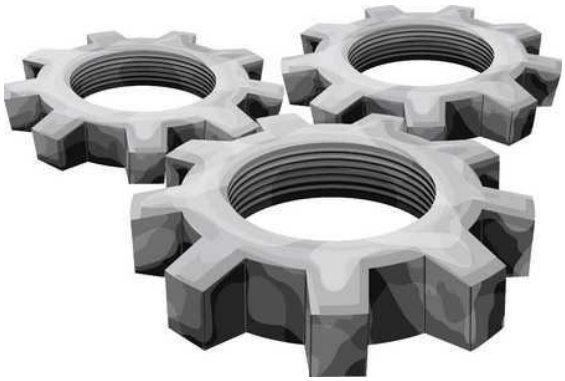
The Need for Life Insurance Medicare Cafeteria Plans



Central Florida Insurance School

Central Florida Insurance School

PHONE: 407-332-6645
FAX: 800-928-9319

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1

THE ART OF "NEEDS" SELLING

WHY THE "NEEDS" APPROACH?

The "needs" approach to selling consists of developing the skills and knowledge you will need to provide your prospects and clients with the life insurance program that BEST SUITS THEIR INDIVIDUAL NEEDS! There are several reasons why the needs approach to sales is so important. First, needs selling is without question the most professional approach to life insurance sales. The advantage to needs selling does not stop with the initial sale. As your clients realize you are really working to match your products to their individual needs, they will gain increased respect for your services and for you as a professional. They will remember you when their needs change or new needs arise.

The needs approach to sales will also result in your clients thinking of you when their friends, family and associates develop insurance needs. This is because they know you will be as professional in determining exactly what type of insurance will create a foundation for peace of mind in a prospects future. Also, when sales are made as a result of a needs approach, there is a far better chance that the policy will stay on the books. For example, if you have sold a policy to provide family income in the event of the breadwinner's death and the policyholder indicates for some reason that he or she is going to drip the policy, you can remind him or her of the need the policy was purchased to meet in the first place. The prospects must have decided at one point in time that this was an important need that should be protected. The needs approach will also result in policies with larger face amounts and a much higher quality of business sold than will other less professional selling methods.

BEGINNING AN INSURANCE PROGRAM

While the ideal situation is to total up all of a prospect's insurance needs and sell one policy to cover these needs, this approach is not always practical. Approaching the sale from a single need basis is generally the best strategy, because often it is simply not possible to sell a policy that will meet all of a prospect's needs in a single presentation. In many cases, you will discover a combination of needs that are simply too large for the prospect to take care of at one time. In these cases, approaching the sale from a single need point of view enables a prospect to BEGIN A PROGRAM which can eventually be expanded to meet the total needs of the prospect and the prospect's family.

BUILDING FUTURE SALES

Single needs selling opens the door to future sales. Of course, as part of your professional service, will want to periodically review the client's situation to see if "needs" have changed. Also, studies have shown that most people buy life insurance at least five times during their lifetime, which is yet another reason single needs selling is an excellent approach. Single needs are easier to present and easier for the prospect to assimilate. This means your chances of making a sale in each presentation are much better.

2

DISCOVERING THE NEED

YOUR SKILLS AND KNOWLEDGE

Knowledge about the various types of life insurance policies and an understanding of individual needs for life insurance are essential elements in insurance planning. The key ingredient to a successful future in insurance planning is your ability to use this knowledge to develop life insurance recommendations for EACH of your clients. Since

each client has unique needs, personal goals, and objectives, every situation requires individual analysis and a customized solution.

KEEPING AN OPEN MIND

It is important to remember not to come into an interview with prepackaged solutions that reflect that you believe that the client's needs will be. While two families MAY SEEM EXACTLY ALIKE on the surface, a closer look will often reveal that they are not the same at all. Their needs may be the same, but their goals and objectives for the future may be far apart. One family may wish to pay off the mortgage in full in the event of premature death while another will be content to provide income to cover this need.

What you believe is best may not be the issue nor the best way to close the case. Harry Truman once said, "The best way to give advice to people is to find out what they want and then advise them to do it." Your job is to find out what your client's individual needs and financial goals are, then develop and suggest ways to implement recommendations that will help your clients achieve those goals during life and at death.

Again, it is extremely important to remember that you should not assume that you know in advance what a prospect's needs are. For example, suppose you are interviewing a young couple who have been married for several years.

DO NOT ASSUME that they plan to have children. If you design a program with this assumption in mind, you may find out that they had no such intention, your assumptions are all wrong. In this case, you have impaired your level of professionalism in this couple's estimation. You have also severely handicapped your chances of making a sale with these prospects, along with any future referrals that they may have provided.

MAKING THE PROSPECT REALIZE THERE IS A NEED

As a life insurance professional, one of your primary functions is to uncover life insurance needs and to outline these needs for your prospects. The greater the prospect's understanding of life insurance needs, the more likely the prospect is to fulfill those needs. Generally, there are only two reasons why a prospect doesn't buy insurance at a particular point in time.

First, the prospect is not aware of a problem. Second, the prospect is not alarmed enough about the problem to take any immediate action to solve it.

A prospect who realizes $40,000 is needed to pay off the mortgage or $25,000 is needed to satisfy some other financial obligation or goal is more likely to buy insurance to satisfy those needs.

DETERMINING YOUR PROSPECT'S EXACT NEED

The best way to obtain the information you need is by questioning your prospects carefully about what their needs are, or what they believe their needs will be in the foreseeable future. Do they want to pay the mortgage off? Do they want to save money for their children? Do they want to have an emergency fund? Are they trying to save for retirement? By allowing your prospects to think about and articulate what they want to accomplish, you will find that you are able to assist with those needs and goals by designing a program that is custom made for them.

OTHER POSSIBLE SOURCES OF INCOME

As you determine what your client's needs are, it is also important that you determine other sources of income that would be available to meet those needs. The availability of savings, pensions, existing life insurance policies, and Social Security all should be investigated.

GROUP LIFE INSURANCE

For example, a prospect may tell you that he or she has group life insurance at work. On the surface, it would seem that group insurance should be considered a source of income in the event of death; however, a closer examination might reveal that the answer is not so clear.

As long a person is employed and covered by group insurance at the time of death, the insurance at work will pay. If the prospect decides to go into business for him or herself, the coverage may terminate.

Unlike individually owned life insurance, which is in force only as long a premium payments are made, group term insurance at work is only good for as long as the employee continues to work for the company. This is why you or your prospect should not count on group insurance as a source of income, since there is no guarantee that the group insurance will be in place at the time of death.

SOCIAL SECURITY

Social Security on the other hand, is a better bet. As long as an individual has paid Social Security taxes through most of his or her working life, Social Security benefits will be paid. However, there is no precise way to determine how much will be paid, since the exact amount of the payments won't be determined until the time the benefits are actually paid. Be aware that the guidelines for Social Security can change year to year depending on the whim of the federal government. The best way to stay current on Social Security is to check on a regular basis with your local Social Security Administration office.

There are certain key indicators that can be used in estimating the amount that will ultimately be paid.

First, the more money a worker has paid into Social Security during a working lifetime, the larger the benefit. Second, when there are two or more dependent children under the age of 18 (19 is the child is still in school), the benefit is larger than if there is only one child.

STICK AROUND

After you have developed a life insurance program for your client, you job is far from over. In fact, it has just begun. The plan you have established fits your client's needs TODAY! You must understand that circumstances constantly change. Your client may change jobs, receive a promotion, get married, or have a child. These are just some of the events that can affect your clients life and change the need for life insurance. This illustrates why it is so important to review your client's program once a year to make sure it is still viable for your clients needs. An annual review may not uncover any additional needs, but is will let your clients know that you are committed to
providing them with professional service. An annual review will go a long way toward maintaining good, persistent business. Don't forget, this is also the perfect time to ask about those referrals we talked about earlier, so "Stick around."

3

FULFILLING THE NEED

FAMILY INCOME

In most cases, the need to provide for family income is by far the largest and therefore most important need for life insurance. When a husband and/or wife is working, the money earned pays for normal ongoing expenses. These expenses include food, clothing, utilities, taxes, medical and dental care, and mortgage or rent payments. However, when a premature death occurs, the money to pay for these ongoing expenses stops abruptly. Most people don't really realize what a significant loss this is.

EMERGENCY FUND

An emergency or opportunity fund is the next need we will review. Again, a realistic estimate is generally adequate for purposes of determining the needed sum - most insurance professionals recommend that a policyowner should provide at least six months salary to the family for an emergency fund in the event of premature death.

An emergency fund should be large enough to provide for those unexpected contingencies that occur invariably at the wrong time - a roof that needs to be replaced, a furnace that breaks down, or some other major appliance repair. In addition, other unexpected bills could arise from major auto repairs or from major medical expenses. An emergency fund can create a reserve that can assure that the surviving family is not forced to cut back on necessities.

Whatever amount is needed, life insurance guarantees that adequate funds will be available when they are needed. While a savings account or other investment could perhaps be established for this purpose, life insurance is truly the only practical way to solve the emergency fund problem.

Only life insurance creates an immediate fund that is ready, in full, at the exact moment it's needed. And as we mentioned earlier, although these costs can vary, most experts feel that an emergency or opportunity fund should contain money equal to at least six months' income. A more precise amount can, of course, be determined by studying individual situations.

PROVISIONS FOR A CLEAN-UP FUND

A clean-up fund should cover all final expenses, You'll find that whatever a family's financial circumstances - whether modest or substantial - the need for cash at death is universal. Death creates debts. And while some of the debts due upon death have been incurred during the normal course of daily life, others have been created by death itself. When we talk about a final expense or clean-up fund, we generally include three major items:

- Expenses for last illness (this includes all medical expenses and fees not covered by medical expense insurance);
- Burial expenses (including funeral, cemetery lot, and gravestone);
- Outstanding bills, loans, and taxes.

Because the exact amount of final expenses incurred by a family when death occurs depends on many variables, there's no stated amount of insurance that can be universally recommended. For example, a last illness could range from a visit to a hospital emergency room to a lingering illness which spans days, months, or even years.

You will find the prospect's opinions and ideas will assist you in making estimates on how much money would be needed for final expenses. For example, in the case of the last illness, find out what the prospect thinks. Group and individual medical expense insurance coverage's obviously influence what kind of impact these expenses have on a prospect's family. It would be a good idea to ask to see your prospect's group certificate or individual policy to make this determination.

Burial costs can also vary dramatically. While these decisions are a matter of personal preference, it is a subject which should be touched upon in computing the final expense fund, it is generally acknowledged that one of life insurance's primary purposes is to protect against the immediate financial losses that result from death. You'll be performing a needed and valuable service by helping your clients provide for this basic and compelling need with the products you sell.

MISCELLANEOUS DEBTS

While we are alive and in good health, we tend to borrow money freely because we're comfortable that we can repay these debts with our future earnings. However, death stops future earnings without eliminating debt. Examples of short term debt include credit card bills, auto loans, department store bills, and other loans which are to be

paid off over a relatively short term. These debts should be viewed as expenses which need to be paid in full immediately upon death and money should be allocated to pay them. Once again, the only logical way to obtain this money is through the proceeds of a life insurance policy.

BLACKOUT PERIOD

Generally, a surviving spouse is eligible for Social Security benefits until the youngest child reaches age 16. Then, benefits stop until the spouse reaches retirement age. This no-benefit period for the spouses is referred to as the "blackout period." The blackout period represents a time when life insurance proceeds can be used to provide the surviving spouse with needed income.

Children will receive a survivor benefit until age 18, or 19 if the child is still in high school. At this time, the surviving spouse is not eligible for Social Security again until reaching retirement age, which can't be before 60. Life insurance coordinated with Social Security benefits can assure a lifetime income for surviving spouses which begins when the dependency period ends and continues until death.

Many spouses who plan to return to work when the dependency period ends still need additional funds to supplement their earnings. Since these needs will vary from family to family, it's best to ask your prospect how much additional income he or she feels the surviving spouse would need after the children are grown. When income gaps emerge, life insurance is the deal solution to satisfy this need.

MORTGAGE INSURANCE OR RENT CONTINUATION INSURANCE

Funds to pay off a mortgage or to continue regular rent payments represents another life insurance need. Interestingly enough, while virtually all homeowners insure their house against fire, the risk of the homeowner dying before the mortgage is repaid is a considerably greater risk. It's a tragedy when survivors are forced to move because of insufficient insurance planning. With mortgage payments canceled, or where rent payments are provided, survivors can continue to live in familiar surroundings while maintaining their accustomed lifestyle.

HOME PROTECTION

Funds to pay off a mortgage or make regular rent payments is an insurance need that cuts across all life style groups, married with or without children, singles, even empty nesters. In fact, if you asked most of your prospects to name their most valuable asset, most would tell you their home! Owning a home is the fulfillment of the American Dream, but fulfillment of that dream doesn't come cheap.

Mortgage payments can account for as much as 25 to 30 percent of a family's gross income. It is without question the most costly fixed expense in most American households. Yet most homeowners fail to protect their home with life insurance, even

though the risk of a homeowner dying before the mortgage is paid is much greater than the risk of fire, theft, or any other peril.

Even more interesting is the fact that for most families, the true homeowner is not the family but the bank. Although it's the family who lives in the house, if mortgage payments are NOT MET, the real homeowner shows up to claim ownership. Today, homes can be purchased with as little as 10 to 20% down, with the remaining percentage spread over 30 years. However, without adequate life insurance coverage to pay the mortgage, the death of a family breadwinner can mean the end of life as the family knows it.

When discussing financial security, one of the most compelling needs in all lifestyle groups is assuring that the family remains at home if a breadwinner dies. The need is obvious to life insurance professionals, and in most cases it's equally clear to prospects.

The number of prospects for home protection is growing every day. Just look around the area where you live and work, and you'll probably see new homes sprouting up like dandelions. Areas which five to ten years ago were being farmed are now housing developments where thousands of families live. The market for life insurance to protect these homes is virtually endless; the only limitation is your ability to locate these prospects.

One excellent source of prospects for mortgage insurance is the county courthouse. Mortgages are a matter of public record and the court clerk can lead you to a list of both old and new mortgages. These lists will provide you with valuable bits of information, including the name of the borrower, mortgage amount, interest rate on the mortgage, length of the mortgage, and when it was originated. This information allows you to get a snapshot of prospects before you actually talk to them, giving you an opportunity to develop a strategy in advance.

Another source of prospects can be gained through establishing a working relationship with a real estate agent. Through the Multiple Listing Service (MILS), real estate agents know who is selling a home and can find out in many cases who is buying a home. The key to any business relationship with real estate agents is to make sure the relationship benefits both parties.

If you know people who are looking to buy or sell a house, you need to provide these leads to the real estate agent you work with. In exchange for that information, you can expect your contact to provide you with the names of people who have recently purchased homes.

Another valuable source of prospects is the old standby - personal observation. By driving though developments and making note of homes that have a "sold" sign on the front lawn, you are targeting future prospects. If people are moving in or have just moved in, you can stop by and briefly introduce yourself.

Welcome them to the neighborhood, give them a business card and offer to stop by after they have settled in to show them the services you provide. Moving into a new

home is a happy time, and as long as you are brief with your initial cold call, you will probably be received cordially.

Remember, although moving into a new home is a happy occasion, it can be stressful too, so make your visit brief and show warmth and understanding for what the family is going through. If you've ever moved into a new home, those feelings will come naturally.

When selling life insurance to protect the home, it's important that you paint a clear picture of what will happen without adequate funds if one of the spouses dies prematurely. If you're working with a single-wage-earner family, then the death of the breadwinner results in a total immediate income loss. And without adequate funds, the family may lose the home they worked so hard to acquire. In addition to the loss of a spouse and parent, the family has the additional burden of having to relocate. The timing couldn't be worse.

Although the sale of the house (assuming it has appreciated in value) can provide additional funds for the family, a forced sale may mean the survivors sell at a bargain basement price since they do not have the luxury of patiently waiting for the best offer. Although survivors could elect to remain in the house and try to make mortgage payments, without the income of the key breadwinner, this plan may not last very long.

Even if you are working with a dual-income family, the scenario remains largely unchanged. This is because most dual-income families support mortgage payments that depend on both incomes. The early death of one partner can leave the remaining partner with the difficult task of paying a mortgage designed for two incomes with only one income. On the bright side, a dual-income family provides you the opportunity to write two policies since each partner needs protection in the event of the death of the other.

A life insurance policy to protect the home ensures that the family can remain in its home as was originally planned. In addition, paying off the mortgage in advance eliminates the payment of future interest charges. If you've totaled up the interest charges on a mortgage, you know just how much these charges can amount to.

For example, on a 30-year mortgage with a $100,000 loan amount, the total interest paid over that 30 years, with an 8% interest rate, is about $164,000. If the policyowner dies 15 years into the montage and the mortgage is paid in full, the family will save over $55,000 in interest payments. The family has also eliminated a large fixed expense which will help them adjust to a reduced income.

When designing the proper program to protect the home, there are three options as follow:

Permanent Insurance

While the mortgage balance is decreasing, the face amount of permanent insurance remains level, which means that as the years go by, the death benefit will exceed the

mortgage balance by a larger and larger amount. This excess money at the time of death can be used to offset other expenses.

Decreasing Term Insurance

Many companies offer a decreasing term policy in which the face amount is tied to the mortgage balance. This is important since the mortgage balance does not decrease in a straight line like most reducing term policies. In fact, the majority of payments in the first 10 to 15 years are used to pay the interest costs with very little being used to pay off the mortgage principal.

For example, let's look at a 30 year mortgage with an 8% interest rate, after payments have been made for 10 years, less than 13% of the mortgage principal has been paid. After 15 years, less than 24% of the mortgage principal is paid even though 50% of the mortgage payments have been made.

Using this approach, the death benefit is less than the mortgage balance throughout the 30 year loan period. A reducing term mortgage policy, on the other hand, has a death benefit which always mirrors the mortgage balance. This ensures that the family can pay off the mortgage in full and own the home outright regardless of when death occurs.

Permanent and Reducing Term Combination.

If a reducing term mortgage policy is not available, then a combination permanent and reducing term policy can be designed to provide adequate coverage at a cost slightly lower than using only a permanent policy. This approach would produce a gradual reduction in the death benefit each year while providing benefits that would always equal or exceed the mortgage balance.

When you are selling universal life with it's flexible premium payments, you have an opportunity to present a unique program to your prospects. You can establish a premium level which, at conservative interest assumptions, would generate sufficient cash accumulation to protect the homeowner against premature death while also providing a fund to pay off the mortgage in advance if the homeowner lives.

Thus, after 20 years of a 30-year mortgage, the policyowner could withdraw cash and pay off the mortgage balance, saving thousands of dollars of interest charges. The program can also be designed to pay off the mortgage even sooner by making larger premium payments and directing the extra money into the cash accumulation fund. This approach has marketing pizzazz since everyone wins - the bonus of paying the mortgage off early if the policyowner lives. It's a package that's hard to beat.

FUNDS FOR EDUCATION

The value of training and education beyond high school is readily acknowledged by virtually everyone. And as a greater number of young adults go to college or seek advanced vocational training, increased needs for educational funds have become more and more widespread.

The combination of more people needing funds for advanced training or education, along with rapidly escalating costs, simply means more people will need larger and larger amounts of money to pay these costs. In assisting parents to prepare for these expenses, you should figure at least $5,000 per year for a public college; anything less than that estimate is unrealistic. Costs for a private college are even greater, with fees going as high as $18,000 a year and beyond.

BUILDING AN EDUCATION FUND

With the cost of a college education rising even faster than the overall rate of inflation, most parents with young children are concerned about whether they will be able to afford to put their children through collage. Parents want the best for their children, and they recognize that a college education is a necessity in today's increasingly competitive society. A permanent life insurance policy is a way to guarantee that money for college is available. The tax-deferred growth inherent in whole life, universal life, or variable life policies assures that the cash values grow on a tax-sheltered basis.

LIFE INSURANCE FOR COLLEGE STUDENTS

Depending upon the state, children are required by law to go to school through the ages of 14 to 16. After that, the law does not require that they attend school; however, a significant number of young men and women recognize the advantages of continuing their education through college, graduate school, and beyond. These students choose to go to school and, in many cases, pay their own way. They have made the transition from child to adult by facing their own financial responsibilities.

Ownership of a life insurance policy is yet another step toward financial responsibility. Although many students don't have a lot of extra money, making clients of college students is a logical first step toward building a clientele you can grow with in the future.

There are a number of good reasons why college students should buy life insurance. First, college is a time when young men and women are making the transition from students to professional business people. College students are learning and recognizing the importance of financial responsibility and independence, and life insurance is the perfect vehicle for accomplishing this objective.

The cash accumulation in permanent life insurance policies not only helps students begin a savings program, it also demonstrates personal responsibility for final expenses in the event of a premature death. Next, by purchasing life insurance, the student locks in a lower premium and guarantees future insurability - a risk that still faces more than just a few young adults.

When looking for life insurance prospects among college students, however, it's important to narrow the focus. The best prospects are generally college juniors, seniors, or graduate students. Since juniors and seniors are in the second half of their college tenure, they're beginning to make post-graduation plans. As such, they're likely to be more receptive to your presentation. Graduate students have already completed undergraduate work and are older and more mature. What's more, many are married, enrolled in professional school, and have a well established need for insurance products.

The advantages life insurance can offer college students are obvious:

- Tax-deferred cash accumulation can help students;
- Begin a savings program which can be used to pay off school loans;
- Provide a down payment on a first home.
- Furnish capital or collateral to start a business.

However, while permanent insurance has these outstanding features, the initial cost is higher than term insurance and may be out of reach for a number of your college age prospects. While term insurance does not have the savings element, it does offer many advantages to the college student who does not have ample discretionary income.

Purchasing term insurance allows prospects to obtain a substantial amount of protection today at an extremely low cost. In addition, the convertibility provision allows clients to switch to permanent insurance at a later date without evidence of insurability. Therefore, while the savings aspect of the program is delayed, the purchase of term insurance guarantees that a permanent insurance program can be established at a later date.

Some agents shy away from college students because they feel students would have difficulty maintaining premium payments because they're short on funds. While it's true that most college students don't have as much money as a 40 year old business-person, in many cases they still have enough money to begin a life insurance program.

Students who work part-time during the school year and full-time in the summer often have sufficient funds and are interested in beginning a life insurance program. In addition, prospecting for college students is not a difficult chore. All schools have a student directory which lists the name, address and phone number of everyone enrolled. Further, direct mail is a good approach with students since studies have shown that college people have an extremely high response rate to mailing programs.

Referrals also work extremely well in this market. College students value the opinion of their colleagues, so don't be shy about using referrals from other students who have done business with you. After you have made a sale, ask whom the student knows who might be interested in beginning a plan of financial independence.

Remember, college students are struggling to make good decisions, and there is comfort in numbers. If their trusted friend Joe Davis liked the program, it must be okay. Once you begin establishing yourself on a college campus, you will soon see the

domino effect in action with more and more students wanting to do business with you because their colleagues have trusted your judgment.

PROFESSIONAL ADVANTAGES

In addition to providing important life insurance benefits for college students, this market offers two significant advantages for the insurance professional.

First, the college market offers excellent opportunities for daytime activity. College students routinely have breaks between their classes or a morning or afternoon free which means they're free for interviews. And since most (if not all) classes are offered on campus, you can conduct multiple interviews in a day with little or no travel.

Second, while college students do not have substantial sums of money today, their incomes will increase dramatically as they enter the work force and for the first time draw attractive salaries. By establishing yourself as their financial advisor, you are well positioned to grow with them as their financial and insurance needs expand.

FUNDS FOR RETIREMENT

No discussion of life insurance needs would be complete without mentioning retirement. Clearly, this represents an important need for life insurance for a surviving spouse as well as for someone contemplating retirement. Millions of cash value life insurance policies that were purchased to protect the family during the breadwinner's working years have been ultimately used to supplement company retirement plans and Social Security benefits at retirement.

The fact is that most people will not save for retirement unless they have a definite plan for savings. Cash value life insurance provides a means of systematically accumulating funds for retirement. For many, this accumulated fund will allow a retired person to enjoy the basic necessities of life without being dependent on others for support. For the more fortunate, this accumulated fund promises travel and the ability to enjoy retirement in ways that would otherwise simply not be possible.

LIFE INSURANCE FOR CHILDREN

Another basic life insurance need that should not be overlooked is life insurance written on the life of a child. These policies are generally referred to as juvenile insurance, they are purchased to provide youngsters with a head start in financial planning, or as a gift of lasting value. No one suffers financially when a child dies; therefore, in the strictest sense, juvenile insurance is rarely "needed."

In fact, those who apply for and own juvenile insurance do so with the anticipation and hope that they will never collect its benefits. And, although juvenile insurance does provide a death benefit, it is rarely, if ever, purchased because a family fears the premature death of a child.

The advantages and benefits of juvenile insurance are not enjoyed until many years later when the juvenile grows up and acquires all of the insurance needs and financial responsibilities that accompany adulthood. Many of the advantages of starting an insurance program at an early age are important considerations when discussing juvenile insurance, especially the extremely low premium rates which mean substantially lower costs through-out the life of the policy.

WHY A PARENT SHOULD CONSIDER INSURANCE ON A CHILD

Basically, there are four reasons that a parent would want to buy life insurance on a child. They are;

- Building a future nest egg.
- Building an education fund.
- Guaranteeing low premiums for life.
- Guaranteeing insurability.

BUILDING A FUTURE NEST EGG

There is no better way to build a nest egg for a child than through the tax-advantaged savings available in a permanent life insurance policy. By purchasing a life insurance policy at an early age, the cash accumulation can be substantial by the time the child becomes an adult. And when the child becomes an adult, money is there when it's needed.. for a down payment on a home, to begin a new business, or begin a marriage on solid financial ground.

