MATURE MARKETS

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GETTING TO KNOW MATURE MARKETS

WHY STUDY MATURE MARKETS

If you are at all "tuned-in" to population trends, you know that the “Graying of America” is well under way. There are 59 million seniors today and every eight seconds a baby boomer turns 55. In a matter of years, they will add 76 million new people to the ranks of the mature market.

It is significant that during the past two decades the older population in our country has grown twice as fast as the rest of the population. The median age, today just under 32 years, is expected to reach 42 years by 2030. Life expectancy, less than 50 years at the turn of the century in 1900, is at an all-time high of nearly 77 years!

Living “long on the tooth”, however, has created a bit of a crisis in America. As people grow older, they face a myriad of problems and needs: reduced spending power, rising health care and insurance costs, loss of health benefits both on the job and in retirement, pensions in jeopardy and changing housing needs to name just a few.

The real tragedy is that most people spend more time planning their family vacations than living to a ripe old age. Perhaps they have planned for the good times and simply ignored the possibility of bad—hoping they wouldn’t catch up with them.

This is where insurance agents can help. The insurance industry is responding to the changing needs of mature Americans with many new or modified products like long term care insurance, Medicare supplements, second-to-die insurance, living benefit riders, universal and variable policies, fixed and indexed annuities and more! All of these products are designed to serve various financial planning and health care functions for an aging society.

The challenge for the insurance professional is to understand these products fully in order to underwrite and "program" insurance protection and investment for optimum results. This course will help! You will also learn the unique needs of the two distinct groups that comprise the growing mature marketplace: seniors and boomers. They are indeed different in their perspective, ethics and views. Your ability to recognize this is critical to meeting their special needs and developing long-term business relationships where all parties are rewarded.

Let’s look at some important facts about mature markets and some ways you can serve them better . . .
IMPORTANT FACTS ABOUT THE MATURE MARKETS

Mature Markets have all the money!
People over 65 hold 50% of all U.S. discretionary income and over three-quarters of all financial assets. Boomers control most of the rest!

Mature Markets control the votes!
In the year 2000, half the voters in the U.S. are age 48 or older. And, since these age groups consistently exercise their right to vote more so than younger generations, proposals to raise taxes or cut benefits to aging Americans are likely to be highly biased in favor of mature markets.

Mature Markets need more underwriting!
Agents who deal in the senior and boomer markets must know everything they can about underwriting because it is more of a factor when dealing with older clients.

Mature Markets will continue to stress our social & health programs!
The age wave will crunch programs like social security and Medicare in the early decades of the 21st century when boomers start reaching retirement age. Why? Because, the number of workers supporting retirees will plummet from 5 in 1990 to only 2.5 by 2030. And, these markets are living longer than ever making the problem long term.

UNDERSTANDING MATURE MARKETS

Statistics on our maturing population are interesting, but in order to serve them better you need to know who they are and what your products can do for them. Some call this process market segmentation, psychographics, or generational marketing. We just call it . . . knowing your client.

Insurance consumers today are much more complex than the relatively homogeneous buyer of the immediate post World War II era. Values back then were stable and centered around a shared vision of the American Dream. Now, we see vastly different values, motivations, life experiences and insurance needs.

By examining the senior and boomer market groups that make up these modern-day, prospects, you will gain the confidence to understand their core needs and their motivation to insure and invest them on several fronts. The result should net a better client-agent relationship, better coverage and a responsible selling experience.

The Senior and Boomer "Cohort Groups"
For purposes of this course of study, the mature market consists of individuals over 50 years of age. In America, this age group consist of two main cohort groups: Seniors and Baby Boomers. A cohort group is simply a band of people who share similar experiences by age, geography, culture, etc. In their book Rocking the Ages, 1998, J. Smith and Ann Clurman suggest that every cohort group passes through the same stages in life, e.g., going to school, graduating getting a driver's license, graduating college, buying a home, the joy and pain of parenting and the uncertainties of retirement. Similarly, each generation or group, must all deal with the same circumstances -- economic downturns, economic booms, wars, droughts,
shortages, real estate appreciation, low interest rates, etc. But, each group responds to these life events in different ways depending on generational differences. Therefore, it is likely that the insurance needs of one group are different than another.

To demonstrate this, let's look at the insurance history of today's seniors. In their younger years, virtually everyone bought whole life insurance to cover burial costs and/or to build a small pot of money down the road. They started with a small whole life policy and paid on it forever. Things like long term care coverage never existed. Contrast this with boomers of today, who are watching their own maturing needs through their parents' experiences and typically buy one or more term/universal/variable policies from $250,000 to $1 million and up to cover huge mortgages, expensive college educations for their kids and/or staggering cost of living expectations if the breadwinner dies young. Both generations bought homes and raised families, but the influences of their individual backgrounds created a need for much different insurance products. The same is true for health and disability coverages. Generations today buy substantially higher liability and lifetime medical limits in response to more lawsuits and escalating hospital bills. Generations past, were more likely to self-insure all or a portion of these coverages because the legal and financial consequences were not as grave.

**What Makes Them “Tick”**

Each of these generations have unique work ethics, styles and views on issues like quality of product, service and their need for insurance. The agent of the new millennium strives to know as much as he can about these consumer groups because providing and servicing their insurance needs is no longer the boring effort it was years ago. These generations are smarter and more demanding. Your ability to respond to their needs will determine your success in developing long-term business relationships where all parties involved are rewarded.

In addition to knowing these clients, you must develop ways to work with them. If you are a young agent, for example, will you be able to convince a senior that you are capable of understanding his needs and meeting them. Older agents may have similar problems getting younger clients to listen or see value in their experience. Let's look at the profile of these clients and the issues you face in serving them:

**Seniors: (Born between the turn of the Century and World War II).**

Seniors accomplished their goals through hard work. They are a very "team-oriented" generation having weathered a depression and major world wars. Almost half of the men of this group served in the military which is probably why this generation is so well taken care of by the government. It also didn't hurt that they saw seven of their own in succession in the White House, beginning with John Kennedy and extending through Lyndon Johnson, Richard Nixon, Gerald Ford, Jimmy Carter, Ronald Regan and George Bush, Sr.

Research has shown that different generations tend to catalyze or define themselves in the shadow of a momentous event or members of their generation. Defining moments for seniors include the bombing of Pearl Harbor, "a date that will live in infamy" said President Roosevelt. Hereos of this generation include MacArthur, Patton, Eisenhower, Winston Churchill, Audie Murphy, Babe Ruth, etc.

As Seniors came of age after World War II, they were armed and motivated by the ideology to rebuild society. They shouldered the burden of ensuring foundations of a better life which, indeed, is the reason that the generations behind them experienced stability and growth. Their self-sacrificing was very aptly summed up by John Kennedy in his inaugural speech when he said "ask not what your country can do for you, but what you can do for your country". Things
weren't easy, but that was ok. Seniors understood that hard work was its own reward and sacrifice a virtue. Duty before pleasure was their creed and their commitment to accomplish their goal was lifelong, not just a flash in the pan.

In essence, unlike many other generations, Seniors had a clear sense of purpose to what they were doing -- sacrificing for their children. Their individual struggles were shared by an entire nation which led to an unprecedented era of cooperation and mutual support. And, their efforts paid off. Success seemed to follow anyone who worked hard. This only reinforced their core belief that anything worth having is worth working to get.

Because they concentrated on their work and sacrifice, Seniors have always looked to the outside for direction and guidance. Authority figures like Dr. Spock were highly praised as was a general respect for government officials. Government programs flourished under the Seniors starting with the GI Bill of Rights which allowed virtually anyone to buy a house or go to school. The suburbs were filled with starter homes while the government provided all the infrastructure.

The prosperity of the Seniors, the respect they felt for institutions and their desire to conform all resulted into a true loyalty toward brand-name products. Seniors postponed a lot of material rewards, but when they finally let loose, they bought up a storm . . . mostly brand names they saw on TV or in ads. Anything that portrayed a glimpse of the American Dream was an immediate success.

Financial services were not complicated and interest rates were low for most of the Senior generation. Seniors paid off homes, created large retirement savings accounts, secure jobs and retired earlier than the generation before them. They are also richer, have more health benefits, better pension plans and live more comfortable lives. And, even in retirement they still want to conform as they flock to senior-oriented communities with names like Sun City and Leisure World.

**Boomers:** *(Born between 1946 and 1964).*

There are 76 million Boomers, making them one of the largest consumer groups ever. Boomers are bound together by their early expectations, skills and values shaped by unbridled economic growth. For them, the bubble would never burst. They grew up in some of the most optimistic, positive times -- the 50's. With few economic worries to distract them, they felt free to focus instead on themselves, on experimentation and on fulfillment. It didn't help that Boomers grew up spoiled and pampered by permissive parents and authority figures who considered self-expression good for them.

Boomers grew up thinking they were special and the media gave them the spotlight at every turn. They were and still are the "stars of the show". They believe themselves to be more interesting then Seniors or the Xers that follow. They also feel a sense of entitlement and expectation simply because of who they are! After all, they are the best educated and most sophisticated Americans in history. Who else is qualified to run the country. Personal freedom was a right not something to earn. They wanted no penalties for breaking the rules and complete impunity from criticism on the job.

For early Boomers, such was their life . . . simple and orderly. However, this all changed with the Vietnam War, Watergate and the economic hard times of the later 1970's. For Boomers, all of these events represented "cracks" in their world. The system was in doubt and the Boomers saw themselves losing ground for the first time. The post 1979 period was definitely a turning point in Boomer attitudes and expectations. A new desire for affluence emerged -- a "he who dies with the most toys wins" attitude. By the mid-1980's, Regan economic and tax policies made this more pronounced by putting more money into the hands of Boomers who realized
that they had to take care of themselves -- RIGHT NOW! It was an era of conspicuous consumption never seen before. BMW's replaced VWs, designer jeans replaced tattered jeans and the Home Shopping Network came into our homes to make it all possible.

Brands for the Boomers no longer dominated the marketplace. They wanted control. Discount and outlet stores thrived. This continued unabated until the shock of the '87 stock market fiasco. Suddenly, Boomers rejected the marketplace. Instead of "shop till you drop" the watchwords were "drop shopping". By the end of the eighties, Boomers were actually losing for the first big time. Even their kids were suffering because BOTH parents were working. Debt was higher than ever and so was their weight.

Boomers reasoned that they worked hard and played by the rules but still failed. Of course, they also believed that it wasn't their fault. They cast themselves as the victims -- a resentment that lasted well into the 1990's.

Today, to a great extent, Boomers have regained their senses. They are realizing that they have created much of their own stress and they will pick their future battles more carefully. They are also realizing that they are in their peak earning years and they need to start saving for retirement. Are their days of rampant spending at an end? NOT! It is important, say the experts, to remember that Boomers are rule breakers. Their individuality is more important than conformity. They have always done things different than the Seniors before them. If it takes some spending to accomplish this, so be it. Boomers are quite service oriented. They want to be liked, yet they are driven and willing to "go the extra mile" with a tremendous sense to "prove" themselves. Boomers have been described as "the most stressed generation in history", however, they are reaching an age when they want to simplify their lives as much as possible.

Now that we have determined who the mature markets are and how they think, let's look at some special ways you can better serve them.
SERVING MATURE MARKETS BETTER

RESPONSIBLE SELLING

Less-than-honest selling is nothing new: Caveat Emptor (buyer beware) is said to have appeared on buildings in ancient Rome. But in the mature market arena, it is the magnitude of damage that heightens the dishonesty. An unsuspecting senior client who buys inadequate LTC coverage, for example, is hurt a lot more than someone who buys a fake Rolex for $20 on the street corner. Or, a baby boomer at his peak earning power is served little by a $50,000 whole life policy when his economic loss is worth up to $1 million. This is why agents need to practice sales ethics.

Most states do not devote large sections of their insurance code to ethics. It’s not ordinarily part of license exams or taught at colleges. Therefore, it is something you choose in order to do a better job for your client. If you need more reasons why you should practice ethical selling, here’s a short list:

- It might keep you from being sued by a client or your insurer.
- The cleaner your record, the less involved underwriters will be in the sales process, i.e., you have more control over the sales process and less compliance.
- Ethical conduct violations drive up the cost of doing business which could affect your commissions, or, completely replace the current system of incentive pay with a salary or other form of measured compensation, i.e., violations can mean less money.
- Ethical conduct problems erode the public trust and that can cut into your sales.
- Ethical conduct lawsuits are now part of how companies are rated. More suits mean a lower rating and a harder sale for you.

There are many industry groups and agent associations who feel that the movement toward insurance sales ethics is way behind schedule. Too much emphasis and money has been spent on grooming sophisticated “salesmen”, they say, when there is a greater need for agent diligence and fair dealing. Especially in the area of seniors where some are extremely vulnerable to less-than-honest sales tactics.

The cornerstone of the agent diligence movement is called agent due care or sales conduct. Roughly translated, the meaning of sales conduct is an agent’s professional and ethical handling and choice of company, product and sales presentation to best serve a client’s financial planning. Others have embellished on this definition where the practice of sales...
diligence might read like this: “Conduct business according to high standards of honesty and fairness and to render that service to its customers which, in the same circumstances, it would demand for itself. Provide competent and customer-focused sales and service. Engage in active and fair competition. Provide advertising and sales materials that are clear as to purpose and honest and fair as to content. Provide fair and expeditious handling of customer complaints and disputes”. In essence, you are placing ethics above selling.

If you believed strongly in sales ethics, you might run your practice by the following credo:

- I will know everything possible about my client’s financial and insurance needs.
- I will have a complete understanding of all products I sell and present them fairly.
- I will find the most suitable product for my client and make sure I place him with financially capable companies without “bashing” the competition.
- I will document any lack of knowledge with a full disclosure agreement.
- I will request each client to sign a binding arbitration agreement for any potential misunderstanding or dispute.

While it would be wonderful if every agent lived by these rules, “real world” situations often get in the way. Taking the time to follow each and every rule would probably add to your workload. On the other hand, a little less free time today might save you considerable time and money by avoiding a major legal confrontation later. Likewise, the loss of a policy sale or two today might make it a whole lot easier to sell one . . . or be referred one . . . next year.

ETHICAL INSURANCE SELLING

Do you think you’re an honest agent? Could you prove it to a jury? What would your mother say about your sales practices? In the end, how will you judge your sales career? By how much money you made? By how many customers you helped? By what you accomplished for your family and your community? The answer lies within you. And, you are not alone if you are not 100% sure. There are many people and industries trying to grapple with the solution to “truth in selling”.

In a way, the insurance industry is battling a decline of sales ethics; a moral combat if you will. One battlefield, where it is difficult to win, is the media, where in recent times consumers read about state regulators warning 147 New York insurers on deceptive selling practices, or one company being penalized more than $700 million for deception, or an insurer’s agreement to pay $25 million to cover the unscrupulous sales techniques of a single agent. Ethical selling, as portrayed by the media, is just another oxymoron.

The troops leading the “offensive” for the industry are sales and motivational speakers and industry associations. Ethics, truth and responsibility are suddenly the core of seminars and newsletters with titles like Winning With Integrity, Selling With Integrity, Principled Persuasion or Selling With Honor. Groups and associations are doing their share by promoting proprietary codes of ethics as the foundation to membership and/or the blueprint for all transactions.

This is not to suggest that simply possessing a moral code is something that sets a professional apart from a mere salesperson. However, maintaining a Code of Ethics does inspire us to do good — especially if the breach of the code means we will lose our membership or be scrutinized by our peers.
Ethics is a trait that develops long before a person chooses LTC insurance as a career. Having high ethical standards, or more simply being honest, can be more important than being right because honesty reflects character while being right reflects a level of ability. Unfortunately, the insurance industry, for the most part, still rewards ability. There are, for example, plenty of "million dollar" marketing winners and "sales achievement awards"; but few, if any, "Ethics & Due Care" certificates.

For some, ethical selling, whether by a code of ethics or just plain honesty, is reward by itself. Consider, for example, the satisfaction you would realize when the interest of a client has been served by the proper placement of insurance.

**ETHICS FROM THE START**

Instilling ethics is a process that must start long before a person chooses insurance as a career. It is probably part of the very fiber that is rooted in the lessons parents teach their children. So, preaching ethics in a forum like this book may not be incentive enough to sway agents to stay on track. It may be easier to explain that honesty and fair play could mean greater sales and lessen the possibility of lawsuits.

Some believe that the ethics problem reflects our current culture which glorifies short-term success at all costs. This includes awards for the most sales in a given period of time as well as "golden boy" stories of the entrepreneur who goes from lonely computer geek to multi-millionaire from a single idea. Neither of these events is meant to say that these individuals accomplished their feats in an unethical manner. It simply "raises the bar" for those who follow them. If those who follow have inadequate skills and work habits, they could employ less than ethical means to reach the same goals.

**ETHICS FOR LIFE**

The insurance industry can do a lot more to promote ethics-building habits. At one insurer group, for instance, building a relationship in sales and marketing is emphasized with a program called **Client for Life.** It's premise is . . . "When you constantly exceed the needs and expectations of your clients, you're doing the right thing". Sales tools such as reports and newsletters are used to educate clients in a non-threatening and highly personalized manner. Long-term success is closely associated with building long-term relationships with clients rather than a quick sale. The results may vary from agent to agent, but a surprising benefit seems to be a **loyalty factor,** where more than 70 percent of sales comes from existing policyholders or their referrals.

**ETHICS FROM EDUCATION**

The customer can’t understand what the salesperson can’t explain. Further, a customer who understands a product is much less vulnerable to deceptive selling. Both statements stress the importance and need for more education. A recent study by the Insurance Institute found that four out of every five people don’t understand their insurance policies. And, if the agent doesn’t understand his product, the company and client are at substantial risk. The same agent ends
up concentrating on a “comfort zone” product or “B-level” service even if it is not the most appropriate one because he is uncertain about newer, more complex products.

Constant training is the answer, as well as making a long-term effort to demystify products. One solution is the translating of legalese into easily understandable, everyday English. This includes brochures, advertising, applications and the policies themselves.

The process of educating ethics is also the responsibility of our schools and universities. Currently, there is a glaring lack of attention to the selling disciplines. Besides learning the nuances of every product and the marketing behind them, young people could be taught the importance and responsibilities associated with being a salesperson. Like the athlete who trains long hours to prepare for the moment of action, sales career individuals can be groomed to do the right thing.

**INTEGRITY**

While many agents believe that "integrity" is a characteristic of choice, many state laws set minimum agent standards to follow, such as:

**Qualifications**

Insurance Commissioners have been known to suspend or revoke an insurance agent’s license if it is determined that he or she is not properly qualified to perform the duties of a person holding the license. Qualification may be interpreted to be the meeting of minimum licensing qualifications (age, exam scores, etc) or beyond.

**Lack of Business Skills or Reputation**

Licenses have been revoked where the agent is NOT of good business reputation, has shown incompetency or untrustworthiness in the conduct of any business, or has exposed the public or those dealing with him or her to danger of loss. In Goldberg vs Barger (1974), an application for an insurance license was denied by one state on the basis of reports and allegations in other states involving the applicant’s violations of laws, misdealing, mismanagement and missing property concerning "non-insurance" companies.

**Activities Circumventing Laws**

Agent licenses have been revoked or suspended for activities where the licensee (1) did not actively and in good faith carry on as a business the transactions that are permitted by law; (2) avoids or prevents the operation or enforcement of insurance laws; (3) knowingly misrepresents any terms or the effect of a policy or contract; or (4) fails to perform a duty or act expressly required of him or her by the insurance code. In Hohreiter vs. Garrison (1947), the Commissioner revoked a license because the agent misrepresented benefits of policies he was selling and had entered false answers in applications as to the physical condition of the applicants. In Steadman vs. McConnell (1957), a Commissioner found a licensee guilty of making false and fraudulent representations for the purpose of inducing persons to take out insurance by misrepresenting the total cash that would be available from the policies.

**Agent Dishonesty**

Agents have lost their license because they have engaged in fraudulent practices or conducted any business in a dishonest manner. A licensee is also subject to disciplinary action if he or she has been convicted of a public offense involving a fraudulent act or an act of dishonesty in acceptance of money or property. Furthermore, most Insurance Commissioners will discipline
any licensee who aids or abets any person in an act or omission which would be grounds for
disciplinary action against the persons he or she aided or abetted. In *McConnell vs. Ehrlich*
(1963), a license was revoked after an agent made a concerted effort to attract "bad risk
business" from drivers who licenses had been suspended or revoked. The Commissioner found
that the agent had sent out deceptive and misleading solicitation letters and advertising from
which it could be inferred that the agents could place automobile insurance at lower rates than
could others because of their “volume plan”. If this wasn’t bad enough, the letters appeared to
be official correspondence of an official state agency. Clients would be induced to sign
contracts with the agents where the agent would advance the premiums to the insurance
company. The prospective insured would agree to repay the agents the amount of the premium
plus “charges” amounting to an interest rate of 40 percent per annum. The interest rates
charged were usurious and violated state law.

**Catchall Category**
In addition to the specific violations above, most states establish that agent responsibilities
MUST NOT violate the “public interest”. This is obviously a catchall category that has been
used where agents have perpetrated acts of mail fraud, securities violations, RICO (Criminal)
violations, etc.

**ETHICS IN YOUR PRACTICE**

Sometimes, you can bring a higher level of ethical conduct to your practice just by the manner in
which you operate. Here are some areas of focus:

**Communication**
Transacting insurance is a communication process. Responsible and ethical agents know how
to simplify, while others tend to complicate their delivery to the point of confusing clients.

The fact is, it's hard for some agents to shut up! Why would a client want to hear about a long
list of features he could find on any brochure? Customers today are sophisticated. They don't
appreciate someone *telling* them what is best for them to do. Responsible agents, instead,
manage to subtly discover and expose the need *without telling*, without arm-twisting or high-
pressure manipulative techniques.

There is a scene from a Woody Allen movie where Woody is a crazy prison inmate. When he
can't take it anymore he plots an elaborate escape, which of course fails. His punishment is the
"locker" . . . solitary confinement. What could be worse? He is locked-up with a big city life
insurance agent and forced to hear his pitch for 3 days! The agony. Don't make your clients
agonize the same way.

Effective communication is also about words. And, words can be important to mature markets.
For instance a lot of agents use the word “planning” when discussing financial or insurance
issues. However, planning does not connote control. Why not use the term “controlling wealth”
instead. Another example is the words “wealth transfer”. If you say “transfer” to a senior it
doesn't help them with their legacy desires and, for many, it means “freeloader”. Better words
might be “creating a legacy”: It’s positive and says something really wonderful!

**Simplify To Educate**
The key to getting through to someone is simplicity. Your insurance presentation could easily
last 3 or 4 hours. But who is willing to listen for this length of time? Even retired seniors don't
want to spend half their day on things that are too complicated. If this wasn't true, every senior would know how to program his VCR or challenge a computer spreadsheet program. The fact is, they don't want to waste their time.

When it comes to keeping things simple, the content of your message is uppermost. The essence of simplicity is the absence of unnecessary elements. Albert Einstein once said . . . "out of clutter, find simplicity".

A concise presentation, however, does not mean shallow. A common mistake is to think that making something easy to understand is a matter of reducing something which is more complete than the "simple" end result. On the contrary, simplicity requires serious thought and effort. It takes more to convey your thoughts and messages in a fewer number of words than to rattle off two hours of statistics and policy features.

A lot of times, making something easier for your client to understand means you have to sacrifice your ego. Face it, you really want to impress clients with your newfound knowledge about long term care facts and features . . . don't you? It's human nature. But, resist the urge to spout.

**Expose Needs**

In the simplest way possible make your case about risks and priorities and determine their needs. Then satisfy their needs in a responsible and professional manner. Layout the possibilities and let them choose. For example, is home care as long as possible with the eventual skilled care of their choice a need? How about assisted living choices or companion care for shopping, cooking, cleaning? Next comes, facility care choices, inflation protection, world-wide coverage. Then discuss tax benefits, ease of claims, the "pool of money" concept, affordability, rate increases, elimination periods and choice of company. Instead of making your policy fit these features, establish their importance and point out that your coverage meets them all!

**Be Knowledgable**

It's nice to make things easy to understand and interesting for your clients. However, never, ever shirk your responsibility to know your product well. Even though you make it sound easy, you have to be able to answer the tough questions and make professional choices. KNOW WHAT YOU SELL!

**MARKETING TO MATURES**

To be an effective and responsible agent you need to know the emotions of your clients and know how to meet their needs. It's called “empathy”. Think of it as "walking a mile in their shoes"; imagine how they perceive you as their agent. Are you too young to gain the confidence of a senior? Are you too old to relate to a boomer? Too stuffy? Are you going to fast? Too slow? Do you "speak" their language using words and mannerisms familiar to them. Is your demeanor so casual that a senior might think of you as rude or disrespectful?

This is not about "selling" something you have, it's about how to better communicate transactions so clients can understand them better. For example, if you were approaching a Senior with a long term care policy suggestion you could leverage the brand name of
a big insurance company a bit, but you would also know that Seniors have come to be somewhat distrustful of big business. You would need to do more to satisfy their need to know more about your insurer.

To be effective, you will also have to reach a variety of client groups on different levels. Seniors and Boomers may not respond as well to websites as will boomers. Boomers will want more detail, while seniors will want to know all the risks in plain English.

While all groups want the best price they can get, price alone is not enough. Every generation has demonstrated they will be willing to pay a little more with a guarantee of better service or some perceived value.

As to efficiency, Boomers and Seniors are pre-occupied about what goes on during the sales process. They see the sales experience as unpleasant. It makes the selling experience shorter and easier to understand. So many times, agents get caught up in "benefit limbo" by preaching facts and figures that clients simply "tune out". When you approach these two groups this way, you lose your clients.

Let's look at some more ways you can reach seniors and boomers more responsibly.

**Seniors:**

Serving seniors responsibly means you must respect their experience. They might like hearing from you how valuable it is to hear the way things worked in the past and that their perseverance is valued. They might also like to see that you are "part of a team" to meet their needs. Messages, literature and brochures should speak to issues of family, home, patriotism and traditional values, e.g., stars and stripes, etc. Use clear enunciation, good grammar and large type. Include "please" and "thank you" and avoid any kind of slang or near-profanity. Also, if it isn't something they feel is needed right away, don't expect seniors to jump on every product you present. They may prefer to get to know you, what to expect from you, your company, your product. They will relate to the true story of your company from where it is to where it is going. Stress the long-haul using "months and years" rather than days and weeks. Seniors will respond to the "personal touch" such as a handwritten note instead of an e-mail or fax. Also, strive to be a respected "mentor" or "coach" to your senior clients. Don't avoid the difficult issues and try to get agreement on potential problems. Agree on a course of action and set a follow-up date.

Financial discipline is still the foundation of this generation. Few of them will betray a lifetime of saving to be big spenders. They might be more willing, however, to spend money on look at something that might benefit their children or grandchildren because they are still the generation that feel they need to make something better for someone else. When it comes to something new or experimental, you will have a much harder time convincing Seniors. They are less likely to want something new before someone else has tried it.

Responsible agents have also learned that you don't treat today's Seniors as decrepit or broken down. They see themselves as active, health, happy and vivacious. Even those who are not so healthy or energetic dislike advertising or products that remind them of their age or problems.

Seniors like consistency and uniformity in their business dealings, as well as brand name companies. They like to conform and believe in logical matters. Conversations should stay "on the topic" and not get "too personal". Seniors are disciplined but they get frustrated like everybody else with things like poor service or poor directions. The history of your products and companies are very important to this group because to a great extent, they base their decisions on what has happened in the past: What worked? What didn't? Details are also
important because seniors are very uncomfortable with conflicts that arise after the sale. Seniors believe very much in law and order so products that might "push the legal limits" may be viewed with suspicion. Technology devices like voice mail, computers or e-mail are not their favorite things. In essence, you are dealing with a very conservative group.

One of the best mediums to reach seniors are lectures or seminars given by an expert. However, this group does not like to be in learning situations (small or large) in which they might look foolish in front of someone because they don't know the right answer. If you ask a question, make sure they can answer it. Information should be organized, well researched and supported by facts, figures, details and examples. Seniors like their information in condensed form.

Also, few, if any, Seniors would like to be known as old. If you are appealing to them to contacting older clients, there is no need to point out that you are doing something a certain way because they are old. You don't need to point out, for instance, that the letter or policy you sent them uses large type to help them read it better. No one wants to be reminded that their body parts are wearing out!

**Boomers:**

Serving boomers responsibly will be a challenge. Like seniors, they need to know that their experience is valued. Messages like, "you're important to our success", "we need your business" or "you will really make a difference" are important reinforcements. They need to know they are part of something dynamic and that in the final analysis "they" will be the winners. Instead of historical significance, stress how your company and products are "leading edge". Always focus on the future or near future, rather than the past. It is not specifically huge amounts of data that impress them, but the nature of the data being "inside edge" or "little known" to anyone else. Third party testimonials or articles from "experts" lends more credence to this group. If you need to coach or mentor a boomer, be tactful. Be warm and find opportunities for agreement and harmony. Ask lots of questions to get to their issues. Think of yourself as an equal but always ask permission . . . "Would it be okay if we talked about your long term care?". Respect them, but be advised that they are not fond of being called "sir" or "ma'am". It reminds them of their age and they are determined to approach old age slowly and with style.

Boomers want to win at most things, however, they are realizing that convenience can also be a good thing. You clearly need to be more detail oriented with Boomers. Technology is important but they are still suspicious. Boomers look for efficient organization of information. Pack it in, but make it easily available. Let them browse.

Brand names are not a "hot button" as long as they have choices. Value, on the other hand, is critical to their thought process -- after all, you can't win if you don't get a good deal!

Because boomers see education as a means of climbing the ladder, they respond well to several learning mediums, especially when presented in a somewhat casual environment. To boomers, lots of information is considered a reward not a liability. Start with an overview and give them an option to get greater into the detail later. Seminars and workshops work good although they, like seniors, shy away from involved role-playing. They like books, videos, self-help guides and audiotapes.

Money will likely still be a problem for Boomers. After years of spending and lack of retirement planning, they need help. And, they will increasingly delegate these matters to experts. Solid instruments designed to help them save are needed most.
Boomers will continue to reject traditional methods. Asking them to do something because it is what work for the people before them (seniors) is a big mistake.

BE NEEDS BASED

Remember, in serving the mature market you are helping people plan their retirement and / or a family legacy. You have an important job by uncovering specific needs and providing effective solutions.

A Needs Based Agent

Success in life insurance selling is anchored in philosophies that win and systems that work. Sales practices should be formed around sound selling systems which provide better results for the life insurance agent and which meet the long term needs and goals of the client. Needs analysis is a procedure to help prospective insurance clients plan for their future financial security by delivering a complete planning service.

Needs-based selling was introduced in 1968 by Thomas J. Wolff, a tenacious and studious life insurance agent, who is today an industry legend. As a young agent, Wolff struggled to make it in the business. While other agents and teachers have dazzled their audiences with tales of sales wizardry and artful cherry-picking among the rich and famous, Tom Wolff told a much different tale. Instead of trying to achieve his place in industry lore by showing everyone how good he was, he taught his students how easy insurance selling could be. Today Tom Wolff is the most credible role model for new agents in the insurance industry.

Wolff’s systems—capital needs analysis and financial needs analysis—are the life insurance industry’s most enduring and practical sales track.

The approach to needs-based selling is widely used in the insurance industry today. It is a basic transferable process for success in life insurance that will work for almost anyone. A needs-driven sales system’s purpose is to analyze a client’s needs and determine how life insurance can best meet those needs. It is not meant to generate the sale based upon the obvious points of the product or the need of the salesperson to produce. It uncovers a prospect’s general financial problems or deficiencies so that the prospect begins to recognize the need. The problem is personalized to arouse interest in a possible solution.

Like any system, needs analysis works effectively only when it is used as it is designed. The system builds upon itself in terms of both content and data and is most effective when used from start to finish. Shortcuts undermine the effectiveness of the process. An agent following this system from start to finish can never be accused of less than professional point-of-sale practices.

Needs-based selling goes into great detail in analyzing needs and creating recommendations that are based upon airtight logic and conclusions. Needs-based selling involves the client, allowing him or her to use his or her own ideas and assumptions. It is a process that allows the prospect to participate in creating his or her own solutions to needs based upon what he or she considers important. Analyses must represent and respect the client’s opinions. The goals are those of the prospect, not the agent. If the goals are not the goals of the prospect, the prospect is not likely to go along with the agent’s recommendations in the end.

The needs-based selling system is characterized by the recognition of accurately assessed needs, which are the result of careful and professional analysis. Through careful fact-finding, information is gathered about the prospect’s desire to provide income to family members in the
event of premature death or disability, as well as to plan for retirement needs and accumulation. The analysis performed is based upon interest rates, inflation assumptions and the prospect's views about his or her objectives and timetables.

Needs analysis helps the agent sell the right amount of life insurance to the client for the right reasons. In today’s competitive environment, agents cannot afford the exposure of makeshift or piecemeal sales practices. They must have a complete, comprehensive selling system. They must provide a needs-based analysis for their clients and generate trustworthy recommendations based on this investigation. Learning how to effectively determine needs gives the opportunity to offer a full array of financial products and services.

This sales system is focused on needs for another reason. In addition to needs being the best reason for a client to buy life insurance, it is also the best reason to sell life insurance. Sales based on greed, i.e., big returns on premium dollars paid, can be made by people other than life insurance agents. A sale based on greed is simply selling a return, or just selling a configuration of numbers on a piece of paper. This type of selling can be done by bankers, stockbrokers or even accountants. Selling based on a genuine need for life insurance is another matter. Needs-based selling is the thing that makes life insurance agents necessary; greed selling is the thing that could make them extinct.

A Complete System

Client analysis selling is only part of the story. Needs-based selling is a complete system for obtaining the appointment, opening the interview and gathering factual data for all types of prospects. At the end of the fact-finding process, a joint decision is made between the prospect and the agent as to which of three cornerstones of financial security is top priority—accumulation (developing a sound plan to assist in paying for education and for other financial objectives), retirement (planning to provide the additional income needed to supplement Social Security, pension plans, existing savings and investments) or protection (planning to assure that obligations are met in the event of death or disability).

The life analysis is usually done first. The fact is that most boomers are underinsured and require more capital in the event of death for college-bound teens, business income replacement, partner buyouts, spouse retirement needs, etc. Seniors, on the hand, are “winding down” their lives with fewer protection needs. However, for those who have not planned as well, an in-force policy that can be sold as a life settlement to pay long term care costs or small burial plan can be a real comfort.

The disability analysis is usually discussed next. Fulfilling the life and disability needs of a client buys the agent the necessary time to accomplish the other objectives—accumulation and retirement planning.

In any one interview, it is recommended that only one of these analyses is utilized. It is important not to overwhelm prospects with information. Covering too much in one interview tends to confuse and tire prospects. Confused and tired prospects won’t (and shouldn’t) make important decisions. The needs analysis system breaks the sales process down into carefully engineered parts:

**The Pre-approach**—This step is designed to get an appointment under favorable conditions for a face-to-face meeting. An effective pre-approach is for the agent to send a letter to the prospect, introducing him/herself, explaining how he or she obtained the prospect’s name and saying he or she will be contacting the prospect shortly for an appointment.
The Approach—The objective of the approach is to obtain the appointment. During the approach, no detailed data-taking or selling takes place. The approach takes place approximately five days after mailing the letter in the pre-approach. The agent may ask if the prospect has received the letter and then ask for a face-to-face meeting. Because of the non-threatening nature of this approach, a high percentage of these telephone calls result in appointments.

The Initial Interview—After a normal exchange of pleasantries and a standard explanation of the agent’s services, the agent’s objective during this initial interview is to gather information and uncover the dominant needs of a prospect. Information such as name, birth date, spouse’s and children’s names and birth dates, address and telephone numbers are gathered at this time. Other information to obtain at this time is occupation, spouse’s occupation and whether or not the prospect is a smoker. Then the prospect is asked to complete a questionnaire, which takes about 10 minutes, rating his or her feelings, concerns and goals in the following areas:

1) Providing educational funds for college-bound children.
2) Retirement planning.
3) Providing funds for long-term nursing home care in the future.
4) Involvement in financial planning by the spouse.
5) Saving a fixed percentage of income.
6) A review of existing property insurance.
7) Insurance of spouse and children.
8) Assuring an income during periods of disability.
9) In the event of death, paying off the mortgage and other debts.
10) In the event of death, allowing the family members to retain their existing lifestyle.
11) Getting help with overall planning. Then, the questionnaire discusses overall planning with regard to:

   a) Whether or not the prospect participates in a pension or profit-sharing plans
   b) Whether the prospect has checked his or her Social Security benefits within the last 12 months.
   c) Whether the prospect has a current and valid will.
   d) Whether the prospect has appointed a guardian for his children (if applicable)
   e) Whether important papers are kept in a safe place.
   f) Whether the family knows the location of the important papers.
   g) Whether the executor of his or her estate is familiar with his or her estate plan.
   h) Whether he or she utilizes a trust in his estate plan.
   i) Whether the prospect feels he does a good job in managing income and expense flow.
   j) Whether the prospect is in good health and has not had difficulty in purchasing insurance.
   k) Whether the spouse participates in the planning of financial affairs.

Next, the prospect’s financial situation must be assessed. This part of the questionnaire covers such areas as annual income, total life insurance, total assets and total liabilities, the value and the mortgage of the residence, and present investments (such as savings and CDs, money markets, mutual funds, real estate other than the residence, stocks and bonds, U.S. government bonds, IRAs, 401(k)s or other salary savings plans, and pension or profit sharing plans).

The questionnaire then assesses the prospect’s financial risk profile. For example, what kind of financial risk is he willing or able to take? Considerable risk? Almost none? Is he willing to
take average risks in order to improve the rate of return? Is he or she willing to take substantial risks in order to maximize the rate of return?

In the next part of the questionnaire, the prospect is asked to make expectations and predictions about his future. For example, will he be changing jobs, starting a business, selling a business, receiving a promotion or retiring? Will he be buying a larger or smaller home, making improvements to a home, caring for a parent/spouse or changing marital status? Does he anticipate getting a raise, getting a bonus, inheriting assets, borrowing money, paying off a loan or purchasing property?

The prospect is then asked whether he or she is interested in discussing such areas as:

1) Investments which are tax favored.
2) Ways to reduce estate taxes and expenses.
3) Ways to continue income if disabled.
4) Ways to provide income for retirement.
5) Ways to provide educational funds.
6) Ways to provide for family in the event of death.
7) A review of all existing insurance.
8) Insurance to pay off mortgage (if applicable).
9) Insurance on his or her spouse.

This initial interview begins the process of building trust. The initial interview and questionnaire allow the agent to screen the prospect and then determine whether to eliminate him or her based on the data gathered or to proceed with the selling process.

The data gathering phase is also designed to help understand people. It is often said that people don’t buy because they are made to understand, rather they buy when they feel they are understood. The more time that is spent in the effective gathering of both facts and feelings, the less time that will be needed to be spent on the close. Being sincerely interested in people will permit them to be openly interested in the full presentation.

The Review—After the prospect completes the questionnaire, the agent reviews it quickly and looks for areas of importance. The agent may discover, for example, that the prospect is not satisfied with the percentage of income he or she is saving, that he or she does not have an understanding of trusts or that he or she does not participate in a pension or profit sharing plan.

Reviewing the questionnaire also allows the agent to uncover the prospect’s interests for future planning (tax-favored investments, disability, retirement planning or education funding).

The relationship should be terminated if the prospect is uncooperative, if his or her assets or income level do not meet the agent’s minimum requirements, or if insurability does not permit the agent to offer help.

The interview should be continued if the prospect agrees that this is an appropriate time to engage in further discussion, or another appointment should be scheduled. An appropriate prelude to further discussion might be advising the prospect that the 15 minutes are up, and that the agent is prepared to leave as promised. The agent may suggest that, based on the information shared, he or she can be of assistance to the prospect in the areas where the prospect’s goals are not being met.

The purpose of this interview is to screen the prospect and uncover his or her needs. Naturally, some cases are more involved than others, and the agent may experience a situation where he
or she feels overwhelmed and in over his or her head. At this time, it is wise to make the decision to involve a manager, trainer or a fellow agent with expertise in the advanced market areas. Even if this means splitting a commission, the agent will benefit by learning more, earning more and developing a loyal client, not just a policyholder.

**The Life Interview**

After having obtained an appointment for the further discussion of the prospect's needs, the agent arrives at the prospect's home. In using the comprehensive system of needs-based selling, the agent should arrive with selling materials. These are the worksheets used for determining the prospect's needs, on which the analysis (goals, needs and objectives) will be performed and calculated. Today this system is also available on computer software.

After the introduction, the agent begins the meeting by asking the prospect if he or she would like to assure financial security for him/herself and his or her family. With an affirmative response, the agent explains the concept of needs analysis as it relates to the prospect's financial needs.

Financial security is usually built upon four types of assets: personal assets (home, auto, savings, investments, etc.); business assets (company-sponsored insurance programs and retirement plans and, in some cases, actual ownership in a business); life insurance (cash funds which are part of life insurance during life and proceeds payable at death); and government programs (Social Security or other entitlements).

The primary question for determining financial need is: What will be the value of these assets when the need arrives? According to a recent study by the U.S. Department of Health and Human Services, for every 100 people who begin careers, at age 65, the following exists: Twenty-five are deceased. Twenty-two have annual incomes below the official government poverty level of $7,000. Forty-nine have annual incomes between $7,000 and $40,000, and the median income for this group is $13,000, i.e., there are as many people below the $13,000 level as there are above it. Only four have incomes over $40,000.

Throughout one's lifetime, the value of expected assets is decreased by these obstacles: inflation; taxes; bad investments; disability; "consumptive saving," or saving to spend (saving for a specific objective); and lack of discipline. The purpose of needs analysis and planning at this time is to assure that no more than absolutely necessary is depleted so that, when necessary, maximum funds are available to the prospect and the prospect's family.

How can financial success be assured? It begins with taking the four steps which lead to financial independence. These four steps are:

1. Set Financial Goals—A prospect who does not know where he or she wants to go will never get there.
2. Prioritize Goals—Most prospects will realize after setting goals that they do not have the resources for achieving them simultaneously, and so they must be prioritized.
3. Initiate a Plan of Action—It is here that most plans fail, because setting and prioritizing goals is of no benefit if the plan is not put into action.
4. Review and Update the Plan Regularly—Needs change as situations change. Marital status, the number of children, earnings, the number of income earners and assets are all subject to change.

At this point, the prospect is likely to agree that taking these four steps would lead him or her further down the road to financial independence. Unfortunately, the longer one waits, the
steeper the climb to reach the same point of financial independence. It is critical to begin the planning as soon as possible, and needs analysis will accomplish this. Now is the time to discuss setting goals and personal financial information (income, savings, assets) with the prospect. From this discussion, most prospects realize they are not pleased with their savings and investment plans so far. Typically, most people spend first and try to save and invest what little is left. These people usually end up with little or no savings. On the other hand, few people save and invest a determined amount first and spend the balance. Those that do accumulate dollars for education, retirement and other objectives, and they generally have money when they really need it.

After the prospect recognizes the need for a financial security plan, he or she must determine how much he or she is willing to allocate. Having determined this, the three cornerstones of financial security are discussed:

1) Accumulation—This is a sound plan for assisting in paying for education and other financial objectives.
2) Retirement—This is a plan for providing the additional income needed to supplement Social Security, pension or profit-sharing plans, existing savings, or investments.
3) Protection—This is a plan for assuring that obligations are met in the event of death or disability.

Since most people cannot afford to plan simultaneously for all of their financial objectives, priorities must be set. There is usually time to prepare for the accumulation and retirement cornerstones, but the impending risk of death and disability indicates that the protection cornerstone should be addressed first. Now begins the analysis of protection needs. There are two types of needs after death: cash needs and income needs.

**Cash Needs**
After death, there is a need for cash to settle the deceased’s estate. The cash needs analysis will determine how much this need will be.

There is a need for an immediate money fund for the bills presented after death. It is impossible to predict what these costs might add up to, but typically, one-half the amount of the annual income of the higher wage earner—either the deceased or his or her spouse—is sufficient. These expenses may include: hospital and medical expenses, funeral expenses, attorney or executor fees, probate court costs and taxes.

Another group of cash demands, including unpaid installment loan balances, notes, auto loans and other outstanding bills, is represented by a debt liquidation fund. This may be estimated based on current debt and should be reviewed each year with the agent.

Further, an emergency fund should be established for unexpected bills which the family may not be able to pay from current income. These may include repairs to home or auto and medical emergencies. Again, one-half the amount of the annual income of the higher wage earner is usually sufficient.

A mortgage or rent fund should be established so that the survivor has a debt-free home or a ten-year rent fund. The amount set aside for the mortgage fund should be the current mortgage balance. An annual review of the changing needs of the client will address the changes in the needs of the mortgage or rent fund.

However, the prospect’s mortgage may be paid off or nearly paid off, in which case the mortgage or rent fund is not as important. The prospect makes this decision. Using needs
analysis, the prospect is involved and participates in creating solutions to his or her own personal needs, using his or her own ideas and premises. The prospect’s goals and objectives are the foundation of needs-based selling.

Incidentally, simply because the money is provided does not mean that it must be used for mortgage payments. For instance, it could be invested and the income obtained from the investment could be used toward mortgage or rent payments. When a parent dies, someone must assume the responsibilities that parent held. Someone must take care of the children, cook, wash, maintain the home and car, etc. Getting someone else to perform these functions requires money in a home care fund. A recent study at Cornell University states that in a family of four, the average annual dollar value of replacing a spouse to perform these functions is $19,050. Ideally, according to a chart of increased projections, this amount should be provided each year for the number of years until the youngest child reaches 18. If the prospect agrees to provide a fund for this purpose, these numbers are only guidelines. The prospect may provide in any amount he or she wishes, if at all.

An educational fund should be established for college or vocational training and, of course, these vary by state and type of school. Today’s minimum recommendation is $45,000 per child for educational training.

To determine the total capital required, the cash needs of the immediate money fund, debt liquidation fund, emergency fund, mortgage or rent fund, home care fund and educational fund are calculated. The assets such as existing life insurance, cash and other investments are subtracted from this, leaving the total capital required in the event of death, i.e., the prospect’s life insurance cash needs, determined by the process of needs analysis.

**Income Needs**

As well as a need for cash, the survivor will have a need for income after the death of one wage earner. The income needs analysis is used to determine how much cash will be necessary for the surviving spouse.

If the cash needs analysis uncovers a substantial need, it may be wise to make that sale first. Because the income needs analysis is more complex, agents frequently rely on a two-interview format when doing income needs analysis. The close can be made based on cash needs, and any additional insurance required to satisfy income needs can be written in later, perhaps at the time of policy delivery.

Based on a government study by the Bureau of Labor Statistics, the following are typical income objectives that may permit a family to live as normally as possible after the death of one wage earner. The assumption is made that the mortgage is paid or a rent fund has been established and that education expenses have been provided for separately, as accomplished in the cash needs analysis:

<table>
<thead>
<tr>
<th>Gross Income</th>
<th>Percentage of Gross Income Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to $48,000</td>
<td>70%</td>
</tr>
<tr>
<td>$48,001 to $53,000</td>
<td>66%</td>
</tr>
<tr>
<td>$53,001 to $59,000</td>
<td>63%</td>
</tr>
<tr>
<td>$59,001 to $65,000</td>
<td>60%</td>
</tr>
<tr>
<td>Over $65,000</td>
<td>57%</td>
</tr>
<tr>
<td>Two-income families at all levels</td>
<td>70%</td>
</tr>
</tbody>
</table>
The income objective (the percentage of gross income required), less the annual Social Security benefit, plus other income (if any), shows the prospect his or her total annual income shortage.

