



LEGAL HOTLINE FOR TEXANS

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HEALTHCARE RIGHTS OF OLDER TEXANS

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The pamphlets of the Legal Hotline for Texans are general in nature and should not be relied on as advice for your particular circumstances. For advice that is specific to your particular circumstances, you should consult a lawyer.

The Legal Hotline for Texans (LHT) is a telephone hotline providing free legal advice and consultation and other free legal services to Texans Age 60 and Older or Eligible for Medicare; Crime Victims Age 60 and Older and their Family Members and Authorized Claimants; and Pension and Retirement Plan Employees, Participants and Beneficiaries.

Eligible Clients can consult with an attorney of the Legal Hotline for Texans free of charge by calling one of the phone numbers listed above. If clients would like to consult with an attorney in their communities, or if ongoing representation by an attorney is needed, the Legal Hotline for Texans may be able to make a referral.

Depending on individual circumstances and local availability, such a referral may be to an organization providing free attorneys to low income persons, or may be to an attorney on the Legal Hotline for Texans' reduced-fee panel, or may be to a statewide or local lawyer referral service.

The Legal Hotline for Texans is a project of the Texas Legal Services Center with support from the Texas Department of Aging, and Disability Services (DADS), the U.S. Centers for Medicare and Medicaid Services (CMS), the U.S. Administration on Aging (AoA) and the Texas Equal Access to Justice Foundation through the Texas Basic Civil Legal Services Program (BCLS) and the Texas Crime Victims Civil Legal Services Program (CVCLS)

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Introduction

This pamphlet discusses several different laws concerning health care which may provide assistance to Texans sixty (60) years of age or older and persons eligible for Medicare. Certain of the programs described here usually assist persons who are sixty-five (65) years of age or older. Many of the programs described here have specific requirements that a person have very low-income and very modest resources. In fact, the only laws discussed in this pamphlet that have no requirements for low-income or modest resources, are the Medicare program, the emergency treatment law, and the income tax law.

It is important to keep in mind that those programs which do have income and resource limits for eligibility frequently change those limits. The limits discussed in this pamphlet are those in effect in 2004 unless otherwise stated.

Many programs also have limitations as to what types of services are “covered” or provided. The Medicare program has premiums, deductibles, and co-insurance amounts. These are discussed in the Medicare section of this pamphlet.

A topic not covered in this pamphlet is the right of every Texan of sound mind to use a Medical Power of Attorney to name an agent to make health care decisions, if incapacity arises. The “Living Will,” or Directive to Physicians, is also not discussed in this pamphlet. These matters are discussed in the pamphlet “Alternatives to Guardianship under Texas Law.” Texans sixty (60) years of age and older and persons eligible for Medicare can request this other pamphlet for no charge from the Legal Hotline for Texans.

This pamphlet discusses the following matters:

1. The rights of all persons in Texas, who need emergency treatment from a hospital, to receive such treatment;
2. The Texas County Indigent Health Care Program;
3. The Hill-Burton Program for reduced-cost, or free, services in health care facilities that were built in whole or in part with Hill-Burton assistance;
4. The deduction, from countable income under the Food Stamp Program, for medical costs in excess of \$35 per month, if the Food Stamp Household has a member in it who is sixty (60) years of age or older;
5. The Medicaid Program, including:
 - a. regular Medicaid;
 - b. Dual Eligibility Programs: QMB/SLMB/QI (Qualified Medicare Beneficiary/Specified Low-Income Medicare Beneficiary/Qualifying Individual) Medicaid; and
 - c. Nursing Home Medicaid.
6. Medicare.
7. Medical Benefits for Veterans.
8. The Federal Income Tax deduction for health care costs.

Not every person can make use of all the rights and benefits discussed in this pamphlet. Some persons can use certain laws and programs, while other persons can use other ones. Each law or program is addressed to its own set of beneficiaries and concerns.

It is beyond the scope of this pamphlet to discuss rights under private health insurance policies, and it is also beyond the scope of this pamphlet to discuss military retiree health benefits other than Veterans’ Health Benefits. Veterans’ Health Benefits are discussed in this pamphlet. For advice and consultation regarding rights under private health insurance policies and military health benefits, other than Veterans’ Health Benefits, if you are a Texan sixty (60) years of age or older, are eligible for Medicare, or are a NFCSP family caregiver, you can consult with an attorney of the Legal Hotline for Texans. You can call the Legal Hotline for Texans, at 1-800-622-2520, TDD 1-877-526-9953 (Travis County: 512-477-3950, TDD 512-381-1179).

Although this pamphlet discusses Nursing Home Medicaid, the pamphlet does not detail the rights of residents in nursing homes. The Legal Hotline for Texans has a separate pamphlet which discusses nursing home

resident rights. Texans sixty (60) years of age and older, persons eligible for Medicare and NFCSP family caregivers can call the Legal Hotline for Texans for that pamphlet.

For many of the programs discussed in this pamphlet, the Legal Hotline for Texans has more detailed information. You can call or write to the Legal Hotline for Texans for that more detailed information, after reading this pamphlet. Also, the lawyers of the Legal Hotline for Texans will answer your questions about your health care rights.

In addition to the topics specifically addressed in this pamphlet, please keep in mind that the Texas Department of Insurance can send you at no cost pamphlets about Medicare Supplemental Insurance (“Medigap”) Policies and about Medicare HMOs; and a pamphlet about Long-Term Care (Nursing Home) Insurance. You may order either or both of those pamphlets, in writing, from:

Texas Department of Insurance
Publications
P.O. Box 149104
Austin, TX 78714-9104

It should be noted that a person who is eligible for QMB Medicaid (which is discussed in this pamphlet as topic 5(b)), usually does not need any “Medigap” (Medicare Supplemental) Insurance Policy.

The topics mentioned above will now be discussed in the order listed.

1. Hospital Treatment for Emergency Medical Needs.

The right of persons in need of emergency hospital treatment, to receive it, arises under what are sometimes called “anti-dumping” laws. These laws forbid “patient dumping.”

What is patient *dumping* and what rights do patients have against dumping? Both Texas and federal law prohibit hospitals from “dumping” patients who are in need of emergency services. “Dumping” is the failure by a hospital to provide emergency services.

Under the Texas Statute, Section 311.021 *et seq.* of the Health and Safety Code, *emergency services* refers to services usually and customarily available at a hospital and that must be provided immediately to:

- sustain a person’s life;
- prevent serious permanent disfigurement or loss or impairment of the function of a body part or organ; or
- provide for the care of a woman in active labor or, if the hospital is not equipped for that service, to provide necessary treatment to allow the woman to travel to a more appropriate facility without undue risk of serious harm.

The Texas emergency services statute applies to “general hospitals” and prohibits the denial of services due to inability to pay, or due to race, religion, or national ancestry if the services are available at the hospital and if the person is diagnosed by a licensed physician as requiring those services. (See Section 311.022(a), Health and Safety Code.)

The Federal Statute, 42 U.S.C. Section 1395dd(e)(1), defines *emergency medical condition* as:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - (ii) serious impairment to bodily functions, or
 - (iii) serious dysfunction of any bodily organ or part; or
- (B) with respect to a pregnant woman who is having contractions:
- (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

See, 42 U.S.C. Section 1395dd(e).

