11 – Disability and Health Insurance Planning

**1 - Disability and Health-Related Personal Loss Exposures**

Each day individuals face numerous exposures that could result in their injury, illness, or disability. In many respects, a long-term disability or health condition could be more damaging to a family’s financial condition than the death of a primary wage earner. When a wage earner dies, a family loses that individual’s income. However, upon the individual’s death, the family no longer incurs costs of living for that individual (such as food, clothing, transportation, housing, medical care, and so forth). Adequate financial assets, life insurance, and survivors benefits can help prevent significant changes to a family’s standard of living, or even financial ruin, when a death occurs.

For example, In the case of death, when a primary wage earner becomes disabled or suffers a serious health condition, the family loses that individual’s income. However, the individual continues to incur costs of living and generally incurs other expenses because of his or her disability or health condition. In both cases, an individual would likely require medical care. **The costs of repeated medical visits or treatments can quickly mount into thousands of dollars and many medical treatments can be very costly, especially for serious medical conditions. If hospitalization or skilled nursing facilities are involved, cost may increase astronomically. A disabled individual might require rehabilitation and/or further education to enable him or her to return to work, either in the same job or in a new profession that better accommodate the disability.**

**Disability Loss Exposures**

**Many people are anxious about the financial impact that death could have on their families. Ironically, the chance that an individual will become disabled is greater than the chance of an early death. Most people fail to consider how a long-term disability – one that lasts 6 months to a year or more – would affect their family.**

**In addition to the loss of the disabled individual’s wages, there are generally medical expenses to be paid (with or without health insurance), and the individual may incur costs for rehabilitation, or for education that he or she could qualify for another type of job in which the disability would not be a concern.**

The Unites States Social Security Administration survey results led to a 2007 estimate that more than 75% of Americans living in the US are insured under the government’s disability insurance program (available to much of the working population). **However, there are limitations to the benefits in the SSDI program, so the need for personal disability insurance remains**.

According to the National Safety Council, in 2008 these were true:

* Every second a disability injury occurs in the US, and every 4 minutes the injury is fatal
* Only 10% of disabling accidents and illness that occur are work-related, the other 90% are not covered by WC

The US Census Bureau reports that in 2008, 18% of Americans were classified as disabled

The Social Security Administration reports:

* As of 2007, 3 out of 10 Americans entering the workforce today will become disabled before they retire
* In 2008, the average monthly benefit paid by SSDI was only $1,004 per month (an income that would not support most families).
* In 2005, only 39% of claims made for SSDI benefits were approved
* As of 2007, excluding workers in public employment, 70% of workers had no long-term disability insurance

**Health-Related Loss Exposures**

Many Americans do not have health insurance, and young, healthy individuals often do not recognize the need for such coverage or the financial benefit it can provide. The high cost and, often the lack of availability of health insurance is a significant reason why many lower-income, single-wage earner families and elderly individuals do not purchase it. The cost of private health insurance for the benefits provided is significantly greater than the cost of group health insurance because private plans lack the cost savings from economies of scale.

Certain individuals belong to associations that offer group healthcare insurance plans with lower premiums. Generally, under private insurance and smaller group plans, individuals or associations select fewer benefits or higher copayments to save money on premiums. Also, these plans might offer benefits only for lesser-quality medications and older treatment methods, often using outdated technology. An added overhead expense in private and small volume health insurance plans, which is reflected in higher premiums, might be costs related to multiple administrative systems for handling enrollments and benefits.

**Many lower-income individuals and families either are unable to purchase or do not have access to health insurance (private or group). The costs of medical treatment often cause uninsured individuals to avoid medical treatment for illnesses or injuries until their health has deteriorated enough that more that more costly medical treatment is required. A disabled individual might lose his or her job, along with any healthcare insurance and disability benefits provided by the employer. Consequently, the choice not to purchase health insurance can ultimately cost far more than the insurance premiums that are saved**.

Individuals who have health insurance tend to live longer and have a better quality of life than uninsured individuals. Individuals who have insurance are more likely to visit healthcare providers for recommended medical examinations, such as regular blood tests, mammograms, prostate exams, routine medical test. When problems are discovered, individuals are more likely to seek the appropriate medical care as soon as possible which decreases overall costs and increases the chance for a healthy outcome.

**Long-Term care Loss exposures**

**Individuals and families who have health insurance can still suffer financial difficulty or devastation because of the costs of long-term care for certain serious medical conditions, such as cancer, dementia, Alzheimer’s disease, and many other diseases. Individuals requiring long-term healthcare might need skilled nursing care after hospitalization or might need long-term in-home healthcare to assist them with their daily activities. The cost for theses services can quickly deplete savings and investments.**

**Insurance Treatment of Disability, Health-Related, and Long-Term Care Loss Exposures**

Various sources offer disability insurance, which replaces lost income when a wage earner becomes disabled. Disability benefits and options can be selected to best meet the needs of the individual or family. In some cases, multiple forms of disability insurance, such as private and government insurance, combine to provide the best coverage.

