Protect Your Assets From The Catastrophic Costs of Nursing Home Care

Vijay Fadia

- **Medicare**
- **Medicaid**
- **Nursing Homes**
- **Medigap and Long-Term Care Insurance**
- **Living Will and Durable Power of Attorney**

IMPORTANT

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Introduction 1

America is getting older. The news should not come as a shock. General improvement in the health of Americans across all strata of our society and tremendous strides in medical technology have made it possible for people to live well into their 80's. The group over age 85 is now the fastest-growing segment of the population. As people are living longer, and are able to function vigorously in their retirement years, their need for medical care has gone up proportionately.

Hard Statistics

The odds of entering a nursing home, and staying for longer periods, increase with age. Statistics show that, at any given time, 22 percent of those age 85 and older are in a nursing home. Because women generally outlive men by several years, they face a 50 percent greater likelihood than men of entering a home after age 65. While the stay in the nursing home for many people is short, lasting only a few weeks, a good number of them are likely to spend two, three or five years.

You may never need a nursing home. But if you live long, odds of your entering a nursing home either for a short duration or lengthy, perhaps permanent stay, go up likewise.

Nursing home care can be very expensive. As a national average, a year in a nursing home now costs between $25,000 and $30,000. In some regions, it can cost as much as $50,000.

Who pays for your nursing home stay? In nearly half the cases, the answer is you. It is not uncommon for a couple or a single person who is forced to enter a nursing home to spend their entire life savings on nursing home care within the span of only a few months. Half of all couples with one spouse in a nursing home lose their life savings within only one year. It is tragic to see these people work hard all through the years, building a nest egg for their golden years, only to have everything taken away by a nursing home. There is absolutely nothing left to show for their years of earnest labor.

Medicaid

But isn't this where our social programs such as Medicare and Medicaid are supposed to come to the rescue, you ask. Unfortunately, the answer unnervingly is negative. Medicare covers nursing home care for acute illness, rehabilitation and therapy, but not custodial care, the type of care most nursing home patients require. As an alternative, you can buy private, long-term care insurance policy, but in most cases such insurance policies are very restrictive and expensive. Medicaid will help with the costs of long-term nursing home care if you are at least 65, blind or disabled and meet certain income and asset limitations. And therein lies the rub. In most cases, you'll be required to turn over most of your life savings to the nursing home to pay its bills before Medicaid will pay a cent.

In most states you can become eligible for Medicaid in one of three ways:

Recipients of Supplement Security Income (SSI) payments are eligible for Medicaid;

Recipients of cash grant payments under one of several pro-

grams, such as Aid to Families with Dependent Children (AFDC) are eligible for Medicaid;

Extended institutional patients in nursing homes or hospitals meeting certain requirements are eligible for Medicaid.

We are primarily interested in the third type of eligibility.

In this book we'll closely look at Medicare (although it doesn't help you much with your nursing home costs), how you can avail yourself of its many not-insignificant benefits; Medicaid and its stringent income and asset guidelines; and above all, how you can legally protect your life savings from the clutches of a nursing home by using strategies and tactics that have made nursing home planning a fertile field for many a lawyers.

Along the way, we'll also look at long-term care and private insurance, including Medigap, and how you should go about selecting a nursing home, should a need arise.

What Does Medicaid Cover?

Medicaid coverage varies significantly from state to state, within the guidelines established by the federal government. All states are required to provide "core" coverage for a variety of services, including inpatient and outpatient hospital services, laboratory and X-ray services in or out of a hospital, skilled care in a nursing home once certain income and asset criteria are met, physicians' and some dentists' services, home health care, medical supplies and appliances, physical and occupational therapy, and speech pathology and audiology services. Many states also include coverage for services for chiropractors, elderly couple by making them become optometrist and podiatrists, dental care including dentures, prosthetic devices, eyeglasses, prescription drugs, and private nurses in a hospital, nursing home or at home. In addition, all states must pay the transportation costs of Medicaid recipients for travel to and from their health care providers. In some states, Medicaid also provides adult day-care services, home-delivered meals, respite care and hospice care for the terminally ill.

In short, even the "core" coverage provided by Medicaid is substantially greater than that offered to Medicare subscribers, and in many cases it exceeds the coverage provided by Medicare supplement insurance. In most states, Medicaid beneficiaries receive virtually ally medical goods and services, even incidental ones, free of charge.

Federal Spousal Impoverishment 2

The Law

Federal law (Section 1924 of the Social Security Act) protects against the impoverishment of a married person resulting from his or her spouse entering a nursing home. This provision is called Federal Spousal Impoverishment. Within certain limitations, it protects both the income and resources of a person whose spouse requires nursing home care.

Federal spousal impoverishment applies when one spouse is in a nursing home and the other spouse remains in the community. The spouse in the nursing home is called the institutional spouse and the spouse at home is called the community spouse.

Federal spousal impoverishment provisions may affect a couple even before a Medicaid application is filed for the institutional spouse. This is because of the resources assessment requirement. The federal law requires the nursing home to advise all new admissions who are married and their families that resources assessments are available from the Department of Health and Welfare upon request. A timely resources assessment may help to shorten the application process. The best time to ask for a resources assessment is at the time the institutional spouse enters the nursing home.

Resources Assessment

What is the resources assessment?

The resources assessment is an evaluation of all resources (assets) owned by the couple as of the date one spouse enters a nursing home for at least thirty days. Resources owned by the couple includes community property as well as the separate property of each spouse.

"Snapshot"

The resources assessment is a "snapshot" of everything the couple owns on the date one spouse enters a nursing home. This "snapshot" is used to figure what is called the spousal share. The spousal share is one-half the total resources owned by the couple. In 1993, up to $70,740 of the spousal share is protected for the community spouse. If the couple owns $25,000 in resources, the spousal share is $12,500 - exactly one-half of the total. If the couple owns resources worth $100,000, the spousal share is $50,000. If the couple owns resources worth $150,000, the spousal share is $75,000; however, $70,740 is the maximum protected for the community spouse. This maximum increases each January as the Consumer Price Index increases.

The resources assessment is also used to figure Medicaid eligibility of the institutional spouse if a Medicaid application is filed.

What are resources?

Resources are things the couple owns. Cash on hand, bank account, stocks, bonds, real property other than their home, vehicles, life insurance and similar real and personal property are all examples of resources. Some resources are not counted. The resources which are not counted include the home the couple lives in, the value of

household goods and personal effects, one car, life insurance if the total face value is under $1,500 for each spouse, up to $1,500 set aside for burial for each spouse and some other items. The Department of Health and Welfare can answer questions about what kinds of resources are countable and what kinds are excluded from being counted toward the resources limit.

Example A couple owns a home worth $50,000, bank accounts totaling $15,000, and stocks worth $20,000. The home is not counted toward the total because the community spouse lives there. This leaves the bank accounts and the stock which total $35,000. The amount of the couple's resources used to figure the spousal share for the community spouse and Medicaid eligibility for the institutional spouse is $35,000.

What is the resources limit?

For Medicaid eligibility, an individual's countable resources cannot be worth more than $2,000. Any excess over $2,000 makes him or her ineligible for Medicaid. If resources are spent down to the $2,000 limit and all other Medicaid eligibility factors are met, the individual qualifies for Medicaid. The Department of Health and Welfare will provide information about Medicaid eligibility requirements in general.

Who must have a resources assessment?

A married person who begins a continuous period of institutionalization in a nursing home on or after September 30, 1989, must have a resources assessment as a condition of eligibility for Medicaid. Resources of a married person who is already in the nursing home on September 30, 1989, are also evaluated but not under the same conditions as the resources assessment for a person admitted Septem-

ber 30, 1989, or later.

Example A married person is admitted to a nursing home on September 30, 1989. A resources assessment is required as a condition of eligibility for Medicaid. The assessment may be done as early as the date of admission even if there is no Medicaid application filed for months or even years. In any case, the assessment goes back to the date of admission, regardless of changes in resources since that date.

Example An institutional spouse was admitted on July 14, 1989. He will not have a resources assessment even if he does not apply for Medicaid until after September 30, 1989. (His resources will, however, be evaluated to determine how much he owns should he apply for Medicaid.) If he leaves and is re-admitted after September 30, 1989, a resources assessment is needed.

When should the resources assessment be requested?

A resources assessment is not required for all married nursing home residents, only for those who may some day need help from Medicaid. It is to the couple's advantage to request a resources assessment as soon as the institutional spouse is admitted, if there is a possibility they may someday wish to apply for Medicaid help with the cost of nursing home care. The Department does a resources assessment and a trial determination of resources eligibility at the couple's request, whether or not they plan to apply for Medicaid right away. The information the Department needs to make the assessment is much easier for the couple to provide if an assessment is requested as soon as possible after the date the institutional spouse is admitted. This date of entry is the critical date for the resources assessment, not the date of a Medicaid application.

What is the "continuous period of institutionalization"?

The resources assessment takes into account all resources owned by the couple as of the date the institutional spouse begins the first continuous period of institutionalization on or after September 30, 1989. The date of institutionalization is used regardless of changes in the amount of the couple's resources after the date and regardless of when a Medicaid application is filed for the institutional spouse.

A "continuous period of institutionalization" is a period of time when:

1. A person enters a nursing home; and

2. Continues or is likely to remain in the nursing home and receive services for at least thirty consecutive days.

How is the resources assessment used?

The resources assessment is used to calculate the spousal share. The spousal share is used to calculate the amount of the couple's resources protected for the community spouse. The spousal share also affects Medicaid eligibility of the institutional spouse. The spousal share is one-half of the couple's total resources. The maximum amount of the couple's resources that may be protected for the community spouse is $70,740 in 1993. (Amount increases annually).

Example A couple owns resources of $80,000. The spousal share is one-half of $80,000, or $40,000. The amount protected for the community spouse is $40,000. A couple owns resources of $200,000. The spousal share is $100,000, however only the maximum of

$70,740 (1993 limit) may be protected for the community spouse.

The amount of resources protected for the community spouse may be higher than the maximum. For example, where resources are producing income for the community spouse and a Department hearing officer or court has ordered that a higher amount of resources needs to be protected to provide enough income to the community spouse, the amount of resources the hearing officer or the court orders protected is used in place of the maximum.

Minimum spousal share

The minimum amount protected for community spouse is $14,200 (1993 minimum).

Example A couple has resources of $10,000. The spousal share is $13,800, the minimum spousal share.

A couple whose total combined resources are $28,400 or less, is entitled to the minimum spousal share. The spousal share can be higher than the minimum ordered by a court.

The 1993 minimum ($14,200) and the maximum ($70,740) increase annually each January according to the percentage increase in the Consumer Price Index (CPI).

Spousal share does not change

Once the spousal share has been calculated, changes in the amount or ownership of the couple's resources will not change the spousal share.

Example The spousal share is $50,000 for someone whose spouse entered a nursing home on October 5, 1989. A Medicaid application

is filed in March, 1993. The spousal share remains $50,000.

The spousal share changes only where the annual increase in the maximum spousal share affects the couple. Not all couples are affected by the annual increase in the maximum spousal share; only those whose resources are more than twice the current spousal share maximum.

These are more examples of the spousal share:

- Couple owns total combined resources of $150,000. The spousal share is $75,000. Of this amount, $70,740 may be protected for the community spouse.
- Couple owns a total of $10,000. The spousal share is $10,000. Even though one-half of $10,000 is $5,000, the couple is entitled to the minimum spousal share of $14,200. Where the couple's total combined resources are worth less than the minimum spousal share, the entire amount may be protected for the community spouse.
- Couple owns a total of $40,000. The spousal share is $20,000. $20,000 is more than the minimum and less than the maximum so $20,000 is protected for the community spouse.

What information is needed for the resources assessment?

To do a resources assessment, the Department of Health and Welfare needs information about everything the couple owns and what it is worth. At the time the assessment is requested, the couple or a person acting for them is asked to fill out a form listing the types of things they own and how much those items are worth. Any intentional false statements, deliberate omissions or misleading information may result in civil or criminal penalties against the person providing the false or misleading information.

The couple is also asked to provide proof of the value of their resources. Any questions about what is acceptable proof will be answered by Department eligibility staff.

If the institutional spouse is applying for Medicaid, the regular Medicaid application form is used by the couple to report resources. If a Medicaid application is not filed at the time the resources assessment is requested, a form called the "Medicaid Resources Declaration for Couples Assessment " is used. A supply of this form will be provided to each nursing home. When the resources assessment is completed, the couple is asked to sign a statement, under penalty of perjury, listing the type and value of each of their countable resources as of the date the institutional spouse began his or her stay in the nursing home. The information is used to compute the amount of the couple's resources the community spouse needs and the amount of the institutional spouse's resources counted against the Medicaid resources limit.

What is the Community Spouse Resources Allowance (CSRA)?

The Community Spouse Resources Allowance or CSRA is the amount of the couple's total combined resources protected for the community spouse. The CSRA equals the spousal share when the spousal share is less than the maximum spousal share and more than the minimum spousal share. If the community spouse owns less than the CSRA, the institutional spouse to make up the shortfall.

The amount transferred to the community spouse is no longer counted as resources of the institutional spouse. As a result, the institutional spouse will have fewer resources to count against the $2,000 Medicaid resources limit.

NOTE: Effective Jan. 1, 1994, the community spouse resource

allowance (CSRA) is $72,660, the maximum spousal income allocation/minimum monthly maintenance need allowance (MMMNA) is $1,817 per month. Contact your state agency for further details.

This is how the CSRA is computed:

1. A couple has total countable resources of $30,000. Of this total each spouse owns $15,000. The spousal share is $15,000, one-half the $30,000 total. The $15,000 spousal share is the CSRA for the community spouse.

2. If the institutional spouse owns $20,000 of the total $30,000 and the community spouse owns $10,000, the community spouse's ownership falls short of the $15,000 spousal share by $5,000. The institutional spouse may transfer $5,000 of his ownership to the community spouse, leaving the institutional spouse with $15,000. The institutional spouse does not qualify for Medicaid yet because his or her resources are considerably higher than the Medicaid resources limit of $2,000.

3. The couple owns resources worth $7,000. The spousal share is the $14,200 minimum. Each spouse owns $3,500, one-half the couple's total resources. The institutional spouse may transfer his or her entire share of the couple's resources to the community spouse or could transfer just enough to bring his or her resources down to the Medicaid resources limit. In this example, he or she may transfer the difference between the $2,000 Medicaid resources limit and $3,500 and would meet the Medicaid resources limit. The amount that may be transferred to the community spouse is the Resource Transfer Allowance (RTA).

What happens if resources change (increase or decrease) between the date the institutional spouse entered the nursing home and the Medicaid application date?

Changes in resources after the date of entry do not change the spousal share but may affect the CSRA and the amount of resources which may be transferred to the community spouse. If resources decrease, it is likely more may be transferred to bring the community spouse up to the CSRA because he or she has fewer resources. If resources increase, it is likely the couple must use up more of their resources before the institutional spouse meets the Medicaid resources limit.

Example The couple owns $70,000 in resources when one spouse enters the nursing home. The spousal share for the community spouse is $35,000 (one-half of $70,000). The spousal share is also the CSRA since the spousal share is more than the minimum and less than the maximum spousal share.

Two years later the couple files a Medicaid application. At that time, the couple's resources are spent down to a total of $30,000. The community spouse owns only $15,000. The CSRA, the amount protected for the community spouse, is $35,000. The institutional spouse may now transfer up to $20,000, the RTA, to the community spouse to bring her resources up to the $35,000 CSRA computed at the time the institutional spouse was admitted to the nursing home.

Example The couple owned $50,000 in resources when the institutional spouse entered the nursing home. The CSRA is $25,000 of the $50,000 total, the institutional spouse owned $30,000 and the community spouse owned $20,000. The RTA is $5,000, the difference between the $25,000 CSRA and the $20,000 resources owned by the community spouse.

A year later when a Medicaid application is filed, the community spouse has received an additional resource and now owns $40,000 in resources. The CSRA is still $25,000. Because the community spouse now owns more than the spousal share, there is no RTA.

How can ownership of resources be transferred?

Generally property transfers between spouses are effected by means of a marriage settlement agreement. The Department has marriage settlement agreement forms available; however, the Department's form is not the only acceptable version. To be valid, transfer of real property (land, buildings) by a marriage settlement agreement must be recorded in the county where the property is situated. Transfer of personal property through a marriage settlement agreement must be notarized but need not be filed with the county recorder. If the institutional spouse transfers more than the amount computed as the Resources Transfer Allowance (RTA), any excess over the RTA will continue to be counted as resources of the institutional spouse.

Where the institutional spouse has decided to transfer property to the community spouse, he or she must sign a statement of intent to transfer the property. There is a thirty-day "protected period" during which the transfer must be completed. If otherwise eligible for Medicaid, the institutional spouse receives benefits during the protected period so long as a statement of intent to transfer has been signed.

If the community spouse then transfers the property to another person, instead of using it to meet his or her needs, the institutional spouse may lose Medicaid coverage for the cost of nursing home care.

What happens if the property is transferred to someone other than the community spouse?

Transfer of property, including a home, to a person other than the community spouse can result in loss of Medicaid benefits for up to thirty months (may be longer under the new law) unless the institutional spouse receives compensation equal to the value of the transferred property. The length of the penalty depends on the value of the transferred property and how much, if anything, was received in return for the property.

The Department of Health and Welfare will answer questions about property transfer.

SOURCE: Department of Health and Welfare

HELP WITH NURSING HOME COSTS

COUNTING THE RESOURCES

HOW WE COUNT YOUR RESOURCES This explains how we count your resources for Medicaid eligibility if you entered a nursing home on or after September 30, 1989, you are currently living in a nursing home, and your husband or wife lives at home.

To qualify for Medicaid in a nursing home, your resources (things you own) must be worth $2,000 or less.

RESOURCES are things you own including cash, savings and checking accounts, certificates of deposit, stocks, bonds, mutual fund shares, promissory notes and other contracts, cars and real estate. Community resources are those owned by both spouses. Separate resources are those owned solely by one spouse. Combined resources are community and separate resources of both spouses added together.

Some items do not count toward the $2,000 maximum resources limit, including:

- Your home, so long as your spouse continues to live there;
- One car;
- Your household goods and personal effects, including one wedding ring and one engagement ring;
- Cash value of life insurance, if the face value on all the person' policies is not over $1,500; and
- Burial plots, and up to $1,500 earmarked for burial are excluded for each spouse.

IMPORTANT DATES Two dates are very important for your resource eligibility: the date you enter the nursing home and the date you apply for Medicaid help with your nursing home costs.

ASSESSMENT We must assess the value of your combined resources as of the date you entered the nursing home and as of the date you apply for Medicaid. This means we will need proof of what you and your spouse own and the value of each item on each of these dates.

RESOURCES PROTECTED FOR YOUR SPOUSE AT HOME Part of your combined resources may be protected for your spouse at home. The amount protected for your spouse depends on the value of your combined resources as of the date you entered the nursing home. Your Medicaid eligibility depends on the value of your combined resources as of the first day of the month you apply for Medicaid. These two dates may be days, months or even years apart.

IMPORTANT

IF YOU THINK YOU MAY SOMEDAY NEED HELP FROM MEDICAID, ASK FOR A RESOURCE ASSESSMENT BY YOUR LOCAL HEALTH AND WELFARE OFFICES AS SOON AS POSSIBLE AFTER YOU ENTER A NURSING HOME.

Specific rules determine the amount of resources protected for your spouse. In 1993, the maximum amount of resources that may be protected for a spouse at home is $70,740. The minimum amount protected is $14,200. Resources that exceed the protected amount count toward the $2,000 Medicaid resource limit, regardless of which spouse may own them.

- If you or your spouse own more than $28,400 but less than $141,480, one-half of your combined resources are protected for your spouse. The rest is counted toward the $2,000 Medicaid resource limit.
- If you and your spouse own less than $28,400, the amount protected for your spouse at home is $14,200. The rest is counted toward the resource limit.
- If you and your spouse own more than $141,480, then $70,740 is protected for the spouse at home and everything over $70,740 counts toward the resource limit.

Example

- You and your spouse own $50,000 in countable resources when you enter the nursing home. Of this, one-half or $25,000, is protected for your spouse at home.
- You and your spouse own $10,000 in countable resources when you enter the nursing home. All of your resources may be protected for your spouse at home. You and your spouse own $200,000 in countable resources when you enter the nursing home. Of this, $70,740 is protected for your spouse.

The amount protected for the spouse at home may be increased if you prove through a Department hearing that the spouse at home needs a larger share of the couple's resources to increase his or her income up to the minimum Community Spouse Allowance.

TRANSFERRING EXCESS RESOURCES Your spouse may own less than the amount of resources protected for him or her under the rules. If so, you may need to legally transfer part of your resources to your spouse to qualify for Medicaid. You may wish to obtain legal advice before you transfer any resources to your spouse. Legal aid services are available in most communities. Your Eligibility Exam-

iner will tell you how much may be transferred but cannot give you legal advice.

IF YOU HAVE ANY QUESTIONS ABOUT HOW WE COUNT YOUR RESOURCES, CONTACT YOUR LOCAL HEALTH AND WELFARE OFFICE AND ASK TO SPEAK TO AN ELIGIBILITY EXAMINER.

HELP WITH NURSING HOME COSTS

COUNTING THE INCOME

HOW WE COUNT YOUR INCOME This explains how we count your income for Medicaid eligibility if you are in a nursing home and have a husband or wife living at home.

INCOME is money you receive. Income includes Social Security, Supplemental Security Income, interest from bank accounts and investments, retirement and other pensions, annuities, wages and other types of money.

To qualify for Medicaid in a nursing home, the money you receive each month must be within certain dollar limits.

For 1993, the maximum monthly income for Medicaid help with nursing home costs is $1,302. Income you receive in your name is counted toward this limit. Income your spouse receives in his or her name is not counted. This is known as the "name on the check" method. If you receive income in both you and your spouse's names, half of the money is counted for each of you.

If you have too much income to qualify using this "name on the check" method, then we use another method. This method counts your share of ownership in the total income of you and your spouse. One-half of your and your spouse's combined community income plus your separate income, if any, is counted toward the income limit. "Community income" is income that belongs to you and your spouse. Separate income is income that belongs solely to you or solely to your spouse.

IF YOU ARE ELIGIBLE FOR MEDICAID After you are found eligible for Medicaid, you must pay part of the cost of your nursing home. This is called your patient liability. Medicaid will pay to the nursing home the difference between your patient liability and the cost of care, up to the maximum Medicaid can pay for nursing home care.

EXCEPT:

You may keep the first $30 of your income for your personal needs in the nursing home.

AND

Part of your income may be used by your spouse at home to meet his or her living expenses.

The rest of your income is payable to the nursing home.

INCOME PROTECTED FOR YOUR SPOUSE AT HOME Some of your income may be used by your spouse at home. This income will not be counted when we calculate the amount you must pay toward your care in the nursing home. The amount of your income that can be used by your spouse is the Community Spouse Allowance (CSA). This is how we calculate the CSA:

How We Calculate the Community Spouse Allowance

1. Add spouse's rent or mortgage payment (plus homeowner's insurance, property taxes) to $153 utility standard. This is the Shelter cost.	Step 1	Spouse's Rent Utility Standard Shelter Cost	 + =	
2. Subtract the $345 shelter standard from the Shelter Cost. This is the Shelter Adjustment.	Step 2	Less Shelter Standard Shelter Adjustment	- =	$345.00
3. Add the Shelter Adjustment to $1.149. This is the Living Allowance.	Step 3	Minimum Living Allowance Living Allowance	+ =	$1,149.00
4. Total spouse's income. This is Spouse Income.	Step 4	Less Spouse's Income	-	
5. Subtract Spouse Income from Living Allowance. This is the Community Spouse Allowance	Step 5	Community Spouse Allowance	=	$

The CSA can be higher than the calculation if you or your spouse prove your spouse needs more to live on. You need to request a hearing if you believe the CSA we calculate is too low.

The amount you pay your spouse, up to the Community Spouse Allowance calculated above, is not counted toward your patient liability.

IF YOU HAVE ANY QUESTIONS ABOUT HOW WE COUNT YOUR INCOME FOR ELIGIBILITY OR PATIENT LIABILITY, CONTACT YOUR LOCAL HEALTH AND WELFARE OFFICE AND ASK TO SPEAK TO AN ELIGIBILITY EXAMINER.

How to Transfer Assets Without Being Penalized 3

A federal government agency for health care, policy and research figures that more than half the women and almost one-third of the men turning 65 this year will spend time in a nursing home before they die. Looking at it another way, seven out of ten couples now reaching 65 can expect at least one partner to be institutionalized in a nursing home sometime before dying. Potential costs of long-term nursing or custodial care constitute the single most threat to the financial welfare of most retirees. It is a matter of record that the savings of over two-thirds of current nursing home residents are totally wiped out within 24 months of their admission.

You've worked hard all your life accumulating a nest egg for the twilight years of your life. One day, you hope, your children will inherit some of these assets. But now the specter of entering a nursing home and losing to it your life's savings is haunting you.

How can you protect your assets from the catastrophic costs of entering a nursing home?

Should you transfer your assets to your children or other family members just before entering a nursing home with the understanding that they will provide for you in the event you recover sufficiently to return home? Even if you were to never return home, you would have protected you children's inheritance by the transfer. In the meantime,

Medicaid will be none the wiser and pick up the huge costs of nursing home care.

It would be safe to say that the thought has occurred to every individual about to enter a nursing home.

