October 2003 EB 2003-00

Health Care Planning:

A Health, Disability, and Long Term Care Risk Management Tool
2003 version

Steve Richards

Department of Applied Economics and Management
College of Agriculture and Life Sciences
Cornell University
Ithaca, NY 14853-7801

Health Care Planning:

A Health, Disability, and Long Term Care Risk Management Tool©

It is the policy of Cornell University actively to support equality of educational and employment opportunity. No person shall be denied admission to any educational program or activity or be denied employment on the basis of any legally prohibited discrimination involving, but not limited to, such factors as race, color, creed, religion, national or ethnic origin, sex, age or handicap. The University is committed to the maintenance of affirmative action programs which will assure the continuation of such equality of opportunity.

Publication Price per Copy: $12

For additional copies, contact:

NY FarmLink Program
Department of Applied Economics & Management
Cornell University
415 Warren Hall
Ithaca, NY 14853-7801
1-800-547-3276

Acknowledgements

The author wishes to thank Faye Anderson, Anita Cassard, Marcy Robinson Dembs, Bruce Erath, Jeff Fetter, Don Gladle, Gale Gould, Mary Jo Long, and Bruce Porter for their input into this document as well as their valuable help in arranging the Agricultural Health Care Summit, on which this workbook was based. However, any errors or omissions are solely the responsibility of the author.

©Copyright 2003. Steve Richards, NY FarmLink, Department of Applied Economics and Management, College of Agriculture and Life Sciences, Cornell University. All rights reserved.

An Important Message

This workbook provides information and general advice about health care law, government services, and insurance products. However laws, government programs, and insurance regulations change frequently and they can be interpreted differently by different people. If your workbook is over a year old, it is most likely out of date. For advice geared toward your specific situation, consult an expert. No published material is a substitute for personalized advice from a knowledgeable lawyer or health care professional. If you need help finding lawyers and other professionals knowledgeable in farm business issues contact NY FarmLink at 1-800-547-3276.

Table of Contents

Introduction 5

- Risk assessment outline
- Risk management and insurance

Chapter 1: Health insurance: Understanding your options 7

- Understanding health insurance terms
- Types of health insurance policies
- What plan is right for me?
- Questions to ask your policy provider

Chapter 2: Federal and state health care programs for those under 65 13

- Individuals and families: Medicaid, Family Health Plus, and the Hill-Burton Act
- Small businesses and families: Healthy New York Program
- Children's insurance: Child Health Plus A and Child Health Plus B
- Pregnant women: PCAP/MOMS

Chapter 3: Healthcare for those over 65 years of age 17

- Medicare
- Medicare Part A and Part B
- Supplemental strategies
- Private insurance: Medicare Supplemental (Medigap)
- Questions to ask your Medigap insurance provider
- New York State programs: EPIC

Chapter 4: Disability: Social Security and Private Insurance 23

- Social Security Disability: Eligibility
- Social Security: payments and supplementing SS Disability income
- Keeping your Social Security Disability benefits
- Private disability insurance/questions to ask your provider

Chapter 5: Assisted Living: Medicare, Medicaid, and Long Term Care Insurance 29

- Assisted Living: chances you'll need it, options, and costs
- How will you pay for it? Medicare, Medicaid, and Long Term Care insurance
- Tips for buying Long Term Care insurance

Chapter 6: Money and Business Saving Strategies 35

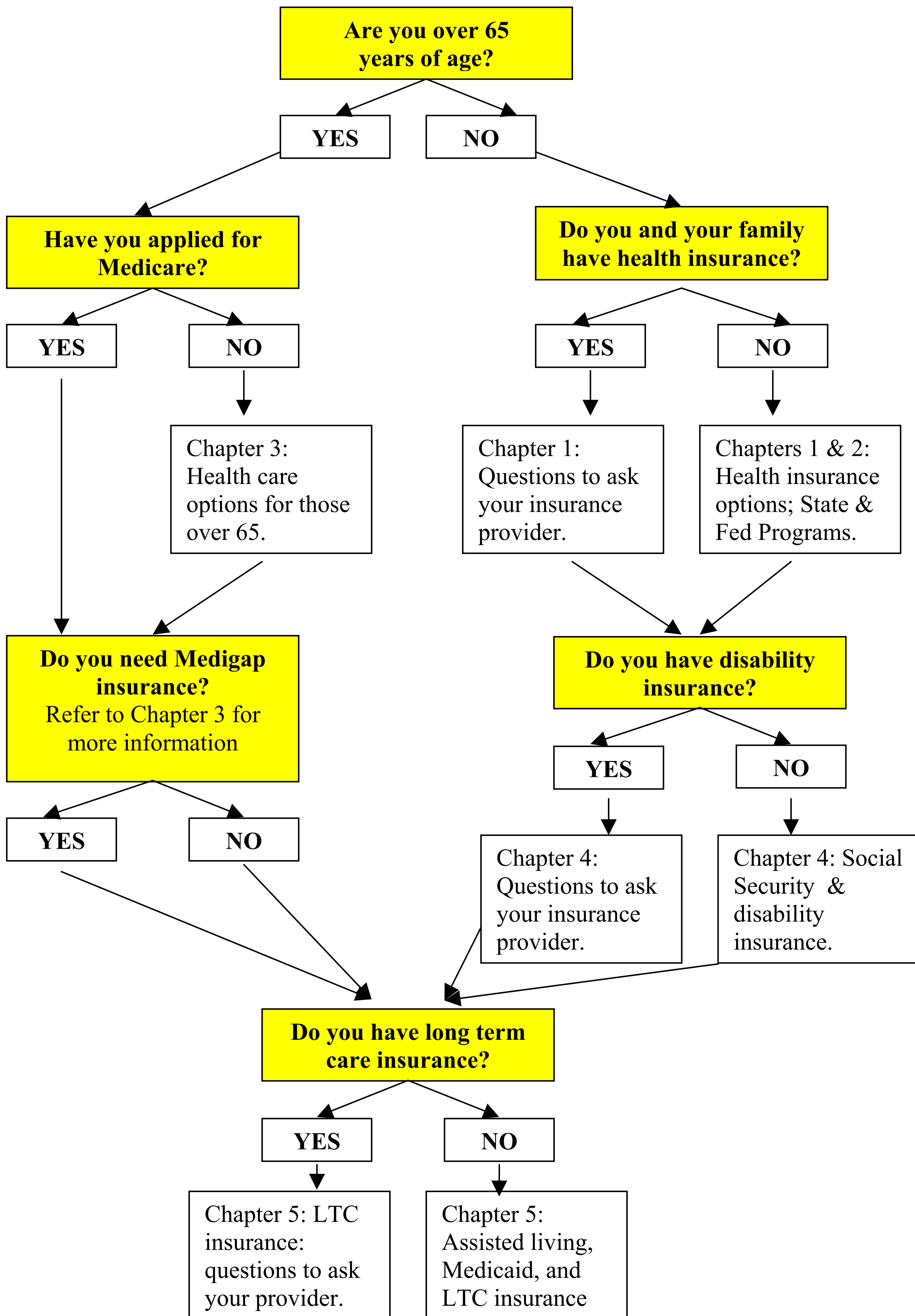
- General ways to save money on insurance
- Health care strategies (insurance and government programs)
- Medicaid and asset protection
- Business continuation strategies

Worksheets 41

- Health insurance quiz
- Checklist: What is most important to you? Worksheet: what is your best buy?
- Worksheet: Determining your disability insurance needs

Resources 45

- Health Care Summit resources and referrals
- County Enroller contact information
- Hill-Burton Act obligated facilities
- NY State Department of Health 1-800 Help lines
- References used for this workbook



Are you over 65 years of age?
YES
NO
Have you applied for Medicare?
Do you and your family have health insurance?
YES
NO
YES
NO
Chapter 3: Health care options for those over 65.
Chapter 1: Questions to ask your insurance provider.
Chapters 1 & 2: Health insurance options; State & Fed Programs.
Do you need Medigap insurance?
Refer to Chapter 3 for more information
Do you have disability insurance?
YES
NO
YES
NO
Chapter 4: Questions to ask your insurance provider.
Chapter 4: Social Security & disability insurance.
Do you have long term care insurance?
YES
NO
Chapter 5: LTC insurance: questions to ask your provider.
Chapter 5: Assisted living, Medicaid, and LTC insurance

Risk management and insurance

The term "risk management" is often used interchangeably with the term "insurance." While this is not necessarily true, risk management does include many options where a decision to purchase insurance is necessary. All insurance policies and insurance companies are not created equal. One must be careful when making a purchase. Below are some general tips one should follow, regardless of the type of policy being considered.

Things to consider when purchasing an insurance policy

1. Review your insurance needs and circumstances. This workbook will help you with this step.
2. Comparison shop. Contact several companies and/or agents to compare benefits, coverage, exclusions, and premiums.
3. Don't be misled by advertising and don't believe anything that isn't in writing.
4. Get your insurance agent's name, address and phone number as well as the parent company that he or she works for.
5. Understand you policy. If you do not, ask for clarification. Do not be afraid to call the insurance agent's parent company or hire an attorney to explain it to you.
6. Be sure the insurance company you are considering is financially stable. Almost all insurers are ranked by either A.M. Best Company, Standard and Poor's Corporation, Fitch IBCA, Dulph & Phelps, and/or Moody's Investors Service. It is advised that you go with a company that is ranked in the top three categories. You can also call the New York State Department of Insurance at 1-800-342-3736.
7. Do not make any quick decisions. Request a copy of the policy and compare it with policies from different insurance companies.
8. Do not be fooled into thinking you need several policies for additional coverage. You only need one good policy.
9. Be sure your application is complete and accurate, including all of your medical history, if applicable. If you application is misleading in any way, you could be denied coverage.
10. Write a check, payable to the insurance company. Do not pay in cash.
11. Your policy should arrive within 60 days. If you do not receive it, contact the company or agent.
12. After you receive your policy, reread it to be sure everything is correct.
13. If something is not correct, or you are unsatisfied with the policy, return the policy within 30 days for a refund. Use certified mail and keep all documentation.
14. Pay premiums on a timely basis. Have the withdrawn from your check automatically, if possible.

Chapter 1: Health Insurance Options[1]

For most people, health insurance choices are governed either by what their employer offers them or which policy they can afford. Few take the next step to read and understand their policies, to make sure that they are covered against a health crisis and a financial disaster. At the very minimum, the policy should fit your specific needs, cover major medical expenses, and pay benefits to the highest level. To familiarize yourself with health insurance policies, you should understand health insurance terms, the types of that are offered, and what questions to ask your insurance provider.

Understanding health insurance terms

Coinsurance: The amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible. The coinsurance rate is usually expressed as a percentage. For example, if the insurance company pays 80 percent of the claim, you pay 20 percent.

Coordination of benefits: A system to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100 percent of the claim.

Co-payments: Another way of sharing medical costs. You pay a flat fee every time you receive a medical service (for example, $5 for every visit to the doctor). The insurance company pays the rest.

Covered expenses: Most insurance plans, whether they are fee-for-service, HMOs, or PPOs, do not pay for all services. Some may not pay for prescription drugs. Others may not pay for mental health care. Covered services are those medical procedures the insurer agrees to pay for. They are listed in the policy.

Deductible: The amount of money you must pay each year to cover your medical care expenses before your insurance policy starts paying.

Exclusions: Specific conditions or circumstances for which the policy will not provide benefits.

Managed care: Ways to manage costs, use, and quality of the health care system. All HMOs and PPOs, and many fee-for-service plans, have managed care.

Maximum out-of-pocket: The most money you will be required pay a year for deductibles and coinsurance. It is a stated dollar amount set by the insurance company, in addition to regular premiums.

Non-cancelable policy: A policy that guarantees you can receive insurance, as long as you pay the premium. It is also called a guaranteed renewable policy.

Preexisting condition: A health problem that existed before the date your insurance became effective.

Premium: The amount you or your employer pays in exchange for insurance coverage.

Primary care doctor: Usually your first contact for health care. This is often a family physician or internist, but some women use their gynecologist. A primary care doctor monitors your health and diagnoses and treats minor health problems, and refers you to specialists if another level of care is needed.

Provider: Any person (doctor, nurse, dentist) or institution (hospital or clinic) that provides medical care.

Third-party payer: Any payer for health care services other than you. This can be an insurance company, an HMO, a PPO, or the Federal Government.

"Customary" fee: Most insurance plans will pay only what they call a reasonable and customary fee for a particular service. If your doctor charges $1,000 for a hernia repair while most doctors in your area charge only $600, you will be billed for the $400 difference. This is in addition to the deductible and coinsurance you would be expected to pay. To avoid this additional cost, ask your doctor to accept your insurance company's payment as full payment. Or shop around to find a doctor who will. Otherwise you will have to pay the rest yourself.

Types of insurance policies

There are three main types of health insurance policies: Fee-For-service, Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs).

Fee-For-Service. This is the traditional kind of health care policy. Insurance companies pay fees for the services provided to the insured people covered by the policy. This type of health insurance offers the most choices of doctors and hospitals. You can choose any doctor you wish and change doctors any time. You can go to any hospital in any part of the country.

With fee-for-service, the insurer only pays for part of your doctor and hospital bills. This is what you pay:

- A monthly fee, called a premium.
- A certain amount of money each year, known as the deductible, before the insurance payments begin. In a typical plan, the deductible might be $250 for each person in your family, with a family deductible of $500 when at least two people in the family have reached the individual deductible. The deductible requirement applies each year of the policy. Also, not all health expenses you have count toward your deductible. Only those covered by the policy do. You need to check the insurance policy to find out which ones are covered.
- After you have paid your deductible amount for the year, you share the bill with the insurance company. For example, you might pay 20 percent while the insurer pays 80 percent. Your portion is called coinsurance.

To receive payment for fee-for-service claims, you may have to fill out forms and send them to your insurer. Sometimes your doctor's office will do this for you. You also need to keep receipts for drugs and other medical costs. You are responsible for keeping track of your medical expenses.

There are limits as to how much an insurance company will pay for your claim if both you and your spouse file for it under two different group insurance plans. A coordination of benefit clause usually limits benefits under two plans to no more than 100 percent of the claim.

Most fee-for-service plans have a "cap," the most you will have to pay for medical bills in any one year. You reach the cap when your out-of-pocket expenses (for your deductible and your coinsurance) total a certain amount. It may be as low as $1,000 or as high as $5,000. Then the insurance company pays the full amount in excess of the cap for the items your policy says it will cover. The cap does not include what you pay for your monthly premium.

Some services are limited or not covered at all. You need to check on preventive health care coverage such as immunizations and well-child care.

There are two kinds of fee-for-service coverage: basic and major medical. Basic protection pays toward the costs of a hospital room and care while you are in the hospital. It covers some hospital services and supplies, such as x-rays and prescribed medicine. Basic coverage also pays toward the cost of surgery, whether it is performed in or out of the hospital, and for some doctor visits. Major medical insurance takes over where your basic coverage leaves off. It covers the cost of long, high-cost illnesses or injuries.

