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PART I - MEDICARE

THE BASICS

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.
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

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 This legislation, however, was repealed by the Medicare Catastrophic Coverage Repeal Act of 1989.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 service
- 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:

- the patient is admitted to the non-participating hospital for emergency treatment, and

- 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 PROGRAM? (PART A)

The program, which is compulsory, provides the following benefits for persons age 65 or older and persons receiving social security disability benefits for 24 months or more:

- The cost of inpatient **hospital care** for up to 90 days in each benefit period (in 2001, the patient pays a deductible amount of $776 for the first 60 days plus $194 a day for each day in excess of 60). There are also 60 additional lifetime reserve days with coinsurance of $388 a day.

- The cost of **post hospital extended** care in a skilled nursing facility for up to 100 days in each benefit period (the patient pays nothing for the first 20 days and up to $97.00 a day after the 20 day).

- The cost of an unlimited number of **home health** service visits made under a plan of treatment established by a physician. The patient pays 20% of the Medicare approved amount for durable medical equipment.

- The cost of **hospice care** for terminally ill patients. The patient pays a co-payment of up to $5 for outpatient prescription drugs and 5% of the Medicare-approved payment amount for impatient respite care (short term care given to a hospice patient by another care giver, so that the usual care giver can rest). The amount a patient pays for respite care can change each year.

- The cost of **blood** at a hospital or skilled nursing facility during a covered stay. The patient pays for the first three pints of blood, unless the patient or someone else donates blood to replace the blood used.

WHAT BENEFITS ARE PAYABLE UNDER 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 a monthly premium for part B of $45.50 (year 2000 premium rate). In some cases this premium is higher if the individual did not choose part B when they first became eligible at age 65. The cost of part B could go up 10% for each 12 months period that Part B would have been available to the insured, but did not sign up for it. The monthly premium is usually taken out of the insured' Social Security, Railroad Retirement or Civil Service Retirement payments. If an individual does not get any of the aforementioned payments, Medicare sends the insured a bill for the premium every three months. There is an annual deductible of $100 (2001 figure), paid by the patient. Then the plan pays 80% of the approved charges above the deductible for the following services:

- Medical and other services: Doctor's services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheel chairs, hospital beds, oxygen, and walkers.) Also covers second surgical opinions. Also covers outpatient physical and occupational therapy including speech-language therapy, as well as, outpatient mental health care. (Patient pays 50% for outpatient mental health care and 20% for all other)

- Home health care visits, if not covered under hospital insurance (but with no cost sharing except for 20% for durable medical equipment, other than the purchase of certain used items).

- Clinical laboratory services include: Diagnostic x-ray, diagnostic laboratory tests, and other diagnostic test. Patient pays nothing for Medicare approved services.

- Blood: Pints of blood received as an outpatient, or as part of a part B covered service. Patient pays for the first three pints of blood, then 20% of the Medicare-approved amount for the additional pints of blood (after the deductible), unless the patient or someone else donates blood to replace what is used.

- Bone Mass Measurements: coverage varies with the individual's health status. Covered are individuals with Medicare who are at risk for losing bone mass. Patient pays 20% of the Medicare-approved amount (or a set co-payment amount) after the yearly Part B deductible.

- Colarectal Cancer Screening: Fecal Occult Blood Test-once every 12 months; Flexible Sigmooidoscopy- once every 48 months; Colonoscopy-once every 24 months if patient is at high risk for cancer of the colon; Barrium Enema. Covered for this portion are all people with Medicare age 50 or older, with no age limitation for having a colonoscopy. Patient portion is zero for fecal occult blood test, 20% of the Medicare approved amount after the yearly Part B deductible for all other (25% if performed in an ambulatory surgical center or hospital outpatient department).

- Diabetes Services: coverage for glucose monitors, test strips, and lancets, diabetes management training if requested by the doctor. Patient pays 20 % of the Medicare approved amount after the yearly part B deductible.

- Prostrate cancer screening: Digital Rectal examination- once every 12 months; Prostate Specific Antigen (PSA) Test-once every 12 months. Available to all men with Medicare age 50 and older. Patient cost is 20% of the Medicare approved amount for the digital rectal exam after the yearly Part B deductible and no co-insurance and no Part B deductible for the PSA Test.

- Outpatient physical therapy and speech pathology.

- Artificial limbs and eyes

- Braces = arm, leg, back and neck.

- Chiropractic services (limited)

- Emergency care

- Eyeglasses-one pair after cataract surgery with an intraocular lens.

- Immunosuppressive drug therapy (limited), extended coverage available for transplant patients including some ESRD patients.

- Kidney dialysis and kidney transplants

- Medical supplies-items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies.

- Outpatient prescription drugs (very limited) for example, some oral cancer drugs.

- Preventive services

- Prosthetic devices, including breast prosthesis after mastectomy.

- Services of practitioners such as clinical psychologists, social workers, and nurse practitioners.

- Transplants- heart. Lung, kidney, pancreas, and liver (under certain conditions)

- Screening pap smears for early detection of cervical cancer. Coverage is provided for screening pap smears once every three years once every 12 months if an individual is high risk for cervical or vaginal cancer, or if of childbearing age having had an abnormal Pap smear in the preceding 36 months. Available to all women with Medicare. Cost to patient is nothing for the Pap smear lab test. 20% of the Medicare approved amount (or set co-payment amount) with no part B deductible for Pap smear collection and pelvic and breast exams.

- Screening mammography. Screening mammography is defined as a radiological procedure provided to a woman for the early detection of breast cancer, including a physician's interpretation of the results of the procedure. Available once every 12 months, includes all women with Medicare age 40 or older. Patient cost is 20% of the Medicare approved amount with no Part B deductible.

- 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.

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:

- bring an action against any entity which would be responsible for payment with respect to such item or service,
- bring an action against any entity (including any physician or provider) which has been paid with respect to such item or service, and
- 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.

THERE ARE IMPORTANT RULES REGARDING WHAT CARE IS 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 individuals 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 Medicare did not cover it. 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 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 1-800-368-5779. In Maryland, call 1-800-638-3986. A person can send his complaints in writing to HHS, OIG, Hot Line, P.O. Box 17303, Baltimore, Maryland 21203-7303.

FOCUS POINTS

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

2. Medicare consists of hospital insurance protection (Part A) and medical insurance protection (Part B).

3. The Department of Health and Human Services contracts with private insurance companies for the processing of payments to patients and health care providers.

4. Under Part B, the private insurance companies are called carriers.

5. Providers who are not certified to participate in the program are called non-participating.

6. Under the Basic Hospital Plan, care in a psychiatric hospital is subject to a lifetime limit of 190 days.

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

8. Care is considered custodial when it is primary for the purpose of meeting personal needs and could be provided by persons with out professional skills or training.

9. Waiver of Beneficiary Liability is the provision in which an individual will not be held responsible for paying for care if he could not reasonably be expected to know Medicare did not cover it.

10. PROs stand for Peer Review Organizations.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- Explain what benefits are provided under the hospital insurance program (Part A).

- Explain what benefits are payable under supplementary medical insurance plan (Part B).

- What did The Spending Reduction Act of 1984 established what?

PART II - 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, 1991, 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;

- to relieve them of unemployment;
- in a hospital, home, or institution where they are inmates or patients;
- on a temporary basis because of an emergency such as a storm, earthquake, flood, fire or snow;
- 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 PAYER? IF SO, WHEN?

Employers must offer employees age 65 or older the same health benefits offered to younger employees. Medicare will become the secondary payer 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 payer 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 payer, 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 payer.

For persons who are not eligible for Social Security or Railroad Retirement benefits, Medicare is also the secondary payer:

- when medical care can be paid for under any liability policy (including automobile policies),
- in the first 18 months for end-stage renal disease under age 65 when private group health insurance provides coverage, and
- 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 100 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?

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,

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 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).

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

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 provide 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 reconsideration the patient may request of-that denial.

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:

- hired after March 1986, or
- 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 in 1997. (The maximum earnings base for Old-Age, Survivors, and Disability Insurance (OASDI) taxes is unlimited in 1997.) For 1997, the rates of the Hospital

Insurance tax are 1.45% for employees and employers and 2.90% for self-employed persons.