In this chapter we will examine the rules governing transfer of assets by a person who's about to enter a nursing home or one who's already in a nursing home, and how such a transfer would affect eligibility to receive benefits under Medicaid. Only by fully understanding them and taking appropriate steps in advance, would you be able to prevent a major portion of your assets going to pay nursing home bills.

The rules of the game have changed drastically since the passage of Revenue Reconciliation Act of 1993. A little-known provision in this massive budget document has made Medicaid attorneys and their meticulous planning almost a thing of the past.

History

Medicare Catastrophic Coverage Act of 1989 repealed prior transfer of asset provisions under both the Supplemental Security Income (SSI) and Medicaid programs. Under the new rules, SSI and Medicaid beneficiaries could make unlimited transfers of assets without losing their eligibility, with one caveat. Federal and state law imposed a penalty for transfer of assets made without receiving fair and valuable consideration by either the community or nursing home spouse. Unlike the previous provisions, the new law only applied to persons receiving nursing home services.

Here was the penalty:

Generally speaking, if a transfer that did not involve fair and valuable consideration occurred on or after July 1, 1989, the maximum penalty period was 30 months from the date of the transfer. The nursing-home spouse was deemed ineligible to receive nursing-home services during this period.

If the transfer occurred prior to July 1, 1989, the maximum penalty was 60 months from the date of the transfer. The claimant and his or her spouse were deemed ineligible for all Title XIX services.

The period of ineligibility was related directly to the cost of nursing-home services in your community and the value of assets transferred. For example, if you gave away $10,000 to your grandson on March 1, 1990 while you were a resident of a nursing home that charged $2,000 per month for its services, you were ineligible for Medicaid nursing-home coverage for 5 months, i.e., till August 1, 1990. You could still be eligible for Medicaid coverage for other services, such as dental care, prescription drugs, etc. during the penalty period.

The transfer-ineligibility rules apply to voluntary transfers of assets made for less than their fair market value. Involuntary transfers such as those made under court orders during divorce or bankruptcy proceedings will not disqualify you from receiving nursing-home benefits under Medicaid, regardless of when the transfers occurred.

The 1989 Medicare legislation that repealed the Catastrophic Coverage Act also rescinded most of the prohibition against so-called "Medicaid trusts," which were thinly-veiled legal devices designed to protect the assets of the elderly while making them eligible for Medicaid's nursing home coverage. The result was the rise of a new

industry consisting of attorneys and financial planners who specialized in drafting Medicaid trusts that met the technical requirements of the law, but whose sole purpose was to protect the assets of clients from the costs of long-term care, whether or not they were truly needy people for whom the Medicaid program was originally intended. The obvious outcome was that many middle-class and some wealthy individuals now started feeding from the same trough where only the poor were previously welcome.

The goal of all "nursing home planning" has been to shelter the assets of the elderly in the event long-term care is required. This goal is achieved in various ways by exploiting many loopholes in the Medicaid system. The principal method has been to convert "countable" assets into exempt assets which is a perfectly legal maneuver. Transfer of assets to children or relatives has been another way of protecting assets but it has its own limitations. Setting up a Medicaid trust has also been a favorite strategy of the wealthy, although this generated its own backlash in the form of a clampdown in the 1993 tax revision.

Medicaid Trusts

Since 1989 Medicaid trusts have become a big business for "elder-practice" attorneys. They have touted, and rightfully so, the benefits of Medicaid trusts in nursing-home planning. Many a book has been written on the subject. In many large cities attorneys hold "free" seminars for senior citizens to explain how the elderly can protect their assets from the ruinous costs of long-term care using various strategies, including some that involve the use of a Medicaid trust. For fees ranging from $2,000 to $5,000 these attorneys would set up a trust device that will insulate the assets from nursing homes, and reduce your resources to a level where you'd become eligible for Medicaid

in the event you were to enter a nursing home.

The practice while being perfectly within the law raises an ethical dilemma. Medicaid was never intended to be a social welfare program for those who can afford to pay their bills; it was an agency of last resort for those in true need. Many middle-class retirees who would never dream of stealing from their neighbors would transfer their assets in a deliberate move to a trust so that they become eligible for Medicaid assistance at the expense of other taxpayers.

In their corner they have many advocates, no less than the attorneys who stand to profit handsomely by rearranging their financial affairs to take advantage of the loopholes in the law. They are able to justify their nursing home planning as akin to bankruptcy planning or other legal tax avoidance planning. It is hard to find true villains in this debate, but suffice it is to say that under our system of tax planning an individual is perfectly within his right to arrange his financial affairs so as to maximize his income and minimize dissipation of his assets—as long as it's done within the law.

Under the Medicaid eligibility rules, an individual may transfer assets of any amount into an irrevocable trust in order to qualify under the income and resource guidelines of Medicaid.

Medicaid trusts are similar to "conventional" irrevocable trust agreements with specific requirements of Medicaid law and special needs of the grantor who may need long-term care. First, the trust instrument mandates that income from the trust, or trust principal if required, be used to pay the costs of long-term nursing care for up to the first 30 months, but no longer. Secondly, the trust assets are employed or invested in such a manner that "countable" income, including "outside" buildup, from the trust will not exceed Medicaid limits. In other words, assets are invested for appreciation, but not for

immediate income which may make the trustor ineligible under Medicaid's income guidelines.

The instrument may contain "springing trust" provision in which the trustor through a revocable trust agreement retains complete control over trust estate until he enters a nursing home, at which time the trust automatically becomes an irrevocable Medicaid trust.

Under the old law, if the trust was set up at least 30 months prior to entering a nursing home, the trust grantor became immediately eligible for Medicaid coverage. If the trust was set up within the 30-month window, the individual may have had to wait for nursing home coverage on the basis of assets transferred and costs of nursing home care in his community. However, in no case would he have had to wait longer than 30 months.

All this has changed now with the passage of the Revenue Reconciliation Act of 1993. In a backlash to the abuse of the Medicaid system by the not-so-needy, the law has severely curtailed the practice of setting up a Medicaid trust for the sole purpose of becoming eligible for nursing home benefits. Further, you can no longer be sure that your "waiting period" would be no more than 30 months.

Nursing Home Planning Made More Difficult

The new tax law (Revenue Reconciliation Act of 1993) has imposed stricter rules for Medicaid eligibility. The rules will make it much more difficult for the elderly to receive Medicaid assistance for nursing home care.

Under the present rules, when a person applies for

Medicaid a snap shot is taken of the person's resources as of the time of application. Current law imposes a maximum waiting period of up to 2 1/2 years between the time a person transfers assets and the time Medicaid will begin paying nursing home bills. Under the new law, the eligibility is determined by looking at any transfer of assets made within the 36 months of entering a nursing home.

Thus, if you give away $300,000 on Jan. 1, 1994 you would become eligible to receive Medicaid after Jan. 1, 1997. But if you were to enter a nursing home prior to Jan. 1, 1997, you may face a tough going. Any transfer of assets within the 36 months preceding the application for Medicaid automatically triggers a period of ineligibility. Under the old law, maximum wait was 30 months. Under the new law the ineligibility period may be anywhere from a month to several years, depending on the amount that was transferred.

The waiting period would vary from state to state, and is calculated by dividing the value of assets transferred by the state's average monthly cost of nursing home care. For example, the average nursing home cost in your area is $3,000 a month, and you gave away $300,000 within the "look-back" period of 36 months, you would have to wait 100 months or 8.3 years from the date of transfer.

The new rules crack down even harder on the use of trusts, essentially making a person ineligible to receive Medicaid payments if that person has set up a Medicaid trust within 5 years of applying for benefits. Another provision of the law would allow all the states to follow the practice of California to seize and sell the home of the Medicaid

patient after death of surviving spouse and any disabled children.

Permissible Transfers

The rule imposing penalty for transfers made without receiving fair market value consideration has a few exceptions, which would allow you to transfer certain assets, under certain circumstances without losing your eligibility for Medicaid benefits.

Exception 1 : An individual can transfer title to his or her home, whether before or after entering a nursing home, to any of the following:

(a) individual's spouse;

(b) any child who is under age 21, or who is blind or permanently and totally disabled;

(c) individual's brother or sister who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the nursing home facility, a medical institution where payment is made for the individual based upon a level of care provided in a nursing facility or to a program of home and community-based services;

(d) individual's son or daughter (other than a child who is under age 21, or who is blind or permanently and totally disabled) who (i) was residing in the individual's home for a period of at least 2 years immediately before the date of the individual's admission to a nursing facility (or one of the other services noted above); and (ii) who the state determined provided care to the individual which permitted the individual to reside at home rather than in a medical institution.

Exception 2: An individual can transfer any assets, besides his or her home, to a child under twenty-one who is blind or permanently and totally disabled.

Exception 3: The law also permits another kind of transfer. An individual, prior to entering a nursing home, may transfer any asset other than a home to a spouse or someone else for the sole benefit of the spouse, if the individual's spouse does not transfer the asset to someone else for less than fair market value. However, after entering the nursing home, the individual may transfer any other asset to the community spouse, who then may transfer the asset to someone else for less than fair market value.

NOTE: Timing is of paramount importance here. The exception delineates the time when the transfer of an asset would not run afoul of the Medicaid eligibility rules. Retransfers by the community spouse are permissible if the initial transfer was made after entering a nursing home. In short, wait until you have entered a nursing-home before transferring an asset.

Exception 4: Finally, the transfer-ineligibility rules do not apply if the individual making the transfer can satisfactorily show to the state that (a) the transfers were exclusively for some purpose other than to qualify for Medicaid; (b) the individual intended to dispose of the asset either at fair market value or for other valuable consideration; or (c) the state determines that denial of eligibility would result in an undue hardship.

Exempt Assets

The above rules regarding transfer-ineligibility from Medicaid nursing-home benefits do not apply to any exempt assets, other than your home. The following assets can be transferred without affecting your eligibility to receive Medicaid nursing-home benefits:

(a) household goods and personal effects up to a value of $2,000 (no limit on the value if the nursing-home resident is married);

(b) one wedding ring and one engagement ring regardless of value, and durable medical equipment;

(c) a motor vehicle with a current market value up to $4,500, or the entire value, if it is used to get to work, to receive medical equipment, or is specially equipped for a handicapped person (again, no limit on the value if the nursing home resident is married);

(d) property essential for self-support; personal property required for the individual's employer for work or land used to produce food for individual's own use; and income-producing property (but only up to an equity value of $6,000, if there is a return of net annual income of at least 6% of the protected equity.)

(e) life insurance policy with a face value no more than $1,500 (for policies over $1,500, only cash surrender value is considered);

(f) burial plots for the use of the person and his or her immediate family;

(g) burial funds up to $1,500 plus accrued interest kept in separately identifiable accounts.

Penalty for Impermissible Transfers

Prior to 1994, if a person entering a nursing home made an impermissible transfer in the past thirty-month period, he was ineligible for nursing home related Medicaid benefits for a period that was lesser of:

(a) 30 months, or

(b) the uncompensated value of the asset transferred divided by the average private costs of the nursing home facility, at the time of application, in the state, (or at state option, in the community in which the person is institutionalized).

In other words, the person making the impermissible transfer could be penalized for as long as 30 months. He would be ineligible to receive nursing home Medicaid benefits for this period.

The above is no longer true. The 1993 tax law, as we saw earlier, imposed a new dimension to the ineligibility period. It introduced a new concept of "look-back" period of 36 months prior to entering a nursing home. Any transfers within this "look-back" period would make you ineligible for nursing home assistance from Medicaid for a period that would be determined by dividing the value of assets transferred by the state's average monthly cost of nursing home care. You could not be sure that your maximum wait period would be 30 months, as was the case under the old law. You could become ineligible to receive Medicaid assistance for several years.

Permissible Transfers - Summary

Medicaid rules allow you to transfer certain assets under certain circumstances without losing eligibility to receive benefits. Here is a summary of such permissible transfers:

Home You can transfer your home, at any time, before or after entering a nursing home, to any of the following persons:

1. Your spouse;
2. Any child who is under 21, blind, or permanently and totally disabled;
3. Your brother or sister who has some ownership interest in your home, and who was living with you for a period of at least one year immediately before entering a nursing home facility;
4. Your son or daughter who was living in your home, for a period of at least two years immediately before your entry to a nursing home and who provided care for you that enabled you to stay at home rather than in a medical institution.

Any other assets The law allows you to transfer other assets, besides your home.

1. Before entering a nursing home, you can transfer any asset other than your home to your spouse, but only if your spouse does not transfer the asset to someone else for less than fair market value.
2. After entering a nursing home, you can transfer any asset other than your home to your spouse at home. He or she then can transfer the asset to someone else for less than fair market value.
3. You can transfer any asset other than your home to your child who is under 21, blind, and totally disabled.

Exempt assets You can transfer any exempt assets, other than your home, to anyone, at anytime. Exempt assets are:

- Household goods and personal effects up to a total value of $2,000;
- Wedding and engagement rings, and durable medical equipment;
- An automobile with a current market value of up to $4,500; no limit on the value of the car if it is used to go to work, to obtain medical treatment, or has been especially equipped for the handicapped;
- Income-producing property essential for self-support;
- Life insurance policy with a face value of no more than $1,500 or the cash surrender value, if greater than this amount;
- Burial plot, and burial funds up to $1,500 placed in a separate account.

Justifiable transfers You can transfer any asset to anyone if you can make a satisfactory showing to Medicaid:

1. that you intended to dispose of the assets at their fair market value;
2. that you transferred the assets exclusively for some purpose other than to qualify for Medicaid; or if
3. the state determines that denying you Medicaid eligibility would result in undue hardship.

Asset Protection Strategies 4

The new law has made nursing home planning difficult by plugging a couple of big loopholes in the Medicaid eligibility rules. This, however, does not mean that you have to surrender all your possessions, including your home, to the nursing home before Medicaid will step in. Many of the rules governing transfer of assets and exempt assets have not changed. Your strategies in protecting your assets from the catastrophic costs of nursing home care should be built around these rules.

Below we lay out various options available to you.

Strategy 1: Convert Non-Exempt Assets Into Exempt Assets

A Close Parallel

When it comes to protecting your assets, a parallel can be drawn between nursing home planning and bankruptcy planning. An individual contemplating the filing of a bankruptcy petition is generally advised to convert non-exempt assets into exempt assets before filing the petition. In bankruptcy law, such practice is not considered to be fraudulent and, in fact, is completely permissible and acceptable.

Congress clearly recognized the value of exempt assets to debtors and even encouraged the practice of converting non-exempt property into exempt property as a step precedent to filing the petition. The House and Senate Reports stated: "As under current law, the debtor will be permitted to convert non-exempt property into exempt property before filing a bankruptcy petition; the practice is not fraudulent as to creditors and permits the debtor to make full use of the exemptions to which he is entitled under the law."

Plans to protect your assets from nursing home costs require judicious use of just such a strategy. Converting non-exempt assets into exempt assets is probably the most effective asset protection strategy in your armor.

A nursing home resident is generally allowed to protect a total of $2,000 in assets from nursing home bills. Above and beyond this $2,000, he can protect certain assets as "exempt" assets. The exempt assets vary from state to state, and married couples have greater protection than unmarried individuals.

For an unmarried individual, his or her home (if certain conditions are met), household goods and personal effects up to a total equity value of $2,000, wedding and engagement rings, automobile (generally up to $4,500), income-producing property up to $6,000 in equity value, life insurance policy with a cash surrender value not to exceed $1,500, and burial plot and funeral costs of up to $1,500 would be exempt.

Married individuals can protect their home, household goods and furnishings, personal effects, and car without any limitation on their value. In addition, they can protect up to $6,000 in income-producing property, life insurance policies with total death benefits not to exceed $1,500, burial plots for both spouses and funeral costs in a limited

amount. The biggest difference in exempt assets between married and unmarried people is the house; the family residence is exempt as long as one spouse is living there.

Your first course of action, prior to entering a nursing home, would be to convert your non-exempt assets, such as bank accounts and CDs, into exempt assets. Obviously, your home is the best exempt asset available to you under the law. Let's see how you can protect you life savings by making a judicious use of this strategy.

Your Home

Nearly every state recognizes a person's home as an exempt asset. The law places no limit on the value of the home. For most Americans, their home is the biggest asset they own and the law considers its entire value as exempt when considering eligibility for nursing home assistance. You should make every effort to maximize the value of this exemption to you.

For married persons, the protection afforded works a little better; they are able to protect their home without regard to its value, and without any conditions. For unmarried persons, the home is protected as long as a dependent relative is living there, or the nursing home resident expresses in writing his or her intention to return to it sometime in the future. Some states require that a physician certify to the effect that the nursing home resident is likely to recover enough to return to his or her home; and some states impose a time limit of 6 months to a year within which the nursing home resident must return to his or her home in order to preserve the exempt status of the home.

Here are some of the things you can do to maximize the value of your home exemption.

1. If you don't own a home, you should consider buying one. For many people, such an investment may be too late and too demanding at this particular stage in life. But if most of your assets are liquid, such as bank checking or savings accounts, stocks and bonds, or investments in CDs, this is the time to convert them into a real property. Your bank accounts or CD assets are not protected from nursing home bills, but your home is. If it seems likely that you or your spouse would have to enter a nursing home, seriously consider buying a home. This is one time when cash in the bank is not a good idea.

2. In keeping with our strategy of maximizing the home exemption, you should pūt as much down as possible while buying your home, so that almost all your non-exempt property acquires an exempt status. If you need cash later, you'll be able to borrow against the equity in your home, generally in the form of a home equity loan or a second mortgage.

Getting saddled with a home mortgage in retirement years is not exactly the advice you'd get from most financial planners. Many elderly people actually prefer to pay cash for a home or put a large payment down. They generally do not like to be burdened with a huge mortgage, simply because they lack a steady income to service the debt. They are more apt to buy a home within their means that has no mortgage at all. Further, a home is probably the most illiquid asset you can own; therefore, if you follow this strategy, you should make provision for sufficient cash on hand for day-to-day living expenses as well as emergency needs.

3. But if you are a typical individual concerned with protecting your assets from nursing home costs, you are more likely to already

own a home. In this case, you should consider paying off the mortgage on your home or any loans you may have against the home. Again, since your entire equity is protected under the law, you should increase the equity in your home to the greatest extent possible. By paying off the mortgage, you have converted cash, a non-exempt asset, into an exempt asset.

4. If you don't have a mortgage, or if you have cash assets remaining after paying off the mortgage, you can sink money in your home by making improvements or additions to your home. Add a room to your house. Install a swimming pool. The net effect would be to increase the value of your home while turning unprotectable cash into a protectable asset.

Pointer: If you're lucky enough to own two homes, make the one more expensive your legal residence. Since the law protects only one home, you should choose the one that's more valuable.

Joint Tenancy Trap

Most married couples own their home in joint tenancy. Joint tenancy has many pitfalls, but it poses a special problem in situations where one of the spouses may be forced to enter a nursing home. Under Medicaid rules, the home remains protected from nursing home bills as long as the other spouse is alive and living there. If that spouse were to die, the nursing home spouse will become sole surviving owner of the house. In that event, the home is likely to lose its exempt status and may be sold to pay nursing home costs.

How do you avoid such a predicament?

Recommendation: To avoid losing the exempt status of your home, the spouse entering the nursing home should immediately transfer the ownership to the spouse at home. You can make such a transfer at any time, before or after entering a nursing home without losing your eligibility for Medicaid. Once, the home is transferred to the community spouse, he or she should place it in a trust naming children or other individuals as beneficiaries. A simple will designating beneficiaries will also suffice. Now if the spouse at home were to die, the house will be passed on to the designated beneficiaries, and not to the nursing home spouse. By employing such a plan, you will have put your home beyond the reach of a nursing home.

You cannot wait till the last minute to do such planning. You can write a will or set up a trust only as long as you are mentally competent. Once you become incompetent, say due to Alzheimer's, you would not be able to execute any of these instruments, and the golden opportunity to plan your financial affairs would have been lost. Since you could not foretell which spouse may end up in a nursing home, your planning should take into account all contingencies.

Household Goods, Personal Effects, and Automobile

In addition to your home the law also allows you to protect household goods and personal items and an automobile. For unmarried individuals the value of these exemptions is limited to $2,000 in the case of household goods and personal items, and $4,500 in the case of an automobile. Married couples can protect an unlimited amount in these assets.

Again, you should use the strategy of converting non-exempt assets into exempt assets to maximize your protection. Granted, the nature of these assets - household goods and automobile - places a

practical limit on the total amount that can be reasonably protected. Nonetheless, you can invest substantial sums of money into these items that are, of course, needed for personal, daily living, and protect the money that otherwise would go to a nursing home.

Other Exempt Assets

You can protect your investments in wedding and engagement rings, income-producing property, a family burial plot and funeral costs up to $1,500 if kept separately. Buy a burial plot for you and your spouse, if you haven't already done so. Set aside funds for funeral costs.

It is obvious that you're not going to be able to protect a large amount of cash by buying these exempt assets. From a practical point of view, such assets give you only a limited ability to convert non-exempt assets into exempt assets. You should, however, know all the avenues open to you.

Strategy 2: Transfer of your home to your child, or brother or sister

Consider this scenario.

You are a widower, living in the home you have owned for over 25 years. Your health has been deteriorating and presently you are forced to enter a nursing home. You are hoping that your stay will be only temporary and that you'll return to your home in the not-too-distant future.

In most states, under the current Medicaid rules, your home would be protected from a nursing home, if you intend to return to your home at sometime in the future. Some states may require you to obtain a doctor's certification that you're likely to recover enough to return home. In addition, some states may impose a time limit, ranging from 6 months to a year, during which your home will be protected; if you're unable to return to your home within this period, your home may have to be sold to finance your nursing home stay.

A possibility exists, therefore, that a person's home, the single most valuable asset he or she owns, may have to be sold to pay nursing home bills. For unmarried individuals, this possibility is real, especially if the nursing home stay turns out to be long or permanent.

The question arises: Can you transfer your home to someone so as to put it beyond the reach of a nursing home?

Medicaid eligibility rules make two important exceptions that allow you to transfer your home, whether before or after entering a nursing home, either to your child or to a brother or sister, and thus protect it from a nursing home.

Exception 1: You can transfer your home, whether before or after entering a nursing home, to your child who has been living with you for a period of at least two years immediately before your admission to a nursing home facility and who provided care that enabled you to stay at home rather than in a nursing home.

Exception 2: You can transfer your home to you brother or sister who has an equity interest in the home and who has been living with you for a period of at least one year immediately before your admission to a nursing home facility.

As you can see, under the right circumstances, these two exceptions may allow you to protect your home from a nursing home. You should look at these provisions carefully and do appropriate planning.

Home No Longer a Safe Harbor

Most recipients of Medicaid assistance for nursing home have assumed that their home was a safe haven, that it was completely protected against the costs of nursing home care. At least in California, this may not be true. And many other states may soon be following California's lead.

In an aggressive attempt to shore up the shaky finances of the public agency, Medi-Cal (Medicaid in California) officials have begun to place liens on homes of the surviving spouses in an attempt to recover medical bills run up by their late spouses in nursing homes. The homes that have long been considered sacrosanct may no longer be so. State officials say they're simply plugging a legal loophole that has given married homeowners favorable treatment by allowing them to shelter a substantial asset at the expense of taxpayers.

The liens as part of the state's "estate recovery program" are being recorded on the homes of deceased Medi-Cal beneficiaries over age 65. They do not have to be paid immediately and do not force the surviving family out of their homes prematurely. The effect of the lien is to serve notice to the public that the state has a certain stake in the equity beyond the surviving spouse's share and this must be paid when the property is sold, transferred or refinanced. In the meantime, there's no interest charged on those nursing home bills that the state has already paid.

Strategy 3: Reimbursing your children for their services

Reimbursing your children for their help is another way to transfer some of your non-exempt wealth to your loved ones, without running afoul of Medicaid rules.

It is not uncommon for adult children to take care of their aged parents. The parents may need help with their finances, in running errands, with chores around the house, in going to a doctor's office, etc. If you have a child or relative who is helping you out in some such manner, you may reimburse him or her for the services rendered.

Reimbursement may take the form of cash or assets transferred. Remember, reimbursement is for valuable consideration and is fully permissible under the Medicaid transfer rules. The only requisite is that the reimbursement be reasonable and commensurate with the services rendered.

Caution: Cash payments and transfer of assets to your children or other relatives for assisting you with your daily chores is likely to draw a close scrutiny from Medicaid officials. It is best to keep these payments in line with what commercial agencies may charge, or what custodial care costs you in your community.

Strategy 4: Transfer of assets to children, relatives or friends

The new law imposes a 36-month "look-back" window in counting resources and determining eligibility for nursing home assistance. If you were to transfer your non-exempt assets to your children, relatives and friends beyond the 36-month window, your eligibility for

Medicaid would not be jeopardized. In transferring the assets, you may have an expectation or unwritten understanding with the transferee that he or she will take care of you when needed. If there's sufficient trust between the parties and you feel comfortable with such an agreement, your assets would be protected against paying nursing home costs.

There's a slight chance that Medicaid officials may view such an arrangement as a contract between the parties which has a value to the Medicaid applicant in the amount of assets transferred, and may disqualify you from receiving assistance.

Strategy 5: Transfer assets to your spouse after entering a nursing home

You can combine what we're suggesting here with what we suggested in Strategy 2 that allows you to protect your home by transferring it to a child or brother or sister under certain circumstances. For instance, you may give part ownership of your home to your brother who's living with you for his help in your daily living.