Health insurance is also available from various sources to pay for routine and/or major medical expenses, such as limited hospitalization, surgery, and so forth. Various levels of coverage and benefits can be selected**. Health insurance premiums vary depending on the benefits selected, the level of care and the age and health of individuals for whom the coverage is purchased. Premiums also vary depending on the source of the insurance plan, such as whether it is obtained through and employer or association (group health insurance plans) or is an individual plan. As with disability insurance, multiple forms of health insurance, such as individual and group plans, and/or the government’s plan (Medicare), may combine to provide the best coverage for individuals who qualify**.

Long-term care insurance has emerged to pay the costs associated with treatment of a serious, long-term medical condition. It helps pay the costs of skilled nursing facilities and other care facilities, adult daycare, and home healthcare. Long-term care insurance is offered by various sources, and option can be selected based on the level of care to be provided and various features of the insurance coverage.

**2 – Disability Income Insurance**

Disability insurance can provide protection against such situations when injury or illness prevents a wage earner from working. Individuals rarely anticipate that they might become so severely ill or injured that they would be unable to work and earn their normal income. Consequently, the need for disability income insurance is often overlooked. Some employers provide disability income insurance for their employees, who may see that provision as a safety net, but a closer inspection of an employer provided disability policy might reveal that employees still bear considerable risk of losing income benefits because of a disability.

Disability income insurance is designed to replace a portion, often 60%, of an individual’s income if he or she becomes disabled. An injury or illness can result in a short-term disability (described as a few days to 89 days) or a long-term disability (described as 90 days up to 5 years, or up to a lifetime benefit limit). Disability insurance policies contain a variety of provisions that specify the length of qualifying disability, the types and extent of disability, the time in which the policy coverage is in effect, the benefits provided, any waiting period before benefits will be paid, and many other features of the policy.

Three types of disability income insurance products and options available to help wage earners avoid the financial duress that is often associated with disability:

* Individual disability income insurance
* Group disability income insurance
* Social Security Disability Income SSDI Program

**Provisions of a Disability Income Policy**

**Benefit Periods**

**A disability income policy specifies a benefit period and a maximum benefit period. The benefit period is the time period for which benefits will be paid to a disabled individual (the insured). As described in the policy, the benefit period ends when the insured “returns to work” or reaches the maximum benefit period. The maximum benefit period is the longest period for which benefits will be paid to the insured.**

Various benefit periods can be provided. Policies with maximum benefit periods that extend many years require higher premiums: therefore, when selecting a maximum benefit period, individuals must consider their financial needs, their own age, and the ages of their dependents, as well as weigh the benefits against the cost.

**Perils Insured Against**

**A disability income policy provides specified benefits in the event that the insured individual suffers any illness, accident, or injury that causes the individual to lose income**. Some disability policies pay disability income benefits for certain types of permanent injuries, such as the loss of a limb or blindness.

**Waiting Period**

Disability income policies do not pay benefits immediately when an individual suffers an illness or injury. Instead, they have a waiting period, often called an elimination period. **The waiting period is the time that elapses after a wage earner becomes disabled, before income benefits will be paid**. The waiting period may be 7 days for short-term disability, or it may be 30 days, 60 days, 90 days, or one year or more for a long-term disability policy. Short-term disability insurance is available as group insurance and may be called a sick leave plan.

**Shorter waiting period require higher insurance premiums to cover the insurer’s costs. Individual insureds often choose the longest waiting period that they can afford to be without income**. Employers who provide group disability income insurance often select a waiting period that takes effect when employee’s short-term disability ends or sick leave has been exhausted.

**Definition of Disability**

A disability income policy’s definition of “disability” describes the extent of disability that is required for income payments to begin. This definition might be based on the insured’s inability to perform occupational duties, on the amount of earned income lost, or both.

When the definition is based on the insured’s inability to perform job duties, the description might refer to “any occupation”, “own occupation”, or “split definition”.

**The term “any occupation” means that the individual is totally disabled an unable to perform the duties of any occupation. A policy that uses the “any occupation” definition of disability will not pay benefits if the insured can perform the duties of another occupation or can attain the necessary education or training to perform the duties of a new occupation.**

**The term “own occupation” means the insured is unable to return to the duties of his or her specific occupation. With an “own occupation” policy, if the insured is able to earn income from another occupation, he or she will still receive 100 percent of the disability benefits. The policy that defines disability as “own occupation” definition requires a higher premium**.

Some policies use a modified “own occupation” definition, which means full benefits are paid if the insured is unable to perform his duties of his or her specific occupation or any other occupation. But if this insured is able to earn income from another occupation, the benefits payments are reduced in proportion to the income earnings from the other occupation.

