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HOW TO COVER THE GAPS IN MEDICARE

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Health Insurance and Long-Term Care Options for the Retired

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See
Medical Expense Record
at the back of the book.

PREFACE TO THE 12TH EDITION

SINCE the first edition of *How to Cover the Gaps in Medicare* was published in 1983, a virtual revolution has occurred in the Nation's system of health care for senior citizens. The costs of hospitalization, Medicare and supplemental health insurance premiums, and nursing-home care are much more than they were then. Doctors and hospitals now are paid according to Government-mandated price arrangements and are threatened by the Government and insurers with sanctions unless they "cut costs" wherever possible. Conclusive evidence of the full effects of such practices on the quality of patient care is not yet in, but it is clear, for example, that elderly patients are being discharged from hospitals much sooner than ever before.

Whatever the clinical effects of these changes may be, the financial impact on elderly health care consumers of health care price increases over the past 17 years has been dramatic. For example, currently two-thirds of elderly nursing home residents are Medicaid recipients. Indeed, in recent decades the health-related financial problems of America's senior citizens have emphasized the need for elderly individuals and their families to seek a range of options that encompasses both health *and* long-term care if they are to avoid financial ruin.

It would be impossible in a general discussion to describe in great detail all of the ramifications of current health care and long-term care trends, or all of the opportunities available to people in different circumstances. It is possible, however, to describe the principal considerations that all of us ought to take into account when we plan for our own futures—and when we exercise our rights as citizens in choosing what type of health care "system" will provide widest accessibility to the best medical care at the lowest cost.

Part 1 of this book briefly describes the history and current provisions of Medicare, which have undergone numerous changes in the past decade. It also traces the history of the "medigap"—the portion of elderly health care costs that has not been covered by either Medicare Part A or Part B. Despite all the talk of "cost containment" there is little evidence that the medigap has begun to shrink. On the contrary, the medigap has grown wider and may continue to do so.

Part 2 describes Medicare supplemental health insurance and different medigap policies. The most significant change since the first edition of this book was published has been the introduction of the National Association of Insurance Commissioners' model regulation for ten standardized Medicare Supplemental Insurance policies. Chapters VI, VII, and VIII review these policies and provide criteria for selecting one. Major changes in Medicare were introduced in 1998, and these are discussed in Chapter IX.

Part 3 discusses long-term care options. Many of the aged understandably are concerned that the costs of long-term care in a nursing home will leave either themselves or their spouses financially destitute. In fact, there are a variety of protections against the costs of such care. Not only have continuing-care and home-care alternatives widened in the past two decades, but changes in Medicaid eligibility rules opened the door to far greater "middle class" participation in that program. Recent legislation has altered some of the rules and penalties relating to transfers of assets in order to become eligible for Medicaid but it is doubtful that these developments will seriously curtail Medicaid eligibility.

Part 4 considers end-of-life decisions that have been necessitated by court rulings relating to "right-to-die" issues. The fact is that your wishes respecting the type and extent of medical care that you receive if you become unable to make your own decisions probably will not be honored unless you follow the specific procedures mandated by the "living will" legislation.

Lastly, an appendix considers some of the issues that have framed the debate over public versus private health care systems, and which promise to attract greater public interest as the costs as well as benefits of public health care become more apparent.

The task of insuring oneself against the risk of illness and the vicissitudes of old age is growing increasingly complex. At the same time, the risks of *not* insuring oneself are more threatening than ever. It is our hope that the pages that follow will be useful as an introductory guide to obtaining whatever protection is available.

I am grateful to my colleague, Dr. Charles Murray, who provided the primary research and editorial support for the preparation of this new edition of *How to Cover the Gaps in Medicare*, and to Jon Sylbert, who designed the text and graphics.

Robert A. Gilmour

Great Barrington
January 2000

Part 1

THE MEDICARE QUANDARY

I.

THE HEALTH INSURANCE PRINCIPLE

AS with other forms of insurance, the purpose of health insurance is to reduce the financial burden of risk by dividing losses among many individuals. In general, health insurance in America has worked much as life insurance, homeowners' insurance, or automobile insurance. The insured pays the insurance company a specified premium and the company guarantees some degree of protection. And like other types of insurance, health insurance premiums and benefits are figured on the basis of average experience. Insurance company actuaries rely on aggregate statistics that tell them how many people in a certain population group will become ill and how much their illnesses will cost in order to fix rates and benefits.

Here the similarity ends. Unlike life insurance or homeowners' insurance, the value of health insurance is *not* measured by the actual amount promised as a benefit—as in a $25,000, $50,000, or $100,000 life or homeowners' policy. And unlike automobile liability insurance, which fixes a limit on the amount that the company will pay, health insurance is "open-ended." That is, no one can say what the maximum benefit return on any given policy will be. Health insurance limitations often are measured *by time* (90 days, 6 months, 1 year, etc.) rather than by dollar amounts. Unlike other forms of insurance, the value of health insurance is measured according to the extent by which it reduces *potential risk* in the event of illness. In short, **how much would the patient still owe after all insurance benefits were exhausted?**

The Unpredictability of Illness or Infirmity: Average Risk vs. Potential Risk

From the individual consumer's perspective, illness or infirmity must be regarded as totally unpredictable. The uncomfortable truth is that no one can predict when illness will strike or what form it will take. Nearly everyone has friends or loved ones who have been hit out of the blue with serious illness or disability. And often the reaction is: "I never would have believed it could happen to such-and-such." Conversely, we all know people who for years think they are desperately ill, yet live on to a ripe old age. In short, sickness—as

well as good health—often comes as a surprise. The belief that the future is easily predicted seems to be a persistent type of human behavior (especially among some economists who ought to know better). It must, however, be excluded from any thought regarding health insurance.

It is also crucial that average risks not be confused with potential risks. Insurance companies structure policy coverages and premium rates around the likelihood of certain conditions occurring. To be sure, a certain percentage of a specified group of people will contract a certain disease or become disabled. But this **average risk experience is of little practical value to the individual**.

The insurance buyer must be concerned with *potential risks* **that seldom occur, but that everyone nevertheless faces**. This point is of the utmost importance, since many insurance companies cite *average statistics* in their sales promotions. Far too many people have been misled by sales presentations giving general figures that frighten them into believing they will contract a certain disease or require a certain type of care. Some companies have relied almost exclusively on the power of such frightening figures to generate purchases of their policies. Again, although the averages may be accurate, they bear no relation to the potential risks arising from the unpredictability of illness.

A hypothetical case from a less emotionally charged situation will illustrate the point. Let us assume for the sake of example that more automobiles are painted white than any other color and that *on average* white cars are involved in more accidents than any other. The question is, would you purchase automobile insurance that protected you only in the event that a *white* automobile collided with you? Obviously not.

The unpredictability of illness and health care costs during recent decades has thrown the health insurance industry into disarray, and this fact has important implications for all health insurance buyers—elderly or not. Aside from the unpredictability of illness, the costs of diagnosing and treating many conditions are uncertain. First, medical technology is rapidly altering diagnostic and therapeutic procedures for most illnesses. Sometimes the actual costs go up, and sometimes they go down. Second, illness varies from place to place and from population to population. There is no sufficiently reliable

way of predicting what will happen in any given area on the basis of aggregate experience. Third, and most important, health care costs vary greatly. Historically, hospital and doctor fees have varied widely from place to place. Medicare administrators have attempted to regulate both hospital and physician fees. But these attempts have introduced new factors that have further complicated Medicare reimbursement procedures.

The consequences of these uncertainties—all of which are related to the unpredictability of illness—are enormous. To a greater extent than in other types of insurance, actuarial "science" in the health insurance field is unreliable.

The result has been an enormous variation in premiums and losses, and this has offered tremendous variation in value for the health insurance buyer. It may pay to expend considerable effort in price shopping for "medigap" insurance; and in that endeavor it is hoped that this booklet will be a useful resource.

II.

MEDICARE

IN order to purchase any medigap insurance policy, you must be insured under Medicare's Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B). However, coverage under both Medicare insurance programs has been subject to frequent change. And each time Medicare's coverage has changed, the terms of coverage of the various medigap policies then in force have also changed. Medicare administrators base their premium decisions and claims payment practices on existing legislation. But as the brief history below suggests, the Medicare laws could change again anytime. Although it may be unsettling, virtually all health insurance decisions that today's senior citizens face should be made with the understanding that they probably will be temporary ones.

Medicare's History

The Medicare program, enacted on July 30, 1965 as Title XVIII of the Social Security Act, became effective July 1, 1966. It consists of two separate parts, Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B). Medicare coverage initially included only Social Security retirement beneficiaries, but subsequently has undergone many changes. Since it first became effective, the Medicare program has been extended at different times to provide coverage to disabled persons entitled to monthly cash benefits under Social Security or the Railroad Retirement program, to pay benefits for hospice care for terminally ill patients, to make Medicare the secondary payer for all workers aged 65 or older and their spouses who are covered by employment-based health insurance, to include payment for immunosuppressive drugs to transplant patients, to provide home health care benefits, and to provide coverage for mental health services.

A comprehensive expansion of Medicare benefits was encompassed in the Medicare Catastrophic Coverage Act of 1988, under which the elderly and disabled were to be protected against the costs of catastrophic medical bills. This Act also provided for broad coverage of outpatient prescription drugs. The new Medicare benefits were to be financed through increases in both Part A and Part B premiums, which sparked a wave of protest from beneficiaries.

MEDICARE BENEFITS SUMMARIZED AND PATIENT FINANCIAL RISK

HOSPITAL INSURANCE — PART A

Type of Service	*Time Limit*	***Patient Risk***	*Medicare Pays*	*Qualifications*	*Exclusions*
Hospital Confinement: semiprivate room and board unless a private room is required for medical reasons. Covers routine nursing, drugs, and normal services, including operating and recovery rooms, medical social services, physical therapy, equipment and medical supplies.	First 60 days each benefit period*	**First $776**	Balance	Age 65 and: (1) Entitled to Social Security (or Railroad Retirement) benefits; or (2) is *not* entitled, a citizen or permanent resident for 5 years, may enroll by paying a monthly fee plus Part B (cost below).	First three pints of blood, private duty nurses, noncovered levels of care; services covered under Part B, television, telephone and luxury items.
	Next 30 days continuous hospital confinement	**$194 each day**			
	Lifetime aggregate reserve of 60 additional days	**$388 each day**			
	After 150 days continuous hospital confinement	**100%**	Nothing		
Skilled Nursing Facilities: following hospital confinement.	First 20 days each benefit period*	**Nothing**	100% of covered charges	Must require skilled nursing or rehabilitation care within 30 days after hospital confinement that lasted at least 3 days.	Same as above; unskilled medical care (such as "Old Age Homes" and Custodial Care).
	Next 80 days continuous confinement	**$97 each day**	Balance		
	After 100 days continuous confinement each benefit period	**100%**	Nothing		
Home Health Care: by visiting nurses, technicians, and therapists.	First 100 days in spell of illness	**Nothing for covered charges; 20% of covered charges for durable medical equipment**	100% of covered services; 80% of covered amount for durable medical equipment	Must be home confined and physician must prescribe nursing/skilled care.	Full-time (private duty) nursing, self-administered drugs, services, covered under Part B.
Hospice Care	As long as the doctor certifies need	**Nothing†**	100% of covered services†	Must be terminally ill.	
Psychiatric Confinement Care	190-day lifetime limit		Same as Hospital Confinement with a lifetime maximum of 190 days.		
Overseas Hospital Care	No coverage	**100% of charges**	Nothing	Some coverage provided only in special circumstances.	

MEDICAL INSURANCE — PART B

Type of Service	*Time Limit*	***Patient Risk***	*Medicare Pays*	*Qualifications*	*Exclusions*
Physicians and Surgeons: services at home, hospital, or office. ***Medical Services and Supplies:*** diagnostic tests, surgical dressings, casts, splints, braces, artificial limbs and eyes, rental or purchase of medical equipment, ambulance, X-ray therapy, professionally administered drugs, some chiropractic services, nonroutine footcare. ***Hospital Care:*** Outpatient	No time limit	**First $100 per calendar year, then 20% of "approved charges" *plus* any excess of charges over Medicare's "approved charges" if doctor or supplier does not accept assignment, up to limit.**	Balance of "approved charges"	Voluntary enrollment, costs $45.50 per month plus 10% (per year) depending on date of enrollment, if you did not sign up when you were first eligible (workers and their spouses with employer group health coverage may delay enrollment and avoid the late enrollment penalty if they meet certain requirements).	Services covered by Workmens' Compensation, private duty nurses, eyeglasses, routine physicals, routine dental work, hearing aids, orthopedic shoes, nonskilled nursing care, cosmetic surgery, charges made by a relative, first three pints of blood in a calendar year, vaccinations, self-administered drugs, preventive care, services in a foreign country.
Home Health Care: visiting nurses, aides, therapists.	Unlimited visits	**Nothing**	100% of approved charges	Same as for Part A home health care.	
Durable medical equipment.	Unlimited	**20% of costs**	80% of costs		Non-medical items.
Psychiatric Outpatient Care	Per calendar year	**First $100, 50% of "allowable charges" plus excess of charges**	You will ordinarily pay 50% of allowable charges. However, you will pay only 20% of allowable outpatient hospital charges if you would have required admission to the hospital without the treatment.		
Overseas Medical Care	No coverage	**100% of charges**	Nothing	Some coverage provided only in special circumstances in Canada and Mexico.	

* Each "benefit period" begins with the first day of hospital confinement and ends after having been discharged from a hospital or skilled nursing facility for 60 consecutive days.

† You pay 5% of cost for prescription drugs, but not more than $5 for each prescription. Also, you pay 5% for the cost of respite care, not to exceed 5 consecutive days, but not more than $776, in total, for a period of hospice care.

Note: In all cases, services and supplies must be provided by Medicare-approved agencies or personnel, except in cases of emergency.

As a result, the Medicare Catastrophic Coverage Repeal Act of 1989 rescinded the Medicare catastrophic benefits legislated the previous year and generally restored Medicare benefit levels to those available prior to January 1, 1989. The earlier legislated premium increases were canceled. An important feature of the Repeal Act holds that "Hospital and skilled-nursing facility days used in 1989 will not be counted when calculating an individual's balance of lifetime reserve days."

Initially, Medicare reimbursed healthcare providers on a fee-for-service basis. However, since 1985, Medicare payments to hospitals have been made under the "Diagnosis Related Group" (DRG) system, which in most cases pays the hospital a fixed fee according to the diagnostic group (*i.e.*, illness) for which you are admitted, no matter how long you stay or what treatment is given. Changes have been made in the terms of benefit payments to Medicare physicians. Under the Omnibus Budget Reconciliation Act of 1989 (OBRA), Medicare physicians are paid according to a fee schedule that was phased in over 5 years, beginning in 1992. The fee schedule is based on what Medicare authorities deem to be a "relative value scale" that pays physicians according to the number of years of training they have received, their overheads, and "geographical differences." *The Act also limits so-called excess charges, or what doctors may charge over and above the Medicare allowed fee.* This last provision is of great significance, inasmuch as doctors' charges in excess of Medicare's approved fees usually have constituted one of the largest financial risks of Medicare beneficiaries. In effect, this legislation has reduced somewhat this category of risk. More recent federal and state legislation has restricted even further what doctors can charge in excess of the Medicare allowed fee.

Most important from the point of view of this booklet, the Omnibus Budget Reconciliation Act of 1990 directed that new standards be set for Medicare supplemental insurance (medigap) policies. *According to the legislation now in force, there must be a 6-month "open enrollment" period for new beneficiaries aged 65 or older during which insurers may not deny coverage or discriminate in the price of the policy.* That is, new Medicare subscribers now are guaranteed the availability of medigap insurance at "regular" premium prices regardless of their health history or present condition. (The insurer may make you wait for up to six months before it pays

benefits for preexisting conditions, but it cannot turn you down.) Moreover, under current law a medigap policy may not be canceled or a renewal refused by the insurer solely on the basis of the health of the policyholder.

Beyond this Federal legislation, the National Association of Insurance Commissioners (NAIC) developed model standards for ten Medicare Supplemental Insurance policies. According to these model standards, insurers are limited to providing policies that adhere to the coverage requirements in the ten model policies. Chapter VI discusses, and Chapter VIII describes a statistical procedure for comparing the relative value of each policy.

Subsequently, the enactment of Medicare Part C (Medicare+Choice) legislation in 1997 introduced several private market-based Medicare health plan options to choose from that provide an alternative to participating in the conventional Medicare plan and purchasing one of the ten standardized supplemental insurance policies. The options available under Medicare+Choice are discussed in Chapter IX.

Who is Eligible for Medicare?

Anyone who is entitled to monthly benefits under the Social Security or Railroad Retirement program is automatically eligible for premium-free benefits under Medicare's Hospital Insurance (Part A). *These persons will be automatically enrolled in Medicare Part A.* In addition, several other classes of persons, who must apply for coverage, are eligible for Medicare Part A, including:

- any disabled individual under age 65 entitled to monthly disability benefits for a total of 24 months (not necessarily consecutive) under Social Security or the Railroad Retirement program is entitled to Medicare Part A coverage (spouses and children of disabled beneficiaries are *not* eligible for Medicare benefits); disabled persons who become ineligible for Social Security benefits because their earnings exceed the maximum allowed have the option to purchase Medicare coverage;

- anyone under age 65 who has end-stage renal disease and who is either fully or currently insured, or is entitled to monthly benefits under the Social Security or Railroad Retirement program or is the spouse or dependent child of such an insured person or

MEDICARE PART B USUALLY PROVIDES COVERAGE FOR:

- Physician services
- Hospital outpatient services
- Physical therapy, speech pathology, and occupational therapy by physicians or institutional providers
- Services of independent physical and occupational therapists, subject to limits
- Non-routine vision services by an optometrist, if they would be covered when performed by a physician (ophthalmologist)
- Diagnostic x-ray, laboratory, and other tests
- X-ray, radium, and radioactive therapy
- Mammography screening
- Some drugs that cannot be self-administered
- Blood transfusions after the first three pints per year
- Surgical dressings, splints, casts, etc., when ordered by a doctor
- Necessary ambulance services
- Rental (and in some cases purchase) of durable medical equipment for home use, when prescribed by a physician
- Home health services (same as Part A)
- Artificial replacements
- Colostomy, ileostomy and urostomy bags and supplies
- Braces for limbs, back, or neck
- Mental health services

beneficiary. Eligibility begins on the first day of the third month following the month in which either dialysis terminates or the individual has a renal transplant;

– anyone aged 65 or older enrolled in the Medicare Supplemental Medical Insurance program (Part B) who is not otherwise entitled to Part A benefits, upon voluntary participation with payment of a hospital insurance premium. (The full Part A premium in 2000 is $301 per month.) Persons who do not purchase Part A coverage within a specific time after becoming eligible because of age are subject to a 10-percent penalty for each 12 months they are late in enrolling. However, the 10-percent penalty will be charged against the Part A premium for only a specified time period (twice the number of years enrollment was delayed), after which the penalty will be eliminated and the premium

MEDICARE PART B USUALLY PROVIDES *NO COVERAGE* FOR:

- Acupuncture
- Chiropractic services*
- Christian Science practitioners' services*
- Cosmetic surgery (except after an accident)
- Custodial care
- Dental care*
- Experimental procedures
- Eyeglasses (unless related to cataract surgery)
- Foot care*
- Foreign health care*
- Hearing aids and examinations
- Homemaker services
- Immunizations except for pneumonia and infection*
- Injections that can be self-administered
- Meals delivered to your home
- Naturopaths' services
- Nursing care on full-time basis at home
- Orthopedic shoes*
- Personal convenience items
- Physical examinations that are routine and related tests†
- Prescription drugs and medicines taken at home
- Preventive care
- Private duty nurses
- Private room*
- Services performed by immediate relatives
- Services not reasonable and necessary
- Services payable by workers' compensation
- Services or items for which you are not legally obligated to pay

* May be covered under special circumstances.

levied as though no delay in enrollment had occurred.

Medicare's Supplemental Medical Insurance (Part B) is available to any U.S. resident, either a citizen or lawfully admitted alien with 5 years continuous residence, aged 65 or older, or any individual entitled to Medicare Part A benefits upon voluntary participation with payment of the Part B premium, which is $45.50 per month in 2000. In addition, anyone under age 65 who is entitled to Medicare Part A benefits may enroll in Part B by paying the premium. Persons who receive Social Security or Railroad Retirement benefits will be automatically covered by Part B insurance unless they indicate that they

do not want it when they become eligible for Part A insurance (the premium is deducted from the Social Security benefit payment).

If you have turned 65 and want to delay your Social Security benefits, you have to apply for Medicare. If you do not enroll in Part B during your initial enrollment period but later decide you want benefits, you can sign up during the general enrollment period each year (January 1 through March 31). However, your benefits will not begin until July 1, and your monthly premium will rise by 10 percent for each 12-month period you are not enrolled in the program.

Under the new Medicare+Choice program, you may opt to join a Medicare managed care plan (e.g., HMO) if you have both Part A Hospital Insurance and Part B Medical Insurance, do not have end-stage renal disease (kidney failure), and live in the service area of the plan. Although Medicare managed care plans are offered by private companies, you are still in the Medicare program. You will keep your Medicare rights and protections as well as receive the regular Medicare covered services.

To purchase a medigap insurance policy, you must be covered under both Part A and Part B of the Medicare program. You have a 6-month open-enrollment period (that begins with the first month that you are age 65 or over and also enrolled in Medicare) to buy the policy of your choice. During this period, you cannot be denied coverage or charged a higher price because of current or past health problems. If you do not enroll during this period, you may not be able to get the policy you want, or you may be charged a higher premium. **You do not need to buy a medigap policy if you are in a Medicare managed care plan, or if you are covered by Medicaid.**

Current Medicare Premiums and Coverage

Under the Medicare benefits structure now in effect, Medicare Hospital Insurance (Part A) pays most hospital costs for the first 60 days of hospitalization after a deductible amount of $776 (see the table on pages 12-13 for a summary of current Medicare benefits and premiums). After that, Medicare pays the balance of covered costs after the patient pays $194 per day for the next 30 days and $388 per day for the following 60 "lifetime aggregate reserve" days. After 150 days of continuous hospitalization, Medicare Part A pays no benefits. Once the 60-day lifetime reserve has been used, it cannot

be applied to subsequent illnesses. Should a new episode require hospitalization after the lifetime reserve has been expended, Medicare Part A benefits will cease after 90 days of confinement.

A PRESCRIPTION FOR MORE BUREAUCRACY

In July 1999, President Clinton unveiled the details of his new proposal to expand Medicare benefits to include coverage of prescription drugs. This new benefit, which is projected to cost over $118 billion over the next decade, would be the largest expansion of Medicare since the program was created in 1965.

Beginning in 2002, Medicare beneficiaries would be able to voluntarily pay an extra premium of $24 each month for drug coverage. In return, the government would pay half of the first $2,000 of prescription drug costs. The premium would gradually increase to $44 by 2008, at which time the cap on coverage would reach $5,000. Seniors with incomes below $11,000 ($17,000 for couples) would not pay premiums or copayments, and the government would pay all of their drug costs up to the coverage cap. (Medicaid now covers prescription drug costs for poor seniors.)

Interestingly, the president's plan would not cover the drug costs that pose the biggest financial risk to the elderly, the potentially huge and often unpredictable "tail-end" drug costs that might remain after private insurance (e.g., medigap) has paid all its benefits. In other words, the proposed plan duplicates the limited prescription drug coverage for "front-end" costs that is already widely available through insurance companies or by enrolling in a Medicare HMO offering such coverage. Paradoxically, the Medicare Catastrophic Act of 1988 expanded Medicare to cover most prescription drug costs above a $600 deductible—i.e., it covered the high tail-end costs. However, the Act was immediately repealed after the elderly protested the additional premium, which varied according to income.

Economically, there is no good reason for the government to provide "front-end" drug benefits solely on the basis of age. It does make political sense, however. Seniors seem to favor the subsidy aspect of such a policy over the insurance feature of covering "tail-end" costs.

Medicare Part A also pays for the costs of 20 days in a skilled nursing facility after a hospitalization of at least 3 days and all but $97 per day of skilled nursing home costs for the next 80 days. After 100 days of such confinement, Medicare Part A pays nothing.

Medicare Part A helps pay for home health care and hospice care. Home health care includes part-time skilled nursing care, physical therapy, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Hospital Insurance covers the first 100 visits following a hospital stay of at least 3 consecutive days or a skilled-nursing facility stay. You must pay 20 percent of the approved amount for durable medical equipment.

Hospice care includes medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, and care in a hospice facility, hospital, or nursing home when necessary. Home care is also covered. You pay $5 for outpatient prescription drugs and $5 per day for inpatient respite care (short-term care given to a hospice patient by another care giver so that the primary care giver can rest). To receive hospice care, patients must be certified as being terminally ill. Benefit periods include two 90-day periods, followed by an unlimited number of 60-day periods.

Medicare's voluntary Medical Insurance (Part B), which costs $45.50 per month if you enroll as soon as you are eligible, pays 80 percent of Medicare's "approved charges" for covered services after the first $100 per calendar year. In most situations, Medicare Part B does **not** provide coverage for outpatient prescription drugs or routine or physical examinations (unless covered as part of Medicare participating Health Maintenance Organization [HMO] services). However, Medicare now provides for a number of preventive measures such as bone mass measurements, colorectal cancer screening, mammogram screening, pap smear and pelvic exams, and various vaccinations. Medicare Part B home health care benefits have also been expanded to include 80 percent of the costs of durable medical equipment purchased for such care. The tables on pages 12 and 13 summarize current Medicare premiums and benefits. The boxes on pages 16 and 17 list specific items that are and are not covered under Medicare Part B.

How Claims are Processed and Benefits are Paid

All Medicare participants are issued a Medicare card that contains

a personal claim number and that must be used whenever a claim is submitted. This card is the only evidence of Medicare insurance that most providers will accept, and Medicare will not pay any claims unless a claim number is provided. (If you are in a Medicare managed care plan, your membership card will have the name of the plan on it.)

Medicare claims usually are processed by third parties that have contracted with the government. For Medicare Part A, claims are processed by insurance companies or other organizations, such as Blue Cross/Blue Shield, that are known as "intermediaries." The hospital will submit charges directly to the intermediary, and the patient will be notified of any amounts that remain due (*i.e.*, the Medicare Part A deductible and charges for uncovered services) after Medicare has paid its benefits.

Medicare Part B claims are submitted directly by the physician who treats you to a "carrier" to be processed. If the physician agrees to accept what is known as "assignment," he or she will be paid according to Medicare's "approved charges" schedule and the patient will be billed only for the Medicare coinsurance amount (*i.e.*, the 20 percent not paid by Medicare). If the physician will not accept "assignment," the doctor's office still must submit a Medicare claim to the carrier in your behalf. The patient will then be billed for the Medicare coinsurances amount *plus* any excess physician's charges up to the Medicare-allowed maximum. Current Federal law limits these excess charges to 15% above the allowed charge. Some state laws limit excess charges even further.

Medicare also may be the "secondary payer" in certain cases where other insurance is in force. For example, if you have an automobile liability insurance policy that pays medical benefits for treatment of injuries sustained in an auto accident, a claim must be submitted to the automobile insurer and that policy's benefits must be paid before Medicare will pay any benefits. Medicare will pay the remainder of Medicare-covered charges as the "secondary payer" up to Medicare limits. Similarly, if you are employed past age 65, are enrolled in Medicare, and are also enrolled in an employer-sponsored health plan, Medicare will be the "secondary payer" with respect to Medicare-covered charges not covered by the employer-sponsored plan. Medicare also will be a "secondary payer" under such an employer-spon-

sored plan for a spouse age 65 or older. Claims and payments processing are considerably different with HMOs, described in Chapter V.

If You Retire Before You or Your Spouse Has Reached Age 65

For most persons, Medicare eligibility begins at age 65. If you retire before that time, you should, if possible, make arrangements to continue the employer-sponsored health plan that provided coverage while you were working—or to convert that insurance to an individual policy, an option that in most instances is required by law (within specified time limits). If you retire at age 65 and become eligible for Medicare but your spouse is under age 65, current law in most states requires that group insurance carriers permit the coverage of a spouse and other dependents to be continued under the employer-sponsored plan. However, the employer has no responsibility to contribute toward the costs of such insurance and the retiree will have to pay whatever premiums are required to keep it in force.

The Politics of Medicare

In March 1999, the National Bipartisan Commission on the Future of Medicare released the final report of its two-year study. Its recommendations, endorsed by only ten of the seventeen members—one short of the number needed to make a formal presentation to Congress—proposed restructuring Medicare as a defined-contribution plan, called "premium-support," along the lines of the Federal Government employees' health care benefit plan. Under this program, the age of Medicare eligibility would be increased to 67 (in line with changes in Social Security) and each beneficiary would receive a fixed payment with which to purchase a public or private health plan.

The report was immediately criticized by the Clinton Administration for not including a prescription drug benefit. President Clinton wants to provide "affordable" drug coverage for all seniors. (See the box on page 19, "A Prescription for More Bureaucracy.")

It remains inescapable that Medicare, as currently administered, is unsustainable on three counts: demographics, technology, and third-party payment. In the year 2011, 77 million baby boomers (people born between 1946 and 1964) will begin flooding into the Medicare system. Over the next fifty years, the number of beneficiaries is expected to more than double while the ratio of workers to retirees is

expected to decline to slightly more than 2 to 1.

In addition to the predictable deleterious effect of such population changes on Medicare's finances, new technologies and treatments that often are invoked only in the final weeks of patients' lives but that account for a substantial proportion of all outlays have greatly increased Medicare's aggregate costs during the past decade. Prolonging for even a short period the length (if not quality) of some seniors' lives has become burdensomely expensive.

Finally, numerous studies suggest that individuals will consume more, and more expensive, health care services if someone other than the consumer bears the cost. There is little reason to think that additional benefits, such as a provision for prescription drugs, would not also be subject to these same demographic, technological, and third-party payer factors that plague the rest of the system.

The direction of most current and proposed reforms—increasing premiums, reducing reimbursement rates, and shunting patients into managed care—does little to address Medicare's structural flaws. Instead, it would seem destined to compound them. As we have observed on many occasions, what seems most needed is not more regulation, but less.

