ARMING THE ADVOCATE

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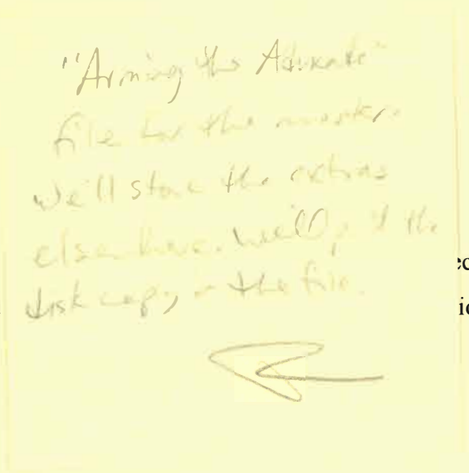
This document is an outline of federal laws that are often implicated in my practice representing persons living with HIV/AIDS. Following the outline are a series of documents which may be helpful to persons who must act on their own behalf in encountering many of the issues faced by PLWH/A's. This information is geared to provide guidance to persons without legal training who must advocate for themselves or others, and is intended to be augmented by oral discussion. This is intended to inform, not to provide legal advice.



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Special thanks to John Warchol for sharing his materials, Keith W. Wilson for his assistance with this seminar, and Christopher D. Glassburn for his commitment and good work.

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I. EMPLOYMENT

Discrimination

A. Americans With Disabilities Act of 1990 (ADA), 42 U.S.C.§12111-122117 (Title I)

No covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions and privileges of employment. 42 U.S.C.§ 12112.

*Applies only to employers having 15 or more employees.

*Does not apply to the U.S.Government (but Section 501 of the Vocational Rehabilitation Act does),Indian Tribes or bona- fide membership clubs that are tax exempt under Section 501 of the Internal Revenue Code.

*the person must be qualified to perform the essential functions of the job with or without reasonable accommodation.

*The person must be disabled, perceived to be disabled, or have a relationship with or association with a disabled person.

*The disability of the person does not have to be the sole factor in employer's decision.

1. Number of Employees: In EEOC and Darlene Walters v. Metropolitan Educational Enterprises, Inc., U.S. Supreme Court held that part-time and full-time employees must be counted to determine if an employer meets the 15 employee minimum required for coverage under Title VII.

2. Reasonable Accommodation: Reasonable accommodation includes job restructuring, part-time or modified work schedules, or reassignment to a vacant position. 42 U.S.C.§12119(9).

CASE: An employee who invokes the accommodation section of the ADA must identify a specific accommodation that would let her do her job. The employee must also show that this accommodation is reasonable. Willis v. Conopco, Inc.,(11th Cir. 1997).

An employer is obligated to provide reasonable accommodation to the employee, assuming he is still able to perform the essential functions of his job, as long as that accommodation does not impose an "undue hardship" on the operation of the employer's business. If the accommodation poses an undue hardship on the employer, the employee must be given the opportunity to provide the accommodation himself.

3. The ADA and HIV/AIDS: The term "disability" means, with respect to an individual-(A) a physical or mental impairment that substantially limits one or more or the major life activities of such individual; (B) a record of such impairment; or (C) being regarded as having such impairment. 42 U.S.C. § 12102(2).

The statutory language of the ADA does not specifically provide protection to persons with

HIV/AIDS. However, the EEOC regulations which interpret the ADA state that HIV/AIDS is a disability protected under the ADA. There is a split in the circuits on the issue of whether asymptomatic HIV is a disability protected under the ADA. The Supreme Court of the United States settled that question for them, holding:

Asymptomatic HIV is a physical impairment that substantially limits the major life activity of reproduction: Bragdon v. Abbott, 118 S.Ct. 2196, (1998).

A dental patient, Ms. Abbott, sued her dentist, Dr. Bragdon, after he refused to treat her in his office when she disclosed her HIV status. The U.S. Supreme Court was asked "whether HIV infection is a disability under the ADA when the infection has not yet progressed to the so-called symptomatic stage".

To answer the question the court considered only part (A) of the definition of disability. The court came up with three step analysis based upon the language of part (A). First, determine whether the person's HIV is a physical impairment. Second, identify the life activity the person claims is being limited and determine whether the activity under the ADA. Third, determine whether the impairment substantially limits the major life activity.

In looking at the first step, the court decided that "HIV infection must be regarded as a physiological disorder with a constant and detrimental effect on the infected person's hemic and lymphatic systems from the moment of infection. HIV infection satisfies the statutory and regulatory definition of a physical impairment during every stage of the disease."

Under the second step, a person must show that his or her HIV limits a major life activity. Ms. Abbott claimed that HIV limited her ability to reproduce and bear children. The court ruled that reproduction is a major life activity for the purposes of the ADA.

It is possible that other major life activities also meet the requirements of the ADA. However, Ms. Abbott claimed only that her ability to reproduce was limited. Therefore, this case decides only whether reproduction is a major life activity. It does not address whether other major life activities meet the definition under the ADA. It is possible that other major life activities which are limited by HIV would not be considered major life activities under the ADA.

Under the third step, a person must show that his or her HIV substantially limits the major life activity he or she claims is limited. The court ruled that HIV substantially limited Ms. Abbott's ability to reproduce.

Finally, the Court noted several decisions by the Department of Justice and other federal agencies which were consistent with its holding that "HIV infection, even in the so-called asymptomatic phase, is an impairment which substantially limits the major life activity of reproduction."

The case resolved the question of whether Ms. Abbott is protected from discrimination under the ADA. However, the ADA allows a place of public accommodation, such as a dentist office, to refuse treatment to a person with a disability if the disability poses a direct threat to the health and safety of others. Under the ADA, a direct threat is defined as a "significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services."

The Court declined to rule on whether Ms Abbott posed a direct threat to Dr. Bragdon. Instead, it sent this issue back down to First Circuit, which previously decided that Ms. Abbott did not pose a direct threat to Dr. Bragdon.

4. Estoppel: There is a split in the circuits over the issue of whether an employee who applies for and/or receives disability benefits is per se barred from filing an ADA discrimination claim.

a. Application for Social Security disability benefits is a bar to an ADA claim. An Employee who applies for Social Security disability benefits is estopped from filing an ADA claim because he has sworn to the SSA that he is unable to perform any job in the national economy and, therefore, cannot perform the essential functions of his job. See McNemar v. The Disney Stores, Inc., 91 F3d 610 (1996).

b. An application for disability benefits is not a per se bar ADA claim. In Swanks v. Washington Metropolitan Area Transit Authority, (D.C. Cir. 1997), the court held that employees who receive Social Security disability benefits are not per se barred from pursuing relief under the ADA. In Lewis v. Zilog, Inc., 908 FSupp 931 (ND Ga 1995) the court held that the employee's application for Long Term Disability benefits was not a per se bar to an ADA claim absent an assessment of the facts of the case.

6. Inquiries and examinations: Employer may not ask whether applicant is disabled. Unless necessary to determine whether an applicant is qualified, physical examinations must be after a job offer, uniformly administered, job-related and consistent with good business practices. 29 C.F.R. 1630.14

7. Enforcement/Remedies: Title I of the ADA (42 U.S.C.§ 12111- 12117) shall be dealt with in a manner consistent with the Vocational Rehabilitation Act of 1973, 29 USCA § 701 et seq., more specifically 29 USCA § 794 (commonly referred to as §504). Title I of the ADA is interpreted under §504. However, the powers, remedies and procedures of Title I shall be the powers, remedies and procedures set forth in 42 USCA § 2000e (Title VII).

*Refer to Title VII and §504 case law to help determine whether a case meets the requirements of the ADA.

*Any claim of discrimination under Title I of the ADA must be filed with the EEOC with 180 days of the last as of discrimination.

*After the client files his charge of discrimination, the EEOC has 180 days to investigate the charge. The client may request a right to sue letter from the EEOC after this 180 days (and in some cases, before the 180 days runs).

*Once a charging party receives the right to sue, he must file a lawsuit within 90 days.

*Helpful Hint: An employer may discover that an employee has HIV/AIDS in many ways. For example, if an employee's health insurance plan is self-funded or partially self- funded by the employer, someone in the company will see any HIV/AIDS claims filed by an employee. These facts may be used to rebut an employer's defense that it had no knowledge of an employee's disability.