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:

- Inpatient hospital care for up to 90 days in each "benefit period.,, The patient pays a deductible of $760 in 1997 for the first 60 days and coinsurance of $190 a day for each additional day up to a maximum of 30 days. In addition, each person has a non-renewable “reserve” of 60 additional hospital days with coinsurance of $380 a day, which can be used once during a lifetime.

- Post-hospital extended care in a skilled nursing facility for up to 100 days in each "benefit period." The patient pays nothing for the first 20 days. After 20 days the patient pays the 1997 coinsurance of $95.00 a day for each additional day up to a maximum of 80 days.

- 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 this 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 patient must pay a "deductible" of $760 in 1997 for the first 60 days in each benefit period. If the stay is longer than 60 days during a benefit period, "coinsurance" of $190 a day must be paid for each additional day up to a maximum of 30 days.

Thus, a 90-day stay would cost the patient $6,460. After 90 days, the patient pays the full bill unless the lifetime reserve of 60 days is drawn upon. The patient must pay coinsurance of $380 a day for these 60 additional "lifetime reserve, days. 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, the "lifetime reserve" of 60 days is not renewable.

In 1989, the patient paid a deductible of $560 for the first period of continuous hospitalization beginning in a calendar year. Inpatient hospital care was covered for an unlimited number of hospital days of covered services. This expanded coverage, for 1989 only, was repealed by the Medicare Catastrophic Coverage Repeal Act of 1989.

Covered Inpatient Services:

- Bed and board in a semi-private rooms (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 hospitals 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:

- with a minimum enrollment of 25,000, not more than half of whom are age 65 or older, and

- 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 dis-enroll from an HMO effective on the first day of the calendar month following the date on which he requested dis-enrollment. Under previous law, dis-enrollment could not be effective until the first day of the second month following the date on which the individual requested dis-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 is 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 coverage and exclusions relating to inpatient hospital care apply. Thus, the patient pays a $760 deductible for the first 60 days, and coinsurance of $190 a day for the next 30 days (plus $380 a day for the 60 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 ($95.00 a day) for each day of service (instead of only for each day after the 20th 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:

- is eligible for Hospital Insurance benefits,
- is certified as terminally ill (i.e., his life expectancy is six months or less), and
- 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 not 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 include 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 re-certified 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 is 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 Medicare does not certify many skilled nursing facilities.

WHAT PROVISIONS ARE THERE FOR CARE IN A SKIILLED 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:

- insertion and sterile irrigation and replacement of catheters,

- application of dressing involving prescription medications and aseptic techniques,

- treatment of extensive bed sores or other widespread skin disorders,

- therapeutic exercises or activities supervised or performed by a qualified occupational or physical therapist,

- training to restore a patient's ability to walk, and

- 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:

- specifically related to a physician's active treatment plan,

- of a complexity, or involve a condition, that requires a physical therapist,

- necessary to establish a safe maintenance program or provided where the patient's condition will improve within a predictable time, and

- of the necessary frequency and duration.

WHAT COSTS DOES THE PATIENT PAY FOR SKIILLED 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 in 1993, the coinsurance is $84.50 a 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:

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

- A physician certifies that the patient needs skilled nursing care on an inpatient basis. Re-certification is required for extended stays.

- 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.

WHEN ARE POST HOSPITAL HOME HEALTH SERVICES PAID?

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 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:

- skilled nursing care on an intermittent basis, or

- physical or speech therapy, or has a continued need for

- 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:

- full-time nursing care at home,
- drugs and biologicals, and
- 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:

- based on and in conformance with a physician's order;
- by or under the supervision of a licensed health professional; and
- for the purpose of diagnosis or treatment of an illness or injury.

Home health agencies are required to provide patients with the following rights:

- the right to be informed of and to participate in planning care and treatment,
- the right to confidentiality of clinical records,
- the right to voice grievances,
- the right to advance notice, including notice in writing, of items and services for which payment will and will not be paid by Medicare,
- the right to have property treated with respect,
- the right to be fully informed in advance of Medicare rights and obligations, and
- 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 $676 initial deductible for inpatient hospital care for 1993 is based on the 1966-68 figure of $40 and increases in average per them 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 them rate. The daily coinsurance for inpatient hospital care for the 61st through 90th days in a benefit period is 1/4 of the initial deductible ($ 169 in 1993). The daily coinsurance for post-hospital extended care after 20 days is 1/8 of this initial deductible ($84.50 in 1993). The lifetime reserve days, coinsurance is 1/2 of the initial deductible ($338 in 1993).

FOCUS POINTS

1. 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.

2. Private organizations are called intermediaries.

3. The system of Medicare reimbursement is called the Prospective Payment System.

4. 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".

5. The expanded coverage, for 1989 only, was repealed by the Medicare Catastrophic Coverage Repeal Act of 1989.

6. A Health Maintenance Organization 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.

7. 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.

8. 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.

9. "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).

10. 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.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- What services are covered over and above the "deductible" and coinsurance" amounts which must be paid by the patient?

- What are the four conditions in which Medicare will pay for hospital care if the patient meets the requirements?

- What inpatient services are covered under Medicare?

- What does the Basic Hospital Insurance Plan not cover?

PART III - 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, 1993, the initial enrollment period begins January 1, 1993 and ends July 31, 1993.

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:

- 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.

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

- 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.

- 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 payer 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 payer 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.

Law establishes the premium rates for 1992-95. (See table.) Premium rates may be increased from time to time if program costs rise. In September of each year (beginning in 1995), the government announces 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 individuals net Social Security check.

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.

Examples of Past Basic Monthly Premium
Supplementary Medical Insurance Plan

Year	Monthly Premium
1992	$31.80
1993	$36.60
1994	$41.40
1995	$46.10

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 was 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 establishes, 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).

According to the Health Care Financing Administration I s impact analysis, Medicare payments under the 1992 system increased significantly for primary care and cognitive services and declined for procedure-based services. Payments to family and general practitioners increased dramatically. Payments for surgical specialties decreased. The system is 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 were 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.

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 ASSIGNIMENT 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.

Medicare 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 IS 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. This portion of Medicare covers the following doctors' fees and services:

- 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 the billing physician documents medical necessity. 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 individuals condition).

- Patient training and education (to the extent that training and educational activities are closely and clearly related to the individuals 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). A doctor or other qualified professionals must perform outpatient services in a qualified facility. Covered

services include physicians' services; physical, speech, occupation and respiratory therapies; and counseling and other related services. A physician who certifies that there is a need for skilled rehabilitation services must refer a patient.

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 lessor of:

- the approved charge of the laboratory, or
- 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 radiological 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:

- No payment will be made for screening mammography for women under age 35.

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

- 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.

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

- 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:

- 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

- 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:

- the cost of second opinions for certain surgical procedures when Medicare requires a second opinion,
- the cost of home health services except the 20% coinsurance charge applies for durable medical equipment (except for the purchase of certain used items),
- pneumococcal vaccine, and
- 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 would 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.

FOCUS POINTS

1. Suppliers are persons or organizations, other than doctors or health care facilities that furnish equipment or services covered by Supplemental Medical Insurance.

2. Under the Supplementary Medical Insurance Plan, Medicare usually pays eighty percent 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.

3. 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.

4. 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 are of management of the care of mothers and babies throughout the maternity cycle.

5. Screening mammography is defined as a radiological procedure provided to a woman for the early detection of breast cancer, including a physician's interpretation of the results of the procedure.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues

- Under the Supplemental Program who is eligible and how does one enroll?

- What services performed by the doctor are covered?

- Under what guidelines, will Medicare cover screening mammography?

PART TWO - C.O.B.R.A. MADE EASY

INTRODUCTION

Health insurance programs allow workers and their families to take care of essential medical needs. These programs can be one of the most important benefits provided by your employer.

There was a time when group health coverage was available only for full-time workers and their families. That changed in 1985 with the passage of health benefit provisions in the **Consolidated Omnibus Budget Reconciliation Act. (C.O.B.R.A.).**

Now, terminated employees or those who lose coverage because of reduced work hours may be able to buy group coverage for themselves and their families for limited periods of time.

