Medicare Advantage insurers a fixed amount of money each month for each Medicare beneficiary they can get to sign-up with the insurers’ Advantage plan. The monthly amount the insurers will receive from Medicare will vary from $800 to $1,200 – depending on the medical condition of the Medicare beneficiaries. These insurers will receive much more if they sign up someone who qualifies for both Medicare and Medicaid (dual eligible). With the money from Medicare, the insurance company must provide each member with the same services that are covered under Medicare Parts A and B – except for hospice care. Medicare is responsible for covering hospice care for all Medicare beneficiaries. Many Advantage plans also include the Medicare Prescription Drugs Part D, hearing, vision, dental care, and wellness programs, but you may have to pay extra for those benefits.

Question: What is a Medicare Advantage PPO Plan?

Answer: With a Medicare Advantage PPO Plan, you pay specific fees if you use the providers in the Plan’s network for healthcare services, but you must pay a higher fee if you go outside the Plan’s network for healthcare services.
When you enroll in a Medicare Advantage HMO, you may only see certain doctors and go to certain hospitals within your area. If you use providers outside the Plan’s network of providers, you will be responsible for the entire medical bill, except for emergency medical services.

“Make sure they take you to an approved Hospital!”

Not all areas offer Medicare Advantage. In 2010, Delaware had only one insurer that offers Medicare Advantage Plans.

**Medicare Enrollment Period**

Initially, you can sign-up for Medicare Advantage three months prior to your 65th birthday and three months after your 65th birthday. After this period, normal enrollment will be between October 15 and December 7 of each year. Your Medicare Advantage coverage will begin on January 1 of the following year. Between January 1 and February 14, you will be allowed to leave your Advantage Plan and switch to Medicare Parts A and B.

You may also switch, change or join another plan if you move out of an Advantage Plan area.

Question: What are my options if my Medicare Advantage insurer discontinues business in my state?
Answer: You will be allowed to enroll with another Advantage insurer in your area or you can sign-up for Original Medicare Part A and Part B.

Under the Advantage (HMO) plan, a network of doctors and hospitals has agreed to treat people from the HMO. You select a primary care physician (PCP) once you become a member of the HMO. The PCP will manage your care and provide you with most of your health care services. Your PCP will decide if you need to see a specialist and will give you a written referral. When you receive your health care services, you present your Medicare Advantage identification card that was given to you when you became a member. You do not use your Medicare red, white, and blue card.

With Medicare Advantage, there are no Medicare Part A hospital deductibles ($1,132 for 2011) or coinsurance amounts to pay.

There are also no Medicare Part B annual deductibles ($162) or coinsurance of 20% each time you see a doctor.

You will pay your doctor a fixed copayment ranging from $15 to $25 per visit. If you need to see a specialist, your copayment will be slightly higher. If you are admitted to a hospital, some Medicare Advantage HMO plans charge a deductible.

Some Advantage plans have zero monthly premium payments. If you decide to see a doctor without a referral and it is not a medical emergency (life-threatening) or a situation requiring urgent care, you will be totally responsible for all medical cost.
Neither Medicare nor your HMO will pay anything towards your medical bill, because Medicare has already given the HMO money to provide you with all of your healthcare services. The HMO pays the hospitals and physicians in its network and expects you to use them when you need medical care.

You cannot purchase a Medigap policy to pay the costs that you are responsible for in your Medicare Advantage plan.

| Medigap policies only work with Original Medicare Parts A and B. |
| The biggest difference between Medicare Advantage and Medigap is that Medigap policies let you use any doctor who participates in Medicare. |

Nearly 8 in 10 Medicare Advantage plans (79%) offered drug coverage in 2011.

**Medicare Advantage Fee - for - Service Plan**

With a Medicare Advantage fee – for- Service Plan, Medicare will pay the insurance companies a fixed monthly dollar amount. The insurers will get this fixed dollar amount for every Medicare enrollee in their Advantage program. The amount the insurers will receive each month will range from $ 800 to $ 1,200 per enrollee.

These Plans are not offered in some areas and many do not have a network of hospitals and doctors to provide health care services. The Fee-For-Service Plan will allow you to use any hospital or doctor who accepts Medicare’s payments. The Plan decides where, when, and how much you are responsible for paying the hospitals, doctors, and clinics. Before using any medical provider, you should call the
providers to see if they will accept the Plan’s terms, conditions, and payments. On the back of your Advantage ID card is the insurance companies’ telephone number. By calling that number, doctors and hospitals will then be able to determine if your Plan’s terms, and payment amounts are acceptable. If they are unacceptable, then the provider will expect you to pay the healthcare services and you will not be reimbursed by your Plan.

Important – Ask your doctor to call your insurer to get approval for any questionable health care services.

The enrollment requirements for Medicare Advantage Fee-For-Service Plans are the same as it is for any Medicare Advantage Plan.
Medicare Part D (The Prescription Drugs Program)  
(27.6 million participants)

Remember, Medicare Parts A and B do not cover prescription drugs.

Medicare Part D is a federal prescription drug program that helps seniors and those who are disabled to pay for their prescription drugs. It is offered to everyone who has Medicare Part A (hospital) or Part B (medical) coverage or who is entitled to it. There are approximately 27.6 million people who are currently enrolled in this program. Ironically, this program is not run by Medicare; it is solely operated by insurance companies that are approved by Medicare. Therefore you can only purchase this drug plan from them. The Medicare Part D plan was signed into law on December 8, 2003, by President George W. Bush. Way to go, George!