Some policies combine basic and major medical coverage into one plan. This is sometimes called a "comprehensive plan." Check your policy to make sure you have both kinds of protection.

Health Maintenance Organizations (HMOs). Health maintenance organizations are prepaid health plans. As an HMO member, you pay a monthly premium. In exchange, the HMO provides comprehensive care for you and your family, including doctors' visits, hospital stays, emergency care, surgery, lab tests, x-rays, and therapy.

The HMO arranges for this care either directly in its own group practice and/or through doctors and other health care professionals under contract. Usually, your choices of doctors and hospitals are limited to those that have agreements with the HMO to provide care. However, exceptions are made in emergencies or when medically necessary.

There may be a small co-payment for each office visit, such as $5 for a doctor's visit or $25 for hospital emergency room treatment. Your total medical costs will likely be lower and more predictable in an HMO than with fee-for-service insurance.

Because HMOs receive a fixed fee for your covered medical care, it is in their interest to make sure you get basic health care for problems before they become serious. HMOs typically provide preventive care, such as office visits, immunizations, well-baby checkups, mammograms, and physicals. The ranges of services covered vary in HMOs, so it is important to compare available plans. Some services, such as outpatient mental health care, often are provided only on a limited basis.

Many people like HMOs because they do not require claim forms for office visits or hospital stays. Instead, members present a card, like a credit card, at the doctor's office or hospital. However, in an HMO you may have to wait longer for an appointment than you would with a fee-for-service plan.

In some HMOs, doctors are salaried and they all have offices in an HMO building at one or more locations in your community as part of a prepaid group practice. In others, independent groups of doctors contract with the HMO to take care of patients. These are called individual practice associations (IPAs) and they are made up of private physicians in private offices who agree to care for HMO members. You select a doctor from a list of participating physicians that make up the IPA network. If you are thinking of switching into an IPA-type of HMO, ask your doctor if he or she participates in the plan.

In almost all HMOs, you either are assigned or you choose one doctor to serve as your primary care doctor. This doctor monitors your health and provides most of your medical care, referring you to specialists and other health care professionals as needed. You usually cannot see a specialist without a referral from your primary care doctor who is expected to manage the care you receive. This is one way that HMOs can limit your choice.

Before choosing an HMO, it is a good idea to talk to people you know who are enrolled in it. Ask them how they like the services and care given.

Preferred Provider Organizations (PPOs). The preferred provider organization is a combination of traditional fee-for-service and an HMO. Like an HMO, there are a limited number of doctors and hospitals to choose from. When you use those providers (sometimes called "preferred" providers, other times called "network" providers), most of your medical bills are covered.

When you go to doctors in the PPO, you present a card and do not have to fill out forms. Usually there is a small co-payment for each visit. For some services, you may have to pay a deductible and coinsurance.

As with an HMO, a PPO requires that you choose a primary care doctor to monitor your health care. Most PPOs cover preventive care. This usually includes visits to the doctor, well-baby care, immunizations, and mammograms.

In a PPO, you can use doctors who are not part of the plan and still receive some coverage. At these times, you will pay a larger portion of the bill yourself (and also fill out the claims forms). Some people like this option because even if their doctor is not a part of the network, it means they don't have to change doctors to join a PPO.

Picking a Health Insurance Policy

Questions to Ask your Insurance Service Provider/Insurance Company

1. What will the plan pay for and what won’t it pay for?
2. Ask your agent to show your policies from several insurers so you can compare them
3. Make sure the policy protects your from large medical costs
4. Make sure you understand the policy—is it right for you with no surprises?
5. Is there a waiting period or a date when the policy starts paying
6. Make sure there is a “free look” clause. Gives you some time to look over the policy and decide whether it is right or not. If you don’t like it, you can return it for a premium refund.
7. Beware of single disease insurance policies—policies that only offer protection for one disease and not others.

Questions to ask about Fee-for-Service insurance

- How much is the monthly premium? What will your total cost be each year? There are individual rates and family rates.
- What does the policy cover? Does it cover prescription drugs, out-of-hospital care, or home care? Are there limits on the amount or the number of days the company will pay for these services? The best plans cover a broad range of services.
- Are you currently being treated for a medical condition that may not be covered under your new plan? Are there limitations or a waiting period involved in the coverage?
- What is the deductible? Often, you can lower your monthly health insurance premium by buying a policy with a higher yearly deductible amount.
- What is the coinsurance rate? What percent of your bills for allowable services will you have to pay?
- What is the maximum you would pay out of pocket per year? How much would it cost you directly before the insurance company would pay everything else?
- Is there a lifetime maximum cap the insurer will pay? The cap is an amount after which the insurance company won't pay anymore. This is important to know if you or someone in your family has an illness that requires expensive treatments.

Questions to ask about an HMO

- Are there many doctors to choose from? Do you select from a list of contract physicians or from the available staff of a group practice? Which doctors are accepting new patients? How hard is it to change doctors if you decide you want someone else? How are referrals to specialists handled?
- Is it easy to get appointments? How far in advance must routine visits be scheduled? What arrangements does the HMO have for handling emergency care?
- Does the HMO offer the services I want? What preventive services are provided? Are there limits on medical tests, surgery, mental health care, home care, or other support offered? What if you need a special service not provided by the HMO?
- What is the service area of the HMO? Where are the facilities located in your community that serve HMO members? How convenient to your home and workplace are the doctors, hospitals, and emergency care centers that make up the HMO network? What happens if you or a family member are out of town and need medical treatment?
- What will the HMO plan cost? What is the yearly total for monthly fees? In addition, are there co-payments for office visits, emergency care, prescribed drugs, or other services? How much?

Questions to ask about a PPO

- Are there many doctors to choose from? Who are the doctors in the PPO network? Where are they located? Which ones are accepting new patients? How are referrals to specialists handled?
- What hospitals are available through the PPO? Where is the nearest hospital in the PPO network? What arrangements does the PPO have for handling emergency care?
- What services are covered? What preventive services are offered? Are there limits on medical tests, out-of-hospital care, mental health care, prescription drugs, or other services that are important to you?
- What will the PPO plan cost? How much is the premium? Is there a per-visit cost for seeing PPO doctors or other types of co-payments for services? What is the difference

in cost between using doctors in the PPO network and those outside it? What is the deductible and coinsurance rate for care outside of the PPO? Is there a limit to the maximum you would pay out of pocket?

Check out your insurer!
Find out what local or national patient advocacy groups have to say about the insurer. There are rankings of HMO's in US News and World Report as well as consumers' guides published by New York State. To obtain a copy of HMO rankings or Managed Care Performance in New York, contact the Department of Health at 518-486-6074 or visit www.health.state.ny.us.

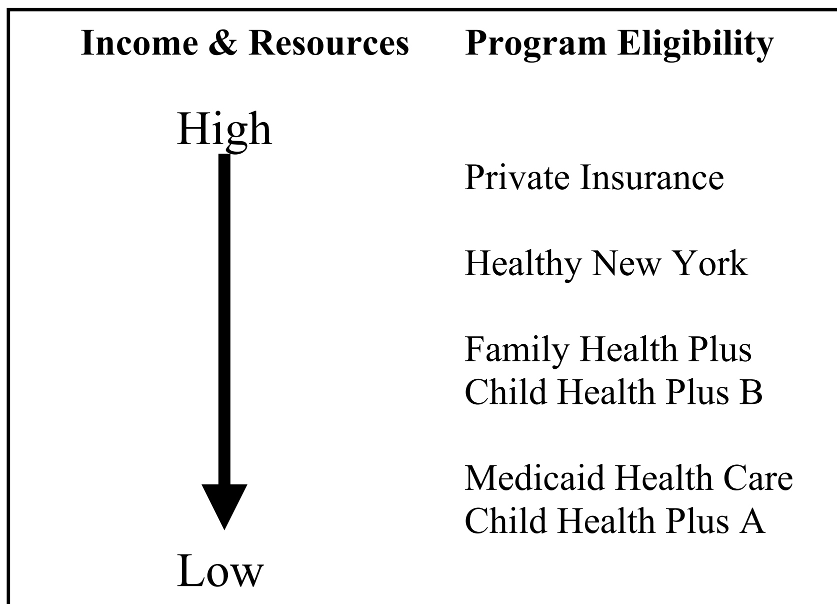
What plan is best for me?
At the back of this workbook, there are three worksheets that will help you decide which insurance policy is best for you:

Health Insurance Quiz, Page 41
Checklist: What is Most Important to You? Page 42
Worksheet: What is Your Best Insurance Buy? Page 43

Chapter 2: Federal and State Programs (Those Under 65)

For those that cannot afford health insurance, there are federal and state programs that can help. Eligibility for these programs is based on income and resources of the individual and/or family. Income being your annual earnings and resources are the assets that you own (savings accounts, house, car, and/or business assets). *To find out if you are eligible for any of the State or Federal Programs in New York, it would be wise to contact a facilitated enroller in your county*. For a list of enrollers, check the reference section in the back of the workbook. Program availability may also vary from county to county.

In general, the table below shows the programs that are available, depending upon income and resource levels:



Individuals and families

Medicaid (1-800-206-8125 or your County Enroller): The Medicaid Program provides medical assistance for certain individuals and families with low incomes and resources. Medicaid eligibility is limited to individuals who fall into specific categories. Although the Federal government establishes general guidelines for the program, the Medicaid program eligibility requirements are actually established by each State and you need to apply for Medicaid in your county of residence. Sources for state information are available through your county enroller (listed in the back) or the New York State Department of Health at Albany County DSS, 162 Washington Avenue, Albany NY 12210; Phone: 1-800-206-8125. Below are the 2003 income and resource guidelines:

Medicaid Health Care		
Family Size	**Gross Income/Month**	**Resource Limits**
1	Under $642	Under $3850
2	Under $934	Under $5600
3	Under $942	Under $5650
4	Under $950	Under $5700
5	Under $992	Under $5950
6	Under $1134	Under $6800

Family Health Plus (1-877-934-7587 or your County Enroller): Family Health Plus is a public health insurance program for adults between the ages of 19 and 64 who do not have health insurance — either on their own or through their employers — but have incomes too high to qualify for Medicaid. Family Health Plus is available to single adults, couples without children, and parents with limited income who are residents of New York State and are United States citizens or fall under one of many immigration categories. Family Health Plus only considers income and does not consider resources (assets) for eligibility—*making many more farm businesses eligible for this program than would be eligible for Medicaid*.

Family Health Plus provides comprehensive coverage, including prevention, primary care, hospitalization, prescriptions and other services. There are no costs to participate in Family Health Plus. Health care is provided through participating managed care plans in your area.

Maximum Gross Annual Income Guide Effective January 1, 2003 (rev. 3/2003)			
Family Size	**Yearly Income**	**Monthly Income**	**Weekly Income**
Single Adult	$ 8,980	$ 749	$173
Couples with No Children	$12,120	$ 1,010	$233
Family Size 2	$18,180	$1,515	$350
Family Size 3	$22,890	$1,908	$440
Family Size 4	$27,600	$2,300	$531
Family Size 5	$32,310	$2,693	$622
Family Size 6	$37,020	$3,085	$712
Family Size 7	$41,730	$3,478	$803
For each additional person add:	$ 4,710	$ 393	$ 90

Hill-Burton Act (1-800-638-0742): In 1946, Congress passed P.L. 79-725, the Hospital Survey and Construction Act, sponsored by Senators Lister Hill and Harold Burton, widely known as the Hill-Burton Act. It was the Nation's major health facility construction program under Title VI of the Public Health Service Act. Originally designed to provide Federal grants to modernize hospitals which had become obsolete due to lack of capital investment throughout the period of the Great Depression and World War II (1929 to 1945), the program has changed over time to address other types of infrastructure needs. Since 1946, more than $4.6 billion in Hill-Burton grant funds as well as $1.5 billion in loans have aided nearly 6,800 health care facilities in over 4,000 communities. **In return for Federal funds, facilities agreed to provide free or reduced charge medical services to persons unable to pay (income based guidelines).**

For more information, refer to the reference section to find a list of Hill-Burton obligated facilities. You may also call the Hill Burton Hotline at 1-800-638-0742, which is open 24 hours a day to answer questions.

Small businesses and families

Healthy New York Program (1-866-432-5849). The Health Care Reform Act of 2000 introduced a program entitled "Healthy NY" which promotes access to quality health care by providing comprehensive health insurance to those citizens who need it most.

The Healthy NY program is designed to assist small business owners in providing their employees and their employees' families with health insurance. In addition, uninsured workers whose employers do not provide health insurance may also purchase comprehensive coverage directly through the Healthy NY program.

Healthy NY is a unique program designed to encourage small employers to offer health insurance coverage to their employees, dependents, and other qualified individuals. It creates standardized health insurance benefit packages to be offered by all health maintenance organizations that are made more affordable through State sponsorship, so that more uninsured small employers and uninsured employed individuals should be able to purchase health insurance coverage.

Although Healthy NY is available to small employers, sole proprietors, and uninsured working individuals, each group has its own distinctive set of eligibility criteria and participation rules. An income eligibility chart for sole proprietors and individuals for 2003 is included below.

Healthy NY Income Guidelines*		
Family Size	Annual Household Income	Monthly Household Income
1	Up to $22,575	Up to $1,882
2	Up to $30,425	Up to $2,536
3	Up to $38,275	Up to $3,190
4	Up to $46,125	Up to $3,844
5	Up to $53,975	Up to $4,498
Each extra person	Add $7,850	Add $655

Children's insurance

Child Health Plus (1-800-698-4KIDS or County Enroller): New York State has a health insurance plan for kids, called Child Health Plus. Depending on your family's income, your child may be eligible to join either Child Health Plus A (formerly Children's Medicaid) or Child Health Plus B. Both Child Heath Plus A and B are available through dozens of providers throughout the state.