If you are entitled to COBRA benefits, your health plan must give you a notice stating your right to choose to continue benefits provided by the plan. You have 60 days to accept coverage or lose all right to benefits. Once COBRA coverage is chosen you are required to pay for the coverage.

FOCUS POINTS

1. C.O.B.R.A. stands for Consolidated Onmibus Budget Reconciliation Act.

2. You have sixty days to accept coverage or lose all rights to benefits.

3. Once COBRA coverage is chosen you are required to pay for the coverage.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- Who benefits form COBRA?

1

CONTINUATION HEALTH LAW

Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act health benefit provisions in 1985. The law amends the employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise would be terminated.

COBRA contains provisions giving certain former employees, retirees, spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available in specific instances. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer formerly paid a part of the premium. It is ordinarily less expensive, though, than individual health coverage.

The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. It applies to plans in the private sector and those sponsored by state and local governments. The law does not, however, apply to plans sponsored by the Federal Government and certain church-related organizations.

Group health plans sponsored by private sector employers generally are welfare benefit plans governed by ERISA and subject to its requirements for reporting and disclosure, fiduciary standards and enforcement. ERISA neither establishes minimum standards or benefit eligibility for welfare plans nor mandates the type or level of

benefits offered to plan participants. It does, though, require that these plans have rules outlining how workers become entitled to benefits.

For COBRA purposes, a group health plan ordinarily is defined as a plan that provides medical benefits for the employer's own employees and their dependents through insurance or otherwise (such as a trust, health maintenance organization, self-funded pay-as-you-go basis, reimbursement or combination of these). Medical benefits provided under the terms of the plan and available to COBRA beneficiaries may include:

- Inpatient and outpatient hospital care.
- Physician care.
- Surgery and other major medical benefits.
- Prescription drugs.
- Any other medical benefits, such as dental and vision care.
- Life insurance, however, is **not a benefit** that must be offered to individuals for purposes of health continuation coverage.

FOCUS POINTS

1. The law amends the employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise would be terminated.

2. COBRA contains provisions giving certain former employees, retirees, spouses, and dependent children the right to temporary continuation of health coverage at group rates.

3. For COBRA purposes, a group is defined as a plan that provides medical benefits for the employer's own employees and their dependents through insurance or otherwise.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- What are some of the benefits provided under the terms of the plan and available to COBRA beneficiaries?

2

QUALIFYING FOR COVERAGE

There are three elements to qualifying for COBRA benefits. COBRA establishes specific criteria for plans, beneficiaries, and events, which initiate the coverage.

PLAN COVERAGE

Group health plans for employers with **20** or more employees on at least 50 percent of the working days in the previous calendar year are subject to COBRA. "Employees" include full-time and part-time workers, agents, independent contractors and directors, and certain self-employed individuals eligible to participate in a group health care plan.

BENEFICIARY COVERAGE

A qualified beneficiary generally is any individual covered by a group health plan on the day before a qualifying event. A qualified beneficiary may be an employee, the

employee's spouse and dependent children, and in certain cases, a retired employee, the retired employee's spouse and dependent children.

QUALIFYING EVENTS

"Qualifying Events" are certain types of events that would cause, except for COBRA continuation coverage, an individual to lose health coverage. The type of qualifying event will determine who the qualified beneficiaries are and the required amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage.

Types of qualifying events for **employees** are:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct".
- Reduction in the number of hours of employment.

Types of qualifying events for **spouses** are:

- Termination of the covered employee's employment for any reason other than "gross misconduct".
- Reduction in the hours worked by the covered employee.
- Covered employee's becoming entitled to Medicare.
- Divorce or legal separation of the covered employee.
- Death of the covered employee.

Types of qualifying events for **dependent children** are:

- Termination of covered employee's employment for any reason other than "gross misconduct".
- Reduction in the hours worked by the covered employee.
- Loss of "dependent child" status under the plan rules.
- Covered employee's becoming entitled to Medicare.
- Divorce or legal separation of the covered employee.
- Death of the covered employee.

FOCUS POINTS

1. Group health plans for employers with 20 or more employees on at least 50% of the working days in the previous calendar year are subject to COBRA.

2. A qualified beneficiary is any individual covered by a group health plan on the day before a qualifying event.

3. "Qualifying Events" are certain types of events that would cause, except for COBRA continuation coverage, an individual to lose health coverage.

4. Reduction in the number of hours employment is an example qualifying events for employees.

5. Loss of "dependent child" status under the plan rules is an example of qualifying events for dependent children.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- What are the three elements needed to qualify for COBRA benefits?

- What does "employees" include?

3

YOUR RIGHTS AS AN EMPLOYEE

NOTICE AND ELECTION PROCEDURES

COBRA outlines procedures for employees and family members to elect continuation coverage and for employers and plans to notify beneficiaries. The qualifying events contained in the law create rights and obligations of employers, plan administrators, and qualified beneficiaries.

Qualified beneficiaries have the right to elect to continue coverage that is identical to the coverage provided under the plan. Employers and plan administrators have an obligation to determine the specific rights of beneficiaries with respect to election, notification and type of coverage options.

NOTICE PROCEDURES

General Notices

An initial general notice must be furnished to covered employees, their spouses and newly hired employees informing them of their rights under COBRA and describing provisions of the law.

COBRA information also is required to be contained in the Summary Plan Description (SPD) which participants receive. ERISA requires that SPD's containing certain plan information and summaries of material changes in plan requirements are furnished to participants in modified and updated SPD'S. Plan administrators must automatically furnish the SPD booklet 90 days after a person becomes a participant or beneficiary or within 120 days after a person becomes a participant or beneficiary or within 120 days after the plan is subject to the reporting and disclosure provisions of the law.

Specific Notices

Specific notice requirements are triggered for employers, qualified beneficiaries and plan administrators when a qualifying event occurs. Employers must notify plan administrators when a qualifying event occurs. Employers must notify plan administrators within 30 days of an employee's death, termination, reduced hours of employment, entitlement to Medicare or a bankruptcy. Multi-employer plans may provide for a longer period of time.

The employee, retiree or family member should notify the plan administrator within 60 days of events consisting of divorce or legal separation or a child's ceasing to be covered as a dependent under plan rules.

Disabled beneficiaries must notify plan administrators of Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the 18-month period of COBRA coverage. These beneficiaries also must notify the plan administrator within 30 days of a final determination that they are no longer disabled.

Plan administrators, upon notification of a qualifying event, must automatically provide a notice to employees and family members of their election rights. The notice must be provided in person or by first class mail within 14 days of receiving information that a qualifying event has occurred.

There are two special exceptions to the notice requirements for multi-employer plans. First, the time frame for providing notices may be extended beyond the 14 and 30-day requirements if allowed by plan rules. Second, employers are relieved of the obligation

to notify plan administrators when employees terminate or reduce their work hours. Plan administrators are responsible for determining whether these qualifying events have occurred.

Election

The election period is the time frame during which each qualified beneficiary may choose whether to continue health care coverage under an employer's group health plan. Qualified beneficiaries have a 60-day period to elect whether to continue coverage. This period is measured from the later of the coverage loss date or the date the notice to elect COBRA coverage is sent. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary.

A covered employee or the covered employee's spouse may elect COBRA coverage on behalf of any other qualified beneficiary. Each qualified beneficiary, however, may independently elect COBRA coverage. A parent or legal guardian may elect on behalf of a minor child.

A waiver of coverage may be revoked by or on behalf of a qualified beneficiary prior to the end of the election period. A beneficiary may then reinstate coverage. Then, the plan need only provide continuation coverage beginning on the date the waiver is revoked.

FOCUS POINTS

1. An initial general notice must be furnished to covered employees, their spouses and newly hired employees informing them of their rights under COBRA and describing provisions of the law.

2. COBRA information is required to be contained in the Summary Plan Description (SPD) which participants receive.

3. The election period is the time frame during which each qualified beneficiary may choose whether to continue health care coverage under an employer's group health plan.