To arrive at the amount of capital required to satisfy the shortage requires making an interest assumption. The capital required must be inflation proof; that is, the anticipated inflation must be offset. For example, if the policy provides $20,000 per year on the date of death, and if inflation were 6 percent, ten years later it would take approximately $36,000 to provide the same standard of living as the $20,000 did ten years earlier. To “inflation proof” $20,000, an amount equal to the anticipated annual inflation rate must be added to the capital. Therefore, if 10 percent is earned, and 6 percent is the anticipated inflation rate, 4 percent is available to be used for living expenses. Thus, 6 percent must be added to the capital to offset inflation. When the original $20,000 has grown to $36,000 at the end of ten years, the $36,000 provides the same purchasing power that the $20,000 did ten years earlier.

Presuming the inflation assumption, the amount of capital needed to provide this income is the annual income shortage divided by the assumed interest rate. This figure (the income need, plus the cash needs determined by the cash needs analysis) is the total capital required upon the death of one wage earner.

The prospect may choose to satisfy only the cash need or the cash need and part of the income need. It is essential to realize that a total need has been uncovered. If at all possible, that entire need should be filled. A large need is a tribute to the standard of living the prospect has established. If anything less than a total need is purchased, the prospect may be an easy sale for the next agent.

**The Disability Interview**

Many people are unconcerned about providing for life insurance protection but are very interested in reviewing their disability income insurance. The greatest asset a boomer has is the ability to earn a living. The greatest concern of seniors is a long-term disability consuming their savings.

A healthy working boomer with a steady income has “ordinary” expenses. The difference between income and expenses is what is saved. If disability strikes (due to sickness or accident), a worker may be confined to a bed, a wheelchair, or may be housebound. Two things will occur: he will not be working, and he or she will not be earning. Normal income will decline or cease. Further, an illness usually causes expenses to increase. When this happens, debt begins. The worker must get well. Two things are needed to get well: time and money.

This raises the question of where the money comes from. The money may come from salary but only for a limited period of time. The money may come from savings; however, an extended disability can quickly wipe out any savings. The money may come from borrowing, but without income, the worker is not likely to get a loan. In any case, the money would have to be repaid. The money may come from selling assets, but are there assets to sell, and would the worker get a fair price?

A disability income plan is ideal. The payment of a relatively small premium can create a continuing flow of income at the precise moment it is needed. A disability plan can make available almost any annual income for a specified benefit period (up to age 65). This is relative to the premium paid. The following represents disability income insurance benefits that are normally available to boomers:
### Annual Income | Benefit
---|---
$15,001 - $20,000 | 70%
$20,001 - $30,000 | 65%
$30,001 - $100,000 | 60%
$100,001 - $200,000 | 55%
$200,001 - $300,000 | 50%
Over $300,000 | 45%

The needs analysis performed for disability income is different from the life insurance needs analysis in that each spouse’s need is calculated separately. Objectives and sources of current income are used to determine whether the client will need additional income protection. Based on a recent study by the U.S. Bureau of Labor Statistics, the following represents the typical income objective needed to permit a worker to maintain his or her present standard of living after the onset of a disability:

Because most individual disability income is generally tax free (unless your employer pays your premiums), a breadwinner at age 55 whose present income is $100,000 would need 65 percent of his present gross income, or $65,000! Most disability policies (even group plans) “cap out” before this level of need is met creating an income gap. And, the average Social Security disability check is only $680 per month. More employers are offering long term care which could help in any home care or nursing home expenses. However, there is clearly a case for back-up reserves for disabled boomers.

### The Accumulation Interview

Although life and disability insurance make up an important cornerstone in overall planning, some people will be unconcerned about providing for protection needs, yet they may be very interested in covering their teenagers education or other accumulation objectives.

A delayed start in the accumulation objective increases the burden. These are three reasons to begin planning as soon as possible for children’s education: 1) death or disability may occur before the children are ready for college, 2) waiting until it is time for college to begin accumulation eliminates the advantage of spreading the cost over many years and 3) borrowing at college time increases the cost by the interest paid.

After the accumulation objective is set and the interest rate is a projected (8 percent), it must be determined how much must be saved each month in order to reach that goal.

This needs analysis is performed for each child, taking into consideration the age of each child and the number of years the fund must accumulate. This fund may be offset by any funds the children have in their own names, scholarships or other monies earmarked for education.

The cash values of accumulation-oriented products such as mutual funds and annuities are often used as funding vehicles for education needs, as are the cash values of permanent life insurance policies.

It must be remembered that taxes have a negative impact on any rate of return. In lieu of a tax-sheltered plan, contributions must be increased to account for the negative impact of taxes.
The Retirement Interview

Those prioritizing their goals and giving retirement funding priority are usually single people of all ages and couples without children. Life is an economic roller coaster. People save money, then spend it or lose it due to bad investments. Throughout different parts of their lives, they are likely to save and invest a great deal of money. However, when these funds are needed most to live on, they may have been spent on other things. What is needed is a plan to assure that the money will be there when it is needed.

Social Security will help, but it will take more than Social Security to provide a secure retirement. The income of most people increases throughout the years, leveling off during the last five years before retirement. On the day of retirement, the earnings cease, and the worker must rely on what has been set aside earlier in his or her career (savings, pension plan and life insurance).

The question to consider is: Will there be enough funds to see the worker through the remainder of his or her life without the benefit of earnings from employment? Major factors to be considered are inflation and the increased longevity of all people today.

The value of funds from other sources is very difficult to calculate. The value of savings and pension plans varies with future earnings, interest rates and employer contributions. At retirement, a worker requires an income equal to 80 percent of the pre-retirement income. Few people ever achieve this result. Each year’s delay in retirement planning creates an even greater need to be met in the subsequent years.

Investment-oriented products such as mutual funds or annuities are often used to fund the retirement need. Because of their tax advantage, these vehicles are often set up in the form of an IRA.

The cash values of permanent life insurance policies are also an excellent source for retirement funds. Funding retirement this way serves another purpose. If the worker should die before reaching retirement, his or her heirs will have the full benefit of the life insurance policy.

Determining retirement needs through needs analysis is much like the needs analysis performed during the disability interview. Annual earnings are multiplied by the number of years a client expects to work. Then, the average annual income is determined, which is a more accurate way to measure earnings potential.

Upon reaching retirement, however, it will not matter how much a worker has earned—it will matter only how much has been saved. Through needs analysis, the client learns how much must be set aside monthly that, allowing for interest, inflation and taxes, will provide 80 percent of his or her annual pre-retirement income, based on age, estimated annual income and the number of working years left before retirement.

Carefully calculated needs analyses can provide future financial security to all clients, meeting their income and protection needs.

An Overview of Life Insurance Needs

To understand why people need and want life insurance protection, it is important to consider human needs in general. To do this, we must explore some basic psychology and understand both the most fundamental and the more sophisticated human needs.

Many of these needs are satisfied by life insurance and the benefits it provides.
Many psychologists who have studied the needs of people in a variety of circumstances and at many levels have identified five primary needs that every individual strives to satisfy. These are:

1) Physiological Needs—These are needs for food, water, air, shelter and clothing in their most basic forms. People who desire any of these things want them at any cost. Until these are satisfied, there is really no ability to consider satisfying other, higher level needs. Visualizing families caught in a war zone of battle without shelter illustrates this level of need. As it relates to financial terms, these needs also include the protection of property and basic survival level income.

2) Security Needs—These are needs for safety, stability and health. Again, people who want in any of these areas become preoccupied with their attempts to satisfy them. Many workers require medical, unemployment and retirement benefits to help satisfy these types of needs. Relating to financial terms, these needs also include protection of income from disability or death and accumulations for retirement.

3) Affiliation Needs—These needs are for love, affection and a feeling of belonging. When the physiological and security needs are satisfied, these social needs arise to motivate individual behavior. These needs are most evident in a person’s behavior as it relates to job satisfaction, the work ethic, team participation, family ties and general well-being. Relevant to financial terms, these needs also include investment with safety of principal.

4) Esteem Needs—These needs include personal feelings of self-worth, recognition and respect from others. People with affiliation needs want others to accept them for what they are and to view them as capable. They accept their esteem needs as being fulfilled when they receive recognition and feedback from others regarding their competence and ability. In financial terms, these needs will require capital growth and above average return on investment.

5) Self-Actualization Needs—These are the most advanced level of needs. They are the needs for self-fulfillment and the realization of personal potential. People striving for self-actualization are often very accepting of themselves and others and are superior at problem solving. The irony is that people who are driven by ambition often sacrifice everything to achieve their quest for self-actualization. In financial terms, these needs can be met by higher risk acceptance to increase net worth and the self-management of money.

Needs in the Insurance Perspective

Thinking of needs as levels of a pyramid, the most fundamental needs would be placed at the base. Until these needs are satisfied, the rest of the structure cannot be properly supported. Using this image to translate needs satisfied by purchasing insurance, we see how fundamental insurance is to people’s lives. Putting “first things first” means purchasing insurance to satisfy and guarantee the continued fulfillment of basic needs before investing dollars to realize higher level needs.

Life insurance can be used to provide protection and needs fulfillment for one’s self and family at the first levels of need: physiological, security and affiliation.

Once these needs have been satisfied with insurance, savings, home ownership, and other basics in life, insurance becomes only part of the individual’s total financial strategy. Many kinds of investments begin to be considered as answers to solving higher level needs. Insurance is not the only answer, but it is the first answer to guaranteeing that basic needs are never unnecessarily jeopardized.

It is important to fully understand these needs and how life insurance solves them. The following are more specific needs:
**Final Expenses**—There are always expenses related to dying. Typically, these needs can be met with four to five times a client's gross monthly income. Life insurance is an excellent way to create a fund when no other capital is available to pay these expenses. In many cases, the prospect will not want to deplete existing assets targeted for family income and will want to add insurance for this purpose.

**Mortgage Liquidation or Payment**—A life insurance fund established to liquidate the mortgage or to meet its continuing payments may mean the difference between keeping the family's home or losing it by default on the mortgage loan or even having to sell it quickly at a much reduced price. For most families, a mortgage is the biggest financial obligation they face. Life insurance can assure the family's housing.

If the family rents a home, it is wise to discuss how future payments can be made to the landlord. Dollars for a rent fund can be added just as easily to insurance needs calculations.

**Education Fund**—College costs are perhaps the most surprising and staggering costs that a family will face. For most families, they rank only second to the mortgage on the family home. The need for education is clear. College graduates can expect to earn over $600,000 more during their careers than those with only high school diplomas. They generally have more rewarding careers and enjoy higher life-styles than people without specialized or college education.

Parents who want to provide a college education for their children must plan carefully to save the huge sums of money required to pay these costs. Scholarships and loans are not as readily available as many people believe. Even with a part-time job providing extra funds for the student, the tuition and living costs are extremely high. Life insurance can help build the cash needed to pay these future bills and guarantee the money to pay for education if the parent dies before the education is completed.

Often, one spouse has been considering going back to school to learn new or better skills. The death of the other spouse can make the need for this additional education critical, since now only one parent must shoulder the entire responsibility for the family. Life insurance can provide the funds needed to send the surviving spouse to college or to graduate school so that he or she can improve the family's income and lifestyle.

**Cash Reserve**—Many people consider funding a cash reserve to pay unexpected bills for health care, home or auto repairs, school trips, etc. Insurance provides the capital when income is lost at death. Additionally, a cash reserve provides for emergencies.

**Adjustment Income**—Although not a common consideration, providing some money to allow survivors to adjust to their new situation after the death of a parent is sometimes a goal. Life insurance can establish this cushion to keep a now-single parent at home for a few months to care for children, to consider career alternatives and to process the estate leisurely, without pressure to act too quickly. It provides for an adjustment period for a family in crisis.

**Standard of Living**—Usually provided for by the wages of a sole income earner or the combined wages of two income earners, the current standard of living would be disrupted at death unless replaced with additional capital. When there is no longer a person at work producing income, there must be money at work producing income. The only alternative sources of income are Social Security or charity, neither of which is totally satisfactory.
Retirement—Most people live to retirement age, but few actually retire successfully in terms of income. Although many retirees do some work, earned income often incurs penalties by reducing Social Security benefits. Without income from working, retirement income must come from Social Security, employer-sponsored pension plans, individual pension plans or savings and investments. Life insurance can help clients accumulate money for retirement so that when they stop working, there is sufficient money to work for them to produce income. Successful retirement requires early planning and a disciplined savings program.

Bequests—Religious bequests and charitable gifts to special organizations or causes are common. A client’s desire to make a gift to charity is generally considered a sufficient insurable interest, although it is usually recommended that other financial needs and obligations, especially to the family, be met first. The majority of gifts to charity are made from income, rather than from accumulated wealth, so most policies designating a charitable organization as beneficiary will be paid out in installments.

Taxes—Sizable estates will have taxes to pay, and taxes cannot be postponed. Regardless of the circumstance, taxes must be paid before any other creditors and survivors get their shares.

Even when there is sufficient liquidity in an estate to pay taxes without insurance, insurance is often purchased to protect other assets and interests. The objective of insurance is to keep the estate whole. It protects the family’s livelihood or living style. It protects the living.

Business Continuity—Business interests may be severely devalued at the death of one of the owners. The deceased’s family may assume it can rely on the deceased’s business to help the family financially. However, the business will likely suffer at the insured’s death. Life insurance can provide the cash needed to preserve the business, whether it is retained for the family, run by a professional manager or sold. Life insurance can assure that both the heirs and surviving owners receive full value for their interests in the business.

In order for the purchase of life insurance to be made, there must be a significant human need. Buying life insurance guarantees these needs are met.

The Total Needs Approach
One of the most important factors to consider in needs based selling is not to overwhelm and confuse clients with too much information at one time. However, it is also important to remember that selling insurance is more than a process of selling; it is a process of total insurance planning for the client. Although the various components of life insurance are presented over the course of many different sessions, working with clients to solve their total needs is the long-term objective for any professional life insurance agent.

The following demonstrates why approaching any client from this total needs perspective is important:

There Is a Greater Need—Although very few clients are in a position to solve more than one of their financial problems at one time, most of them recognize that they really do not want to put small patches on big problems or to fail to identify all of the needs they have or may have in the future. Even if all concerns cannot be completed immediately, working with prospects to identify all of their goals and the ways in which to achieve them will give them a more clear picture of where they stand. This ability to see the big picture will make it easier to appreciate each of the smaller pieces of the plan. Their understanding will motivate them to solve as many
problems as possible. They will come to see it as a package of coordinated protection for personal, family and business interests.

**Expectations**—Clients expect professional behavior, which includes thoroughness. The failure to discuss all the client’s options and to work toward solving all client needs falls short of fulfilling the client’s expectations.

**Ethics**—There are ethical considerations to be observed. These include standards for professional behavior which demand that someone not be left inadequately protected. This requires more than just selling the mortgage policy or the college fund program. It means discussing all of the client’s needs, understanding all of the client’s financial goals, examining how far along he or she is in meeting objectives and developing a plan for taking him or her there. Clients must not be sold piecemeal, leaving them only partially protected.

**Strong Markets**—The best prospects for complete planning of total insurance needs are those people who have more complex financial situations and higher income brackets. The life insurance agent’s professional planning services are tailored to meet the needs of markets that not only want, but can afford, the products offered.

**Quality of Client**—People who buy a plan of insurance, rather than the cheapest policy available, recognize that the proper plan of insurance is the best way to achieve the protection they need and want. With the big picture in place, they are not so confused by loose pieces of the puzzle. They tend to keep their coverage intact, make premium payments on time and are less likely to accept recommendations from someone who does not understand their total needs. They understand the value of their protection.

Personalization makes the plan more than an important insurance document. Clients will refer to it any time someone suggests that they buy additional coverage. They will want to know how it fits into their personally tailored plan and will not be eager to tamper with the complete security it is designed to provide.

**Prospecting Ease**—Prospecting is easier with the total needs approach. First, referrals are greater in number. Secondly, when asking for appointments, a better response is obtained from referrals.

**Repeat Sales**—In the eyes of the client, thorough planning puts the agent in the position of advisor, rather than just someone who sells him or her insurance. As situations change, needs for coverage often increase, and, not surprisingly, the respected and trusted agent is the first one called upon to handle these needs.

**Self-Satisfaction**—The agent’s efforts are as important to him/herself as they are to the client. Planning a total needs program is a big effort, but it is also complete. The agent will know he or she has done everything possible to help prospects and clients and will gain considerable satisfaction from this.

Clients face a variety of changes every day of their lives, and their finances are not exempt. Properly done, the total needs approach assures clients the best opportunity to solve changing problems in changing environments.

The approach to total needs helps clients to understand the needs they want to fulfill. The number of issues to consider in insurance planning makes it a complex process. Add to this the changing circumstances in the client’s life, and the need for such planning is evident. The client
benefits from the opportunity to find solutions to his or her problems. The agent benefits since the sale of insurance becomes easier when the insurance becomes part of the solution, rather than the only solution offered.

After the death of an insured, many decisions must be made. Should the children be kept in private schools? Should the mortgage be paid off? Should liquid assets be drawn on for immediate cash needs? For those without total needs planning, some decisions will be based solely on the availability of funds provided by Social Security or by employee benefit plans. But in total needs planning, mere assumptions cannot be relied upon. The agent’s knowledge of the dreams and realities of a family’s life will help him or her in the services he or she is asked to provide. These are services which make a difference.

Perhaps the greatest benefit of total insurance planning is the satisfaction the client feels in knowing that there is a plan to meet present and future personal and family needs. The plan is complete, documented and can be referred to when needed.

Distinctions Among Planning Processes
There is great controversy over the terms “insurance planning for total needs,” “estate planning” and “financial planning.” Clear distinctions should be made between these.

Insurance planning for total needs is a process of examining all of the client’s needs, comparing needs with means and selling, if appropriate, the types of policies and the amounts of insurance that best suit the client’s needs. The client is concerned not only with education or mortgage liquidation. There are many problems to be solved, and there are many financial goals to be achieved.

Estate planning (discussed later) is the process of examining all of the goals of the client, as well as calculating the financial consequences of dying. It involves calculating estate taxes and liquidity problems associated with death, and requires knowledge and experience in estate law and taxation. However, it may also include a determination of life income needs for survivors.

Financial planning (discussed later) is the process of examining all of the client’s goals and objectives, doing a comprehensive analysis of all present financial factors (insurance, investments, savings, pending inheritance, etc.) and assessing the appropriate risk levels for investments. It involves planning redistribution and acquisition of assets according to needs and objectives. This process requires a working knowledge of investments, as well as insurance and estate taxation. When done for a fee, financial planning is regulated by the rules of the Securities and Exchange Commission regarding investment advice.

BE SOLUTIONS ORIENTED

Clients who have needs, also need solutions. A responsible agent understands that this starts with matching specific needs of a client to dozens of policy features and benefit options – this is not a job for sissies! When all is said and done, however, a responsible, solutions-based agent must take the final step to assure himself and client that your insurance or planning suggestion is the most effective way to handle economic and health needs. You must sprinkle your client meetings with the following questions:

• Does this make sense to you?
• Have I given you all the information you need to make a decision?
• Is there something else I can answer to assure you that this is the right solution based on your needs?

These are essential questions because they help “clear the air” circulating around any doubts or concerns your client may have. And, they can also help limit your liability if something goes wrong down the road (more ideas on reducing conflicts with clients later).

A positive response to these questions is the feedback you need to know that you have “gotten through” to your client and are providing some real solutions to some very important long term care needs.

**MONITOR THE CLIENT CONTINUUM**

A continuum is something with a continuous structure. Your life is a continuum of events from going to school, to graduating college, to getting married, to getting your insurance license, etc. It is a structure that is constantly changing, yet continuous until you die. Top agents recognize that there is also a *client continuum* within which clients progress through life and lifestyle changes.

Consider the following scenarios for an agent selling long term care in the mature market:

• You've been helping Doctor Smith with his disability insurance needs for 10 years. As he nears retirement you suggest the idea of phasing out of his disability program and using the same funds to buy a long term care policy. The continuum changes from income replacement needs to coverage for long term care.

• Recent surveys show that 33% of all LTCI buyers are under age 65. This compares to only 19% five years ago. An increase in married and wealthy purchases is also noted. The LTC client continuum suggests that your emphasis should shift toward younger (boomer), wealthier couples.

• Demographers say that every eight seconds, a baby boomer turns 55. By 2030 there will be 76 million boomers age 65 and older. Another study suggests that by the same year, at their current pace, Medicaid expenditures will EXCEED total federal revenues. The continuum suggests that you learn ways to help boomers.

• Statistics in the long term care industry support the proposition that women incur more long term care expenses than men. Consider the fact that 80% of nursing home admissions are women aged 82 or over. They're single at this point and their nursing home stay is usually 50% longer than men. Claims in the continuum suggests women need LTC coverage more than men.

• You have several wealthy clients who have built substantial estates in excess of $1 million. Traditional thinking suggests that the very wealthy don't need long term care. However, does it stand to reason that anyone smart enough to amass a large estate might want to transfer the risk of a long term care illness to someone else? The continuum suggests that the suitability of long term care spans many different market groups and asset ranges.

• In recent years, a lower occupancy trend in nursing homes suggests that people prefer long term care alternatives such as home care, assisted living homes and adult day care centers. Continuum changes suggest that comprehensive LTC coverage is the trend.

• HIPPA (1996) established a whole new class of "tax-qualified" LTC policies. New legislation is moving toward "above the line" tax deductions and even tax credits for caregivers. The LTC continuum suggests that private LTC coverage is on the rise as government wants out of the long term care business.

• Stand alone LTC policies can be expensive. Watch for more "in sickness and in health" type products that blend LTC benefits, annuities and life insurance. How about a fixed immediate
Before you can convince a client, you have to convince yourself.

Before you can convince a client, you have to convince yourself. The continuum suggests that clients need LTC options.

As you can see, the client continuum is in a constant flux as it responds to new terms, new legislation, coverage limitations, underwriting changes, medical breakthroughs and other market-driven demands. Sometimes, agents who have been in the business for many years fall into the trap of failing to hone their skills to keep up with the times. Stay focused and "tune in" to current events. Use this knowledge to provide "cutting edge" service and products to responsibly meet changing client demands.

**SELL ONLY WHAT YOU KNOW AND BELIEVE IN**

Ask yourself these questions. Do you really know your insurance product? Does the client really need it? Is it worth the premium you are asking? Do you believe it is supported by a stable, long-term company? Would your mother or father approve of you selling it? If you can answer "yes" to these questions, you will surely be able to provide your client enough reasons to invest in a policy. Anything else is a hard sell.

Face facts, no matter how ethical and honest you are . . . people you have never met or see only once a year don't trust you (not yet anyway). They are skeptical and have doubts about your product and about cracking open their wallet and sending you away with any of their hard earned money. You have the same concerns every time you make a purchase from someone that you do not know . . . don't you?

Unfortunately, there is no secret formula or catch phrase that will hypnotize your clients and make them believe everything you say. You won't prove your knowledge and prove you believe by talking the talk . . . instead, you convince your clients by walking the walk. You get them to pay attention by what you do and how you do it. Ask questions, listen to answers and transfer your feelings for you, your company, and your solutions. Be proud of what you sell and believe in what you sell. Communicate that to your clients and they will beat a path to your door.

Before responsible communication can take place, you have to convince yourself it is the best solution for your clients. And, you can't sell what you don't know. See the next section on Insurance for Matures for essential questions you can ask about any product before selling.

**AVOID THE SELLING MISTAKES OF OTHER AGENTS**

It is predicted that some of the most highly litigated products in the insurance industry will those sold to mature markets. Why? Some policies selling today can and will fail to meet client needs when they need them. For instance, with a product as new and complicated as long term care, and the time that passes before it might be used, there is a lot that can go wrong. This is all the more reason that your clients need to "lean on you" for your advice. You must be knowledgeable in your product, sell only what you understand and be certain it meets the stated needs of your client to the best of your ability.
A proper attitude about this responsibility is not only prudent, but important to your success. No agent can really prosper and move forward if he leaves a trail of dazed and unhappy clients behind. Understanding the mistakes of others and not making them yourself is probably the best way to assure this doesn’t happen. You have several ways to evaluate your selling performance, our advice is to let one measure be the problems you avoid in helping clients acquire valuable insurance protection and effective, safe investment opportunities.

Likewise, it does little to build a thriving insurance practice only to have it all taken away from a single lawsuit. When you avoid the legal problems in selling insurance, you are protecting your own future as well.

**A Bad Image?**

Since the first insurance commission check was cashed, complaints have been made against sellers and selling practices. Even the most reputable insurers stand accused. Perhaps the nature of mature market transactions confuses both agents and buyers, leading to false impressions. Perhaps some unethical agents are drawn toward policies sold to the elderly because they are often vulnerable to scare tactics and pressure pitches.

A U.S. House of Representatives investigation into the regulation of certain policies, including long term care, found more serious defects:

- Purchasers do not understand how limited the coverage purchased is.
- Policies seem to be drafted more with an intention of limiting claims than to restricting claims to valid circumstances.
- Policies reflect illusionary benefits.
- Sales presentations are poor in quality and misleading.
- Sales are made to persons who cannot afford to keep the policies in force for more than a few years.
- There is an absence of non-forfeiture values and consequent loss of benefits by most purchasers.
- Policies are marketing with fixed benefits and rising premiums.
- There is inadequate and misleading information about inflation protection.
- There is inappropriate taxation by the federal government
- There is inadequate technical information on solvency standards.

In 1991, two congressional committees, the Select Committee on Aging and the Committee on Small Business, combined to publish a report on long-term care insurance. The committees found that agents' knowledge of product was "appalling" and characterized such insurance as "not a good buy" (at the time) because the policies would not pay when people most needed it.

The industry and government is working on some of these deficiencies, and to their credit, policies have come a long way. As far as what agents can do, help may lie in filtering out who needs coverage and full disclosure of its limitations.

Let’s look at some practices that have and continue to cause problems for consumers and the industry alike.
Selling Practices

Thousands of people sign up insurance policies and investment contracts each year with only the vaguest idea of what they are buying. That is because agents and brokers choose the company, the policy and made decisions about the size of the benefits, when benefits should begin, how long they should last and what extras to tack on.

While it may seem that an agent is simply doing his or her job in advising clients on these decisions, he is also assuming liability. And, the fact is that some agents can "embellish the facts", distorting the true value of their product, or worse, ignore important benefit options. Again, more legal exposure since ALL options must be presented to clients.

In a recent article on “agent responsibility” in Senior Market magazine, author Dick Duff poses some questions you should ask to test your own level of responsibility:

- Do you believe that when a prospect “knows too much” they’ll procrastinate and even refuse to buy?
- When a client asks a difficult question, is it easier to finesse the issues, admit you don’t know or halt the matter and search for the answers?
- Would you make the same recommendation you just made to a family member?
- If a prospect isn’t clear about a beneficiary designation, do you suggest he call a CPA or attorney or do you advise a temporary beneficiary such as “my estate” subject to change on policy delivery?
- Is it best to tell a prospect only what is necessary or do you educate and inform?
- Do you carefully explain high surrender charges and a longer surrender period when you sell a “bonus annuity”?
- After someone buys, do you seek an extended relationship, or do you move on to the next prospect?
- Do you routinely sign mailed-in applications as an agent-witness? Or, do you merely explain to the issuer in writing what actually happened?
- Do you have clients complete all applications in their handwriting? Or, do you ask the questions, interpret the answers and fill in the blanks?
- When you disagree with an attorney or CPA’s work, is it better to raise any issues directly with the client, or privately, with the advisor?
- Do you prefer great insurers that pay average compensation, average carriers that pay great compensation or good companies that pay good compensation?
- Do you prefer strong relationships with a few insurers or tend to recommend only those carriers who offer competitive products?
- What’s more important: relationships with clients, meeting an insurer’s sales requirements or maintaining your technical and professional standards?

As Dick further explains in his article, there is no right answer to these questions. However, consistency and fairness in your practice is important. In other words, you should follow procedures and treat one client the same as another; treat clients the way you would like to be treated; update your skills, respect the private information of others; place a client’s interest above your own and be a positive force in your community and industry.

Insurer Problems

Agents are not the only weak link when it comes to selling mistakes. Insurance companies have made their own share of blunders. Here’s just a few...
**Post Claims Underwriting**

There are and continue to be many abuses by insurers. A prime example of early problems in the long term care field was North Dakota’s experience with Providers Fidelity Life Insurance. An investigation in 1987 revealed that Providers Fidelity was engaging in several prohibited practices, including **post claims underwriting**. The company accepted applicants with little or no real health underwriting, but when these individuals attempted to file claims, the company engaged in vigorous investigation of the individual’s health in an attempt to demonstrate that the individual had not disclosed all of his or her health problems on the application. The company would then rescind the policy instead of paying the claim, alleging misrepresentation of a health condition on the part of the applicant. The company used a vague and confusing health questionnaire to aid in this practice. In addition, the company attempted to deny claims to victims of Alzheimer’s disease by using the mental illness exclusion. When pressure was brought to bear against Providers by state regulators they tried to cancel all of their policies in North Dakota without notifying the Department of Insurance. Needless to say, they were unsuccessful, all policies were ordered reinstated and monitored to this day.

**Rate Stability**

Another “black eye” for the industry targets premium increases. In the case of long term care, for example, companies are unwilling to guarantee rates far into the future because they have too little data to accurately predict how many people will file claims, how large those claims will be and how many people will let their policies lapse. So, how come most policies today have rate guarantees? Because, insurers promise they will not raise premiums due to age or health for existing policyholders, but that does not guarantee that the premium will stay the same. While insurers do not raise individual policyholder premiums they can and do raise rates for policyholders as a class. A class of business might be considered all retired teachers in the state of California who are over the age of 73. The most painful example involves 6,000 people holding policies from United Equitable, an early seller in the business. In some states, these policyholders have experienced rate increases of 100 percent or more.

Many states do not track premium increases but they have been estimated to be between 25 and 100 percent since the 1980’s on average. Worse yet, because insurers may raise rates in one state and not another, and because there is little information on the subject, it’s impossible to pinpoint companies most likely to raise rates. That makes things tough for consumers and agents alike. In effect, there is no real rate history. Agents should caution clients that premiums may rise as much as 50 percent.

**Policy Lapses**

Policy lapses are yet another sad tale in the marketing of insurance. It is been said by some that the industry’s “dirty little secret” is that most companies issuing policies do not expect them to remain in force long enough to benefit the purchasers. Lapse rates for long term care insurance are just starting to be tracked by some states. Industry estimates are somewhere between 5 percent and 30 percent of all long term care policyholders drop their policies each year. A company with a low premium may almost assuredly be counting on many policies to lapse before benefits need to be paid. If not, they may have to raise rates. Therefore, if the policy you are offering has some of the lowest rates available, you should assume that some premium increases will be required along the way. Experts advise that a client’s budget be able to handle increases of at least 50 percent over the long haul.

**Agent Beware**

The line between legal responsibility and agent misconduct can often be very, very thin. Few agents can say they have never gone out on a limb, looked the other way or fudged just a little
when selling and serving a client. These indiscretions, hopefully tiny and few in number, usually lead to nothing. But when something goes wrong, an agent's biggest fear comes true . . . a malpractice lawsuit.

The selling insurance is complex. There are still many unknown factors about premiums or benefits; the clientele are typically old and forgetful and the proof that you did a good or bad job may not surface for 20 or 30 years; all of which promote the possibility that a lawsuit could land in your lap at anytime, up through your own retirement. That is why agents must practice due care at every moment and through every phase of the long term care sale.

A few ways to minimize conflicts between yourself, clients and your carrier include:

- Select product that is suitable for your client.
- Know the product you are selling, including all reasonably priced and widely available options the policy offers.
- Be sure coverage is adequate at the time of sale.
- Be wary of "special agent relationships" that may define you as a fiduciary to the client.
- Avoid dual agency status where you have defined yourself as an "expert" or having special knowledge.
- Develop standard operating procedures to handle all clients the same.
- Consult an attorney or capable advisor before giving clients advice in areas of taxation, estate planning, asset protection, financial planning, etc.

Since long term care is a recent product there are few legal cases to relate. However, this will not stop the malpractice attorney. He will use other cases, in other areas of life, health and even casualty insurance to prove his case. For that reason, the savvy agent should know his legal responsibilities and duties.

**Basic Agent Duties**

The agent / broker generally assumes duties normally found in any agency relationship. The primary obligation here is to select a company and coverage and bind the coverage (if the agent has binding authority, i.e., property/casualty agents). However, since clients typically request coverage, the basic duty may expand to include the agent deciding whether the requested coverage is available and whether the insured qualifies for it (Harnett, Responsibilities of Insurance Agents - 1990). The mere existence of an agency relationship, or the simple selling of insurance, imposes no duty on the agent/broker to advise the insured on specific insurance matters (Jones vs Grewe –1987). In other words, in the eyes of the law there is a big difference between an agent who "sells" long term care and one who does "long term care consulting".

Duty also DOES NOT require the broker/agent to secure complete insurance protection against any conceivable loss the insured might incur, but there may be a duty to explain policy options that are widely available at a reasonable cost (Southwest vs Binsfield - 1995). Remember options like inflation protection, non-forfeiture, assisted living, cognitive reinstatement, benefit riders, etc. If they are widely available at a reasonable cost, you should be advising your client they exist and offer them in your presentation.

An agent's duty to provide correct coverage is not triggered by a client's request for "full coverage" because that request is NOT a specific inquiry about a specific type of coverage (Small vs King - 1996). In other words, just because a client asks for full coverage, an agent may not be liable to provide it. However, if a client requests specific coverage, the agent is responsible to see if it is available and determine if the client qualifies. Is a senior asking you to
suggest appropriate coverages for him at his station in life a specific request? If your business with a client covered everything but long term care, are you liable for his long term health bills? The answer to both questions is a “possible yes.” Your liability depends on individual facts.

An insured is entitled to rely on an agent/broker's advice on the meaning of policy provisions. In Stivers vs National American Insurance - 1957, it is suggested that client reliance may sometimes be unjustified, as when the advice given by the agent "is in patent conflict with the terms of the policy". Clearly, there is much to say about "bending" the meaning of policy and annuity contracts to fit the sale. Suffice to say, this case will apply to anything an agent says that conflicts with the policy or advertising.

It is a clear legal responsibility of agents to understand the difference between two products that he is attempting to sell (Benton vs Paul Revere Life - 1994). Whether an agent has an affirmative duty to inform a client of possible gaps in coverage depends on the relationship of the parties, specific requests of the client and the professional judgement of the agent (Born vs Medico Life Insurance Co - 1988). Once again, the law is saying that there are no excuses for agents not understanding the policies they sell. Further, if the relationship you have with your client goes beyond agent/client contact, you could be liable for any gaps in coverage that might develop.

Once a policy is issued, traditional theories of legal conduct provide that an agent does not have the duty to ferret out, at regular intervals, information which brings the policyholder within provisions of a policy (Gabrielson vs Warnemunde - 1988). In essence, it seems the courts have been more concerned about general agent duties to inform clients of appropriate coverage at the time of sale. Recent departures from this opinion include a case where an agent was found liable for failing to determine that the insurance policy was no longer needed by the client (Grace vs Interstate Life - 1996). In another example, an agent assured his client that the limits of the policy continued to meet his needs when they actually fell short (Free vs Republic Insurance - 1992), i.e., agent duties may also include informing clients their coverage is appropriate after the sale. Although each case stands on its own, the underlying determinant of "after sale" duty may be the "special relationship" that exists between client and agent, e.g., an agent handling the client's business for an extended period of time may assume a higher standard of care.

These are the basic agent responsibilities. Agents are not precluded from assuming additional responsibility, which they normally do in most client transactions. When a lawsuit arises, however, it is the client's burden to show that greater duty is the result of an express or implied agreement between agent and client (Jones vs Grewe - 1987) where the agent has taken more responsibility. In most instances, the facts of the particular case determine whether the court finds a greater duty has been assumed.

**Records and Standard Procedures**

One of the first things a malpractice attorney looks to establish in a case against you is that you did not follow some form of standard operating procedure in dealing with his client. Your client files, which he will always force you to produce, are evidence that you handled his client in an organized manner or not. This is why it is extremely important that you be consistent in your approach to ALL clients. For example, if you require your clients to sign a letter of understanding about your services, but fail to do this for a particular client or series of clients, your procedures are compromised and potentially useless in your defense.
Consistency in your presentation is also important, but you must also be able to individualize facts, figures or circumstances to reflect your client's situation. Documenting the outcome of your client meetings is also a great way to later justify your recommendation to purchase a particular option or their refusal to take it. Maybe you simply discussed an option, but recommended he discuss it with his accountant or attorney. Here again, documentation in your files or a written acknowledgement by your client will go a long way in court if something went wrong.

Some or all of the clients you sell to are senior citizens who are apt to forget discussions or remember them completely different than you. Your records will be valuable to prove your actions to them as well as to satisfy complaints from people that support them like their children or advisors. One possible precaution might be to involve some or all of your client's support people.

**Prohibited Marketing Practices**

The list of things you should NOT do in selling long term care insurance could easily fill a book. In a nutshell, an LTC agent has the duty of honesty, good faith and fair dealing. In addition, he must make sure to avoid any of the following acts related to unfair practices, unfair methods of competition or unfair and deceptive acts:

- Making unfair or inaccurate comparisons.
- Advising or selling excessive insurance.
- Falsifying records for purposes of defrauding any company or person.
- Misrepresenting insurance company assets.
- Misrepresenting terms of a policy.
- Rebating-giving something of value in order to induce someone to buy insurance.
- Defamation of any insurance company.
- Using unverified numbers in advertising or financial standings.
- Inducing a person to let their existing policy lapse.
- Implying that a policy is in some guaranteed by a federal agency or state body.
- All conversations regarding insurance must be identified by the agent as being "insurance" and cannot disguise the product.
- Sales promotions cannot be misleading in any way.
- The agent must fully disclose the name of the insurance company represented at all times.
- Agents must insure that when making presentations, in any type media, that the materials being used are truthful and all reacquired information is being disclosed.

**Agent vs. Professional**

Despite rules which seem to offer reasonable protection of the agent producer, it should be made clear that agent wrongdoings outside the agency contract and other torts, WILL subject the agent to additional liability exposure, and it is easier than you think to step outside your agency agreement. If you read any book on agent liability, you will learn that a "dual agency" is a situation where the agent first represents the client as agent, then switches to agent of the company when business is placed. Now consider that dual agency, and the added liability it creates, also occurs when an agent assumes non-agency duties by agreement or simply by professing to have special expertise. A slogan on a business card, letterhead or company brochure such as, "John Smith, Long Term Care Specialist", may be sufficient to establish you as an agent and an expert in the eyes of the law. When dual agencies such as these exist, the agent may be held liable for a breach of fiduciary duties owed directly to clients (Sobotor vs Prudential Property & Casualty - 1984) and, perhaps, contract and statute duties to the insurer. (Kurtz, Richards, Wilson & Co vs Insurance Communicators Marketing Corp - 1993).
It is clear that activities beyond the scope of an agency contract can be dangerous to your financial health. If you go there, you need to proceed cautiously. This is NOT an indictment of any agent who seeks to improve his practice by becoming a true insurance professional, complete with degrees and designations. The existence of these honors, by themselves, is not the problem nor a target. As a matter of fact, some feel that the presence of these awards may inhibit a client's willingness to file a claim. Rather, it is the agent who, regardless of his degrees or credentials, professes to be an expert but fails to deliver. In essence, we are talking about failed promises. Agent wrongdoings in this area represent the majority of ALL insurance conflicts.

If you are somewhat confused about this agent / professional controversy you are not alone. There are many agents of professional status, such as CLUs, CPCUs, CICs, AAIs, ARMs and more, who practice due care for all the right reasons. Most stay clear of conflict by managing it. There may also be an entire army of extremely qualified agents who stay clear of professional designations for fear that the added exposure can't be managed. Perhaps there is room toward the middle. A position we call responsible agent. These individuals also practice due care, yet operate strictly within the bounds of agency. They accurately describe policy options that are widely available, but "pass" on outside inquiries, not because they don't know, rather the request goes beyond the scope of their authority. They do not profess to be experts but know their product better than anyone. Their goal is simply to be the most responsible agent possible.

What Policies Say vs What They Mean

No matter how clear the language, all policies will contain areas of ambiguity. The universal rule of policy ambiguity, generally upheld by most state courts, goes something like this: If the policy could imply to a reasonable or average policy holder that coverage is in force, yet that exact language does not exist in the policy, then coverage DOES extend to the policy holder. Agents may easily be involved in claims resulting from contract ambiguity.

Client Understanding and Reading of Policies

In days gone by, courts required people to be accountable for their actions. Clients were required to live up to the terms and conditions of a policy even though they did not read them or fully understand what they read. Agents have been cleared in many policy conflicts simply by pointing out the applicable clause or meaning. Consumer groups kicked and screamed and pushed for simplified wording.

Today, policies are indeed more user friendly and the courts are still sympathetic to consumer confusion about their policies. Now, policy conflicts are determined by whether it was reasonable for a certain client to have read his policy and/or understand its meaning. The decision can be based on how simple or complex the policy is written or the client's level of sophistication (Karem vs St Paul - 1973 or Greenfield vs Insurance Inc - 1971). Each case stands on its own.

Minimum Standards

Courts have upheld that even though a policy does not promise to expressly act in good faith and fair dealings, it is the minimum that policy holders can expect. Agents owe a duty of good faith and fair dealings to their clients and their insurer (American Indemnity vs. Baumgart - 1982).
Selecting the Right Insurer

Uninsured seniors and boomers constitute a lucrative market. As a result, hundreds of insurance companies now offer long-term care policies. There are many types of policies to select from and a variety of insurance companies offering these policies. We already described policy choices in detail (Habit #7). Let’s look closer at how you can select a carrier.

Too Good To Be True

It is an old-age adage, but it has never taken on more meaning. Agents might be advised to at least be suspicious of a company offering a "better deal" than anyone else. It is common sense that something along the way will suffer as it did in the case of some life companies that invested in junk bonds and many casualty companies who participated in deep discount premium wars where expenses and claim costs at times exceeded income. This can only represent a degenerative financial condition for the insurer.

Recent problems with a popular LTC insurer is evidence that easy underwriting, combined with a "killer product" is too good to be true. The insurer is close to liquidation and the protection of thousands of policyholders is at question.

Also remember that insurance professionals, as salesmen, want to believe something is a better product or a better company. By their very nature salesmen often "get sold" as easy as some clients. It would be wise to be critical of all brochures and analysis distributed by a carrier which portray it to be the "best" or "safest".

Size of Company

Statistically, fewer failures have hit companies with assets greater than $50 million. It is thought that larger companies have more diverse product lines, big sales forces, better management talent—inhessence, they are better equipped to ride out financial cycles. In recent wide scale downgrading of insurers, A.M. Best seems to have favored significantly larger companies in the over $600 million category. However, another advisor feels that a small, well capitalized company can deliver as more or more solvency protection as a large one suffering from capital anemia.

Lines of Business

An agent may not have many choices over the company he writes, e.g., worker's comp coverage can only be secured with a carrier willing to write worker's comp. It has been suggested, however, that agents may consider evaluating multi-line companies to determine if one of the lines is weak enough to "down-drag" a profitable line. An example could be a life company that also writes health insurance as a direct line or business or by affiliation. If health carriers become threatened under a new national health care proposal, it could spell trouble for an insurer's health line which can affect ALL lines of business written. Of course, this is not to say that a multi-line carrier cannot be profitable and solvent.

State Admitted

Checking that an insurer is licensed or admitted to do business in the state at least assures that the company has met solvency and financial reporting standards. Most states offer toll free numbers for these inquiries. Some states will also divulge the rank of an insurer by the number of complaints per premium volume.

Mergers

Insurance ratings are sacred territory. A rating drop against Mutual Benefit Life triggered a run on that insurer which caused its conservatorship. This news and the overall crisis of confidence
surrounding the insurance industry has prompted insurers to consider many options to shore up these ratings. One option is the merger. The combining of companies can be critical to retaining policyholders, attracting new customers and maintaining investment capital sources. Some experts believe that consolidations in the insurance industry will become more commonplace in the future. One source estimated that the current number of life insurance companies--estimated at 2,000--will merge down to an eventual 200 insurers by the year 2000.

**Parent & Holding Company Affiliation**

Who or what kind of company owns the insurer that is considered. Is the parent sufficiently solvent that it will not recruit or siphon funds from the insurer? In a like manner, does the insurer own an affiliate that may likely need capital infusion from the insurer? Has the agent's insurer recently created an affiliate and are the assets in this affiliate some of the non performing or under performing investments of the original insurer? Is a merger in the offing that might mingle your client's A-rated company with a larger B+ company? In what partnerships or joint ventures does the insurer participate? Do these entities own problem real estate properties of the original insurer? Has the insurer invested in other insurance companies and have those companies, in turn, invested back in the original insurer or one of its affiliates?

Name recognition can go a long way in giving a client a high level of comfort. In the early 1980's, for example, Cal Farm Insurance, a B rated company, was proud to point out that it was owned by the California Farm Bureau, a 100 year old company. By the mid 1980's, however, Cal Farm Insurance was liquidated by the California Department of Insurance for overextending itself on financial guarantee bonds that it could not pay. Because the claimants were considered to be sophisticated investors, they received only 25 cents on the dollar and forced to foreclose on the properties behind the financial guarantee bonds by themselves. The California Farm Bureau was not considered as a source to pay any deficiencies.

Other abuses have occurred with a slightly different twist. For example, Senate investigations have revealed that the failure of many insurers can be directly tied to the "milking" of these companies by a "non-insurance" parent. Further, not all abuses have been on the side of the parent. Insurance companies themselves have been known to tap huge sums of capital from their parents, commingle assets and devise elaborate schemes including sale and leaseback arrangements and the securitization of future revenues.

**Using the Rating Services**

There are many different ways to develop rules of thumb using rating service information. One approach might be to delineate a "range of acceptability" among specific rating companies. For example, if an agent were ultra conservative, he or she may set a rule that all his chosen companies must be in the top two categories of the four major rating services:

- A++ or A+ from A.M. Best
- AAA or AA+ from Standard & Poors
- Aaa or Aa1 from Moody's
- AAA or AA+ from Duff & Phelps

A slightly less rigid approach would establish a minimum rating requirement of NOT lower than the fourth category from any of the major companies:

- A- from A.M. Best
- AA- from Standard & Poors
- Aa3 from Moody's
- AA- from Duff & Phelps
Or perhaps, an agent might decide that a company must only meet one or more requirements from three of the four major rating companies. A word of caution is in order regarding ratings. Agents who do not find a company rated must investigate the reason. If the company has not been around long enough to rate, it may be better to avoid doing business unless a reinsurance contract with respectable contract is in force. Or, it may be necessary to ask the insurer or the rating company is a rating was issued but suppressed from being published. Currently, only Standard & Poors and Duff & Phelps will suppress a rating.

**Variations in Ratings**

One major rating agency suggests a way to determine if an insurer is running into difficulty is to monitor several ratings. If the ratings vary widely, this should send a signal that there are other factors of concern regarding the insurer. A recent example is United Pacific Life. In 1992 they were rated A-plus by Duff and Phelps, BBB by Standard & Poors and Ba-1 by Moody's.

**Government Regulations**

In addition to agent due care issues just discussed, there are a myriad of common practice rules and regulations that guide the marketing of insurance, long term care policies and annuities.

The problem for regulators is how to strike a balance between protecting consumers and product. Proponents of strict regulation fear that if tough regulations are not imposed, consumers will not be protected against inferior products and fraud. Opponents of strict regulation argue that officials sometimes do not have enough information or experience to regulate intelligently and that flexibility is needed to prevent financial losses that may discourage the industry from providing further coverage.