To be eligible for either Child Health Plus A or Child Health Plus B, children must be under the age of 19 and be residents of New York State. Whether a child qualifies for Child Health Plus A or Child Health Plus B depends on gross family income. Children who are not eligible for Child Health Plus A can enroll in Child Health Plus B if they don't already have health insurance and are not eligible for coverage under the public employees' state health benefits plan. Below is the 2003 chart of income eligibility and premiums for 2003. *Your County Enroller has the most updated income charts available for eligibility under Child Health Plus A and Child Health Plus B.*

Family Size	Gross Income/Month	Gross Income/Month	Gross Income/Month	Gross Income/Month	Income Over
1	$642 to $996	$996 to $1197	$1197 to $1662	$1662 to $1871	$1,871
2	$934 to $1344	$1344 to $1615	$1615 to $2243	$2243 to $2525	$2,525
3	$942 to $1692	$1692 to $2034	$2034 to $2824	$2824 to $3180	$3,180
4	$950 to $2040	$2040 to $2453	$2453 to $3404	$3404 to $3834	$3,834
5	$992 to $2388	$2388 to $2871	$2871 to $3985	$3985 to $4488	$4,488
6	$1134 to $2736	$2736 to $3290	$3290 to $4566	$4566 to $5412	$5,142
Each add'l	+$142 to $349	+$419	+$581	+$655	
Eligibility	**CHP A/Medicaid**	**Child Health Plus B**	**Child Health Plus B**	**Child Health Plus B**	**CHP B**
Premiums	**$0**	**$0**	**$9/child; $27/family**	**$15/child; $45/family**	**Full premium**

Pregnant women

PCAP/MOMS (1-800-522-5006): The Prenatal Care Assistance Program (PCAP) offers complete pregnancy care and other health care services to women and teens who live in New York State. The Medicaid Obstetrical and Maternal Services (MOMS) Program provides complete pregnancy services in areas of the state where PCAP health centers are not located. There's no cost to eligible women who participate in MOMS or PCAP! Call the 1-800 number above to find out more about eligibility.

Prescription drug help

Needy Meds (www.needymeds.com): Many drug manufacturers have what's called Patient Assistance Programs. These programs are designed to help those who can't afford their medicines obtain them at no cost or low cost. Unfortunately, many people, including doctors, nurses, social workers, and patients, don't know that these programs exist. The needy meds website contains the latest, most complete, and most accurate information on patient assistance programs available. You do not apply for these programs through needy meds, rather you apply through the individual drug manufacturers. You will need to know who manufactures your prescriptions so that you can apply to the correct manufacturer.

Chapter 3: Health Care For Those Over 65

Federal programs

Medicare (1-800-772-1213): Medicare is a federal program that assists persons over 65 in paying their medical costs. The program is divided into three parts: A, B, and C. Part A is hospital insurance (inpatient), and covers most of the costs involved in a hospital stay. Part B is medical insurance, and pays some of the costs of doctors and outpatient care. Part C is a collection of Medicare supplemental policies often called Medicare +Choice plans.

The Medicare program is administered through private insurance providers—so most of the correspondences to/from Medicare will come through a private provider (i.e. Blue Cross/Blue Shield).

Medicare Part A: Hospital care

Eligibility: Persons over 65 years of age (and some others listed below).

Cost/Premiums: Most qualify for free coverage. Those who are automatically eligible for free coverage are:

- ☒ People over 65 who are eligible for Social Security retirement benefits.
- ☒ People over 65 who are eligible to collect Social Security dependants or survivors benefits.
- ☒ People of any age who have been entitled to Social Security disability benefits for 24 months (does not have to be consecutive).
- ☒ Anyone who has permanent kidney failure; requiring dialysis—if they or their spouse has acquired the appropriate number of Social Security work credits.
- ☒ Anyone who has Lou Gehrigs disease or end stage renal failure.

Those that do not qualify for free coverage may still obtain Medicare Part A, but will have to pay a monthly premium. *Those that have over 30 work credits pay a lower premium than those who have less than 30 credits (for an explanation of work credits, see the section on Social Security Disability in Chapter 4)*.

Coverage: Mostly those costs associated with inpatient care in the United States. In some cases, Medicare Part A will pay for some Skilled Nursing Facility Care (up to 100 days), but you must have a prior stay (at least 3 consecutive days) in a hospital and your doctor must verify that you needed daily skilled nursing care for medical treatment (custodial care like feeding, bathing, and eating are not covered). Doctor’s bills are not covered by Medicare Part A. Also, Medicare Part A coverage only extends to a Medicare Approved Facility or Health Care Agency. Hospice care (home health care for the terminally ill) can be almost fully covered by Medicare Part A.

How much does Medicare Part A pay? Medicare Part A may not pay the full bill, depending upon what the treatment was, how long you stayed in the hospital, and what your deductible is (which is increased every year). For more information, refer to a Medicare Benefits publication listed in the reference section of the workbook.

Medicare Part B: Medical insurance
Eligibility: Any US citizen that is over 65 years of age.

Cost/Premiums: everyone enrolled in Medicare Part B must pay a monthly premium.

Coverage: Medicare Part B is for medically necessary services: a portion of doctor bills, outpatient care, laboratory and diagnostic work, some home health care, and rehabilitation. Very few medical supplies or drugs are covered by Medicare Part B (although prescription drug benefits are in the works in congress at this time). There are also tough restrictions on what is covered and what benefits will be paid for. For instance, non-traditional medical care, vaccinations and immunizations (except for the flu vaccine), prescription drugs (not yet anyway), eyesight and hearing exams, and dental work are not covered by Medicare Part B.

How much does Medicare Part B pay? This depends upon your deductible, and the approved amounts for each procedure that Medicare specifies. Medicare only pays for 80% of approved charges (the amount that Medicare thinks is fair for that particular service or procedure). If the bill is above what Medicare has approved, you pay that amount out of your pocket as well. The most dangerous of these charges are the outpatient bills—which can leave the patient paying up to 50% of the total bill.

Important Note: To be eligible to participate in a Medicare Supplemental insurance plan (Medigap or Medicare Part C), you need to have applied for Medicare part B. If you already receive Social Security retirement benefits, you will automatically be enrolled in Medicare Part B. However, if you are not automatically enrolled and do not apply for Medicare Part B within 3 months of turning 65, you will end up paying more for Medicare Supplemental insurance! Also, many insurance plans switch you automatically from your previous plan to a Medicare supplemental plan after you turn 65. If you have not applied for Medicare and you make a claim, you will be responsible for the portion that Medicare Part B would have paid, had you applied for it.

Medicare Part C and other supplemental strategies
The short descriptions of Medicare above show that Medicare does not provide full coverage for all health care needs. In total, Medicare only pays for about half of all medical costs for people over 65[2]. What can a senior citizen do about these gaps in Medicare coverage? There are six basic strategies:

1. Do nothing: pay for the uncovered service out of pocket.

2. Hold on to your current health insurance policy. A good idea for those employed by others—the costs of the policy are born by someone else. Those that own their own businesses might find this more expensive than some of the other options, but the costs and benefits have to be compared to make a good decision—it might be quite a bit cheaper, depending upon what coverage is most important to you at the time. Holding on to your current policy might be difficult: Insurance companies and employers will try to push those over 65 into some sort of plan that includes Medicare. In addition, if you are transferring the business or retiring, your current policy provider may drop you

automatically when your name no longer appears on the business tax returns. Some managed care policies will drop seniors for no reason at all.

3. Purchase a Medigap policy: Medigap Insurance, or Medicare Supplemental Insurance, is designed to fill the holes in health care that Medicare doesn't cover. When purchasing Medigap Insurance, keep in mind what specific gaps in Medicare that you want to fill. See the section below for more information on Medigap policies.

4. Medicare Part C Managed Care (Medicare + Choice Plan): Just like it works with regular managed care policies before your were 65. Basically, you agree to receive care from specific doctors and hospitals for a reduced fee. You need to be careful when making this decision, as this may affect your future choices of Medigap insurance, and the HMO providers can drop your coverage with a written notice at any time. The Medicare Managed Care plans take one of four structures:

   a *Health Maintenance Organization*: the least expensive, but most restrictive. All care for the patient has to come from the designated "network" which comprises the Health Maintenance Organization (HMO).
   b *HMO with Point of Service (POS)*: like an HMO, but you can visit any doctor you like without first visiting your primary care physician. More expensive than a traditional HMO.
   c *Preferred Provider Organization (PPO)*: basically the same as HMO with Point of Service, but that you choose who provides your health care from a list of network members.
   d *Provider Sponsored Organization (PSO)*: you contract directly with a group of physicians that have established their own network, skipping the middleman.

5. Medicare Part C Fee-for-Service Plans (Medicare + Choice Plan): Medicare pays the doctor or hospital for the care you get and you pay the co-payment and an additional premium. Judging what expenses will be out of pocket can be tricky, as any expenses above what the plan agrees to pay come out of your pocket. Just like managed care providers, fee-for-service insurance providers can drop your coverage at any time.

6. Medicaid: Remember, Medicaid is for low-income and financially needy people, which includes those over 65. If you are eligible for Medicaid, you can have Medicaid pick up costs that aren't covered by Medicare; including diagnostic and preventative care and eyeglasses. Medicaid can also pay the deductibles (the 20% portion of charges not paid by Medicare) and the Medicare premiums.

Private insurance (Medicare supplemental policies)
The federal government has regulated Medigap insurance policies into just 10 different choices of coverage. These plans, A through J, are standard Medicare supplemental policies at all insurance companies. See the table and descriptions below to compare policies. Plans H, I, and J are not offered in New York State.

Medigap Benefits by Plan

Medigap Benefits	A	B	C	D	E	F	G	H	I	J
Core Benefits	x	x	x	x	x	x	x	x	x	x
Part A Hospital Deductible		x	x	x	x	x	x	x	x	x
Part A: Skilled Nursing Home Co- Insurance			x	x	x	x	x	x	x	x
Part B deductible			x			x				x
Foreign Travel			x	x	x	x	x	x	x	x
At home Recovery				x			x		x	x
Part B: Excess Doctor Charges						100%	80%		100%	100%
Preventative Screening					x					x
Outpatient Prescription drugs								Basic	Basic	Extended

Core Benefits offered by ALL Medigap plans (A through J):

- Hospital co-insurance payment for days 61 through 90.
- Co-insurance payment during the 60 lifetime reserve days. (See Medicare Part A for more information).
- Full coverage for 365 hospital confinement days after the lifetime reserve days are used. Beneficiaries may be responsible for payment when Medigap hospital benefits are exhausted.
- Co-insurance payment for Part B services (usually 20% of approved amount; 50% of approved charges for outpatient mental health services) after the $100 dollar annual deductible.
- First three pints of blood per calendar year.

Medigap policies pay most, if not all, of the Medicare co-insurance payments and most of the Medicare deductibles. Not all states carry all ten Medigap plans. Here is a list of the specific Medigap plans and what they cover beyond the core benefits.

Policy A pays only for the basic Medigap benefits.

Policies B through J pay the hospital deductible.

Policies C through J pay the skilled nursing facility co-payment for days 21 through 100. Also, foreign travel emergencies are partially covered with a $250 dollar deductible and provides 80% coverage.

Policies C, F, and J pay for Part B deductible.

Policies F, I, and J pay a 100% of Medicare Part B excess charges. **Part G** pays 80% of these excess charges.

Policies D,G, I, and J pay for at-home assistance with the Activities Of Daily Living for those patients recovering from an illness, injury, or surgery. Activities Of Daily Living (ADLs) are defined as a person’s ability to perform the following functions: bathing, eating, dressing, toileting, and grooming. The patient must be receiving skilled home care that is covered by Medicare.

Policies H and I pay for 50% of the cost of prescription drugs up to a maximum annual benefit of $1,250 dollars after the person meets a $250 dollar per year deductible. **Policy J** pays for the same service but the maximum annual benefit is up to $3,000 dollars. *These policies are not available in New York State.*

Plans E and J pay for a certain amount of preventive medicine. The specific amount may vary from state to state.

Questions to ask your Medigap insurance provider:

How much? Although the benefits for each Medigap plan are standardized, the prices for these plans are not. Shop around to find the best price! After all, you know what product you are getting due to the government standardization of these policies.

What are the premium terms? Under what circumstances can a premium be raised? There are a couple ways that an insurance company can set the premium increase terms—called "rating."

- Level premiums: premium not based on your age, but rather based on the type of Medigap coverage that you have. Does not mean that your premium will stay the same throughout the life of the policy. When the insurance company increases the premiums of all similar policies, your premium will be increased by the same amount.
- Attained age: premiums are based on how old you are—the older you get, the more expensive the premiums become.
- Issue age: your premium is tied to how old you are and what policy you chose. For instance, if you bought Medigap policy F at age 65, your premium would stay the same as all Medigap F policies sold to 65 year-olds in future years.
- No age rating: policies that charge the same amount, regardless of age.

Open enrollment: you are guaranteed the right to buy a Medigap policy without medical screening, if you purchase the policy within 6 months of applying for Medicare or leave a Medicare managed care plan within a year of turning 65. If you move to a different state, switch plans, or apply after your open enrollment period, you will need to inquire about what changes in terms and premiums the insurance provider is going to specify.

Pre-existing illness exclusion: Most policies contain a pre-existing illness exclusion, which does not pay for pre-existing illnesses or medical conditions (that you have been treated for in the last 6 months). How long is this exclusion period? 1 month, 6 months, longer? If you have a serious illness, you may want to dish out the money for a policy with little or no exclusions, if possible.

How many different policies does your insurance provider handle? Those that handle more policies may know of more flexible and/or cheaper policies than those that just handle one company's policies.

Get a second opinion: try calling the New York Health Insurance Counseling and Advocacy Program (HICAP) at (800)333-4114. This agency provides consumer counseling about Medicare, Medigap, and Managed Care issues.

Preview policy: Most insurance companies will allow you to look over a policy for 10 days. If you decide that you don't want the policy, you can return it for a premium refund.

If you are buying a new Medigap policy to replace one that you already have (you have already jumped through the hoops of buying a Medigap policy during your open enrollment period), you have the right to return the policy within 30 days.

Other tips: Avoid single disease policies, mail or TV offers, and "limited time offers" that sound too good to be true—they are.

New York State programs

Elderly Pharmaceutical Insurance Coverage (EPIC) (1-800-332-3742): prescription drug insurance coverage for New York residents over 65 years of age. Eligibility is income based, and is currently for those people who earn less than $35,000/year (single) and $50,000/year (married). Senior citizens must pay a small premium and receive a large discount on prescription medications.

Other prescription drug help

Needy Meds (www.needymeds.com): Many drug manufacturers have what's called Patient Assistance Programs. These programs are designed to help those who can't afford their medicines obtain them at no cost or low cost. Unfortunately, many people, including doctors, nurses, social workers, and patients, don't know that these programs exist. The needy meds website contains the latest, most complete, and most accurate information on patient assistance programs available. You do not apply for these programs through needy meds, rather you apply through the individual drug manufacturers. You will need to know who manufactures your prescriptions so that you can apply to the correct manufacturer.

Chapter 4: Disability: Social Security and Insurance

<u>Social Security Disability</u>
Many people think of Social Security as just a retirement payment benefit. Many people do not realize that there are disability, dependent, and survivor benefits. For the purpose of this workbook we will briefly summarize the disability benefits, the gaps in protection, and strategies on how to fill those gaps.

<u>Social Security Disability eligibility</u>

Work credits. To be eligible for social security benefits, you have to have paid into Social Security. The Social Security system measures the amount paid into the system through what is called **work credits**. In 2003, to receive 1 work credit, you must have paid social security taxes (or self employment tax) on $890 of income (net income for farm businesses). Therefore, in order to earn the full 4 credits a year, one must have paid social security taxes on at least $3560 of income*. The number of work credits needed to qualify for disability benefits depends on the age of the individual and when they become disabled. The following are the criteria that the Social Security Administration uses to qualify individuals:

1. The individual must have one or more work credits for each year between 1950 and the year they became disabled, or have reached the age of 62.
2. Or, the individual must have one or more work credits each year from the year they turned 21 (if that was after 1950) until they became disabled (or they turned 62).