Question: My wife and I are both 65 and are planning on enrolling in the Medigap Plan F, because it is the most popular plan and covers all the deductible and coinsurance that Medicare does not pay. My understanding is that this plan also offers Medicare prescription drugs Part D coverage. Is this true?

Answer: False. As of 2011, all Medigap plans are no longer allowed to offer the Medicare drug plan.

Question: Will the Medicare Advantage plan cover prescription drugs?
Answer: Maybe. Some plans do and others don’t. The Medicare Advantage plans that include (Part D) coverage are called “MA-PDs.” With these plans, you get Medicare Parts A, B, and D coverage all wrapped up in one package. A possible drawback is that many of these plans are setup as HMOs.

Question: Must I be age 65 or older to sign up for this drug plan?

Answer: No. Medicare offers this prescription drug coverage to everyone who has at least Medicare Part A or Part B coverage. Remember, those who are disabled or suffering from kidney disorders do not have to be 65 to get Medicare.

There are two ways you can get Medicare prescription drug coverage:

1. The Medicare Prescription Drug Plan can be added to your Medicare Part A and Part B coverage.

2. Purchase a Medicare Advantage Plan that includes prescription drug coverage.

Penalties for not signing up

If you decide not to join a Medicare drug plan when you are first eligible, and you don’t have other creditable prescription drug coverage, you will most likely have to pay a late enrollment penalty in the future. If you currently have drug coverage, your plan will notify you every year to let you know if it is a creditable drug plan or not.

Please keep this information in a safe place, because to enroll in the Medicare Part D later on, you may have to prove to the insurance company that you were not without credible drug coverage for 63 consecutive days or longer. If you have no evidence (written proof) to
that effect, you may have to pay a late penalty of 1% for every full month you were without **creditable coverage**.

Question: I just turned 65, and I am currently enrolled in my employer’s drug plan. I understand that it is a creditable plan and therefore I am not planning on signing up for the Medicare drug plan. Can you tell me where I can get the documents to show proof I have creditable drug coverage?

Answer: If your drug plan is creditable, your plan will notify you every year, stating that it is a creditable drug plan.

Each Medicare prescription drug plan can vary in cost and drugs covered.

Premium: You usually have to pay a premium for Medicare Part D. The average premium is $31.17, in 2013, but premiums can vary from as little as $15 per month to as much as $79 per month. Low premium plans will offer generic drugs with very few brand name drugs, while the higher premium plans will include generic drugs and a lot more brand-name prescription drugs. If your modified adjusted gross income reported on your federal tax return from 2 years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain amount, you will have to pay a higher monthly premium for Part D coverage. This is just one way of keeping this drug program financially solvent.

You can also go to www.medicare.gov to find and compare plans in your area. The website tools are easy to use, and you can customize your search as follows:

(1) The maximum monthly premiums you are willing to pay

(2) Whether you prefer brand-name drugs over generic
(3) How far you are willing to travel to get your drugs

(4) Your preference for mail order service, etc.

You may have to pay more

The Part D monthly premium could be higher based on your income. This includes Part D coverage you get from a Medicare Prescription Drug Plan, a Medicare Advantage Plan, or a Medicare Cost Plan that includes Medicare prescription drug coverage. If your modified adjusted gross income as reported on your federal tax return from two years ago is above a certain amount, you will pay a higher monthly premium. This is just another method of keeping this drug program financially sound.

Question: What do I do if I cannot afford to pay the premium for this drug plan?

Answer: Many people qualify to get extra help paying their Medicare prescription drug costs but don’t know it. Those who qualify and join a Medicare drug plan get 95% of their costs covered. People who qualify in 2011 pay no more than $2.50 for each generic drug and $6.30 for each brand-name drug they purchase.

Each state has a Medicare Savings Program that may help pay your Medicare premiums and, in some cases, your Part A and B deductibles, coinsurance, and copayments. In order to qualify for this program, you must meet the following criteria:
• Have Medicare Part A coverage
• Be single and have monthly income of less than $1,246 and resources of less than $6,680
• Be married and living together with a joint monthly income of less than $1,675 and resources of less than $10,020

Note: These amounts may change every year, and each state figures your income and resources differently. If you are receiving benefits through Medicaid, you will be automatically enrolled in the Part D plan.

Resource: For more information, call your state Health Insurance Assistance Program (SHIP).

If you need help to pay for Medicare Part D, you can also visit the Social Security Administration website at www.ssa.gov to apply online or call 1-800-772-1213 to apply by phone.

Pay a deductible

In 2011, some Medicare Part D plans require you to pay a deductible of up to $310 per year before Medicare pays anything, but, fortunately, some plans do not have annual deductibles.

Question: Which plans do not have annual deductibles?

Answer: You can go to the Medicare finder at www.medicare.gov

Question: When can I enroll, and which insurances offer these drug plans?

Answer: You can sign up or change your plan between November 15th and December 31st each year. Your coverage will begin on January 1st of the new year. You should enroll this year if you are eligible, or you run the risk of having to pay more if you decide to join later.
What does it cover? All Medicare drug plans must provide at least a standard level of coverage set by Medicare. However, plans offer different combinations of coverage and cost sharing. Having a variety of plans to choose from gives you the chance to pick a plan that meets your needs. Choosing a plan that fits your situation allows you to get the coverage you want at the best possible price. So shop around or go to www.medicare.gov

All medications are placed into categories which are called “formularies” (see note 12). Each drug plan has a list of specific drugs it covers in its formularies. The plan can change the drugs yearly. Generally, these drugs can be found in the plan’s formulary guide, which is available on its website. The plan will only pay its share of the cost of your drugs if you purchase your drugs (that are on its list) from a pharmacy or distributor that participates in that plan.