4. A waiver of coverage may be revoked by or on behalf of a qualified beneficiary prior to the end of the election period.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

1. What do the qualifying events contained in the law create?

2. What are the two special exceptions to the notice requirements for multi-employer plan?

4

COVERED BENEFITS

Qualified beneficiaries must be offered benefits identical to those received immediately before qualifying for continuation coverage.

For example, a beneficiary may have had medical, hospitalization, dental, vision and prescription benefits under single or multiple plans maintained by the employer. Assuming a qualified beneficiary had been covered by three separate health plans of his former employer on the day preceding the qualifying event, that individual has the right to elect to continue coverage in any of the three health plans.

If a plan provides both core and non-core benefits, individuals may generally elect either the entire package or just core benefits. Individuals do not have to be given the option to elect just the non-core benefits unless those were the only benefits carried under that particular plan before a qualifying event.

Non-core benefits are vision and dental services, except where they are mandated by law in which case they become core benefits. Core benefits include all other benefits received by a beneficiary immediately before qualifying for COBRA coverage.

Beneficiaries may change coverage during periods of open enrollment by the plan.

FOCUS POINTS

1. Qualified beneficiaries must be offered benefits identical to those received immediately before qualifying for continuation coverage.

2. Non-core benefits are vision and dental services, except where they are mandated by law in which case they become core benefits.

3. Core benefits include all other benefits received by a beneficiary immediately before qualifying for COBRA coverage.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- Give an example of qualified beneficiaries.

- When may beneficiaries change coverage?

5

DURATION OF COVERAGE

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible to pay for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Coverage **begins** on the date that coverage would otherwise have been lost by reason of a qualifying event and end when:

- The last day of maximum coverage is reached.
- Premiums are not paid on a timely basis.
- The employer ceases to maintain any group health plan.
- Coverage is obtained with another employer group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary.

Special rules for disabled individuals may extend the maximum periods of coverage. If a qualified beneficiary is determined under title II or XVI of the Social Security Act to have been disabled at the time of a termination of employment or reduction in hours of employment and the qualified beneficiary properly notifies the plan administrator of the disability determination, the 18 month period is expanded to 29 months.

Although COBRA specifies certain maximum required periods of time that continued health coverage must be offered to qualified beneficiaries, COBRA does not prohibit plans from offering continuation health coverage that goes beyond the COBRA periods.

Some plans allow beneficiaries to convert group health coverage to an individual policy. In this case, you must be given the option to enroll in a conversion health plan. You usually must enroll in the plan within 180 days before your COBRA coverage ends. The premium is generally not at a group rate. The conversion option, however, is not available if you end COBRA coverage before reaching the maximum period of entitlement or it is unavailable under the plan.

FOCUS POINTS

1. COBRA establishes required periods of coverage for continuation health benefits.

2. If qualified beneficiary is determined under title II or XVI of the Social Security Act to have been disabled, the 18-month period is expanded to twenty-nine months.

3. In a conversion health plan you must enroll in the plan within 180 days before your COBRA coverage ends.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- Coverage begins on the date that coverage would otherwise have been lost by reason of a qualifying event and end when?

6

PAYING FOR COBRA

Beneficiaries may be required to pay the entire premium for coverage. It cannot exceed 102 percent of the costs to the plan for similarly situated individuals who have not incurred a qualifying event. Premiums reflect the **total** cost of group health coverage, including both the portion paid by employees and any portion paid by the employer before the qualifying event, plus two percent for administrative costs.

For disabled beneficiaries, the premium may be increased after 18 months to 150 percent of the plan's total costs of coverage for the last 11 months of continuation coverage.

Premiums due may be increased if the costs to the plan increase but generally must be fixed in advance of each 12-month premium cycle. The plan must allow you to elect to pay premiums on a monthly basis if requested by you.

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment must cover the period of coverage from the date of COBRA election retroactive to the date of the qualifying event. Premiums for successive periods of coverage are due on the date stated in the plan with a minimum 30-day grace period for payments. No payment, however, need be made earlier than 45 days after the date of the election.

The due date may not be prior to the first day of the period of coverage. For example, the due date for the month of January could not be prior to January lst and coverage for January could not be canceled if payment is made by January 31st.

Premiums for the rest of the COBRA period must be made within 30 days of the due date for each such premium or such longer period as provided by the plan.

COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to deductibles, catastrophic and other benefit limits.

FOCUS POINTS

1. The premium cannot exceed 102 percent of the costs to the plan for similarly situated individuals who have not incurred a qualifying event.

2. The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary.

3. Premiums for the rest of the COBRA period must be made within thirty days of the due date for each such premium or such longer period as provided by the plan.

4. COBRA beneficiaries remain subject to the rules of the plan and therefore must satisfy all costs related to deductables, catastrophic and other benefit limits.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- For disabled beneficiaries, the premium must be increased when and to what?

7

CLAIMS PROCEDURES

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures are to be included in the SPD booklet.

You should submit a written claim for benefits to whomever is designated to operate the health plan (employer, plan administrator, etc.). If the claim is denied, notice of denial must be in writing and furnished generally within 90 days after the claim is filed. The notice should state the reasons for the denial, and any additional information needed to support the claim and procedures for appealing the denial.

You have 60 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless the plan:

- Provides for a special hearing, or
- A group, which meets, only on a periodic basis, must make the decision.

Contact the plan administrator for more information on filing a claim for benefits. Complete plan rules are available from employers or benefits offices. There can be charges of up to 25 cents a page for copies of plan rules.

FOCUS POINTS

1. Health plan rules must explain how to obtain benefits and must include written procedures for processing claims.

2. Claims procedures are to be included in the SPD booklet.

3. Copies of plan rules can charge up to twenty-five cents a page.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- You have 60 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless what?

8

ROLE OF THE FEDERAL GOVERNMENT

Continuation coverage laws are administered by several agencies. The Departments of Labor and the Treasury have jurisdiction over private sector health plans. The United States Public Health Service administers the continuation coverage law as it affects public sector health plans.

The Labor Department's interpretative and regulatory responsibility is limited to the disclosure and notification requirements.

The Internal Revenue Service, which is in the Department of the Treasury, is responsible for publishing regulations on COBRA provisions relating to eligibility and premiums. Both Labor and Treasury share jurisdiction for enforcement.

The U.S. Public Health Service, located in the Department of Health and Human Services, has published the Title XXII of the Public Health Service Act entitled "Requirements for Certain Group Health plans for Certain State and Local Employees".

A law similar to COBRA covers Federal employees. Those employees should contact the personnel office serving their agency for more information on temporary extensions of health benefits.

CONCLUSION

Rising medical costs have transformed health benefits from a privilege to a household necessity for most Americans. The COBRA law creates an opportunity for persons to retain this important benefit.

Workers need to be aware of changes in health care laws to preserve their benefit rights. A good starting point is reading your plan booklet. Most of the specific rules on COBRA benefits can be found there or with the person who manages your plan.

Be sure to periodically contact the your health plan to find out about any changes in the type or level of benefits offered by the plan.

FOCUS POINTS

1. The Department of Labor and Department of Treasury have jurisdiction over private sector health plans.

2. The United States Public Health Service administers the continuation coverage law as it affects public sector health plans.

3. The Labor Department's interpretative and regulatory responsibility is limited to the disclosure and notification requirements.

4. The Internal Revenue Service, which is in the Department of the Treasury is responsible for publishing regulations on COBRA provisions relating to eligibility and premiums.

5. The Title XXII of the Public Health Service Act entitled "Requirements for Certain Group Health plans for Certain State and Local Employees".

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- What does the COBRA law create?

- Where can most of the specific rules on COBRA benefits be found?

PART THREE - CAFETERIA PLAN

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 re-circulate 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 re-circulation 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 on 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 individuals compensation. The level usually is based on the occupation, salary range and industry rating, or the differences that exist between certain types of non-hazardous, 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 retirees, 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.

Both employees and employers make contributions to the program 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 equals 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 un-reimbursed 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:

	Without Cafeteria	***With 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	-375-00	0
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.