At least 6 credits are always required and the maximum anyone needs are 40 credits. Those that become disabled due to blindness may have an easier time of qualifying. Below is a handy table to use to determine how many credits may be needed:

If you were born after 1929 and became disabled at:	These are how many work credits you may need to apply for disability benefits.
Under age 24	6 credits
Between 24 and 31 years old	2credits per year between age 21 and the disability (1/2 the usual amount needed).
Younger than 42 years	20 credits
44 years old	22 credits
46 years old	24 credits
48 years old	26 credits
50 years old	28 credits
52 years old	30 credits
54 years old	32 credits
56 years old	34 credits
58 years old	36 credits
60 years old	38 credits
62 years or older	40 credits

Requirement of recent work. You must have earned 20 of the required work credits within ten years of becoming disabled. If you are a younger worker (under 31) or blind, these rules are relaxed.

***Farm businesses—a special note**: Farm businesses that have had a negative net income can make payments to social security through a voluntary election. Currently (2003), a farm can elect to pay self employment taxes on $1600 of income a year even if their net income is negative. However, this is not enough to buy 2 work credits a year—which could cause serious problems with eligibility for social security benefits, especially the recent work requirement explained above. Another consideration for farm businesses that are sole proprietors—if the proprietor's family members are not paid through payroll (social security is withheld), they are not earning work credits and will not receive social security disability benefits should they become disabled (there are provisions for widows and widowers explained below). Social Security retirement benefits are another consideration as well, but are not covered in this booklet.

Special qualifiers: As already mentioned, if you are blind, you do not have to meet the requirement of recent work, just meet the credit requirement. If you are a widow or widower over the age of 50, you may be able to receive disability benefits (even if you don't have enough work credits) if your spouse had attained the proper number of credits, you became disabled less than 7 years after your spouse's death, and haven't remarried. If you fall into one of these categories, you may want to research these possibilities further with an administrative law attorney.

You must meet Social Security's definition of disability. Your disability must be a medically defined physical or mental disability that is both:

1. Expected to last at least one year or to result in death within a year.
2. Prevents you from performing any gainful work.

The Social Security Administration has listed some covered disabilities to make the process of defining a disability a little easier. However, this list doesn't automatically qualify you for benefits, nor does not being on the list automatically disqualify you. To view the full listings, they can be found in CFR Title 20, Part 404, Subpart P, Appendix 1.

- Heart, lung, or blood vessel disease causing breathlessness, pain, or fatigue in spite of medical treatment.
- Severe arthritis—restricting the ability to move freely or use one's hands.
- Mental illness that prevent gainful employment.
- Brain damage or abnormality that causes severe loss of judgment, intellect, orientation, or memory
- Progressive cancer which has not been controlled or cured.
- AIDS or any secondary diseases related to AIDS (which prevents gainful employment).
- Digestive diseases which result in malnutrition, weakness, and anemia.
- Loss of a leg
- Loss of the major functions of both arms, both legs, or an arm and a leg.
- Loss of function of the kidneys
- Inability to speak

No substantial gainful employment. Many of the disabilities above specifically state this fact. The way that social security defines “gainful employment” is earning $780 a month or more (2003). The primary proof that you need is that you can no longer do your usual work. Social Security will then try to determine if you can still be employed at this level of pay, if you can do the work, and if these jobs exist in your area. If they determine that you can find gainful employment, you may not be eligible for benefits.

How much does Social Security Disability pay?

Payments are based on your average lifetime earnings and family makeup. This figure will be different for everyone. Those that earned more in their lifetime will get more benefits, but not much more than those that earned below an average of $30,000 per year. Payments range from a low of $500 a month to a high of $2,000 a month. To get an exact estimate of your Social Security benefits, look on your annual statement mailed to you from the Social Security Administration. If you cannot find your report, you must contact the Social Security Administration and request another statement (1-800-772-1213).

Strategies for supplementing Social Security disability

Social Security disability benefits may not be enough to live on, so one must look at collecting all of the other benefits that might be available. You cannot collect more than one Social Security benefit at a time (i.e. retirement, disability, etc.), except for SSI (explained below). Some strategies for supplementing disability income are:

Earn income while collecting benefits. Social Security usually permits one to earn up to the “gainful employment level” of $780 while collecting disability benefits. Self employed persons may come under more scrutiny, as they have ways of shifting income around in their own businesses.

Other disability benefits. You are allowed to collect disability payments from a private insurance policy, an employer, or the Veterans Administration at the same time you collect Social Security disability. Private disability insurance will be reviewed further in the following section.

Workers’ compensation. If you are injured while on the payroll of someone else (or your business is structured as a corporation), you may collect workers’ compensation at the same time as your Social Security disability benefits.

Medicare Part A and B. After you have collected 2 years of disability benefits, you are eligible for Medicare Part A (free) and Medicare Part B (premium charged), regardless of your age.

Medicaid. If you have few assets and a limited income, you may be eligible for Medicaid. The rules for disabled people qualifying for Medicaid is no different than those for non-disabled people—eligibility is based on assets (resources) and income. You can collect Medicaid benefits at the same time you collect Social Security disability benefits.

Supplemental Security Income (SSI). To be eligible for SSI benefits, you need to meet four basic requirements:

1. You must be over 65 or disabled.
2. You must be a citizen of the United States (some exceptions apply)

3. Your *countable* monthly income very low (somewhere around $500/month for individuals and $750/month for couples—what is countable income has many rules, but actually make it easier to qualify, as not all earned income is countable).
4. You must have less than $2,000 in assets (individual) or less than $3,000 in assets for a couple. Again, some items are countable, others are not. Houses and cars are not considered "countable."

Keeping your disability benefits

Social Security will periodically review your case to determine if you should still be receiving benefits. The review consists of: Social Security calling you for an appointment, interviewing you about your disability, income levels, and work that you are doing (if any). If your benefits are denied, you can appeal the decision. For more information on keeping your Social Security benefits, you should read Nolo's guide to Social Security Disability: Getting and Keeping Your Benefits by David A Morton III, Nolo Press, Berkeley CA, 2001.

Private disability insurance/questions to ask your provider

Private disability insurance can provide a supplement for Social Security disability. For those that may not qualify for Social Security disability, private insurance would be the primary benefit source for disabled people. Those that own their own businesses, don't withhold payroll taxes (like a corporation), and haven't kept up with their work credits through payment of self employment tax, often don't qualify for social security disability. Private insurance policies in this instance are a must! If you need private disability insurance, here are some questions to ask when looking for a policy:

1. What are the policy's definitions of disability? Are they more stringent than Social Security? Do they plug the gaps that are found in the Social Security coverage
2. What is the length of coverage? Short term policies normally cover up to 30 weeks; long term policies cover a number of years.
3. What is the elimination period? Before a short term or long term policy kicks in, there is a waiting period. How long is it and is this an acceptable amount of time to be without any income?
4. Aggregate clause: sets a maximum on the amount of benefits that can be paid out over the life of the policy. What is this maximum?
5. Exclusions: policies may state that certain disabilities are excluded from coverage. What are these exclusions? Does the policy exclude disabilities that you might be exposed to?
6. Coordination of benefits: Your policy may coordinate benefits with any other insurance providers you may have. Make sure that this is not to your detriment. If you are eligible to receive Social Security disability benefits, make sure that these don't reduce the amount of benefits available to you through your private insurer.
7. Recurrent disabilities: your policy may state that a disability must be the result of entirely new causes—or have a waiting period—between periods of disability in order for a second period of disability will be covered.
8. Definition of occupation: It is important to know what is considered to be your occupation. Your disability policy should define disability as not being able to perform your occupation. Your policy should adequately describe your occupation, not simply state that a disability is that you aren't able to perform any work at all.
9. Future increase options: Can you increase the amount of your coverage sometime in the future without having to buy a new policy?
10. Accidental death and dismemberment: A lump sum payout if you become dismembered or killed on the job.

11. Organ donor benefits: If you donate organ tissue, the policy will cover you if you become disabled during your recovery.
12. Survivor benefit: If you die due to your disability before your policy lapses, will the remainder of the benefits be paid out to a survivor?
13. Rehabilitation benefit: Will your policy pay for rehabilitation (over and above your current payments)?
14. Cost of living adjustments: is your benefit indexed for inflation or is it a set amount? If you have a long term policy, will the benefit be increased each year with the cost of inflation?
15. Renew ability: will your policy allow you to renew without a physical exam?
16. Waiver of premium clause: if your disability policy is tied to a life insurance policy, you may be able to waive the premiums you have to pay to your life insurance policy should you become disabled.
17. Partial disability: can your policy pay you a partial amount of benefits if you are easing back into your normal work routine? Can the disability benefits make up for what you would be earning if you could work full time?
18. When is the policy underwritten: Before your disability or after. To protect yourself, you should have all the facts known up front and have the policy underwritten when you purchase it, not when you become disabled. Policies that are underwritten at the time of disability might provide wiggle room for an insurance underwriter to not pay the claim.
19. Is the policy portable: If you change jobs or lose your job, will you be able to retain your policy with the same premiums and benefits?
20. How is the insurer ranked? Almost all insurers are ranked by either A.M. Best Company, Standard and Poor's Corporation, Fitch IBCA, Dulph & Phelps, and/or Moody's Investors Service. It is advised that you go with a company that is ranked in the top three categories.

How much disability insurance do you need?

You can get your insurer's opinion on this amount, or you can determine it for yourself. In the appendix, there is a worksheet on **page 44** that helps one decide how much disability insurance that they may need.

Chapter 5: Assisted Living: Medicare, Medicaid and Long Term Care Insurance

Assisted living: what are the chances you will need it?

Although assisted living is often thought to be synonymous to nursing home care, it is not the case. People that need long term care or assisted living may still be living at home or living with relatives or friends. About 1.5 million senior citizens need nursing home care (or 4% of the senior citizen population). While that may seem small, consider that over 6.5 million senior citizens—or 18% of the senior citizen population—in the United States are in need of some sort of long term care. *By just using averages, it looks like about 1 in 5 senior citizens will need some sort of assisted living*. These odds are good enough to prove two things: you need to plan for the possibilities of needing long term care and you need to figure out a way to pay for it.

Assisted living possibilities

There are options for where a person receives their care. These options are home care, residential care, and nursing home care.

> **Home care**: Assisted living in one's home or a family member's home. These tasks can be performed by family or an outside agency, depending on the type and frequency of assistance needed. There are home care agencies that will send trained medical personnel out to the home to help with medical procedures. Housekeeping and home maintenance wouldn't be performed by these personnel and would have to be picked up by the family.
>
> **Residential care**: What used to be called a "retirement home." These facilities can provide some assisted living functions and social activities for seniors.
>
> **Nursing home care**: Necessary for those who need around the clock assistance.

These options need to be discussed with your family. What options do you prefer? Is your family willing to help out if you become disabled and dependant upon them for your care? It may be impossible to guess which option will be right for you before the time comes, due to factors pertaining to what type of care is needed. However, you may be able to rule out some of the alternatives right away after discussions with your family.

What are the costs?[3 4]

Home care is the cheapest route, with costs ranging from $3,000 to $10,000 a year. Residential facilities are next in line, averaging about $30,000 a year. Nursing homes are the most expensive, with costs being anywhere from $50,000 to $100,000 a year. The average cost of nursing home care in New York State is $70,000 a year (2003 figures).

What it the length of time someone needs long term care?

> **Nursing home care**: The average stay in a nursing home is a statistic that is thrown around a lot. This statistic can be high or low, depending upon what ages of participants are in the survey and whether or not the survey was of current residents, discharged residents, or both. In the National Nursing Home Survey study by the CDD/NCHS, a study of discharged patients—those that have completed their stay in the nursing home—showed that the average stay for adults 45 and older was close to one year (388 days). If the survey includes *all* nursing home residents (including younger people who will be there for their entire lives), the average length of stay is closer to 2.5 years (901 days).

Home care and residential care: Statistics are spotty, but it may be fairly safe to assume that these figures would be similar to those found in nursing home surveys.

How will you pay for it?

If we take the cost averages and combine them with lengths of stay, the total bill for long term care can range from $3,000 to $250,000 with an expected value (multiplying the probabilities of needing a nursing home times the length of stay {range} times the cost {range}) from $600 to $50,000—meaning that there is definitely a good possibility that *some* long term care costs are in your future. Also remember, if you have a family business, than this question becomes "how is the business going to pay for it?"

There are a few options, *depending upon what type of long term care you will need*. These options are: paying for it yourself, Medicare, Medigap Insurance, Medicare Managed Care, Medicaid, and Long Term Care insurance.

Paying for it yourself: You will need to estimate how much money you will need to save in order to provide yourself with your long term care needs. Judging from the statistics, to cover the high end of the average, you should save around $300,000. This could be part of your retirement goals as well. After all, that is what a retirement fund is for—taking care of yourself after you stop working. The negatives of this plan are that it could use all of your savings. The positives of this plan are that your choices for what type of care you receive are left open.

Medicare. Medicare pays for items that are deemed "medically necessary". Custodial or "personal" care, like feeding, bathing, etc. is not covered. Medicare may pay for home care, but on a short term basis. Medicare will not pick up any of the tab for residential care and will only pay for nursing home care following a hospital stay (full payment for 20 days, partial payment for 100 days).

Medigap Insurance. Some policies provide limited coverage for short term home care. Many of the policies may supplement what Medicare agrees to cover (same rules as above). Long term coverage and residential care are not covered.

Medicare Managed Care. Similar to both Medicare and Medigap Insurance coverage. Some managed care plans will help more with home care, but again, this is on a short term basis.

Medicaid. Medicaid will pay for home care: both personal and medical. This may be of limited duration as well. Residential care is not covered, but nursing home care is covered without any time limits imposed. Eligibility rules are the same as were mentioned before in this workbook. The person applying has to have very little income and few assets. This could be a problem if business assets are still in control of the person applying to Medicaid, as they could put a lien on the business property to recoup the nursing home expenses.

Long Term Care insurance. The policies may vary depending upon what you want the policy to cover. Home care and nursing home care are the two items that are covered. Depending on the coverage, these items may not fully cover all costs associated with care. Coverage depends upon how much of a premium you can afford to pay. In New York, you should make sure that your policy is part of the New York State Partnership for Long

Term Care, which allows seniors to protect their assets while remaining eligible for Medicaid. For more information about the partnership, call 1-888-697-7582 or email pltc@health.state.ny.us. If you think you may move from New York in the future, you should look at a national policy, as the New York partnership coverage may not be as portable. Other states may have partnership programs as well.