Because with life insurance, the policy's cash value acts as a reserve fund that can be used to meet future needs. This is why there is no better gift a parent or grandparent can give a child than the opportunity to begin life with a financial head start.

BUILDING AN EDUCATION FUND

With the cost of a college education rising even faster than the overall rate of inflation, most parents with young children are concerned about whether they will be able to afford to put their children through college. Parents want the best for their children, and they recognize that a college education is essentially a necessity in today's increasingly competitive society. A permanent life insurance policy is a way to guarantee that money for college is available. The tax deferred growth inherent in whole life, universal life, or variable life policies assures that the cash values grow on a tax-sheltered basis.

GUARANTEED LOW PREMIUMS FOR LIFE

Once a child becomes an adult and has accepted his or her own financial responsibilities, the need for life insurance becomes crystal clear and the values inherent in juvenile policies even clearer. When a permanent life insurance policy is purchased on a child's life, the premiums are guaranteed because they are based on

the insured's age at the time the policy is issued. The younger the insured, the lower the premium.

For example, the premium on a 5 year old child can be one half that of a 25 year old adult. By purchasing insurance for youngsters, parents and grandparents can be assured that when the child grows up and assumes responsibility for the premium payments, the cost will be substantially lower than comparable insurance coverage purchased at that time. And though the child won't appreciate the benefits when it's purchased, the grown up undoubtedly will.

GUARANTEED INSURABILITY

While money pays for life insurance coverage, it's the insured's good health which allows it to be purchased. If the insured is in poor health, all the money in the world would not be enough to purchase life insurance coverage. And since no one can predict the future, no one knows for sure which healthy child will become a healthy adult. A 15 year old boy diagnosed as a diabetic may not be able to purchase life insurance protection, but if a policy was taken out when that same child was five, there is guaranteed insurance protection for life.

With this need in mind, the addition of a future purchase option makes tremendous sense when selling juvenile insurance. Not only is the current level of insurance protection assured, but the ability to increase insurance coverage, without regard to future insurability, is also guaranteed.

By now, you should have noticed that we did not go over the need for money to meet final expenses in the event of a child's death. While this need does exist, it is a topic most prospects simply will not discuss openly. While adults recognize that they

will eventually die and that proper financial planning for that event is important, the possibility of a child's death is a topic most would not or should not talk about.

The death of a child is remote, but if it does occur, there is a need for money to meet final expenses. Rather than selling a separate policy to address this unlikely event, however, a more common approach is to add a children's term supplement rider to the parent's policy. This is a very inexpensive optional benefit that can usually be added routinely without a great deal of discussion.

INSURANCE FOR THE HOMEMAKER

One of the most neglected needs for life insurance in a family is related to the critical role of the homemaker. It's a fact that the career of running a home and raising a family has an economic value that is every bit as important to that family's welfare as a career outside the home. And it's likely that you'll find career homemakers represented among your clients.

LIFE INSURANCE FOR HANDICAPPED CHILDREN

While most children are healthy, you should be sensitive to the special needs of families with handicapped children. Nothing causes greater concern to parents than the possibility of a handicapped child being left without an adequate means for support. And nothing is better suited to protect against this unfortunate possibility than life insurance on the parents' lives. Without this protection, the child may be left without any means of support if his or her parents die.

LIFE INSURANCE FOR THE DEPENDENT PARENT

An aging, dependent parent represents another life insurance need. You'll find that sons or daughters who are partially or totally responsible for the support of a parent are often responsive to insuring against the loss of income that their premature death would produce.

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WORKING SINGLES

People are waiting longer to get married than they did in previous generations; consequently, you have a larger than ever market of young men and women who are not married and are earning a good income. Another factor that affects this market segment is the rising divorce rate which divides a married couple into two single wage-earners. What's more, men and women in this market segment are equally concerned about their careers, financial security, and the role life insurance may play in these plans.

THE INSURANCE NEEDS OF SINGLES

At first glance, single people do not appear to have the immediate need for life insurance that is often more apparent in other general categories. The young single is usually healthy, probably working in a job that provides some group life insurance benefits, and perhaps lives with a roommate or at home with parents, brothers and sisters. The single prospect may simply see no need for new life insurance at this time.

But looks can be deceiving. This is where you can open new doors of financial independence and satisfaction for singles by assisting them in recognizing needs and arriving at the amount of insurance required to satisfy those needs. In essence, by taking a needs approach, you are identifying what makes each prospect's needs totally unlike another person's in seemingly similar circumstances.

It is hardly possible for a person to die today and not create a financial need of some measure. While for some this need may only be funeral expenses, today's inflationary economy requires complete and periodic examination of even that basic requirement. And even if this need has been met, other needs may emerge during your discussions or during your sales presentation. For example, you might ask these questions;

- Does the prospect plan to marry in the near future?

- Has the prospect undertaken any immediate indebtedness, for instance, a new car or boat?
- Are there college costs yet unpaid, costs that could fall on some else's shoulders should the prospect die prematurely?

You should also not overlook additional factors such as unusual financial responsibilities over and above normal living requirements. For example, perhaps your prospect is the sole support of elderly or disabled parents. In some cases, even younger brothers and sisters could be dependent upon this single breadwinner. The main point is this: Don't allow yourself to be frightened away from what, at first glance, appears to be a person with no apparent need for life insurance.

There are a number of additional reasons young singles should consider life insurance. As you know, health factors contribute heavily to a person's ability to purchase new life insurance. Though most young single persons are in good health, that condition could change overnight. However, by beginning a program now, the prospect's insurability can be protected. If a future purchase option is purchased, additional amounts of life insurance will be available regardless of the prospect's health at that time.

Further, premium rates increase each year as the prospect grows older. Stated another way, the prospect or client will never be able to buy life insurance in the future at a premium rate as low as the one at his or her present age. When you are discussing needs with your prospects, you often find that needs turn into desires. Because of this, you should never underestimate the desire for personal satisfaction as a reason for buying.

Today's economic conditions impress on young adults more and more the desire to establish financial responsibility early in their careers. And it has been almost unanimous among financial advisors that the establishment of a sound life insurance program, guaranteeing low premium rates and future insurability in many instances, should take a high priority in a young person's financial planning.

The insurance needs of working singles can be grouped into four categories. These are as follows:

FUTURE INSURANCE NEEDS

It's important that you paint an optimistic picture of the future for single prospects, including increased income, marriage, children, and home ownership. In addition, it's important to remind singles that there is no better time to establish the foundation of a financial plan than RIGHT NOW!

Establishing a life insurance program today offers some distinct advantages;

First, by purchasing permanent insurance at a younger age, the client locks in a guaranteed premium which would be higher if he or she waited until marriage. Second, by starting a permanent insurance plan today, the client is getting a head start on building cash values. Third, by including a future purchase option with the policy,

the client is assured that he or she will be able to purchase insurance in the future regardless of health.

FAMILY OBLIGATIONS

Just because a person isn't married doesn't mean that he or she has no outside obligations. Singles may have elderly parents or an ill brother or sister they're responsible for. Singles may be supporting a family member and wish to make sure that support continues in the event of death. When interviewing a single prospect, be sure to ask whether they are providing financial support for anyone other than themselves. If the answer is yes, then life insurance is the perfect vehicle for guaranteeing that money is available when it's needed.

SAVINGS

Life insurance offers an excellent way for a young person to save money while taking care of other financial responsibilities. And as we mentioned earlier, universal life, variable life, or variable universal life, as well as whole life, allow an individual to save money without paying current income tax on the growth.

Most young single people have limited, if any, experience in financial planning. By doing a thorough job, you can establish the basis for a long term business relationship that will stretch many years into the future. Then, when your clients' income and responsibilities increase, you will be there to cover increasing financial needs. As your clients grow, you can grow with them.

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MARRIED OR SINGLE WITH CHILDREN

MARRIED WITHOUT A FAMILY

Not that many years ago, the typical American family consisted of a man and woman who married when they graduated from high school or college. Once married, the typical couple had two or more children, usually after a year or two of marriage. Mom stayed home to raise the children, and Dad supported them.

Today, there is no such thing as the typical family. People are waiting longer to get married, after they are married, they may wait five years or longer before raising a family. Some couples choose not to have children at all. The result is this change in demographics is that there are more married couples with dual incomes and no children. Some may be right out of high school but a fair number are older, more mature, and more interested in long term financial security. The insurance needs of these young couples can be classified as follows:

FINAL EXPENSES

As we have discussed earlier, death creates debt. Funeral and other long and short term debts. When dealing with young couples, you have twice as many opportunities to make a sale since both spouses need protection.

PROTECTING THE DUAL INCOME LIFESTYLE

In most married households without children, both spouses work. While it would be nice if the couple were living on one income and banking the other, the reality is that most couples have created a lifestyle that is firmly established on both incomes. Two income families present twice as many opportunities since it is conceivable that either

income could be lost through premature death. The death of either spouse would result in a financial loss to the survivor.

As an insurance professional, you must determine:

How much income would be lost and,

What the consequences of this loss would be.

By making these determinations, you can help prospects arrive at their own conclusions as to where the heavier burden rests. If the wife, for example, has a much smaller income, one that would not sustain her should her husband die, you must determine through discussion an insurable priority.

It is important not to discriminate when examining the husband's and wife's income. they may be equal or the wife may earn more. Whichever is the case, you can be sure the couple is probably equally dependent.

You should also discuss other factors such as, how long should lost income be replaced? Should it be replaced in its entirety? You are creating an awareness as to potential problem areas brought on by death, and together you and your prospects match their needs with your products.

A SAVING/SHELTER PLAN

A two-income family without children where both the husband and wife are working have probably felt the brunt of the IRS at tax time since their combined income propels them into a higher tax bracket. These couples are often looking for ways to shelter some of their savings. A permanent life insurance policy, universal life, variable life or whole life, is often a good solution to this problem.

Additionally, universal life and variable universal life offer the added advantage of allowing policyowners to place a sizable amount of additional money in the policy which could be added to a cash accumulation fund. these funds would enjoy immediate tax-deferred growth.

INSURANCE IN THE FUTURE

If your prospects are planning to raise a family, now is the time for them to establish a life insurance program. There is no guarantee that your prospects health will remain as it is, and there is always the risk that when they need the protection, all the money in the world wont' be able to buy it if they aren't healthy. That is why it is a good idea to consider including a future purchase option to ensure that the policyowner can

increase coverage when needed. In addition, by purchasing coverage today, your prospect is buying insurance at lowest possible premium.

It should be clear by now that when selling to married couples with no children your interview must include both spouses. In most cases, financial decisions are made jointly and since both are usually working full-time, you have an opportunity to sell insurance on both the husband and wife. Your interview can be conducted either in the prospect's home or in your office. It is usually easier to arrange an interview in the prospects home, but you must remember a few ground rules:

The interview should take place in a setting where you can comfortably lay out your sales material. Although an interview in the living room allows your prospects to get relaxed in their favorite char or couch, it may not offer the business environment you need. Also, make sure there are no distractions. If the television has been left on, politely ask your prospect to turn it off.

Although the great majority of your interviews will probably be in the prospects' home, the best place to hold the sales interview is still in your office. In an office interview, you avoid potential distractions because you control the atmosphere plus you have access to any and all resources available in your office, which will help you make the finest presentation possible. It's cumbersome to carry audiovisual material to a client's house and even more difficult to try and set up the equipment so that your presentation looks professional.

By holding the interview in your office or in your conference room, you can prepare everything in advance an take advantage of any of the resources available there. You also set yourself apart from other insurance agents who are more anxious to meet with prospects in their homes. When attempting to set an interview in your office, you may meet some initial resistance.

The prospects will want to know why you can't come to them. However, you should point out that as a professional, many of the tools and materials you need are in the office. Be polite but firm in requesting an office interview and be sure to present yourself as a professional who needs to work out of an office to do the best possible job. Not all prospects will respond favorably, but those who do will accept you as a professional and be extremely receptive at the interview.

The bottom line is that when you meet with married prospects, do not automatically assume that they plan to have children. You should also not assume that if they DO plan to have children, the wife will (or will not) continue working full time. Always inquire how individual couples see their future and design a plan which fits those needs, because this is your opportunity to demonstrate the value of your personalized service.

CHILDREN ENTER THE PICTURE

Most of us think of a typical family as a husband, a wife, and two children. However, there are a large number of children being raised by single parents. That's why agents working with single parents or parents with children should remember that "typical" is not

so typical anymore. You will find that other than having children, these prospects may have little else in common.

With single parents or families where only one spouse is earning an income, the need for life insurance is obvious. If the sole breadwinner dies, the family's lifestyle can be destroyed without proper planning.

Families with two incomes may feel if one spouse dies, the remaining partner can carry the load. In most cases, however, some gentle probing will reveal the fact that the family's lifestyle is based on both incomes. If one stops, the financial strain on the remaining spouse would be tremendous. Don't overlook the spouse who is not employed outside the home as a prospect for life insurance either.

As mentioned earlier, although this spouse is not producing income, there are additional expenses, such as child care costs, housekeeping, etc., which represent yet another need for cash.

When prospecting in the family market, there are numerous sources available. The first one we already mentioned, the city directory. All you need to take advantage of this tool is locate addresses with children listed a residents. You will also be able to determine if it's a single parent household. Birth listings in the newspaper are yet another source of prospects. If it's the family's first child, there is no better time to underscore the importance of life insurance in the new parents' overall financial plan.

We will go over the four major categories of life insurance needs for families in the following pages, they are: CASH NEEDS, INCOME NEEDS, HOUSING FUNDS, and EDUCATION NEEDS.

CASH NEEDS

These needs include the cost of a funeral and short-term debts, such as credit card charges, installment loans, and so forth.

INCOME NEEDS

When a breadwinner dies, the main source of income dies too. Since most families base their financial plans on the assumption that earned income will continue to roll in on a steady basis, the sudden death of the wage-earner puts an immediate end to all future plans.

Also, there are fixed expenses such as food, clothing, and shelter, which must be paid. Additional expenses such as transportation, medical, and incidental expenses for the children must also be paid. Life insurance is the only way to assure money is there when it's needed to pay these expenses.

EDUCATION

It is probably not an overstatement to say that families want to provide the best for their children. Nor is it unlikely that for most families this means a college education. Families recognize just how expensive this can be and, when possible, many establish a savings account to assure that the money is available when their children reach college age.

A parent's death, however, can short-circuit these programs, jeopardizing education opportunities for the children. If a college education is a high priority to your prospects, it's your job to make sure that the life insurance program you develop provides adequate funds to meet this need.

When reviewing a family's financial needs in the event of premature death, expenses owed should be offset by assets owned. In discussing these assets, be sure to point out the benefits available from Social Security. Most families do not realize that substantial benefits may be available from Social Security in the event of a breadwinner's death.

The amount varies according to the age of the individual at the time of the death, the earnings of the deceased prior to death, and the number and ages of children. Depending upon individual circumstances, the family can receive as much as $2,000 a month or more. Or they may receive nothing.

You may not know the exact amount of Social Security income the surviving family will receive until benefits are applied for, but you can approximate the benefit and build it into your recommendation. Your knowledge of Social Security benefits will demonstrate that you are not trying to build a larger than necessary life insurance need, but rather that you are illustrating a realistic picture of life insurance needs.

THE EMPTY NEST

Tom and Mary are in their fifties. Their children are 25 and 28, and both are living on their own. The oldest child is married and has one child, and Tom and Mary are the doting grandparents. With their children out of the house, it would seem that Tom and Mary would have little, if any, need for life insurance. A closer look reveals that people like Tom and Mary need life insurance protection just as much as the other groups we have reviewed.

FINAL EXPENSES

The first and most obvious need for life insurance is to cover final expenses. Funeral costs and short-term debts which linger on, such as the cost of a college education, and in some cases, graduate school. Your prospects may have taken a loan to finance the cost of their children's education and may still be paying that loan off long after the children are gone. This obligation will not be forgiven if one of the parents dies. The remaining spouse will have to assume responsibility for the debt and it may be larger than either spouse could handle alone. A life insurance policy can guarantee that the loan will be repaid in the event of premature death.

INCOME

In addition, even though there are no dependent children at home, there is still a need for income if a primary breadwinner dies. Though many surviving spouses are earning an income, in many cases that income is not enough to cover fixed expenses and retirement. And since the surviving spouse is not eligible for Social Security benefits for the period from the youngest child's 16th birthday to the spouse's age 60, the income need can be quite urgent.

RETIREMENT

For most empty nesters, retirement planning is an important priority. Now that the children are raised, this market group focuses on its own financial needs. Retirement planning at this stage of life has a high priority and permanent life insurance, with it's tax deferred cash accumulations, offers the ideal vehicle for retirement funding. Also, life insurance guarantees that the retirement income will be there even if one of the partners dies prematurely without completing the planned savings program. No other savings plan can guarantee retirement benefits will be available when they're needed if death cuts short the expected "savings period."

MORTGAGE

A couple in their fifties has very likely lived in the same house for a longer time than most. You may assume that a large portion of the mortgage has been paid off; however, this could be misleading since payments made in the early years are primarily being used to pay interest, with very little money going to retire the principal. Consider the $100,000 mortgage at 8% with a 30 year term. Over $27,000 in interest can be saved if this loan is paid off at the 20 year mark. This is a large financial obligation that should be protected by life insurance.

When working with empty nesters, you can safely assume that they have purchased some life insurance during their lifetimes. However, don't assume that they are adequately protected now. You still need to review their existing insurance policies and determine if the in-force policies satisfy their current needs. Also check to see if they have any permanent life insurance policies that they have stopped paying premiums on. You may find they have whole life insurance or extended term which would pay a death benefit. Since many of these prospects may have inadequate protection, a professional review of their entire life insurance program makes good business sense.

Prospects who have term insurance might find that now is the perfect time to convert those policies to a permanent protection plan. As insureds near retirement age, term rates begin to skyrocket, often to the point that it's simply too expensive to continue coverage. By converting to permanent insurance, the premium is level and it guarantees that insureds are owners, not renters of their insurance coverage.

In addition, policyowners who discontinue term coverage are left with nothing since term insurance provides no cash accumulation. A conversion to permanent insurance allows policyowners to accumulate cash value on a tax-deferred basis. Since prospects at this stage of their careers are at or near peak earning capacity and since

they don't have dependent children, or the expenses that accompany dependency, they generally will have more disposable income. The initial higher premium for permanent insurance will be offset somewhat by the tax-deferred cash accumulation feature.

Even if prospects have adequate life insurance to protect themselves, there are still other sales opportunities. While the children may not be living at home, one or more of them may not be financially independent yet. A recently married child may be struggling financially. In a case like this, you may want to discuss the possibility of providing children with a gift of life insurance. Since the parents have adequate coverage, they obviously recognize the importance of life insurance in overall planning.

Point out that they can initially pay the premiums on a life insurance policy for a son or daughter and transfer the premium responsibilities to the children when they are financially stable.

If your prospects are grandparents, you can also discuss what a wonderful gift life insurance would be for the grandchildren. For a low premium based on a young child's age, grandparents can establish a life insurance program which could help to finance a grandchild's college education. The key point to remember in working with empty nesters is that step one is to thoroughly review existing life insurance to determine how "well" it will protect their current needs. This initial and very important step will establish you as an insurance professional, and since most of these prospects are at their peak earning capacity, it can lead to large premium sales as well.

TIME TO RETIRE

As individuals near retirement, their concerns change from dying too soon to living too long. They want to be sure that there is adequate money to allow them to live comfortably until they die, and if they should die soon after retirement, they want to

make sure that their spouses will have a comfortable income throughout their lives. Life insurance can play a key role in assuring that these goals are met.

MAXIMIZING YOUR PROSPECTS PENSION

One way to effectively plan for retirement is through a creative marketing approach called "Pension Maximization." When individuals retiree after many years with a company, they will be able to choose how they take their pension retirement income.

They generally have two choices as follows:

1. The retiree can choose the maximum retirement benefit amount, but if he or she dies, the spouse receives no benefits thereafter; or
2. The retiree can choose a reduced retirement benefit amount so that the spouse would continue to receive a benefit if the retiree dies.

In almost every case, the retiree chooses the reduced benefit amount to guarantee the spouse's financial security, even though this option could reduce the benefit to 70 or 80% of the maximum amount. However, through a program called Pension Maximization, the retiree can choose the maximum option and still guarantee an income for this or her spouse in the event of the retiree's death.

The plan works like this. The retiree selects the maximum benefit and purchases a life insurance policy to provide income for the spouse at the retiree's death. This plan offers the retiree several advantages. In many cases, the monthly premium for the life insurance is less than the amount of the pension income reduction. Thus, the retiree receives a higher net income.

Depending upon the cash accumulation growth, the premiums may end in 10 to 20 years, providing for a paid-up policy. Thus, if the retiree lives a long life, the pension benefit will increase and the premium is no longer owed. If the spouse dies first, the retiree can cash in the policy. In addition, the retiree will still receive the maximum retirement benefit. Remember, if the retiree chooses the reduced retirement benefit and the spouse dies first, the retiree still receives the benefit.

If the retiree dies first, the proceeds from the life insurance policy are used to provide the surviving spouse with a guaranteed income for life.

If both the retiree and spouse continue to live, part of the policy cash values can be used to supplement their income tax free.

Regardless of whether the retiree dies early, the spouse dies first, or they both live a long life, a Pension Maximization program can provide an equal and in many cases, larger retirement benefit than would have been available by choosing a reduced retirement benefit.

Whether you are approaching a family with a newborn child, a 65 year old retiree, or anyone in between, there is a universal need for life insurance. Your job is to identify these needs and develop the best life insurance program for each situation that you can.

6

THE NEEDS OF THE BUSINESS

UNDERSTANDING TYPES OF BUSINESSES

Your primary source of prospects at the start of your insurance career will be individuals and families. However, you may find that referrals coupled with the personal contacts you have with business people will inevitably lead you to business prospects.

It is important that you have a basic understanding of key business life insurance needs so that you recognize potential sales opportunities when they arise. We will begin discussion of this type of market by reviewing the three different types of business organizations as follows:

SOLE PROPRIETORSHIPS

Sole proprietorships are the simplest and most abundant type of business organization. Approximately four out of every five businesses in the United States are operated as sole proprietorships. As its name implies, a sole proprietorship is a business which is owned by one person.

The owner or proprietor usually manages the business. Depending upon the size of the organization, the business may or may not include additional employees. Since the proprietor is a sole owner, he or she makes all business decisions without interference from outsiders. For tax purposes in the case of a sole proprietorship, there is not distinction between business income and personal income. Income from the business is treated as personal income of the owner and business expenses are deducted from income on the proprietor's individual return.

THE PARTNERSHIP

A partnership is a business operated by two or more people for profit. Usually a written agreement is signed by the partners outlining their respective ownership in the business, although a written agreement is not legally required. In addition, partners may or may not have an equal interest in the business. For tax purposes, income is offset by expenses and the net income for the partnership is calculated. The partnership must file a tax return, but it does not pay any income tax. Based on each partner's share of ownership, the appropriate partnership income is reported on each partner's individual tax return.

THE CORPORATION

A corporation is distinguished from a sole proprietorship and a partnership in a significant way; A corporation is a separate legal and taxable entity. In both a sole proprietorship and a partnership, the owners can be held personally liable for business debts. The stockholders of a corporation, on the other hand, are responsible for corporate debts only to the extent of their investment in the business.

Therefore, if a corporation has three stockholders who each invested $10,000 in the business, each stockholder would be responsible for no more than $10,000 of corporate debt. In addition, stockholders of a corporation are only taxed on the income they realize in the form of salary or dividends. The corporation is a separate taxable entity that files a separate return with the IRS and pays taxes on all net income.

Regardless of the type of business organization, problems arise when the business owner dies. Ideally, business owners draft wills that make provisions for disposition of their business interests. Without proper life insurance, however, a business owner's heirs still may not ultimately realize the full value of the deceased business owner's interest.

THE SOLE PROPRIETOR'S DILEMMA

To illustrate this point, let's look at Mr. Thompson, who is the sole proprietor of a card shop in a suburban mall. The store is open 75 hours a week. Thompson is in the store 50 to 60 hours a week. He has two employees, one of whom has worked with him for the past five years. Mr. Thompson has a wife and two children, ages 10 and 12. His wife works in the public library and is not involved in the business. Let's look at what would happen to the business if Mr. Thompson died.

Fortunately, Mr. Thompson has drawn up a will leaving the business to his wife. However, she knows nothing about cards or the other gift items the store sells, and would not be able to run the store in her husband's absence. What about the employee who has worked five years for Mr. Thompson? Couldn't he run the store if Thompson died? The employee would be capable of managing the store, but he knows little about the other aspects of the business since Mr. Thompson handled all purchasing and financial matters himself. In short, although the employee has been

with the store for five years, he doesn't have the experience he needs to replenish merchandise and make necessary financial decisions.

The store has $100,000 worth of merchandise, but after the merchandise is sold neither Mrs. Thompson nor the experienced employee would know how to order new merchandise and sell it at a profit. Even though they could purchase new merchandise, they simply don't have the business acumen Mr. Thompson had about what would sell. As you can see, it wouldn't be long before the business Mr. Thompson left to his wife would begin to depreciate in value, leaving Mrs. Thompson and the children with a steadily shrinking asset.

She could, of course, try to sell the business as a going concern. But potential buyers would soon recognize it as a forced sale, so it's unlikely that she would be able to realize the full market value of the business. We should also point out that if the business owner's will does not explicitly pass the business on to a family member, or if no will was prepared, then the business automatically stops when the business owner dies. In a case like this, the legal representative of the sole proprietor's estate is legally bound to discontinue the business as soon as possible.