	Without Cafeteria	***With 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 saving on payroll taxes, and some cost important controls.

FOCUS POINTS

1. ZEBRAS stood for Zero Balance Reimbursement Account.

2. Short term disability income plans and long term plans serve the same purpose: To income for the employee while they are disabled.

3. Dental insurance typically includes deductible amounts and coinsurance elements.

4. Term life insurance is usually stated in terms of salary.

5. 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.

6. The major medical plan carries the basic medical plan benefits along with extended maximums to help pay for the more serious illnesses or accidents.

7. "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.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- What are the basic established plans? Explain

- What are the mandated plans common to all states?

- Explain the workings of a cafeteria plan.

2

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. Law mandates such close scrutiny 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 childcare.

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 its 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 whom,

- 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 125 CAFETERIA PLAN MID YEAR STATUS CHANGES-RULES 2000

In 2000, the IRS released new rules regarding when employees can change their cafeteria plan elections during a plan year. These rules are effective on the first day of the plan year that started in 2001. There are 12 events that could support a mid year election change. Here is a summary of the 12 events.

In general employees who experience any of the 12 events can change their elections for pretax premiums (medical, dental, life, disability, etc.) medical expense reimbursement accounts (medical FSAs) and dependent care reimbursement accounts unless noted otherwise. The new rules generally allow more flexibility for employees, especially with regard to dependent care accounts. Employees can now change their elections mid year if their day care costs increase or decrease or they change providers.

1. **A Change in Status**. In order for an employee to change his or her cafeteria plan election mid-year, a change in status event must have occurred and the employee's request to change must be consistent with the event. In other words, the plan administrator should ask himself two questions: (1) Did the employee incur a change in status? (2) Does the change in status event affect coverage elegibility of the employee, spouse or dependent?

   There are six events that can qualify as a change in status event:

   1. Change in the employee's legal marital status. This includes marriage, divorce, the death of a spouse, legal separation and annulment.

   2. Change in the number of dependents. This includes, adoption, placement for adoption and death. Note: a dependent is defined as a tax dependent under Code Section 152.

   3. Change in employment status: This applies to any employment status change by the employee, his spouse or dependents that affects benefit eligibility. Such events are termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave, a change in worksite; or a change from salaried to hourly, part-time to full-time, union to non-union, etc.

   4. Dependent satisfies (or ceases to satisfy) dependent eligibility requirements. A change may be allowed if a dependent satisfies or ceases to satisfy the requirements for coverage due to attainment of age, gain or loss of student status, marriage, or any similar circumstances.

   5. Residence change. If a change in residence affects the employee's eligibility for coverage, an election change may be allowed (e.g. an employee moves outside of an HMO's coverage area.)

6. Adoption Assistance Commencement or termination of adoption proceedings would allow an election change under an adoption assistance program.

2. **Cost Changes**. If the cost of coverage increases (or decreases) during a period of coverage, the employer can automatically increase (or decrease) the affected employee's contributions (not applicable to FSAs).

3. **Election of Alternative Coverage if Significant Cost Increase**. If the cost of coverage significantly increases during a period of coverage, employees can either make a corresponding change to their contributions or revoke their elections and choose similar coverage (not applicable to FSAs)

4. **Significant Curtailment in Coverage**. If coverage under a plan is signifantly curtailed or ceases during a period of coverage, affected employees can revoke their elections and make new elections for similar coverage (not applicable to FSAs).

5. **Addition (or elimination) of a Coverage Option**. If a new coverage option is offered, affected employees can elect the newly-added option. If an existing coverage option is eliminated, affected employees can elect another option (not applicable to medical FSAs)

6. **Change in Spouse or Dependent Coverage under their Employer's Plan**. An employee can change his election due to a change in his spouse's or dependent's coverage under their employer's plan. For example: John has elected family coverage under a calendar year plan. His wife's employer's plan runs from July to June and she elects single coverage under her plan beginning July 1. John should be allowed to change his coverage to single under the plan effective July 1. (not applicable to FSAs)

7. **FMLA Leaves**. An employee can (a) pre-pay his or her contributions on a pretax basis, (b) make contributions on a month-by-month basis (pretax if the employee is receiving salary continuation payments) or (c) catch up his or her contributions after returning to work.
8. **401(k) Election Changes**. Employees who elect to participate in the 401l(k) option under a cafeteria plan can change their 401(k) deferral percentage during the year. (Only applicable to the 401 (k) election).

9. **HIPAA Special Enrollment Events**. An employee can change his cafeteria plan election to correspond with his/her special enrollment rights under HIPAA such as when he or she gains dependents through marriage, birth or adoption or loss coverage under another group health plan. The special enrollment period that relates to birth or adoption may not be less than 30 days with coverage retroactive to the date of the event. (Applies to medical coverage and some dental, vision, and medical FSAs)

10. **COBRA Events**. An employee can increase his contributions during a year to pay for COBRA coverage. (Applies to medical coverage and some dental vision coverage.

11. **Judgements, Decrees or Orders**. An employee can change his election under a cafeteria plan to add or drop medical coverage pursuant to a court order. (Applies only to medical, dental and vision coverage and medical FSAs)

12. **Entitlement to Medicare or Medicaid**. Entitlement to Medicare or Medicaid may allow an employee to drop or reduce health coverage under his employer's plan. (Applies only to medical coverage and medical FSAs.

SECTION 79: GROUP TERM LIFE INSURANCE

Section 79 covers the group term life insurance aspect of a cafeteria plan. Normally, employers 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: NON-DISCRIMINATION

Section 89 is the Code section upon which the previous Code sections (6specially 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 non-working 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, 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 that, because of one or more of the following qualifying events, are no longer eligible to receive benefits under the employer's group plan:

- Terminations 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 dependents) 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 judgement 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.

FOCUS POINTS

1. No one can be required to complete more than three years of employment in order to be eligible to participate in a cafeteria plan.

2. A cafeteria plan may not discriminate in towards highly compensated employees regarding eligibility, contribution to the plan, or benefits.

3. 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.

4. Section seventy-nine covers the group term life insurance aspect of a cafeteria plan.

5. ERISA stands for Employee Retirement Income Security Act of 1974.

6. Two major provisions of ERISA are that any benefit plan established under the United States Tax Codes must be in writing and be communicated to all plan participants.

7. TEFRA stand for Tax Equity and Fiscal Responsibility Act of 1982.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- What are the Internal Revenue Code sections that deal with a cafeteria plan?

- What is a key employee by definition?

- Define a highly compensated employee.

3

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 could be taken. This 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.

BRINGING THE EMPLOYEES INTO THE PROGRAM

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 coverage, 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 that 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, the participant according to the "budget" pays the money into the account 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:

- 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.

- 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. In as much as the disability income and medical reimbursement plans would be able 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 pay-out - 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 re-circulated 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 "over-budgeted", 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.

FOCUS POINTS

1. The 1986 Tax Reform Act cut back dramatically on many previously available tax deductions.

2. The cafeteria plan offers a plan design in which everyone wins.

3. A subject survey is used to gain information and statistics to help outline the options on the proposal to be submitted to the employer.

4. The plan option(s), employer, and employee are all forms of the proposal.

5. 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.

6. A medical care reimbursement account is set up by an individual who has established a "budget" pays the money into the account he or she established.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- The goals and objectives of the employer will usually center of what topics?

- Explain the schedule in which the stages in which the program can be implemented.

4

HOW TO ADMINISTRATE & COMMUNICATE THE PLAN

COMMUNICATION

Cafeteria plans are best communicated with a four-stage process that begins during the sale phase and continues well past the implementation of the program. This four-stage process consists of:

The Announcement Stage

You must follow the process by creating awareness of the cafeteria plan. You started this process when the decision-maker at your prospective client company allowed you to survey the employees to determine the company's demographics and the current structure of the benefit program. During the announcement stage, it is best to define the current coverage and give the participants an explanation of the purpose of each plan; what is a medical plan? What would you have to pay for a particular accident or illness if the plan was not available? Follow these steps through all of the plans.