**The Consumer's Right To Know**

Beyond rules and regulations that say you must do a good job, agent's should want to do a good job to protect consumers and their clients alike. A consumer Bill of Rights for buyers has often been suggested. In the long term care market, such a Bill of Rights has been developed with contributions from consumer and industry representatives. When an insurance agent is marketing a long-term policy to a consumer, he must remember that the consumer has the right to know the following features and/or his rights with respect to a long-term care policy:

- That the company is licensed by the Office of the State Insurance Commissioner to sell long-term care insurance in that particular state and that the policy being offered has been approved.
- Whether the policy qualifies as a medical expense for federal tax purposes. (Only unreimbursed medical expenses greater than 7.5 percent of adjusted gross income can be deducted.)
- That the insurance agent must give the consumer a copy of the "Shoppers Guide to Long-Term Care Insurance" from the National Association of Insurance Commissioners. This guide includes a suitability worksheet to help consumers decide if long-term care insurance is a wise choice.
- What the premium cost will be and if there are any other out-of-pocket costs associated with buying and using the policy such as waiting periods, deductibles, or copayments. The consumer also has the right to know that premiums can increase over time.
- The places where covered benefits will be provided such as at home, in a nursing home, assisted living facility, or adult day care center.
- What benefits are covered, how a policy holder will qualify for benefits, and when benefits would end.
- Whether the policy includes inflation protection and how much this optional benefit costs.
• That an application for long-term care insurance can be denied and that the company must give the individual, in writing, the reason for the denial. At the policy holder's request, the insurance company will notify the doctor if the denial is due to a medical condition. (Denial by one company does not necessarily mean denial by another company.)

• That the policy holder can cancel the policy in the first 30 days and receive a full refund. The consumer does not have to give a reason for canceling the policy. He also has the right to know what will happen if he must cancel the policy after the first 30 days.

• The consumer can file a complaint with the office of the State Insurance Commissioner if a claim for covered care is denied, if he feels harassed or pressured by a sales agent to purchase a policy, or if he has any other concerns about the insurance, the agent, or the company.

Coverage
Every insurance policy is a legal contract developed by teams of skilled lawyers working and modifying the document over a period of many years. Every time a new court decision alters existing law, trained contract specialists modify the contract in order to assure compliance with new developments. Understanding what a policy means and comparing the policies of different companies require an understanding of the jargon of the insurance industry and a familiarity with insurance law.

If a potential policy holder has any doubts what the contract means and whether or not it will protect him after paying his premiums, an insurance agent has the responsibility for informing his client. The key to having a satisfied client is to encourage him to read the insurance policy carefully. Courts have declined to rule that a misleading advertising brochure was actionable but held that what was needed to determine the relationship between the consumer and the insurance company was to be sure that the consumer read the policy. Agents should always read and have available specimen policies for this purpose.

Replacement Guidelines
In order to identify replacements, insurers must inquire about replacement in their policy applications, as required by the replacement rules. Typically, the insurer asks the consumer and the agent to certify whether any existing insurance is to be replaced or changed. Unfortunately, these terms are not especially meaningful to most people. Producers and company personnel are expected to accurately determine whether the transaction constitutes a replacement. Once it is determined that a replacement is involved, the insurer and agent have certain obligations.

If a long-term care policy is replaced with another, insurers must: Offer to check the policies for duplicate coverage. Warn the policy holder in writing not to drop any policy until the free look period is over. Give credit for time spent under the previous policy toward satisfying waiting periods for coverage of preexisting conditions.

Specific Disclosures
The list of forms and disclosures you must present your clients is sometimes overwhelming! For the most part, your carrier should provide you these documents and keep you informed as to how and when to use them. Here is just a short list of documents you may need to handle:

• Disclosure to sell life insurance or annuity product to a person aged 65 or older
• Disclosure to sell a Medicaid related life insurance, annuity, long term care or Medicare supplement product to a person aged 65 years or older.
Disclosure to any elder that the sale or liquidation of any stock, IRA, CD, mutual fund or annuity used to buy any life insurance or annuity product may have tax consequences, withdrawal penalties or other associated costs.

- Tax Qualified and Non Tax Qualified Comparison
- Outline of Coverage
- Resource Disclosure (Places or government agencies to advise consumers)
- The Long Term Care Insurance Shopper's Guide
- The Long Term Care Personal Worksheet
- Long Term Care Suitability
- Replacement of accident and sickness / LTC insurance
- Rate Stability (history of premium increases / potential future increases)

**E&O Insurance**

In closing, we would like to discuss the importance of errors and omissions insurance. Like other professionals, LTC insurance agents should carry their own errors and omissions insurance. One author suggests that the highest level of agent ethics occurs when errors and omissions insurance is purchased for the protection of clients. While this is indeed a noble gesture, it is more likely that agents purchase these policies for more selfish motives. After all, the issues in this on mistakes made by other agents make it is clear we have entered an era of high accountability and cannot hope to survive a major claim without this protection. In some states, for example, the punitive awards can be as high as three times the amount of compensatory awards (some E&O policies do not cover punitive damages).

Faced with these kinds of actions, insurers, who many times foot the bill for agent mistakes, are less timid about suing their agents and brokers for any malfeasance. Of course, to some extent, the very existence of errors and omissions insurance may be a factor in an agent being named in litigation that he may otherwise have avoided. In a case involving several security salesmen, for example, a pre-trial judge asked for a show of agents who did NOT have errors and omissions insurance. They were excused from the case! This could happen again, or not at all. Who wants to take the chance?

There is no standard errors and omissions policy. Most policies are written on a claims-made basis rather than on an occurrence basis. Claims made means the insurer is ONLY responsible for claims filed while the policy was in force. For LTCI policies, this represents a real problem where policy benefits, or the lack thereof, do nto surface for 30 or 40 years – well after an agent leaves the LTC business, moves or retires. Even death is not an excuse, where a "hot shot" attorney can file his client's claim against the agent's estate!!

E&O policies today also have some very significant limitations, caps, gaps, consent clauses and relatively high deductibles. So many loopholes, in fact, that an agent is likely to feel the financial impact of any litigation almost immediately and under certain conditions may receive NO protection whatsoever. Some older style policies even require the agent to pay the entire claim before the errors and omissions insurer has any obligation at all. These are referred to indemnification policies.

**Exclusions**

In many instances, the choice of a errors and omissions policy doesn’t center on the limits or features an agent wants, rather it comes down, for many, to what the agent can afford. Unless agents find a way to finance the huge premiums, through banks or association groups, this often leads to the agent accepting many policy exclusions.
Aside from the primary limits of the policy ($1 Million seems to be the limit of choice for most agents) the cost of defense is the most important exclusion to watch. Does your errors and omission policy include defense costs as part of the limit? If so, the amount of money available to pay monetary or punitive awards will be significantly reduced. Defense costs can also be limited to a percentage of policy limits. Here, when the number is reached, you start paying for the balance of defense costs. Obviously, the best errors and omission plan will pay for all defense costs in addition to policy limits.

The claims made exclusion is the next consideration. If you have one, you will be covered for only the claims that occur while the policy is in force. If so, how will you handle a claim problem that occurs down the road, say at retirement, when you have dropped your policy? Actually, you may have little choice in the matter since most policies today are written on a claims made basis versus an occurrence basis. However, there are endorsements, discussed later, that can help protect you in the “down the road” scenarios.

In addition to the claims made limitation, there are many other important coverage exclusions an agent must consider, such as: insurer insolvency, receivership, bankruptcy, liquidation or financial inability to pay; acts by the agent that are dishonest, fraudulent, criminal, malicious or committed while knowing the conduct was wrong; promises or guarantees as to interest rates or fluctuations of interest rates in policies sold, the market value of any insurance or financial product or future premium payments; activities of the agent related to any employee benefit plan as defined under ERISA; agent violations of the rules and regulations of the Securities Exchange Commission, the National Association of Security dealers or any similar federal or state security statute; violations of the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA); discrimination or unfair competition charges, violations of the Racketeer Influenced Corrupt Organizations Act (RICO), and structured settlement placements. Policies that will refuse to pay if you have used an insurance carrier with less than an “A-” rating from AM Best.

In most of the instances above, the standard agent's errors and omissions policy WILL NOT PAY a claim. In the case of an insolvent company that retains client's money or refuses to make good on a claim, the agent WILL NOT even be defended according to specific terms that exist in most policies.

Also, be aware of specific limitations. You may not be covered by errors and omissions in the following areas: punitive damages, business outside the state or country; failure to give notice if new employees or agents are added to your staff; fraudulent or dishonest acts of employees or agent staff; negligence may be covered, but bodily injury and property damage may not; judgements -- some policies only pay if a judgement is obtained against you; some exclude contractual obligations in the form of “hold harmless” clauses (watch them); outside services like the sale of securities, real estate or notary work.

Most errors and omissions policies are far from perfect. However, before losing interest in buying this valuable coverage, you should consider the high costs, and lost production time, associated in the defense of even one protected client claim and any subsequent judgement requiring an agent to pay any deficiencies and possible attorney/court fees. The cost of the average errors and omissions policy is cheap when compared to these costs.

Endorsements & Options
If you want your errors and omissions to do more, you can pay more and upgrade your coverage. Critical policy options that you might consider include first dollar defense coverage, defense costs in addition to policy limits, adequate liability limits ($1 million minimum), the
availability of prior-acts coverage, coverage carrier solvency and “tail” coverage so you and your estate can remain protected in the future.

Obviously, the concerned agent would do better to avoid malpractice claims at the outset by doing everything possible to investigate safety and solvency of any proposed carrier, acting professionally, keeping current, due care, etc. Further, there is no substitute for operating in a prudent, ethical manner rather than rely only on an errors and omission policy. After all, can there be any point to work and build a practice to lose everything to the dissatisfaction of one client?

**E&O Claims**

If you feel you have a potential errors and omissions claim, you should first review your policy to follow the reporting requirements that need to meet. Most E & O carriers want you to report an incident right away. However, it is important to know what your company determines to be an “incident”. Is it an actual claim? Is it a threat of a claim? If in doubt, you might want to call the company anyway and discuss it with them.

Generally, it is in your best interest to cooperate fully with the company by assisting in any evidence gathering and witness lists. However, this same spirit of cooperation does NOT always extend to your client. Most errors and omissions insurers do NOT want you or any staff member to make any voluntary admission of guilt to the client. Never blame the insurance company in any way or make any statement that might lead them to believe that the situation will be cured. While you can be cordial and calm in dealing with the client, be careful NOT to give any advice, legal or otherwise. If you are absolutely positive the claim is wrong, you can deny it, but never offer to settle.

If the situation involves a claim between the agent and a represented insurance company, the same precautions must be taken. In essence, you can’t afford to “prejudice” your case in any way. Violating this errors and omissions contractual promise is the sure way for coverage to be canceled.

Cooperation also extends to any settlement offer proposed by your errors and omissions company. If your E&O insurer suggests a settlement offer that you do not agree with, and the case ended with a higher judgement that the settlement, you could be held liable for the difference as well as any amounts that exceed policy limits.
INSURANCE PROTECTION FOR MATURE MARKETS

The needs of mature market groups is far more complex than those of younger generations. Instead of simply covering an economic loss of a breadwinner, insurance may play a critical role in a client’s planning of his estate, business, investments, retirement, tax reduction, long term care and more! For the agent, this means a working understanding is needed for a wide variety of insurance products; including how they function, their specific role in helping mature markets and various implications concerning taxation and eligibility.

For instance, if you are recommending a client surrender a policy he already owns and use the proceeds to buy Medigap or long term care insurance, you need to know and/or advise the client that the transaction may generate some taxable income. The taxes he must pay may reduce the amount he has available to buy the coverage you recommend. In another example, your recommendation to take a lump sum from a life insurance policy might limit or exclude a client from Medicaid eligibility. Clients need to understand this may happen in order to make prudent decisions.

Purchasing life insurance is probably one of the very few ways that one can establish an estate or protect one from being devastated. We all know that no one can predict their day of death, so life insurance can provide the means to help meet that person’s financial goals and objectives. In the case of estate or tax planning, insurance can provide a “safety net” or “pot of money” to continue a business or cover estate / tax liabilities. Health and long term care coverages are critical to preserving estates and a client’s piece of mind.

Here are products you will use as protection:

TERM INSURANCE

Term insurance, as the name denotes, will provide insurance protection for a “period of time”. This period will typically be one year but can vary from insurance policy to insurance policy.

Some insurance companies will have policies that also provide for other terms such as five (5), ten (10) or even twenty (20) years. Some are renewable with further underwriting, others are guaranteed level. Make sure you obtain a specimen policy for every product you market to be sure you know exactly what your client is getting.

What is most important to remember is that term insurance provides pure insurance protection only and will not provide any cash savings of any kind. However, there are situations where the amount of insurance protection needed for a specified period of time makes term are far better choice than whole life varieties.
Term Insurance and Mature Clients

Some believe that term insurance is only for younger clients wishing to cover the “economic gap” left when a breadwinner dies prematurely. Boomers and seniors, however, have similar needs, only with a twist. Consider the following:

• A boomer in the prime of his peak earning years with kids in college needs major insurance protection to allow college completion and replace his higher income and lifestyle needs — boomers do not have a lot of savings and they are accustomed to having what they want, when they want it. Term policies can cover this current need. While life would be cost prohibitive for the amount of coverage needed.

• Mature executives need large key man policies or sufficient buy-sell agreements to cover their premature death at their place of work or business.

• Matures who are major stockholders / business owners need a plan to dispose of their stock for the successful continuation of their business (Section 303).

• Seniors who need to cover, temporary but large, estate or income tax liabilities may find term policies far more reasonable than whole life.

Types of Term Insurance

• Level Term Insurance
• Decreasing Term Insurance
• Increasing Term Insurance

Level Term Insurance
An example of level term is when an insured purchases a $100,000 (10) year policy. The term insurance coverage will last for a period of 10 years and will have a level death benefit throughout the entire 10 years of $100,000. At the end of the term the protection will expire.

Decreasing Term Insurance
Decreasing term insurance provides insurance protection that will decrease over the period that is covered. As an example, let’s suppose your clients purchase a $150,000 thirty (30) year term insurance policy to provide protection when they purchased a home.

This type of protection is perfect for the homeowner who needs added protection in case of an untimely death. The face amount will decrease over time and should do so in proportion to the mortgage principal amount as it decreases.

Increasing Term Insurance
The death benefit with increasing term insurance policies will provide a death benefit that increases over the period of the policy. As an example, a client decides to purchase a increasing term policy to provide coverage when certain lifetime situations occur, such as getting married, having children, buying a home etc.

Unfortunately, one of the problems with term insurance is that it gets more and more costly as the insured gets older. As you will soon see, Universal Insurance can also provide coverage for the same situations as would increasing term insurance but will also accumulate tax deferred savings which term insurance cannot do.

Renewal & Conversion Privileges
A term policy that does not include renewal of conversion provisions will, at the need of the stated term, provide no further insurance coverage. Renewal and conversion offer more flexibility for the mature buyer, but may cost more for the privilege.
Renewable term gives the insured the option of renewing the policy at the end of the term, usually in the same amount and for the same term with no proof of insurability. A re-entry product can allow for continued coverage at favorable rates if the insured submits proof of insurability.

Unless some form of renewal or re-entry is provided, term insurers typically adjust premiums based on the insured’s attained age at renewal, but not typically based on his medical condition. Therefore, at a higher attained age for the new term, the premium may be much higher at renewal than at original application.

**Tiered Term Strategy**
Term policies today are normally structured for a premium that is level or guaranteed level for a specified period of time. This can provide mature markets an interesting approach to protection that can provide maximum amounts of coverage for the least price possible.

Let’s say you are talking to a mature in his late 40’s. He probably still has younger children or kids headed to college. He may also own a business or have an estate tax liability he wishes to cover. Or, it may simply be his wish to make sure his spouse is provided for well.

An agent may suggest that this mature client may satisfy many of these requirements using several term policies in place of one large one or a whole life or universal product that may not provide enough protection. (The amounts suggested are simply for illustration. Your client may need more or less coverage.)

**Tier 1**: A $500,000 level term policy with guaranteed level premiums for 10 years. This is the foundation for this client’s protection. It replaces economic loss for the next 15 years, which are by far years of higher exposure. Kids need to complete their schooling and his spouse may need to provide for them in many other ways while they are still living at home. Since the client is needing this large amount of protection to cover a short-term exposure, the expiration of this policy will not be missed.

**Tier 2**: A $250,000 level term policy with a guaranteed level premium for 20 years. This level of coverage can provide protection for this client and his family through his retirement in his late 60’s. There is little reason that someone in his late 60’s would be wanting or needing to pay life insurance premiums. By this time, he should have an estate of sufficient size to care for his spouse in the event of his death. Therefore, the loss of this policy, if the client decides not to re-enter or renew should not be critical.

**Tier 3**: A $100,000 level term policy with guaranteed level premium for 30 years. This policy is inexpensive and provides a level of coverage for this client beyond his retirement years. It may be considered an extra “layer” of protection for his spouse that could help with final medical expenses, long term care bills, etc.

Some may argue that a single whole life or universal policy might provide the same client “permanent” protection through his lifetime. Yes, this is true, however, agents need to balance the ability of clients to pay in exchange for the level of protection they need. Few matures will be able to or justify the cost of a $250,000 or $500,000 whole life policy, yet they NEED this kind of protection. Term policies provide the level of protection they need at a reasonable cost. Further, those that provide convertibility to whole life or living benefits (advanced death benefits) can provide some of the same benefits of whole life, without the cost.
In any case, clients need to be advised that their term policies may simply extinguish themselves with no further benefits. For those who really understand, these same policies, while no longer effective after 10, 20 or 30 years, have also provided far more meaningful protection along the way than a single, smaller whole life policy.

Perhaps there is also middle ground to choose a combination of term and whole life coverage. One for long-term permanent protection for spouse and family (whole life), one or more for the high exposure years (term).

WHOLE LIFE INSURANCE

This type of insurance is also known as straight life. It will provide insurance protection that typically has a level death benefit along with level premium payments. This means, of course, that both the death benefit and amount of premiums will remain constant for the insured’s life.

Premiums will be paid by the insured for his/her entire lifetime, which is considered to be 100 years. At age 100 the policy is said to endow and the insured can walk away with the full face amount.

Who knows what a 100 year old person will be able to do with the money, but never the less, the insured will have the total amount in hand.

Limited Pay Whole Life
This type of insurance is also a whole life policy, but instead of paying premiums until the age of 100, the insured will make a limited number of payments for a period of years such as 7 years, 10 years etc. The limited payments will still provide two important benefits;

A. Insurance coverage will continue until the age of 100.
B. After the limited payments are made, no additional payments will be required.

Endowment Life Insurance
A pure endowment promises to pay the face amount when one of the following three things take place;

1. Death
2. Attainment of a pre-determined age
3. When a certain event takes place

As an example: One of your clients wants to have $50,000 in five years to help pay for his child’s college education. At the same time, he wants insurance protection in case he dies prior to this event.

Your client can purchase endowment life insurance with a face amount of $50,000. This will insure a death benefit if he dies during this time period as well as $50,000 at the end of the five year time period if the death does not occur. Obviously, the premium payments will be substantially larger than a whole life insurance policy or almost any other traditional life product.
**Adjustable Whole Life**

This is a variation of both straight life and term insurance. In theory, as a person's life changes, the whole life insurance policy can also be adjusted such as the face amount and premiums.

Within certain limits, the insured may raise or lower the face amount of the policy, increase or decrease the premium, lengthen or shorten the period of protection, and lengthen or shorten the premium payment period.

During the different phases of this type of insurance policy, the adjustable policy may provide lifetime protection with whole life or limited protection with term insurance.

After issue, the premium and or the face amount may be adjusted at any monthly anniversary. When the premiums paid exceed the cost of protection, the policy cash value increases. On the other hand, when the cost of protection exceeds the premiums paid, the cash value diminishes.

Flexibility is the major appeal of this type of insurance policy.

**SURVIVORSHIP LIFE INSURANCE**

Survivorship life is a type of joint insurance designed to provide life insurance coverage for two individuals. One of the many advantages of this type of insurance is that it provides less expensive coverage for two persons.

Other specific features include:

- Helping estate liquidity and conservation
- Can help with the transfer of a family owned business
- Charitable giving
- Supplement retirement income
- College funding plans for children and possibly for grandchildren
- A minimum guaranteed interest rate
- Affordable coverage
- Premium payment flexibility
- Death benefit is payable upon the death of the second insured
- Death benefit is paid directly to the designated beneficiary and paid federally income tax free
- Policy values grow at competitive rates of interest
- Premiums can be paid monthly, quarterly, annually or even for a limited number of years
- Riders are available to expand benefits

**Survivorship Term Rider** allows the insured to increase the amount of life insurance protection payable upon the death of the second insured. This joint term life insurance offers maximum protection for the premium dollar.

**Additional Insured Rider** provides individual term life insurance. The benefit payable at the time of each individual's death. Some policies allow as much as eight individuals that can be insured under this rider.

**Policy Split Option Rider** is available to married insureds. This rider allows the couple to split the policy in the event that the marital relationship is dissolved, or the marital deduction is eliminated, or the maximum estate tax is reduced to 25% or less.
Importance of Survivorship Life Insurance
As a financial professional you should consider the following markets prime for survivorship life:

Large Taxable Estates

Federal estate tax liabilities do not begin to accumulate until the last survivor’s taxable estate reaches beyond the $600,000 level. More and more people are reaching this threshold at a faster pace than ever before.

Estates With Non-Liquid Assets

Many clients have their money tied up in real estate, collectibles and other non-liquid types of assets.

Two Working Spouses With Children

If both parents died, the children may be faced with no income. If the spouses do live to their life expectancies, the policy can provide liquidity to conserve the estate for their children.

Dependents With Special Needs

The family may have dependents who are handicapped, elderly or have other special needs. This type of insurance policy could provide the funds necessary to continue meeting these special needs upon the death of the surviving spouse.

Survivorship Policies

Survivorship insurance, also known as Second-To-Die, is taken out on the lives of both a husband and wife. However, the policy pays off only when the surviving spouse dies, that is, the second to die. Both deaths must occur before the policy pays off. Naturally, with a second to die policy, the lower survivorship risk permits lower premiums than conventional life insurance policies. Also, in many situations, second to die coverage conforms to the need for estate tax dollars.

For example, suppose a married couple plans that the combination of the $700,000 federal estate tax exemption and the marital deduction results in no estate tax when the first spouse dies. Since the marital deduction defers estate tax until the surviving spouse dies, the estate tax would normally become due at that time. However, a second to-die policy in place would pay off at this time.

The marketing emphasis concerning second to die polices is on its cost. The premiums are much less than the traditional single life policies. Also, a second to die policy has a vanishing premium.

Vanishing premium policies receive sufficient funds through several larger premium payments. This allows the contract to continue without additional infusions of cash. Vanishing premiums build up the policy savings account so that the premiums may cease. The policy relies upon interest alone to pay mortality charges and provide for growth of the savings account.

The more traditional life policies perform this achievement over a period of 20, 30 or 40 years. With a vanishing premium universal life insurance policy, however, this is typically accomplished in 5 to 10 years.
A wide choice of send-to-die policies is available: whole life, whole life reflecting interest rate changes, universal life or a combination of whole life and term. Policies can be purchased with a single premium or with continuing premiums, with an option of making a large payment to convert the policy to paid-up status. The best policy for your client is the most cost effective and the one that will perform in both economic upturns and difficult times. Policy premiums will reflect the fact that lapse rates are much lower for survivorship contracts so insurers must have enough money available to cope with the higher persistency.

UNIVERSAL LIFE INSURANCE

One could compare universal life insurance to having both term insurance and a cash accumulation account. The following are basic features of standard universal life insurance policies.

- Similar to permanent insurance, as it offers a cash accumulation savings account
- Cash values can be adjusted
- Cash accumulates on a tax deferred basis which helps to improve the return, due to compounding
- Variable rate of interest applies
- Current rate of interest is assigned and can be changed monthly, quarterly or even annually. The mode of change is based on policy rules
- There is a guaranteed minimum rate of interest also applied to each universal life policy. The current rate being paid can never be less than the minimum guarantee
- Policy loans are available which could make the loan not only tax free but possibly without any net cost

*Example:* If the interest rate for a loan is 5%, and guaranteed minimum rate is also 5%, it can be argued that the net effective cost for the loan is zero. However, there are those who would argue that there really is a cost for the loan because while the minimum guaranteed rate is being applied, the current rate (i.e. 7%) is not. Therefore, the real cost of a loan using these numbers would be 5% (loan interest), plus loss of the current rate of 7%, minus the minimum of 5% or 7%.

**Cash Accumulation Account**

As with many other types of insurance products, such as annuities, the cash account of Universal Life will accumulate on a tax deferred basis.

As premiums are paid for an insured’s policy, part of the premium will be placed into the cash accumulation account where the current interest rate will be applied by the insurance company. The current rate can go up or down depending on the investment returns of the insurance company and current interest rates in general. Obviously, if the policy is held until death, income taxes will not have to be paid on the tax deferred savings.

Also, Universal Life Insurance policies provide a minimum guaranteed interest rate. This is typically somewhere between 4-5% and the return can never go below this rate. It would probably be safe to say that the current rate will probably never get as low as the minimum guaranteed rate as insurance companies would have a tough time selling insurance.

Common sense dictates that as the insured deposits additional premium the cash accumulation account will grow at an even greater rate. In fact, if an insured decided to take the single premium option the cash accumulation account will result in faster total savings than other premium payment modes.
**Mechanics of Paying Premiums**

After a universal insurance policy is issued, the initial premium, upon acceptance by the insurance company will be “unbundled”. This means that the premium will be separated into the insurance costs and charges, on one hand, and the remaining cash on the other.

As additional premium is paid, it will be placed directly into the cash accumulation account. The cost of insurance and any other charges will be taken out of the account as they accrue and are due. The remainder of the cash accumulation account will grow at the current rate.

**Premium Modes**

Just like other types of insurance, premiums for universal life insurance policies can be paid monthly, quarterly, semi-annually and annually. Once again, the quicker the money is placed into the cash account, the quicker the cash will accumulate.

Premiums can also be paid by a single premium payment or even in a limited pay mode such as 20 pay life. The limited pay mode may also be referred to as the vanishing premium mode. One must be careful, however, that vanishing premiums may not work due to falling interest rates as the lower rates will not sustain the growth needed in the cash accumulation account to pay the premium.

At some point in time the insured may be required to either pay in additional funds as a premium or lower the death benefit. The point must be made of the danger of “vanishing premiums” as Universal Life Insurance is interest sensitive and can be effected in an adverse way when a lower interest rate environment exists as it did in 1993 and currently exists in 1995.

**KEY EMPLOYEE LIFE INSURANCE**

For mature market individuals who are still working, key man life insurance can provide valuable protection for both the surviving spouse and the surviving business.

First of all, to set the record straight, there is no such thing as key employee insurance or key man insurance. Key employee insurance can be permanent (whole life) insurance which is capable of building cash values and placed on the life of the person identified as a “key employee”. A company may alternatively buy a term or universal life for the same employee for a specified period of time and amount. Of course, the key employee is an individual who is considered to be valuable to the company and the business. Without this individual the company may suffer a number of different types of losses which will ultimately effect the financial bottom line.

The insurance is purchased by the company as the owner of the policy, pays the premiums is usually the beneficiary. Typically, the insurance is purchased for the benefit of the business, not the employee.

Consider the following possible losses to a company and more specifically the possibility that they will cause damage to inventory, building, equipment and more:

- Fire
- Wind
- Theft
- Vandalism
- Robbery
Companies must consider how these perils can cause losses and more importantly, how to shift the risk away from the company. Yes, purchasing insurance will certainly provide a major way of shifting any potential losses to the insurance company.

But, what about potential losses as a result of the loss of a key employee? What about the costs of replacement and the loss of business? Without insurance, the loss from any one of the above risks might endanger the success of the company. Unfortunately, key employees really can’t be replaced. Finding the “right” replacement is a costly experience. The use of insurance will help.

**Insuring the Right Employee**

The key employees must be identified by the company prior to the purchase of any insurance. After all, it doesn’t make any sense to purchase life insurance on all of the employees. Obviously, this would be quite an expensive proposition.

Let’s take a look at the following situations which may help search out who is a Key employee and would contribute to the success of the business:

- Managers
- Highly paid employees
- Responsible for sales
- Highly thought of individuals

**Training and Key Employees**

While searching out those individuals listed above it is almost as important to determine whether training programs are available for management personnel. If the personnel in the company have not been adequately trained and if the managers have not received management training, identifying key employees would not be necessary as there wouldn’t be any.

As a company identifies key employees the recognition of training must be discussed and reviewed. Obviously, if a trained individual was available to step into the position of the key employee, losses would be minimized by the company.

Larger companies usually provide its employees with more in depth training programs than usually found in smaller companies. The point I’m trying to make is that prospecting for key employee insurance is best with smaller, rather than larger companies.

**Other Potential Key Employees**

It is not always possible to identify key employees just from titles. It’s probably just as important to look at the total contributions of these employees to help determine their importance. Most of the time you will have to analyze these indicators in a subjective way.

**Other Key Employee Indicators**

- Relationship with both employees and management
- Involvement in sales or production
- Non-employee owners or investors
- Character
- Ability
- Contributions
- Skill
- Experience
Losses Sustained From the Death Of a Key Employee

Most business owners will agree that insurance is needed to be reimbursed from losses from such things as fire, wind, burglary and other miscellaneous property and casualty causes. In fact, selling this type of insurance is quite easy and readily acceptable by business owners.

However, convincing a business owner to purchase insurance on a key employee is more difficult as the benefits are more difficult to comprehend. Let’s take a look at the potential losses that will result from the death of a key employee:

- Loss of managerial skill
- Loss of managerial experience
- Decrease in sales
- Decrease in customer service
- Reduction in production
- Potential loss of credit by creditors
- Cost of recruiting a replacement
- Training the replacement

BUY-SELL INSURANCE

Many working matures own small businesses as proprietors or in partnership arrangements. In the event of the death or disability of a small business owner, a plan must be put into place that will permit the successful continuation of the business. The buy-sell agreement is a means of prearranging for this sale. It is a binding contract for the designated buyer to purchase the business as a going concern carried out upon the business owner’s death.

Effective planning for the continuation of a sole proprietorship requires finding a successor to the business. When this person is found, a buy-sell agreement can be arranged for the benefit of both the selling proprietor and the purchaser. Usually, this person is a key associate who is closely tied to the business. The buyer does not necessarily have to be one person; a group of associates may elect to purchase the business.

Although a purchaser from the outside may be found, this is not likely or advisable. A sole proprietorship is usually an intricate and personal endeavor. An outsider is not likely to have the personal knowledge of the business or an awareness of its complexities.

The Contents of the Buy-Sell Agreement

Using a buy-sell agreement, the business owner and the buyer essentially set up a prearranged market for the business. The buy-sell agreement must contain a specified purchase price or some valuation formula that is to be applied at the time of death to produce a purchase price.

The agreement must further provide that the buyer has the cash available to pay the price in full, or nearly in full, when the purchase takes place. It is not enough simply to find a buyer and to make some sort of promise that the transaction will take place. There must be an effective way to fund the buy-sell agreement.

The most effective, convenient and practical way to fund the buy-sell agreement is with life insurance on the life of the proprietor. The amount of the insurance is also the amount of the purchase price that has been agreed upon. By using such an arrangement, both the buyer and the seller are assured that the necessary cash to carry out their plan will be available when it is needed.
Alternatives to using insurance to finance the buy-sell agreement are not realistic. For the purposes of discussion, some of these plans include saving for the purchase price, making the payments in installments and borrowing the necessary funds. However, none of these methods is practical.

An insured buy-sell agreement is basically an advance installment plan for the payment of the purchase price. These payments can be made on whatever schedule is convenient. They may be made monthly, quarterly, semi-annually or on some other basis.

**The Benefits of the Buy-Sell Agreement**

The obvious benefit of the buy-sell agreement in this case is that the purchaser acquires the business as a going concern. When no such plans are made, the business is not likely to survive long without its owner. Therefore, it loses its going concern value.

When a buy-sell agreement is in place, the deceased's estate does not suffer liquidation losses. The buy-sell arrangement permits the deceased's family to receive the full value of the business in cash.

**The Buy-Sell Agreement and the Partnership**

A business partnership has a need for a buy-sell agreement for many of the same reasons as a sole proprietorship, although it is a completely different type of entity. The partnership is more complex, and more people are affected in different ways in the event of the death or disability of a partner.

A buy-sell agreement is essential for a partnership business for many reasons. Some of these are:

- There are greater liabilities involved. Essentially, a partnership implies that there is the unlimited personal liability of each partner. In other words, each partner is
- There are contributions from more than one source to the partnership. Initial contributions are made by the partners when forming the partnership. The sum of all of the partnership assets, including these initial capital contributions, are considered to be partnership property.

**The Consequences of Not Having a Buy-Sell Agreement in Place**

Given these crucial issues, the consequences to the surviving partners and the deceased partner's family can be devastating, in the event of the death or disability of a partner. A partnership differs greatly from a sole proprietor's business, which may be bequeathed like any other personal property, or the sale of which may be arranged in the event of the owner's death.

Without an express agreement, in the event of the death of a partner, the partnership itself is automatically dissolved. This is one of the fundamental rules of partnership law. The partnership may be reformed, or it may be reconstituted with the surviving partners or new ones. Technically, however, this process is the creation and formation of a brand new partnership.

When a partner dies, the partnership must be dissolved because the death has resulted in a change in the relationship of the partners. Therefore, the partnership, as it was originally formed, no longer exists. Next, the partnership business must be wound up or liquidated. Finally, the partnership must be terminated, eliminating the surviving partner's authority.
Alternatives to Forced Liquidation

If no buy-sell agreement has been made arranging for the disposition of the deceased partner's interest, many unfortunate events can take place. Inevitably, there are losses suffered by everyone. The following is a discussion of some of the alternatives to liquidating the partnership when no buy-sell agreement has been put into place:

- The surviving partners may form a new partnership with the heirs of the deceased. This is not a practical alternative, because the heirs cannot enter the partnership until the estate administration has been completed. Besides, this plan can work only if the personal representative is the heir. Further, since all partners must agree on who the partners are, this can only happen if the partners and the heir agree to be partners. Spouses who have not formerly been involved in the partnership business typically do not make good partners due to their lack of experience.

- The heirs may purchase the interests of the surviving partners. This plan is not a practical one for the partners because they would be left without their business, their jobs and their livelihoods. This plan is not a practical plan for the heirs, because they would have to carry on the business without the skills and expertise of the departed partners who made the partnership successful in the first place.

- The surviving partners may purchase the interest of the deceased. While this plan may seem like a sound one, the personal representative, acting in the best interests of the deceased's family, may demand that the partnership be liquidated. This plan also assumes that the partners would have the immediate cash available at the time of death, which is not a likely event without an insured buy-sell agreement in place.

- The buy-sell agreement seems to be the best alternative to the liquidation of the partnership. It can be set up prior to the death of a partner and can eliminate the possibilities of any liquidation losses to the partnership. However, as with the buy-sell agreement used in the sole proprietorship, although the objective of the arrangement may be noble, it must also be suitably financed.

Financing the Buy-Sell Agreement With Life Insurance

A partnership business financed with life insurance may be arranged in one of several ways:

- A cross purchase agreement may be used. For smaller partnerships, the cross purchase plan is usually the most efficient method of financing. Using the cross purchase agreement, the partners agree to purchase a deceased partner's interest in the partnership. The partners themselves pay for and own the policies on the other partners. A cross purchase plan ensures the worth of each partner's share because the amount of insurance on each partner is the amount approximating his share of the purchase price, if another partner predeceases him.

- An entity agreement may be used. In larger partnerships, a cross purchase plan doesn't make much sense. With each of the partners purchasing life insurance policies on each of the others, this plan could become unmanageable. An entity agreement involves the partnership itself. The partnership pays for a single policy on each partner's life. The parties to an entity agreement are the partnership and the individual partners.

- Using an insured buy-sell agreement offers great advantages to the partnership. It assures the continuation of the partnership business without interruption, and any liquidation losses are averted. From the perspective of the estate, the family receives payment in full for the deceased's interest immediately.
FINAL EXPENSE INSURANCE

Final expense insurance, also known as burial insurance or simplified issue life insurance is most often a whole life insurance product with a simple application process and small face value. Typical face values range from $5,000 to $25,000 although policies can often be written outside of that range. This type of insurance is designed to be conveniently purchased without the requirement of a medical exam or a complex questionnaire. Applications can often be completed over the phone, only a few health questions are asked and no home visit is ever required.

This type of policy is sold where the primary concern of the mature client is the payment of final expenses such as:

- Medical Bills
- Funeral Expenses
- Outstanding Debts
- Administrative Expenses

Aside from the simple application process this type of insurance can provide:

- An accumulating cash value that is available for emergency expenses.
- A death benefit that never decreases.
- Premiums that never increase.
- Policy cannot be canceled regardless of age or health as long as premiums are paid.
- Accelerated death benefit: Receive up to 50% of the death benefit early if diagnosed with terminal illness.

When sold to an appropriate person (elderly, ill, or lower income), burial insurance is easy to apply for and low risk. When sold to people that don't need it (affluent, young, vulnerable seniors, etc), it is a waste of client's money.

**Types of Final Expense Insurance**

Immediate Full Death Benefits are generally available to qualifying applicants when no serious or immediate health concerns are presented.

Graded Death Benefits are available when serious health concerns are presented. Graded plans provide limited benefits during the first few years of the policy.

Guaranteed Issue Benefit Plans may also be available if an applicant's health makes him ineligible for the standard or graded burial insurance products. These are available regardless of health and provide a graded benefit that provides a full death benefit after three years of policy payments and limited benefits before that.

Permanent plans are almost always “whole life” based insurance products. This means, as long as the client pays his premium, the policy will stay in force, usually until he dies or in some cases until he reaches 100. The premium and death benefit are guaranteed to remain the same and there may be a “cash value” associated. Most final expense policies sold are whole life or permanent plans.

Term insurance plans are also available based on the applicant deciding "how long" he wants this life policy to stay in force. Usually, these plans allow the applicant to choose between a 10, 15, or 20 year contract.
The premium and death benefit are guaranteed to remain the same for the entire contract period. So for example, let’s say a client decides that he needs coverage for only 10 years. During the ten year period, the premiums and death benefit remains the same, however, if he lives beyond the ten years, he will have no coverage. The life policy will cease to exist. This type of product is less expensive than their permanent plans.

**Typical Payment Plans Available**

A Level Pay Plan calls for premiums to be paid for the life of the policy.

A 10 Pay Plan calls for premiums to be paid for 10 years.

A Single Pay Plan requires only one premium payment.

10 pay and single pay plans will often include an annual growth rate on the death benefit

**Features of Final Expenses Insurance**

- Most policies are guaranteed or simplified issued.
- No medical exam is required.
- Usually final expense insurance has a 1-5 year waiting period, for example if the insured dies 6 months after policy issuance, only the premium will be reimbursed to the beneficiary.
- Guaranteed issued means, once you complete the application in its entirety, the insurance carrier "guarantees" to issue you a policy. Regardless of the status of your health, you will automatically qualify for these plans.
- Guaranteed issued plans are more expensive than simplified or fully underwritten ones and can run as much as 100% higher in price than fully underwritten policies. Why? Because the insurance company will accept all health risks!
- Simplified issued means, once you complete the application in its entirety, the insurance company will perform "limited" underwriting. The typical application will usually ask no more than four medical related questions. Once your application has been through underwriting & "I" dots; the insurance company can either accept or decline coverage.
- This type of plan is much easier to qualify for than fully underwritten, however, the cost can be as much as 25-50% higher

**Disadvantages of Burial or Final Expense Insurance**

- Maximums of only $5,000-$50,000
- Heart problems and terminal illness may not qualify
- Only get a full benefit after 1-5 year waiting period
- Good health doesn't qualify for lower premiums
- May not be available to children or over 80
- Low or negative return on cash value
- Premiums may total more than the death benefit

**INSURANCE & LIVING BENEFITS / RIDERS**

Mature clients now have several options for their insurance policies to provide liquidity and/or special care funds without dying to get them. All are based on the same theme: Benefits that might ordinarily be paid at death may be accessed sooner. Or, in the case of some riders, the
client has the reserved right to purchase coverage at a later time or receive benefits based on a certain “trigger” of events.

**Living Benefits**
We have classed these benefits under the name “living benefits”. However, agents may be more familiar with terms such as life settlements, accelerated benefits or viatical settlements. Some living benefits are presented in the form of riders and more companies are modifying existing policies in order to add these riders. Typically, the basic premium cost will be increased by 5-15 percent to pay for the rider, although some riders can increase the cost of a basic policy by as much as 33 percent.

**Long Term Care Living Benefits**
Long-term care riders to life policies or annuities often pay living benefits when a serious illness occurs, even when no nursing home care is needed. For example, victims of strokes, heart attacks, cancer, coronary artery surgery, and renal failure can collect benefits while they are still living. Sometimes the policy holder can receive as much as 25 or 50 percent of the policy’s face value up front, rather than in regular monthly payments.

These riders have limits. They may not cover nursing home stays outside the United States or long-term care resulting from alcoholism, drug addiction, or attempted suicides. The long-term care riders usually cover nursing home care only after a stay in a hospital or in a skilled nursing home where medical treatment is dispensed. Most nursing home residents enter the homes directly, not after a stay in a hospital or skilled nursing homes.

The money available for nursing home benefits on a long-term care rider is normally two percent of insurance coverage per month. By this rule, a $100,000 policy would pay $2,000 per month. However, if the policy is over $150,000, the policy holder may get less than two percent. For example, suppose the policy holder has a $300,000 life insurance policy with a long-term care rider, and he is confined to a nursing home. This insured may get two percent of the first $150,000 ($3,000) plus one-half percent of the next $150,000 ($750) for a total of $3,750 per month. Also, some policies place a limit on the monthly payment amount. Some policies permit the policy holder to collect 100 percent of the amount of the life insurance, while others cap it at 50 percent. Most polices require that the policy holder pay at least for the first 60 days of nursing home care before a long-term care rider kicks in.

With some riders, the policy holder will have to make out-of-pocket payments for at least 180 days before he can collect. Some long-term care riders will not pay until the policy holder has been paying the extra premium for at least three years. For example, if an individual buys a long-term care rider in 1997, he may not be able to collect before 2000, 2002, or some other date.

Most long-term care riders will pay for skilled care or intermediate care nursing home stays. However, some riders do not pay for custodial care. Others will pay only after a specified number of days in a hospital or a specified number of weeks in a skilled care or an intermediate care home. While receiving benefits from a long-term care rider, the policy holder is not obligated to keep paying premiums if the rider has a waiver of premium feature.

The problems with funding long term care coverage through an accelerated death benefit policy are obvious: Benefits may be slower than a stand alone policy, benefit triggers can be tricky and there is typically no inflation protection other than by expensive inflation riders. Furthermore, the death benefits that could have gone to an insured’s estate are usually “eaten-up” in long term care costs thus defeating the purpose of buying a life insurance policy.
It is significant to note that the tax treatment of accelerated death benefits has changed as a result of HIPPA (Health insurance Portability and Accountability Act). Signed by President Clinton in 1996, this new law provides for **tax free treatment of accelerated death benefits for terminal and chronically ill people paid directly by insurance companies.** This should serve as another reason for the seriously ill to make use of accelerated provisions in their life policies for current “living benefits”, including long term care where permitted. Caution must be advised, however, in how one defines terminal or chronic illness to the satisfaction of the Internal Revenue Service.

**Viatical Settlements**

A viatical settlement is a transaction whereby a non-related party purchases all beneficial interest in a life insurance policy insuring the life of a terminally ill person. Since many long term care patients are terminal, they may consider selling the proceeds of their life insurance policy before they die to use the funds for current, more pressing medical needs and expenses. Or, using the funds to purchase long term care insurance.

The theory behind these transactions may sound gruesome, but can be beneficial for both parties. Think of it, by the time a terminally ill person considers “selling” his or her life insurance policy, they are typically on their “last leg”, financially speaking. The income realized from the sale of the life insurance policy can be **very welcome.**

The mechanics of the transaction are fairly simple. A third party “broker” or viatical company pays the terminally ill person a percentage of the death benefit and becomes the owner and beneficiary of the policy. The terminally ill person receives a lump sum of money to use **now.** When he dies, the proceeds of the policy go to the viatical company. Viatical companies are usually funded through investors and buy all kinds of policies: Term, whole life, universal life, group life, etc. The policy must have been in force for at least two years and not be subject to a contestability period. In some cases the viatical company even continues paying the premium on the policy to keep it going. Also, viatical companies are known to work with a combination of **accelerated death benefits AND viatical settlements** to net an even greater sum of cash for the seller of the policy.

More and more, people diagnosed with other terminal illnesses are turning to viatical settlements to meet their financial needs -- **including long term care.** The list includes terminal sufferers with cancer, “Lou Gehrig's Disease, cardiovascular illness and more. As a matter of fact, the statistics point to a larger market for viatical settlement from terminally ill patients with cancer who, in 1995, represented 78 percent of all hospice care admissions versus AIDS at only 4 percent. The industry is expecting more cases from non-AIDS related illnesses as more people learn about the product.

A real boost to viatical settlements should also come as a result of HIPPA (The Health Insurance Portability and Accountability Act) of 1996 which allows people diagnosed with a terminal illness to sell their life insurance policies to viatical settlement companies for a **tax free lump sum payment.** This tax free provision will apply ONLY to people whose life expectancy is less than 24 months and the purchasing company must be licensed by the state in which the viator (seller) resides.

Policies of all sizes are viaticated and twenty-one states have adopted all or a portion of the regulations for viatical settlements set forth by the National Association of Insurance Commissioners. And, the Viatical Association of America has established minimum standards of consumer protection for its viatical company members.
Life Settlements
In theory, life settlements work the same as viaticals: A policyowner agrees to sell his or her policy for an agreed upon sum of money to a third-party funding company who then becomes the new owner and beneficiary. The difference is that life settlements do not depend on the insured being terminally ill. Instead, older policyowners are considered. Generally, a client must be over the age of 70 to be considered for a life settlement although individuals as young as 65 are reviewed. Policies must be beyond the “contestable” period and have a face amount over $100,000. The funding company simply "banks" his deal on the proposition that the insured has a life expectancy of "x" and he will get the full amount of the policy proceeds back at death. The insured can use his funds to pay medical or long term care or buy a long term care insurance policy.

Mature clients may also consider selling an existing life insurance policy to reduce the amount of policy proceeds going to his gross estate. Or, a client may consider selling a life insurance policy to replace highly appreciated assets that were donated to charity.

Tax consequences vary, but generally, all life settlement funds up to the tax basis are received tax-free. Funds in excess of the basis, up to the cash surrender value, are treated as ordinary income, while funds in excess of the CSV are treated as long term capital gain. The Health Insurance Portability and Accountability Act of 1996 makes the proceeds of a life settlement TAX-FREE for individuals who are terminally or chronically ill.

Other Living Benefit Riders
In a unique twist, some insurers are providing policyholders the “reserved right” to add coverage benefits, such as long term care, down the road based on current underwriting!

Here’s how one plan works: The insurer offers a rider that guarantees the client who buys certain life policies from them the option to buy a “stand alone” long term care insurance policy in the future. The rider works by taking advantage of the medical examinations and underwriting the client undergoes when he applies for the life insurance today. By using the same medical information to set the LTC premium as it uses to set the life insurance premiums, the insurer ensures that the client can get an LTC policy when he’s ready for it in the future.