Medicaid nursing home rules provide an important loophole with regards to transfer of assets. In a nutshell, it boils down to when the actual transfer is made between the spouses. Timing is crucial, as you'll see below.

You can transfer your assets to your spouse before entering a nursing home but then he or she cannot transfer these to someone else for less than the fair market value. However, if you transfer these same assets after entering a nursing home, but before applying for Medicaid, the spouse at home can transfer the assets to someone else for less than the fair market value, and not affect your eligibility to receive

Medicaid nursing home benefits. Let's examine how such a transfer can be made so as to protect your assets from a nursing home.

Illustration: You are entering a nursing home and own $150,000 in "other" non-exempt assets, such as cash, securities, CDs, etc. After entering the nursing home you immediately transfer these assets to your spouse, who then transfers them to your child. Your spouse owns $50,000 in her own name. You then apply for Medicaid benefits.

To determine eligibility for Medicaid, both spouses' resources are pulled together, only half of which the spouse at home (the community spouse) is allowed to protect, to a maximum of $70,740 (in 1993). You as a nursing home resident, are allowed to protect assets worth $2,000. In this instance, since your combined spousal resources amount to $50,000, your spouse is allowed to protect $25,000, you are allowed to protect $2,000, and $23,000 goes to the nursing home.

The $150,000 that you transferred to your spouse after entering the nursing home, who then transferred the amount to your child, will not be taken into account; that amount remains protected.

If, however, you had transferred $150,000 a day before entering the nursing home, your spouse could not transfer these assets to your child without incurring a penalty from Medicaid. The penalty may make you ineligible to receive nursing home benefits for a period of up to 30 months.

In transferring your assets, the date of transfer plays an important role in either preserving or destroying your eligibility for Medicaid benefits. As we've seen in transfers that are permitted by rules, you can transfer any assets other than your home, after entering a nursing home, to your spouse. He or she can then transfer these assets to anyone else without affecting your eligibility. However, if you had

transferred the same assets the day before entering a nursing home, your spouse than would be prohibited from transferring these assets to any other person for less than full value.

Caution: New rules taking effect since the Revenue Reconciliation Act of 1993 make such transfers hazardous. You must consult an attorney familiar with Medicaid rules before implementing such a strategy.

Strategy 6: Buy an annuity

By annuitizing liquid assets, a portion of otherwise "countable " financial resources can be converted into largely (perhaps totally) exempt income.

You and your spouse own $140,000 in countable resources when your spouse enters the nursing home. Of this, $70,740 (in 1993) is protected for you and your spouse at home. The rest is counted toward the $2,000 Medicaid resource limit. Your spouse won't qualify for Medicaid until you've spent down almost all of his share.

You could, on the other hand, take the nearly $70,000 and buy an annuity for life that pays, say, $6,000 per year in income. This is your income and it won't be used to pay your spouse's nursing home bills. Since you have not made any transfers to a third party, no question of Medicaid ineligibility arises either. The only thing you have to watch out for is that the annuity is irrevocable and nonassignable.

Strategy 7: Set up a Medicaid trust

We already have examined the use of Medicaid trust in planning for nursing home care. It has been an invaluable tool for many people with high levels of assets which would normally be used up to pay for

nursing home bills. The new law has put an added restriction on the use of Medicaid trusts by imposing a 5-year ineligibility period. This should not, however, deter you from using trusts as essential tools for nursing home planning and estate planning in general.

When it comes to Medicaid trusts, keep in mind the following points:

1) The trust must be an irrevocable device; once set up, you'll not be permitted to make any changes or take the assets back. The revocable living trust, commonly used for probate avoidance, is of little use in this regard.

2) Neither you nor your spouse can act as trustee of the trust; it must be a third party, such as, an adult child, a friend or relative, or a bank.

3)You may get the income from the trust, but you may not get the principal.

Medicaid trusts are not for everybody. You lose control of your assets, and therefore considerable thought and legal advice must be put into planning for a Medicaid trust. But they do serve the useful purpose of protecting your assets from the costs of nursing home care. And as a collateral benefit, you would have done some valuable estate planning by removing the assets from your estate and ensuring desired distribution to your heirs.

Other Asset Protection Strategies

Amy Budish and Armond Budish in their book, *Golden Opportunities,* published by Henry Holt and Company explore many strategies directed toward protecting assets from the costs of nursing home care and making one eligible for Medicaid. Some of their strategies involve crative interpretation of Medicaid rules and require precise application, but they are worth careful consideration. As they readily admit, they are not certain if many strategies will work in all states and, of course, they advise you to consult a lawyer before taking any steps.

Below is a brief discussion of these strategies.

1. The law guarantees the community spouse a minimum amount of income which in most states is $1,149 per month. This is the community spouse's living allowance. If the spouse at home doesn't have enough income to reach the minimum, the difference generally is made up from the income of the spouse in the nursing home. Medicaid counts nursing home spouse's share of ownership in the total income of both spouses. One-half of the combined community income plus the separate income of the nursing home spouse is counted toward the income limit. In this way, you can transfer some of the excess income of the nursing home spouse (which otherwise would make him ineligible for Medicaid) to the spouse at home.

The income of the spouse-at-home can be brought up to the minimum by transferring some of the nursing home spouse's income to the spouse at home. If, however, the nursing home spouse refuses to do so, which he can legally do, the spouse at home should be allowed to keep sufficient assets to her name that will generate income to bring her to the minimum level.

2. If you have liquid assets, such as cash in a savings account or stocks and bonds, you may consider opening a joint account with your child who has the right to withdraw the entire sum in the account. Such accounts are normally called "and/or" and require signature of either one of the two parties.

If you were to enter a nursing home, your child should withdraw money from the account as he rightfully can, making you eligible for Medicaid. If the account were such that would require you "and" your child to sign to withdraw funds, the strategy may not work since Medicaid would argue that each party owns one-half of the funds.

Before employing this strategy, check with local Medicaid office; it may not be acceptable in every state.

3. In some cases, divorce may be an answer to your nursing home woes. If a couple owns considerable non-exempt property and one of the spouses has to enter a nursing home, divorce may protect the assets. An uncontested divorce that awards the spouse at home all of the non-exempt property would allow the spouse entering the nursing home apply for Medicaid without triggering any transfer-of-assets ineligibility period. This is an unpleasant scenario but may be necessary to protect the assets.

4. Under Medicaid guidelines for countable resources in determining help with nursing home costs, the maximum amount of resources that may be protected for a spouse at home is $70,740. Since resources of both spouses are pooled together, each deemed to be owning one-half of the total, shuffling assets between spouses, in and of itself, won't protect a couple's life savings when one must enter a nursing home. To qualify for Medicaid, the spouse in the nursing home must own resources worth no more than $2,000.

This does not mean that you need not take further steps to protect your remaining resources. Most married couples own majority of their assets jointly with rights of survivorship. They also usually have reciprocal wills: each person's will leaves everything to the other. If the spouse at home were to die first, jointly-held assets would go to the other spouse, who under Medicaid rules for unmarried individuals is allowed to keep only about $2,000. Recommended strategy would be for the spouse at home to execute a new will or living trust that leaves all of her assets to her children upon her death.

In all of the above scenarios where we have laid out various courses of action, we're assuming that you're legally competent to make decisions and take action, such as transfer assets, give property to your children, etc. But such a course of action may not be available in every case. If you were to become incompetent due to, say, Alzheimer's disease or a debilitating stroke, you'll be legally barred from taking action and your family may be forced to go to court to have a conservator appointed of your estate. As we have observed elsewhere in the book, court-appointed conservator has a fidiciary duty to the principal and, ironically, he would be barred from taking exactly the steps that may protect principal's estate. You can avoid such a calamity by preparing a durable power of attorney that allows an attorney-in-fact to act in your capacity. He would be able to transfer assets and do all that's necessary to protect them. The durable power of attorney may be a "springing" kind which means it would become effective only in the event you were to become incompetent. Elsewhere in the book, we've discussed this subject at length.

Medicare 5

If you are like most older Americans covered by Medicare, there are aspects of the federal health insurance program that you find complex and confusing. You may be uncertain about what Medicare covers and doesn't cover and how much it pays toward your medical expenses. And, like many other beneficiaries, you want to know what, if any, additional health insurance you should buy.

What is Medicare?

Medicare is a federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under 65. It is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS). The Social Security Administration, also a part of HHS, provides information about the program and handles enrollment.

Two Parts of Medicare

Medicare has two parts—Hospital Insurance (Part A) and Medical Insurance (Part B). Part A is financed through part of the Social Security (FICA) tax paid by workers and their employers. You do not have to pay a monthly premium for Medicare Part A if you or your spouse are entitled to benefits under either the Social Security or Railroad Retirement systems or worked a sufficient period of time in federal, state, or local government employment to be insured.

If you do not qualify for premium-free Part A benefits, you may purchase the coverage if you are at least age 65 and meet certain requirements. You also may buy Part A if you are under age 65, were previously entitled to Medicare under the disability provisions and you still have the same disabling impairment but your disability benefits were terminated because of your work and earnings. The Part A monthly premium in 1993 was $221.

Part B is optional and is offered to all beneficiaries when they become entitled to Part A. It also may be purchased by most persons age 65 or over who do not qualify for premium-free Part A coverage. The Part B premium in 1993 was $36.60 each month.

You are automatically enrolled in Part B when you become entitled to Part A unless you state that you don't want it. Although you do not have to purchase Part B, it is an excellent buy because the federal government pays about 75 percent of the program costs. Your Medicare card shows the coverage you have [Hospital Insurance (Part A), Medical Insurance (Part B), or both] and the date your coverage started. If you only have one part of Medicare, you can get information about getting the other part from any Social Security office.

Medicare Hospital Insurance Benefits (Part A)

When all program requirements are met, Medicare Part A will help pay for medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice care. In addition, Part A pays the full cost of medically necessary home health care and 80 percent of the approved cost for durable medical equipment supplied under the home health benefit.

Benefits Periods

Medicare Part A benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive a Medicare-covered service in a hospital. It ends when you have been out of a hospital or skilled nursing facility for 60 days in a row. It also ends if you remain in a skilled nursing facility but do not receive any skilled care there for 60 days in a row.

If you enter a hospital again after 60 days, a new benefit period begins. With each new benefit period, all Part A benefits are renewed except for any life-time reserve days or psychiatric hospital benefits that were used. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care.

Inpatient Hospital Care

If you are hospitalized, Medicare will pay all charges (over the deductible) for covered hospital services during the first 60 days of a benefit period. The Part A deductible in 1993 was $676 per benefit period. You are responsible for the deductible.

For the 61st through the 90th day, Part A pays for all covered services except for coinsurance of $169 a day in 1993. You are responsible for the coinsurance.

Under Part A, you also have a lifetime reserve of 60 days for inpatient hospital care. These lifetime reserve days may be used whenever you need more than 90 days of inpatient hospital care in a benefit period. When a reserve day is used, Part A pays for all covered services except for coinsurance of $338 a day in 1993. Again, the coinsurance is your responsibility. Once used, reserve days are not renewed.

Skilled Care or Custodial Care?

The only type of "nursing home" care Medicare helps pay for is skilled nursing facility care. Medicare does not pay for custodial care when that is the only kind of care you need.

Care is considered custodial when it is primarily for the purpose of helping the patient with daily living or meeting personal needs, and could be provided safely and reasonably by people without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

Gaps in Medicare Inpatient Hospital Coverage

-You pay $676 deductible on first a dmission to hospital in each benefit period.

-You pay $169 daily coinsurance for days 61 through 90.

-You pay $338 daily coinsurance for each "life-time reserve day" used.

-Coverage beyond 90 days in any benefit period is limited to the number of lifetime reserve days available and that you use.

-No coverage for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services.

-To the extent the 3-pint blood deductible is met under Part B, it does not have to be met under Part A.

-No coverage for a private hospital room, unless medically necessary, or for a private duty nurse.

-No coverage for personal convenience items, such as a telephone or television in a hospital room.

-No coverage for care that is not medically necessary or for non-emergency care in a hospital not certified by Medicare.

-No coverage for care received outside the U.S. and its territories, except under limited circumstances in Canada and Mexico.

Skilled Nursing Facility Care

A skilled nursing facility (SNF) is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility, such as a hospital. Medicare benefits are payable only if you require daily skilled care which, as a practical matter, can only be provided in a SNF on an inpatient basis, and the care is provided in a SNF certified by Medicare. Medicare will not pay for your stay in a SNF if the services you receive are primarily personal care or custodial services, such as assistance in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

To qualify for Medicare coverage for SNF care, you must have been in a hospital at least three consecutive days (not counting the day of discharge) before entering a SNF. You must be admitted to the SNF for the same condition for which you were treated in the hospital and generally the admission must be within 30 days of your discharge from the hospital. Your physician must certify that you need, and receive, skilled nursing or skilled rehabilitation services on a daily basis.

Medicare can help pay for up to 100 days of skilled care in a SNF during a benefit period. All covered services for the first 20 days of care are fully paid by Medicare. All covered services for the next 80 days are paid by Medicare except for a daily coinsurance amount. The daily coinsurance in 1993 was $84.50. You are responsible for the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

Gaps in Medicare Skilled Nursing Facility Coverage

-You pay $84.50 daily coinsurance for days 21 through 100 in each benefit period.

-No coverage beyond 100 days in a benefit period.

-No coverage for care in a nursing home, or in a SNF not certified by Medicare, or for just custodial care in Medicare-certified SNF.

-No coverage for the 3-pint blood deductible (see list of gaps under inpatient hospital care).

Home Health Care

Part A fully covers medically necessary home health visits if you are homebound, including part-time or intermittent skilled nursing services. A Medicare-certified home health agency can also furnish the services of physical and speech therapists.

Should you require speech or physical therapy, or intermittent skilled nursing services, are confined to your home, and are under the care of a physician, Part A can also pay for other services. They include necessary part-time or intermittent home health aide services, occupational therapy, medical social services, and medical supplies. Coverage is also provided for a portion of the cost of durable medical equipment (DME) provided under a plan-of-care set up and overseen by a physician.

Gaps in Medicare Home Health Coverage

-No coverage for full-time nursing care.

-No coverage for drugs, or for meals delivered to your home.

-You pay 20% of the Medicare-approved amount for DME, plus charges in excess of the approved amount on assigned claims.

-No coverage for homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

Hospice Care

Medicare beneficiaries certified as terminally ill may choose to receive hospice care rather than regular Medicare benefits for their terminal illness. Part A can pay for two 90-day hospice benefit periods, a subsequent period of 30 days, and a subsequent extension of unlimited duration. If you enroll in a Medicare-certified hospice program, you will receive medical and support services necessary for symptom management and pain relief. When these services - which are most often provided in your home - are furnished by a Medicare-certified hospice program, the coverage includes: physician services, nursing care, medical appliances and supplies (including drugs for symptom management and pain relief), short-term inpatient care, counseling, therapies, and home health aide and homemaker services.

Medicare's Part A and Part B deductibles do not apply to services and supplies furnished under the hospice benefit. You must pay only limited charges for outpatient drugs and inpatient respite care. In the event you require medical services for a condition unrelated to the terminal illness, regular Medicare benefits are available. When regular benefits are used, you are responsible for the applicable Medicare deductible and coinsurance amounts.

Gaps in Medicare Hospice Coverage

-You pay limited charges for inpatient respite care and outpatient drugs.

-You pay deductibles and coinsurance amounts when regular Medicare benefits are used for treatment of a condition other than the terminal illness.

Psychiatric Hospital Care

Part A helps pay for up to 190 days of inpatient care in a Medicare-participating psychiatric hospital in your lifetime. Once you have used 190 days (or have used fewer than 190 days but have exhausted your inpatient hospital coverage), Part A doesn't pay for any more inpatient care in a psychiatric hospital.

However, psychiatric care in general hospitals, rather than in free-standing psychiatric hospitals, is not subject to this 190-day limit. Inpatient psychiatric care in a general hospital is treated the same as other Medicare inpatient hospital care. If you are a patient in a psychiatric hospital on the first day of your entitlement to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for.

Gaps in Medicare Inpatient Psychiatric Hospital Care

-No coverage for care after you have received 190 days of such specialized treatment in your lifetime (even if you have not yet exhausted your inpatient hospital coverage).

Medicare Medical Insurance (Part B) Benefits

Part B helps pay for medically necessary physician services no matter where you receive them at home, in the doctor's office, in a clinic, nursing home, or hospital. It also covers related medical services and supplies, medically necessary outpatient hospital services, X-rays and laboratory tests. Coverage is also provided for certain ambulance services and the in-home use of durable medical equipment, such as wheelchairs and hospital beds.

Additionally, Part B covers physical therapy, occupational therapy, and speech pathology services in a doctor's office, as an outpatient, or in your home. Mental health services are covered along with mammograms and Pap smears. And if you qualify for home health care but do not have Part A, then Part B pays for all covered home health visits.

Outpatient prescription drugs generally are not covered by Part B. The exceptions include certain drugs furnished hospice enrollees, non-self administrable drugs provided as part of a physician's services, and special drugs, such as drugs furnished during the first year after an organ transplantation and erythropoetin for home dialysis patients.

When you use your Part B benefits, you will be required to pay the first $100 (the annual deductible) each calendar year. The deductible must represent charges for services and supplies covered by Medicare. It also must be based on the Medicare approved amounts, not the actual charges billed by your physician or medical supplier.

After you meet the deductible, Medicare Part B generally pays 80 percent of the Medicare-approved amount for covered services you receive the rest of the year. You are responsible for the other 20

percent. You have no deductible or coinsurance for home health services. You do, however, have to pay 20 percent of the Medicare-approved amount for durable medical equipment supplied under the home health benefit.

If a doctor or supplier does not accept assignment of your Medicare claim and charges more than Medicare's approved amount, you are generally liable for the difference. The difference to be paid is called the "excess charge" or "balance billing." You should be aware, however, that there are certain charge limitations mandated by federal law (discussed below) and that some states also limit physical charges.

Medicare-Approved Amount

The Medicare-approved amount for physician services covered by Part B is based on a national fee schedule. The schedule assigns a dollar value to each physician service based on work, practice costs and malpractice insurance costs. Under the new payment system, each time you go to a physician for a service covered by Medicare, the amount Medicare will recognize for that service will be taken from the national fee schedule. Medicare generally pays 80 percent of that amount.

Because you cannot tell in advance whether the approved amount and the actual charge for covered services and supplies will be the same, always ask your physicians and suppliers whether they accept assignment of Medicare claims.

Accepting Assignment

Those who take assignment on a Medicare claim agree to accept the Medicare-approved amount as payment in full. They are paid directly by the Medicare carrier, except for the deductible and coinsurance amounts that you must pay. For example, for your first annual visit, if you go to a participating physician, or if you go to a non-participating physician who accepts assignment, and the Medicare-approved amount for the service you receive is $200, you will be billed $120: $100 for the annual deductible plus 20 percent of the remaining $100, or $20. Medicare would pay the other $80. Having met the deductible for the year, the next time you use Part B services furnished by a physician or medical supplier who accepts assignment, you would be responsible for only 20 percent of the Medicare-approved amount.

Physicians and suppliers who sign Medicare participation agreements accept assignment on all Medicare claims. Their names and addresses are listed in *The Medicare Participating Physician/Supplier Directory.* The directory is distributed to senior citizen organizations, all Social Security and Railroad Retirement Board offices, all hospitals, and all state and area offices of the Administration on Aging. The directory may also be obtained free of charge from the insurance carrier that processes Medicare Part B claims in your area, or you can call the carrier for the names of Medicare-participating physicians or suppliers.

While your physician or supplier may not be a Medicare-participating physician or supplier, ask before you receive any services whether he or she will accept assignment of your Medicare claim. Many physicians and suppliers accept assignment on a case-by-case basis. Regardless of whether your physicians and suppliers accepted assignment, they are required to file your Medicare claim for you.

However, if they don't accept assignment, you are responsible for paying all permissible charges. Medicare will then reimburse you its share of the approved amount.

In certain situations non-participating providers of services are required by law to accept assignment. For instance, all physicians and qualified laboratories must accept assignment for Medicare-covered clinical diagnostic laboratory tests. Physicians also must accept assignment for covered services provided to beneficiaries with incomes low enough to qualify for Medicaid payment of their Medicare cost-sharing requirements.

Physician Charge Limits

Physicians who do not accept assignment of a Medicare claim are limited as to the amount they can charge for covered services. The most these physicians can charge for services covered by Medicare is 115 percent of the fee schedule amount for non-participating physicians.

Physicians who knowingly, willfully, and repeatedly charge more than these amounts are subject to sanctions. If you think you have been overcharged, or you want to know what the limiting charge is for a particular service, contact your Medicare carrier. Limiting charge information also appears on the *Explanation of Medicare Benefits* (EOMB) form that you generally receive when you go to a physician for a Medicare-covered service. You do not have to pay charges that exceed the legal limit.

If you think your doctor has exceeded the charge limit, you should contact the doctor and ask for a reduction in the charge, or a refund, if you have paid more than the charge limit. If you cannot resolve the issue with the doctor, you can call your Medicare carrier and ask for assistance.

Another federal law requires doctors who do not accept assignment for elective surgery to give you a written estimate of your costs before the surgery if the total charge will be $500 or more. If the doctor did not give you a written estimate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount.

You should also be aware that any non-participating physician who provides you with services that he or she knows or has reason to believe Medicare will determine to be medically unnecessary and thus will not pay for, is required to so notify you in writing before

performing the service. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

Gaps in Medicare Coverage for Doctors and Medical Suppliers

-You pay $100 annual deductible.

-Generally, you pay 20% coinsurance.

-You pay legally permissible charges in excess of the Medicare-approved amount for unassigned claims.

-You pay 50% of approved charges for most outpatient mental health treatment.

-You pay all charges in excess of Medicare's maximum yearly limit of $600 for independent physical or occupational therapists.

-No coverage for most self-administerable prescription drugs or immunizations, except for pneumococcal and hepatitis B vaccinations.

-No coverage for routine physicals and other screening services, except for mammograms and Pap smears.

-No coverage for hearing aids or routine hearing loss examinations.

-No coverage for most services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.

-No coverage for dental care or dentures.

-No coverage for acupuncture treatment.

-No coverage for care received outside the United States and its territories, except under limited circumstances in Canada and Mexico.

-No coverage for routine foot care except when a medical condition affecting the lower limbs (such as diabetes) requires care by a podiatrist or doctor of medicine.

-No coverage for services of naturopaths, Christian Science practitioners, immediate relatives, or charges imposed by members of your household.

-No coverage for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part A, it does not have to be met under Part B.

-No coverage for routine eye examinations or eyeglasses, except prosthetic lenses, if needed, after cataract surgery.

Medicare Benefit Charts

As you can see from the preceding information, Medicare does not pay the entire cost for all services covered by the program. You or your Medicare supplemental insurance company must pay certain deductibles and coinsurance amounts and charges in excess of Medicare's approved amount for covered services and supplies.

The charts on the next pages describe Medicare benefits only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private insurance.

MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES PER BENEFIT PERIOD (1)

Services	Benefit	Medicare Pays**	You Pay**
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $676	$676
	61st to 90th day	All but $169 a day	$169 a day
	91st to 150th day*	All but $338 a day	$338 a day
	Beyond 150 days	Nothing	All costs
POSTHOSPITAL SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days, enter a Medicare-approved facility generally within 30 days after hospital discharge, and meet other program reqirements. (2)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $84.50 a day	up to $84.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Medically necessary skilled care, home health aide services, medical supplies, etc.	Part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Full scope of pain relief and support services available to the terminally ill.	As long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Blood	All but first 3 pints per calendar year.	For first 3 pints.***

* 60 reserve days may be used only once.

** These figures are for 1993 and are subject to change each year.

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

(1) A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row or remain in a skilled nursing facility but do not receive skilled care there for 60 days in a row.

(2) Neither Medicare nor Medigap insurance will pay for most nursing home care.

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES PER CALENDAR YEAR

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $100 deductible); 50% of approved charges for most outpatient mental health services.	$100 deductible,* plus 20% of approved amount and charges above approved amount.** 50% of approved charges for mental health services.
CLINICAL LABORATORY SERVICES	Blood tests, biopsies, urinalysis, etc.	Generally 100% of approved amount.	Nothing for services.
HOME HEALTH CARE Medically necessary skilled care, home health aide services, medical supplies, etc.	Part-time or intermittent nursing care and other services for as long as you meet criteria for benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Reasonable and necessary services for the diagnosis or treatment of an illness or injury.	Unlimited if medically necessary.	80% of approved amount (after $100 deductible).	Subject to deductible plus 20% of billed amount.
BLOOD	Blood	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible).***

* Once you have had $100 of expense for covered services, the Part B deductible does not apply to any other covered services you receive for the rest of the year.

** The amount by which a physician's charge can exceed the Medicare-approved amount is limited by law (see page 6).

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

This is not a bill.

Explanation of Your Medicare PartB Benefits

JOHN D DOE
APARTMENT 12C
65 WOODLAWN DRIVE
BALTIMORE, MARYLAND 21207-1111

Your Medicare number is: 123-45-6789A

Summary of this notice dated June 1, 1992

Total charges:	$ 300.00
Total Medicare approved:	$ 180.00
We are paying you:	$ 144.00
Your total responsibility:	$ 216.00

Details about this notice (See the back for more information)

Control number 0000-0000-0000

You received these services from your provider: Elm Street Clinic, Mailing address: 123 Elm Street, Baltimore, Md. 21228

Services and Service Codes	Dates	Charge	Medicare Approved	Notes
Dr. Mary Smith				
3 office visits [00000]	May 01-08, 1992	$ 300.00	$ 180.00	a,b

Your provider did not accept assignment. We are paying you the amount that we owe you. See #4 on the back of this notice.