Business assets must be converted to cash, either through the sale of the entire business or a liquidation that sells off the assets on a piecemeal basis. In either event, it is virtually certain that the beneficiaries would receive far less than full value for the business interest.

THE SOLUTION TO THE DILEMMA

Life insurance can solve this problem by providing additional funds to make up the difference between the current value of the business and the amount that would be received in a forced sale. Although Mr. Thompson may have left his wife a business worth $200,000 when he was alive, after his death his widow would probably be fortunate to get $100,000 for the business, just fifty cents on the dollar. A life insurance policy for $100,000, when combined with the money realized from selling the assets, would provide Mrs. Thompson and the children with the full value of the business.

THE PROBLEMS WITH PARTNERSHIPS

A partnership also represents some unique problems when one of the partners dies. For example, let's assume that Mr. Thompson from our example was in partnership with Mr. Grove and that each one owned 50% of the business. All business decisions were made jointly and in the ten years they were in business, they were always able to reach amicable agreements on most business matters.

Each worked 50 to 60 hours in the store and both contributed equally to the store's success. If Mr. Thompson died, he could leave his 50% share in the business to his wife through the provisions contained in his will. This means that 50% of any profits from the business would go to Mrs. Thompson. Over the last few years, the business has generated a profit of $40,000 for each partner. Mrs. Thompson could continue to count on her share of the store's profits as long as the business prospers. This may be dandy for Mrs. Thompson, but it's not so equitable for Mr. Grove. Let's see why.

ALTERNATIVES FOR SURVIVING PARTNERS

Since Mrs. Thompson knows nothing about the business, Mr. Grove is now 100% responsible for running the store. Yet he still receives only 50% of the store's profits. What are his choices? First, he can increase the number of hours he works to make up for the loss of his partner. But no matter how many extra hours he works, his share of the profits will only be 50%. The problem facing Mr. Grove is that he is not only working to provide a living for his own family, he's working to support his deceased partner's family as well.

The second option is for Mr. Grove to hire an employee to replace Mr. Thompson. This option has problems too, since a new employee simply wouldn't have the skills or knowledge that Thompson ;had, nor would a new employee be able to contribute as significantly to the business. In addition, salary for the new employee would be an additional expense that would serve to reduce the income that could be drawn from the business. anyway you look at it, the surviving partner is in a "no win" situation.

Even if Mrs. Thompson had participated in the business and was able to step in and immediately contribute, everything still may not be rosy. While Mr. Thompson and Mr. Grove saw eye to eye on most business matters, Mrs. Thompson may have different ideas on how the business should be run. Most partners have spent years developing and refining their skills in owning and operating a successful partnership, and the addition of a new partner, even if it is a member of the deceased partner's family, may not be as easy as it looks.

Another possibility may be that Mrs. Thompson recognizes that she can't contribute to the business and decides to sell her interest. Most likely, she will first approach Mr. Grove and ask him to buy out her interest in the business. Even if they can agree on a fair price for her share, there's still a question of where the money is to come from. Mr. Grove may not have $100,000 to purchase the business. He could go to the bank and borrow the money, but he's going to be paying interest on that loan for years to come.

If he is unable to raise the money or unwilling to pay Mrs. Thompson's asking price, she might attempt to sell her share of the business to someone else. However, Mr. Grove cannot be forced to accept an outside purchaser as a partner. If a satisfactory agreement cannot be worked out, the partnership may have to be liquidated, probably at a forced sale price. It should be clear that the death of a partner can cause many problems which can cause both emotional and financial stress. there is only one sure way to avoid these problems and that is through the execution of a buy-sell agreement.

BUY-SELLS

A buy-sell agreement is a binding contract between business owners which states that the estate will sell the deceased owner's interest and the surviving owner will buy the interest at an agree-upon price. Both the value of the business and the purchase price are stated in the agreement so there are no disputes when an owner dies. An agreement assures:

That the deceased owner's heirs receive full value for the business interest; and...
The surviving owner or owners retain control of the business.

HOW THE BUY-SELL WORKS

To make the agreement work, cash must be available to guarantee that the deceased partner's interest can be purchased by the surviving partner(s) at the agreed-upon price. There's only one way to make this guarantee, and that is with life insurance. When a buy-sell agreement is drafted, life insurance should be purchased on the partners' lives to assure that the money required for purchasing the interest is available when a partner dies. Let's illustrate how this would work for Mr. Thompson and Mr. Grove. Suppose the business was valued at $200,000 and Grove and Thompson were equal partners.

If Mr. Thompson died, Mr. Grove would receive $100,000 from the life insurance policy and would, under the terms of the buy-sell agreement, immediately pay the $100,000 to Mr. Thompson's heirs to purchase the business interest. As a result, Mr. Thompson's heirs receive full value for the business and Mr. Grove becomes sole owner of the business. If a third partner, Mr. Simmons, were involved, and if all partners owned an equal share of the business, and the partnership was again valued at $200,000, the agreement would go like this:

If Mr. Thompson were to die, Mr. Grove and Mr. Simmons would each purchase 50% of his interest in the business from his heirs. Thus, Mr. Simmons and Mr. Grove would be left as equal partners in the business and Mr. Thompson's heirs would receive the full value of $66,666 for his interest, ($33,333 from each of the two remaining partners).

The agreements we have just discussed are known as "cross-purchase plans." They are the most common type of buy-sell agreement in a partnership situation. With a cross-purchase plan, each partner individually purchases and owns life insurance on the other partner(s). This arrangement works well when there are two or three

partners. If there are more than three partners, a cross-purchase plan can be cumbersome due to the large number of policies required.

For example, if there were five partners, each would be required to purchase a life insurance policy on the other four partners for a total of 20 policies. The solution to this problem would be to establish an "entity purchase plan."

In this plan, the partnership purchases life insurance on each partner, rather than each of the partners individually purchasing policies on each other. In the case of five partners, only one policy would be needed for each partner. When a partner dies, the partnership buys the deceased partner's interest from the heirs. Each of the remaining partners would then own 25% of the partnership.

Your prospects may consider other options for solving the various problems we have discussed in this chapter.

Following are some of these possible alternatives and reasons why they would be difficult.

PERSONAL SAVINGS

Most business owners reinvest their savings in the business. Most feel that they can get a better return on their money than they would be investing in the stock market. Thus, it's highly unlikely that the owners will have enough liquidity to buy out a deceased partner's interest.

BORROW MONEY

Assuming that a loan could be secured, the business owner would have to repay the loan with interest, which can be a heavy financial burden to carry. Even if the remaining partner can handle this financial obligation, there is no guarantee that a loan could be secured. Potential lenders may be concerned about the stability of the business when a partner has died. They may feel the deceased partner played such a major role in the business' success that the remaining partner would not be able to maintain a profitable business.

SINKING FUND

With this plan, each partner saves a specific amount of money on a regular basis so that after a predetermined period of time there is enough money available to purchase the business interest. Once again, this plan is based on shaky assumptions.

First, this solution assumes that the business will remain consistently healthy so that there is no interruption in the amount being saved. Second, to be successful it requires that the partners live long enough to complete the sinking fund. If one of the partners dies before the plan is fully funded, then the buy out agreement fails.

It is evident that life insurance is the only way that the owners can be certain that cash to fund the agreement will be available when it's needed whether that need comes next month, next year, or 20 years from now. Any other alternatives can fall short and leave the surviving partner or partners and the deceased partner's heirs in a position that creates unnecessary emotional and financial hardship.

KEY EMPLOYEES

Another business life insurance need you should know about is key employee coverage. Key employee policies are used to minimize the financial impact the death of a key employee can have on the business. Let's use Mr. Thompson and Ben Windom. Mr. Thompson opened a card shop in a suburban mall ten years ago. Ben Windom was one of his first employees and is now the manager of the original store. Mr. Thompson's confidence in Ben's managerial abilities convinced him that he could open another store in a different mall.

Since the new store opened, Mr. Thompson is spending almost all of his time trying to get it established. He's entrusted Ben with the original store. Because of Ben's experience and dedication, the store runs just as smoothly as when Mr. Thompson was there, and the profitability of the store remains unchanged. Mr. Thompson could afford to open a new store because he knew that Ben Windom's knowledge and experience would allow him to personally manage the business. Without Ben, however, Mr. Thompson wouldn't have had the opportunity to expand his business.

It was a wise business decision for Mr. Thompson, but it could become a disastrous one if Ben Windom were to die. If this tragedy occurred, Mr. Thompson would have to attempt to manage both stores until he found a replacement for Ben, which would be a difficult chore. Why? When he found someone capable of doing the job, there would be a training period before the new employee could handle the responsibilities of the job.

Even after training was complete, it's highly unlikely that the new manager could contribute to the profitability of the business in the way that Ben did, at least for a number of years. The fact is that it could be many, many years before a new manager could fill Ben's shoes. During that time, it's more than likely that the profitability of the business would suffer.

It is not uncommon for businesses to insure physical assets from loss due to fire or theft. It makes sense to insure business assets even though it's safe to say that most physical assets could be replaced even if they weren't insured. The most important business asset, however, may be the efforts of a key employee. Business owners simply cannot replace the years of experience, knowledge, and skills of a valued employee in a week, a month, or even a year.

Ben Windom wasn't an asset to Mr. Thompson the day he was hired. However, after working many years in the job, cultivating knowledge, developing skills, and establishing important business relationships with customers and employees, Ben became more than an employee. He became a key contributor to the profits of the business. Although no one person is irreplaceable, most business owners would agree that key people cannot be replaced easily or in a short period of time. Mr. Thompson could hire another manager; the question is how long would it take before a new manager reached the level of performance that Ben had achieved? And how much would the business suffer in the meantime?

OTHER BENEFITS OF KEY EMPLOYEE INSURANCE

It should also be recognized that a key employee life insurance policy can be valuable even if an employee lives a long and healthy life. By using a permanent life insurance product, the policy will have growing cash values and since the premiums are paid by the business, the cash value is an asset on the business' books. These cash values can be used as collateral for a loan or they can be borrowed. The cash value is also useful

when a key employee leaves the firm since the policy can be cashed in and the money used to hire and train a replacement.

The point to remember about key employees is that the success or failure of most businesses can be directly tied to the "human factor." Physical assets don't make a business profitable; high-quality people do. Any business that sees fit to insure its physical assets should see the wisdom of insuring against the loss of the business' most valuable asset.... its key employees.

KEY EMPLOYEE INCENTIVE PLANS

Providing key employees with competitive salaries for the work they do is a difficult task. If an employee's compensation package is not commensurate with what other companies in the same industry are paying for similar positions, these key employees may leave to find work elsewhere. A simple solution is to pay higher salaries than the competition, but this can have two drawbacks. First, no matter how much a key employee is being paid when a competitor wants to recruit this person, they can always offer a salary that's even higher.

Second, as a key employee's salary increases, so does his or her income tax burden. thus, what may seem like a large increase in salary may be negated by the income tax due on the addition. To recruit and retain key employees, more creative methods of compensation may be needed. We will discuss two possible methods in the following paragraphs.

DEFERRED COMPENSATION

Deferred compensation is a plan where current salary is withheld or deferred until retirement. With deferred compensation, money earned for work done today is paid out at a later date. Since the employee does not receive the income, he or she is not currently taxed. The income is taxed when it is distributed at retirement.

With deferred compensation, an employee may actually keep more income since he or she may be in a lower tax bracket at retirement. In addition, because most people experience a decreased income at retirement, deferring income until this time provides additional revenue when it is needed most.

A deferred compensation plan also binds a key employee to the company since these plans usually stipulate that the employee must remain with the company for a predetermined period of time to receive deferred income. If the employee leaves the firm during this period of time, he or she forfeits all rights to the income.

Clearly this type of arrangement discourages an employee from seeking employment elsewhere since all deferred compensation would be lost. In addition to retaining key employees, deferred compensation is an excellent benefit to offer topnotch candidates for key positions in the company. Another firm may offer a higher salary,

but after taxes the net increase in income may not be that large. Deferred compensation is a creative and effective approach that is appealing to key employees who are concerned about their retirement.

HOW THE DEFERRED COMPENSATION PLAN WORKS

Under a deferred compensation agreement, the employer promises to pay a benefit at retirement for a specified period of time. this payment is guaranteed to the employee or to the employee's beneficiary if the employee dies during or prior to retirement. To fund retirement income, the company may establish a deferred annuity fund or some other investment vehicle where money is systematically put away to guarantee future payments. While this approach assures that the money will be there if the employee lives to reach retirement age, it is highly unlikely that the company will have sufficient funds on hand if the employee dies PRIOR to retirement.

To guarantee payment in the event of the employee's premature death, the company should purchase a life insurance policy on the key beneficiary as well. if the employee does live to retirement, the policy's can value can be used to fully or partially make the deferred payments.

The life insurance policy is usually a permanent policy designed to be paid at age 65 or another designated retirement age. If the employee dies prior to retirement, then the life insurance benefit can be used by the company to fulfill the terms of the deferred compensation agreement. However, if the employee lives to retirement, the company has two options.

First, it can use funds from the cash value to make the monthly income payments. Many companies include the guaranteed cash value from the life policy in their agreement. Second, if the company has sufficient funds to pay the deferred payments, it may leave the policy intact and receive the policy proceeds whenever the employee dies.

Since a deferred compensation plan doesn't have to be approved by the IRS, a company can establish this plan for selected employees at its discretion. Unlike other employee benefits, the company is not required to provide similar benefits for all employees. A deferred compensation plan is an individual agreement between the employer and the employee. Its terms must be agreed upon by both parties.

A contract is then drawn up by an attorney which stipulates what is required of each party. The contract specifies what the employer will pay at retirement or in the event of death, and how long the employee must remain with the company to qualify for the specified benefit.

The premiums for the life insurance policy are not tax-deductible to the employer. the life insurance policy is separate from the plan and is strictly a vehicle for the employer to ensure that money is available to fund this obligation if the employee dies prematurely. The employee has no interest in the life insurance policy. As such, there are no tax consequences to the employee. Since the premiums are not tax-deductible to the employer, neither are the proceeds subject to tax.

ADVANTAGES TO THE EMPLOYER

A deferred compensation plan offers advantages to employers and employees that are far greater than simple salary increases. For the employer, the plan serves as a "golden handcuff." It discourages key employees from leaving the company since they would forfeit the benefits from the plan.

A life insurance policy is an essential part of the funding for the employer since it guarantees fulfillment of the obligation in the event of the employee's death prior to retirement. The cash value in the policy can also help fund the deferred payments if the employee lives to retirement.

ADVANTAGES TO THE EMPLOYEE

For the employee, a deferred compensation plan provides additional benefits at retirement so long as the employee remains with the company. Since the employee will likely be in a lower tax bracket at retirement, the employee retains more after-tax money. In addition, even if the total benefit is $200,000, the employee is taxed on the money only as it is received. Thus, if payments are to be made over 20 years, then the employee only pays taxes on $10,000 a year rather than on the whole amount.

SPLIT DOLLAR LIFE INSURANCE PLANS

A split-dollar insurance plan is another creative method of compensating key employees.... helping to tie them to the company. A split-dollar plan is a way of assisting key employees in the purchase of additional life insurance they may not be able to afford. This approach allows the employer and employee to share the premium. It's a plan which is beneficial to employees who have young children, mortgage payments, or other substantial needs for personal life insurance protection. It's also attractive to older, more established employees who may have children in college and thus need additional life insurance to protect that obligation.

DETERMINING THE STRUCTURE OF THE PLAN

There are numerous methods for splitting the premium payments in split dollar plans. The traditional method, however, is for the employer to pay that part of the premium which equals the annual increase in the policy's cash value; the employee pays the balance. for example, if the annual premium in a given year was $2,500 and the cash value increase was $1,500, the employee would contribute the balance of $1,000. The only problem with this approach is that in the early years of the policy when there is little, if any, growth in the cash value, the employee's cost is most, if not all, of the premium.

To offset this problem, many plans are established where the cash value until retirement is totaled and then averaged for the length of the policy. Thus a level split is established

which remains intact each and every year. For example, if the policy has 25 years until the employee retires and the total cash value at that time will be $30,000, based on policy guarantees, then the level contribution by the employer each year toward the premium is $1,200.

Under the traditional plan, if the employee dies the accumulated cash value goes to the employer and the employee's beneficiary receives the difference between the face amount and the cash value, Under the level premium approach, the employer receives the total premium it has paid into the policy and the employee's beneficiary receives the difference between the face amount and the total premium paid by the employer. There is, however, a potential problem for the employee in this approach. As the cash value grows each year, the death benefit payable to the beneficiary shrinks.

This situation can be rectified in one of two ways;

First, if the life insurance policy pays dividends, the dividends can be used to purchase one year term insurance equal to the policy's cash value. Second, if a universal life policy is being used, Option B would be chosen which provides that the death benefit equals the face amount plus the cash value. This guarantees that a level death benefit is payable to the employee's beneficiary.

If the employee lives to retirement age, the employer is entitled to keep the cash value if it chooses. However, the company may want to use the cash value to fund a retirement plan for the employee. As with deferred compensation, a split-dollar insurance plan does not require IRS approval. The employer can offer this plan to selected employees. It's under no obligation to offer similar benefits to other employees. To install the plan, an agreement is drafted which outlines the breakdown of premium payments as well as other terms of the plan.

ADVANTAGES OF SPLIT-DOLLAR PLANS

A split-dollar life insurance plan offers many advantages to both employers and employees. For the employer, it helps retain key employees since the employer's contribution to the plan is dependent upon the employee remaining with the firm. In addition, there is no direct cost to the employer since the company will always receive the premiums it has paid when the employee retires or dies.

The only cost is interest that would have been earned on invested funds. For the employee, a split-dollar life insurance plan helps purchase needed personal life insurance at a reduced and affordable cost, thanks to the employer's contribution to the premium.

As you can see, with the above overviews to some of the business applications for life insurance, that in addition to providing valuable personal and family protection, life insurance offers many benefits to business owners and their families as well

7

DEFINITIONS USED IN LIFE INSURANCE PLANS

A

AGE CHANGE - The point in the 12 months between natural birthdays at which the individual is considered to be of the next higher age for the purpose of insurance rates. Most life insurers consider that point as halfway between birthdays. Health insurers frequently use the age at last birthday until the next birthday is actually reached.
AGE LIMITS - The ages below or above which an insurer will not issue a given policy.
AGENT - An individual appointed by an insurer to solicit, negotiate, effect or countersign insurance contracts on its behalf. (See also Producer)
ALIEN COMPANY OR INSURER - An insurer organized and domiciled in a country other than the United States.
APPLICANT - The party submitting an application to an insurer for an insurance policy.
ATTAINED AGE - The age an insured has reached on a given date.

B

BENEFICIARY - A person who may become eligible to receive, or is receiving, benefits under an insurance plan, other than as an insured.
BENEFICIARY CHANGE - A change in the policy which alters the previous beneficiary designation. Must be made by formal application to the insurer. Compare to Beneficiary, Irrevocable.
BENEFICIARY, IRREVOCABLE - A named beneficiary whose status as beneficiary cannot be changed without his or her permission.
BENEFICIARY, PRIMARY - The person first designated to receive the proceeds of a policy, as named in the policy.

C

CANCELLATION - Termination of the insurance contract by voluntary act of the insurer or insured, effected in accordance with provisions in the contract or by mutual agreement.
CARRIER - The insurance company that "carries" the insurance. The term "insurer" is preferred.
CASH SURRENDER VALUE - In life insurance, the value in a policy that is the legal property of the policyowner, and which the policyowner may receive if the policy is surrendered for cash. Synonymous with cash value.
CLAIM - The demand of an insured or his or her representative or beneficiary for benefits as provided by an insurance policy.
COMMISSION - The portion of the premium stipulated in the agency contract to be retained by the agent as compensation for sales, service, and distribution of insurance policies.
CONCEALMENT - The withholding, by an applicant for insurance, of facts that materially affect an insurance risk or loss.
CONDITIONAL RECEIPT - Provides that if the premium accompanies the application, the coverage is in force from the date of application (whether the policy has yet been issued or not) provided the insurer would have issued the coverage on the basis of facts as revealed by the application and other usual sources of underwriting information.
CONTINGENT BENEFICIARY - Person or persons named to receive benefits if the primary beneficiary is not alive at the time the insured dies.

D

DEATH BENEFIT - The policy proceeds to be paid upon the death of the insured.
DEATH CLAIM - A formal request for payment of policy benefits occasioned by the death of the insured. Should be made through the agent, but may be made directly to the home office. Requires a copy of the death certificate as proof of death and is made by the beneficiary.
DECLARATION PAGE - The portion of an insurance policy containing the information regarding the risk.
DECREASING TERM INSURANCE - Term insurance for which the initial amount gradually decreases until the expiration date of the policy, at which time it reaches zero.
DEFERRED ANNUITY - An annuity on which payments to the annuitant are delayed until a specified future date.
DOMESTIC COMPANY - An insurer formed under the laws of the state in which the insurance is written.
DOUBLE INDEMNITY - Payment of twice the basic benefit in event of loss resulting from specified causes or under specified circumstances.

E

EFFECTIVE DATE - The date on which an insurance policy goes into effect.
ENDORSEMENT - Technically, a change made directly on the policy form by writing, printing, stamping or typewriting and approved by an executive officer of the insurer. In general use, also may refer to a change made by means of a form attached to the policy.

ESTATE - Assets of an individual comprising total worth. Includes any life insurance in force.
EXCLUSIONS - Stated exceptions to prior provisions in a policy. Common exclusions in health policies include pre-existing conditions, suicide, self-inflicted injuries, and many others. In life policies, common exclusions are death through flying in a private airplane, riot, or state of war.
EXPIRATION - The date upon which a policy's coverage ceases.

F

FACE AMOUNT - The amount indicated on the face of a life policy that will be paid at death or when the policy matures.
FAMILY PLAN POLICY - An all-family plan, usually with permanent insurance on the father's life, with mother and children automatically covered for lesser amount -- usually term -- all paid by a single premium.
FOREIGN COMPANY - An insurer organized under the laws of a state other than the one where the insurance is written.
FRAUD - An intentional misrepresentation made by a person with the intent to gain an advantage and relied upon by a second party which suffers a loss as a result.

G

GRACE PERIOD - A period of time after the premium due date during which a policy remains in force without penalty even though the premium due has not been paid. Commonly 30 or 31 days in life insurance policies; seven, 10, or 31 days in various health insurance policies.

H

HOME OFFICE - The place where an insurance company maintains its chief executives and general supervisory departments.

I

INSURABILITY - The condition of the proposed insured as to age, occupation, physical condition, medical history, moral fitness, financial condition and other factors that makes the individual an acceptable risk to an insurance company.
INSURABLE INTEREST - In life and health insurance, the interest of one party in the possible death or disability of an insured that would result in a significant emotional or financial loss. Such an interest must exist in order for the party to purchase insurance on the life or health of another. In property-casualty insurance, a financial interest is property.
INSURANCE DEPARTMENT - A governmental bureau in each state of territory (and federal government in Canada) charged with administration of the insurance laws, including licensing, examination, and regulation of agents and insurers. In some jurisdictions, the department is a division of some other state departments or bureau.
INSURED - The party to an insurance contract to whom, or on behalf of whom, the insurer agrees to indemnify for losses, provide benefits, or render service.

INSURER - The party to an insurance contract that undertakes to indemnify for losses, provide other pecuniary benefits, or render service. Also called insurance company and sometimes insurance carrier.

L

LAPSED POLICY - A policy for which the policyholder has failed to make the premium payment during the grace period, causing the coverage to be terminated.
LICENSE, AGENTS' - A state-conferred license that enables an insurance agent to do business in the conferring state. Renewable annually. Subject to an initial written examination and to suspension or revocation for certain offenses.
LIFE EXPECTANCY - Average number of years of life remaining for persons at any given age.
LIFE INSURANCE - Insurance paying a specified amount upon the death of the insured to the insured's estate or to a beneficiary.
LOAN VALUE - The amount of cash value reposing in a policy which may be borrowed by the insured.

M

MISREPRESENTATION - On the part of an insurer or its agent, falsely representing the terms, benefits, or privileges of a policy. On the part of an applicant, falsely representing the health or other condition of the proposed insured.
MORTALITY RATE - The average number of people who die each year.

N

NONFORFEITURE OPTION - A legal provision whereby the life insurance policyowner may take the accumulated values in a policy as (1) paid-up insurance for a lesser amount; (2) extended term insurance; or (3) lump-sum payment of cash value, less any unpaid premiums, or outstanding loans.
NONPARTICIPATING POLICY - A policy that does not provide for the policyowner to share in dividends. Also called a no-par policy.
NONRESIDENT AGENT - An agent licensed in a state in which he or she is not a resident.

O

ORDINARY AGENT - An agent selling ordinary life insurance.
ORDINARY LIFE INSURANCE - Life insurance other than group life. Ordinary life may be either permanent or temporary term.

P

PAID-UP INSURANCE - A nonforfeiture option in life insurance policies under which insurance exists and no further premium payments are required.
PARTICIPATING POLICY - A policy in which the policyowner receives a share of policy dividends. Also called par policy.
PERMANENT INSURANCE - Life insurance with some type of cash value accumulation.

POLICY LOAN - A loan to the policyholder from the insurer using the insurance cash value as collateral.
PRE-AUTHORIZED CHECK PLAN - An arrangement under which the policyowner authorizes the insurer to draft his or her bank account for the (usually monthly) premium.
PRIMARY BENEFICIARY - The beneficiary named first to receive proceeds or benefits of a policy that provides death benefits.
PROOF OF DEATH - A usual requirement before paying a death claim is that a formal proof of death form of some type be submitted to the insurer.