B.Rehabilitation Act of 1973, 29 USCA § 701 et seq.(§503, §504)

Prohibits discrimination against handicapped individuals by federal contractors (§503) and by recipients of federal financial assistance, federal contracts, and federal departments and agencies (§504.)

C. Employment Retirement Income Security Act (ERISA),29 USCA 1001 et seq.

Protects the interests of employees and their beneficiaries regarding employee benefit plans. ERISA also prohibits an employer from discriminating or taking adverse action against an employee in an attempt to prevent the employee and/or his beneficiary from collecting benefits under the benefit plan. ERISA §510

*ERISA preempts state law.

*If the 180 day statute of limitations under the ADA runs, an ERISA claim may still exist.

*ERISA does not have the 15 employee requirement of the ADA.

*ERISA has a variety of statute of limitations.

D. Civil Rights of 1991, 42 USCA § 1981a

Provides for jury trials and compensatory and punitive damages for intentional discrimination of persons protected by the ADA.

E. Civil Rights Act of 1964, 42 USCA §2000e (Title VII)

Prohibits employers with 15 or more employees from discriminating on the basis of race, sex, religion, color, national or ethnic origin. The ADA refers to this statute to provide the types of damages and other sanctions available under the ADA.

Leave of Absence

Family and Medical Leave Act of 1993 (FMLA), 29 USCA §2601

Provides up to twelve weeks of unpaid leave (unless the employer already has a paid leave policy) for individual and family medical and emergency problems. Employer must retain the employee's health and related benefit coverage during the leave, and must return employee to same or equivalent position upon return from leave (unless employee is a key employee).

*Employers of 50 or more employees, plus all government entities (regardless of the number of employees).

*Employee must have worked for 12 consecutive months prior to leave.

*The employee must give notice of the need for leave 30 days in advance of the leave or as soon as is practicable.

*If the employee does not return to work, the employer may request reimbursement for health benefits and start COBRA coverage.

*Enforce through the Department of Labor, or through private right of action, with two year statute of limitations.

II. PUBLIC SERVICES

Discrimination

Americans With Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12131-12134 (Title II)

No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied of the services, programs or activities of a public entity, or be subjected to discrimination by any such entity. 42 USCA § 12132.

*A public entity is a state or local government, any department, agency, special purpose district, or other instrumentality of a state or local government.

1. Zoning: In Pack v. Clayton County, (ND Ga 1995) the court made an unpublished decision that a county zoning action was discriminatory, and thus violated the ADA (the case settled after the judge made known her intent to rule that the zoning practice was discriminatory). In Innovative Health Systems, Inc. v. White Plains, New York, (2nd. Cir. 1997), the court held that zoning decisions fall within the discrimination ban of the ADA and of the Vocational Rehabilitation Act

of 1973. In United States v. City of Charlotte, (WD NC, 1995) the court ruled that zoning is not a service, program or activity of the city and therefore not covered under the ADA, although the court allowed the claim to stand under the Fair Housing Amendments Act and Vocational Rehabilitation Act.

2. Enforcement/Remedies: The remedies, procedures and rights set forth in §504 of the Federal Rehabilitation Act (29 USCA § 794 (a)) shall be the remedies, procedures and rights provided by Title II to any person alleging discrimination in violation of Title II.

III. PUBLIC ACCOMMODATIONS

Discrimination

Americans with Disabilities Act (ADA), 42 USCA §§ 12181-12189 (Title III)

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation. 42 USCA §12182.

*Prohibits discrimination in public accommodations and services operated by private entities.

*Public accommodations are broadly defined as restaurants, bars, stadiums, theaters, stores, galleries, zoos, private schools, hotels, spas, shelters, doctors' offices, lawyers' offices, etc.

1.Insurance policies: There is a split in the circuits over the issue of whether insurance policies are places of public accommodation.

a. Insurance policies may be places of public accommodation: Assessment of the "safe harbor" exemption of the ADA is required. World Insurance Co. v. Branch,(ND Ga May, 1997). See Car Parts Distribution Center, Inc. v. Automotive Wholesalers Association of New England, Inc.,37 F3d 12 (1st Cir. 1994).

b. Insurance policies are not a place of public accommodation: An insurance policy issued through an employer is not a place of public accommodation. Parker v. Metropolitan Life Insurance Co., (6th Cir. August 1, 1997).

2. Enforcement/Remedies: The remedies and procedures set forth in Title VII (42 U.S.C.A. § 2000a - 3(a)) are the remedies and procedures provided to any person who is being subjected to discrimination on the basis of disability in violation of Title VII.

*Monetary damages may be sought only by the Department of Justice.

*Private action is limited to injunctive relief.

*Businesses with fewer than 15 employees are not exempt.

*Private clubs and religious organizations are exempt.

IV. DEBTOR RELIEF

A. Debtor's rights: Debtors are protected under the Fair Debt Collection Practices Act from illegal actions of debt collectors. 15 U.S.C.A. §1692 et seq.

B. Many clients with HIV/AIDS are "Judgment proof":

*Social Security disability benefits (SSDI/SSI) cannot be assigned to creditors. 42 U.S.C.A.§§407, 1383 (a)(2)(iii)(III).

*A creditor cannot "freeze"a debtor's bank account if the account contains only Social Security benefits. Therefore, Social Security benefits should not be co-mingled with other income.

*Veterans are protected from creditors. 38 U.S.C.A. § 5301(a).

V. INSURANCE

Group Health Insurance

A. Health Insurance Portability and Accountability Act (HIPAA or Kennedy-Kassebaum Bill) 42 U.S.C.A. §300gg et seq.

*Limits pre-existing conditions exclusions to 12 months (18 months for late enrollees).

*Prohibits discriminations against employees and defendants based on their health status.

*Guarantees renewability and availability of health coverage to certain employees and individuals.

*Protects many workers who lose health coverage by providing better access to individual health insurance coverage.

B. Consolidated Omnibus Budget Reconciliation Act (COBRA), 29 U.S.C.A.§1161 et seq.

An employee covered by group health insurance has the right to extend that group coverage at the employee's expense after a qualifying event, provided that the termination is not for gross misconduct. 29 U.S.C. §1163.

*COBRA is governed by ERISA.

*Applies only to employers with 20 or more employees on a typical business day during the preceding calendar year. 29 U.S.C. §1161(b).

1. Length of continuation:

*18 months.

*29 months. If Social Security determines that the employee's disability onset date fall within 60 days of the employee's qualifying event date, and if the employee so notifies the plan administrator within 60 days of the date of the Social Security notice, the COBRA continuation can last an additional 11 months (for a total of 29 months coverage - essential for disabled due to 29 month Medicare waiting period).

2. 44 day Notice requirement: Employer must notify plan administrator within 30 days. Plan administrator must notify employee within 14 days. 29 U.S.C. 1166 (a)(2) and (c).

3. Election within 60 days: Employee must complete form provided by the employer and return that form within 60 days. 29 U.S.C. §1165(1)(C).

*Employee should make a copy of the completed form and the outside of the envelope and mail the completed form by certified maid, return receipt requested.

4. Cost: Up to 102% of the employer's cost for the first 18 months of coverage, 29 U.S.C.A. §1162(3), and up to 150% of the employer's cost for additional 11 months of coverage.

*Public assistance programs pay premiums for eligible individuals.

5. Right of conversion at the end of the COBRA coverage.

*Guaranteed under HIPAA if requirements met.

*Guaranteed if such a conversion option is otherwise generally available to similarly situated active

employees under the group plan. The terms and cost of coverage can change, but no medical examination can be required. 29 U.S.C.§1162(5).

*If the conversion option is not otherwise generally available, no requirement that conversion be made available at the end of the COBRA period. 52 Fed. Reg. 22716,22731 (1987) (Question and answer 43), unless under HIPAA.

Income

A. Viatical Settlement and Living Needs Benefits:

Both group and individual term life insurance policies can be cashed in prior to death for a price. Two methods are often available. the first is viatical settlement, which is a transaction between the owner of the policy and a non-insurance company that buys the policy at a (usually deep)discount. The second is the living needs benefits or accelerated death benefit, which involves a transaction between the owner/insured and the insurance carrier. The second method is an express, purchased benefit of the policy and so is not automatically available to each insured.