Notes:

a The approved amount is based on the fee schedule.

b Your doctor did not accept assignment for this service. Under federal law, your doctor cannot charge more than $216.00

Here's an explanation of this notice:

Of the total charges, Medicare approved	**$180.00**	**See #4 on the back.**
Less Medicare copayment amount	**- 36.00**	**Your co-payment is 20%.**
Amount after copay	**$144.00**	
We are paying you	**$144.00**	**Please cash the enclosed check right away.**
Of the total charges	**$300.00**	
Less amount exceeding charge limit	**- 84.00**	**You are not responsible for this amount which is in excess of the Medicare limiting charge. See note b.**
The total you are responsible for	**$216.00**	**The provider may bill you for this amount.**

IMPORTANT: If you have questions about this notice, call (carrier name) at (carrier telephone number) or write us at (carrier mailing address). You will need this notice if you contact us.

If you feel our decision, you must WRITE to us before December 1, 1992. See #2 on the back.

How to Appeal Medicare Decisions 6

If you disagree with a decision on the amount Medicare will pay on a claim or whether services you received are covered by Medicare, you have the right to appeal the decision. The notice Medicare sends you tells you the decision made on the claim and exactly what appeal steps you can take. Appealing decisions by Part A providers, peer review organizations, intermediaries, carriers and health maintenance organizations is discussed below.

Appealing Decisions Made by Providers of Part A Services

In many cases the first written notice of noncoverage you receive will come from the provider of the services (for example, a hospital, skilled-nursing facility, home health agency or hospice). This notice of noncoverage from the provider should explain why the provider believes Medicare will not pay for the services. This notice is not an official Medicare determination, but you can ask the provider to get an official Medicare determination. If you ask for an official Medicare determination, the provider must file a claim on your behalf to Medicare. Then you will receive a Notice of Utilization, which is the official Medicare determination. If you still disagree, you can appeal by following the instructions on the Notice of Utilization.

Appealing Decisions Made by Peer Review Organizations (PROs)

When you are admitted to a Medicare-participating hospital, you will be given a notice called *An Important Message From Medicare.* The notice contains a brief description of PROs, and the name, address and phone number of the PRO in your state. Also, it describes your appeal rights

PROs make determinations mainly about inpatient hospital care and ambulatory surgical center care. The PROs decide whether care provided to Medicare patients is medically necessary, provided in the most appropriate setting, and is good quality. When you disagree with a PRO decision about your case, you can appeal by requesting a reconsideration. Then, if you disagree with the PRO's reconsidered decision, and the amount remaining in question is $200 or more, you can request a hearing by an Administrative Law Judge. Cases involving $2,000 or more can eventually be appealed to a Federal Court.

If you belong to a Medicare health maintenance organization (HMO), the HMO will usually make decisions about the medical necessity, the appropriateness of the setting and the quality of your care. In most cases, you do not have the right to register complaints about the quality of your hospital care to the PRO.

Note: In the case of elective (non-emergency) surgery, either the hospital or the PRO may be involved in pre-admission decisions. If the hospital believes that your proposed stay will not be covered by Medicare, it may recommend, without consulting PRO, that you not be admitted to the hospital. If this is the case, the hospital must give you its decision in writing. If you or your doctor disagree with the hospital's decision, you should make a request to the PRO for

immediate review. If you want an immediate review, you must make your request, by telephone or in writing, within three calendar days after receipt of the notice.

Appealing Decisions of Intermediaries on Part A Claims

Appeals of decisions on most other services covered under Medicare Part A (skilled-nursing facility care, home health care, hospice services, and a few inpatient hospital matters not handled by PROs) are handled by Medicare intermediaries. If you disagree with the intermediary's initial decision, you have 60 days from the date you receive the initial decision to request a reconsideration. The request can be submitted directly to the intermediary or through Social Security. If you disagree with the intermediary's reconsidered decision and the amount remaining in question is $100 or more, you have 60 days from the date you receive the reconsidered decision to request a hearing by an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

Appealing Decisions Made by Carriers on Part B Claims

If you disagree with Medicare's decision on a Part B claim, you have the right to appeal that decision. You have six months from the date of the decision to ask the carrier to review it. Then, if you disagree with the carrier's written explanation of its review decision and the amount remaining in question is $100 or more, you have six months from the date of the review decision to request a hearing before a carrier hearing officer. You may combine claims that have been reviewed or reopened so long as all claims combined are at the proper level of appeal and the appeal for each claim combined is filed on time.

If you disagree with the carrier hearing officer's decision and the amount remaining in question is $500 or more, you have 60 days from

the date you receive the decision to request a hearing before an Administrative Law Judge. You may combine claims that have had a carrier hearing officer's decision so long as the appeal for each claim combined is filed 60 days of the date you received the carrier hearing decision for that claim. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

Appealing Decisions Made by Health Maintenance Organizations (HMOs)

If you have Medicare coverage through an HMO, decisions about coverage and payment for services will usually be made by your HMO. When your HMO makes a decision to deny payment for Medicare-covered services or refuses to provide Medicare-covered supplies you request, you will be given a *Notice of Initial Determination.* Along with the notice, your HMO is required to provide a full, written explanation of your appeal rights.

If you believe that the decision your HMO made was not correct, you have the right for reconsideration within 60 days after you receive the *Notice of Initial Determination.* Your request must be in writing. You may mail it or deliver it personally to your HMO or to a Social Security Office (or the Railroad Retirement Board if you get Medicare through Railroad Retirement).

Your HMO is responsible for reconsidering its initial determination to deny payment or services. If your HMO does not rule fully in your favor, the HMO must send your reconsideration request to the Health Care Financing Administration (HCFA) for a review and determination.

If you disagree with HCFA's decision, and the amount in question is $100 or more, you have 60 days from receipt of HCFA's decision to

request a hearing before an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

For More Information

If you need more information about your right to appeal and how to request it, call Social Security, or the Medicare intermediary or carrier in your state. (The number of the Medicare intermediary or carrier is listed on the notice explaining Medicare's decision on the claim. If you need more information about your right to appeal a Peer Review Organization (PRO) decision, you can call the PRO in your state.

SOURCE: U.S. Department of Health and Human Services; Health Care Financing Administration.

Medigap Insurance 7

For people of age 65 and over, Medicare, the federal program of health insurance, is a God-send. It covers a major portion of inpatient hospital care and costs of physicians and medical supplies. But there are sizable gaps in Medicare coverage as we have noted in the previous chapter. Medicare was never meant to be an all-inclusive health insurance program. You'll have to decide for yourself whether you need private health insurance in addition to your Medicare protection.

Private Insurance

Insurance companies classify medical costs in two categories. When you have to be hospitalized, there are initial "front-end" costs for which you are personally liable, such as Medicare deductibles and copayments. These costs are predictable and in most cases manageable. If they were the only costs you faced, you probably could dispense with "Medigap" insurance.

Unfortunately, there are "tail-end" costs, expenses for which you are liable after Medicare has paid all its benefits. Unlike the initial costs of an illness, the tail-end costs are virtually unpredictable. Medicare does not cover them, and they are a major cause of financial ruin. It is for the tail-end costs that you principally need Medigap insurance.

In general it is advisable to buy the additional protection that private health insurance can provide. If you decide to buy supplement insurance, shop carefully and buy a policy that offers the kind of

additional help you think you need most. Do not be misled by the claims of a private insurer or a private insurance agent that you will be "fully" protected by buying private insurance.

A variety of private insurance policies is available to help pay for medical expenses, services and supplies that Medicare covers only partly or not at all. The basic types of policies include: (1) Medicare supplement (Medigap) policies, which pay some of the money amounts that Medicare does not pay for covered services; (2) coordinated care plans (which include health maintenance organizations (HMOs) and competitive medical plans (CMPs), from which you purchase health care services directly for a fixed monthly premium; (3) continuation or conversion of employer-provided insurance or other policy you have when you reach 65; (4) nursing home or long-term care policies, which pay cash amounts for each day of covered nursing home or at-home care; (5) hospital indemnity policies, which pay cash amounts for each day of inpatient hospital services; and, (6) specified disease policies, which pay only when you need treatment for the disease insured against.

Medigap Insurance

Medigap insurance is regulated by federal and state law and must be clearly identified as Medicare supplement insurance. It is designed specifically to complement Medicare's benefits by filling in some of the gaps in Medicare coverage. Medigap policies pay most, if not all, coinsurance amounts and may provide coverage for Medicare's deductibles. Some policies also pay for limited health services not covered by Medicare, such as outpatient prescription drugs.

Note that the definition of a Medigap policy under federal laws does not include all insurance products that may help you cover out-

of-pocket costs. For example, a health plan offered by a company for current or former employees, or by a labor organization for current or former members, does not have to satisfy federal requirements that are applicable to Medigap insurance. Moreover, limited benefit plans, such as hospital indemnity insurance (discussed below) are not Medigap insurance, Similarly, coverage provided to individuals enrolled in coordinated care plans such as health maintenance organizations (HMOs), pursuant to contracts or agreements with the federal government, does not meet the definition of Medigap insurance even though some of the coverage may be similar. (The Medigap requirements do, however, apply to supplement insurance products HMOs may sell to individual Medicare beneficiaries who are not enrolled under a federal contract or government.)

Unlike some types of health coverage that restrict where and from whom you can receive care, most Medigap policies pay the same supplement benefits regardless of your choice of health-care provider. If Medicare pays for a service, wherever provided, the standard Medigap policy must pay its regular share benefits. The only exception is Medicare SELECT, discussed later.

When shopping for a Medigap policy, compare benefits and premiums and be satisfied that the insurer is reputable before buying. And in selecting the benefits that meet your needs, remember that Medicare pays only for services it determines to be medically necessary and only the amount it determines to be reasonable. Some of the 10 standard Medigap plans pay for limited services not covered by Medicare and some pay for charges in excess of Medicare's approved amount.

Ten Standard Medigap Plans

New regulations that went into effect on or before July 30, 1992, in nearly all states, U.S. territories, and the District of Columbia generally limit the number of different Medigap policies that can be sold in any of these jurisdictions to no more than 10 standard benefit plans.

One of the 10 standard plans, which were developed by the National Association of Insurance Commissioners and incorporated into federal law, is a "core" benefit package (Plan "A"). Each of the other nine includes the core package plus a different combination of benefits. Insurers are not permitted to change the combination of benefits in any of the 10 standard plans or to change the letter designations that range from "A" to "J." They may, however, add names or titles to the letter designations.

While a state may limit the number of plans available in the state to fewer than 10 — and some have — each state must allow the sale of Plan A. Just as states are not required to approve all 10 plans, Medigap insurers are not required to offer all of the plans approved for sale in each of the states in which they do business. Each Medigap insurer must, however, offer Plan A.

Each of the 10 plans must cover specific expenses either not covered or not fully covered by Medicare, with "A" being the most basic policy and "J" the most comprehensive. To make it easier for consumers to compare plans and premiums, the same format, language, and definitions must be used in describing the benefits of each of the 10 standard plans. A uniform chart and outline of coverage also must be used to summarize those benefits. With standardization, each company's products are alike, so they are competing on service, reliability and price.

Besides the standardized benefits plans, federal law permits states to allow an insurer to add "new and innovative benefits" to a standard plan that otherwise complies with applicable standards. Any such new or innovative benefits must be cost-effective, not otherwise available in the marketplace, and offered in a manner that is consistent with the goal of simplification.

The new Medigap regulatory programs are in effect in all jurisdictions except Montana, Oregon, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands. The Montana and Oregon legislatures, which did not meet in 1992, are expected to complete action early in 1993 on Medigap regulatory programs. Until the new regulations are adopted, non-standard policies may continue to be sold along with the 10 standard plans in both Montana and Oregon.

Waivers were granted to Minnesota, Massachusetts, and Wisconsin because they already had their own standardization programs for Medigap insurance. If you live in one of these states, you should contact the state insurance department to find out what Medigap coverage is available to you. In these states, new regulatory programs are in effect, but the benefit packages are different than the 10 standard plans.

All jurisdictions that have the new regulations in force, except Delaware, Pennsylvania and Vermont, permit the sale of all 10 Medigap benefit plans. Delaware does not permit plans C, F, G and H, and Pennsylvania and Vermont do not permit Plans F, G and I.

Under the new regulations, all Medigap plans must have a loss ratio of at least 65 percent for individual policies and 75 percent for group policies. This means that on average either 65 cents or 75 cents of each premium dollar goes for benefits.

Older Medigap Policies

The new federal requirements generally do not apply to Medigap policies in force in a state before the new requirements took effect in that state. Depending on which state you live in, you will not have to switch to one of the new standardized plans if you have an older policy that is guaranteed renewable. Some states, however, have specific requirements that affect existing non-standard policies. For example, some states require or permit insurers to convert older policies to the new standardized plans. Check with your state insurance department to find out what state-specific requirements are in force. Even if you are not required to convert an older policy, you may want to consider switching to one of the new Medigap policies if it is to your advantage and an insurer is willing to sell you one.

If you do switch, you will not be allowed to go back to the old policy. Before switching, compare benefits and premiums, and determine if there are waiting periods for any of the benefits in the new policy. Some of the older policies may provide superior coverage, especially for prescription drugs and extended skilled nursing care.

If you had the old Medigap policy at least 6 months and you decided to switch, the new policy is not permitted to impose a waiting period for a preexisting condition if you satisfied a waiting period for a similar benefit under your old policy. If, however, a benefit is included in the new policy that was not in the old policy, a waiting period of up to 6 months — unless prohibited by your state — may be applied to that particular benefit.

Because it is unlawful for anyone to sell you insurance that duplicated coverage you already have, and because you do not need

more than one Medigap policy, you must sign a statement that you intend to replace your current policy and will not keep both policies. Do not cancel the old policy until the new one is in force and you have decided to keep it.

Carrier Filing of Medigap Claims

Under certain circumstances, you may not have to file a separate claim with your Medigap insurer to have payment made directly to your physician or medical supplier.

By law, Medicare carrier must send your claim to the Medigap insurer when the following three conditions are met for Medicare Part B claim: (1) your physician or supplier must have signed a participation agreement with Medicare to accept assignment of Medicare claims for all patients who are Medicare beneficiaries; (2) your policy must be a Medigap policy; and (3) you must instruct your physician to indicate on the Medicare claim form that you wish payment of Medigap benefits to be made to the participating physician or supplier. Your physician will put your Medigap policy number on the Medicare claim form.

When these conditions are met, your Medicare carrier will process the Medicare claim, send you an Explanation of Medicare Benefits (EOMB). Your Medigap insurer will pay benefits directly to your physician or medical supplier and send you a notice that they have done so.

If the insurer refuses to pay the physician directly when these conditions are met, you should report this to your state insurance department. For more information on Medigap claim filing by the carrier, contact your local Medicare carrier. Look in *The Medicare Handbook* for the name and telephone number of the carrier for your area.

Medicare SELECT

A new Medicare supplement health insurance product called "Medicare SELECT" is permitted to be sold in Alabama, Arizona, California, Florida, Indiana, Kentucky, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington and Wisconsin.

Medicare SELECT, which may be offered in the designated states by insurance companies and health maintenance organizations (HMOs), is the same as standard Medigap insurance in nearly all respects. If you buy a Medicare SELECT policy, you are buying one of the 10 standard Medigap plans.

The only difference between Medicare SELECT and standard Medigap insurance is that Medicare SELECT policies will only pay full supplement benefits if covered services are obtained through specified health care professionals. Medicare SELECT policies are expected to have lower premiums because of this limitation. The specified health care professionals, called "preferred providers," are selected by the insurance company or HMO. Each insurer of a Medicare SELECT policy makes arrangements with its own network of preferred providers.

If you have a Medicare SELECT policy, each time you receive covered services from a preferred provider, Medicare will pay its share of the approved charges and the insurer will pay the full supplemental benefits provided for in the policy. Medicare SELECT insurers must also pay supplemental benefits for emergency health care furnished by providers outside the preferred provider network.

In general, Medicare SELECT policies deny payment or pay less than the full benefit if you go outside the network for non-emergency

services. Medicare, however, will still pay its share of approved charges if the services you receive outside the network are services covered by Medicare.

During 1992 through 1994, Medicare SELECT policies will be evaluated to determine if they should be made available throughout the nation. Companies selling Medicare SELECT policies are required to provide for the continuation of coverage if the policies are discontinued. If the program is not extended, Medicare SELECT policyholders will have the option to purchase any standard Medigap policy that the insurance company or HMO offers, if in fact it issues Medigap insurance other than Medicare SELECT. To the extent possible, the replacement policy would have to provide similar benefits.

New Medicare Beneficiary's Right to Medigap Coverage

Congress has established a 6-month open enrollment period for buying Medicare supplement health insurance (Medigap). The law, which became effective November 5, 1991, guarantees that for 6 months immediately following enrollment in Medicare's Medical Insurance program (Part B), persons aged 65 or older cannot be denied Medigap insurance because of health problems.

During this period, you have the choice of any of the different Medigap policies sold by any insurer doing Medigap business in your state. The company cannot deny or condition the issuance or effectiveness, or discriminate in the pricing of a policy, because of your medical history, health status, or claims experience. The company can, however, impose the same preexisting conditions restrictions that it applies to Medigap policies sold outside the open enrollment period.

Many individuals are enrolled automatically in Part B as soon as they turn 65, or they sign up during an initial 7-month enrollment period that begins 3 months before they turn 65. If you are in this group, your Medigap open enrollment period starts as soon as your Part B coverage starts in the month you turn 65 (or shortly thereafter, depending on when you applied for Part B).

Others may delay their enrollment in Part B. If you continue to work after age 65 and choose to be covered by an employer insurance plan or are covered under a spouse's employment-related insurance instead of by Medicare Part B, you will have a special 7-month enrollment period for Part B. It begins with the month you or your spouse's work ends or when you are no longer covered under the employer plan, whichever comes first. Your 6-month Medigap open enrollment period starts when your Part B coverage begins.

If you are 65 or older and eligible for Part B but chose not to buy it when it first became available to you, you may sign up for Part B during the annual general enrollment period from January through March. Once your Part B coverage is effective (in July of the year in which you sign up), you will have the regular 6-month guaranteed open enrollment period in which to select a Medigap policy.

Your Medicare card shows the effective dates for your Part A and/or Part B coverage. To figure whether you are in your Medigap open enrollment period, add 6 months to the effective date of your Part B coverage. If the date is in the future and you are at least 65, you are eligible for open enrollment. If the date is in the past, you are not eligible.

If you are under age 65, disabled, and enrolled in Medicare Part B, you are not eligible for open enrollment unless your state requires open enrollment for persons under 65 who qualify for Medicare because of a disability.

SOURCE: Guide to Health Insurance for People with Medicare: National Association of Insurance Commissioners and U.S. Department of Health and Human Services.

PLAN F **includes the core benefits *plus:***

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for 100% of Medicare Part B excess charges.*

PLAN G **includes the core benefits *plus:***

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for 80% of Medicare Part B excess charges.*
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for at-home recovery (see Plan D).

PLAN H **includes the core benefits *plus:***

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of $1,250 after the policyholder meets a $250 per year deductible (this is called the "basic" prescription drug benefit).

PLAN I **includes the core benefits *plus:***

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for 100% of Medicare Part B excess charges.*
- Basic prescription drug coverage (see Plan H for description).
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for at-home recovery (see Plan D).

PLAN J **includes the core benefits *plus:***

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges.*
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for preventive medical care (see Plan E).
- Coverage for at-home recovery (see Plan D).
- Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of $3,000 after the policyholder meets a $250 per year deductible (this is called the "extended" drug benefit).

* Plan pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges (up to the amount of charge limitations set by either Medicare or state law).

10 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS

CORE BENEFITS	PLAN A	PLAN B	PLAN C	PLAN D	PLAN E	PLAN F	PLAN G	PLAN H	PLAN I	PLAN J
Part A Hospital (Days 61-90)	X	X	X	X	X	X	X	X	X	X
Lifetime Reserve Days(91-150)	X	X	X	X	X	X	X	X	X	X
365 Life Hosp. Days-100%	X	X	X	X	X	X	X	X	X	X
Parts A and B Blood	X	X	X	X	X	X	X	X	X	X
Part B Coinsurance-20%	X	X	X	X	X	X	X	X	X	X
ADDITIONAL BENEFITS	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
Skilled Nursing Facility Coinsurance (Days 21-100)			X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X
Part B Deductible			X			X				X
Part B Excess Charges						100%	80%		100%	100%
Foreign Travel Emergency			X	X	X	X	X	X	X	X
At-Home Recovery				X			X		X	X
Prescription Drugs								1	1	2
Preventive Medical Care					X					X

Core Benefits pay the patient's share of Medicare's approved amount for physician services (generally 20%) after $100 annual deductible, the patient's cost of a long hospital stay ($169/day for days 60-90, $338/day for days 91-150, approved costs not paid by Medicare after day 150 to a total of 365 days lifetime), and charges for the first 3 pints of blood not covered by Medicare.

Two prescription drug benefits are offered:

1. a "basic" benefit with $250 annual deductible, 50% coinsurance and a $1,250 maximum annual benefit (Plans H and I above), and
2. an "extended" benefit (Plan J above) containing a $250 annual deductible, 50% coinsurance and a $3,000 maximum annual benefit.

Each of the 10 plans has a letter designation ranging from "A" through "J". Insurance companies are not permitted to change these designations or to substitute other names or titles. They may, however, add names or titles to these letter designations. While companies are not required to offer all of the plans, they all must make Plan A available if they sell any of the other 9 in a state.

Standard Medigap Plans

Following is a list of the 10 standard plans and the benefits provided by each:

PLAN A (the basic policy) consists of these core benefits:

- Coverage for the Part A coinsurance amount ($169 per day in 1993) for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount ($338 per day in 1993) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System or another appropriate standard of payment.
- Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services (generally 20% of approved amount) after $100 annual deductible is met.

PLAN B includes the core benefits *plus:*

- Coverage for the Medicare Part A inpatient hospital deductible ($676 per benefit period in 1993).

PLAN C includes the core benefits *plus:*

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care coinsurance amount ($84.50 per day for days 21 through 100 per benefit period in 1993.
- Coverage for the Medicare Part B deductible ($100 per calendar year in 1993).
- Coverage for medically necessary emergency care in a foreign country.

PLAN D includes the core benefits *plus:*

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1600 per year for short-term, at-home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery. There are various benefit requirements and limitations.

PLAN E includes the core benefits *plus:*

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for medically necessary emergency care in a foreign country.
- Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for such things as a physical examination, flu shot, serum cholesterol screening, hearing test, diabetes screenings, and thyroid function test.

Long-Term Care 8

Graying of America

This year more than 6 million men and women over the age of 65 are estimated to need long-term care. By the year 2000, based on current estimates, 7.5 million older Americans will need long-term care. Most can be cared for at home; family members and friends are the sole caregivers for 70 percent of these elderly people. But a study by the U.S. Department of Health and Human Services indicates that people aged 65 in 1990 face a 40 percent lifetime risk of entering a nursing home. About 10 percent will stay there five years or longer.

The American population is growing older, and the group over 85 is now the fastest-growing segment of the population. The odds of entering a nursing home, and staying for longer periods, increase with age. In fact, statistics show that, at any given time, 22 percent of those aged 85 and older are in a nursing home. Because women generally outlive men by several years, they face a 50 percent greater likelihood than men of entering a nursing home after age 65.

You may never need a nursing home. But the longer you live, the greater the chance that you will need some form of long-term care.

What Is Long-Term Care?

Most people associate long-term care with services provided to persons with chronic illness or disability, over an extended period of time, particularly in a nursing home environment. This may be true

in many cases, especially where a person is unable to take care of himself or herself and has no other family member to assist in the daily health and personal needs.

In a vast majority of cases, however, long-term care is provided in the elderly person's home by other family members. Such help in a home setting allows a person to receive the essential care and assistance that he or she needs, and still enjoy the freedom and warmth of his or her home.

Where family members are not available to provide the care, the elderly person is forced to look for other home health and care agencies, adult-care centers, or other community-based long-term care providers. But such services are not easy to find and where available are extremely costly, often beyond the means of most senior citizens.

In this chapter, we'll discuss various means of planning and obtaining long-term care, custodial or health-related, that an elderly person so desperately needs, but is often unable to obtain under reasonable terms.

What Does Long-Term Care Include?

With advances in medical science, more and more Americans are living well past the age where they are able to care for themselves. Increasingly, our elderly population is dependent on others for personal and health needs; the services they need are generally defined as long-term care.

A person suffering from chronic illness or disability that leaves him unable to care for himself for an extended period of time will require long-term care. Long-term care is not limited to the care

provided in a nursing home; it includes services provided in your own home or those provided in your community, which may be in the form of help with daily activities such as bathing and dressing. Long-term care may be needed by a young or middle-aged person who has been in an accident or suffered a debilitating illness. But most long-term care services are used by older people.

Long-term services can be divided into three categories:

- Services provided in your home
- Community-based services
- Care provided in an institution, such as a nursing home or a skilled-care facility

Services Provided in Your Home

Services provided in your home may include medical services provided by professionals, such as physical therapists; part time or around-the-clock nursing care; or it can be personal care designed to assist you in your daily chores, such as bathing, dressing or grooming, walking or doing errands.