R

REBATE - Giving or offering to give something of value other than the benefits of a policy as an inducement to buy insurance, a practice illegal in all states except Florida.
REINSTATEMENT - (1) Putting a lapsed policy back in force, sometimes requiring the payment of back premiums and evidence of insurability, (2) In some health policies, reinstating or restoring the amount of benefits available when the payment of claims has reduced the principal amount of the policy by the amount of the claims. Provision is usually made for a method of reinstating the policy to its original amount. This may be done automatically either with or without premium consideration or at the request of the insured. Often found in group health contracts and may be called restoration of benefits.
RIDER - An amendment attached to a policy that modifies the conditions of the policy by expanding or decreasing its benefits or excluding certain conditions from coverage.

S

SETTLEMENT OPTION - A method of receiving life insurance proceeds other than a lump sum.
STANDARD RISK - A risk that meets the same conditions of health, physical condition and morals as the tabular risks on which the rate is based without extra rating or special restrictions.
SUICIDE CLAUSE - In a life insurance policy, states that if the insured commits suicide within a specified period of time, the policy will be voided. Paid premiums are usually refunded. The time limit is generally one or two years.

T

TERM INSURANCE - Life insurance that normally does not have cash accumulations and is issued to remain in force for a specified period of time, following which it is subject to renewal or termination.

U

UNIFORM POLICY PROVISIONS - A set of standardized provisions used in health insurance policies, of which 12 are required and 11 are optional. All states use these provisions, although they are permitted to revise the wording as long as it is at least as beneficial to the insured as the original wording.

W

WAIVER OF PREMIUM PROVISION - When included, provides that premiums are waived and the policy remains in force if the insured becomes totally and permanently disabled.

WHOLE LIFE -- Permanent life insurance on which premiums are paid for the entire life of the insured.

PART TWO: MEDICARE

1

THE BASICS OF MEDICARE

THE DEFINITION OF MEDICARE

Medicare is a federal health insurance program for persons 65 or older, persons of any age with permanent kidney failure, and certain disabled persons.[1]

It is administered by the Health Care Financing Administration within the Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program.

Medicare consists of Hospital Insurance protection (Part A) and Medical Insurance protection (Part B).

Part A provides institutional care, including inpatient hospital care, skilled nursing home care, home health care, and, under certain circumstances, hospice care. Part A is financed for the most part by Social Security payroll tax deductions, which are deposited in the Federal Hospital Insurance Trust Fund. Medicare beneficiaries also participate in the financing of Part A by paying deductibles, coinsurance and premiums.

Part B is a voluntary program of health insurance which covers physician 's services, outpatient hospital care, physical therapy, ambulance trips, medical equipment, prosthesis, and a number of other services not covered under Part A. It is financed

[1] NOTE: There is an insert provided with this book that outlines current Medicare coverage amounts. Please refer to this insert where indicated in the text of this Medicare section.

through monthly premiums paid by those who enroll and contributions from the federal government. The government's share of the cost far exceeds that paid by those enrolled.

Catastrophic coverage was introduced in 1989 after Congress passed the Medicare Catastrophic Coverage Act of 1988 (MCCA). This legislation, however, was repealed by the Medicare Catastrophic Coverage Repeal Act of 1989. MCCA had expanded coverage for inpatient hospital care, skilled nursing facility care, hospice care and home health care. It also provided coverage for all prescription drugs by 1991 and for home intravenous drug therapy, mammography screening and respite care.

The Department of Health and Human Services contracts with private insurance companies for the processing of payments to patients and health care providers. These private insurance companies are called fiscal intermediaries under Part A and are selected by the health care providers. Under Part B, these private insurance companies are called carriers and are selected by the Department of Health and Human Services.

WHO DIRECTS & ADMINISTERS MEDICARE?

The Health Care Financing Administration, whose central office is in Baltimore, Maryland, directs Medicare and Medicaid programs. The Social Security Administration processes Medicare applications and claims, but it does not set Medicare policy. The Health Care Financing Administration sets the standards which hospitals, skilled nursing facilities, home health agencies, and hospices must meet in order to be certified as qualified providers of services.

WHAT HOSPITAL INSURANCE PROTECTION DOES MEDICARE PROVIDE?

Persons protected have benefits paid for certain hospital and related health care services when they incur expenses for such services.

A person entitled to social security monthly benefits or a qualified railroad retirement beneficiary is automatically entitled to Hospital Insurance protection beginning with the first day of the month of attainment of age 65. An individual who is insured for monthly benefits need not actually file to receive the benefits. However, benefits are usually not paid for services furnished outside the United States.

Medicare does not pay for services covered under automobile medical, no-fault, or liability insurance. It also does not pay for services covered under an employer's group health plan if an employed individual (and his spouse) decide to be covered by the employer's plan while entitled to Medicare Hospital Insurance protection. In these cases, the employer's plan, or the automobile medical, no-fault, or liability insurance, pays its benefits first. Medicare may then pay for any services not covered in whole or in part by the insurance or the employer's plan.

WHAT MEDICAL INSURANCE PROTECTION DOES MEDICARE PROVIDE?

Persons protected have benefits paid for certain physicians' services (including surgery), home health services, and some other items and services not covered by Hospital Insurance protection.

Medical Insurance protection is financed through premiums paid by each person who enrolls (or by the state where the person is enrolled under a federal-state agreement) and through contributions appropriated from federal general revenues.

WHO IS PERMITTED TO PROVIDE SERVICES & SUPPLIES UNDER MEDICARE?

Health care organizations and professionals providing services to Medicare beneficiaries must meet all licensing requirements of state or local health authorities. The organizations and persons listed below also must meet additional Medicare requirements before payments can be made for their services:

* Hospitals

* Skilled nursing facilities

* Home health agencies

* Hospice programs

* Independent diagnostic laboratories and organizations providing X-ray services

* Organizations providing outpatient physical therapy and speech pathology services

* Facilities providing outpatient rehabilitation facilities

* Ambulance firms

* Chiropractors

* Independent physical therapists (those who furnish services in the patient's home or in their offices)

* Facilities providing kidney dialysis or transplant services

* Rural health clinics

All hospitals, skilled nursing facilities, and home health agencies participating in the Medicare program must comply with title VI of the Civil Rights Act, which prohibits discrimination because of race, color, or national origin.

Medicare does not pay for care received from a hospital, skilled nursing facility, home health agency, or hospice that is not certified to participate in the program. Such providers are referred to as non-participating. But Hospital Insurance can help pay for care in a qualified non-participating hospital if: (1) the patient is admitted to the non-participating hospital for emergency treatment, and (2) the non-participating hospital is the closest one that is equipped to handle the emergency. Under Medicare, emergency treatment means treatment that is immediately necessary to prevent death or serious impairment to health.

If the non-participating hospital elects to submit the claim for Medicare payment, Medicare will pay the hospital directly except for any deductible or coinsurance amounts. If the hospital does not submit the claim, the patient may submit the claim and receive payment. In this case, the patient would reimburse the hospital.

WHAT BENEFITS ARE PROVIDED UNDER THE HOSPITAL INSURANCE PROTECTION? (PART A)

PLEASE REFER TO THE INSERT SHEET TO FILL IN THESE FIGURES

- The current year's deductible for each 90 day benefit period of hospitalization is $_____.
- From the 60th day to the 90th day of hospitalization the benefit is $_____ per day which is always 25% of the year's deductible.
- There is also a 60 day lifetime reserve benefit for hospitalization and that benefit is $____ per day which is always 50% of the current year's deductible.
- The cost of post hospital long term care in a skilled nursing facility for up to 100 days in each benefit period. The first 20 days are paid at 100%. The patient then pays $____ a day from the 21st to the 100th day. (This amount is always 1/8th of the current year's deductible.

WHAT BENEFITS ARE PAYABLE UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PLAN? (PART B)

The Supplementary Medical Insurance Plan is offered to almost all persons age 65 or over on a voluntary basis. In addition, the program is offered to all disabled Social Security and Railroad Retirement beneficiaries who have received disability benefits for at least 24 months. There is an annual deductible of $100, paid by the patient. Then the plan pays 80% of the approved charges above the deductible for the following services:

- Physicians' and surgeons' services, whether furnished in a hospital, clinic, office, home or elsewhere.

- Home health care visits, if not covered under hospital insurance (but with no cost sharing except for durable medical equipment, other than the purchase of certain used items).
- Diagnostic x-ray, diagnostic laboratory tests, and other diagnostic tests (no cost-sharing).
- Outpatient physical therapy and speech pathology.
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, rental of durable medical equipment, etc.
- Ambulance transportation.
- The cost of blood clotting factors and supplies necessary for the self administration of the clotting factor.
- Services and supplies relating to a physician's services and hospital services rendered to outpatients; this includes drugs and biologicals which cannot be self-administered.
- Dentists' bills for jaw or facial bone surgery, whether required because of accident or disease. Also covered are hospital stays warranted by the severity of a non covered dental procedure, and services provided by dentists which would be covered when provided by a physician. Bills for ordinary dental care are not covered.
- Comprehensive outpatient rehabilitation facility services performed by a doctor or other qualified professionals in a qualified facility. Therapy and supplies are covered.
- Antigens prepared by one doctor and sent to another for administration to the patient.
- The cost of pneumococcal vaccine (no cost-sharing).
- The cost of hepatitis B vaccine for high and intermediate risk individuals when it is administered in a hospital or renal dialysis facility.
- Certified nurse-midwife services.
- Partial hospitalization services incident to a physician's services.

- Screening pap smears for early detection of cervical cancer. Coverage is provided for screening pap smears once every three years, except in cases where the Health Care Financing Administration has established shorter time periods for testing women at high risk of developing cervical cancer.
- Screening mammography. Screening mammography is defined as a radiologic procedure provided to a woman for the early detection of breast cancer, including a physician's interpretation of the results of the procedure.
- The cost of an injectable drug for the treatment of a bone fracture related to post-menopausal osteoporosis.
- Eyeglasses following cataract surgery.
- Services of nurse practitioners and clinical nurse specialists in rural areas for the services they are authorized to perform under state law and regulations.

- The cost of psychiatric treatment outside a hospital for mental, psychoneurotic, and personality disorders is covered. However, coinsurance is usually 50% instead of 20%.

WHAT ABOUT AN OVER-ALL LIMIT THAT A PERSON CAN RECEIVE UNDER MEDICARE?

Under the Basic Hospital Plan, benefits begin anew in each benefit period. In addition, there are no dollar limits under the Supplementary Medical Insurance Plan except for psychiatric care and independent physical and occupational therapy. Under the Basic Hospital Plan, care in a psychiatric hospital is subject to a lifetime limit of 190 days. (The time a patient has spent in a hospital for psychiatric care immediately prior to becoming eligible for Medicare counts against the special 150-day limit in the first hospitalization period, but not against the 190-day lifetime limit.) Under the Supplementary Medical Plan, coverage of psychiatric treatment outside a hospital is subject to an annual benefit limit of $1,100 and services of independent physical therapists are reimbursable to no more than $750 per calendar year (as also applies to the services of independent occupational therapists).

Medicare may limit benefit payments for services for which other third party insurance programs (e.g., workers' compensation, auto or liability insurance, and employer health plans) may ultimately be liable. The Spending Reduction Act of 1984 establishes the statutory right of Medicare to: (I) bring an action against any entity which would be responsible for payment with respect to such item or service, (2) bring an action against any entity (including any physician or provider) which has been paid with respect to such item or service, and (3) join or intervene in an action against a third party.

AT WHAT TIME DO MEDICARE BENEFITS BECOME AVAILABLE?

Medicare benefits become available at the beginning of the month in which the individual reaches age 65. This is true even if the individual is still working. Medicare

benefits are also available after the individual has been receiving Social Security disability benefits for two years or if the individual has chronic kidney disease.

Every Medicare patient must be under the care of a physician.

WHEN IS A MEDICARE CARD ISSUED?

A Medicare card is issued to a person after he becomes eligible for Medicare benefits. The card shows the person's coverage (Hospital Insurance, Supplementary Medical Insurance and Catastrophic Drug Insurance, or both) and the date protection started. The card also shows the person's health insurance claim number. The claim number has nine digits and a letter. On some cards, there will be another number after the letter. The full claim number must always be included on all Medicare claims and correspondence. When a husband and wife both have Medicare, they will receive separate cards and different claim numbers. Each spouse must use the exact name and claim number shown on his card.

Important points to remember:

- The patient should always show his Medicare card when receiving services that Medicare can help pay for.

- The patient should always write his health insurance claim number (including the letter) on any bills he sends in and on any correspondence about Medicare. Also, the patient should have the Medicare card available when making a telephone inquiry.

- The patient should carry the card whenever away from home. If it is lost, immediately ask a representative at any Social Security office for a new one. The patient should use his Medicare card only after the effective date shown on the card.

- Medicare cards made of metal or plastic, which are sold by some manufacturers, are not a substitute for the officially issued Medicare card.

- Never permit someone else to use your Medicare card.

IMPORTANT RULES REGARDING CARE COVERED UNDER MEDICARE

Medicare does not cover custodial care or care that is not "reasonable and necessary" for the diagnosis or treatment of an illness or injury.

Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if an individual is in a participating hospital or skilled nursing facility or the individual is receiving care from a participating home health agency, Medicare does not cover his care if it is mainly custodial.

If a doctor places an individual in a hospital or skilled nursing facility when the kind of care the individual needs could be provided elsewhere, the individual's stay is not considered reasonable and necessary. Medicare will not cover the stay. If an individual stays in a hospital or skilled nursing facility longer than he needs to be there, Medicare payments will end when further inpatient care is no longer reasonable or necessary.

If a doctor (or other practitioner) comes to treat a person or that person visits the doctor for treatment more often than is the usual medical practice in the area, Medicare will not cover the "extra" visits unless there are medical complications.

Note, however, that an individual will not be held responsible for paying for care if he could not reasonably be expected to know it was not covered by Medicare. This provision is called the "Waiver of Beneficiary Liability." The waiver provision applies only when the care is not covered because it was custodial care or was not reasonable or necessary for the diagnosis or treatment. Also, the waiver provision does not apply to

Supplementary Medical Insurance claims unless the doctor or other person who furnished the services agreed to payment under the assignment method.

WHAT ARE PRO'S?

Peer Review Organizations (PROs) are groups of practicing doctors who are paid by the federal government to review hospital care of Medicare patients. There are PROs in each state to help Medicare decide whether inpatient care is reasonable and necessary, meets the standards of quality accepted by the medical profession, and is provided in the appropriate setting.

In addition, PROs respond to requests for review of hospital decisions or reconsideration of PRO decisions made about hospital stays. They also investigate individual patient complaints.

Whenever a patient is admitted to a Medicare-participating hospital, he will be given "An Important Message From Medicare," which briefly describes his appeal rights as a hospital patient and supplies the name, address, and phone number of the PRO in his state.

If a patient disagrees with the decision of a PRO, he can appeal by requesting a reconsideration. Then, if the patient disagrees with the PRO's reconsideration decision and the amount in question is $200 or more, he can request a hearing by an Administrative Law Judge. Cases involving $2,000 or more can eventually be appealed to a federal court.

Appeals of decisions on all other services covered under the Hospital Insurance Plan (skilled nursing facility care, home health care, hospice services, and some inpatient hospital matters not handled by PROs) are handled by Medicare intermediaries.

WHEN DOES THE FRAUD AND ABUSE HOTLINE BECOME NECESSARY?

If a person has reason to believe that a doctor, hospital, or other provider of health care services is performing unnecessary or inappropriate services, or is billing Medicare for services he did not receive, he can report evidence of fraud, waste or abuse to the Health Care Financing Administration by using a toll-free Hot Line. The toll-free number is 1-800-269-0271. A person can send his complaints in writing to HHS, OIG, Hot Line, P.O. Box 17303, Baltimore, Maryland 21203-7303.

2

PART A: BASIC MEDICAL INSURANCE

WHO IS ELIGIBLE FOR BENEFITS?

All persons age 65 and over who are entitled to monthly Social Security cash benefits (or would be entitled except that an application for cash benefits has not been filed), or monthly cash benefits under Railroad Retirement programs (whether retired or not), are eligible for benefits.

Persons age 65 and over can receive Medicare benefits even if they continue to work. Enrollment in the program while working will not affect the amount of future Social Security benefits.

A dependent or survivor of a person entitled to Hospital insurance benefits, or a dependent of a person under age 65 who is entitled to retirement or disability benefits, is also eligible for Hospital Insurance benefits if such dependent or survivor is at least 65 years old. For example, a woman age 65 or over who is entitled to a spouse's or widow's Social Security benefit is eligible for benefits under the Basic Hospital Insurance Plan.

A Social Security disability beneficiary is covered under Medicare after entitlement to disability benefits for 24 months or more. Those covered include disabled workers at any age, disabled widows and widowers age 50 or over, beneficiaries age 18 or older who receive benefits because of disability beginning before age 22, and disabled qualified railroad retirement annuitants.

A person who becomes re-entitled to disability benefits within five years after the end of a previous period of entitlement (within seven years in the case of disabled widows or widowers and disabled children) is automatically eligible for Medicare coverage without having to wait another 24 months. However, if the previous period of disability ends after February 20, 1988, he is covered under Medicare without again having to meet the 24 month waiting period requirement, regardless of not meeting the five year

(or seven year) requirement, if his current impairment is the same as (or directly related to) that in the previous period of disability.

Coverage will continue for 24 months after an individual is no longer entitled to receive disability payments because he has returned to work, provided he was considered disabled on or after December 10, 1980, and the disabling condition continues.

PEOPLE WITH END-STAGE RENAL DISEASE HAVE SPECIAL ELIGIBILITY RULES

Insured workers (and their dependents) with end-stage renal disease who require renal dialysis or a kidney transplant are deemed disabled for Medicare coverage purposes even if they are working. Coverage can begin with the first day of the third month after the month dialysis treatments begin. This three month waiting period is waived if the individual participates in a self-care dialysis training course during the waiting period.

Medicare coverage based on transplant begins with the month of the transplant or with either of the two preceding months if the patient was hospitalized during either of those months for procedures preliminary to transplant. If entitlement could be based on more than one of the factors, the earliest date is used.

Beginning July 1, l991, coverage is provided for the self-administration of erythropoietin for home renal dialysis patients.

During a period of up to the first 18 months of entitlement, Medicare benefits are secondary to benefits payable under an employer's health benefit plan for individuals entitled to Medicare solely on the basis of end-stage renal disease. During this period, if an employer plan pays less than the provider's charges, then Medicare may supplement the plan's payments.

GOVERNMENT EMPLOYEES HAVE SPECIAL ELIGIBILITY RULES

Federal employees who were not covered under Social Security (e.g., temporary workers have been covered since 1951) began paying the portion of Social Security tax that is creditable for Medicare purposes in 1983. A transitional provision provides credit for retroactive hospital quarters of coverage for federal employees who were employed before 1983 and also on January 1, 1983.

State and local government employees hired after March 31, 1986, are covered under Medicare coverage and tax provisions. A person who was performing substantial and regular service for a state or local government before April 1,1986, is not covered provided he was a bona fide employee on March 31, 1986, and the employment relationship was not entered into in order to meet the requirements for exemptions from coverage.
State or local government employees whose employment is terminated after March 31, 1986, are covered under Medicare if they are later rehired.

Beginning after June 30, 1991, state and local government workers who are not covered by a retirement system in conjunction with their employment, and who are not already subject to the Medicare Hospital Insurance tax, are also automatically covered and must pay such taxes. A retirement system is defined as a pension, annuity, retirement, or similar fund or system established by a state or by a political subdivision of a state.

Individuals are not automatically covered under Medicare if employed by a state or local government

(1) to relieve them of unemployment;

(2) in a hospital, home, or institution where they are inmates or patients;

(3) on a temporary basis because of an emergency such as a storm, earthquake, flood, fire or snow;

(4) if the individuals qualify as interns, student nurses or other student employees of District of Columbia government hospitals, unless the individuals are medical or dental interns or medical or dental residents in training.

State governments may voluntarily enter into agreements to extend Medicare coverage to employees not covered under the rules above.

IS MEDICARE A SECONDARY PAYOR? IF SO, WHEN?

Employers must offer employees age 65 or older the same health benefits offered to younger employees. Medicare will become the secondary payor for these employees age 65 or older. (This requirement does not apply to employers with less than 20 employees.) Medicare benefits are also secondary to benefits payable under employer health benefit plans for spouses age 65 or older of employed individuals of any age. Regulations issued by the Health Care Financing Administration state that Medicare is the secondary payor even if the employer health plan expressly stipulates that its benefits are secondary to Medicare. The regulations also include the federal government in the definition of an employer to which the secondary payment provisions apply. An employee may reject the employer's plan and retain Medicare as the primary payor, but regulations prevent employers from offering a health plan or option designed to induce the employee to reject the employer's plan and retain Medicare as the primary payor.

For persons who are not eligible for Social Security or Railroad Retirement benefits, Medicare is also the secondary payor: (1) when medical care can be paid for under any liability policy (including automobile policies), (2) in the first 18 months for end-stage renal disease under age 65 when private group health insurance provides coverage, and (3) when a disability beneficiary (under age 65) is covered under an employer plan as a current employee (or family member of an employee) for employers with at least l00 employees (effective only in January 1987 through September 1995).

IF YOU ARE INELIGIBLE FOR SOCIAL SECURITY OR RAILROAD RETIREMENT, WHEN DOES QUALIFYING FOR HOSPITAL INSURANCE BENEFITS BEGIN?

Most persons age 65 or over and otherwise ineligible for Hospital Insurance may enroll voluntarily and pay a monthly premium if they are also enrolled for Supplementary Medical Insurance.

Most persons who reached age 65 before 1968 are eligible to enroll for Hospital Insurance for which no premiums need be paid even if they have no coverage under Social Security. Also eligible for enrollment under this transitional provision are persons age 65 and over with specified amounts of earnings credits less than that required for cash benefit eligibility.

Not eligible under the transitional provision are retired federal employees covered by the Federal Employees' Health Benefits Act of 1959, nonresidents of the United States, or aliens admitted for permanent residence unless they have five consecutive years of residence and the required covered quarters.

WHEN CAN AN INDIVIDUAL NOT ELIGIBLE FOR THE HOSPITAL INSURANCE PLAN BE ENROLLED?

Yes. An individual is eligible to enroll in the Hospital Insurance Plan if he: (1) has attained age 65, (2) is enrolled in the Supplementary Medical Insurance plan (see SECTION C), (3) is a resident of the United States and is either (a) a citizen or (b) an alien lawfully admitted for permanent residence who has resided in the United States continuously for five years, and (4) is not otherwise entitled to Hospital Insurance benefits.

Disabled individuals under age 65 may also be able to obtain Medicare Part A coverage through monthly premiums. The Omnibus Budget Reconciliation Act of 1989 extended eligibility to individuals under age 65 who qualify for Part A benefits on the basis of a disabling physical or mental impairment, but who lose entitlement because they have earnings that exceed the eligibility limit for Social Security disability benefits and are not otherwise entitled to Part A benefits.

The monthly premium for the current year is $_____(Please see insert sheet for the figures).

The premium for an individual who enrolls after the close of the initial enrollment period or who re-enrolls is increased by 10% if there were at least 12 months of delayed enrollment, regardless of how late the individual enrolls.

The increased-premium paying period is limited to twice the number of years an individual delayed enrolling. The premium then reverts to the standard monthly premium in effect at that time.

WHAT PART DOES THE HEALTH CARE FINANCING ADMINISTRATION PLAY?

The Health Care Financing Administration enters into agreements with state agencies and with fiscal intermediaries (such as Blue Cross and other health insurance organizations) to administer the Hospital Insurance Plan.

State agencies survey institutions to determine whether they meet the conditions for participation as a hospital, skilled nursing facility, home health agency, or hospice. They also help the institutions meet the conditions for participation.

Private organizations called intermediaries determine the amount of Hospital Insurance benefits payable to hospitals, skilled nursing facilities, hospices, and home health agencies; pay hospital insurance benefits to hospitals, skilled nursing facilities, hospices, and home health agencies out of funds advanced by the federal government; help hospitals, skilled nursing facilities, hospices, and home health agencies establish and maintain necessary financial records; serve as a channel of communication of information relating to the Hospital Insurance protection; and audit records of hospitals, skilled nursing facilities, hospices, and home health agencies, as necessary, to insure that payment of Hospital Insurance benefits is proper.

Each provider of services can nominate a fiscal intermediary to work with or can deal directly with the Health Care Financing Administration. Fiscal intermediaries are reimbursed for their reasonable costs of administration

WHAT IS A PPS?

Beginning October 1,1983, Medicare began basing most hospital payments on the patient's diagnosis at the time of admission rather than the costs the hospital incurred prior to discharging the patient.

This system of Medicare reimbursement is called the Prospective Payment System (PPS). Each patient is assigned to a diagnosis related group (DRG), and the hospital receives a corresponding flat-rate payment regardless of the number of days stayed or services received. If the actual cost of a hospital stay is less than the DRG payment, the hospital keeps the difference; if the cost is greater, the hospital may lose the difference. A hospital can receive a payment higher than the DRG amount, but to do so it must show that the length of stay or the cost of treatment greatly exceeds the average for that DRG.

After 1987, reimbursement for inpatient hospital services is based on uniform sums for about 475 Diagnosis Related Groups (varying between rural and urban facilities). All other services are reimbursed on a reasonable cost basis. For services rendered during October 17, 1989 through December 1989, the reimbursement amounts were reduced by 2.092 percent. Services rendered for January through September 1990 were reduced by 1.42 percent (as a result of the Gramm-Rudman-Hollings Act).