Under a disability policy that uses a “split definition” for disability, the “any” and “own” occupation concepts are combined. The policy might use an “any occupation” definition for the first 6 months of disability, and then it might revert to an “own occupation” definition of disability extends beyond 6 months.

When the definition of disability is based on the amount of earned income lost, a specified percentage of earned income lost will result in the payment of benefits. If a nurse was injured an could not perform her nursing duties but she could perform the duties of a desk job, with a decrease in salary of 30%. Under a disability policy that states that benefits will be paid if earned income is reduced by 25% or more, the nurse would receive full benefits from this policy.

Some policies combine these approaches in defining disability. For example, a policy might apply the amount of earned income lost approach to the first 6 months of disability and then apply and “own occupation” approach to the remaining benefit period, up to the maximum period or when the disability ends.

**Benefits Provided**

The benefits provided under a disability income policy vary depending on the type of disability policy: Individual, group, or SSDI. The benefits tie together all of the policy features – such as the waiting period, the benefits periods the perils insured against, and the definition of disability-with features such as the amount of coverage and the payment period (weekly, monthly), and any terms for coordination of benefits with other disability income policies.

**Renewal or Continuance Provision**

A provision in a disability income policy specifies whether it is noncancelable, guaranteed renewable, or conditionally renewable. The provision determines whether the policy can be renewed by the insured, whether the insurer can cancel the contract, whether the insurer is required to grant renewal on request, or whether the policy term 9including premiums) may be changed at renewal.

**A noncancelable disability income policy can never be canceled by the insurer. Additionally, the insurer cannot change the benefits provided the rates, or other policy features unless the insured requests a change**. A noncancelable policy is most attractive to insureds.

**A guaranteed renewable policy will continue as long as the premiums continue to be paid, up to a specified age, such as 65 or 70, as long as the insured is gainfully employed (earning a reasonable salary). Even though the insurer must renew the policy at the insured’s request, the insurer reserves the right to raise premiums on renewal for reasons specified in the contract**. This alternative is less attractive to insured.

**A conditionally renewable policy provides that the insurer has an option to increase the premium and change the policy terms at renewal. Also, this policy allows the insurer to cancel the contract if the conditions for renewal are not met**.

**Individual Disability Income Insurance**

Individual disability income insurance generally provides monthly benefits to a disabled wage earner for a selected period to reimburse the wage earner’s income during a period of total or partial disability. Individual policies will usually replace 60% of an insured’s lost income and sometimes up to 70% or 80% under some plans.

Coverages and provisions under individual disability income insurance are typically the same as those for group insurance. Some life insurance policies include riders that provide disability coverage.

**Individual disability income insurance is purchased using after-tax dollars. Consequently, disability benefits that are paid from an individual policy are not taxable t the insured. This enables the insured to receive more disability income at the time it is needed most. Individual insurance does not require membership in a group, and a job change will not affect coverage (as in an employer provided group insurance). Individual insurance does not require tenure before the benefits are available, and limits may be selected to allow the individual insurance to supplement other disability income insurance coverages provided through employers, associations, and the government**.

Various options, often called riders, are available for purchase with an individual disability income insurance policy. Premiums for these riders vary based on the payout-the amount of benefits the insurer is likely to pay.

Common individual disability income Riders:

Waiver of premium, guaranteed insurability every 5 years option to increase benefits by specified amount, cost of living adjustment (COLA) – each year 4%, Future increase option (FIO) until age of 55, Automatic Increase Rider (AIR) – 25% increase each year for first 5, Residual (partial) disability – 20% after 2 years, Social Security Supplement.

**Group Disability Income Insurance**

Group disability income insurance is made available through an employer or some type of association. Because an individual organization purchases many policies, economies of scale enable the insurer to offer lower premiums to the insured individuals.

**Premiums are paid by the employer in part or in full, and premiums may be deducted from the insured’s payroll on a before-tax basis; consequently, benefits are taxed as ordinary income when they are paid to the insured during disability. Because group policies are purchased in bulk, options are limited with the options available in individuals plans. Under most LTD plans when the individual’s employment or association ends, the group disability income coverage terminates. The coverage also terminates if the employer fails to pay the premium for the employee, or if the group policy is terminated by the employer or association.**

Most group LTD plans use a split definition of disability, with which an “own occupation” definition applies for an initial disability period, such as 2 years, and then an “any occupation” definition applies for the remaining benefit period until the maximum benefit period is reached.

Most LTD plans have a coordination-of-benefits provision that defines how disability income benefits from other plans, such as SSDI and state disability plans, will affect benefits paid by the LTD plan.