Before choosing a drug plan, do not forget to compare plans in your area. Also try to find out how often the plan changes drugs on its list. Some plans change drugs on a regular basis. It pays to do your homework.

Question: Why would the plan change a drug on its list?

Answer: The plan might remove a drug based on how well it works, how much it costs, and so on. Some plans require certain drugs to be pre-approved, and those drugs will be posted on their websites.

Tip:

If you have any questions about Medicare prescription drug coverage, including each plan’s formularies, please call Medicare at: 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. Or visit www.medicare.gov.
Now that we have accumulated some knowledge about the Medicare Part D plan, let’s see how the plan really works.

**Premiums and Coinsurance**

As previously mentioned, drug plans charge a monthly premium that will vary by plan, but the national average cost is about $32.34 per month.

After you pay the plan’s deductible, up to $310 per year, you then pay 25% of the drug cost, and Medicare pays 75% until the total cost of the drugs that were paid by you and the plan have reached $2,970 – **in 2013**. (This includes the deductible, but **not the monthly premiums**).

Stop! Although it is possible that you may have to pay a deductible, some plans do not require it. So, chill out! You may not have to pay one. What you really need to know is that once the **total amount you paid** for the drugs, plus the **total amount the plan paid** have reached a total of $2,970, you are then on your own in regard to paying your drug bill. Remember, your part of the total bill may or may not include a deductible, depending on whether you paid one or not. The $2,970 definitely **does not include your monthly premiums**.

**Here comes the monkey wrench!**

Once the total costs for the covered drugs have reached $2,970, you enter the **Donut Hole**. While in the **Donut Hole**, you are responsible for all of your drug bills until you have spent a total of $4,750 of your own money for the entire year.

**Stop!** This means that you will be floating around in the Donut Hole until all your drug bills for the year total $4,750. Fortunately, studies
have indicated that most people who are enrolled in the Medicare Part D plan will never enter the Donut Hole in the first place. Only about **14%** of people do.

Question: Why is the percentage so small?

Answer: Because it’s likely that the total amount that you paid plus what the plan paid probably will not total $2,970 for the year. Many Medicare drug plans place drugs into "tiers." Drugs in each tier have a different cost. Some plans may have more tiers, and some may have fewer. Here is an example: tier 1 drugs, which are mostly generic, cost $4 for a 30-day supply, but tier 2 drugs, which are mostly preferred, brand-name prescription drugs, may cost $29 for a 30-day supply, and so on. The average drug copayment for Medicare beneficiaries was $10.73 in 2011. This low copayment may be explained, in part, to Medicare / Medicaid beneficiaries only having to pay $2.50 for their generic drugs and $6.30 for brand name drugs. Studies have shown that over the years, Medicare participants are steadily increasing their use of generics.

Fortunately, in 2013, you will get a 52.50% discount on all **brand-name drugs if you are ever in the Donut Hole.** This is because of a special agreement that the Obama administration made with Pharmaceutical Research and Manufactures of America in which the pharmaceutical drug companies agreed to donate $80 billion over a ten year period to help reduce seniors’ drug costs. You are entitled to this 52.50% discount on brand-name drugs, whether you purchase them at a pharmacy or online.
Many Americans are unaware that the new national health program is designed to further reduce the cost of drugs for those who are in the Donut Hole by subsidizing their cost for generic and brand-name drugs while gradually phasing out the Donut Hole, so that it will be virtually nonexistent by the year 2020. Good job, Obama!

Question: What did the drug companies get out of the deal?

Answer: The Obama administration agreed not to try to cut any more money than $80 billion from the drug maker’s revenue. The administration also agreed not to support any legislation that is proposed in Congress that would allow people to buy prescription drugs from other countries, such as Canada, where the drugs cost less. Source: McKnight News, June 23, 2009.

Once you reach the point at which your total drug bill for the year is $4,750, you exit the Donut Hole and enter what is called Part D’s catastrophic coverage. The Medicare drug plan will then pay 95% of the cost of your covered drugs for the remainder of the year, and you will be responsible for the remaining 5%.

Many people who have paid a lot of money for their prescriptions each year because of illness or disability will probably see a clear advantage of enrolling in the Medicare Part D plan. For example, an individual who has been paying $10,000 or more for drugs stands to see huge out-of-pocket savings by signing up for the Part D plan and paying no more than $4,750 per year. On the other hand, someone who is healthy and doesn’t spend much on medications may be reluctant to sign up, because he or she sees less benefit in doing so.

Question: Why?
Answer: Because someone who is healthy is probably taking little or no drugs and does not want to pay the monthly premium for this insurance. The government understands this, and that’s why it has imposed the 1% per month late enrollment penalty for those who refuse to sign up when they were eligible. You have to understand that Medicare needs those healthy participants to help finance those who are unhealthy. Remember, the Medicare Prescription Drug Program is nothing more than an insurance plan; therefore it is all about the numbers. The more people Medicare can get to sign up, the healthier the program will be financially. Knowledge is light!

Question: Will some drug plans help pay for the cost for generic and brand-name drugs while I am in the Donut Hole?

Answer: Yes, some Part D plans will continue sharing the cost for covered drugs while you are in the Donut Hole.

Question: How will I know that the $2,970 has been reached?