Tips for buying Long Term Care insurance. The most important tip is that you read and understand your policy. Ignore promotions and sales advice—these advertisements may not have anything to do with your particular policy.

1. Anticipate that premiums are going to rise as you get older. Make sure you can afford the premiums when you are on a fixed income. You don't want to have to cancel your policy before you have need to use it. Some companies are counting on you canceling your policy due to high premiums. The National Association of Insurance Commissioners reports that of those that buy LTC insurance at age 60, 95% will have canceled their coverage by age 80—when they need it the most.
2. If you don't understand your policy—pay an attorney to review it for you. A couple hundred dollars to have someone review the policy for you can pay off. After all, you will be spending thousands in premiums (**costs can range from $2000 to $10,000 a year**) for your insurance coverage.
3. Deal only with an established and respected insurance brokerage. If you deal with an exclusive agent, obtain opinions from independent brokers.
4. What benefits are offered by the policy? There are no standard long term care policy benefits per se. Some policies only provide care for home care and not nursing home care and visa versa. Make sure you know what the policy will pay for. Rarely will policies pay family members to help care for an individual.
5. Approved facilities. Some policies want you to have the care given by "approved facilities" or "approved home health aides." Who is approved, where are they located, and what is the quality of their care?
6. Custodial care. Those items that aren't "medically necessary." What does this include? Are you going to have to pay separately for things such as eating, bathing, and housekeeping?
7. Medicare approved facilities and Long Term Care approved facilities. These two may not be the same. If you are going to apply for short term nursing home benefits through Medicare before you go on your Long Term Care policy—can you stay in the same location?
8. Common policy exclusions: Mental disease and nervous disorders (Is Alzheimer's disease covered?), addictions to drugs and alcohol, injuries and illnesses caused by war (terrorism too?), treatment paid for by the government, self inflicted injuries (such as suicide attempts).
9. What are the limits on the benefits? Benefits are usually in terms of how much coverage per day the policy will pay. How do these benefits compare with what nursing home costs are in your area? How will these benefits compare with nursing home costs in your area when you need to use the policy (costs may have risen sharply between the time you purchased the policy and the time you use it).
10. Multiple admittances to the nursing home. Some policies have a waiting period if you are discharged, but have to re enter the nursing home later.
11. Waiting period: when do the benefits start? How long before the policy starts paying for your care?
12. Inflation protection. Are you protected against rising costs? Make sure that you are! Companies offer two ways to protect against this—one is an offer to buy more

coverage at a later date (without proof of insurability) and another is to use an inflation factor to raise your coverage each year. Make sure that the inflation factor used is based on compounding, not a simple % added on each year.

13. Waiver of premium. Once you start receiving benefits, you should not have to pay premiums on the policy.
14. Non forfeiture benefits. If the policy is cancelled for non-payment, are there some benefits that will still be paid?
15. Death benefits. An agreement to refund your estate any premiums paid less benefits paid to you.
16. Benefit conditions "gate keepers". What qualifies you to receive benefits? Who decides if you receive benefits or not? Will your doctor decide? Does the insurance company decide? What are the terms: sickness or injury? Unable to perform activities of daily living? How terms are defined and how strict are they? These terms, conditions, and gate keepers are used to cut costs for the insurance company. Some examples of gate keeper that have been in past policies:
    a. Requiring hospital stay before going into the nursing home. According to a congressional study, 57% of nursing home applicants did not have a prior hospital stay.
    b. Requiring an acute condition before service would be covered. Acute is something that is specifically defined, occurring over a short period of time. However, 47% of all nursing home residents have chronic illnesses and would be exempt from benefits under this policy.
    c. Limiting services to be provided only by licensed practitioners and registered nurses. This excludes those things that nurses and practitioners don't do—like cooking cleaning, and general nursing home supervision.
    d. Restricted lists of who is "certified" to provide care.
    e. Covering only "skilled" care. Similar to term "c" above. Almost 50% of people receiving nursing home services do not require "skilled care."
    f. The inability to perform three or more Activities of Daily Living (ADL's). These items are: bathing, dressing, toileting, transferring, and continence. Most seniors only need help with 2 or 3 of these activities.
    g. "Continual Assistance." A senior is only covered if they need continual assistance with their Activities of Daily Living. Since most people will be able to do these things on their own once in a while, most people would not be covered under this policy definition.
    h. Insurance company doctors. Advisors paid by the insurance company to over rule the decisions made by the patient's doctor.
    i. Service based coverage. The services covered are defined. Those not specified are not covered.

17. Eligibility to buy coverage. If you look like you are a likely candidate for a nursing home, you will be less likely to buy long term care insurance. If you lie about your health on your application, the company may rescind your application or deny coverage later on.
18. Renew ability. Can you renew without a problem? Renew ability does not mean that you will be offered a good price, though.
19. Is all care covered? All care may not be covered (due to the reasons mentioned above). Most policies do not cover the full cost of long term care, so some of your life savings are still at risk. Sales tactics of "protect your life savings" may be over exaggerated in some instances.

20. Read the fine print. What agents say and what the fine print says can be different. This may not be an intention to mislead; it may be that the agent doesn't fully understand the policy. What someone says is not binding—what is written is.
21. Written notice of disability. Some companies need a written notice of claim within a specified time period. If you are late, you get no benefits.

Chapter 6: Money and Business Saving Strategies

Health care planning needs to be managed just as closely as any other facet of a family business. Just like a business might keep track of its accounts with a particular supplier—getting volume discounts, paying their invoices on time, insuring that the quality and quantity ordered are correct, et cetera—a farm family should manage their health care needs. The suppliers of health care are more than just your insurance provider; they can be your doctor, your pharmacist, your hospital, your dentist, your employer, and the federal government.

Knowing who is in charge of deciding what kind of care you receive and how much that is going to cost you is a critical step in this process. The previous chapters have tried to help with this type of education and planning. Once you know the rules of the game, playing the game is not as intimidating. Here are some strategies that may help you and your business save money through planning for your health care needs.

General ways to save money on insurance

A basic premise for insurance is that you should only buy it for those situations that you can't save enough. Between the insurer's cost of processing claims and profit, the expected return on your money is low or negative. But, it is better than being wiped out by a catastrophe.

1. Review your insurance and eliminate duplicate coverage. If you are covered through work, usually medical, why buy extra insurance? You can't get paid twice for the same expenses on many policies (due to coordination of benefits clauses).
2. Sole proprietors without employees are more expensive to insure than proprietors with employees or legal business partnerships (such as an LLC, C Corp, or S Corp). This is due to certain legislation that pertains to New York businesses. You may find a cheaper policy by simply adding a person to your payroll—ask your insurance agent about your options.
3. If you have an individual policy, have you looked at a group policy through a provider or small business association? Examples of associations in New York would be local chambers of commerce, milk cooperatives, New York Farm Bureau, American Association of Retired People, and the New York State Direct Farmers Marketing Association. There may be business income guidelines or other restrictions that businesses have to meet before joining a particular association.
4. Raise your deductibles (medical, home, car, etc.) to the appropriate level, usually $500 or $1000($1000-$2500 for medical). Put the premium savings aside to cover the amount of the deductible for when you have a claim.
5. Shop around for insurance. You can easily save 25% and sometimes up to 50% by shopping around. However, make sure you don’t compromise the quality of your coverage; compare apples to apples as they say.
6. Carefully evaluate any "extras" in the insurance policy. In most cases, they aren't worth it.
7. Ask what discounts are available.

Health care money saving strategies

Negotiate with doctors and hospitals. Many consumers can successfully lower their hospital, doctor, or pharmacist bills simply by asking. According to a survey by Harris Interactive Health Care News, about half of all requests for reduced medical bills are successful. Some tips are to plead your case in person and to offer to pay the discounted amount immediately (with cash or credit card).

Review your hospital bills to find possible mistakes. A recent (2002) survey by Consumer Reports found that 5% of all medical bills had mistakes. In addition, those that owed $2000 or more were twice as likely to find billing errors. Some tips for avoiding this type of mistake are to: know what your insurance coverage will pay for ahead of time, keep track of the tests and treatments you receive in the hospital, compare your "explanation of benefits" to your hospital bill, and if charges are lumped together (and look suspicious) ask for an itemized bill.

What to do when your plan won't pay. First of all, you have to follow the guidelines of your plan. If you do not follow the plan's guidelines (which can be strict with HMOs and PPOs), you will most likely end up paying for the medical care out of your pocket. However, there are some times when you do follow the rules, and the plan still doesn't pay. Some tips to those that find themselves in these situations are:

- Call your plan representative ahead of time to ask about your coverage. Take notes along with the date, time, and who you talked to.
- When you have a problem with a claim, you should call your plan representative to ask for an explanation. Again, take notes.
- If any inconsistencies are found, call the plan's administrator. If that fails, file a grievance with your health plan.
- Don't give up, don't give up, don't give up!

Using Medical Savings Accounts (MSAs). At least until December of 2003 (it will probably be continued after that), there exists a medical savings account for small businesses and sole proprietors called an Archer MSA (medical savings account), which allows you to set aside money, tax free, to pay for medical expenses. Unlike other medical savings accounts (which go by the rule "use it or lose it"), you can use an Archer MSA to roll over unused funds into subsequent years. This can allow a family business to purchase a high deductible insurance policy (saving lots of money in premiums) and plug the savings (tax free) into a medical savings account.

Use both insurance and government program benefits. In some cases, you will be eligible for a government program to supplement your insurance policy. Three examples:

- Dual coverage: Insuring yourself against loss of income with disability insurance. Social Security disability allows you to claim benefits while collecting private insurance benefits as well. If you are thinking about dual coverage, just make sure that your insurance policy doesn't coordinate benefits with government benefits, or your may be wasting your money.
- Hybrid coverage: What about insuring some parts of your business through private insurers and other parts through government programs? One strategy that is popular with families in New York businesses is to insure both adults in the family through private insurance as individuals (policies that have lower premiums than a family policy) and insure their children through the New York State program Child Health Plus B (where the premiums are quite low, depending upon income). If you are thinking about a hybrid approach, just make sure that you truly are covering yourself and your family.
- Planning: During certain times of your life, you need more coverage than others. If you have a family and a business to support, you cannot afford to have high health care bills or a loss of income due to disability. Also, you face different risks in different phases of your life—young people tend to use less heath care services

for example. Through planning, you can raise and lower your insurance levels (and costs) depending upon your situation.

Obtain a job with health insurance benefits. Sometimes family members will work part-time elsewhere to get health insurance coverage. In other instances, a member of the family business works full time elsewhere to obtain health coverage for the entire family. Just be sure that the time spent at the other job doesn't adversely affect the business at home and that the insurance coverage you are getting in return is worth the effort.

Prescription drugs: certain insurers offer a drug card program, generic drugs, and mail order options in order to reduce prescription costs. Inquire about these options with your insurance carrier or broker.

Retirees: some carriers will not cover retirees. This has been mentioned before in the workbook. Also, those that do not have tax returns from the business (schedule F, C, 1065, or 1120S for example) filed in their name may also be dropped from coverage (which is an important aspect to think about before you transfer the farm business). Make sure you know your insurance carrier's rules before exiting the business. Some carriers want to see a written succession plan and/or the retiree's name written into the operating agreement before agreeing to continue health insurance coverage.

Government program strategies

Government programs are run similarly to private insurance programs. In fact, many government programs are run by private insurance companies (like Medicare, for instance). Just like the advice above, you need to follow the rules of your health care plan to the letter. Some additional advice for government programs is to:

- Apply for all the programs you might be eligible for. Don't be scared off by eligibility rules if you need health care and can't afford it.
- If you think you deserve benefits and have been unfairly denied, get someone to help you! There are many good people in your county and state that can help. Sometimes, you just need to speak in the same terms as the people you are applying to. All the government health care terms sound similar and it is easy to make mistakes.
- If applying to a program will have an effect on your assets or income, consult an accountant or attorney that is familiar with government health care programs.
- Don't give up.

Government employees. There are quite a few programs for those that are involved in federal, state, county and military service. *These benefits, in many cases, are available to those who have retired from these services as well.* Have you worked for the county, state or US government in your past? If you think that you may be eligible for any of the programs below, contact the appropriate office listed.

Federal Government Employees (Office of Personnel Management 1-888-767-6738)

Federal employee health benefits plan (FEHBP)
Federal employee disability retirement (FERS) benefits
Flexible Spending Accounts (FSA) or medical savings accounts
Federal Group Life Insurance (FEGLI)
Federal Long Term Care Insurance Program (FLTCIP)

State and County Employees (New York State Dept. of Civil Service 1-800-833-4344)
New York State Health Insurance Program (NYSHIP)
NYS Public Employee and Retiree Long Term Care Insurance Plan (NYPERL)
Income Protection Plan (short term and long term disability)
GHI Dental Insurance

Veterans Administration benefits (Department of Veteran Affairs 1-800-827-1000)
VA medical/dental services
VA Nursing home services
VA Burial services

College students. Most colleges, especially those with university hospitals, offer very affordable health care coverage to students. *This includes both younger and older students*. If you or your children are attending college, look into what health benefits they offer. Part time students are also covered in some circumstances. If you are in need of both health care coverage and more education, this could be a great fit!

Medicaid and asset protection

What if you have a lot of assets, but are cash poor? Sometimes farm businesses find themselves in this position—unable to afford the premiums on long term care insurance, unable to meet the resource requirements of Medicaid (due to all the assets in the farm business), and unable to afford the costs of long term care. There are ways to protect one's business through asset transfer and application to Medicaid for nursing home benefits. Medicaid allows some transfer of assets without penalty and has restrictions on the remainder. Below are the three categories of asset transfer as defined by Medicaid. Income eligibility for Medicaid varies from state to state and can become confusing depending upon who earns the money and who is in the nursing home—check with your local social service agency or an elder law attorney.

Permissible transfer of property: Depending on the applicant's marital status and state of residence, these assets can differ. The lists below are general guidelines.

Unmarried individuals: The following property can be transferred without being penalized by Medicaid:

- House: If transferred to the applicant's minor child (or if the child is blind or disabled). If the applicant's child (of any age) has lived in the home for at least 2 years prior to the applicant's entry into the nursing home. If the house is transferred to a brother or sister who has a financial interest in the home and has lived there for at least one year previous.
- Car: worth up to $4,500
- Personal belongings: up to $2,000
- Other: wedding and engagement rings, $2,000 in stocks or CDs, life insurance with a face value of less than $1,500, a burial plot, and $1,500 in burial expense savings.

Married couples: The following property can be transferred without being penalized by Medicaid:

- House: in which the at-home spouse lives, regardless of value.
- A "Community Spouse Resource Amount", which would be half the amount of the couples' non-exempt liquid assets (stocks, bonds, bank accounts, etc.). This amount varies from state to state and increases

annually with the cost of living index. The current maximum amount being $90,660 in NY in 2003
- Car: regardless of value
- Furniture and household goods: regardless of value.
- Other: wedding and engagement rings, life insurance of face value less than $1,500, two burial plots and burial expense savings of up to $3,000.