*Non-taxable with certain restrictions.

*May adversely affect public benefits.

B. Long Term Disability (LTD) and Short Term Disability(STD):

Private insurance which provides income in the event of disability.

*STD generally limited to six months.

*Most LTD benefits will be offset by other disability income such as Social Security or VA benefits.

*Appeal, Appeal, Appeal. Most insurance companies will initially deny an application for LTD, and some will deny STD. Appeal must be filed within 60 days of denial. ERISA provides for response times to appeal.

*Standard for LTD approval is generally unable to do the current job. Much easier to meet than Social Security standard. Distinguish between whether "disability" means unable to perform *current* occupation or *any* occupation.

VI. HOUSING

Discrimination

A. Fair Housing Amendments Act (FHAA) 42 U.S.C.A. §3604

It shall be unlawful to discriminate in the sale or rental or otherwise make unavailable or deny, a dwelling to any buyer or renter, a person residing in or intending to reside in the dwelling, or any person associated with that buyer or renter.

It shall be unlawful to discriminate against any person in the terms, conditions or privileges of sale or rental or in the provision of services of facilities in connection with such dwelling because of a handicap of that buyer or renter, a person residing or intending to reside in the dwelling, or any person associated with that buyer or renter.

*Landlords must allow reasonable modifications of leased property by the disabled person at the person's own expense. The resident may be required to restore the property to its former condition

a the end of the lease term. Modifications include a widened doorway or support rails.

*Must accommodate a resident's disability in regard to rules, policies, practices and services. Such as a reserved parking space or allowing a cooler by the door for meals-on-wheels.

B. Americans With Disabilities Act of 1990 (ADA), 42 U.S.C. §§ 12131-12134 (Title II)

See section IV "Public Services" portion of this summary.

Supplemental

Information

BACK TO WORK WITH SOCIAL SECURITY

I. INTRODUCTION

Work incentive programs have been developed to meet the needs of SSDI and SSI beneficiaries, many of whom are still able to work. In the case of a concurrent benefits recipient, the SSDI and SSI work incentives overlap yet function "independently" of one another. These programs are under-utilized and far are not perfect but they provide financial and medical protection for disabled persons making the transition into the work-force.

II. WORK INCENTIVES WHICH APPLY ONLY TO SSDI BENEFICIARIES

A. The Trial Work Period (TWP)

1. A nine month trial work period during which beneficiaries have their income and work activity disregarded for eligibility determinations with the exception listed in 6 below.
2. The income earned during this period has no effect on SSDI.
3. Eligible the first month the beneficiary is entitled to benefits or has filed for benefits, whichever is later, so long as still considered disabled.
4. For a month to count the beneficiary must have performed services. Services are provided in any month in which a beneficiary earns greater than $200, free of subsidies, and provides work services of value to an employer. The SSA can only count that income that is actually earned.
5. The 9 month TWP need not be consecutive but must occur within a 60-month "rolling period." After TWP has been exhausted, the SSA will consider whether the work activity engaged in, and the income produced, give rise to an ability to engage in SGA.
6. Beneficiaries are presumed to be engaged in SGA when their earned income exceeds $500/month. This income will be counted only when it is a product of the beneficiary's own labor. If a beneficiary performs, or is able to perform, SGA, benefits will be discontinued after 3 months. If the beneficiary is not performing SGA, benefits will continue to be paid as they were prior to and during the TWP.

B. Extended Period of Eligibility (EPE)

1. EPE begins the month immediately after the 9th month of TWP and continues for 36 consecutive months.
2. During the EPE, benefits are paid each month the beneficiary's earnings fall below the $500 SGA level. Each month earnings are in excess of the SGA level, the beneficiary is not entitled to benefits.
3. All recipients who have complete the TWP will enter the EPE.
4. Eligibility will not terminate until the end of the 36 month EPE.

C. Extended Medicare Benefits

1. Medicare benefits will continue throughout the EPE and for the next consecutive 3 months regardless of whether cash SSDI payments are made during this time.
2. There are no application requirements for this extension but the disabled worker must continue to be medically disabled.
3. These benefits can continue even if the recipient is expected to recover, despite evidence that the recipient's condition is no longer disabling, as long as the recipient remains in an approved Vocational Rehabilitation program. SEE IV. BELOW

III. WORK INCENTIVES WHICH APPLY ONLY TO SSI BENEFICIARIES

A. The Earned Income Exclusion

1. A large portion of a beneficiary's earned income is disregarded when determining monthly SSI payments through this program.
2. Excluded from earned income is
   a. The first $65- earned; AND
   b. One-half of any remaining earned income.

   Any remaining income is considered the beneficiary's "countable" earned income. This is set off, dollar for dollar, against the monthly SSI benefit payable to the beneficiary.
3. The beneficiary need take no action other than reporting earned income (within 10 days of receiving it) to SSA in order to take advantage of this exclusion.
4. This exclusion applies whether or not the beneficiary is engaged in SGA.

B. The s1619 Program

1. In general

   a. The SSI beneficiary must be performing work on an SGA basis in order to participate in this program. In other words, the beneficiary must earn at least $500- a month while providing "services."
   b. Enrollment in this program occurs automatically as the beneficiary reports earned income that meets SGA levels. Enrollment and unenrollment will occur automatically as income fluctuates above and below the SGA level.
   c. This requires the beneficiary to timely and accurately report earned income, work hour increases and/or decreases, work activity termination, etc.
2. s1619(a) - Special Cash Benefits
   a. The special cash benefits provided by s1619(a) replace regular s1611 SSI cash payments when a beneficiary returns to work and earned income is at, or above, SGA levels.
   b. For monthly payment amount purposes the SSA will continue to use the regular payment rates and the general exclusions applicable to earned income. The beneficiary should experience no change other than the expected decrease in monthly SSI payments resulting from receipt of earned income.
   c. These benefits are not time limited. A beneficiary will be able to participate as long as that beneficiary continues to meet the SSI program requirements.
   d. The statute has been amended to prohibit the termination of any SSI beneficiary who engages in SGA in the absence of medical improvement that is directly related to ability to work.
   e. To qualify, a beneficiary must:
      (1) have been eligible for an SSI payment at least one month prior to starting work at the SGA level;
      (2) continue to be disabled; AND
      (3) meet all income and resource requirements of the SSI program.
   f. The beneficiary's resources must continue to remain within the general SSI program limits.
   g. Unearned income must also be considered in order to avoid the elimination of eligibility.

[This is merely a reminder to beneficiaries that unearned income is considered in calculations of what benefits they are entitled to.]

3. s1619(b) - Continued Medicaid Eligibility

   a. At the point where earnings rise to the level of "zeroing out" special cash benefits eligibility, the beneficiary reaches the "earnings threshold" giving rise to s1619(b) eligibility.

b. This allows for the continuation of Medicaid coverage

c. As with s1619(a), enrollment will occur automatically. Eligibility fluctuations between s1619(a), s1619(b), and s1611 also will occur automatically.

d. All SSI eligibility criteria must be met on a continuous basis in order to become and remain qualified for s1619(b) Medicaid coverage. Must:
   (1) have been eligible to receive SSI cash benefits for at least 1 month prior to starting work at SGA levels;
   (2) still be disabled;
   (3) need Medicaid coverage to work;
   (4) earn gross income at levels that are insufficient to replace Medicaid with private insurance; AND
   (5) continue to meet all resource and income criteria of the SSI program.

e. The SSA will rarely decide that a beneficiary does not need Medicaid in order to work but can. The following considerations will be considered:
   (1) whether Medicaid coverage has been used within the prior 12 month period;
   (2) whether Medicaid coverage is expected to be used within the following 12 months;
   (3) whether an affordable alternative to Medicaid exists for the beneficiary.

f. When earnings are sufficient to replace Medicaid with private insurance, the threshold for s1619(b) is reached. This income level represents the s1619(a) threshold (income sufficient to exhaust special cash benefits) plus the average Medicaid expenditure beneficiaries.

g. If a beneficiary's income exceeds this second threshold and that beneficiary's medical expenses are significant, an "individualized threshold" can be established upon request. SSA will add the annualized Medicaid expenditure for that particular beneficiary to the statewide applied s1619(a) threshold in order to establish an individualized threshold. This threshold becomes the income level that will represent the amount of income that will trigger a s1619(b) termination.

h. Example: s1619(a) threshold set at $14,5000 and the s1619(b) threshold set at $21,000. Should a disabled beneficiary have Medicaid expenses totaling $10,000 for the prior year and should the benefit request an individualized threshold, it would be set by SSA at $24,500.