Answer: Each month, the plan will mail you a statement indicating what drugs were paid by both you and the plan. When the total amount reaches $2,830, you are then responsible for all drug bills until your total out-of-pocket cost, during the year is $4,750. Once that happens, the plan will virtually be responsible for paying all your drug bills through the end of the year.

Question: How do my other insurance plans work with Medicare Drug Coverage?

Answer: If you have an insurance plan or union at work, find out from your plan provider how it works with, or is affected by, Medicare prescription drug coverage.
As you can see, Medicare is not one insurance plan but several. It is a combination of governmental and private insurance plans. You have to select which ones are right for you.
Qualified Long-Term Care Insurance Contract

A contract issued after 1996 is a qualified long term care insurance contract if it meets the requirements of section 7702B, including the requirement that the insured must be a chronically ill individual. A contract issued before 1997 generally is treated as a qualified long-term care insurance contract if it met state law requirements for long-term care insurance contracts and it has not been materially changed.

Chronically ill individual

A chronically ill individual is someone who has been certified (at least annually) by a licensed health care practitioner as:

1. Being unable to perform, without substantial assistance from another individual, at least two daily living activities (eating, toileting, transferring, bathing, dressing, and continence) for at least 90 days due to a loss of functional capacity; or
2. Having a level of disability similar to the level of disability in 1 above (as prescribed by regulations); or
3. Requiring a substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

Terminally ill individual

A terminally ill individual is someone who has been certified by a physician as having an illness or physical condition that can reasonably be expected to result in death in 24 months or less.
People who choose long term care insurance to cover any future needs often do so for some of the following reasons:

1. They want to preserve their assets for spouses and heirs.
2. They want to avoid being dependent on Medicaid or their family or friends.
3. They desire to be cared for at home as long as possible.
4. They want to be assured of getting into a desirable nursing home of their choice.
5. They want to have a peace of mind.
6. They want to prevent the caregiver (loved ones) from impoverishing them while being cared for.

Long Term Care Premiums

Premiums for long term care insurance vary greatly among insurers. Premiums are based on age at time of application, prior and current health conditions, the benefits selected, the number of years the insurer has to payout benefits.

People who purchase long-term care insurance should plan on paying premiums for the rest of their lives or until they need to use the benefits. Premiums may also increase in the future.

Types of services covered

Most long-term care policies offer coverage for a full range of care services. They include the following:

1. Home care
2. Care provided at adult day care center.
3. Care provided at an assisted living center.
4. Skilled nursing.
5. Hospice facilities

Assisted living facilities have become increasingly popular since they provide help with ADL’s (activities of daily living, such as bathing, eating, dressing etc.) or supervision for the cognitively impaired. Which include diseases such as Alzheimer’s, while encouraging independence and privacy in a home like environment.

**Eligibility for Benefits**

Typical benefits are payable to the insured when he or she is unable to perform a certain number of the ADL’s such as two out of five or two out of six.

The insured is eligible for benefits if:

1. A licensed health care practitioner has certified within the last 12 months that the insured is unable to perform, without substantial assistance from another person, at least two activities of daily living for an expected period of at least 90 days due to a loss of functional capacity. Or the insured requires substantial supervision due to severe cognitive impairment.

The insurance company must agree with the certification and approve a Written Plan of Care established by a licensed Health Care Practitioner or their own care coordinator.

Often the insurance company has the right to reassess whether the insured is still eligible for benefits. They usually review the insured’s condition every 12 months.
Notice of Benefit Eligibility Decision

The insurance company will send a written notice of their decision on whether the insured is eligible for benefits after receiving all the information from the insured.

If the insurer determines that the insured is eligible for benefits, the notice will state the date as of which the insured is eligible for benefits and will include claim forms.

If the insurer determines that the insured is not eligible for benefits, the notice will provide the reason(s) for the denial. The insured may appeal the insurer’s decision to an appeals committee independent third party, or seek judicial review from the courts.

Waiting Period

The waiting period is the number of days during which the insured must be eligible for benefits and receiving covered services before the insurer will start paying benefits. The waiting period options offered to consumers varies considerably. The typical waiting period options might be 20 or 90 days.

Usually the insured has to satisfy the waiting period once in his or her lifetime.

The waiting period usually does not apply to Hospice Care, Respite Services and Caregiver Training.

Hospice care

When the insured is in a Hospice facility, the insurer will pay for:

1. Room and board
2. Hospice care
3. Drugs, incontinence supplies, dietary supplements, personal medical equipment and laundry services.

**Services Provided by a Formal Caregiver At Home**

The insurer will pay for the following services provided to the insured by a formal Caregiver at home:

1. Nursing Care
2. Maintenance or Personal Care
3. Therapy Services

**Hospice Care at Home**

The insurer will pay for Hospice Care provided to the insured at home.

**Bed Reservations**

The insurer will pay for actual charges incurred for Bed Reservations. Sometimes the insurer has to stay in the hospital for a period of time, leaving the bed at the nursing home vacant. With this benefit, the insured will be assured of having a bed when he or she returns. Benefits for Bed Reservations are usually limited to 30 days per calendar year.

**Caregiver Training**

The insurer usually will pay for Caregiver Training. Benefits for Caregiver training are usually limited to an amount equal to seven to ten times the insured’s Daily Benefit Amount.

**Respite Services**

Insurance companies will pay for Respite Services:

1. Provided in a Nursing Home, assisted living facility or hospice facility.
2. Provided by a formal caregiver at home
3. Provided at an Adult Day Care Center.