III.

WHY YOU NEED "MEDIGAP" INSURANCE

FOR any illness, there will be immediate costs. You will have to visit the doctor at least once or twice. Furthermore, if the condition requires it, you will have to be hospitalized for a day or two. These initial costs, which are predictable and inevitable with most illnesses, are termed "front-end" costs by the insurance companies. They apply to the early stages of treatment, and your personal liability for them usually corresponds to your Medicare deductibles. If these were the only costs that Medicare enrollees faced, they would have little need for "medigap" insurance.

"Tail-end" costs, on the other hand, refer to those expenses that occur toward the end of an illness or remain *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 if they are not protected against, they can lead to financial ruin. Extended hospital confinements can easily run into tens, and often hundreds, of thousands of dollars.

Many insurance policies cover both front-end and tail-end costs. But many others offer some sort of option, for example, reduced tail-end coverage in return for front-end coverage. When presented with this option, **always choose the best tail-end coverage**. The later stages of hospital and medical care have the greatest financial risks. Front-end costs occur more often but they are more financially manageable. Tail-end costs are by far the largest part of the "medigap."

Any Medicare supplemental insurance policy that you purchase should, first and foremost, provide coverage for the costs of the two categories of tail-end costs that pose the greatest risk to Medicare patients: (1) the costs of catastrophic illness that may continue after Medicare Part A benefits run out; and (2) the costs that remain after Medicare Part B has paid its 80 percent of "approved charges."

And as uncertain as its future is, for many people Medicare itself still is essential to their protection against the financial risk of health expenses. **Virtually all current supplemental health plans require your participation in both Medicare programs. Therefore, until such time as genuine changes in the relation between Medicare**

and private fee-for-service care actually are implemented, it is imperative that you secure both Part A and Part B Medicare coverage.

The expansion of Medicare benefits described in the preceding chapter may suggest that Medicare participants are less exposed to the financial costs of hospital and medical care than they were when the Medicare program began. This is not the case. The "acid test" of any insurance program is the amount that remains after all insurance benefits have been exhausted. By this measure, the medigap (the difference between what Medicare pays and what you still owe) is getting wider.

Many Medicare participants have complained about the high costs of prescription drugs, which usually are not covered by Medicare. Although the median expenditure per Medicare beneficiary on prescription medication (in 1995) was $343, the costs of drugs pale in comparison with the potential financial risks of lengthy hospitalization and medical treatment.

Personal Financial Risk of Hospitalization Is Greater

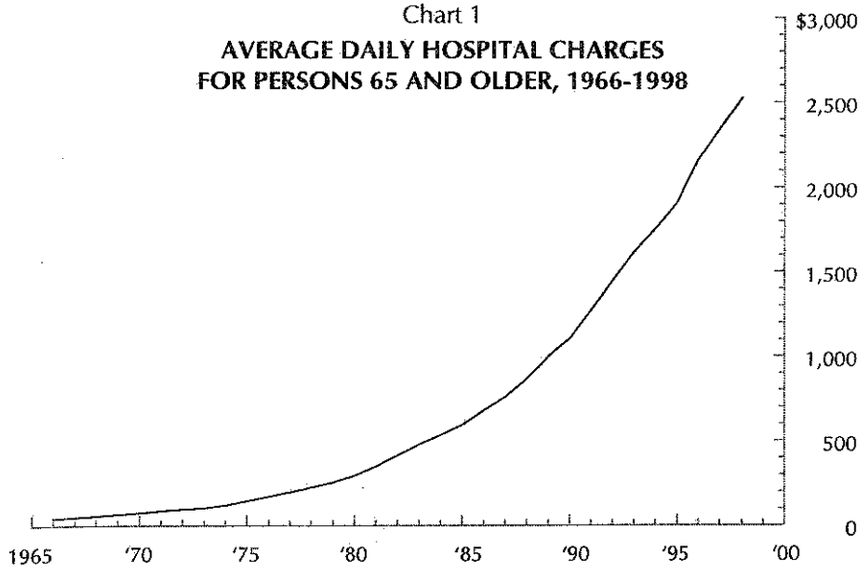
The average costs of a day's stay in the hospital have increased more than 25 times since 1966, when Medicare first paid hospital benefits. At that time, the average daily cost of hospitalization was $44. By 1981, 1 day in the hospital cost nearly $350, and by 1998 (the most recent available data) **daily hospital costs for Medicare patients averaged $2,545**. Today, they almost surely are even higher than that. As Chart 1 clearly illustrates, increases in daily hospital charges are getting larger.

Medicare Part A benefits simply have not kept pace with this increase in hospital charges—a fact reflected in the decreasing portion of actual hospital charges that Medicare has paid. In 1968, Medicare Part A paid over 80 percent of all hospital charges of Medicare patients. By 1998 (again, the most recent available data), Medicare Part A benefits paid only 45 percent of covered hospital charges. Chart 2 shows this trend.

The decreasing proportion of Medicare Part A payments shown in Chart 2 probably reflects changes in both Medicare's payment system and the clinical treatment of Medicare patients. Beginning in 1985, the Medicare authorities initiated the DRG prospective pay-

Chart 1

AVERAGE DAILY HOSPITAL CHARGES FOR PERSONS 65 AND OLDER, 1966-1998



Sources: *Social Security Bulletin, Annual Statistical Supplement 1999.*

ment system described earlier, which plainly has resulted in reductions in the actual portion of charges paid by Medicare. At this time, however, it is not clear what portion of actual charges not paid by Medicare is being "absorbed" by the hospitals and what is being passed on to Medicare patients as unpaid bills. Whatever the actual distribution of liabilities, it is difficult to imagine that Medicare patients' liabilities have not increased in these circumstances.

Equally important, one effect of the DRG payment system has been to reduce the average length of stay for Medicare patients by half—from over 12 days prior to prospective payment to under 6 days in 1998. Whatever this change may imply for the quality of patient treatment, statistically it favors a decrease in the percentage of actual charges paid by Medicare, since the shorter the stay, the larger the portion of total expense represented by the "front-end" Part A deductible. (It may also reflect the tendency to keep only genuinely catastrophically ill patients hospitalized for lengthy periods, which also would tend to reduce the percentage of costs paid by Medicare, since those patients stay after Medicare benefits have been reduced or terminated).

In any event, **your personal financial risk for hospital costs is**

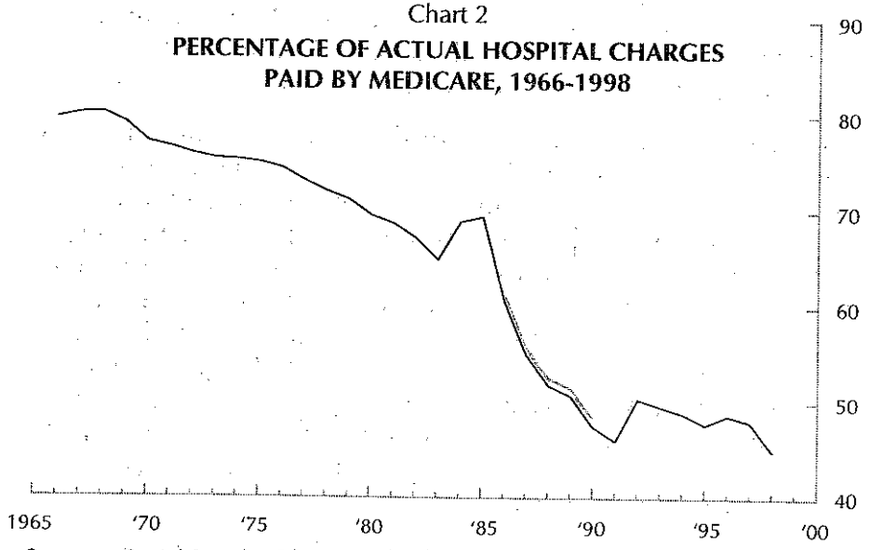
much greater than it was only a few years ago. The front-end risks of hospitalization have increased from $60 in 1971 to $776 in 2000, but these are manageable amounts. Tail-end risks have increased much more. In 1971, 12 months in the hospital left Medicare patients at risk for just over $20,000. Today, the risk of that confinement is over 24 times that, or more than $500,000. Moreover, this risk accounts **only for hospital expenses.** Medical and surgical costs are an additional risk. Table 1 shows how the estimated amount of risk for some different hospital stays has changed since 1971.

The Importance of "Assignment"

Assignment only applies to the services and supplies covered by Part B and only works with the "original" (fee-for-service) Medicare plan. Assignment does not apply if you are in a Medicare managed care plan (*i.e.*, HMO). "Assignment" simply means that the doctor or other health specialist who treats you agrees to accept as full payment Medicare's "approved charges." You will be responsible only for the $100 medical deductible plus additional coinsurance payments (the 20 percent of "approved charges"). Assignment does not mean that you have no liability, but it guarantees that a physician will not bill you for amounts beyond the Medicare approved charges.

Chart 2

PERCENTAGE OF ACTUAL HOSPITAL CHARGES PAID BY MEDICARE, 1966-1998



Sources: *Social Security Bulletin, Annual Statistical Supplement 1999.*

Table 1

ESTIMATED FINANCIAL RISK OF HOSPITALIZATION, 1971-1997

	Amount Not Paid by Medicare for:					
	60 Days	*90 Days*	*5 Months*	*6 Months*	*9 Months*	*12 Months*
1971	$ 60	510	2,310	4,950	12,870	20,790
1972	$ 68	578	2,618	5,528	14,258	22,988
1973	$ 72	612	2,772	5,922	15,372	24,822
1974	$ 84	714	3,234	6,834	17,634	28,434
1975	$ 92	782	3,542	7,892	20,942	33,992
1976	$104	884	4,004	9,134	24,524	39,914
1977	$124	1,054	4,774	10,684	28,414	46,144
1978	$144	1,224	5,544	12,294	32,544	52,794
1979	$160	1,360	6,160	13,810	36,760	59,710
1980	$180	1,530	6,930	15,750	42,210	68,670
1981	$204	1,734	7,854	18,294	49,614	80,934
1982	$260	2,210	10,010	22,400	59,570	96,740
1983	$304	2,584	11,704	26,044	69,064	112,084
1984	$356	3,026	13,706	29,696	77,666	125,636
1985	$400	3,400	15,400	33,220	86,680	140,140
1986	$492	4,182	18,942	39,312	100,422	161,532
1987	$520	4,420	20,020	42,730	110,860	178,990
1988	$540	4,590	20,790	46,710	124,470	202,230
1990*	$592	5,032	22,792	55,852	155,032	254,212
1991	$628	5,338	24,178	62,278	176,578	290,878
1992	$652	5,542	25,102	68,482	198,622	328,762
1993	$676	5,746	26,026	74,446	219,706	364,966
1994	$696	5,916	26,796	79,356	237,036	394,716
1995	$716	6,086	27,566	84,896	256,886	428,876
1996	$736	6,256	28,336	90,869	278,468	466,066
1997	$760	6,460	29,260	97,468	302,092	506,716

* Amounts for 1989 omitted due to statistical distortion from the passage and repeal of the Medicare Catastrophic Coverage Act.

According to the Health Care Financing Administration, all doctors and other health professionals who have contracts with Medicare (*i.e.*, treat some patients for a predetermined fee according to a contract with Medicare) are required by law to accept Medicare's assignment of fees. Other physicians who accept assignment are on record at local Social Security Offices. **To find physicians in your area who accept assignment, call your local Social Security Office and ask for the "Medpar List."**

If you locate physicians who will accept assignment of fees, your

financial risk can be effectively limited to the known Medicare deductible and coinsurance requirement for covered services. In these circumstances, Medicare Supplemental Insurance that restricts coverage to Medicare's coinsurance liability is adequate. You would be throwing money away by purchasing a policy that promises to pay more than 20 percent of Medicare's approved charges.

However, financial risk is the *least* of your risks in the event of life-threatening illness. You must be satisfied with the quality of health care you receive, and in this respect for any number of reasons you may not always wish to be treated by doctors who accept assignment. Top-flight specialists, for example, often charge fees that are beyond those approved by Medicare—and, as discussed below, in such cases patient risk can be substantial. Federal law restricts doctors who do not accept assignment but do provide services to patients that will be billed through Medicare from charging more than 15% above Medicare's approved charge and some states have even lower limits. (In New York, the limit for most services is 5%.) Other specialists may not agree to any Medicare participation whatsoever, and require a private fee-for-services contract. Currently there is no

Table 2
REDUCTIONS OF UNASSIGNED CLAIMS UNDER MEDICARE, PART B, 1971-1998

Year	*Percent of Claims Reduced*	*Average Percent Reduction of Charges*	Year	*Percent of Claims Reduced*	*Average Percent Reduction of Charges*
1971	57.6	12.5	1985	84.6	25.9
1972	59.3	12.0	1986	85.0	26.9
1973	66.4	12.6	1987	82.4	24.7
1974	72.7	14.7	1988	86.4	25.0
1975	77.4	17.7	1989	90.1	25.0
1976	78.9	19.8	1990	90.4	25.3
1977	77.1	19.0	1991	91.3	23.1
1978	77.5	19.2	1992	82.9	18.5
1979	80.9	20.7	1993	86.5	16.5
1980	84.3	22.5	1994	86.4	16.3
1981	85.8	23.8	1995	83.4	15.4
1982	85.4	23.9	1996	84.4	15.8
1983	82.7	22.9	1997	84.4	16.4
1984	83.7	24.2	1998	82.3	17.1

Source: U.S. Department of Health and Human Services, Social Security Administration, *Social Security Bulletin; Annual Statistical Supplement, 1999.*

INSURANCE IMPLICATIONS OF "COST CONTAINMENT"

Statistical evidence of changes in the quality of health care delivered to Medicare patients that may be related to "cost containment" initiatives of Medicare authorities, private insurers, and health care providers is as yet inconclusive. Nevertheless, it seems clear that where rapid reductions in medical staff are undertaken as a cost-saving measure, patient care is bound to be affected.

For example, a recent survey of nurses conducted by the American Journal of Nursing found that more than two thirds of nurses reporting said that they don't have time to perform basic nursing care, like teaching patients how to tend to wounds or inject themselves with insulin. More than half reported they were too busy to consult with other members of the patient's health-care team. A full one third would not recommend that their family members receive care at the facility where they work.

Such reductions have resulted in what some medical analysts believe is a "hospital nightmare," in which fewer staff are doing more work and there is "the imminent danger of errors of judgment and misassessment." More likely, simple schedules are apt to be confused: medication schedules may become lax; routine care or prescribed therapy may be missed; changes in patient condition may escape notice; responsibilities may be juggled; and so on. In any event, hospital staff errors or neglect could be harmful, if not life-threatening.

None of the NAIC approved Medicare supplemental insurance policies now provides coverage for the costs of private duty nurses. **Nevertheless, private duty nursing coverage would seem to be desirable, especially in instances where reference to the records of a local Peer Review Organization reveals that a medical facility has a below-average record of performance.** In the current situation, the easiest way to obtain "coverage" for private nursing costs may be through the purchase of a hospital indemnity policy, discussed in Chapter IV.

limit on fee schedules agreed to under such private contracts. For more information on assignment, call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy of *Medicare & You: Does your doctor or supplier accept "assignment?"* This publication is also

available on the internet at www.medicare.gov.

Medical Claims Reduced

Medicare patients' average personal financial liability for physicians' and other professional services has been greater than that for hospital costs. Doctors' bills have accounted for the largest part of private liabilities by a wide margin. Even after Medicare Part B paid its benefits, doctors' bills have remained a large financial risk for most Medicare subscribers. In 1978, for example, Medicare and other Government programs paid for 87.5 percent of all hospital costs of retired persons, but they paid only 59.4 percent of doctors' and other professional fees. For every health care dollar that Medicare enrollees were required to pay that year (either themselves or through private insurance), only about 23¢ were for hospital charges. More than 37¢ were for doctors' bills. This is due to the fact that Medicare will pay only its "allowed charges," not what a doctor may actually charge. In 2000, Medicare pays 80 percent of *allowable charges* after the $100 deductible has been paid by the patient. However, patient risk may still be great, since a doctor may charge as much as 15% more than allowable charges.

Most people entering the Medicare program probably expect that Part B insurance will pay 80 percent of their doctors' bills. This is not necessarily the case. As Table 2 shows, the proportion of unas-

A MEDICARE-RELATED HEALTH RISK

The implementation of the prospective payment system based on DRG categories may itself pose a new "health risk" to Medicare patients. Medicare officials have become alarmed at reported instances of premature release of patients — that is, where hospitals release patients "quicker and sicker." They soon will require hospitals to inform Medicare patients of their legal right to challenge their discharge from a hospital if they or their physicians believe such discharge is premature.

"Dumping" of Medicare patients whose hospital stay exceeds the DRG patient allowance for their diagnosis is a predictable result of the prospective payment system. Whether wittingly or unwittingly, hospital officials in a number of reported cases have informed their Medicare patients that their "Medicare hospital benefits have run out" and that therefore the hospital must discharge them. You should be aware that **the prospective payment system does not limit your stay in the hospital to the time corresponding to the reimbursement provided by any diagnosis related group. Your benefits cannot "run out" before your discharge is clinically warranted. As a Medicare patient, you have a right to appeal your discharge to the local medical peer review organization. That organization must issue a decision within 3 days of receiving your appeal.**

If your appeal is granted, you may stay in the hospital and it must absorb any cost of your treatment that exceeds the DRG reimbursement amount.

If your appeal is denied, you still cannot be charged for the 3 days of your hospitalization following the hospital's notification of its intent to discharge you.

Although one would expect that in most cases of attempted premature discharge, your attending physicians would offer full support of any warranted appeal you may make (or actually initiate same), as a Medicare patient you should be aware that the prospective payment system has imposed disincentives to such appeals by physicians: even if a doctor follows the guidelines set by a peer review panel to admit or retain a patient, the same panel can later disallow the stay and reimbursement. Peer review panels are primarily engaged in slashing expenses, and any physician who interferes with a review organization's task of cutting costs risks being labeled a "Medicare abuser" and losing hospital privileges.

Thus, it is your responsibility to initiate the appeal process if, after consultation with your physician, you feel that you are being discharged prematurely.

Probably your best "guarantee" that a hospital will not try to discharge you prematurely is a Medicare supplemental insurance policy that promises to pay hospitalization benefits in excess of Medicare's DRG-based reimbursement. Unfortunately, most insurers have discontinued this benefit.

Part 2

HOW TO PROTECT YOURSELF AGAINST THE "MEDIGAP"

IV.

ALTERNATIVES TO HEALTH INSURANCE POLICIES

FOR a number of years, many health-related insurance policies have aimed at the Medicare market. This is understandable. For the past 50 years, the retired have had the most reliable incomes of any segment of the population. Although small in relation to their working-years' incomes, the more-or-less guaranteed aspect of retirement income, combined with the health consequences of aging, generated a great deal of market interest within the insurance industry.

One result of this interest has been the proliferation of limited-coverage health policies. These have relatively low premiums and are affordable to most retired persons. However, they cover only a small portion of the potential health risk of the elderly. These policies isolate a particular disease or situation, and their sales approach generally exploits the understandable fears of most of us. **Limited-coverage policies are not the bargains they appear to be and are no substitute for comprehensive insurance.**

In general, any policy that limits coverage to a particular set of conditions violates the health insurance principle, which is to **reduce potential risk** regardless of the circumstances of illness. All states allow the sale of limited policies in one form or another. But Federal law prohibits their sale as "supplemental health insurance." Limited policies such as accident, "dread disease" or cancer, and daily indemnity insurance leave wide gaps in coverage and thus in financial risk. Their traditional popularity testifies powerfully to the persistence of the myths surrounding elderly health risks. For the most part, these policies create only the illusion of greater protection.

Accident Insurance

Accident insurance is *not* health insurance. These policies pay hospital and medical costs only if you have been injured as a result of accident. They frequently impose limits on benefits that are far below actual costs of rehabilitation.

Accident indemnity policies, which promise to pay a specified amount for the loss of one or both eyes, arms, or legs in an accident,

are so narrowly written that they apply only in an infinitesimally small set of circumstances. Amputees who have had their limbs removed for clinical reasons, for example, are not protected by such policies. **Accident insurance is a waste of money.**

"Dread Disease" and Cancer Policies

These policies, which usually are solicited either through the mail, in newspapers and magazines, or door to door by salesmen working on commission, are notoriously poor values. Their appeal is based on unrealistic fears, and a number of states have prohibited their sale. They provide coverage only for very specific conditions and are no substitute for comprehensive insurance.

Even if you do contract an insured disease, the chances are you will not be in the hospital long enough to see a benefit return large enough to justify the premiums on these policies. Moreover, special disease policies normally do not provide protection against many types of costs incurred as a result of the disease, such as home care, transportation, and rehabilitation.

Most cancer policies contain one or more of the following limiting conditions:

- Some pay only if you are hospitalized. Today, most cancer care, such as radiation treatment and chemotherapy, is provided on an outpatient basis. The average hospital stay for cancer patients is less than 7.5 days.
- No policy will provide protection against cancer **diagnosed before you applied** for the policy.
- Most cancer insurance **does not cover related illnesses**, and there are many related illnesses such as infection, diabetes, or pneumonia.
- These policies often require waiting periods of 30 days or even several months before coverage becomes effective. Many stop paying benefits after a fixed period of 24 or 36 months.
- Although a number of these policies increase coverage after 90 consecutive days in the hospital, this feature is nearly worthless since 99 percent of all cancer patients spend fewer than 60 days in the hospital.

Cancer policies have traditionally posted the lowest loss ratios—sometimes only 20 percent—of all forms of health insurance. As with accident indemnity policies, **special disease insurance is a waste of money.**

Hospital Indemnity Policies

Hospital indemnity policies, which promise to pay you a fixed amount for each day you spend in the hospital, have been widely advertised on television. Actors hired for their high "trust quotients" counsel elderly viewers in soothing, yet urgent, tones to subscribe to their particular plan, which is often made to sound exclusive. In fact, **indemnity policies**, which usually promise to pay between $50 and $100 a day, **are not health insurance.** Although they may be useful in some circumstances, as discussed below, **the average benefit return does not justify the premium cost of this kind of insurance.**

When an Indemnity Policy May Be Useful

Indemnity policies may have value under some conditions. You may have noticed that **advertisements describe them as supplemental income plans. They are**, in fact, **prohibited by law from being advertised as otherwise.** If you already have supplemental insurance, an indemnity policy may be attractive as a source of income in the event of extended hospitalization. This type of benefit can help to defray associated expenses—transportation, home maintenance, and other expenses after you leave the hospital—that may not otherwise be covered by health insurance.

Many people buy indemnity policies in hopes that they will "make money" if they get sick. Purchased this way, an indemnity policy is a gamble and nothing else. It is the same as buying a lottery ticket. If your **potential risk does not justify the policy**—either because it is too high or too low—**you are throwing your money away**.

Whether or not an indemnity policy is worthwhile to you, depends on two separate considerations. First, to what extent will hospitalization place you at financial risk for nonmedical reasons? Second, to what extent will the policy reduce this financial risk?

Everyone incurs some nonmedical expense as a result of hospital confinement. If nothing else, the lawn has to be mowed and house-

hold chores have to be done. The important question is, can these routine expenses be handled out of pocket, or does your situation involve financial risk that merits the purchase of separate income insurance? For example, would you have to hire full-time help to maintain your residence while you were in the hospital? Would you suffer a loss of essential income? Would others be deprived of your needed services as a result of your absence (if, say, your spouse or another household member relies on you for daily care)? Do you conduct a business that would require you to employ someone if you were in the hospital? In short, the extent of your nonmedical risk determines if you should consider an indemnity policy. This, of course, assumes that you can afford its premium costs over and above the price of supplemental health insurance. **You should not sacrifice supplemental health insurance coverage in order to pay premiums on a hospital indemnity policy.**

As a rule of thumb, a hospital indemnity policy may be justified only if it reduces your nonmedical potential risk by between 50 percent and 150 percent. If it reduces your risk by less than 50 percent, you need some other form of protection. If it pays you more than 150 percent of your anticipated risk, you are better off to absorb the risk.

In addition, a hospital indemnity policy might now be useful for one medical reason. The new medigap policies (described in Chapter VI) no longer offer to provide coverage for private duty nursing costs. Inasmuch as many physicians now advise that a private duty nurse is highly desirable in many clinical situations, a hospital indemnity policy may be a useful way of covering all or a part of such expense. Some *existing* medigap policies continue to provide coverage for private duty nursing—and holders of those policies might be well-advised to retain them.

To find the best value in indemnity policies, calculate a benefit-cost index by dividing the benefit for the first 30 days of hospitalization by the monthly premium. The higher the index figure, the better the value.

Example:

Policy A pays $75 per day after the first 3 days of hospitalization and costs $6.52 per month.

Policy B pays $60 per day as soon as you enter the hospital and costs $5.89 per month.

Which is the better value?

Solution:

Policy A: 27 x 75 ÷ 6.52 = 310.58
Policy B: 30 x 60 ÷ 5.89 = 305.60

The index for Policy A is higher; therefore, Policy A represents the better value.

Health Associations

Health associations (not to be confused with Health Maintenance Organizations, discussed in Chapter V) usually are local organizations designed to provide routine and emergency health care more conveniently in relatively isolated areas. They usually operate one or more clinics and employ a small number of physicians, dentists, and supporting staff.

For a nominal fee of $20 to $40 per year, anyone can join the association. Membership entitles you to participation in the association's programs and allows you to make appointments with doctors and dentists at the association's clinics.

Health associations provide no health insurance, however. **You are responsible for any charges. You must have your own insurance.** Aside from the convenience it may offer, health association membership has another advantage. Medicare participating health associations must agree to accept Medicare approved charges as payment in full. (You still are responsible for the 20 percent of "approved charges" that Medicare does not pay.) **If you have a Medicare supplemental policy that does not cover the difference between Medicare's "approved charges" and actual cost, membership in a health association may be a wise investment.**

Employer Insurance and Self-Insurance

Many corporate employers participate in group health insurance programs offered by various insurance companies. These group employee plans often give the best value available in health insurance to employees, and many—though not all—are convertible to Medicare supplemental plans after retirement. If you are employed by a

company that has a health insurance plan, you should contact the personnel or benefits office to determine what kind of protection is available to you after retirement. **As a rule, employer-obtained group insurance offers a far better value than individual policies**, but not always. You must compare with other forms of health coverage, such as Health Maintenance Organizations, which are discussed in Chapter V.

A small percentage of employers now offer their employees health plans that are totally independent of the insurance industry. Insurance spokesmen refer to such plans as "self-insurance," and for obvious reasons insurance industry representatives seldom publicize the availability of such plans. In the case of self-insurance, a company or corporation contracts independently with physicians and hospitals to provide health care to its employees. In a few instances, such as the Kaiser complex in California, employers have constructed their own hospital facilities.

Contracts with employers are particularly inviting to Health Maintenance Organizations and Preferred Provider Organizations. In this instance, costs are kept down and benefits often are greater than other arrangements provide. This type of "self-insurance" has become increasingly popular with employers with access to Health Maintenance Organizations and Preferred Provider Organizations.

V.

HEALTH MAINTENANCE ORGANIZATIONS

MEDICARE Health Maintenance Organizations (HMOs) began serving Medicare beneficiaries in 1982. Since 1990, the number of plans providing care to Medicare beneficiaries has fluctuated, but the number of beneficiaries who choose to enroll in managed care plans has continued to grow. In 1985, for example, more than 1.2 million beneficiaries were enrolled in 191 managed health care plans across the United States. Currently, more than 6.2 million of the roughly 39 million (15 percent) Medicare beneficiaries are enrolled in over 300 HMOs. Approximately 50,000 beneficiaries per month, on average, enrolled in Medicare HMOs during 1999.

However popular these plans appear to be, you should keep in mind that Medicare HMOs (and other coordinated care plans) decide each year whether to continue operating in selected counties or entire service areas. In 1999, 41 plans did not renew their contracts and 58 reduced their service areas, affecting 327,000 beneficiaries. About three-fourths of those affected had the option of choosing a different HMO plan. The 327,000 beneficiaries affected in 1999 is less the 407,000 who were affected the year before. On the other hand, in 1998, the Health Care Finance Administration (HCFA) approved 39 applications for plans to begin service or expand their service areas, and reviewed another 29 applicants in 1999. Some applications included areas with few or no existing Medicare HMOs.

A General Accounting Office (GAO) report found that plan withdrawals cannot be traced to a single cause—a portion may have been the result of plans deciding they were unable to compete effectively in the market, unable to establish provider networks, or dissatisfied with payment levels. Every managed care plan that serves Medicare beneficiaries will receive an average increase of 5 percent in reimbursements in 2000. That's higher than the 2 percent increase for 1998 and 1999. However, this increase is not sufficient to cover escalating health costs. Medical cost trends, especially pharmacy coverage, have outpaced the 5 percent increase in reimbursement rates.

How HMOs Work

Health Maintenance Organizations, although not technically "insurance," in theory provide health care more efficiently than conventional fee-for-service arrangements. An HMO operates as a combination of insurance company and doctor/hospital. Like an insurance company, an HMO pays health care costs in return for a monthly or annual premium. Like a doctor or hospital, it furnishes actual health care.

HMOs eliminate the principal middleman, namely the insurance company, and this helps to keep operating costs down. HMOs contract directly with hospitals and other health care providers for services that are provided to their subscribers. The major cost saving for an HMO thus is that the participating hospitals and doctors have greater incentives to keep costs down. They are paid a predetermined amount based on the number of patients they serve and the types of services they provide, rather than a fee based on the actual costs of providing these services. If the actual costs exceed the predetermined payment, they lose money.

HMOs offer their services at premiums comparable to or often lower than those of supplemental policies, and they generally provide better coverage. Federally certified HMOs must offer all services covered by Medicare and must meet minimum protection standards prescribed for supplemental health insurance policies. Most HMOs currently offer plans that pay for physical examinations, office visits, immunizations, routine eye examinations, and hearing aid examinations. Some provide coverage for a portion or all of the costs of drugs prescribed by HMO physicians.

Moreover, HMO subscribers do not have to worry about the irregularities of Medicare's "approved charges" schedule. HMOs have no preexisting illness clauses, waiting periods, or elimination periods. Members are entitled to full coverage as soon as they enroll.