For example, let’s say you have a boomer that feels he is too young or he is just not ready to buy a long term care stand alone policy yet he needs some additional life insurance. An agent convinces him to buy the LTC rider. Now, future health problems will not affect the client’s ability to purchase LTC insurance. NO additional medical exams or question will be required if he decides to exercise the option. So, he could elect to buy, even if he has a long term care condition at the time. Of course, a pre-existing condition situation such as this would completely preclude him from buying an ordinary LTC policy.

What’s the hitch? Well, the cost of the rider is only between $5 and $10 monthly, but to reduce their exposure, the insurer limits to total coverage. The maximum amount of LTC insurance available when the client exercises his option varies based on where he lives and how long he waited before buying the LTC policy. This lifetime coverage cap can range from $130,000 to $185,000. The client is also limited as to WHEN he can buy. He can only exercise his options during years that end in “0” or “5”. Still, it is an interesting option. It’s better than nothing and it can be cheap assurance that at least some LTC coverage is possible.
SENIOR HEALTH INSURANCE

Senior Health Continuum Needs
The health continuum suggests that you monitor your clients to determine their specific and changing needs. For instance, let’s say you have been helping Doctor Smith with his disability insurance needs for 10 years. As he nears retirement, it becomes your responsibility to suggest the idea of phasing out his disability program and using the same funds to buy a long term care policy.

Likewise, let’s say you have also worked with Mary Lou by providing her and family comprehensive health coverage for many years. As Mary Lou reaches 65 and is accepted for full Medicare benefits, it is your obligation to withdraw her private health coverages. For most agents, this would be standard practice. After all, no client needs Medicare AND private health protection. In the case of one agent, however, it just didn’t happen, and he paid the price.

The case was Grace vs Interstate Life (1996). An agent obtained a health insurance policy for a Ms. Grace who kept it going for almost ten years. Benefits of this policy were substantially replaced by Medicare after the client reached age 65. However, the agent continued to collect premiums and said nothing. When Ms. Grace found out about the duplication in coverage she sued and won. The courts determined that a special relationship existed between agent and client that created a duty for agent to disclose the duplication in coverage. The courts found him personally liable for unnecessary premiums and other damages.

Medicare
A good portion of your discussions with clients will involve Medicare. Agents who work in the mature market must fully understand this area in order to explain benefits as well as what clients cannot expect it to cover. And, if you are offering a senior HMO as an alternative, you must be able to make accurate and realistic comparisons.

What Does Medicare Cover
Medicare hospital insurance helps pay for medically necessary care in a Medicare-approved hospital, skilled nursing facility, and hospice. It is very important to understand the distinction that a skilled nursing facility care is not the same as custodial nursing home care.

Skilled nursing care is acute care, while custodial is long-term care. Most nursing homes in the United States are not skilled nursing facilities, and many skilled nursing facilities are not certified by Medicare. So in conclusion, Medicare will provide for less than 2% of a client’s long-term care health payments. Medicare will, however, provide payment for health care for individuals over the age of 65 and certain individuals under the age of 65 with significant disabilities. So, Medicare is basically a health insurance program for senior citizens. The benefits available under Medicare are similar to those under most health insurance plans in the way they lack substantial or even modest levels of long-term care.

Medicare does not usually pay for nursing home costs, but the federal Medicare Catastrophic Coverage Act (MECCA), enacted in 1988, adds confusion, since it allows Medicare to pay for a limited amount of nursing home costs that previously were, for the most part, paid by Medicaid. However, these benefits were only for patients who qualified for welfare benefits, since such long-term care costs were not deemed to be medically necessary.

Medicare only pays for “Skilled Care in a Nursing Home” or “Intermittent Care in a Nursing Home or at Home”. Medicare does NOT pay for intermediate or custodial care, such as that required for Alzheimer’s patients. The following table will help put this into perspective:
As mentioned, Medicare pays for skilled care only. Medicare will pay the full cost to stay in a Nursing Home Facility for only 20 days. It will pay a part of the cost for the next 80 days, but only if you are receiving a “skilled” level of care. Medicare pays absolutely NOTHING after 100 days. Medicare does NOT cover custodial care or intermediate care, except for intermittent skilled services received.

Medicare, with its limited coverage, is not a solution for long-term care. It can afford some adjunct assistance in paying for initial admissions, and should not be overlooked as a source in the event that a current private pay resident enters a hospital and later re-enters the nursing facility, with needs that may fall within the health care guidelines.

Curiously, current federal laws seem to encourage skilled nursing facilities to refuse to submit Medicare claims. Consequently, the patient, his or her family, and their professional advisors should not be shy about pursuing at the very least the initial stages of an appeal.

**Medicare Part A**

Medicare Part A covers some costs related to hospital stays and is available for people who are 65 years old and over. When all program requirements are met, Medicare part A will help pay the costs for medically necessary inpatient services customarily supplied in a hospital or skilled nursing facility and for hospice care for the terminally ill. Medicare Part A also pays the full cost of medically necessary home health care and 80 percent of approved costs for durable medical equipment supplied under the home health benefit. Medicare Part A covers only those services that are considered medically necessary and only those charges that are considered reasonable.

All persons age 65 and over who are entitled to monthly Social Security cash benefits or monthly cash benefits under Railroad Retirement Benefits are eligible for Medicare Part A benefits free of charge. Others may be eligible for Medicare if they pay a monthly premium. Persons age 65 and over can receive Medicare benefits even if they continue to work. Enrollment in the program while working does not affect the amount of future Social Security benefits.

Enrollees in Part A are automatically offered the option of enrolling in Part B. However, they do not have to accept Part B if they do not want the coverage. Part A is financed through the Social Security (FICA) tax paid by workers and employers. The Health Care Financing Administration enters into agreements with state agencies and with intermediaries 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.

An individual does not have to pay a monthly premium for Medicare Part A if he or a spouse is entitled to benefits under either the Social Security or Railroad Retirement systems, if he has worked a sufficient period of time in government employment to be insured, or if he is under age 65 and has met the disability program’s requirements. Those who do not meet the above
coverage requirement may voluntarily enroll in Medicare for a monthly premium determined by the number of quarters (less than 40) that they paid into Social Security or Railroad Retirement.

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. Additionally, a dependent or survivor is eligible for hospital insurance benefits if that person is entitled to a spouse’s or widow’s Social Security benefit.

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, and beneficiaries age 18 or older who receive benefits because of disability beginning before age 22.

Hospital Benefits
Hospital benefits entitle an individual to 90 days of in hospital care for each benefit period. A benefit period begins when the insured enters the hospital and ends after he has been out of the hospital (or skilled nursing facility) for at least 60 continuous days. There is a deductible for each benefit period. In addition, the individual must pay a coinsurance amount for days 61 through 90. After exhausting 90 days of coverage, Medicare will pay for an additional 60 days of care in that person’s lifetime. However, the insured may have to pay a coinsurance amount during these final 60 days of care.

Medicare Part B
Medicare Part B changes annually. However, it basically covers most reasonable and necessary medical services with little benefit in the long term care areas. An individual can receive this coverage once he turns 65, but he must pay a monthly premium. If he waits to enroll in Part B until after age 65, the monthly premium may be higher, since Medicare imposes a 10 percent premium penalty for every year that enrollment is delayed. However, if an individual is working and is covered under his employer’s group health plan, he may delay enrolling without a penalty until seven months after retirement. This enrollment period is a seven-month period beginning on the first day of the third month before the month he attains age 65. For example, if the person’s 65th birthday is April 10, 2001, the initial enrollment period begins January 1, 2001 and ends July 31, 2001

If a person decides not to enroll in the initial enrollment period, he may enroll during a special enrollment period beginning with the first day of the first month in which he is no longer enrolled in a group health plan by reason of employment, and the enrollment period ends months later.

Medicare sets approved charges for all of the medical services it covers. Medicare does not cover many common health expenses such as prescription drugs, routine checkups, vision and hearing care, custodial care, and dental care. It also does not cover experimental procedures. Medicare does cover biannual mammograms, tri-annual pap smears, or flu vaccines.

Under Medicare Part B, an individual must pay an annual deductible. Once the deductible has been met, Medicare generally will pay 80 percent of its approved charge for medical care. The following doctors’ fees and services are covered by this portion of Medicare:

- Doctors’ services are covered wherever furnished in the United States. This includes the cost of house calls, office visits, and doctors’ services in a hospital or other institution. It includes the fees of physicians, surgeons, pathologists, radiologists, anesthesiologists, and osteopaths.
- Services of clinical psychologists are covered if they would otherwise be covered when furnished by a physician.
• 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 is not included if performed more frequently than once every 60 days. Exceptions are authorized if medical necessity is documented by the billing physician.
• The cost of routine physicals, most vaccine shots, examinations for eyeglasses and hearing aids is not covered.
• The cost of diagnosis and treatment of eye and ear ailments is covered.
• Plastic surgery for purely cosmetic reasons is excluded. However, plastic surgery for repair of an accidental injury, an impaired limb, or a malformed part of the body is covered.
• Charges imposed by an immediate relative (for example, a doctor who is a son or daughter or brother or sister of the patient) are not 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.

Accepting Assignment
Some health care providers take assignment which means that they agree to accept Medicare's approved charge as payment in full. Medicare pays 80 percent of the approved charge, and the individual pays the remaining 20 percent. Local Medicare carriers have a directory which lists all doctors and suppliers in the area who take assignment. If an individual wants to limit the amount he pays for medical expenses, he can obtain a copy of this directory and use it when choosing a health care provider.

Even when doctors do not take assignment, federal law limits the amount that they may charge Medicare patients. This limit is 15 percent above Medicare's approved charge. Some states have stricter limits with respect to what doctors can charge Medicare patients.

Payment of Claims
A Patient’s Request for Medicare Payment form is used for submitting a supplementary medical insurance claim. This form must be submitted to the Medicare carrier in order for supplementary medical insurance to pay for covered services of doctors and suppliers. All Social Security offices and Medicare carriers and most doctors’ offices have copies of this form.

If a doctor or supplier participates in Medicare or uses the assignment method of payment, he submits the claim. If the doctor of supplier does not accept assignment, the patient submits the claim, using the Patient’s Request for Medicare Payment form. It doesn’t matter whether all bills are from one doctor or supplier or from a number of different doctors or suppliers. A patient can send in the bills either before or after he pays them.

The itemized bill must show the following:
• The place where the patient received the services
• A description of the services
• The charge for each service
• The doctor or supplier who provided the services
• The patient’s name and health insurance claim number

If the bill does not contain all of this information, payment may be delayed. It is also helpful if the nature of the patient’s illness, that is, the diagnosis, is shown on the bill. A patient submitting a claim for the rental or purchase of durable medical equipment should include the bill from the
supplier and the doctor’s prescription. The prescription must show the equipment needed, the medical reason for the need, and estimate how long the equipment will be medically necessary.

Before any supplementary medical insurance payment can be made, a person’s record must show that he has met a $75 deductible. Once a person has met the deductible, he should send in future bills for covered services as soon as he gets them so that Medicare payment can be made promptly. If all medical bills for the year amount to less than $75, supplementary medical insurance will not pay any part of that person’s bills for the year.

If the person filing a claim dies and payments are due, special rules apply for services covered under the supplementary medical insurance plan. Hospital insurance payments due will be paid directly to the hospital, skilled nursing facility, home health agency, or hospice that provided covered services. If the bill was paid by the patient or with funds from the patient’s estate, payment will be made either to the estate representative or to a surviving member of the patient’s immediate family. If someone other than the patient paid the bill, payment may be made to that person. If the bill has not been paid and the doctor or supplier does not accept assignment, the supplementary medical insurance payment can be made to the person who has the legal obligation to pay the bill for the deceased patient. This person can claim the supplementary medical insurance payment either before or after paying the bill.

The time limit for submitting a supplementary medical insurance plan claim is 15 months. For example, for services received between October 1, 1999 and September 30, 2000, a claim must be submitted by December 31, 2001. If a person disagrees with a decision on the amount Medicare will pay on a claim or whether services received are covered by Medicare, he has the right to ask for a review of the decision. The notice from Medicare advising a person of the payment decision also tells him about his right of appeal and how to request it.

If a person needs more information about his right to appeal, he should contact his local Social Security office, the Medicare intermediary or carrier, or the Peer Review Organization (PRO) in his state. Peer Review Organizations assign committees to conduct reviews involving Medicare and its decisions.

A supplementary medical insurance claim may be appealed by the patient, the doctor, or the supplier who submits the claim. Medicare will notify the claimant of the decision made on the claim. If the person disputes the decision, he can ask the Medicare carrier for a review of the claim. If the claim is still disputed and if the amount in dispute is $100 or more, a hearing can be requested. Appeals can eventually be appealed to a federal court.

**Medicare’s Prospective Payment System & DRG**
Under Medicare’s Prospective Payment System, first effective in 1983, and updated by the Benefits Improvement and Protection Act of 2000 (BIPA 2000), Medicare hospital payments are based on the patient’s diagnosis at the time of admission to the hospital. The costs incurred after admissions are not relevant.

An incoming hospital patient is assigned to a diagnosis-related group (DRG). The hospital’s payment from Medicare is the flat amount that Medicare establishes for the DRG. DRGs are based upon a system which starts with all of the possible diagnoses listed in the International Classification of Diseases, then classified into 23 major diagnostic categories, and finally divided into 477 distinct groups. If the patient stays in the hospital for 8 days but the relevant DRG says that 4 days is the standard stay for the patient’s disease, then Medicare pays for only 4 days. On the other hand, if the hospital treats and releases in 2 days, the hospital still gets paid for 4 days.
Of course, hospitals maintain that they care for a patient as long as it is medically necessary to do so, regardless of the Medicare DRG. But the DRG system clearly gives hospitals an incentive to curtail care in the following ways:

- Early discharge of patients
- Refusal to admit Medicare patients who’s treatment and stay will probably exceed the average

Medicare does attempt to monitor quality care and access by entering into contracts with peer review organizations (PROs) in each state. These groups investigate and review hospital admission and length of stay practices. Patients who are denied admission have an option to appeal.

**Medicare & Long-Term Care**
Medicare is inextricably connected to long-term care by virtue of the fact that changes in the Medicare system of payments has lead to a boom in long-term care services. In essence, Medicare has promoted a system that gives hospitals an incentive to move patients out quickly, sometimes without regard to the patient’s actual condition or need for continuing care. The Mayo Clinic coined this practice as the “quicker and sicker” release of patients.

Because hospitals release patients quicker and sicker, there has been a 40% increase in nursing home admissions since the start of the PPS and DRG payment system described above. The bigger problem is that when patients are released from the hospital to the nursing home, only 2% meet the criteria for payment of their nursing home stay from Medicare. It should be obvious to agents that this information is essential to the health care planning of their clients and the pending need for long-term care coverage.

**Medicare Patients Bill of Rights**
Medicare recipients have their own Patients Bill of Rights. The issues involved in these rights are many of the same issues dealt with in the Patients Bill of Rights that Congress has considered for managed care members outside of Medicare. The rights are as follows, as listed in the *Medicare & You 2000 Handbook*, published by the Health Care Financing Administration:

*If you have Medicare, you have certain guaranteed rights. You have them whether you are in the Original Medicare Plan or a Medicare managed care plan.*

*You have the right to get emergency care when and where you need it, without prior approval. If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.*

*You have the right to appeal if Medicare does not pay for a covered service you have been given, or if your doctor or hospital does not give you a service that you believe should be covered.*

*You have the right to know all your treatment options from your health care provider in language that is clear to you. Medicare must give you information about what is covered and how much you have to pay. Medicare managed care plans cannot have rules that stop a doctor from telling you everything you need to know about your health care, including treatment options.*

*You have the right to have any personal information that Medicare collects kept private. Medicare may collect information about you as part of its regular business, such as*
paying your bills. The law requires Medicare to keep this information private. When Medicare asks for this kind of information, we must tell you that the law lets us collect it for payment and health treatment purposes. You have the right to know why we need it, whether it is required or optional, what happens if you don't give the information, and how it will be used.

You have a right to choose a women’s health specialist from your plan's list of doctors to meet your women's health care needs.

If you have a complex or serious medical condition, you have a right to have enough visits to a specialist to deal with your needs.

You have a right to know how your plan pays its doctors. If you want to know how your plan pays its doctors, the plan must tell you in writing. You also have the right to know whether your doctor owns all or part of a health care facility. For example, a lab that he or she refers you to for a blood test.

If you have concerns or problems with your plan which are not about payment or service requests, you have a right to file a grievance. A grievance is a type of complaint. For example, if you believe your plan's hours of operation should be different, you can file a grievance. If you believe you are not getting a high quality of care, you may either file a grievance with your plan or with the Peer Review Organization (PRO) in your State.

You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare Plan or a Medicare managed care plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal. If you are in the Original Medicare Plan, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from a company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.

If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours.

The Medicare managed care plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. See your plan’s membership materials or contact your plan for details about your Medicare appeal rights.

**Medicare Supplement Insurance**

There are many gaps in coverage left by Medicare such as limited benefit periods, deductibles, coinsurance and exclusions that can be filled with a private Medicare supplement policy . . . sometimes called **Medigap Coverage**.

There is a common misconception that supplemental health care insurance policies (known as Medigap insurance policies) will cover long-term care. Supplemental policies cover no further than the primary insurance, in this case Medicare. The supplemental policies merely cover the deductibles and the co-payments of covered Medicare expenses.
Medigap Standard Policies

Before Medicare rules allowed recipients to enroll in Medicare managed care plans, they were limited to using Medigap insurance policies. Medigap insurance policies, as their name suggests, are designed to fill the gaps Medicare coverage leaves. These policies are designed to pay items such as Medicare coinsurance amounts and Medicare deductibles and to provide coverage for services not paid for by Medicare. Some Medigap policies will pay for the amount charged for services above the Medicare-approved amount. Medigap insurance policies vary in the scope of coverage they provide. Premiums for Medigap insurance are generally more expensive than premiums required for Medicare managed care plans, and the broader the coverage the Medigap policy provides, the more expensive the premium.

OBRA Medigap Legislation

The Omnibus Budget Reform Act of 1990 (OBRA ‘90) included legislation to prohibit the practice of any insurer from offering any policy that duplicates Medicare coverage. This practice was prohibited because it resulted in the insured paying premiums to the insurer for coverage he or she would receive through Medicare.

OBRA 1990 also changed the structure under which commissions are paid on Medigap policies. First year commissions on Medigap policies may not be greater than twice the second year’s commissions, and the second through fifty year commission must be equal. States may also have additional regulations regarding Medigap policy commissions. If a Medicare recipient is enrolled in a Medicare managed care plan, the recipient may keep any Medigap policy he or she has. The Medigap policy only applies when a recipient is on the original Medicare plan.

There are ten standard Medigap policy types. The federal government, in cooperation with the states, required these ten plans in part to assist consumers from being confused by too many plan options. Insurers offering the standard plans are required to use the same language, format and definitions in Medigap insurance policies. A standardized chart and outline of coverage is also required for all Medigap providers.

Policies issued to residents of Minnesota, Massachusetts and Wisconsin are exempt from the requirements of the standardized plans. These states had Medigap plans in place prior to the passing of federal regulations that the regulators determined did not have to change. The ten basic Medigap policies are identified as plans A to J. The dollar figures noted in the following plan descriptions are subject to change.

Medigap Plan A – Basic Policy

The benefits under the Medigap Basic Policy include:

- Coverage for the Part A coinsurance amount for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount for each of Medicare’s 60 non-renewable lifetime hospital inpatient reserve days used.
- Coverage for 100% of Medicare Part A eligible hospital expenses after all Medicare hospital benefits are exhausted. The coverage limit is a maximum of 365 days of additional inpatient hospital care during the policyholder’s lifetime. The benefit is paid at the rate Medicare pays hospitals under the Prospective Payment System (PPS), or under another appropriate standard of payment for hospitals not subject to the PPS.
- Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services after the $100 annual deductible is met.
Medigap Plan B
Plan B includes the same benefits as Plan A, plus coverage for the Medicare Part A inpatient hospital deductible.

Medigap Plan C
Plan C includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- Coverage for the Medicare Part B deductible.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Medigap Plan D
Plan D includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living for those recovering from an illness, injury or surgery.

Medigap Plan E
Plan E includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- Coverage for the Medicare Part B excess charges. The plan pays a specified percentage of the difference between the Medicare-approved amount for Part B services and the actual charges, up to an amount of charges limited either by state regulation or by Medicare.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible. This benefit has a $50,000 lifetime maximum.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1600 per year for short-term, at-home assistance with activities of daily living.

Medigap Plan F
Plan F includes the same benefits as Plan A, plus:

- Coverage for the Medicare Part A inpatient hospital deductible.
- Coverage for the skilled nursing facility care coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges (as explained under Plan E).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for services such as a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test.
• Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living for those recovering from an illness, injury or surgery.
• Coverage for an extended drug benefit. This provision pays 50% of the cost of prescription drugs up to a maximum annual benefit of $3,000 after the policyholder meets a $250 per year deductible.
• A future high deductible option.

**Medigap Plan G**

Plan G includes the same benefits as Plan A, plus:

• Coverage for the Medicare Part A inpatient hospital deductible.
• Coverage for the skilled nursing facility care coinsurance amount.
• Coverage for 80% of Medicare Part B excess charges.
• 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
• Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living for those recovering from an illness, injury or surgery.

**Medigap Plan H**

Plan H includes the same benefits as Plan A, plus:

• Coverage for the Medicare Part A inpatient hospital deductible.
• Coverage for the skilled nursing facility care coinsurance amount.
• Coverage for the Medicare Part B deductible.
• 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
• Coverage for an extended drug benefit. This provision pays 50% of the cost of prescription drugs up to a maximum annual benefit of $3,000 after the policyholder meets a $250 per year deductible.

**Medigap Plan I**

Plan I includes the same benefits as Plan A, plus:

• Coverage for the Medicare Part A inpatient hospital deductible.
• Coverage for the skilled nursing facility care coinsurance amount.
• Coverage for the Medicare Part B deductible.
• 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
• Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for services such as a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test.

**Medigap Plan J**

Plan J includes the same benefits as Plan A, plus:

• Coverage for the Medicare Part A inpatient hospital deductible.
• Coverage for the skilled nursing facility care coinsurance amount.
• Coverage for the Medicare Part B deductible.
• 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
• Coverage for 100% of Medicare Plan B excess charges.
• A future high deductible option.

An insurer may offer benefits in addition to a standardized plan. Federal law allows an insurer to add “new and innovative benefits” to Medigap policies. Any such additional benefits must be cost-effective, not otherwise available in the marketplace, and offered in a manner that is consistent with the goal of simplifying Medigap insurance.

**Enrollment in Medigap Policies**

Any person who is age 65 or older and has enrolled in Medicare Part B has a right to buy a Medigap policy regardless of health. This open enrollment period lasts for six months from the date these two conditions are met. During open enrollment, the Medigap insurer cannot deny or condition the issuance or effectiveness, or discriminate in the pricing of a policy, because of the insured’s medical history, health status or claims experience. If an insured enrolls in a Medigap policy outside of this open enrollment period, however, the insurer can apply any pre-existing condition restrictions that are normally part of the policy.

Beginning July 1, 1998, Medigap policies cannot apply pre-existing condition provisions to anyone who is age 65 or over and has had Medigap or qualified employer health insurance continuously for at least six months.

**Medigap Policies and Health Care Continuation**

In most states, if a person is 65 or older and if his or her health insurance is discontinued under one of the circumstances below, the person is guaranteed the ability to buy a Medigap policy.

The conditions under which this guarantee applies include any of the following situations:

• The insured was enrolled in an employer group health plan with benefits that supplement Medicare benefits and the plan stopped providing those benefits.
• The insured was enrolled in a Medicare Health Maintenance Organization, Health Care Prepayment Plan, or Medicare SELECT policy and the insured’s enrollment ended due to the insured moving outside of the plan’s service area, or because the plan’s contract with Medicare ended, or because the insured elected to leave the plan.
• The insured enrolled in a Medigap policy and coverage stopped because of the insolvency of the company, because of other involuntary termination of coverage (and there is no State law for continuing that coverage), or the company violated or misrepresented a provision of the policy.

If one of these situations apply and the insured applies for the new policy within 63 days of losing health coverage, the insured is guaranteed to be able to buy a new Medicare supplemental policy if:

• the insured was enrolled in Medicare, or
• if the insured had a Medigap policy and dropped it to enroll in a Medicare managed care or Medicare SELECT policy for the first time, or
• if the insured chose to disenroll from the Medicare HMO or Medicare SELECT policy within 12 months of first enrolling.
Under this guarantee, an insurer may sell the insured Medigap Plan A, B, C or F. All Medigap providers sell Plan A, and those who normally sell plans B, C or F must offer these plans to persons to whom this guarantee is applicable.

Medigap and Long Term Care
As we have discussed, the most aggressive Medigap plans extend coverage to “at-home recovery” (short term assistance with activities of daily living) and skilled care may provide for items like IV’s, bedsore care and physical therapy. But, once health progress stops, the condition is termed chronic and no longer covered. That is why someone like an Alzheimer’s patient is considered under these plans to need little or no skilled care. He is not covered by Medicare or a supplement plan yet cognitive impairment may limit his abilities to perform simple activities such as bathing or eating. Patients like this move through the evolution process . . . from acute to chronic conditions leading to the need for nursing home care or advanced home health assistance. The Health Care Administration estimates that Medicare and private insurance like Medicare supplement plans provide only 12 percent of the nation’s total long term care expenses.

Medicare SELECT Policies
Medicare SELECT policies are very similar to the standard Medigap policies. The important difference between SELECT policies and Medigap policies is that the insurer offering the plan requires that the insured must use specific hospitals, and in some cases, specific doctors, in order to be covered by the insurance. Emergency services are generally exempted from this requirement under these policies. Because SELECT policies use preferred providers the insurance premiums are normally lower than comparable Medigap policies.

The Medicare+Choice MSA
The Budget Act of 1997 introduced the Medicare+Choice MSA. The Medicare+Choice MSA, or Medicare MSA, allows a Medicare recipient to instruct the Secretary of Health and Human Services to make contributions to a Medicare MSA. Distributions from the Medicare MSA are used to pay qualified medical expenses rather than having Medicare pay these expenses. If distributions are used for this purpose, the distributions are tax-free. The Medicare MSA became available in 1999. Like other MSAs, the Medicare MSA can be used in conjunction with managed care plans.

The reason Congress created the Medicare+Choice MSA is to decrease the costs of the Medicare program, or at least to slow down the increases in Medicare spending. If individuals are made responsible for their own health expenditures, and if they are given a tax incentive to keep medical expenditures down, Congress reasoned, the growth of Medicare spending will be “tempered.” Besides the issue of expenses, Medicare+Choice MSAs give senior citizens more choice regarding their health care.

Eligibility and Contribution Rules of the Medicare MSA

Eligibility
Individuals on Medicare are eligible for the Medicare MSA. Generally, this includes individuals who are 65 or older, those who are permanently and totally disabled, and certain individuals with specific diseases that Medicare covers.

Contributions
Contributions to Medicare MSAs are made by the Secretary of Health and Human Services. The Secretary pays for a high-deductible insurance policy, and also makes a contribution to the Medicare MSA for the eligible individual. When the Medicare MSA laws were passed, it was
estimated that the contribution to a Medicare MSA would be between $1500 to $2100 per year. Contributions are not includible in the income of the Medicare MSA holder.

**Medicare MSA High-Deductible Insurance Policy Requirements**
Under Medicare MSA rules, the high-deductible insurance policy must provide reimbursement for services covered by Medicare Parts A and B, after a deductible of not more than $2,250 and not less than $1,500, in 1999. These levels are indexed for inflation after 1999. The individual Medicare MSA holder chooses the high-deductible plan that will be used in conjunction with the Medicare MSA. The Medicare MSA plan must also include a cap of $3000 in out-of-pocket expenses.

**Medicare MSA Trustee**
The trustee of a Medicare MSA can be a bank, insurance company or other entity which will administer the MSA in accordance with Medicare MSA rules.

**Medicare MSA Investments**
Medicare MSAs may not be invested in life insurance.

**Excess Contributions**
Like other MSAs and IRAs, if an excess contribution is made to a Medicare MSA, an excise tax of 6% is due on the excess contribution.

**Distribution Rules Of Medicare MSAs**
If distributions of Medicare MSAs are used for qualified medical expenses, the distribution is not taxable. The definition of qualified medical expenses for a Medicare MSA is the same as that for other MSAs, except that qualified medical expenses do not include payment of medical expenses for anyone except the individual MSA holder. Medical expenses of a spouse or dependent are not qualified medical expenses under Medicare+Choice MSA rules.

**Additional Tax on Distributions**
Any distribution which is not for a qualified medical expense is subject to an additional tax of 50% on the excess of:

- The amount of the payment or distribution, over
- The excess (if any) of:
  1. The fair market value of the assets in such MSA as of the close of the calendar year preceding the calendar year in which the taxable year begins, over
  2. An amount equal to 60 percent of the deductible under the Medicare+Choice MSA plan covering the account holder as of January 1 of the calendar year in which the taxable year begins.

The exceptions to this tax are distributions that are due to death or due to disability. The 15% additional tax that applies to non-qualified medical expense distributions of regular MSAs does not apply to Medicare MSAs.

**Distributions Due to Death**

**Spousal Beneficiary**
If a spousal beneficiary is named on a Medicare MSA, the surviving spouse is treated as the Medicare MSA holder.
Non-Spousal Beneficiary
If a non-spousal beneficiary is named on a Medicare MSA, the MSA ends upon the death of the Medicare MSA holder. The value of the Medicare MSA is includible in the gross income of the beneficiary in the year of death of the MSA holder. If no beneficiary is named, the value of the Medicare MSA is includible in the gross income of the deceased when the final tax return is calculated.

Distributions Due to Divorce
The same rules applied to regular MSAs regarding distributions due to divorce apply to Medicare MSAs. Distributions from an MSA under a divorce decree or separation agreement are not taxable. The recipient is treated as an MSA account holder, and the distribution will continue to be treated as an MSA.

Trustee-to-Trustee Transfers
A trustee-to-trustee transfer from one Medicare MSA to another for the same account holder is not considered a taxable transaction. A trustee-to-trustee transfer is a distribution that is made directly from the trustee or administrator of an MSA account to another trustee or administrator of an MSA account.

Senior HMO’s
In lieu of Medicare and a Medicare supplement policy, a popular choice is the managed care plans which are often called HMO’s or Coordinated Care Plans. Most of these plans collect a fixed monthly payment from the government, regardless of the patient’s health, and must promise to cover all patient needs that would have been paid under Medicare. To contain costs, many of these groups contract with specific health care providers and clinics to offer Medicare services. In some cases, manage care groups provide a bit more than Medicare or supplement plans as an incentive to switch. Unlimited prescriptions drugs and some respite care are a couple of examples that have been used to attract Medicare enrollees. Currently, about 15 percent of the people eligible for Medicare choose managed care plans. Congress is happy about this because the government’s monthly commitment is fixed and these private concerns are far better at cost containment than Medicare.

The concept of senior managed care is being tested in some our country on a grand scale. The primary advantage to this type of system is that it is a prepaid health care plan that promotes wellness and preventative medicine.

The predicted effects of managed care tend to offset the advantages of a more traditional comprehensive health care program. Under a managed care program, doctors are salaried, and their earnings are not affected by quantity of care. Therefore, there is no incentive to overtreat patients. As a result, waste and unneeded services are minimized. The purpose of managed care is to promote cost effectiveness of medical services.

It must be emphasized that while senior HMO’s offer a few more frills than Medicare, they do not cover long term care. Services such as nursing homes and home health care are excluded for chronic conditions.

New Medicare HMO Rules
Sweeping cost containment measures in the Senior HMO industry are changing certain rules and benefits. The Medicare HMOs say problems have resulted from soaring drug and medical costs that outstripped payment increases from the Medicare program. Some are leaving the Medicare field completely, while others are imposing stiff limits on prescription drugs and other benefits while charging higher out-of-pocket fees for things such as hospital care, kidney dialysis and cancer drugs. For the first time, many Senior HMOs will also be charging monthly
premium fees, higher office visit charges and restricting prescriptions to generic drugs. Other changes have to do with a senior’s ability to move from and between HMO plans. Beginning in the year 2000, those within Medicare managed care plans may withdraw from the plan at any time for any reason. If recipient does leave the plan, he or she is automatically returned to the original Medicare Plan. In the year 2002, more restrictions will be in effect regarding when a recipient may leave a plan.

Effective January 1, 2002, seniors can leave their Medicare HMO and join another only one time each year during the month of November. The plan to which they switch must be accepting new members at time of the switch.

Exceptions to this rule allow changes if:

- The health plan leaves Medicare
- The senior moves out of the plan’s service area
- Medicare makes a special exception

**Medicare Managed Care Plan Benefits**

The plan must provide or arrange for, at a minimum, all medically necessary services (except hospice services) that are covered under Parts A and B. These services include, but are not limited to:

- Inpatient hospital care for up to 90 days in each benefit period, plus any lifetime reserve days available out of 60 total lifetime reserve days. (There is a 190 day lifetime limit for care in a Medicare certified psychiatric hospital);
- Inpatient care in a skilled nursing facility for up to 100 days of post-hospital care for each benefit period;
- Physician services and services incident to their services, including first and second surgical opinion in the plan, manual manipulation of the spine to correct subluxation demonstrated by physician-read x-ray, and non-routine podiatric services (e.g., plantar warts and mycotic toenails);
- Outpatient physical therapy, occupational therapy, and speech pathology services;
- Ambulatory surgical center services;
- Outpatient hospital services;
- Comprehensive outpatient rehabilitation facility services;
- Home health services;
- Diagnostic laboratory, x-ray and other diagnostic tests, including portable x-rays used in the home;
- The following drugs and biologicals:
  - Blood;
  - Hemophilia clotting factors;
  - Antigens;
  - Pneumococcal vaccine;
  - Hepatitis b vaccine for persons at high or intermediate risk of contracting the disease;
  - Drugs used in immunosuppressive therapy for one year beginning with the date of discharge from the inpatient hospital stay during which a Medicare-covered organ transplant is performed;
  - Effective June 1989, erythropoietin for dialysis patients who meet the medical criteria, administered either in the dialysis facility, or incident to the professional services of a physician, or, effective July 1991, self-administered by home dialysis patients; and
  - Injectable drugs for treatment of osteoporosis if the patient is homebound and cannot self-administer the drug (as certified by a physician;
• Surgical dressings, splints, casts;
• Braces, and artificial limbs and eyes;
• Prosthetic devices;
• Durable medical equipment;
• X-ray, radium and radioactive isotope therapy;
• Ambulance services when transportation by other means is contraindicated by the individual's condition;
• Treatment of end stage renal disease;
• Outpatient treatment of mental illness;
• Outpatient physical therapy and speech pathology services; and
• Screening mammography and pap smears according to a schedule based on age and risk of developing breast or cervical cancer.

Medicare also covers services in the following settings:

• Rural health clinics;
• Comprehensive outpatient rehabilitation facilities;
• Ambulatory surgical centers, but only for those service that appear on the list of covered procedures; and
• Federally qualified health centers

Normal Medicare coverage and/or payment rules may not apply in these special settings.

Medicare covers the services of the following non-physician practitioners):

• Clinical psychologists;
• Clinical social workers;
• Physician assistants;
• Nurse practitioners;
• Clinical nurse specialists;
• Nurse midwives; and
• Certified registered nurse anesthetists.

Transplants
The managed care plan is required to cover organ and tissue transplants that the Secretary determines are not experimental. Required transplants include:

• Kidney;
• Heart;
• Liver;
• Bone marrow; and
• Cornea.

The managed care plan is required to provide or arrange for certain transplants in out-of-area hospitals. Heart and liver transplants may only be performed in Medicare approved transplant centers. Not all hospitals performing transplants are Medicare approved transplant centers, even if they are participating hospitals for other services. If one of the managed care plan's Medicare enrollees is a candidate for heart or liver transplant surgery, the plan must give him or her written notification that the procedure is a covered Medicare service and that it is performed in facilities specially approved by Medicare. The transplant facility makes the determination as to whether the enrollee meets the patient selection criteria.
The managed care plan must refer enrollees who are appropriate candidates only to Medicare approved heart or liver transplant facilities for evaluation. The facility determines whether to perform the transplant. Failure to refer appropriate candidates to, or to provide or arrange for the service in, a Medicare approved heart or liver transplant center is subject to a civil money penalty of up to $25,000 for each violation.

As benefits become covered, in some cases, they must be made available to Medicare enrollees on the effective date of Medicare coverage.

**Medically Necessary Emergency Care**
The plan must assure that medically necessary emergency care is available 24 hours a day, 7 days a week. Beneficiaries are not required to receive emergency services at the managed care plan facilities nor are they required to secure prior approval for emergency services provided inside or outside the managed care plan’s geographic area. The plan must provide a system to pay claims for emergency services provided out-of-plan and pay for all emergency services provided out-of-plan.

Under Medicare managed care rules, *emergency services* mean covered inpatient and outpatient services that are:

- Furnished by an appropriate source other than the organization;
- Needed immediately because of an injury or sudden illness; and
- Needed because the time required to reach the organization's providers or suppliers (or alternatives authorized by the organization) would have meant risk of permanent damage to the patient's health. Such services must be, or appear to be, needed immediately.

Medicare plan rules do not allow a managed care plan to deny care on an emergency-care basis if the symptoms appeared to be such that immediate medical attention was necessary. The following examples are from Section 2104 of the *Health Maintenance Organization/Competitive Medical Plan (HMO/CMP) Manual* published by the HCFA:

*Example: while visiting her son, a 70 year old woman with a history of cardiac arrhythmias experiences a rapid onset of chest pain, nonproductive hacky cough, and generalized tired feeling. The son - calls his own physician, who recommends he bring his mother in to see him right away. After the physician evaluates the patient, the physician diagnosis is a common cold, and he prescribes two over-the-counter medications for treatment.*

*In this case, the HMO/competitive medical plan is required to pay for the physician's services because the enrollee's medical condition appeared to require immediate medical services. There does not need to be a threat to a patient's life. An emergency is determined at the time a service is delivered. Do not require prior authorization. The plan may request notification within 48 hours of an emergency admission or as soon thereafter as medically reasonable. However, payment may not be denied if notification is not received.*

*If it is clearly a case of routine illness where the patient's medical condition never was, or never appeared to be, an emergency as defined above, then the managed care plan is not responsible for payment of claims for the services. Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature.*

*All procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered. An example is a member who is treated in an emergency room for chest pain and the attending physician orders diagnostic pulmonary*
angiography as part of the evaluation. Upon retrospective review, the plan cannot decide that the angiography was unnecessary and refuse to cover this service.

If during treatment for an emergency situation, the enrollee receives care for an unrelated problem, the managed care plan is not responsible for the care provided for this unrelated non-emergency problem. An example is a member who is treated for a fracture and the attending physician also treats a skin lesion. The managed care plan is not responsible for any costs, such as a biopsy, associated with treatment of this unrelated non-emergency care.

After the emergency, the plan must also pay the cost of medically necessary follow-up care.

**Transfers**

If one of the managed care plan’s Medicare enrollees receives emergency medical care in a non-plan hospital, the plan may wish to transfer the patient to the managed care plan’s facility (or a facility that the plan designates) as soon as possible. The plan must pay the transfer costs, such as an ambulance charge, if transfer costs are necessary.

Under the Act, the hospital must first determine whether the patient’s condition has stabilized within the meaning of the statute. In general, this means that within reasonable medical probability, no material deterioration of the condition is likely to result from, or occur during, the transfer.

If the patient’s condition has not stabilized, the patient may only be transferred if the patient makes an informed, written request for transfer, or the attending physician or appropriate medical authority signs a certification that the risks of the transfer are outweighed by the medical benefits expected from transfer to another medical facility. If these conditions are met, then the transfer may be made, but only if it also meets the definition of an appropriate transfer.

In general terms, an appropriate transfer is one in which:

- The transferring hospital: Provides medical treatment to minimize the risks to the individual; forwards all relevant medical records, and uses qualified personnel and transportation equipment for the transfer;
- The receiving facility: Has available space and qualified personnel, and except for specialized facilities that under the Act cannot refuse a transfer, agrees to accept the transfer and provide appropriate medical treatment; and
- The transfer meets any other requirements the secretary may find necessary in the interest of health and safety of individuals.

If the transferring hospital fails to meet these requirements, it may lose its Medicare provider agreement or be subject to civil money penalties or a civil action for damages. Physicians involved in an improper transfer may also be subject to civil money penalties and may be excluded from participation in Medicare.

If there is a disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding on the HMO or competitive medical plan.

**Urgently Needed Services**

Urgently needed services are Medicare covered services required in order to prevent a serious deterioration of an enrollee’s health that results from an unforeseen illness or an injury. The plan must cover these services if:
• The enrollee is temporarily absent from the managed care plan’s geographic area, and
• The receipt of health care services cannot be delayed until the enrollee returns to the managed care plan’s geographic area. The enrollee is not required to return to the service area because of the urgently needed services.

Urgently needed care pertains only to out-of-area care to treat an unforeseen condition. Prior authorization is not needed in seeking urgently needed services. The managed care plan’s marketing materials must clearly describe the concept of urgently needed services as well as include an explanation of the enrollee’s rights in these situations.

The following examples are from Section 2105 of the Health Maintenance Organization / Competitive Medical Plan (HMO/CMP) Manual and are regarding the plan’s responsibilities related to urgently needed care:

Example: a 72 year old man had a left femoral bypass graft 6 weeks ago. He goes on his previously scheduled vacation to his sister’s house who lives out of the service area. While there, he begins to notice left leg numbness that is occurring with greater frequency and intensity and is not totally relieved by his medications. His sister takes him to see her physician.

The plan must pay for the physician’s services because the enrollee’s medical condition appeared to be such that the provision of medical services could not be delayed until the enrollee returned to the managed care plan’s service area.

Services that can be foreseen are not considered urgently needed services, and the managed care plan is not required to pay for these services without prior authorization.

For example, the managed care plan is not required to pay without prior authorization when a member who needs routine dialysis or oxygen therapy travels outside the managed care plan’s service area for a personal emergency or a vacation. The plan must develop a clear policy regarding the plan’s responsibility and the beneficiary’s financial responsibility in these situations. The plan should consider making special arrangements with providers outside the managed care plan’s service area or clearly discussing any restrictions on out-of-area coverage with Medicare beneficiaries at the time of application. Marketing materials must clearly describe the limits of the plan’s out-of-area coverage.

The plan must assume responsibility for urgently needed services without regard to the length of absence from the geographic area, as long as the enrollee maintains membership in the managed care plan’s plan. However, if the enrollee is absent for an extended period (beyond 90 consecutive days) and the managed care plan has not been notified and have not arranged for membership to continue, the plan may assume that the move is a permanent move and begin procedures to disenroll the beneficiary. If the managed care plan does not disenroll the beneficiary and the plan knows that he/she is absent for more than 90 consecutive days, then the managed care plan is liable for all services rendered, including routine care. (see “2001ff.)

Cover medically necessary follow-up care to emergency and urgent care situations if that care cannot be delayed without adverse medical effects.

The managed care plan is financially responsible for services that it denies or fails to furnish that are found, upon appeal, to be services that should have been furnished.

**Beneficiary Coinsurance Amount**
If the managed care plan is a risk HMO or competitive medical plan, the sum of the managed care plan’s charges for copayments, coinsurance, or deductibles may not exceed, on the
average, the national actuarial value of the coinsurance and deductible amounts the beneficiary would have paid had he or she not been enrolled in a Medicare contracting plan.

While the plan may negotiate lower payment amounts with providers and suppliers, it is ultimately the managed care plan's responsibility to assume full financial responsibility for the services. The plan must assure that the beneficiary has no liability beyond any approved copayments.

Similarly, if the plan is determined, upon appeal, to be liable for services that a beneficiary obtained without authorization because the plan improperly denied coverage, the beneficiary does not have liability for any balance billing from the provider of such services. In this instance also, the managed care plan is liable for paying the full charges or paying whatever amount the plan can negotiate with the provider as payment in full. The beneficiary is only liable to the plan for copayments or other beneficiary liability amounts approved as part of the managed care plan's Medicare contract.

**Supplemental Benefits Subject to Premium**
The plan may also offer supplemental benefits that are beyond the scope of Medicare coverage. Enrollees may be charged an additional premium over and above the amounts which may be charged to cover Medicare deductible and coinsurance amounts. The amounts charged to cover supplemental services must be separately identified and may not exceed certain maximum amounts.

**Prohibition on Health Screening**
Except as provided below, the plan may not require a Medicare enrollee, as part of enrollment, reenrollment or receipt of any services, to submit to or pass a health examination. This prohibition on health screening applies to any service or set of services offered to Medicare enrollees, whether they are required services under Medicare, additional services, or mandatory or optional supplemental services. There are penalties specified in the law for violations of the health screening prohibitions.

**Exceptions**
The plan may not enroll persons who have been medically determined to have end stage renal disease or who have elected the Medicare hospice benefit (unless they are already enrolled in the organization and convert to the Medicare contract when they become Medicare eligible, in which case the plan may not disenroll them).

**Services Authorized by a Plan Physician**
The plan must ensure that physicians or providers know whether services are covered by Medicare or by the managed care plan as an additional or supplemental benefit, and that they properly use the authorization system that is established. If a Medicare beneficiary receives services under the direction or authorization of a **plan physician**, who is any physician who contracts with an HMO or competitive medical plan or is otherwise associated with the HMO or competitive medical plan, and the beneficiary has not been informed that he or she is liable for the costs of such services, then the plan must pay for such services. The plan may not, after the service is received, overturn a plan physician's decision that a service is medically reasonable and necessary. The plan may not deny coverage retroactively for a service ordered by a plan physician based upon a determination that the service exceeds Medicare limits, e.g., that it was a custodial rather than a skilled nursing service.

The only exceptions to these instruction are (1) the presence of written evidence (including clear specification of non-coverage in marketing material) that the HMO physician advises the beneficiary before each and every service is received that the service is not covered unless
further action is taken by the member and (2) cases where the beneficiary should be expected to know the services were not covered by Medicare, e.g., for acupuncture. The plan may require the Medicare enrollee to receive prior authorization from a primary care physician or a gatekeeper before specialty care is received.

If one of the plan’s physicians provides or directs a beneficiary to receive a covered Medicare service without following the managed care plan’s internal procedures, the plan must pay for the service. The plan may not penalize a beneficiary who has already received a service if the authorizing physician’s referral was improper or the specialist delivered the service without the necessary authorization.

**Availability, Accessibility And Continuity Of Services**

All medically necessary Medicare covered services, supplemental services, and additional benefits must be available and accessible with reasonable promptness to Medicare members.

The provider networks for Medicare enrollees must be sufficient to deliver inpatient and outpatient primary and specialty services to current and expected Medicare members in the managed care plan or to make appropriate referrals. If the plan loses providers in a portion of the service area during the contract year, the plan must still assure the provision of covered services.

The provider networks for Medicare enrollees must be from the same networks that the plan uses for commercial members. However, the Medicare network may be a subset of a larger commercial network as long as there are no Medicare only providers.

Marketing materials must clearly state providers or physicians currently available to Medicare members and those accepting new patients.

Services are generally considered accessible if they reflect usual practice and travel arrangements in the local area. Generally, this is within 30 minutes travel time from the Medicare beneficiary’s residence. Exceptions may be made if the usual travel patterns for medical care exceed 30 minutes.

Medically necessary emergency care must be available and accessible 24 hours a day, 7 days a week.