The federal emergency services statute applies to “participating” hospitals. A participating hospital is a hospital which has entered into a Medicare provider agreement under Section 1395cc. (See 42 U.S.C. Section 1395dd(e)(2).) Most hospitals are participants. The federal anti-dumping statute would be violated by a hospital (with an emergency department) failing to provide an “appropriate screening examination” when an individual comes to the emergency room and a request is made on the individual’s behalf for examination or treatment for a medical condition. Under the federal anti-dumping statute, if an individual comes to a hospital which has an emergency department and the hospital determines that the individual has an emergency medical condition, the hospital must either *provide further medical examination and such treatment as is required to stabilize the medical condition, or transfer the individual to another medical facility.* (See 42 U.S.C. Section 1395dd(b).)

Appropriate Transfer

Under the federal anti-dumping law, an “appropriate transfer” can only occur if the individual (or a legally responsible person acting on the individual’s behalf), after being informed of the first hospital’s obligations and of the risks of transfer, requests the transfer *in writing*, or if it is *certified in writing* that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the risks of transfer to the individual. (See 42 U.S.C. Section 1395dd(c)(1).)

Further, under the federal anti-dumping statute, an appropriate transfer to a medical facility is a transfer:

- (1) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to an individual’s health or in the case of a woman in labor, the health of the unborn child;
- (2) to a receiving facility which has available space and qualified personnel for the treatment of the individual, and which has agreed to accept transfer of the individual and to provide appropriate medical treatment;
- (3) in which the transferring hospital send the receiving facility all medical records related to the individual’s emergency condition. Included in these records will be any observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification and the name and address of any on call physician who has refused or failed to appear within a reasonable time to provide necessary stabilization; and
- (4) through qualified personnel and transportation equipment, including the use of necessary and medically appropriate life support measures during the transfer. (See 42 U.S.C. Section 1395dd(c)(2).)

What to do if your rights under the anti-dumping laws have been violated: If your right to emergency medical treatment at a hospital has been violated, you should try to get appropriate medical care elsewhere, as fast as possible. Then you should consult a lawyer, so that the wrong that was done you can be redressed.

The federal anti-dumping statute explicitly gives an injured person a private cause of action--a right to sue for damages. If the federal anti-dumping statute has been violated, an individual who has suffered personal harm as a direct result of a hospital’s violation of the federal law can recover whatever damages a state would allow for personal injury as well as appropriate equitable relief. Equitable relief can include an order forbidding the hospital from repeating its wrongful conduct.

A claim under the federal anti-dumping statute can be brought in either state or federal court. If the case is brought in federal court, state claims for medical malpractice arising out of the denial of treatment can be heard by the federal court.

The federally created cause of action has a *two-year* statute of limitations, which begins to run with the date of the violation. Thus, any lawsuit, under the federal law, must be filed within two years of the denial of services.

Under the federal anti-dumping law, the federal government can seek a civil money penalty of not more than \$50,000 for each violation of the Act (or not more than \$25,000 in the case of a hospital with less than 100 beds). Thus, an injured person has the option of bringing the violation to the attention of the Centers for Medicare and Medicaid Services for action by its Office of Inspector General (IG). For gross and flagrant, or repeated

violations, the IG can seek to exclude the hospital from the Medicare program (and also from the Medicaid program). The Office of Inspector General Hotline Number is: 1-800-368-5779.

It should be noted that neither the state nor federal anti-dumping law excuses a person from paying for medical care. A person who lacks private insurance and who is eligible for Medicare should consider whether Medicare will pay for the service. A person who cannot pay for emergency treatment which has been received should consider whether Medicaid, Hill-Burton, or the County Indigent Health Care Program will be a source of payment for services billed for by a hospital which has honored its anti-dumping responsibilities. These programs are discussed elsewhere in this pamphlet. Persons sixty years of age or older should keep in mind that, under the food stamp program, health care expenses are deductible from gross income, to arrive at countable Food Stamp income, to the extent that the health care expenses exceed \$35 per month total.

Texans sixty (60) years of age and older and persons eligible for Medicare who believe their right to emergency hospital treatment has been violated can call the Legal Hotline for Texans for legal advice or legal services and a referral for on-going representation, if that is appropriate.

2. The Texas County Indigent Health Care Program. [Health & Safety Code, Chapter 61; 25 T.A.C. Chapter 14]

In Texas, persons of very low income and very modest resources may be able to receive medical treatment under the County Indigent Health Care Program (CIHCP). Who operates this program, who is eligible for it, and what services are available varies from county to county among the 254 counties in Texas. In certain counties, the county itself operates the Indigent Health Care Program. A county may require eligible county residents to obtain care from a mandated provider, except in an emergency; when medically inappropriate or when care is not available. In certain counties, a public hospital provides indigent health care to some or all county residents. In certain counties, a hospital district provides indigent health care. The only way to know who is responsible for providing indigent health care in your geographic area is to phone your local office of the Texas Department of Health and ask who operates the Indigent Health Care Program for your geographic area.

As noted, the eligibility standards and services available under the Indigent Health Care Program also vary, depending on whether it is a county, a public hospital, or a hospital district, that is responsible for operating the program in your area.

The only provider of Indigent Health Care, for whom eligibility criteria are relatively certain statewide, is a county. If it is your county that is responsible for indigent health care, the county must determine eligibility in accordance with the standards similar to those used to determine eligibility under the Temporary Assistance to Needy Families (TANF) program. The same income and resource criteria are used, even though the Indigent Health Care Program is completely different from the TANF program. (Indeed, persons eligible for TANF--dependent children and their caretakers--are eligible for Medicaid, and therefore should not need Indigent Health Care). The precise eligibility conditions for county-provided indigent health care are found by calling the Texas department of Health Services office at (512) 338-6461.

What are the eligibility standards for county-operated Indigent Health Care?

Countable Monthly Income must be less than \$158 for an individual, or \$213 for a couple. Countable Resources cannot exceed \$2,000, or \$3,000 for a (CIHCP) household with an elderly or disabled member. Homesteads are exempt. The fair market value of \$4,650 of each motor vehicle is also exempt.

What is Countable Income?

Countable Income is any type of payment that is a regular and predictable gain or benefit, other than income that is exempted or deducted. Educational assistance payments, energy assistance payments which are based on need, foster care payments, government housing or rental subsidies, TANF benefits, veterans benefits that meet a

special need, and food stamp benefits are exempted -- do not count as income for county-operated indigent health care. If one or more member(s) of a household receive SSI, the income and resources of the SSI recipient(s) are exempt. (And, of course, the SSI recipient(s) would not be applying for indigent health care because SSI recipients receive Medicaid, as discussed below). SSI applicants are not eligible until their SSI application is denied.

After determining what income is exempt and adding together all non-exempt income, there are certain deductions that reduce non-exempt income down to countable income.

There are income deductions for:

- Work-related expenses;
- Dependent care expenses; and
- Earned Income Disregard.

These deductions will now be discussed.

The work-related expense deduction is a standard \$120 a month deduction from the earned income of each household member who is applying for indigent health care.

The dependent care is to cover the costs of care for a dependent child or incapacitated adult if the care is necessary to allow the person applying for indigent health care to work. Under these circumstances, a maximum monthly dependent care deduction is allowed of up to \$200 actual expenses for each dependent.

The earned income disregard is calculated after the \$120 standard work-related expense deduction has been subtracted from earned income. The earned income disregard is 1/3 of remaining earned income of each employed household member after the standard work-related expense deduction has been deducted.

As noted above, if non-exempt monthly income, minus applicable deductions, is less than \$158 for an individual, or less than \$213 for a couple, there is income eligibility for county-operated indigent health care. However, resources must still be at or below allowable limits.

What are the resource limits for county-operated indigent health care?