HMOs now exist in many localities. The best way to find out if you are in an HMO area is to look in the Yellow Pages under "Health Maintenance Organizations" or, as mentioned above, contact your local Social Security office or the national Medicare Hotline at 1-800-MEDICARE (1-800-633-4227) or visit the Medicare website at www.medicare.gov.

Disadvantages of HMOs

If HMOs sound "too good to be true," in some situations that may be the case. Membership in a Health Maintenance Organization may pose two potentially serious risks: 1) reportedly, the quality of care delivered by some HMOs is unsatisfactory, and 2) some HMOs have been financially troubled and could leave their members at great risk if they go broke.

With respect to the first concern, a major disadvantage of HMO membership is that once enrolled, members are limited to care under its physicians and its participating hospitals. Many HMOs advertise that they have a large number of member physicians, and often their prospectuses list all physicians who participate in their program. By implication, HMO members are free to choose their care providers from a large number of clinical personnel. In practice, the number of participating doctors may be deceptive. Very often, the most sought-after physicians already are "fully subscribed." Even though the total number of physicians in the HMO may be quite large, the number of physicians who will accept *new* patients may be quite small, and consist of relatively inexperienced practitioners.

Before you join an HMO, you should determine which HMO physicians are available to *new* members. If you are not satisfied with that list of doctors, you should go elsewhere.

If you become dissatisfied with one doctor, you can change to another within the organization. But you still are limited to care under HMO physicians. This rule does not apply in the event you need the services of a specialist who is not in the HMO. In this case, HMO physicians will refer you to several specialists, and the HMO may pay the costs of whomever you select.

If an illness requires major surgery, it normally must be performed in an HMO participating hospital. You are free to choose your own surgeon, but if you elect to have surgery performed elsewhere, you likely will have to pay a portion or all of the bill yourself.

The current dangers of HMO membership relate directly to the type of physicians they may attract and to mismanagement that has landed a number of them in financial difficulty. Although there are many "first-rate" HMO physicians, reportedly in some HMOs the clinical staffs are simply not as qualified as non-HMO doctors in a

given area. Moreover, cost-cutting measures reportedly have led to numerous abuses and inconveniences for members: long waiting times for appointments, tests, and treatment; repeated shifting of patient assignments (you may not see the same doctor from one visit to the next); lack of concern for patient welfare; and reluctance to proceed with high-cost treatment even when it is clinically warranted. In short, some HMOs reportedly place their patients at clinical risk that would more likely be avoided with conventional doctor-patient arrangements.

Of course, many HMOs have none of these troubles—but it is worth your time to determine the performance record of any such organization you are thinking of joining. Interview the HMO's physicians and supporting staff (ask to see their credentials). Ask a few nurses at your local hospital about the HMO physicians. Find out as much as you can about its participating hospitals. Ask to see the résumé of any doctor you are considering as a "primary care provider." And, most important, try to interview other members. Are they satisfied with the care they have been getting? Do they have complaints that have not been satisfied? Would they join the HMO now, knowing what they know about its operations? Give further consideration to joining only if you are satisfied on all counts.

Although speaking with other members of an HMO is a good idea, information about a plan's quality is available from Medicare's internet site at www.medicare.gov. The information under the "Helping You Stay Healthy" and "About Your Providers" pages was collected from the managed care plans and carefully checked for accuracy by Medicare. The currently available quality information is for calendar year 1997 and was collected using the Health Plan Employer Data and Information Set (HEDIS). "Helping You Stay Healthy" includes information such as the percentage of female plan members who received a mammogram and the percentage of plan members seen by a provider in the past year. "About Your Providers" includes data on the percentage of primary care doctors who are board certified, the percentage of specialists who are board certified, and the percentage of providers who stayed in the managed care plan for at least 1 year. As a rule of thumb, when measuring quality, a difference of 10 percentage points between plans' scores on a particular measure indicates a significant difference.

Additional information on the quality of Medicare providers is provided under the heading "Beneficiary Satisfaction." Medicare beneficiaries were surveyed and asked whether their doctors explained things in a way they could understand, and whether it was easy to get a referral to a specialist. The plans also receive overall ratings for the plan and the health care patients received.

Managed care plans differ in quality. If you have determined that the quality of medical services provided by the HMO meets your criteria, you still must be concerned about its financial health.

Medicare regulations require that defunct HMOs continue to provide coverage for Medicare subscribers for 6 months after bankruptcy is declared. While this provision provides some protection, it does not address the difficulties that elderly members may encounter when they try to obtain new supplemental insurance. For example, if your Medicare HMO plan stops participating in Medicare or giving care in your area, you only have the right to buy medigap plans A, B, C, or F (if they are sold in your state and as long as you apply no later than 63 calendar days after your health coverage ends). You may still be able to purchase one of the other six standardized medigap plans, but there may be conditions placed on the policy (*e.g.*, a waiting period), exclusions for preexisting conditions, or higher premiums because of past or present health problems.

The financial "balance sheet" of an HMO may be as important to your continued protection as the quality of its physicians. As many as two-thirds of the country's HMOs have at times operated in the red, and many of these could be sold off or merged with other organizations. You should try to find out exactly what the financial status is of any HMO you are thinking of joining. Below are some questions that you should ask before you sign up for membership.

- Ask how long it has been in business (if it was only recently organized, do not join it) and request a copy of its most-recent financial statement.
- Ask if it is an independent financial entity or part of a larger organization (HMO chain). If it is part of a larger chain, ask to see the annual report of the parent group.
- Is it owned by an insurance company? If it is, check that company's financial statements. If the HMO is taking losses,

the company may try to sell it or dismantle it.

- Ask if the Medicare segment of the HMO is reporting losses, and if there are plans to cancel membership for Medicare recipients.
- Ask how many of the HMO's physicians have left the organization during the past 5 years, and why. If there has been a "mass exodus" of doctors, you want to know why; try to interview any such physicians.

How to Double-Check an HMO's Financial Status

If HMO representatives are reluctant to answer your questions or do not provide you with the materials you request, do not do further business with them. If they provide answers, you still should "double check" the accuracy of their statements.

Best's *Managed Care Reports-HMO*, Standard and Poor's, and Weiss Ratings now provide financial reports and ratings for HMOs. These may be available in the reference section of your local library. Rating agencies are also available by phone: A.M. Best Company, (908) 439-2200; Standard & Poor's, (212) 208-1527; Weiss Research, Inc., (800) 289-9222. Other HMO "chains" are listed in the *Value Line Investment Survey*, a regularly updated survey that ranks the safety and financial performance of publicly traded stocks.

The HMO/Medicare Outlook

As a result of the losses suffered by the HMO industry, a major restructuring has occurred among many of the organizations that performed poorly. It is a matter of common sense that Medicare recipients avoid any HMO that is likely to be liquidated or cancel Medicare memberships. However, if you find an HMO that is well-established, financially strong, and clinically superior, membership may still provide good value relative to that of conventional medigap insurance. Otherwise, it would seem prudent to forgo such membership until a more financially solid HMO is available.

Leaving a Medicare HMO Plan

In the year 2000, you may leave a plan for any reason at any time. Simply write to the plan or the Social Security Administration (1-800-772-1213) and tell them you want to leave. You will be automatically return to the original Medicare plan, unless you join another Medicare+Choice plan (discussed in Chapter IX). In most cases, your new coverage starts the month after you leave the plan.

However, starting in 2002, you will only be allowed to disenroll during the first 6 months of the year. In the year 2003 and beyond, the disenrollment period will be limited to the first 3 months of each year.

If you join a Medicare HMO (or other Medicare managed care plan), drop your medigap policy, and then later disenroll from the HMO, you may be able to return to the medigap policy that you dropped. You will be able to get your old medigap policy back if (1) this was the first time that you joined a Medicare HMO; (2) you leave the medicare HMO within one year after joining; and (3) you apply for your former medigap policy within 63 calendar days after the health plan coverage ends. Of course, this all assumes that your previous medigap insurance company still sells the same policy in your state. If your previous policy is not available, you are guaranteed the right to purchase medigap policies A, B, C, or F from any insurance company which sells these plans in your state (again, within 63 calendar days after health care coverage ends).

If you enrolled in a Medicare HMO when you first became eligible for Medicare at age 65 and you disenrolled from the HMO within one year after joining, you have the right to purchase any medigap policy sold in your state, with no conditions such as a waiting period and no preexisting condition exclusion, and without discrimination in the price of the policy based on your health status, within 63 calendar days after your HMO plan coverage ends.

The protections and guarantees outlined above are important. If you, say, voluntarily disenroll from a Medicare HMO 2 years after joining, and wish to purchase a medigap policy, you will be subject to insurance companies' underwriting standards. That is, you run the risk of not being able to buy any policy because your health condition is unacceptable, risk paying a higher premium, or risk having preexisting conditions limitations imposed. The point is that you once you are enrolled in a Medicare HMO for 1 year or more, you may find it difficult or costly—if not impossible—to get a medigap policy should you then decide to disenroll from the Medicare HMO.

Other Medicare HMO Enrollment Situations

If you lose your Medicare HMO coverage—as opposed to voluntarily disenrolling—your rights are the same as if you dropped your medigap policy to enroll in a Medicare HMO and then decided to disenroll as described above. You must have lost your health care coverage because your HMO plan terminated its Medicare participation or stopped providing care in your area, you moved outside the HMO plan's area, or you left the plan because it failed to meet its contract obligations to you.

The protections will not be guaranteed if you voluntarily disenroll before the health coverage ends or is lost. (You may start checking into alternatives so as to have a new policy in place right away and avoid coverage gaps.) Make sure you keep a copy of your plan's termination letter in case you have to prove that you lost coverage in a situation described above.

VI.

MEDICARE SUPPLEMENTAL INSURANCE

SINCE July 31, 1992, any insurer offering Medicare Supplemental Insurance has been required to restrict policy offerings to ten "approved" policies labeled A through J as stipulated by federal and subsequent state regulations. In 1997, Congress allowed insurers to also offer a high-deductible option ($1,500 in 1999) for plans F and J. This does not mean that insurance companies are prohibited from selling other types of policies. But they may not be called "Medicare Supplemental Insurance."

In this chapter the major provisions of each of these ten policies are described. With the important exceptions noted below, in states that have approved the NAIC model regulation any Medicare Supplemental Insurance policies offered for sale must adhere strictly to those provisions. (Some choices may not be available in Massachusetts, Minnesota, and Wisconsin because these states already required standardized medigap policies prior to 1992.) The intent of the framers of these new model standards was to simplify the medigap insurance decisions of consumers by requiring that insurers offer policies that are strictly comparable, thus permitting accurate "price shopping."

However, one provision of the NAIC regulation and an "exogenous" provision of the Omnibus Budget Reconciliation Act of 1990 would seem to have created a gaping loophole that may permit insurers to tinker with the NAIC policy requirements. According to the NAIC regulation, "The issuer of a Medicare supplement policy may, with the prior approval of the [State] commissioner [of insurance], offer new or innovative benefits in addition to the benefits provided in a policy that otherwise complies with the applicable standards." And according to the Omnibus Budget Reconciliation Act of 1990, issuers of Medicare supplement policies are not prohibited from offering discounts to policyholders "for the purchase of items or services not covered under its Medicare supplement policies (for example: discounts on hearing aids or eyeglasses)." In short, the insurers may simply find new ways to make their medigap policies unique—which would largely defeat the intent of the "simplified" NAIC regulations.

NAIC MEDICARE SUPPLEMENT PLAN STANDARDS

Benefit	A	B	C	D	E	F[2]	G	H	I	J[2]
Core[1]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Skilled nursing facility			✓	✓	✓	✓	✓	✓	✓	✓
Part A (hospital) deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
Part B (physician) deductible			✓			✓				✓
Part B (physician) excess charges						100%	80%		100%	100%
Foreign emergency care			✓	✓	✓	✓	✓	✓	✓	✓
At-home recovery care				✓			✓		✓	✓
Prescription drugs								Basic[3]	Basic[3]	Ext'd[3]
Preventive screening					✓					✓
Total Average Cost‡	$528	838	908	872	870	1,117	1,050	1,203	1,344	1,811
Distribution of Sales‡	5.1%	17	21	8.4	0.8	29.7	2.2	2.7	5.9	6.9

[1] Core benefits include: Part A (hospital) coinsurance plus a lifetime maximum benefit for an additional 365 days; Part B (physician) coinsurance, subject to the Part B deductible; and the first three (3) pints of blood each year.

[2] Plans F and J also have a high deductible option ($1500 in 1999).

[3] Basic coverage: After you pay $250 per year deductible, the plan pays 50% of prescription drug costs up to a maximum of $1,250 per year ($3,000 per year for extended coverage).

‡ See Lauren A. McCormack *et al.*, "Medigap Reform Legislation of 1990: Have the Objectives Been Met?" *Health Care Finance Review* (Fall 1996) p. 157 ff. See also George S. Chulis *et al.*, "Ownership and Average Premiums for Medicare Supplemental Insurance Policies," *Health Care Finance Review* (Fall 1995) p. 255 ff.

The Ten NAIC Approved Medicare Supplemental Insurance Plans

Be that as it is, the NAIC regulation is very specific about the benefits that the ten approved policies *must* contain. Any insurer who wants to sell Medicare Supplemental Insurance in a state must offer a basic policy (Policy A) that contains only the "core" benefits that are common to all approved policies. Insurers who offer the core policy may or may not offer any or all of the other approved policies that contain additional benefits. However, no policy may duplicate coverage that is provided by either Medicare Part A or Part B. (You don't need to buy a medigap policy if you are in a Medicare managed care plan, or if you are covered by Medicaid. Generally, it is not legal for anyone to sell you one in such cases.) The terms of coverage provided by the ten Medicare Supplemental Insurance policies approved in the NAIC model regulation are summarized in the table on page 54. The specific provisions of each of the policies are as follows:

Plan A (core policy) provides: (1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period (in 2000, that amount is $194 per day); (2) Coverage of Part A Medicare Eligible Expenses incurred as daily hospital charges during use of Medicare's lifetime inpatient reserve days (in 2000, $388 per day); (3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days; (4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations; and (5) Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

Plan A thus provides basic coverage for the hospitalization costs of catastrophic illness up to a year after Medicare benefits cease, and for medical costs for all Medicare-approved charges. The nine Medicare Supplemental Insurance policies described below that offer ad-

ditional benefits must include the Plan A core benefits.

Plan B provides *only*: Core benefits plus the Medicare Part A deductible ($776 in 2000).

Plan C provides *only*: Core benefits plus the Medicare Part A deductible; coverage from the 21st day through the 100th day in a Medicare benefit period for the coinsurance amount of Medicare eligible post-hospital skilled nursing facility care charges eligible under Medicare Part A ($97 per day in 2000); the Medicare Part B deductible ($100); and medically necessary emergency care in a foreign country.

Plan D provides *only*: Core benefits plus the Medicare Part A deductible; skilled nursing home care same as in Plan C; medically necessary emergency care in a foreign country; and coverage for at-home services associated with short-term assistance with activities of daily living for those recovering from an illness, injury, or surgery. Coverage for at-home services is limited to 7 visits in any one week, where each consecutive 4 hours in a 24-hour period is deemed one visit, the maximum reimbursement is $40 per visit, the attending physician certifies visits as necessary, and the total number of at-home recovery visits does not exceed the number of Medicare-approved home health care visits under a Medicare-approved Home Care Plan of Treatment. (Medigap policies do not cover care provided by family members or unpaid volunteers.)

Plan E provides *only*: Core benefits plus the Medicare Part A deductible; skilled nursing care as in Plan C; and medically necessary emergency care in a foreign country; and coverage for the following preventive health services: an annual physical examination that may include (1) tetanus and diphtheria boosters, (2) pure tone hearing screening tests, (3) dipstick urinalysis for hematuria, bacteriuria, and proteinuria, (4) thyroid function test for women, (5) fecal occult blood tests and/or digital rectal examination, (6) cholesterol screening every 5 years; and influenza vaccine administered at any appropriate time during the year. Reimbursement shall be for the actual charges up to 100% of Medicare-approved amounts to a maximum of $120 per year. The $120 annual limit on benefits for preventive care reduces the protection offered by that coverage, and may not justify the additional premium. In effect, individuals who purchase such coverage are simply "prepaying" the affordable costs of

the annual physical examination.

Plan F provides *only*: Core benefits plus Part A deductible; skilled nursing care as in Plan C; the Medicare Part B deductible; coverage for 100% of the difference between the actual Medicare Part B charge as billed, not to exceed the charges as set forth by the "Resource-Based Relative Value Scale" or other lawful maximum physician or provider charges, and the Medicare-approved Part B charge; and medically necessary emergency care in a foreign country. Coverage of Medicare Part B excess charges is of no value where physicians are required to accept Medicare assignment, and is of reduced value where the excess fees that physicians may charge are limited.

Plan F also has a high-deductible option ($1,500 in 1999). It requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) in the amount of $1,500 (in 1999) before the policy begins payment of benefits. The prescription drug deductible must be met as well. After 1999, the deductible increases by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U) for the 12-month period ending with August of the preceding year.

Plan G provides *only*: Core benefits plus Part A deductible; skilled nursing care as in Plan C; coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed the charges as set forth by the "Resource-Based Relative Value Scale" or other lawful maximum physician or provider charges, and the Medicare-approved Part B charge; and medically necessary emergency care in a foreign country. Again, coverage of Medicare Part B excess charges is of no value where physicians are required to accept Medicare assignment, and is of reduced value where the excess fees that physicians may charge are limited. Coverage for at-home care as in Plan D is also included.

Plan H provides *only*: Core benefits plus Part A deductible; skilled nursing care as in Plan C; emergency care in a foreign country; coverage of 50% of outpatient prescription drug charges after a $250 annual deductible, to a maximum of $1,250, to the extent not covered by Medicare.

Plan I provides *only*: Core benefits plus Part A deductible; skilled nursing care as in Plan C; 100% of Part B excess charges as in Plan

F; emergency care in a foreign country; and at-home care as in Plan D; prescription drug benefits as in Plan H.

Plan J provides *only*: Core benefits plus Part A deductible; skilled nursing care as in Plan C; the Medicare Part B deductible; 100% of Part B excess charges as in Plan F; emergency care in a foreign country; at-home care as in Plan D; an extended prescription drug benefit that provides coverage for 50% of outpatient prescription drug charges, after a $250 annual deductible, to a maximum of $3,000 per calendar year, to the extent not covered by Medicare; and preventive medical care as in Plan E. There is also a high-deductible option available for Plan J that works just like the high-deductible option available for Plan F described above.

What is Medicare SELECT?

Medicare SELECT was introduced on a trial basis in 15 states in 1994, expanded to all 50 states in 1995, and made permanent in 1998. Medicare SELECT is a type of standardized medigap insurance policy. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized medigap plans A through J. With a Medicare SELECT policy, you may need to use specific hospitals and doctors to get full insurance benefits (except in an emergency). For this reason, Medicare SELECT premiums are generally 15 to 25 percent lower than comparable medigap policies that do not have this selected-provider feature. Although there are nearly 500,000 beneficiaries in the program, Medicare SELECT may not be offered in your state. For more information call your state insurance department (see Chapter VII).

How Much Does Medigap Insurance Cost?

Costs vary from plan to plan, from insurance company to insurance company, and from state to state. The bottom line is that medigap premiums vary widely and it is in your financial interest to shop around. The table on page 54 shows the average cost for each of the various standardized plans. Premiums for medigap insurance rose by 40 percent in some states between 1995 and 1996 and continue to rise.

Beneficiaries should consider what one policy is likely to cost over 5 or 10 years compared to premiums for other policies. In other words, what you pay when you first buy a policy and what it costs in

the future depends on the method used to price the policy. If a policy is "community rated," all policy holders pay the same premium, regardless of age. Companies are required to sell community rate policies in Connecticut, Maine, Massachusetts, Minnesota, New York, and Washington. If a policy is "issue-age rated," the premium will depend on the age of the beneficiary at the time the policy is purchased. Florida and Georgia both require companies to sell issue-age policies. Most medigap policies today are what is called "attained-age rated." With attained-age policies, premiums rise as you get older. For example, while the initial premium for an attained-age policy is generally lower than that of either a community rated or issue-age rated policy, just the opposite situation is likely to develop as the beneficiary ages. There is no way to predict how much a policy's premiums may rise as you get older. A policy with an attractive premium at age 65 may not turn out to be the same bargain it was at age 70 or 75.

The Relative Value of Plan Options

What you pay for a medigap policy largely depends on how much coverage you want—the more the coverage, the more the cost. You should not, however, purchase the most comprehensive policy just because you can afford the premiums. Certain plans may provide relative value—that is, when comparing two plans, one plan may not be worth the additional premiums you would pay for it.

Part B Deductible and Preventive Screening benefits are not major expenses and so are less important than the other remaining options — Part B excess charges, at-home recovery and prescription drugs.

At-home recovery benefits pay no more than $40 per visit and $1,600 per year. In order to receive this benefit, you must be receiving Medicare-covered home health services already. Medicare coverage may be ample for the same services that the at-home recovery benefit would cover. The benefit tends to be expensive and may not be worth the additional premiums you would pay for it.

Part B excess charges are now somewhat less important than they were because of federal and state limitations on balance billing. However, $115,000 worth of physician bills that were 15% above Medicare's allowed charge would leave you with a liability of

$15,000.

Your decision may therefore be simplified, particularly if you have some idea of your particular risks relating to Part B excess charges or prescription drugs, since these are the two benefits which could make the largest difference in your costs and risks, assuming you are choosing a policy from Plan C to Plan J. If you think Part B excess charges are likely to be important, Plans F, I, or J give maximum benefits; Plan G provides the 80% benefit. If you think prescription drugs are likely to be important, Plans H and I give basic coverage; Plan J gives extended coverage. However, the prescription drug benefit makes these plans expensive. Because of the deductible ($250) and 50 percent coinsurance, you would have to spend more than $2,750 a year for drugs to make Plans H and I worthwhile. Plan J makes sense if you spend at least $6,250 a year on prescription drugs.

Plans C and F are the most widely sold plans and identical except that only Plan F covers Part B excess charges. Plan F costs on average $200 more than Plan C. Neither plan covers at-home recovery or prescription drugs.

Beware the "Hard Sell"

Whenever major changes occur in a program such as Medicare, opportunities are created for the insurance companies to exploit a newly created market. Today, the "Medicare roller coaster" has created just such an opportunity and, not surprisingly, the sales forces of most health insurers have marshaled their considerable talents to convince Medicare subscribers that they need their company's policy. As in all such situations, exaggeration of risks and benefits sometimes plays a part in the sales presentation. We review below a number of tactics—and potential sales abuses—to which consumers should be alert.

"Lead cards." Reportedly, a number of marketing organizations currently are mailing what are called "lead cards" to Medicare subscribers in many states in order to identify potential supplemental insurance buyers. Usually, these mailings come in official-looking envelopes with an official-sounding name that conveys the impression the sender is connected with a Government agency. The enclosed letter warns of supposed great risks faced by the elderly as a

result of changes in Medicare and purports to offer the addressee important information if the enclosed form is filled out (stating name, address, age, Social Security number, and the like) and returned to the sender. Often, the subject of insurance is not mentioned in the lead card, but that is the purpose of the mailing.

In fact, the names and addresses that are returned on the cards to the marketing firm are then sold to insurance companies or their agents as "hot prospects" for Medicare supplemental insurance. California has prohibited the mailing of one firm's lead cards, but U.S. postal authorities and the other state insurance regulators have taken no action. If you receive such a mailing, you should be aware that, if you return the card, in all likelihood your name will be sold to an insurer who then will try to sell you a policy.*

Appeals to urgency. Insurance salespersons may stress that you must "act now" to get the most coverage from a particular insurance policy. In fact, once a policy prospectus has been developed, the terms of coverage for that policy will not change no matter how long a buyer waits to purchase it. High pressure sales techniques that stress the urgency of acquiring a particular policy simply are designed to get you to "sign on the dotted line" as soon as possible.

In some situations, however, it may make sense to buy a policy sooner rather than later. For example, if you have decided that a policy provides adequate coverage at a reasonable cost, and if premium costs will increase if, say, you become a year older (for insurance purposes) at an imminent birth date, it will save you money to sign the insurance contract before that time.

Duplicate coverage. The NAIC Model Standards prevent supplemental policies from duplicating Medicare benefits, but they do not address the sale of policies that may replicate *other* supplemental policies. Although it violates most states' fair sales practices legislation, insurance sales personnel may try to find a way around the rules and sell you what amounts to duplicate coverage. For example, the salesperson may not inquire if you already own a Medicare supple-

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* For a more thorough review of the deceptive practices used in the sales of Medicare supplemental insurance, see *Consumer Reports,* August 1994, "Filling the Gaps in Medicare" and September 1994, "Five Ways to Cover the Gaps in Medicare."

Table 3
UNDERWRITING LOSS EXPERIENCE OF THE 50 LARGEST MEDIGAP INSURERS

Company Name	Loss Ratio	Company Name	Loss Ratio
Prudential Ins Co	98.8	State Farm Mutual Automobile Ins Co	76.6
Bankers Life & Casualty Co	71.9	Union Bankers Ins Co	90.9
Empire Blue Cross & Blue Shield	93.0	BCBSM Inc	78.2
United American Ins Co	68.4	Capital Blue Cross	90.8
Medical Service Assoc of PA	93.4	Hartford Life Ins Co	84.7
Blue Cross & Blue Shield of FL	84.2	Arkansas Blue Cross & Blue Shield	89.7
Health Care SVC Corp	81.9	Anthem Health Plans	89.1
Blue Cross & Blue Shield of VA	77.2	Blue Cross & Blue Shield of MO	79.4
Blue Cross & Blue Shield of NC	81.2	Blue Cross & Blue Shield of MD Inc	77.7
Blue Cross & Blue Shield of NJ	90.0	Community Ins Co DBA Anthem	78.6
Physicians Mutual Ins Co	77.2	Blue Cross & Blue Shield Mut of OH	78.5
Pioneer Life Ins Co	68.1	Blue Cross & Blue Shield of RI	95.7
Mutual of Omaha Ins Co	68.4	Principal Mutual Life Ins Co	78.3
Anthem Ins Co	73.9	Blue Cross & Blue Shield United of WI	72.6
IASD Health Services Corp	91.3	First National Life Ins Co	85.5
Blue Cross & Blue Shield of MI	132.7	LA Health Service & Indemnity Co	91.7
Blue Cross & Blue Shield of AL	92.3	Blue Cross & Blue Shield of NE	76.9
Blue Cross & Blue Shield of TN	91.6	Assoc Hospital Service of Maine	98.4
Blue Cross & Blue Shield of CT	90.9	Blue Cross & Blue Shield of TX Inc	81.2
Standard Life & Accident Ins Co	71.0	Group Health Service of OK Inc	87.5
Blue Cross & Blue Shield of KS Inc	92.4	Equitable Life & Casualty	76.0
Blue Cross of Western PA	90.8	Blue Cross & Blue Shield of GA Inc	81.6
American Family Life Asr Co	68.1	American General Life & Acc Ins Co	77.0
Independence Blue Cross	112.8	Humana Ins Co	74.4
American Republic Ins Co	66.8	Allianz Life Ins Co of NA	75.7

Source: National Association of Insurance Commissioners, 1995.

mental policy, and if challenged later be able to say that he or she was unaware that the policy offered replicated existing coverage. Or the sales pitch may emphasize that the offered policy provides additional coverage from the supplemental policy you own and that both are needed to provide "comprehensive protection." Do not be deceived by such appeals. You should look for the best supplemental policy for your circumstances and buy that policy and only that policy.

"Mining for gold." Beware of salespeople who immediately try to find out how much you are worth. They may want to know how large a policy they can sell, not what may be the best buy for you. Do not offer information about your personal finances. After all alternatives have been explored and you have had a chance to compare a number of different policies at your leisure and out of the watchful

Table 4
UNDERWRITING LOSS AND EXPENSE RATIOS OF THE 50 LARGEST WRITERS OF ACCIDENT AND HEALTH INSURANCE

Company	Loss Ratio	Expense Ratio
Blue Cross & Blue Shield of MI	92.3	8.5
Prudential Ins Co of America	87.2	24.8
American Family Life Columbus	85.5	28.0
Highmark, Inc.	90.3	13.6
Empire BC & BS	89.1	12.9
Guardian Life Ins Co of Amer	83.2	23.7
Principal Mutual Life	83.4	22.0
Continental Assurance Company	91.2	9.9
Connecticut General Life Ins	89.5	11.4
Metropolitan Life Ins Co	100.6	15.8
United HealthCare Ins Co	82.7	11.2
Aetna Life Ins Co	84.9	30.7
Blue Cross & Blue Shield of TX	87.7	14.9
UNUM Life Ins Co of Amer	79.5	33.5
Employers Health Ins Co	71.8	19.8
Mutual of Omaha Ins Co	76.8	25.2
Community Insurance Company	83.4	19.3
Blue Cross & Blue Shield of FL	80.6	17.3
Health Ins Plan of Greater NY	92.3	8.4
Health Care Service Corp	87.5	14.5
Blue Cross & Blue Shield of NJ	82.1	17.4
Trigon Insurance Company	85.4	12.6
Chattanooga Hospital & Medical	90.5	10.6
Blue Cross and Blue Shield of NC	88.4	18.3
Bankers Life and Casualty Co	74.7	20.4
Paul Revere Life Ins Co	91.0	35.3
Hartford L & A Ins Co	87.6	22.1
Finger Lakes Health Ins Co	96.0	6.1
Wellmark, Inc.	84.9	13.8
United Wisconsin Life Ins Co	76.0	24.5
UNICARE Life & Health Ins Co	89.9	12.6
Fortis Benefits Ins Co	80.0	29.6
Blue Cross of WA & AK	88.3	14.3
Anthem Insurance Companies Inc	79.8	26.8
American Life Ins Co – DE	51.8	34.2
Life Ins Co of North America	84.1	26.0
Blue Cross & Blue Shield of MN	85.3	16.2
Triple-S, Inc.	89.2	11.3
Regence BC BS of Oregon	87.0	14.2
New York Life & Health	83.4	18.1
Trustmark Insurance Co (Mutual)	77.4	23.1
Combined Ins Company of Amer	40.6	51.6
Fortis Ins Co	68.0	38.8
Provident Life & Acc	105.2	37.9
John Alden Life Ins Co	75.7	36.4
Blue Cross & Blue Shield of KS	88.0	14.5
Blue Cross & Blue Shield of CNY	92.0	9.0
General Electric Capital Assur	76.5	43.2
Great-West Life & Ann Ins	42.6	51.9
J C Penney Life Ins Co	38.0	60.3

Source: Best's Review, December 1999.

eye of the salesperson, you may want to review how much insurance you can "afford" with a *disinterested* third party (your financial adviser or banker, for example). But opening your financial account books to the insurance salesperson may invite sales abuses.

