What are the chances
that you will require some form of
Convalescent Care or Recovery Care
during your lifetime?

Many people believe it will never happen to them:

IN FACT:

A gallup poll indicates that 76% of Americans believe that they will never need any type of long-term care services.*

***Source: American Health Care Association, 2006**

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However…

The U.S. Department of Health and Human Services did a study which indicates that a person age 65 faces at least a 70% lifetime risk of needing some type of long-term care services.
But, only about 10% will stay in a nursing home five years or longer.

Approximately 12 million Americans needed long-term care in 2007.

The lifetime probability of becoming disabled in at least two activities of daily living or of being cognitively impaired is 68% for people 65 and older.*

85% of Nursing Home Population is over 65 years of age. 67.2% of Nursing Home Population are women.

***Source: Health Insurance Association of America**

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Remember…

7 in 10 people turning age 65 can expect to use some form of Recovery Care or long term care during their lifetime.

*Source: Administration on Aging

Also, when they get there…

According to a 2006 survey,*

82.4% of nursing home discharges stayed **12 months or less.**

The **average** length of stay in a nursing home for people 65 or older was **276 days** in 2008.

*Source: U.S. Department of Health and Human Service; "The National Nursing Home Survey," Series 13, No. 147

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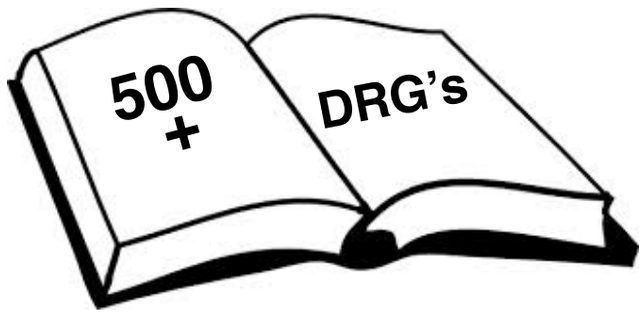
Why is that?



In 1983, Medicare shifted its payment strategy to the "prospective payment system." Instead of reimbursing hospitals for the actual costs of treating patients, the government now pays a set fee according to almost 500 "Diagnostic Related Groups" or DRG's.

*Source: U.S. Department of Health and Human Service; "The National Nursing Home Survey," Series 13, No. 147

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As a result…

Medicare now pays hospitals for a fixed number of days for a particular diagnosis and treatment.

This gives hospitals incentive to move patients out once they reach this arbitrary number of days' stay - regardless of the patient's actual condition or need for continuing care.

SO,

Shorter hospital stays increase the need for rehabilitative and recuperative services such as nursing home.

And again,

The average length of stay in a nursing home for elderly discharges was 276 days in 2008.

Source: Vital and health Statistics of the Centers for Disease Control and Prevention/National Center of health Statistics, Advance Data, Number 312, April 25, 2000

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Can you count on Medicare? Benefits are limited:

Days 1 - 20	**Medicare Pays All Costs at 100% if specific tests are met.**
Days 21 - 100	**You pay 100% daily co-payment of up to $176.00**
Days 100 & beyond	**Medicare pays ZERO**

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In addition…

Medicare has a number of limitations.

- Medicare only pays for nursing home care preceded by a minimum of a three-day inpatient hospital stay.
- You must enter extended care facility within 30 days of leaving the hospital, and for the same condition you were hospitalized.
- Medicare does not cover Custodial Care - ***only Daily Skilled Care*** (5 days per week)
- You must show improvement in capability and have rehabilitation potential.
- Medicare pays nothing for assisted living.

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Examples of Medically Necessary Care NOT covered by Medicare

Broken ankle - outpatient surgery sent to SNF for Rehab for 30 days.

Why wasn't this covered?

Fell forward, breaking both arms and was sent to SNF to be cared for. Did not require skilled care.

Why wasn't this covered?

Broken hip - kept in hospital "Under Observation" before going to Skilled Nursing Facility

Why wasn't this covered?

Treated in hospital for pneumonia for 3 days, then sent to SNF. (Did not show signs of improvement)

Why wasn't this covered?

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NOTICE OF MEDICARE CLAIM DETERMINATION

INTERMEDIARY NUMBER, NAME AND ADDRESS	DATE YOUR HEALTH INSURANCE CLAIM NO.