**Social Security Disability Income Program (SSDI)**

**Rules to qualify under the SSDI program are strict compared with other disability plans. The program provides 2 protections for disabled workers:**

* **Monthly cash benefits**
* **Establishment of a period of disability**

**The requirements for these two protections are nearly the same so a disabled worker is generally eligible for both.**

**Disability Definition**

To be considered “disabled” under Social Security, a worker must be unable to engage in any substantial gainful activity because of a “medically determinable” physical or mental impairment as defined in the Social Security law. A substantial gainful activity is one that requires significant activities that are physical, mental, or a combination of the two, in work that is performed for profit, even if no profit is realized. This work will qualify whether it is full time or part time work. This disability definition is comparable to an “any occupation” definition, as it encompasses the individual’s previous work and any type of work that could be expected for the individual’s age, education, and work experience.

Furthermore, for a worker to qualify as disabled, the worker’s impairment must be established by objective medical evidence, and it must be expected to last for at least 12 consecutive months or result in the individual’s death.

**Monthly Cash Benefits**

Payment of benefits requires a 5-month waiting period. Benefits are paid to individuals who have yet to reach full retirement age under Social Security.

The monthly cash benefit is generally equal to the primary insurance amount (PIA) as described in the Social Security law. Auxiliary benefits may also be provided for a qualified disabled worker’s eligible dependents.

Disabled worker benefits may be reduced, including the auxiliary benefits, to fully or partially offset any WC benefit and any disability benefits received under a federal, state, or local disability plan.

**Establishment of a Disability Period**

Establishment of a disability period is essential for determination of numerous Social Security benefits. A “period of disability” under the Social Security law is a continuous period during which an individual is disabled. The established period of disability is not counted in determining an individual’s insured status under Social Security and is not counted in determining the monthly benefits amount payable to the worker and his or her dependents. **This period of disability is used in determining other types of Social Security benefits for the worker’s family.**

A period of disability must be established during a worker’s disability or within 12 months after the disability ends, assuming the worker has met “disability insured status” and the disability lasted at least 5 consecutive months. The waiting period may have some exceptions if the worker suffers a subsequent disability.

**3 – Health Insurance Plans**

Most American healthcare consumers participate in group healthcare plans (as opposed to individual plans). In addition to employer self-insured plans, three broad types of healthcare plans provide the majority of private health care resources for Americans:

* Traditional health insurance plans
* Managed-care plans
* Consumer-directed health care plans (CDHPs)

Self-Insurance Plans – in addition to the availability of commercial health insurance and Blue Cross and Blue Shield plans, many employers self-insure part or all of the health insurance benefits they provide to their employees. Self-insurance, also called self-funding, means that the employer funds and pays part or all of an employee’s medical expenses. Employers that self-insure either perform their own claim processing or contract with third-party administrators to manage the plans, including enrolling employees and processing claims.

**Traditional Health Insurance Plans**

**Traditional health insurance plans insure many individual and families through the use of “fee for service” or indemnity plan coverage. Providers of traditional health insurance pans include commercial insurers and Blue Cross and Blue Shield plans.**

Major life and health insurers, and some property-casualty insurers, offer commercial, or private, health insurance (any nongovernmental health coverage) to the public. Commercial health insurance offers many benefits packages and premium variations, often tailored to specific needs of large or small groups, or individuals.

Individual plan consumers include workers of all ages with no employer-sponsored health insurance coverage, young unemployed adults, and business owners with no group coverage. Purchasers of nongroup policies for family coverage tend to be over the age of 35.

Blue Cross and Blue Shield plans historically were not-for-profit plans, they are now often administered by for-profit organizations. Because of this not-for-profit history, BC BS providers usually are not described as “commercial insurers” and typically are regulated by state laws separate from those regulating other insurers. BC BS plans provide basic medical expense coverage and major medical insurance on either an individual or a group basis. BC BS plan also sponsor managed-care plans.

Blue Cross plans usually contract with hospitals and pay them directly, rather than paying insureds (also called “subscribers”). And Blue Shield plans often pay physicians directly. Basic medical expense coverage pays for routine healthcare expenses. Major medical insurance plans provide broader coverage for medical expenses, as well as catastrophic coverage for more costly treatment.

**Managed-Care Plans**

Managed-care plans manage the quality of their members’ care and control healthcare costs. Managed-care plans often involve the same insurers that administer traditional plans; however, managed care involves and insurer negotiating benefits and fees with a network of healthcare providers. The customer receives a significant premium savings and reduced out-of-pocket costs as a result, but often with reduced flexibility. Some plans provide emergency care, while other do not or only provide emergency services at a higher cost to the member. **These are the most prevalent forms of managed-care plans**:

* **Health maintenance organization (HMO**) – **an HMO contracts with healthcare providers to provide comprehensive services to its members for a low, fixed, prepaid fee, with small co-payments for routine visits. A “gatekeeper physician” usually must preapprove specialists; visits. HMO’s control costs by requiring preapproval for specified physician’s treatments and specialists’ services, along with oversight of diagnostic tests and treatments**.
* **Preferred provider Organization (PPO**) **– PPO members may choose any provider (more flexible), but preferred providers offer decreased medical service costs and lower deductibles**. No primary physician is required, and any physician may make specialist referrals. **PPOs are one of the more expensive forms of managed-care plans, but they are popular because they blend the advantages of both traditional indemnity plans and HMOs.**
* **Exclusive provider organization (EPO)** – EPOs contract with insurers to provide healthcare to plan members at a much lower premium than healthcare provided by other plans. The EPO charges insurers an access fee for use of the network, negotiates with healthcare providers to set fee schedules for guaranteed service levels, and helps resolve issue between insurers and healthcare providers. Except for emergencies, plan members must exclusively use EPO network healthcare providers.
* **Point-of-service (POS) plan** – a POS has characteristics of both HOS and PPO, but more closely resembles an HMO. A POS controls medical costs, but the member must choose a primary care physician from within the POS network. This physician become the member’s “point-of-service” and can refer a member inside or outside the network. Some services are provided by non-network providers with reduced POS payments. The POS handles all paperwork and billings for network care, whereas the member handles paperwork, bills, and record keeping for out of network care.

Some private insurers extend managed-care benefits to Medicare recipients. Medicare Advantage (MA) plans, often called Medicare Part C, offer options similar to other managed-care plans. In addition to the basic benefits provided by Medicare under Part A and Part B, beneficiaries may be eligible for managed-care services and supplemental benefits and health services. Some supplemental benefits are mandatory for enrollees, and others are options. MA plans may offer these managed-care options:

* HMO
* Provider sponsored organizations
* PPO
* Medical savings accounts (MSA’s)
* Private fee-for-services (PFFS) plans
* Special needs plans (SNP)

**Consumer-Directed Health Plans**

Consumer-directed health plans (CDHPs) provide consumers with access to high-quality care without requiring deductibles for preventive care. CDHPs can provide healthcare benefits to those who might otherwise be uninsured. CDHPs usually include three major components:

* An HAS or health reimbursement arrangement (HRA)
* High-deductible medical coverage, with preventive care not charged against the deductible
* Access to informational tools for making informed healthcare decisions

**People covered y CDHPs pay lower premiums for their health coverage because the deductibles are high. Using either an HAS or HRE, they set aside money that can be used to help satisfy the deductible. HSAs are funded by enrollees themselves, and the money in the HSA can be rolled over for future use at year’s end**. No taxes are withheld from the funds contributed to an HSA. **The money in an HRA is contributed by the employer and is not included in the employee’s income for tax purposes. The employer’s distributions to the employee are tax deductible, and unused funds in HRA accounts can be rolled over from year to year for future use**.

Basic provisions of the Affordable Care Act of 2010

Intended to reform the private health insurance industry and help curb rising medical care costs. The Affordable Care act was upheld by the United States Supreme Court in 2 major challenges. All of its provisions are in effect as of 2015. Provisions of the act make health insurance available to more individuals and provide improved coverage provisions. These benefits are or will be evident under the new law:

* Insurers cannot decline insurance for children (under the age of 190 with pre-existing medical conditions; this will extend to individuals of all ages as of 2014
* Adjust children (up to age 26) can join or remain covered under a parent’s healthcare plan
* Insurers cannot rescind benefits (retroactively cancel) because an insured or the employer made an honest mistake or omission
* Insurers cannot place lifetime dollar limits on essential benefits; annual dollar limits are being phased out and will not be allowed after 2014
* Insurers may be required to pay for certain preventative services (such as screening, flu and pneumonia vaccines, well-baby and well-child visits) without applying co-payments, coinsurance or deductibles
* Individuals can choose primary care physicians from within a plan’s provide network, can obtain services from an OB-GYN without referral from a physician and can seek emergency care at a hospital outside the plans network without prior approval
* Insurers are required to spend set percentages of premiums received on direct medical care or improvements to the quality of care provided, and must meet annual federal reporting requirements; insurers must provide rebates to participants if the percentages are not met

**4 – Government Provided Health Insurance**

Medicare and Medicaid provide the cornerstone of America’s healthcare services.

**People age 65 and older, under 65 with certain disabilities, or for all ages with specified medical conditions can qualify to receive federal Medicare Health benefits.**

In addition to original Medicare Part A and Part B, the Medicare Advantage (MA) program (called Part C) became available in 1997. Some private insurers offer Medicare Supplement Insurance (Medigap) to cover costs that are not paid by Medicare. 2003 Modernization Act provided Medicare Part D – Drug coverage.

**Original Medicare**

Medicare is part of the federal Old Age and Survivors Disability Health Insurance (OASDH) program. It is social insurance program that covers the medical expense of most individuals age 65 and older, providing them with an affordable healthcare option.