**Adult Day Care Center**

Benefits will usually cover services provided to the insured at an adult day care center.

Adult Day Care Centers offer a variety of custodial and medical services for seniors. These services are provided during the day and evenings. A typical center will offer the following services:

- Comprehensive, professional medical care
- Safe and dependable door-to-door transportation
- Special programs for seniors with Alzheimer’s disease
- Comfortable and secure places to spend the day
- Nutritious meals
- Trained professional staff
- Extended and flexible hours
- Caregiver assistance
- Full schedule of interesting activities for the seniors

Usually, these centers will cost much less than home care or a nursing home. A typical daily fee at an adult day care center is between $70.00 and $75.00. The transportation cost is extra, and it can range between $15.00 to $17.00 per day. The typical daily rate for a nursing home is $150.00 and up for residents in 2005. There are approximately 3,500 adult day care centers in the United States, but recent studies have projected a demand for 10,000.
**International Benefits**

Insurers will pay benefits for covered services received outside the United States. When the insured receives such services, the insurance company will pay benefits up to 80% of the insured’s daily benefit amounts.

**Maximum Benefit**

Consumers are usually offered a wide choice of maximum daily benefit amount for covered home health care and nursing home stay.

A typical LTC (Long Term Care) policy might offer the consumer a daily benefit of $100/day, $150/day, $250/day etc.

**Length of Benefit Period**

The consumer usually can decide the length of time the daily benefits will be paid to the insured. The typical period is three to five years or a lifetime.

**Grace Period**

There is a 30-day grace period for payment of premiums. This means that the insurer must receive the premium by the 30th day after the date it is due. Otherwise the insurer will issue the insured a written notice of termination of coverage. Then the insured will usually have 30 to 40 days from the date of termination letter to pay the premium, or the coverage will end.

It is advisable for the insured to designate a person to whom the insurer will also send any notice of termination that is sent to the insured. The designated person will not be responsible for premium payments.
**Waiver of Premium**

After a confinement of 60, 90 or 180 days, the insurer usually waives all premiums until the insured has recovered from his or her disability.

Some insurers will give clients a 10% discount on their premiums if they are in good health when they apply for coverage. If both the husband and wife are eligible and they apply for individual coverage, some insurers will give them as much as 25% discount on their premiums.

**Nonforfeiture Benefits**

If, for whatever reason, the policyowner drops the coverage and he has a nonforfeiture benefit in his policy, he will receive some value for the money that was paid into the policy. Without this benefit, the policy owner will receive nothing even if he had paid premiums for 15 or 25 years before dropping the policy. In some nonforfeiture benefits, when the policyowner stop paying premiums, the insurance company gives him a paid-up LTC policy with a shorter benefit period. How many years depends on how long the premiums were paid. Since it is paid-up, the policyowner will not have to pay any more premiums.

**Exclusions**

The common exclusion in LTC policies:

1. War and acts of war
2. Care or treatment for alcoholism or drug addiction
3. Illness, treatment or medical condition arising from:
   a. Participating in a felony
   b. Riot or insurrection
   c. Attempted suicide
Inflation Protection

Purchasing Inflation Protection before age 75 is essential when a person buys long-term care insurance. It ensures that the insured has adequate coverage in the future. This protection is intended to keep pace with the cost of inflation. This protection increases the cost of the policy, but gives the insured coverage that will mean something when he or she needs it.

Free look - Period

Buyers of long term care policies are required to have a free - look period to decide if they want it or not. During the free look, they can cancel the policy and get their money back. In some states the insurance company must tell the buyer about the free-look period on the cover page of the policy. In most states buyers have 30 days to cancel, but in some it is less time.

How to cancel,

- Send the policy to the insurance company along with a short letter asking for a refund.
- Send both the policy and letter by certified mail. Keep the mailing receipt.
- Keep a copy of all letters.

It usually takes four to six weeks to get the refund.
Policies issued after January 1, 1997, which provide tax incentives, are classified as “Tax-Qualified Policies (TQ), and those without any tax incentives are classified as “Non-Qualified Policies” (NTQ).

Premiums for TQ policies may be included as a medical expense if the person itemizes his or her deductions and if medical expenses exceed 7.5% of adjusted gross income, the excess is deductible on the federal income tax return. The amount depends on the person’s age, as shown below.

<table>
<thead>
<tr>
<th>Age</th>
<th>maximum that can be claimed</th>
</tr>
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<tbody>
<tr>
<td>Age 40 or younger</td>
<td>$370</td>
</tr>
<tr>
<td>Older than 40 but more than 50</td>
<td>$700</td>
</tr>
<tr>
<td>Older than 50 but not more than 60</td>
<td>$1,400</td>
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<tr>
<td>Older than 60 but not more than 70</td>
<td>$3,720</td>
</tr>
<tr>
<td>Older than 70</td>
<td>$4,660</td>
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Long Term Care policy benefit payments, when received are free from federal income tax. Premiums from NTQ cannot be deducted as a medical expense, and it is unclear if benefits received will or will not be taxable. Most policies issued before 1997 are considered “Tax Qualified Policies.”

Maryland treatment for Tax – Qualified Long Term Care Policies

The state of Maryland gives consumers who purchase Qualified long-term care policies after July 1, 2000 tax credit against state income taxes. Credit capped at $500. A person can claim 100% of premium for self, spouse, parents or children up to $500 cap. The state will
monitor legislation to see how many people claim credit and evaluate the impact if any on Medicaid program.