4. Property Essential for Self Support

a. An SSI beneficiary may exclude resources that are determined to be essential for self-support.

b. Property essential to self-support can include real and personal property used in a trade or business, nonbusiness income-producing property and property used to produce goods or services essential to an individual's daily activities.

c. If the individual's principal place of residence qualifies under the home exclusion, it is not considered in evaluating property essential to self support.

d. The consideration of property is limited to the beneficiary's equity interest. The total maximum exclusion is limited to $6,000. This does not apply to property used in a trade or business or by such individual as an employee.

e. To be excluded, the property must yield an annual rate of return of at least 6% of its equity value.

f. A property producing less than 6% will be subject to this exclusion if the failure to do so is beyond the control of the beneficiary and a reasonable expectation of 6% production in the future exists.

g. The equity value that does not fall under this exclusion will be considered a countable resource and will be applied to the general resource exclusion.

IV. WORK INCENTIVES AVAILABLE TO SSI AND SSDI BENEFICIARIES

A. Vocational Rehabilitation (VR) Programs

1. If a beneficiary is participating in an "approved vocational rehabilitation program" SSI and SSDI benefits will continue until that plan is completed it is terminated the beneficiary ceases to participate. Income earned however will effect the amount of SSI that may be payable in any month during which work activity is completed.

2. These programs, provided by the state, may include job training, counseling, modifications to a home or automobile to improve accessibility; tuition and other financial assistance needed to attend school, etc.

3. Refusal, without good cause, to participate in an approved program of VR may result in a loss of benefits. "Good cause" exists when any of the following occur:

   a. the beneficiary is already enrolled in a program;
   b. the beneficiary is already attending school;
   c. the beneficiary is physically or mentally incapable of participating;
   d. the rehabilitation program would interfere with the beneficiary's medical program;
   e. the program is away from the beneficiary's home and would be harmful to the beneficiary's family's health and welfare;
   f. the beneficiary is, or within 3 months will be, working; OR
   g. the beneficiary is a member of a recognized religious group which believes in the power of prayer for healing, and their faith is the sole reason for refusal.

4. SSA may approve any vocational program and not just those developed by a state agency. The program must present a significant likelihood that it will enable the beneficiary to return to work on a permanent basis.

B. Impairment Related Work Expenses (IRWEs)

1. SSA allows deductions from gross wages of SSI and SSDI beneficiaries for expenses, services, and/or items necessary to the beneficiary's work effort.

2. IRWEs are deducted from countable income prior to the offsetting of income against the monthly SSI grant. They will be deducted prior to SSA's SGA determination.

3. An IRWE is an expense that meets the following conditions:
   a. it enables the beneficiary to work;
   b. it is paid for by the beneficiary;
   c. it is not reimbursable by private or public sources;
   d. the cost is reasonable (fair market value);
   e. it is needed because of the impairment; AND
   f. it is necessary to perform the job.

4. For purposes of SSDI and SSI, deductions are allowed for "services" expenses if the service is received while the beneficiary is working and payment is made in a month during which work was performed. The payment for an "item" will be deductible if the payment is made in a month of work activity regardless of when the item was purchased.

5. IRWE's include, but are not limited to:

a. a medication needed for work activity;
b. personal assistance in traveling to, preparing for, or performing personal functions at work;
c. prescribed treatment or therapy necessary to control a disabling condition;
d. durable medical equipment;
e. prosthetic devices;
f. driver assistance or taxis where such special transportation is not usually required by unimpaired individuals;
g. work related equipment;
h. exterior residential modifications, etc.

6. Services performed by a family member may be claimed as an IRWE if the services;

a. are performed for a cash fee; AND
b. result in an economic loss to the family member in the form of a reduction or termination of employment in order to perform the needed services.

7. As long term payment plans may be required to purchase equipment needed to assist in work activity, SSA will treat any large, non-recurring payments (e.g. a down-payment) to be deducted during one work month or amortized over a 12 month period.

8. Generally, only durable medical equipment is allowed to be deducted in anticipation of work.

C. Subsidies

1. A subsidy is a work related support that a beneficiary receives on the job which results in wages greater than the actual value of the services that are performed. A beneficiary receives a subsidy when the beneficiary's work requires either of the following:

a. more supervision than other equally paid employees doing the same job receive; OR
b. fewer or simpler tasks than other equally paid employees doing the same job are required to complete.

2. When considering work activity, the SSA can only consider wages earned by a beneficiary's own labor. The concept of subsidy will allow an amount of earned income to be deducted prior to a determination as to whether the beneficiary is, or has engaged in SGA.

3. An SSI beneficiary will have all income actually received considered as earned income, limiting subsidy usage to initial application SGA defense. In other words, once someone is receiving SSI benefits, any income, earned or unearned (such as subsidies) will be considered when determining their income. Therefore, the only time subsidies will help is to reduce one's income initially, when the SSA determines who is eligible for SSI benefits; i.e. who is disabled (not able to perform SGA).

4. SSDI beneficiaries will find subsidies useful at initial application and continuing disability review where income is measured only by what is actually earned.

D. Plans to Achieve Self Support (PASS)

1. A beneficiary may set aside both income and resources with an approved PASS. By isolating them from remaining income/resources, the SSA will exclude them for SSI financial eligibility purposes.

2. If at any time any amount of set aside funds is used by the beneficiary for expenses other than those set forth in PASS, the "income sheltering" effect of the PASS will "break" and all set aside

funds will be considered an available resource.

3. A person with a PASS must continue to meet the basic disability requirements of the SSI and SSDI programs.

4. In order to develop a PASS that will likely be approved by SSA the plan must:
   a. be in writing;
   b. have a specific work goal the individual can obtain;
   c. be designed specifically for the individual;
   d. have a time frame for attaining the work goal. the SSA requires that the work goal be achievable within 48 months. However, PASS plans are subject to adjustment. Initially a plan will be approved for 18 months. Non-educational goals are expected to be achieved within 36 months;
   e. show what money and resources will be used, show how they will be used, and show how they will be set aside and kept identifiable; AND
   f. be subject to periodic review by SSA.

5. A disabled person may put cash or other liquid resources in their PASS. Large settlements or back awards can also fund the PASS.

6. It is important to be as specific as possible in order to avoid the need to make frequent adjustments to an approved plan.

7. SSA must approve the plan before income or resources are set aside.

For more information about the Social Security Administration
Check out their Web page at: **www.ssa.gov**

SOCIAL SECURITY online

The Official Web Site of the Social Security Administration

Wednesday, 30-Sep-98 14:05:13 EDT

Benefits
- Benefit publications
- Información en Español
- Disability information
- How to reach Social Security
- How to apply for services
- Forms
- International benefits
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Online Direct Services
- Request a Personal Earnings & Benefit Estimate Statement
- Read Our Report: "Privacy & Customer Service in the Electronic Age"
- Find a local office

Services for Businesses
- SSA services for businesses
- Employer wage reporting
- Selling to SSA
- International agreements

Research & Data
- Research, evaluation & statistics
- Office of the Actuary

Financing, Planning & Budgets
- Budget & planning
- Financing: 1998 Trustees Report

Freedom of Information & Privacy
- Reading room
- Web privacy policy

Understanding Social Security

Understanding Social Security
Help with understanding the history, the benefits, and financing of the Social Security program of today, so that you can make informed choices about the Social Security program of tomorrow.

Did you know...? **7.4 million people receive $5.2 billion annually in benefits to widows, widowers, or children of a worker who has died.**

New and Noteworthy

Last updated September 24, 1998

Social Security Regulations
The complete Code of Federal Regulations, cross-referenced for ease of use, is now online.

Social Security and the Year 2000
SSA is confident that all its benefit payments will continue uninterrupted in the new century. See our new page on the Year 2000 problem and what Social Security is doing about it.