SERVICES PROVIDED BY: (Name and Address)

PROVIDER NUMBER

TYPE OF SERVICES PROVIDED	DATE OF ADMISSION OR FIRST VISIT	NOTICE COVERS PERIOD
q HOSPITAL q SKILLED NURSING FACILITY q HOME HEALTH AGENCY q OTHER	INSURANCE q HOSPITAL q MEDICAL	FROM THROUGH

This concerns the services you received from the facility shown above. Medicare cannot pay for part of these services for the following reason:

One of the qualifications for Medicare coverage of skilled nursing facility services is that you must require, on a daily basis, skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. Skilled nursing or skilled rehabilitation services must be performed by, or under the supervision of, a professional nurse or a physical, speech, or occupational therapist to achieve the medically desired effect. Skilled services that may be needed in a skilled nursing facility include:

- Skilled management and evaluation by a professional nurse or therapist for medical reasons to promote your recovery and medical safety;
- Skilled observation and assessment when your medical condition is unstable or there is a likelihood of a change requiring a skilled nurse to evaluate the need for changes in your plan of care;
- Teaching and training by skilled personnel necessary to help you manage your plan of care; and
- Certain service(s) recognized by Medicare as always requiring skilled nursing or skilled rehabilitation if it is reasonable and necessary for the treatment of illness or injury, for example, nasogastric tube feeding. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 411.15(k) and 42 CFR 409.31-.35.

We reviewed the medical information submitted and have determined that services you received were not covered. Therefore, the services rendered will not be reimbursed by Medicare because skilled services were not provided daily.

If you do not agree with this determination, you have the right to appeal. You must file a written request for reconsideration within 60 days from the date of receipt on this notice. You may make your request through this office or any Social Security Office.

If you want help with your appeal, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups such as lawyer referral services that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

Cc: Sandy Regional Care Center. AG/wdg

Nursing Home Care is Expensive!

The national average for private pay Nursing Home Care is $146.00 per day, or $53,290 per year.

However, only 9% of all Nursing Home residents are even covered by Medicare in the first place.

Source: NCFA National Expenditures Data, 2006

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Let's examine YOUR options after Medicare benefits are exhausted…

MEDICAID

Do you want to "spend down" your assets in order to qualify for welfare assistance?

PERSONAL SAVINGS

Are your savings large enough to pay the cost of extended care and still meet your other needs and obligations?

FAMILY

Do you want to depend on your family to pay for your extended care needs?

or

PRIVATE INSURANCE

A personal health insurance program can help to preserve your retirement savings and your family's assets while providing you with peace of mind.

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Linda Ruthardt, the Insurance Commissioner of Massachusetts, in 1995 said this:

"The day is coming when people will demand the right to buy a policy to cover their nursing home short stay when they are discharged "sicker" and need to access benefits they can use in real life rather than in theory."

Source: National Underwriter, July 31, 1995

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That day is here…

There is a suitable, more affordable alternative…

It's called

Short-Term Care

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Examine the benefits of a Short-Term Care policy

- Covers all levels of care - skilled care not required
- No prior hospitalization required
- You select the benefits to meet your budget and needs
- Flexible benefit periods long enough to cover average stay in nursing facility
- 100% of your benefits are restored after you've been free from care for 6 months
- Lifetime maximum benefit = 2x the benefit period selected
- Full benefits paid for Alzheimer's, senile dementia, Parkinson's Disease, or cognitively impaired
- Benefits are payable when it is medically determined that you are unable to perform 2 Activities of Daily Living (ADL's)
- Guaranteed renewable* - The company may not cancel your policy as long as your premiums are paid on time
- Level premiums** - Your premiums cannot be raised because of a change in your age or health

*Exclusions and limitations apply - refer to the Outline of Coverage for details

** Premiums are subject to change on a class basis

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Which Benefit Period do you feel best fits your needs?

120 Days **240 Days** **360 Days**

Which Benefit Amount do you feel best fits your budget?

$100/Day **$150/Day** **$200/Day**

or some other amount per day

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What are the odds?

Comparing Insurable Risks:

1 in 49	**Suffer a loss due to fire***
1 in 49	**Will die or be injured as a result of an automobile accident****
7 in 10	**People turning 65 can expect to use some form of Recovery Care or Long Term Care during their lifetime**

*NFPS's Survey of Fire Departments for 1999 U.S. Fire Experience

** 1999 Motor Vehicle Crash Data from the Fatality Analysis Reporting System and General Estimates System

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What are the payment sources for nursing home care?