**Virginia treatment for Tax-Qualified Long-Term Care Policies**

Virginia statutes permit a deduction from federal adjusted gross income for the amount paid in long term care insurance premiums provided the individual has not claimed a deduction for federal tax purposes or a credit under Virginia tax code 58.1-339.11. This code permits a credit against the individual's income taxes that shall not exceed 15 percent of the amount of long term care insurance premium paid during the taxable year. And, the credit can not be claimed to the extent that the individual has claimed a deduction for federal tax purposes.

**Tax treatment of dollar amounts policyholders receive from their long-term care policies.**

According to the Internal Revenue Service (Publication 525), long-term care insurance is treated much like health insurance—the dollar amounts the policyholder receives (other than dividends and premium refunds) for personal injury or sickness generally are excludable from income, and the premiums paid generally are tax deductible. Long-term care policies must have these features to qualify for the deductions: be guaranteed renewable; not provide for a cash surrender value or other money that can be paid, assigned, pledged or borrowed; and not pay for or reimburse expenses that would be reimbursed under Medicare.
MARKETING LONG TERM CARE INSURANCE

The number of Americans who purchased long-term care insurance increased more than tenfold in the last 15 years, according to a survey from the Health Insurance Association of America.

In 2010, between 7 and 9 million people had private LTCI in the United States.

Although premiums varied widely based primarily on benefit design and entry age, the HIAA found the average premium paid in 2001 remained nearly constant when compared to the average premium paid two years ago.

HIAA estimates that roughly 70% of all individual long term care policies sold remain in effect today.

Minimum & Maximum ages to buy Long Term Care Policies

Many experts suggest that the individual LTC market begins at age 40. Consumers will not even consider their long term care needs until around that age. Here is a list of reasons why:

1. People are more concerned about paying off their debts

2. Their kids are in college or about to start, and they may have to use some of their nest egg to fund their kids’ education.

3. They are just beginning to put money away for their retirement.
4. They still think that they have immortality. Therefore, they procrastinate.

5. They just don’t know the purpose for a long term care policy. And people usually don’t buy things that they don’t understand.

The most common maximum ages in more recent LTC policies are between 79 and 82. Policies purchased at these ages are very expensive.

The Ideal buyer of Long Term Care Policies

- Between the ages of 50 and 64
- In good health
- Have discretionary income
- Don’t want to be a burden to the family
- Has assets to protect

People who retired early are often excellent buyers of LTC policies. They are usually well-off financially and LTC premiums are reasonable between age 50 and 60. These people also plan ahead for a rainy day.

The cost for Long Term Care Insurance

The premium will be lower if purchased at a younger age, higher if purchased at an older age. If the policy is purchased at age 75, the premium will usually be much higher and can be more than double than if bought at age 65.

If the policy has a large daily benefit, a longer maximum benefit period, or a home health care benefit, it will also cost more. Inflation protection can add 25% to 40% to the premium. Nonforfeiture benefits can add 10% to 100% to the premium.
Maryland and Virginia Partnership Programs

Why should American plan for long-term care? Because, at least 70 percent of people over age 65 will require some long-term care services at some point in their lives. And, contrary to what many people believe, Medicare and private health insurance programs do not pay for the majority of long-term care services that most people need - help with personal care such as dressing or using the bathroom independently. Planning is essential for you to be able to get the care you might need.

With the Deficit Reduction Act of 2005, the federal government sent a clear message to Americans — paying for long-term care is your responsibility.

The Act made it more difficult to qualify for Medicaid paid long-term care. It also expanded the Partnership Program.

A Partnership Program is a collaboration or “partnership” among a state government, the private insurance companies selling long-term care insurance in that state, and state residents who buy long-term care Partnership policies.

The purpose of the Maryland and Virginia’s Long-Term Care Insurance Partnership program is to make the purchase of short term more comprehensive long-term care insurance meaningful by linking these special policies (called Partnership qualified policies) with Medicaid for those who continue to require care.

Partnership qualified policies must meet special requirements that can differ somewhat from state to state. Most states require Partnership policies to offer comprehensive benefits (cover institutional and home services), be Tax Qualified, provide certain specific consumer protections, and include state specific provisions for inflation.
protection. Often the only difference between a partnership qualified policy and other long-term care insurance policies sold in a state is the amount and type of inflation protection required by the state.

Income & Asset Protection

A Maryland and Virginia’s Partnership for Long-Term Care qualified policy provides you, as the purchaser, with the right to apply for Medicaid under modified eligibility rules that include a special feature called an ‘asset disregard’. This allows you to keep assets that would otherwise not be allowed if you need to apply, and qualify, for Medicaid in order to receive additional long-term care services. The amount of assets Medicaid will disregard is equal to the amount of the benefits you actually receive under your long term care Partnership qualified policy.

Since these policies must include inflation protection, the amount of the benefits you receive can be higher than the amount of insurance protection you originally purchased. If you have a Partnership-qualified long term care insurance policy and receive $200,000 in benefits, you can apply for Medicaid and, if eligible, retain $200,000 worth of assets over and above the State’s Medicaid asset threshold. In most states the asset threshold is $2,000 for a single person. Asset thresholds for married couples are typically more generous.