Evaluating the Insurers

Industry specialists agree about what the future of health care insurance holds: higher premiums, rate increases, restructured benefit offerings, additional "out-of-pocket" expenses, continued growth in the size of the uninsured population, more mergers and acquisitions, amended prescription benefits and more failures by healthcare companies. Furthermore, a host of regulatory and performance issues will affect various products and markets.

The combination of sharply rising health care costs, Government regulation, actuarial imprecision, and managerial confusion has resulted in substantial underwriting losses for some insurers in the past decade or so. (Underwriting losses occur when companies pay out more in benefits and operating expenses than they take in as premium income) One might well question how insurance companies can continue in business after taking losses. All insurance companies have two sources of income—premiums and investments. For most of the last decade, premium income was inadequate to cover benefit expenditures. But until now investment income more than made up for premium losses. Thus far, many insurers have been able to absorb underwriting losses because investment yields have been historically high. But it is by no means certain that investment "gains" can continue to offset underwriting losses.

Unless premium charges are brought into line with benefit payouts, the continued solvency of life and health insurers will depend on adequate investment earnings—and as recent events suggest, the financial markets can be highly volatile. Heavy reliance on unstable investment returns has, in fact, made insurers especially vulnerable to a situation where health care costs and benefit payments may continue to increase at the same time that offsetting yields on investments become more difficult to achieve. In short, many insurance companies could find themselves in a classic financial squeeze, a possibility that has led some industry analysts to speculate that further "shakeouts" may occur—that is, that the weaker companies will continue to be forced out of business or merged with healthier ones.

What this situation means to you as a health insurance consumer is that you must take care to ascertain that any policy you buy is with a healthy insurer—and that it is likely to return good value. With respect to the former, we recommend that policies be purchased only from companies that are rated "A+" or "A++" by *Best's Insurance Reports*. *Best's Reports* represent an opinion based on a comprehensive quantitative and qualitative evaluation of a company's financial strength, operating performance, and market profile. (Chapter VII discusses how to use *Best's Reports*.)

Another useful measure of both the financial health of a company and the value that it returns to policyholders is the so-called loss ratio, which represents the percentage of premiums that are returned to policyholders as benefits. Many state departments of insurance have prepared brief guides to supplemental health insurance for Medicare subscribers. And a number of these advise supplemental insurance buyers to use insurance companies' loss ratios as a means of comparing the relative value of policies. Low loss ratios are a sign that a policy is not returning value to policyholders. Federal law stipulates that a cumulative 65 percent loss ratio for individual policies (75 percent for group policies) must be met over the life of a policy, which is assumed to be 15 years. Insurers are required to pay refunds or provide credits to policyholders when Medigap policies fail to meet loss ratio standards.

Table 3 shows the underwriting loss ratios of the 50 largest writers (by premiums) of accident and health insurance in 1998. As that table illustrates, the majority of companies writing policies in the accident and health insurance field currently are posting underwriting loss ratios that are very high. Traditionally, insurance actuaries aim at achieving underwriting loss ratios in the range of 70 to 75 percent. Losses in this range allow a company to retain an attractive marketing stance, yet still permit the company to turn an acceptable underwriting profit. Losses much over 75 percent, however, may be risky to the company—and here a difference of a few percentage points can make the difference between profit and loss, and, eventually, between solvency and insolvency. One supposes it is a matter of some concern to those involved that, in 1998, 36 of the 50 largest insurers posted loss ratios above 80 percent, by conventional standards a somewhat risky level. In short, check out the financial health as well as the benefits and premium costs of any insurer whose

policy you are considering. Even the best coverage at a low price will be useless if the company cannot pay claims promptly (or at all).

VII.

SHOPPING FOR A MEDICARE SUPPLEMENTAL POLICY

INSURANCE agents are trained to emphasize the advantages of their company's policies and the drawbacks of their competitors' products. Insurance salespeople hope to convince you that their policy represents the best value by "comparing" it with other policies. Do not be deceived. These sales-oriented comparisons often are designed to make one policy look much better than all the rest and are unreliable. In all likelihood, few, if any, will offer all ten medigap plans—and they will, no doubt, develop sales presentations that emphasize the benefits only of the plans they do offer.

Ultimately, it is up to you to find the best value through independent inquiry. Do not rely on salespeople, and do not rely on friends who claim to have found a "great deal." Friends may be well-meaning, but they also may not have all the facts relevant to your situation.

Every State Is Different

Today, insurance analysts are especially concerned that large differences in premiums from one geographical area to another hamper their ability to monitor actuarial performance and set realistic premium rates. A number of companies already have established a computerized consortium data bank that allows each member to draw on the experience of others in the consortium. But so far this project has barely gotten started and ironically is facing antitrust opposition. Many insurers are still more or less in the dark about industry-wide actuarial experience.

What this means to you as an insurance buyer is that there still are wide variations in premium costs from company to company and from state to state. Even within some states, prices on the same policy are different. In fact, in the larger metropolitan areas of the Northeast and the Midwest, your premium cost may depend on the side of town in which you reside. In short, a policy that may represent the best value in one state or locality will not necessarily be the best value in another state or locality. **You cannot rely on the advice of others who reside outside your area.**

The State Insurance Department

A number of state insurance departments have consumer affairs divisions that provide information free to prospective insurance buyers. As a first step in shopping for a Medicare supplemental policy, contact the State Insurance Department to see if your state has such a service. If it does not, urge that one be established.

Therefore, consult the accompanying National Directory of State Insurance Departments, and write or telephone to request a list of all Medicare supplemental insurance providers currently offering policies in your locality. Make certain you get current addresses and telephone numbers.

At the same time, ask for any related literature. A number of state insurance departments have prepared guides to supplemental insurance, and most contain pertinent information regarding the peculiarities of such insurance in their states.

When you have obtained a list of Medicare supplemental insurance providers for your area, contact each. Request full policy details, including coverage, exclusions or restrictions, waiting periods, renewability, and premium rates. If any policy does not meet the NAIC Model Standards or the additional requirements of your state, contact the State Insurance Department and report the discrepancy.

Using Best's Insurance Reports

To determine the status of each company for which you have a policy prospectus, consult *Best's Insurance Reports: Life and Health.* Even fewer insurance buyers know about *Best's* than about their state insurance department, but it is an equally useful resource. A. M. Best Co. is an independent insurance evaluator that publishes monthly and annual reports on a variety of issues regarding the insurance industry. The reference librarian in your local library will direct you to *Best's Reports.*

You want to consult *Best's Insurance Reports: Life and Health* for the most recent year available. This will be a large, heavy, red bound volume that resembles an encyclopedia in looks and contains nearly as much information. *Best's Reports* lists virtually all insurance companies currently writing policies in the United States. *Best's* rates each company on a letter grade: "A++" and "A+" (Superior),

"A" and "A–" (Excellent), "B++" and "B+" (Very Good), "B" and "B–" (Good), "C++" and "C+" (Fair), "C" and "C–" (Marginal), "D" (Below Minimum Standards), "E" (Under State Supervision), and "F" (In Liquidation). Any company with a B rating or lower is being "damned with faint praise." As a general rule, it is advisable to insure only with those companies rated A+ or A++. Ratings are also available from Standard and Poor's Ratings Group, Duff and Phelps Credit Rating Company and Weiss Ratings, Inc. Ratings are available by phone: A.M. Best Company, (908) 439-2200; Duff & Phelps, Inc., (312) 368-3157; Standard & Poor's, (212) 208-1527; Weiss Research, Inc., (800) 289-9222. Insurance News Network has a website at www.insure.com which makes ratings from Standard and Poor's and Duff and Phelps available. Quotesmith.com (www.quotesmith.com) provides free instant Medicare supplement insurance quotes from up to 80 companies along with the latest A. M. Best, Duff & Phelps, Moody's, Standard & Poor's and Weiss ratings for each company.

What You Should Ask the Insurance People Before You Buy

A policy may look good on paper, but if the company refuses for one reason or another to pay the promised benefit, or if benefits are so slow in coming that they cause you worry, inconvenience, and embarrassment, you may want to avoid that policy. This remains true no matter how low the premiums or how high the supposed coverage. Therefore, you should learn the claims response record of the company before you purchase a policy. In this regard, the **important facts are not published. Consequently, it is up to you to question the insurance agent on a number of matters.**

First, ask the agent what the actual loss ratio on the policy (or on a similar policy if the policy you are considering is new) has been for the past few years. This figure may differ from the "anticipated loss ratio" usually cited in promotional literature. If the actual figure is much lower than the anticipated figure, you want to know why.

Second, ask the agent to tell you the average time it takes to get a claim processed and for you or your doctor or hospital to receive payment. It can be annoying and costly if benefits are inordinately slow in coming through. Ask where your claim will go and who has to approve it. Is claim authorization made locally, or are all

NATIONAL DIRECTORY OF STATE INSURANCE DEPARTMENTS

Write or telephone the State Insurance Department at the following locations:

Alabama, Montgomery 36130-3351	334-269-3550
Alaska, Anchorage 99515	907-465-2515
Arizona, Phoenix 85018	602-912-8400
Arkansas, Little Rock 72204	800-282-9134
California, Sacramento 85814	213-346-6400
Colorado, Denver 80202	303-894-7499
Connecticut, Hartford 06142-0816	860-297-3800
Delaware, Dover 19904	302-739-4251
D.C., Washington 20001	202-727-8000
Florida, Tallahassee 32399-0300	850-922-3100
Georgia, Atlanta 30334	404-656-2070
Hawaii, Honolulu 96811	808-586-2790
Idaho, Boise 83720-0043	208-334-4250
Illinois, Springfield 62767	217-782-4515
Indiana, Indianapolis 46204	317-232-2385
Iowa, Des Moines 50319	515-281-5705
Kansas, Topeka 66612	785-296-3071
Kentucky, Frankfort 40602	800-595-6053
Louisiana, Baton Rouge 70804-9214	225-342-5900
Maine, Augusta 04333	800-300-5000
Maryland, Baltimore 21202-2272	410-468-2000
Massachusetts, Boston 02210-2223	617-521-7777
Michigan, Lansing 48909	517-373-9273
Minnesota, St. Paul 55101-2362	651-297-7161
Mississippi, Jackson 39205	601-359-3569
Missouri, Jefferson City 65102-0690	573-751-4126
Montana, Helena 59601	406-444-2040
Nebraska, Lincoln 68508	402-471-2201
Nevada, Carson City 89710	775-687-4270
New Hampshire, Concord 03301	603-271-2261
New Jersey, Trenton 08625	609-292-5313
New Mexico, Santa Fe 87504-1269	505-827-4297
New York, New York 10013	212-480-2301
North Carolina, Raleigh 27611	919-733-7343
North Dakota, Bismarck 58505-0320	701-328-2440

Ohio, Columbus 43215-1067	614-644-2658
Oklahoma, Oklahoma City 73152-3408	800-522-0071
Oregon, Salem 97310	503-947-7980
Pennsylvania, Harrisburg 17120	717-787-2317
Rhode Island, Providence 02903-4233	401-222-2223
South Carolina, Columbia 29202-3105	803-737-6160
South Dakota, Pierre 57501-5070	605-773-3563
Tennessee, Nashville 37243	615-741-2241
Texas, Austin 78714-9091	512-463-6169
Utah, Salt Lake City 84114-6901	801-538-3800
Vermont, Montpelier 05620-3101	802-828-3301
Virginia, Richmond 23219	804-371-9741
Washington, Lacey 98504-0256	360-753-7301
West Virginia, Charleston 25305-0540	304-558-3354
Wisconsin, Madison 53707	608-266-3585
Wyoming, Cheyenne 82002	307-777-7401

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claims forwarded to the "head office"?

Third, ask what your rights are as a policyholder in the event that your claim is reduced or denied. Find out what percentage of claims is reduced and what percentage is denied on the policy you are investigating. And find out why such claims have been reduced or denied. Your questioning may very well make the insurance representative uncomfortable, but it is your right and in your interest to ask. **If the salesperson is uncooperative or if he is pleasant but never provides you the information you want, do not do business with that person.** The overwhelming majority of insurers have scrupulous claims procedures, but a few have been known to try to cut losses through legal challenges to claims. You want to be certain that any policy you purchase will pay benefits promptly as promised.

Ask to see a claim form. Is it straightforward and simple? Or is it overly complex?

Find out if you will be paid benefits directly or if the insurance company will make payments directly to the health care provider. Generally, it saves you time and trouble if the company will make payments directly to the doctor. Many doctors have arrangements with insurers so that you need not bother with filing claim forms at all.

Others have no such arrangements, and it is up to you to take care of the bills and file for your insurance benefits. If you are still ill when the bills start to come in, this task can be burdensome. If the company will pay benefits directly to the health care provider, ask how you will be notified that such payment has been made. This is important, since all too often the doctor's office will mistakenly continue to bill you for charges already paid by your insurance. You need evidence that the bill has been paid. The absence of such notification also will alert you that the company may not have paid the bill.

A related matter concerns claims procedure in the event that you require treatment out-of-state, or even outside of your "prevailing charge" area. **Ask the insurance representative how out-of-state claims will be evaluated.** Many insurance companies calculate premiums on the basis of actuarial estimates for a limited geographical area. Some of them will pay only the "prevailing charges" of your area even though the charges in the other area may be higher. In that event, **you can be left at substantial risk**. For example, if you reside in a rural or suburban area and are stricken with an illness that requires emergency surgery in a large metropolitan area, the difference in coverage from one "prevailing charge" area to the other could easily amount to hundreds, if not thousands, of dollars. This is a significant matter, because the incidence of illness among retired persons is statistically greater during holiday visits with relatives and friends than at other times. And you certainly want to be protected during those times.

What You Should Tell the Insurance People Before You Buy

It is unfortunate but true that all too many of the claims difficulties retired people have reported in the past were their own fault. Policyholders have **paid hundreds and hundreds of dollars in premiums only to have their claims legally denied by the insurance company when illness struck.** In most of these cases, **the claimants either gave false information or withheld pertinent information of which they had knowledge when they completed their applications for insurance.**

Open Enrollment Requirement

The new NAIC Medicare model legislation requires that new

Medicare subscribers be allowed a 6-month "open enrollment" period in which they cannot be denied Medicare Supplemental Insurance on account of their health status, previous claims history, or medical condition. Section 11 of the NAIC Model Standards provisions states: "No issuer of Medicare supplement policies in this state may deny or condition the issuance or effectiveness of any Medicare supplement policy available for sale in this state, nor may it discriminate in the pricing of such policy because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy is submitted during the six (6) month period beginning with the first month in which an individual (who is 65 years of age or older) first enrolled for benefits under Medicare Part B." Most states now have adopted such legislation.

Take advantage of this window of opportunity. If you don't, you may not be able to get the policy you want, may face a preexisting-condition limitation, may have to pay more for any given policy, or even run the risk of not being able to buy a policy at all. This point cannot be overemphasized—**once you sign up for Medicare Part B, make sure you don't let the six-month open-enrollment period for purchasing a Medicare supplement insurance policy pass by.**

Even with the open enrollment guarantee, the medical history that you will be required to submit when applying for a policy constitutes an integral part of the insurance contract. If that medical history can be demonstrated to have been willfully falsified, the insurance contract may not be legally binding.

It is therefore crucial that you complete the medical history form accurately. Do not be concerned about reporting illness that required hospitalization, surgery, or other treatment in the past. A person who reaches age 65 with no prior history of illness is the exception, not the rule.

Do not think that because you may not have to submit to a physical examination, your health history is not of consequence to the insurance company. It is. That is why the health history you complete becomes a part of the contract.

Even though you may sign a contract, pay premiums, and be

issued a policy, an incorrect health history could mean that you have absolutely no insurance.

Therefore, answer all questions regarding your health honestly and completely. This does not mean that you will be required to recall everything that happened to you in the past. But as a matter of contractual integrity, you are obliged to do the best you can. To do otherwise is to place yourself at enormous risk.

How Much Can You Afford?

You must expect to pay between about $1,000 and $2,000 annually (at present rates) for a Medicare supplemental insurance policy that provides adequate protection. For a couple, then, $2,000 to $4,000 per year. About 14 percent of the value of the Nation's output consists of medical services. Elderly health care costs are proportionally much greater than those of the general population.

In short, you ought to view this expense as a matter of necessity. There is no question that health insurance costs are high, but the risks of remaining underinsured are much higher. In the case of most retired couples with a financial stake to protect, the cost of an adequate policy will not mean the difference between comfort and deprivation. Moreover, it is not advisable to try to save a hundred dollars or so by automatically choosing the lowest-premium Medicare supplemental insurance policy. Rather, the insurance buyer's task is to find the best coverage at the best price within the affordable range.

VIII.

RANKING THE NAIC POLICIES BY COST AND RISK

DESPITE the "simplification" of medigap insurance through the NAIC's delineation of ten standard policies, there still is no easy way to determine which policy offers the best value for a particular individual. Of course, the task of comparing similar policies has been made immeasurably easier: other things being equal, for identical policies the one with the lowest premium is the best value. But that type of comparison does not address the problem of which options might be most valuable to individual consumers. Indeed, advice about the value of different coverage options often is vague and subjective. Although we know of no foolproof method for evaluating the relative values of the health insurance policies now on the market, we try here to provide a procedure that can be applied to virtually anyone's particular circumstance.

Many state insurance departments have booklets available to help you compare the NAIC supplemental policies. These usually include two or three pages of comparison worksheets for you to fill in policy options and compare prices. These guides advise you to "weigh each option carefully" and to "decide which is best for you." Unfortunately, they usually do not tell you how to weigh options or how to arrive at an informed decision regarding them. With little or no help, you are asked to compare different options whose value to you remains unknown. Here we try to be more specific.

There are two overriding concerns that ought to form the basis of any evaluation of health insurance. The first is risk. Since the purpose of health insurance is to reduce your financial risk, you must determine the extent to which any given policy would reduce your risk in the event of illness. **The second factor is cost.** How much would you have to pay for this protection? Stated simply, **the cost-risk principle demands that you elect insurance that provides the most protection against risk at the lowest cost.**

Fortunately, there is an uncomplicated statistical expression of this principle that allows you to compare the relative value of policies. For the purpose of evaluating health insurance policies, the index of comparison is called the "cost-risk index." It is arrived at in the following manner:

Cost-Risk Index = Cost x Risk

The lower the cost-risk index, the better the value. The higher the index, the worse the value.

Determining cost is usually quite simple; **cost is the annual premium on the policy**. Many insurance companies quote monthly, quarterly, or semiannual premiums in order to make the amount seem smaller and thus more affordable. These must be converted to an annual figure. If the premium is quoted as a monthly amount, multiply it by 12 to get the annual premium. If the premium is quoted as a quarterly premium, multiply it by 4. If semiannual, multiply by 2.

Determining risk is more complicated. **Determination of risk requires a risk design based on a hypothetical situation or situations.** In short, you assume the need for a certain type of care and then calculate how much protection a policy would not provide in the event of such need. **Your risk is taken as the amount you would still owe for such care after both Medicare and the supplemental policy had paid their benefits.** Use of the hypothetical case in risk evaluation is a relatively uncomplicated procedure. And even though calculating risk this way can be time-consuming, it is the most useful way.

Advantages of Multiple-Case Evaluation of Risk

Previous uses of hypothetical cases in the evaluation of Medicare supplemental insurance have relied mainly on a single-case risk design. That is, the determination of risk was based on only one hypothetical situation. Although a single-case design is of some value and is not very time-consuming to develop, a multiple-case risk design can be more useful.

Multiple-case risk designs incorporate both the strengths and weaknesses in coverage over a number of policy provisions. Single-case designs of necessity exclude one or more provisions from the determination of risk.

Further, multiple-case risk designs allow flexibility and weighting. You can accommodate average risks based on the reported experience of the Medicare population, infrequent but potentially catastrophic risks, and the likelihood of known risks based on your own health history.

In short, multiple-case designs can take into account a variety of potential risks, which single-case designs cannot. The fact is that there are a wide variety of potentially ruinous illnesses that require many different types of care — and hence insurance coverage.

The risk design shown below was determined after consultation with health care planners and with reference to the *Activity Reports* of the Commission on Professional and Hospital Activities. It incorporates both average risk experience and potential risk experience. In keeping with the health insurance principle, weight has been given to the potential risks. This design may be used as shown or adjusted to accommodate your own health situation:

Sample Risk Design

Case 1: Average Hospital Confinement
5-day hospitalization
Medical expense of $7,500

Case 2: Intermediate Hospital Confinement/
Intermediate Skilled Nursing Facility Confinement
21-day hospitalization
30-day skilled nursing facility confinement
Medical expense of $25,000

Case 3: Extended Hospital Confinement
100-day hospitalization
Medical expense of $85,000

Case 4: Extended Skilled Nursing Facility Confinement
16-day hospitalization
180-day skilled nursing facility confinement
Medical expense of $35,000

Case 5: Extended Hospital Confinement/
Extended Skilled Nursing Facility Confinement
180-day hospitalization
150-day skilled nursing facility confinement
Medical expense of $200,000

To determine the total risk associated with this risk design for each policy you are considering, ascertain probable daily hospital and skilled nursing facility costs for your locality (call the billing department of your hospital or local nursing facility and request

current daily charges) and then calculate what you would still owe after the insurance benefits had been paid for each case and then sum these five amounts. That is your total estimated financial risk.

It must be emphasized that this "Sample Risk Design" is based on a distribution of both **potential** and **average** risks. It has been constructed to accommodate a variety of hypothetical situations. However, it was figured without regard to **individual health experience, which can have a significant bearing on the value of a particular policy.** Of course, potential risks must always be accorded the greatest weight in the multiple-case evaluation of risk. And in the absence of prior knowledge of illness or the likelihood of illness, averages represent a statistical means of assessing intermediate risks. For persons whose health history indicates no particular risk, the sample risk design will provide an indication of how different policies compare in relation to average risk experience.

Your health history may suggest that your risks in some areas may be greater than in others. This knowledge should, and can, be incorporated into any risk design. If you are aware of an existing condition, or have parents and relatives who have been stricken with an illness requiring specific care, then you ought to use this knowledge to advantage. If, for example, you or members of your family are prone to illness requiring long-term care in a skilled nursing facility, then your design ought to include a hypothetical case to that effect. Or if you or members of your immediate family suffer from a chronic condition that requires regular physician visits and treatment, but not hospitalization or skilled nursing facility confinement, then your risk design ought to give more weight to that condition.

In short, **so long as you include potential risks in your risk design, then you can weight your evaluation according to the specific knowledge that you possess regarding your individual health risks.**

For the most part this is a matter of "fine tuning" and is not likely to affect greatly the rank order of policies. In cases where there is a close decision to be made, however, it may suggest the more attractive alternative.

Using the Cost-Risk Index

In order to compare the relative values of specific policies, calcu-

late the cost-risk index for each by multiplying the total risk as determined above by the annual premium amount.

The resulting cost-risk index rank (*i.e.*, the indexes listed by magnitude) must be interpreted with discretion. The rankings that you calculate ought **not to be taken as an "absolute" indication that one policy represents a "better value" than another**, or vice versa. Rather, the index rank provides you only with one statistical indication of how different policies may or may not represent value in view of your own needs and resources.

Such indexes and rankings do, however, serve as broad indicators of relative value. **A policy with a relatively low cost-risk index usually means that it is a good value.** Risk is by far the larger factor in the cost-risk formula, so that a low index nearly always indicates low risk. Low price and low risk determine good value. A policy with an intermediate index value might indicate any of several situations: 1) risk might be low, but price is high; 2) price might be low, but risk is relatively high; or 3) both price and risk are moderate.

A policy with a high index, however, usually indicates poor value. Either the risk is high, or the cost is high, or both. In general, the lower the cost-risk index, the better the value.

IX.

MEDICARE+CHOICE

THE Balanced Budget Act of 1997 expanded Medicare's health plan options with the creation of a parallel program called Medicare+Choice. In addition to the "original" Medicare and Medicare supplemental insurance plans, Medicare participants now, subject to availability, will be able to choose among a variety of qualified private market-based health care plans similar to those available to the nonMedicare population. The new options include managed care plans such as Health Maintenance Organizations (HMOs), HMOs with Point of Service (POS) option, Provider Sponsored Organizations (PSOs), and Preferred Provider Organizations (PPOs). Medicare+Choice also includes a variety of non managed care arrangements such as private fee-for-service (PFFS) plans, Medicare Medical Savings Account (MSA) plans, and the ability to contract privately with a doctor outside the Medicare system to provide Medicare-covered services.

Medicare+Choice Basics

Under what is now called the "original Medicare plan," Medicare pays doctors and other health care providers directly for each service a patient receives. Under Medicare+Choice health plans, Medicare pays a lump sum, called the capitation rate, to the plan administrator and the plan then manages the services you receive. In other words, the Medicare+Choice options are a shift toward a "defined contribution" plan and away from the original "defined benefit" plan.

To be eligible for the new Medicare health plans you must have both Medicare Parts A and B, and live in the health plan's service area. Unfortunately, few if any of the options may be available where you live. Where options are available, no matter which you choose, you are still in the Medicare program. Each Medicare+Choice plan must provide all Medicare-covered services, except hospice care. In addition, you retain the same rights and protections afforded under the original Medicare program.

Your choice of plans, however, will affect your costs, what extra benefits you receive (*e.g.*, prescription drugs) and how much choice you have among doctors, specialists, and hospitals (*i.e.*, quality and

access). Beware that any plan's benefits and costs are subject to change from year to year, and that Medicare health plans are free to terminate their contract with Medicare at any time.

Until 2002, you can enroll in any of the managed plans or a PFFS plan at any time. The plan cannot refuse to enroll you. You may also elect to disenroll for any reason from most Medicare health plans and return to the original Medicare plan or enroll in a different qualified plan. After 2002, Medicare beneficiaries can enroll and disenroll only during the first three months of the year, or the first three months of eligibility in a year in the case of newly eligible beneficiaries. Special rules apply for enrolling and disenrolling in a Medicare MSA.

If your Medicare+Choice plan coverage ends because your plan terminated its Medicare participation or stopped providing care in your area, you moved outside the plan's service area, or you left the plan because it failed to meet its contract obligations to you, you have the right to purchase medigap policies A, B, C, or F that are sold in your state as long as you apply within 63 days of losing your coverage. The insurance company cannot deny you the policy, place conditions on the policy such as a waiting period, apply a preexisting condition exclusion, or discriminate in the price of the policy based on your health status.

If you have a medigap policy and then drop it when you join a Medicare+Choice plan, you will be allowed to return to your original medigap policy if it is still available from the same insurance company. If it is not still available, you have the same rights to buy a medigap policy as you would if your coverage ended. You are guaranteed issuance of any of the 10 standardized medigap policies available if, when you first became eligible for Medicare at age 65, you enrolled in a Medicare+Choice plan and then disenrolled from that plan within 12 months of the effective date of your enrollment.

Should you voluntarily disenroll from a Medicare+Choice plan one year or more after joining and decide to return to the original Medicare plan and wish to purchase a medigap policy, you run the risk of being subjected to medical underwriting standards. The insurance company may deny your application, or impose policy restrictions and charge you more.

Medicare beneficiaries can choose to remain in the **original fee-for-service plan** run by the Federal Government. You pay the $45.50 Part B premium, Part A and Part B deductibles and any fees for services not fully covered by Medicare. You have access to any doctor that accepts Medicare and you receive the basic Part A and Part B services discussed in Chapter II. This choice entails significant financial risks because many medical expenses are not covered by Medicare; thus, our observations discussed in earlier chapters about Medicare supplemental insurance continue to apply.

The first group of Medicare+Choice options is to choose one of the various types of managed care—HMO, HMO with POS options, PPO, or PSO. Managed care combines the roles of insurer and health care provider. By eliminating the middlemen (*i.e.*, the insurance companies), managed care theoretically enhances efficiency and reduces costs. Under managed care, your out-of-pocket costs (what you must pay) are generally lower. Another advantage is that beneficiaries do not have to contend with burdensome paperwork.

Your choice of doctors and hospitals depends on the type of managed care plan. Members in an HMO or PSO must use the plan's doctors and hospitals. The plans must approve treatment and make referrals. PPOs and HMOs with POS options usually let you use doctors and hospitals outside the plan—albeit at extra out-of-pocket cost. Although the number of physicians in a managed care plan may be very large, the number accepting new patients may be quite small, and comprised mostly of relatively inexperienced practitioners. Finally, recognize that managed care suffers from an inherent conflict of interest; that is, it attempts to minimize costs and to maximize patient welfare at the same time. If the latter objective is subordinated to the former, patients may face serious health risks; inadequate attention placed on the former may jeopardize the plan's financial well-being.

Medicare Health Maintenance Organizations (HMOs) have existed for around 15 years, and our observations in Chapter V apply. The focus here will be on **HMOs with a Point of Service (POS)** option. Originally referred to as "open-ended HMOs," POS plans have been around since 1961. These plans combine features from both HMO and PPO (discussed below) plans. Members can

choose to use the HMO network or go outside the network each time they need care. If they choose to use the network, the care is coordinated by their primary care physicians.

From a purely financial standpoint, it is always in the member's best interest to use the network. However, from a health care standpoint, it may make sense to go outside the network for certain care. In this case, the member can go to the provider of his or her choice—*i.e.*, the primary care physician or so-called gatekeeper is not involved. Claims for out-of-network care are reimbursed after any applicable deductible and coinsurance provisions are met. A further complication is that non-network providers may not accept assignment of benefits or charge much more than the network's reimbursement levels.

POS plans are best suited for people who would generally stay within the HMO network for most of their routine care, but value the ability to go out-of-network in the event that a major illness strikes. In essence, the POS option would act as a (costly) safety valve.