Resources are assets or possessions which an applicant can convert to cash to meet immediate needs. Examples of resources are cash, bank accounts, stocks, bonds, certificates of deposit, vehicles, boats, campers, buildings, land and mineral rights, KEOGHs, and IRAs.

A household is not eligible for county-provided Indigent Health Care if the total value of countable available resources is over \$2,000, or \$3,000 if a household member is elderly or disabled. If a resource is not exempted from being counted, its equity value will be counted to determine if the household has more than the limit in countable resources. If all property that is counted does not exceed the limit, there is "resource" eligibility for county-provided indigent health care.

Certain resources, however, are exempt. These exempt assets are not counted in determining eligibility for county-provided Indigent Health Care: Burial plots; one prepaid burial insurance policy per household member (and one prepaid funeral plan or agreement per household member); the homestead; jointly owned property that cannot be sold or divided; personal possessions, 401k Plans, life insurance (up to \$1,500 cash value), trust funds, and inaccessible resources.

As noted above, it is only for counties that there are definite eligibility criteria. For other providers of indigent health care--such as public hospitals and hospital districts--the criteria are not so certain. If a public hospital had eligibility criteria on January 1, 1985, those criteria still apply. If a public hospital did not have such criteria on January 1, 1985, then the public hospital must use the eligibility criteria that apply to counties. For hospital districts, the eligibility criteria are set forth in the statute that created the hospital district. The eligibility criteria will therefore vary from hospital district to hospital district.

Penalties for Transferring Resources

Households are ineligible if within three years before application or any time after certification they transferred a countable resource for less than its fair market value to qualify for county medical assistance. The household remains ineligible for two years, beginning with the date the resource was transferred. The penalty applies only if the value of the transferred resource added to the household's other countable resources would have affected eligibility. If spouses are separated, transfer of separate property by one spouse does not affect the eligibility of the other spouse.

If there is income-eligibility and resource-eligibility for indigent health care, what services must be provided?

This again varies, depending on whether the county is responsible for providing indigent health care, or a public hospital is responsible, or a hospital district. As noted above, the only way to know what entity is responsible for providing indigent health care in a particular area is to call the local office of the State of Texas Health and Human Services Commission and ask. After learning what agency is responsible, you can look at the information below to determine what services the particular indigent health care program provides.

Under the Indigent Health Care Program:

A county shall provide the following basic health services:

- (1) Primary and preventative services designed to meet the needs of the community, including:
 - (A) immunizations;
 - (B) medical screening services; and
 - (C) annual physical examinations;
- (2) inpatient and outpatient hospital services;
- (3) rural health clinics**;
- (4) laboratory and x-ray services;
- (5) family planning services;
- (6) physician services;
- (7) payment for not more than three (3) prescription drugs per month; and
- (8) skilled nursing facility services regarding of the patient's age.

* Counties are *not* required to establish the facilities that provide these services.

** There are approximately 485 rural health care clinics in Texas. To locate the one nearest you, contact the Office for Rural Community Affairs at 1-800-544-2042.

Optional Health Care Services

A county may provide other medically necessary services or supplies that the county determines to be cost effective, including:

- (1) ambulatory surgical center services;
- (2) diabetic and colostomy medical supplies and equipment;
- (3) durable medical equipment;
- (4) home and community health care services;
- (5) services provided by licensed master/medical social workers – advanced clinical practitioners;
- (6) psychological counseling services;
- (7) services provided by physician assistants, nurse practitioners, certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists;
- (8) dental care;
- (9) vision care, including eyeglasses;
- (10) services provided by federally qualified health centers;
- (11) emergency medical services; and
- (12) any other health service determined to be cost effective.

Public hospitals must provide the following medical services:

- Inpatient hospital services
- Outpatient hospital services

Hospital districts must provide the services required by the Texas Constitution and the statute creating the district. There are no specific instructions regarding services hospital districts must provide.

Employment Services Program

A county may establish procedures for administering an employment services program and requiring an applicant or eligible resident to register for work with the Texas Workforce Commission. [61.042(a), HS Code] The county shall notify all persons with pending applications and eligible residents of the employment services program requirements not less than 30 days before the program is established. Persons age 60 and older are exempt from employment services.

VERY IMPORTANT: Before incurring medical expense, if you want the Indigent Health Care Program to pay for it, you should apply ahead of time for Indigent Health Care.

Can there be retroactive eligibility for county-provided Indigent Health Care?

Yes. A household is retroactively eligible in any one or all of the 3 months before the month the identifiable application was received if both of the following conditions were met for the month(s):

- The household met all eligibility requirements
- The household received mandatory services and the bills for these services are unpaid.

The beginning date of retroactive eligibility in a month is the first calendar day.

Example of Retroactive Eligibility: The county receives an identifiable application of January 8. The application is completed on February 24. In the 3 months before January, the household met all eligibility requirements and received mandatory services that are unpaid in the months of October and December. The household is retroactively eligible for the months of October and December.

ADDITIONAL VERY IMPORTANT POINT: Even if you are not eligible for Indigent Health Care, you may be eligible for health services under one of the other programs described in this pamphlet. Also, many cities have programs that provide health care to certain low-income persons. Often, the main hospital in a city will know about local programs that provide health care to low-income persons. Senior Citizen Centers, the local Council of Governments, the local Area Agency on Aging, the local office of the Texas Health and Human Services Commission, the local United Way, and the Texas Department of Aging and Disability Services may know about local programs of health care, in addition to what is discussed in this pamphlet.

3. The Hill-Burton Program

This is a federal program which helped many hospitals, some nursing homes, and some clinics to build or expand. In return for receiving federal grants and/or loans, such health care facilities agreed to provide services on a reduced-cost, or free, basis to persons with low income. A hospital, nursing home, or clinic that has such a Hill-Burton obligation usually only has it for twenty (20) years. Also, often, for a particular facility, during each year (and usually before the end of it), that year's Hill-Burton obligation is "met" and no more reduced-cost or free services are required to be provided by that facility until the next year begins.[See 42 C.F.R. part 124]

If a health care facility is under a Hill-Burton obligation, it must use written guidelines to determine who is eligible for such services. The general guidelines are provided below. These guidelines change annually in April. Certain Hill-Burton facilities are allowed to use alternative guidelines. The general income limits for 2005, for different sizes of family units, for Hill-Burton services are:

Hill-Burton Program 2005 Income Limits

Size of family unit	Maximum annual income	Maximum monthly income
1	\$9,570	\$797
2	\$12,830	\$1070
3	\$16,090	\$1,341
4	\$19,350	\$1,613
5	\$22,610	\$1,885
6	\$25,870	\$2,156
7	\$29,130	\$2,428
8	\$32,390	\$2,700

Note: For families with more than eight members, add \$3,260/year (272/month) for each additional member.

The Legal Hotline for Texans has a pamphlet which discusses the Hill-Burton Program in greater detail. The pamphlet contains a list of Texas facilities that still have a Hill-Burton obligation. If you believe you would qualify for Hill-Burton services, feel free to call the Legal Hotline for Texans for its more detailed pamphlet about the Hill-Burton program. You can reach the federal agency that administers the Hill-Burton Program (called the Division of Facilities Compliance and Recovery (DFCR) by calling 1-800-638-0742.

4. The Food Stamp deduction for medical expenses in excess of \$35 per month.

Under the federal Food Stamp Program, for persons sixty (60) years of age and older, there is a special provision for medical expenses in excess of \$35 per month.