The following is an example of how a Partnership for Long-Term Care Qualified policy works in the states of Maryland and Virginia. Let's say William purchases a Maryland Partnership for Long-Term Care policy with a value of $200,000. Some years later he receives benefits under that policy up to the policy’s lifetime maximum coverage (adjusted for inflation) equaling $250,000. William eventually requires more long-term care services, and applies for Medicaid. If William's policy was not a Partnership-qualified policy, in order to qualify for Medicaid, he would be entitled to keep only $2,000 in assets. He would have to spend down any assets over and above this amount. However, because William bought a Partnership-qualified policy, if he needs to apply for Medicaid and is deemed eligible, he can keep $252,000 in assets and
the State will not recover those funds after his death. However, any assets William has over and above the $252,000 would have to be spent in order for him to be eligible for Medicaid. For a couple the exempt amounts would be more.

Unfunded Liability

Long-term care is one of the largest unfunded liabilities facing families and our government today. Recent legislative underscores the government’s support for the idea that private insurance must assume the lead in providing for Americans’ long-term care. Yet, many of the 78 million Baby Boomers who are fast heading into retirement have not planned for their future long-term care.

In addition, many retirees who once thought they could afford to self-insure long-term care expenses are facing the need to protect their shrinking assets in a down market making it much more difficult to self-insure these expenses.

Long-Term Care Partnership Policies

Partnership for Long-Term Care qualified policies are designed to preserve your independence, quality of life and protect assets. Partnership long-term care policies offer the same benefits and options as non-Partnership policies and cost the same as non-Partnership policies.

Maryland and Virginia’s Partnership for Long-Term Care policy benefits include:
• Daily or monthly benefit
• Choice of elimination period or deductible
• Comprehensive coverage, including home, adult day care and facility coverage
• Benefit period (pool of money)
• Discounts
One factor that distinguishes a partnership policy from a non-partnership policy is the mandatory age appropriate inflation protection. This automatically increases your benefits to keep up with the increased cost of care. Partnership policies must provide inflation protection at issue as follows:

60 and younger: automatic compound inflation
61–75: any inflation protection (compound, simple, CPI)
76 and older: inflation protection is discretionary

The Guaranteed Purchase Option or Future Purchase Option inflation benefit offered by many carriers, also referred to as GPO or FPO, does not qualify as an inflation option under the Partnership as this type of inflation protection is considered optional since the insured can opt not to exercise it.

Policy Underwriting

Residents of both Maryland and Virginia must qualify medically for a Partnership for Long-Term Care policy just as they would for traditional long-term care insurance. The younger you are, the better the chance to qualify at favorable rates and lower premium.

**Virginia’s long-term care insurance partnership program**

Agent’s long-term care partnership training requirements. Insurance agents must not sell partnership policies unless they have a health license and have completed an initial (8) hour training and an ongoing training every 24 months thereafter.

All Partnership Policies must meet all the applicable requirements of the National Association of Insurance Commissioners’ insurance model act and model regulations.
Partnership policies must meet consumers inflation protection requirements listed on page 64.

Partnership policies must not be sold or issued unless filed with and approved by the Virginia Insurance Commissioner.

Insurers selling partnership policies shall obtain verification from their agents that they have received the proper training to sell, solicit or negotiate the insurers’ partnership policies.

Insurance companies selling partnership policies shall provide to the United States Secretary of Health and Human Services total amount paid in claims, the number of policies terminated and dates of termination, and any other information the Secretary determines may be appropriate.
What is a Medigap Policy?

A Medigap policy is a health insurance policy sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage.

There are 10 standardized Medigap plans called “A” through “N.” The front of a Medigap policy must clearly identify it as “Medicare Supplement Insurance.” Each plan A through N has a different set of benefits. Plan A covers only the basic (core) benefits. These basic benefits are included in all the Plans, A through J, Plan J offers the most benefits.

When consumers purchase a Medigap policy, they pay a premium to the insurance company. As long as they pay their premium, a policy bought after 1990 is automatically renewed each year.

Medigap policies only help pay health care cost if the person have the original Medicare Plan. Consumers don’t need to buy a Medigap policy if they are in a Medicare + Choice plan. In fact, it is illegal for insurance agents to sell a Medigap policy if they know the client is in one of these plans.
Power of Attorney & a Living Will

After helping the client to determine which long term care policy is right for him, the insurance agent should make it clear to the client the necessity of obtaining documents that will instruct his loved ones and doctors what life-prolonging measures he wants. This may help to avoid problems in the event that he (client) can’t speak for himself.

Basically, there are two documents that will be needed: a health care power of attorney and a living will. These two documents often can be combined into one document. In some states, this document is called an advanced directive. Since state law governs matters of this nature, the document often has different names and rules.

The living will allows the client to make his wishes known about what medical treatments he wants, or does not want, and in matters, such as being in a vegetative state or terminally ill with no chance of recovery.

By addressing these matters in advance, the client may be able to make it clear what he wants and who he wants to make those important decisions. By doing so, he can save his family a great deal of difficult decision-making, stress, and self-doubt.

In Maryland, the signing of an advance directive must be witnessed by two independent individuals. This means that they can not be the client’s doctor or an heir.

The client doesn’t need a lawyer to draw up these documents. He can buy software with the documents, and some states put their forms on-line. Hospitals and nursing homes generally offer the documents during admissions. The documents can also be found on Kaplan’s group website: www.partnershipforcaring.org.
It might be worth it to the client to have a lawyer draw up the documents because the fee for this service is usually nominal, and the client can be assured the documents comply with state law.

The client should give copies of the documents to those who will need them. Lawyers often make several original copies, keeping one for themselves, one for the client’s doctor and one for the health care agent, or caregiver.