Preferred Provider Organizations (PPOs), whose roots can be traced back to the early 1930s, try to lower costs without compromising quality. A PPO is made up of medical providers (hospitals and physicians) who agree to provide services at negotiated fees. Third party payers, such as insurance companies or large employers, are able to access the network to provide health care services for covered individuals. The PPO charges an access fee that varies with the services used. PPOs do not generally require members to choose a "gatekeeper."

Like HMO plans with POS option, PPOs are best suited to people that plan to stay "in-network" for most their health care services, but do not want to be permanently "locked-in" to a particular doctor or hospital or always find it necessary to obtain permission from a primary care physician to see a specialist.

The final type of Medicare+Choice coordinated care plan is a **Provider-Sponsored Organization (PSO)**. Under the new legislation, doctors and hospitals are allowed to form their own plans. Precisely the same considerations would seem to imply to these groups as to HMOs and PPOs. There is no experience with such organizations to date, but presumably a PSO would involve a somewhat (perhaps markedly) more limited network of care-givers than either HMOs or PPOs. If such groups do develop as relatively small local networks, it would seem crucial that enrollees be permitted to seek treatment outside the PSO like PPOs and HMOs with POS option. If not, patient choice could be severely limited.

A genuine departure from managed care arrangements is a **private fee-for-service (PFFS)** plan. A PFFS plan is health plan that is offered by a private insurance company to Medicare beneficiaries. Medicare pays a set amount of money every month to the private company to provide coverage to people with Medicare on a pay-per-visit arrangement.

A PFFS plan works somewhat like being in the original Medicare plan (run by the Government) and having a separate medigap policy. The similarity is that health care providers of the patients' choosing supply hospitalization and medical services on a fee-for-service. Here the similarity ends. Under the PFFS plan, the private insurer—not Medicare—decides how much to reimburse for the services you receive. You pay the monthly Part B premium; any additional monthly premium the PFFS plan charges above the Part B premium; any additional monthly premium the PFFS plan charges for extra benefits; and any plan deductible, coinsurance, or copayment amounts (which can differ from those under the original Medicare plan).

Although this option is touted as being a "revolutionary innovation" in Medicare, private fee-for-service plans have been around for many years. Very simply, these plans were widely available as the standard form of health insurance before the inception of Medicare. Experience then suggests that it yielded highly favorable results: i.e., coverage that could be tailored to the consumer's circumstances, wide patient choice, and market-directed pricing of health care goods and services. In short, it worked then and, if allowed to develop as the market dictates, could be expected to work once again.

Another genuine departure from Medicare's "managed care" arrangements is a test program called the **Medicare Medical Savings Account (MSA)** plan. A Medicare MSA plan has two parts: (1) a tax-free savings account, and (2) a health policy that has a high deductible (no more than $6,000 in 1999). Medicare pays the health policy premiums and deposits money into the savings account, which you use to pay your "qualifying" medical bills. Once you have met

the deductible, the health policy pays.

The total amount of money that Medicare puts into your medical savings account and pays for the health insurance component of the plan equals the same amount that Medicare would have spent if you had selected another Medicare+Choice option. Since the total amount Medicare pays is fixed, the higher the health policy premium of the MSA plan you choose is, the less Medicare will be able to deposit (in one lump sum at the beginning of the year) into your medical savings account and vice versa. In addition, a higher deductible would tend to reduce the health policy premiums and increase the amount deposited in your savings account. In all likelihood, the amount of money in your savings account would be less than the plan's deductible for the first few years. No one but Medicare can put money into your account, and you are not allowed to purchase other health insurance that would cover the policy's deductible. If you use all the money in your Medicare MSA before you reach the plan's deductible, the difference will have to be made up out-of-pocket. Another restriction is that medical expenses paid from your account cannot be deducted on your yearly income tax.

This provision, if it actually becomes available, has many advantages. Even though recent rulings prohibit account holders from depositing their own funds in an MSA, such a plan would permit elderly health care consumers to manage their own health-related finances to a much larger extent than other alternatives (with the exception of PFFS plans). Moreover, if the funds in a Medicare MSA were not required for medical expenses, they could be passed through the accountholder's estate or else be spent otherwise (subject to restrictions, penalties, or both).

Perhaps the largest long-term benefit of such an arrangement is that widespread participation in Medicare MSAs could vastly diminish the subsidy effect that for decades has propelled the spiral for Medicare-related goods and services (see the Appendix, "The Other Side of Public Health Care"). For the first time since Medicare's inception, under the MSA program patients themselves would have direct financial responsibility (*i.e.*, they would become primary payers) for the front-end costs of their care, and a significant incentive to measure their demand for health care against other needs and preferences.

Information on Options Available in Your Area

To help Medicare beneficiaries find out about existing Medicare health plan options available in their area, the Health Care Financing Administration (HCFA) designed an interactive data base called "Medicare Compare." The data base, updated quarterly, is available (along with other information concerning Medicare) on the internet at www.medicare.gov. Those without access to the internet at home or through a friend may find it worthwhile to visit their local library, community college, or senior center and ask for assistance in getting on the website. (You can also call 1-800-MEDICARE (1-800-633-4227) for more information about the various Medicare+Choice options and for local information on the Medicare health plans in your area.)

Once on the website, type in your zip code or click on your state and then county to call up the plans in your area. (Most, if not all of your Medicare+Choice options available will be HMOs.) Next, select a topic. You can choose to view "Costs and Benefits" or "Quality" information.

The "Cost and Benefits" topic allows you to compare the original Medicare plan and Medicare+Choice plans available in your service area. You can compare plans in three ways: (1) "Basic Information" (side-by-side comparison of basic plan information, cost, doctor and hospital choice, prescription drug benefits, and extra benefits); (2) "Detailed Information" for each plan covering 24 categories of benefits; and (3) "Specific Service" (side-by-side comparison of all plans by a service you select—*e.g.*, prescription drugs).

If you are mainly interested in any plan for its prescription drug benefit, realize that coverage caps, co-payments, and how the price of a drug is applied to the cap (ask the plan) will affect the value of the benefit. To determine the value of the drug benefit, first total how much all your drugs would cost to purchase for the year, then subtract the sum of the following items: the plan's co-payments, the uncovered cost (cost after co-payments less cap), and the annual plan premium. The larger this difference is, the greater the benefit of the drug coverage. Note that owing to the rising cost of pharmaceuticals, many plans are raising premiums, raising co-payments, lowering caps, only paying for drugs on an approved list (called the formulary), or some combination thereof.

In addition to costs and benefits, the website provides quality information on plans and providers. You may search under "Helping You Stay Healthy" (information about plans, such as plan members seen by a provider in the last year); "About Your Provider" (information about providers in the plans, such as the percentage of doctors and specialists who are Board certified, and the percentage of providers who have stayed in the plan at least one year); and "Beneficiary Satisfaction" (information about how beneficiaries rate their experiences in the plan). Unfortunately, much of the information is not available for many of the plans. Of course, obtaining as much information as possible about any plan you may consider joining is advisable—given the varied experience of different insurers and managed-care plans.

Information that is not available on the website—but is equally as important as costs, benefits, and quality—is the financial condition of the health plan insurers and managed-care organizations under consideration. Best's (908-439-2200), Standard and Poor's (212-438-7212), and Weiss Ratings (800-289-9222) all provide reports and ratings for HMOs. These may be available in the reference section of your local public or college library. Be wary of any newly organized managed-care plan, plans reporting losses (many currently are), and evidence of a mass exodus of doctors.

Outlook

At this time, depending on your geographic area, Medicare+Choice offers most persons little more than a Hobson's choice; that is, no choice at all other than conventional Medicare. In areas where choices do exist, the only available option is likely to be one or more Medicare HMOs. To date, the HCFA has not contracted with any PPO, PFFS, or Medicare MSA plans. It's too soon to know whether seniors will have a menu of genuine options beyond various managed-care arrangements—which at bottom must depend on the behavior of healthcare providers, insurers, and Medicare consumers themselves.

Private Contracts

Perhaps the most controversial provision under Medicare Part C as now legislated, this option presumably would permit Medicare enrollees to contract privately with physicians of their choosing en-

tirely independently of Medicare. Medicare would pay none of the physician's charges and it would be the responsibility of the patient to negotiate fees under such contracts unfettered by any price regulations. It is not clear at this time if such contracts would apply only to medical services, or what role Medicare might take in absorbing the costs of hospitalization under such a contractual arrangement. However, there has been much confusion in the outraged response to this provision in some dirigiste circles.

Prior to the Medicare+Choice legislation, Medicare patients had long obtained medical services outside the Medicare apparatus—for both Medicare-covered services and services not covered by Medicare. However, confusion arose as to whether "excess fee restrictions" imposed by federal and state law applied to Medicare-covered services delivered outside the Medicare program. The original intent of adding the private contracting option to the Medicare Part C legislation, according to the bill's sponsors, was to make it explicit that Medicare patients had the right to contract privately with a doctor of their choice for medical services for which no claim for payment is submitted to Medicare—regardless of whether the care was a Medicare-covered service or not. The logic was that patients had a right to contract privately for medical care services, and any restrictions regarding excess fees did not apply if Medicare wasn't billed.

The final Medicare Part C legislation did include a provision for private contracting between doctors and patients. However, a hitch—known as Section 4507—was attached to the bill with virtually no publicity or debate. Section 4507 prohibits Medicare patients from going outside Medicare for Medicare-covered services and paying for them out of pocket **unless the doctor who provides the services forswears any Medicare program involvement for at least 2 years.** Medicare patients are free to obtain *non-covered* services on their own if they choose to pay for the service themselves.

Section 4507 is supposed to prevent doctors from treating both Medicare patients and Medicare-eligible private patients at the same time. The fear, held by those opposed to patients being able to contract privately for Medicare-covered services, is that it would lead to a two-tiered system with private patients getting more and better medical care than their Medicare-pay counterparts. It was also as-

serted that under such private arrangements, there would be "no limit" to what a physician might charge a patient.

From an economic perspective, this argument reveals a profound ignorance of market processes. Rather than a two-tier system, what is more likely to develop is a no-tier system. For instance, a specialist who has opted out of Medicare because he or she contracts privately with Medicare-eligible patients may be willing but unable under Section 4507 to take on a Medicare-pay patient. In addition, as we have observed in relation to many other transactions, "for every seller there must be a buyer." The market for medical services is no exception, and in voluntary transactions the price of *anything* has a limit: namely, what the buyer is willing to pay. If market transactions actually revealed that the prices physicians were able to get for their services were "exorbitantly high," the forces of supply and demand soon would provide more doctors seeking those prices — and fees would collapse. If allowed to develop unfettered, a genuinely private medical services market almost surely would, *ceteris parabis*, see a slower rate of increase in medical costs.

What Should You Do?

The point is that not only Section 4507, but probably a number of the new Part C options will be challenged one way or another, if they ever actually are introduced. Already opponents of Medicare+Choice say that the new options will advantage "the rich" while "the poor" will be forced to accept second-class health care, and they vow to fight for its repeal.

Moreover, at this time no one knows what the specific terms of any Part C plans that come to market will be. Because they have little or no claims or loss experience, very often it is the newest products to reach the healthcare market that carry the highest costs to consumers (as with, say, long-term care policies when they first were introduced). On the other hand, sometimes "getting in on the ground floor" is the best way to save money. For the elderly healthcare consumer this situation is likely to further confound the task of finding the lowest-cost protection against the expense of illness and incapacity.

In these circumstances, it will pay elderly healthcare consumers to remain as flexible as possible. At present, the shortest-term renewable coverage with the shortest exit-notice terms would seem to be advantageous. Even currently available coverage and premiums could change markedly if a significant portion of current Medicare subscribers choose to enroll in one of the Medicare+Choice program plans (medigap policy premiums might even go down). But whatever options eventually reach the market, the underlying financial considerations discussed in the previous chapters will not change: *i.e.*, cover the major risks first—which means acquiring the most comprehensive tail-end coverage available, whoever the provider may be.

Part 3

LONG-TERM CARE OPTIONS

X.

LONG-TERM CARE INSURANCE

THE greatest nonmedical financial risk associated with aging is the cost of custodial nursing care. Considerable media attention has been focused on the development of insurance contracts for older Americans that promise to pay benefits for custodial nursing care as well as for skilled nursing care. *Money* featured an article titled "When A Nursing Home Becomes Your Poorhouse." That discussion advises that "you can cushion the cost [of nursing home care]—albeit at steep prices—with these new policies." Similarly, *U.S. News & World Report* reported that "the latest policies already offer a useful extra planning tool for many people and provide at least a partial solution to the harrowing costs of long-term care."

Many insurers have marketed nursing care indemnity policies in the past decade. Their literature understandably has directed attention toward potential risks. Insurance companies' promotional brochures stress statistics such as: "The costs of nursing home care today runs around $40,000 per year"; "Less than $6.00 out of every $100.00 spent on nursing home care will be paid by Medicare"; and "One-third of all patients nationwide who tried to pay for their own nursing home care became eligible for Medicaid within just one year of nursing home admission." The implication that a high proportion of older Americans are impoverished by nursing home costs, and that "useful" protection against long-term custodial nursing home expense now is available has predictably generated great interest among Medicare subscribers. However, despite the hype, market-penetration levels among consumers age 65 and older are currently between 5 and 7 percent.

Many of the early nursing home policies were very high-priced indemnity contracts that provided limited coverage far below that required for protection against the catastrophic costs of long-term custodial care. For annual premiums of between about $1,250 and $2,500 per year (at age 65), some nursing home indemnity contracts promised to pay daily benefits of $100 for a period of 3 to 5 years for a combination of skilled and custodial nursing facility and home health care. The premium costs rose to $1,700 to $3,200 per year at

age 70 and much higher at more advanced ages.

In many instances, the policy provisions—which in some respects resembled those of prior "special disease" insurance contracts that have been prohibited from sale in many states—effectively precluded payment of *any* benefits for custodial care. Moreover, the reported loss ratios of several companies offering nursing home indemnity policies were exceptionally low, suggesting that benefit returns did not justify the premium amounts collected.

In the past decade, however, some of the most objectionable features of earlier policies, such as those requiring prior hospitalization before admission to a nursing home or excluding coverage for nursing care required for Alzheimer's disease, have been eliminated from many nursing home insurance policies. However, policies sold earlier may retain clauses that make them practically worthless as "insurance" and if you hold one of those policies you should review its provisions and obtain modifications if necessary. Some states have adopted or are considering legislation that requires certain minimum requirements for long-term care insurance.

In this respect, in January 1991 the National Association of Insurance Commissioners (NAIC) revised its "model regulation" for long-term care insurance. Most states have now adopted this "model;" a review of its major provisions may help you to decide if a long-term care policy you are considering meets the requirements that are considered minimum by the insurance regulators.

According to the NAIC model, all long-term care insurance policies should provide at least the following:

- Definitions of terms used in the policy should be stated clearly in the policy itself. The terms that are specifically enumerated in the NAIC model are: "acute condition," "home health care services," "Medicare," "mental or nervous disorder," "skilled nursing care," "intermediate care," "personal care," "home care." In addition, a complete description of all providers of services, especially in relation to licensure or certification requirements or degree status must be included in the policy. A number of policies have failed to pay claims because the care provided did not meet the technical definition of "covered" care. For example, claims of holders of some policies that had prior hospi-

talization requirements were denied because the hospitalization did not meet the company's definition of "acute care"; other policyholders have had benefits withheld because the care provider was not licensed by the state, as required by the policy; still others have had their claims denied because the facility did not meet the company's criteria, which were not stated in the policy. In short, if *all* terms of the policy are not described clearly and completely, the insurance company may deny benefits for services that you thought were covered but that are disqualified by criteria that are not stated explicitly in the policy.

- All policies must be "guaranteed renewable" or "noncancellable." The "guaranteed renewable" feature should provide that you may continue the policy by timely payment of premiums and that the insurer cannot change the terms of the policy. However, *the insurer may change the premiums*, which could make the policy prohibitively expensive. The term "noncancellable," in contrast, should be used only when the insured has the right to continue the policy in force by timely payment of premiums and when *the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.*
- Limitations and exclusions of coverage may be permitted only in the following situations: preexisting conditions or diseases; mental or nervous disorders, excepting Alzheimer's Disease; alcoholism or drug addiction; illness or condition arising from war or act of war, participation in a felony, service in the armed forces, suicide, attempted suicide or self-inflicted injury, or aviation (applies only to non-fare-paying passengers); services provided in a Government facility and for which benefits are available under Medicare or other Government program; and geographical limitations for services (*i.e.*, for care outside the policyholder's area). Plainly, exclusions permitted under the NAIC model are numerous, and you should carefully review any exclusions that apply to any policy you are considering. For example, the geographical limitation alone may be significant if your children live outside the area—the policy might not cover care provided in a locale near to them. Be sure that the definitions of excluded coverage are specific and clearly understood. If you have any questions about what is or is not covered, ask the agent for a clarification *in writing*. If you decide to purchase

the policy, any such written documents should be kept with it.

- Group long-term care insurance should be convertible to individual long-term care insurance with comparable coverage for a period of 31 days following the discontinuation of group insurance to anyone continuously insured under the group policy for a period of 6 months.
- Any riders or endorsements that reduce benefits or coverage require signed acceptance by the insured individual.
- Any policy that pays benefits according to standards described as "usual and customary" or "reasonable and customary" must include a definition of such terms as a separate paragraph in the policy.
- No insurer may engage in "post-claims underwriting." Many complaints from policyholders relate to the insurance companies' practice of reviewing health histories only *after* a claim has been filed. If the history is found inadequate, the company may decide to deny the claim and refund the premiums paid into the policy. To prevent this, the NAIC requires that a number of provisions be added to the medical history application, among them: a listing of all medications that have been prescribed by a doctor (which would indicate a specific condition); a statement indicating that a false medical history may invalidate the policy; the requirement that insurers obtain either a report of the insured's physical examination, an assessment of functional capacity, an attending physician's statement, or copies of medical records; that the insurer accept such medical histories before or at the time the policy is issued; and that the insurer maintain a record of all policy or certificate recessions.
- No long-term care policy may require: prior nursing home or other nursing and/or therapeutic services before home health care benefits are paid; that home health care services must be provided by a registered nurse or licensed practical nurse; that the insured/claimant must have an acute condition before home health services are covered; and that services be provided by a Medicare-certified agency or provider.
- Insurers must offer to provide policyholders with the option to purchase "inflation protection." This option is very significant,

because the costs of long-term care are increasing faster than the rate of price inflation. Thus, the nominal benefits offered by a policy may be woefully inadequate to cover the actual costs of care when it is needed. Many policies now offer to increase benefits by 5 percent per year or some such amount. In fact, if price inflation accelerates, even this "protection" may be inadequate. *A provision that guarantees to pay a specified percentage of actual charges and has no dollar limit provides far better "inflation protection."*

- All individual long-term care policies must experience loss ratios of at least 60 percent. That is, 60 percent of premiums collected must be returned as benefits to insureds. In fact, the accounting procedures used to project loss ratios are extraordinarily complex and subject to manipulation. The loss experience with long-term care insurance has been minimal, and until there is an adequate record, any projections of loss ratios probably ought to be viewed as self-serving "guesstimates."
- Long-term care insurance sales representatives are prohibited from the following practices: "twisting" (making misleading representations); "high pressure tactics" (any method tending to induce the purchase of insurance through force, fright, threat, whether explicit or implicit); and "cold lead advertising" (marketing that fails to disclose that the purpose of the solicitation is to sell insurance). Of course, "prohibiting" insurance salespeople from engaging in such practices is the same as passing legislation that requires the leopard to change its spots. As in dealings with other sales personnel, do not be pressured into anything. If any insurance representative says you must "sign right away" or the policy will not be available, walk away. Consider purchasing a policy only after you have had the chance to review its provisions (in private and with the counsel of knowledgeable third parties) and to compare its costs and benefits with a number of other policies.

Note that the NAIC model standards do not prescribe the specific benefits that a long-term policy must offer. It may offer minimal benefits at very high cost. Thus, even a policy that claims to adhere to the NAIC model may not provide adequate coverage. Of the states that have adopted legislation establishing mini-

mum coverage for long-term care policies, New York has the most stringent requirements. Unless the policy you are considering has been approved for sale by the State of New York, you might be advised to avoid it (ask the sales representative, or better, call the New York State Insurance Department to determine whether or not the policy has been approved there).

The 1996 Health Insurance Portability and Accountability Act allows certain premiums for long-term care insurance to be deducted from taxable income. Your long-term care premiums can be added to your other deductible medical expenses and if all of your medical expenses are greater than 7.5% of your adjusted gross income, this will increase your itemized deductions. For premiums to be deductible, plans must be "qualified" by meeting federal standards. The benefits qualified long-term care policies are tax free. The premiums for nonqualified plans are not deductible, and the IRS has yet to rule on taxation of benefits from nonqualified policies. Consult a tax attorney or accountant for more specific advice on this tax issue.

For those interested, the NAIC's free booklet "A Shopper's Guide to Long-Term Care Insurance" is available on request from NAIC, 2301 McGee, Suite 800, Kansas City, Missouri 64108-2604, (816) 842-3600, website at www.naic.org.

"Low" Early-Retirement Premiums: An Advantage to Whom?

Insurance companies offering nursing home indemnity contracts have made much of the alleged "fact" that nursing home insurance probably will not be profitable to insurers, and premiums will not be affordable to most potential insurance buyers, unless the policies are purchased a number of years before there is a significant probability that nursing home care will be required. With this in mind, every insurer that has tested the market with a nursing home policy has made substantial effort to advertise the "advantage" to consumers of buying such a policy at, say, age 55 or 65, before annual premiums become prohibitively costly. (At more advanced ages, the policies that offer the most comprehensive benefits carry premium costs of about $5,000 to $10,000 per year, which presumably is beyond the means of many, and probably most, retired persons.)

However, in the great majority of instances, retired persons probably would be better off financially to invest the premium amounts

prudently in a personal investment account rather than make premium payments for years.

Take, for example, the costs and promised benefits of one representative policy. This nursing home insurance policy had a maximum benefit of $146,000 for 4 consecutive years of skilled and custodial nursing home care (it paid $100 a day). If purchased at age 65, the annual premium was $1,740 (maximum), presumably an affordable amount for many retireds. However, if purchased at age 75, the annual premium was $5,260 (maximum)—clearly beyond the financial means of many, if not most, septuagenarians.

It is very unlikely that the benefits received from such a policy purchased at age 65 would justify the cost to the buyer. Let us assume for the sake of example that some nursing home care becomes needed at age 85 (even though the chances of nursing home confinement then are only about 1 in 7 for men and 1 in 4 for women). Had the policy been purchased at age 65, as much as $34,800 would have been paid into the policy before it returned any benefit. If the same amount had been invested over that period of time, depending on the rate of return on the investment, by age 85 the total amount of accrued interest and principal might be, respectively, $59,600 (5 percent yield), $80,300 (7.5 percent), or even $110,100 or more (10 percent or higher). At present custodial nursing home rates, $110,100 will purchase about 3 years of custodial nursing home care. That is virtually as much "coverage" as is likely to be available from most nursing home policies that are now being sold.

In short, if you paid premiums for 20 years amounting to tens of thousands of dollars, at the end of that time there still would be only about 1 chance in 5 that you would receive *any* benefit (*assuming* that your illness required hospital and skilled nursing home confinements that satisfied the conditions for payment of benefits). On the other hand, if you had invested the same amounts in interest-bearing accounts or dividend-yielding securities, by the end of 20 years you would have a sizable fund to draw on, if needed. But, again, there would be only about a 20 percent chance that you would have to tap the fund. The much stronger probability would be that you would *not* need it and that it would pass to your heirs as part of your estate—or could be designated in a will by you for whatever purpose you might desire.

There is little justification for pouring thousands of dollars before retirement or early in retirement into a limited-coverage nursing home policy. Indeed, any "sales pitch" that exhorts the need for such a policy must ignore the obvious shortcomings of all such limited-coverage policies: namely, that if long-term nursing home care *were* required, say, beginning at age 66, according to the "coverage" provided by many of the policies now being sold, benefits would run out before even age 70. The "insured" would be faced with financial disaster in any event. Obviously, the insurance companies want your money as soon as they can get it—that is to *their advantage*. Giving it to them many years before benefits may be needed, however, will not protect you against financial catastrophe.

*Will You Need Nursing Home Care?**

Most of the literature sent out by insurance companies to promote their policies may exaggerate the probability that any individual will require long-term nursing home care. For example, a handsome brochure promoting one company's long-term care policy quotes an American Health Care Association spokesman as authority for the assertion that "Actuarial risk is nearly 1 out of 2 for an individual age 65 plus to require professional services of a nursing home." Regardless of the possible technical accuracy of such a statement ("professional services of a nursing home" can be very broadly interpreted), it is misleading. This statement may frighten some people into buying a policy, but far fewer elderly Americans ever are required to be confined in nursing homes for many years than the insurance salespeople would have you believe.

Long-term care insurance products have increased from a half dozen or so just a decade ago to literally hundreds today. New forms of nursing care coverage are being introduced almost daily; and, in the absence of any industry-wide agreement as to what are the actual

* Statistical Note: In the previous edition of this book, data in the following two sections came from extensive studies that were part of the 1985 National Nursing Home Survey, Series 13, No. 103 (March 1990), U.S. Department of Health and Human Services, National Center for Health Statistics (NCHS), Vital and Health Statistics. A more limited study of nursing homes was undertaken in 1995. The published data from that survey are as yet fragmentary, but the results available strongly suggest that the trends revealed by the 1985 survey have persisted.

risks to insurers and insureds, consumers today face a bewildering array of policy options and costs.

It is beyond the scope of this brief discussion to consider all the factors involved in this new market. However, inasmuch as current nursing care insurance sales efforts may be directed at those consumers who are least apt to require nursing care, it may be useful to review the characteristics of nursing home residents as reported in public and private sources.

Surveys of nursing home utilization by the Department of Health and Human Services' National Center for Health Statistics (NCHS) have generally been regarded as the most accurate measures to date of the long-term care risks of the elderly. From the perspective of healthcare policy makers, the most explosive statistics to come out of the NCHS studies are that about 2 in 5 persons over age 65 will require nursing home care at some time in their lives and that, on average, those now in nursing homes have been confined almost 3 years.* These statistics taken together have been cited by healthcare activists and insurance salespeople alike as evidence that the elderly face a very substantial risk of confinement in a nursing home for many years.

Such a conclusion is unwarranted. Even though as many as 40 percent of today's elderly *may* at some time require care in a nursing home, the overwhelming number of nursing home admissions result in short stays. An NCHS 1984-85 survey of discharges from nursing homes (not included in the 1995 survey), which includes "discharges" of dead patients, shows that more than half of all discharges (51.6 percent) were for stays of less than 3 months; and almost three-quarters of all discharged patients had been confined for under a year. Indeed, patients who had been confined for 3 years or longer represented only 10.9 percent of all discharges.†

What accounts for the seeming discrepancy between these two sets of data? The NCHS 1985 and 1995 surveys of nursing home residents are *population* censuses, nothing more. As with any census, they count only those who reside at a given place at the time the

* All citations of *residency* data are from the source cited in the table on page 105.
† See NCHS, Vital and Health Statistics, *Discharges From Nursing Homes: 1985 National Nursing Home Survey*, Series 13, No. 103 (March 1990).

census is taken. They say nothing about those who may have lived there previously or about those who will live there at some future time. The 1985 NCHS survey of nursing home discharges, on the other hand, is a rough record of the "flow" of patients over a specified time period, and includes the experience of short-stay patients. Although it is far from clear that the available discharge data are representative of the "average" nursing home experience of the elderly (if there is such a thing), they plainly indicate that the risks of long-term confinement have been far less than might be inferred from the NCHS surveys of nursing home residents.

The nursing home residency pattern may illustrate a phenomenon that is common to virtually any institution that has certain population limits. Stated simply, nursing homes tend to generate *populations* of long-term residents. The reason is uncomplicated, but an illustration may be helpful. Assume, for example, that a nursing home has 50 beds and that initially it admits patients with a wide range of clinical problems. Of those initial 50, 20 die within a few weeks of admission and 25 return home, leaving five still in residence and 45 beds available. Of the 45 "new" patients, 20 die and 20 go home—but five remain, enlarging the number of long-term residents to ten and leaving only 40 beds available. And so on, until most beds are occupied by long-term patients. Unless an institution specifically reserves a percentage of its beds for "transients," over time almost all beds in a given facility will become occupied by long-term patients. While the NCHS nursing home utilization surveys confirm this circumstance, they reveal nothing about the experiences of the vastly greater number of patients who were discharged after short stays, or about those who never were admitted to a nursing home at all.

This process is also characteristic of organizations as diverse as social or athletic clubs, which tend to become more exclusive because openings become available only as current members die; academic departments in colleges and universities that confer lifetime tenure, which become bloated with senior faculty; and prisons, which tend to become populated mainly with "lifers" as lesser felons serve out their time and are paroled while the incorrigibles remain incarcerated (which accounts for the fact that even though crime rates may not accelerate, prison "shortages" still occur).

SELECTED CHARACTERISTICS OF NURSING HOME RESIDENTS
(Percent of All Residents Over 65)

	1985			1995		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
65 - 74	6.1	10.0	16.1	6.7	10.7	17.5
75 - 84	10.6	28.0	38.6	10.4	32.0	42.3
85 +	8.5	36.8	45.3	7.6	32.6	40.2
Total	25.3	74.7	100.0	24.7	75.3	100.0
Married	7.1	5.5	12.7	9.2	7.4	16.6
Unmarried	18.1	69.2	87.3	15.6	67.9	83.4

Source: U.S. Department of Health and Human Services, National Center for Health Statistics, Vital and Health Statistics, *Nursing Home Utilization by Current Residents: United States, 1985*, Series 13: Data from the National Health Survey, No. 102, October 1989, DHHS Publication No. (PHS) 89-1763.

Who Needs Long-Term Care?

The nursing home *residency* data shown in the accompanying table are more useful for the light they shed on some key characteristics of those requiring long-term care. Even though nursing home insurance sales promotions often target married men, the data in the table suggest that this group represents only a small fraction of those receiving long-term care. Women over 65 far outnumber men over 65 in nursing homes, and unmarried patients outnumber married ones by an even greater margin (almost nine to one). The incidence of nursing home confinement for *unmarried* men over 65 is about twice the incidence for married men over 65, but the former are outnumbered by unmarried women four to one. Indeed, at more than two-thirds of the over 65 nursing home population, single women constitute by far the largest category of long-term care patients.