Health Maintenance Organizations (HMOs) are covered by special reimbursement provisions to reward them financially because of what is believed to be their more favorable operating experience.

Hospitals must provide inpatient care for Medicare beneficiaries as long as it is medically necessary. This must be done even when the cost of the beneficiary's care greatly exceeds the payment the hospital will receive from Medicare.

Despite the requirement to provide care for as long as it is medically necessary, the PPS provides hospitals with the possible incentive to refuse to admit patients for medical procedures that might not be reimbursed by Medicare. Hospitals also have the incentive to treat and discharge patients within or less than the time frame established by the reimbursement rate for a particular DRG.

The Health Care Financing Administration contracts with peer review organizations (PROs) in each state to conduct pre-admission, continued stay, and retrospective reviews of the services delivered by a hospital. The reviews determine whether such services are reasonable and necessary. The PRO is also responsible for ensuring that the cost control incentives of the PPS do not adversely affect patients' access to hospitals or the quality of hospital care.

If the hospital, without consulting the PRO, recommends against admitting a patient, review of this decision may be obtained by the patient by writing the PRO in the patient's state. If the PRO participated in the pre-admission denial of the patient, then a reconsideration of that denial may be requested by the patient.

MUST THE BASIC HOSPITAL PLAN BE COMPULSORY?

Yes. Every person who works in employment or self-employment covered by the Social Security Act, or in employment covered by the Railroad Retirement Act, must pay the Hospital Insurance tax and will be eligible for Hospital Insurance benefits if

fully insured when he reaches age 65, receives disability benefits for more than 24 months, or has end-stage renal disease.

HOW DO YOU FINANCE THE PLAN?

By a separate Hospital Insurance tax imposed upon employers, employees and self-employed persons. The tax must be paid by every individual, regardless of age, who is subject to the regular Social Security tax or to the Railroad Retirement tax. It must also be paid by all federal employees and by all state and local government employees (1) hired after March 1986, or (2) not covered by a state retirement system in conjunction with their employment (beginning July 2, 1991).

The maximum earnings base (the maximum amount of annual earnings subject to tax) is unlimited as of 1997. (The maximum earnings base for Old-Age, Survivors, and Disability Insurance (OASDI) taxes is unlimited as of 1997.)

There is a special federal (and generally following through to state) income tax deduction of 50% of the OASDI/Hospital Insurance self-employment tax. This income tax deduction, which is taken directly against net self-employment income, is designed to treat the self-employed in much the same manner as employees and employers are treated for Social Security and income tax purposes under present law.

WHAT SERVICES ARE PROVIDED?

Over and above the "deductible" and "coinsurance" amounts which must be paid by the patient, the following services are covered:

(PLEASE REFER TO THE INSERT SHEET TO FILL IN THESE FIGURES)

- The current year's deductible for each 90 day benefit period of hospitalization is $_____.
- From the 60th day to the 90th day of hospitalization the benefit is $_____ per day which is always 25% of the year's deductible.
- There is also a 60 day lifetime reserve benefit for hospitalization and that benefit is $_____ per day which is always 50% of the current year's deductible.
- The cost of post hospital long term care in a skilled nursing facility for up to 100 days in each benefit period. The first 20 days are paid at 100%. The patient then pays $_____ a day from the 21st to the 100th day. (This amount is always 1/8th of the current year's deductible.
- An unlimited number of post-hospital home health services. The patient pays nothing toward home health services.
- Hospice care for terminally ill patients.

States are required to pay the Medicare premiums and cost-sharing for Medicaid recipients and other indigent persons who qualify for Medicare. States must also pay the Medicare deductibles, coinsurance, and the amount of the approved charge which must be paid under the Supplementary Medical Insurance plan for the indigent.

WHAT INPATIENT BENEFITS ARE PAID?

Except for the "deductible" and "coinsurance" amounts which must be paid by the patient, Medicare helps pay for inpatient hospital service for up to 90 days in each "benefit period."

Medicare will also pay (except for a coinsurance amount) for 60 additional hospital days over each person's lifetime (applies to disabled beneficiaries at any age; others after age 65).

Medicare pays for hospital care if the patient meets the following four conditions: (1) a doctor prescribes inpatient hospital care for treatment of the illness or injury, (2) the patient requires the kind of care that can only be provided in a hospital, (3) the hospital is participating in Medicare, and (4) the Utilization Review Committee or a Peer Review Organization (PRO) does not disapprove of the stay.

The coinsurance amounts are based on those in effect when services are furnished, rather than on those in effect at the beginning of the beneficiary's spell of illness (benefit period).

The 90-day benefit period starts again with each spell of illness. A "benefit period" begins the day a patient is admitted to a hospital. It ends when the patient has been in neither a hospital nor a facility primarily furnishing skilled nursing or rehabilitative services for 60 straight days. There is no limit on the number of 90-day benefit periods a person can have in a lifetime (except in the case of hospitalization for mental illness). However, she "lifetime reserve" of 60 days is not renewable.

The following inpatient services are covered:

* Bed and board in a semi-private room (two to four beds) or a ward (five or more beds). Medicare will pay the cost of a private room only if it is required for medical reasons. If the patient requests a private room, Medicare will pay the cost of semi-private accommodations; the patient must pay the extra charge for the private room. The patient or family must be told the amount of this extra charge when a private room is requested. Normally, Medicare patients are assigned to semi-private rooms. Ward assignments are made only under extraordinary circumstances.

- Nursing services provided by or under the supervision of licensed nursing personnel (other than the services of a private duty nurse or attendant).

- Services of the hospital's medical social workers.

- Use of regular hospital equipment, supplies and appliances, such as oxygen tents, wheel chairs, crutches, casts, surgical dressings, and splints.

- Drugs and biologicals ordinarily furnished by the hospital.

- Diagnostic or therapeutic items and services ordinarily furnished by the hospital or by others (including clinical psychologists, as defined by the Health Care Financing Administration), under arrangements made with the hospital.

- Operating room costs, including hospital costs for anesthesia services.

- Services of interns and residents in training under an approved teaching program.

- Blood transfusions, after the first three pints. Patients must pay for the first three pints of blood unless they secure donors or the hospital receives the blood at no charge other than a processing charge. Medicare pays blood processing charges beginning with the first pint. The term "blood" includes packed aught blood cells as

well as whole blood. If the blood deductible is satisfied under Part B of Medicare, it will reduce the blood deductible requirements under Hospital Insurance (Part A).

- X-rays and other radiology services, including radiation therapy, billed by the hospital.
- Lab tests.
- Cost of special care units, such as an intensive care unit, coronary care unit, etc.
- Rehabilitation services, such as physical therapy, occupational therapy, and speech pathology services.
- Appliances (such as pacemakers, colostomy fittings, and artificial limbs) which are permanently installed while in the hospital.
- The Basic Hospital Insurance Plan does not pay for:
- Services of physicians and surgeons, including the services of pathologists, radiologists, anesthesiologists, and physiatrist. (Nor does Part A of Medicare pay for the services of a physician, resident physician or intern—except those provided by an intern or resident in training under an approved teaching program.)
- Services of a private duty nurse or attendant, unless the patient's condition requires such services and the nurse or attendant is a bona fide employee of the hospital.
- Personal convenience items supplied at the patient's request, such as television rental, radio rental, or telephone.
- The first three pints of blood.
- Supplies, appliances and equipment for use outside the hospital, unless continued use is required (e.g., a pacemaker).

WHAT IS AN HMO?

A Health Maintenance Organization (HMO) is a form of prepayment group practice providing service to its enrollees either directly or under arrangements with hospitals, skilled nursing facilities, or other health care suppliers. Generally, services include those covered under both the Basic Hospital Insurance Plan and the voluntary Supplementary Medical Insurance Plan, and are available to all Medicare beneficiaries in the area served by the HMO.

Qualified HMOs are paid on an estimated per capita basis. Such payments are made only to established HMOs, which are those: (I) with a minimum enrollment of 25,000, not more than half of whom are age 65 or older, and (2) which have been in operation for at least two years. Exception to the size requirement is provided for HMOs in small communities or sparsely populated areas (5,000 members and three years of operation).

HMOs which do not meet the requirements for fully qualified HMOs can contract for Medicare participation and be paid on a reasonable cost basis for their services.

The Department of Health and Human Services designates a single 3 day period each year in which all HMOs in an area participating in Medicare must have an open enrollment period. During this 3 day period, HMOs must accept Medicare beneficiaries up to the limits of their capacity.

An individual may un-enroll from an HMO effective on the first day of the calendar month following the date on which he requested un-enrollment. Under previous law, un-enrollment could not be effective until the first day of the second month following the date on which the individual requested un-enrollment.

HMOs must provide assurances to the Health Care Financing Administration that if they cease to provide items and services for which they have contracted, they will provide or arrange for supplemental coverage of Medicare benefits relating to a preexisting condition. This requirement applies to all individuals enrolled with HMOs who receive Medicare benefits. Items and services must be provided for six months or the duration of the exclusion period, whichever is less.

HMO beneficiaries must pay the same Medicare premiums as other Medicare beneficiaries.

CAN YOU BE AN INPATIENT IN A PSYCHIATRIC HOSPITAL?

Yes, but benefits for psychiatric hospital care are subject to a lifetime limit of 190 days. Furthermore, if the patient is already in a mental hospital when he becomes eligible for Medicare, the time spent there in the 150-day period before becoming eligible will be counted against the maximum of 150 days available in such cases (including any later period of such hospitalization when he has not been out of a mental hospital for at least 60 consecutive days between hospitalizations).

However, this latter limitation does not apply to inpatient service in a general hospital for other than psychiatric care.

WHAT ABOUT CARE IN A CHRISTIAN SCIENCE SANATORIUM?

Benefits are payable for services provided by a Christian Science sanatorium operated or certified by the First Church of Christ Scientist in Boston. In general, these institutions can participate in the plan as a hospital and the regular coverages and exclusions relating to inpatient hospital care apply. Thus, the patient pays the current year's deductible for the first 60 days, and coinsurance of 25% of the current year's deductible per day, for the next 30 days (plus 50% of the current year's deductible per day for the 60 day lifetime reserve days). A Christian Science sanatorium may also be paid as a skilled nursing facility. However, extended care benefits will be paid for only 30 days in a calendar year (instead of the usual 100 days), and the patient must pay the

coinsurance amount(1/8 of the current year's deductible) for each day of service (instead of from the 21st to 100th day).

ARE YOU ALLOWED TO CHOOSE YOUR OWN HOSPITAL?

Except for certain emergency cases, Medicare will pay only to "qualified" hospitals, skilled nursing facilities, home health agencies and hospices.

Use of a Mexican or Canadian hospital by a United States resident is authorized when such hospital is closer to his residence or more accessible than the nearest hospital in the United States. But such hospitals must be approved. Medicare also authorizes payment for emergency care in a Canadian hospital when the emergency occurred in the United States or in transit between Alaska and other continental states. Necessary physicians' services in connection with such Mexican or Canadian hospitalization are authorized under Medicare's Supplementary Medical Insurance Plan.

IS DOCTOR CERTIFICATION FOR HOSPITALIZATION REQUIRED?

Initial certification is no longer required except for inpatient psychiatric hospital services and inpatient tuberculosis hospital services. For prolonged hospital stays, however, certification by a doctor will be required as often, and with such supporting material, as is stipulated in regulations under the law.

HOW DOES AN HMO OR HOSPITAL QUALIFY FOR MEDICARE PAYMENTS?

It must meet certain standards and must enter into a Medicare agreement with the federal government. However, provision is made for paying nonparticipating hospitals in cases of emergency.

HOW IS HOSPICE CARE COVERED?

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

Hospice care is covered under the Hospital Insurance Plan when the beneficiary: (1) is eligible for Hospital Insurance benefits, (2) is certified as terminally ill (i.e., his life expectancy is six months or less), and (3) files a statement electing to waive all other Medicare coverage for hospice care from hospice programs other than the one he has chosen, and electing no to receive other services related to treatment of the terminal condition. (The beneficiary can later revoke the election.)

The following are covered hospice services:

* Nursing care provided by or under the supervision of a registered nurse.

* Physician's services.

* Medical social services provided by a social worker under a physician's direction.

* Counseling (including dietary counseling) with respect to care of the terminally ill patient and adjustment to his death.

* Short-term inpatient care provided in a participating hospice, hospital or skilled nursing facility.

* Medical appliances and supplies, including drugs and biologicals. Only drugs used primarily to relieve pain and control symptoms of the terminal illness are covered.

* Services of a home health aide and homemaker services.

The benefit period consists of two 90-day periods and one 30-day period.

The hospice benefit may be extended beyond the 210-day limit if the beneficiary is recertified as terminally ill by the medical director or the physician member of the interdisciplinary group of the hospice program.

The amount paid by Medicare is equal to the reasonable costs of providing hospice care or based on other tests of reasonableness as prescribed by regulations. No payment may be made for bereavement counseling, and no reimbursement may be made for other counseling services (including nutritional and dietary counseling) as separate services.

Prescription drugs for symptom management and pain relief are covered, whether in or out of a hospice, with coinsurance of 5% of reasonable cost (but not more than $5 per prescription).

Respite care as an inpatient in a hospice (to give a period of relief to the family providing home care for the patient, available for no more than 5 consecutive days) is covered with coinsurance of 5% (but not to exceed, in the aggregate in a period of respite care (which ends after 14 consecutive days when the hospice care option is not in effect), the amount of the hospital initial deductible in effect when the hospice benefits coverage began).

Persons must be certified as terminally ill within two days after hospice care is initiated. However, beginning January 1, 1990, if verbal certification is provided within two days, certification may occur within eight days after care is initiated.

WHAT IS CONSIDERED A QUALIFIED SKILLED NURSING CARE FACILITY?

A skilled nursing facility may be a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital, or a section of a facility another part of which is an old-age home. Not all nursing homes will qualify; those which offer only custodial care

are excluded. The facility must be primarily engaged in providing skilled nursing care or rehabilitation services for injured, disabled or sick persons. At least one registered nurse must be employed full-time and adequate nursing service (which may include practical nurses) must be provided at all times. Every patient must be under the supervision of a doctor, and a doctor must always be available for emergency care.

Generally, the facility must be certified by the state. It also must have a written agreement with a hospital that is participating in the Medicare program for the transfer of patients.

Skilled nursing care is care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled nursing care and skilled rehabilitation services must be needed and received on a daily basis (at least five days a week) or the patient is not eligible for Medicare coverage.

A skilled nursing facility must provide 24 hour nursing service and must employ a registered professional nurse during a day tour of duty of at least 8 hours a day, seven days a week. The facility must require that the medical care of every resident be provided under the supervision of a physician, and have a physician available to furnish necessary medical care in case of emergency.

Many residents of nursing homes will not qualify for Medicare coverage because coverage is restricted to patients in need of skilled nursing and rehabilitative services on a daily basis.

The initial determination of Medicare coverage is made by the nursing home, but the nursing home cannot charge the patient for care provided before it notifies the patient in writing that it believes Medicare will not pay for the care. The patient may not challenge the nursing home's non-coverage determination until a claim has been submitted to and denied by the Medicare intermediary. The patient does have the right to require a nursing home to submit its claim to the Medicare intermediary so that the intermediary can determine if the nursing home was correct in denying coverage.

Skilled nursing facilities must provide patients with the following rights:

- equal access and admission,
- notice of rights and services,
- transfers and discharge rights,
- the right to pre-transfer and pre-discharge notice,
- access and visitation rights,
- rights relating to the protection of resident funds, and
- certain other specified rights.

An institution which is primarily for the care and treatment of mental diseases or tuberculosis is not a skilled nursing facility.

Most nursing homes in the United States are *not* skilled nursing facilities and many skilled nursing facilities are not certified by Medicare.

WHAT PROVISIONS ARE THERE FOR CARE IN A SKILLED NURSING OR OTHER SUCH TYPE FACILITY?

In order to qualify for extended care benefits, the patient must have been hospitalized for at least three days, and must have been admitted to the skilled nursing facility within 30 days after discharge from the hospital.

Legislation enacted in 1982 permits skilled nursing facility coverage without regard to the three-day prior hospital stay requirement if there is no increase in cost to the program involved, and the acute care nature of the benefit is not altered. Persons covered without a prior hospital stay may be subject to limitations in the scope of or extent of services. The Department of Health and Human Services will decide when to lift the three-day prior hospital stay requirement but has not done so yet (and is not likely to do so).

Except for a coinsurance amount payable by the patient after the first 20 days, Hospital Insurance will pay the reasonable cost of post-hospital care in a skilled nursing facility for up to 100 days in a benefit period.

The following items and services are covered:

* Bed and board in semi-private accommodations (two to four beds in a room).
* Nursing care provided by, or under the supervision of, a registered nurse (but not private-duty nursing).
* Drugs, biologicals, supplies, appliances and equipment for use in the facility.
* Medical services of interns and residents in training under an approved teaching program of a hospital.
* Other diagnostic or therapeutic services provided by a hospital with which the facility has a transfer agreement.
* Rehabilitation services, such as physical, occupational, and therapy.
* Such other health services as are generally provided by a skilled nursing facility.

The following services are not covered:

* Personal convenience items that the patient requests, such as a television, radio, or telephone.

Private duty nurses or attendants.

* Any extra charges for a private room, unless it is determined to be medically necessary.

* Custodial care, including assistance with the activities of daily living (i.e., walking, getting in and out of bed, bathing, dressing, and feeding), special diets, and supervision of medication that can usually be self administered.

Federal regulations include the following services for skilled rehabilitation and nursing care: (1) insertion and sterile irrigation and replacement of catheters, (2) application of dressing involving prescription medications and aseptic techniques, (3) treatment of

extensive bed sores or other widespread skin disorders, (4) therapeutic exercises or activities supervised or performed by a qualified occupational or physical therapist, (5) training to restore a patient's ability to walk, and (6) range of motion exercises that are part of a physical therapist's active treatment to restore a patient's mobility.

A number of services involving the development, management and evaluation of a patient care plan may qualify as skilled services. These services are "skilled" if the patient's condition requires the services to be provided or supervised by a professional to meet the patient's needs, promote recovery, and ensure the patient's medical safety. For example, a patient with a history of diabetes and heart problems,
who is recovering from a broken arm, may require skin care, medication, a special diet, an exercise program to preserve muscle tone, and observation to detect signs of deterioration or complications. Although none of these required services are "skilled" on their own, the combination, provided by a professional, may be considered "skilled."

To qualify for skilled nursing facility reimbursement, skilled physical therapy must be: (I) specifically related to a physician's active treatment plan, (2) of a complexity, or involve a condition, that requires a physical therapist, (3) necessary to establish a safe maintenance program or provided where the patient's condition will improve within a predictable time, and (4) of the necessary frequency and duration.

WHAT COSTS DOES THE PATIENT PAY FOR SKILLED NURSING?

The patient pays nothing for the first 20 days of covered services in each spell of illness; after 20 days, coinsurance is payable for each additional day, up to a maximum of 80 days. For a patient in a skilled nursing facility during this current year, the coinsurance is 1/8 of the current year's deductible per day.

There is no lifetime limit on the amount of skilled nursing facility care provided under Hospital Insurance. Except for the coinsurance (which must be paid after the first 20 days in each spell of illness), the plan will pay the cost of 100 days' post-hospital care in each benefit period, regardless of how many benefit periods the person may have. After 100 days of coverage, the patient must pay the full cost of skilled nursing facility care.

WHEN WILL PAYMENT BE MADE FOR THIS CARE?

Payment will be made for skilled nursing care only if the following conditions are met:

(1) The beneficiary files a written request for payment (another person may sign the request if it is impracticable for the patient to sign).

(2) A physician certifies that the patient needs skilled nursing care on an inpatient basis. Recertification is required for extended stays.

(3) The facility is "participating" under Medicare law. Hospital Insurance cannot pay for a person's stay if he needs skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if a person does not need to be in a skilled nursing

facility to get skilled rehabilitation services. And, Hospital Insurance cannot pay for a person's stay if the rehabilitation services are no longer improving his condition and could be carried out by someone other than a physical therapist or physical therapist assistant.

Hospital Insurance covers the cost of an unlimited number of home health visits made on an "intermittent" basis under a plan of treatment established by a physician.

"Intermittent" is defined, in general, as care for up to six days a week, for up to three consecutive weeks (but not more than 35 hours per week).

A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy, in the home.

Hospital Insurance can pay for home health visits if all four of the following conditions are met:

(1) The care provided includes intermittent part-time skilled nursing care, physical therapy, or speech therapy,

(2) The person is confined at home,

(3) A doctor determines the need for home health care and sets up a home health plan for the person, and

(4) The home health agency providing services is participating in Medicare.

A doctor must certify that the person is under a doctor's care, under a plan of care established and periodically reviewed by a doctor, confined to the home, and in need of: (1) skilled nursing care on an intermittent basis, or (2) physical or speech therapy, or has a continued need for (3) occupational therapy when eligibility for home health services has been established because of a prior need for intermittent skilled nursing care, speech therapy, or physical therapy in the current or prior certification period.

Home health aids, whether employed directly by a home health agency or made available through contract with another entity, must successfully complete a training and competency evaluation program or competency evaluation program approved by the Department of Health and Human Services.

Generally, a doctor may not make the determination in item 3 above for a patient with any agency in which the doctor has a significant ownership interest or a significant financial or contractual relationship. However, a doctor who has a financial interest in an agency which is a sole community health agency may carry out certification and plan of care functions for patients served by that agency.

IS POST-HOSPITAL HOME HEALTH COVERED?

The following post-hospital home health services are covered under Hospital Insurance:

* Intermittent part-time skilled nursing care.

* Physical therapy.

* Speech therapy.

If a person needs intermittent part-time skilled nursing care, physical therapy, or speech therapy, Medicare also pays for:

* Part-time services of a home health aid.

* Medical social services.

* Medical supplies.

* Durable medical equipment (80% of approved cost)

* Occupational therapy.

The patient pays nothing for home health visits.

Both Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) cover home health visits, but Hospital Insurance pays if the patient is eligible under both programs. There is no limit to the number of visits.

Medicare does not cover home care services furnished primarily to assist people in meeting personal, family, and domestic needs. These non-covered services include general household services, preparing meals, shopping, or assisting in bathing, dressing, or other personal needs. Medicare also does not pay for: (1) full-time nursing care at home, (2) drugs and biologicals, and (3) blood transfusions.

While the patient must be homebound to be eligible for benefits, payment will be made for services furnished at a hospital, skilled nursing facility, or rehabilitation center if the patient's condition requires the use of equipment that ordinarily cannot be taken to the patient's home. However, Medicare will not pay the patient's transportation costs.

A patient is considered "confined to the home" if he or she has a condition, due to illness or injury, that restricts the ability to leave home except with the assistance of another person or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the patient has a condition such that leaving home is medically unsafe. While a patient does not have to be bedridden to be considered "confined to the home", the condition should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing
effort, and that absences from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

Infrequent means an average of five or fewer absences per calendar month, excluding absences to receive medical treatment that cannot be furnished in the home. Short duration means an average of three or fewer hours per absence from the home within a calendar month, excluding absences to receive medical treatment that cannot be furnished in the home. Absences for medical treatment must be: (1) based on and in

conformance with a physician's order; (2) by or under the supervision of a licensed health professional; and (3) for the purpose of diagnosis or treatment of an illness or injury.

Home health agencies are required to provide patients with the following rights: (1) the right to be informed of and to participate in planning care and treatment, (2) the right to confidentiality of clinical records, (3) the right to voice grievances, (4) the right to advance notice, including notice in writing, of items and services for which payment will and will not be paid by Medicare, (5) the right to have property treated with respect, (6) the right to be fully informed in advance of Medicare rights and obligations, and (7) the right to be informed of the availability of a state Home Health Agency Hot Line.

ARE OUTPATIENT COSTS PAID?

No, outpatient diagnostic services are covered under the Supplementary Medical Insurance Plan.

MUST YOU BE IN FINANCIAL NEED TO RECEIVE BENEFITS?

No, benefits are payable to rich and poor alike.

WILL THE DEDUCTIBLE & COINSURANCE REMAIN THE SAME?

No. The initial deductible for inpatient hospital care for the current year is based on the 1966-68 figure of $40 and increases in average per diem inpatient hospital cost since 1966 (and also some legislative changes) and, beginning with the 1987 determination, on increases in average national hospital costs, based on a hospital-cost "market basket" index. The daily coinsurance amounts are based on this per diem rate. The daily coinsurance for inpatient hospital care for the 61st through 90th days in a benefit period is 25% of the current year's deductible. The daily coinsurance for post-hospital extended care after 20 days is 1/8 of the current year's deductible. The lifetime reserve days' coinsurance is 50% of the current year's deductible.

3

PART B: SUPPLEMENTAL MEDICAL INSURANCE

UNDER THE SUPPLEMENTAL PROGRAM, WHO IS ELIGIBLE?

All persons entitled to Medicare Hospital Insurance may enroll in the Supplementary Medical Insurance Plan (Part B). Thus, Social Security and Railroad Retirement beneficiaries, age 65 or over, are automatically eligible. Other persons age 65 or over may enroll provided they are residents of the United States and are either: (1) citizens, or (2) lawfully admitted aliens who have resided in the United States continuously for at least five years at the time of enrollment.

Disabled beneficiaries (workers under age 65, widows aged 50-64, and children aged 18 or over disabled before age 22) who have been on the benefit roll as a disability beneficiary for at least two years are covered in the same manner as persons age 65 or over. (This includes disabled railroad retirement beneficiaries.) Disability cases are also covered for 36 months after cash benefits cease for a worker who is engaging in substantial gainful employment but has not medically recovered. (Disability benefits are, under such circumstances, paid for the first nine months of the trial-work period and then for an additional three months.) After 36 months, and during continued disability, voluntary coverage is available in the same manner as for non-insured persons age 65 or over.