Employment Opportunities in the Office of Research, Evaluation and Statistics
SSA's Office of Research, Evaluation and Statistics has several opportunities for positions as Economists and Program Analysts in Baltimore and Washington DC. Jobs available are GS-12 to GS-15 grade levels and the announcements close on October 2.

Social Security Fights Fraud
A special unit of SSA's Office of Inspector General is attacking scams on a variety of fronts, from schemes run by immigrant groups to 'inside jobs' that bilk the government out of millions.

Employers, Here's Help for the 1998 Tax Filing Season
We have an improved and expanded guide to Wage Reporting for Employers.

Personal Earnings and Benefit Estimate Statement

VA Medical Care Benefits: An Overview

GENERAL

Service Connected Disability (38 U.S.C.A. §101(16):
The term 'service connected' means, with respect to disability or death, that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated, in line of duty in the active military, naval, or air service.

Non-Service Connected Disability (38 U.S.C.A. § 101(17):
...with respect to disability or death... "not incurred" from a disability...in line of duty.

Basic Entitlement
Two primary requirements for receiving veterans' benefits:

(1) Discharged under conditions other than dishonorable;
(2) Length of service: For individuals who served prior to Sep. 8, 1980, there is no length of service requirement for general eligibility. For those who enlisted after this date, they must complete a minimum period of service, either 24 months of continuous active duty or the full period for which the veteran was called or ordered to active duty.

SERVICE-CONNECTED DISABILITY

Hospital Care § 1710
The Secretary shall furnish hospital care and medical services and may furnish nursing home care, which the Secretary determines to be needed, to any veteran:

(a)(1)(A) for a service-connected disability;
(B) who has a service-connected disability rated at 50 percent or more. [Although the VA may choose, at its discretion to cover lower ratings]
(a)(2)(A) who has a compensable service-connected disability rated less than 50 percent;
(B) whose discharge or release from active military duty was for a disability that was incurred or aggravated in the line of duty;
(C) entitled to disability compensation;
(D) who is a former prisoner of war;
(E) who is a veteran of the Mexican border period or of WWI;
(F) who was exposed to a toxic substance, etc.;
(G) who is unable to defray the expenses of necessary care as determined under section 1722(a) of this title. [SEE NEXT SECTION]. According to the VA (see (a)(1)(B) above) this indicates that this subsection applies only to veterans with service-connected disabilities rated at less than 10% or with only non-service-connected disabilities.
(a)(3) In the case of a veteran who is not described above, the Secretary may furnish hospital care and nursing home care to a veteran which the Secretary determines is needed for a non-service connected disability, subject to subsections (f) & (g) of § 1710 (The veteran must agree to pay an amount as determined in those subsections).
(c) While any veteran is receiving hospital care or nursing home care in any Department facility, the Secretary may furnish medical services to correct or treat any non-service connected disability if the veteran is willing and the Secretary finds such services to be reasonably necessary to protect the health of such veteran.
(h) Nothing in section 1710 requires the Secretary to furnish care to a veteran to whom another agency

of Federal, State, or local government has a duty under law to provide care in an institution of such government.

DEFRAYING EXPENSES (38 C.F.R. §17.47):

(d)(1) For purposes of determining eligibility for hospital or nursing home care under §17.47(a), a veteran will be determined unable to defray the expenses of necessary care if the veteran agrees to provide verifiable evidence, as determined by the Secretary, that:

(i) The veteran is eligible to receive medical assistance under a State plan approved under title XIX of the Social Security Act; or
(ii) The veteran is in receipt of pension under 38 U.S.C. 1521; or
(iii) The veteran's attributable income does not exceed $15,000 if the veteran has no dependents, $18,000 if the veteran has one dependent, plus $1,000 for each additional dependent.

RATINGS FOR HIV-RELATED ILLNESS (38 C.F.R. §4.88b):

AIDS with recurrent opportunistic infections or with secondary diseases afflicting multiple body systems; HIV-related illness with debility and progressive weight loss, without remission, or few or brief remissions...100%

Refractory constitutional symptoms, diarrhea, and pathological weight loss, or; minimum rating following development of AIDS-related opportunistic infection or neoplasm...60%

Recurrent constitutional symptoms, intermittent diarrhea, and on approved medication(s), or; minimum rating with T4 cell count less than 200, or Hairy Cell Leukoplakia, or Oral Candidiasis...30%

Following development of definite medical symptoms, T4 cell count of 200 or more and less than 500, and on approved medication(s), or with evidence of depression or memory loss with employment limitations...10%

Asymptomatic, following initial diagnosis of HIV infection, with or without lymphadenopathy or decreased T4 cell count...0%

NOTE (1): The term "approved medication(s)" includes medications prescribed as part of a research protocol at an authorized medical institution.
NOTE (2): Psychiatric or central nervous system manifestation, opportunistic infections, and neoplasms may be rated separately under appropriate codes if higher overall evaluation results, but not in combination with percentages otherwise assignable above.

TRANSPORTATION (38 C.F.R. § 17.143 (cited below) & 38 U.S.C.A. §111):

(b) Transportation at Government expense shall be authorized for the following categories of VA beneficiaries:
(1) A veteran or other person traveling in connection with treatment for a service-connected disability (irrespective of percent of disability).
(2) A veteran with a service-connected disability rated at 30% or more, for treatment of any condition.
(3) A veteran receiving VA pension benefits.
(4) A veteran whose annual income as determined under 38 U.S.C. 1503, does not exceed the maximum annual rate of pension which would be payable if the veteran were eligible for pension,

or who is unable to defray the expenses of travel.

(e) A veteran shall be considered unable to defray the expenses of travel if:

(1) Previous annual income does not exceed the maximum annual rate of pension which would be payable if the person were eligible for pension; or

(2) The person is able to demonstrate that due to circumstances income in the year of application will not exceed the maximum annual rate discussed in subsection (1).

(3) The person has a service-connected disability rated at least 30%; or

(4) The person is traveling in connection with treatment of a service-connected disability.

According to the VA, the VA facility to which veterans are sent is based on a congressional determination arrived at according to geographic location and population density. A veteran-resident of Savannah is sent to Charleston because it is the closest facility and the hospital is located there because of the large numbers of veterans who reside in or near the city.

For more information about the Veterans Administration
Check out their Web page at: **www.va.org**
or call the National Veterans Legal Project at
(202) 265-8305

Welcome to HCFA
the Medicare and Medicaid Agency
Health Care Financing Administration

Welcome to the **Health Care Financing Administration** (HCFA), the federal agency that administers the **Medicare**, **Medicaid** and **Child Health** Insurance Programs.

HCFA provides health insurance for over 74 million Americans through Medicare, Medicaid and Child Health. The majority of these individuals receive their benefits through the **fee-for-service** delivery system, however, an increasing number are choosing **managed care** plans.

In addition to providing health insurance, HCFA also performs a number of quality-focused activities, including regulation of **laboratory testing** (CLIA), **surveys and certification**, and **quality-of-care** improvement.

HCFA Special Projects and Initiatives include:
-- Year-2000 Compliance,
-- Medicare Integrity Program (MIP),
-- Fraud and Abuse,
-- Philadelphia's "Your Medicare Center", and
-- State Health Reform.

DHHS Initiatives in which HCFA is involved include:
-- Summary of HCFA's FY 1999 Annual Performance Plan (APP),
-- Insurance Reform (HIPAA), and
-- Administration Simplification (AS),
which includes:
"PAYERID" and
"National Provider Identifier"

Look here for more information on important developments.

About HCFA
Quick Navigate

In the News
September 30, 1998

- **Medicaid Managed Care Proposed Rule for the Balanced Budget Act of 1997, BBA** Now Available
- **Public Use Files Catalog (PUFs)** Updated as of Oct. 1, 1998:
- **U.S Health Care Spending Projections, 1997-2007** are now available
- **Medicare and You** -- 1998 Medicare Handbook
- Children's Health Insurance Program Outreach Conference -- **"Partnering with Historically Black Colleges and Universities"**
- Federal Register Notice on **Schedules of Limitations** on HHA Costs
- Report to Congress -- **Nursing Home** Quality Assurance
- Medicare + Choice Program Standards Published in **Regulation**
- **Hearings and Appeals**
- CHIP Plan Approval **Press Releases**
- HCFA **Employment** Opportunities

For the most current information, see the **Events, Meetings, and Workgroups** Page

HCFA Local Information
State Query

State	State Name	HCFA Region No	Regional Office Location	Phone
OK	Oklahoma	6	Dallas	(214) 767-6401

Insurance Counseling General Information Phone	Medicare Carrier	Peer Review Organization (PRO)	Durable Medical Equipment Carrier
1-800-763-2828 405-521-6628	Aetna Life Insurance Company 1-800-522-9079 or 405-848-7711	Oklahoma Foundation for Peer Review 1-800-522-3414 or 405-840-2891	Palmetto Government Benefits Administrators 1-800-213-5452

An * preceeding a PRO phone number indicates that out-of-state collect calls will be accepted.