Not surprisingly, the services obtained in your home would cost considerably less than the same services provided in a nursing home. The costs for services at home vary anywhere from $10 per hour for an aide to attend to your personal needs to $25 to $30 per hour for a registered nurse, and may go as high as $50 to $75 per hour for an occupational or physical therapist.

Currently, Medicare will pay for your home health services, if such services are prescribed by a physician and are rendered by a home health agency that is certified by Medicare. Medicare Part B will also reimburse up to 80 percent of the cost of certain durable medical

equipment, such as wheel chairs, hospital beds and oxygen machines.

For those who qualify, Medicaid, a federally-mandated program administered by states, will pick up the cost of part-time skilled nursing care provided in your home, and medical supplies and equipment necessary.

Your third option would be to obtain a private long-term insurance policy. We'll cover this subject in detail in another chapter of this book.

Other in-home services include help with chores, or running errands, delivery of meals to your home, telephone reassurance services, friendly visitor services, and emergency response systems. As a rule, these kinds of in-home services are not covered by Medicare, Medicaid or private insurance, because they do not provide actual medical attention.

Community-Based Services

A wide range of services are available in most communities to meet the long-term care needs of elderly persons. In many cases, such services enable the elderly person to avoid entering a nursing home. Community-based services include: visiting nurses, home health aides such as physical or occupational therapists, friendly visitor services, meals on wheels, and respite care.

Respite care may include services provided to family members caring for a chronically ill or disabled person at home. The care may be for only a few hours a day or several days at a time, and is intended to provide a break to caregivers from daily responsibility. Such care is generally provided by volunteers in the community, a religious group or other organizations dedicated to providing services to senior

citizens.

Neither Medicare nor private medical supplemental insurance will pay for any of the community-based services that we've just described. Chore services, home-delivered meals, friendly visitors, and telephone reassurance programs are sometimes funded by the Older Americans Act or grants. You should contact your local department on aging to see where such services are provided and whether they are funded by the government.

Nursing Home Care

For many people, in-home or community-based services for long-term care are not a viable option. Such people are either chronically ill or recovering from an acute illness and they require constant medical or therapeutic rehabilitation services. For them, nursing home is the only option that would meet their needs. A nursing home provides around-the-clock physical care and attention, room and board, medical supervision and occupational and rehabilitation therapy; it also provides a social environment and companionship for the elderly.

Nursing home care can be divided into three categories:

Skilled nursing care This is the kind of care required by someone who is chronically ill or is recovering from an acute illness. The services include around-the-clock care and supervision by a registered nurse, under the direction of a physician who is available in an emergency. Such care may cost anywhere from $75 to $150 a day. As a national average, a year in a nursing home now costs between $25,000 to $30,000. In some regions, it can cost as much as $50,000.

Intermediate nursing care This is the kind of care for those who need

some, but not necessarily around-the-clock, nursing assistance and supervision. The cost may be between $50 to $75 a day.

Custodial care Custodial care consists of room and board and assistance with personal care such as bathing, dressing, feeding, exercising, etc. Custodial care generally does not include medical or nursing care. Cost for such services ranges from $35 to $55 a day.

After a hospital stay of at least three consecutive days, Medicare covers 100 days of skilled nursing or rehabilitation care in a skilled nursing facility, provided the facility is approved by Medicare and your treatment is connected with the illness that caused you to be hospitalized. The first 20 days are paid in full by Medicare; the beneficiary is responsible for the $74 per day coinsurance payment for days 21 through 100. Medicare provides no assistance for custodial or intermediate nursing home care.

Depending upon the state you live in, Medicaid may cover the cost of skilled and intermediate nursing home care for eligible recipients. Since the requirements vary widely from state to state, you should contact your local agency that administers Medicaid in your state.

Who Pays for the Long-Term Care?

Regardless of where the care is provided, in a nursing home, in the community or in the person's own home, one thing is certain: such care is extremely expensive. The latest surveys show that the annual cost for nursing home care can range from $25,000 to $50,000 with the average being $37,000. Home-care expenses vary greatly depending upon the services provided; most such services generally cost between $10 to $20 an hour.

Bringing an aide into your home just three times a week to help with dressing, bathing, preparing meals and similar household chores easily can cost $600 each month, or $7,200 a year. Add in the cost of skilled help, such as physical therapists, and these costs can be much greater.

Let us look at some of the existing programs and see how they can help you pay for long-term care.

Medicare

Many people are under the mistaken notion that Medicare will pay for long-term care in the event that they need it. Nothing can be farther from the truth. Neither Medicare nor private Medicare supplemental insurance will cover the long-term care expenses of an elderly person.

Medicare is a federal health insurance program, designed to provide health care benefits to all Americans age 65 and older. Medicare Part A covers in-patient hospital care, skilled-nursing facility care up to 100 days and hospice care for a maximum of 210 days. Medicare also pays for some skilled at-home care but only for a short-term unstable conditions and not for the on-going assistance that elderly people need.

Medicare does not cover custodial or intermediate nursing home care. All that it will cover are skilled-nursing care and skilled rehabilitation services. The bottom line is, Medicare pays less than 2 percent of the nation's total nursing home costs.

Medicare Supplemental Insurance (Medigap)

If you think that buying supplemental Medicare insurance, popularly called Medigap insurance, would be your answer to long-term care, again you're wrong. Medigap is a private health insurance option designed to supplement your Medicare coverage. It generally pays for the non-covered cost of Medicare-covered services only, such as hospital deductibles, and physician co-payments. In most cases, a Medigap policy will not pay for long-term care services.

Medicaid

Medicaid is a jointly-administered federal and state program designed to provide medical care for low-income Americans. It is a payer of last resort for those people who have exhausted their personal financial resources. Persons who are eligible for state public assistance or for Supplemental Security Income (SSI), the federal program for the aged, blind, or disabled poor, automatically qualify for Medicaid. In almost all states Medicaid pays for long-term nursing and custodial services that are not covered by Medicare. However, there are strict income and asset eligibility standards and these vary significantly from state to state.

Prior to September 30, 1989 when one spouse was forced to enter a nursing home, the spouse at home had to "spend down" virtually all of his or her income and assets before Medicaid would cover the cost of the care. For example, in order to qualify for Medicaid, the couple's joint assets could not exceed $2,700, and income for the spouse living

in the community could be set as low as the Supplemental Security Income (SSI) limit of about $75 per month.

Things have gotten a little better since then.

The positive thing that came out of the 1988 Medicare Catastrophic Care Coverage Act is the provision that removes the specter of "spousal impoverishment."

Under the current law, states must allow the spouse at home to retain at least $825 per month of income. Further, the community spouse can also retain a minimum of $12,000 in liquid assets in addition to the couple's home, and may retain as high as $70,740 of assets. The remaining assets must be used to pay for nursing home care.

Unfortunately, two out of three persons who enter nursing homes as private payers use up their resources in a year and are forced to apply for Medicaid. In 1989 Medicaid paid 42 percent of our nation's total nursing home bill. The largest payers, however, were the nursing home residents themselves, accounting for nearly half (49 percent) of total payments.

Who Pays for Long-Term Care?

Medicare	2%
Medicaid	42%
Individuals	49%
Long-term care insurance	7%

Long-Term Care Insurance 9

Many people think that Medicare, the federal health insurance program for older people, will pay the costs of nursing home and at-home care. But as we already saw, Medicare pays for very little of the extended day-in day-out care that many older people need. Medicare supplemental insurance fills gaps in Medicare-covered services only, such as doctor and hospital bills.

In most cases long-term care is paid by the people who need it. Unfortunately, they are not able to do it for very long. The cost of nursing home stay being what it is, most elderly people exhaust their life savings within a few months or years, and then are forced to turn to Medicaid for support. Medicaid will pick up the tab as it does with nearly half of all nursing home costs in the country if the recipient meets stringent state and federal guidelines regarding income and assets. So we come to the option of financing long-term care through private pre-paid plans, akin to plans that pay doctor and hospital bills for most Americans.

You may not know whether you'll need long-term care, but statistics tell a lot. According to one study, 43 percent of those who turned age 65 in 1990 will enter a nursing home at some time during their life. Among all persons who live to age 65, about 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.

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

Long-Term Care Insurance

Over the last few years, a relatively new insurance product has begun to emerge, commonly called long-term care insurance, or sometimes nursing home or convalescent insurance. This insurance can help meet expenses arising from long-term care needs of the elderly, both in a nursing home and in the community. More than 100 companies offer private long-term care insurance today, and that number is rising as more insurance companies seek to fill this growing need.

Most policies available today are called "indemnity" policies, meaning they pay a specific dollar amount for each day of nursing home care (or each home care visit if home care is covered in the policy). Daily benefits can vary from as low as $10 per day to $100 per day or more. Obviously, the higher the daily benefit chosen, the higher the premium paid. The daily benefit for at-home care is usually half the benefit for nursing home care.

No policy, however, provides full coverage for all expenses. Further, many policies are not indexed with the cost of nursing home care over a period of time. This is why many people prefer policies that offer an inflation adjustment feature. The initial benefit amount increases automatically each year at a specified rate (say 5 percent)

over specified period of time (such as 15 years).

Some companies offer long-term care coverage as part of an individual life insurance policy. Under this arrangement, a certain percentage of the policy's death benefit is paid for each month the policyholder requires long-term care, instead of to the beneficiary at the policyholder's death.

Minimum Standards of Coverage

Long-term care insurance is a relatively new product and the coverage provided varies widely from company to company and from state to state. What should you look for in good long-term care policy?

Many states have enacted into law minimum standards of coverage that a long-term care insurance policy marketed in the state should provide. Here is a sampling of provisions you should look for in a policy:

• The policy should provide at least 24 months of coverage for all levels of nursing home care. If economically feasible, you should look for a policy that provides for even a longer stay, generally 3 to 4 years. While a majority of people admitted to nursing homes spend only three months or less, the average length of stay for long-term patients is 2 1/2 years. Roughly one out of ten nursing home patients will stay three years or more. Keep these statistics in mind while choosing length of coverage.

• A good policy should not exclude coverage beyond six months for pre-existing conditions (for treatment or medical advice recommended or received within the nine months prior to coverage.)

• A good policy should also provide inflation protection. Remem-

ber, the policy that you buy today will not be used for several years hence. When you do apply for the benefits, inflation may have pushed the cost of nursing home care far higher than originally contracted for. You should look for a policy that will keep pace with inflation.

Your current policy may cover a nursing home benefit of $60 per day. However, 15 years from now when you do need to enter a nursing home the cost may be considerably higher. Without inflation protection your coverage may be meaningless. (The current inflation estimate for nursing home costs is 5.6 percent per year.)

In general, look for a policy which offers to increase your benefit yearly, or reserve the option to purchase a higher benefit at a future time (without waiting periods), or better yet, if you can afford it, buy a policy that will pay actual nursing home costs.

- Your policy should not mandate increases in your premiums as you get older, and should not cancel coverage based on age or failing health status.

- Many states require that a nursing home insurance policy has a 30-day "free look" provision. Always insist on this "cooling off" period.

- The policy you choose should not require hospitalization in order to qualify for nursing home coverage.

- It should specifically cover Alzheimer's disease and related dementias.

- It should have reasonable waiting period before it will start paying benefits, generally 20 to 30 days. Eight out of 10 persons admitted to nursing homes from hospitals are there for three months

or less. If you have sufficient resources to pay out of pocket for a short nursing home stay, you can choose a longer waiting period (up to 100 days) and save on premiums.

In addition, you may want to make sure that your policy provides coverage for non-skilled home care and adult day care. Generally, most policies require either a prior nursing home stay or stipulate that home-care benefits could be received only if skilled care is needed. Make sure you understand the conditions under which home-care benefits are available.

Is Long-Term Care Insurance For You?

Long-term care insurance is very expensive and is generally unaffordable to a majority of older persons. Most policies currently available range in price from under $100 to more than $8,000 per year. Most long-term care insurance is sold to persons age 55 or older. After age 80, many companies will not accept new applications. Your age at the time of the purchase is an important factor in determining how much you will pay.

Other factors which affect the price of insurance include: your health condition at the time of purchase, level of benefits chosen, length of coverage and waiting periods.

As a general rule of thumb, umless your income is $15,000 or more annually and your assets (excluding your home) exceed $50,000, long-term care insurance is probably not for you.

Things to Know About Long-Term Care Insurance

Since long-term care insurance is such a new product, most people do not have suffcient experience or knowledge to make an intelligent choice. The policies marketed by various insurance companies vary greatly in the kind of coverage provided, and each policy has a set of limitations and exclusions that would curtail the coverage you'll receive. Here, we'll look at some of the factors that affect the premium you pay and the benefits you receive.

For instance, if your only source of income is a minimum Social Security benefit or Supplemental Security Income (SSI), you should not purchase a 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 for family members.

Age and eligibility Most individual policies are available only to those applicants between the age of 50 and 80. You may have difficulty buying long-term care insurance if you are 80 or over. The younger you are when you buy the policy, the lower the premium. Most policies generally provide for level premium, which means that it will not rise with your age, unless there is an increase for every policyholder in the class.

Some insurance companies will not sell long-term care insurance to persons with certain medical conditions or history that would put them at higher risk of needing nursing home care. However, this does not mean that you must have perfect health in order to be acceptable to insurance companies. Most people develop some health problems with age, and insurance companies take this into account.

Never be dishonest in filling out a medical questionnaire. In fact, you may want to ask your doctor to review your questionnaire to make sure it contains correct and up-to-date information about your health and medical history. Some companies may not verify your medical history until you make a claim for benefits. If they discover at that point that you were less than truthful in your application, they may refuse coverage and cancel your policy. In such a case, you'll have paid premiums for a number of years, only to have your claim denied for providing inaccurate information on the medical questionnaire.

Pre-existing conditions Most insurance policies will carry an exclusion for pre-existing conditions, which means that you'll be denied coverage for a period of time for nursing home care related to a health problem for which you had received treatment or medical advice within the previous nine months. Such health problems are considered pre-existing conditions. If you need long-term care within six months of the policy's issue date for a condition for which treatment was either under way or had been recommended before you took the policy, you may be denied benefits.

Elimination or deductible periods These are defined as the number of days you must be confined in a facility or the number of home-care visits you must receive before policy benefits begin. For example, if your policy has an elimination period of 20 days for nursing home care or home-health visits, your policy will begin paying benefits on the 21st day. Usually the longer the eliminaton or deductible period, the lower the premium.

Indemnity value and duration of benefits Most long-term care insurance policies are indemnity policies, meaning that they pay a certain dollar amount for each day of nursing home care. In general, the higher the indemnity value the higher the premium for the policy. Similarly, a policy that provides a longer period of coverage will cost

more than the one that provides a shorter period of coverage. For example, a policy that pays $100 a day for up to 5 years of nursing home care will cost considerably more than a policy that pays $50 a day for three years.

Long-term care policies generally limit benefits to a maximum dollar amount or a maximum number of days and often have separate benefit limits applied to nursing home and home health care within the same policy. For example, a policy may offer five years of nursing home coverage (many policies now offer lifetime nursing home coverage) and two years of home health care coverage.

Generally, there are two ways in which companies define a policy's maximum benefit period. Under one definition, a policy may offer a one-time maximum benefit period. A policy with five years of nursing home coverage, issued by a company using this definition, would pay just once in a policyholder's lifetime. Other policies offer a maximum benefit period for each "period of confinement." Under this second definition, a policy with a five-year maximum benefit period would cover more than one nursing home stay lasting up to five years each if the stays were separated by six months or more.

Waiver of premium This provision allows you to stop paying premiums during the time you are receiving benefits. There may be restrictions on this provision, such as a requirement to be in a nursing home for any length of time (for example, 90 days) before premiums are waived.

Renewability Most state regulations require that long-term care policies marketed in their state should be guaranteed renewable for life. In other words, once a policy is sold to an individual it cannot be cancelled, except for non-payment of premiums. Premiums can be increased, however, if they are increased for an entire class of

policyholders.

Exclusions Policies may not pay for long-term care related to inorganic mental or nervous conditions, alcoholism, mental retardation, or certain other health conditions or situations. However, most policies will cover long-term care related to Alzheimer's disease and other related cognitive impairments, which are the leading causes for nursing home admissions.

What do policies cost? According Health Insurance Association of America, in 1990, individual policies without an inflation adjustment feature ranged in cost from about $480 per year to more than $3,800. Inflation adjustments can add 25 percent to 60 percent to your premium, depending on the option you select, but can keep benefits in line with rising costs.

In 1990, a policy offering an $80 per day nursing home benefit for four years, with a 20-day deductible, cost a 50-year-old about $480 per year. For someone who was 65 years old in 1990, the same policy cost about $1,135 and for a 79-year-old, the cost was $3,840. The same policy with an inflation feature may cost $660 at age 50, $1,400 at age 65, and $4,200 at age 79.

What Do Long-term Insurance Policies Cover?

Generally, today's policies cover skilled, intermediate and custodial care in state-licensed nursing homes. They also cover home health services provided by state-licensed and/or Medicare-certified home health agencies. Many newer policies also cover adult day care and other care in the community.

Although there may be some difference in definition from policy to policy, it's important to understand the general distinctions among the levels of nursing home care.

Skilled care generally refers to care given by a registered nurse or therapist - usually on a daily basis - under the supervision of a physician. Skilled care follows a treatment plan and lasts for relatively short periods of time.

Intermediate care refers to occasional nursing and rehabilitative care under the supervision of skilled medical personnel. It is less specialized and less comprehensive than skilled nursing care, and may last considerably longer.

Custodial care - assistance with the activities of daily living (bathing, dressing, eating, etc.) - often involves nonmedical personnel. Much of the care given in nursing homes, particularly during extended stays, is custodial care.

Most long-term care policies will pay benefits either when care is medically necessary and prescribed by the patient's physician or when need is demonstrated by the inability to perform a specific number of personal functions such as bathing, dressing or eating. Most policies no longer require a hospital stay before paying nursing home benefits.

On the home front, policies usually cover home care services such as skilled or nonskilled nursing care, physical therapy, homemakers and home health aids. Most policies no longer require a certain period of nursing home care before covering home health care services.

You may obtain a list of all companies offering long-term care policies by writing to:

Health Insurance Association of America
P.O. Box 41455
Washington, DC 20018

Appendix B shows such a list.

HIAA has prepared a long-term care policy checklist that may help you in comparing various policies you may be considering. You should do your comparison shopping keeping in mind at least the factors shown in the checklist.

You can obtain more information on long-term care insurance from:

National Association of Insurance Commissioners
120 W. 12th Street, Suite 1100
Kansas City, MO 64105-1925
(816) 842-3600

Innovations in Nursing Home Insurance Policies

Nursing home policy is a relatively new product. In a short period of time, it has quickly become a best-selling product for the insurance industry. Last year, sales of long-term care policies jumped 36 percent to an all time high of 1 1/2 million policies. Such gains came despite stiff premiums charged for the insurance. Premiums for long-term care policies could run as high as $4,000 a year.

The industry has added a few wrinkles to the basic nursing home policy to increase its market share. Here is one of the innovations offered by Penn Treaty Life of Allentown, Penn. Its basic long-term care would cost $1,200 a year for a healthy 65-year-old man. He can, however, get back 89 percent of all the premiums paid if he buys an optional rider to the policy. In order to get the refund of the premiums paid, he must stay healthy long enough. There are no refunds for the first five years. From years six through ten, he could start receiving back 30 percent to 80 percent of all the premiums paid up to that time, provided he stays healthy and does not use his nursing home benefits.

The optional rider to the policy that allows the insured to receive a portion of his premiums back raises the original cost from $1,200 a year to $1,668. If the person stays healthy for 10 years the refund of the premiums would reduce his annual cost to $331.50. If, however, the man has to enter a nursing home and collect insurance benefits that exceed his paid-in premiums by 20 percent, he won't be eligible for any refund of the premium.

The rider may be an attractive option for those who feel they will stay healthy long enough but want to have the assurance and protection of a nursing home policy in the eventuality that they have to enter a nursing home.

In response to the escalating costs of nursing home care, CNA Insurance Co. of Chicago has come up with a policy that automatically increases the daily long-term care benefit by 5 percent a year, without any limitation to the maximum amount. Keep in mind that this 5 percent increase in the benefit may still not be enough because medical costs have been rising at a rate of 10 percent to 35 percent extra, depending on the age and desired benefits.

A basic policy that would cost $617 in annual premiums for a 65-year-old healthy man would cost $784 for the added inflation protection. You would have to receive at least 5 years of increased benefits to justify this 27 percent increase in the premiums.

Recommendation: Take a long hard look at the policy you are buying and any optional features you might want to add, to see if the added cost of such features would be worth the benefits you may receive.

Shopping for a Long-Term Care Policy
Factors to Evaluate

	Policy A	Policy B
1. Covered Services: ■ Skilled nursing care ■ Intermediate care ■ Custodial care ■ Home health care ■ Other care		
2. Benefits paid per day: ■ Skilled nursing care ■ Intermediate care ■ Custodial care ■ Home health care ■ Other care		
3. Inflation Protection: Does the policy provide for inflation protection? What is the percent of increase in benefits per year? How much additional premium?		
4. Maximum lifetime benefits Does the policy put a cap on the maximum lifetime benefit that would be paid? What is the length of coverage?		

	Policy A	Policy B
5. Maximum stay Does the policy put a limit on the number of days in a nursing home per illness that would be covered?		
6. Pre-existing conditions What is the exclusionary period for pre-existing conditions?		
7. Alzheimer's disease coverage Does the policy cover Alzheimer's disease and other dementia-related conditions? What health conditions are specifically excluded?		
8. Deductible period What is the elimination or deductible period? What is the number of days you'll have to stay in a nursing home before the policy will begin to pay?		
9. Prior hospitalization Does the policy require a prior hospitalization before you qualify for nursing-home care?		

	Policy A	Policy B
10. Prior nursing-home stay Does the policy require a prior nursing-home stay bedore you qualify for home-health care?		
11. Physician certification Do you need a certification by a physician to qualify for the benefits?		
12. Guaranteed renewal Can the policy be cancelled? Does it provide for guaranteed renewability for life?		
13. Age of enrollment What is the age group for enrollment in the plan? Is there a maximum age beyond which you cannot buy the policy?		
14. Annual premiums at age 55 years: 65 years: 75 years:		

Living Will 10

"No right is held more sacred or is more carefully guarded by the common law than the right of every individual to the possession and control of his own person, free from all restraints or interference by others, unless by clear and unquestionable authority of law."

-U.S. Supreme Court in 1981 *(Union Pacific Railway Co. v. Botsford)*

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault for which he is liable in damages."

-A New York Court in 1914 *(Schloendorff v. New York Hospital)*

"Anglo-American law starts with the premise of thoroughgoing self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery or other medical treatment. A doctor may well believe that operation or form of treatment is desirable or necessary, but the law does not permit him to substitute his judgment for that of the patient by any form of artifice or deception.

-A Kansas Court in 1960 *(Natanson v. Kline)*

Evolution of the Right to Die

It is possible that you or your spouse may never have to enter a nursing home. There is, however, one other facet of planning for old age, considered by many to be of even greater urgency and importance, that requires your attention. This has to do with the medical treatment provided to you in the event you are terminally ill and are no longer capable of making decisions or expressing your wishes.

Medical science has advanced to such a stage where a person who only a few years ago would ordinarily have succumbed to an illness or injury can now be kept alive indefinitely. Life-sustaining measures, often heroic in scope, succeed in prolonging a patient's life. But sadly, what is being kept alive is often nothing more than a body in a vegetative state.

Society at large, and our legislatures and courts in particular, have realized this problem and are coming to grip with the necessity of addressing it in more than just medical or legal terms: the problem needs to be addressed in human terms. Right to choose a medical treatment or a technology option that may prolong a life indefinitely is now almost universally as personal and inalienable to every individual.

Medical and legal professions are doing some catching up of their own. Some of the practices that were controversial or even illegal five years ago in the care of a dying patient have now become commonplace. One example is do-not-resuscitate (DNR) orders. Physicians, hospitals and family members routinely debate such a course of action in treating a terminally-ill or injured person and often find themselves in complete agreement.

Similarly, a few years ago, a distinction was being made between discontinuing life-sustaining measures that used latest medical technologies and equipment and withholding of nutrition and hydration from a terminally ill or permanently comatose patient. In some people's view, withholding of food and nutrition from a dying patient, as opposed to not taking heroic measures to prolong life, was an "active" form of "right to die" practice, only one step removed from euthanasia, and therefore not acceptable; but such a distinction, semantic at best, has lost its meaning in most medical and legal circles.

The right to refuse treatment finds its legal basis in two principles: the common law right of self-determination and the right of privacy guaranteed in the U.S. Constitution.

As a general rule, it is now not only permissible, but mandatory under certain circumstances, to withhold or withdraw life-sustaining measures if this is in accordance with the patient's expressed wishes.

Legal doctrine has now made a full circle by holding that in some cases a provider of medical services may be held liable for damages if it continues to prolong a life by taking extraordinary measures in knowing contravention of a patient's wishes.

Living Will Statutes

Forty-one states and the District of Columbia have now enacted statutes, generally know as "natural death" or "living will" acts, that recognize a terminally-ill patient's right to say "no" to further treatment. Living will laws release doctors and other health care providers from liability when they act in accordance with the patient's instructions.

The following jurisdictions have enacted living will legislation:

Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersy, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, and the District of Columbia.

The following states authorize only the appointment of a health care agent:

Massachusetts, Michigan, and New York.