Also covered are persons with end-stage renal disease who require dialysis or kidney transplant and are eligible for Hospital Insurance (Part A).

HOW DOES ONE ENROLL?

Those who are receiving Social Security and Railroad Retirement benefits will be enrolled automatically at the time they become entitled to Hospital Insurance unless they elect not to be covered by signing a form, which will be sent to them. Others may enroll at their nearest Social Security office.

A notice of automatic enrollment is sent to persons automatically covered because of entitlement to social security or railroad retirement benefits. A person must file the form rejecting coverage before coverage begins or, if later, within two months after the month in which the notice of automatic enrollment was sent to him.

A person's initial enrollment period is a seven-month period beginning on the first day of the third month before the month age 65 is attained. For example, if the person's 65th birthday is April 10, 1997 the initial enrollment period begins January 1, 1997 and ends July 31, 1997.

If a person decides not to enroll in the initial enrollment period, he or she may enroll during a general enrollment period.

In order to obtain coverage at the earliest possible date, a person must enroll before the beginning of the month in which age 65 is reached. For a person who enrolls during the initial enrollment period, the effective date of coverage is as follows:

(1) If the person enrolls before the month in which age 65 is reached, coverage will commence the first day of the month in which age 65 is reached.

(2) If the person enrolls during the month in which age 65 is reached, coverage will commence the first day of the following month.

(3) If the person enrolls in the month after the month in which age 65 is reached, coverage will commence the first day of the second month after the month of enrollment.

(4) If the person enrolls more than one month, but at least within three months) after the month in which age 65 is reached, coverage will commence the first day of the month following the month of enrollment.

A seven-month special enrollment period is provided if Medicare has been the secondary payor of benefits for individuals age 65 and older who are covered under an employer group health plan because of current employment. The special enrollment period generally begins with the month in which coverage under the private plan ends.

Coverage under Supplementary Medical Insurance will begin with the month after coverage under the private plan ends if the individual enrolls in such month - or with the month after enrollment, if the individual enrolls during the balance of the special enrollment period.

WHAT HAPPENS IF I DECLINE TO ENROLL DURING THE AUTOMATIC ENROLLMENT PERIOD?

Anyone who declines to enroll during his initial enrollment period may enroll during a general enrollment period. There are general enrollment periods each year from January 1st through March 31st. Coverage begins with the following July.

The premium will be higher for a person who fails to enroll within 12 months, or who drops out of the plan and later re-enrolls. The monthly premium will be increased by 10% for each full 12 months during which he could have been, but was not, enrolled.

If a person declines to enroll (or terminate enrollment at a time when Medicare is secondary payor to his employer group health plan, the months in which he is covered under the employer group health plan (based on current employment) and Hospital Insurance will not be counted as months during which he could have been but was not enrolled in Supplementary Medical Insurance for the purpose of determining if the premium amount should be increased above the basic rate.

CAN A STATE ENROLL ME?

A state may enroll and pay the premiums for a person eligible to enroll for Supplementary Medical Insurance and qualifying for welfare assistance if it requested an agreement to do so with the Department of Health and Human Services before January 1, 1970, or during 1981. The types of welfare assistance recipients the state agrees to enroll are called the "coverage group."

WHO FINANCES SUPPLEMENTAL MEDICAL INSURANCE?

Supplementary Medical Insurance is voluntary and is financed through premiums paid by people who enroll and through funds from the federal government. Each person who enrolls must pay a basic monthly premium, and the federal government will pay about three times as much as a matching amount from general revenues.

The premium rates are established by law. Premium rates may be increased from time to time if program costs rise. In September of each year (beginning in 1995), the government will announce the premium rate for the 12-month period starting the following January.

As to the premium rate after 1995, should no Social Security cost-of-living adjustment take place, the monthly premium will not be increased for that year. In the case of an individual who has the Supplementary Medical Insurance premium deducted from the Social Security check, if the amount of the cost-of-living adjustment is less than the

amount of the increase in the premium, the premium increase will be reduced so as to avoid a reduction in the individual's net Social Security check.

The monthly premium for each individual enrolled in the Supplementary Medical Insurance Plan will be $_____for the current year. **(Please see the insert).**

The premium rate for a person who enrolls after the first period when enrollment is open, or who re-enrolls after terminating coverage, will be increased by 10% for each full 12 months he or she stayed out of the program.

These monthly premiums are, of course, in addition to the "deductible" and "coinsurance" amounts, which must be paid by the patient.

In addition to the "regular" monthly Supplementary Medical Insurance premium, each person enrolled in the Supplementary Medical Insurance Plan in 1989 paid an additional flat-rate premium of $4 (except for persons who were not covered under Hospital Insurance, who paid nothing in 1989, but would have paid much larger additional flat-rate premiums in 1989 and after, than other persons).

Catastrophic coverage benefits after 1989 and the catastrophic coverage premium were repealed by the Medicare Catastrophic Coverage Repeal Act of 1989.

Persons covered will have the premiums deducted from their Social Security, railroad retirement or federal civil service retirement benefit checks. Persons who are not receiving any of these government benefits will pay the premiums directly to the government.

Direct payment of premiums is usually made on a quarterly basis with a grace period, determined by the Secretary of the Department of Health and Human Services, of up to 90 days.

Public assistance agencies may enroll, and pay premiums for, public assistance recipients (Supplemental Security Income program). States must pay premiums for specified low-income persons.

If a person's Social Security or railroad retirement benefits are suspended because of excess earnings, and benefits won't be resumed until the next taxable year, the person will be billed directly for overdue Medicare premiums. If Social Security or railroad retirement benefits will be resumed before the close of the taxable year, overdue premiums are deducted from the Social Security or railroad retirement cash benefits when they resume.

Premiums must be paid for the entire month of death even though coverage ends on the day of death.

HOW DO THEY DETERMINE APPROVED CHARGES?

A new system of Medicare Part B payments to doctors and suppliers is being phased in over a five year period, beginning January 1, 1992.

Before January 1 of each year beginning with 1992, the Health Care Financing Administration must establish, by regulation, fee schedules for payment amounts for

physicians' services in all fee schedule areas. The fee schedule must include national uniform relative values for all physicians' services. The relative value of each service must be the sum of relative value units (RVUs) representing physician work, experience, and the cost of malpractice insurance. Nationally uniform relative values are adjusted for each locality by a geographic adjustment factor (GAF).

The new fee schedule must be phased in over four years, with the new rules fully effective in 1996. During 1992 through 1995, transition provisions generally blend the old payment amounts with the new.

According to the Health Care Financing Administration ' s impact analysis, Medicare payments under the new system will increase significantly for primary care and cognitive services and decline for procedure-based services. Payments to family and general practitioners will increase dramatically. Payments for surgical specialties will decrease. The system will be oriented toward primary care and most rural areas and away from specialized procedures and urban areas.

Prior to 1992, Medicare payments were based on the "reasonable charges" approved by the Medicare carrier. The Medicare carrier for an area determined the approved charges for covered services and supplies under a procedure prescribed by law. Each year, the carrier reviewed the actual charges made by doctors and suppliers in the area during the previous year. Based on this review, new approved charges were put into effect on October 1 of each year. First, the carrier determined the customary charge (generally the charge most frequently made) by each doctor and supplier for each separate service or supply furnished to patients in the previous calendar year. Next, the carrier determined the prevailing charge for each covered service and supply. The prevailing charge was the amount which was high enough to cover the customary charges in three out of every four bills submitted in the previous year for each service and supply. When a Medicare claim was submitted, the carrier compared the actual charge shown on the claim with the customary and prevailing charges for that service or supply. The charge approved by the carrier was either the customary charge, the prevailing charge, or the actual charge, whichever was lowest.

HOW ARE PAYMENTS MADE?

There are two ways payments are made under the Supplementary Medical Insurance Plan. Payment can be made directly to the doctor or supplier. This is the assignment method of payment. Or, payment can be made to the patient.

The assignment method, in which the doctor or supplier receives the Supplementary Medical Insurance payment directly from Medicare, can save the patient time and money. When the assignment method is used, the doctor or supplier agrees that his total charge for the covered service will be the charge approved by the Medicare carrier. Medicare pays the doctor or supplier 80% of the approved charge, after subtracting any part of the $ 100 deductible the patient has not paid.

The doctor or supplier can charge the patient only for the part of the $100 deductible he has not met and for the coinsurance, which is the remaining 20% of the approved

charge. Of course, a doctor or supplier also can charge the patient for any services that Medicare does not cover.

If a doctor does not accept assignment (nonparticipating physician), Medicare pays the patient 80% of the approved charge, after subtracting any part of the $100 deductible the patient has not paid. The doctor or supplier can bill the patient for his actual charge even if it is more than the charge approved by the Medicare carrier.

Effective for services on or after September 1, 1990 all Part B bills must be submitted to the carrier by the physician or supplier without charge, even if the physician or supplier does not take assignment. Claims must be submitted within one year of the date the service is provided.

Utilizing a doctor who accepts assignment under Medicare can make a big difference in a patient's out-of-pocket costs.

> ***Example***. Mrs. Smith has surgery after meeting the $100 deductible for Supplementary Medical Insurance. Dr. Jones, who is not a participating physician and does not limit his charges to the Medicare fee schedule, bills Mrs. Smith $1,200 for the surgery. The Medicare fee schedule sets the charge for this surgery at $1,100. Medicare will pay $880 (80 percent of the Medicare fee) and Mrs. Smith must pay the remaining $320 of the $1,200 fee.
>
> If Dr. Jones was a participating physician under Medicare, Mrs. Smith would have to pay only $220 (20 percent of the approved charge of $1,100 that Medicare does not pay).

If a physician does not accept the assignment method, he must refund all amounts collected from Medicare beneficiaries on claims for services that are deemed not medically necessary. The Medicare carrier will send a notice to the beneficiary and physician advising them of the basis for denial, the right of appeal, and the requirement of a refund.

There is a ceiling on the fees charged to Medicare patients by nonparticipating physicians.

Physicians must give written notice prior to elective surgery for which the fee is $500 or more. The notice must state the physician's estimated actual charge, the estimated Medicare-approved charge, the excess of the actual charge over the approved charge, and the applicable coinsurance amount. This requirement applies to non-emergency surgical procedures only. (Emergency surgery is surgery performed under conditions and circumstances, which afford no alternatives to the physician or the patient and, if delayed, could result in death or permanent impairment of health.)

If the physician fails to make this fee disclosure, and the surgery was non-emergency surgery, the physician must refund amounts collected in excess of the

Medicare-approved Part B charge. The physician is subject to sanctions if he knowingly and willfully fails to comply with this refund requirement.

DO ALL DOCTORS ACCEPT ASSIGNMENT AND HOW DO I FIND OUT IF THEY DO?

Doctors and suppliers sign agreements in advance to accept assignment for all Medicare claims. They are given the opportunity to sign participation agreements each year.

The names and addresses of Medicare-participating doctors and suppliers are listed in the Medicare-Participating Physician/Supplier Directory. This directory is available for review in all Social Security offices and state and area offices of the Administration on Aging. Also, the directory can be purchased from any Medicare carrier.

Participating doctors and suppliers may display emblems or certificates, which show that they accept assignment on all Medicare claims.

WHAT IS A MEDICARE SUPPLIER?

Suppliers are persons or organizations, other than doctors or health care facilities that furnish equipment or services covered by Supplementary Medical Insurance. For example, ambulance firms, independent laboratories, and organizations that rent or sell medical equipment are considered suppliers.

WHAT PORTION DOES THE PATIENT PAY?

The patient pays the first $1000 of covered expenses incurred in each calendar year. Medicare pays 80% of the balance of the approved charges (50% generally for out-of-hospital psychiatric services) over the $100 deductible. However, there is no cost-sharing for most home health services, pneumococcal vaccine, the costs of second opinions for certain surgical procedures when Medicare requires such opinions, and out patient clinical diagnostic laboratory tests performed by hospitals

and independent laboratories which are Medicare-certified and by physicians who accept assignment.

HOW DO YOU FIND OUT HOW MUCH WILL BE PAID?

After the patient or the doctor or supplier sends in a Supplementary Medical Insurance claim, Medicare will send the patient a notice entitled Explanation of Medicare Benefits to explain to the patient the decision on the claim.

This notice shows what services were covered, what charges were approved, how much was credited toward the patient's $ 100 annual deductible, and the amount Medicare paid.

WHAT SERVICES PERFORMED BY THE DOCTOR ARE COVERED?

Under the Supplementary Medical Insurance Plan, Medicare usually pays 80% of the approved charges for doctors' services and the cost of other services that are covered under the Hospital Insurance Plan after the patient pays the first $100 of such covered services in each calendar year. The following doctors' fees and services are covered by this portion of Medicare:

* Doctors' services are covered wherever furnished in the United States. This includes the cost of house calls, of office visits, and doctors' services in a hospital or other institution. It includes the fees of physicians, surgeons, pathologists, radiologists, anesthesiologists, physiatrist, and osteopaths.

* Services of clinical psychologists are covered if they would otherwise be covered when furnished by a physician (or as an incident to a physician's services).

* Services by chiropractors with respect to treatment of subluxation of the spine by means of manual manipulation are covered.

* Fees of podiatrists are covered, including fees for the treatment of plantar warts, but not for routine foot care. The cost of treatment of debridement of mycotic toenails i.e., the care of toenails with a fungal infection) is not included if performed more frequently than once every 60 days. Exceptions are authorized if medical necessity is documented by the billing physician. The Health Care Financing Administration is studying the cost effectiveness of covering therapeutic shoes for individuals with severe diabetic foot disease. The cost of such shoes, if prescribed by a podiatrist or other qualified physician, may be covered under Medicare.

- The cost of diagnosis and treatment of eye and ear ailments is covered. Also covered is an optometrist's treatment of aphakia.
- Plastic surgery for purely cosmetic reasons is excluded; but plastic surgery for repair of an accidental injury, an impaired limb or a malformed part of the body is covered.
- Radiological or pathological services furnished by a physician to a hospital inpatient are covered.
- Immuno-suppressive drugs used in the first year of transplantation are covered.

The cost of routine physical, most vaccine shots, examinations for eyeglasses (except after cataract surgery) and hearing aids is not covered.

Charges imposed by an immediate relative (e.g., a doctor who is the son/daughter or brother/sister of the patient) are not covered.

ARE OUTPATIENT PHYSICAL THERAPY & SPEECH PATHOLOGY COVERED?

Outpatient physical therapy and speech pathology services are covered if received as part of a patient's treatment in a doctor's office or as an outpatient of a participating hospital, skilled nursing facility, or home health agency or approved clinic, rehabilitative agency, or public health agency. Services must be furnished under a plan established by a physician or physical therapist. A physician is required to review all plans of care.

A podiatrist (when acting within the scope of his practice) is a physician for purposes of establishing a plan for outpatient physical therapy. A dentist and podiatrist are also within the definition of a physician for purposes of outpatient ambulatory surgery in a physician's office.

Supplementary Medical Insurance payment for services of independent physical therapists is limited to a maximum of $750 in approved charges in any one year. Services of independent occupational therapists are covered up to a maximum of $750 in approved charges for such services in a calendar year.

WHAT ABOUT PARTIAL HOSPITAL SERVICES WHEN CONNECTED TO A DOCTORS SERVICES?

Partial hospitalization services are items and services prescribed by a physician and provided in a program under the supervision of a physician pursuant to an individualized written plan of treatment. This is effective January 1, 1989.

The program must be hospital-based or hospital-affiliated and must be in a distinct and organized intensive ambulatory treatment service offering less than 24 hour daily care.

Covered items and services are:

- Individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized by state law).
- Occupational therapy requiring the skills of a qualified occupational therapist.
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients.
- Drugs and biologicals furnished for therapeutic purposes (which cannot be self-administered).
- Individualized activity therapies that are not primarily recreational or diversionary.
- Family counseling (the primary purpose of which is treatment of the individual's condition).
- Patient training and education (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment).
- Other necessary items and services (not including meals and transportation).

WHAT ABOUT CERTIFIED NURSE- MIDWIFE SERVICES?

Certified nurse-midwife services performed on or after July 1, 1988, are covered. A certified nurse-midwife is a registered nurse who has successfully completed a program of study and clinical experience meeting prescribed guidelines or who has been certified by a recognized organization and who performs services in the area of management of the care of mothers and babies throughout the maternity cycle.

Certified nurse-midwife services are services furnished by a certified nurse midwife and such services and supplies as are incident to the nurse-midwife's service. The service must be authorized under state law.

Coverage is not limited to services provided during the maternity cycle.

The amount paid by Medicare for such services is based upon a fee schedule but cannot exceed 65% of the prevailing charge allowed for the same service performed by a physician.

WHAT COVERAGE IS THERE FOR DENTAL WORK?

Dentists' bills for jaw or facial bone surgery, whether required because of accident or disease, are covered. Also covered are hospital stays warranted by the severity of the non covered dental procedure, and services provided by dentists which would be covered under current law when provided by a physician. However, bills for ordinary dental work are not covered.

WHAT COVERAGE IS THERE FOR MEDICAL EQUIPMENT?

The following medical equipment is covered: surgical dressings, splints, casts and other devices for reduction of fractures and dislocations; rental or purchase of durable medical equipment, such as iron lungs, oxygen tents, hospital beds and wheelchairs, for use in the patient's home; prosthetic devices, such as artificial heart
valves or synthetic arteries, designed to replace part or all of an internal organ (but not false teeth, hearing aids, or eyeglasses); colostomy or ileostomy bags and certain related supplies; breast prostheses (including a surgical brassiere) after a mastectomy; braces for arm, leg, back, or neck; and artificial limbs and eyes. Orthopedic shoes are not covered unless they are part of leg braces and the cost is included in the orthopedist's charge. Adhesive tape, antiseptics and other common first-aid supplies are also not included.

WHAT ABOUT AN AMBULANCE SERVICE?

Yes, but only if the patient's condition does not permit the use of other methods of transportation and the ambulance, equipment and personnel meet Medicare requirements. Supplementary Medical Insurance can help pay for ambulance transportation from the scene of an accident to a hospital, from a patient's home to a hospital or skilled nursing facility, between hospitals and skilled nursing facilities, or from a hospital or skilled nursing facility to the patient's home.

Also, if the patient is an inpatient in a hospital or skilled nursing facility which cannot provide a medically necessary service, Supplementary Medical Insurance can help pay for round trip ambulance transportation to the nearest appropriate facility. Medicare does not pay for ambulance use from a patient's home to a doctor's office.

Supplementary Medical Insurance usually can help pay for ambulance transportation only in the patient's local area. But, if there are no local facilities equipped to provide the care the patient needs, Supplementary Medical Insurance will help pay for necessary ambulance transportation to the closest facility outside the patient's local area that can provide the necessary care. If the patient chooses to go to another institution that is farther away, Medicare payment will be based on the reasonable charge for transportation to the closest facility.

Necessary ambulance services in connection with a covered inpatient stay in a Canadian or Mexican hospital can also be covered by Supplementary Medical Insurance.

WHAT IS PAID FOR PSYCHIATRIC OUTPATIENT TREATMENT?

Supplementary Medical Insurance will pay the cost of psychiatric treatment outside a hospital for mental, psychoneurotic or personality disorders, but with 50% coinsurance instead of the usual 20% (except that 20% coinsurance applies if services are provided on a hospital-outpatient basis if, in the absence thereof, hospitalization would have been required.)

ARE VACCINES COVERED?

The cost of pneumococcal vaccine is covered, and the cost of hepatitis B vaccine for high and intermediate risk individuals is covered when it is administered in a hospital or renal dialysis facility.

ARE ANTIGENS COVERED?

Antigens prepared by one doctor and sent to another for administration to the patient are covered.

IS A LIVER TRANSPLANT COVERED?

The Department of Health and Human Services is implementing a policy under which a liver transplant is not considered an experimental procedure for Medicare beneficiaries solely because an individual is over 18 years of age.

A liver transplant will be covered when reasonably and medically necessary. The Department of Health and Human Services will place appropriate limiting criteria on

coverage, disease state, and the institution providing the care, so as to ensure the highest quality of medical care demonstrated to be consistent with successful outcomes.

ARE SERVICES AT A COMPREHENSIVE OUTPATIENT FACILITY COVERED?

Under certain circumstances, Medicare can help pay for outpatient services received from a comprehensive outpatient rehabilitation facility (CORF). Outpatient services must be performed by a doctor or other qualified professionals in a qualified facility. Covered services include physicians' services; physical, speech, occupation and respiratory therapies; and counseling and other related services. A patient must be referred by a physician who certifies that there is a need for skilled rehabilitation services.

WHAT ABOUT HOME HEALTH CARE? IS IT COVERED?

Yes, an unlimited number of home health services each calendar year are covered. This would include the same services as described in B-25. A doctor must certify to the need for the home visits. These home visits are covered under the Hospital Insurance Plan unless the person only has Supplementary Medical Insurance coverage (and then under that program).

WHAT ABOUT INDEPENDENT CLINICAL LABS? AM I COVERED?

Yes, but a physician who includes charges for independent clinical laboratory services in his bill is entitled to the lesser of: (1) the approved charge of the laboratory, or (2) the amount actually charged by the physician. The physician's charge can include a small fee for handling the specimen.

ARE PAP SMEARS COVERED?

Screening pap smears for early detection of cervical cancer are covered beginning January 1, 1990. Coverage is provided for a screening pap smear once every three years, except in cases where the Health Care Financing Administration has established shorter time periods for testing women at high risk of developing cervical cancer.

IS SCREENING MAMMOGRAPHY COVERED?

Screening mammography is covered beginning January 1, 1991. Screening mammography is defined as a radiologic procedure provided to a woman for the early detection of breast cancer, including a physician's interpretation of the results of the procedure.

Medicare will cover screening mammography under the following guidelines:

(1) No payment will be made for screening mammography for women under age 35.

(2) Payment will be made for only one screening mammography for women over age 34 but under age 40.

(3) For women over age 39 but under age 50, payment will be made annually (provided eleven months elapse after the last screening) for those at high risk of developing breast cancer, or biennially (provided 23 months elapse after the last screening) for those not at high risk of developing breast cancer.

(4) For women over age 49 but under age 65, payment will be made annually (provided eleven months elapse after the last screening).

(5) For women over age 64, payment will be made biennially (provided 23 months elapse after the last screening).

IS POST-MENOPAUSAL OSTEOPOROSIS COVERED?

Beginning January 1, 1991, the cost of an injectable drug for the treatment of a bone fracture related to post-menopausal osteoporosis is covered under the following conditions: (1) the patient's attending physician certifies that the patient is unable to learn the skills needed to self-administer (or is physically or mentally incapable of administering) the drug, and (2) the patient meets the requirements for Medicare coverage of home health services.

ARE EYEGLASSES COVERED?

One pair of eyeglasses are covered following cataract surgery, beginning January 1, 1991.

WHAT OTHER BENEFITS ARE THERE?

Additional benefits include:

* The cost of blood clotting factors and supplies necessary for the self administration of the clotting factor.

* Services and supplies relating to a physician's services and hospital services rendered to outpatients; this includes drugs and biological which cannot be self-administered.

* Radiation therapy with X-ray, radium or radioactive isotopes (including technician services).

WHEN DOES COST SHARING APPLY?

A patient does not have to pay the $100 deductible or the 20% coinsurance for the following services: (1) the cost of second opinions for certain surgical procedures when Medicare requires a second opinion, (2) the cost of home health services except the 20% coinsurance charge applies for durable medical equipment (except for the purchase of certain used items), (3) pneumococcal vaccine, and (4) outpatient clinical

diagnostic laboratory tests performed by physicians who take assignments, or by hospitals or independent laboratories that are Medicare-certified.

IS BLOOD COVERED?

Both Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) can help pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration.

If a patient receives blood as an inpatient of a hospital or skilled nursing facility, the Hospital Insurance Plan can pay all of the blood costs, except for a deductible charged for the first three pints of whole blood or units of packed red cells in each benefit period. The deductible is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

The patient is responsible for the deductible for the first three pints or units of blood furnished by a hospital or skilled nursing facility in a calendar year. If the patient is charged a deductible, he has the option of either paying the deductible or having the blood replaced.

A hospital or skilled nursing facility cannot charge a patient for any of the first three pints of blood he replaces. Any blood deductible satisfied under the Supplementary Medical Insurance Plan will reduce the blood deductible requirements under the Hospital Insurance Plan. Prior to January 1, 1989, the three pint blood deductible applied separately under both the Hospital Insurance Plan and the Supplementary Medical Insurance Plan.

Supplementary Medical Insurance can help pay for blood and blood components received as an outpatient or as part of other covered services, except for a deductible charged for the first three pints or units received in each calendar year. After the patient has met the $100 deductible, Supplementary Medical Insurance pays 80% of the approved charge for blood starting with the fourth pint in a calendar year.

PART THREE:

CAFETERIA PLANS

1

A LOOK BACK IN TIME

Cafeteria plans are anything but new. Actually, they were developed during the early 1970's and at that time they were known as ZEBRAs. This stood for Zero Balance Reimbursement Account. These were accounts set up for key individuals in participating companies and were used to pay for certain benefits not ordinarily available to all employees. Payment was made by payroll deduction or through company contributions to a reimbursement account. Some of these programs were used to finance legitimate benefit programs, some for highly discriminatory plans. Because the programs were virtually unregulated, there was plenty of abuse.