The likelihood that either spouse will require long-term care during the early years of retirement is very slight. In 1995, only 1.3 percent of men and women aged 65-74 years were confined in a nursing home. Among *married* persons aged 65-74 nursing home residency rates are minuscule: around 0.25% of the population in that age group.

The chances that nursing home care will be needed increase markedly with age. Of those aged 75-84 years, about 3.3 percent of the men and 6.5 percent of the women were receiving long-term care. However, nursing home residency jumps sharply among those 85

years and older. Of those elderly, about 1 in 10 men and 1 in 6 women resided in nursing homes in 1995. *However, the elderly 85 years and older now in nursing homes represent a much smaller fraction of the original population. Male nursing home residents 85 years or older in 1995 constituted only about 1.1 percent, and women residents 85 and older only about 3.5 percent, of the population over age 65 twenty years earlier.*

Moreover, the medical data suggest that mental condition may now be a key factor, if not the key factor, in a majority of nursing home admissions. According to the 1985 survey, nursing home patients suffered from a variety of physical ills that are listed as the "primary diagnosis." However, even the most common of these diagnoses, heart disease and cerebrovascular disease, were represented by only 17.4 percent and 10.8 percent, respectively, of all nursing home residents.

Mental deterioration, on the other hand, was a far more prevalent condition: "Overall, 66 percent of all nursing home residents were reported to have at least one of the following conditions: mental retardation, alcohol abuse or dependence, drug abuse or dependence, senile dementia or chronic and organic brain syndrome, depressive disorders, schizophrenia, other psychoses, anxiety disorders, personality or character disorders, or other mental disorders." Of the two-thirds of residents who were mentally impaired, the vast majority (87 percent) when interviewed were found "to have one or more behavioral problems: disrobing or exposing oneself, screaming, being physically abusive to self or others, stealing, getting lost or wandering into unacceptable places, or inability to avoid simple dangers... underscoring the increasing role of nursing homes in caring for the chronically mentally ill.... Cognitive impairment and behavioral problems have been cited as reasons for nursing home admission."

In short, the characteristics of current long-term nursing home residents tend to be far more specific than might be implied by popular discussions of the "long-term care crisis." Many of the elderly may have one or more physical conditions that prevent them from being totally independent. But this does not necessarily mean that they all will end up in nursing homes. A spouse, family relations, friends, or a variety of home care services for seniors often can

provide the required help. In these circumstances, most older people with disabilities apparently can manage in a noninstitutional setting, provided they have use of their mental faculties. This experience applies especially to elderly married men, who on average can be expected to die before their spouses (men have shorter life expectancies than women and in most marriages the wife is younger than the husband).

In contrast, most nursing home admissions that result in long-term stays are those of aged single men and women (mostly women) without family or friends to care for them, usually because mental impairment and associated behavioral problems have made them dangerous to themselves or difficult to care for.

Nursing Homes In Perspective

The nursing home is a relatively modern creation that evolved mainly as a result of two concurrent developments: the advent of modern antibiotics, which increased life expectancies markedly, and increased "middle-class" affluence that followed World War II. Prior to that time, care for the elderly infirm usually was provided either through family arrangements or through numerous voluntary organizations, charities, and churches that sponsored "old folks homes." In most cases, the burden of such care probably was less than might be imagined today. Regardless of who was caring for them, most elderly people who subsequently contracted serious illnesses—pneumonia or some other infectious disease—died, and the care giver was relieved of further responsibility.

The mass market for care of the elderly in nursing homes *per se* evolved during the 1950s under specific circumstances that mirrored, among other things, the state of medical technology at that time, the relative affordability of nursing home care, and an absence of other "support services" for the elderly. Perhaps most significant from the point of view of family members who would otherwise be required to provide care, medical technology had fostered greatly lengthened periods of elder dependency: the new drugs kept people alive, but often in physical circumstances that did not permit them to live independently. A parent might recover from a serious illness and require more care than ever. Without other services available, the nursing home provided an efficient solution.

Only in recent decades have medical procedures (artificial joints, bypass surgery, organ transplants, drug therapy, eye surgery, and the like) routinely enabled many older people whose conditions formerly would have made them nursing home candidates to continue to "manage" their own lives. With increasing availability of home care services, a primary concern of many elderly with disabilities may not be how long they will be confined in a nursing home, but rather how best to manage the many other services that are available to them. In any event, the period of absolute dependency, when institutionalization may be necessary, seems very likely to shrink—possibly dramatically.

Unless the number of new beds increases markedly, the demographic factors discussed above in themselves may increasingly limit the availability of *long-term* nursing home space to those with the greatest dependencies (mostly the chronically mentally ill). Nursing homes may in effect become surrogate mental institutions—a process that to some extent probably already has been accelerated by the deinstitutionalization of mental patients—and long-term care for other elderly routinely provided by other means.

In short, the market for nursing home care is not immune to change. Rather, the pace of change in medicine and support services virtually guarantees that things will *not* stay as they are. It remains to be seen if consumer demand for nursing home care already may have peaked. But, given the uncertainties, a narrowly written nursing home insurance policy that promises to pay benefits only far in the future would seem to offer little comfort. Most people probably would be better off to invest their funds to be used when needed according to the best option then available.

In any event, the "Catch 22" with respect to obtaining adequate nursing home insurance is that high-risk persons are precisely the ones insurance companies seek to screen out during the application process. If you are in a high-risk category that would justify an "investment" in a long-term care policy, you may not be able to obtain one.

Limited-Benefit Indemnity Contracts

Nursing home policies are heavily weighted in favor of the insurer. There are very significant differences in the implications for

an insurer's loss risk involved in screening against "bad risks" for different kinds of insurance. A comparison of some of the actuarial factors applying to whole-life insurance contracts and nursing home indemnity policies may suggest the extent to which the limited-benefit indemnity contracts now being billed as nursing home insurance could be a potential windfall for some insurers.

Consider one inescapable fact: everyone dies. The actuarial tables that insurance companies use to establish the premium and benefit levels of whole-life insurance contracts reflect that fact. The selection process involved in the sale of life insurance is designed to assure that policies are issued to average or better-than-average risks, or if they are issued to bad risks, that premiums are adjusted upward accordingly. But in any case, the life insurer must accept the strong likelihood that, if the policy is kept in force, there will be a payout on that policy—because the insured dies and the death benefit must be paid or because the policy "matures" at some date and the company is responsible to the beneficiary for its "surrender value."

By contrast, nursing home indemnity contracts provide insurers with far greater opportunities to exclude bad risks. As far as possible they will try to issue only contracts for which the likelihood is high that no benefits ever will be paid out. To repeat, unlike the life insurance situation where everyone either dies or receives a payment for the investment portion of the policy, the odds are very high that an individual aged 65 will *not* require lengthy nursing home care of any kind during the remainder of his or her lifetime and will receive no benefits whatsoever from a limited-benefit indemnity contract. Nursing home indemnity contracts do not accrue to some surrender value, as does whole-life insurance. Moreover, unlike most health insurance contracts, which have "open-ended benefits" that generally are not limited to any dollar amount, nursing home indemnity policies promise to pay only a fixed amount that in many cases could fall far short of actual costs of care.

Viewed from the perspective of other types of limited-coverage policies still being sold, nursing home indemnity policies would seem to combine the worst features of the hospital indemnity and "special disease" contracts. Like the hospital indemnity policies, most nursing home contracts would pay only a portion of actual costs for a specified period of time. Since every policy on the market

today is "closed-ended," you simply cannot obtain adequate protection against any genuinely catastrophic expense of long-term nursing home care.

Like the "special disease" indemnity policies, most nursing home indemnity contracts still have conditions and exclusions that could significantly restrict the number of instances where benefits would pay for custodial nursing home care, which is the type of care most of those who do enter nursing facilities require. Some policies still promise to pay benefits for custodial nursing home care only after a period of skilled nursing home care. But most custodial care patients do *not* require skilled nursing home care before they are confined to custodial care facilities.

Virtually all nursing home indemnity policies have "Pre-Existing Condition Limitations" that withhold benefit payments for 6 months or a year after the policy becomes effective for care required for any preexisting condition. This limitation is especially significant since the fine print in a number of policies describes preexisting condition so broadly that benefits might be denied in many instances. For example, one policy describes a preexisting condition as "the existence of symptoms, within one year preceding your policy effective date, which would cause an ordinarily prudent person to seek diagnosis, care or treatment." In the hands of a clever company lawyer, such a statement in a policy instrument signed by the "insured" is, in effect, a license to steal.

Although an insurer might not abuse such "loopholes," similar clauses in many "cancer insurance" and earlier "Medigap" policies (and their abuse by unscrupulous insurers) provoked numerous investigations of the practices of insurance companies and led to the prohibition of such policies in many states.

The Outlook for Reform

A decade ago we predicted that nursing home insurance as it then was being marketed could well become the subject of investigation by insurance regulators and consumer advocates. Since that time, numerous complaints of "scare tactics, high-pressure sales, improper replacement and overselling" have given rise to demands for greater oversight of sales practices for such policies. Some states now have enacted laws establishing minimum requirements for long-term care

policies.

Industry officials claim that low market-penetration levels reflect seniors' misperception of their level of long-term care coverage. In other words, the elderly believe, should they ever need long-term care, they're covered through their health insurance or by Social Security, Medicare, or Medicaid. Industry leaders think what is needed is a consumer awareness ad campaign. However, just as important a point is that long-term care insurance—as currently marketed—remains confusing. The cost of long-term care policies varies greatly, and it is often unclear why. In addition, consumers must struggle to understand and be able to compare how benefits are paid, what services are covered, where services are covered, what is not covered, when and why benefits are triggered, and so forth. Although the policies may be less deceptive, they remain very confusing.

A More Promising Approach

From both the buyer's and the insurer's points of view, a major problem with existing nursing home insurance contracts is that they rely on actuarial "models" for which no reliable data exist. In a thoughtful study of the nursing home insurance problem, Max E. Lemberger has proposed that long-term care insurance be fashioned after a type of insurance that has long been marketed with favorable results for both insurers and insureds—namely, long-term disability insurance, which is, after all, what custodial nursing home insurance amounts to. He writes: "The long-term care products developed by the industry to date—all suffer from a common problem—one that originates in the model we have used to underwrite these policies. LTC insurance has been built on a major medical model, so the products resemble the old-fashioned hospital indemnity products that paid a specified amount for each day in the hospital.

"This model, however, has serious limitations when used for long-term care insurance, which can better be insured using a disability model.

"Taking this disability concept and moving to the over-65 market of retirees,... coverage would provide economic restoration associated with the loss of functional abilities."*

* See Max E. Lemberger, "A New Deal for Long-Term Care," *Best's Review*, October 1987, pp. 50-54.

Lemberger proposes that future long-term care policies ought to be designed to cover a wide range of risks that embrace not only the possible need for nursing home care (of whatever variety), but also the various degrees of "disability" that result from aging. His point is that the "risk pool" must be broadened very substantially if such insurance is to be made affordable to most persons, and coverage must provide protection against a much broader range of losses for a longer period of one's life.

This approach would seem to offer an alternative to a situation in which the pool of high-risk insureds is relatively small, the insurers' loss experiences virtually are nonexistent, and premiums are arbitrarily (if not abusively) priced. The life insurance industry has developed new "long-term care" life insurance products that have expanded the risk pool, and so lowered premium costs for insureds. We can only hope they will be allowed to develop in a market environment.

Long-Term Care (Living Benefits) Life Insurance

A growing number of insurers now offer policyholders the option of taking their death benefits *before* they die. This innovation was introduced in the United States several years ago in response to AIDS patients seeking additional financial resources to help cover medical costs. Since then, this provision has been expanded to cover most terminal illnesses and many catastrophic illnesses as well. The option is available in new policies or as a rider to existing ones.

The logic behind offering "living benefits" is simple. The insurance company eventually will have to pay death benefits to a terminally ill policyholder's beneficiary, and it makes little difference whether they pay it slightly sooner rather than later. The cost to the insurer of doing so is minimal, representing only the potential interest earnings lost on the benefit when it is paid out, say, a year earlier. Insurers can make up this cost by paying a "living benefit" that is somewhat less than the face value of the policy. The attraction for the insured is that accelerated benefits (as they also are called) can help defray medical costs and reduce the financial upheaval that can follow even an expected death. Moreover, the insured could conceivably use the funds to finance lifesaving medical treatment.

The most conservative policies provide early death benefits only

in the case of terminal illness. The living benefit is a percentage of the face value of the policy, typically ranging from 50 to 80 percent. Some insurers also offer accelerated benefits to cover long-term care or confinement in a nursing home, regardless of whether the patient is terminally ill. In these cases, the insured may be allowed to choose a monthly benefit rather than a lump sum. The monthly benefit is usually a percentage of the face value. For example, a $150,000 policy might pay 2 percent of the face value, or $3,000, per month. In other words, the benefit is a fixed amount that does not vary with the actual costs of care. (In this respect, the living benefit is similar to a hospital indemnity policy.) Whether the insured chooses a lump sum or monthly benefits, he can elect the living benefits option only once, and the consent of the beneficiary may be required.

There are as yet no industry standards with respect to the specifications of accelerated payment policies. Policy provisions vary widely among companies. For example, some pay long-term "catastrophic" benefits only after the insured has been confined to a nursing home for 3 or even 6 months. Others pay these monthly benefits only if the insured is hospitalized prior to confinement in a nursing home (most nursing home residents do not require hospitalization). Others restrict the types of illnesses that qualify for benefits. The broadest coverage includes heart disease, life-threatening cancer, stroke, Alzheimer's disease, kidney failure, and liver failure. Most cover any illness that leaves the insured with a life expectancy of 12 months or less (although even this provision may vary among policies). Any diagnosis requires verification by a doctor. In addition to differences in coverage, the percentage of the face value paid in advance also varies from company to company.

Since living benefits policies were introduced fairly recently there are many questions about them yet to be answered. For example, it is not clear whether they provide life or health insurance. The most conservative policies, those that pay reduced death benefits only in the case of terminal illness, are very similar to traditional life insurance policies. The more comprehensive policies, covering nursing home care for an indefinite period, are closer to being medical insurance.

The Health Insurance Portability and Accountability Act of 1996 eliminates the income tax on certain advanced payments of life in-

surance, including accelerated death benefits under a standard life insurance policy. For payments to avoid taxation, a chronically ill person must be certified by a licensed health care practitioner to be unable to perform at least two of six daily living activities for at least 90 days. Those six activities are eating, toileting, transferring, bathing, dressing, and continence. Persons that need to be supervised to protect their personal health or safety (*e.g.*, Alzheimer's patients) also fall under the standard.

Accelerated benefit payments are only treated as tax-free if they are paid under a rider or other contractual agreement as they would be under a long-term care insurance policy. The payments are not tax-free if an insured's long-term care is already being paid for by long-term care insurance or Medicaid. Tax-free payments are capped under the same standard regarding long-term care payments (currently $190 per day or $69,350 if received for the full year). Benefits received that exceed the cap are taxable as income, unless those benefits go to pay for qualified long-term care services.

Older people who might otherwise let their life insurance lapse (say, because their children have grown) might instead choose to keep it in force in order to take advantage of the tax-free availability of accelerated benefit payments. The cost of this simple rider is minimal, and some companies provide it at no extra premium charge. However, living benefits are not costless. **The death benefit, the cash value, and the loan value of the policy all will be reduced if the insured takes advantage of the early benefits option.**

Individuals lacking adequate health insurance could also benefit from accelerated benefits. The benefits could finance medical care that might otherwise be unaffordable. However, it should be remembered that insurers have almost no experience with living benefits policies. Their costs could turn out to be higher than expected (*e.g.*, if monthly benefits to nursing home residents continue longer than expected). In that event, companies would likely restrict their "medical" coverage and adjust their premiums and benefits. In view of the uncertainty over how well these policies will perform in the future, potential buyers should be wary of contracts that promise overly generous benefits. Cash-value contracts that offer exceptionally generous living benefits "at no extra charge" also should be examined closely—hidden costs may be built into the policy in the form of

higher mortality expenses, a slower build up of cash value, etc.

Further, a number of questions remain as to the actual protection that such policies might provide under current circumstances. In this respect, there are three major drawbacks to virtually all such policies:

1) Currently, the wording of all policies that we have seen contains "weasel words" that give insurers a strong edge in claims disputes. This is understandable, since the insurers themselves admit that they have no idea of what their actual loss experience is apt to be. Consumers, therefore, may have far less protection than they think.

2) No LTC or "living benefit" rider that applies to standard life insurance, which has a death benefit stated as a nominal face amount, can protect the insured against the ravages of price inflation. You might purchase such a policy now, only to find that the nominal amount of coverage offered is totally inadequate to meet actual long-term care expenses even just a few years from now.

3) Most important, no one knows what the Government will do. If initiatives to expand Medicare or other Federal insurance programs to include long-term care succeed, then funds invested now to cover long-term care could be wasted.

In short, life insurance that provides for long-term care would seem to be a useful approach in a private market environment. However, it could be a waste of money in a socialized insurance market. We long have advised that term life insurance rather than whole life insurance is generally a better buy in a volatile financial world. In our view, the currently available long-term care riders to whole life policies do not change the situation; it would be prudent for younger insurance buyers to await further developments before they commit themselves to costly and perhaps useless insurance.

XI.

LONG-TERM CARE ALTERNATIVES: CONTINUING CARE RETIREMENT COMMUNITIES AND HOME HEALTH/ELDER CARE

PRESUMABLY, the overwhelming majority of us would rather spend our declining years in home surroundings of our own choosing rather than in an institutionalized setting that is forced on us. As discussed in the preceding chapter, the possibility that you will end up residing many years in a nursing home actually is quite small. Statistically, the vast majority of elderly Americans live out their lives outside of nursing facilities in their own or in family members' homes.

However, this aggregate experience should not be taken to indicate that many older people will not at some point in their lives require assistance, perhaps substantial assistance, with their living arrangements, or decide to move to more convenient homes. Fortunately, today there are a variety of alternatives for long-term care that for many people may largely obviate the need for any extended stay in a nursing facility. In this chapter, we discuss two options—Continuing Care (Life-Care) Retirement Communities and Home Health and Elder Care—that have become widely used alternatives to conventional nursing home care.

Continuing Care Retirement Communities

Continuing Care contracts, sometimes called Life Care contracts, are offered by more than 900 Continuing Care Retirement Communities (CCRCs) throughout the United States. In brief, a Continuing Care Retirement Community is one that guarantees living accommodations *and* health care services, including custodial nursing care if needed, for life. **Residents of CCRCs still must have Medicare and supplemental insurance coverage, since CCRCs do not pay for medical bills**. Rather, they guarantee to provide long-term care nursing facilities, usually for life, as part of the Continuing Care contract. The physical accommodations in different CCRCs vary widely—from luxury apartments or bungalows to modest studios—as do the communities' related amenities. Some have auditoriums, tennis courts and swimming pools, elaborate recreation centers, libraries, shopping facilities, movie theaters, and the like on the pre-

mises. Often, planned outings and other activities are an integral part of CCRC life.

A principal advantage of CCRCs is that they guarantee to provide the level of care that is required throughout your life and insure that both you and your spouse can live without the worry of not knowing "what comes next." Couples who join life-care communities know what facilities they will occupy if they become unable to manage for themselves. And they have the comfort and convenience of being able to continue to "live together" in the community even though one spouse may require full-time nursing care.

In fact, the vast majority of CCRC residents move into such communities some years before they require nursing care (average age at entrance is about 75 years). Typically, a couple will live in their apartment or bungalow some years before one of them needs nursing care. When that time comes, nursing facilities usually are available on the premises and the non-institutionalized spouse may remain in the apartment. Often, nursing care arrangements proceed flexibly—for example, with daily or weekend visits "home." Or if the need for nursing care ceases, say, after convalescence from surgery or an illness, the patient simply returns to his or her apartment (unless the institutionalization of a surviving spouse is terminal).

Typically, the CCRC will provide the care that is needed in the setting that is appropriate for that level of assistance. The staff may prepare meals (available for home delivery or in a common dining room), provide housekeeping services, and offer custodial or nursing care on a regular basis while you continue to live in an independent setting.

CCRCs probably are not for everyone. Even though they permit independent living for as long as possible, most such communities cannot avoid an "institutional atmosphere." To some extent, this is intentional—and may be in the interest of most residents. Although residents are free to do as they wish, they are encouraged to participate in community activities as a means of enriching their lives. For many older people, this is a desirable feature, while for others it may not be.

The genuine drawbacks of CCRCs may be more obvious. For one, they are relatively expensive. The initial "entrance fee" varies, de-

pending on the type of living unit and the CCRC. Currently, entrance fees for a studio or "alcove" apartment (*i.e.*, one room with kitchen and bath) at the least-costly CCRCs range between about $45,000 - $50,000. At the "top-end" of the scale, the entrance fee for a luxury 2-bedroom suite at a high-cost CCRC may be $250,000 or more.

The entrance fee usually is a lump-sum payment that you are required to make on signing the Continuing Care contract. The entrance-fee refund policies of different communities vary depending on how you leave the community (before the contract expires, on death, or after the contract ends). In some communities, there is a fully refundable entrance fee; others refund a percentage of the fees (as much as 90 percent) regardless of when or how you leave; in others the amount of the refund decreases the longer you stay (an amortized refund); and in others the entrance fee is a nonrefundable "gift."

In addition to the entrance fee, there is a monthly fee, which may range anywhere from about $450 per month for a low cost CCRC in Oklahoma to about $4,000 per month for a high-cost CCRC in California. In short, in addition to the entrance fee, current CCRC residents can expect to pay from around $5,000 to $50,000 per year in monthly maintenance charges. For most residents, monthly fees fall between these extremes—from $1,250 to $2,500, or between $15,000 and $30,000 per year.

Both the entrance fee and the monthly maintenance fee will vary depending on the type of contract for services you sign. The more services that are provided in the contract, the more costly it will be. In general, Continuing Care contracts fall into one of three categories, described below.

1) **All-Inclusive Plans**. All-inclusive plans provide that for the payment of the entrance fee and monthly fee, you will receive all the services, as needed, that are provided by the CCRC. *Residential services* usually include apartment cleaning and maintenance, dining room service, flat linen laundry service, grounds maintenance, kitchen appliances, personal laundry facilities, dietetic services, use of scheduled transportation by the community, storage, tray service, if needed, and utilities. *Health-related services* usually include an emergency call system, home health care (in your apartment), long-term nursing care, recreational therapy, and social services. With

these plans, your total costs are predictable. The major exception is possible inflation-adjustments to the monthly fee, which in all likelihood will be substantial, unless the contract provides for no such adjustments.

2) **Modified Plans**. Modified plans usually provide some of the residential services listed above, but require an additional fee for other services. They also provide only a *specified amount* of long-term nursing care. If that amount is exceeded, an additional charge is levied. Home health care usually is not included in modified plans and additional charges are added for it.

3) **Fee-for-Service Plans**. This type of plan usually provides an independent living unit, limited residential services, and guarantees *access to* nursing care. It does not, however, pay for nursing care. Residents must pay full per diem charges for nursing care, when required. Total costs under fee-for-service plans are least predictable.

Perhaps the chief difficulty with CCRCs is that, in the broadest sense, you have little flexibility to alter arrangements once you have moved in. Few people want or, if they have poured most of their funds into a CCRC, are able to change residences late in life. For many people, once they have committed funds to a facility they share its fate. If its finances go downhill and the food service suddenly starts serving "mystery meals" 7 days a week, the attendants are less-attentive than when you entered the community, or the buildings and grounds, security arrangements, etc., begin to deteriorate, you may be stuck. This situation differs from services that you purchase independently. Those you can change if they are not doing a satisfactory job.

What You See Now Is Not What You May Get Later

Any CCRC facility's greatest costs are apt to occur when the residential population matures and requires more services. Thus it may not be prudent to enter a "new" CCRC, with a large population of relatively young healthy adults—no matter how appealing it may be now. It is this type of facility that is least tested, and could deteriorate dramatically as the fit become unfit. In this respect, the safest facility (in terms of the quality of services it is likely to provide in the future) is one that has a "mature" population. If the facility is

handling the needs of those people well, and its finances remain sound, then it probably is a good bet.

Thus, it pays to "shop around" for a CCRC. The best way to determine if a facility is well-managed is to visit it. Talk to the current residents. Are they satisfied with the services provided? Is the food good? Has there been any deterioration in the physical facilities or in the "extras" that the CCRC provides? Most important, obtain copies of the organization's financial statements and review them with your accountant. If they are unsatisfactory or leave unanswered questions, look elsewhere. Finally, buy only a Continuing Care contract that offers a substantial refund at *any* time during the contract's life.

If you are interested in learning more about Continuing Care Retirement Communities, you should obtain a number of separate publications. Most state insurance departments, listed in Chapter VII, have published free guides to Continuing Care Retirement Communities. You should also send for a copy of "The Continuing Care Retirement Community; A Guidebook for Consumers," and "Consumer Directory of Continuing Care Retirement Communities," both available from the American Association of Homes and Services for the Aging (AAHSA), 901 E Street NW, Suite 500, Washington, D.C. 20004-2011, 202-783-2242, www.aahsa.org. The Continuing Care Accreditation Commission (CCAC) establishes standards for CCRC quality and provides consumers with information and a list of CCAC accredited communities. Contact the Continuing Care Accreditation Commission (CCAC), 901 E St. NW, Suite 500, Washington DC 20004; 202-783-7286; www.ccaconline.org.

After you have determined costs and living conditions of a number of CCRCs, you will be in a better position to compare those costs and services with the costs of services that might be obtained elsewhere and that would permit you and your spouse to continue to live in a noninstitutional setting—namely, your own home. **In any event, if you think a CCRC may be right for you, start looking early. The waiting lists for entrance into the most desirable communities may be as long as 10 years.**

Home Health/Elder Care

Presumably, the vast majority of elderly people would prefer to

remain at home even though they may require assistance of some form—housekeeping services, personal services, health care, or whatever. In fact, many of the services that are provided by nursing homes now are available on a home-care basis from independent contractors. Some services are covered by Medicare or Medicaid and many operate on a nonprofit basis or are subsidized by local agencies for the aging. Some are provided free of charge.

A wide variety of home-health care and elder care services are now available in most metropolitan communities. Health care services include home skilled nursing care, custodial nursing care, home therapy and clinical testing services (*e.g.*, routine blood tests can be performed by a health care technician in your own home, saving a trip to the doctor's office or clinic). In addition, many local elder care agencies provide low cost or free transportation for senior citizens, volunteer housekeeping services, live-in companion referrals, "meals on wheels" food services, shopping services, and the like. And today, so-called "life-call" communications services are widely available to homebound seniors for a relatively modest fee.

Your Own "Life-Care" Home?

In short, especially in view of the Medicaid exemption of assets held in the home, it may be possible for many elderly persons to create their own "life-care" home by altering the structure physically as may be required to accommodate walkers or wheelchairs—or adding a "companion's quarters"—and utilizing the many home-health and elder care services now available. Of course, this requires planning ahead and the expenditure of resources. But if a comparison of costs and benefits of home care with the major alternatives (*i.e.*, nursing homes and continuing care retirement communities) reveals substantial potential savings, you may be better off to consider a home-care plan of your own design.

It would be impossible in a publication of this scope to describe all of the services, and their costs, available in each locality in the United States. Your local Yellow Pages may contain listings under "Home Health Services" and "Senior Citizens' Service Organizations" that can direct you to local care providers. The accompanying "Directory of State Aging and Adult Protective Service Agencies" lists offices that can provide you with further information. In addition to the offices listed there, the location and telephone number of

the National Association of Area Agencies on Aging (or "N4A") affiliate nearest you can be obtained by calling the toll-free telephone number for NAAAA's Eldercare Locator 1-800-677-1116 or on their website at www.n4a.org. Complete information on the NAAA's 4,800 agencies nationwide is available. You may write to the National Association of Area Agencies on Aging at 927 15th St. NW, 6th Floor, Washington, D.C. 20005. Information is also available from the Federal Administration on Aging, 330 Independence Ave., SW, Washington, DC 20201; 202-619-7501; www.aoa.dhhs.gov.