Penalized transfer of assets to an individual: All other assets that are transferred to individuals can be penalized by Medicaid *for up to 36 months* after the transfer has taken place. Medicaid has a formula that determines the penalty on transfers.

$$\text{Months ineligible for Medicaid} = \frac{\text{Amount of the transfer}}{\text{Average monthly cost of nursing home care in your area}}$$

For example, the costs of nursing home care in New York (as determined by Medicaid in 2003) are as follows: Central NY ($5390), Long Island ($8583), NYC ($8157), Northeastern NY ($5998), Northern Metropolitan ($7464), Rochester ($6058), and Western ($5614). So, let's say that you transferred some of your Central NY farm business worth $100,000 to your children. Medicaid would declare you ineligible for: $100,000/$5390 = 18 months. So, for 18 months after the transfer, you would not be eligible for Medicaid. The maximum time for this penalty period is 36 months. In this example, anyone in Central New York transferring property worth more than $194,000 to an individual would have to wait 36 months before being eligible to apply for Medicaid.

Penalized transfer of assets to an irrevocable trust: The same rules as above, except that the ineligibility period can be up to 5 years from the date of the transfer. Using the numbers above, anyone in Central New York transferring property worth more than $194,000 to an irrevocable trust would have to wait 60 months after the transfer to be eligible for Medicaid.

Note: Tax consequences of property transfers. When property is transferred all at once, during the life of the individual, it is called a "gift" by the Internal Revenue Service. *Before considering a gift, one should talk to their tax accountant about the ramifications of gifting business property. There are some drawbacks due to the taxable basis in the property remaining the same after the gift is made.* Also, any gifts made during the lifetime of the individual are added back into the deceased person's estate before determining estate tax liability.

Medicaid and asset protection: Other strategies

There are many strategies to protect assets from long term care expenses and Medicaid ineligibility. If you are interested in planning for this, you should talk to an attorney that specializes in estate planning or elder law. Below are just some basic strategies.

Purchase a long term care policy long enough to get through waiting period. A policy (of up to five years) to cover the expenses of long term care before you are eligible for Medicaid. So, if you become disabled and need nursing home care, you transfer your assets on day one and when the insurance expires you can apply to Medicaid and not worry about the "look-back" provisions (unless the laws have changed by that time). Or,

if it is cheaper, transfer the assets today and pay the premiums until the waiting period is past.

Investing in exempt assets: If you are in a state that exempts the items listed above, you may elect to invest in those items. The house is a primary place for investments for many people that apply for Medicaid. However, make sure that your house is exempt from Medicaid rules before you start investing.

Life Estate: What if you elect to transfer all your assets, including your house, to your children to avoid the risk of not being eligible for Medicaid? What gives you security that you won't be "out on the street" if there is a disagreement, if the new owners decide to sell the property, or if the banker forecloses on the current owners? A life estate can transfer the title of the property to another person while reserving the use of the property for those that are specified. Besides providing security for the person transferring the property, it also lessens the value of the asset to the person who retains life use. The person retaining use now has what is called a "remainder" value, which is calculated by an IRS formula. This remainder value would be less than the entire value of the property before the transfer. However, this residual value can be used to calculate Medicaid eligibility and/or pay for nursing home care.

Business continuation strategies

Most businesses need people to run the day to day operations. In a small business, the owners are very crucial to the business's success. If a primary owner/operator is injured or disabled, a business needs to have some contingency plans in place. Some of the ways to protect a business from suffering due to the disability of a business owner include: a power of attorney for finances, a health care proxy, key person insurance, and a properly written buy-sell agreement.

Power of Attorney for finances: A legal document that enables someone else to make financial decisions for you, should you become unable to do so. Every business owner should have someone designated to make financial decisions for them, should they become disabled.

Health Care Proxy: A legal document that allow someone else to make health care decisions for you, should you become unable to do so.

Key Person insurance: A form of life/disability insurance that pays out when the owner (or crucial employee) of a business dies or becomes disabled.

Buy-Sell agreement: If your business is owned by two or more individuals, it is a good idea to have a properly written buy-sell agreement. A buy-sell agreement isn't exactly what it sounds like; it's not the tool you would use to buy and sell companies. Basically, a buy-sell agreement is a contract that can control who owns an interest in your business, when that interest can be sold, and at what price. This agreement can provide insurance to all parties in the business against loss of a business partner due to retirement, disability, death, or disagreement. The agreement can be written to state what triggering event (such as disability) is required in order for a business partner to be bought out of a business, and at what price.

Insurance Quiz

For each group, choose the statement 1 or 2 that best describes how you feel:

1. Having complete freedom to choose doctors and hospitals is the most important thing to me in a health plan, even if it costs more.
2. Holding down my costs is the most important thing to me, even if it means limiting some of my choices.

1. I travel a lot or have children that live away from me and we may need to see doctors in other parts of the country.
2. I do not travel a lot and almost all care for my family will be needed in our local area.

1. I don't mind a health insurance plan that includes filling out forms or keeping receipts and sending them in for payment.
2. I prefer not to fill out forms or keep receipts. I want most of my care covered without a lot of paperwork.

1. In addition to my premiums, I am willing to pay for the cost of routine and preventive care, such as office visits, checkups, and shots. I also like knowing that I can get an appointment for these services when I want one.
2. I want a health plan that includes routine and preventive care. I don't mind if I have to wait for these services to be scheduled for an available appointment with my doctor.

1. If I need to see a specialist, I probably will ask my doctor for a recommendation, but I want to decide whom to go to and when. I don't want to have to see my primary care doctor each time before I can see a specialist.
2. I don't mind if my primary care doctor must refer me to specialists. If my doctor doesn't think I need special services, that is fine with me.

If your answers are mostly 1: You want to make your own health care choices, even if it costs you more and takes more paperwork. Fee-for-service may be the best plan for you.

If your answers are mostly 2: You are willing to give up some choices to hold down your medical costs. You also want help in managing your care. Consider a health maintenance organization.

If your answers are some 1's and some 2's: You might want to look for a plan such as a preferred provider organization that combines some of the features of fee-for-service and a health maintenance organization.

The differences among fee-for-service plans, HMOs, and PPOs are not as clear-cut as they once were. Fee-for-service plans have adopted some activities used by HMOs and PPOs to control the use of medical services. And HMOs and PPOs are offering more freedom to choose doctors, the way fee-for-service plans do. By studying your health insurance options carefully, you will be able to pick the one that provides you with the coverage you need, no matter what it is called.

What's Most Important to You in an Insurance Plan?

Insurance plans vary. Before choosing a plan, decide what is most important to you. This checklist can help. Put a check in front of those services that are important to you. Then see how many of these services are in Policy #1, Policy #2, and Policy #3. On the checklist, write in the coinsurance or co-payment rate, if there is one, and any limits on service.

Remember that the most important service to be covered is hospitalization. If you are not covered for hospital care, then one sickness could cost you thousands of dollars, even hundreds of thousands of dollars.

Coverage	Policy #1	Policy #2	Policy #3
Hospital Care			
Surgery (inpatient & outpatient)			
Office visits to your doctor			
Maternity care			
Well-baby care			
Immunizations			
Mammograms			
Medical tests, x-rays			
Mental health care			
Dental care, braces and cleaning			
Vision care, eyeglasses and exams			
Prescription drugs			
Home health care			
Nursing home care			
Services needed that are excluded			
Choice of doctors			
Convenient location (doc & hosp)			
Ease of getting appointments			
Minimal paperwork			
Waiting period before coverage			
Other Considerations:			

Worksheet: What Is Your Best Insurance Buy?

It is difficult to determine exactly what you will spend a year on health care. You do not know whether you will be sick 6 months from now and need an operation. Hopefully, you will not.

Using this worksheet, you can begin to make some rough estimates. Much will depend on what service you need or want, how many people are in your family, your age, and other factors. Do you need to have your eyes tested this year? Will you have a mammogram or other cancer screening test? Does your child need immunizations?

Look at your medical and insurance records from last year as a guide to what services you might use this year. Add up the actual costs to you, including premiums. Estimate what you might spend on your health care in terms of deductibles, coinsurance and/or co-payments, and services that are not covered.

Compare Policy #1, Policy #2, and Policy #3 to determine which the best buy is for you.

Comparing Costs and Benefits	Policy #1	Policy #2	Policy #3
What is your monthly premium?			
Individual:			
Family:			
Multiply by 12 for annual cost:			
What is your deductible?			
Individual:			
Family:			
What is your coinsurance rate (if any)			
What is your co-payment (if any)			
Note if there is a higher rate for special services, such as outpatient mental health?			
Are there any annual limits for days or services covered and the amount of benefits you can receive?			
What is the maximum out-of-pocket expense you will have to bear?			
What is the lifetime limit (if any) on benefits you may receive?			
Other Fees/Benefits:			
Total estimated Annual cost to you:			

Now look back at the previous worksheet: the checklist of services that are important to you. ***Is your best buy the same policy that gives you the most services you need?***

Determining Your Disability Insurance Needs

Estimate the monthly amount that you would receive from the following sources in the event you were to become disabled:

Social Security benefits (for total disability only		________
Employer-provided disability insurance	+ ________	
Private disability insurance	+ ________	
Other government disability insurance	+ ________	
Reduction of insurance premiums or loan payment due to waiver of premium options.	+ ________	
Total Monthly Disability Benefits		= ________
Enter current **monthly** take-home pay		________
Subtract total **monthly** disability benefits from above		- ________
Additional Monthly Disability Income Needed:		= ________

* The benefits listed may not apply to all disabilities. For example, benefits may not be paid for partial disabilities. Some of the sources may only provide long-term benefits. Benefits may not be paid for disabilities that last only for a short period of time.

Adapted from: Garman, E. T., and Forque, R. E. (1994). *Personal Finance*. Boston: Houghton Mifflin.

Health Care Summit Resources and Referrals

Administrative Law: Disability and Workers Compensation

Mary Jo Long: Mary Jo Long is an attorney who focuses primarily in representing individual with disabilities in their applications for social security disability, workers compensation benefits, New York State Disability Retirement and some private disability insurance disputes. She has practiced law since 1977 and has an office in Afton, New York. She is also active in the Northeast Organic Farming Association of New York.

534 Chase Road
Afton, NY 13730
607-639-2783
mjlong@clarityconnect.com

Disability: Health & Safety, Advocacy & Support.

Holly Cestero: Holley Cestero is the outreach coordinator for the New York AgrAbility Project, which offers agricultural worksite and equipment assessments and modification suggestions, assistance with resource identification and acquisition, agricultural task assessments and guidance on how to restructure these tasks to accommodate a disability, and secondary injury and disability prevention ideas and suggestions.

NY AgrAbility Project
777 Warren Rd.
Ithaca, NY 14850
607-257-9716

Estate Planning, Elder Law, and Business Succession

Marcy Robinson Dembs: Marcy Robinson Dembs is a 1985 magna cum laude graduate of the Syracuse University College of Law. In 1995 she joined Menter, Rudin & Trivelpiece, P.C. after practicing with two well known Central New York law firms where she developed her estate planning practice. In 1997 she became head of the firm's Estate Planning and Administration Department. Mrs. Dembs maintains offices in the firm's Syracuse and Watertown locations. A frequent lecturer for local civic groups and insurance professionals, she has also lectured for the New York State Bar Association. Mrs. Dembs appears regularly on WWNY-TV, the Watertown, New York CBS affiliate. Mrs. Dembs is a member of the Onondaga County, Jefferson County and New York State Bar Associations.

Menter, Rudin, and Trivelpiece, P.C.
500 South Salina Street
Syracuse, NY 13202
315-474-7541 (Syracuse)
315-786-7950 (Watertown)

Health Care Summit Resources and Referrals

Estate Planning, Elder Law, and Business Succession

Jeff Fetter: Jeffrey M. Fetter is a partner of Scolaro, Shulman, Cohen, Fetter & Burstein, P.C. in Syracuse, New York and is Chairman of the Business Practice Group. His practice focuses on business, estate, tax and succession planning for closely held and family owned enterprises. Legal services Jeff provides his clients include: state, federal and international tax and business planning; estate and long term care planning; business and succession planning for closely held and family owned business enterprises; e-commerce planning; employee and shareholder/principal relations and employee benefits; protection of intellectual property; transactional planning; acquisitions, dispositions, mergers, tax-free reorganization of business entities; entity structuring; contract negotiation, dispute resolution; international contracts and business planning and the dissolutions of business entities.

Scolaro, Shulman, Cohen, Fetter, and Burstein
90 Presidential Plaza
Syracuse, NY 13202
315-471-8111 (receptionist)
315-477-6256 (direct line)

David T. Pullen, Esq: David T. Pullen is a partner with Richardson & Pullen, P.C. David practice focuses on real estate, Trusts, Estate Planning & Probate, Estate Planning & Medicaid Planning, Succession Planning, Business and Corporate Law, and Farm Service and Farm Credit practices.

Richardson & Pullen, P.C.
21 Minard Street
PO Box 182
Fillmore, NY 14735-0182
585-567-2222
rppc@rochester.rr.com

Insurance: Health, Disability, Life, and Long Term Care

Faye Anderson: Faye Anderson, CLU, has built a career by helping professional, business owners, and individuals achieve financial success through retirement, investment, and estate planning strategies. Entrepreneur and business owner, Faye Anderson's experience and track record in the financial business arena include: 20 years in the NBT Bank Trust Department, Vice Presidency of a pension administration firm, and founder of A. Benefits Company, Anderson Consulting Group, LTD.

Anderson Consulting Group, LTD.
50 West Main Street
Norwich, NY 13815
607-336-3293
faye@ascent.net

Health Care Summit Resources and Referrals

Insurance: Health, Disability, and Long Term Care

David Arnold: David Arnold is a licensed broker with Brad Peck Insurance. Brad Peck Inc. was founded in 1945 to provide for the insurance needs of the community. Because they are insurance brokers, they can provide you with numerous choices for insurance coverage; providing more choices for comprehensive coverage at cost effective rates. Kirk Kneller, President & Owner, along with his friendly and competent staff, have over one hundred years of experience in the insurance industry.

Brad Peck Insurance
1676 Route 7A, Box 88
Copake, NY 12516
518-329-3131 (phone)
518-755-4800 (cell)
518-329-3333 (fax)

Bruce Erath: Bruce Erath, CLU ChFC, is a business consultant with Elwyn G. Voss Associates in Norwich, New York. Elwyn G. Voss & Associates mission is to add financial value in the creation, preservation, utilization, and distribution of our clients' personal and business estates. Services include: retirement planning, business organization and succession planning, employee benefits, and estate planning strategies. Products include: key person and group benefits, investments, life insurance, disability insurance, and long term care insurance.