Medicare	9%
Medicaid	40%
Other (including private insurance, other public funds and other private funds)	12%
Out-of-Pocket	39%

Source: NCFA National Expenditures Data, 2006

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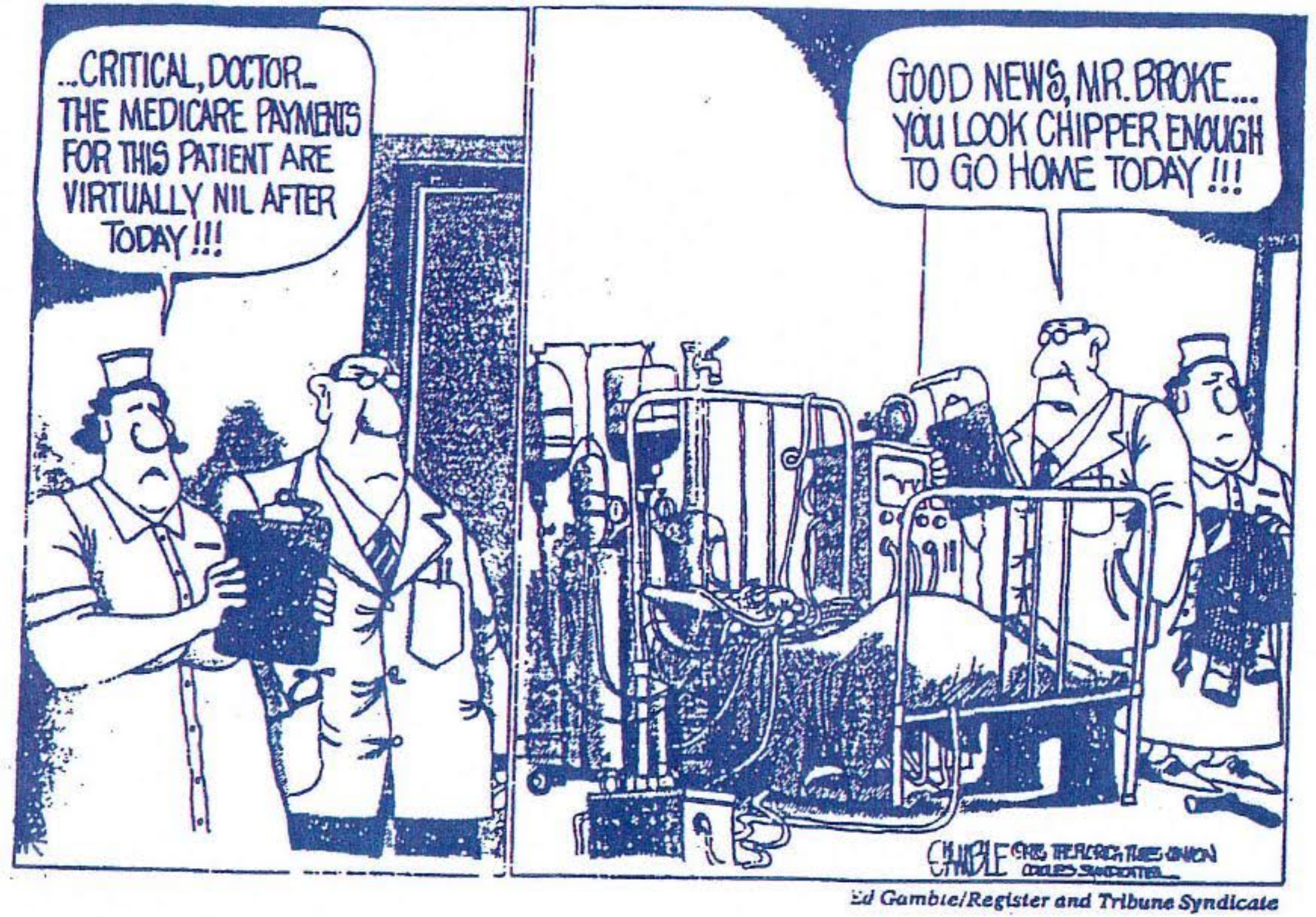

Ed Gambie/Register and Tribune Syndicate

"Today, more nursing home patients arrive from hospitals than they once did. And many nursing home officials believe that because hospitals themselves are under pressure to contain costs, they discharge patients 'quicker and sicker'".

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Question?

How Do Medicare Advantage Plans Pay?

When considering Short Term Care with Medicare Advantage,

Remember…

Copays for skilled nursing facilities, on most plans, begin on day 21

Your agent can discuss your special needs with you.

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