The principal applied in the early plans was that because of the individual involved never really received the money, he or she should not have to pay taxes on that money. This is the same principle used to establish deferred compensation programs, though the circumstance surrounding deferred compensation are entirely different. There was another problem concerning ZEBRAS, an oversight that spelled their quick exit from the benefits field. The bottom line was, ZEBRAS did not live up to their name. They did not reduce to zero at year's end. Monies left in many of the account were allowed to recirculate into the same account the next year.

The Revenue Act of 1978 was directed at the ZEBRAS. Using the doctrine of constructive receipt, the Act disallowed all plans that involved the contribution of taxable income into accounts that, in essence, paid for personal expenses. The IRS contended that it did not matter whether or not an individual saw the money, touched the money, put the money in his or her pocket, the individual had the opportunity to put the money involved to his or her use and benefit. The recirculation of the funds at year's end confirmed the doctrine of constructive receipt. Hence, any money put into a ZEBRA account is considered income and thus taxable to the person for whom the account was established.

Since 1970, the whole issue of cafeteria plans has centered around constructive receipt. Section 125 of the Code specifically states that failure to meet the standards of

the Internal Revenue Code means all participants in the plan in question will be in constructive receipt of the funds.

The Revenue Act of 1978 blocked future development of ZEBRA plans. Not until 1984 when the Tax Reform Act of 1984 specified that money left in payroll deduction or company contribution accounts at the end of a taxable year was forfeit by the individual. This principle has become known as "use it or lose it". Though the 1984 Tax Reform Act constructive receipt, other guidelines were not issued. Guidelines for nondiscrimination, the types of benefit plans and funding methods. None were answered by the 1984 act.

This void of guidelines and regulations served as a block to the development of cafeteria plans. Employers just did not want to take the chance that their plan, if installed before all the guidelines were published, would not meet the federal standards and consequently be disallowed. The Tax Reform Act of 1986 addressed many of the much needed guidelines, thus paving the way for cafeteria plans; so much so that 22 percent of the corporations and businesses in the United States have installed them, with an expected growth rate of up to 50 percent of all businesses by the end of 1990.

It must be pointed out that the Revenue Act of 1987 targeted cafeteria plans on the amount of cash a plan participant would be eligible to take out of a plan. For a time, it seemed that the whole issue of cafeteria plans would go right back to square one, thought the Conference Committee of the House and Senate tabled the idea.

You can see that the history of cafeteria plans has not been a steady one, mainly because of the lack of clear, concise regulations and guidelines. These are now in place and we should have a clear path to the future, or, until the next tax reform act comes before Congress. Stay informed as to the current situation involving cafeteria plans. Many employers will not be aware of their present status and will attempt to turn off the conversation because they think the plans are still frozen in tax limbo. They are not. Let's go back to the basics for a few minutes to take a look at the comparisons between a traditional employee benefit plan and a cafeteria plan.

ESTABLISHED PLANS

- Long and Short Term Disability
- Dental Insurance
- Term Life Insurance
- Medical Coverage
- Retirement Income Plans

Disability Plans

Disability plans will pay benefits to a disabled employee based on a stated level of the individual's compensation. The level usually is based on the occupation, salary range and industry rating, or the differences that exist between certain types of nonhazardous, semi-hazardous, and hazardous occupation. You might find a short term disability income policy in effect at the company you are calling on. This type

pays a benefit for relatively short periods of time and might act as the deductible or gatekeeper to the long term disability plan. Short term disability income plans and long term plans serve the same purpose: To income for the employee while they are disabled.

Dental Insurance Plans

Dental insurance typically includes deductible amounts and coinsurance elements. The "cap" comes with a maximum amount that would be paid annually. One distinctive feature of dental insurance plans is that routine maintenance, such as cleaning, fluoride treatments, etc., usually is paid for 100 percent by the plan.

Term Life Insurance Programs

Term life insurance is usually stated in terms of salary (i.e. one times annual salary; two times annual salary). There is a maximum death benefit of $50,000 for employer paid contributions, beyond which the contributions are taxable to the employee. Sometimes family plan coverage is included, which pays a fixed face amount (i.e. $2,000) per dependent family member.

Medical Coverage Insurance

There are two types: A basic and a major medical superimposed on the basic plan. It also can be part of the benefit package as one plan - a comprehensive policy. The basic policy usually covers the more standard accidents or illnesses that call for short term hospital stays and medical costs that usually are determinable with reasonable accuracy. In most cases, the basic policy will have a "cap" or maximum that the plan will pay for any one sickness or injury. Once the cap is reached, benefits then are paid for by the super-imposed major medical policy. In this case, the basic plan acts as the deductible for the major medical policy. There is usually a stated dollar amount deductible and a coinsurance percent, typically 20 percent, paid for by the employee.

The major medical plan carries the basic medical plan benefits along with extended maximums to help pay for the more serious illnesses or accidents. The features are similar to the basic plan; a 20 percent coinsurance with a stated dollar deductible and a lifetime maximum benefit.

Retirement Income Plans

If the retirement program involves what is termed a "tax-qualified" plan this means that the plan has met all the requirements of the tax code and that all contributions to the plan are tax deductible to the employer. The employee's benefits usually are paid at retirement and are based on the amount of contributions made on his or her behalf, the length of time the contributions have been made and the growth of the investment fund over the course of time the employee has been a member of the plan. These six plans constitute a basic employee benefit package.

MANDATED PROGRAMS (REQUIRED BY LAW)

Now we will concentrate on those plans applicable to all states. Some states will have variations of these plans or will have individually mandated plans. The mandated plans common to all states are:

Social Security
Unemployment Compensation
Workers' Compensation

Social Security

Social Security is a federally administered plan that provides benefits for retiree's, the permanently and totally disabled, survivors of deceased plan participants and, under the Medicare phase of the program, hospital and medical care benefits for participants aged 65 or older. Contributions to the program are made by both employees and employers on a matching basis. A self employed person also is covered through contributions based on his or her self employment income. These contributions are paid to a government trust fund, from which benefits are paid.

Unemployment Compensation

This is a state-administered program, the federal government acts in the capacity of a supporting player. As the term indicates, benefits are paid to qualified individuals who have lost employment. These benefits are paid up to stated maximums to unemployed individuals while they seek employment elsewhere.

Contributions paid to the State depend on the amount of unemployment claims a particular company has. Should a company terminate 50 out of 100 employees as opposed to 25 out of 100 employees, the former would have a higher unemployment tax rate.

Workers' Compensation

This program was designed to cover a worker against sickness or injury on the job. The coverage is normally purchased through a private insurance carrier and the premium is based upon the company's payroll and the type of work involved.
Basically, benefits are paid for medical care, rehabilitation, disability and death. Over the years, workers' compensation has caused much controversy among unions, employees, state governments and others. However, for the most part, it is now well accepted throughout the country.

THE WORKINGS OF A CAFETERIA PLAN

Let's look at a basic employee benefit program concept and apply it to the Andex Corporation. Andex currently has these basic benefit plans:

- Group Term insurance equal the employee's annual pay.
- A medical plan with a $250 annual deductible, 20 percent coinsurance after the deductible up to $5,000, then the plan pays 100 percent up to a maximum of $35,000.
- Once the $35,000 maximum is reached the major medical portion of the plan kicks in and benefits are paid at 100 percent, up to a lifetime maximum of one million dollars.
- A long term disability plan paying up to 55 percent of salary.
- A dental insurance plan that pays 100 percent for preventive services with a $100 annual deductible for basic and major services for individuals; $200 for a family; with an annual maximum of $1,000 per individual.

Andex pays $170 per month for the whole package of benefits per individual. There are 50 employees at the firm and the current annual premium for Andex is $102,000 ($102,000 = $170 x 12 x 50). Andex has just received word that there will be a 30 percent rate increase in both the medical and dental plans, which will raise the total premiums for Andex to well over $132,000 per year.

Andex has decided that $170 per employee per month is as high as it intends to go. The company now wants to create an employee benefit program that will provide the employees with the security they want, at an affordable cost, and, at the same time, fit a wide variety of needs. How can a cafeteria plan help Andex?

First, design a "core benefit program" that provides a basic level of protection for each employee and his or her dependents (if applicable). Assume that the basic level of protection is: Group term life insurance equal to one half annual pay. A $500 deductible medical plan, 80 percent coinsurance up to $3,000 of covered expenses. The plan pays 100 percent of all covered expenses after the coinsurance up to a maximum of $50,000. 50 percent of annual pay long term disability plan. Dental insurance with a $200 annual deductible for individuals, $300 family; up to an annual maximum of $750 per individual.

Let's say the core package of benefits costs $127 per month per employee, leaving an excess of $40 per employee per month to finance the "optional benefit plans". These optional plans also can be paid for by the employee with before-tax dollars. In this case, let's assume that the employee may contribute up to $200 a month in before-tax earnings to the optional benefit portion of the program.

Adding the optional benefits area, the employees would find a wide variety of levels from which to choose. Reduced deductibles; higher maximum benefits; coverage for dependents; additional face amounts of group term life insurance - even additional plans for vision care or prescription drugs.

Every cost in the optional benefits area are paid for with the dollars set aside by the company in the form of "credits" and by the employee contributing before-tax dollars, which also can be converted into credits. Each optional benefit carries a price tag stated in terms of credits. Any credits not used could be paid out in cash to the

employee, or used to purchase additional personal life insurance, long-term disability or hospital indemnity coverage.

For example here is how the cafeteria plan works on a personal level; Doris has worked for Andex for five years. She earns a monthly gross salary of $1,600, is married with children in a day-care center. She pays $200 per month for the day-care and has personal unreimbursed medical expenses of $60 per month. Under the cafeteria plan, her optional benefit election totals $115 per month.

Gross Monthly Pay	$1,600.00
Federal and State Taxes	- 222.00
Social Security Deduction	- 120.00
Net Monthly Pay =	$1,258.00

If the cafeteria plan were not in place, Dolores' take-home pay would be further reduced by these amounts.

Net Monthly Pay	$1,258.00
day-care Expenses	-200.00
Personal Medical	-60.00
Group Medical Premium	-115.00
Net Pay =	$ 883.00

Note that Dolores' second round of reductions to her take home pay come at a point that is termed "below-the-line", meaning they are paid "after" all taxes have been deducted. A cafeteria plan participant is able to move the second round of reductions "above-the-line"

Look at this example of how the "Below-the-line" and "Above-the-line" reductions compare:

	With Cafeteria	**Without Cafeteria**
Gross Monthly Pay	$1,600.00	$1,600.00
Nontaxable Benefits:		
Group Medical	0	-115.00
Day Care	0	-200.00
Personal Medical	0	-60.00
Taxable Income	$1,600.00	$1,225.00
Federal & State Taxes	-222.00	-135.43
Social Security	120.16	- 91.99
After tax benefits costs	0	-375.00
Spendable Income	$ 882.84	$ 997.58

Monthly increase in take-home pay	$ 114.74
Annual increase in take-home pay	$1,376.88

How does this apply to the employer? Let's assume that Andex has 1,000 employees, all paid the same amount as Dolores and all having the same salary deductions as she has. Let's also assume that total payroll tax, state and federal, is 12 percent.

	With Cafeteria	Without Cafeteria	
Total Monthly Payroll	$1,600,000	$1,225,000	12 percent Payroll Taxes
	-192,000	-147,000	

Monthly difference in payroll taxes	$ 45,000
Annual difference in payroll taxes	$ 540,000

So far, we have discussed the "core-plus" program, a core of basic protection paid for by the employer with optional benefits selected by the employee. There is a **modular program**, as well as a **cost-shared program**, which we will cover later on.

What have we accomplished with the installation of a cafeteria plan at Andex.

All employees can now choose the benefits he or she wants and needs to fit his or her own personal program and budget. They will save money of their federal and states taxes. The owner gains boost in employee morale, a savings on payroll taxes, and some cost important controls.

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CAFETERIA PLANS TAX CONSIDERATIONS

AT THE FEDERAL LEVEL

Except for the sale and exchange of financial securities (stocks, bonds, etc.), perhaps no other financial arena in the United States today is as closely regulated and monitored as that of employee benefits. Such close scrutiny is mandated by law and backed by a multitude of regulations, each of which has a direct relationship with the other. The single most important purpose for these regulations is to very carefully define what can, and can't be done concerning cafeteria plans.

You need to be knowledgeable of the Internal Revenue code regulations on cafeteria plans. If a plan fails to meet **any** of the Code requirements, it will be disallowed. That means that it will not be regarded as a tax-deductible program for the employer. In addition to that, the employees covered under the plan would then be regarded as being in constructive receipt of the benefit dollars being spent on their behalf and would be liable for the taxes on those benefits dollars.

The Internal Revenue Code sections that deal with a cafeteria plan are:

Section 125 Sets forth specific regulations on cafeteria plans.
Section 79: Establishes group term life insurance regulations.
Section 89: Provides nondiscrimination regulations.
Section 105: Defines additional nondiscrimination regulations.
Section 129: Sets forth regulations on dependent child care.

REQUIREMENTS OF SECTION 125

If one were to view a cafeteria plan as a radio or television network, Section 125 would be the headquarters or flagship station. It is through this section of the code that the cafeteria plan draws one of it's generic names, **Section 125.** The IRS definition of a cafeteria plan is quite simple; any employee benefit program that allows a participant to choose among two or more benefits consisting of cash or otherwise nontaxable benefits is a cafeteria plan. Amounts contributed to the program are excludable form the income of the participant to the extent that they choose "qualified benefits."

In this instance, a "qualified benefit" plan would be the traditional medical expense plans long associated with basic and major medical, group life insurance and both long and short term disability plans. The section goes on to include as qualified those amounts that were normally considered to be out of pocket expenses under a traditional group medical plan; Eyeglasses, deductible, dental expense, coinsurance, and so forth. Also included under the qualified banner are expenses incurred for day care centers for dependent children.

As you might notice, the section also tells you what a cafeteria plan **isn't.** Under the Code, the following are **not** considered to be part of a cafeteria plan.

- Deferred compensation plans, if receipt of compensation is deferred beyond two and one half months after the close of the tax year, (December 31st), the plan is a deferred compensation plan.
- Scholarship or fellowship programs. Rules for these programs in Section 1941.
- Employer provided transportation, which is covered under Section 1987A.
- Education assistance programs (as in training courses or night school classes for employees), which are controlled by Section 1989.

Who is Eligible to Participate

There is only one rule for eligibility; No one can be required to complete more than **three** years of employment in order to be eligible to participate in a cafeteria plan. Anyone meeting the eligibility rule must be allowed to participate no later than the first day of the first plan year beginning after they have satisfied the employment requirement.

Regarding Anti-discrimination

This rule is easy to understand. A cafeteria plan may not discriminate in towards **highly compensated employees** regarding eligibility, contribution to the plan, or benefits.

A **highly compensated employee** is defined as one who, Is an officer of the sponsoring company with an income of $45,000 or more; Is a five percent owner of the sponsoring company; Is a member of the top 20 percent of the company earning $50,000 per year

or more; or, is an employee of the sponsoring company earning $75,000 or more per year.

The Tests of Eligibility

All cafeteria plans must establish their eligibility provisions so that 90 percent of the non-highly compensated employees are eligible to participate and would, if they participated, receive a benefit of at least 50 percent of the largest benefit available to a highly compensated employee. At least 50 percent of those eligible to join the cafeteria plan must be non-highly compensated employees. That no plan provisions discriminate in favor of highly compensated employees.

What Is a Key Employee by Definition

- An officer of the sponsoring company.
- A five percent or more owner of the sponsoring company.
- A one percent or more owner of the sponsoring company with $150,000 or more of annual compensation.
- One of the top ten individuals in terms of ownership in the sponsoring company.

As you can see, the definitions of a highly compensated employee and a key employee are much the same. The distinctions can be very subtle and important. This is true if you wish to gain plan approval by the IRS and to continue to have that plan tax approved. Form 5500 must be filed annually showing the benefits paid to assure that the plan does not discriminate in favor of key and highly compensated employees. If the plan does discriminate, it will be disqualified and all previous tax benefits received, such the reduction in taxable income and the business deduction for premiums and expenses paid for by the employer, will be termed taxable income.

To avoid these tax problems, and to assure that the plan is not discriminatory, the key and highly compensated employees must not receive more than 25 percent of the total benefits provided all employees during the plan year. This means that if total benefits for the year came to $100,000, the benefits paid to the key and highly compensated group cannot exceed $25,000 for that plan year.

The Alternative Test

As the title implies, the alternative test can be used as an alternative to the eligibility test mentioned earlier. The alternative test requires that at least 80 percent of the non-highly compensated employees must be covered at all times during the plan year. In addition, the plan must not contain any eligibility provision that discriminates in favor of highly compensated employees.

While the alternative test seems to be a more attractive method to meet the requirements of the Code, you should know that an 80 percent participation percentage at all times could be an extremely difficult objective to meet, especially in light of a high turnover industry or company. A second caution is also in order; The alternative test could be amended in future years as sections of the code are reviewed by the IRS and new sections published.

Rules for Participation

If an individual participates in a cafeteria plan, he or she will not be eligible to use the medical insurance premiums, or additional medical expenses incurred during the tax year, as a deduction on Schedule A. The same holds true for the tax credit available for child care.

Any funds left in a cafeteria plan account at the end of the tax year must be forfeited. (Use it or lose it!). Profit-Sharing, 401(k), and stock bonus plans are the only deferred compensation plans allowed. Amounts from one account cannot be used to pay expenses for another account. A participant cannot make any changes in his or her account(s) during the year unless the participant terminates employment, gets married, has a child, or has a death in the immediate family.

Rules Regarding Reporting Requirements

The employer must report the following information each year:
The number of employees of the employer; the number of employees eligible to participate under the plan; the number of employees actually participating in the plan; the total cost of the plan during the year; the number of highly compensated individuals in the company; and the name, address, and identification number of the employer; along with a description of the type of business in which the employer is engaged.

SECTION 79: GROUP TERM LIFE INSURANCE

Section 79 covers the group term life insurance aspect of a cafeteria plan. Normally, employer paid life insurance premiums are not an excludable amount under a cafeteria plan. However, owing to its presence as a major employee benefit, cafeteria plans are allowed to include group term life coverage up to a maximum of $50,000 of face amount.

Premiums used to pay in excess of that face amount are taxable income for the employee participant. The language covering eligibility and participation are identical to Section 125.

SECTION 89: NONDISCRIMINATION

Section 89 is the Code section upon which the previous Code sections (especially Section 125) depend for the definitions of highly compensated individuals, the eligibility rules and the nondiscrimination rules. Under prior law, discriminatory plans were permissible if an employer did not have a cafeteria plan. As of January, 1989, final regulations were effective for all plan years. As Section 89 is now fully effective and synchronized with the other Code sections, the discriminatory plans also must be amended, or face the loss of their tax-qualified status.

SECTION 105: MORE NONDISCRIMINATION

Additional rules are: The cafeteria plan may not discriminate in favor of highly compensated employees regarding eligibility to participate. Additionally, the plan must provide the same benefits to non-highly compensated employees as provided to highly compensated employees.

SECTION 129: DAY-CARE PROGRAMS

A taxpayer cannot set up a dependent care account within a cafeteria plan, receive the benefits of having his or her taxable income reduced by the amounts spent for dependent care, and then also take the tax credit on his or her form 1040.

Day-care assistance within the Cafeteria plan

There is a $5,000 cap on the amount excludable from the gross income of participating employees. This cap is reduced to $2,500 for a married employee filing a separate return. Individuals choosing the exclusion from taxable income available under the cafeteria plan are not allowed to claim the credit. The plan may not discriminate in favor of highly compensated employees regarding eligibility. Benefits provided to non-highly compensated employees must be at least 55 percent of the benefits provided highly compensated employees. Dependent care benefits under a cafeteria plan are generally taxable to employees with nonworking spouses.

OTHER FEDERAL LEGISLATION

IRS Code Sections regarding the cafeteria plan thus far have been mainly concerned with the dollar aspects of the program. Going beyond the financial areas, there are additional federal laws that affect the general conduct of the plan; its implementation; communication to participants; and its permanence in the community. There are also federal laws governing plan participant rights, and the rights of family members. We will discuss these laws in the following section:

ERISA

(Employee Retirement Income Security Act of 1974), targeted for pension and profit-sharing plans, this act establishes standards and guarantees for plan benefits and for the security of trust funds set aside for future and present benefits. Two major provisions of ERISA are that any benefit plan established under the United States Tax Codes must (A) Be in writing and, (B) Be communicated to all plan participants.

Any plan participant has the right to examine the plan documents that established the plan. The documents may be examined on company property and at a time designated by the company, but they must be made available upon the request of a qualified plan participant. At the same time, the plan must be communicated to all participants and those eligible to participate through what is called an SPD (Summary

Plan Description). An SPD has to be written in plain English, subject to tests that measure the difficulty of the subject matter and the manner in which it is presented.

Other provisions dealing with communication include the requirement that plan participants be furnished a Summary Annual Report showing the financial condition of the plan at the close of the plan year. Lastly, should an event occur that affects the status of a plan, each participant must be notified of that event within a 30 day period. ERISA established that a plan administrator be appointed within each sponsoring firm for handling communication both within the firm and with those agencies of the federal government charged with supervising benefit plans. These agencies include the Department of Labor, the IRS, and the Pension Benefit Guaranty Corporation. Since the latter deals only with the financial stability of pension and profit-sharing plans.

We'll bypass PBGC and concentrate on the communication that must be furnished to the Department of Labor and the IRS. The following must be filed with the DOL:

- Copies of the plan document establishing the plan.
- Copies of the Summary Plan Description furnished each plan participant.
- Copies of the Summary Annual Report that were furnished each plan participant, and,
- Copies of the summary of material modification, which serves to notify plan participants of plan changes.

The following must be filed with the IRS:

- Either Form 5500, which is the annual tax return for plans covering 100 or more participants, or Form 5500-C, for plans with less than 100 participants.
- Form 5500-R, which is a tri-annual tax form filed in lieu of 5500 or 5500-C on the scheduled date. As documentation for the above, actuarial evaluations, experience data, and transactional information must be filed with the 5500 series. An optional form is Schedule P, a fiduciary's report, which can be attached to 5500.
- Form SSA which is a statement of terminated participants with vested benefits.

In addition to being filed with the IRS, these documents also must be made available to plan participants upon request.

TEFRA

This stands for (Tax Equity and Fiscal Responsibility Act of 1982). Again, the primary objective of the act was to focus on pension and profit sharing plans in general, and cafeteria plans specifically.

In a general sense, TEFRA acted as an equity producing device that "smoothed out" the differences in employee benefit plans that had been established over time. Many of these plans favored highly compensated individuals and were, by the language of TEFRA, discriminatory. TEFRA acknowledged the existence of the plans and, through its provisions, required that the plans be identified to the IRS and DOL through their

reporting mechanisms. Once identified, the plans had to be amended according to the legislative language of TEFRA and follow its regulations for continued enjoyment of a tax favored status.

Most of the details spelled out in TEFRA are not vital to our study of cafeteria plans, however, you should be aware of the act's handling of the following:

- TEFRA established the definition of what is termed a "top-heavy plan," or a benefit plan that favors the key employees of a company by 60 percent or more in benefits.
- TEFRA clarified the definition of a "key employee." This definition was adopted by the 1986 Tax Reform Act and incorporated into Code Language.
- TEFRA also redefined certain provisions affecting group term life insurance, notably in the valuation of coverage in excess of $50,000 of face amount. Because of this action, group term life was included as part of the benefit package of a cafeteria plan (subject to the "key employee" or "highly compensated" employee restrictions we discussed earlier).

COBRA

COBRA stands for the (Consolidated Omnibus Budget Reconciliation Act of 1985) and forms the last segment of our legislative trio affecting cafeteria plans and employee benefit programs.

In complying with those sections of the act affecting them, employers must report to the IRS, to the Department of Labor and to the Department of Health and Human Services. Regarding employee benefits, COBRA focuses on continuation of coverage for participants and/or their dependents who, because of one or more of the following qualifying events, are no longer eligible to receive benefits under the employer's group plan:

- Termination of the participant's employment for any reason other than gross misconduct.
- Death of employee or divorce; and,

- Dependent child reaching maximum age for coverage under the plan.

All employees and their dependents must be notified of their rights under COBRA when they become plan participants and when a qualifying event occurs. If the participant and/or dependent(s) wish to extend their benefits, they must pay the employer the full monthly premium. The employer also may add a two percent administrative fee. The extension can be for up to 36 months, depending on the qualifying event.

As we said in the beginning, no other financially oriented activity, other than stocks and bonds, is as closely monitored and regulated as that of employee benefits. Because of this, a word of caution is in order; **in case of doubt or confusion, consult with a third-party professional,** someone whose judgment and expertise is highly regarded by your client and insurance carrier. With the extreme volume of legislation involved and the

interrelationship of all these laws, codes, and regulations, an outside opinion should clarify things significantly.

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CAFETERIA PLANS THE DESIGN OF A CAFETERIA PLAN

THE EMPLOYER'S OBJECTIVES

At some point in your initial interview with the decision maker for your prospective client company, it is critical that you begin the process of identifying the employer's objectives for the company's employee benefit program, both as it stands today and his or her future objectives. Chances are that the current program has not been reviewed for some time and, even if it has, the odds are that it should be reviewed in light of the trend toward two-income families, the rapid increase in medical care and hospitalization costs and the opportunities offered by the Tax Reform Act of 1986. Goals and objectives of the employer will usually center on the following topics:

IMPROVING CURRENT BENEFITS

All employers wish to improve the benefit package offered by their program. Unfortunately, improvements cost money, dollars that the company usually cannot afford at the present time. Discussion in this area should focus on "Forget the dollars involved for right now, what would you want to do to improve the benefit package for your employees assuming you had unlimited funds?"