Although the statutes vary in detail from state to state, they all succeed in providing a terminally-ill patient with an acceptable alternative to put into practice his or her expressed wishes, especially at a time when the patient may not be physically or mentally capable of doing so.

The statutes differ in their definition of certain medical terms such as "terminal illness"; some states require a certification from not only the attending physician, but also from a second doctor. Almost all states require the living will document to be witnessed by at least two disinterested individuals. Some states specify that the patient's signature be properly acknowledged before a notary public.

Some states allow the person to designate a close relative or other proxy to make crucial medical care decisions in the event he or she becomes incompetent, whereas some states do not allow anyone but the patient to make such decisions. All patients, however, do have the

right to refuse treatment, and this is not abridged or impaired either by the presence or absence of a specific statute.

Choosing a Course of Action

A person entering a nursing home or other long-term care facility must squarely face this crucial decision. The first step would be an open and frank dialogue with other members of the family, physician, clergy or other concerned individuals. All options must be explored and a specific course of action must be discussed and decided.

If it is decided that a living will should be executed, you are encouraged to use a statutory form, wherever possible. Such form would be generally recognized in the state and would bring compliance with the patient's wishes from the medical profession when the situation so demands. Even in states that have no statutory enactment of natural death laws a person should be encouraged to use general forms of living will to clearly state his or her preferences. The U.S. Supreme Court has recently held that a person's wishes when expressed clearly and unambiguously should be honored as consistent with the constitutionally guaranteed right to die.

A Real Life Story

Living Will in Action

On November 11, Choice in Dying, Inc. (CID) received a call from Mrs. Sylvia Gray of New York, who was encountering serious trouble having a friend's living will honored. The friend, Belle P., was in the late stages of Alzheimer's disease and lived in a nursing home. She had been admitted to the hospital because she was not eating and had become malnourished. A temporary feeding tube had been inserted through Mrs. P's nose into her stomach. When hospital staff told Mrs. Gray that they intended to implant a permanent feeding tube into Mrs. P's stomach, Mrs. Gray contacted CID.

The hospital had a copy of Mrs. P's living will, which said that she did not want life support - including tube feeding - if her doctor determined that it "would serve only to prolong artificially the dying process." Mrs. P's doctor took that to mean that she only intended to refuse life support if she were "terminal." Howver, he did not believe she qualified as terminal; he said she was in good health. Mrs. Gray saw things differently. She and Mrs. P. had discussed their treatment wishes when they signed their living wills, and she was sure that Mrs. P. had never wanted life support if her underlying condition was irreversible, whether or not the condition was considered terminal. But the hospital told Mrs. Gray that unless she got a court order to prevent the operation, a feeding tube would be implanted the next day.

Getting a Court Order

Our first step was to explain the legal facts to Mrs. Gray. A doctor can treat a patient only with the patient's consent; if the patient is incompetent, an appointed proxy or the next of kin must give consent before treatment can proceed. Since Mrs. P. had no family or proxy, no one could consent to the surgery. The hospital could not legally operate unless they received permission from the court. The burden was on them, not Mrs. Gray.

With CID's help, Mrs. Gray made sure the hospital followed the correct procedure, and when they did go to court, CID helped Mrs. Gray convince the court to uphold Mrs. P.'s living will. Even with a court order stating that the living will was in effect, Mrs. Gray still had to see that the hospital removed the temporary feeding tube. Then, when Mrs. P. was moved back to the nursing home, the staff raised new concerns. Should they re-admit her to the hospital if complications arose? If she developed an infection, should they use antibiotics? CID worked with the home to help them focus on taking only those measures that would make Mrs. P's death comfortable. Finally, Mrs. P. died eight days after her feeding tube was removed...a little over two months after Sylvia Gray first contacted CID.

An Agent Is Extra Protection

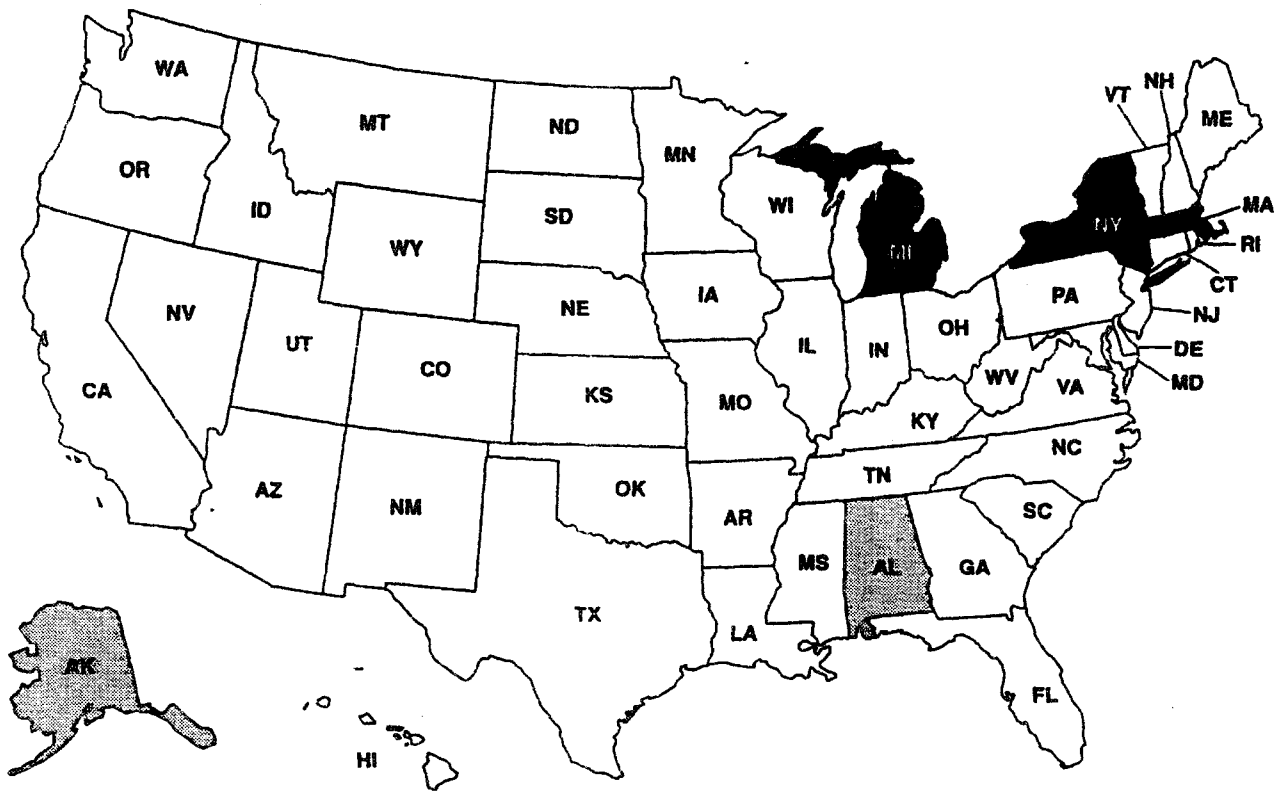
Mrs. P.'s living will worked in the end. Without it, under the new law in her state, the feeding tube would almost definitely have been implanted. At the same time, it took months, money and great commitment to have Mrs. P.'s wishes

honored. If she had legally appointed Mrs. Gray as her health care agent, Mrs. Gray would have had full authority to refuse life support on Mrs. P.'s behalf, and the conflict would probably not have arisen.

Courtesy of Choice in Dying, Inc.

June 1993

State Statutes Governing Living Wills and Appointment of Health Care Agents



Jurisdictions with legislation that authorizes both living wills and the appointment of a health care agent (**the District of Columbia and 45 states: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming**).

States with legislation that authorizes only living wills (**2 states: Alabama and Alaska**).

States with legislation that authorizes only the appointment of a health care agent (**3 states: Massachusetts, Michigan and New York**).

Note: The specifics of living will and health care agent legislation vary greatly from state to state. In addition, many states also have court-made law that affects residents' rights. For information about specific state laws, please contact Choice In Dying.

Produced by **Choice In Dying, Inc.** (formerly Concern for Dying/Society for the Right to Die)
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Your Questions About Living Will Answered 11

Choice in Dying, Inc. (formerly Concern for Dying/ Society for the Right to Die) has published general information on living wills in the form of questions and answers. We've reproduced below with permission some of this information in the hope that it will help you in arriving at an intelligent choice.

What is a living will?

It is a statement, signed by you and witnessed, which tells your family and your doctor your directions about life-prolonging medical procedures when your condition is hopeless and there's no chance of regaining what you consider to be a meaningful life.

Why do you need a living will?

Medical advances can now keep you "alive" when your mind is gone and your body has stopped functioning naturally. Under constitutional and common law, you have the right to refuse treatment. A living will gives you the opportunity to express your wishes in advance, since you may not be able to make them known when it becomes important to do so.

What are "life-prolonging procedures"?

These may include hooking up to a machine when you cannot breathe on your own, performing operations or prescribing antibiotics that cannot realistically increase your chance of recovery, starting your heart mechanically when it has stopped beating, or feeding you by tube. You may, if you wish, specifically list in your living will the procedures you would or would not want administered. (If you do not include specifics, the general directions in the living will declaration will stand for wishes regarding treatment under the circumstances described. Your doctor and others will be informed that you want only comfort measures.)

What are comfort measures?

Medication, nursing care and other treatment administered for the purpose of keeping you as comfortable and free from pain as possible.

What is meant by "other instructions/comments"?

Your living will should say exactly what you want it to say. This means that you are free to add any directions to it that you wish. Space is provided for this.

Can you choose someone else to speak for you if you cannot speak for yourself?

Your living will provides for this. It offers you a second protection in allowing you to name a person you trust (your "proxy") to make medical decisions for you in accordance with your wishes at a time when you cannot make them for yourself.

Should your living will be witnessed?

You should sign it and date it in the presence of two witnesses. These may be any adult persons of your choice.

What should you do with your living will?

It is important that your family knows how you feel, and your living will provides an opportunity to open up discussions of a subject that is too often not talked about. You should give a copy of the signed document to the people who might someday have to produce it on your account. If you have a family doctor, it is most important that you discuss it with him or her as well, and have a copy placed in your medical file. If you do not have a family doctor, it is doubly important that you discuss it with someone close to you. You should also keep a copy among your important personal papers, in a place known to your family, so it can be easily located. You might also carry a card in your wallet stating that you have signed a living will and indicating where it can be found. Do not place it in a safety box, where it would not be readily available when needed. If you change doctors, make sure your new doctor has a copy.

Is a living will legally binding?

You have the constitutional and common law right to refuse any treatment you do not want. Living wills have been given weight in court decisions as evidence of a person's intent. Even though your state may not yet have passed a living will law, it is the best protection available to you until it does. In fact, a doctor or hospital treating you against your wishes (or those put forward by your proxy) may be liable for damages.

The laws of states that have passed living will legislation contain the document form to be used by residents of those states. If you live in a state that has a living will law, you can obtain the appropriate form, along with instructions for its use, from Choice in Dying, Inc. In addition, you may sign and give to your family and doctor the living will. In that way you'll be telling them your personal wishes. This document can be especially important to you, too, if you are traveling and become hospitalized in a state without a living will law.

How can you make sure your living will will be viewed as an up-to-date document?

Review it occasionally, and initial and date it, to show that it continues to express your choices accurately. You may make additions, changes, or deletions, provided they are clearly initialed and dated. Make sure any changes are shown on all copies, too. (You can, of course, revoke your living will at any time if you change your mind.)

Does a living will affect life insurance?

No, and nearly all the living will laws that have been passed clearly state that new insurance applications cannot be turned down or existing policies affected by the signing of a living will. Signing of a living will, or terminating artificial life-prolonging treatment, or not starting treatment at all, is not considered suicide or assisted suicide.

How did the living will originate?

The term "living will" has become part of our everyday vocabulary, and yet few are aware of its history. In 1967 a Chicago attorney, Luis Kutner, addressed a Society for the Right to Die meeting. By law, he said, a patient cannot be subjected to treatment against his or her

wishes. When the patient's condition is such that neither consent nor refusal can be expressed, a physician might assume that everything possible must be done to preserve life. To prevent treatment that may be contrary to the patient's will, Mr. Kutner proposed that a person while still of sound mind draw up a document as a "testament permitting death."

At that meeting in 1967, Society members were asked to "draw up such a living will which might serve as a sample or a suggestion" for others. Since then, there have been several versions of the living will and millions of copies distributed.

Choice in Dying, Inc. is a not-for-profit organization which depends entirely on the support of individual contributors. The basic annual membership is $15, entitling you to receive information on right-to-die developments which may someday affect you or those close to you, a subscription to society newsletter and, at the start of each calendar year, a wallet-size living will membership card.

We encourage our supporters to contribute more than the basic membership dues if possible, enabling us to push ahead ever more effectively in the effort to protect every citizen's right to a natural death.

Reprinted with permission of the Society for the Right to Die, now known as Choice in Dying, Inc. They can be reached at 200 Varick Street, 10th Floor, New York, NY 10014-4810.
Phone (212) 366-5540.

Living Will Declaration

To My Family, Doctors, and All Those Concerned with My Care

I, _____, being sound of mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care.

If I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, I direct my attending physician to withhold treatment that merely prolongs my dying. I further direct that treatment be limited to measures to keep me comfortable and to relieve pain.

These directions express my legal right to refuse treatment. Therefore, I expect my family, doctors, and everyone concerned with my care to regard themselves as legally and morally bound to act in accord to my wishes, and in so doing to be free of any legal liability for having followed my directions.

I especially do not want: _____

_____

_____

_____

Other instructions/comments: _____

_____

_____

_____

Proxy Designation Clause: Should I become unable to communicate my instructions as stated above, I designate the following to act in my behalf:

Name _____

Address _____

If the person I have named above is unable to act on my behalf, I authorize the following person to do so:

Name _____

Address _____

Signed _____ Date _____

Witness _____ Witness _____

Address _____ Adddress _____

City, State _____ City, State _____

Notes:

1. This living will declaration sets forth your directions regarding medical treatment.

2. You have the right to refuse treatment you do not want, and you may request the care you do want.

3. You may list specific treatment you do not want. For example:
   Cardiac resuscitation
   Mechanical respiration
   Artificial feeding/fluids by tube

Otherwise, your general statement in the declaration will stand for your wishes.

4. You may want to add instructions for care you do want; for example, pain medication; or that you prefer to die at home if possible.

5. If you want, you can name someone to see that your wishes are carried out, but you do not have to do this.

6. Sign and date the declaration in the presence of two adult witnesses, who should also sign.

7. Keep the signed original with your personal papers at home. Give signed copies to doctors, family, and proxy. Review your Declaration from time to time; initial and date it to show it still expresses your intent.

Courtesy of Society for the Right to Die, 250 West 57th street, New York, NY 10107.

Selecting a Nursing Home 12

Entering a nursing home is probably the most wrenching decision an older person and his or her families are called upon to make. As Americans live longer due to better medical care and improved health standards, a greater proportion of our elderly population faces the prospect of spending time in a nursing home.

For some, the stay in a nursing home may only be temporary, but for many others, the stay may last until they die, which may be several years. The nursing home becomes their new home.

Statistics indicate that by the end of this century, over eight million Americans 65 and over will need some kind of long-term care due to chronic illness or some other disability. A majority of these Americans will be taken care of in their own homes by family and friends, but nearly one-third may have to resort to nursing-home care.

It is estimated that two out of five people aged 65 or older will enter a nursing home. Half of them will need to stay six months to less; the other half will spend on the average 2.5 years. Only a small number will stay 5 years or longer.

Do You Need A Nursing Home?

Even before you begin the selection process, you should ask yourself why you are considering nursing home care. If you are considering

nursing home placement because you're having problems managing without assistance in your home, you may be able to use services in your community to assist you in the home, such as homemaker services, home delivered meals, and home health care.

Other alternatives to nursing home care may include licensed personal care homes or domiciliary care homes. These homes assist with personal care, such as bathing and dressing. They can also assist with the handling of finances and are usually less expensive and less structured than a nursing home.

In many cases, your state department on aging may have a program to help you assess various options for care available and determine one that is most appropriate for you. Nursing home care is just one of your options. Often, an individual found eligible for nursing home care can remain in the community if appropriate home care and other community services are available

If you are coming out of the hospital, talk to your social worker or discharge planner about how your needs can best be met. The hospital social worker should be familiar with the long-term care facilities and services in your area and would be able to offer assistance.

Personal Considerations

Listed below are some of the most important factors that you need to consider in your search for a nursing home. You will want to address these questions even before you visit a nursing home.

Is the nursing home in a convenient location?

The location of a nursing home may be one of the most important features in the selection process. This is especially true if your stay will be long term.

Is the home located in an area where family and friends will be able to visit you on a regular basis? Will your physician be able to come to this facility to treat you, or will you have to change doctors? Can you get transportation from the facility to visit the people and places you know and like? Does the facility offer transportation, and if so, under what conditions can you use it?

Do you want a religiously affiliated home?

Many nursing homes are operated by religious denominations. Some of these give preferences to members of their own denomination. Therefore, some nursing homes may or may not be available to you depending on your religious affiliation.

Do you have special needs?

With the help of your physician, determine your special needs. You may need a special service or therapy which some nursing homes may not provide. For example, if you depend on a ventilator, need intravenous therapy or require mental health services, you may find that some nursing homes are unable or reluctant to admit you. Some nursing homes do not offer certain types of rehabilitation or "skilled care" but only provide intermediate or a lower level of care. Some nursing homes also have special Alzheimer's disease and related disorders units.

Don't be afraid to ask about the nursing home's ability and willingness to meet your needs. You can save yourself considerable time by doing so.

Is your need immediate?

The availability of a nursing home bed may vary according to your particular circumstance and geographic location. Some nursing homes may have a waiting list, particularly those operated by counties. If your need is immediate then some homes may not be available to you. However, there are some facilities that give priority to an applicant who has immediate need.

If you are told that the nursing home of your choice has a waiting list, ask how quickly the list moves and when you can reasonably expect to be admitted. See if you can transfer from another facility at a later date, if you go somewhere else temporarily.

Financial Considerations

How will you pay for your care?

It is absolutely vital to have a clear understanding of financial requirements before entering a nursing home. Nursing home care is expensive and hidden charges can add substantially to the cost.

Your means of paying for nursing home care may narrow your choices in two ways:

First, if you will be relying on Medicare or Medical Assistance

(Medicaid) to pay, they will only pay for care in nursing homes that have been certified to participate in these programs. Although most nursing homes participate in Medicare and Medicaid programs, some do not. Therefore, you should find out whether a nursing home participates in one or both of these programs.

Since nursing home care is costly, keep in mind that you may probably exhaust your financial resources at some point while paying for nursing home care. If you run out of money, you may have to rely on Medicaid for future payment, even if you were able to pay privately or with insurance at the beginning. If you are still medically in need of nursing home care, a nursing home that participates in Medicaid must continue to care for you after you "convert" to Medicaid from private pay status, but a non-participating nursing home can discharge you.

Second, some nursing homes avoid admitting residents who are currently or will soon become Medicaid recipients. This is because they can charge higher rates for private paying residents than they receive under the Medicaid program. You should find out if the nursing home of your choice freely accepts Medicaid residents, if you will be relying on Medicaid at the beginning of your stay.

More About Medicare and Medicaid

Medicare contributes little to nursing home care. It is a federal health insurance program which pays for some skilled nursing care for a maximum of 100 days for persons 65 years of age and over who are in need of intensive nursing care following hospitalization. However, most people do not qualify medically for anything close to the full 100 days of payments. For more information on this program, contact your local Social Security office or hospital social worker.

Medicaid is a joint state and federal program that will pay for nursing home care for an unlimited time for most persons who need such care and whose income and resources are below a certain level. It is also available to nursing home residents who have spent most of their resources while paying for nursing home care. For more information on this program, call your local County Assistance Office or Area Agency on Aging.

Spousal Impoverishment Under Medicaid

There is a federal law designed to protect a spouse living in the community from being impoverished when their husband or wife goes into a nursing home and has also applied for Medicaid. Your local County Assistance Office or Area Agency on Aging have more information on what to do to protect your spouse's income and resources before you enter a nursing home.

Private Insurance

There are a number of private long-term care insurance policies available to help pay for nursing home care. However, these policies vary in the coverage and benefits they provide. Some policies include benefits for nursing home care. It is very important to examine these policies carefully because some require prior hospitalization, or that some other special condition exists before nursing home care will be covered. If you have an insurance policy, review it carefully to determine if it is going to cover your nursing home care. Seek the assistance of an attorney or someone who is familiar with the different types of long-term care insurance policies.

Paying Privately

For private pay residents, there are no rules to govern what is included in the basic rate and what is extra. Therefore, be sure to find out what the daily rate is and what services are covered before you sign an admissions agreement with a nursing home. This way, you can do comparative shopping as an informed consumer.

Keep in mind that the average cost for nursing home care in most parts of the country is about $30,000 per year. Therefore, even if you start by paying privately for your care, you will probably exhaust your financial resources at some point and have to convert to Medicaid.

Quality of Life

Now that you have narrowed your choices to homes that are most convenient, affordable, able to meet your needs, and willing to admit you, you will want to visit the homes on your list. Try to visit homes more than once and try to visit during different times of the day. Weekends and evenings are also good times to visit to determine if the care is consistent. If possible, visit around mealtime so you can observe a meal being served.

The true test of a nursing home is its care and attitude toward residents. The quality of nursing care and the attitude of the nursing staff will affect your sense of well-being more than any other aspect of the nursing home.

What to Look For

Most of the care in nursing homes is given by nurse aides. You can tell a lot about a nursing home by observing how they interact with the residents. Here are some questions you should ask yourself during your visit to the nursing homes on your list:

Are aides treating residents with dignity? Do they knock on doors before entering a resident's room? Do they close doors or curtains when helping residents dress, bath, or use the bathroom? Are call bells being answered promptly? Are residents being spoken to in a caring and considerate manner, even those residents who appear to be confused? Do aides put residents in restraints for convenience sake? Do they dress residents or let them stay in hospital gowns all day? Are residents confined to a specific area or are they encouraged to move about and socialize? Are room-bound residents being checked on to make sure they are comfortable? Is the quality of care consistent on all shifts?

The quality of the professional nursing staff is more difficult for the lay person to judge. You can determine the attitudes of the nurses by watching them interact with residents. But their reputation with physicians, hospital social workers, and other health care professionals may be a better measure of the quality of the care they provide. Talk to any contacts that you have in the health field to learn about the nursing home's reputation.

The Department of Health or the Department of Public Social Services perform annual inspections of nursing homes. Homes are required to post the latest inspections in a place that is readily available to residents. Ask to see a copy of the home's latest survey or contact your local Ombudsman on how you can go about getting the home's most recent survey.

Morale

High morale of the residents usually indicates the kind of nursing home that really is like a "home." You want to find out what steps the nursing home and staff have taken to promote morale.

Do residents have personal furniture, other personal belongings, plants, and pictures in their rooms or do the rooms remind you of a hospital? Is there a bustle of residents and staff involved in various activities and chatting with each other, or are residents lined up in the lounge silently staring at the television? Is there an activities coordinator and what kinds of activities are there? Are residents outside if the weather is nice? What are the visiting hours and are exceptions granted when the hours are not convenient for visitors? Do volunteers from the community come to visit? Are trips and visits outside the nursing home encouraged? Are there places for private discussions and telephone conversations?

The true test is not what the administrator or the activities director might tell you. Walk around on your own and talk to residents and family members to find out what their feelings are about the nursing home. Are they willing to speak freely or do they fear retaliation from staff if they speak to you? Is there a residents' council which discusses the concerns of the residents and recommends changes to the administration? Ask to speak to the members of the council or make arrangements to attend the next resident council meeting.

Safety and Cleanliness

It goes without saying that a nursing home should be safe and clean. Here are some things to look for:

Are stairs and hallways clear of obstacles, well lighted and equipped with handrails? Do bathtubs, showers, and toilets have grab bars? Do the beds adjust in height? Are spills cleaned immediately? Look for smoke detectors and evacuation diagram on each floor. Ask a staff person if "no smoking" policies are observed.

A home should be free from permanent bad odors or cover-up deodorant smells. Are linens clean? Are spills wiped up immediately? Are there dirty window sills, counter tops, bedside tables or floors? These are signs that a nursing home doesn't measure up in housekeeping.

Food

One of the most common criticisms of nursing homes is the food. Ask several residents how they like the food. Ask to see copies of the menus for several weeks. Are the meals balanced and appetizing or repetitive and boring? What snacks are available between meals and in the evening? Is there any policy about visitors bringing food? Can visitors join you for a meal in the dining room? What say do you have in planning meals? Can you get substitute items if you don't like what is being served? What provisions are made for special diets? Does the home have a registered dietitian? Ask to see a meal being served. Is the setting for meals pleasant? Does the meal look appetizing? Are residents encouraged to go to the dining room for meals, or do they stay in their rooms and eat alone?

Other Considerations

There are other matters that you may want to consider at this time. For example, do you want to prepare a durable power of attorney to appoint someone to act in your behalf if you should become unable to

do so? Do you want to handle your own finances, or do you want the nursing home to handle such matters? What relatives or friends could the nursing home contact should the need arise? Do you want to make any statements about whether and under what circumstances you would want life-sustaining medical procedures, should the need arise? Talk these matters over with family, friends or the Ombudsman if they concern you.

SOURCE: Pennsylvania Department of Aging and the Office of the State Long-Term Care Ombudsman.