In its Guide to the Food Stamp Program, the Food Research and Action Center has provided this excellent description of the deduction for medical costs in excess of \$35, under the federal Food Stamp Program:

Medical costs include doctor, dentist, and hospital bills, prescription drugs and over-the-counter medicine prescribed by a doctor, Medicare and insurance premiums, payments, and deductibles, payments to someone to care for the elderly or disabled person in the home, transportation to and from the doctor or hospital, medical supplies that you need, payments to a nursing home for the care of someone who was in your household before he or she became sick and other medical costs that are not paid for you. You CANNOT deduct any part of the medical costs that insurance, Medicare, medical assistance, or any other source will pay or reimburse you for.

As noted, if medical costs--as just described--exceed \$35 per month, the costs above \$35 per month are deducted from monthly income to determine countable income for food stamp purposes. This deduction can increase the amount of food stamps for older persons already eligible for food stamps, and it can allow some older persons to be eligible for food stamps who otherwise would not receive them.

For more detailed advice and consultation regarding the Food Stamp Program, including the medical expense deduction, Texans sixty (60) years of age and older, persons eligible for Medicare and NFCSP family caregivers can call the Legal Hotline for Texans.

5. The Medicaid Program, including regular Medicaid, Dual Eligibility (OMB/SLMB/QI) Medicaid, and the Nursing Home Medicaid Program.

MEDICAID

Medicaid is a “need”-based program. Even if other requirements of eligibility are met, income that is not modest will cause ineligibility, as will resources that are not modest. These income and resource criteria are

discussed below. Also there are basically three types of Medicaid--"regular" Medicaid, "QMB" and "SLMB" Medicaid (including the QI buy-in programs), and "nursing home" Medicaid.

Medicaid is financed by federal and state appropriations. The amount of the federal share varies from state to state. Medicaid in Texas is administered by the Texas Department of Human Services (DHS). DHS cannot require a separate application for Medicaid, from persons who receive AFDC or Supplemental Security Income (SSI). For persons who receive SSI, Medicaid eligibility is certified to DHS by a magnetic "tape match" from the Social Security Administration, which administers SSI.

Persons who do not qualify for Medicaid on the basis of AFDC or SSI, would apply for Medicaid at the local (county) office of the Texas DHS.

Medicaid eligibility and benefits are as follows:

1. Regular Medicaid eligibility and Nursing Home Medicaid eligibility are not uniform among the states. Rather, the federal Medicaid statute, 42 U.S.C. 1396a et seq. sets eligibility floors for each type of Medicaid program, and sets benefit floors for regular Medicaid and nursing home Medicaid. The QMB/SLMB/QI program is more uniform across the nation. These matters are discussed under each program's portion of the eligibility and benefits discussions, which follow.

A. Regular Medicaid.

Persons eligible for regular Medicaid include mainly persons who qualify for Temporary Assistance for Needy Families (TANF) (formerly Aid to Families with Dependent Children -AFDC), and persons who qualify for Supplemental Security Income (SSI). Although some persons sixty (60) years of age and older qualify for TANF by virtue of custody of dependent minors, the major category of older persons who are eligible for regular Medicaid are those who are eligible for SSI. SSI is a federally-funded program that provides modest benefits to the elderly (65 years of age), blind, and disabled.

To qualify for SSI (and through it, for Medicaid), one must have countable income below the benefit levels, and resources that do not exceed the resource limits. There is a \$20 deduction for any type of income. After totaling up all countable income, \$20 can be deducted from the total to determine if income is below benefit levels (which means SSI and Medicaid will be provided, if resources are low enough).

IMPORTANT: There is a special deduction in determining eligibility for SSI (and hence, Medicaid) for income from work. Also, a few types of "income" do not count. For further details, Texans sixty (60) years of age and older can call the Legal Hotline for Texans.

The SSI benefit levels for 2005 are: \$579/month for an individual. If both spouses of a couple are eligible (because both present one or more of these: age 65, disability, and/or blindness), the couple SSI benefit rate is \$869/month. As noted, if countable income is below these limits, there is income-eligibility for SSI, and hence for Medicaid.

The SSI resource limits are \$2,000 for an individual, and \$3,000 for a couple. Certain resources--homestead, personal effects, household goods of \$2,000 or less in equity value, one car, a second car if necessary for employment, medical treatment, or transportation of a handicapped person or necessary due to climate, terrain, or similar factors, and life insurance with a cash value of \$1,500 or less, and burial plots and a burial fund worth \$1,500 or less, are excluded.

Aliens, whether legal residents of the United States or not, generally are not eligible for SSI or Medicaid. You must be a citizen of the United States either by birth or naturalization. Some legal resident aliens are eligible. If you are a legal resident alien, and (1) if you are a refugee or asylee, (2) if you have an extensive work history in the United States (at least forty quarters of Social Security credits) or (3) if you are, or your spouse is, a U. S. veteran or on active duty in the United States military, you may be eligible.

The benefits under the regular Medicaid program are set forth on the next sheet labeled "Regular Medicaid Coverage".

REGULAR MEDICAID COVERAGE (Pertinent to Older Texans)

These services are provided by the Medicaid program in Texas, to eligible persons:

In-patient hospital services. Thirty days per spell of illness are covered--after that, there must be a break of sixty days before coverage occurs again. Usual hospital services are covered; occupational therapy is not covered. There is a \$200,000 per year per individual limit.

Outpatient hospital services. Diagnosis, therapy, rehabilitation, and palliation, furnished by or under the direction of a physician are covered. Drugs that can be self-administered are not covered under this coverage.

Rural health clinic services and other ambulatory services furnished by a rural health clinic. In general, there is a limit of twelve visits per recipient per year, although prior authorization can be sought for more visits.

Laboratory and X-ray services ordered by a physician.

Nursing home services. In addition, payment will be made to hold beds for three days' absence, when the absence is pre-authorized as therapeutic and is part of the patient's total plan of care, as directed by the doctor.

Physician's services--reasonably and medically necessary. Recipient-initiated second opinions regarding surgery are covered.

Podiatrist services--if Medicare would cover them.

Optometrist services--An eye exam each two years, a pair of glasses each two years. No coverage for lost or destroyed eye wear.

Chiropractor services--for manual manipulation of the spine--no more than twelve visits per year are covered.

Audiologist services--for the provision of hearing aids.

Home health services--not more than fifty visits per year. Oxygen and rented equipment are not covered. Home-health care providers must be Medicare-approved.

Dental services--but only those that would be covered if provided by a licensed physician.

Drug prescriptions--no more than three in any month. (Limit not imposed on nursing home Medicaid recipients).

Hearing aids--Not more than one each six years. Prior authorization is required.

Hospice services--Requires the recipient to sign an "election statement." Doctor must certify life expectancy of six months or less. Maximum coverage: 210 days per recipient.

Case management services--to help those who are mentally retarded, or who have a related condition, to obtain needed medical, social, educational, or other services.

Transportation--Other transportation must be unavailable.

Christian Science sanatoria services. Must be in a facility approved for this by T.D.H.S.

Emergency hospital services--must be in a Medicaid-approved hospital.

Personal care services in the recipient's home--Must be prescribed, must be provided under the supervision of a registered nurse, must be pre-authorized. Cannot exceed thirty hours per week. Consists of help with activities of daily living and nontechnical medical observation necessitated by chronic medical condition complicated by functional limitations.

Day activities--if prescribed by a doctor to treat a chronic medical condition which will benefit from the service; requires the supervision of a licensed nurse, and is limited to no more than ten hours per day nor more than 230 hours per month.

Ambulatory surgical center services--if the surgery would be approved by Medicare; the center must be participating in Medicare.