**Continuity Of Care**

*Continuity of care* refers to the continuous flow of care in a timely and appropriate manner. Continuity includes linkages between primary and specialty care, coordination among specialists, appropriate combinations of prescribed medications, coordinated use of ancillary services, appropriate discharge planning, and timely placement at different levels of care including hospital, skilled nursing and home health care. HCFA recommends that the plan develop a comprehensive treatment plan for the overall health maintenance and management of each Medicare beneficiary. The plan should include any treatment modalities that are employed to offset any illness and related medical conditions. The plan should also include treatment at the proper level of care and assure adequate follow-up for the health maintenance of each beneficiary.

The plan must also provide a basic system for continuity of care and case management. This may be established through reliance on a primary physician who serves as an enrollee's case coordinator. The plan must establish and maintain a record keeping system that includes health and medical information on each Medicare enrollee. The plan must also assure that the system is readily available to appropriate professionals.
Managed Care Plan Arrangements for Health Services
The managed care plan’s health care providers and suppliers must meet applicable Medicare regulations and be certified for participation in the Medicare program. The managed care plan’s arrangements with providers and suppliers must assure that health services are available and accessible to all of the managed care plan’s members and must promote continuity of health care. Also, the plan must assure that participating providers and suppliers follow the managed care plan’s programs and procedures. Typical contracts include provisions for:

- Participation by providers and suppliers in the HMO or competitive medical plan's quality assurance and utilization review programs,
- Medical coverage after office hours and during absences,
- Cooperation with peer review organizations for purposes of medical record review,
- Incentive or risk sharing arrangements,
- Types of services to be provided,
- Treatment for Medicare enrollees, and
- Adherence to the managed care plan’s medical policies.

Hospital And Nursing Facility Services
The plan or the managed care plan’s affiliated providers/suppliers must arrange or provide all hospital services except when:

- Emergencies occur outside the service area,
- Emergencies occur within the area that result in treatment at a non-affiliated hospital, or
- Urgently needed services occur out of the area.

The managed care plan is responsible for paying for services in these three situations.

The plan must furnish the required hospital services to Medicare enrollees through hospitals that meet conditions of Medicare participation. Criteria for hospital participation are:

- Compliance with federal laws and regulations relating to the health and safety of patients,
- State licensure, and
- Assurance that hospital personnel have credentials required by federal, state or local laws.

An HMO or competitive medical plan must also have arrangements for skilled nursing services. These services are provided through skilled nursing facilities that must meet conditions of Medicare participation.

Hospital Admitting Privileges
The managed care plan’s primary care physicians and specialists must have hospital admitting privileges to at least one of the hospitals with which the managed care plan has arrangements. Also, the hospitals in which the physicians are privileged must serve the area from which the physicians draw the managed care plan’s enrollees.

Professional Services
Medicare benefits provided by licensed health professionals, including physicians, must be provided or arranged through:

- Physicians or health professionals who are on the managed care plan’s staff,
- A medical group or groups,
- One or more individual practice associations (IPAs),
- Physicians or health professionals under direct service contracts with the plan, or
• Any combination of the above.

In order to provide services at the most efficient and cost effective level, the plan may enter into arrangements with other health professionals who are licensed, certified, or practice under an institutional license, or other authority consistent with state law. For example, if a health service provided by a physician may also be provided under applicable state law by a dentist, optometrist, chiropractor or other health care personnel, the plan may have these professionals provide this service. However, all providers and suppliers rendering services to Medicare enrollees must be Medicare certified.

For services performed by non-physicians, direct physician supervision of such services is required. The supervising physician or physicians must be available during office hours to perform medical rather than administrative services. In an HMO or competitive medical plan setting, the following practitioners are excepted from the physician supervision requirement under certain circumstances:

• Physician assistants,
• Nurse practitioners,
• Clinical psychologists,
• Certified nurse midwives,
• Clinical social workers, and
• Registered nurse anesthetists.

Availability and Accessibility of Services
The plan must assure that all Medicare covered services, supplemental services, and additional benefits that members have contracted for in the managed care plan’s geographic area are available and accessible. The managed care plan’s geographic area is the contract area, approved by HCFA, in which the plan provide or arrange for the provision of health services and in which the plan enroll Medicare members.

The plan must construct provider and supplier networks or make arrangements for referrals for Medicare enrollees sufficient to deliver inpatient and outpatient primary and specialty services to current and expected Medicare members in the managed care plan. Marketing materials and other member information must include a description of the managed care plan’s participating providers and suppliers as well as the managed care plan’s contract area.

Services must be available and accessible with reasonable promptness with respect to geographic location, hours of operation, and provision for after hours care. Providers and suppliers must be located throughout the geographic area.

Services are generally considered accessible if they reflect usual practice and travel arrangements in the local area. Generally hospital and primary care physician services must be within 30 minutes travel time for members. This guideline does not apply if usual travel patterns in a service area for hospital and primary care physician services exceed 30 minutes. For example, travel time might be greater than 30 minutes in a rural area.

The provider and supplier networks for Medicare enrollees must be the same that the plan uses for commercial members. However, the Medicare network may be a subset of a larger commercial network as long as there are no Medicare only providers and suppliers. This does not restrict some providers and suppliers from treating only Medicare enrollees as the result of non-Medicare enrollees not choosing certain providers and suppliers, location in a senior center, or the nature of a supplier's practice (e.g., gerontologists).
If the plan loses physicians in a portion of the service area during the contract year, the managed care plan is still responsible for assuring the provision of covered services. The plan must inform members, in writing, 30 days before a physician or supplier terminates affiliation.

Some physicians and other providers in the managed care plan’s network may go through periods of time when they are not accepting new patients. The plan must state in the managed care plan’s marketing materials which physicians and providers are not accepting new patients. These materials must be updated annually or more frequently as changes in the managed care plan’s provider and supplier network take place.

Generally, if a Medicare certified facility such as a skilled nursing facility is not available in the managed care plan’s area, the managed care plan is still responsible for providing Medicare-covered services.

If a provider (i.e. Hospital, skilled nursing facility or other entity having a Medicare provider agreement under the Act) chooses not to admit the managed care plan’s Medicare enrollees, then the HMO may not refer its commercial enrollees to this provider. Providers may apply any restriction on admission that is not otherwise prohibited by state or federal law, but only if the restriction is applied the same way to non-Medicare beneficiaries as it is to Medicare beneficiaries. A hospital or skilled nursing facility can refuse to admit a Medicare HMO or competitive medical plan enrollee (except in emergencies) if the same criteria for denying admission are applied equally to all enrollees (of the HMO or competitive medical plan) seeking admission, regardless of their Medicare entitlement.

**Accessibility and Hours of Operation**

Hours of operation for health services for membership must be convenient to the population served and must reflect patterns of care in the managed care plan’s geographic area. The plan must make provisions for after hours care, including emergency care.

Medically necessary emergency care must be available and accessible 24 hours a day, 7 days a week. Member information must include a clear definition of a medical emergency and the procedures for obtaining care in such a situation. Specifically, these materials must address how to obtain care or authorization:

- During office hours in the service area,
- After office hours in the service area, and
- Outside of the service area.

**Monitoring**

The plan must have systems in place to collect data to evaluate the availability and accessibility of services that plan provides or arranges. Specifically, these systems monitor factors such as the following:

- Waiting times to obtain appointments for routine scheduled and urgent care,
- Waiting times to receive services at physician offices and clinical and diagnostic facilities,
- Procedures for receiving and analyzing member complaints,
- Telephone access to the plan and primary care physician for routine and urgent care, as well as in emergencies, both during and after office hours,
- Inappropriate use of emergency services as an indication of lack of availability and accessibility of plan services,
- Number of requests as well as reason for requests to change primary care physicians,
- Number of physician requests to close their practice to new patients,
• Physician back-up and on-call arrangements for primary care physicians, and
• Volume of out-of-plan referrals by specialty and service.
• Monitoring availability and accessibility of care can be done through:
• Surveying physician offices and other plan facilities initially and on a continued routine basis,
• Surveying promptness of services at physician offices and other plan facilities with feedback to the offices and facilities surveyed,
• Tracking physician turnover and the stability of the provider/supplier network,
• Surveying waiting times for an appointment at physician offices and other plan facilities with feedback to these offices and facilities,
• Reviewing appointment scheduling procedures,
• Reviewing member complaints on availability, accessibility and other quality of care issues, and
• Analyzing the system used to determine the need for additional providers/suppliers and the system for recruiting.

**Continuity of Care**

*Continuity of care* is the degree to which the care needed by a patient is coordinated effectively among practitioners across provider organizations over time. This concept emphasizes:

• Coordination of health care services among primary and specialty care physicians,
• Coordination among specialists,
• Appropriate combinations of prescribed medications,
• Coordinated use of ancillary services, including social services and other community resources,
• Appropriate discharge planning, and
• Timely placement at different levels of care, including hospital, skilled nursing facility and home health care.

Services provided to members must be structured in a manner that assures continuity. The plan can achieve this by having a primary physician responsible for coordinating a member's overall health care and by maintaining record keeping systems through which pertinent information relating to the health care of the member is accumulated and readily available and shared among appropriate professionals and available for external peer review. The plan must make arrangements for the physician or other health professional coordinating the members overall health care to be kept informed about referral services provided to members.

The plan must also employ systems to promote continuity of care and case management. This could include development of a plan for the overall treatment of each patient. The plan could cover the full course of illness and related medical conditions. It should also address issues related to treatment at the proper level of care and ensure adequate follow-up.

**Coverage Under Medicare Managed Care Plans**

There are several positive aspects related to Medicare managed care plans. All care is covered through the plans, not just the care covered through the Original Medicare Plan. Extra services are generally provided as well, including:

• Eye exams
• Discounts for eyeglasses
• Annual well-patient physicals
• Annual mammograms
• Prescription drug allowances
Some plans also provide basic dental coverage. Besides these advantages, enrollees may be attracted to Medicare managed care plans because the managed care plan will screen the physicians who provide care within the plan.

Disadvantages related to Medicare managed care plans include the necessity of getting physician referrals in order to see a specialist. The ability to enroll in a plan and receive treatment may be restricted to a certain geographic territory. In addition, as with all managed care plans, physicians are generally given incentives to see patients as few times as possible.

Additional concerns related to Medicare managed care plans include the fact that plans may withdraw from participation after twelve months. This can leave a patient at the least inconvenienced and at the most, left the ability to continue care under a trusted physician.

Another concern is that although plans are prohibited from health screening in order to deny Medicare applicants coverage, it has been claimed that some plans eliminate higher risk patients by providing poor service to them.

**Medicaid**

As big as your job was to explain the Medicare "minefield", you have a bigger job with Medicaid. Clients do not understand it AT ALL and most still believe that it will somehow help them if they have a long term care episode.

The fact is, Medicaid is a needs based program providing of long-term care for those who qualify -- mostly the poor and indigent. Even though it provides approximately 45% of the funding for long-term care, qualifying can often be a major problem. As an example:

> Let’s suppose that Linda, a seventy-two year old single woman, lives on her fixed monthly pension of $890. Linda’s health deteriorates, and it appears she must enter a nursing home. Linda’s only other assets are savings of $21,000. Linda lives in an income cap state, and the maximum allowable income to qualify for Medicaid is $850 a month. Since Linda’s income exceeds this amount, and since she can do nothing to change it, she cannot qualify, even after she spends her life’s savings down to zero.

Medicaid, can be considered both a companion and competitor of private long-term health care policies. Educating clients about the Medicaid "minefield" can be a very convincing way to motivate them to buy LTC insurance.

It is very important to note to your client, that the purchase of a long term care insurance policy does not ensure that he or she will avoid Medicaid when they need long term care. Whether that is to their advantage depends upon the particular circumstances. People who are unlikely to be able to afford premiums, unable to absorb even a moderate increase in LTC premiums may find Medicaid as their only safety net.

**Problems In The Marketplace**

There is a lot of discussions and accusations about the quality of care afforded a Medicaid patient and the problems associated with being a Medicaid provider. Consider these recent events:

- Nursing home chains nationwide are reporting significant financial difficulties as a result of more Medicaid patients and poor reimbursement levels. The Washington Business Journal comments "...Medicaid will eventually drag the assisted living (residential care homes) industry down the same tortuous path as it has done with the nursing home industry: low
reimbursement (that often doesn't even cover the cost of providing care), mandated services, costly regulation, and oversight . . . "

- Many states reimburse nursing homes at a rate less than $80 per day. Stephen Morrisette, President of the Virginia health Care Association says "How many hotels can you stop at and get a room for that? And we provide not just a room but 24-hour nursing care and meals and therapy and activities."
- Sara Speights of the Texas Association for Home Care stated that "Agencies cannot deliver quality services and adequate care at only 30%-40% of costs. We estimate that about fifty percent of home care agencies in Texas will be forced to close their doors . . . "
- McKnight's Long Term Care News reported that 17% of all nursing facilities in Massachusetts filed for bankruptcy in 2000; 11% in California.
- Federal Medicaid Director Sally Rishardson said . . . "While we hope these organizations (nursing homes) will see their way through these difficult periods, we are nevertheless concerned that the quality of care residents receive in chain facilities . . . If financial difficulties persist, it is possible that some facilities may decide to withdraw their participation in the Medicare or Medicaid Programs".

It is evident from this information that low Medicaid reimbursement rates weigh like an anchor on nursing homes around the country. They drag down the industry's ability to pay acceptable salaries, hire competent people, and provide quality care. Many institutions simply don't like to take Medicaid patients.

Adding to the problem are the following Medicaid "minefields" your clients should know:

- The number of Medicaid-certified providers of long-term care services around the country is limited. So even if the individual qualifies for the program, it may be difficult to find a provider to use.
- Once someone qualifies for Medicaid in a nursing home, the worries don't end. All of a sudden, the Medicaid resident, loses his or her ability to choose a nursing home as you will read below.
- Not all nursing homes accept Medicaid residents. Many facilities are for private pay residents only. One school of thought provides the rationale: If Medicaid doesn't reimburse for the full cost of care (in doesn't in most states), then private pay residents subsidize Medicaid residents. Therefore, a total private pay facility might be able to provide care at a lower cost because the residents there are not subsidizing the expense of providing care to other residents.
- Not all nursing homes have room for a Medicaid resident. Most facilities allocate a certain number of beds for Medicaid, and private pay residents. In theory, a nursing home administrator may want a private pay bed to remain empty while a waiting list exists for Medicaid residents.
- If a Medicaid bed is not available at the time someone needs one, there will be a search for a Medicaid available bed. One could open up down the block from someone's favorite facility or it may be on the other side of town or even in the next county. People may have to wait at home or the hospital until a Medicaid bed becomes available.
- Let's assume everything works out as the attorney said it would—money is hidden, Medicaid is paying the bills, and the resident is in a great facility. What happens when this person must enter a hospital to recover from a heart attack, stroke, or broken hip? Medicaid will pay the nursing home to hold the bed for only a week or two. After that time, the recovering Medicaid patient, who left the facility of choice, again starts looking for a facility. A Medicaid resident will find it harder to get into the better facilities than a private pay resident.
- Once someone else pays the bills, the nursing home resident is at the mercy of the payor. Thus, it is not always desirable when Medicaid pays the bills. And, as we discussed at the
very beginning of this section, anyone interested in the quality of LTC system should not rely on the welfare support system alone.

A recent piece on the Mr. Long Term Care Website (www.mrltc.com) is a dramatic demonstration of the lack of choice when Medicaid is involved.

Mark is a 46-year-old with multiple sclerosis. For more than a decade, Mark’s wife has been his primary caregiver. She too was suffering from fatigue, depression, insomnia and various chronic stress related disorders. In the last 12 months, Mark was in and out of the hospital with various infections, skin ulcers, etc. He was beginning to believe that he might never return home again. And, Mark knew his wife could no longer handle the emotional and psychological stress of 24/7 caregiving. The thought of life in a nursing home terrified him, but the real crisis had yet to reach shore.

As it turns out, young, otherwise healthy, alert MS patients on Medicaid have extremely poor “placement rates”. There wasn’t a nursing home within 80 miles that would accept Mark. Their search expanded to homes within a 120-mile radius with nothing yet. Even when Mark is accepted, it would mean that he would only see his wife three or four times a month.

The conclusion? If a patient doesn’t have to rely on Medicaid when he/she first enters the nursing home, he or she may have a better choice of homes and perhaps higher quality service.

**What Does Medicaid Cover?**

Unlike Medicare, Medicaid is jointly funded and administered by the state and the federal government. Because each state administers the Medicaid program and is free to tailor its Medicaid rules within federal guidelines, the Medicaid program varies considerably from state to state.

In general, Medicaid pays for hospital, medical, prescription drug and “medically necessary” nursing home care. The Medicaid system was originally intended to be a “safety net”. It was established to assist families in crisis and help the medically needy who lacked access to medical care. Above all, it was designed as a short-term solution for health care. Use of the system, however, has been far different than was intended. The program now has the stigma of a social welfare program providing current, on-going and long-term health care for families and seniors alike. Combined with our rapidly aging population and the high costs associated with long-term care, it is easy to see why there is great concern.

Medicaid is a needs based program (the exact opposite of Medicare). Medicaid provides benefits only to those who demonstrate a financial need. This means that a patient cannot have more than a limited amount of cash or other available assets. States that operate their Medicaid programs this way are called Share the Cost states. Of course, there are exemptions and methods for families to restructure their assets to qualify for Medicaid benefits. This process is called spenddown. It is a complicated area, but essential to the understanding of Medicaid and long term care. We will discuss it more later.

**Basic Services Offered By Medicaid**

Federal law and regulations specify a list of basic services that must be included in any state Medicaid program. Those services include:

- Inpatient hospital services
- Outpatient hospital services, including ambulance services offered and included in the state’s Medicaid plan.
• Physician services furnished in the physician’s office, patient’s home, hospital, skilled nursing facility, or elsewhere. Also, medical and surgical services furnished by a dentist where state law permits either physicians or dentists to perform such services.
• Laboratory and x-ray services
• Skilled nursing facility services for individuals 21 and over. Coverage does not include services in an institution for mental diseases or tuberculosis, but does include early and periodic screening, diagnosis, and treatment of individuals under age 21 for physical and mental defect.
• Home health care for persons eligible for skilled nursing facility services.
• Family planning services and supplies.
• Rural health clinic services, including ambulance services offered and included in the state’s Medicaid plan.
• Federally qualified health center services.
• Services of certified pediatric or family nurse practitioners.
• Early and periodic screening diagnostic and treatment services for children under 21.

Medicaid Eligibility
To be eligible for Medicaid, a person can only have a certain amount of income and/or assets, i.e., “resources”. In a nutshell, the system is designed to “impoverish” an individual before benefits can be allowed. It is no wonder, then, why people have turned, in record numbers, to lawyers and financial advisors to find loopholes -- ways to divest themselves of income and assets in order to qualify. This process is known as the spenddown. In fact, an entire industry has grown around strategies for spenddown called Medicaid Planning.

Before we get to specific spenddown rules, let’s look at basic eligibility tests – the starting point for anyone considering Medicaid assistance:

A Basic Need
To begin, an individual wishing to apply to Medicaid must be in need of care. He or she must be 65 or older, disabled in some way – blind, physically disabled, mentally disabled, etc. The disabled person may also be less than age 65 and qualify if they meet other income / asset eligibility categories.

A forty something year old blind or paralyzed person meets the category requirements. A seventy year old or sixty-six year old on the other hand need not be disabled except that she/he must need long term care and, of course, meet the income and asset requirements below.

Income
Generally speaking, for a person to be eligible for Medicaid he must spend all his income -- Social Security, pensions, interest, dividends, and so on -- on nursing home care before Medicaid helps.

The applicant will not qualify if her/his income exceeds an amount set by the state. This amount changes from time to time and varies from one state to another. If the income dollars, taxable or non-taxable, surpass the state limit, Medicaid will not be approved.

The income restrictions are severe. In some states, income is “capped” at a certain figure per month, even if all assets are “spent down” and even if this income doesn’t cover the cost of the nursing home.

Example: Let’s suppose that Joan, a 73-year-old single woman, lives on her fixed monthly pension of $925 per month. Joan’s health deteriorates and it appears she must enter a nursing home. Her only other assets are savings of $25,000. She lives in a state
that "caps" income with a maximum allowable income to qualify of $850 per month. Since Joan's income exceeds this amount, and since she can do nothing to change it, she cannot qualify, even after she spends her life's savings down to zero.

Married couples are treated differently. Once a spouse is in a nursing home, each spouse's income is considered separately. This allows the healthy or "at home" spouse to keep their own income. Problems occur when a bulk of the income is still being received by the spouse in the nursing home. Where a couple is attempting to qualify for Medicaid, the name on the check rule is applied:

Example: Frank and Eleanor are married and receive income from several sources. Eleanor's Alzheimer's condition was being handled by Frank at home with help from family members and incidental private care services paid for by Frank. As her illness worsened, Frank could no longer provide the level of care needed and Eleanor was admitted to a nursing home. Frank applied to Medicaid where his income was analyzed as follows:

Income paid to Frank from his company pension plan was considered his income and not part of the Medicaid formula, i.e., the "name on the check" is Frank's so this income remains with Frank.

Dividend and interest income on Frank and Eleanor's small stock fund and a small CD is paid to BOTH and there is no division or share indicated. This income is considered belonging one half to each. So, 50% of this income will not be available to Frank since the "name on the check" is BOTH Frank and Eleanor.

Eleanor also receives a check every month from a trust set up by her parents. Since the name on the check is her's, alone this income will be used to pay nursing care costs before Medicaid pays.

Still more can be kept, in certain areas, if a hardship will result. Additional expenses such as housing payments, taxes and utilities may increase the monthly allowance.

All of these guidelines and limits are a clear reminder that Medicaid benefit programs are designed for low income individuals. And, the "minefield" effect of complicated guidelines and eligibility rules is most likely designed to contain costs, i.e, the harder it is to qualify, the less people that do.

Assets
Asset qualification is the most difficult aspect when seeking eligibility for Medicaid. Most seniors have accumulated more in assets than their one-year income. Their home and savings are the key parts of eligibility.

In most states, the principal residence is exempt from asset eligibility determination IF a spouse or valid dependent lives in it or if the absent Medicaid recipient expects to return to it. You can be terminal and proclaim from the bed your expectation of returning and no one can nay-say you. (They can "nay-say" you all day, but they can't lift your Medicaid eligibility or, perhaps more important at THAT point, your house from your estate—at least off the moment).

In addition, you can keep a burial plot, $1,500 in cash to bury yourself (government is certainly not in THAT business), life insurance up to $1,500 or less (not much) and any property producing income that you use to pay nursing home bills. You can keep personal jewelry, and one car usually.
**Medicaid Spenddown**

The process by which medical and nursing home care reduces a person’s assets to qualify for Medicaid is known as a *spenddown*. Some have referred to it as the “path to poverty”. In essence, a person can’t get assistance until virtually all assets are depleted. Certain assets are considered *noncountable* or exempt. They include:

- a house used as a primary residence.
- a car for transportation to work or medical services
- a wedding ring
- a cemetery plot
- household furniture
- cash surrender value of life insurance under $1,500
- real property if it is essential for support (land to grow food) or it produces income for one’s daily activities.

Assets that are *countable* vary from state to state. The general rule is, if the principal of the item can be accessed (even if it cost a penalty to get), it counts as an asset for Medicaid purposes. Here is a short list of what counts:

- cash, CD’s and money market accounts
- stocks, bonds, mutual funds
- treasury notes and treasury bills
- vacation homes and second vehicles
- cash value life insurance and deferred annuities
- revocable living trusts

Certain other items are exempt because of their protection under federal law. These items include:

- Food stamp coupons
- US Department of Agriculture donated foods
- Supplemental food assistance programs
- Benefits received under the Nutrition Program for the Elderly
- Payments received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970
- Tax exempt portions of payments made under the Alaska Native Claims Settlement Act
- Receipts distributed to certain Indian tribunal members
- Certain student loan funds
- Supplement security income payments received by recipients who do not reside in certain group care facilities
- Certain state provided assistance to senior citizens for property tax relief or other needs
- Payments made to veterans from the Agent Orange Settlement Fund
- Certain payments made by the US Government to citizens of Japanese ancestry who were interned during World War II
- Assets which are unavailable to the person.
- Finally, there is an asset disregard of $2,000 in cash or other assets.

Medicaid rules do not also require the immediate impoverishment of a spouse. But, the limits of what can be kept may mean a lower quality of life than what he or she is accustomed to living.

In addition to exempt assets mentioned above, the amount a spouse can keep varies from state to state. The maximum is typically around $75,000. The amount that can be kept is determined
by adding ALL available assets of BOTH husband and wife. If one-half of the total does not exceed the amounts above, the spouse can keep them. The rest must be sold and used to pay any medical bills before Medicaid will participate.

**Giving Away Assets & Income**
Transferring assets or income in order to qualify for Medicaid is a topic of much discussion. There are five obstacles that your clients must consider before considering this strategy.

**It's complicated.** The process of divesting may require an irrevocable trust and legal property transfers. To stay within the law and avoid financial penalties will unquestionably require the services of an elder attorney. The costs and paper maze will sidetrack most. Transfers may also have serious negative income tax consequences.

**It requires advance planning.** OBRA '93 established a 36 month “look-back”. Assets given away within three years of applying for Medicaid are assumed to be transferred to avoid payment of medical expenses. The look-back is 60 months for transfers of income or principal to an irrevocable trust. The penalty for either is a period of ineligibility equal to the amount of the “illegal” transfer.

Example: In anticipation of filing for Medicaid assistance, Dick transferred $30,000 to his son in October 2000. In May of 2001, Dick entered a nursing home and entered his formal application to Medicaid in July of the same year. Since an uncompensated transfer (gift) occurred 9 months prior to Dick’s application for Medicaid, he will be subject to a period of ineligibility (because it is within the 36 month look-back period). The period of disqualification is $30,000 divided by $3,262, the average private pay rate (This rate changes each year). Dick will be ineligible for 9.19 months.

**It can be a criminal offense.** HIPPA, effective January 1, 1997, has made it a misdemeanor punishable by a fine of $10,000 or one year imprisonment, or both to “… knowingly and willfully dispose of assets (including any transfer in trust) in order for an individual to become eligible for medical assistance (Medicaid).” Since no amendment was created, this law eased substantially for seniors, i.e., “grandma will not go to jail”. However, it is a still a felony for a service provider or professional, such as an insurance agent, to help someone transfer assets. The fine is $25,000 or five years in prison or both.

**It is only cancelled out.** In the end, Medicaid recipients who temporarily avoid spending their own assets or income must still pay it back because OBRA '93 requires estate recovery. Every state is required to pursue the estate of a deceased Medicaid recipient to recover any assets not subject to probate. They have a right to lien property and seek recovery from assets in which the recipient had any interest at the time of death. Even a life estate in a former house that was transferred to a child years ago could be attached.

**There is loss of control and choice.** When all assets are out of the individual’s control he is finally eligible for Medicaid, but at what cost? If he recovers, there is little to come back to enjoy. Further, as a Medicaid patient there are few choices as to doctors, facility location and upgrades. Some facilities do not accept Medicaid and ones that do may not be located near family and friends. Also, there is a remote chance that rates paid by Medicaid … typically lower than private pay … result in fewer service upgrades, furnishings, etc.

The thrust of all these efforts is clear and chilling: Congress wants middle class citizens to buy long term care insurance and stay away from Medicaid.
Medicaid Trusts

It is important for insurance professionals to understand that clients are no longer able to shelter nonexempt income and property within trusts as a way of establishing Medicaid eligibility. Rules on these trusts and annuities were filed January 1998 as Director Letters #95-75 and #96-68 (now Section 50489 of Title 22). These regulations impact all trusts established on or after 8/11/93 containing the income, property or property rights of an individual or individual’s spouse.

Now, if an individual or spouse creates a trust, Medicaid counts as currently available anything contained within that trust (if not normally exempt; such as a home) regardless of when or whether distributions can be made and regardless of any special use limitations. This means that no matter how remote the possibility of a distribution may be, it will be currently counted for purposes of establishing eligibility for Medicaid. In addition, anything that cannot be released under any circumstances is subject to a “transfer-of-property penalty” which means that an individual may be ineligible for nursing facility care for the number of months that the property could have paid for their care at the average private pay rate.

There is one exception: trusts established for a disabled individual by someone other than him where there is specific language contained in the trust requiring repayment to DHS for the cost of medical assistance upon the death or earlier termination of the trust.

Annuities And Medicaid

Using annuities to protect assets from the nursing home expense has become very popular. Two recent books on the subject, The Medicaid Planning Handbook by Alexander A. Bove, Jr. and Avoiding the Medicaid Trap by Armond Buddish, specifically discuss the use of annuities to avoid Medicaid seizure. In fact, two insurance companies have designed deferred annuity products with features that are implemented at the appropriate time to get around Medicaid rules.

Although the Kennedy Kassebaum Bill continues to sanction annuities as a tool in the Medicaid spenddown scenario, there are many potential disasters with using annuities to shield assets. Following are some parameters to remember:

- Many states’ rules for Medicaid differ greatly. It is important to learn as much as possible about your own state’s specific rules.
- The annuity must be annuitized prior to applying for Medicaid. Many consumers who own deferred annuities will not remember that they must annuitize the policy prior to applying for Medicaid. Once the Medicaid applicant reveals that their annuity is a deferred annuity, then it’s too late. Medicaid (Social Services) will order the policy owner to either cash in the annuity for spend-down or simply disqualify the applicant for having assets that exceed the qualifying amount.
- If you purchase an annuity for the purpose of protecting your money from nursing home spend down, there is no guarantee that Medicaid will not simply change their qualification rules in order to disqualify such Medicaid applicants. The government is an expert at changing the rules.
- Under the Kennedy Kassebaum and OBRA ‘93 Act, an annuity must have life expectancy payout rates that are in accord with the latest social security mortality tables. Many insurance companies’ payout rates are not compliance.
- Some annuities will not allow you to annuitize the first year. Therefore, if your situation should require annuitization during the first year, you would simply be out of luck! (There are other annuities that will not allow annuitization for 5-15 years.)
- If a deferred annuity is purchased to shield assets against Medicaid, the purchaser will often make a spouse the annuitant, so that in the event of nursing home confinement, the deferred annuity can be annuitized with income.
going to the spouse. However, if the annuitant predeceases the annuity owner, the death benefit is triggered. In some cases, a surrender charge is charged upon the death of the annuitant. In addition, the owner of the annuity will receive notice from the IRS for the taxable gain, not a pleasant experience. Finally, since the spouse is usually the primary beneficiary, the proceeds will be made payable to the contingent beneficiary. This is most likely the children and not the owner of the policy. This scenario could cause exercise of your E&O.

- Many purchasers do not understand how Medicaid actually works and therefore are not qualified to engage in this type of planning.
- OBRA 93 established and mandated a 60-month look back for deferred annuities. Many State Medicaid offices use this provision to initiate or trigger the ineligibility penalty period, creating an array of problems that may ultimately be attributable to ownership of a deferred annuity.
- Using an annuitized annuity to shield assets loses its glitter when it comes to single individuals, since the annuitized income cannot be directed to another individual as with married couples and the income stops should the income recipient die.
- What happens when the annuitant simply dies? You cannot attempt to qualify for medicaid by annuitizing your policy with the intention of passing excessive monies to your heirs. Under the Estate Recovery rules passed by OBRA 93, any income that continues to heirs after your death could be subject to recovery by Medicaid.
- It is worth considering that if you annuitize based on your life expectancy, the interest rate provided by the company may be quite low!
- If the annuity owner has to enter a nursing home because he has become incapacitated or mentally incompetent, who can make the decision to either gift the annuity policy or simply annuitize it? No one can, unless there is a durable power of attorney which grants such power. Even having a durable power of attorney is no guarantee, since many documents do not contain the requisite language for gifting or annuitizing such a policy.
- You cannot use a section 1035 exchange to avoid some of the problems mentioned above (see, for example, items 4), 5), and 6) because this procedure requires that the owner and annuitant in the successor contract remain the same.

In short, the advice to anyone considering the purchase of an annuity to shield their assets from Medicaid is: Let the buyer beware!

Example: John wants to reside in a nursing home that costs $3,500 per month. In order to pass Medicaid qualification tests, he uses a significant portion of his assets to purchase an immediate fixed annuity that pays $1,200 per month for life. John's only other income, from Social Security, is $950, making the monthly income total $2,150. However, in order to qualify for Medicaid, his monthly income must be less than $2,050 in his state.

According to the Medicaid eligibility rules, Bill now has too much money coming in. In the process of "ridding" himself of much of his assets, he has established a guaranteed income that is too high and that he has no way of reducing. Even worse, this amount of income very likely won't be sufficient to cover the cost of his current medical expenses. In short, not only has Bill failed to qualify for Medicaid coverage, he has also locked himself into a situation in which his current income is not enough to meet the medical expenses that he alone is obligated to pay.

Medicaid Estate Recovery
Federal law requires each state to recover the costs of nursing facility and other medical services from the estates of Medicaid recipients. This means that every state is federally mandated to recover from Medicaid recipients who receive services at the age of 55 or older, or
in a nursing home, in order to help pay Medicaid covered expenses for the increasing number of individuals needing medical care.

**Example:** Mr. Roberts, a widower, left his only property, a house valued at $175,000, to his son. At the time of his death, Medical had provided $24,000 for his nursing home care. In addition to this claim, there was a total of $10,000 in funeral bills and costs for probating his estate. Mr. Roberts’ son received $141,000 ($175,000 - $24,000 - $10,000 + $141,000) after all the claims were paid.

Recoveries from a deceased recipient’s estate will include all medical expenses paid by Medicaid. These expenses include:

- Health insurance premiums (including Medicare),
- Nursing home services,
- Home and community based services,
- Hospital services,
- Prescription drug services, and
- All other Medicaid covered services.

Food stamps, emergency assistance and cash grants are not Medicaid costs, and will not be recovered under this process.

How do clients know when Medicaid intends to try to recover from their estate? Medicaid should provide notice that the Estate Recovery Program exists when they first apply for Medicaid. When Medicaid is actually trying to get recovery, it must notify the legally authorized representative of your estate. If there is no representative, they must try to notify known family members or heirs.

Before 1993, Medicaid could only recover from your estate if it discovered that you had owned assets during the period in which you received benefits and that those assets would have made you ineligible for Medicaid. In 1993, recovery powers were greatly expanded for people who receive Medicaid after October 1, 1993 and who die after that date.

Medicaid can now try to recover after a client’s death in these additional situations:

- If the client is 55 years old or older when they receive Medicaid; or
- If the client received Medicaid under a provision that disregards certain assets because they have purchased a long-term care insurance policy, e.g., A State-Approved Long Term Care Partnership Program

**Frequently Asked Medicaid Recovery Questions**

**What portions of your client’s estate are protected from recovery by Medicaid?** If they own a joint tenancy in real estate with someone else, that real estate cannot be recovered by Medicaid. If they have sold or transferred property to someone without keeping any interest in that property for themselves, that property is also protected for recovery purposes.

**NOTE:** If clients transfer any property for less than its fair market value, they could have trouble getting Medicaid for nursing home or other long term care for three years after transferring the property.

If clients own any personal property, such as a car or a bank account, in joint tenancy with someone other than their spouse, a blind or disabled child, or a child under 21, Medicaid may try
to recover against that property. It is not clear whether Medicaid can recover personal property held in joint tenancy.

**Can Medicaid recover from a spouse's estate?** No.

**What are the so-called “lookback” provisions?** OBRA '93 established a 36 month “lookback”. Assets given away within 36 months of applying for Medicaid are assumed to be transferred to avoid payment of medical expenses. The look-back is 60 months for transfers of income or principal to an irrevocable trust. The penalty for either is a period of ineligibility equal to the amount of the “illegal” transfer

**What is the treatment of property transfers made during the Medicaid “lookback” period?**

If the transfer in means an outright gift or sale at less than “fair market value”, Medicaid will calculate the period of ineligibility for nursing facility level of care. It will be the number of months resulting when the “net fair market value” of the transferred is divided by the monthly average private nursing facility costs (ADPPR).

**Are “exempt assets” protected against Medicaid Estate Recovery?** No, even the home, if it has not been previously transferred, is part of the estate against which Medicaid has the right to recover the cost of Medicaid benefits received after the recipient is age 55. Such recovery will not occur until after the death of the community spouse and/or there are no more dependents.

**Are there any other protections?** Yes. If a client dies leaving a "dependent," Medicaid will not file a claim against their estate. A dependent is a surviving spouse, a child under the age of 21, or a child who is blind or permanently or totally disabled. If clients leave an estate that will be probated, any claim for recovery from their estate must be filed within four months after death. If, at the end of that four-month period, a surviving spouse or disabled child is still living, or if there is still a child under 21, Medicaid will not try to recover from the probated estate. If an estate will not be probated, Medicaid will not try to recover from it if, two years after death, the surviving spouse or disabled child are still living, or if there is still a child under 21.

A client’s estate can also be protected if Medicaid’s actions will create an "undue hardship" on someone who survives him or her. Medicaid will look at the following circumstances to decide whether undue hardship exists for the survivor:

- Whether the property was the primary residence of the person claiming undue hardship;
- Whether that person used personal resources to maintain the property, pay taxes, etc.;
- Whether that person lived on the property and provided significant care so that you could remain at home for a longer period of time;
- Whether that person had entered into a contract with you in which the residence was held as security or in which the residence was supposed to be transferred to that person for value already received by you;
- Whether you had promised that the residence would belong to that person after your death and the person had relied on that promise and would be harmed if the promise were not met;
- Whether that person is a resident and co-owner of the property; or
- Whether the property produces income necessary for that person’s support.

**Medicaid Liens**

Liens against the real property of a recipient may be filed when the state determines that the recipient cannot reasonably be expected to return home. The purpose of the lien is to recover any payments made by the State on behalf of the Medicaid recipient. A lien does not change property ownership. However, it does represent a debt that must be satisfied when the property is sold, transferred, or the recipient dies.
Written notice will be provided ninety (90) days prior to filing a lien. Medicaid recipients or their personal representatives will have an opportunity to present any objections during a hearing process.

Automatic statutory liens are also imposed against judgments, awards and settlements in lawsuits when the state has provided medical assistance to a recipient for which a third party is responsible.

**Medicaid and Long Term Care**

Medicaid has become a public assistance program . . . welfare . . . that combined pay for a majority of all current nursing home patient days in the United States. Some states are spending more money on Medicaid than on education prompting national debate on how to finance long-term care. The program has a dismal reputation for access, quality, reimbursement, discrimination and institutional bias. Nevertheless, citizens, private attorneys and even public entities such as state Long-Term Care Partnerships encourage middle class people to virtually impoverish themselves in order to gain access. This process is referred to as Medicaid Planning.

The government wants to stop the practice of transferring assets and other abuses of the Medicaid system. That is why a flurry of legislation has created tax incentives for citizens to buy their own, private long-term care insurance. Additionally, rules have been established that make it a crime to transfer assets to avoid paying for long-term care expenses.

On the industry side of the scales, nursing homes that accept Medicaid, are now required to notify new residents who pay with private funds at entry that they might have to move if they eventually run out of money and need to rely on Medicaid. Up to now, nursing homes took private payers, and kept them when they could no longer pay, shifting them to Medicaid. They felt it was “bad public relations” to kick these patients out. Nursing home giant Vencor tried this a couple years ago and suffered a huge scandal, together with falling share values.

The new law may furnish nursing homes with yet another incentive to leave the Medicaid program and another argument convincing prospects for long-term care that if they want quality care, they must insure it on their own.

Since no other payment source for custodial long term care service has surfaced, the Medicaid program has become the largest payor for these services when people cannot afford to pay. With the significant costs associated with receiving long term care services, many people who were otherwise middle-income find it necessary to apply for Medicaid.

**Example:** Mr. Smith worked for the school district for 42 years! He isn’t poor or impoverished.”. You even know that Mr. Smith gets $1500 per month in retirement and was proud of a small savings and some investment he had. It just does not sound right, does it? But you also know they had to put Mr. Smith in a nursing home over a year ago.

You have never thought much about how he has been paying for it. You know now, because of this training, that Medicare and health insurance pays nothing toward custodial care. Sadly, Mr. Smith did not know it either.

Well, Mr. Smith is paying for it out of his retirement, savings and investments. The nursing home runs $3,600 per month. With $2,100 per month being paid in a co-pay, it is not going to last long. What will happen to Mr. Smith when he does not have the extra money to supplement his retirement to pay for the nursing home? Another scenario that could have landed Mr. Smith in this frustrating situation is one where he purchased a $50
a day without inflation protection, long term care insurance policy 10 years ago. At that
time the cost of care was around $65-70 a day. Mr. Smith thought he could manage the
other $15-20 a day and still have money left at the end of the month for personal items.
The cost today is $120 a day. Mr. Smith has to co-pay $70 a day or $2,100 per month.
Remember, Mr. Smith only gets $1,500 per month. Mr. Smith will have to spend all his
assets and “impoverish” himself. When this happens to Mr. Smith, he falls into the
category of “medically needy”. Who would have thought this possible?

You have no idea how often this situation happens. It can play out in a variety of ways but it
happens more than we would like to see and to people we never would have expected. Good
planning can keep it from happening and that is part of what you are here to learn. It is also
your job to let them know.

**Medicaid Conclusions**
The U.S still lacks a universal system for medical and long term care and Medicaid is NOT it!
Medicaid programs pauperizes families who must use it, and encourage the non-poor to try
methods (some now considered a crime) to transfer assets to qualify.

Medicaid was created as a public welfare program for the indigent funded by Federal, state and
local governments. Some of the benefits go to families and dependent children but a huge and
growing portion is for the aged, blind and disabled. One private study indicates that over 25
percent of Medicaid funds were for nursing home costs in 1995 alone.

The problem is obvious. A huge portion of our senior population has been caught “off-guard”.
Their longevity combined with escalating costs of long term care has created a need to try and
capture the benefits of Medicaid. If they don’t, a reasonable stay in a nursing home could
impoverish their entire estate.

It is a small wonder, then, why these people have turned in record numbers to lawyers and
financial advisers to find Medicaid **loopholes** -- ways to divest themselves of income and assets
in order to qualify for Medicaid.

Privately funded long term care insurance is seen as a substitute for some form of national long
term health plan. But it may come too late for anyone who has accumulated a modest nest egg.
They may not be able to afford the premiums and they can’t go it alone. Finding a way to qualify
under Medicaid is, for them, a viable option.

As discussed, Medicaid programs can vary from state to state. Therefore, the insurance
professional, when marketing long-term care insurance in more than one state, must become
familiar with the Medicaid programs in each of those states

It is recommended that any Medicaid plan should be reviewed at least every two years to see if
it is the best plan in light of current state law. Make sure you are aware of the planning options
available and seek the necessary advice in carrying out the “best plan for you”. This will be well
worth the time and expense and it can be thought of as a part of the cost of “health care
insurance”.

**A Word of Caution**
The Medicaid system is basically a form of welfare. The rules can and do change frequently.
Consequently, advising persons about Medicaid carries with it a certain amount of risk.
“Grandfathering” of an existing situation under which one may qualify for Medicaid when the
rules change is uncertain. When consulting with a client on Medicaid, agents are urged to
disclose to the client the risks, and to continually keep abreast of changes in the law. Because
the Medicaid program varies and constantly changes, the information contained within this chapter is intended to be illustrative in nature.

**In-Home Supportive Services**
The In-Home Supportive Services (IHSS) program is administered by the various county Departments of Social Services under guidelines established by the state. IHSS provides assistance to eligible aged, blind and disabled persons who are unable to remain in their homes safely without assistance. Most people are eligible for IHSS when they meet eligibility criteria for the Supplemental Security Income / State Supplementary Program (SSI/SSP) for the aged, blind and disabled.
The services available through IHSS are domestic services such as heavy cleaning, meal preparation and clean-up, laundry services and reasonable shopping.

**What are other eligibility criteria for IHSS?**

- You must be a citizen of the U.S. or a qualified alien.
- You must live at home (acute care hospital, long term care facilities and licensed community care facilities are not considered “at home”).
- Personal property may not exceed $2,000 for an individual or $3,000 for a couple.
- Depending on the amount of your income, you may be required to pay for a portion of your IHSS benefits (share of cost).

**How does the IHSS program work?**

- A county social worker will interview you at your home to determine your eligibility and need for IHSS. Based on your ability to safely perform certain tasks for yourself, the social worker will assess the types of services you need and the amount of time the county will authorize for each of these services.
- If you are approved for IHSS, you must hire someone to perform the authorized services.
- If your county has contracted IHSS providers, you may choose to have services provided by the contractor.
- The current IHSS hourly rate set by State law. Currently, about $6.00 per hour.

**BOOMER HEALTH INSURANCE**

**Trends**
Boomers have significantly different health and disability needs compared to seniors. The continuum suggest that while in their peak earning years, boomers will seek the best treatments, the best doctors and they will want to be served NOW! This theory suggests that the most comprehensive health insurance available is the policy of choice for boomers today.

However, as boomers continue to “gray” and cost-containment measures in the health industry expand, boomers will seek out cheaper, but effective ways of delivering their health care. This could mean bare bones type policies with high deductibles. They will seek alternative remedies and rely more on medications to keep them healthier than any previous generation. IN fact, experts say the boomers are the most medicated generation yet!

As they near retirement, it will be discovered that Medicare must be scaled back because the sheer size of the generation will make it impossible to provide the same level of care their parents enjoyed. However, it is though that boomers will live longer than their parents. Many acute diseases will be prevented and chronic ones managed better than ever before.
**Traditional Health Coverage**

Policies are distinguished between those covering ONLY disability, to those covering disability AND medical, hospital, surgical benefits; to those policies covering ONLY medical, surgical and hospital expenses. The latter is defined as a “health benefit plan”.

Disability insurance insures against losses which result from injury to or sickness of an insured person. It does not include insurance against the liability of an insured person for injuries to third persons.

**LOSSES COVERED BY DISABILITY INSURANCE**

The principal types of losses insured against by disability (health) insurance are:

- Expenses incurred for hospital confinement and for medical and surgical treatment ("hospital, medical and surgical");
- Fixed daily benefits for hospital confinement ("hospital indemnity");
- Loss-of-income resulting from injury or sickness ("loss-of-time");
- Accidental death and dismemberment;
- Loan payments becoming due while disabled ("credit disability" and "mortgage disability");
- Office or business expenses which continue during the disability of a professional or proprietor, such as office rent, etc. ("business overhead expense").

Disability insurance is also used for special business and investment purposes, such as funding "buy-out" agreements when a partner in a partnership or a stockholder in a close corporation becomes permanently disabled or to provide funding for a continuing investment program during the disability of the investor.

**TYPES OF HEALTH / DISABILITY COVERAGE**

Insurance regulations, which establish Standard Supplemental Disclosure Forms which must be used in soliciting disability insurance, classify disability coverages into the following major categories:

"**Basic Hospital Expense Coverage**" provides benefits for expenses incurred for daily hospital room and board and usually covers miscellaneous hospital services incurred as a result of covered accident or sickness. Benefits may be subject to a deductible amount and to a co-payment requirement.

"**Basic Medical–Surgical Expense Coverage**" provides benefits for expenses incurred for surgical, anesthesia and in-hospital medical services incurred as a result of covered accident or sickness. Benefits may be subject to a deductible amount and to a co-payment requirement.

**Basic Hospital and Medical–Surgical Coverage** provides benefits for expenses incurred for daily hospital room and board, miscellaneous hospital services, surgical, anesthesia and in-hospital medical services incurred as a result of covered accident or sickness. Benefits may be subject to a deductible amount and to a co-payment requirement.