Elwyn G. Voss and Associates
6403 County Road 32
Norwich, NY 13815
607-334-7080 (phone)

Bruce Porter: Bruce Porter is a general agent with Farm Family Insurance. The Farm Family group of insurance companies serves the needs of policyholders in 12 Northeastern states with both life and property/casualty insurance products. Farm Family Life Insurance Company, Farm Family Casualty Insurance Company, and United Farm Family Insurance Company are part of the Farm Family group of companies, headquartered in Glenmont, New York, which has been providing insurance protection for families and businesses in rural and suburban areas since the mid-1950s. Farm Family is proud of its long-standing role of service to the agribusiness community in the Northeastern United States.

Farm Family Insurance
41 Liberty Street
Batavia NY 14020 (offices located throughout the state)
1-800-544-5010 or 585-343-5010

Health Care Summit Resources and Referrals

Insurance: Health, Disability, and Long Term Care

Don Gladle: Don Gladle is the founder of Gladle & Associates, LLC. Gladle & Associates, LLC, offers many programs designed with the agri-business needs and objectives in mind. Gladle Associates' objective is to expand their services to the dairy industry in order to provide a better product mix. It is their main goal to provide the support and service to assist dairy producers in maximizing the benefits received from their insurance plans. Gladle & Associates continuously provide educational programs to enable producers to become more familiar with Gladle's products and services, and to feel more comfortable with the coverage they receive.

Gladle and Associates
PO Box 6487
216 Washington Street
Watertown, NY 13601
1-800-479-8153

APPENDICES: IMPORTANT CONTACT INFORMATION

Federal and State Enrollment Facilitators: New York Counties

Albany County
- Albany County DSS 518-447-7404
- Fidelis/NYS Catholic Health Plan 888-343-3547
- The Healthy Capital District Initiative 518-462-7040

Allegany County
- Allegany County DSS 585-268-9622
- HealthNow/BCBS-WNY/Community Blue 866-231-0847
- Yates County SSAY Rural Health Network 800-346-2211

Broome County
- Broome County DSS 607-778-2604
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Mothers & Babies of SCNY 800-231-0744

Cattaraugus County
- Cattaraugus County DSS 716-373-8065
- Fidelis/NYS Catholic Health Plan 888-343-3547
- HealthNow/BCBC-WNY/Community Blue 866-231-0847
- Southern Tier Healthcare System 716-372-0614

Cayuga County
- Cayuga Cty Dept. of Health & Human Svcs 315-253-1382
- Cayuga County DSS 315-253-1382
- United HealthCare of Upstate NY 800-339-5380

Chautauqua County
- Chautauqua County DSS 716-753-4421
- Chautauqua Opportunities 716-366-4373
- Fidelis/NYS Catholic Health Plan 888-343-3547
- HealthNow/BCBC-WNY/Community Blue 866-231-0847

Chemung County
- Chemung County DSS 607-737-5360
- Chemung County Lead Agency (DSS) 607-737-5373

Chenango County
- Chenango County DSS 607-337-1500
- Chenango County Health Network 607-337-4128

Clinton County
- Clinton County DSS 518-565-3330
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Upper Hudson Primary Care Consortium 518-562-3740

Columbia County
- Columbia County Community Healthcare 518-822-9600
- Columbia County DSS 518-828-9411
- Fidelis/NYS Catholic Health Plan 888-343-3547
- WellCare 800-288-5441

Cortland County
- Cortland County DSS 607-753-5133
- Cortland Community Health Department 607-758-5565
- Fidelis/NYS Catholic Health Plan 888-343-3547

Delaware County
- Delaware County DSS 607-746-2325
- Mothers & Babies of SCNY 800-231-0744

Federal and State Enrollment Facilitators: New York Counties

Dutchess County
- Dutchess County Community Action 845-452-5104
- Dutchess County DSS 845-486-3340
- WellCare 800-288-5441

Erie County
- Buffalo Community Health 800-427-8490
- Erie County DOH 716-858-7207
- Erie County DSS 716-858-6582
- Fidelis/NYS Catholic Health Plan 888-343-3547
- HealthNow/BCBS-WNY/Community Blue 866-231-0847
- Kaleida Health 716-859-2161

Essex County
- Essex County DSS 518-873-3441
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Upper Hudson Primary Care Consortium 518-562-3740

Franklin County
- Franklin County DSS 518-481-1799
- St. Regis Mohawk Health Services 518-358-3414
- Upper Hudson Primary Care Consortium 518-562-3740

Fulton County
- Fulton County DSS 518-736-5625
- Fulton Montgomery CHP/Medicaid Cons. 518-775-4092

Genesee County
- Genesee County DSS 585-344-2587
- HealthNow/BCBS-WNY/Community Blue 866-231-0847
- Lake Plains Community Care Network 585-345-6110

Hamilton County
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Fulton/Montgomery CHP/Medicaid Cons. 518-775-4092
- Hamilton County DSS 518-648-6131
- Upper Hudson Primary Care Consortium 518-562-3740

Herkimer County
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Herkimer County DSS 315-867-1581
- Mowhawk Valley Perinatal Network 315-732-4657
- United Healthcare of Upstate NY 800-339-5380

Jefferson County
- Jefferson County DSS 315-785-3322
- North Country Prenatal/Perinatal Council 315-788-8533

Lewis County
- Lewis County DSS 315-376-5400
- North Country Prenatal/Perinatal Council 315-788-8533

Livingston County
- Coordinated Care Services 585-613-7662
- Livingston County DSS 585-243-7300

Madison County
- Madison County DSS 315-366-2479
- Mohawk Valley Perinatal Network 315-732-4657
- United Healthcare of Upstate NY 800-339-5380

Monroe County
- Coordinated Care Services, Inc. 585-613-7662
- Monroe County DSS 585-274-6309

Federal and State Enrollment Facilitators: New York Counties

Montgomery County

- Fulton/Montgomery CHP/Medicaid Cons. 518-775-4092
- Montgomery County DSS 518-853-8316

Niagara County

- Erie County Department of Health 716-858-7207
- Fidelis/NYS Catholic Health Plan 888-343-3547
- HealthNow/BCBS-WNY/Community Blue 866-231-0847
- Niagara County DSS 716-278-8710

Oneida County

- Fidelis/NYS Catholic Health Plan 888-343-3547
- Mohawk Valley Perinatal Network 315-732-4657
- Oneida County DSS 315-798-5632
- United Healthcare of Upstate NY 800-339-5380

Onondaga County

- Fidelis/NYS Catholic Health Plan 888-343-3547
- Onondaga County DSS 315-435-2928
- Onondaga County Health Department 315-435-6808
- Total Care/Syracuse PHSP 800-223-7242
- United Healthcare of Upstate NY 800-339-5380

Ontario County

- Ontario County DSS 585-396-4060
- Thompson Health System 888-758-7658
- Yates County Rural Health Network 800-346-2211

Orange County

- Affinity Health Plan 866-247-5678
- Maternal Infant Services Network 845-928-7448
- Orange County DSS 845-291-4000
- Westchester PHSP/Health Source 800-339-4557

Orleans County

- Fidelis/NYS Catholic Health Plan 888-343-3547
- HealthNow/BCBS-WNY/Community Blue 866-231-0847
- Lake Plains Community Care Network 585-345-6110
- Orleans County DSS 585-589-7004

Oswego County

- Fidelis/NYS Catholic Health Plan 888-343-3547
- Oswego County DSS 315-963-5000
- Oswego County Opportunities 315-598-4715
- Total Care/Syracuse PHSP 800-223-7242
- United Healthcare of Upstate NY 800-339-5380

Otsego County

- Mothers and Babies of SCNY 800-231-0744
- Otsego County DSS 607-544-2100

Putnam County

- Maternal Infant Services Network 845-928-7448
- Putnam County DSS 845-225-7040

Oswego County

- Fidelis/NYS Catholic Health Plan 888-343-3547
- Oswego County DSS 315-963-5000
- Oswego County Opportunities 315-598-4715
- Total Care/Syracuse PHSP 800-223-7242
- United Healthcare of Upstate NY 800-339-5380

Federal and State Enrollment Facilitators: New York Counties

Otsego County
- Mothers and Babies of SCNY 800-231-0744
- Otsego County DSS 607-544-2100

Putnam County
- Maternal Infant Services Network 845-928-7448
- Putnam County DSS 845-225-7040

Rensselaer County
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Rennselaer County DSS 518-270-3917
- The Healthy Capital District Initiative 518-462-7040
- WellCare 800-288-5441

Rockland County
- Affinity Health Plan 866-247-5678
- Community Choice Health Plan 800-929-9656
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Rockland County DOH 845-364-3312
- Rockland County DSS 845-364-3040
- Westchester PHSP/Health Source 800-339-4557

Saratoga County
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Saratoga Care/Benedict Health Center 518-580-2021
- Saratoga County DSS 518-884-4148

Schenectady County
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Schenectady County DSS 518-388-4445
- The Healthy Capital District Initiative 518-462-7040

Schoharie County
- Schoharie Community Action Program 518-234-2568
- Schoharie County DSS 518-295-8334

Schuyler County
- Schuyler County DSS 607-535-8303
- Yates County Rural Health Network 800-346-2211

Seneca County
- Seneca County DSS 315-539-1800
- Yates County Rural Health Network 800-346-2211

St. Lawrence County
- North Country Prenatal/Perinatal Council 315-788-8533
- St. Lawrence County DSS 315-379-2179
- St. Regis Mowhawk Health Services 518-358-3141

Stueben County
- Stueben County DSS 607-776-7611
- Yates County Rural Health Network 800-346-2211

Suffolk County
- Affinity Health Plan 866-247-5678
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Health and Welfare Council of Long Island 516-483-1110
- Health First PHSP 800-404-8778
- HIP 888-224-5286
- Nassau-Suffolk Hospital Council 631-435-3000
- Suffolk County DSS 631-852-3710
- United Healthcare of NY 888-617-8979

Federal and State Enrollment Facilitators: New York Counties

Sullivan County
- Maternal Infant Services Network 845-928-7448
- Sullivan County DSS 845-292-0100
- Westchester PHSP/Health Source 800-339-4557

Tioga County
- Mothers and Babies of SCNY 800-231-0744
- Tioga County DSS 607-687-8300

Tompkins County
- Mothers and Babies of SCNY 800-231-0744
- Tompkins County DSS 607-274-5359

Ulster County
- Maternal Infant Services Network 845-928-7448
- Ulster County DSS 845-334-5035
- WellCare 800-288-5441

Warren County
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Upper Hudson Primary Care Consortium 518-562-3740
- Warren County DSS 518-761-6300

Washington County
- Fidelis/NYS Catholic Health Plan 888-343-3547
- Upper Hudson Primary Care Consortium 518-562-3740
- Washington County DSS 518-746-2300

Wayne County
- Wayne County DSS 315-946-4881
- Yates County Rural Health Network 800-346-2211

Wyoming County
- HealthNow/BCBS-WNY/Community Blue 866-231-0847
- Lake Plains Community Care Network 585-345-6110
- Wyoming County DSS 585-786-8900

Yates County
- Yates County DSS 315-536-5183
- Yates County Rural Health Network 800-346-2211

Hill Burton Act Hospitals

STATE NEW YORK

I.D. #	FACILITY NAME	FACILITY TYPE	TELEPHONE #	FACILITY ADDRESS	CITY	COUNTY	ZIP
360014	PLEASANT VALLEY HOME	NURSING HOME	518-638-8274	ROUTE 40	ARGYLE	WASHINGTON	12809
360018	* GENESEE CO NRSG HOME	NURSING HOME	716-344-0584	278 BANK STREET	BATAVIA	GENESEE	14020
360023	* SOUTHSIDE HOSP	GENERAL HOSP	631-968-3001	301 EAST MAIN STREET	BAY SHORE	SUFFOLK	11706
360024	ST FRANCIS HOSP BEACON	GENERAL HOSP	914-831-3500	DELAVAN AVENUE	BEACON	DUTCHESS	12508
360143	* CALVARY HOSP	GENERAL HOSP	212-863-6900	1740 EASTCHESTER ROAD	BRONX	BRONX	10461
360258	BRONX-LEBANON SP CC	NURSING HOME	718-590-1800	1265 FULTON AVE	BRONX	BRONX	10456
360264	BRONX-LEBANON IDC	OUTPATIENT	718 299-6910	1276 FULTON AVE	BRONX	BRONX	10456
360268	* MORRIS HEIGHTS HLTH CTR	OUTPATIENT FAC	- -	85 WEST BURNSIDE AVENUE	BRONX		10453
360030	KINGS COUNTY HOSP CTR	OUTPATIENT FAC	718-630-3101	451 CLARKSON AVENUE	BROOKLYN	KINGS	11203
360032	LUTHERAN MEDICAL CTR	GENERAL HOSP	718-630-7000	150 - 55TH STREET	BROOKLYN	KINGS	11220
360035	# INTERFAITH MEDICAL CTR	GENERAL HOSP	718-935-7000	1545 ATLANTIC AVENUE	BROOKLYN	KINGS	11213
360266	BUSHWICK CLINIC	OUTPATIENT FAC	718-260-2968	1149 MYRTLE AVENUE	BROOKLYN	KINGS	11210
360267	* SUNSET PARK FAMILY H C	OUTPATIENT FAC	718-630-7000	150 55TH STREET	BROOKLYN	KINGS	11220
360046	COMM GEN HOS-HERMAN DIV	GENERAL HOSP	845-887-5530	8081 ROUTH 97	CALLICOON	SULLIVAN	12723
360047	* MARY MCCLELLAN HOSP	GENERAL HOSP	518-677-2611	ONE MYRTLE AVENUE	CAMBRIDGE	WASHINGTON	12816
360053	# CLIFTON SPRINGS HOSP	GENERAL HOSP	315-462-9561	2 COULTER ROAD	CLIFTON SPRGS	ONTARIO	14432
360062	# CUBA MEMORIAL HOSP	GENERAL HOSP	716-968-2000	140 WEST MAIN STREET	CUBA	ALLEGANY	14727
360068	HORACE NYE HOME	NURSING HOME	518-873-3570	ESSEX CO GVMT CTR	ELIZABETHTOWN	ESSEX	12932
360082	* FULTON CO RES HLTH CARE	NURSING HOME	518-725-8631	847 COHWY 122	GLOVERSVILLE	FULTON	12078
360085	* ORANGE CO HOME & INFIRM	NURSING HOME	914-294-7971	BOX 59 QUARRY RD	GOSHEN	ORANGE	10924
360089	* GROTON COMM HLTH CR CTR	OUTPATIENT FAC	607-898-5873	100 SYKES STREET	GROTON	TOMPKINS	13073
360092	COMM GN HSP HARRIS DIV	GENERAL HOSP	914-794-3300	BUSHVILLE ROAD	HARRIS	SULLIVAN	12742
360109	* BENEDICTINE HOSP	GENERAL HOSP	914-338-2500	105 MARYS AVENUE	KINGSTON	ULSTER	12401
360251	* COMMUNITY REHAB CENTER	REHAB FAC	845-336-7235	WEBSTER STREET	KINGSTON	ULSTER	12401
360249	CATTARAUGUS CO HM INF	NURSING HOME	716-353-8516	ROUTE 16	MACHIAS	CATTARAUGUS	14101
360133	SCHUYLER HOSP	GENERAL HOSP	607-535-7121	MONTOUR TOWNSEND B 307	MONTOUR FALLS	SCHUYLER	14865
360136	MOUNT VERNON HOSP	GENERAL HOSP	914-664-8000	12 NORTH SEVENTH AVENUE	MOUNT VERNON	WESTCHESTER	10550
360145	* HARLEM HOSP CTR	GENERAL HOSP	212-939-1000	506 LENOX AVENUE	NEW YORK	NEW YORK	10037
360155	# ST LUKE'S/ROOSEVELT HOS	GENERAL HOSP	212-523-4000	1111 AMSTERDAM AVE	NEW YORK	NEW YORK	10025
360256	HIGHBRIDGE-WOODYCREST C	NURSING HOME	718-293-3200	936 WOODYCREST AVENUE	NEW YORK	BRONX	10452
360259	* GOLDWATER MEMORIAL HOSP	NURSING HOME	212-750-5980	FRANKLIN D ROOSEVELT ISLAND	NEW YORK	NEW YORK	10044
360263	* COLER MEMORIAL HOSPITAL	GENERAL HOSP	212-848-6027	FRANKLIN D. ROOSEVELT ISLAND	NEW YORK	MANHATTAN	10044
360265	RIVINGTON H C FACILITY	NURSING HOME	212-539-6450	45 RIVINGTON STREET	NEW YORK	NEW YORK	10002
360159	VIA HEALTH OF WAYNE	GENERAL HOSP	315-332-2022	P O BOX 111	NEWARK	WAYNE	14513
360163	CHENANGO MEMORIAL HOSP	GENERAL HOSP	607-337-4152	179 NORTH BROAD STREET	NORWICH	CHENANGO	13815
360168	CATTARAUGUS NRSNG HOME	NURSING HOME	716-373-1910	2245 WEST STATE STREET	OLEAN	CATTARAUGUS	14760
360252	* OSSINING O D FAMILY H C	OUTPATIENT FAC	914-941-1263	165 MAIN STREET	OSSINING	WESTCHESTER	10562
360253	* HUDSON RIVER HLTH CARE	OUTPATIENT FAC	914-739-8105	1037 MAIN STREET	PEEKSKILL	WESTCHESTER	10566
360191	# HIGHLAND HOSP	GENERAL HOSP	716-473-2200	SOUTH AVENUE AT BELLEVUE DRIVE	ROCHESTER	MONROE	14620
360212	SOUTHAMPTON HOSP	GENERAL HOSP	631-726-8200	240 MEETING HOUSE LANE	SOUTHAMPTON	SUFFOLK	11968
360213	BERTRAND CHAFFEE HOSP	GENERAL HOSP	716-592-2871	224 EAST MAIN	SPRINGVILLE	ERIE	14141
360231	* BLYTHEDALE CHILDS HOSP	REHAB FAC	914-592-7555	BRADHURST AVENUE	VALHALLA	WESTCHESTER	10595