Home-health and community based services. Texas has obtained a waiver to provide these as an alternative to institutionalization.

Medicare premiums, deductibles, and co-insurance amounts. Paid for recipients of regular Medicaid or QMB.

Eligibility for nursing home Medicaid does not automatically mean eligibility for these benefits.

B. The Dual Eligibility Programs: Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), and Qualifying Individual (QI).

The QMB program pays--for eligible persons--the Medicare premiums, co-insurance and deductible amounts. The SLMB program pays the Medicare premiums only. The QI program pays all or part of the Medicare Part B premium, depending on the beneficiary's income level. To be eligible for QMB, SLMB, or QI, a person must be enrolled in Medicare Part A. Other eligibility criteria are set forth below. For further information, including a more detailed pamphlet on these programs, Texans sixty (60) years of age and older and persons eligible for Medicare can contact the Legal Hotline for Texans.

Eligibility as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual Beneficiary (QI)

Medicare entitlement:

Must be enrolled in Medicare Part A

- be at least age 65, or
- receive disability benefits from the Social Security Administration for 24 months, or
- have chronic renal disease

Income:

- Maximum gross monthly income

QMB Program:

Individual: \$798

Couple: \$1,070

SLMB Program:

Individual: \$957

Couple: \$1,283

QI-1 Program:

Individual: \$1,077

Couple: \$1,424

QDWI Program:

Individual: \$1,595

Couple: \$2,139

- What counts as income?

Social Security Benefits
Railroad Retirement Benefits
State or Local Retirement Benefits
Interest or Dividends
Gifts or Contributions

Civil Service Annuities
Veterans Benefits
Private Pension Benefits
Royalty and Rental Payments
Earnings or Wages

Resources:

- Maximum countable resources

Individual - \$4,000

Couple - \$6,000

- What counts as a resource?

Bank Accounts and CD's
Real Property
Life Insurance Policies
Burial Plots and Funds

Stocks and Bonds
Oil/Gas/Mineral Rights
Jewelry and Antiques
Cars and Other Vehicles

- What can be excluded from countable resources?

Homestead where the individual or his spouse lives or intends to live.

Life insurance if the face value is \$1,500 or less.

Burial funds of \$1,500 (less any excluded life insurance). Must be separate from other resources.

One car worth less than \$4,500, or more if needed for necessary transportation.

Burial spaces for the individual, spouse and close relatives.

Benefits provided to a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI) are as follows:

For the **QMB** Program, The Texas Health and Human Services Commission pays Medicare premiums (both Parts A and B), deductibles, and coinsurance fees for Medicare-covered services.

For the **SLMB** Program, the Texas Health and Human Services Commission pays only the Medicare premiums, **not** the deductibles or coinsurance amounts.

For the **QI** program, the Texas Health and Human Services Commission pays all or part of the Medicare Part B premium, depending on the beneficiary's income.

As a QMB, SLMB, or QI, an individual does not receive regular Medicaid benefits. Each month the department sends the QMB a special identification card which should be shown to the QMB's medical service providers.

C. Nursing Home Medicaid.

The Nursing Home Medicaid Program provides long-term care to persons eligible for it. There must be a medical need for long-term care. Countable income for an individual cannot exceed \$1,737. Countable resources for an individual cannot exceed \$2,000. If the individual is married, and the spouse will be staying at home, the spouse can keep one-half of the couple's countable resources (but no more than \$95,100; nor less than \$19,020). The spouse at home is entitled to \$2,377.50 of the couple's combined income. These figures are all as of January 2005.

Income of a couple beyond \$2,422.50 must be devoted to the cost of nursing home care. Medicaid pays the rest of the monthly bill for nursing home care. In the case of an individual, monthly income over \$45 must be devoted to the cost of nursing home care and Medicaid pays the rest of the bill. Remember: The individual's income cannot exceed \$1,737 under the Nursing Home Medicaid program (January 2005 limit).

Further details on the Nursing Home Medicaid Program are on the next sheet. Texans sixty (60) years of age and older and persons eligible for Medicare can call the Legal Hotline for Texans for more advice regarding the Nursing Home Medicaid Program. The Legal Hotline for Texans has a more detailed pamphlet on Nursing Home Medicaid.

In sum, there are three main Medicaid programs that benefit Texans sixty (60) year of age and older. But each Medicaid Program has its own, detailed eligibility criteria. For each program, income and resources must be relatively modest, although each program has its own particular income and resource limits.

Eligibility for the MEDICAID Nursing Facility Program

Income:

Maximum gross income

- Individual and individual with an ineligible spouse: \$1,737
- Couple (when there is medical necessity for nursing home care for both): \$3,474 (2005)

What counts as income

- | | |
|-------------------------------|--------------------------------------|
| - Social Security Benefits | - Civil Service Annuities |
| - Veterans Benefits | - Railroad Retirement Benefits |
| - Private Pension Benefits | - State or Local Retirement Benefits |
| - Interest or Dividends | - Gifts or Contributions |
| - Royalty and Rental Payments | - Earnings or Wages |

Resources:

Maximum countable resources

- Individual: \$2,000 Couple: \$3,000

What is a resource?

- | | |
|---------------------------|---------------------------|
| - Bank Accounts and CD's | - Stocks and Bonds |
| - Real Property | - Oil/Gas/Mineral Rights |
| - Life Insurance Policies | - Jewelry and Antiques |
| - Burial Plots and Funds | - Cars and other Vehicles |

What can be excluded:

- Homestead where the individual intends to return.
- Life insurance if the face value is \$1,500 or less.
- Separately identifiable burial funds of \$1,500 (less any excluded life insurance).
- Car worth \$4,500 or less, or more if needed for necessary transportation.
- Burial spaces for the individual, spouse and close relatives.

Protected resources amount for a spouse in the community:

- Minimum: \$19,020 - Maximum (without fair hearing or court order): \$95,100
(excludes value of homestead, household goods, personal goods, one car and burial funds)

Other:

- Pre-admission Screening (and Annual Resident Review). If the person has a mental illness, mental retardation, or a related condition, the PASARR determination must be that admission to a nursing facilities is the most appropriate service over all other alternatives.
- Medical Need. The person must meet medical necessity criteria or ICF MR level of care criteria.
- Residency. The person must be a resident of Texas and U.S. citizen. Some legal resident aliens are eligible. If you are a legal resident alien, and (1) if you are a refugee or asylee, (2) if you have an extensive work history in the United States (at least forty quarters of Social Security earnings credits) or (3) if you are, or your spouse is, a U. S. veteran or on active duty in the United States military.
- Living Arrangement. The person must be a patient in a Medicaid-contracted long-term care facility for 30 consecutive days.
- Risk Assessment. The person must meet risk of admission to a nursing facility criteria.

Applied Income (beneficiary income applied to nursing home costs):

- Individual: Total gross income less \$45 for personal needs
- Individual with a spouse in the community: Total gross couple income less \$45 for personal needs, less \$2,377.50 for community spouse less certain amount for dependents living with the community spouse.
- Couple (when there is medical necessity for nursing home care for both): Total gross income less \$90 for personal needs.
- Certain incurred medical expenses are deducted if the Medicaid program does not cover direct payment for the services.
- The personal needs allowance was reduced from \$60 to \$45 effective September 1, 2003. (40 TAC § 15.450

6. Medicare

Medicare is not a “need-based” program, except for some prescription drugs benefits. Assuming other eligibility requirements are met, persons of great wealth and of no wealth are equally eligible, and receive the same benefits, except for some prescription drugs.