Once the company has approved the proposal you developed for the plan design, the formal process of communication goes into high gear. You now have the responsibility of conducting a series of participant meetings to fully explain the new program and how it affects each member of the company.

Once you've established your meeting schedule, you can use the announcement of these meetings to arouse interest in the new program. Two effective tools to meet this objective are the payroll stuffer and the poster. The payroll stuffer can be inserted in each employee's pay envelope on the payday closest to your scheduled meetings. The poster can be put up in employer-approved areas where it can be seen and noted. Both poster and stuffer should carry the same message, which is:

> *"Announcing the Andex company Cafeteria Plan, Increased benefits with tax savings. Increased Benefits! Tax Savings! More Take home Pay! A new approach to our Benefits Program!"*

The flip side of the poster and the payroll stuffer could read:

> *"Every dollar you put into our new Cafeteria Plan Program means tax savings for you. The amount of savings depends upon your individual tax bracket and circumstances, but everyone will benefit!"*

ADMINISTRATION AND COMMUNICATION

Education

The goal of your employee meetings is to educate the employees regarding the benefit plans being offered and the choices available to each participant. To achieve this goal, you're going to have to do a lot of preliminary work. You're going to need displays, audio-visual presentation, and a live presentation.

The displays can be as elaborate or as simple as your budget and judgment allow. One set of displays could feature the company's benefit program as it stood before the introduction of the cafeteria plan; the other set could illustrate the options available under a cafeteria plan. Other displays could feature sample before and after tax savings. Don't forget to include Social Security as a part of the display.

One topic that is bound to start a great deal of discussion is the increase in mandated social security contributions since 1970. You can show through a display how these contributions have increased in size ten times over this period.

An audio-visual format should form the foundation of your presentation. This is recommended because a professionally prepared script, colorful slides or overhead transparencies and an audio tape will serve to create interest, move things along efficiently and present the most important information in a thorough manner. Also, you won't risk the chance of omitting something due to lack of time. Audio-visual presentations can be paced precisely, present the information clearly and save your energy for the "live" presentation, which is your responsibility.

During the live presentation, you can use your displays as learning tools. Illustrate the old program as compared to the wide range of options available under the cafeteria plan. Again, show examples of tax savings available with the cafeteria plan and go over the options, making sure everyone understands how the new program operates.
As you reach the close of the presentation, you can distribute a handout that will play an important role in the next communication stage. This tool is the benefits work sheet. The work sheet can be introduced by saying, "I know everyone wants to learn how he or she can earn that $675 per hour for this session. I have an even better idea. You can nail down that $675 for this hour's session, plus another $100 besides. Your goal is to reduce your taxable income so you won't have to pay as much in taxes as you've been paying. What you have to do is find out just what you've been spending for all the items on this work sheet.

ADMINISTRATION AND COMMUNICATION

We'll need to work with some pretty accurate figures, so get your spouse, last year's check stubs, receipts, anything that can help you pin down these expenses as accurately as possible. What you do NOT want to do is overestimate. If you do, and you set up an account that's going to have too much money in it at the end of the year, that money is forfeit. You lose it! It's gone forever! Now, who wants to just guess at these figures?"

THE ENROLLMENT PROCESS

Since you have done such a terrific job of arousing the interest of all the company employees and educating them in the program. You are now ready to begin enrollment of the participants. If most of your income from this case is coming from the commissions off the sale of individual products available in the benefit enhancement accounts, this is the Super Bowl. Up to now, everything you've done was in anticipation of this event.

Since enrollments will vary from one company to another, from one program to another, etc. these are some general rules to keep in mind:

- The enrollment meeting room should be private and comfortable for your participant.

- Always have a supply of benefit work sheets and a calculator.

- Be informative and professional during each enrollment. DO NOT ASSUME that a participant does not want to enroll in any phase of the plan. Your job is to make sure that each employee clearly understands the benefits of the program.

If you will be enrolling with a software package:

- Make sure you know how to run the software. Hold a practice session well ahead of the enrollment session. Bring along a description of how to run the software with you.

- The participant should sit next to you in full view of the computer screen.

- Check supply of printer paper before beginning each enrollment.

Should a computer and software not be available, assemble the completed work sheets and have the tax savings calculated by your home office, or by an accountant.

ADMINISTRATION AND COMMUNICATION

And again, should you have a computer and software, be thoroughly familiar with its operation and the mechanics of working with the software. Try some practice sessions with the equipment prior to the enrollments, as you won't have time at enrollment to try to figure out how to do a calculation or work in an option.

THE FOLLOW-UP.

You know the term "orphan policy owner." You also know the statistics on those individuals and families who, once having purchased a financial product or an insurance product, never see the person from whom they purchased the product again.

This type of situation cannot exist in a cafeteria plan. At a minimum of once a year, essential follow up work must be done. The recommended schedule is twice a year

follow up visits to your client. These follow up visits are not to be confused with the annual re-enrollment session that must be scheduled at the end of the year. Since participants have the right to amend their program once each tax year, a re-enrollment session is required.

The purpose of these follow up visits is to check on the progress of the program, see if there are any questions that have come up since your last visit, schedule meetings with participants who have any special requests or problems and, especially, show your concern for everyone's welfare and appreciation for the opportunity to be of service.

Administration

An effective administration system for a cafeteria plan usually consists of the following:

- An employee statement of account.
- A company statement of account.
- A discrimination report.
- A disbursement record.
- Message file.
- COBRA file.

ADMINISTRATION AND COMMUNICATION

Statement of Account for the Employee

This is a computerized report showing each employee-participant in the plan the transactions that took place over the transaction period (i.e. monthly, or quarterly). It shows the activity that occurred in the accounts selected by the participant, the budgeted dollars and amounts expended.

Each account being maintained by the administrator for the participant should be accounted for on the report sent to the participant. Of special importance are contributions that were budgeted to be spent, but, as yet, have not been spent. (i.e., a budget for eyeglasses at $200 that has not been spent). These should be pointed out

to the participant in a footnote to his or her statement. Account overages of this kind cannot be transferred from one account to another (i.e., medical expenses to dependent care) and if the year ends without the money being spent. It is forfeit.

Statement of Account for the Company

The company should receive a regularly scheduled report from the plan administrator showing the volume of transactions occurring within the plan, just the same as the participants. Again, you want the report to show names of persons, amounts involved, budgeted amounts and any discrepancies. Amounts owed by the company should be indicated prominently.

The Discrimination Report

Of extreme importance to the company is a discrimination report. This will show the benefit amounts involved for all key and highly compensated employees, whose total benefit amounts are not to exceed 25 percent of the overall benefit amounts.

Remember, the IRS requires that the above information has to be filled and that the final test for discrimination be based on disbursements.

The Disbursement Record

This would be the documentation for the reports given the company on a regular basis. It could be reserved as to be provided on a "on demand" basis by the company; if so requested, given to the company on a regular schedule.

MESSAGE FILE.

This is self-explanatory; messages exchanged between all parties involved in the plan should be maintained.

C.O.B.R.A. file.

Remember the employee/dependent rights to benefits we discussed earlier and how COBRA protected those rights? Remember that this is the principle-monitored program handled by the IRS, the Department of Human Services and the Department of Labor. There are computer software packages available to help you administer a cafeteria plan in accordance with COBRA regulations. Your client already may have such a software package since COBRA is an across the board requirement affecting traditional health plans as well as cafeteria plans.

Also tied with an effective administration system are claims handling, maintenance of the plan document, reports filed with the monitoring agency or agencies, the Summary Plan description and its amendments, election and amendment to election forms, enrollment records and the annual filings for the IRS: 5500, 5500-C, or 5500-R.

Effective communication and administration are the foundations upon which a profitable cafeteria plan rests. Without communication, the participants won't have the knowledge upon which to base a decision. Without administration, the program won't be able to function, much less file the necessary reports with the federal government agencies involved. Luckily, a PC and related software can be of tremendous assistance in these areas, as well as the consulting firms that exist to help handle these details.

FOCUS POINTS

1. During the announcement stage, it is best to define the urrent coverage and give the participants an explanation of the purpose of each plan.