"**Hospital Confinement Indemnity Coverage**" provides a stipulated daily benefit for hospital confinement as a result of covered accident or sickness. Other benefits, such as accidental death and dismemberment coverage, are often provided. Benefits may be subject to elimination periods.
"Major Medical Expense Coverage" provides benefits for major hospital, medical and surgical expenses incurred as a result of covered accident or sickness. Benefits are usually provided for daily hospital room and board, miscellaneous hospital services, surgical and anesthesia services, in hospital medical services and prosthetic appliances, among other expenses. The maximum benefit for covered charges usually exceeds $10,000. Benefits are subject to substantial fixed or variable deductibles and may be subject to a co-payment requirement. Such coverage is often designed to be supplemental to "Basic Hospital and Medical-Surgical Coverage".

"Comprehensive Major Medical Expense Coverage" provides those benefits enumerated in the preceding paragraph, except that coverage is not designed to supplement other coverage and is usually subject only to modest fixed deductible amounts. Benefits are usually subject to a co-payment requirement.

"Disability Income Protection Coverage" provides benefits on account of the insured's inability, as a result of covered accident or sickness, to perform certain activities as defined in the policy. If the insured is employed for wage or profit, these activities are usually defined in terms of the insured's occupation or any occupation for which the insured is or becomes qualified by reason of education, training or experience. Where the insured is not employed for wage or profit, these activities are usually defined in terms of activities of a person of like age or sex. Benefits may be designed to replace lost income ("loss-of-time"), to make payments on loans ("credit"), or to pay expenses of the insured's office or business which continue during the insured's disability ("business overhead expense").

"Accident Only Coverage" provides any one, or a combination, of the foregoing types of coverage for losses resulting only from covered accidents. These policies usually provide an accidental death and dismemberment benefit in conjunction with loss-of-time or hospital and medical-surgical benefits. The accidental death and dismemberment benefit payable will sometimes vary depending upon the type of accident.

"Specified Disease Coverage" usually provides hospital and medical-surgical benefits for losses resulting only from the disease or diseases specified in the policy. Such benefits are usually designed to supplement other hospital and medical-surgical coverages which the insured has. The most common of such policies provide supplemental benefits for the treatment of cancer.

"Specified Accident Coverage" provides the same types of benefits as "Accident Only Coverage", except that coverage is limited to one or more types of accidents specified in the policy. The most common such policies provide accidental death and dismemberment benefits for losses resulting from common carrier (principally aircraft) accidents. Many policies sold in conjunction with newspaper and magazine subscriptions combine coverages for specific diseases and specific accidents.

DISABILITY INSURANCE DISCLOSURES
The Health Insurance Disclosure Act of 1974 requires that a Standard Supplemental Disclosure Form ("Outline of Coverage") be provided to the prospective insured or group master policyholder whenever a specific disability insurance policy is solicited. (The Act establishes slightly different technical requirements for individual and group insurance policies.) The outline of Coverage summarizes the important provisions of the solicited policy in six paragraphs with the following captions:

- Read Your Policy Carefully. This paragraph warns the insured that the outline is only a summary of the policy and that the policy is the entire contract and should be read carefully.
• The second paragraph is captioned with the name of one of the types of coverages. This paragraph describes the benefits usually provided by the type of coverage being offered. However, the coverage being summarized may provide more or fewer benefits than those described in this paragraph. This paragraph may be omitted at the insurer's option.
• Benefits of This Policy.
• Exceptions, Reductions and Limitations of This Policy.
• Renewability of This Policy.
• Premium for This Policy.

The Outlines of Coverage are prepared by the insurer and all companies must follow the same format, which is prescribed by the Commissioner's regulations. However, the producer is responsible for the proper delivery of Outlines of Coverage when personally soliciting policies. Outlines of Coverage are also required in advertisements which contain applications for insurance.

TYPES OF DISABILITY POLICIES

"Blanket policies" are issued to master policyholders to provide benefits for members of eligible groups under circumstances specified in the Insurance Code.

"Group policies" are issued to master policyholders to provide benefits for members of eligible groups defined in the Insurance Code. Group members must be provided with individual "certificates of insurance" describing the major features of the master policy.

"Individual policies" are issued to individuals or heads of households to provide benefits for them and/or their dependents.

Members of groups covered under "blanket" and "group" disability policies have no direct contractual relationship with the insurer. Holders of individual policies contract directly with the insurer.

Except for credit disability policies, there are no standardized disability insurance policies established by law or recommended by the disability insurance industry. However, most disability policies are required to contain the Compulsory Uniform Provisions and, in some cases, may be required to contain one or more Optional Uniform Provisions. These Provisions are set forth in the Insurance Code and in the Regulations of the Insurance Commissioner.

Except in the case of credit disability insurance, solicitations for disability policies must include standard supplemental disclosure forms. These forms are "standard" in that the information required to be disclosed and the format of that disclosure are Established by the Commissioner's regulations, but most of the text used in the forms is drafted by the insurers.

INDIVIDUAL DISABILITY INSURANCE

"Individual disability" insurance policies may be issued under the following circumstances:

• To individual persons.
• To heads of households providing benefits for themselves and their dependents ("family" policies).
• To employees of a common employer or to members of a common association ("selected group" or "franchise" policies).
• To individuals or heads of household no longer eligible for group insurance coverage ("group conversion" policies).
The following types of disability benefits, when included in or attached to life insurance policies, are exempt from most of the Insurance Code Sections and Commissioner's Regulations applicable to individual disability policies:

1) Additional benefits for accidental death or dismemberment;
2) Waiver of premium benefits;
3) Loss of time benefits subject to elimination periods of at least 90 days.

Any other disability benefits are subject to the same requirements as if they were included in an individual disability policy.

Regardless of the coverage provided, all individual disability policies must comply with technical requirements relating to format and basic rules of administration. (Blanket and group disability policies are also subject to most of these requirements.) The more important of these requirements are summarized below:

**Policy Format**: An individual disability policy must:

- State the entire premium and other considerations for its issue;
- State the time when coverage commences and terminates;
- Comply with requirements relating to type size, form numbers, location of exceptions, limitations & reductions, and references to outside documents;
- Contain no reduction on account of age which, based upon the individual's age, is effective at issue.

**Administrative Provisions**: The following are the major provisions found in the individual disability policies. Group or blanket policies contain similar types of provisions plus additional provisions relating to eligibility, premium computation, etc., unique to such policies.

The "schedule" lists the names of the person or persons insured, the effective date of coverage, the premium and the policy serial number. Where benefits are variable at the option of the insured, the schedule usually details the benefit amounts, benefit periods and elimination periods. Special provisions applicable only to the individual insured, such as waiver of coverage for specified medical conditions, are sometimes printed on the schedule.

The "insuring clause" sets forth the formal agreement of the company to insure the insured. This clause often contains basic limitations of coverage, such as exclusion of occupational injury.

The "renewal provision" sets forth the terms upon which the insured may renew the policy. This provision will also set forth the insurer's right to terminate coverage, if any. Any right the insurer has to change premium rates should also be disclosed in this provision.

The "benefit provisions" set forth in detail the benefits provided by the policy.

The "exceptions, reductions and limitations provision" sets forth those losses which, although within the coverage defined in the insuring clause and/or benefit provisions, are still excluded from coverage. Exceptions, reductions and limitations may alternatively be stated in the benefit provisions to which they apply.

The "eligibility and termination provisions" are found in family policies and set forth the provisions under which coverage on the insured's spouse and dependents commences and terminates.
Uniform provisions: All disability policies must include the "compulsory uniform provisions" and may include one or more "optional uniform provisions". "Compulsory Uniform Provisions" are usually repeated verbatim in the policy, but that may be modified with the approval of the Insurance Commissioner. Policies issued by mutual or reciprocal insurers usually contain additional provisions relating to the policyholders voting rights. Both types of uniform provisions are discussed below.

GROUP DISABILITY INSURANCE
The only forms of group disability insurance are employee-employer, agent-principal, trustee, association, educational institution-student and borrower-purchaser.

Types of Group Disability Insurance
Employee-employer group disability insurance is written under a master policy issued to the employer or a trustee of an association of employers and covering employees of a governmental unit or district, employees of a common employer, or employees of the employers forming an association. The insurance must be offered to all of the employees or to all of a class determined by conditions pertaining to employment and must cover not less than 3 employees or employees together with their dependents or spouses and be on a plan which will preclude individual selection as to the amount of insurance coverage.

Agent-Principal group disability insurance is written under a master policy issued to a life or life and disability insurer and covering not less than 3 agents.

Association group disability insurance is written under a master policy issued to an association having a constitution formed and continuously maintained for purposes other than that of obtaining insurance. The insurance must be offered to all members of the association and cover not less than 3 members or members together with their dependents or spouses and at least 25 percent of all eligible members under a plan which precludes individual selection as to amount of insurance. The policy must require the premium to be paid either by payroll deduction or by some person acting for the association.

Trustee group disability insurance is written under a master policy issued to any trustees eligible to have issued to them a trustee group life policy and insuring not less than 3 employees or union members.

Educational institution-student disability insurance is written under a master policy issued to the school district, college, school or its governing board covering not less than 50 pupils of said institution and providing hospital, medical and surgical expenses resulting from accident to such students while properly on or being transported to or from the school premises or school-sponsored activities by such institution.

A certificate stating the benefits and exceptions of the master policy must be delivered to each insured employee, agent, or member (excluding dependents and spouses).
Employee-employer group policies may provide that the term "employee" includes officers, managers, and employees of subsidiary or affiliated corporation and the proprietors, partners, and employees of affiliated individuals and firms. Employee-employer group policies issued to a co-partnership or an individual employer may define the term "employee" to include the individual proprietor or partners of the policyholder. Such proprietors or partners must be actively engaged in and devote a substantial part of their time to the business. Trustee group policies may define the term "employee" to include (1) the individual proprietor and partners of any employers which are individual proprietors or partnerships, (2) the employees of an association and (3) the trustee or trustees or the employees of the trustee or trustees, or both, if their duties are principally connected with such trusteeship. Association group disability policies may define the term "members" to include the employees of the association. However, a director of a corporate employer may not become insured under a group disability policy unless he or "he is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director.

RENEWABILITY

There are two major classes of renewability provisions: those in which the insurer reserves some right to terminate the coverage and those in which the insurer guarantees to renew the policy for the insured's life or to a specified age.

The following types of renewability provisions are classified as optionally renewable:

- The insurer reserves the right to terminate the policy at any time with a pro rata refund of unearned premium ("cancelable" policies);
- The insurer reserves the right to terminate the policy at the end of any period for which premium has been paid ("non-renew") subject to prior notice ("optionally renewable" policies);
- The insurer reserves the right to non-renew an individual policy only if it non-renews all policies of the same form number issued in the state or issued to members or employees of a specified organization. ("collectively renewable" or "non-renew-one, non-renew-all" policies);
- The insurer can non-renew the policy only if the insured ceases to comply with one or more specified conditions, such as continued employment, employment in a specified business or profession, or continued membership in an association. Such provisions often reserve to the insurer the right to collectively non-renew all policies. ("conditionally renewable");
- Features of two or more of the preceding types of "optionally renewable" provisions may be combined in a renewal provision.

The two types of guaranteed renewable provisions, "guaranteed renewable" and "noncancellable" or "noncancellable and guaranteed renewable" have been discussed previously. Some "guaranteed renewable" or "noncancellable" loss-of-time policies provide for continuation of coverage after a specified age (usually 65), on an "optionally renewable" or "conditionally renewable" basis.

DISABILITY INSURANCE TERMS

Total disability is usually defined in terms of the insured's inability to perform the material or important occupational duties ("occupation total disability") or the inability to perform the duties of any occupation for which the insured is reasonably suited by education, training or experience ("any occupation total disability"). Most long-term loss-of-time policies contain both definitions, the former being in effect for a specified initial period of disability and the latter being in effect for the remainder of the benefit period. For example, policies providing loss-of-time
benefits to-age-65 may provide that the "occupation" definition will be in effect for the first two to
ten years of total disability, depending upon the policy.

Total disability for homemakers, retired persons and juveniles is usually defined in terms of the
insured's inability to perform the duties of a person of like age and sex.

**Partial disability** is usually defined as the insured's inability to perform one or more but not all
the material or important occupational duties. It may also be defined in terms of the percentage
of normal working hours worked by the insured. The term "residual disability" is often applied to
partial disability benefits which provide benefits proportional to the insured's loss of income due
to disability. Partial disability benefit periods are generally limited to three or six months in length
and often must follow a period of total disability. Residual benefits may be so limited or they may
be payable for the same period as the total disability benefit, depending on the policy.

**Nonoccupational policies** are policies usually issued to persons whose hazardous
occupations would make them uninsurable otherwise or to persons who have adequate
coverage specifically for occupational injuries. Such policies exclude coverage for injuries
incurred while engaged in activities for wage or profit.

**Transportation ticket policies** are short-term non-renewable accident policies often sold at
transportation terminals or by travel agencies, often to cover a specific journey. They usually
provide substantial accidental death and dismemberment benefits and often provide some
medical expense benefits. Such policies are frequently issued in conjunction with a casualty
policy covering loss or damage to baggage or personal effects. These coverages are usually
provided on a combination policy form.

Another type of travel disability policy available through travel agents reimburses the traveler for
ticket expenses incurred when he or she is prevented from embarking on or completing a
charter flight because of accident of sickness.

**Managed Care**
An important element of today's health care for boomers is managed care. There are a wide
variety of managed care plans available today. Many involve HMOs but other types of
managed care structures also exist. HMOs are by far the most common form of managed care
structure.

Generally, the HMO structure works as follows:

- A person enrolls in the HMO.
- The HMO promises to provide services including routine, preventative, specialty care and
  hospitalizations in return for a monthly premium or fee which may be paid by the member or
  may be paid in all or in part by the member’s employer.
- The member must generally select a primary-care physician.
- The member pays a small copayment or fee for services provided. No deductible or
  coinsurance applies.
- Care that is provided outside of the network is either not covered by the HMO or is covered
  in a manner similar to traditional fee-for-service insurance.

**Staff HMOs**
Staff model HMOs are one of the oldest forms of HMOs. Under a staff model HMO, the HMO
owns and operates the health centers and clinics that provide care under the HMO plan.
Physicians who give care to members are salaried employees of the HMO.
**Group HMOs**

Another early model of HMOs is the *Group HMO*. Under the Group HMO model, health centers are not owned by the HMO. The HMO contracts with one or more medical groups to provide the services within the plan. The physicians within the plan operate as an independent partnership or as professional corporations, separate from the HMO.

**Comparison of Managed Care to Traditional Fee-For-Service Health Plans**

<table>
<thead>
<tr>
<th>Managed Care</th>
<th>Fee-For-Service Care</th>
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<tbody>
<tr>
<td>Members receive care from the health care providers within the network.</td>
<td>Patient selects any physician or provider.</td>
</tr>
<tr>
<td>Plans include coverage for routine and preventative care, along with care for treatment of illness or accident.</td>
<td>Plan generally covers treatment of illness or accident, not routine or preventative care.</td>
</tr>
<tr>
<td>Any necessary care from a Specialist or through a hospital is generally authorized by a primary-care physician and arranged by the HMO.</td>
<td>Although insured may have to notify an insurer in advance of specialty or hospital care, traditional fee-for-service plans do not place restrictions on this care.</td>
</tr>
<tr>
<td>Managed care plans generally include no deductible nor coinsurance requirements for care given within the plan’s network.</td>
<td>Fee-for-service plans include deductibles and coinsurance requirements.</td>
</tr>
<tr>
<td>Managed care plans cover most or all of the care provided within the network, but do not cover care outside of the network.</td>
<td>Under fee-for-service plans there is no <em>inside of network, outside of network</em> issue. All care provided is subject to the same rules contained in the health plan.</td>
</tr>
<tr>
<td>Under many managed care structures, the plan arranges for and is responsible for the care given the patient.</td>
<td>Under fee-for-service plans, the physicians and health care providers are responsible for the care given to a patient. The insurer is not involved.</td>
</tr>
<tr>
<td>Managed care plans do not involve paperwork for the patient; there are no claims forms.</td>
<td>Under traditional health plans, the physician or patient must complete claims forms in order to receive reimbursement from the insurer.</td>
</tr>
<tr>
<td>Premiums are generally lower in managed care plans, particularly HMOs, than under fee-for-service based plans.</td>
<td>Premiums in fee-for-service plans are commonly 20% higher than in HMO plans.</td>
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Managed Fee-For-Service Plans

Managed fee-for-service plans were an early attempt by insurers to try to control costs by including some oversight of a patient’s doctor prior to paying for benefits. These plans had broad conditions, such as requiring a second physician’s opinion before certain forms of care would be paid for, limiting the number of days payment would be made for hospitalization for certain conditions, and similar provisions. These plans did result in some cost containment, but have in general been replaced by plans offered through Preferred Provider Organizations.

Preferred Provider Organizations

Preferred Provider Organizations, or PPOs, allow insurers to exercise more control over the physician’s care than did managed fee-for-service plans. As under group model HMOs, the physicians within a PPO are not employees of the HMO. Rather, they are physicians who enter into contractual arrangements with the PPO, generally an insurer, to provide services within the plan. The insurer generally includes provisions in the plan which give the insurer the ability to oversee some aspects of the care given by the provider.

Under a PPO arrangement, a member of the PPO chooses a preferred provider from a list issued by the insurer. The insurer pays for a greater percentage of the cost of care given by a preferred provider than care provided by a non-preferred provider. The preferred providers accept lower fees for their services from the insurer because being listed as a preferred provider gives them access to more patients.

PPOs were popular as an early form of managed care, but lost popularity because some physicians involved in PPOs increased their income by requiring patients to be treated more frequently than necessary and providing expensive treatment during appointments. When such abuse occurred, the insurer and in some cases the employer who commonly paid for these plans, did not experience cost savings but instead saw an increase in health care costs. To avoid the risk of abuse, many insurers stopped offering plans including reimbursement to physicians for services rendered.

Exclusive Provider Organizations

Plans offered through Exclusive Provider Organizations, or EPOs, involve a group of physicians and one or more hospital and other medical care providers. The group contracts with an insurer, an employer or other sponsoring organization to provide care. EPO arrangements are similar to PPO arrangements, except that only care received by the EPO is covered by the plan.

Point of Service Plans

Point of Service Plans, or POS plans, are plans that allow for the use of both HMO and non-network providers. They were created in response to members’ desire to have greater choice regarding the care they receive. Under a POS, the HMO coverage generally applies only to the care given by a physician who is part of the HMO network, for emergency care, and for approved care from an outside specialist. If care is provided by a non-network provider or outside of the rules of the HMO plan, it is covered by a traditional health plan, involving deductibles and coinsurance requirements.

POS plans meet the needs of consumers who do not want to switch doctors in order to be covered by an employer’s health plan or who do not like some other aspect of HMO coverage. POS plans generally have higher premiums than HMO plans, and the coordination of care that occurs under an HMO form of managed care may be more difficult to arrange under a POS, since both network and non-network providers may be involved in the care of a patient.
**Independent Practice Associations**
The fastest growing form of HMO is the *Independent Practice Association*, or IPA, HMO. A large number of individual practitioners contract with the HMO to provide health care services. These practitioners may have exclusive contracts to offer care under the HMO in certain geographical areas, or may be one of many groups of physicians who offer care through the HMO. The IPA may have the responsibility of coordinating care for members and overseeing the care given by the IPA physicians. Members of the IPA HMO choose a primary-care physician from among the many independent practitioners. The independent practitioners also see fee-for-service patients.

The structure of an IPA is generally as follows, although contractual arrangements vary:

- The HMO capitates, or pays a monthly fee, to the IPA.
- The IPA subcapitates, or pays a smaller monthly fee, to the primary care physicians within the IPA.
- The IPA deposits the remainder of the fees received from the HMO in a *risk pool*. The risk pool is to be used to pay for specialists, hospital care and other services.
- Annually, the money left in the risk pool, if any, is shared among the IPA’s physicians and the HMO. If a loss occurs, the HMO also has some share in the loss.

In some cases, the IPA enters into *full risk contracts* with the HMO, wherein they take a higher fee from the HMO and do not share, or share very little of, the profit with the HMO. Of course, under a full risk contractual arrangement, the IPA also is hit for any losses with little or minimal sharing with the HMO.

IPAs are the fastest growing form of HMO. The number of IPA HMO arrangements grew 35% between 1995 and 1996. It is estimated that over 60% of HMO arrangements are IPAs and eleven of the twenty-five largest individual HMOs are IPA plans.

**How Managed Care Plans Reduce Expenses**
Managed care plans attempt to provide necessary care to plan members while controlling expenses. Employers, who are the parties who are responsible for making managed care available to most managed care recipients, are interested in keeping health care expenses as low as possible. Managed care members also want to keep their fees and premiums to relatively low levels. Governments, who sponsor plans for people of low-income, for the aged, for government employees and for prisoners, also want low cost health care. Managed care was developed in large part due to demands from the public for low cost health care.

**Physician’s Compensation**
One of the ways managed care plans control expenses is through compensation arrangements with physicians. There are a variety of different compensation plans used. Each one attempts to fairly compensate physicians while maintaining reasonable care standards for members.

Before discussing managed care physician compensation packages, remember that managed care as it developed in the 1970’s was responding to many complaints about fee-for-service compensation arrangements. Under fee-for-service arrangements, doctors have a monetary incentive to provide as many health care services as possible. It was believed by some that fee-for-service arrangements were the root of the escalating health costs in the 60’s and 70’s. Doctors were viewed as money-hungry, as prescribing unneeded care in order to line their own pockets with profits. Many physicians during this time period graduated with their medical degrees in specialty fields, helping to fuel accusations by critically minded observers that graduating medical doctors were greedy and obtained these specialty degrees in order to be able to charge higher fees for their services.
Today, the various compensation arrangements in place try to reduce the incentive to provide unnecessary care while not removing the important incentives to providing necessary care. Some arrangements are seen as more successful at meeting these objectives than others.

One method managed care plans use to compensate physicians is to put them on a salary. Some salary plans include a small incentive arrangement based on keeping costs down to a certain level. Under such arrangements, the physicians are employees of the managed care organization. It is thought by proponents of this method that salary arrangements reduce the incentive to over prescribe and yet do nothing to discourage the rendering of appropriate care. Detractors of these compensation arrangements point out that the less work a doctor does for his or her salary, the higher the effective salary earned. For example, if two physicians both earn $200,000 annually and one works sixty hours per week and the other 35 hours per week, the physician working 35 hours per week has effectively been paid more than the physician who worked 60 hours per week. Another criticism of salary plans is that the doctors who accept salary plans are those who cannot “make it” financially under a compensation plan that pays based on being able to attract and keep patients. Detractors of salary plans claim that less qualified doctors are attracted to salary plans because they aren’t able to make a living in a practice where their income was based on serving their own patients. Proponents respond that physicians who want to ensure that their patients are not impacted by the physician’s ability to grow wealthy are attracted to salary plans.

Another compensation method used is capitation, where a physician within the plan is paid a flat fee per member under his or her care. Such plans also include incentives based on meeting financial targets. These incentives may be a large part of the physician’s compensation or a relatively small part. Those who favor capitation plus incentive plans believe they are effective at reducing the physician’s motivation to over treat, since regardless of the number of times a patient is seen, within target boundaries, the physician is paid the same amount.

Opponents of capitation plus incentive plans say that physicians are given too many incentives to give as little care as possible. There is particularly strong criticism levied against plans under which a physician can earn as much as 50% or more of his or her annual compensation based on meeting financial targets such as keeping referrals to specialists, hospitalization days and specialized testing under certain limits.

A third method of controlling expenses through physician compensation under managed care plan is through **paying physicians on a discounted fee-for-service basis.** Under such arrangements, the physician agrees to receive a discounted amount for the various services provided. These arrangements also generally include a generous amount of oversight authority over the physician’s care by the managed care plan. Such plans may include in their provisions oversight committees, written standards of care to be prescribed based on different medical conditions, maximum authorized hospitalization days, etc. Proponents of this type of system like the fact that physicians receive a controlled monetary incentive to provide more care than they believe physicians may provide under capitation systems. Detractors believe that physicians need to have more incentives to reduce unnecessary care.

A fourth type of compensation arrangement is constructed so that physicians are **shareholders** in the managed care plan. As shareholders, the physicians’ incomes are based on controlling expenditures under the plan. Proponents of this type of arrangement like the medicine as private business’ aspect. They believe that the plan will succeed or fail based on the physician’s quality of care and the response of members, or the **marketplace,** to their care. Proponents also like the fact that only those who are licensed by the medical field are both determining what type of care will be given and are providing the care. This eliminates the criticism that can be leveled against other arrangements if the plan’s rules are made and/or
reviewed by non-medical personnel or when medical personnel reviewing care given are rewarded monetarily for authorizing as little care as possible. Those who disagree with this type of plan believe physicians should not be business people, and should not have to worry about whether their business is profitable or not. Opponents can include those who believe all health care providers should operate on a not-for-profit basis.

Compensation plans may not fall easily into one of these four groups, but may include a mixture of elements from each basic type. However, the common element found in managed care compensation plans is that they each include methods to control health care costs.

**Physician as Gatekeeper**
Another way managed care plans reduce expenditures is through the utilization of physicians as gatekeepers. Each member is generally assigned or selects a primary care physician who must refer the patient to specialists and authorize tests and hospitalization. By placing the primary care physician in this position, managed care plans have a method of overseeing what care is being prescribed and to reduce unnecessary procedures. One of the reasons this type of structure was put into place was to combat the complaints of the 70's that doctors were prescribing unnecessary hospitalization and other treatments.

**Risk Selection**
Managed care plans may also reduce plan expenditures through selection of the members within the plan. State regulations may not allow denial of coverage by a plan for many health reasons, and federal regulations also prohibit group plans from excluding people with certain health conditions, but plans may still practice risk selection in ways other than denying entry into a plan. Marketing devices, such as offering exercise programs, can attract healthier members. Some employer plans include rewards for those who meet certain health lifestyle criteria. Another way plans practice risk selection is to include, within state regulations, rating systems. Under rating systems, members are divided into sub-groups. All members of each sub-group are charged the same premium or fee for membership in the managed care plan. In this way, members of the various sub-groups are charged a fee based on the risk factors they contain.

**External Review**
Finally, some managed care plans utilize external vendors to perform reviews of care prescribed, member satisfaction and other elements of managed care administration. The use of external vendors is becoming more popular. By using an external vendor, managed care plans hope to reduce the criticism that profit-mongering is the motive behind care prescribed and care denied and hope to be able to demonstrate that they are giving reasonable and adequate care. An external vendor should be able to provide an additional “check” on the tendency of physicians to either over prescribe or under prescribe care. Some regulators are pushing for state-run or state regulated external vendor organizations. Those who believe the state should be involved are wary that for-profit external vendors will act in favor of the managed care plans paying their fees.

Managing health care costs is a difficult endeavor. Plans must balance many factors in their attempts to provide the best care at the lowest prices. The many complicated and interrelated issues involved, and the concerns of regulators, employers and plan members will continue to keep managed care in the center of public debate.

**MANAGED CARE PROVISIONS**
Managed care plans contain some unique provisions and terms. This chapter will explain many of the important elements included within them.
Enrollment
The most common method of enrolling in a managed care plan is through an employer. Those eligible for Medicare can also enroll in managed care plans. Some managed care programs make themselves available to individual purchasers as well. For those who may have difficulty joining a managed care program because they are self-employed, are not eligible for employer benefits or don’t have access to managed care plans on an individual basis, managed care may be available on a group basis through state or local governmental programs or through cooperatives or associations.

Enrollment Through An Employer
When an employee joins a managed care program through an employer, the employee becomes part of a group coverage plan. Group coverage plans provide specified benefits to members who meet the criteria of the group. All employees of a business or several businesses may comprise a group.

Group coverage plans, when compared to individual coverage plans, generally have certain advantages:

- They are generally less expensive than individual plans.
- An individual or family member that may have difficulty receiving medical coverage will generally be accepted under a group coverage plan.
- The employee portion of the premium payments is often made as a payroll deduction, so the employee will not accidentally cancel coverage through non-payment of premium.

Group plans can have disadvantages as well. In some cases, the lower premium associated with the plan occurs because the provisions within the plan include more limited coverage benefits than individual plans. Or, waiting periods may be included before certain benefits apply under certain group plans. However, regulations applicable to group health plans limit the extent to which a group plan can include waiting periods, as will be discussed later in this chapter. Group plans may also provide limited coverage, such as a lifetime coverage cap. It may be because of limited coverage provisions or coverage caps that the plan does not exclude those with conditions that would prohibit them from being covered by an individual plan.

Group plans do not always include all these disadvantages. They may be relatively less expensive due to the high number of members within the plan resulting in lower costs due to risk spreading. The managed care organization, such as an HMO, may have contracted with providers within the plan to give care at significant discounts.

Employers may offer a choice of managed care plans or traditional health plans to employees. Some may offer more than one type of managed care plan, or may offer both a POS and HMO plan. If managed care is not available in the area in which the business operates, the employer will not be able to offer managed care. This situation is more and more uncommon, since managed care popularity has caused it to spread throughout the country.

An employee may join a managed care plan through an employer when hired. New members can also join during the annual open enrollment period. Once an employee is enrolled, if the employee is responsible for all or a portion of the premium payment, the payment will generally be deducted from his or her paycheck at least monthly, and remitted to the managed care organization.

Enrollment as an Individual
Many managed care organizations offer plans to individuals, such as the self-employed. As more and more people leave corporations to operate as independent contractors or to start their
own businesses, more and more managed care organizations are offering plans within the individual marketplace.

Individual plans may require a more lengthy application process than group plans, and may also require a medical examination before a member can be accepted into the plan. Some states have regulations that do not allow a managed care organization to do such health screening. State regulations may also prohibit excluding individuals from coverage due to pre-existing conditions, from adding exclusions to a health plan, or from extending waiting periods based on an individual’s pre-existing conditions. Federal regulations regarding pre-existing conditions and waiting periods do not generally apply to individual health plans.

**Enrollment Through a Cooperative**

The process of enrolling through a cooperative or association is similar to enrolling through an employer in some ways. Coverage through cooperatives and associations, whether governmental, an association of CPAs, of computer programmers, or through a credit union or even membership in a superstore, is all offered on a group basis. A limited application process is used, and no medical exam is generally required. All applicants are generally accepted. Unlike enrolling through an employer plan, a member enrolling through a cooperative or association must pay the entire premium amount. The premium can normally be automatically withdrawn from a bank account on a monthly basis in order to make the process more convenient and reduce the likelihood that a payment will be missed and the coverage cancelled.

**Pre-Existing Conditions**

A plan’s provisions regarding pre-existing conditions can be very important to the purchaser. Many forms of managed care plans do not place any restrictions on pre-existing conditions. HMOs for example, generally do not. However, plans such as POS plans may impose waiting periods for certain conditions if care is received outside of the managed care network. State regulations may prohibit health plans from excluding conditions or imposing waiting periods, however.

Pre-existing condition exclusions and waiting periods are also limited through federal COBRA regulations and other related laws. The *Consolidated Omnibus Budget Reconciliation Act of 1985*, or COBRA, includes requirements for group health plans regarding health care continuation. COBRA has been amended and expanded by the Omnibus Budget Reconciliation Act of 1986 (OBRA ’86), the Tax Reform Act of 1986 (TRA ’86), the Technical and Miscellaneous Revenue Act of 1988 (TAMRA), the Omnibus Budget Reconciliation Act of 1990 (OBRA ‘90), the Small Business Job Protection Act of 1996 (SBJPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under these regulations a *group health plan* is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families. The regulations also apply to certain individual health plans, if maintained by an employer or employee organization for employees.
Under COBRA, generally, qualified beneficiaries must be given the opportunity to continue health care coverage provided through an employer’s health plan. A qualified beneficiary, under IRS final regulations issued December 28, 1998, is in general, (1) any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the spouse of a covered employee, or the dependent child of a covered employee, or (2) any child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. Qualifying events, or events that trigger COBRA continuation coverage, include termination from employment, resignation, death, entitlement to Medicare, reduction in hours to a level below that required by the employer for health care coverage, employer bankruptcy, and in certain cases divorce, legal marital separation, and a child’s loss of eligibility for coverage.

If a health plan covered by COBRA does not comply with requirements under COBRA, an excise tax is imposed on the employer and/or the plan. In addition, qualified beneficiaries who are harmed by this lack of compliance can file a lawsuit against the plan or employer for damages.

The terms of COBRA allow for the qualified beneficiary to be required to pay for the continuation of coverage; the employer does not have to pay the premium. In addition, the plan may charge additional administrative costs of up to 2% of the premium fees. The coverage under COBRA is required to be generally the same as the coverage the qualified beneficiary had before the qualifying event. The employer can give the beneficiary the option of eliminating benefits that are considered noncore, such as dental and vision care.

HIPAA regulations, under Section 9801, Increased portability through limitation on preexisting condition exclusions, state that, generally, a group health plan may only impose a preexisting condition exclusion if the exclusion relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date and the exclusion is in force for not more than 12 months, or up to 18 months for late enrollees. Under certain conditions the maximum exclusion period may be reduced by periods of creditable coverage. For example, if an individual was enrolled in a group health plan upon being hired by an employer, the new group health plan must give the employee credit for the time covered by the original health plan. The regulations define creditable coverage to include coverage under the following:

- A group health plan.
- Health insurance coverage.
- Part A or part B of title XVIII of the Social Security Act.
- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
- Chapter 55 of Title 10, United States Code.
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- A health plan offered under chapter 89 of title 5, Unites States Code.
- A public health plan.
- A health benefit plan under section 5(e) of the Peace Corp Acts.

Also under HIPAA, a group health plan may not impose any preexisting condition exclusion to:

- A newborn who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;
A child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last thirty-day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage; or

Any condition related to pregnancy.

Certain coverages may carry additional waiting periods, however. These coverages include:

- Prescription coverage
- Vision coverage
- Dental coverage
- Mental health coverage
- Substance abuse coverage

However, if the individual had coverage under creditable coverage for any of these items, no additional waiting period can be applied.

**Enrollment Eligibility**

HIPAA also includes regulations regarding eligibility requirements for group health plans. Generally, a group health plan may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on any of the following factors applicable to the individual or dependent of the individual:

- Health status
- Medical condition (including both physical and mental illness)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability (including conditions arising out of acts of domestic violence)
- Disability

However, the regulations found in IRC Section 9802 are not to be construed to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment or service) other than those provided under the terms of the plan, nor to prevent such a plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

**Premium Payments**

HIPAA also does not allow group health plans to discriminate on the basis of the factors listed previously (health status, medical condition, etc.) in determining premium payments. A group health plan may not require any individual to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on these factors. These regulations state that they are not intended to restrict the amount that an employer may be charged for coverage under a group health plan or to prevent a group health plan from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.
Role of the Primary Care Physician

An important issue within a managed care plan is the role of the primary care physician. This physician has a tremendous impact on the type of care the member receives, not just from that physician, but also from other medical caregivers. Under managed care plans, the primary care physician has four important roles: caregiver, consultant, gatekeeper and advocate.

**Caregiver**

As the name *primary care physician* suggests, under managed care plans, this physician is likely to provide the member with most of the medical care the member requires. Because of the primary care physician’s important role, members should select their physician with care.

Managed care plans may differ in the way they decide whom to include as a primary care physician within their plan. Some managed care plans may have several standards a prospective primary care physician must meet in order to become part of the plan. For example, the plan may require the physician to attend certain instructional meetings regarding the plan provisions, may require that the physician have certain educational credentials, may require that physicians provide references from inside the medical community, or may have other screening devices in place to make sure physicians with unsatisfactory practices are not included in the plan.

Once a physician is part of the network, plans may have methods of monitoring the care given and prescribed by the doctor. Some periodically contact members and conduct surveys about the care the member has received. Others have advisory boards that review the care and treatment provided by primary care physicians within the plan. Many plans also have methods of disciplining or correcting physicians who do not meet the plan’s standard of care.

Some plans do not have, or have only minimal, processes in place for the screening of prospective primary care physicians. Others do not have processes to oversee physician’s care. Plans without these processes are becoming more and more rare due to the scrutiny managed care is receiving by both regulators and the media. If a member believes a physician is not providing care as required by the plan, and the plan is unresponsive to the member’s concerns, the member may report problems to the state’s insurance department. Depending upon the type of complaint, the authorized staff of the insurance department often takes steps to see the complaint resolved.

**Consultant**

The primary care physician also acts as a consultant. If coordinated care is provided, the primary care physician is an important member of the team, helping to decide what type of and to what extent care is provided. The primary care physician also acts as an expert consultant to the member. The member expects this physician to know when to refer the member to specialists or when to undergo special tests.

**Gatekeeper**

The primary care physician also acts as a gatekeeper under many managed care programs. The primary care physician must provide referrals in order for the member to see a specialist, to undergo certain tests, or be provided with hospitalization or surgical care.

**Advocate**

Finally, the primary care physician is an advocate for the patient. The primary care physician works with the managed care organization to ensure that the member receives the care needed. Sometimes, the physician must prove to the managed care organization that the patient requires care that the managed care organization does not normally provide. The physician
may have to take up the patient’s cause with an oversight committee from the managed care organization and provide good, solid reasons why the patient needs special care.

Sometimes, the roles of the primary care physician can be in conflict with one another. As gatekeeper, the primary care physician is responsible to the managed care organization to try to keep care costs down and to prevent the member from receiving unnecessary care. As caregiver, however, the physician must try to provide the best care possible. It is possible that a physician may err on the side of cost control and not refer a member to a specialist when the member needs it. Members of managed care plans should contact the managed care organization if the member believes the physician is not treating him or her as needed. Most managed care plans have a process under which a member can appeal a decision. Some managed care patients have gone to physicians outside the plan to get a second opinion, and if that opinion disagrees with the primary care physician’s or the plan’s opinion, the member uses the second opinion to encourage the physician or plan to change its mind about what medical care should be given.

**Medically Necessary Services**
Managed care plans promise to provide medically necessary services, within the scope of the plan’s provisions. Generally, managed care plans determine what care is medically necessary through a process of utilization management or utilization review. Whether care is medically necessary or not is based on the managed care plan’s utilization review; it is not based solely on the opinion of the patient’s physician.

Basically, under a utilization review process, the managed care organization compiles criteria, or uses criteria experts have compiled, under which various medical treatments will be covered. If a patient’s situation meets the criteria, the care received is covered by the plan, and if not, the care is not covered, or only partially covered.

If a member believes that care should be given and covered even though the managed care organization denies the coverage of the claim, the member must file an appeal. The process of the appeal varies based on state regulations and plan rules, but generally, the appeal process is first handled by non-physician medical providers and the appeal then moves up the chain to licensed physicians. Many states now require that physicians sign any care denials and may also require that an explanation of the denial be given to the patient.

**Care Provided**
Managed care plans provide various types of care. Each type of care provided under the plan may have different stipulations concerning when the care is covered and when it is not.

**Preventative Care**
Managed care plans generally cover a wide variety of preventative care. Immunizations, screening tests such as mammograms and those for prostate cancer, cholesterol levels and blood pressure, pap smears, as well as care used to manage chronic conditions such as diabetes or asthma, are generally covered.

Plans vary regarding how often tests are covered, for what age groups they are covered, and other criteria that might have to be met in order for various preventative care treatments to be covered. For example, mammograms are often covered on an annual basis once a female reaches forty. Immunizations may be covered only through a child’s age twelve. Testing for prostate cancer may be covered for males over fifty. Plans may also vary regarding what type of health care provider can perform exams or tests and whether a referral from a primary care physician is required in order to undergo a test or exam.
Other ways managed care plans may cover preventative care is through the holding of classes or seminars that provide instruction in weight management, smoking prevention, stress management, and management of conditions such as diabetes, high blood pressure or asthma.

**Emergency Care**

Managed care plans generally divide emergency care into two classifications: urgent and life-threatening. Urgent refers to conditions that need immediate attention, but are not life-threatening. Such conditions may include a broken ankle or broken arm, a severe cut that requires stitches, an extremely high fever perhaps accompanied by a sore throat, or continuous vomiting. Often, a managed care organization will cover such care only if the member contacts their primary care physician of the managed care organization prior to going to the emergency room. Under some managed care plans, such care is only covered if a certain hospital’s or hospital network’s emergency services are utilized.

Life-threatening refers to conditions that could result in death, serious disability, disfigurement, or a long-term medical problem. Managed care plans do not require authorization from a primary care physician in order for emergency care for life-threatening conditions to be covered. However, many managed care plans require that they be notified within 24 to 48 hours of the member’s treatment.

Each plan may have slightly different parameters regarding what conditions must be present in order for care to be covered as a life-threatening emergency. It is common for plans to include the following conditions as those considered life-threatening: possible poisoning, possible heart attack, possible stroke, convulsions, severe burns, loss of consciousness after a blow to the head, injuries as a result of being crushed, and so on.

It can be difficult for a member facing an emergency to be able to distinguish between what conditions are urgent and what conditions are life-threatening. Plans generally recommend calling the primary care physician or the plan before going to the emergency room, if at all possible. If for some reason the member, or the person calling on the member’s behalf, cannot reach the appropriate physician or the managed care organization, he or she should note the time and phone number called so that documentation can be provided to the managed care organization that the member tried to receive instruction and authorization prior to going to the emergency room, if such documentation becomes necessary. The caller should also leave a message at the number called giving the time, a brief description of the condition, and what emergency room will be used.

Managed care organizations today generally cover emergency care based on the diagnosis after emergency care is administered. One can imagine that patients may feel unfairly treated by the managed care organization when they believe they need emergency care and the managed care organization does not cover the care given because it turns out the patient’s condition did not warrant emergency services. This issue is one being carefully looked at by lawmakers today.

**Away-From Home Care**

Managed care plans also have differences regarding how they cover care received out of the area in which the member resides and out of the service area the managed care organization. Generally, emergency care is treated by managed care plans in the same manner whether the care is provided within the network or out of the area. Rules regarding away-from home hospitalization or non-emergency care can vary greatly from plan to plan.

Routine care is unlikely to be covered by the managed care plan if performed out-of-the-area. However, some plans cover such care for college students away from home and covered by the
Care for conditions such as the flu or serious cold may also be covered if a member calls the managed care organization prior to treatment.

**Care From Specialists**
Managed care plans also vary regarding the methods under which care from specialists is covered. Some plans require a referral from the primary care physician in order for the plan to cover care from a specialist. Other plans allow the member to go to specialists without a referral, but may not cover all the costs of such care.

Managed care plans may include specialists within the plan network, or the plan may refer patients to specialists outside the plan. Plans may also vary regarding what type of physician is considered a specialist. Specialties that may be covered by the plan include:

- Allergies
- Cardiology
- Ear, Nose and Throat
- Fertility
- Gastroenterology
- Gynecology
- Infectious Diseases
- Neurology
- Obstetrics
- Occupational Therapy
- Optometry
- Physical Therapy
- Radiology
- Speech Therapy
- Surgery
- Urology

**Hospital Care**
Under managed care plans, hospital care must generally be authorized by the managed care organization and/or the primary physician. The plan may require that the member attend a specific hospital, or may have a choice of hospitals from which the member may receive care.

Under some managed care plans, hospitalization is subject to a utilization review. This review may include both whether hospitalization is necessary and a determination of how long the patient should remain in the hospital. Under other plans, the hospital medical staff will coordinate care with the primary care physician and this team will determine when a patient should be discharged.

Plans can differ regarding which hospitalization services are covered and which are not. For example, private rooms may not be covered, or covered only under certain circumstances. Television provided in the room and other non-medical services may or may not be covered by the plan.

**Skilled Nursing and Rehabilitative Care**
Skilled nursing and rehabilitative care can be given at home or at a skilled nursing facility. Managed care plans may cover skilled nursing and rehabilitative care. The plan may require that such care be authorized by the plan prior to being given in order for the care to be covered. The plan may have health care providers within the plan that will give the skilled nursing or rehabilitative care, or may allow the patient to receive such care from providers outside of the
plan. Skilled nursing and rehabilitative care covered by managed care plans is short-term care, and generally will be covered for a maximum of a specified number of days. Long-term care, such as that provided by nursing homes to elderly patients, is not generally covered by managed care plans.

**Home Health Care**
Health care services are now more and more often provided in the home. Types of services that may be given in the home include nursing services, home health aide services such as bathing and dressing, physical therapy, occupational therapy, speech therapy, respiratory therapy, nutritional services, medical services, social services, and medical supplies or equipment services provided in the home. Managed care plans may cover this care if authorized by a primary care physician. Home care such as meals and housekeeping are not generally covered by managed care plans.

**Hospice Care**
A hospice is a facility that primarily provides care for terminally ill patients. Hospices do not provide care to treat the illness or disease, such as chemotherapy. Rather, a hospice provides pain medication and other services such as counseling to help the terminally ill patient be as comfortable as possible. Managed care plans may cover such care. Plans that cover hospice care generally require that the care must be authorized by the patient’s primary care physician. Like skilled care, hospice care is generally covered for up to a maximum number of days.

**Alternative Medicine**
It is becoming more common for managed care plans to cover alternative medical treatments such as acupuncture, chiropractic care, homeopathic care and nutritional therapy. However, many plans still do not. Managed care plans generally cover treatments that are acceptable to the medical community at large. Formularies and utilization review processes use well recognized treatments and remedies. Most alternative medical treatments do not meet such criteria.

**Family Planning**
Family planning services, such as providing treatment to combat infertility, pregnancy testing, birth control counseling and so on, may be covered under managed care plans. Some plans may provide coverage for all family planning services, and other plans may not. State laws may require that certain items be covered by managed care plans, such as birth control pills if a patient is covered by a prescription drug plan.

Plans that cover family planning services such as infertility treatments vary in which services are covered and which are not. Infertility treatment may be covered only up to a certain age, for example. The plan may only cover treatment for up to a specified period of time, or for a certain number of treatments.

**Maternity Care**
Because managed care plans focus on preventative care, they provide coverage for prenatal and maternity care. Generally, managed care plans cover all checkups during pregnancy, necessary tests and child birthing, breast-feeding and newborn care classes. The plan will also cover care needed during labor and delivery. Once the baby is born, managed care plans cover immunizations and well-baby checkups. Some plans also provide follow-up care and instructions once the mother and baby are at home soon after giving birth.
Some plans will allow the mother to continue to receive care from a previous physician if the mother becomes a member while she is pregnant. Others require that the mother choose a physician within the plan’s network. Some plans will cover the use of a midwife.

**Pediatric Care**
As mentioned, managed care plans cover immunizations for children. They also cover visits to the physician for treatment for earaches, colds, sore throats, the flu, diarrhea, scrapes and bruises and other common childhood ailments. As children get older, many plans offer services such as classes or counseling on drug prevention, smoking prevention and other issues affecting teenagers today.

**Senior Health care**
Managed care plans include many benefits for people as they age. Many cover annual checkups for people in or past their middle years for items such as:

- Breast cancer
- Prostate cancer
- Colorectal cancer
- Blood pressure levels
- Cholesterol levels

Care for conditions commonly associated with aging is also covered by many plans. Care can be received for diabetes, osteoporosis, arthritis, hearing loss, strokes, incontinence, digestive problems, Alzheimer’s disease, and other conditions, whether easily treatable or serious. Some plans also cover care given to treat mental health conditions such as depression and anxiety. Classes and seminars may also be provided through the plan which cover topics of interest to patients in or entering their senior years.

The need for prescription drugs often increases with age and prescription coverage is offered by managed care plans, although the coverage may require payment of additional premium. Many plans include provisions enabling the review of the prescriptions prescribed by physicians within the network to ensure safety in the prescriptions’ use.

Primary care physicians can often meet the care needs of aging patients, but those with certain conditions may need to see specialists or select a new primary care physician with experience in geriatrics or other relevant area. It is also important to remember that managed care plans do not provide long-term care benefits. Long-term care insurance policies may be an additional form of insurance that aging adults require to meet health care needs.