Under the original Medicare program, beneficiaries have 2 basic coverages: Part A (hospital insurance) and Part B (medical insurance). Beneficiaries have options when deciding how to receive Medicare-covered services. The options available can vary depending on where the beneficiary lives. Most beneficiaries are placed in the original Medicare program, but they can then review their health and prescription needs annually and switch to different plans during certain periods toward the end of each year.

Medicare Part A is largely financed through payroll taxes paid by employees and employers. Medicare B is largely financed through a monthly premium paid by beneficiaries and the federal government’s general revenues.

Medicare Part A helps pay for in-hospital services, and Medicare Part B pays for medically necessary non-hospital services.

**Generally, people are eligible for Medicare if they or their spouse worked for at least 10 years in Medicare covered employment, are age 65 or older, and are a citizen or permanent residents of the US. People who are not yet 65 may qualify for coverage if they have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant).**

Most people receive Part A automatically when they reach age 65. Enrolling in Part B is options. A beneficiary can enroll in Part B any time during the 7-month period that begins 3 months before turning 65. The premium is usually taken out of monthly social security, Railroad Retirement, or Civil Service Retirement payments, and beneficiaries who do not receive those payments must pay the Part B premium every 3 months.

**Medicare Advantage (Part C)**

**Beneficiaries who need more services than Medicare covers can choose private health insurance (Medicare-approved) plans called Medicare Advantage (MA) plans or Part C plans. Part C plans cover medically necessary care offered by nearly any hospital or doctor in the country, but they do not cover all healthcare costs. The benefits offered by MA plans must be at least equal Medicare Part A and B benefits, but they do not have to cover every benefit in the same manner.**

The plans, services and fees of MA plans vary by location. People participating in an MA plan may pay a monthly premium in addition to the Medicare Part B premium and generally pay a fixed co-payment for each doctor visit.

**MA plans can use excess Medicare subsidies to offer supplemental benefits to members. Some plans limit members’ annual out-of-pocket spending to protect against catastrophic medical costs or to provide benefits not available through Medicare.**

**A Medicare beneficiary can choose between different types of MA plans**:

* **Medicare Managed-care plans – such as HMOs, PPO, and others – also called coordinated care, they require fixed fees and co-payments for services obtained from preferred providers. These plans also offer prescription drug plans that replace the need for Medicare Part D**.
* Private fee-for-service (PFFS) plans – the beneficiary may go to any Medicare approved doctor or hospital that accepts the plan’s payment. Medicare pays the PFFS plan portion of the premium, and the beneficiary must pay the difference to the provider.
* Special needs plans (SNP) – providing more-focused healthcare for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medial conditions. SNP providers coordinate the services and medical care providers to meet beneficiaries’ unique needs. SNPs are required to provide Medicare prescription drug coverage.

**Medicare Supplement Insurance (Medigap)**

Medicare Supplement Insurance policies (also called Medigap policies) are sold by private insurers to fill the gaps in original Medicare Part A and B coverage. Premiums for Medigap policies can be costly, but they provide coverage for a number of benefits and fill the gaps left within Medicare provisions. However, the benefits provided by Medigap policies do not include paying the costs for Medicare Parts C and D. Additionally, a person who has purchased a MA plan does not require a Medigap policy because the benefits covered are typically the same.

**Medicare Prescription drug Coverage (Part D)**

**Medicare Part D is a voluntary program through which the government subsidizes the costs of beneficiaries’ prescription drugs underwritten through private insurance carriers**. It provides coverage for beneficiaries who have very high or unexpected prescription drug bills. All Medicare beneficiaries are eligible for this coverage, except when it is provided separately under MA plans.

Beneficiaries may sign up for Part D upon first becoming eligible for Medicare (3 months before the month they reach 65 years of age until here months after they turn 65. If they receive Medicare coverage as a result of a disability, they can sign up from 3 months before to 3 months after their 25th month of receiving cash disability payments. Medicare beneficiaries generally pay monthly premiums for Part D, which vary by plan, and a yearly deductible.

**Medicaid**

**Medicaid is a means-tested federal-state welfare program that covers the medical expenses of low-income persons, including those who are aged, blind, or disabled; members of families with dependent children; and pregnant women and certain children. Low-income Medicare beneficiaries requiring nursing home coverage are also eligible. An investigative process determines eligibility**.

Benefits and eligibility for Medicaid can vary by state because states help fund the program. The federal government pays almost 60% of all Medicaid expenses, so while each state administers its own program, the federal Centers for Medicare and Medicaid Services (DMS) set requirements for quality, funding, and eligibility. To receive matching funds and grants, each state must conform to federal guidelines. Each stat’s poverty level determines the federal matching formula. The wealthiest state receive a federal match of 50%, while poorer states receive a greater percentage of funding. Medicaid’s costs average 22% of each state’s budget.

The largest group of Medicaid recipients is children, composing almost ½ the number of total recipients. A limited income is one of the primary eligibility requirements for Medicaid, but poverty alone does not qualify applicants.