HCFA TTY For the Hearing and Speech Impaired: **1-800-820-1202**.

State Specific **MEDICAID** Information and Contacts

Back to Local Information Map
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Do I Need to Take Medicare Part B?

10/15/1998 02:51:48 PM EST

Some people may not want to apply for Medicare Part B (Medical Insurance) when they become eligible. If you are one of the following, you can delay enrollment in Medicare Part B, without penalty.

- If you turn 65, **continue to work**, and are covered by an employer group health plan, you may want to delay enrolling in Medicare Part B

  *Group health plans of employers with 20 or more employees **must** offer **active** workers who are 65 or older the same health benefits provided to younger employees.*

- If you turn 65 and are covered under your **working** spouse's employer group health plan, you may want to delay enrolling in Medicare Part B

  *Group health plans of employers with 20 or more employees **must** offer the spouses (who are 65 or older) of workers, the same health benefits given to younger spouses.*

- If you are under 65 and receiving Medicare due to a disability, you **continue to work**, and are covered by an employer group health plan, you may want to delay enrolling in Medicare Part B

  *Group health plans of employers with 100 or more employees **must** offer disabled workers the same health benefits provided to other employees.*

- If you are under 65 and receiving Medicare due to a disability, and are covered under your **working** spouse's employer group health plan, you may want to delay enrolling in Medicare Part B

  *Group health plans of employers with 100 or more employees **must** offer the disabled spouses of workers, the same health benefits given to non-disabled spouses.*

The employer group health plan may cover the items normally covered by Medicare Part B. In this case, it may not be necessary to enroll in Medicare Part B and pay the Part B premium.

If you are a worker, spouse, disabled worker or disabled spouse, and choose to have continued coverage under the employer group health plan, you can refuse Medicare Part B during the automatic or initial enrollment period. You wait to sign up for Medicare Part B during the special enrollment period, a 7 month period that begins with the month the group health coverage ends or the month employment ends, whichever comes first. You will not be enrolling late, so you will not have any penalty.

If you choose coverage under the employer group health plan, Medicare will be the "secondary payer," which means the employer plan pays first. If the employer group health plan does not pay all the patient's expenses, Medicare may pay the balance or, they may pay only a portion or, they may not pay anything. **An employer group health plan must be primary or nothing. They are NOT allowed to offer people Medicare supplemental coverage.**

Whether to enroll in Medicare Part B or to choose an employer group health plan is a VERY importantdecision. For help in making this decision, see "Questions To Ask When Considering A Supplement To Medicare". Contact a *SHIIP* counselor at (800) 452-4800 or (317) 232-5299, to help.

Back Medicare Index

AN IMPORTANT MESSAGE FOR BENEFICIARIES ENROLLED IN MEDICARE HEALTH MAINTENANCE ORGANIZATIONS

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3 THINGS TO REMEMBER
1.) You should know that no matter what happens, you are still in Medicare.
2.) Your current HMO is required to cover you until December 31, 1998.
3.) If you are affected by a plan non-renewal, you have time to make a choice. Consider your options carefully.

You may read or hear about managed care plan withdrawing from Medicare in your area. A decision to withdraw is called a non-renewal. If you are in the Original Medicare Plan, you are not affected. If you are in a Medicare managed care plan, you may be affected, but you are still covered by Medicare.

Medicare benefits will always be available to Medicare beneficiaries. Medicare benefits can be delivered either through the traditional pay per visit arrangement, known as the Original Medicare Plan, or in some areas through managed care arrangements.

Individuals affected by a plan non-renewal will receive a notice from their plan no later than November 2, 1998. Your current Medicare Health Maintenance Organization (HMO) is required to cover you until December 31, 1998.

If you are affected by a plan non-renewal, you have time to make a choice. Changing the way you receive your health care is an important decision. You may wish to ask your family, friends, or doctor for help. Special rules may apply when you disenroll from a Medicare health plan and return to the Original Medicare Plan with a supplemental insurance policy (Medigap). If you or your spouse has health care coverage through a former employer or union, contact your benefits representative before you make a new health plan choice. If you have Medicaid coverage, do not make a new health plan choice until you contact the State Medical Assistance Office.

We understand that the withdrawal from Medicare of some managed care plans has disrupted the lives of Medicare beneficiaries enrolled in these plans. To ease this transition, HCFA is committed to ensuring that beneficiaries have useful information about Medicare and the rights and protections available to beneficiaries affected by these plan withdrawals.

Click here for more information from Medicare about your options and protections.

IMPORTANT INFORMATION ABOUT MEDICARE BENEFITS

Where Managed Care Plans Have Decided Not to Renew Their Medicare Contracts

Throughout the country, HCFA contracts with managed care plans to provide Medicare benefits. Managed care plans are independent businesses which voluntarily enter into annual contracts with the Health Care Financing Administration to provide services to Medicare beneficiaries. HCFA pays the contracting plans a monthly amount for each enrolled Medicare member in exchange for providing all Medicare covered services to these members.

Medicare managed care contracts are for a calendar year. Each year, as a matter of doing business, plans review their options and make a choice of whether or not to continue their contract, adjust premiums and/or benefits, extend their service areas or not renew the contract. A decision not to participate is called a nonrenewal. Nonrenewal decisions can apply to an entire plan contract or only to selected counties served by that plan.

HCFA is responsible for assuring that contracting managed care plans meet their contractual obligations. However, HCFA has no control over the plans annual business decisions, nor can HCFA force plans to renew their contracts.

For calendar 1999, some managed care plans have decided not to renew their contracts to provide services to Medicare beneficiaries in certain states and selected counties.

If you are a member of a plan that has chosen not to contract to provide Medicare benefits in calendar 1999, the plan will send you a notification no later than November 2, 1998. You will need to decide how you want to receive your Medicare services after December 31, 1998.

- You may be able to join another Medicare managed care plan similar to the one in which you are currently enrolled; OR
- You can return to the Original Medicare Plan.

Either way, you are still in the Medicare program and will receive all the Medicare covered services.

Changing the way you receive your health care is an important decision. You may wish to ask your family, friends, or doctor for help. Special rules may apply when you disenroll from a Medicare health plan and return to the Original Medicare Plan with a supplemental insurance policy (Medigap). If you or your spouse have health care coverage through a former employer or union, contact your benefits representative before you make a new health plan choice. If you have Medicaid coverage, do not make a new health plan choice until you contact the State Medical Assistance Office.

Joining Another Medicare Managed Care Plan

You may wish to join another Medicare managed care plan. Beginning January 1, 1999, new rules will in most cases allow you to be enrolled in this kind of plan only if you are entitled to Medicare Parts A and B and do not have permanent kidney failure (ESRD). If you choose to enroll in another Medicare managed care organization before December 31, 1998, you will automatically be disenrolled from the current plan.

Beginning November 2, 1998, the Medicare Compare section of this website will have information about available plans and their benefits. If you require information before November 2, or need further assistance, call your State Health Insurance Assistance Program (SHIP). The phone number for the SHIP in your state is available in the Who to Contact section of this website.

Plans that contract with HCFA to provide services to Medicare beneficiaries during calendar 1999 are required to accept your enrollment in November 1998, to be effective January 1, 1999. Call these plans with your questions about premiums, benefits, their enrollment process, and effective dates of coverage.

Please note that some of these Medicare managed care organizations may also accept your enrollment during the month of December. Be sure to enroll no later than December 31, 1998 for your coverage to begin January 1, 1999.