**Women’s Health**
Women have special health care needs. Women may require care related to menstruation, fertility, reproduction, childbirth, menopause, breast cancer, cervical cancer and other conditions related to their gender. Some managed care plans include women’s health clinics as part of their network of providers. Some also allow a gynecologist to be a primary care physician.

**Mental Health and Substance Abuse Care**
Managed care plans vary in the scope and depth of coverage for mental health and substance abuse related care. Some state laws include regulations that require that certain minimum levels of such care be covered. Other states have no such requirements.
Some plans may cover such care for a certain number of visits. For example, a plan may cover up to three visits to a psychologist for marital counseling, or may cover drug abuse therapy up to a certain maximum dollar amount of services. A plan may also cover only assessment services.

Plans may allow a member to self-refer to a mental health or substance abuse emergency center. Others allow self-referrals for non-emergency mental health care, especially if mental health care providers are a part of the plan’s network. Some require a referral from a primary care physician for such services.

Plans that provide coverage for substance abuse and mental health care differ regarding whether the patient may select their own therapist, whether a therapist will be selected by the plan, or whether care is covered if provided by a therapist outside the plan network.

Some plans may offer group counseling or programs for conditions such as eating disorders or coping with abuse, or other mental health conditions that can be improved by such programs. Other plans do not offer group counseling for these conditions.

**Prescription Drugs**

Prescription drug coverage is generally offered by managed care plans for additional premiums or member fees. Some plans cover prescriptions filled by network pharmacies only and others have no restrictions regarding where prescriptions must be filled in order to be covered. Of course, prescriptions are generally covered only if written by a primary care physician or other authorized physician under the plan.

It is not uncommon for managed care plans to cover prescriptions based on a *formulary*. A formulary is a list of medications that are used to treat various conditions and is used by physicians within a plan as a guide for prescribing medication appropriate to a patient’s condition. Generally, if medications are prescribed according to the formulary, the managed care plan will cover these medications at a higher level than medications not on the list.

As with other services covered, managed care plans cover prescription drugs considered medically necessary. Experimental drugs and drugs used for cosmetic purposes are not covered. Drugs used for birth control purposes may or may not be covered; state regulations may require that they be covered.

Prescription drug coverage often has associated with it a separate premium or different copayment amount than other care covered under a plan. Drugs may be covered on a percentage of cost basis rather than on a copayment basis. Prescription drugs may also be subject to a specified annual coverage limit separate from other coverage limits.

**Other Provided Care**

Other care that may be covered under managed care plans can include dental, hearing and vision care. Plans may categorize this care as *medically necessary, preventative and not-medically necessary*.

Medically necessary care includes care such as that required after an accident, or care required due to an infection. Preventative care includes care such as teeth cleaning or routine hearing and vision examinations. Non-medically necessary care includes items such as dentures, hearing aids and corrective lenses.

Some managed care plans offer no coverage or limited coverage for preventative vision, dental or hearing care. Coverage for routine dental examinations may be limited to patients under the
It is not uncommon for preventative vision care not to be covered under low-fee managed care plans.

**Administration of Managed Care Plans**

Another important aspect of managed care plans is their administration. The way a plan is administered can affect the patient’s benefits over time. Administration of the plan includes implementation of coverage changes, changes in premium, how coordination of benefits is handled, how coverage is terminated and the process involved when switching coverage plans.

**Coverage Changes**

Coverage or benefit changes can occur for a number of reasons under a managed care plan. State or federal regulations may result in required changes in benefits, the employer who sponsors a plan may negotiate for changes in coverage with the managed care provider, or the managed care provider may change product specifications. Technological advances and new medically accepted treatments can motivate a managed care plan’s decision makers to change the scope of benefits provided.

Before a coverage change takes effect, the plan will notify each member. The plan will issue an amendment to the policy or may issue a new contract with updated provisions.

Changes in coverage cannot be made if state or federal regulations prohibit them. If a regulation exists requiring certain minimum levels of coverage or that disallows certain exclusions, changes that would cause these provisions to violate regulations cannot be made. Allowable changes generally include such items as:

- Increases in co-payments or member fees
- Changes in various limits of coverage, for example, changes in charges for prescription coverage
- Broadened coverage based on state or federal requirements
- Changes in the physicians, clinics or other health care providers within the plan’s network
- Changes due to mergers and acquisitions in the managed care field

**Premium or Fee Changes**

Premiums can generally change annually. Under a group plan, all affected members will experience the premium change at the same time, such as at the beginning of a new plan year. Under individual plans, premium changes will generally be made at each policy anniversary.

Premiums may be changed for many reasons. Under group plans, the contract with an employer will reflect expected expenses related to the group insured. Some groups have relatively higher expenses than another group for various reasons. A group of employees may have a high number of older employees that begin to need additional care. Or, a business may include several females in their child bearing years and a relatively high percentage of them become pregnant. Children within the families enrolled may happen to have a high incidence of allergies, asthma, or other serious condition. If a group happens to incur relatively higher expenses than the managed care plan expected, premiums will likely go up.

The age of enrollees also affects the premiums charged. A new premium bracket may apply at age 30, 40, 50 and so on. When a member enters the new premium bracket, premiums go up.

The managed care plan must notify members within a specified time prior to the date the fee change takes affect. Depending on plan rules and, often, state regulations, notification may be anywhere from thirty to ninety days before the new fee schedule’s implementations.
**Coordination of Benefits**

Some people are covered by more than one managed care or insurance plan. For example, both spouses may be employed and each enroll the other in their employer-sponsored health plan. Other circumstances that can result in being covered by more than one plan can include being involved in an auto accident and the applicable auto insurance providing certain medical expense coverage, being involved in an accident at another person’s home and applicable homeowner’s insurance providing medical coverage, or being involved in an accident at work where Workers’ Compensation insurance applies.

Managed care plan language varies regarding how its coverage is applied when there is duplicate coverage. Generally, all insurance policies and managed care plans exclude coverage if care is covered by Workers’ Compensation, government provided disability insurance and the like. If more than one insurance policy does apply to the same injury, accident, sickness or other condition, it is common for the language in a policy such as a homeowners or automobile policy to assume that the other insurance is the primary insurance. If both plans or contracts assume that the other is the primary insurer, the terms of the plan will often allow for a sharing of the cost of care, up to the applicable limits of coverage. Managed care plan provisions can be complicated. Under some circumstances, a plan may be primary, and if other circumstances apply, the same plan may be considered to provide secondary coverage.

**Subrogation**

An important legal concept applied to many types of insurance and to managed care plans is the concept of subrogation. To subrogate means essentially to substitute. As this concept relates to insurance or health care coverage, it means that the insurer’s or health care plan’s right to collect payment from a liable party is substituted for the patient’s right if the insurer or health care plan has paid for the patient’s care. For example, if someone causes a patient’s injury and the managed care plan pays for the patient’s care, the managed care plan can “go after” the person responsible for causing the injury in order to be recompensed for the payments made to cover the patient’s cost of care. It is also possible that the managed care plan will “go after” the patient for compensation. This can occur if the patient receives payment for the injury from another insurer or from a responsible party, and the managed care plan had paid for the care associated with the injury. The managed care plan will expect to be reimbursed for the expenses it has incurred on the patient’s behalf.

**Terminating Coverage**

The provisions under which coverage may be terminated vary based on the plan, state regulations and whether the plan is a group or individual plan. Under employer-sponsored group plans, a member’s coverage may be terminated, subject to COBRA rules, if the employee resigns, is terminated, or retires. Termination can also occur if the employer does not pay the applicable premium. Another reason coverage may be terminated under either employer sponsored or individual managed care plans is if the plan has rules that require that members live within a specified area and the member moves. Coverage can also be terminated if it is found that the member or applicant has provided false or misleading information on the plan application, or if a member commits fraud. Finally, most plans terminate members once they are eligible for Medicare, or require that they switch to a Medicare approved program offered by the plan.

A managed care plan must follow certain rules when termination occurs. State regulations require that adequate notice be provided prior to termination and many also require that reasons for the termination be given and the options the member has to avoid termination be stated. Of course, if fraud were committed, the member cannot avoid termination.
As discussed earlier in this chapter, if a managed care member is terminated under an employer-sponsored plan, the plan must follow COBRA rules, and so may be able to continue coverage by paying the required premium. Besides the option of continuing coverage through COBRA, some managed care plans offer group plan members the ability to convert to individual coverage. The plan may have a variety of individual plans from which to choose and the former group member may be able to join one that meets his or her coverage needs, perhaps with a higher deductible than the group plan, so that the coverage is affordable.

**Switching Coverage Plans**
As discussed earlier under the topic Preexisting Conditions, in certain cases, a group health plan must give a new member credit for prior coverage, which reduces the length of the waiting period related to certain preexisting conditions. The prior health plan must provide certification of creditable coverage at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, or in the case of an individual become covered under COBRA, at the time the individual ceases to be covered under COBRA. A plan must also provide documentation of creditable coverage upon the request of an individual made not later than twenty-four months after the date of cessation of coverage.

Also, as mentioned, under state and federal COBRA rules, qualified beneficiaries must be given the opportunity to continue health care coverage provided through an employer’s health plan.

**General Exclusions**
The types of care that the plan does not cover are included in the general exclusions section of the agreement or contract. Depending on the plan, exclusions may include:

- Acupuncture
- Admission prior to coverage
- Alcoholism and related conditions
- Chemical dependency and related conditions
- Cosmetic or reconstructive surgery
- Custodial care
- Dental procedures
- Experimental procedures
- Hearing aids
- Infertility
- Lifestyle modification
- On-the-job injuries covered by Workers’ Compensation
- Orthotic devices
- Outpatient treatment for mental or nervous disorders
- Services through city, county, state or federal law
- Sexual disorders
- Sterilization and related conditions
- Vision services
- War-related conditions

**Medical Savings Accounts**
The Medical Savings Account, or MSA, was created by the Health Insurance Portability and Accountability Act of 1996. This Act authorizes an MSA pilot program. The program allows 750,000 MSAs to be established between 1997 and the year 2000. After this time period, Congress must act in order to allow for the establishment of additional MSAs.
The MSA was created as a means to reduce health care expenses. Under an MSA program, the individual pays for health care directly. This is in contrast to coverage through a conventional health coverage plan, where the insurer or managed care organization decides which medical expenses to pay for, and how much to pay. By giving the individual the freedom to pay for just those services the individual needs, health expenses should decrease, Congress reasoned. In addition, the individual has an incentive to keep health costs low, since unused values of the MSA can be used for future health care expenses. While money remains in the MSA, it grows tax-deferred. Contributions to MSAs may be deductible as well. MSA accounts can be used in conjunction with high deductible managed care plans.

An MSA is basically a personal savings account used to pay for unreimbursed medical expenses. A high deductible health plan is purchased on the MSA holder. The MSA holder contributes an amount not greater than a certain percentage of the deductible into the MSA. The amount contributed earns interest tax-deferred in the MSA. When the MSA values are distributed to pay for certain medical expenses, the amount distributed is tax-free. Other distributions are taxable.

**Eligibility and Contribution Rules of MSAs**

**Eligibility**

MSAs are available to employees or the spouse of an employee of a “small employer” who maintains an individual or family “high-deductible health plan” for the employee. MSAs are also available to self-employed individuals and the spouse of self-employed individuals who maintain an individual or family “high-deductible health plan covering the individual and or spouse.

The term **small employer** is defined in IRC section 220(c)(4):

- In general. The term “small employer” means, with respect to any calendar year, any employer if such employer employed an average of 50 or fewer employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.
- Employers not in existence in the preceding year. In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.
- Such employer met the requirement of subparagraph (A) (determined without regard to subparagraph (B)) for any preceding calendar year after 1996,
- Any amount was contributed to the medical savings account of any employee of such employer with respect to coverage of such employee under a high deductible health plan of such employer during such preceding calendar year and such amount was excludable from gross income under section 106(b) or allowable as a deduction under this section, and
- Such employer employed an average of 200 or fewer employees on business days during each preceding calendar year after 1996.

**High Deductible Health Plans**

A **high-deductible health plan** is defined in IRC section 220(c)(2)

- In the case of self-only coverage, a plan which has an annual deductible which is not less than $1,500 and not more than $2,250.
• in the case of family coverage, which has an annual deductible which is not less than $3,000 and not more than $4,500, and
• the annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed

(1) $3,000 for self-only coverage, and
(2) $5,500 for family coverage.

The deductibility levels and out-of-pocket expense levels in code section 220 are indexed for inflation beginning after 1998. There is no requirement that the high-deductible insurance plan be offered by any specific type of health coverage provider.

If an employee is also covered by a health plan that is not a high-deductible health plan, the employee is not eligible for an MSA. However, an employee may maintain certain types of insurance that will not be considered when determining whether the employee is covered by a non-high-deductible health plan. Insurance that covers accidents, disability, dental care, vision care or long-term care does not cause ineligibility for an MSA. Neither does Medicare supplemental insurance, insurance if substantially all the coverage relates to liabilities under workers’ compensation laws, tort liabilities, liabilities related to ownership or use of property, insurance for a specified disease or illness, or insurance which pays a fixed amount per period for hospitalization.

**Contributions**
Contributions to MSAs may be made by the eligible employee or spouse, or by the employer. If an employer makes a contribution to the MSA, the employee or spouse may not make a contribution to the MSA for that tax year. If a self-employed individual or spouse of a self-employed individual establishes an MSA, the self-employed person or spouse makes the contributions.

**Maximum Contributions**
The maximum monthly contributions which may be made to an MSA are 65% of the deductible of an individual coverage high-deductible insurance plan and 75% of the deductible of a family coverage high-deductible insurance plan, based on each month the individual is eligible for coverage. A family coverage plan is one that is not an individual coverage plan.

Assume an individual is covered by an individual coverage high-deductible plan which has a deductible of $1500. He became eligible for an MSA on April 1, and remained eligible through December 31 of that year, or for nine months. His maximum contribution to an MSA would be ((65% x 1500) x 9 months/12 months), or $731.25. If he had been eligible for the full calendar year, his maximum contribution amount would have been $975.

**Deductibility of Contributions**
Contributions are deductible in the tax year they are made. If the employer contributes to the MSA for an employee, the employer excludes the contribution amount from the employee’s income. If the eligible employee or the self-employed individual makes the contribution, the employee or self-employed person takes a deduction against adjusted gross income for the contribution to the MSA. The amount deducted or excluded from gross income cannot exceed the maximum contribution limit of MSAs.

**Spousal Rules**
If an individual coverage health plan is owned, MSA spousal rules do not apply. However, if either spouse has a family coverage plan, to determine the applicability of MSA contribution and eligibility rules, the following rules apply:
• Both spouses are treated as having family coverage. Therefore, the maximum contribution level for the spousal MSAs is 75% of the deductible amount of the family coverage insurance.
• Unless the spouses agree to a different division, the contribution maximum for each spouse’s MSA is equal to 50% of the total maximum contribution level.

Like IRAs, each MSA is individually owned. The contributions and earnings within an MSA belong to each spouse individually.

**MSA Investments**
Contributions to MSAs must be made in cash. The trustee of an MSA may be a bank, an insurance company, or other entity that will administer the trust in accordance with MSA regulations. MSA contributions may not be invested in life insurance.

**Excess Contributions**
An excess contribution is a contribution to an MSA which exceeds the maximum contribution amounts, or which are contributed on behalf of an individual who is not eligible for an MSA. Excess contributions are includible in gross income and are subject to an excise tax of six percent, just like excess contributions to IRAs. If the excess contribution is removed from the MSA prior to the tax due date, the excise tax is not applied.

**Distribution Rules of MSA Accounts**
If distributions from MSAs are used to pay “qualified medical expenses”, the distribution is not includible in income. The distribution is tax-free.

A qualified medical expense is defined in IRC section 220(d)(2) and section 213(d):

**Section 220(d)(2)**
(2)Qualified medical expenses.
A)In general. The term “qualified medical expenses” means, with respect to an account holder, amounts paid by such holder for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

**Section 213(d)(1)**
(2) The term “medical care” means amounts paid
(A) For the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,
(B) For transportation primarily for and essential to medical care referred to in subparagraph (A)
(C) For qualified long-term care services
(D) For for any long-term care insurance contract

Payment of insurance premiums is not considered a qualified medical expense except when used to pay for long-term care insurance.

MSA contributions are tax-deductible, or in the case of employer contributions, are made up of pre-tax dollars. Since the contribution amounts have never been taxed or are deducted from taxes due, when they are withdrawn for purposes other than qualified medical expenses, the entire distribution is taxable, not just the earnings portion.
**Additional Tax on Distributions**
If a distribution is not made for qualified medical expenses, in addition to being includible in income, an additional tax of 15% on the amount included in income distribution is also applied, unless the distribution is made after the MSA holder reaches age 65.

**Medical Expense Deduction**
Generally, medical expenses that exceed a certain percentage of adjusted gross income may be deducted for taxes. If an individual pays these expenses using an MSA distribution, however, these medical expenses may not be deducted.

**Spousal Beneficiary**
Upon the MSA holder’s death, if a spousal beneficiary was named, the spouse may continue the MSA as his or her own MSA. The surviving spouse may continue to contribute to the MSA, make distributions, etc., as an MSA holder.

**Non-Spousal Beneficiary**
If a beneficiary is named to the MSA who is not the spouse of the MSA holder, the MSA ceases to exist upon the death of the MSA holder. The fair market value of the MSA at the MSA holder’s death is includible in the gross income of the beneficiary. If no beneficiary was named, the fair market value of the MSA is includible as gross income of the deceased.

**Distributions Due to Divorce**
Distributions from an MSA under a divorce decree or separation agreement are not taxable. The recipient is treated as an MSA account holder, and the distribution will continue to be treated as an MSA.

**Rollover Rules of the MSA**
Rollovers may be made from MSA to MSA. As long as the rollover is completed within sixty days, the transaction is not subject to current taxation.

**Numeric Limitations of MSAs**
The Health Reform Act, which created tax-deferred MSAs, established a pilot period for the MSA program. The pilot period extends from 1997 to 2000. Generally, the maximum number of individuals who can benefit annually from an MSA is 750,000 during this period. MSA trustees must report to the IRS the number of MSAs opened in order for the IRS to monitor these numbers.

If a person establishes an MSA prior to the end of the pilot period, he or she may continue to contribute to an MSA and make distributions. If the pilot period is to be cut off earlier than the year 2000, the IRS will make an announcement no later than October 1 of the year in which MSA availability will be cut off.

**During the pilot period, the Comptroller General of the U.S. must enter into a contract with an organization with expertise in health economics, health insurance markets and actuarial science to conduct a comprehensive study regarding the effects of MSAs in the small group market on:**

- Selection (including adverse selection),
- Health costs, including the impact on premiums of individuals with comprehensive coverage,
- Use of preventive care
- consumer choice
- The scope of coverage of high deductible plans purchased in conjunction with an MSA and
• Other relevant issues, to be submitted to the Congress (From the Congressional Committee Report regarding Medical Savings Accounts)

**Health Insurance Continuation**
Boomers and matures who are nearing retirement or laid off must be given the opportunity by their employer to continue coverage. In effect, the ex-employee “buys into” the former employer’s group health plan. This is extremely important coverage, especially for those younger than 65, who are not Medicare-eligible and/or ones who have a pre-existing condition.

Continuation coverage often ends when the employee becomes eligible for Medicare but his dependents may still have the right to continuation coverage for themselves.

Employees and their dependents are guaranteed continued coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act). However, there are some limitations. For instance, employers are not required to allow continuation of coverage beyond 18 or 36 months—most provide 6 months—depending on the situation. The former employee pays the bill at the full cost charged for group coverage and possibly an extra 2% for administration.

Employers are under no obligation to provide health benefits to their retired employees. Likewise, there is no requirement that they be provided to active employees. This fact, in combination with most employers right to amend or terminate existing benefits make it especially important that any boomer have a contingency plan to replace health benefits.

Most group health plans, however, have what is called a **conversion feature** which allows retirees to buy minimum coverage like a basic hospital. Unfortunately, in addition to these policies being limited, they are very expensive.

**Deferred Compensation Plans**
There are many advantages of using life insurance to fund a deferred compensation plan. Some of these are:

• The informal funding of a deferred compensation plan through life insurance is attractive when the plan provides the payment of death benefits. When life insurance is used as a funding technique, the employer’s obligation to pay the death benefit is met in the event of the early death of the employee.

• Using life insurance as an informal funding device takes advantage of the tax-free state of the cash value of the policy during the accumulation period.

• When the employee reaches his retirement age, the employer has the option of either using the cash values of the life insurance policy to pay the retirement benefits or, if other assets are available, it may use those, keeping the policy in force and collecting the death proceeds at the death of the employee. In many cases, the death proceeds that the employer receives from the insurance company can be more than the company would have paid out to the employee and his beneficiaries as benefits under the plan.

• Life insurance funding of a deferred compensation plan makes available the waiver of premium benefit, relieving the employer of the obligation to pay premiums if the insured employee becomes totally and permanently disabled. Using this waiver of premium benefit, even though the premiums are waived, the policy remains in force. Its cash values continue to grow. When these dollars are no longer needed to pay the premiums, they can be used in other ways. They can be used to provide disability income to the employee, or they can be used to reduce the employer’s cost of the plan.
Life insurance funding of a deferred compensation plan makes available settlement options. This is especially attractive when the plan requires the employer to pay a life income to the employee. By electing a life income option, the employer can essentially pass on the risk of the employee's living beyond his normal life expectancy to the insurer. When life insurance is used to fund a deferred compensation plan, the employer is generally the policy owner, the premium payer and the beneficiary of the policy.

Premium payments are not considered tax-deductible. This is because the employer has a beneficial interest in the policy. The guaranteed cash values and policy dividends accumulate tax-free. However, if the dividends are left on deposit at interest with the insurer, the interest earned on these dividends is considered taxable income. Like other life insurance proceeds, any death benefit proceeds received by the employer are received tax-free.

**Split Dollar Life Insurance Plans**

Split dollar life insurance plans involve both the employer and the employee. It is an arrangement for purchasing a cash value or permanent life insurance policy. Split dollar insurance plans permit a person to secure insurance at a cost that is less than if he had to purchase it on his own.

The term "split dollar" refers to the split, or the division, of the insurance proceeds. In most cases, the employee splits the premium with his employer. They also share in the proceeds of the insurance. This type of split dollar plan is referred to as a contributory split dollar insurance plan. In contrast, a noncontributory split dollar insurance plan is one in which the employer contributes the entire premium. This plan is most often used as a form of executive compensation.

As a form of executive compensation, split dollar insurance may be used as a fringe benefit for certain high-level employees. There are many other uses for the split dollar insurance plan. It can be effectively used to provide a salary continuation plan to the surviving spouse of a key employee. It can also be used to fund a cross purchase buy-sell agreement. Or, split dollar insurance may be used simply to establish some type of insurance protection at a more reasonable cost to an employee.

The split dollar concept is considered a discriminatory one. That is, a company may limit split dollar coverage to any class of employees that it chooses.

**The Split Dollar Concept and Taxation**

When an ordinary life insurance policy is purchased, some of the premium payment is used to provide the pure death protection, and the balance held by the insurance company is the cash value. Interest on the policy is not subject to taxation until the policy is cashed in.

Using the split dollar method, the executive and the company share the cost of a life insurance policy. The employer usually pays the part of the premium that equals the increase in the cash value of the policy for the current year.

The executive pays the balance of the premium due, which is the term element of the premium, or the part of the premium that covers the pure death protection. This is a benefit to the executive’s family if he should die young. In the event of the executive’s death, the company receives the part of the insurance proceeds that equals the policy’s cash value. In later years, the amount of these proceeds could exceed the company’s actual investment in the policy.

Following the split dollar formula, the executive pays the greatest part of the premium cost in the first few years of the policy. After that time, he pays little or nothing. When the executive dies,
the beneficiaries of the policy collect the proceeds, excluding the cash surrender value to which the employer is entitled.

If the employee does not die before his retirement, the employer essentially recovers its premiums. In essence, the company has given the executive an annual bonus that is equal to the annual interest earnings on the policy. From the executive's standpoint, he has not been taxed on these earnings. He is taxed only when the policy is liquidated. As the cash value of the policy increases, the potential proceeds decrease. This is why split dollar insurance is most practical for younger executives. However, in some circumstances, the split dollar insurance plan is used for older executives who want to transfer some of their wealth to an uninsured spouse or to children or grandchildren.

The split dollar arrangement provides a means of doing this with minimal or no transfer taxes. The death benefit is payable free of estate tax, income tax and transfer tax. The cash value and death benefit can roll over to the beneficiary.

**Types of Split Dollar Systems**

There are two major systems for establishing split dollar life insurance:

**The Endorsement System**

The endorsement system of split dollar life insurance provides that the insurance on the life of an executive is owned by the employer. The employer is accountable for making the premium payments. Using the endorsement system, the employee's rights are protected by an endorsement on the policy. This endorsement affords the designation of the beneficiary to receive any proceeds in excess of the cash surrender. Therefore, the employee is protected because the employer's power to change the beneficiary has been eliminated. Under some endorsement systems, however, the ownership of the life policy may be split. The executive owns the portion of the death proceeds that exceed the cash surrender value, and the employer retains all other rights to the policy.

**The Collateral Assignment System**

When the collateral assignment system of split dollar life insurance is used, the insurance on the life of the executive is owned by the executive himself. The executive owns all rights and benefits to the policy, and he is responsible for the payment of the premiums. When using this system, however, each year the employer must make a loan to the executive in an amount that is equal to the annual increase in the cash surrender value of the policy. This loan is made interest-free.

**Split Dollar Insurance Plans and Other Tax Issues**

As with other life insurance proceeds, the insurance proceeds of split dollar life insurance are received tax-free by the employer and the employee’s beneficiary. This includes the proceeds to the company, if the company is named as the beneficiary. Further, the beneficiary may escape paying estate taxes if the employee makes an absolute assignment of the proceeds to the beneficiary.

There is, however, some tax liability associated with split dollar insurance arrangements. Because the company's payments toward the split dollar insurance arrangement are for the benefit of the employee, the employee must pay taxes on the premium cost.

Essentially, these payments are considered a form of compensation by the Internal Revenue Service. The taxed amount is equal to the cost of one-year term insurance for the amount of coverage in that year, but this amount is reduced by the premiums that the employee actually pays.
In some cases, dividends on split dollar insurance are payable to the employee. These may be used to purchase additional insurance. Such a plan offsets the advancing drop in insurance coverage that occurs as the cash surrender value of the policy increases. These dividends are taxable income to the executive.

When the company makes split dollar insurance premiums on behalf of a top executive, the employer does not receive any tax deduction for these payments. The employer may collect the cash surrender value of the policy free from income tax, however.

**Financed Life Insurance**

Sometimes, companies employ the technique of financed life insurance to pay for part of the split dollar insurance. Using a split dollar arrangement, if the executive dies, his employer receives the amount of money that has been paid into the policy.

If, however, the company is reluctant to commit the funds over this period of time, the company can borrow against the cash surrender value of the policy to fund some of the premium cost, thereby financing the life insurance. Financed life insurance in no way affects the tax handling of the insurance premiums or proceeds.

When using financed life insurance, there are limitations on a company’s tax deductions for interest paid on the borrowed funds. The company may not deduct interest on financed life insurance unless at least four of the first seven years’ premiums are paid without borrowing. In the years in which the premiums are paid with borrowed funds, the amount borrowed against the cash surrender value cannot exceed the amount of one year’s premium.

**Offsetting the Employee’s Cost**

It is possible to provide split dollar insurance and offset all or some of the employee’s cost. First, the employer may pay the full cost of the premium. However, when doing so, the employer may not deduct the amount of these premiums, and the employee is taxed on the full value of term coverage.

Alternatively, the company may pay to the employee a "bonus" that is equal to the value of his term insurance benefit. This is the amount that the employee contributes as his premium cost. Although the end result is the same as the illustration above, using this technique provides the employer with the benefit of deducting the amount of the bonus. Finally, the company may pay to the employee a bonus that is equal to the term insurance cost plus the tax on that amount. When using this approach, there is generally no tax liability to the executive connected with the insurance or the bonus. In this case, the company is permitted to deduct the entire amount of the bonus.

**LONG TERM CARE INSURANCE**

Most people are unaware or deny their risk of needing long term care services. Research suggests that persons who live to age 65 face a **four out of ten chance** of spending some time in a nursing home before they die and a **one in six chance** of spending more than one year. However, senior citizens are not the only ones with long term care illnesses. Surprisingly, more than 10 percent of the people now living in nursing homes and personal care homes are under age 65.
People seem willing to accept the possibility that they will someday get sick and visit a doctor or be admitted to a hospital, but few people are willing to admit they face a significant lifetime risk of becoming disabled and using expensive nursing home or home care services. This is a habit to change! Long term care is indeed a priority and risk that consumers need to manage.

Tragically, many consumers have convinced themselves that Medicare, Medigap supplement policies, Medicaid or their HMO will cover long term care. They do not. Again, people (your clients) need to change their habits or else be forced to rely on welfare or the graces of people willing to take care of them!

LTCI buyers also need to get over their resistance to the higher cost associated with quality care. People who want quality care need to plan now. The government will simply not provide it. Private insurers can and will. Evidence is the evolution of LTC policies from an era of limited, bare bones coverage, to comprehensive plans complete with alternative care options. This is a higher quality care that comes with a higher price.

I can’t afford it? You certainly hear this complaint. And, historically, the elderly were disproportionately poor, unable to afford substantial premium payments. This is less true now as the income of elderly has increased a great deal over the last twenty years. While the elderly still have factions of poverty and near poverty, most current evidence suggests that the elderly as a whole are roughly as well off as the rest of the population. Most estimates of the future income and assets of the elderly project substantial improvements.

LTC Insurers and Agents
On the supply side, the single-most critical obstacle to marketing is the fact that LTCI has not qualified as a core product. Most agents have yet to embrace this product fully (big mistake) and insurers are not yet sure about its profitability (see below). When carriers are willing to tie LTCI sales performance to trips to the Bahamas and gift bonuses, you will know it has reached full product status.

Of course, responsible producers already know the rewards of LTCI. It is a product that virtually everyone needs and wants to hear about. For the less than ethical, this is the cue to abuse and confuse clients, especially the more vulnerable senior. There will always be agents in this category. They seize the opportunity to earn a commission at any price. Others are simply not understanding the depth and breadth of the market. They end up missing entire market groups who are viable and active buyers such as boomers and even younger working adults. LTCI is also NOT an area to simply “dabble”. The product is more complex and mistakes are far-reaching. Producers who sell responsibly must shed the notion that it is just another source of commissions. You must believe in and fully understand this product before you can safely transact it. These are agent habits that must change quickly.

Why haven’t insurers flocked to LTCI? They’re still caught up in the risk. There’s the moral hazard and adverse selection. Moral hazard is the increased use of services that results when people have insurance coverage. Since most LTC is currently provided by family members at no formal costs, the possible increase in use is large. Thus, there is a substantial possibility of increased use of services by a large number of persons who would “medically” qualify. Insurers also worry about adverse selection which is the possibility that people who “know” they will use long term care services will disproportionately buy the insurance, driving up use beyond expectations. This creates a vicious circle where premiums have to be raised, causing low risk people to drop their policies and force additional increases in premiums.

Insurers are also concerned about the timing of premium payments and the ultimate use of benefits. Long term care is needed principally by the elderly, especially those age 85 and over.
And, there is likely to be a very long time between initial purchase of the insurance policy and its eventual use. For example, a policy bought at age 65 probably will not be used for 20 years; a policy bought at age 45 probably may not be used for 40 years. Unforeseen changes in disability or mortality rates, utilization patterns, inflation in nursing home and home care costs, or the rate of return on an insurer's financial reserves can dramatically change a profitable policy into a highly unprofitable one.

Despite all the barriers and reasons LTCI has not sold in the past, insurers and agents (the smart ones) are moving forward. Policies are improving rapidly, major marketing efforts are being developed and the marketplace (LTCI buyers) are responding in force.

There is no better time to be involved in responsibly selling long term care insurance. And, it is a perfect time to break old habits that have been keeping production down and/or prohibiting you from transacting this dynamic product at all.

**The Long Term Care Medical Continuum**

Long term care must also be evaluated in light of the LTC medical continuum. Residential care facilities and adult day care, for example, are increasingly covered in today's policies while earlier policies restricted benefit payments to only those facilities that offered Adult Day Care. Another example might be new generation policies that cover home care and special services, without which the insured would require institutional care. Agents need to understand how the policies they offer relate to the Continuum of Care from the standpoint of policy triggers, ADLs, mental deterioration, etc. This can only be accomplished by evaluating individual policies on a case by case basis.

You must constantly monitor policy benefits to make sure they are meeting the medical continuum. Here are some recent benefit trends shaping the continuum:

- Dependent spouse home care provisions allow the policyholder's spouse to concurrently receive home health care coverage during the same visit by the same provider. The purpose of this benefit is to protect the financial interests of the married couple by reducing their out-of-pocket expenses.
- Weekly home health care provisions change the **daily benefit** for home health care services to **weekly benefits**. Often times, an individual needs intensive nursing services in a short period of time which may exceed the daily cost cap. Now, the policyholder would have access to the entire weekly amount to pay for these same services.
- Flex fund benefits allow policyholders to use their "bucket of money" to cover a variety of LTC expenses that are not otherwise covered under the policy while he or she is living at home. An example might be reimbursement of home health care expenses that exceed the daily benefit amount.
- Enhanced elimination periods liberalize how days are credited toward the elimination period. In the case of multiple, but separated periods of care, for example, this provision would provide that each date of service would satisfy the elimination period regardless of whether it was accumulated under separate claims.
- Spousal survivorship / waiver provisions waive the policyholder's premium in the event that his or her spouse dies or goes on claim after a defined period. Conditions to waiver might include the need for both spouses to have policies in force for a certain period of time (say 10 years).

All of these continuum changes suggest that LTCI is becoming much more than an asset protection vehicle. Clients now need LTC coverage to satisfy their long term care lifestyle needs, e.g., home care as long as possible, companion shopping aides, etc.
More On The LTC Medical Continuum

The long term care medical continuum is also the ever-expanding and multi-faceted range of services needed by the long term care market. Today’s continuum might consist of the following:

**Chore services:** Volunteers buy groceries, mow lawns, vacuum, run errands, etc.

**Home visitors:** Meals-on-Wheels, story reading, companionship, etc.

**Senior centers:** Social activities, dances, bus tours, etc.

**Adult day care:** Daytime activities, lunches, therapy, games, etc.

**Home health care:** In-home services by nurses, physical therapists and dieticians, etc.

**Rehabilitation programs:** Provide extensive physical therapy, occupational therapy and speech therapy.

**Respite care:** Individuals provide relief to aid primary caregivers.

**Retirement housing communities:** For the independent elderly, offering individual units, security, social activities, etc.

**Continuing care communities and centers:** Designed to meet residents’ changing needs from retirement housing through skilled care.

**Assisted living centers:** Offer medical attention, as well as assistance with eating, bathing and other activities of daily living.

**Nursing facilities / skilled nursing:** Provide intensive nursing care around the clock.

**Subacute care:** Provide post-acute or heavy skilled care that is expected to be of shorter duration than usual skilled care.

**Acute care:** Surgical or hospital with lengths of stays limited by diagnosis-related insurance coverage.

Sell What You Know

Ask yourself these questions. Do you really know your long term care product? Is it worth the premium you are asking? Do you believe it is supported by a stable, long-term company? Would your mother or father approve of you selling it? If you can answer "yes" to these questions, you will surely be able to provide your client enough reasons to invest in a policy. Anything else is a hard sell.

Before you can convince a client, you have to convince yourself.

Face facts, no matter how ethical and honest you are . . . people you have never met or see only once a year don't trust you (not yet anyway). They are skeptical and have doubts about your product and about cracking open their wallet and sending you away with any of their hard earned money. You have the same concerns every time you make a purchase from someone that you do not know . . . don't you?

Unfortunately, there is no secret formula or catch phrase that will hypnotize your clients and make them believe everything you say. You won't prove your knowledge and prove you believe by talking the talk . . . instead, you convince your clients by walking the walk. You get them to pay attention by what you do and how you do it. Ask questions, listen to answers and transfer your feelings for you, your company, and your solutions. Be proud of what you sell and believe in what you sell. Communicate that to your clients and they will beat a path to your door.

Before responsible LTC communication can take place, you have to convince yourself it is the best solution for your clients. And, you can't sell what you don't know. So, here's a dose of basic LTC:
**Defining Long Term Care**

Long-term care is the kind of help you need if you are unable to care for yourself because of a chronic illness or disability. Section 7702B of HIPPA 1996 defines a “chronically ill” individual as someone unable to perform at least two activities of daily living for a period of at least 90 days and/or someone who requires “substantial supervision” to protect themselves from threats to health and safety due to severe cognitive impairment. Long term care services can range from help with daily activities of living, such as bathing, shopping or dressing, to skilled nursing care in a nursing home. Care can be provided by friends and family, local home care agencies, adult day care programs, nursing homes, and residential and retirement facilities.

The traditional long-term care policy is defined as any accident and health insurance policy or rider advertised, marketed offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than acute care unit of a hospital.

Many states have introduced “partnership” programs between the state and private insurance carriers. The goal of most partnership programs is to find a workable solution to the problem of financial impoverishment that happens when long term care expenses hit low-to-middle income families. In addition to traditional long term care benefits, these policies usually carry an asset protection feature that assures the beneficiary that he or she will keep a certain amount of assets and STILL qualify for Medicaid.

**Long Term Care Services and the People Who Need Them**

Long term care services might be needed by almost anyone. An accident or sudden serious illness could be the trigger as well as a slow progressive condition like rheumatoid arthritis, Alzheimer’s / Parkinsons or cardiovascular disease. Conditions are likely to befall any age and gender although women seem to need them more than men for various reasons.

Long term care services can be purchased with insurance benefits, provided by government entities or paid “out-of-pocket”. Some long-term care policies ONLY cover services in a nursing home (intermediate care and skilled care facilities). Newer and more popular plans cover home and community-based service. In some instances, the home and community-based services, which often can help a person avoid going to a nursing home, have limitations. So, be sure to read the policy carefully.

Policy benefits can be used to purchase Medicaid-eligible long-term care services which include the following:

1. Long-term care services available under Medicaid home and community-based services provided by a licensed home health agency, and speech, occupational, and physical therapy and medical transportation;

2. Long-term care services covered under the Medicaid home and community-based services waivers for the aged, the disabled, and HIV/AIDS victims, including homemaker, chore-housekeeping, personal care attendant, adult day care, assistive equipment, home renovation, home-delivered meals, and emergency response systems offered by Medicaid approved providers as part of an individual assessment and plan of care developed by a
Long term care services may "evolve" from emergent . . . to acute . . . to chronic.

Types of Care

Skilled Care
Skilled nursing care is care that can only be performed by, or under the supervision of licensed nursing personnel. Skilled nursing facilities must provide twenty-four (24) hour nursing service and must require that the medical care of every resident/patient be provided under supervision of a physician.

Intermediate Care
Intermediate care is that type of care that is not as demanding as skilled care but requires more attention than custodial care. Because the patient's condition is not as demanding as a skilled care patient, the twenty-four (24) hour nursing program is not required. Because of their mental or physical conditions, patients in intermediate care facilities require care and services above and beyond that which can be provided through institutional facilities.

Custodial Care
An individual in need of custodial care typically would be in some need of help in personal needs such as dressing, bathing etc. Certainly, this type of care is nowhere close to the demanding needs required in a skilled care situation.

Hospital Based Nursing Facilities
These services are also known as extended care facilities and are actually departments located within hospitals. They provide the highest levels of medical and nursing care, including 24 hour monitoring and intensive rehabilitative therapies. They are intended to follow acute hospital care due to serious illness, injury or surgery.

One of the major differences between the hospital and nursing home facilities is that the hospital facilities are not meant to be a permanent residence but rather for a short term until the patient can be sent home or maintained elsewhere. It should be obvious that hospital based care will be very expensive as compared to other types of long-term services available.

Skilled Nursing Facilities
Non-hospital based skilled nursing facilities provide a relatively high level of nursing and other medical care, as well as a personal care and assistance. These type patients are typically in need of close monitoring due to illnesses or impairments.

Licensed nursing is available around the clock with at least one supervising registered nurse on duty at all times. Additionally, most other prescribed medical services can also be provided, including rehabilitative services. Depending on the seriousness of the illness, a stay in a skilled nursing facility can be for a short-term or even extended to a long-term stay.

Intermediate Care Facilities
These facilities provide less nursing and other medical care than the skilled nursing facilities. They are geared for long-term residents with chronic illnesses or impairments but whose conditions are as acute as those who would stay in the skilled nursing facilities.
Staffs are geared toward personal care and assistance with rehabilitative services optionally available. Typically, these types of facilities will not cost as much as the skilled facility and therefore the number of intermediate care facilities available will be limited.

Intermediate care facilities may also provide a combination of both skilled and intermediate services. However, because of the flexibility and diversification of services, the more serious patients may not receive the same degree of care that a dedicated skilled facility may provide. Additionally, the high cost of skilled medical care may be passed on to those who are not in need of those services.

**Assisted Living vs. Nursing Home**

Assisted living centers are a form of intermediate care facility that should not be confused with skilled nursing care. Assisted living facilities can take up a special wing of a building or they can be “mom and pop” operations as small as six beds in a private home.

The difference between an assisted living facility and a nursing home lies in the degree of assistance needed by the patient. Nursing home residents typically need help with four activities of daily living while assisted living residents need help with only two ADLs. Assisted living provides a place for people who are not typically bed-bound but can’t stay at home anymore because they need help.

Newer long term care policies provide assisted living benefits as a percentage of the nursing home benefit (usually half) although some offer equal benefits. Policyholders generally qualify for assisted living coverage where they are unable to perform two or more activities of daily living. In some cases, cognitive impairment may trigger coverage.

Assisted living is considered an alternative to nursing homes care and one of the fastest growing segments among long term care providers.

**Home Care**

Home care includes a multitude of medical and personal services that can be provided at home. The word “home” is usually used to the context of meaning the private home of the person or even the home of a relative or friend. Typical Home Care services can include the following:

- **Homemaker** - A home-care agency staff member who provides meal planning and preparation (including assistance with special diets), routine housework, shopping, and assistance with personal care. This is considered to be non-medical support provided by trained and professionally supervised homemakers to maintain, strengthen and safeguard the functioning of individuals in their own homes.

  Specific components of homemaker service include the following:

  - Teaching and/or performing of meal planning and preparation
  - Routine housekeeping skills/tasks
  - Shopping skills/tasks
  - Home maintenance and repairs
  - Assisting with self-administered medication which shall be limited to reminding the client to take the medicine, reading instructions for utilization, uncapping medication containers and providing the proper liquid and utensil with which to take medications.
✓ Assisting with following a written special diet plan and reinforcement of diet
  maintenance
✓ Observing client’s functioning and reporting to the appropriate supervisory personnel
✓ Performing and/or assisting with personal care tasks (e.g., shaving, shampooing,
  combing, bathing, cleaning teeth or dentures and preparation of appropriate supplies,
  transferring client, and assisting client with range of motion.
✓ Escorting the client to medical facilities, errands, shopping and individual business

- **Health Care** - These are medically-related services prescribed by a physician including
  nursing services, physical, respiratory, or speech therapy, and performance or personal care
  and medication administration.
- **Personal Care** - assistance with personal needs such as hygiene, dressing, bathing etc.
  This can be performed by a Personal Assistant who would be directed by you or your
  representative to assist with household tasks and personal care as listed above. The
  person hired must meet specific requirements of the insurance companies.
- **Nutritional needs** - meal planning, cooking and delivery
- **Special needs** - transportation, telephone and companions.
- **Emergency Home Response System** - Communication devices which signal a network of
  emergency responders. The system must provide 24-hour a day emergency communication
  link to assistance outside the home for individuals so severely disabled that they are
  incapable of using conventional or modified communication devices such as the telephone,
  and who have no other persons available in the home should an emergency arise. An
  Electronic Home Response Center is part of a network of emergency responders.
- **Remodeling** - Modification of your home to enable you to be less dependent on direct
  assistance from others. Examples include, installation of ramps, grab bars, or widening
  doorways for wheelchair access.
- **Assistive Equipment** - Equipment with a useful life of at least one year, designed to
  increase independent functioning (e.g. wheelchair).
- **Other Approved Services** - Partnership Policies also provide alternate services deemed
  essential to prevent institutional care and offered by licensed or approved providers. These
  “other” services must be approved in advance by the Department of Public Aid and the
  insurance company.

**Adult Day Care**
Direct care and supervision of individuals in a community-based setting. Services include
transportation to and from the adult care center, assistance with activities of daily living, meals
and snacks, health and medication monitoring, and an activity program. These programs can
be useful for working couples willing to care for an elderly parent who needs some form of
supervision. Adult day care can also respond to a need for planned therapy or learning
activities and better nutrition.

Adult care emphasizes both achievement and a continued effort to retain and enhance
independence. For the elderly, adult day care enables them to live at home and to retain
community contacts.

**Alternative Care Facilities**
Senior citizens needing daily living assistance are always looking for alternatives from having to
enter a nursing home. Two of these alternatives include Life Care Communities (LCC) and
Continuing Care Retirement Communities (CCRC).

Many communities require individuals to carry a Medicare-supplement policy in addition to Parts
A and B of Medicare. This requirement, often written into the contract, ensures that the
Retirement Communities do not have to pay for acute illnesses.
Some Communities also require that individuals carry long-term care insurance. Since these facilities aren’t generally funded in advance, the policies help pay for resident’s care. Some facilities that require long-term care policies want residents to buy the policies they have pre-selected. Others may require the purchase of a long-term care policy but don’t specify the policy that they would prefer.

**Life Care Community (LCC)**
A Life Care Community is a living accommodation where one can expect to live an active, independent life for many years. Later, should additional care be necessary, it is available on the same premises at two different levels.

The first level, independent living, is something like living in a nice resort hotel. There are recreational facilities such as exercise rooms, swimming pools, crafts rooms etc. Balanced meals and transportation to local malls are even provided. Most people enter a LCC somewhere between the ages of 74 and 78. It is estimated that the average healthy resident can enjoy ten years or more of active, independent living before other care services are needed.

The second level is generally known as assisted living. It is sometimes referred to as custodial care. Residents at this stage of their life may need someone to serve meals, bathe, dress and even take care of medication needs. In many communities, a separate facility within easy walking distance is provided for those who need this kind of assistance.

The third level is considered to be skilled nursing and requires 24-hour care with a registered nurse present. At this level, the resident is under the care of his/her own doctor.

**Continuing-Care Retirement Communities**
Continuing Care Retirement Communities, sometimes called Life Care Communities, combine all three levels of care - independent living, assisted living and nursing home care in a single setting. Traditionally, such communities have required a sizeable entry fee, plus monthly maintenance fees, in exchange for a living unit, meals, and health care coverage, up to the nursing home level. In recent years some communities have begun to offer their services on a month to month rental basis with health care coverage being paid for at the time of need rather than on the basis of the coverage afforded by the traditional entry fee or ‘life care’ endowment. “

Today there are many "continuing care" communities, but very few actual "life care" communities. Some states have passed legislation that requires specific features be present before a facility can advertise themselves as a life care facility. Such as:

- Guaranteed health care coverage for life - no exceptions;
- A guarantee that if the resident's resources were exhausted that they could not lose their residence or their benefits( i.e. they had to be financially subsidized by the retirement community)
- The retirement community had to have a nursing facility within the community itself .
- The residence (apartment) that they occupied when they entered the community could not be taken from the resident for any reason.