2. The goal of your employee meetings is to educate the employees regarding the benefit plans being offered and the choices available to each participant.

3. Statement account is a computerized report showing watch employee-participant in the plan the transactions that took place over the transaction period.

4. The discrimination report will show the benefit amounts involved for all key and highly compensated employees, whose total benefit amounts are not to exceed 25 % of the overall benefit amounts.

5. Effective communication and administration are the foundations upon which a profitable cafeteria plan rests.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- What are some of the general rules for the enrollment process?

- What does an effective administration system for a cafeteria plan consist of?

PART FOUR - DISABILITY INCOME PLANS

1

THE BASICS OF THE POLICIES

UNDERSTANDING THE IMPORTANCE OF DISABILITY INCOME

If you had a machine that produced 15 crisp $100.00 bills each month, how would you take care of it? Would you cover it? Would you oil it? Would you insure it? Of course you would!

You are that money machine. You are the one that produces an income each month.

Disability Income Insurance is one of the most undersold and overlooked markets in the insurance business. Surveys taken tell us that 85%, yes, 85% of workers surveyed in companies, that employ 3 to 50 employees, have **NO SHORT TERM OR LONG TERM DISABILITY.**

It has been said that 97 out of 100 American families would be bankrupt if they missed just **THREE PAYCHECKS!**

If you went to your doctor today and he said, "Well, the tests have come back and you need to go home and get in bed and stay flat on your back for 7 months because the illness you have requires this." Would you have a problem paying your bills? Some say "I have money in the bank!" or "I have sick pay at work" or "My friends will support me" (That's the funniest of all of them). Well, the truth is that the majority of us would be in serious financial trouble. The light company, phone company, Mortgage Company, and auto finance company could care less. They want their money and NOW!

POLICY ELIMINATION PERIOD

An important factor to consider here is how long would you be able to continue your present standard of living in the event of a total disability. That is how long can you wait before the company begins paying you benefits? This is called the policy elimination period.

The following elimination periods are available:

- 14 day (very rare and hard to find).
- 30 day
- 60 day
- 90 day
- 180 day
- 365 day

Obviously the policy elimination period has a great deal to do with the premium you will pay. The longer you wait, the less it costs. The shorter the wait, the higher the cost.

You need to consider the following factors in determining your policy elimination period:

- How much liquidity of assets or savings do you have?
- Do you have a short-term disability policy at work?

- Do you have sick days, accumulated holidays, or bonus days at work that you may use?
- Do you have vacation time coming?
- Does your spouse have an income you can depend on?
- Do you have sources of unearned income from rentals, investments, dividends, interest and the like?
- Very carefully make a list of your fixed expenses and know exactly how long the above four factors can provide you an income.

Now you can intelligently determine the proper policy elimination period.

BENEFIT PERIOD

Another factor that affects the cost of your disability income policy is its benefit period. This is the period of time that benefits will be paid to you for total disability. Typical benefit periods are as follows:

- One year.
- Two years.
- Five years.
- Age 65.
- Lifetime.

The average disability lasts 9 to 18 months. However, depending on your occupation and the definition of your occupation, the benefit period is a major consideration. For example, if you are a Plastic Surgeon, losing a hand is a major disability and you certainly would want to have an age 65 or lifetime benefit period. If however, you are a tow truck driver, a one or two-year benefit period might be just fine.

HOW IS A DISABILITY POLICY RENEWABLE?

There are two types of renewal provisions in disability plans.

- Non-cancelable
- Guaranteed Renewable

DEFINITION OF NON-CANCELABLE

This type is the most favorable to you and the one that the underwriters look at the closest. So long as you pay your premiums on time to a pre-determined date, usually age 65, the company CANNOT:

- Cancel the policy
- Change any provisions
- Add any riders that restrict coverage
- Add any changes to the policy
- Raise the premiums

DEFINITION OF GUARANTEED RENEWABLE

A disability policy may be Guaranteed Renewable Only. This means that the company CANNOT do any of the above five **EXCEPT number 5.** The company CAN raise the premiums but you cannot be singled out. The company must raise the premium for all that are either in that class or that type of policy contracts.

WHAT HAPPENS WHEN YOU TURN 65?

In order to keep the policy beyond age 65, you must

- Be employed full-time under their definition
- Pay your premiums on time.

HOW IMPORTANT IS THE DEFINITION OF TOTAL DISABILITY?

This definition determines if you will get paid or not when a claim is filed. It is very important. Basically, the definition of TOTAL DISABILITY IS AS FOLLOWS:

- YOU CANNOT OR ARE UNABLE TO WORK AT **ONE** OR MORE OF THE IMPORTANT DUTIES OF YOUR REGULAR JOB.

- YOU ARE UNDER THE CARE OF A QUALIFIED AND LICENSED PHYSICIAN.

OCCUPATIONS

One of the most important considerations in issuing a disability policy is the insured's occupation. Obviously, the more hazardous your job, the higher the premium because of the inherent risks factors. Therefore, companies take a close look at the following categories regarding your occupation:

- Do you travel a lot in your job?
- What kinds of materials, machines, or tools do you use?
- What industry is your company engaged in?
- Do you manage others?
- Is your job seasonal in nature?
- Are you prone to being laid off or having your hours shortened?

OCCUPATIONAL CLASSIFICATIONS

Disability policies can use a class grouping or an alphabetical grouping for occupations. The five most common are:

- Class One or AAAA.

- Class Two or AAA.
- Class Three or AA.
- Class Four or A.
- Class Five or B.

CLASS ONE OR AAAA.

Occupations commonly found here are the ones with favorable claims experience such as CPA's, Dentists, Doctors, Vets, etc.

CLASS TWO OR AAA.

Occupations in this group are typically Managerial, Technical, Professional, and Executive types who's duties are generally restricted to the office.

CLASS THREE OR AA.

Occupations here are comprised of Supervisors of performing employees but not those that do the actual operations. Merchants, Salespeople, Store Managers are a few examples.

CLASS FOUR OR A.

Here you will find skilled labor type of occupations such as home construction and small construction machines to name a few.

CLASS FIVE OR B.

Here we find the most hazardous of the occupational classifications and the most difficult to insure. A Motorcycle Police Officer, Bricklayer, or Welder are prime examples.

INCOME REQUIREMENTS

This area is one that is very strictly underwritten in that companies do not want to permit you to earn more income while disabled than you would while working. Obviously, this situation would cultivate false claims and malingering disabilities. Therefore, companies place a percentage of monthly benefits to your monthly-earned income. Typically, companies will issue a monthly benefit equal to from 40 to 70% of your earned income. For example, if you earn $3,000 per month, you can expect a company to give you a monthly benefit of from $1,200 (40% of $3,000) to $2,100 (70% of $3,000) or any amount in between.

Companies are looking for "earned income, which can best be defined as income for which you must sweat. Companies also look at "unearned income" such as rental income, royalties, investments, or dividends. Since this is income that would normally continue even if you were disabled it is generally not considered in the percentage formula and in some cases, it may even reduce the amount the company is willing to issue as benefit.

WHAT TYPES OF OCCUPATION DEFINITIONS ARE THERE?

- Your regular occupation.
- A limited regular occupation.
- Your regular occupation (Not working).
- Non - Occupation.

YOUR REGULAR OCCUPATION

This definition is the best of the choices. However, it usually applies only to insured's that are in highly professional positions such as dentists, lawyers and doctors. This definition covers the insured's "usual work" and a claim will be paid when the insured satisfies this stipulation.

A LIMITED REGULAR OCCUPATION

This is the second best of the choices. The major difference is that the insured would not be considered disabled for the full benefit period. For example if the benefit period were 5 years, the policy may cover you for 3 of those years under the regular occupation definition. However, after the 3 years definition has been satisfied the policy would contain an additional condition the last 2 years of the benefit period and it may then say :

> *Coverage will continue if the insured is not working in a reasonable occupation or if the insured is unable to work in a reasonable occupation.*

YOUR REGULAR OCCUPATION (NOT WORKING)

In order to qualify for disability benefits under this definition you must be:

- Unable to do the substantial and material duties of your job AND not work in a reasonable occupation.