CONTAINING COSTS

Raising the issue of inflation should provide you with a great deal of information regarding the specific things an employer would like to do. One of the benefits of a cafeteria plan is that once the employees are involved, they have a direct link with the expense of the plan, they then are motivated to help find ways to contain costs.

HELPING EMPLOYEES SAVE TAXES

The 1986 Tax Reform Act cut back dramatically on many previously available tax deductions; the two-income married couple deduction; the increase to seven and one half percent of adjusted gross income in the threshold before any deduction can be taken for medical expenses; the loss of the state sales tax deduction; and the reduction in the consumer interest deduction. Also, non-reimbursed employee expenses were moved from that of a direct deduction to where they have to exceed two and one half percent of adjusted gross income before any deduction can be taken. This an excellent opportunity for the employer to demonstrate that he is aware of the problems and actually wants to do something to help.

REDUCING PAYROLL TAXES

TRA'86 not only reduced the areas of tax relief for individuals, it also reduced many areas of corporate tax relief. Many cash-starved companies are eagerly searching for additional sources of funds, and cost reduction as well. There could easily be a ten percent decrease in current payroll taxes with the establishment of a cafeteria plan. With a $100,000 monthly payroll, who wouldn't want to save $10,000 in taxes?

EMPLOYER/EMPLOYEE COST SHARING

Used in conjunction with a cost containment objective, a cafeteria plan offers a new opportunity for the employer and the employee to become partners in the operations of the company benefit plan. Cost containment is part of this objective, but a cafeteria plan goes beyond that to offer new ways to use the benefit dollars wisely and use the savings to provide additional benefits elsewhere. This could be an opportunity for the employer and employee to become partners in cost containment, but also, provide future openings for improved, or new plans.

EVERYONE WINS

The cafeteria plan offers a plan design in which everyone wins; the employees receive an increase in take home pay. They have the opportunity to choose their own benefits. The employer gains increased payroll tax benefits and a chance to control benefit costs. Also, the employer gains the improved morale of the labor force and new funds for company operations.

PROGRAM IMPLEMENTATION

Once you have established the above benefits with the employer, you can now begin to implement the program in stages. These stages can be established according to this schedule:

Step 1. Move current contributions from after tax to before tax dollar status. Set up accounts that enable the participants to pay for eligible health care and dependent day care expenses.

Step 2. Add additional accounts according to fulfillment of initial plan goals and experience. The employer can monitor costs and adjust plan design accordingly; the employee can gain experience in plan budgeting and choice selection.

Moving on Step 1 is of immediate concern if the employer wishes to attack the entire set of six objectives simultaneously. Not only will the savings become evident within short order, but the current benefit package does not have to be disturbed one bit. What changes is merely the handling of the funds from one mode of operation to another. Step 2 can be moved on gradually, as experience and familiarity with the program become more settled.

EMPLOYEE SURVEYS

A major part of the design process is gathering the statistics you need for the employee group. Not only is it important from an IRS standpoint regarding plan eligibility and participation, but you also will need the information to determine your client's demographics. How many young, single people are there? How many young, married? How many two-income families? How many couples with children, younger or older? You must also identify your key employees and/or highly compensated employees and develop statistics for them.

You are beginning the **objective** survey and the **subjective** survey process. The employer can assist you with the objective survey giving you the bare bones numbers you need to help develop the plan design. This is essentially completing a census form for an employee group and should be familiar to you. A subjective survey is used to gain information and statistics to help outline the options on the proposal to be submitted to the employer. This information includes;

- Does the company have a 401(k) plan?
- What type of retirement income plan does the company have?
- What type of benefits, such as dental insurance, optical coverage, prescription drugs, etc.
- Do the current programs follow the company's fiscal year, taxable year or do they have their own plan year?

- What type communication system does the company employ, employee newspaper, outside consulting firm, etc.?

You must complete the employer's survey with the help of the company's payroll department, human resources department, or financial accountant. The employee's survey could be conducted through employee meetings. Remember that this is the information-gathering stage, not a sales presentation. You must obtain as much information as you can, analyze it in a clear cut way, and present it to the decision maker in such as way as to allow a decision to be made without any doubts or questions.

THE PROPOSAL

All the information you have spent so much time and effort gathering and analyzing will be used to accomplish the following proposals:

- The plan option(s) Proposal
- The employer Proposal
- The employee Proposal

The Plan Option(s) Proposal

The proposal to be presented to the employer will depend upon many sources of information; discussions with the employer and his or her representative, the objective survey of individuals, pay levels, martial status and position with the employer, the subjective survey and the employee survey that showed the level of benefits currently in place and those benefits that should be there, but, for one reason or another, haven't been implemented until now. Lastly, do not ignore budget. The spirit of the employer may be willing but the budget is weak.

Your own experience and instincts also have a bearing. You should be in a position to know what comparable companies in the same industry, size and demographic makeup are providing and what other companies have implemented. The actual plan design to be presented has a multitude of variations what will go to shape the plan proposal. No matter what the final plan turns out to be, it will follow one of the following models.

The Core Program

This was discussed earlier. In review, the method employed is to create a core of basic benefits what will be provided to each employee. Quite often, this core program is provided without cost to the employee. The purpose of the core program is to make sure that each employee has a solid plan of protection in case of illness, injury, or death. The core could be the present program, or it could be a stripped down version consisting of basic life insurance, medical benefits and disability benefits.

If the present program is stripped down, with quite a bit of cost savings to the employer, consideration should be given to the creation of a credit system that would be the employer's contribution to the optional benefit fund from which employees could draw and help pay for their optional benefits.

Elective Benefits

This is the heart of a cafeteria plan for it is here that employees can pick and choose according to their needs. These can include, but are not limited to:

- Decreasing levels of deductible (i.e. $500 base on core $400, $300, $200, $100, first dollar coverage);
- Decreasing levels of coinsurance (i.e. starting at 20 percent with the core plan, work downwards to fully paid for by the plan coverage):
- Increasing amounts of life insurance.
- The opportunity to purchase other types of benefit plans; dental coverage, eyeglasses, prescription drugs, etc.
- Additional amounts of long term disability coverage.

Again, the plan design is subject to a wide variety of informational sources and limitations such as budget. However creativity should be encouraged no matter what limitations exist. A cafeteria plan allows for a wide horizon of options in plan design.

The Modular Approach

This method could work with a core quite easily, or, a core could be developed as a stand alone module. The principle in the modular approach is to design different modules that will fit the needs, pocketbook and desires of the company's employee population. The benefits are pre-designed into packages containing various combinations of medical, dental, vision, dependent coverages, and so on. The individual employee can choose the module that fits his or her needs, desires, and ability to pay the premium. The modules can also be designed to fit specific groups of employees, such as employees with dependents in addition to a spouse, employees with working spouses, single employees, etc.

The Cost Sharing Approach

This is more of a method than a package. The point to be made with this approach is that the employer can continue to provide the current employee benefit program with no change. This approach is especially effective where an extensive benefit program has evolved over time. Rather than dismantle it because of future increases in premiums, the employer simply freezes the plan as it is, and continues to pay all the current premiums. Employees will be required to pay for their share of the future benefit costs.

The Credit Approach

Mentioned earlier, the credit approach is more of process than a package or product. In this case, the current monthly expenses being paid for by the employer are converted into employee credits. The employee can add to the credit bank and purchase optional or modular benefit packages. In some IRS approved plans, the employee could also **convert** credits, such as extra vacation time, into credits to be used for an annual physical exam.

Medical Care Reimbursement Accounts

A medical care reimbursement account can be a major supplement to a company's cafeteria plan. This type of account is set up by an individual who has established a "budget" for the medical expenses not normally covered by an employee benefit plan. Through payroll deduction, money is paid into the account by the participant according to the "budget" he or she established. As the individual incurs the medical expense, he or she obtains a receipt for the payment, submits that receipt to the plan administrator along with a request for reimbursement from the account. At year's end, all the dollars expended go to reduce taxable income dollar for dollar.

The purpose of this account is two-fold:

A) Most employee benefit medical plans do not pay for "routine" medical expenses, school physical, annual checkups, visits to the doctor for a minor complaint, regular prescriptions such as insulin or high blood pressure medicine. These expenses can add up at the end of the year. The employee who establishes one of these accounts will certainly be glad if he or she is facing surgery. The account can be budgeted for the out of pocket cash deductible and any coinsurance payments that have to be made for the medical plan.

B) Since most benefit plans do not pay for these types of expenses, the most logical place to obtain some form of relief would be though deduction on federal income tax. Currently, only those medical expenses that exceed 7.5 percent of adjusted gross income can be deducted.

Being able to use the cafeteria plan as a dollar for dollar reduction in taxable income can be a welcome benefit for the individuals described above.

Day Care Expense Account for Dependents

This is a reimbursement account similar in approach to the medical expense account just discussed. In this case, reimbursement is for expense incurred for dependent care, for the care of a dependent under the age of 15 or a mentally or physically disabled dependent of any age.

The following restrictions apply to these accounts:

- The dependent care is necessary for the participant to work.
- Both the employee and spouse must work.
- The expense can't exceed the income of the spouse or employee, whichever is lower. The Day Care facility must be state licensed.
- A dependent care program may not discriminate in favor of highly compensated employees in regard to eligibility, contributions, or benefits.
- There is a $5,000 cap or maximum on the amount that can be excluded from taxable income each year.

THE EMPLOYER PROPOSAL

If your cost proposal is going to include your own recommendations for insurance plans that will either replace or supplement the current group insurance plans, you will obviously need the three-year-look-back experience records from the employer.

This is an IRS requirement, and is used in the identification of highly compensated and key employees. You will also need the employee information you obtained through the objective and subjective surveys.

At this point, and depending on the goals and objectives of your client, you can establish separate cost estimates and tax savings statistics for "core plus" type account levels. These would be supplemental/additional to the current plans, or those you are going to propose. They could, for example, provide for lower deductibles; additional life insurance coverage up to a maximum of $50,000; additional long-term disability coverage; or increased levels of benefits for a dental insurance plan.

You can also propose additional plans that could strengthen the current program, such as prescription drugs; eyeglasses; dental insurance, etc. You might also suggest the placement of a 401(k) plan, if one is not in place, which can be included in a cafeteria plan and used as a "more bang for the buck" taxable income reduction. Again, all of this depends upon the client's goals, the benefit dollars available from both employer and employee, and the status of the employee benefit program currently in place.

Whatever the final selection, if your plan design has included the employer's goals and the employee's needs and desires, everyone's interest will be served. If installed, an add on account will help to diversify and broaden the base of the core benefits, so that the employees will be able to select both the range and the depth of benefit plans that fit their needs. In a sense, this captures the basic concept of a cafeteria plan, because it is in this context that you are in a cafeteria, choosing that which suits you and your family's needs and lifestyle.

THE EMPLOYEE PROPOSAL

The objective here is to show the participant what his or her net income will look like once the cafeteria plan is established. This proposal can be used at the enrollment sessions - when you meet with each participant one on one to discuss his or her needs and the needs of the family members.

Benefit Enhancement Accounts

In addition to the optional accounts discussed earlier for supplemental or modular plans, we will now discuss benefit enhancement accounts.

What's the difference? Under benefit enhancement, the plan design encompasses insurance programs to help make up the difference in monthly retirement income benefits that are lost because the participants will be contributing less to their Social Security. Using a benefit enhancement plan we could replace each dollar of Social Security benefits lost with five dollars. In addition, the participants should be made aware of the wide range of benefits and options available under a Universal Life plan, a Variable life plan, or a Variable/Universal life plan. These differ quite a bit from the

traditional whole life plans and can offer life insurance protection plus an opportunity for investment gain, something no other investment program can provide.

The following plans could be included for benefit enhancement accounts:

- Additional life insurance coverage such as; Universal Life, Variable Life, Variable-Universal Life, Interest-Sensitive Whole Life;
- A retirement/survivor coverage;
- Additional long term disability income coverage; or,
- A medical reimbursement plan.

These accounts can be funded with the tax saving dollars that result from the application of the core and core-plus accounts. Inasmuch as the disability income and medical reimbursement plans would be acceptable for reducing income, additional tax reductions would result from the purchase of these plans.

Other Considerations

So far, we have covered the basic objective for a cafeteria plan. To help the employer attain his or her goals for an employee benefit program; to set up the plan so that the employer attains those goals, but so that the employees have the opportunity to pick and choose those benefits that will meet their needs; and to provide the benefit of a significant reduction in the employee's taxable income so that equally significant reductions can be made in the amount of federal and state taxes to be paid. Lastly, the benefit enhancement accounts will provide protection plus investment opportunities not previously available to the employees.

In designing the cafeteria plan and the proposals to be presented to the employer and the employees, there are three other considerations that must be dealt with. These are: Adverse selection, Dependent Care, and, forfeitures of account balances at the end of the taxable year.

Adverse Selection

As anyone who has worked in the employee benefit field and individual health insurance market knows, the problem of adverse selection comes with both territories. Adverse selection can generally be defined as the opportunity to select those benefits that the policyholder or certificate holder will utilize to the maximum, at the lowest possible out of pocket cost to that policyholder or certificate holder. For example, adverse selection will occur when a benefit program is designed with a low deductible and a very high maximum payout - such as in a dental plan with a $100 per family deductible, but with maximum benefits.

Adverse selection also can occur when a person, who is a policyholder or certificate holder, has the ability to change or add on to his or her coverage once he or she has been accepted into the plan. For example, someone could get into a plan by selecting a high deductible. Once in, they will then modify their contract to lower the deductible.

How do you control adverse selection in a cafeteria plan? Some of these ideas can be included in your cafeteria plan: Impose limits and restrictions on any coverage that

can be obtained at a later date once participants have passed initial enrollment. For example, a two year waiting period can be required before a change to a higher benefit amount or a lower deductible is allowed.

Use the modular plan approach and price each of the modules accordingly. For example, a dental plan with a high utilization rate can be priced higher at some ages and benefit levels than pricing a disability income plan. The modules can also be packages so that high levels of benefits with similar selection patterns are not offered in the same benefit grouping. For example, do not team a $100 basic medical deductible with a $100 dental. Instead, team up a $200 medical plan deductible with a $400 dental plan deductible.

Use a "carrot" approach. If the plan carries cost containment approaches such as preferred providers; second opinions; and hospital pre-admission testing, offer a bonus of a credit toward the deductible if all of the cost containment measures are followed by the participant.

Dependent Care

The 1986 Tax Reform Act has helped individual taxpayers with the increase in the amount allowed for personal exemptions and the standard deduction and the liberalization in the rules for the adjusted gross income needed to qualify for the earned income credit.

These changes have altered the results that can be obtained with a cafeteria plan dependent care account. While taxable income can still be decreased dollar for dollar by the amounts allocated to dependent care expenses, the tax credit available for the same circumstances does result in a higher return for the individual than if he or she elected the cafeteria plan method.

During discussions with the employer and employees, the best course of action is to recommend the tax credit route for dependent care. Should future tax legislation reverse directions and reduce the credit and increase taxes, we do have an apparatus to reduce taxable income with the cafeteria plan account.

Account Balance Forfeitures

The ZEBRA plans failed to gain approval by the IRS because the account balances at year's end were recirculated at the start of the new year. This gave rise to the question of constructive receipt. In 1984, the IRS issued regulations on the now-famous "use it or lose it" rule. Basically, all account balances must be down to **zero** by the end of the taxable year. If not, the balance is forfeited to the company. A forfeiture could result because an account is "overbudgeted", hence the need for conservatism. It can also result because the expected expenditure did not materialize.

The company can donate all forfeitures to charity or offset the company's contribution to the traditional benefit costs (medical, major medical, life insurance, etc.) or contribute the money to an employee activity fund.

To make sure that ill feelings or misunderstandings do not occur, this rule must be explained thoroughly to all parties.

Quiz Questions – Need for Life Insurance

1. **A procedure used by some insurers to accelerate the point at which the premium vanishes is to pay the premium by**
   (a) loaning to the cash values
   (b) eliminating the cash values
   (c) borrowing against the cash values (Page 110)
   (d) multiplying the cash values

2. **The other, more permanent type, comes with an additional feature that builds tax-deferred savings called**
   (a) bank account
   (b) IRA
   (c) cash value (Page 18)
   (d) retirement value

3. **Some variable policies guarantee to pay the original death benefit even if the policy's investment account has dwindled to**
   (a) $2,500
   (b) $1,000
   (c) $100
   (d) Zero (Page 28)

4. **There is a possibility that there will be tax consequences as of the first death depending on**
   (a) the cash value of the policy
   (b) the amount of ownership time
   (c) number of owners
   (d) **who owns the policy (page 43)**

5. **Universal life is kind of a cross between whole life and**
   (a) **term insurance (Page 118)**
   (b) permanent insurance
   (c) universal insurance
   (d) single-premium insurance

6. **A surviving spouse is eligible for Social Security benefits until youngest child reaches age _____.**
   (a) 10
   (b) 15
   (c) 16 (Page 14)
   (d) 18

7. **Reasons for getting Life insurance on a child are all but**
   (a) Building a future nest egg
   (b) Building an education fund
   (c) Guaranteed low premiums for life
   (d) Guaranteed insurability for life (Page 21)

8. **A Buy-sell agreement is a binding contract between business owners which states the estate will sell the deceased owner's interest and the surviving owner will buy the interest at a agreed upon price.**
   (a) True (Page 38)
   (b) False

9. **By law, any partner's death automatically _____the partnership.**

(a) Dissolved (Page 39)
(b) Renews
(c) Enhances
(d) Expands

10. With Deferred Compensation, money earned for work is being
(a) Invested
(b) Withheld (Page 42)
(c) Paid directly to you
(d) Paid to multiple partners

11. Whole Life insurance is permanent life insurance on which premiums are paid for the entire life of the insured.
(a) True (Page 51)
(b) False

12. Part B of Medicare is described as:
(a) Hospital Insurance Protection
(b) Major Medical Insurance
(c) Supplementary Medical Insurance (page 53)
(d) Medical Insurance Protection

13. Medicare pays for hospital care if the patient meets four (4) conditions. Which of the following is NOT one of the four:
(a) The patient requests hospital admission. (Page 67)
(b) A doctor prescribes hospital care.
(c) The hospital is participating in Medicare.
(d) The needed care can only be provided in a hospital.

14. Medicare's annual deductible for hospitalization:
(a) Can only increase 3% per year.
(b) Will probably increase from year to year. (Page 56)
(c) Can only increase a maximum of 5%.
(d) Will never change.

15. The additional premium for Part "B" benefits is:
(a) Paid in full by the Federal Government.
(b) Waived for 5 years.
(c) Deducted from your Social Security Check. (Page 59)
(d) Paid by you on an annual basis.

16. One pair of eyeglasses is provided under Medicare:
(a) Each calendar year.
(b) Every five years.
(c) Following cataract surgery. (Page 86)
(d) To everyone over age 70.

17. Part A of Medicare is described as:
(a) Supplemental Medical Insurance.
(b) Supplementary Major Medical Insurance.
(c) Major Medical Insurance.
(d) Hospital Insurance Protection. (Page 53)

18. After 20 days in a nursing home, there is additional coverage for another ___ days during which time the patient pays a co-insurance.
(a) 50

(b) 80 (Page 75)
(c) 90
(d) 100

19. Part B of Medicare is described as:
(a) Hospital Insurance Protection
(b) Major Medical Insurance
(c) Medical Insurance Protection (Page 53)
(d) Necessary Insurance

20. Both Hospital Insurance and Supplementary Medical Insurance cover home health visits.
(a) Yes (Page 77)
(b) No

21. Medicare does not pay for transportation costs.
(a) True (Page 77)
(b) False

22. An example of a Medicare Supplier would be all but:
(a) Ambulance firms
(b) Independent laboratories
(c) Medical renal equipment company
(d) Pharmacist (page 85)

23. A deferred compensation plan is which of the following?
(a) Tax free
(b) salary reduction (Page 42)
(c) Employer motivated
(d) A non-discriminatory plan

24. Which are the most important aspects of qualified retirement plans to employers?
I. Attracting & retaining key employees
II. Increased productivity
III. Retiring employees humanely
IV. Forced savings
(a) I and II
(b) I, II, III
(c) I, II and IV
(d) All (Page 41)

25. **A plan, usually funded by life insurance, to purchase a deceased partner's share of a business is known as a:**
(a) deferred compensation plan
(b) qualified retirement plan
(c) key employee life policy
(d) buy and sell agreement (page 38)

26. **A split dollar insurance plan pertains to:**
(a) Health insurance
(b) Life and health
(c) Individual life insurance (Page 44)
(d) Group life insurance

27. Who direct & administers Medicare?
(a) Health Care Financing Administration (page 54)
(b) The Administration of Medicare
(c) Department of Health and Human Services
(d) Public Health Service

28. Social Security Dependent survivor benefits are:

(a) restricted to people over age 64.
(b) generally reduced to disabled dependent
(c) a form of government life insurance
children who reach 21. (Page 10)
(d) available to all, but only after 12 quarters of gainful employment.

29. Medicare Part B includes all of the following except:

(a) hospitalization (Page 53)
(b) ambulance service
(c) x-rays
(d) medical equipment rental

30. Medicare is a health insurance program funded by the federal government from

(a) property tax
(b) the lottery
(c) government fund raisers
(d) payroll tax contributions and general tax revenues (Page 81)

31. Which of the following are not eligible for Medicare coverage?

(a) People age 65 and older who are eligible for Social Security
(b) People age 65 and older not eligible for Social Security, but willing to pay a monthly premium
(c) People of any age who have been entitled to disability benefits
(d) People with any life-threatening condition (Page 61)

32. Which of the following services is provided under Medicare:

I. In-patient hospital services
II. Physicians and surgeon's services in a hospital or clinic.
III. Hospice benefits
IV. Home health care
(a) I & II
(b) I, II, III
(c) **all (Page 71)**
(d) none

33. A "cafeteria plan" is a benefit arrangement which:

(a) restricts choice of benefits to the employer.
(b) **allows employees to tailor their benefit package to meet their specific needs. (Page 109)**
(c) restricts choice of benefits to the insurance company.
(d) None of the above

34. An applicant for an health insurance policy has a heart condition of which he is aware. He answered "no" to the question pertaining to heart problems. His answer is considered to be a:

(a) warranty
(b) concealment
(c) fraudulent (Page 48)
(d) representation

35. Which of the following is true about Medicare?

(a) it is a program for welfare recipients
(b) it has two parts: Part A and Part B (Page 53)
(c) it is free medical care similar to Canada
(d) Part A requires that a premium be paid

36. Which part of Medicare requires premium payment by eligible participants?

(a) Part A, basic hospital insurance
(b) Part B, supplementary medical insurance (Page 58)

(c) Respite care
(d) All of the above

37. Persons over 65 can be entitled to:
(a) Medicare Part A
(b) Medicare Part B
(c) Medicaid
(d) **All of the above (Page 53)**

38. Medicare Part B includes all the following except:
(a) A health care aids
(b) psychiatric care
(c) post hospital skilled nursing care (Page 57)
(d) physician's services in hospital, clinic, or home

39. Medicare supplement insurance is designed to:
(a) take care of all expenses not covered by Medicare.
(b) pay at least some of the health care costs that Medicare will not pay. (Page 56)
(c) provide health care coverage for poor people on welfare.
(d) prevent spousal impoverishment.

40. Medicare has as its primary purpose to provide Hospital and Medical Expense protection to those Americans who:
(a) are 65 years of age or older. (Page 53)
(b) cannot afford health insurance.
(c) are on Social Security.
(d) belong to the AARP (American Association of Retired Persons).

_____	1 BENEFICIARY	A. Person or persons named to receive benefits if the primary beneficiary is not alive at the time the insured dies.
_____	2 CASH SURRENDER VALUE	B. The date upon which a policy's coverage ceases.
_____	3 CLAIM	C. On the part of an insurer or its agent, falsely representing the terms, benefits, or privileges of a policy. On the part of an applicant, falsely representing the health or other condition of the proposed insured.
_____	4 CONTINGENT BENEFICIARY	D. Permanent life insurance on which premiums are paid for the entire life of the insured.
_____	5 DEFERRED ANNUITY	E. The demand of an insured or his or her representative or beneficiary for benefits as provided by an insurance policy.
_____	6 DOMESTIC COMPANY	F. An insurer formed under the laws of the state in which the insurance is written.
_____	7 DOUBLE INDEMNITY	G. Giving or offering to give something of value other than the benefits of a policy as an inducement to buy insurance, a practice illegal in all states except Florida.
_____	8 EXPIRATION	G. A person who may become eligible to receive, or is receiving, benefits under an insurance plan, other than as an insured.
_____	9 TERM INSURANCE	H. A method of receiving life insurance proceeds other than a lump sum.
_____	10 MISREPRESENTATION	I. In life insurance, the value in a policy that is the legal property of the policy owner, and which the policy owner may receive if the policy is surrendered for cash. Synonymous with cash value.
_____	11 FRAUD	J. An annuity on which payments to the annuitant are delayed until a specified future date.
_____	12 REBATE	K. An amendment attached to a policy that modifies the conditions of the policy by expanding or decreasing its benefits or excluding certain conditions from coverage.
_____	13 WHOLE LIFE	L. Life insurance that normally does not have cash accumulations and is issued to remain in force for a specified period of time, following which it is subject to renewal or termination.
_____	14 RIDER	M. Payment of twice the basic benefit in event of loss resulting from specified causes or under specified circumstances.
_____	15 SETTLEMENT OPTION	N. An intentional misrepresentation made by a person with the intent to gain an advantage and relied upon by a second party which suffers a loss as a result.

Vocabulary Quiz

Answers: 1) G 2) I 3) E 4) A 5) J 6) F 7) M 8) B 9) L 10) C 11) N 12) G 13) D 14) K 15) H