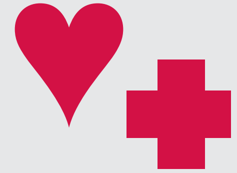
Life & Health Insurance Advisor



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The Documents Every Adult Needs

What kind of medical care would you want if you were too ill or hurt to express your wishes? Do your loved ones know what kind of end-of-life care you want to have…or avoid? And who will have the authority to make medical decisions on your behalf if you can't?

If you were incapable of speaking or making a decision, would you want to leave these decisions to strangers? Or to chance? Probably not. So although it's not pleasant to think about these possibilities, we're going to discuss two important documents that every adult needs: the living will and a durable power of attorney for healthcare.

Advance directives

Advance directives are legal documents that allow you to convey your decisions about the care you want to receive if you become terminally ill, permanently unconscious or enter a persistent vegetative state. An advance directive provides a way for you to communicate your wishes to family, friends and health care professionals when you are unable to do so.

When faced with an end-of-life situation, adult patients have the right to determine the amount and type of healthcare they receive. You can continue to receive aggressive medical treatments, which might not cure you but might prolong your life for a short time. However, some more aggressive or experimental treatments can cause pain and might even hasten the end. You can also request or refuse treatments to increase your comfort, such as pain medications, hydration and antibiotics.

The two documents that constitute advance directives are a *living will* and a *durable power of attorney for healthcare.* Most, if not all, states recognize these as legally binding documents when drawn up and signed while the patient still possesses his/her full mental faculties.

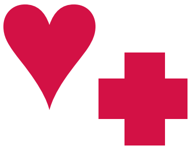
The living will provides general information about how you feel about care intended to sustain life, as well as specifying the

DOCUMENTS—continued on Page 3

This Just In

Healthcare fraud costs the U.S. more than $60 billion each year, estimates the National Health Care Anti-fraud Association (NHCAA). For individuals, fraud costs you by adding to your premium costs; it can also jeopardize your health if someone steals your medical identity. The NHCAA offers the following tips to avoid medical fraud:

- **Beware of "free" offers. Offers of "free" services are often fraud schemes designed to bill you and your insurance company illegally for thousands of dollars of treatments you never received.**
- **Protect your health insurance card like your credit card. In the wrong hands, a health insurance card is a license to steal. Don't give policy numbers or other identifying information to door-to-door salesmen or telephone solicitors.**
- **If you suspect health insurance fraud, call your insurance company immediately. If you suspect a health provider is committing fraud, file a complaint with the state medical board.**



Individual Health Coverage A, B, Cs

U.S. Census data revealed that the percent of the population with employer-based coverage dropped to 59 percent in 2007 (the last year for which complete data are available). At the same time, nearly 9 percent of the population relied on individually purchased private insurance for health insurance coverage. With employer-based coverage decreasing, the percent of people who will need to find their coverage in the individual market — or go without — is likely to increase.

A. How to Find Insurance

Most people obtain their health insurance coverage on the private market (as opposed to public programs, such as Medicare or Medicaid). Private health insurers provide health insurance coverage to individuals through either an employment-based (group) plan or individual plan. Your employer or union may purchase group health coverage on behalf of its employees or members. You can also buy group coverage through a group you belong to, such as a professional association. However, beware associations that exist only to sell group coverage — the coverage they provide often does not meet state requirements and might lack the protections you automatically enjoy when you buy coverage through a state-licensed insurer.

B. How to Apply

When you apply for individual coverage, the insurer will require you to complete a detailed health insurance application, which will ask about your current health and health history. The insurer will also require your permission to review your medical files. Depending on your age and health history, the insurer might also require you to take a paramedical exam, where a nurse or other specially trained medical professional will review your application, take your blood pressure, temperature and blood and urine samples.

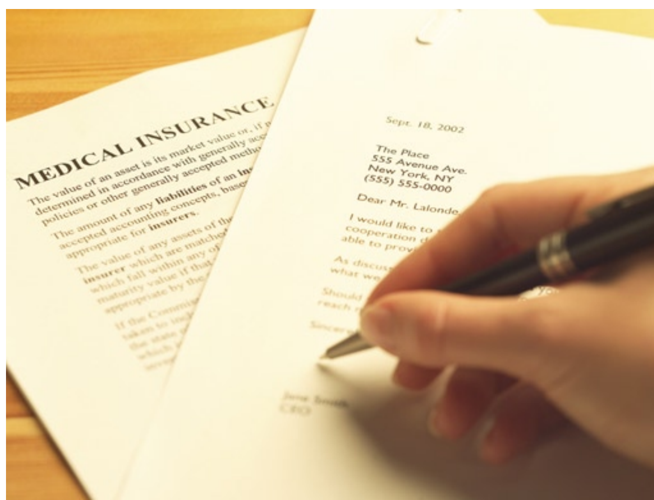
Once your application is completed, it goes to the insurer's underwriting department. Most policies undergo an automatic process; however, sometimes an underwriter will review a particular policy. An underwriter is an insurance professional who evaluates the risk involved in insuring any individual or property. The underwriter determines whether the insurer should offer or deny coverage, determines the rate the insured should pay, and whether the insurer should exclude any coverages.