NON-OCCUPATION

Rather than specially address an occupation, this definition says that you are totally disabled if:

- You are unable to work at any job for which you are reasonably suited for by training, education or experience.

WAIVER OF PREMIUM

This provision is usually part of all disability contracts. It states that if the insured is disabled more that 6 months (some may be 90 days) the premiums are waived until the insured goes back to work and no longer disabled or the benefit period expires. Some policies also refund the premiums you paid during the 6 month (or 90 day) period while you were waiting for the waiver provision to start.

EXCLUSIONS

There are three that commonly appear in most disability policies. They are:

1. Self inflicted injury.
2. Pregnancy.
3. War.

Some companies have removed the pregnancy exclusion in order to be more attractive to the female market.

GRACE PERIOD

The grace period is defined as the period of time beyond the due date that you may pay the premium without the policy lapsing. This is 31 days in most disability policies. During the grace period, the policy stays in force so long as you pay the premium that is due before the end of the 31st day.

CONTESTABILITY

Disability policies contain a period of contestability, which is usually two years. It should be noted that some policies exclude periods of disability during the two years. During the period of contestability the insurance company is given time to determine if any misstatements were made so that they can have the option of either rewriting the policy, or canceling it. After two years, there is nothing that can be done if misstatements are discovered.

FOCUS POINTS

1. The Policy elimination period is how long you can wait before the company begins paying you benefits.

2. The longer you wait, the less it costs and the shorter you wait, the higher the cost.

3. The benefit period is the period of time that benefits will be paid to you for total disability.

4. The average disability lasts nine to eighteen months.

5. Guaranteed renewable means that the company CAN raise the premiums but you cannot be singled out.

6. Total disability is when you cannot or are unable to work at one or more of the important duties of your regular job and you are under the care of a qualified and licensed physician.

7. Your regular occupation covers the insured's "usual work" and a claim will be paid when the insured satisfies this stipulation.

8. Non-occupation is when you are unable to work at any job for which you are reasonably suited for by training, education, or experience.

9. Self inflicted injury, Pregnancy and war are three exclusions that are commonly appear in most disability policies.

10. The grace period is defined as the period of time beyond the due date that you may pay the premium without the policy lapsing.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- What CANNOT the insurance company do as long as you pay your premium on time to a pre-determined date?

- What are the most common occupational classifications? What occupations fall into each?

2

DISABILITY POLICY OPTIONS

CUSTOMIZING YOUR POLICY

Flexibility is one of disability income's strong suits in that you are able to add a lot of bells and whistles or options to customize your disability policy.

For example, the following are common "options" that are available:

1. Cost of living
2. Future increase of monthly benefit
3. Hospital confinement
4. Life extension
5. Social Security rider
6. Cash back option

COST OF LIVING

This is an excellent option considering today's inflationary trend. This option permits the insured to increase his monthly income benefit based upon certain factors. The increase may be tied to the Consumer Price Index or it can be guaranteed to specific limits. Some can have a cap as to the maximum. Others have no cap and allow you to continue increasing your coverage until you reach age 65.

FUTURE INCREASE OF MONTHLY BENEFIT

This option allows you to increase your monthly benefit without evidence of insurability on specific future dates. Examples of times in which you may increase your monthly benefit are:

- Every fourth policy year anniversary up to a specific number or amount.
- The birth of a child.
- Marriage.
- Purchasing a new home.

Typically, the policy states that when any of the above events take place, you may increase your monthly benefit a specific amount each time such as $300 or $400 per month up to a final monthly maximum.

HOSPITAL CONFINEMENT

This option permits you to purchase a specific daily benefit in addition to your regular monthly disability income benefit. This option requires that you are admitted to the hospital as an "Inpatient" and during that time, the policy pays a daily benefit of $25 to $200 for each day that you are in the hospital.

LIFE EXTENSION

This option is available when the basic policy has an age 65-benefit period. It extends the benefit period for total disability to the lifetime of the insured in ONE of the four following ways:

1. Lifetime benefits are paid if total disability begins before age 50, 55, or 60.

2. Lifetime benefits are paid if total disability before a specific age, but, at a reduced percentage of the policies monthly income benefit. An example of this might be that you are 60 years of age and become totally disabled, the full monthly benefit will be paid to you until you are 65, then at age 65, the lifetime extension is reduced to 50%.

3. Lifetime benefits are paid if total disability is caused by an **ACCIDENT** before age 65. This does not include illness and benefits would cease at age 65 with no lifetime extension.

4. Lifetime benefits are paid if total disability occurs before age 65 and there are absolutely no other restrictions as to accident or sickness, age of onset of disability prior to age 65, or reduction in benefit. Obviously, this is the best of the four, and also the most expensive.

SOCIAL SECURITY RIDER

Here a benefit is paid to you if Social Security does not pay benefits. This is an excellent rider for the money in that Social Security is the most difficult disability income benefit to qualify for. Social Security has been known to deny in excess of 65% of all claims for benefits.

Basically this rider stipulates that you will receive an additional monthly benefit above and beyond your basic monthly benefit if Social Security benefits are denied. If however, Social Security does approve benefits, then the insurance company will not pay this additional monthly benefit. Another way in which this option works is that your basic monthly benefit WILL BE REDUCED by any amount Social Security pays.

CASH BACK OPTION

Many people feel that this option is expensive and impractical. One of their major complaints is that their money does not earn any interest. An insurance company charges an additional premium, which can be very substantial, for the cash back option. The two most common cash back options are as follows:

1. The company will return to you at age 65 all premiums paid less any benefits received. In the event benefits received exceed the premiums you have paid to age 65, there is no return of your premium. Some companies will permit you to drop the cash back option and reduce your premium accordingly should you ever reach the point that benefits paid exceed your premiums and there is no way for you to get your premiums back. However, most companies continue charging you the additional premiums for the cash back option even when benefits paid exceed your premiums.

2. The company will review your policy every ten years (rather than waiting to age 65), and return 80% of all premiums paid, less any benefits received. You can then use this return or premium to pay future premiums. Obviously most people will find other uses for the money.

FOCUS POINTS

1. Flexibility is one of disability income's strong suits in that you are able to add a lot of bells and whistles or options to customize your disability policy.

2. Hospital confinement option permits you to purchase a specific daily benefit in addition to your regular monthly disability income benefit.

3. Social Security has been known to deny in excess of 65% of all claims for benefits.

4. The cash back option is known to be expensive and impractical.

5. Cash back option is available when the basic policy has an age 65-benefit period.

FOOD FOR THOUGHT

To better understand the issues discussed take a few minutes to think about or perhaps on a separate piece of paper outline your perceptions of the following thought provoking issues.

- What are some examples of times in which you may increase your monthly benefits?

- What are the four ways the life extension option extends the benefit period for total disability to the lifetime of the insured?

PUBLISHER'S NOTE

IMPORTANT NOTICE

EVERY CARE HAS BEEN TAKEN TO ENSURE THAT THE INFORMATION IN THIS GUIDE IS AS ACCURATE AS POSSIBLE AT THE TIME OF PUBLICATION. PLEASE BE ADVISED THAT LAWS AND PROCEDURES ARE CONSTANTLY CHANGING AND ARE ALSO SUBJECT TO DIFFERING INTERPRETATIONS. HOWEVER, NEITHER THE AUTHORS NOR THE PUBLISHERS ACCEPT ANY RESPONSIBILITY FOR ANY LOSS, INJURY, OR INCONVENIENCE SUSTAINED BY ANYONE USING THIS GUIDE. THIS INFORMATION IS INTENDED TO PROVIDE GENERAL INFORMATION AND BACKGROUND AND IS DISTRIBUTED ON THE BASIS THAT THE AUTHORS ARE NOT ENGAGED IN RENDERING LEGAL, ACCOUNTING, OR ANY OTHER PROFESSIONAL SERVICE OR ADVICE. THIS GUIDE WAS DESIGNED TO GIVE YOU AN OVERVIEW OF THE INFORMATION PRESENTED AND IS NOT A SUBSTITUTE FOR PROFESSIONAL CONSULTATION.

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