Medicare eligibility is as follows:

1. It is uniform in all parts of the United States.
2. Medicare consists of two parts: Part A (“Hospital Insurance”) and Part B (“Medical Insurance”).

Medicare Part A is financed by payroll taxes and deductibles and coinsurance amounts, and by premiums for those who must pay a premium. Medicare Part B is financed by premiums, and appropriations from the federal treasury.

3. Part A. Persons eligible for Medicare Part A are:

- a. Those 65 and older who receive benefits under the Social Security or Railroad Retirement System, or who could receive such benefits but did not file for them, or who qualify on the basis of employment with the federal government. Also, state and local governmental employees hired after April 1, 1986 are covered by Medicare Part A, at age 65.

- b. Those under age 65 who have end-stage renal disease (ESRD) and who are “fully or currently insured” under the Social Security program (or Railroad Retirement), or who are entitled to monthly Social Security or Railroad Retirement Benefits, or who are the spouse of a person who meets either of these requirements.

- c. Persons who have received 24 months worth of Social Security Disability benefits and who are now receiving their 25th month of Social Security Disability benefits.

Medicare Part A premium. Persons in the above categories do **not** pay a premium for Medicare Part A. Persons over age 65 who are not eligible for Social Security or Railroad Retirement Benefits, and certain disabled persons under age 65 who also are not eligible for Social Security or Railroad Retirement Benefits may obtain Medicare Part A by paying a premium, which in 2005 is \$375 per month. This is called “Premium Medicare.”

For regular (non-premium) Part A Medicare, there is no disqualification for being an alien. However, if one is not eligible for regular Medicare Part A, but rather is only eligible for premium Part A, one must be a citizen or a lawful permanent resident (“LPR”) who has resided in the United States continuously for the five-year period immediately preceding the month in which he or she meets all other requirements.

Application for Medicare Part A benefits is **not** required for persons who are entitled to monthly Social Security or Railroad Retirement benefits. Other persons must file a separate application for Medicare Part A with the Social Security Administration.

4. Part B. Persons eligible for Medicare part B are:

- a. Those entitled to Medicare Part A; and

- b. Those who are 65 years of age, and who reside in the United States and who are citizens (or LPR’s who have resided in the U.S. continuously during the five years preceding month of application).

Medicare Part B premium. All persons enrolled in Medicare Part B must pay a premium for Medicare Part B. The 2005 Part B premium is \$78.20 per month. For enrollees receiving Social Security who are not eligible for QMB/SLMB Medicaid (see Medicaid discussion), this premium is deducted from the monthly Social Security benefit.

Application. For most persons, there is **not** a separate application for Medicare Part B. Rather, there is automatic enrollment. All persons entitled to Medicare part A are deemed enrolled in Part B, unless part B enrollment is affirmatively refused. This refusal to enroll can be accomplished by a signed statement from the person, stating that Medicare Part B enrollment is not desired. A person presently enrolled can terminate

enrollment after coverage has begun. Persons who are eligible for Medicare Part B but who are not automatically enrolled, and persons who terminated enrollment, but want to resume coverage, can enroll during the “general enrollment period,” which is Jan. 1 - March 31 of each calendar year. In addition, there is an “initial enrollment period,” which is the 7-month period that begins 3 months before the month that the individual is eligible for Medicare Part B, and ends 3 months after that month. 42 C.F.R. 407.14. Persons enrolling in Medicare Part B **later** than they first could have, incur an increased Part B premium. The monthly premium is increased 10% for each full 12 months that the person could have been but was not enrolled. 42 U.S.C. 1395r.

Federal law, 42 U.S.C. 1395ss, regulates the sale of Medicare supplemental insurance policies. In particular, it is forbidden for such policies to duplicate health benefits the person is otherwise entitled to, and if the purchaser is entitled to Medicare Part A or enrolled in Medicare Part B, the seller must obtain from the purchaser a written statement of what other health insurance policies the purchaser has, and whether the purchaser is entitled to Medicaid (regular, QMB, SLMB, or other Medicaid). As noted earlier in this pamphlet, the Texas Department of Insurance will send you, upon request, at no charge, pamphlets about Medicare Supplemental Insurance (“Medigap” insurance) and Medicare HMO’s. Persons eligible for Medicaid are very unlikely to need “Medigap” insurance.

Medicare Benefits.

PART A. Medicare Part A provides coverage of hospitalization, skilled nursing facility care, and hospice care.

Hospital benefits.

Part A hospital benefits cover the following, provided to an in-patient: Room and board, drugs and biologicals, equipment and supplies, diagnostic and therapeutic items and services, nursing services (but not private duty nursing), and the services of interns, residents, teaching physicians, and staff doctors not directly related to the personal treatment of individual patients (services of the doctor(s) providing individual personal treatment are covered under Part B).

Deductibles and coinsurance provisions pertaining to hospitalization coverage in 2005 are as follows: There is a \$912 deductible per benefit period (also called “spell of illness”). For days 61 - 90 of hospitalization in a benefit period, there is a \$228 per day coinsurance amount. If more than 90 days of hospitalization are needed in a benefit period, the beneficiary then must draw upon a limited set of 60 lifetime reserve days. For each reserve day used, there is a \$456 per day coinsurance amount.

Skilled nursing facility benefits.

The skilled nursing facility benefit of Medicare Part A pays toward post-hospital care in skilled nursing facilities for up to 100 days per benefit period, if the Medicare coverage requirements are met. The patient receives full coverage during days 1 - 20, and for days 21 - 100 there is a \$114 per day coinsurance. Further requirements are that (1) a physician must certify that the patient needs skilled nursing facility care, (2) the patient must have been hospitalized for at least 3 days before the admission to the skilled nursing facility, and the admission must be within 30 days of the hospital stay, (3) the beneficiary must require daily skilled nursing or rehabilitation services, and (4) the care needed must only be available in a skilled nursing facility on an inpatient basis. Sources: Overview of the Medicare Program, Center for Medicare Advocacy, Inc. (South Windham, CT); http://medicare.custhelp.com/cgi-bin/medicare.cfg/php/enduser/std_adp.php?p_faqid=1444&p_created=1066324968.

Hospice care.

Hospice care is directed toward palliation (mitigation of symptoms) rather than cure. It requires (1) a doctor’s certification that the patient is terminally ill, and (2) an election by the patient that, for the diagnosis involved, hospice care, and not regular Medicare benefits will be provided. If the patient suffers a different diagnosis while receiving hospice benefits for one diagnosis, regular Medicare benefits are available for the different diagnosis. The beneficiary can elect two 90-day periods and one additional 30-day period of hospice care. 42 C.F.R. 418.21. Hospice benefits do not require entry into a hospice facility. The only coinsurance

amounts under the hospice benefit are the lesser of 5% or \$5 for drugs and biologicals, and 5% for each day of inpatient respite care. 42 C.F.R. 418.400.

PART B. Medicare Part B provides coverage of: physician's services, services and supplies, including drugs and biologicals which cannot be self-administered, furnished incidental to physicians' services, diagnostic x-rays, diagnostic laboratory test, and other diagnostic tests, x-ray therapy, radium therapy, and radioactive isotope therapy, surgical dressings, splints, casts, and other devices used for fractures and dislocations, durable medical equipment, prosthetic devices, braces, trusses, artificial limbs and eyes, ambulance services, some outpatient and ambulatory surgical services, some outpatient hospital services, some physical therapy services, some occupational therapy, some outpatient speech therapy, comprehensive outpatient rehabilitation facility services, rural health clinic services, institutional and home dialysis services, supplies and equipment, ambulatory surgical center services, antigens and blood clotting factors, pneumococcal vaccination and hepatitis B vaccine, and some HMO services. Recently, screening mammography services were added (42 U.S.C. 1395m(c)), as was limited coverage for post-menopausal osteoporosis drug injections (42 U.S.C. 1395x(O),(jj)). The Part B home health care benefit covers part-time or intermittent nursing care provided by or under the supervision of registered professional nurses, part-time or intermittent services of home health aides, physical, occupational or speech therapy, medical social services provided under the direction of a physician, medical supplies, and the use of medical appliances, and any of the foregoing items provided on an outpatient basis under arrangements by a home health agency.