Some states have "guaranteed issue" laws that require insurers to cover all applicants for individual health coverage, regardless of health. Others have a community rating system, in which everyone in a geographical area pays the same for their coverage, regardless of health. While this might sound like a good idea, in those states, you will generally pay more for coverage. Why? Studies have found that a relatively small percentage of people accounts for the lion's share of healthcare spending. In fact, a Kaiser Family Foundation study found that, in 2006, "almost half of all health care spending was used to treat just 5 percent of the population."

If your state does not have guaranteed issue laws, you might have problems finding individual coverage if you have a pre-existing health condition. However, most states have a high-risk insurance pool, which pools together individuals the private market declines to insure. These pools provide a safety net for those who would otherwise not qualify for individual health coverage because of a medical condition.

Each state's risk pool operates differently. Most operate as a state-created nonprofit, which contracts with an insurance company to administer the pool. If you obtain coverage through a pool, you'll likely pay more than one of your peers with no pre-existing conditions; however, the state usually limits premiums and often has to subsidize coverage.

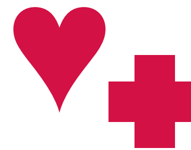
COVERAGE—continued on Page 3



States with High-Risk Pools

Alabama (for portability only)
Alaska
Arkansas
California
Colorado
Connecticut
Florida (not open for new enrollees)
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maryland
Minnesota
Mississippi
Missouri
Montana
Nebraska
New Hampshire
New Mexico
North Carolina
North Dakota
Oklahoma
Oregon
South Carolina
South Dakota
Tennessee
Texas
Utah
Washington
West Virginia
Wisconsin
Wyoming

Source: National Association of State Comprehensive Insurance Plans



DOCUMENTS—*continued from Page 1*

types of medical procedures or custodial care you want or don't want when you are either at the end of life or in a permanent state of unconsciousness. You can use the living will to request or refuse care such as:

- Cardiopulmonary resuscitation (CPR)
- Dialysis
- Ventilators
- Tube feeding
- Hydration
- Antibiotics

You can also use the living will to state whether you want to donate your organs or tissues, and to specify which ones.

A durable power of attorney for health care is a document that names your health care proxy. Your proxy is someone you trust to make health decisions on your behalf if you are unable to do so. Generally, the proxy should be someone who knows you well but will not profit from your death.

As medical information changes so rapidly, you might not want to rely only on a living will, as it might not cover all the contingencies available. Some documents combine both the living will and the durable power of attorney. Your hospital or attorney can provide you with standard forms; you can also find forms online by state by going to www.usa.gov and typing in "durable power of attorney for healthcare" in the search box.

We recommend talking over your healthcare decisions with your physicians and family members. To be binding, your documents should be signed by two witnesses who do not stand to profit from your death or by a notary, depending on your state. For legal advice, please contact your attorney.

COVERAGE—*continued from Page 2*

However, most individuals will have access to a wide variety of individual health insurance policies. According to research by the trade group America's Health Insurance Plans (AHIP), insurers offered coverage to 89 percent of applicants undergoing medical underwriting.

C. How Much It Costs

Health insurance has one primary purpose: to protect insureds from catastrophic healthcare costs. When you buy health insurance, you can't expect your policy to pay for all your medical expenses — that would make coverage prohibitively expensive for all insureds.

Health insurers design their plans with cost-sharing features, such as deductibles, co-payments and coinsurance, that force insureds to share in the cost of their healthcare. Why? Cost-sharing eliminates duplication and waste, because when consumers share in the cost of their coverage, they are more likely to think twice about whether they really need to make an office visit for a simple cold, or to take an expensive prescription drug when an over-the-counter remedy will do the job.

The cost-sharing features in your policy help determine your actual cost of coverage. Although some plan designs have higher out-of-pocket costs, your premiums should be lower. Cost-sharing features include:

Co-payment: The fixed dollar amount an insured person must pay when receiving a medical service. The insurer reimburses the provider for the rest of the charge, subject to "reasonable and customary" rules and your coinsurance and deductible.

Coinsurance: The stated percentage of medical expenses the insured must pay after meeting the policy deductible, if any.

Deductible: A fixed dollar amount during the benefit period — usually a year — that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles. Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission.

Maximum plan dollar limit: The maximum amount the insurer will pay toward the covered expenses of the insured and each covered dependent under the health plan. Plans can have a yearly and/or a lifetime maximum dollar limit. Look for a policy with a lifetime maximum of at least $1 million. Less than that, and you could be dangerously underinsured.