DIRECTORY OF STATE AGING AND ADULT PROTECTIVE SERVICE AGENCIES

Alabama

Commission on Aging ..... (334) 242-5743
770 Washington Ave., Suite 470, P. O. Box 301851, Montgomery, AL 36130-1851

Adult Services Division ..... (205) 242-1350
Dept. of Human Resources, S. Gordon Persons Bldg., 50 Ripley St., Montgomery, AL 36130

Alaska

Division of Senior Services ..... (907) 269-3666
3601 C St., Suite 310, Anchorage, AK 99503-5984

Adult Services Program ..... (907) 465-2145
Division of Family & Young Services, Dept. of Health & Social Services, Pouch H-05, Juneau, AK 99811-0630

Arizona

Aging and Adult Administration ..... (602) 542-4446
1789 W. Jefferson St., Phoenix, AZ 85007

Arkansas

Division of Aging & Adult Services ..... (501) 682-2441
1417 Donaghey Plaza South, P. O. Box 1437/Slot 1412, Little Rock, AR 72203-1437

California

Department of Aging ..... (916) 322-3887
1600 K St., Sacramento, CA 85814

Adult Services Bureau ..... (916) 322-6320
Adult & Family Services Division, Dept. of Social Services, 744 P St., Room 692, Sacramento, CA 95814

Colorado

Aging & Adult Services ..... (303) 620-4147
Dept. of Human Services, 110 16th St., Suite 200, Denver, CO 80203-1714

Connecticut

Connecticut Commission on Aging ..... (860) 424-5360
25 Sigourney St., Hartford, CT 06106-5052

Delaware

Services for Aging & Adults with Physical Disabilities ..... (302) 577-4791
Dept. of Health & Social Services, 1901 N. Dupont Hwy., New Castle, DE 19720

District of Columbia

Office on Aging ..... (202) 727-5626
441 4th St., N.W., 9th Fl., Washington, D.C. 20001

Family Services Administration ..... (202) 727-0113
Commission on Social Services, Dept. of Human Services, Randall Bldg., 1st & Eye Sts., S.W., Washington, D.C. 20024

Florida

Department of Elder Affairs ..... (800) 96ELDER
4040 Esplanade Way, Suite 260, Tallahassee, FL 32399-7000

Elder Abuse Hotline ..... In-State: (800) 96-ABUSE

Georgia

Division of Aging Services ..... (404) 657-5258
Dept. of Human Resources, 2 Peachtree St., N.W., Room 18.403, Atlanta, GA 30303

Adult Services Unit ..... (404) 894-4440
Social Services Section, Division of Family & Children Services, Dept. of Human Resources, 878 Peachtree St., N.E., Suite 503, Atlanta, GA 30309

Guam

Division of Senior Services 011 (671) 475-0262
Dept. of Public Health & Social Services, Government of Guam, Post Office Box 2816, Agana, GU 96910

Hawaii

Executive Office on Aging ..... (808) 586-0100
250 S. Hotel St., Suite 107, Honolulu, HI 96813

Adult Services ..... (808) 548-5902
Dept. of Human Services, P. O. Box 339, Honolulu, HI 96809

Idaho

Commission on Aging ..... (208) 334-3833
3880 Americana Terr., Ste.120, Boise, ID 83706

Social Services ..... (208) 334-5702
Division of Family & Children's Services, Dept. of Health & Welfare, 450 W. State St., 10th Fl., Boise, ID 83720

Illinois

Department on Aging ..... (800) 252-8966
421 E. Capitol Ave., #100, Springfield, IL 62701-1789

Indiana

Division of Aging and Home Services ..... (800) 545-7763
402 W. Washington St., P. O. Box 7083, Indianapolis, IN 46207-7083

Adult Protective Services Program ..... (317) 232-1750
Adult Services Division, Dept. of Human Services, 251 N. Illinois St., P. O. Box 7083, Indianapolis, IN 46207-7083

Adult Abuse Hotline ..... In-State: (800) 992-6978

Iowa

Department of Elder Affairs ..... (515) 281-5187
200 10th St., 3rd Fl., Des Moines, IA 50309-3609

Adult Services ..... (515) 281-6219
Bureau of Adult, Children, & Family Services, Dept. of Human Services, Hoover Bldg., 5th Fl., Des Moines, IA 50319

Kansas

Department on Aging ..... (785) 296-4986
503 S. Kansas Ave., New England Bldg. , Topeka, KS 66603

Commission on Adult Services ..... (913) 296-4300
Dept. of Social & Rehabilitative Services, 300 S.W. Oakley, West Hall, Topeka, KS 66606

Kentucky

Division of Aging Services ..... (502) 564-7372
Cabinet of Family & Children, 275 E. Main St., Frankfort, KY 40621

Adult Services ..... (502) 564-7043
Division of Family Services, Dept. for Social Services, Cabinet for Human Resources, 275 E. Main St., Frankfort, KY 40621

Louisiana

Governor's Office of Elderly Affairs ..... (504) 925-1700
4550 N. Boulevard, 2nd Fl., P. O. Box 80374, Baton Rouge, LA 70806-0374

Program Operations Services ..... (504) 342-9931
Division of Children, Youth, & Family Services, Dept. of Social Services, 1967 North St., P. O. Box 3318, Baton Rouge, LA 70820

Maine

Bureau of Elder & Adult Services ..... (207) 624-5335
State House, Station 11, Augusta, ME 04333

Maryland

Office on Aging ..... (410) 767-1074
301 W. Preston St., Room 1007, Baltimore, MD 21201

Adult Protective Services ..... (301) 333-0156
Dept. of Human Resources, 311 W. Saratoga St., Baltimore, MD 21201

Massachusetts

Executive Office of Elder Affairs ..... (800) 882-2003
1 Ashburton Place, 5th Fl., Boston, MA 02108

Elder Abuse Hotline ..... In-State: (800) 922-2275

Michigan

Office of Services to the Aging ..... (517) 373-8230
611 W. Ottawa St., P. O. Box 30676, Lansing, MI 48909

Adult Services Administration ..... (517) 373-2869
Dept. of Social Services, 300 S. Capitol Ave., P. O. Box 30037, Lansing, MI 48909

Minnesota

Board on Aging ..... (651) 297-3933
Human Services Bldg., 4th Fl., 444 Lafayette Road, St. Paul, MN 55155

Adult Protection ..... (612) 296-4019
Dept. of Human Services, 444 Lafayette Road, St. Paul, MN 55155-3843

Mississippi

Division of Aging & Adult Services ..... (601) 359-4484
750 North State St., Jackson, MS 39202

Protection Division ..... (601) 354-6644
Bureau of Family and Children's Services, Dept. of Public Welfare, P. O. Box 352, Jackson, MS 39205

Missouri

Division of Aging ..... (573) 751-3082
Dept. of Social Services, P. O. Box 1337, 615 Howerton Court, Jefferson City, MO 65102

Elder Abuse/Neglect Hotline ..... In-State: (800) 392-0210

Montana

Div. of Senior & Long Term Care/DPHHS ..... (800) 332-2272
P. O. Box 4210, Helena, MT 59604-4210

Adult Protective Services ..... (406) 444-4077
Program Bureau, Program and Planning Division, Dept. of Family Services, P. O. Box 8005, Helena, MT 59604

Nebraska

Department on Aging ..... (800) 942-7830
State Office Bldg., 301 Centennial Mall-South, Lincoln, NE 68509-5044

Nebraska (continued)

Special Services for Children & Adults ..... (402) 471-9345
Medical Services Division, Dept. of Social Services, P. O. Box 95026, 301 Centennial Mall-South, 5th Fl., Lincoln, NE 68509-5026

Nevada

Division for Aging Services ..... (800) 243-3638
Dept. of Human Resources, 340 N. 11th St., Suite 203, Las Vegas, NV 89101

Social Services ..... (775) 687-4128
State Welfare Division, Dept. of Human Resources, Capitol Complex, 2527 N. Carson, Carson City, NV 89710

New Hampshire

Division of Elderly & Adult Services ..... (800) 351-1888
Dept. of Health & Human Services, State Office Park South, 129 Pleasant St., Concord, NH 03301

New Jersey

Division on Aging ..... (800) 792-8820
Dept. of Community Affairs, 101 S. Broad St., CN 807, Trenton, NJ 08625-0807

Adult Protective Services ..... (609) 292-6726
Division of Youth & Family Services, Dept. of Human Services, 1 S. Montgomery St., CN 717, Trenton, NJ 08625

New Mexico

State Agency on Aging ..... (800) 432-2080
La Villa Rivera Bldg., 224 E. Palace Ave., Santa Fe, NM 87501

Adult Services Bureau ..... (800) 432-6217
Social Services Division, Human Services Dept., P. O. Box 2348, Pollon Bldg., Santa Fe, NM 87504-2348

New York

State Office for the Aging ..... (800) 342-9871
2 Empire State Plaza, Albany, NY 12223-0001

Division of Adult Services ..... (518) 432-2974
Dept. of Social Services, 40 N. Pearl St., Albany, NY 12243

North Carolina

Division of Aging ..... (919) 733-3983
693 Palmer Drive, 210 Mail Serv. Ctr., Raleigh, NC 27699

Adult Protective Services Program ..... (919) 733-3818
Division of Social Services, Adult & Family Services, Dept. of Human Resources, 325 N. Salisbury St., Raleigh, NC 27611

North Dakota

Aging Services Division ..... (800) 328-8910
Dept. of Human Services, 600 E. Blvd. Dept 325, Bismarck, ND 58505-0250

Northern Mariana Islands

Office of Aging ..... (607) 234-6011
Dept. of Community & Cultural Affairs, Civic Center, Saipan, CM Northern Mariana Islands 96950

Ohio

Department of Aging ..... (614) 466-5500
50 W. Broad St., 9th Fl., Columbus, OH 43215-3363

Bureau of Adult Services ..... (614) 466-9596
Division of Adult & Child Care Services, Family, Children, & Adult Services, Dept. of Human Services, 30 E. Broad St., Columbus, OH 43266-0423

Oklahoma

Aging Services Division ..... (405) 521-2327
Dept. of Human Services, 312 NE 28th St., Oklahoma City, OK 73125

adult Protective Services/ Geriatric Care .... (405) 521-4214 *or* 521-3440 *or* 521-3660
Division of Services for the Aging, Dept. of Human Services, 312 N.E. 28th St., Oklahoma City, OK 73105

Elder Abuse Hotline ..... In-State: (800) 522-3511

Oregon

Senior & Disabled Services Division ..... (800) 232-3020
500 Summer St., NE, 2nd Fl., Salem, OR 97310-1015

Abuse and Protective Services ..... (503) 378-3751
Senior Services Division, Dept. of Human Resources, 313 Public Service Bldg., Salem, OR 97310

Pennsylvania

Department of Aging ..... (717) 783-1550
"APPRISE" Health Insurance Counseling & Assistance, 555 Walnut, 5th Floor, Harrisburg, PA 17101-1919

Fraud and Abuse Hotline ..... In-State: (800) 992-2433

Puerto Rico

Governor's Office of Elderly Affairs ..... (809) 722-2429
Gericulture Commission Box 11398, Santurce, PR 00910

Services to Adults ..... (809)723-2127
Dept. of Social Services, P.O. Box 11398, Fernandez Juncos Station, Santurce, PR 00910

Rhode Island

Department of Elderly Affairs ..... (401) 222-2858
160 Pine St., Providence, RI 02903

Adult Services ..... (401) 462-2121
Dept. of Human Services, 600 New London Ave., Cranston, RI 02920

Samoa (American)

Territorial Administration on Aging 011 (684) 633-1252
Government of American Samoa, Pago Pago, AS 96799

South Carolina

Dept. of Health & Human Serv. ..... (803) 898-2500
P.O. Box 8206, Columbia, SC 29202-8206

Division of Adult Services ..... (803) 734-5730
Office of Children, Family and Adult Services, Dept. of Social Services, P. O. Box 1520, Columbia, SC 29202-1520

South Dakota

Office of Adult Services and Aging ..... (605) 773-3656
700 Governor's Drive, Pierre, SD 57501-2291

Tennessee

Commission on Aging ..... (615) 741-2056
Andrew Jackson Bldg., 9th Fl., 500 Deadrick St., Nashville, TN 37243

Adult Protective Services ..... (615) 741-5926
Social Services Programs, Dept. of Human Services, Citizens Plaza, 400 Deaderick St., Nashville, TN 37219

Texas

Department of Aging ..... (512) 424-6840
P. O. Box 12786, 4000 N. Lamar, 4th Fl., Austin, TX 78711

Texas (continued)

Adult Protective Services ..... (512) 438-3011
Dept. of Human Services, P. O. Box 149030, Austin, TX 78714

Federated States of Micronesia

State Agency on Aging ..... (691) 320-2733
Office of Health Services, Ponape, E.C.I., FM 96941

Utah

Division of Aging and Adult Services ..... (801) 538-3910
120 North 200 West, Salt Lake City, UT 84103

Vermont

Department of Aging & Disabilities ..... (802) 241-2400
Waterbury Complex, 103 S. Main St., Waterbury, VT 05671-2301

Adult Protective Services ..... (802) 241-2131
Division of Social Services, Dept. of Social & Rehabilitation Services, 103 S. Main St., Waterbury, VT 05676

Virginia

Department for the Aging ..... (800) 552-3402
1600 Forest, Ste. 102, Richmond, VA 23229

Adult Protective Services ..... (804) 662-9241
Bureau of Adult & Family Services, Division of Service Programs, Dept. of Social Services, 8007 Discovery Drive, Richmond, VA 23229-8699

Virgin Islands

Senior Citizen Affairs Division ..... (809) 772-0930
Dept. of Human Services, 19 Estate Diamond, Fredericksted, St. Croix, Virgin Islands 00840

Division of Adult Services ..... (809) 774-0930
Dept. of Human Services, Barbel Plaza South, St. Thomas, VI 00802

Washington

Aging & Adult Services Administration ..... (206) 586-3768
Dept. of Social & Health Services, P. O. Box 45600, Olympia, WA 98504-5600

Adult Protective Services Program ..... (206) 753-5227
Aging and Adult Services, Dept. of Social & Health Services, 623 8th S.E., Olympia, WA 98504-0095

West Virginia

Commission on Aging ..... (304) 558-3317
State Capitol Complex, Bldg. 3, Rm. 206, Charleston, WV 25305

Services to the Aged, Blind and Disabled ..... (304) 348-7980
Social Services Bureau, Dept. of Human Services, State Capitol Complex, Bldg. 6, Room B850, Charleston, WV 25305

Wisconsin

Dept. of Health & Human Serv. ..... (608) 266-1865
1 Wilson St., Madison, WI 53702

Wyoming

Division on Aging ..... (800) 442-2766
Hathaway Bldg., 2300 Capitol Ave., Room 139, Cheyenne, WY 82002

Family Services ..... (307) 777-6095
Division of Public Assistance & Social Services, Dept. of Health & Social Services, Hathaway Bldg., Cheyenne, WY 82002-0710

XII.

MEDICAID: A MIDDLE-CLASS FINANCIAL OPTION?

THE 1989 repeal of the Medicare Catastrophic Coverage Act opened the door to vastly increased enrollment of otherwise "middle-class" beneficiaries in the Federal-State cosponsored Medicaid programs originally intended to provide care for only the neediest patients. Amendments to the Medicaid Law in 1993 and the Health Insurance Portability and Accountability Act, signed in August 1996 and amended in the Balanced Budget Act, effective August 1997, have complicated this somewhat by changing rules and criminalizing some activities, but middle-class use of Medicaid for long-term care is not likely to be significantly reduced, especially if provisions of the recent legislation are amended again or repealed.

Medicaid plays a substantial role in financing long-long term care. The Medicaid program pays for an average of 45 percent of all care provided in custodial nursing care and home health services. In 1997, Medicaid payments for nursing facility and home health care totaled roughly $43 billion for the 3.4 million recipients of these services—an average expenditure of $12,500 per long-term recipient. Medicaid is the primary source of payment for both men and women at the time of admission. Not surprisingly, long-term care spending now plays an increasingly larger role in total Medicaid spending. Medicaid payments for long-term care amount to one-third of Medicaid's budget.

Lobbyists for the elderly have long insisted that the potential costs of long-term nursing or custodial care constitute the single largest potential financial risk for most retirees of average means. Indeed, the costs of just a year's stay in a nursing home now average nationwide about $40,000 (in some states, such as New York, the cost is almost double that amount). It is a matter of record that the savings of over two-thirds of current nursing home residents are totally depleted within 24 months of their admission. Elder advocates have publicized such data and vigorously promoted Medicare coverage for long-term custodial care. Understandably many retirees are concerned that nursing home costs could quickly wipe them out. In fact, only a relatively small proportion of the elderly face lengthy confinement in a nursing home. Even so, the fear that nursing home

costs could be disastrous has spawned a new branch of the financial planning industry, as described below.

The 1989 Medicare legislation that repealed the Catastrophic Coverage Act also rescinded most of the prohibitions against so-called "Medicaid trusts," which permit retirees to become eligible for Medicaid's nursing home coverage without dissipating their estates, and provided substantial protection against the impoverishment of at-home spouses of institutionalized Medicaid patients. The apparent result has been a proliferation both of attorneys who specialize in drafting Medicaid trusts that meet the technical requirements of the law and of middle-class clients who want their wealth sheltered in the event they need long-term care.

Reportedly, the liberalized treatment of trust arrangements designed to promote Medicaid eligibility was a "compromise" intended to offset in part the effects of the repeal of Medicare's catastrophic coverage provisions and to provide some relief for those forced to enter nursing homes. From the perspective of the Washington lawmakers, it also achieved other goals. Unlike Medicare, which is Federally funded, a substantial portion of the costs of Medicaid programs is funded by *state* taxes. In effect, by stanching Medicare catastrophic illness and long-term care coverage but at the same time relaxing middle-class prohibitions on Medicaid eligibility, Congress shifted a portion of the costs of such programs onto the states.

The liberalization of Medicaid eligibility has been somewhat reversed in the last few years. The 1993 Amendments to the Medicaid Law require states to increase the "look-back" for transfer of assets to 3 years for transfers to individuals and to 5 years for transfers to certain types of trusts. This law also required states to remove the cap on penalties for such transfers in terms of the period of ineligibility (POI) that results from proscribed transfers. The penalty for transferring assets at less than market value for the purpose of becoming eligible for Medicaid is calculated by dividing the value of the transferred assets by the average monthly private pay rate for nursing facilities in the particular state. The result is the number of months of ineligibility for receiving Medicaid. The 1988 legislation had capped this period of ineligibility at 30 months; the 1993 legislation removed the cap.

The Health Insurance Portability and Accountability Act, also

known as the Kassebaum-Kennedy health reform bill, made asset transfers to qualify for Medicaid for nursing home or other long-term care a federal crime in addition to already being penalized with periods of ineligibility. This provision passed with no hearings and no debate and no members of the House of Representatives were willing to claim authorship of it. The provision, dubbed the "Granny Goes to Jail Law," was poorly drafted and unclear on many issues, such as who might be prosecuted and whether the crime involved was a felony or misdemeanor.

The Balanced Budget Act of 1997 (the budget reconciliation bill) amended this provision to read that the criminal penalties applied only to those who "for a fee counsel or assist an individual to make certain transfers of assets" for the purpose of qualifying for Medicaid. The law, now tabbed "Granny's Lawyer Goes to Jail," came under immediate fire. In 1998, Attorney General Janet Reno stated that she would not enforce the law. Later, the New York State Bar Association challenged the law's constitutionality and won a nationwide injunction against its enforcement. The Justice Department filed a notice of appeal, which was ultimately withdrawn. In any event, **one should understand the eligibility rules and should not try to apply for Medicare during a period of ineligibility.**

Ironically, the recent legislation may not discourage such asset shifting, but rather may encourage more and earlier transfers. The new difference in look-back periods, 3 years for transfers to individuals and 5 years for transfers to trusts, may also encourage relatively more transfers to individuals rather than to trusts. **One issue that few people seem to consider, however, is that a significant proportion of nursing home residents recover from the conditions that led to their confinement and go home again. If these people have intentionally impoverished themselves in order to be eligible for Medicaid, they may find that they are unable to support themselves or are at the mercy of the beneficiaries of their transferred wealth.**

The new legislation has increased the already complicated problems that accompany such transfers. With the legislation, it has become crucial that application for Medicaid not be submitted until at least 3 years after transfers to individuals and 5 years after transfers to some trusts. Application during these look-back periods may re-

sult in penalties under the new periods of ineligibility and possibly criminal action against paid advisors. This area of legislation could change frequently over the next few years. For current information on Medicaid and other legal issues for elders, contact National Senior Citizens Legal Center, 1101 14th St. NW Suite 400, Washington, DC, 20005, (202) 289-6976, website www.nsclc.org.

Comprehensive Medicaid Coverage

Medicaid coverage for medical services varies markedly from state to state within the range of Federal Medicaid standards. All states are required to provide "core" coverage for a variety of services, including: inpatient and outpatient hospital services, laboratory and x-ray services, skilled nursing facility services, 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 of chiropractors, optometrists and podiatrists, private nurses, dental care (including dentures), eyeglasses, and prescription drugs. Most pertinent from the point of view of this discussion, Medicaid pays for the costs of *custodial* nursing home care once certain income and asset criteria are met. In addition, all states must pay the transportation costs of Medicaid recipients for travel to and from their health care providers.

In short, even the "core" coverage provided by Medicaid is substantially greater than that offered to Medicare subscribers, or to most holders of even the most costly Medicare supplemental insurance policies (none of which, for example, pays transportation costs other than for ambulance services). In most states, Medicaid beneficiaries receive virtually all medical goods and services, even peripheral ones, free of charge.

From a clinical perspective, Medicaid's chief drawback has been that not all physicians and health care institutions will take Medicaid cases. Especially in the case of nursing home care, the better-rated care facilities may not accept Medicaid patients. The result has been that many impoverished Medicaid recipients have been forced to accept treatment at substandard "Medicaid clinics" and ended up at "Medicaid mill" nursing homes. In the case of middle-class retirees whose financial plans include the deliberate transfer of assets and "spend downs" described below to qualify for Medicaid coverage,

however, nursing home admission can be made on a private-payment basis and the "cold-shoulder" treatment usually reserved for destitute Medicaid patients avoided.

Medicaid Eligibility Requirements

Each state determines its own Medicaid eligibility requirements within broad Federal guidelines. Generally, however, states are required to provide Medicaid services to most recipients of Federal and/or state income assistance or related programs. Recipients who in most states automatically qualify for Medicaid include those receiving Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), and certain Medicare beneficiaries (discussed below). States may also provide Medicaid coverage for a variety of "categorically needy" groups, including infants and pregnant women whose family income is at or below 133 percent of the Federal poverty level; aged, blind, or disabled adults whose incomes and assets may be above the SSI threshold but below the Federal poverty level; institutionalized persons with income and resources below specified limits; and "medically needy" persons. Many have further expanded coverage to those with family income below 185 percent of the poverty level.

Some aged, blind, and disabled persons are covered under both Medicare and Medicaid as "dual beneficiaries" whose Medicare Part B premiums and Medicare coinsurance are paid by Medicaid. Dual beneficiaries also receive some, but not all, of the more-comprehensive Medicaid coverage described above, including eyeglasses and hearing aids. Such "qualified Medicare beneficiaries" are individuals with incomes at or below the Federal poverty level and resources at or below twice the standard allowed under the SSI program.

The SSI threshold amounts for income and resources may vary somewhat from state to state. But generally Medicare beneficiaries, to become eligible for Medicaid, must have "countable" income below the Federal "administrative poverty income guideline" (currently $8,484 per year for a single individual 65 years or over and about $11,304 for a couple 65 years or over) and resources of no more than $4,000 ($6,000 for a couple).

However, not all income is included in "countable" income and certain assets are exempt from the inventory of resources. In the case

of a spouse who must enter a nursing home, income deductions are permitted for the maintenance of non-institutionalized family members. In addition to a $30 "personal needs allowance," a "monthly needs allowance" for the at-home spouse of from $1,383 to $2,049, and an allowance for each additional family member of at least one-third of the monthly needs allowance for the at-home spouse, are deducted from the institutionalized spouse's income. (With the maximum allowable deductions, actual income available to an at-home spouse alone could approach $25,000 per year.)

More important, under SSI eligibility requirements an individual's or couple's home, automobile (up to a certain value), household goods and personal effects of "reasonable" value, and burial plots and life insurance with a face value up to $1,500 or burial funds up to $1,500 are exempt from the SSI inventory. And in the case of a Medicare-Medicaid dual beneficiary who enters a nursing home, the "spousal impoverishment protection" provisions of the 1989 repeal of the Medicare Catastrophic Coverage Act allow that the non-institutionalized spouse is entitled to retain a minimum of $16,824 or one-half of the couple's total resources up to a maximum of $84,120. Moreover, if one partner must enter a nursing home, the spousal impoverishment legislation protects SSI-exempt resources (car, household goods, and personal effects) to *any* value, even if it is much higher than SSI limits.

In short, current legislation provides liberal exemptions of both income and assets from consideration under Medicaid eligibility tests. Today many of the "middle class" aged may qualify for Medicaid and still retain substantial income and resources. This is especially so if a couple's liquid assets (bank accounts, CDs, stocks, bonds, etc.) are converted into exempt assets and a portion of them sufficient to produce income up to the Medicaid limits annuitized.

Asset Conversion

For couples with liquid assets under $350,000 or so, the least involved and least costly way to protect financial resources from Medicaid "spend down" requirements is to convert them to exempt-category assets. For example, all outstanding debt should be paid off at once. If a couple's home has a mortgage, nonexempt assets held in savings accounts, stocks, and bonds can be used to pay off the outstanding mortgage balance, which immediately converts those funds

to an exempt category, the home. If the couple rents but has substantial savings, the savings can be used to purchase a condominium home that will be exempt. Or if the family car needs replacing, nonexempt resources could be used to purchase a new one, which would be exempt under the spousal impoverishment protection legislation.

Similarly, liquid assets can be used to make home improvements or to purchase household goods that are exempt from Medicaid resource limitations. Preventive and cost-saving home repairs can be made that would be prohibitively expensive under Medicaid's income limitations—a new roof, siding, windows, plumbing and heating, wiring, insulation, or energy-efficient labor saving appliances that reduce living costs for the at-home spouse. Even major remodeling (a new kitchen or bathrooms), additions to the structure, or "low-maintenance" landscaping might be contemplated as a means of protecting assets at the same time they "make life easier" for the spouse at home.

And by annuitizing remaining liquid assets, a portion of otherwise "countable" financial resources can be converted into largely (or perhaps totally) exempt income. At current annuity rates, a $100,000 lifetime annuity purchased at age 65 would yield an income of about $8,000 per year to an at-home (female) spouse ($10,000 per year if aged 75).

Pouring assets into the family home provides "ironclad" protection only so long as the non-institutionalized spouse or certain other relations reside there. After that spouse or other relations vacate the residence or die, the state may (but is not required to) seek "recovery" of Medicaid outlays for nursing home expenses after the death of the institutionalized beneficiary—unless the property has been transferred outright to another party (*e.g.*, to the heirs).

Medicaid Trusts

In situations where total "countable" assets exceed Medicaid limits even after the above measures have been taken—say, between $400,000 and $600,000—assets now can still be sheltered by means of so-called "Medicaid trusts." In brief, the Medicaid law does not permit individuals to transfer assets to individuals or to a trust in order to qualify under Medicaid's income and resource limits within

certain "look-back" periods. Federal law requires that states "look back" at least 3 years for transfers of assets to individuals (and some trusts) and at least 5 years for transfers of assets to certain trusts. Once the look-back period is over, however, the grantor can become eligible for Medicaid coverage.

Medicaid trusts became big business during the past decade. Reportedly, "elder-practice" law firms in the larger metropolitan areas regularly hosted Medicaid trust promotions for senior citizen audiences in hopes of drumming up clients. For legal costs of between $2,500 and $3,500, such firms will draft a trust agreement that meets Medicaid qualifications.

Medicaid trusts usually are "conventional" irrevocable trust agreements with special provisions added to satisfy the needs of long-term care patients and the requirements of the Medicaid authorities. Although each agreement is different depending on individual circumstances, Medicaid trusts generally have had two common characteristics: (1) they require that income from the trust, or trust principal as required, be used to pay the costs of long-term nursing care during periods of ineligibility; and (2) they are designed so that "countable" income, including "outside" buildup, from the trust would not exceed Medicaid limits (thus, trust assets could be limited to low-income or no-income holdings). Such provisions could be made through a "springing trust" arrangement in which a *revocable* trust agreement, which retains complete control of trust assets until the last minute, would automatically become an *irrevocable* Medicaid trust when the grantor entered a nursing home. Trusts agreements are, no doubt, being modified as needed to conform to the new legal requirements.

A Public/Private Medicaid "Partnership"?

The increased use of Medicaid by "middle-class" recipients has prompted officials in some states to try to find ways to reduce the consequent financial strain on state budgets. One current "experiment" involves a public/private "partnership" that provides incentives for elderly persons to purchase private long-term care insurance in return for the state's promise to waive Medicaid eligibility "spend-down" requirements for custodial nursing home costs when private insurance benefits cease.

Experiments in four states (California, Connecticut, Indiana, and New York) comprise the Partnership for Long-Term Care under a grant from the Robert Wood Johnson Foundation Program to Promote Long-Term Care Insurance for the Elderly. If these experimental programs are successful, they could be adopted by the other states as well.

The information for the program in New York State clearly states that the "desired market" is primarily the middle-class elderly. The target market includes single persons with a total income of at least $30,000 and assets of at least $60,000 (excluding home) and married persons with incomes above $40,000 and assets over $140,000.

According to the New York plan, individuals who participate in the experiment must purchase and maintain in force an approved private nursing home insurance policy that promises to pay benefits for nursing home care for 3 years, 6 years of home care, or an equivalent combination of both. In return, assets (but not income) will be disregarded when eligibility for Medicaid is being determined. Income will be considered in determining Medicaid eligibility.

Interested persons residing in the states that currently are participating in the Robert Wood Johnson Program can write to the Partnership for Long-Term Care, National Program Office, Center of Aging, Room 1240, HHP Building, University of Maryland, College Park, MD 20742-2611, call 301-405-1077, or go to www.inform.umd.edu/aging/PLTC for more information.

Must We All Become Thieves?

Of course, Medicaid never was intended to be a financial tool of the middle class, as it apparently has or may soon become. It was designed to provide medical relief to the genuinely needy. Almost surely, some middle-class retirees who would *never* steal from their neighbors but *have* taken advantage of Medicaid trusts are uncomfortable with the notion that in their efforts to prevent the dissipation of their own wealth they have gone on the dole at the expense of other taxpayers. In this respect, a number of commentators who usually favor social legislation—and who supported the extension of Medicare to cover costs of catastrophic care—have observed that middle-class "abuse" of Medicaid threatens to bankrupt the program.

Others, including the attorneys who profit therefrom, defend the use of Medicaid trusts as a legal means to preserve one's hard-earned wealth that in practical effect is no different from tax shelters, which permit some to pay less tax than others who deploy their assets in less-advantaged ways. Still others argue that by entering the Medicaid rolls they simply are seeking partial restitution for the Government's prior confiscation of their wealth that has funded programs that almost surely will impoverish their children and grandchildren unless their inheritance is preserved.

From a purely ethical standpoint, it may be difficult for most people to distinguish the "right" from the "wrong" in any of these positions. Rather, it would seem that questions of who are the "more deserving" are largely political and are incapable of final resolution. What is more clear is that many no doubt *will* take advantage of all legal means to prevent the dissipation of their wealth. The inexorable result is the tendency to make "suckers" of anyone who does not do likewise, even if he or she is in general sympathy with the original goals of programs such as Medicaid.

This process seems characteristic of almost any regime that seeks, beyond some as-yet unmeasured extent, to advantage some people at the expense of others. Seemingly, those who are disadvantaged eventually seek redress by one means or another, usually by demanding "benefits" for themselves. The result effectively defeats the original intent of the program.

Part 4

END-OF-LIFE DECISIONS

XIII.