For additional information, contact U.S. Department of Health and Human Services which puts out a *Guide to Choosing a Nursing Home.*

Checklist For Selecting A Nursing Home

Below is a checklist that you may want to use in selecting a nursing home. We recommend that you visit the nursing home, talk with the present and past residents, meet with the staff and check with the local nursing home regulatory body, then weigh all of the information carefully.

Licensing and Certification

1. Is the nursing home licensed by the state Board of Health or other nursing home regulatory agency?

_____

_____

2. Does the nursing home belong to the American Health Association or the American Association of Homes for the Aging?

_____

_____

3. Is the home certified for Medicare or Medicaid reimbursement?

_____

_____

4. Has the nursing home been cited for any violations of health, medical, or personnel standards by the state?

_____

_____

Residents' Rights

5. Is a written statement spelling out the residents' "Bill of Rights" prominently displayed in the facility? From your conversation with the present residents, does it appear that the nursing home adheres to this code to the satisfaction of the residents?

_____

_____

Location

6. Is the nursing home located in the vicinity of your present home or homes of the members of your family?

_____

_____

7. Is the location of the facility such that family, friends, and your physician can visit you conveniently? Is there public transportation nearby?

_____

_____

Premises

8. Are the premises clean, attractive and inviting? Are the surrounding grounds well manicured and adequately maintained?

9. Is the home well-lighted and pleasantly and tastefully decorated ?

10. Are residents' rooms attractive, cheerful, clean and bright? Are the rooms designed and furnished with an eye toward the comfort, convenience and safety of elderly and handicapped people?

11. How many residents are assigned to a room? Are single rooms available? How much more will the resident have to pay?

12. Is the furniture comfortable, safe, and easy to use by elderly people? Is there a telephone in each room?

13. Does the facility have proper air conditioning and heating systems?

14. Are the rooms kept at a comfortable temperature?

15. Are residents' beds easy to reach? Is there a call button near each bed?

16. Is sufficient closet space provided for storage of clothes, shoes, and personal belongings?

17. Are toilet and bathroom facilities clean and adequately maintained? Are they accessible to handicapped residents?

18. Are residents allowed to bring their own furniture, recreational equipment or other personal items?

19. Is the residents' privacy respected?

20. Is there a lounge area available for residents and visitors? Is the area clean, lighted and well-furnished?

21. Does the lounge area have smoking and non-smoking sections?

22. Does the home provide a visiting area for the friends and family of the resident? Is there a private area available for visits?

_____

_____

23. Are the hallways wide enough to accommodate wheelchairs and other special equipment? Is the home properly designed for handicapped access?

_____

_____

24. Are the exits marked clearly for fire, earthquake and other emergencies?

_____

_____

25. Are halls and stairways well-lit and well marked? Is there a public address system installed in the home?

_____

_____

26. Is there a public telephone available for residents' use? Can they receive phone calls during normal hours?

_____

_____

27. Does each room have a window opening to the outside? Does each room open to a hallway?

_____

_____

28. Is each room equipped with its own bathroom and toilet facilities?

_____

_____

29. Do bathroom and toilet facilities have adequate privacy? Is there an emergency call button in their bathroom?

_____

_____

30. Does the nursing home have an outside area where the residents can walk for fresh air, sunshine and exercise?

_____

_____

Safety Features

31. Are rooms equipped with smoke-detectors, automatic sprinklers and other emergency buttons?

_____

_____

32. Are there fire extinguishers in the hallways and other public areas? Does the home exhibit an up-to-date fire inspection certificate?

_____

_____

33. Is an emergency evacuation plan in case of fire or earthquake posted prominently in various locations?

_____

_____

Dining Facilities

34. Is the kitchen clean and well-equipped?

_____

_____

35. Are foods stored in a clean, refrigerated area?

_____

_____

36. Do the workers handle food in a safe and sanitary manner? Do they wear clean uniforms and hairnets?

_____

_____

37. Is the dining hall clean, comfortable and pleasantly furnished?

38. Is the dining area sufficiently large for the residents of the nursing home? Are residents permitted to take their meals in their rooms?

39. Is the dining area accessible for residents with wheel chairs?

40. Is there a daily menu posted on the wall?

41. Observe the foods served at meal times. Is the meal served the same as listed on the menu?

42. Sample a meal. Does the food appear appetizing and nutritious? Is it served in a tasteful manner?

43. Does the nursing home employ a certified dietitian?

_____

_____

44. What are the meal hours?

_____

_____

45. Can the residents get snacks in between meals and before bedtime?

_____

_____

46. Observe the residents at a meal hour. Do they seem to enjoy their meals?

_____

_____

47. Is there a lively conversation going on at mealtime?

_____

_____

48. Are residents encouraged to eat their meals in the dining room ?

_____

_____

49. For residents who are ill, is there an adequate staff to serve their meals in their rooms?

_____

_____

Transportation

50. Does the nursing home provide transportation for its residents for visits to medical clinics, churches and recreational facilities?

_____

_____

51. Is the nursing home easily accessible by public transportation?

_____

_____

Recreational Activities

52. Does the nursing home organize recreational and cultural activities for its residents?

_____

_____

53. Are there individual and group activities?

_____

_____

54. Are residents encouraged to participate in planning the activities?

_____

_____

55. Are there separate activities available for patients who are physically unable to participate in common activities?

_____

_____

56. What kind of activities are provided for residents who are confined to their room or bed?

_____

_____

57. Is there a special person on the staff of the nursing home who coordinates various activities for the residents?

_____

_____

58. Is there a schedule of activities posted in the nursing home?

_____

_____

59. Are there special activities for the holidays, weekends and special occasions?

_____

_____

Your Rights as a Nursing Home Resident 13

Residents' Rights

Under state and federal regulations, nursing and rest homes must assure residents of their basic rights. These rights include:

Rules and Policies

At the time of admission each resident, or a next of kin or a representative, shall be given a written copy of all the rules and policies of the nursing home. This person shall also receive a written notification of subsequent changes in the rules and policies of the nursing home.

A schedule of the exact amount charged for each service must be prepared by the nursing or rest home administrator and maintained on up-to-date basis and provided to each resident on request.

Under no circumstances shall a resident, other than a private-paying resident, be charged for services not covered by the Social

Security Act.

Residents shall be permitted to examine bills and be provided with an explanation of any charges on them.

Private-paying residents must be allowed reasonable written notice of the intent of the nursing or rest home to increase per diem rates and other services, prior to the effective date of the increase.

Residents must be given reasonable notice of an intended involuntary transfer. This notice should allow for sufficient time to make the necessary arrangements for transfer to a new location.

The nursing home or rest home cannot interfere with the management of a resident's personal and financial affairs. In many homes the nursing home administration will require residents to keep their money in a fund for safekeeping. Residents are free to withdraw amounts from such a fund at any reasonable time.

Residents must be given a locked drawer or another secured type of space and key for safekeeping of personal possessions.

The nursing or rest home must provide at least one telephone for the residents' use, which may be coin operated, and is located so as to assure privacy during use.

Access

The nursing home or rest home shall not interfere with a resident's right to communicate privately with anyone of his/her choice either inside or outside the nursing home, with the condition that such communication is not medically disapproved.

A resident has the right to join any social, or religious activity of his/her choice, unless it is medically prohibited, and so noted in the medical records.

Under no circumstances is a resident's mail to be opened by the nursing home staff, unless such action is specifically provided for in his/her medical record.

A resident has the right to speak to an Ombudsman and have his/her complaints addressed, free from retaliation.

Discharge and Transfer

A resident may not be transferred without his/her consent unless:

a. a physician orders such transfer;
b. there are reasons related to health and welfare which are so indicated in the resident's medical records;
c. there is non-payment of fees, except as prohibited by the Social Security Act;
d. required by state or federal agencies (relating to the conditions and quality of care in the nursing or rest homes.)

If a family or rest home decides to discharge a resident, the resident and his family or next of kin must be given a written notification, with reasonable advance notice.

If a nursing or rest home cannot provide the level of care required by the resident, it must give reasonable written notification and locate an appropriate facility which will accept the resident.

Medical Treatment

Residents must be assured of their privacy during medical examination.

A resident should be permitted to examine his/her medical or personal records, and also authorize someone to do so on his/her behalf.

A resident may refuse treatment or drugs if he/she has a question or doubt about the potential benefit of the treatment.

A resident has the right to be informed of medical diagnosis, treatment and care, and to participate in planning the care.

A resident has the right to be given the name of the physician responsible for the resident's care.

A resident has the right to be free from chemical or physical restraints unless they are medically necessary and ordered by a physician.

A resident has the right to have significant changes in. the resident's health reported to the resident's next of kin.

A resident has the right to adequate and appropriate care.

Other Rights

Residents shall not be required to perform any functions or services for the nursing or rest home which are not included in his/her plan of care.

If it can be arranged, married residents shall be permitted to share a room, unless it is medically prohibited in either resident's medical records.

SOURCE: A Consumer's Guide to Nursing and Rest Homes: Massachusetts Long-Term Care Ombudsman Program

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Statistics on Disability

As the saying goes, there are only two certainties in life: death and taxes. Many people, appreciating the inevitability of death and taxes do provide for them by preparing a will, creating trusts, or through other estate planning means. However, the problems created by disability, physical or mental, are largely ignored. The lack of interest can be attributed to the certainty of death and the uncertainty of disability, but those who have personally experienced disability, even temporarily, or have had a member of the family incapacitated, know the importance of planning for such an occurrence.

Statistically speaking, a person, at any given point in life, is more likely to suffer physical or mental disability than death. Insurance statistics tell us that a 22-year old person is 7.5 times more likely to suffer a disability of 90 days or more than to die. At age 62, he or she is still 4.25 times more likely to suffer a disability than to die. In fact one out of every two Americans will suffer a lengthy period of disability during his lifetime.

The life expectancy of Americans, men and women, has jumped several years in the last decade, largely due to improved medical technology. Although they are living longer, an increasing number of our old people live in a state of disability. These are the realities of our modern society.

The disability may be physical or mental. A physical disability may force an individual into early retirement and impede his ability to effectively manage his assets. It may also make it impossible for him to physically supervise or participate in the mangement of his property. Physical disability often brings an emotional despair. Although a severely disabled person may continue to exercise sound judgment and is competent to make decisions about his financial affairs, the physical limitation may necessitate delegating power to someone else.

Mental disability presents even more serious problems for the person, for it may result in involuntary loss of capacity to make legal decisions for himself. An incompetent person cannot make a will, cannot enter into contracts, or otherwise dispose of his property.

A serious mental or physical disability can actually be more devastating to a family than death. Death usually brings additional resources such as insurance and employee death benefits; a disability can be a severe, continuous drain on the finances of the family and bring on emotional distress.

Traditional Means of Dealing With Incompetency

In the absence of any planning for the contingency, the traditional way of dealing with a person's incompetency requires petitioning a court for the appointment of a conservator, guardian or committee. A member of the family, a close friend or some other person may be forced to ask the court to declare the person incompetent and appoint a conservator of the person and property.

The term "conservatorship" means a form of court-supervised administration of the assets, and perhaps of the person of the disabled individual. Some states differentiate between the terms

"conservator" and "guardian," while others do not. The terms are often used interchangeably. A conservator of the property and person may be the same person, or there may be two different persons appointed in respective capacities. For instance, in New York, if a person is adjudged incompetent, a court may appoint a committee of the person, of the property, or of both. However, if a person has suffered some impairment in (but not a total loss of) his ability to manage his affairs, the court may appoint a conservator, primarily to handle his property.

Duties of a Conservator

A conservator operates in the capacity of a fiduciary. He takes control of the principal's property, prepares an inventory, posts a bond, and proceeds generally by petition and order to invest and expend the principal's estate for his and his dependents' care and comfort. The conservator is required to make a periodic accounting to the court of his actions.

Disadvantages of Conservatorship Proceedings

Convervatorship or guardianship proceedings, as they are called, are highly undesirable. First, they are extremely costly. In New York state, a 1973 study revealed that the average cost of a conservatorship proceeding was no less than $10,000 in terms of attorney's fees and court costs. In most instances, the conservator is required to post a fiduciary bond. Such proceedings are public and embarrassing to the person being declared incompetent and to his family. The proceedings, like any court action, are highly time-consuming.

The greatest disadvantage of conservatorship is the lack of flexibility in its administration. The powers of the conservator are severely restricted. For example, a conservator is not allowed to invade the principal of the disabled person's estate without court approval, even though he may feel that such an expenditure would benefit the individual. He may also be reluctant to invest or expand the capital; he may not feel secure in pursuing aggressive business or tax planning strategies. A conservatorship almost always deals a fatal blow to a business enterprise. The fact that a conservator is required to seek court approval for every major action and make periodic accounting to the court adds to the costs and delays.

In the context of planning for nursing-home care and protecting your assets from its ruinous costs, conservatorship or guardianship poses almost insurmountable problems. If no financial planning has been done before the need for a conservator has arisen, it would be almost too late to do so once a conservator has been appointed. Many of the strategies to qualify for Medicaid involve transferring of assets to the spouse or children, conversion of liquid but non-exempt resources into a home, setting up of a Medicaid trust to shelter assets from a nursing home, etc. All of these strategies involve imaginative and aggressive use of Medicaid regulations. On the surface they are designed to render the nursing-home applicant destitute, without his own resources to pay for the long-term care although the end result is to save his hard-won assets for his family and heirs.

Why can't a conservator or guardian employ these strategies for the principal? Because a conservator always operates under the supervision of probate court and is accountable to the court for his actions, he is unlikely (and probably without legal authority) to do something that would actually impoverish the principal, regardless of the fact that the principal, were he competent, would have done

exactly that. Theoretically, a conservator is supposed to act in the best interest of the principal, and to do otherwise would be a breach of fiduciary duty. Ironically, his inactions in this instance would be detrimental to the principal.

Avoiding Conservatorship

The law, however, provides an easy, inexpensive and efficient solution to the problem. Surprisingly, many people are not aware of the actual mechanics and advantages of the remedy provided by the law. The remedy comes in two forms: general power of attorney and durable power of attorney. Their applications are determined by the condition of the principal, whether he has become incompetent or not.

A regular or general power of attorney gives another person the authority to act in behalf of the principal in specific situations in a limited capacity. For instance, you may give your son, relative or friend a power of attorney to execute a contract or deed to sell your house while you're away temporarily. The power of attorney could also be broad, allowing the agent to handle all of your financial affairs. Of course, you retain the authority to revoke the power of attorney at any time you wish.

Drawback of General Power of Attorney

As you can see, a general power of attorney has its uses, and is routinely used during the principal's temporary absences. However, it has one fatal drawback. Under the law, a general power of attorney becomes inoperative upon the incompetence of the principal. In other words, the power is of no use just when it is needed the most - during the incapacity of the principal.

This incidentally creates another problem, making the power less effective even when the principal is competent. Third parties dealing with the agent of the principal can never be certain that the principal has not become incapacitated and the power they are asked to rely upon has not been terminated. In many instances, they may require additional assurances that the principal is still competent and the power is valid before dealing with the agent.

Civil Law vs. Common Law

It is important, at this point, to distinguish the common law rule from the civil law. Under the civil law rule, while the principal's death or incapacity has the effect of terminating the agent's authority, the agent's power to bind the principal, or his estate, continues until such time as the agent, or third party dealing with the agent, has actual notice of the principal's death or incapacity. The Uniform Probate Code adopts the civil law rule. Most states have adopted provisions of the Uniform Probate Code in enacting their durable power of attorney statutes. Therefore, an agent, pursuant to the authority granted under a durable power of attorney, can bind the principal as long as he does not have actual knowledge of the principal's death or incompetency.

Durable Power of Attorney

The durable power of attorney is a creature of the state statutes that were designed to make a power of attorney survive the incompetency of the principal. As such, a durable power of attorney is effective where a general power of attorney fails. Before we examine the solutions offered by the durable power of attorney, let's see how, in the absence of a durable power of attorney, you or your parents could lose everything to a nursing home.

Say your mother owns several assets such as cash, CD's, stocks and bonds and her home, all in her name. Suddenly she suffers a stroke, becomes incapacitated and has to be admitted to a nursing home. Since she owns all the assets in her name, which she cannot now transfer to anyone due to her incompetency, her nursing-home bills will use up everything she owns. Medicaid will come to rescue only after she has exhausted nearly all her resources.

A durable power of attorney would have made a big difference. You as her attorney-in-fact would have been able to do the necessary financial planning to preserve the assets.

History of the Durable Power of Attorney

The durable power of attorney is a relatively new piece of legislation. When the National Conference of Commissioners on Uniform State Laws began its work on the Uniform Probate Code in the late 1960's, it was becoming increasingly clear that an alternative had to be found to the conservatorship and guardianship proceedings for the incompetent person. Such proceedings, as we have noted, are highly cumbersome, expensive and embarrassing to the family. Since a general power of attorney becomes invalid upon the incapacity of the principal, guardianship or conservatorship proceeding remained the only means of providing for the incompetent person's affairs.

A recommended solution was to make the power of attorney "durable" so that it will survive the incompetency of the principal. Such a result, it was proposed, can be achieved by incorporating appropriate language in the power that will indicate the intention of the maker that the authority granted shall remain unaffected during the principal's subsequent disability or incapacity, or that the power shall become effective upon the disability or incapacity of the principal.

In 1979, the National Conference of Commissioners on Uniform State Laws patterned the Uniform Durable Power of Attorney Act, making it a freestanding statute which can be adopted by a state as an alternative to adopting the durable power of attorney provisions of the Uniform Probate Code.

At present, all fifty states have legislation on their books that authorizes writing a durable power of attorney. District of Columbia is the only exception. Although there are some major differences among states, most states have either adopted in entirety or followed closely the language of the provisions of the Uniform Probate Code.

Some Useful Terms

Before we go any further, it is necessary to understand a few legal terms used in connection with the durable power of attorney.

Principal This is the maker of the durable power of attorney. As a principal, you authorize someone to act in your stead by means of a durable step into his shoes and make decisions regarding his person and property. Your attorney-in-fact may be your spouse, an adult child, a close relative or a trusted friend. Needless to say, you must exercise very good judgment in selecting the attorney-in-fact. Most states do not impose any restrictions on who can be your attorney-in-fact.

Agent This term is synonymous with attorney-in-fact.

Attorney-In-Fact This is the person appointed by the principal to step into his shoes and make decisions regarding his person and property. Your attorney-in-fact may be your spouse, an adult child, a close relative or a trusted friend. Needless to say, you must exercise

very good judgment in selecting the attorney-in-fact. Most states do not impose any restrictions on who can be your attorney-in-fact.

Incompetent This is the general term used to describe the physical or mental incapacity of a person. An incompetent person cannot enter into a contract. A durable power of attorney can be executed only so long as you are competent. Incompetence may have been brought on by serious accident or injury, or as a result of old age and failing health.

Some states have made an attempt to define disability. Here's the way New Jersey defines it:

"A principal shall be under disability if he is unable to manage his property and affairs effectively for reasons such as mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, confinement, detention by a foreign power, or disappearance."

Life-prolonging procedure This describes a treatment or procedure designed to extend life using heroic means for the sole purpose of keeping the patient alive, generally in a brain-dead, comatose condition: Virginia has codified the definition, and it may be as good as any one will find.

"Life prolonging procedure means any procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore, or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. Life prolonging procedure shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort, care or to alleviate pain.

"Springing" Durable Power of Attorney

The most common obstacle faced by planners in persuading an individual to plan for disability through the use of durable power of attorney is the general apprehension on the part of the individual that the mere creation of a power and appointment of an agent would result in immediate loss of control over his assets.

Since the individual is presently healthy and fully capable of handling his affairs, why create a power of attorney that may mean that someone else would make decisions affecting his person and property? Such fears are understandable, but proper drafting of a durable power of attorney can allay such fears and contribute toward effective planning. One solution is the "springing" durable power of attorney.

The Uniform Probate Code authorized the framing of a durable power of attorney so that it becomes effective only upon the principal's disability. In other words, the power "springs" into effect only after the principal has become incapacitated. Until such occurrence of incapacity, the principal continues to retain full control over his or her affairs. The power of attorney becomes a standby measure, ready to spring into effect if the disability occurs.

In order to make a durable power of attorney "springing," the Uniform Probate Code suggests inclusion of the following words or similar language showing the intent of the principal that the power is to become effective upon the disability or incapacity of the principal: "The power of attorney shall become effective upon the disability or incapacity of the principal."

The main advantage of a springing durable power of attorney is to a principal who is in perfect health at present and capable of handling his affairs, and is reluctant to grant broad authority to someone over his person and property.

A springing durable power of attorney allows him to prepare and execute the instrument while he is competent, but defer its effectiveness until such time as is needed. If the disability never occurs, the power is never transferred. In any event, he has provided for a future event which otherwise might force his family to undertake costly, cumbersome and embarrassing court proceedings.

Determination of Disability

The most obvious problem associated with such a power is the difficulty of determining when the power has "sprung" into effectiveness. Therefore, in drafting a "springing" durable power of attorney, care must be taken to provide for a procedure for determination of the principal's incapacity -- without having to go to court. The procedure should be such that third parties dealing with the agent of the principal will be satisfied that the principal has indeed become incapacitated. Anything short of clear and convincing evidence may prompt third parties to refuse to act without a judicial declaration of incapacity, in which case all the advantage of a durable power of attorney would be lost.

The procedure recommended here for determination of the principal's incapacity is certification by two licensed physicians not related by blood or marriage to either the principal or the agent. Most third parties including banks, insurance companies and title companies will regard such a medical certification sufficiently acceptable. Of course, in some instances, they may demand evidence of continued incapacity. It may be prudent to have a certificate that is no older than six months to a year.

The other problem for the drafter of a durable power of attorney is how to define incapacity. Most people define incapacity as when the principal has become incapable of caring for himself and when he is not physically and mentally capable of managing his financial affairs.

Some estate planners have recommended a slightly modified approach to drafting a durable power of attorney. Under this approach, the power becomes effective upon either incapacity or some form of certification by the principal. In such an arrangement, the agency is established immediately, but the agent is prohibited from acting until the principal (1) is determined to be incompetent, or (2) has executed a self-certification that the power has become effective.

The "springing" durable power of attorney is not authorized in all the states. In states that do not permit a "springing" durable power of attorney, it will be necessary to execute a power that becomes effective immediately on creation of the instrument. For all practical purposes, execution of a power that becomes effective immediately should not pose any problems for you in your continued exercise of power over your assets and your ability to carry out your financial transactions - as long as you have prudently selected your attorney-in-fact and safeguarded the instrument of power to prevent possible abuse. When the need arises, the attorney-in-fact will be able to step in, recover the instrument, and exercise the authority granted.

A power that becomes effective immediately upon execution has one advantage over "springing" durable power of attorney. There is no necessity to determine if the principal has indeed become incapacitated - a determination that may require medical certification or some other procedure.

The following states do not authorize the "springing" durable power of attorney: Connecticut, Florida, Georgia, Illinois, Louisiana, Mississippi, Missouri, New Hampshire, New York, Ohio, Oregon, South Carolina, Texas, Virginia and West Virginia. As mentioned earlier, the District of Columbia has no durable power of attorney legislation.

Your Agent

It is beyond the scope of this book to go into great detail concerning the framing and functioning of a durable power of attorney, but the following information should answer most questions you may have concerning your agent.

1. The agent must act only within the scope of the authority granted in the power.

2. At all times the agent should keep the best interest of the principal in mind. He is required to act in a prudent and reasonable manner.

3. There can be no conflict of interest between the agent and the principal.

4. The agent is required to keep proper records, inventories and accounts of the principal's assets. He may be required to make an accounting to the principal or to a court-appointed conservator.

5. The agent is not to commingle the properties and funds of the principal with either his or those of someone else's.

6. The agent must cease to act for the principal immediately upon revocation of his power or upon the death of the principal.

7. Since an agent may die, resign, or become incapacitated, a provision should be made for the appointment of a successor attorney-in-fact.

8. Most states are silent on the subject of remuneration for the attorney-in-fact (the agent), but they apply the judicial standard of

reasonableness, and this may bring uncertain results. It is recommended that specific provisions regarding compensation for the agent be included in the durable power of attorney itself, or in a separate agreement. In some cases, the question of compensation never arises, as when a close member of the family is appointed as an agent.

9. One way an abuse of power can occur is when an agent takes actions under the durable power of attorney while the principal is still competent and able to attend to his affairs. It is of vital importance that you retain full control over the original and all copies of the power at all times. Another area of concern is when a person chooses his or her spouse to act as attorney-in-fact, a very natural thing for many people to do. However, occasionally the relationship sours and the marriage is dissolved. Some estate planners suggest that if the spouse is asked to act as attorney-in-fact, a clause should be included in the durable power of attorney which would automatically revoke the power in the event marriage is dissolved. Of course, if the principal is still competent he would have the option to revoke the power himself.

Health Care Powers

The use of durable power of attorney in asset management and financial transactions has become relatively common in recent years as the people have become increasingly aware of the problems brought on by incompetency. The same cannot be said about its use in authorizing health-care decisions for the principal.

At present, only California and Pennsylvania have statutes that expressly permit framing of a durable power of attorney for health care. The remaining states, however, do not place any restrictions on the subject matter that may be covered under a durable power of attorney. The statutes, in general, authorize the appointment of an attorney-in-fact for the "care, custody and control of the person and property of the principal." Presumably this would indicate that the agent is authorized to make decisions regarding the medical treatment of the principal.