Conditions for receipt of Medicare home health care are:

- (1) a doctor must certify the need for home health care,
- (2) the patient must be confined to his or her home, and
- (3) the patient must need skilled nursing care on an intermittent basis.

When payment is made under Medicare Part B for durable medical equipment there is a 20% coinsurance. Source: Overview of the Medicare Program, Center for Medicare Advocacy, Inc. (South Windham, CT).

Excluded from coverage are: Services which are not reasonable or necessary, custodial care, personal comfort items and services, care which does not meaningfully contribute to the treatment of illness, injury, or a malformed body member, prescription drugs which do not require administration by a physician, routine physical checkups, eyeglasses or contact lenses in most cases, eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses, hearing aids and examinations for hearing aids, immunizations except for pneumococcal and hepatitis B vaccine, orthopedic shoes and other supportive devices for the foot unless intended as an instrumental part of a leg brace, cosmetic surgery, most dental services, routine foot care. Source: The Medicare Part B Benefit, Center for Medicare Advocacy, Inc. (South Windham, CT). Note that the Medicare program that will pay for a portion of prescription drugs does not go into effect until 2006; however, Medicare is in the process of contracting with private companies to attempt to offer a prescription drug discount card in the near future.

There is a \$110 per year deductible under Part B, and a 20% coinsurance amount for most services.

The mechanics of payment under Part B have certain variations. If a physician is a "participating" physician, that means that he or she has agreed to "accept assignment" on all Medicare Part B claims. "Accepting assignment" means the doctor agrees to be bound by the Medicare allowable amount for a particular procedure, and the patient's only liability is for the unmet deductible for the year, and for 20% of the allowable charge for the particular procedure. Some doctors, for their own philosophical reasons, have declined to be "participating" physicians, but still accept assignment on some claims, and not on others. On claims for which assignment is accepted, the doctor cannot seek more from the patient than the unmet deductible and the coinsurance (20% of the allowable amount). In regard to claims on which assignment is accepted, Medicare sends its check directly to the physician. In regard to claims on which assignment is not accepted (which is the case for some or all claims from

a non-participating physician), the doctor cannot bill a Medicare recipient for more than the “limiting charge.” The limiting charge is usually no higher than 115% of the Medicare allowable amount. A patient who has received the services of a physician, in regard to which assignment is not accepted, will receive a check from Medicare for 80% of the allowable amount. The patient is responsible for payment of the physician’s bill (but not more than 115% of the allowable amount) in a non-assignment situation. The “limiting charge” concept has not been well publicized by the Centers for Medicare and Medicaid Services (CMS), but it is federal law, found at 42 U.S.C. 1395w-4(g).

The Medicare Reform Act is officially called the Medicare Prescription Drug Improvement and Modernization Act of 2003. The new law will add options to Medicare. CMS, the agency that manages Medicare advises that seniors who are happy with their Medicare coverage will not be required to make any changes under the new law. In 2004 Medicare will contract with private companies to provide a prescription drug discount card. Enrollment is projected to begin in May 2004, and cards are expected to provide a discount of up to 25% on prescription medicines. Medicare will send each enrollee information on how to apply for a discount card. Beginning in 2004, Medicare + Choice plans will be called Medicare Advantage plans. In 2005 the following benefits will be added to Medicare Part B: blood tests to screen for early detection of heart disease and diabetes screening tests. In 2006 the new prescription drug benefits will take effect. Plans will vary; however, CMS predicts that the plans will generally work as follows. The prescription drug plans will have a projected premium of approximately \$35 per month. Enrollees will pay a \$250 deductible. Medicare will pay 75% of prescription drug costs between \$250 and \$2,250. The enrollee will pay 25% of costs between \$250 and \$2,250. Medicare will pay nothing for drug costs between \$2,250 and \$3,600. Enrollees will bear 100% of prescription drug costs above \$2,250 up to \$3,600. Medicare will pay 95% of prescription drug costs over \$3,600, and the enrollee will pay 5% of those costs. People with low incomes will receive help with prescription drug premiums and deductibles. The income limits will not be set until 2005. For more information, call 1-800-MEDICARE. (Source: <http://www.medicare.gov/Publications/Pubs/pdf/11054.pdf>).

7. Medical Benefits for Veterans.

The Veterans Administration provides certain medical benefits to certain categories of veterans. Some basic aspects of eligibility and benefits are discussed below. Texans sixty (60) years of age and older and persons eligible for Medicare can call the Legal Hotline for Texans for more details for their particular situations.

In 1996, Congress (Public Law 104-262, the *Veterans Health Care Eligibility Reform Act of 1996*) made changes, designed to simplify eligibility, to the Veterans Health Benefit programs. Eligible veterans now receive a comprehensive health care package that is portable across the entire VA health care system. Veterans are placed in “priority groups” based on the nature and level of disability, combat history, income level, and current health care needs. Priority Groups 1 through 6 are enrolled without a copayment requirement. Priority Group 7, for veterans who do not meet qualifications for groups 1 to 6, allows for enrollment with a copayment requirement. Funding for Veterans Health Benefits may be changed by Congress from time to time. Enrollment from year to year is permitted beginning with Priority Group 1, and extending through as many priority groups, in order, as funds are allocated to cover. Affected veterans are notified each year, by letter from the VA, regarding continuation of coverage.

Eligibility for Veterans’ Health Care.

In order for you to be eligible for enrollment for healthcare, you must have:

- Been discharged from active military service under honorable conditions.
- Served a minimum of 2 years if discharged after September 7, 1980 (prior to this date there is no time limit).
- If a National Guardsmen or Reservist, served the entire period for which you were called to active duty other than for training purposes only.

Veterans may **apply for enrollment** at any time. The application, VA form 10-10EZ, can be obtained from any VA office.

Priority Groups are as follows (source: Department of Veterans Affairs internet site <http://www.va.gov/health/elig/eligibility.html>):

Priority Group 1: Veterans with service-connected disabilities rated 50% or more disabling.

Priority Group 2: Veterans with service-connected disabilities rated 30% or 40% disabling.

Priority Group 3:

- _ Veterans who are former POWs
- _ Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- _ Veterans with service-connected disabilities rated 10% or 20% disabling
- _ Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, “benefits for individuals disabled by treatment or vocational rehabilitation”

Priority Group 4

- _ Veterans who are receiving aid and attendance or housebound benefits
- _ Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5: Nonservice-connected veterans and service-connected veterans rated 0% disabled whose annual income and net worth are below the established dollar threshold.

Priority Group 6: All other eligible veterans who are not required to make copayments for their care, including:

- _ World War I and Mexican Border War veterans
- _ Veterans receiving care solely for disabilities resulting from exposure to toxic substances, radiation or for disorders associated with service in the Gulf War; or for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998
- _ compensable 0% service-connected veterans

Priority Group 7: Nonservice-connected veterans and noncompensable 0% service-connected veterans whose needed care cannot be provided by enrolling in any of the groups above and who agree to pay specified co-payment.