Medicaid provides the largest portion of federal money spent on healthcare for people living with HIV/AIDS, who usually most progress from an HIV-positive diagnosis to AIDs before qualifying as “disabled’

Retirees and other people facing nursing home costs are subject to special eligibility standards.

**Eligibility: Age, Pregnancy, Disability, Blindness, Income and resources, Status as a US citizen or lawfully admitted immigrant**.

**Long-Term Care insurance**

Long-term care insurance is an increasingly important coverage. Almost half of all people who have reached age 60 will require some form of long-term care during their lifetimes. The overall average length of stay in a nursing home is about 2 ½ years, and the cost of long-term care is staggering.

When choosing a long-term care (LTC) policy, a consumer should bear in mind many considerations regarding benefits, coverage triggers, eligibility, and other economic issues.

Group and individual policy insurers take different approaches to eligibility, and age is the most important factor.

**Coverage Basics**

**Long-term care insurance can provide for the daily custodial care as well as the long-term nursing care than an individual may need outside of a hospital. Neither Medicare nor private medical insurance covers long-term care for expenses associated with confinements in such facilities as nursing home or custodial care centers for extended periods, skilled nursing care after 100 days, custodial care, nonmedical care that helps an individual with the activities of daily living (ADLs) or intermediate nursing care.**

Additionally, most elderly patients in nursing homes do not qualify for tong-term care under the strict eligibility requirements of Medicaid. Medicaid pays a large percentage of the nation’s nursing home bills. However, many participants do not qualify for Medicaid, and applicant may have to dispose of assets to qualify for benefits. Additionally, some nursing homes do not accept Medicaid recipients. LTC insurance provides a means to preserve the assets of individuals who require long term care, as well as the assets of their families.

Individuals can purchase LTC insurance, and some employers offer group plans that enable individuals to obtain coverage at reduced rates.

No standard LTC policy exists, and a consumer should consider several basic aspects of policies when comparing them:

* Benefit period – length of time after filing a claim that the insurer will pay for care (one year to lifetime coverage)
* Daily Benefit – the maximum dollar or percentage amount the insurer will pay for care daily (from $30 to $300 per day)
* Elimination period or deductible – the length of time and amount of money and insured must pay out of pocket before the insurer starts to pay (from first day to one-year wait)
* Level of inflation protection – the amount which benefits will increase over time to keep up with inflation

**Coverage Triggers**

A critical LTC policy provision involves the conditions that determine who is eligible to receive benefits, often referred to as coverage triggers. The most common triggers are activities of daily living (ADLs), medical necessity, and cognitive impairment, which necessitates care to protect the patient and others from threats to safety caused by the patient’s condition.

Under most LTC policies, an insured qualifies for benefits when unable to perform a specified number (such as two or three) of the ADLs listed in the LTC policy.

**Benefits Typically Provided**

**Purchases of LTC insurance typically have a choice of benefits – such as daily benefit of up to $80 $120, or $160 – that is paid over a maximum period of 2, 3 or 4 years, or for the insured’s lifetime.** Some insurance allows purchasers to select a maximum lifetime benefit amount, such as $300,000. Some policies provide a maximum benefit equal to the daily dollar limit times the policy duration. Additionally, policies can cover home healthcare, adult day care, and respite care.

A “bed reservation benefit guarantee” holds a bed for a short hospital stay, paying for a number of days to hold a nursing home bed in case the insured requires hospitalization.

The policies typically covered skilled nursing home care, intermediate nursing care and custodial care.

The majority of LTC policies sold today are comprehensive policies. They typically cover care and services in a variety of long-term care setting, for which they pay daily benefits.

* The insured’s home, skilled nursing care; occupational, speech, physical, and rehabilitation therapy; help with personal care, some homemaker services, such as meal prep or housekeeping, in conjunction with the personal care services
* Adjust day care centers
* Hospice care
* Respite care
* Assisted living facilities
* Alzheimer’s special care facilities
* Nursing homes

Many policies may also pay for services or devices to support insureds living at home

* Equipment as in-home electronic monitoring systems
* Home modifications, such as grab bars and ramps
* Transportation to medical appointments
* Training for a friend or relative to learn to provide personal care safely and appropriately

Some policies provide some payment for family members or friends to help care for an insured, but they may do so on a limited basis or only in relation to the costs that family member incurs.

Most policies provide the services of a care coordinator, usually a nurse or social worker in the insured’s community.

**Benefits Typically excluded**

LTC policies have these typical exclusions:

* Care or services provided by a family member, unless is a regular employee of an organization providing the treatment
* Care of services for which no charge is made in absence of insurance
* Care or services provided outside the US
* Care or services resulting from a war or an act of war, whether declared or not
* Care of services resulting from an attempt as suicide (while sane or not) or an intentionally self-inflicted injury
* Care or services for alcoholism or drug addiction (unless addiction to prescription medication when administered upon the advice of a physician)
* Treatment provided in a government facility (unless otherwise required by law)
* Services for which benefits are available under Medicare or another governmental program (except Medicaid).