Maximum out-of-pocket expense: The maximum dollar amount a policyholder must pay out of pocket during a year. Until this maximum is met, the plan and insured share in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, except co-pays, up to the lifetime maximum.

For assistance in comparing different policies or finding coverage to meet your needs, please contact us.

LONG-TERM CARE—*continued from Page 4*

community. Who is eligible and what services are covered vary from state to state. Most often, eligibility is based on your income and personal resources. Individuals must generally "spend down" their assets before Medicaid will pay for nursing home care.

Today, most long-term care policies will pay for home health care, as well as a stay in a nursing home or assisted living facility, for those who need help with the activities of daily living.

Myth #3: Long-term care insurance is expensive.

In 2008, a basic policy would have cost a healthy, married 55-year-old an average of $709 per year for a $100 daily benefit, according to the American Association for Long-Term Care Insurance, an insurer association. That might sound like a lot of money…until you compare it to the cost of a nursing home stay.

The younger you are, the less you'll pay for long-term care coverage. Compare the $709 per year to what a 65-year-old would pay — an average of $1,342 per year for the same daily benefit. By buying your coverage now, rather than when you're older, you can lock in lower premiums. You'll save money and have peace of mind, knowing you're protecting your assets. For information, please contact us.

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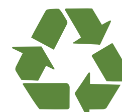

What You Know About Long-Term Care Might Be Wrong (and why you should care)

Spending a day in a nursing home can cost as much as staying in a four-star hotel. Unfortunately, many Americans end up spending more time in nursing homes than in four-star hotels. Here's what you need to know about budgeting for your long-term care needs.

The U.S. Office of Personnel Management released the following sobering statistics:

- 48.6 percent of people 65 and older may spend time in a nursing home
- 71.8 percent of people 65 and older are expected to use some form of home health care
- 40 percent of the people receiving long-term care are between the ages of 18-64

Despite these facts, only 16 percent of Americans over the age of 65 had long-term care insurance in 2005, according to a report by America's Health Insurance Plans (AHIP), a health insurance trade association. AHIP studied LTC buying patterns over 15 years, from 1990-2005. The study reveals some commonly held myths about long-term care that prevent people from buying this important coverage.

Myth #1: Nursing home care doesn't cost that much.

The study found a strong link between understanding the cost of nursing home care and buying long-term care insurance. In fact, 70 percent of non-buyers underestimated the cost of nursing home care in their area, while only 14 percent of the buyers did.

Now let's see how you do. What do you think a year in a nursing home costs?

According to a survey released in October 2008 by MetLife, the cost of a private room in a nursing home averaged $191 daily, or $69,715 annually, in 2008. Remember, those are averages — if you live in an urban or high-cost area, nursing home costs will likely be higher.

Myth #2: Medicare or Medicaid will pay.

Generally, Medicare doesn't pay for long-term care. It pays only for medically necessary skilled nursing facility or home health care, rather than the "custodial" or non-skilled care that helps people with the activities of daily living. These activities include dressing, bathing, eating and using the bathroom.

Medicaid is a state and federal government program that pays for certain health services and nursing home care for older people with low incomes and limited assets. In most states, Medicaid also pays for some long-term care services at home and in the

LONG-TERM CARE—continued on Page 3

Are you an "impaired risk"?

Insurers sometimes deny life or health insurance to applicants deemed an "impaired risk." Insures define an impaired, or substandard, risk as a person whose health, hobbies or habits make him more risky to insure. Factors that could push you into this category include:

- **Health problems, such as coronary disease, strokes, diabetes or depression**
- **Unhealthy habits, such as smoking, unsafe driving, alcoholism or drug abuse**
- **Risky hobbies, such as race car driving, sky diving, extreme sports**

Being an impaired risk doesn't necessarily mean you won't find life or health insurance. It will just take longer; you will likely pay more; and your policy might exclude specific conditions or activities.

An experienced agent or broker can help you find coverage for impaired risks. The first thing to do is to be completely honest about your health history and/or activities. Hiding information might make it impossible to obtain coverage if an insurer uncovers it during underwriting. Omitting material facts can also lead to a policy rescission, or unilateral cancellation by the insurer. Although rare, most rescissions occur when the insured files a claim — and needs the coverage most.

Once you and your agent have completed your application, the agent will obtain an attending physician's statement, or APS. This includes detailed information about your health condition and treatment. Some insurers or underwriters will use only a summary of the APS. In this case, an agent might use the services of a specialist — usually someone with underwriting experience — to write the APS summary so it properly highlights the positive aspects of your health history.

If you had at least 18 months of continuous "creditable coverage" under a group health plan, HIPAA, the Health Insurance Portability and Accountability Act, might require your insurer to issue an individual conversion policy without regard to your current health status. Conversion policies can be expensive — we can help you compare them to other options available. ■