Returning to the Original Medicare Plan

You can return to the Original Medicare Plan in one of two ways:

1.) Remain enrolled in your current plan until December 31, 1998, and you will be automatically returned to the Original Medicare Plan starting January 1, 1999; OR

2.) Return to the Original Medicare Plan before December 31, 1998, by:

a.) Submitting a written request to disenroll to your current plan **or**

b.) Contacting your local Social Security Office, or Railroad Retirement Office (if you are retired from the railroad) and ask for disenrollment information. You will be disenrolled effective the first day of the month following the month you requested disenrollment. For example, if you request disenrollment on November 20th, you will be returned to the Original Medicare Program effective December 1, 1998.

If you do choose to disenroll before December 31, you should understand that until your disenrollment from your current plan is effective, you must continue to follow plan rules for receiving your health care services.

Caution: If you disenroll before December 31, 1998, you may not be guaranteed certain Medigap protections. Whether you disenroll before December 31, 1998 or allow your enrollment to be automatically terminated on that date affects your rights to Medigap coverage under the law.

IMPORTANT MEDIGAP INFORMATION

If you choose the Original Medicare Plan, you may decide that you need more coverage than Medicare provides. Supplemental insurance policies may pay for some or all of the Medicare coinsurance amounts; some or all deductibles; and certain services not covered by the Original Medicare Plan at all. Therefore, you may want to consider buying a Medicare supplemental (Medigap) policy to help pay for those costs.

You have the following options regarding Medigap policies:

1. As long as you apply for a Medigap policy not later than 63 days after your coverage with your current plan terminates on December 31, 1998, you are guaranteed the right to buy any Medigap plan designated A, B, C or F that is offered in your State. Companies selling these policies cannot place conditions on the policy (such as an exclusion of benefits based on a pre-existing condition) or discriminate in the price of the policy because of your health status, claims experience, receipt of health care or your medical condition.

   Caution: While you can apply for one of these policies before December 31, 1998, the protections described above will not apply if you voluntarily disenroll before your coverage terminates. You should keep a copy of your notification letter as proof to the Medigap insurer that you lost your coverage under this plan.

2. If you dropped a Medigap policy to join your current plan and you have never enrolled in a similar health plan since starting Medicare, you **are guaranteed the right** to return to the Medigap policy you dropped if:

   - The Medigap policy you dropped is still being sold by the same insurance company;
   - You disenroll from your current health plan no later than 12 months after you initially enrolled in it (you do not have to wait until December 31, 1998);
   - You reapply for the policy you dropped no later than 63 days after you disenroll from this plan.

   Caution: If your previous policy is no longer available, you are still guaranteed the right to buy from any Medigap carrier any Medigap plan designated A, B, C or F that the carrier offers in your State (as described above.). However, remember that in this situation the 63-day period for filing your Medigap application will begin on the effective date of your disenrollment.

   Please make sure your old policy is still available from your original insurer before you disenroll from this plan. If it is not available, you will have more time to make a decision about your Medigap options if you simply remain enrolled until your current health plan terminates your coverage on December 31. You will then have 63 days from your last day of coverage under your current plan to apply for a plan designated A, B, C or F. (Revised effective October 9, 1998)

If you encounter any difficulties in obtaining a Medigap policy, please contact your State Insurance Department. Please contact your HCFA Regional Office if you need additional assistance in resolving your concerns. The phone numbers for these offices are available in the Who to Contact section of this website.

Pre-existing Condition Protection

By law, your current plan must arrange for you to be protected against any pre-existing condition exclusions under a Medigap policy for up to six months after it terminates your coverage. Your plan must notify you of the arrangement that they have made

vailable to you.

IMPORTANT INFORMATION FOR PART B-ONLY MEMBERS

oining Another Medicare Managed Care Plan Before 1999

n order to continue to receive your Part B benefits from a Medicare managed care plan without having to enroll in Medicare Part A, you MUST enroll in another Medicare managed care plan no later than November 30, 1998.

- Beginning January 1, 1999, new Medicare rules require that you be enrolled in Medicare Part A and Part B before you can enroll in most Medicare managed care plans. (A managed care plan that is reimbursed by HCFA on what is known as a cost basis may be available to you without having Part A).
- However, as long as you switch to another Medicare managed care plan by November 30 of this year, the new rules will permit you to remain enrolled in that Medicare managed care organization even though you do not have Medicare Part A.

f you don't enroll in another Medicare managed care organization by November 30, 1998, you will automatically be enrolled in he Original Medicare Plan on January 1, 1999.

ADDITIONAL ASSISTANCE

Your State Health Insurance Assistance Program is available to assist you in understanding this information and in making any important decisions. **The number for the SHIP in your state can be found in the Who to Contact Section of this website.**

Starting November 2, 1998, up-to-date information about plans available during 1999 can be found in Medicare Compare ocated in the Managed Care section of this website. After November 2, 1998, you can request information on Medicare+Choice health plans available in your area by using the automated Medicare Special Information number 1-800-318-2596 or TTY at 1-877-486-2048).

Additional information that provides commonly asked questions and answers is available by accessing the Managed Care Non-Renewal section of HCFA.gov.

Note 2: When You and Medicare Disagree:

The law allows you to appeal Medicare's decisions about what and how much it will cover. Rulings involving the quality of your care may also be appealed. Under Part A, you can appeal to the organization that told you Medicare wouldn't pay your claim - your hospital, peer review organization (PRO) or intermediary (the private insurer the government has chosen to handle Part A claims).

For disagreements about Part B services, you can ask for review by the carrier (the private insurer Medicare contracts with to process claims). If you belong to a Medicare health maintenance organization (HMO), you may request a review by the HMO. If it decides against you, it must send you a letter detailing how to appeal further.

If disagreements involve Part A or Medicare HMOs, disputes involving $100 or more can be further appealed to an administrative law judge (ALJ) of the Social Security Administration. Part B disputes can be appealed to an ALJ if they involve $500 or more. The Medicare hotline or your local Social Security office can tell you how to appeal. Cases involving $1,000 or more can be appealed to a federal court.

It's important to move quickly if you want to appeal. Medicare gives you only 60 days to formally begin the appeal process for a Part A or HMO decision with which you disagree. For Part B, you have six months.

For questions about quality of hospital care or whether hospital services were medically necessary, you can ask the peer review organization in your state to review your case. The federal government contracts with these practicing doctors, who review hospital records to determine whether appropriate care was given.

PROs can also help if you believe you have been refused admission to a hospital improperly or are being told to leave a hospital too soon; you can get an expedited review. Steps for appealing a PRO's decision are outlined in the Medicare handbook. You can get the name and address of your PRO from the handbook, from your hospital or from your local Social Security office.

Questions? Every state has counseling office to answer your questions about health insurance, including Medicare. To find your state counseling office, call the Medicare hotline at (800) 638-6833.

Courtesy AARP 6/95

MEDIA OUTLETS

The media consists o more than just the evening television news or the morning newspaper. Each of the following outlets have distinct characteristics, challenges and opportunities:

Print
Daily news
Investigative pieces or series
Letters to the editor
Guest "op ed" pieces
Editorials
Features
Photo essays

Alternative Print
Trade publications
Minority publications
Religious publications
Special interest publications

Radio
News
Editorials
Talk Shows
Special Events

Television
Daily news
Investigations
Series
Editorials
Features
Special Events

WHO TO ADDRESS WITH STORY IDEAS

call ahead to get name of individual

Substance first, then it is important to present it in the most convenient way and to the right person.

Stories can be pitched to local or regional daily newspapers, weekly newspapers, wire services, trade publications, organization newsletters and broadcast media including TV and radio.

Job Titles: Your contacts at each type of medium will have different job titles/descriptions. You can increase your success rate by knowing who to contact. Here are a few suggestions:

Television:

* assignment editor - ask for the **day** assignment editor, but if you have a story to be covered nights or weekends, please note that these are separate positions
* specialty reporter - such as health/medical, political, business or feature reporter
* producer - by individual program, contact if trying to book a guest on a talk show or program segment

Radio:

* news director
* specialty reporter
* producer - by individual program

Newspapers and Magazines:

* specialty reporter
* city and/or general editor - for local story at publication without specialty reporter
* features editor - for human interest story at publication without specialty reporter

Who to Address With Story Ideas
(Continued)

Deadlines: Being aware of organizational deadlines can help you pitch with a greater success rate. Be aware of the following deadline guidelines:

Television:

* Day assignment editors are often busy with planning meetings between 9 a.m. and 10 a.m. They also take lunch and become frantic and hard to deal with by 4 p.m. as they approach deadline. Try to pitch your story one or two weeks before event and best times to call are 10 a.m. to 3 p.m.