The client should keep the documents in a safe deposit box that both he and the caregiver has access. It is very important for the client to choose someone who will be mentally and emotionally able to comply with his wishes. Experts suggest that an alternate health care agent or caregiver be named, in case the first choice can’t make the decisions.
GLOSSARY

**Accelerated Death Benefit** - A feature of a life insurance policy that lets you use some of the policy’s death benefit prior to death.

**Activities of Daily Living (ADLs)** - Everyday functions and activities individuals usually do without help. ADL functions include bathing, continence, dressing, eating, toileting, and transferring. Many policies use the inability to do a certain number of ADLs (such as 2 of 6) to decide when to pay benefits.

**Adult Day Care** - Care during the day for adults, usually at senior or community centers.

**Alzheimer’s Disease** - A progressive, degenerative form of dementia that causes severe intellectual deterioration.

**Assisted Living Facility** - A residential living arrangement that provides individualized personal care and health services for people who require assistance with activities of daily living.

**Benefit Triggers** - Term used by insurance companies to describe when to pay benefits.

**Care Management Services** - Services in which a professional, typically a nurse or social worker, may arrange, monitor, or coordinate long-term care services.

**Cash Surrender Value** - The amount of money you may be entitled to receive from the insurance company when you terminate a life insurance or annuity policy. The amount of cash value will be
determined as stated in the policy.

**Chronic Illness** - An illness with one or more of the following characteristics: permanency, residual disability, requires rehabilitation training, or requires a long period of supervision, observation, or care.

**Cognitive Impairment** - A deficiency in a person’s short- or long-term memory; orientation as to person, place and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

**Community-Based Services** - Services designed to help older people stay independent and in their own homes.

**Custodial Care** (Personal Care) - Care to help individuals meet personal needs such as bathing, dressing, and eating. Care may be provided by someone without professional training.

**Daily Benefit** - The amount of insurance benefit in dollars a person chooses to buy for long-term care expenses.

**Dementia** - Deterioration of intellectual faculties due to a disorder of the brain.

**Elimination Period** - A type of deductible; the length of time the individual must pay for covered services before the insurance company will begin to make payments. The longer the elimination period in a policy, the lower the premium.

**Guaranteed Renewable** - When a policy cannot be cancelled and must be renewed when it expires unless benefits have been exhausted. The company cannot change the coverage or refuse to renew the coverage for other than nonpayment of premiums (including health conditions and/or marital or employment status).

**Health Insurance Portability and Accountability Act (HIPAA)** - Federal health insurance legislation passed in 1996 that allows, under specified conditions, long-term care insurance policies to be qualified for certain tax benefits.
**Home Health Care** - Services for occupational, physical, respiratory, speech therapy, or nursing care. Also included are medical, social worker, home health aide, and homemaker services.

**Homemaker Services** - Household services done by someone other than yourself because you’re unable to do them.

**Inflation Protection** - A policy option that provides for increases in benefit levels to help pay for expected increases in the costs of long-term care services.

**Lapse** - Termination of a policy when a renewal premium is not paid.

**Medicaid** - A joint federal/state program that pays for health care services for those with low incomes or very high medical bills relative to income and assets.

**Medicare** - The federal program providing hospital and medical insurance to people aged 65 or older and to certain ill or disabled persons. Benefits for nursing home and home health services are limited.

**Medicare Supplement Insurance** - A private insurance policy that covers many of the gaps in Medicare coverage.

**National Association of Insurance Commissioners (NAIC)** - Membership organization of insurance commissioners. One of its goals is to promote uniformity of state regulation and legislation related to insurance.

**Noncancellable Policies** - Insurance contract that cannot be cancelled and the rates cannot be changed by the insurance company.

**Nonforfeiture Benefits** - A policy feature that returns at least part of the premiums to you if you cancel your policy or let it lapse.
**Pre-existing Condition** - Illnesses or disability for which you were treated or advised within a time period before applying for a life or health insurance policy.

**Rescind** - When the insurance company voids (cancels) a policy.

**Respite Care** - Offers a few hours to several days of help to relieve family caregivers.

**Rider** - Addition to an insurance policy that changes the provisions of the policy.

**Spend Down** - A requirement that an individual use up most of his or her income and assets to meet Medicaid eligibility requirements.

**State Health Insurance Assistance Program** - Federally funded program to train volunteers to provide counseling on the insurance needs of senior citizens. See pages 31-37 for a list of State Health Insurance Assistance Programs (SHIP).

**Substantial Assistance** - Means hands-on or stand-by help required to do ADLs.

**Substantial Supervision** - The presence of a person directing and watching over another who has a cognitive impairment.

**Tax-Qualified Long-Term Care Insurance Policy** - A policy that conforms to certain standards in federal law and offers certain federal tax advantages.

**Term Life Insurance** - Covers a person for a period of one or more years. It pays a death benefit only if you die during that term. It generally does not build cash value.

**Third Party Notice** - A benefit that lets you name someone who the insurance company would notify if your coverage is about to end due to lack of premium payment. This can be a relative, friend, or
professional such as a lawyer or accountant, for example.

**Underwriting** - The process of examining, accepting, or rejecting insurance risks, and classifying those selected, in order to charge the proper premium for each.

**Universal Life Insurance** - A kind of flexible policy that lets you vary your premium payments and adjust the face amount of your coverage.

**Waiver of Premium** - A provision in an insurance policy that relieves the insured of paying the premiums while receiving benefits.

**Whole Life Insurance** - Policies that build a cash value and cover a person for as long as he or she lives if premiums continue to he paid.