LEGAL CONSIDERATIONS

OF great concern to many older people is the possibility that if they become irreversibly ill and are unable to make decisions for themselves, artificial means will be used to prolong their lives long after they have any hope of recovery and long after they would wish to remain "alive," were they able to speak for themselves. Not only does such treatment often prolong the anguish of family and friends, but it also can be financially devastating to the survivors who may be forced to pay the costs of such care.

In today's litigious society, however, virtually no care provider—hospital, nursing home, or physician—is willing to accept the potential liability for withholding life-prolonging care. This is so even when a patient's life is being sustained under highly artificial circumstances and where there is no hope of recovery.

The only way to insure that your wishes are carried out is to state your instructions in writing according to the procedures required by the pertinent laws of the state in which you reside.

Living Wills

All 50 states and the District of Columbia have enacted "living will" laws that specify the legal language individuals must follow in declaring their wishes with respect to medical treatment in the event they should become unable to make decisions. In the states that have such laws, it is not necessary to have a lawyer draw up a living will. However, you must use the form that has been approved for use in your state. To obtain a copy of a living will form for your state, see your attorney or send for your state's advance directive package and booklet, "Questions and Answers: Advance Directives and End-of-Life Decisions" ($5.95) from Choice in Dying, 1035 30th St., Washington, DC 20007, 1-800-989-WILL (9455), or website at www.choices.org. This organization provides forms free of charge, although a donation is requested. See also, "Ten Myths About Advance Directives" and "Shape Your Health Care Future With Health Care Advance Directives" from the American Bar Association's Commission on Legal Problems of the Elderly at www.abanet.org/elderly/home.html. The ABA can also be reached by writing the

American Bar Association, 740 Fifteenth Street, NW, Washington, DC 20005-1022 or dialing 202-662-8690.

You should also ask your doctors and local hospital for a copy of any form to which they require a living will to adhere before they will honor its instructions.

All living wills must be signed and witnessed, and it is prudent, and may be required by law, to have such documents notarized as well. *Witnesses to a living will may not be anyone who would "benefit" from your death (through an inheritance or otherwise).* Usually the following individuals are specifically prohibited by statute from witnessing a living will: anyone related to the declarant by blood or marriage; any heir or claimant to any part of the declarant's estate, including creditors; the declarant's physician or physician's employee; any employee of the patient's health facility; or any other person responsible for the patient's health care.

Once the living will is prepared, you should keep the original with your personal papers. You should give copies to your doctors, members of your family, and your health care proxy (discussed in the section that follows). Some states require that a living will be updated periodically. Even if your state does not, you should review the living will periodically to make sure that it still accurately states your wishes, and initial and date it to so indicate.

In some states the prescribed form must be followed precisely. In other states, however, the living will form permits personalized instructions. The contents of the living will in these states obviously will differ for each individual depending on his or her wishes with respect to certain medical circumstances, including "hydration" and "feeding," that *must* be specified in the document.

Since the issues involved may be complex, it is important that individuals determine their wishes with respect to medical treatment while they are still able, and discuss them with the physician, loved ones, and health care proxy.

In states that have no living will legislation, living will declarations should be drafted to meet the requirements of health care providers and other pertinent law. Printed on the following page is one sample form that has been widely distributed in those states and may serve as a foundation for a living will declaration (and health care

proxy) in consultation with your attorney and health care providers.

Again, in states that have living will laws, you must follow the

LIVING WILL DECLARATION

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

I, ..., being of sound 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 or withdraw 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 right to refuse treatment. Therefore I expect my family, doctor, and everyone concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes, and in so doing to be free of any legal liability for having followed my direction.

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 person to act in my behalf:

Name: _____

Address: _____

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

Name: _____

Address: _____

Signed: _____ Date:_____

Witness: (Name & Address) Witness: (Name & Address)

prescribed form for the state. The sample form is not intended to be used as a "finished document," but only as a *possible* starting point for drafting a living will in consultation with your attorney and other interested parties. Depending on your situation, other forms may be more useful as a starting point. Indeed, in some states that do not have specific living will laws, such as New Jersey, attorneys have available a lengthy living will form that has been drafted to accommodate that state's relatively lengthy comprehensive body of law respecting refusal of life-supporting medical care.

Durable Powers of Attorney for Health Care (Health Care Proxies)

Many health care analysts advise that a durable power of attorney for health care (health care proxy) should accompany the living will, as in the sample form on page 147. The specified living will forms in some states include such a health care proxy, and should be used when available.

In brief, a durable power of attorney for health care empowers someone of your choosing to act in your behalf should you become unable to make decisions for yourself. Plainly, you should choose your surrogate carefully, and discuss with him or her your wishes as expressed in your living will thoroughly, even if that requires going into specific detail about precise procedures and under precisely which circumstances you do or do not wish them to be used. In most states and the District of Columbia, health care proxies are permitted to make medical decisions specifically including decisions to withdraw or withhold life support. However, in other states the force of health care proxies is limited to one degree or another. Nevertheless, a health care proxy who also is supported by a properly drafted living will declaration is in a strong position to see that your wishes are carried out.

As with living wills, the legal forms for health care proxies vary from state to state. You should use the form that is specified by your state. These forms are available from Choice in Dying, cited above. A sample health care proxy that may serve as a rough example is printed on the following page. This form should not be used as your living will.

It should be noted that even the most carefully prepared documents cannot guarantee that all your wishes will be carried out. However, if you have not prepared a living will or a health care proxy, it is almost guaranteed that they will *not* be. For more information about living wills and health care proxies, write to AARP Fulfillment, 601 E Street NW, Washington, D.C. 20049, or phone 1-800-424-3410 and request the free booklet *Tomorrow's Choices* (D-13479). The AARP's website is www.aarp.org.

HEALTH CARE PROXY

1. I, ... *(name)*..... , hereby appoint .....*(name, home address, telephone number)*..... as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

2. Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. _____

_____

3. Name of substitute or fill-in agent if the person I appoint above is unable, unwilling, or unavailable to act as my health care agent. .....*(Name, home address, telephone number.)*.....

4. Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated here: _____

_____

5. Signature, address and date _____

Witness: (name and address) Witness: (name and address)

The proxy may not be a witness, and the two witnesses must be individuals who do not stand to benefit from the death of the proxy maker; both must be 18 or older.

XIV.

FUNERAL OPTIONS

DEATH is one of the few events that every human experiences. Nevertheless, the disposition of a person's physical remains often is one of the least-planned of his or her affairs. Fears about death understandably may make all concerned, especially family members, reluctant to discuss or plan funeral arrangements much in advance of actual need. However, "last minute" arrangements made in hastened or anguished circumstances can be far more costly—sometimes onerously so to survivors—than informed decisions reached before death stares one in the face. As a practical matter, the disposition of one's physical remains might prudently be arranged just as one plans for the disposition of one's legal estate.

In this respect there are far more funeral options available than many may realize. For many people, knowing that after they die they will be celebrated by a funeral that spares no expense and is attended by a host of friends and family is an important source of satisfaction during their remaining lifetime. For others, a private funeral of modest proportions that does not pose a financial burden to survivors, or deplete the estate that will pass to heirs, is desirable. Still others may prefer that no funeral service be held, and that their remains be disposed of in the least costly fashion. Your own wishes probably will not be fulfilled unless you make them known—and unless you have the opportunity to review the options that are available for a particular type of funeral arrangement.

Funeral Regulations

Whatever those wishes may be, a variety of state and Federal laws regulate funeral practice, and it is in your interest and the interest of your survivors to be familiar with the principal laws governing the disposition of human remains and funeral industry operations. The Federal Trade Commission developed a trade regulation, known as the FTC **Funeral Rule (16 CFR Part 453)**, that became effective on April 30, 1984 and that enables consumers to obtain information about funeral costs. Among other provisions, the **Funeral Rule** requires: that funeral providers give price information over the telephone (which relieves buyers of funeral services of subtle "pressure" tactics that may be employed in a face-to-face meeting with

funeral personnel) and that funeral providers give on request a general price list of all items and services offered.

In order to help consumers decide on whether to purchase it, the **Funeral Rule** also requires that customers be given information about embalming and specifies that funeral providers: 1) not falsely state that embalming is required by law; 2) must disclose in writing (with some exceptions) when embalming is *not* required by law; 3) may not charge a fee for unauthorized embalming unless it is required by law; 4) disclose in writing that (usually) you have the right to choose between cremation or immediate burial if you do not want embalming; and 5) disclose in writing under what circumstances embalming is a practical necessity.

The **Funeral Rule** stipulates that funeral providers disclose any fees that they charge for so-called "cash advance" items related to funeral arrangements. These are items or services that the funeral director purchases in your behalf, but that you could purchase yourself, and include flowers, obituary notices, clergy honoraria, and the like. The **Funeral Rule** requires that the provider inform you if a fee is added to the price of cash advance items or if the provider gets a "kick back" from any of the suppliers.

One of the most costly items in most funerals is the casket. However, in some circumstances a casket may not be appropriate. For consumers who select direct cremation, for example, an inexpensive alternative container or unfinished wood box that will be destroyed during cremation may suffice. Under the **Funeral Rule** funeral directors who offer cremation services are prohibited from telling you that state or local law requires a casket for direct cremations and must make an unfinished wood box or alternative container available.

In short, there are a variety of options available for conventional funerals that could bewilder your survivors. It is not much trouble to telephone one or more funeral providers in your locality, listed under "Funeral Homes" in the Yellow Pages, to request a "general price list" of funeral items and services. Such lists are yours to keep, and you may wish to discuss them with whomever you expect to be in charge of funeral arrangements when the time comes— and to indicate on the price list exactly what you want. A copy of this list, with your written instructions, ought to be kept in an available location in the event of your death, and be made known ahead of time to your spouse or anyone else who may require such information.

For further information on the laws governing funerals in your state, how to make funeral arrangements, or the options available, you may want to contact Funeral and Memorial Societies of America, P.O. Box 10, Hinesburg, VT 05461, (802) 482-3437, www.funerals.org. This is a consumer organization that disseminates information about alternatives for funeral or non-funeral dispositions whose purpose is to encourage advance planning and cost efficiency. The Cremation Association of North America, 401 North Michigan Avenue, Chicago IL 60611, (312) 644-6610, is an association of 750 crematories, cemeteries and funeral homes that offer cremation. The National Research and Information Center, 2250 E. Devon Ave. #250, Des Plaines, IL 60018, (800) 662-7666 makes available a Funeral Service Consumer Assistance Program, with information on death, grief and funerals.

For a free copy of "Funerals: A Consumer Guide," telephone or write the Consumer Response Center, Federal Trade Commission, 600 Pennsylvania, NW, Room H-130, Washington, D.C. 20580-0001, (877) FTC-HELP or visit their website at www.ftc.gov. Additional information concerning the Funeral Rule is available on the FTC website at www.ftc.gov.ftc.consumer.html.

Pre-Paid Funerals

Many of the Nation's funeral directors urge consumers to pay for their own funerals in advance—termed "pre-need"—which they say will not only save grief-stricken survivors the trouble of making funeral arrangements but also save money by locking-in the current price for funeral goods and services.

In principle this may seem a prudent course. In practice, however, it requires that consumers take a number of precautions to insure that when the time comes they will get the funeral that they already have purchased. Reportedly, in a number of instances, prepaid funeral funds have gone not into a trust account or life insurance policy, but into a managed-money account to which the funeral director may have direct access. And in several instances, the funeral director has used the funds for other purposes or the managed accounts have gone bankrupt.

If you are considering prepaid funeral arrangements, you should determine how your funds will be held in trust. **If they are not placed in an escrow account, trust account, or life insurance policy to which the funeral firm does not have access, do not do business with that firm.**

Equally important, **make sure that you can get a refund if you change your mind**. Where funds are held in a deposit fund or trust account at a financial institution, you should be able to receive a refund in accordance with the terms of the written contract (there probably will be a penalty for "early withdrawal"). If the funds are poured into a life insurance or annuity contract, the terms of the prepaid arrangement should permit you to receive the cash surrender value of the contract.

Burial Insurance

There is an alternative to "prepaid" funeral arrangements that can achieve many of the same goals—namely, to save your survivors the expense of your funeral—but provide some flexibility that is not available when you contract far ahead of time with a particular funeral provider. Very simply, you can "pre-fund" your own funeral, to be carried out according to your instructions, by purchasing a life insurance policy with a death benefit adequate to cover the costs of the funeral you desire. Although it does not relieve your survivors of all funeral tasks, such a plan will insure that the funds are available when needed—and could cost substantially less than the prepaid funeral, depending on the premiums that you must pay to keep the insurance in force before you die. For example, if you purchase a level-premium policy and die shortly after the policy becomes effective, your estate probably will save much of the cost of your funeral. Of course, you have to qualify for life insurance. If you are in poor health, you may not be able to get insurance, or the death benefit may not justify the premium costs.

Low-Cost or No-Cost Alternatives

For those who do not want a "conventional" funeral, there are legal non-funeral options that may be appealing. There are four legal methods of disposition of human remains: burial, entombment, cremation, or **donation for scientific study**.

Many large medical centers that also are teaching or research

hospitals accept donations of human remains for purposes of teaching or research. In most instances there is a set "donation fee" that the facility will pay upon receipt of such remains. In many states, such donations are regulated by a state Anatomical Board that pays the fees to the donor's estate, which then can either be retained as part of the estate or in turn donated to a charity of one's choosing. Arrangements should be made in advance and interested individuals should contact the medical facility to which they wish to donate to obtain information about the forms they must complete and the procedures that must be followed. All such donations are revocable by alternate instructions prior to death.

We also are aware of at least one non-funeral cremation plan that, for a fee of less than $1,500, will provide removal of the remains from the place of death anywhere in the United States, transportation to a holding facility pending procurement of the signed death certificate and disposition permit, cremation, urn, professional and administrative services as needed, and scattering of remains by sea, rose garden, or return to the family, as desired. For further information, contact The Neptune Society, 1721 West Magnolia Boulevard, Burbank, California 91506, (800) 201-3315, www.neptunesociety.com. This is a for-profit firm that also has offices in California, Florida and New York.

Finally, in some states, such as Texas, a family may bury its own dead without using a licensed funeral director. Do-it-yourself burials require at minimum a statement of death, death certificate, and burial-transit permit. In many states, local ordinances govern do-it-yourself burials, which may be prohibited in some jurisdictions. To obtain information about laws governing funerals by non-licensed family members, contact the Funeral and Memorial Societies, cited above.

Appendix

THE OTHER SIDE OF PUBLIC HEALTH CARE

POPULAR sentiment in favor of some type of socialized health insurance evidently flourishes in the United States today. For example, to the extent that there is dissatisfaction among the elderly with Medicare, it is chiefly because it is said to be "too costly" and affords "too few benefits." And if the outraged response of elderly voters to the Medicare surtax to finance catastrophic coverage is any indication,* many people now receiving heavily subsidized benefits are unwilling to give them up. Given the political clout of the elderly, it seems very unlikely that *nominal*† Medicare benefits will be reduced soon.

At the same time, there appears to be growing public recognition that the present arrangement places an unfair burden on others. For example, families with young children, who are thought to be just as deserving of access to health care as are either the elderly or Medicaid recipients who pay nothing for their care, are disadvantaged under the present system. Today many are forced to contribute precious financial resources for the care of others while they themselves must go without.

An evidently growing segment of the public believes that an equitable solution to this disparate treatment is a publicly financed universal health care system that would favor no class of beneficiaries over any other and, it is thought, would be less costly than either the current "mixed" health care arrangements or a purely market-based regime. As appealing as it may seem at first blush, from the perspective of both sound economics and social ethics, there would appear to be many difficulties with this approach.

Health Care Spending in Perspective

One of the principal advantages publicly financed health care is

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* Elder activists forced the repeal of the entire catastrophic coverage program on the basis of objections to the surtax on the high-income elderly, which would have helped to finance the program.

† This does not imply that actual benefits will not continue to be curtailed through reduced Medicare reimbursement practices under the DRG and relative value scale payment policies.

said to have over a market-based health care system is that a public system would be better equipped to "contain costs." As a primary example of the deficiencies of market-based medicine, advocates of universal health insurance cite the fact that, as a percent of Gross Domestic Product (GDP), health care expenditures in the United States are greater than in any other major industrialized nation—and still are increasing.

Although the numbers may be accurate, this argument is spurious. For one, a relatively high level of spending *per se* in no way reflects "deficiencies" in the way health care is provided. From a market perspective there is no rationale for believing that *any* particular level of health care expenditures represents the optimum. Individuals decide how much they wish to spend on their health in relation to other things, and very often that decision depends on the proportion of their wealth that *must* be spent on life's other necessities—food, shelter, clothing, etc. It is a matter of supposition that in economies where the necessities of life require less of one's resources, a relatively greater proportion will be directed toward improving health and longevity, which are the fundamental measures of the standard of living in any society. That the United States spends proportionally more on health care than any other country may indicate not that we somehow have "fallen behind" in managing health care, but that we have advanced economically beyond other nations—to the point that health concerns are markedly greater priorities here than elsewhere.

Hence, that we have chosen to devote more of our resources toward improving our health properly might be viewed as an indication of our relatively greater affluence. And there is ample reason to suppose that an even greater portion of our resources may be channeled that way in the future, especially if medical advances continue to encourage even greater consumption. Who would not want to invest in the discovery of a fountain of youth, which is what modern medicine in effect promises today? It should come as no surprise that the "product" of medicine in the United States, which has enabled millions to enjoy longer lives in better health than ever before, in recent decades has attained greater appeal in relation to other things.

Or to put it another way, in the last 3 decades consumer spending on, say, recreational goods and services has increased markedly as a proportion of total spending. Yet no one complains that the relative

level of spending on such items as stereos, VCRs, speedboats, or Las Vegas vacations, which is much higher in the United States than in most other countries, is "too high." Why, then, the preoccupation with containing the level of spending on health care, especially when it would seem to mirror priorities that, literally, are healthy ones?

Beyond this, our relatively greater health expenditures also reflect the aging of America and the fact that for the majority of the population life expectancies have increased markedly.* In relation to GDP, health care expenditures can be expected to increase disproportionately as the proportion of the elderly and longevity increase. The reason is uncomplicated: the aged contribute proportionally less to the other GDP components than they do to its health care component (the elderly consume relatively more health services than other age groups at the same time that, as retireds, they contribute less to the nonconsumption components of GDP). In part, then, our current level of spending on health care has been a predictable result of demographic contours that have little if anything to do with the way the health care markets operate.

Subsidies Create Price Spirals

But perhaps the greatest misunderstanding of health care cost pressures involves the Medicare and Medicaid subsidies. Appeals for greater Government intervention in our health care system often lay the blame for "high costs" on mismanaged hospitals, greedy doctors and lawyers (who prosecute malpractice suits), and profit-seeking insurance companies. But the chief culprits are Medicare and Medicaid themselves.

It is an axiom of economics that *subsidies of any kind create shortages that promote price spirals*. Subsidies affect supply, demand, and prices. Agricultural subsidies often involve restrictions on supply as well as "price supports" in the form of government purchases at above-market prices.

In the instances of Medicare and Medicaid, which serve to enlarge demand for medical services, the fully predictable result has been to increase the prices. It would seem that whenever a third party as-

* Only a very sharp reduction in life expectancy among young minorities, which is a consequence primarily of social pathology, has reduced aggregate life expectancies below those of some other industrialized nations.

sumes responsibility for payments there is a subsidy effect, with demand tending to increase and prices tending to be pressured upward. For example, it almost surely is not coincidental that with the advent of tax-exempt employer sponsored group health insurance after World War II, health care prices began to increase faster than the prices of other things. Indeed, the prices of health care related goods and services as measured by the Consumer Price Index (CPI) have increased faster than the prices of other goods and services in all but 6 years since 1947. The prices of Medicare-covered services, which hugely increased subsidies to elderly consumers, skyrocketed after its introduction in 1966.

Chart 1 shows the price of a semiprivate hospital room relative to the prices of five other types of health-related goods and services from 1947 to 1995. An increase in the relative price of a hospital room in any given period indicates that the change in the price of the hospital room was greater than the change in the price of the comparison item during that period. The chart shows clearly that the price of a hospital room accelerated in relation to the price of four relatively unsubsidized comparison items (dental care, eye care, prescription drugs, and vitamin supplements) precisely at the time Medicare was established in 1966. On the other hand, the price of hospital rooms relative to the price of physicians' services, which also were subsidized in 1966, accelerated much less, if at all. That is, the prices of subsidized hospital rooms and physicians' services both accelerated much more than those of the unsubsidized items. This is what economic theory would predict, and this is what has happened.

Subsidies Foster Scarcities—and Rationing

Even less well understood is the tendency for health care subsidies over the long run to create scarcities. Producer subsidies to farmers or manufacturers are designed to foster scarcity directly by keeping goods from reaching the market (*e.g.*, payments to farmers to keep land idle, grain purchase and storage programs, or quotas on auto imports). But consumer subsidies indirectly produce the same effects, which in the case of health care are especially injurious.

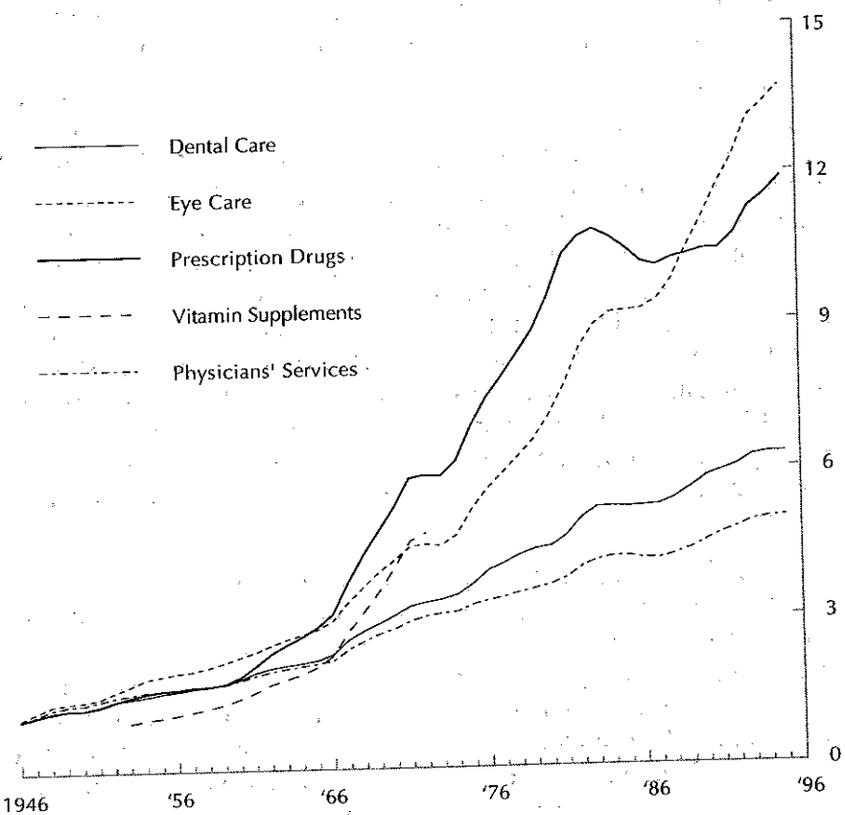
Stated simply, consumer subsidies for health care trigger a spiral of events that begins with accelerated demand and culminates in rationing, in which access to goods and services can be manipulated to suit the wishes of those with the greatest political clout. This has

happened in virtually every country that has adopted state-sponsored universal health insurance, and its implications dwarf the current "right to life" versus "pro-choice" abortion debate.

Ultimately, access to care is decided politically by the elite in power (one shudders to think what preferences some political factions might legislate). The eventual result is that someone other than the patient or the physician—usually a bureaucrat administering the "regulations" who has no interest in the outcome—decides who does or does not get what kind of care. A chief problem with the politically based allocation of scarce resources is that almost inevitably those resources are

Chart 1

RELATIVE PRICE OF Semiprivate HOSPITAL ROOMS



Source: Bureau of Labor Statistics, *Handbook of Labor Statistics* and *CPI Detailed Report.*

used in ways favored by the elite in control, but which may not be (indeed, almost never are) their most efficient use. Medical entitlements to sophisticated procedures such as heart bypass operations may be enormously politically attractive, but they are not cost effective in comparison with, say, immunization programs.

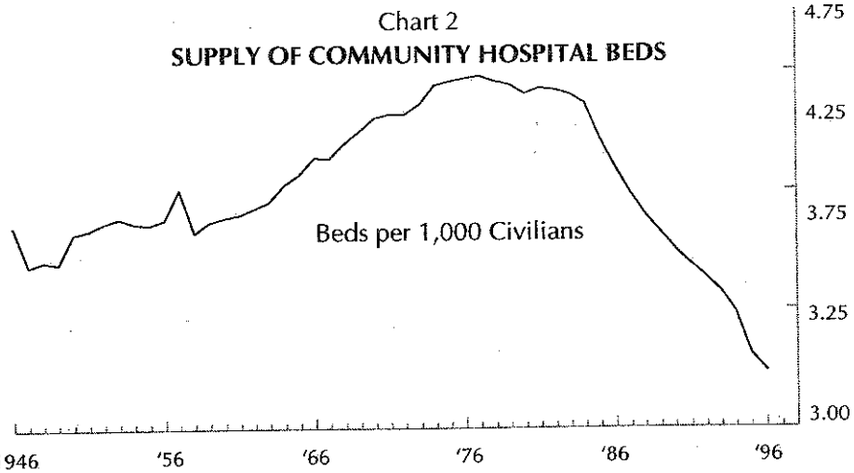
The point is that wherever resources are scarce, all needs cannot be satisfied and someone must make the decision as to how they will be distributed. In a market-based health care system, those decisions are made by the patient and doctor, who together arrive at the most cost-effective course of treatment within the range of affordability. Under this arrangement, virtually everyone who needs it gets some care. In a socialized health care environment, someone other than the patient or the doctor makes those decisions based on priorities that often are mechanistic and that may deny all care to those who do not meet certain qualifications (say, because you are "too old" or have "no dependents" or are not in a "crucial occupation").

The flip side of this situation is "supply side" scarcity that results from restraints that often are concurrently imposed on the providers of the subsidized goods and services. In the case of Medicare and Medicaid, for example, at least one "cost containment" initiative undertaken in the 1980s appears to have had measurable effects on the supply of one health care commodity. As shown in Chart 2, the supply of community hospital beds has dropped sharply since Medicare's substitution of the DRG prospective payment system for reimbursement of actual charges. (The average length of stay for Medicare patients decreased markedly following the introduction of the DRG system. Under that system, hospitals are paid a fixed fee for a given diagnosis and they benefit financially if actual costs are less than the payment they receive—that is, if patients are discharged quickly.)

Beyond this, regulation of physicians' charges under Medicare's "relative value scale" reimbursement policy almost surely will have unintended consequences over the long run. The reasoning behind the "relative value" policy is roughly as follows: on the basis of the time and resources it takes them to learn their respective specialties and the time they actually spend with patients, some doctors are paid "too much" and some "too little" under market-based pricing, and therefore all doctors' charges should be regulated to reflect more

Chart 2

SUPPLY OF COMMUNITY HOSPITAL BEDS



Source: *Historical Statistics of the United States: Colonial Times to 1970* and *Statistical Abstract of the United States.*

accurately the relative value of their inputs.

Such logic is seriously flawed, and betrays a lack of understanding of the role of prices (doctors' fees) in promoting self-regulating markets. It appears to depend on the assumption that the current allocation of human resources in the training of physicians reflects "optimal utility." In fact, the very presence of the "imbalances" that the relative value regime seeks to redress is *prima facie* evidence that this cannot be so. The genius of the market is that when some jobs are paid "too much" while others are paid "too little," soon there will be more people available to do the higher paying job. Markets rarely, if ever, reach, let alone sustain, equilibrium. But the continual process of adjustment insures that, *ceteris paribus*, vast imbalances cannot persist.

To enshrine existing imbalances via some incomes policy, which is what the "relative value scale" reimbursement scheme does, is economic insanity. Over the long run, it can be expected to drive talented individuals *away* from those medical occupations that, as evidenced by market prices, are most valued. Indeed, the long-run effects of price restraints, rationing of health care and the concomitant dilution of physician authority, and the many other attributes of politically regulated medicine are not hard to predict: they very likely will drive talented individuals away from medicine. In their most

completely developed expression (*i.e.*, in fully socialized medical environments) such restraints have been a powerful prescription for scarcities, even of the most elementary medical goods and services. Reportedly, it was hard to find even a bottle of aspirin in Soviet Russia during its final years.

Problems with Health Care "Rights"

Many people apparently believe that equal access to health care is a "right" which everyone in an advanced country such as the United States ought to enjoy. At the very least, however, the notion of rights of any kind requires that they be describable. In the case of health care, this would seem to imply some related level of benefits that is obvious. But it isn't. Some people rush to the doctor for every stubbed toe while others may be on their death beds before they will consent to see a doctor; the hypochondriac demands more care than the Christian Scientist.

The result is that any health care "rights" assigned to individuals with such disparate behavior will, in all likelihood, be viewed differently by their possessors. Some will view their rights far more expansively than others. And if health care rights are viewed broadly to describe treatment on demand, it is the hypochondriac who will consume scarce resources at the expense of others. If such rights are not so viewed, as they almost certainly would not be, then the problem of rationing is reintroduced, and the "rights" made conditional—which is but another way of saying there are no rights at all.

The larger problem is that human health and human behavior often are directly linked. Of course, many people who are "health conscious" and act in ways to promote their own good health still have heart attacks, get cancer, or suffer illness no matter how assiduously they follow a health regimen. But others by free choice engage in behavior that is known to lead directly to illness or accident. A question that follows is: should others be forced to pay the costs of care of those who persist in behavior that is risky? In this context, health care rights that convey equal access to care, or care on demand, would seem to imply disregard for the possible individual and social advantages of one type of behavior over another. Put another way, they would seem to subsidize pathological behavior which, broadly described, accounts for a substantial portion of health care expenditures in the United States today.

MEDICAL EXPENSE RECORD

			Medicare Paid		Supplemental Insurance Paid		Personal Payments		
Date	Description of Charges	Amount	Amount	Date	Amount	Date	Balance	Amount Paid	Date

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