* Reporters and producers are also best reached between 10 a.m. and 3 p.m. They get crazy as deadline approaches, too.

Newspapers:

* Editors usually have early morning planning meetings and late afternoon deadlines as well, so it is best to call between 10 a.m. and 3 p.m.

* Reporters can best be reached between 9 a.m. and 3 p.m. Late afternoon deadlines can make contact difficult.

Radio:

* News directors, reporters and producers are best contacted early in the day between 9 a.m. and 2 p.m.

Magazines:

* Any time of day seems okay to contact magazine personnel, however, the key here is to be aware of how far in advance they are preparing each issue. Most publications work at least six weeks to two months in advance. Before you start to pitch, do your homework and find out the magazine's editorial calendar.

THE TEN COMMANDMENTS OF MEDIA

I. Be open and cooperative. Never lie.

II. Personalize the organization; make sure media knows what we do; the good stuff

III. Develop media contacts.

IV. Take good stories to them.

V. Respond quickly.

VI. Never say, "No comment."

VII. It's OK to say, "I don't know." (But, I'll find out)

VIII. If you screw up, confess and repent.

IX. Use the big dump. maybe give more if they asked for it appropriate

X. Prepare for a media disaster.

Keep notes re. what you tell reporter

Sample Column/Position Paper

NAMES REPORTING:Non-Urban Perspective **By Robert W. Bush**

In the early 1980's, thousands of "Ronald Reagans" took the test to determine whether they were positive for HIV. In certain states, at that time, you'd have to give your name to get tested at all. Rather than brave the losses and humiliations hazarded by a disclosed positive status, these thousands adopted ironic pseudonyms to protect themselves. Thousands more simply refused to get tested.

Today, in Savannah, the Georgia Department of Human Resources(DHR) is holding a hearing to solicit feedback on the reporting of the names of individuals who test positive for the HIV virus. Did they forget the point made by the ersatz Reagans? Or are they unaware that in non-urban Georgia, the consequences of testing positive for HIV are often so traumatically life-changing that people will forego testing and, even, necessary medical care to avoid them.

If the DHR were based in rural Georgia, this meeting wouldn't be necessary. DHR would already know that, in non-metropolitan counties, keeping confidence often means "keep it to yourself". Your bank teller may be your cousin, your pastor's wife may be your clinic nurse and everybody knows your daddy. Every friend, every acquaintance is a possible breach of privacy. And, once privacy is breached, there's no restoring it. You can't unring a bell.

In these areas that make up the lion's share of our state, education about the rights of PLWH/A's hasn't convinced many persons that confidentiality and accommodation are two of them. And enforcement measures have not been strong. Try finding a local attorney to sue a local business for employment discrimination, and you often find that that attorney fears your illness, disapproves of your "lifestyle" , is intimidated by the politics of the task or doesn't see enough in damages to motivate them to take the case. Most are not going to take it to make a point.

Effectually, in these places, you can lose your job, be denied medical care, or be humiliated through the rumor mill without recourse. As a consequence, you feel the bonds with your friends and family weakening because of the pressure they feel from their social groups--if those bonds survive at all.

In spite of this, those of us who work with HIV realize that tracking the incidences of AIDS instead of the incidences of new infections is not working. We must be able to track the course of HIV while it is still fresh, or we cannot devise effective prevention efforts. But we don't have to take names.

Unique Identifier systems create a new and unique "name" for persons being

tested by using bits of data about that person. An inadvertant glance at such a list of names would attach no status to any person. But, it would allow public health to track the epidemic. And there's evidence that such a system can be implemented without prohibitive cost if states commit to doing so.

The surveillence objective which DHR seeks to accomplish requires a partnership. Names belong to the people who hold them. How likely is it that persons who believe they may be at risk for AIDS will voluntarily give up their names, when many of our influential elected representatives paint them as a threat to family values? When many of them are aware of the Tuskegee experiments, where african-american soldiers were unknowingly injected with the virus that causes syphilis?

And many of the pundits who have weighed in on this issue beg the next question: why shouldn't we report the names of persons testing positive for HIV if we have been reporting the names of those testing positive for syphilis and other infectious diseases for years. For those of us who live outside the I-285 oval and who work with AIDS the answer is obvious: fear of syphilis has never motivated church communities to cast out their own members, nor, probably, caused job loss and ostracism from family. AIDS has.

And it still does. Before it makes it decision, DHR needs to listen to those who know their own communities. Sixty-eight percent of the HIV-positive respondents in a rural study conducted by the University of Vermont stated that fear of disclosure of their status was a barrier to their seeking treatment for HIV. Forty-four percent listed fear of being stigmatized by their community as a barrier, and forty-one percent responded that, even after testing positive, it took them longer than a year to seek treatment. And, even as the overall number of AIDS cases begins to decline, the numbers in small towns continues to rise.

People will forego testing if they fear the ramifications of disclosure. They cross state lines from Alabama, South Carolina, and other states that currently report by name. Otherwise, they wait until their illness has progressed to a critical stage before they will seek medical care.

Names reporting is a system that works from a strict public health perspective. If the entire United States were peopled by the colleagues of those who work at DHR, or by other persons with direct exposure to AIDS, who see PLWH/A's as people and not increments of immoral conduct, then that system might work.

As it is now, it will simply create more victims of AIDS-phobia.

The following is a list of websites that provide information on HIV/AIDS which have come to our attention through our contributors and readers. Please contact our office if you know of a website that should be included in this list.

ACT UP New York
http://www.actupny.org
ACT UP Golden Gate
http://www.actupgg.org
AIDS Clinical Trial Information Service
http://www.actis.org
AIDS Education Global Information System
http://www.aegis.com
AIDS Program at San Francisco General Hospital
http://sfghaids.ucsf.edu
AIDS Project LA
http://204.179.124.76/apla/
AIDS Survival Project
http://www.mindspring.com/~asp/index.htm
AIDS Treatment Data Network
http://www.aidsnyc.org/
AIDS Treatment Newsletter
http://www.jri.org/infoweb/treatment/library/atn/index.htm
American Medical Association
http://www.ama-assn.org/special/hiv/hivhome.htm
BETA Online
http://gopher.hivnet.org:70/1s/magazines/beta
The Body
http://www.thebody.com/
CDC National AIDS Clearing House
http://www.cdcnac.org/
Comm. AIDS Treatment Information Exchange
http://catie.ca
Critical Path AIDS Project
http://www.critpath.org/
CyberQueer Lounge AIDS Info
http://www.cyberzine.com/CLAIDS/AIDS/aidspage.html
Gay Mens' Health Crisis
http://www.gmhc.org/
HEAL
http://thorup.com/HEAL/healindex.html
Healthcare Communications Group
http://www.healthcg.com
HIV Insite
http://hivinsite.ucsf.edu/
HIV 'n' Alive
http://hivnalive.org
HIVNet
http://www.hivnet.org/
International Association of Physicians in AIDS Care
http://www.iapac.org/
Johns Hopkins University AIDS Service
http://www.hopkins-aids.edu
JRI-Health Infoweb
http://www.infoweb.org
Medscape
http://www.medscape.com/
National AIDS Treatment Advocacy Projec
http://www.aidsnyc.org/natap
National Association of People with AIDS
http://www.thecure.org/
National Institute of Allergy and Infectiou Diseases
http://niaid.nih.gov
National Library of Medicine
http://www.nlm.nih.gov
POZ
http://www.poz.com/
Project Inform
http://www.projinf.org
Protease Inhibitor Response Project
http://www.netcom.com/~protease
The Safer Sex Page
http://www.safersex.org/
San Fransisco AIDS Foundation
http://www.sfaf.org
Search For A Cure
http://www.sfac.org
University of California AIDS Web Site
http://hivinsite.ucsf.edu
Vanderbilt University Medical Center HIV/AIDS Online Help
http://www.mc.vanderbilt.edu/adl aids_project/help.html