Although most policies do not pay for care the insured receives from a family member, friend, or other individual who is not normally paid to provide care, some policies provide a cash payment for each day that the insured receives care from anyone, even if it is a family member or friend. These policies cost about 25-40% more but allow more flexibility in using benefit dollars.

Most policies require that the facility, agency, or individual providing care meet certain minimum standards with respect to quality, safety, and training.

LTC policies focus on paying for the types of services and providers that meet the needs of insured who cannot perform the Activities of Daily living (ADLS)on their own or who have cognitive impairment needs.

Some policies provide coverage for care related to everyday household needs such as housekeeping, laundry, meals, and managing medications – so called “instrumental activities of daily living”

Finally, LTC policies do not pay for items provided solely for the insured’s comfort or convenience, such as TV or hair salon.

**Applicants for long-term care policies should consider coverage triggers, inflation protection, guaranteed renewability, nonforfeiture options, tax treatment, waiver of premiums, elimination periods and eligibility provisions**.

**Inflation Protection**

Inflation can substantially erode the real value of LTC insurance benefits. Insurers use two major methods for providing protection against inflation;

* Some policies allow insured to purchase additional amounts of insurance in the future with no evidence of insurability. Premium is based on the insured’s current age, but no evidence of insurability is required.
* Other policies provide an automatic benefit increase in which the daily benefit is increased by a specified percentage for a number of years, such as 5% annual for the next 10-20 years. Adding an automatic benefit increase is expensive and may double the annual premium in some cases, especially if an insured is at an advanced age when they purchase the policy

**Guaranteed Renewability**

Most individual LTC insurance policies have guaranteed renewability provisions. An LTC insurer cannot cancel the policy on the basis of change in the insured’s health. Once the policy has been issued, it cannot be canceled. However, premiums can be increased for underwriting class in which the insured is placed.

**Nonforfeiture Options**

When the insured cancel an LTC policy, the premiums paid for the policy until the policy is canceled can be returned to the insured or used to purchase the same benefit for a shorter benefit period or a reduced benefit for the existing benefit period.

The nonforfeiture value is similar to a reduced paid up amount of insurance after the premiums have been paid for a number of years.

**Tax Treatment**

Insured can deduct premiums charged for LTC policies as itemized medical expenses on federal tax returns. An insured who pays more than 7.5% of adjusted income for medical expenses (including LTC insurance premiums) can deduct those expenses from federal income taxes. Some special LTC insurance policies are tax-qualified (nontaxed) policies, which makes the LTC benefits tax-free. Nonqualified polices require that the insured pay additional taxes based on the value of the benefits received.

Some states allow LTC premium deductions on state income tax returns, regardless of whether a policy is federally qualified. Employees in group plan generally can pay premiums with pretax dollars.

**Waiver of premium**

Allow for an incapacitated insured to stop paying premiums while receiving benefits and keeping the policy in force with full coverage. In many cases, the premiums must be paid until a time period (usually several months) has been satisfied, and then they are waived. An LTC policy might have a requirement that the insured be in a nursing home or a specified period, such as 60-90 days, before a waiver of premium is allowed.

**Elimination Period**

Most LTC insurance plans are sold subject to an elimination period that functions like a time deductible. The LTC policy elimination period or deductible is the length of time and the amount of money an insured must pay out of pocket before the insurer starts to pay. The time span can range from 1st day coverage to 1 year. A longer elimination period can substantially reduce the annual premium.

Eligibility Provisions

Individual LTC insurance is medically underwritten meaning that an insurer can refuse an application for a policy from an applicant who does not meet medical guidelines.

Age is the primary factor in determining the cost of an LTC policy. The younger an insured is, the less expensive the premiums. However, the younger insured will also pay premiums over a longer time. The best time for a consumer to purchase an LTC policy is between ages 50-55 because premiums will cost nearly twice as much for a policy purchased in one’s 60s.

LTC insurers have varied underwriting guidelines, and many medical conditions are not insurable under most LTC plans. Many conditions controlled with medications are insurable. An applicant must list on the application any current or past medical problems, as well as provide medical records from healthcare providers.

Some insurers reject LTC applicants’ and a husband and wife with different risk characteristics can receive a different underwriting decision from the same insurer based on that insurer’s medical underwriting guidelines.

All LTC insurance policies have physician certification or (gatekeeper) provisions that determine whether the insured is eligible for policy benefits. A gatekeeper provision states the requirements that the insured must meet to receive benefits.

A common type of gatekeeper provision requires that, to qualify for coverage, the insured must be able to perform a certain number of ADLs, such as 2 out of 5, without help from another person.