Under a durable power of attorney for health care, an attorney-in-fact would be entitled to obtain and examine all medical records, receive information concerning the proposed health care, consent to or decline specific medical treatment and control disclosure of medical records. He would be empowered to authorize the principal's admission to a medical, nursing, convalescent or similar facility, and for this purpose he may enter into contractual agreement with the health-care provider. He also would have the power to authorize medical and surgical procedures for the principal, including the administration of drugs and intravenous feeding. Under the power, he would hire and discharge doctors, nurses and other medical personnel for the benefit of the principal.

Finally, in the case of a terminally ill patient, an attorney-in-fact may be called upon to make decisions regarding withholding or withdrawing of medical treatment which may include food and water.

In California, for example, Civil Code Section 2500 provides for a statutory form of durable power of attorney for health care. The purpose of such a document is to allow you to designate an agent empowered to make medical decisions in your behalf in the event of incompetency. It is recommended that, should you decide to execute such a power of attorney, you do so in conjunction with the "*Directive to Physicians*". Forms for the directive are available from Choice in Dying, Inc., an organization that champions the right to self-determination of an incompetent person.

Durable Power of Attorney or Living Will?

Durable powers of attorney for health care have important advantages over living wills. Living wills are primarily used when a patient is terminally ill and death is imminent, whereas a durable power of attorney for health care can generally be used to delegate authority for health care decisions in all cases of patient incompetence. In other words, a durable power of attorney has much wider application than a living will.

Durable power of attorney, unlike a living will, offers a crucial benefit to the attending physician in that he can talk to the agent who is authorized to make decisions in behalf of the patient. Physicians will feel less vulnerable to legal challenges if they rely upon the instructions of an agent who was personally designated by the patient, than if they were to rely upon the informal consent of a relative or the family. The durable power of attorney for health care resolves uncertainty about who is authorized to consent for the incapacitated patient, especially when relatives are in disagreement among themselves or when the family disagrees with the physician. The concept of durable power of attorney conforms more closely than a living will to the legal model of informed consent.

The obvious disadvantage of a durable power of attorney is possible abuse by the agent, if he stands to gain by unscrupulous exercise of the power vested in him by the principal. Such a possibility can, of course, be averted by judicious selection of the agent. Second concern in the exercise of durable power of attorney is that the agent many not exercise the very power when needed that he is authorized and trusted

to exercise. A close family member who acts as the agent may be too overwhelmed with grief or too emotionally overwrought to make the critical decision. So there exists the ever-present danger of an agent not faithfully carrying out the patient's wishes, or acting against the patient's best interests when those wishes are unclear.

There is one other significant difference between living wills and durable powers of attorney for health care. Agents under a durable power of attorney for health care are not required to act for the principal; they are given the power, but not the obligation. Powers granted an agent to act on behalf of the principal are permissive. On the other hand, living will directives are obligatory on the physician.

Appendix A: Directory of State Insurance Departments and Agencies on Aging

DIRECTORY OF STATE INSURANCE DEPARTMENTS AND AGENCIES ON AGING

Each State has its own laws and regulations governing all types of insurance. The insurance offices listed in the left column of this directory are responsible for enforcing these laws, as well as providing the public with information about insurance. The agencies on aging, listed in the right column, are responsible for coordinating services for older Americans. The middle column of the directory lists the telephone number to call for insurance counseling services. Calls to an 800 number listed in this directory are free when made within the respective state.

INSURANCE DEPARTMENTS	INSURANCE COUNSELING	AGENCIES ON AGING
Insurance Department 135 South Union St. Montgomery, AL 36130-3401 (205) 269-3550	**Alabama** 1-800-242-5463	Commission on Aging 770 Washington Ave., Suite 470 Montgomery, AL 36130 1-800-243-5463 (205) 242-5743
Division of Insurance 800 E. Dimond, Suite 560 Anchorage, AK 99515 (907) 349-1230	**Alaska** (907) 563-5654	Older Alaskans Commission P.O. Box C MS 0209 Juneau, AK 99811 (907) 465-3250
Insurance Department Office of the Governor Pago Pago, AS 96797 011-684/633-4116	**American Samoa**	Territorial Administration on Aging Government of American Samoa Pago Pago, AS 96799 (684) 633-1251
Insurance Department Consumer Affairs and Investigation Div. 3030 N. Third St. Phoenix, AZ 85012 (602) 255-4783	**Arizona** 1-800-432-4040	Dept. of Economic Security Aging & Adult Administration 1789 W. Jefferson St. Phoenix, AZ 85007 (602) 542-4446
Insurance Department Seniors Insurance Network 1123 S. University 400 University Tower Bldg. Little Rock, AR 72204-5494 (501) 686-2900	**Arkansas** 1-800-852-5494	Division of Aging and and Adult Services Donaghey Plaza South 7th & Main Sts., Suite 1417 P.O. Box 1417/Slot 1412 Little Rock, AR 72203-1437 (501) 682-2441
Insurance Department Consumer Services Div. 3450 Wilshire Blvd. Los Angeles, CA 90010 1-800-927-4357	**California** 1-800-927-4357	Department of Aging 1600 K Street Sacramento, CA 95814 (916) 322-3887

INSURANCE DEPARTMENT	INSURANCE COUNSELING	AGENCIES ON AGING
Insurance Division 1560 Broadway Suite 850 Denver, CO 80202 (303) 894-7499	**Colorado** (303) 894-7499	Aging and Adult Services Dept. of Social Services 1575 Sherman St., 10th Fl. Denver, CO 80203-1714 (303) 866-3851
	Commonwealth of the Northern Mariana Islands	Department of Community and Cultural Affairs Civic Center Commonwealth of the Northern Mariana Islands Saipan, CM 96950 (607) 234-6011
Insurance Department 153 Market Street P.O. Box 816 Hartford, CT 06142-0816 (203) 297-3800	**Connecticut** 1-800-443-9946	Department on Aging 175 Main Street Hartford, CT 06106 1-800-443-9946 (203) 566-7772
Insurance Department 841 Silver Lake Blvd. Dover, DE 19901 (302) 739-4251	**Delaware** 1-800-851-3535	Division of Aging Dept. of Health and Social Services 11901 DuPont Highway New Castle, DE 19720 (302) 577-4660
Insurance Department 613 G Street, NW Room 638 P.O. Box 37200 Washington, D.C.20001-7200 (202) 727-8009	**District of Columbia** (202) 724-5626	Office on Aging 1424 K Street, NW 2nd Floor Washington, D.C. 20005 (202) 724-5626 (202) 724-5622
	Federated States of Micronesia	State Agency on Aging Office of Health Services Federated States of Micronesia Ponape, E.C.I. 96941
Dept. of Insurance State Capitol, Plaza 11 Tallahassee, FL 32399-0300 1-800-342-2762 (904) 922-3100	**Florida** (904) 922-2073	Office on Aging & Adult Services 1317 Winewood Boulevard Building 2, Room 323 Tallahassee, FL 32399-0700 (904) 488-8922

INSURANCE DEPARTMENTS	INSURANCE COUNSELING	AGENCIES ON AGING
Insurance Department 2 Martin L. King, Jr., Dr. 716 West Tower Atlanta, GA 30334 (404) 656-2056	**Georgia** (404) 894-5333	Office of Aging Dept. of Human Resources 878 Peachtree St., NE, Rm 632 Atlanta, GA 30309 (404) 894-5333
Insurance Department 855 W. Marine Drive P.O. Box 2796 Agana, Guam 96910 011 (671) 477-5144	**Guam**	Division of Senior Citizens Dept. of Public Health and Social Services P.O. Box 2816 Agana, Guam 96910 011 (671) 734-4361
Dept. of Commerce and Consumer Affairs Insurance Division P.O. Box 3614 Honolulu, HI 96811 (808) 586-2790	**Hawaii** (808) 586-0100	Executive Office on Aging 335 Merchant Street Room 241 Honolulu, HI 96813 (808) 586-0100
Insurance Department Public Service Dept. 500 South 10th St. Boise, ID 83720 (208) 334-4350	**Idaho** 1-800-247-4422	Office on Aging Statehouse, Room 108 Boise, ID 83720 (208) 334-3833
Insurance Department 320 W. Washington St. 4th Floor Springfield, IL 62767 (217) 782-4515	**Illinois** 1-800-548-9034	Department on Aging 421 E. Capitol Avenue Springfield, IL 62701 (217) 785-2870
Insurance Department 311 W. Washington St. Suite 300 Indianapolis, IN 46204 1-800-622-4461 (317) 232-2395	**Indiana** 1-800-552-4800	Dept. of Human Services 402 W. Washington St. P.O. Box 7083 Indianapolis, IN 46207-7083 (317) 232-7020
Insurance Division Lucas State Office Bldg. E. 12th & Grand Sts. 6th Floor Des Moines, IA 50319 (515) 281-5705	**Iowa** (515) 281-5705	Dept. of Elder Affairs Jewett Bldg., Suite 236 914 Grand Avenue Des Moines, IA 50309 (515) 281-5187

INSURANCE DEPARTMENTS	INSURANCE COUNSELING	AGENCIES ON AGING
Insurance Department 420 S.W. 9th Street Topeka, KS 66612 (913) 296-3071 1-800-432-2484	**Kansas** **1-800-432-3535**	Department of Aging 122-S. Docking State Office Building 915 S.W. Harrison Topeka, KS 66612-1500 (913) 296-4986
Insurance Department 229 W. Main Street P.O. Box 517 Frankfort, KY 40602 (502) 564-3630	**Kentucky** **1-800-372-2973**	Division of Aging Services Dept. of Social Services 275 E. Main Street Frankfort, KY 40621 (502) 564-6930
Insurance Department P.O. Box 94214 Baton Rouge, LA 70804-9214 (504) 342-5900 1-800-259-5301	**Louisiana** **1-800-259-5301**	Governor's Office of Elderly Affairs 4550 N. Boulevard P.O. Box 80374 Baton Rouge, LA 70896-0374 (504) 925-1700
Bureau of Insurance Consumer Division State House, Station 34 Augusta, ME 04333 (207) 582-8707	**Maine** **1-800-750-5353**	Bureau of Elder and Adult Services 35 Anthony Ave., Station 11 Augusta, ME 04333 (207) 624-5335
Insurance Department Complaints and Investigation Unit 501 St. Paul Place Baltimore, MD 21202-2272 (410) 333-6300	**Maryland** **1-800-243-3425**	State Agency on Aging 301 W. Preston Street Room 1004 Baltimore, MD 21201 (410) 225-1102
Insurance Division Consumer Services Section 280 Friend Street Boston, MA 02114 (617) 727-7189	**Massachusetts** **(617) 727-7750**	Executive Office of Elder Affairs 1 Ashburton Place, 5th Floor Boston, MA 02108 1-800-882-20003 (617) 727-7750
Insurance Department P.O. Box 30220 Lansing, MI 48909 (517) 373-0220	**Michigan** **(517) 373-8230**	Office of Services to the Aging 611 W. Ottawa Street P.O. Box 30026 Lansing, MI 48909 (517) 373-8230

INSURANCE DEPARTMENTS	INSURANCE COUNSELING	AGENCIES ON AGING
Insurance Department Department of Commerce 133 E. 7th Street St. Paul, MN 55101-2362 (612) 296-4026	**Minnesota** **1-800-392-0343**	Board on Aging Human Services Building 4th Floor 444 Lafayette Road St. Paul, MN 55155-3843 (612) 296-2770
Insurance Department Consumer Assistance Division P.O. Box 79 Jackson, MS 39205 (601) 359-3569	**Mississippi** **Counseling services not provided at this time.**	Council on Aging 455 N. Lamar Street Jackson, MS 39202 1-800-345-6347 (601) 359-6770
Department of Insurance Consumer Services Section P.O. Box 690 Jefferson City, MO 65102-0690 1-800-726-7390 (314) 751-2640	**Missouri** **1-800-726-7390**	Division of Aging Dept. of Social Services P.O. Box 1337 615 Howerton Court Jefferson, MO 65102-1337 (314) 751-3082
Insurance Department 126 N. Sanders Mitchell Bldg., Rm. 270 P.O. Box 4009 Helena, MT 59604 1-800-332-6148 (406) 444-2040	**Montana** **1-800-332-2272**	The Governor's Office on Aging State Capitol Building Room 219 Helena, MT 59620 1-800-332-2272 (406) 444-3111
Insurance Department Terminal Building 941 O St., Suite 400 Lincoln, NE 68508 (402) 471-2201	**Nebraska** **(402) 471-4887**	Department on Aging State Office Building 301 Centennial Mall South Lincoln, NE 68509-5044 (402) 471-2306
Department of Insurance Consumer Services 1665 Hot Springs Road Capitol Complex Carson City, NV 89701 (702) 687-4270 1-800-992-0900	**Nevada** **(702) 687-4270**	Dept. of Human Resources Division for Aging Services 340 N. 11th St., Suite 114 Las Vegas, NV 89101 (702) 486-3545

INSURANCE DEPARTMENTS	INSURANCE COUNSELING	AGENCIES ON AGING
Insurance Department Life and Health Division 169 Manchester St. Concord, NH 03301 (603) 271-2261 1-800-852-3416	New Hampshire (603) 271-4642	Dept. of Health and Human Services Division of Elderly and Adult Services 6 Hazen Drive Concord, NH 03301 (603) 271-4680
Insurance Department 20 West State Street Roebling Building Trenton, NJ 08625 (609) 292-5360	New Jersey 1-800-792-8820	Dept. of Community Affairs Division on Aging S. Broad and Front Sts. CN 807 Trenton, NJ 08625-0807 1-800-792-8820 (609) 292-0920
Insurance Department P.O. Box 1269 Santa Fe, NM 87504-1269 (505) 827-4500	New Mexico 1-800-432-2080	Agency on Aging La Villa Rivera Bldg. 224 E. Palace Ave. 1st Fl. Santa Fe, NM 87501 1-800-432-2080 (505) 827-7640
Insurance Department 160 West Broadway New York, NY 10013 (212) 602-0203 Outside of New York City 1-800-342-3736	New York 1-800-342-9871	State Office for the Aging 2 Empire State Plaza Albany, NY 12223-0001 1-800-342-9871 (518) 474-5731
Insurance Department Seniors Health Insurance Information Program (SHIIP) P.O. Box 26387 Raleigh, NC 27611 (919) 733-0111 (SHIIP) 1-800-662-7777 (Consumer services)	North Carolina 1-800-443-9354	Dept. of Human Resources Division of Aging 693 Palmer Drive Raleigh, NC 27626-0531 (919) 733-3983
Insurance Department Capitol Bldg., 5th Fl 600 E. Boulevard Bismarck, ND 58505-0320 1-800-247-0560 (701) 224-2440	North Dakota 1-800-247-0560	Dept. of Human Services Aging Services Division State Capitol Building Bismarck, ND 58507-7070 (701) 224-2577

INSURANCE DEPARTMENTS	INSURANCE COUNSELING	AGENCIES ON AGING
	Ohio **1-800-686-1578**	
Insurance Department Consumer Services Division 2100 Stella Court Columbus, OH 43266-0566 1-800-686-1526 (614) 644-2673		Department of Aging 50 W. Broad Street 8th Floor Columbus, OH 43266-0501 (614) 466-1221
	Oklahoma **(405) 521-6628**	
Insurance Department P.O. Box 53408 Oklahoma City, OK 73152-3408 (405) 521-2828		Dept. of Human Services Aging Services Division 312 NE 28th Street Oklahoma City, OK 73125 (405) 521-2327
	Oregon **(503) 378-4484**	
Department of Insurance and Finance Insurance Division Consumer Advocacy 440 Labor & Industries Building Salem, OR 97310 (503) 378-4484		Dept. of Human Resources Senior Services Division 500 Summer St., NE, 2nd. Floor Salem, OR 97310 1-800-232-3020 (503) 378-4728
	Palau	
		State Agency on Aging Dept. of Social Services Republic of Palau Koror, Palau 96940
	Pennsylvania **(717) 783-8975**	
Insurance Department Consumer Services Bureau 1321 Strawberry Square Harrisburg, PA 17120 (717) 787-2317		Department of Aging 231 State Street Barto Building Harrisburg, PA 17101 (717) 783-1550
	Puerto Rico **(809) 721-5710**	
Insurance Department Fernandez Juncos Station P.O. Box 8330 Santurce, PR 00910 (809) 722-8686		Governors Office of Elderly Affairs Gericulture Commission Box 11398 Santurce, PR 00910 (809) 722-2429
	Republic of the Marshall Islands	
		State Agency on Aging Dept. of Social Services Republic of the Marshall Islands Marjuro, Marshall Islands 96960

INSURANCE DEPARTMENTS	INSURANCE COUNSELING	AGENCIES ON AGING
	Rhode Island 1-800-322-2880	
Insurance Division 233 Richmond St., Suite 233 Providence, RI 02903-4233 (401) 277-2223		Dept. of Elderly Affairs 160 Pine Street Providence, RI 02903 (401) 277-2858
	South Carolina 1-800-868-9095	
Insurance Department Consumer Assistance Section P.O. Box 100105 Columbia, SC 29202-3105 (803) 737-6140 1-800-768-3467		Commission on Aging 400 Arbor Lake Drive Suite B-500 Columbia, SC 29223 (803) 735-0210
	South Dakota (605) 773-3656	
Insurance Department Enforcement 910 E. Sioux Avenue Pierre, SD 57501-3940 (605) 773-3563		Agency on Aging Richard F. Kneip Building 700 Governors Drive Pierre, SD 57501-2291 (605) 773-3656
	Tennessee 1-800-525-2816	
Dept. of Commerce & Insurance Insurance Assistance Office 4th Floor 500 James Robertson Pkwy. Nashville, TN 37243 1-800-525-2816 (615) 741-4955		Commission on Aging 706 Church Street Suite 201 Nashville, TN 37243-0860 (615) 741-20656
	Texas 1-800-252-9240	
Department of Insurance Complaints Resolution, MC 111-1A 333 Guadalupe St., P.O. Box 149091 Austin, TX 78714-9091 (512) 463-6515 1-800-252-3439		Department on Aging P.O. Box 12786 Capitol Station 949 U.S. Rt. 35, South Austin, TX 78741 (512) 444-2727
	Utah (801) 538-3910	
Insurance Department Consumer Services 3110 State Office Bldg. Salt Lake City, UT 84114 1-800-439-3805 (801) 538-3805		Division of Aging and Adult Services 120 North 200 West P.O. Box 45500 Salt Lake City UT 84103 (801) 538-3910
	Vermont 1-800-642-5119	
Dept. of Banking & Insurance Consumer Complaint Division 89 Main Street, Drawer 20 Montpelier, VT 05620-3101 (802) 828-3301		Office on Aging Waterbury Complex 103 S. Main Street Waterbury, VT 05671-2301 (802) 241-2400

INSURANCE DEPARTMENTS	INSURANCE COUNSELING	AGENCIES ON AGING
Insurance Department Consumer Services Division 700 Jefferson Building P.O. Box 1157 Richmond, VA 23209 (804) 786-7691	**Virginia** 1-800-552-4464	Dept. for the Aging 700 Centre, 10th Floor 700 E. Franklin Street Richmond, VA 23219-2327 1-800-552-4464 (804) 225-2271
Insurance Department Kongens Gade No. 18 St. Thomas, VI 00802 (809) 774-2991	**Virgin Islands** (809) 774-2991	Dept. of Human Services 19 Estate Diamond Frederick Sted St. Croix, VI 00840 (809) 772-4850
Insurance Department Insurance Bldg. AQ21 P.O. Box 40255 Olympia WA 98504-0255 1-800-562-6900 (206) 753-7300	**Washington** 1-800-562-6900	Aging & Adult Services Admin. Dept. of Social & Health Servcs. 12th and Jefferson Sts. Mail Stop OB-44-A Olympia, WA 98504 (206) 586-3768
Insurance Department 2019 Washington St., E. Charleston, WV 25305 (304) 348-3386 1-800-642-9004 1-800-435-7381 (hearing impaired)	**West Virginia** (304) 558-3317	Commission on Aging State Capitol Complex Holly Grove Charleston, WV 25305 (304) 558-3317
Insurance Department Complaints Department P.O. Box 7873 Madison, WI 53707 1-800-236-8517 (608) 266-0103	**Wisconsin** 1-800-242-1060	Bureau on Aging Department of Health and Social Services P.O. Box 7851 217 S. Hamilton St., Suite 300 Madison, WI 53707 (608) 266-2536
Insurance Department Herschler Building 122 W. 25th Street Cheyenne, WY 82002 1-800-442-4333 (307) 777-7401	**Wyoming** 1-800-442-4333 Ext. 6888	Division on Aging Hathaway Building 2300 Capitol Ave., Room 139 Cheyenne, WY 82002 1-800-442-2766 (307) 777-7986

Appendix B: Companies Selling Long-Term Care Insurance

Acceleration Life Insurance Company

Adjusted Life Insurance Company

Aetna Life & Casualty

AIG Life Insurance Company

Allstate Life Insurance Company

American Benefit Life Insurance Company

American Independent Life Insurance Company

American Integrity Insurance Company

American Travelers Life Insurance Company

AMEX Life Assurance Company

American Centurian Life & Accident Assurance Company

IDS Life Insurance Company

Associated Doctors Health and Life Insurance Company

Atlantic American Life Insurance Company
Bankers Fidelity Life Insurance Company

Atlantic & Pacific Life Insurance Company of America

Bankers Life & Casualty Company

Bankers Multiple Life Insurance Company

Certified Life Insurance Company

Union Bankers Insurance Company

Blue Cross and Blue Shield of Arizona

California Physician's Insurance Company
(subsidiary of Blue Shield of CA)

Blue Cross and Blue Shield of Connecticut

Blue Cross and Blue Shield of Indiana

Blue Cross and Blue Shield of Kansas

Blue Cross and Blue Shield of Kentucky

Blue Cross and Blue Shield of Minnesota

Blue Cross and Blue Shield of Montana

Combined Services, Inc.
(subsidiary of Blue Cross/Shield of NH)

Finger Lakes LTC Insurance Company
(subsidiary of Blue Cross/Shield of Rochester)

Group Insurance Services
(subsidiary of Blue Cross/Shield of NC)

Blue Cross and Blue Shield of North Dakota

Medical Life Insurance Company
(subsidiary of Blue Cross/Shield Mutual of Northern OH)

Consumer Services Casualty Insurance Company
(subsidiary of Blue Cross/Shield of UT)

Blue Cross and Blue Shield of West Virginia

Blue Cross and Blue Shield of Wyoming

Blue Cross of Washington and Alaska

Bradford National Life Insurance Company

Central Life Assurance Company

Central Security Life Insurance

Central States Health and Life Company of Omaha

Colonial Life & Accident Insurance Company

Columbia Life Insurance Company

Columbia Accident and Health Insurance Company
Combined Insurance Company of America

Commonwealth Life Insurance Company

Continental Casualty Company (CNA)

Valley Forge Life Insurance Company

County Life Insurance Company

Equitable Life Insurance Company

Federal Home Life Insurance Company

Harvest Life Insurance Company

First National Life Insurance

First Penn Pacific Life Insurance Company

First United American Life Insurance Company

Gerber Life Insurance Company

Golden Rule Insurance Company

Great Fidelity Life Insurance Company

Great Republic Insurance Company

Hartford Insurance Company

Independence Nursing Insurance Company
Integrity National Insurance Company

ITT Life Insurance Company

John Alden Life Insurance Company

John Hancock Mutual Life Insurance Company

Life Investors Insurance Company of America

NN Investors Life Insurance Company

Life and Health Insurance Company of America

Lincoln Benefit Life Company

Lincoln National Life Insurance Company

Lutheran Brotherhood

Medical Life Insurance Company

Medico Life Insurance Company

Mutual Protective Insurance Company

Metropolitan Life Insurance Company

MidAmerica Mutual Life Insurance Company

The Midland Mutual Life Insurance Company

MONY Financial Services
Mutual of Omaha

National Foundation Life Insurance Company

National States Insurance Company

National Travelers Life Insurance Company

New York Life Insurance Company

North American Life & Casualty Company

Northwestern National Life Insurance Company

Old Southern Life

Pan-American Life Insurance Company

Pekin Life Insurance Company

Penn Treaty Insurance Company

People's Security Life Insurance Company

Physicians Mutual Insurance Company

Physicians Mutual Insurance Company

Pilgrim Life Insurance Company

Pioneer Life Insurance Company of Illinois

The Principal Financial Group

Providers Fidelity Life Insurance Company

Prudential Insurance Company of America

Pyramid Life Insurance Company

Reserve Life Insurance Company

Security Connecticut Life Insurance Company

Sentry Life Insurance Company

Standard Life & Accident Insurance Company

State Life Insurance Company of Indianapolis

Time Insurance Company

Transport Life Insurance

The Travelers Insurance Company

Union Labor Life Insurance

United American Insurance Company

United Farm Bureau Family Life Insurance Company

United General Life Insurance Company

United Security Assurance Company of Pennsylvania

UNUM Life Insurance Company

Washington Health Services

World Life and Health Insurance Company of Pennsylvania

NOTE: Company names that are italicized are affiliates or subsidiaries of the company above them.

SOURCES: Department of Health and Human Services, Health Insurance Association of America, American Council of Life Insurance, Blue Cross and Blue Shield Association and Consumer's Union.

For further information, contact:

Health Insurance Association of America
1025 Connecticut Avenue, N.W.
Washington, D.C. 20036-3998
(202) 233-7780

You may also contact your State Department of Insurance for more information.