VA Uniform Benefits Package Benefits

(source: <http://www.va.gov/health/elig/benefits.html>)

The Uniform Benefits Package is provided to all enrolled veterans. “Needed” hospital and outpatient care are provided. VA defines “needed” as “care or service that will promote, preserve, and restore health.”

Services Covered

Drugs, Biologicals, and Medical Devices approved by the Food and Drug Administration (FDA)
Elective Sterilization (Tubal Ligation or Vasectomy)
Emergency Care in VA Facilities
Home Health Care
Hospice Care
Hospital and Outpatient Care
Maternity Benefits
Medical and Surgical Care
Mental Health Care
Palliative Care
Preventive Care and Services
Prosthetics and Orthotics
Rehabilitation Care and Service
Respite Care
Substance Abuse Services

Services not covered

Abortions and Abortion Counseling
Drugs, Biologicals, and Medical Devices not approved by the Food and Drug Administration (FDA)
Gender Alterations
Membership in Health Clubs and Spas
Private Duty Nursing

Services covered under special authorities

Adult Day Health Care
Dental Care
Domiciliary Care
Emergency Care in Non-VA Facilities
Homeless Programs
Non-VA Care
Nursing Home Care
Readjustment Counseling Service (Vet Centers)
Sensory-Neural Aids (i.e., eyeglasses, contact lenses, hearing aids)
Sexual Trauma Counseling

Copayments and Private Insurance

(sources: <http://www.va.gov/health/elig/copayments.html>; <http://www.va.gov/health/elig/insurance.html>)

Copayments may be charged for veterans in certain priority groups, for treatment of non-service-connected disabilities.

- Prescription copayments, when applicable, are \$7 for a 30-day supply.
- Outpatient copayment will be based on primary care visits (\$15), specialty care visits (\$50).

- Inpatient copayment is set at \$840 for the first 90 days in the hospital.
- Nursing Home copayment is set at a maximum of \$97 per day.

Dates effective for 2005.

Veterans subject to copayment, but unable to pay, may request a waiver (for copayments already incurred), or a hardship determination (for future copayments). The VA requires detailed financial information from a veteran applying for waiver or hardship determination, and makes its decision based on the financial information provided.

For veterans with **private health insurance**, the VA bills the private insurer for the cost of care of a non-service-connected condition. Beginning in September 2003, the VA will fill certain prescriptions made by a non-VA doctor until the Veteran's first visit with a VA doctor if the Veteran had applied for enrollment in the VA health system before July, 25, 2003. There is a co-payment based on financial means.

How to contact the Department of Veterans Affairs: The VA now has a toll-free number,
1-877-222-VETS

for use by any veteran seeking additional information. Information can also be obtained from any local VA health care facility.

In regard to Veterans Health Benefits, when feasible, it is always best to verify with the Department of Veterans Affairs that you are eligible for services and that the VA will pay for the services that you seek. It is very difficult--and often impossible--to obtain retroactive VA coverage for health care already received. As noted, the Legal Hotline for Texans can provide certain further details about VA Health Care benefits.

8. Income Tax Provisions Relating to Health Care Expenses.

For persons who have income high enough to file a federal income tax return, certain medical and dental expenses that are in excess of 7.5% of adjusted gross income are deductible. Further details on this are provided in IRS Publication 17.

Expenses which are included in the deduction are:

- Prescription medicines (those requiring a prescription by a doctor for their use by an individual) and insulin
- Medical services fees (from doctors, dentists, surgeons, specialists, and other medical practitioners)
- Special items (artificial limbs, false teeth, eyeglasses, contact lenses, hearing aids, crutches, wheelchair, etc.)
- Hospital services fees (lab work, therapy, nursing services, surgery, etc.)
- Meals and lodging provided by a hospital during medical treatment
- Psychiatric care at a specially equipped medical center (includes meals and lodging)
- Treatment at a drug or alcohol center (includes meals and lodging provided by the center)
- Special school or home for mentally or physically handicapped persons (see IRS Publication 502)
- Birth control pills prescribed by your doctor
- Legal abortion
- Legal operation to prevent having children
- Expenses of an organ donor
- Oxygen equipment and oxygen
- Cost and care of guide dogs or other animals aiding the blind, deaf, and disabled
- Part of life-care fee paid to retirement home designated for medical care
- Certain medical and hospital insurance premiums

- Certain transportation for needed medical care
- Capital expenses for equipment or improvements to your home needed for medical care (see IRS Publ. 502)
- Cost of lead-based paint removal (see IRS Publication 502)
- Wages for nursing services (see IRS Publication 502)
- Social Security tax for worker providing medical care (see IRS Publication 926)

Expenses which are not deductible are:

- Medicine you buy without a prescription
- Toothpaste, toiletries, cosmetics, etc.
- Illegal operation or treatment
- Maternity clothes
- Diaper service
- Nursing care for a healthy baby
- Medical insurance included in a car insurance policy covering all persons injured in or by your car
- Surgery for purely cosmetic reasons
- Expenses for your general health (even if following your doctor's advice) such as -
- Trip for general health improvement
- Weight loss program
- Program to stop smoking
- Household help (even if you are physically unable to do housework)
- Health club dues
- Social activities, such as dancing or swimming lessons
- Funeral, burial or cremation expenses.

As noted, IRS Publication 17 has a more complete discussion of the deduction. IRS Publication 17 is usually available at the nearest public library, at the nearest IRS office, and via the internet at <http://www.irs.gov/pub/irs-pdf/p17.pdf>.

Further General Comments

This pamphlet has discussed several very different and complex health care rights. Not everyone can use every right discussed in this pamphlet. This pamphlet is not meant to provide advice for you to act on in specific circumstances. For advice in specific circumstances, you should seek the assistance of a lawyer. Texans sixty (60) years of age and older, persons eligible for Medicare and NFCSP family caregivers can obtain cost-free advice and consultation from the Legal Hotline for Texans by calling 1-800-622-2520, TDD 1-877-526-9953 (Travis County: 477-3950, TDD 381-1179), Monday - Friday, 9:00 a.m. to 5:00 p.m.

Especially seek early legal advice if you have applied for, and been denied a benefit described in this pamphlet. The benefits have certain appeal processes, by which a denial can be appealed. But the appeal processes often have very short deadlines.

As indicated in this pamphlet, the Legal Hotline for Texans has several more detailed pamphlets on many particular topics of health law. They are free of charge to Texans age sixty (60) and older and persons eligible for Medicare.

As mentioned at the beginning, every Texan of sound mind has the right to use a Medical Power of Attorney to name an agent to make health care decisions, if incapacity arises. The "Living Will" is also a document that Texans of sound mind can execute. These matters are not discussed in this pamphlet, but are discussed in the pamphlet "Alternatives to Guardianship under Texas Law." Texans sixty (60) years of age and older and persons eligible for Medicare can request this other pamphlet for no charge from the Legal Hotline for Texans.

Conclusion

As stated above, this pamphlet has discussed several very complex matters. As stated at the beginning, and above, this pamphlet provides only general information and is **NO** substitute for individual consultation with a lawyer, either by phone or in person. The lawyers of the Legal Hotline for Texans provide cost-free advice and consultation to Texans sixty (60) years of age and older and persons eligible for Medicare. The lawyers provide these services by telephone [1-800-622-2520, TDD 1-877-526-9953 or (Austin: 512/477-3950, TDD 512/381-1179)], Monday through Friday, 9:00 a.m. to 5:00 p.m.

Web site: www.tlsc.org/hotline.html