* THESE FACILITIES ARE CERTIFIED UNDER A COMPLIANCE ALTERNATIVE. THEIR PROGRAMS MAY BE CALLED EITHER A FREE CARE, A CHARITY CARE, A DISCOUNTED SERVICES, OR AN INDIGENT CARE PROGRAM, ETC. THESE PROGRAMS MAY HAVE DIFFERENT ELIGIBILITY AND FINANCIAL CRITERIA.

THE FACILITY INCLUDES MULTIPLE MEDICAL BUILDINGS. SUPPLEMENTAL LISTING FOLLOWS.

I.D. #	FACILITY NAME	FACILITY ADDRESS	CITY	STATE	ZIP
360035	BEDFORD AMBULATORY CARE	485 THROOP AVENUE	BROOKLYN	NY	11201
360035	INTERFAITH M C/ST JOHNS	1545 ATLANTIC AVENUE	BROOKLYN	NY	11213
360035	JEWISH H MC OF BROOKLYN	555 PROSPECT PLACE	BROOKLYN	NY	11230
360035	PARKWAY FAMILY HLTH CTR	391 EASTERN PARKWAY	BROOKLYN	NY	11238
360035	RALPH AVENUE M C CENTER	38-40 RALPH AVENUE	BROOKLYN	NY	11213
360035	ST JOHNS BROWNSVILLE	379 ROCKAWAY AVENUE	BROOKLYN	NY	11221
360035	ST JOHNS BUSHWICK MMTP	1727 BROADWAY	BROOKLYN	NY	22107
360053	ADDITIONS RECOVERY CTR	468 SOUTH PEARL STREET	CANANDAIGUA	NY	14424
360053	ALCOHOL REHAB CENTER	7 NORTH STREET	CANANDAIGUA	NY	14424
360053	CANAL PARK FAMILY MED	555 WEST MAIN STREET	PALMYRA	NY	14522
360053	FINGER LAKES BREASTCARE	4 COULTER ROAD	CLIFTON SPRING	NY	14432
360053	FINGER LAKES COM CANCER	6 COULTER ROAD	CLIFTON SPRING	NY	14432
360053	LYONS DIAG/TREATMENT CT	122 BROAD STREET	LYONS	NY	14439
360053	LYONS MEDICAL CENTER	43-45 PHELPS STREET	LYONS	NY	14489
360053	PAL-MAC MEDICAL CENTER	1900 WEST WAYNE PLAZA	MACEDON	NY	14502
360053	PRIMARY CARE EXTENSION	MGB 2ND FLOOR	CLIFTON SPRING	NY	11432
360053	SENECA FALLS DIAG/TREAT	2 FALL STREET	SENECA FALLS	NY	13148
360062	CUBA MEM HOSP W MAIN MC	138 WEST MAIN STREET	CUBA	NY	14727
360155	FAMILY CARE GROUP PRAC	411 WEST 114TH STREET	NEW YORK	NY	10025
360155	MENTAL HLTH CLINIC	15 WEST 65TH STREET	NEW YORK	NY	10023
360155	PSYCHIATRIC DAY CARE	411 WEST 114TH STREET	NEW YORK	NY	10025
360155	ROOSEVELT HOSP DIV	428 W 59TH STREET	NEW YORK	NY	10019
360155	ROOSEVELT HOSP DIV	910 9TH AVENUE BUILDING	NEW YORK	NY	10019
360155	SMITHERS ALCOHOLISM CTR	56 EAST 93RD STREET	NEW YORK	NY	10028
360155	SMITHERS CLINIC	17 WEST 60TH STREET	NEW YORK	NY	10023
360155	TRINITY HOUSE	324 WEST 108TH STREET	NEW YORK	NY	10025
360191	AVON FAMILY MEDICINE	190 CLINTON STREET EXTENSION	AVON	NY	14414
360191	DOWNTOWN HEALTH CLINIC	AKA URAN CTR PRIMARY CARE	ROCHESTER	NY	14604
360191	GATES/CHILI PRI MD CARE	AKA WEST CHILI OB & CHILI FAM	ROCHESTER	NY	14624
360191	HIGHLAND OB/GYN	520 WHITE SPRUCE BOULEVARD	ROCHESTER	NY	14623
360191	JACOB W HOLLER FAM M C	AKA FAMILY MEDICINE	ROCHESTER	NY	14620
360191	N ROCHESTER FAM MED EXT	240 RIDGE ROAD EAST	ROCHESTER	NY	14621
360191	PARMA HEALTH CENTER	1024 HILTON PARMA CORNERS ROAD	HILTON	NY	14468
360191	PRIMARY MED & PRENATAL	AKA PENFIELD OB&PENFIELD FAMIL	PENFIELD	NY	14526
360191	PRIMARY MED CARE EXT CL	AKA HIGHLAND PARK	ROCHESTER	NY	14620
360191	PRIMARY MED&PRENATAL	AKA DAVID-IUPPA & WEST RIDGE	ROCHESTER	NY	14626
360191	RUSH FAMILY MEDICINE	15 HIGH TECH DRIVE	RUSH	NY	14543

County Departments of Health, New York State

The directory of county departments of health is located at:
http://www.health.state.ny.us/nysdoh/lhu/map.htm

New York State Department of Health Toll-Free 800 Help lines

AIDS

General Information
1-800-541-AIDS

General Information, Spanish Language
1-800-233-7432

AIDS Drug Assistance Program (ADAP)
1-800-542-2437

AIDS Counseling & Testing
Buffalo
1-800-962-5064
Nassau
1-800-462-6785
New Rochelle
1-800-828-0064
Rochester
1-800-962-5063
Syracuse
1-800-562-9423
Suffolk
1-800-462-6786
Troy
1-800-962-5065
Queens
1-800-462-6785

NYS After Hours Hotline (Monday-Friday 4pm to 8pm and Saturday & Sunday 10am to 6pm)
1-800-872-2777

Cancer Information

CANCER CAN-DIAL
PRE-RECORDED TAPES
845-3380
(Erie Co. Only)
1-800-462-1884
(elsewhere in New York State)

Cancer Maps
1-800-458-1158

Roswell Park Cancer Institute

Referral Services
1-800-767-9355

General Information
Switchboard
1-800-685-6825

Ovarian Cancer Information
1-800-682-7426

Environmental Health 1-800-458-1158
Covering the Following Programs:

- Asbestos and Lead Removal
- Community Health Studies
- Community Sanitation Issues
- Fish Advisories
- Food Protection, Recalls and Illnesses
- Hazardous Waste Sites
- Health Effects of Pesticides, Insect Repellents, and Chemicals
- Indoor Air Quality
- Oil or Chemical Spills
- Public Water Supplies
- Radon, Radiation, Radioactive Materials
- Regulated Facilities Such as Motels, Restaurants, Children's Camps and Public Beaches
- Smoking and Tobacco Regulations
- Worker Safety Issues

Food and Nutrition Programs

Child and Adult Care Food Program
1-800-942-3858

Growing Up Healthy Hotline
1-800-522-5006

Covering the Following Programs:
- Early Intervention Program
- Food and Nutrition (FAN)
- Growing Up Healthy
- HIB Disease
- Immunization
- Infant Health Assessment
- PCAP (Prenatal Care Assistance Program)
- Sudden Infant Death Syndrome (SIDS)
- Teen Pregnancy
- WIC

Health Insurance

Child Health Plus
1-800-698-4KIDS

Fraud and Abuse Hotline
1-800-542-0424

Participant Helpline
1-800-332-3742

Provider Helpline
1-800-634-1340

Family Health Plus
1-877-9FHPLUS
(1-877-934-7587)

Prenatal Care Assistance Program (PCAP)
1 (800) 522-5006

Home Health Care

Including Information about Certified Home Health Care Agencies
1-800-628-5972

Hospital Care

Housing and Adult Services

Eastern New York
1-800-286-4830

Western New York
1-800-462-6443

Metropolitan New York
1-800-554-5391

Long Island
1-800-635-7920

Long-Term Care Insurance

1-888-NYS-PLTC

Managed Care Complaints:

1-800-206-8125

Medicaid Managed Care Information:

1-800-505-5678
(in New York City)

1-888-367-6557
(outside New York City)

Nursing Home Patient Care Complaints

Centralized Complaint Intake Program
161 Delaware Avenue
Delmar, New York 12054

phone: 1-888-201-4563

e-mail: nhintake@health.state.ny.us

Occupational Health

Occupational Disease and Fatality Reporting
1-866-807-2130

Office of Professional Medical Conduct (OPMC)

Complaints and Inquiries
1-800-663-6114

Organ & Tissue Donation Information

1-866-NYDONOR (1-866-693-6667)

Smokers Quit line

1-888-609-6292

West Nile Virus

1-800-458-1158

Workbook References

References: Footnoted

[1] *Checkup on Health Insurance Choices*. AHCPR Publication No. 93-0018, December 1992. Agency for Health Care Policy and Research, Rockville, MD. http://www.ahrq.gov/consumer/insuranc.htm

[2] Matthews, Joseph, and Dorothy Berman. Social Security, Medicare, and Government Pensions: Get the most out of your retirement and medical benefits. Nolo Press, 2002. Berkeley, California.

[3] Matthews, Joseph. Beat the Nursing Home Trap: A consumer's guide to assisted living and long term care. Nolo Press, 1999. Berkeley California.

[4] Met Life (2000) citation in an EF Moody report on nursing home statistics. 9/3/2003.

References: Summarized

Alexander, Richard. (Editor) "Avoiding Fraud When Buying Long-Term Care Insurance: A Guide for Consumers and Their Families." Alexander, Hawes, and Audit, LLP. San Jose, California, 95112.

Matthews, Joseph. Beat the Nursing Home Trap, Nolo Press, 1999. Berkeley California

United Seniors Health Cooperative, 1334 G Street, N.W., Suite #500, Washington, D.C., 20005-4706, 202.393.6222.

Susan Polniaszek, Long-Term Care: A Dollar and Sense Guide, 1991 Edition, United Seniors Health Cooperative, Washington, D.C., 1991.

Susan E. Polniaszek and James P. Firman, Long-Term Care Insurance: A Professional's Guide to Selecting Policies, United Seniors Health Cooperative, Washington, D.C., 1991.

National Association of Insurance Commissioners (NAIC), 120 W. 12th Street, Suite 1100, Kansas City, Missouri, 1990.

Health Insurance Association of America, The Consumer's Guide to Long-Term Care Insurance, 1025 Connecticut Avenue, N.W., Washington, D.C., 20036-3998, 202.223.7780, 1991.

LTC News & Comment, 5808 Lake Washington Blvd., N.E., Suite 410, Kirkland, WA 98033, 206.827.8626.

Ken Scholen, Retirement Income on the House: Cashing in on your Home with a "Reverse" Mortgage, NCHEC Press, Marshall, Minnesota, 1992.

"Who Pays for Nursing Homes?" Consumer Reports, September 1995.

Center for Medicare and Medicaid Services. Department of Health and Human Service, United States Government, September 2003. www.cms.hhs.gov.

Social Security Administration. United States Government, September 2003. www.ssa.gov.

New York State Department of Health. New York State Government. September 2003. www.health.state.ny.us.

Haggle with your doctor, cut your bill. www.Insure.com. September 2003.

Decoding Your Doctor Bills. www.ConsumerReports.org. January 2003.

When Your Health Plan Won't Pay. www.Insure.com. September 2003.

A Health Care Plan that can save your thousands. Terry Savage. www.moneycentral.msn.com. September 2003.

Office of Special Programs. Health, Resources, and Services Administration. US Department of Health and Human Services. United States Government. www.hsra.gov.osp/