Very few continuing care retirement communities meet these stringent requirements, although they may provide many if not all of the services and benefits of a true lifecare’ community. Therefore strictly speaking a lifecare' community is always a "continuing care" community, but most CCRC's are not 'lifecare' communities and do not advertise themselves as such. Also A
substantial percentage of CCRC's are now managed by "for profit" companies instead of the traditional religious non profit associations that dominated the industry prior to 1970. This has led to a number of interesting and innovative types of continuing care retirement communities in recent years. Today, CCRCs are the fastest growing segment of the housing market for older Americans. In return for substantial entrance fees, these communities promise a place to live for the rest of your life, some, if not all, of your meals, and most important, nursing care, should the need for it arise.

Skilled nursing is provided round-the-clock on special floors or even in a separate building, if necessary. Not all residents will need nursing care, but for those who do, their care is funded with the fees paid by all the residents. In this sense, CCRCs work like any insurance policy. Premiums paid by all policyholders are pooled to pay benefits to those who suffer some misfortune. “

Entrance fees are high, and most people entering a facility use the equity in their homes to pay for them. Entrance fees average from about $50,000 to $75,000 for one-bedroom apartments to about $76,000 to $96,000 for two bedrooms.

Respite & Transportation Issues
This is a short-term substitute care for chronic individuals that relieves the primary caregiver. It is not a single, specific program but rather a service provided in a variety of optional settings. It gives caretakers of patients the opportunity to respond to their own needs or take care of personal matters. This is a very flexible program. This care can be delivered at home or in an institutional setting. Bottom line, respite can meet various objectives for the caregiver, the care recipient, and the community at large.

Example: Robert is a 73 senior who suffers from a combination of Alzheimer’s and Parkinsons. Because of his physical and cognitive impairments, Robert needs substantial supervision. His wife Betty has elected to take of Robert at home with help from her family. Unfortunately, the sons are limited to helping ONLY on the weekends. This left Betty with a full 5 days of caregiving which at times was very taxing – both physically and mentally. To help break-up the week, Betty arranged for respite care for Robert during the middle of the week. This allowed her to get out for 4 hours or so to do shopping and just get away from the constant care that Robert needed. The respite caregiver was unskilled, but knowledgeable in the areas of supervising Robert during his meals (to prevent choking) as well as hands-on and standby assistance when he moved from his chair to the bed.

The fate of elderly persons may very well depend upon the ability to get to shopping and medical appointments. Transportation to medical appointments is provided by adult day care centers and homemakers, and the homemaker service offers shopping assistance. Medical transportation is also available in many areas of the state.

Long-Term Care Policies
Long-term care insurance is an extremely practical method available to cover the cost of chronic care. A recent survey by the National Association of Insurance Commissioners (1997) concluded that the top 3 reasons for purchasing LTCI was:

1) To avoid dependence on others and maintain independence.
2) To guarantee affordable services in a world of rising costs.
3) To protect assets.
While these issues are clear to consumers, there is a great deal of debate concerning long-term care insurance. The insurance industry claims that long-term care insurance is the method of the future to pay for long-term care. Critics claim that long-term care policies are deceptive, inadequate and too costly. Over the past five to ten years there has been a dramatic change in the quality and nature of long-term care insurance policies.

Most states have adopted laws and regulations concerning long-term care insurance which forced the quality of insurance products to improve. This is especially true since the introduction of the National Association of Insurance Commissioners Model Act and Regulation on Long-Term Care Insurance.

Long-term care insurance has become the fastest growing type of health insurance sold in recent years. Spurred by the pending “elder boom” and its promise of an enormous market, hundreds of private insurers have joined the field since 1987. Despite all the hoopla, however, private LTC still cover less than 5 percent of all long term care expenses. And, despite recent tax legislation favoring LTC deductibility, unless a major acceptance or government promotion of private LTC insurance occurs, it is likely that Medicaid and out-of-pocket costs will continue to fund over 80% of all LTC costs in the near future. Longer term, the burden will shift more to the individual where private pay, LTCI will play more prominent roles in LTC funding.

Most long-term care insurance policies pay indemnity benefits based on certain benefit triggers called Activities of Daily Living (ADLs) directly to individual policy holders. These payments enable insured patients to purchase nursing home care privately instead of relying on Medicaid. If everyone who can afford it were to purchase long-term care insurance, financing problems for nursing homes would decline, Medicaid costs would plummet, and both public and private patients would experience easier access to quality care.

Insurance companies promote long-term care insurance as a protection for assets that are built up over a lifetime. Another reason for insurance is to protect your assets for your spouse or family. Or you may simply feel more comfortable having a policy that helps you avoid nursing facilities by obtaining care at home. Private LTCI can also eliminate or reduce the chances of impoverishment or reliance on government programs or family members in the later years. There are those individuals that decide to buy a policy as a means of getting into a more desirable nursing home or any nursing at all -- Remember, not all institutions accept Medicaid patients.

Of course, one of the major problems with purchasing a long-term care insurance policy is whether an individual, such as a retiree, can afford the cost. For a portion of retirees, the answer is no. The average annual per capita income for someone 65 or over is about $17,000. If a 65 year-old with average income could pay about $2,000 each year for a good long-term care policy with inflation protection 12 percent of his/her annual income would be exhausted. Add other expenses and you can see that it may be quite difficult for some elderly people to handle these kind of premiums. What are some accepted benchmarks of LTCI affordability?

- Consumer reports says that anybody who can set aside $160,000 (1997) at compound interest solely to pay nursing home care may not need a policy at all.
- The National Association of Insurance Commissioner’s Shopper’s Guide says that if an individual’s only source of income is a minimum Social Security benefit or Supplemental Social Security Income OR if someone has trouble stretching income to meet financial obligations such as paying for utilities, food or medicine, they should not buy a policy.
- NOLO Press says that if you have to pay more than 5 percent of your income for long term care policy premiums, it’s a bad investment. NAIC uses a 7 percent factor.
Again, this is where agents must counsel clients on the need for “some” benefits or perhaps **NO benefits at all**. Perhaps a policy with shorter policy benefits, a higher elimination period or fewer bells and whistles such as compound inflation protection. Some of these changes might offend LTC purists, but as we said, some protection is better than none.

**Matching Client Needs to Policy Benefits**

Once your client’s needs and priorities are uncovered, the job of matching policy benefits begins. In the world of long term care insurance, no two policies are the same. In many cases, the changes from one plan to the next relate to the definitions of **“covered services”**. There are countless choices to make concerning benefits, length of coverage and services needed and purchasers are likewise varied in their needs and ability to pay.

Certain features of some long term care policies will be worth more to certain people. Some people will demand only the best care at any price. Others prefer a higher degree of self-insurance requiring only “basic” LTC insurance benefits. And, all agents should know that there are specific instances where clients should be advised to hold-off or completely avoid buying long term care coverage. In essence, there is no single approach to design or evaluate a long term care contract. Rather, the responsible agent should make a careful client suitability assessment followed by a needs analysis to target the most beneficial features and options.

The purchase of LTCI does not ensure that all LTC costs are avoided.

Also, as good as LTC coverage seems, it is extremely important for you to know and point out to your clients that **the purchase of long term care insurance does not ensure that someone will avoid ALL long term care costs**. A person who owns a policy could still end up on an assistance program like Medicaid. How does this happen? Like other forms of insurance, people buy less than they need, or, they refuse an option like inflation protection leading to coverage short falls. There is also the possibility that an insurer waives their specific condition or simply goes out of business.

Choosing the most workable long term care insurance policy is a process that starts with the knowledge you just acquired, followed by some detailed methods and queries:

- **Obtain a specimen policy and read it.**
- **Determine the daily or lifetime benefits needed.** Does the policy match? How much does it cost to upgrade?
- **Determine how long benefits need to last.**
- **Will benefits automatically increase or does the client have options to increase them.**
- **Find out exactly how the policyholder qualifies for benefits.**
- **How soon after an illness or chronic condition should benefits begin?**
- **What services are needed and covered?**
- **Should the policy be “tax qualified” or “non-tax qualified”?**

Let’s discuss these topics in detail:

**Specimen Policies**

An insurance agent should never sell an important product like long term care without first obtaining and understanding a specimen policy from the insurer. One of the most important reasons to obtain them is the rapid evolution of products, policies and definitions, e.g., what is an “applicant”, “certificate”, “group policy”, etc. Selling without one is like operating a computer without an instruction manual or help screens.
For example, a long term care policy that considers a person disabled if someone has to be present to assist when they get out of bed is different than a policy that requires “hands on” assistance to actually lift the person out of bed. One could trigger benefits, the other would not. While this may seem like “splitting hairs” to you, it is a big deal to a policyholder and caregiver who must spend thousands of dollars to hire help when a policy fails. He and his attorney may just as well ask you to pay these costs if they were led to believe they were covered.

A close review of a specimen policy would also uncover the basic purpose of the policy. For example, a stand alone home health care contract might easily be misconstrued as long term care coverage. A specimen policy would determine if these benefits continue or end when a policyholder enters a nursing home. Could you hear the client’s attorney asking you why you did not suggest nursing home coverage? As far-fetched as this seems, be aware that agents have been held liable for not knowing the basic features of policies they sell. Further exposure may accrue if there is a policy option that is widely available at a reasonable cost that the agent failed to present or offer to the client. The best way to cover all the bases is to know all the features and options as explained in the specimen policy. Do not depend on the insurance company literature or illustrations to give all the information needed to properly evaluate a policy. Obtain a specimen policy and review it carefully.

Daily Benefits Needed

Providers of LTC are responding to legislation and added competition by expanding LTC benefits. The heart of these changes is the daily benefit. Amounts can range from $20 to $300 per day for a range of services. Important evaluation questions include:

- **Is the benefit amount enough to meet the cost of local nursing homes or services near where your client plans to retire?** Costs can range from $90 in the mid-west to $300 in New York City. Be sure to advise clients that costs may exceed benefits.

- **Does the policy indemnify for a fixed daily amount or simply reimburse for actual costs?** Most policies are indemnity plans that can cover incidental costs versus reimbursement contracts that cover actual costs. Reimbursement plans generally pay less, but also cost less.

- **What is the daily benefit for home care and assisted living?** Typical policies cover these conditions at 50—70 percent of nursing home benefits. Unfortunately, the cost of either can meet or exceed nursing home expenses.

- **What about weekly home health care provisions?** Some policyholders need intensive care services in a short period of time which may exceed the daily benefit amount. A weekly home care provision gives the individual access to the entire weekly amount to pay for such services / visits.

- **Can benefits be used as a pool of money for both nursing and assisted living / home care?** A pool of money may use the maximum benefits of the policy sooner but at least the cost of BOTH assisted living and home care is covered for the meantime.

- **Can the benefit amount be increased later? If so, will underwriting be required?** This can be a valuable option for meeting unanticipated care down the road. However, added benefits are usually associated with higher premiums, especially if the new insurance is written at the insured’s attained age.

- **Can the benefits be decreased if the cost of the policy becomes too much to pay?** Coverage will drop, but at least some benefits will be paid.

- **Can benefits be purchased jointly for a married couple?** The discount is typically 10 to 15 percent.
In many cases, one spouse or the other may be uninsurable due to illness or age. The well spouse should especially consider long-term care, since he is likely to survive the ill spouse and will, therefore, have no spouse to care for him. In addition, the well spouse would likely spend some considerable time providing care for the ill, uninsurable spouse.

The cost of long-term care insurance is most severe for married couples. Each may need coverage, and this doubles the premium amounts paid. Some insurers are introducing family policies that cover spouses. There is generally a price break, if both are in good health, because the odds are against both needing long-term care.

A new twist in the care of couples is the Dependent Spouse Home Care Provision. This allows the policyholder’s spouse to concurrently receive home health care coverage during the same visit by the same provider. It makes sense! Care for both spouses at the same time. Out-of-pocket expenses are reduced all the way around.

Another long-term care insurance policy is a life insurance policy with long-term care coverage as an integral part, not as an added rider. With this type of insurance policy, an individual can buy a paid up policy with one premium. The coverage is for two people, usually spouses. The life insurance does not pay out until both spouses die. After one spouse dies, the other is still covered for long-term care expenses.

Example: A couple purchased a long-term care insurance policy in 2001, paying a $50,000 single premium. He is 60, and she is 52. The original death benefit will be $165,000. Assume the premium earns 8.75 percent per year. Assume that in the year 2011, the husband goes into a nursing home that costs $3,000 per month. He remains in the nursing home for one year, accumulating a $36,000 bill, all of which would be paid by the insurance policy. Then he dies. His widow is still covered. In the year 2028, when she is 79, she goes into a nursing home, which at that time, costs $5,000 per month. She is in the nursing home for four years, at a total cost of $240,000. Again, all of the costs are paid by the long-term care insurance policy. In 2033, she dies. Even though $276,000 has been paid in nursing home costs, there is still $105,000 in life insurance proceeds for the policy’s beneficiaries. If the tax laws in 2033 are the same as they are today, no income tax will be due on the $105,000.

Let’s look at some more policy benefits to assess:

- **Is a survivorship benefit available?** Some insurance policies that cover both spouses have a “survivorship” benefit. Under a survivorship benefit, when one spouse dies, the other owes no further payments, as long as the policy has been in force for at least ten years.

- **Will benefits be paid if the caregiver is a friend or family member? What about caregiver training?** Some policies allow this under home care benefits. The daily benefit for informal care is typically one-half the home care benefit.

- **How much does home care coverage add to the premium?** Home care benefits are typically one-half the nursing home benefit but could raise premiums by 30 percent or more. Policies where home care benefits equal nursing benefits will probably increase rates about 50 percent.

- **Is the premium for benefits more than 5 percent of the client’s income?** Some industry analysts believe that the cost of long term care should not exceed this threshold.

- **Are premiums guaranteed to stay level?** It’s doubtful. Clients should know that rates can increase by state residency or by class of policyholder. Some say that clients should
prepare for an average 50 percent increase over time. Remember, extremely low premiums today, might guarantee rate increases later.

- **Is there a limited pay or “paid-up” feature?** Nonforfeiture or paid-up features are an option that clients should know about. They can be expensive now but useful later, e.g., a working couple with strong income today can retire with a paid-up policy.

- **Is there a “flex fund” provision?** This is slightly different from a pool of money in that the policyholder may use these funds to pay for a variety of long-term care expenses that are not otherwise covered under the policy, e.g., using flex fund amounts to satisfy some or all of the elimination period.

**How Long Will Benefits Last**

Choosing the length of time that benefits should be paid is an individual choice. Companies offer, one, two, three, four, five or six years and lifetime options. In a perfect insurance world everyone would want lifetime benefits. But is the price worth it? A nursing home-only policy for a 65 year-old, for example, may run $1,400 - $2,000 per year with a lifetime benefit. A four-year benefit period is about 30 percent less and a two-year benefit would cost one-half the lifetime option.

When selecting a benefit period, keep in mind the following statistics from the an AARP June 1997 survey: Nearly 90 percent of all people who enter a nursing home between the ages of 65 and 85 stay an average of 2.5 years; The average duration of home caregiving is 4.5 years.

Here are some additional questions and comments to help you assess this category:

- **Is there a restoration of benefits clause?** If a policyholder receives care in a nursing home and recovers, the policy benefits may be restored to the original level.

- **Does the insurer count days or years?** Most benefits are expressed in years but insurers actually count days. In some cases insurers will count three or four days as a week. This is a completely unacceptable condition.

- **Do benefits paid through an HMO count as a full day?** Although it is rare, some policies count a day of care provided through an HMO as less than a full day. This could be a bonus for the insured.

- **Do home health care and adult day care benefits pay for a full day?** This can be important to the relief and effectiveness of the primary caregiver.

**Can Benefits Increase or Decrease**

After a client is convinced that long-term care insurance is an essential part of their financial planning there are decisions to be made on the many optional benefits available.

- **Do nursing home / home health care benefits increase automatically?** Nursing home costs have been increasing between 8 and 9 percent since 1985. A cost of $110 per day today will run up to $513 in 20 years at 8 percent inflation.

- **Is the increase based on the Consumer Price Index, Medical Price Index or is it fixed?** No one knows the future, but if benefits at least kept pace with inflation the policyholder should have some form of additional protection against rising costs.

- **Is there a “cap” on the amount benefits can increase?** Beware of companies that “cap” their inflation increases to two or three times the base benefits.

- **Are future benefit increases available on demand?** Some policies offer the option to increase benefits every so often at the client’s attained age. Look for additional underwriting and be alert to any condition that eliminates this option if it has been offered and refused by the policyholder a specific number of times.
• **What kind of inflation protection is offered?** Protection can increase at 5% compounded or 5% simple. The corresponding increase in premium would be about 60% and 50%. A daily benefit of $110 today will grow to $292 in 20 years at 5% compounded vs $220 under 5% simple.

• **What is the cost of waiting to buy inflation protection later?** Policies that allow the purchase of additional coverage later can be cheap today but expensive down the road. A 65-year old might pay only $770 today for a policy with optional increases compared to $1,598 for one with automatic protection. In 20 years, however, the policy with optional increases could cost over $5,000 compared to the same $1,598 for automatic benefit increase protection.

• **If inflation protection is too expensive for a client today, is it cheaper to just increase benefit levels?** Perhaps. A premium for higher benefits but no automatic inflation protection will most likely cost less today. The risk taken is that clients may be unable to afford the coverage needed in 10, 20 or 30 years or simply have to accept lower benefit levels than would have been provided with automatic protection. These are trade-offs that need to be discussed with clients.

Optional benefits can go a long way to solving a client’s long term care insurance needs and they should always be recommended. However, agents should be careful of riders that look too good to be true; they probably are. Additionally, it doesn’t make sense to sacrifice good carriers and good base benefits for an attractive option with an inferior company with less than comparable base features.

**How Do Policyholders Qualify for Benefits**

In general, the longer the list of qualifying daily activities (ADLs) and the fewer a policyholder must fail, the easier it is to get benefits. Most policies will specify that the insured must fail two or three of these activities to begin receiving benefits. Agents should be aware that the number of activities may not be as important as the type. For example, with one company a policyholder must fail two activities in dressing and mobility. This could be harder to qualify than another policy requiring three activities; bathing, dressing, eating.

Here are some evaluation comments and questions:

• **Are bathing and dressing on the list of daily activities?** If a bathing or dressing disability is a trigger of coverage, policyholders will have a much easier qualification and will qualify sooner since these are two of the first daily activities that chronically ill people are likely to fail.

• **Are activities explained in different ways than other policies?** Some define an eating disability as the inability to feed oneself while another may define it as the need for someone to watch over the party eating. Look for clarification on all activities of daily living as well as terms like: assisted living, walking or wheeling, cognitive impairment, ambulating, transferring, etc.

• **Does the policy assess physical activities on a “standby” or “hands-on” basis?** IRS 97-31 rules clarify the difference: “Hands on” assistance means the physical assistance of another person without which the individual would be unable to perform the ADL. “Standby assistance” means the presence of another person within arm’s reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL. More on this in Section 6.8. Suffice to say, policies that cover only individuals requiring “hands-on” assistance would generally provide fewer benefits than one that included “standby assistance”.

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**If a benefit or service is not listed in the policy, there is no harm to ask for it to be covered.**

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• Will the policy pay on a “medical necessity”? Patients can be too frail to care for themselves from a medical condition like coronary disease, yet still able to perform daily activities. “Tax qualified” plans do not recognize medical necessity.
• Are there special underwriting definitions? One company uses the term “standard” to describe its worst class. For another, it means mid-grade.
• Is there “lifestyle” underwriting that will automatically cause an application denial? One company says that anyone who needs assistance with housekeeping, shopping and household finances is simply unacceptable.
• Does the policy require special equipment installation before benefits can begin? Some insurers may require the insured to install grab bars or a shower stall in place of a tub before they will pay benefits. These restrictions are not favorable to the policyholder.
• What are the measures of cognitive impairment? Look for methods that fairly measure cognitive impairment using terms like thinking, reasoning, remembering, memory, etc. HIPPA provisions measure cognitive ability based on whether the individual needs “substantial supervision” to protect himself from threats to health and safety.
• Is cognitive impairment measured separately from physical measures of ability? A company that uses physical methods to determine cognitive assessment may overlook people who can pass the test or perform daily activities but forget how or why they did them. Worse yet, their mental impairment could become a threat to how they do them in the future.

When Should Benefits Begin
The choice of an elimination or waiting period depends on a client’s needs and ability to cover the early costs in a chronic illness. Elimination periods generally run 30, 90 or 180 days with options to lengthen this time more in exchange for reduced premiums. As with other forms of insurance, this trade-off can be attractive. Some would say, however, that the lower premium creates a “false economy” A policy with a 90-day elimination, for example, might cost $300 per year less than a policy with 20-day elimination. After 20 years, a policyholder would save about $6,000 in premiums, but with 5 percent inflation, the 70 additional days of care would cost over $20,000.

Others argue that a longer elimination may be the only way people can afford insurance and that a little “self-insurance” for a short duration is generally not significant when compared to long run premiums. The alternative, they say, could mean no insurance at all.

When evaluating long term care policies look for the definition of an elimination period. Can insureds accumulate days over a period of time? Are there separate eliminations for different services or providers? If so, a policyholder who needs both may create difficulties in qualifying for benefits. An enhanced elimination period provision liberalizes how days are credited toward the elimination period in that each date of service would satisfy the elimination period regardless of whether it was accumulated under separate claims.

Does the policy offer consecutive days for home health care or adult day services? If these services are used only a few days a week does the policy count consecutive days toward the elimination period?

What Special Services are Covered
• Does the policy pay for home care alterations? Some will pay for stair lifts, ramps, grab bars, etc.; allowing an insured to receive care at home.
• Is there a return of premium or nonforfeiture option and how much does it cost? Clients are always concerned about paying insurance premiums and getting nothing in return. Offering them this option may increase premiums by 30 to 50 percent, but they will be certain to get something out of the policy.
• **Is there a vesting schedule on any return of premium?** Return of premium riders typically start or “vest” after five years. Some return more as the years go by. The return of premium is paid upon termination of the policy by lapse or death.

• **Determine how the policy’s nonforfeiture options work.** Nonforfeiture options will either return premiums or pay benefits. The benefit may be purchased as “full” (it accrues regardless of claims paid) or “limited” (claims are subtracted from any premiums or benefits paid).

• Nonforfeiture and return of premium options may be better suited to the policyholder who doubts he will use his coverage but still wants something out of the policy. He would have discretionary income and liquid assets to make the increased premiums. In essence, the cost of these additional options represent a potential loss in the time value of money.

• **Is there a cognitive reinstatement option?** Where mental impairment has set in, policyholders may forget to make premium payments and risk cancellation. This clause allows reinstatement for up to five months so long as all back payments and proof of cognitive impairment is made.

**What about other useful policy features?** Some examples of options to discuss with clients include bed reservation (If an insured goes home, bed space is reserved in case he returns within a specified period) for nursing homes, waiver of premium, respite care and survivorship benefit.

### Tax Qualified vs Non-tax Qualified Policies

The advent of HIPPA (Health Insurance Portability and Accountability Act), also known as Kennedy-Kassebaum, has created a new evaluation procedure for agents to make: tax-qualified or non-tax qualified contracts. At the outset, it may seem ridiculous to want or recommend anything except a “tax qualified” policy. However, as you will soon see, nothing is “black and white” in the tax arena. Non-tax qualified policies may, in fact, be better policies. Then again, this has to be tempered with the “taxable uncertainty” surrounding NTQ policies.

The IRS seems unwilling to take a position here and CPA’s and accountant’s are providing different stories on how premiums and benefits are being taxed. This makes NTQ policies dangerous territory for agent’s to handle. However, there could be certain advantages of NTQ to consider. The bottom line is ALWAYS, ALWAYS advise clients to seek competent tax counsel when making LTC purchasing decisions.

Now to some analysis.

The first order of comparison between TQ and NTQ policies is the tax issue itself. Agents need to help a client determine whether the tax breaks associated with a tax qualified policy are meaningful to the client. Clients who itemize on their tax return have a potential need for tax deductions; those that don’t itemize have little need for them. Remember also that the tax status of your client may change dramatically as he or she moves from full employment to retirement.

The next order of analysis is benefits. Guidelines from the IRS have been helpful in establishing tax qualified status based on many “safe-harbor” definitions of terms like “substantial assistance”, “hands-on assistance”, “standby assistance”, “severe cognitive impairment” and “substantial supervision”.

When insured individuals comply with these guidelines, certain payments received on account of a chronically ill individual from a qualified LTC insurance contract are excluded from income. In
addition, certain expenditures incurred for qualified LTC services required by a chronically ill individual are deductible as medical care expenses.

Medical necessity means a doctor or qualified party has certified that a person’s health will deteriorate without nursing or home care.

In general, tax qualified plans are, for the meantime, considered more restrictive than non-tax qualified policies. The basis for this evaluation is the requirement that two out of six activities of daily living must be failed to qualify for a tax-qualified plan while many non-tax plans allow two out of seven. Further, a licensed health care provider must certify chronic illness under tax qualified plans and “medical necessity” is not considered a trigger for benefits while it is quite common in non-tax plans.

The best example of how these restrictions may effect a policyholder was presented by Consumer Reports (10/97). Their discussions with one insurer uncovered an alarming result. The company estimated that under the tax-qualified triggers currently in place, 40 percent of its paid claims or home care would NOT have been paid; 20 percent would NOT have been paid for nursing home claims.

IRS Notice 97-31 provides very specific guidance relating to qualified long term care services and qualified long term care insurance contracts under sections 213, 7702B and 4980C of the Internal Revenue Code. Let’s look at a few definitions that would be minimum requirements to establish tax qualified status for an LTC contract:

- **Substantial assistance** means hands-on assistance or standby assistance
- **Hands-on assistance** means the physical assistance of another person without which the individual would be unable to perform the ADL.
- **Standby assistance** means the presence of another person within arm’s reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL
- **Substantial supervision** means continual supervision by another person that is necessary to protect a severely cognitively impaired individual from threats to his or her health or safety.

HIPPA allows up to a $2,500 deduction for premiums used to buy tax-qualified long term care insurance. However, since less than one third of all taxpayers itemize (very few of them seniors), this deduction may not be a significant incentive to buy tax-qualified plans. Even among those who do itemize, the expense is deductible only to the extent it exceeds 7.5 percent of the policyholders adjusted gross income. However, new proposals feature an **above the line** tax deduction and tax credits for caregivers. Surveys show that LTC prospects will be more inclined to purchase if these types of proposals are passed.

Scales tip slightly more toward tax-qualified plans when considering the taxation of benefits. Under the new law, tax-qualified long term care policies are now treated in the same manner as health insurance contracts where benefits received are excluded from income. In the case of long term care, however, the amount of this exclusion is capped at $200 per day for 2001 and indexed for inflation in future years. HIPPA and the Internal Revenue Service have not ruled (why we don’t know) on the taxation of benefits from non-tax qualified policies. Endorsers of

| Medical necessity means a doctor or qualified party has certified that a person’s health will deteriorate without nursing or home care. |
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tax-qualified plans will say that policyholders no longer need to worry about paying taxes on their benefits or having to buy additional insurance to pay for long term care expenses with some left over to pay taxes.

It is important that all agents make careful evaluation in replacing policies issued prior to 1/1/97 with newer policies. From all information we can gather, these older policies have been “grandfathered” and receive the same tax treatment as the new tax-qualified contracts. In any decision to replace one of these older policies, the loss of these tax considerations must be considered. Making major revisions to the policy to upgrade benefits or purchase options is considered a violation that will also jeopardize tax benefit status. However, policy upgrades that are already built-in to the policy, such as a non-forfeiture provision, are not considered a material change and would retain all tax benefits. Some older policies also have easier benefit triggers that clients may not want to replace.

**Funding Long Term Care**

The unfortunate reality of long term care is that neither the government nor most people want to pay for it. Clients want to ignore the fact that "the long goodbye" of a chronic illness could wipe them out financially or cause them to rely on the charity of family members and others. And, the government is beginning to realize that if Medicaid costs keep going at their current pace, they will actually exceed all federal revenues by 2030!

In the not-too-distant future, quality long term care will be the responsibility of the individual. A major portion of this care can be financed through LTC insurance, but some may also be the responsibility of each client in the form of private pay . . . private investments and savings.

We need to discuss all these possibilities to arm you with the information necessary to educate your clients that a careful path must be chosen to avoid the obstacles and disappointments "planted" in the LTC funding minefield.

**Too Many, Too Soon?**

In her article *Long Term Care: The Perfect Storm*, author Carolyn Kates describes the demographic, technological and societal trends that are rapidly accelerating long term care funding and services to a "fearful collision".

In a nutshell, we are moving to a time when the number of seniors collecting benefits from government will grossly outnumber the number of people supporting it. One forecast suggests that at some point in the future, there will be only one taxpayer supporting 40 Social Security beneficiaries Outrageous! This is exactly the opposite of what existed at the start of the program!

Kates goes on to say that technological advances and healthier lifestyles are leading to longer life expectancies. Seventy years ago, the average life span was 63, now it is 76 and climbing. With people living longer, a greater stress is placed on government budgets.

Finally, Kates describes the societal changes that are making it more and more difficult for people who need long term care to rely on their families for help. "High divorce rates, single parent households, two-income families and other developments have weakened the first line of care for aging or infirm--the traditional nuclear family".

**Affordability**

According to the *American Medical Association*, the elderly paid out more money to cover nursing home expenses than any other aspect of their health care. Even so, some can't meet the staggering costs on their own, and Medicare coverage is limited. Faced with an average
outlay of $41,000+ a year in most states, and double or triple that in some urban areas, many of the elderly in nursing homes are faced with watching a lifetime of savings evaporate within a few years. Care provided in the home can be just as expensive with unlicensed health care professionals charging $120 to $180 per day for 24-hour supportive care. RNs or LVNs will bill from $35 to $70 for a two-hour visit.

The massive amount of care provided by family members and other unpaid caregivers adds another dimension to the social costs of long-term care. More than 70% of those receiving long-term care must rely exclusively on unpaid caregivers. Can baby boomers and other rely on their children for the same contribution of time and effort? Probably not.

So, one of your jobs is to convince prospects that the costs of LTC can go way beyond their resources. This will not be too difficult once you realize that the average citizen out here is not likely to handle a 96-month bout with Alzheimers at $158 per day. With inflation thrown in, the bill can approach $1 million!

Buy long term care insurance? Not everyone can afford long term care premiums at first blush. Of course, if you have had your client complete a client profile you would already know this. So, sometimes you need to be creative; look in places you might not ordinarily look to find the resources to get your clients covered. We will discuss these options later.

Of course, you don't always have to cover everything. A lot of private pay people are just as likely to go for a bare bones plan with high eliminations or an "in sickness and in health" type policy that combines life or annuity product with LTC coverage. This way, they can do a little self-insuring yet cover the main bases. Documenting a client’s preference for “minimal” coverage such as this is important to your long-term claim exposure.

**Private Pay**
Integrated somewhere in American values is the concept that people should take primary responsibility for their own lives and their personal expenses. We are encouraged to earn our own way. Health care provisions can be seen as a personal investment, planned and funded by the individual. Unfortunately, this is not a subject people like to discuss, much less set aside a percentage of their paycheck to finance.

That is why it is the job of agents in the U.S. to explain the need for private pay and LTC insurance. For example, it might surprise a lot of clients to learn that despite all the talk about Medicare and Medicaid, a lot of long-term care is paid privately (approximately 49%). This means that most patients pay for long-term care out of their own pockets, whether the care is skilled, intermediate or custodial.

With government cutbacks, can anyone expect this to improve? Not! Our government now spends close to $75 billion a year for long term care services. This can't go on. And, the fact that HIPPA created tax incentives to purchase LTC insurance is an important cue that it won't.

**The government wants “out” of the long term care business.**

**Accelerated Death or “Living Benefits”**
Life insurance that provides accelerated death benefits to pay medical expenses first came on the scene in 1988. Since then, they have been offered by over 100 insurers; enjoying a 228 percent increase in policies sold. As of 1994, these policies represented just under 12 percent
of the total market. More companies are modifying existing policies in order to add these riders. Typically, the basic premium cost will be increased by 5-15 percent to pay for the rider, although some riders can increase the cost of a basic policy by as much as 33 percent.

In recent years, insurers have been offering long term care-specific riders as accelerated death benefits. Despite this improvement, these policies should not be sold as long term care insurance. A long-term care rider will pay some of the policy’s death benefit while an individual is still alive. For example, suppose a person has $300,000 worth of life insurance coverage. Assume he spends three years in a nursing home. Since he has a long-term care rider on that life insurance policy, $75,000 is paid out for nursing home costs ($3,000 per month for 25 months) while he is still alive. When the insured dies, the beneficiaries will receive $225,000 instead of $300,000. When he taps into the long-term care living benefits, he is using the cash value that would ordinarily belong to the beneficiaries.

Long-term care riders often pay living benefits when a serious illness occurs, even when no nursing home care is needed. For example, victims of strokes, heart attacks, cancer, coronary artery surgery, and renal failure can collect benefits while they are still living. Sometimes the policy holder can receive as much as 25 percent of the policy’s face value up front, rather than in regular monthly payments.

These riders have limits. They may not cover nursing home stays outside the United States or long-term care resulting from alcoholism, drug addiction, or attempted suicides. The long-term care riders usually cover nursing home care only after a stay in a hospital or in a skilled nursing home where medical treatment is dispensed. Most nursing home residents enter the homes directly, not after a stay in a hospital or skilled nursing homes.

The money available for nursing home benefits on a long-term care rider is normally two percent of insurance coverage per month. By this rule, a $100,000 policy would pay $2,000 per month. However, if the policy is over $150,000, the policy holder may get less than two percent. For example, suppose the policy holder has a $300,000 life insurance policy with a long-term care rider, and he is confined to a nursing home. This insured may get two percent of the first $150,000 ($3,000) plus one-half percent of the next $150,000 ($750) for a total of $3,750 per month.

Also, some policies place a limit on the monthly payment amount. Some policies permit the policy holder to collect 100 percent of the amount of the life insurance, while others cap it at 50 percent. Most polices require that the policy holder pay at least for the first 60 days of nursing home care before a long-term care rider kicks in.

With some riders, the policy holder will have to make out-of-pocket payments for at least 180 days before he can collect. Some long-term care riders will not pay until the policy holder has been paying the extra premium for at least three years. For example, if an individual buys a long-term care rider in 1997, he may not be able to collect before 2000, 2002, or some other date.

Most long-term care riders will pay for skilled care or intermediate care nursing home stays. However, some riders do not pay for custodial care. Others will pay only after a specified number of days in a hospital or a specified number of weeks in a skilled care or an intermediate care home. While receiving benefits from a long-term care rider, the policy holder is not obligated to keep paying premiums if the rider has a waiver of premium feature.

The problems with funding long term care coverage through an accelerated death benefit policy are obvious: Benefits may be slower than a stand alone policy, benefit triggers can be tricky
and there is typically no inflation protection other than by expensive inflation riders. Furthermore, the death benefits that could have gone to an insured’s estate are usually “eaten-up” in long term care costs thus defeating the purpose of buying a life insurance policy.

It is significant to note that the tax treatment of accelerated death benefits has changed as a result of HIPPA (Health insurance Portability and Accountability Act). Signed by President Clinton in 1996, this new law provides for **tax free treatment of accelerated death benefits for terminal and chronically ill people paid directly by insurance companies**. This should serve as another reason for the seriously ill to make use of accelerated provisions in their life policies for current “living benefits”, including long term care where permitted. Caution must be advised, however, in how one defines terminal or chronic illness to the satisfaction of the Internal Revenue Service.

**Viatical Settlements**
A viatical settlement is a transaction whereby a non-related party purchases all beneficial interest in a life insurance policy insuring the life of a terminally ill person. Since many long term care patients are terminal, they may consider selling the proceeds of their life insurance policy before they die to use the funds for current, more pressing medical needs and expenses. Or, using the funds to purchase long term care insurance.

The theory behind these transactions may sound gruesome, but can be beneficial for both parties. Think of it, by the time a terminally ill person considers “selling” his or her life insurance policy, they are typically on their “last leg”, financially speaking. The income realized from the sale of the life insurance policy can be **very welcome**.

The mechanics of the transaction are fairly simple. A third party “broker” or viatical company pays the terminally ill person a percentage of the death benefit and becomes the owner and beneficiary of the policy. The terminally ill person receives a lump sum of money to use **now**. When he dies, the proceeds of the policy go to the viatical company. Viatical companies are usually funded through investors and buy all kinds of policies: Term, whole life, universal life, group life, etc. The policy must have been in force for at least two years and not be subject to a contestability period. In some cases the viatical company even continues paying the premium on the policy to keep it going. Also, viatical companies are known to work with a combination of **accelerated death benefits AND viatical settlements** to net an even greater sum of cash for the seller of the policy.

More and more, people diagnosed with other terminal illnesses are turning to viatical settlements to meet their financial needs -- **including long term care**. The list includes terminal sufferers with cancer, “Lou Gehrig’s Disease, cardiovascular illness and more. As a matter of fact, the statistics point to a larger market for viatical settlement from terminally ill patients with cancer who, in 1995, represented 78 percent of all hospice care admissions versus AIDS at only 4 percent. The industry is expecting more cases from non-AIDS related illnesses as more people learn about the product.

A real boost to viatical settlements should also come as a result of HIPPA (The Health Insurance Portability and Accountability Act) of 1996 which allows people diagnosed with a terminal illness to sell their life insurance policies to viatical settlement companies for a **tax free lump sum payment**. This tax free provision will apply ONLY to people whose life expectancy is less than 24 months and the purchasing company must be licensed by the state in which the viator (seller) resides.

Policies of all sizes are viaticated and twenty-one states have adopted all or a portion of the regulations for viatical settlements set forth by the National Association of Insurance
Commissioners. And, the Viatical Association of America has established minimum standards
of consumer protection for its viatical company members.

**Life Settlements**

In theory, life settlements work the same as viaticals: A policyowner agrees to sell his or her
policy for an agreed upon sum of money to a third-party funding company who then becomes
the new owner and beneficiary. The difference is that life settlements do not depend on the
insured being terminally ill. Instead, older policyowners are considered (as young as 65 years
of age). The funding company simply "banks" his deal on the proposition that the insured has a
life expectancy of "x" and he will get the full amount of the policy proceeds back at death. The
insured can use his funds to pay medical or long term care or buy a long term care insurance
policy.

The Health Insurance Portability and Accountability Act of 1996 makes the proceeds of a life
settlement TAX-FREE for individuals who are terminally or chronically ill.

**Single Premium Life / Fixed Annuity and LTC Rider**

We call these "in sickness and in health plans" because they involve the combination of long
term care insurance funding, available in a specially designed life insurance policy or annuity
that combines tax deferred cash values, a death benefit and long term care insurance. Issues
ages can be as low as 40 years and joint policies can also be written if certain parameters are
met.

The typical policy is designed around a single premium deposit (minimums of $10,000) with an
average amount being $50,000 and even $100,000. It would not be uncommon for people to
transfer the funds in a large CD to this product providing they are not in need of the monthly
interest for living expenses.

One product approach builds on the single premium investment . . . let's use $50,000. For a
single female aged 65 who is underwritten as “preferred” a death benefit equal to $110,000 is
available to the named beneficiaries. The company also credits a current rate of return on the
single premium which is then reduced slightly (say 1.5% to 2%) to cover the next benefit which
is long term care. On the same $50,000 single investment, the company offers a pot of
money equal to double the death benefits ($220,000 in this case) to provide convalescent care
for at least 4 years. This includes a nursing home daily benefit of $150, a home health benefit
of $75 per day and an adult care daily benefit of $37. These benefits begin after a 90 day
elimination period and would continue as long as the insured remains eligible and until
exhausted. If long term care expenses did not use all of the “pot of money”, the excess remains
available thereby extending coverage into 5 or more years. Other features include 24-hour
liquidity for other emergencies and a cancellation guarantee that promises the insured the
original premium deposit, less any amounts paid for convalescent care benefits.

Newer versions of this product are available with annual installments, say over 10 years. One
company suggests that clients make the annual payments through their children by gifting the
$10,000 or $20,000 each year. The client remains as the insured of the contract with the
children as owners and beneficiaries. The client’s estate is reduced by the gift amount . . .
thereby reducing the taxable estate. Likewise the policy proceeds are not part of the estate.
When a long term care need is presented, the proceeds “kick-in”. If they are never needed, the
children receive a tax-free death benefit. **Always check with an estate / tax advisor before
implementing any such plan.**
Other variations of this product offer an independent rider that does not effect the life insurance policy or its cash values. Any benefits paid for long term care such as a nursing home would not reduce the death benefits or cash values of the policy. Of course, there would be maximum daily and lifetime benefits associated with such a contract and a client should expect to pay considerable more for the privilege.

Still other variations include a universal life policy where up to two percent of the death benefit can be accelerated each month to pay for long term care expenses, following a 90-day waiting period. As benefits are paid, the policy’s death benefit and gross cash value are reduced.

Who would use these policies? Anyone who cannot see themselves paying years of long term care premiums for coverage they may never use. And, if the long term care benefits in the policy are not needed; a sudden death, for example, their heirs are at least entitled to the policies death benefit.

Of course, without inflation protection, even the long term care benefits in the examples above can be eroded quickly. If such protection is available as an additional rider it should be considered. The result will probably be a significant reduction in the current interest rate or higher premiums and only a comparison analysis with a stand alone long term care policy can determine it’s feasibility.

One bright light here is the effect of HIPPA. Prior to the new health care legislation the gain in cash value within these types of policy were tax deferred but taxable when long term care benefits were paid. Now, these benefits will be tax-free as long as they do not exceed the greater of $200 per day ($73,000 annually) or actual costs.

Annuities
For years, the insurance industry has designed annuity contracts that appeal to the liquidity needs of seniors and other market groups. Most new generation annuity policies, for example, offer free withdrawals that allow the owner to withdraw 10 percent or 15 percent of the account value every year. These withdrawals can be used for any purpose including medical costs and long term care. More significant are the nursing home and terminal illness waivers found in many competitive annuity products. Now the contract owner can withdraw . . . penalty free . . . .Large portions of the account value (usually up to 50 percent) without penalty or surrender charges so long as the proceeds are used for nursing care or terminal illness expenses.

Drawbacks to both long term care riders and annuity coverage should be noted: Benefits paid may be less than the standard long term care policy, particularly in areas such as home health care and assisted living. Similarly, the duration of payments will most certainly be limited. And, without inflation protection, the proceeds may do little to cover actual LTC costs. “Pot of money” approaches will most likely be exhausted in a matter of years or sooner and few, if any, can be expected to provide lifetime benefits. Then again, such long term benefit durations in stand alone long term care insurance, while available, are very costly leading to few takers anyway.

Reverse Mortgages
Another form of possible income is through a reverse mortgage in which a client can withdraw the equity in his home in the form of a loan and use the money for living expenses. Typically, the loan proceeds are paid out monthly, but other arrangements can be made. The loan balance increases each month as payments are received. Additionally, interest is added to the growing balance.

Many seniors in this country work diligently to make sure that when they retire they own their home “free and clear”. If medical expenses start piling up, many can find themselves in a situation where they are house-rich but cash poor. The reverse mortgage is an excellent way
for these older homeowners to convert home equity into needed cash without immediately selling the home.

In the typical reverse mortgage transaction, a lender agrees to pay the homeowner a specified payment each month. The balance owed the lender grows as more monies are disbursed to the homeowner. The total accumulated balance is considered a loan against the homeowner’s equity but no repayment is required until the borrower dies, moves or sells the home. If there are two spouses who own the house, there is no repayment due until the last surviving borrower dies or sells or moves from the home.

Most lenders who participate in reverse mortgage plans require the homeowner to be 62 years of age or older. Homes must be single family (not condominiums unless they are FHA-approved). There are no income qualifications and little, if any, credit requirements because the owner is not going to make any payments. The maximum loan amount varies per locality, from $67,500 in low-cost rural areas to $151,725 in costlier housing markets. The amount also varies on the client’s age. Payments are based on actuarial tables. In addition to the full loan amount, the borrower is liable for fees, points, closing costs, insurance premiums, plus all interest. Interest and closing rates are generally higher than those in conventional mortgages. Liability to homeowners is limited to the value of his home, i.e., they can’t be made to pay from other assets. Some reverse mortgage financing programs are FHA-insured, however, many lenders require no insurance -- they are simply banking on the owner’s large “pot of equity” to secure the deal. The proceeds from a reverse mortgage can be used for any purpose, including long term care expenses and they are tax free to the homeowner.

**Sale Leasebacks**

Another method seniors use to tap the equity in their homes is called the sale leaseback. Here, the owner sells his home and leases it back from the person who bought it. Like the reverse mortgage, the owner now has access to the equity in the home in the form of a lump sum or by monthly mortgage payments from the new buyer. In essence the buyer in these transactions is buying a *life tenancy.*

Unlike the reverse mortgage, there are some potential negative tax consequences that make the sale leaseback tricky. Installment payments in a sale leaseback deal are *taxable income* and may be subject to BOTH capital gains and income taxes where the IRS views the transaction as a bona fide sale.
KNOW ALL THAT YOU CAN ABOUT UNDERWRITING

Underwriting and how premiums are determined (ratings) is a very appropriate topic for a course on mature markets because as many as 30% of your applications could be rejected due to medical underwriting, i.e., health questions and uncertainties. Underwriting is tougher here than other markets. Further, if you continually submit higher-than-normal amounts of applications that are rejected, your income suffers and your clients suffer an emotional downer. Likewise, if you do not follow some basic suitability rules and sell people policies they cannot afford (suitability underwriting), you will experience a higher-than-normal lapse rate among clients who buy now and later drop their policies. You will lose thousands of dollars in trailing commissions, future business that same client may have generated for you and, in some states, you may be "categorized" as an irresponsible agent leading to fines, penalties and possible loss of license.

Ratings should be of interest to you because it is the system insurers use to "price" policies. Why should you be concerned about premium stability after you have sold a policy? Well, for one thing, you might be sued for not disclosing the possibility that rates for the class of policies you sold can increase. Rate increases are also harmful to your future business. Not only can they cost you a client, but they create the need for new selling requirements to be added to the already existing minefield of disclosures you must present to your clients. As of the writing of this sales system, for example, the NAIC (National Association of Insurance Commissioners) is recommending that when selling long term care a special disclosure be added showing your insurer's rate increase history and a signed acknowledgement that rates on his policy can increase in the future. What is your company's rate increase history? By the way, are you making sure that your clients understand that even though their premiums may not increase due to age or physical condition, they are part of a class of policy holders that can increase?

**Underwriting Measures Risk To Benefits**

Underwriting is not an exact science, It is very subjective. Also, long term care underwriting is different than life insurance or general health insurance underwriting as is the underwriting you need to do for a 55 year-old term insurance buyer compared to an 80-year-old long term care applicant.

One thing is certain about underwriting the mature market: There is a much higher risk to insurers because of the low cost of premiums weighed against potentially high benefit payouts.
Think about it, would you be willing to guarantee to pay up to $100,000 per year to reimburse potential long term care costs that you know are going to effect about 60% of the population? What would you charge for this service? $200 per month; $300 per month? Furthermore, what if a state agency told you that even though you want to charge more for this service, you must payout at least 60% of the premiums you collected in benefits before you could raise your rates, would you want to get involved?

These are the conditions that insurance companies must comply with in order to get products approved. In addition, most insurance products, continually transforming. Older long term care policies, for example, covered only the cost of nursing homes while current versions dabble in home care services and adult day care. New and evolving products are challenging for insurers especially when policies sold years and years ago have yet to file claims. Such is the nature where policies sold to a client at age 60 may never be used until age 85. Can you imagine trying to plan for these events? To add to the problem, much lower policy lapses are occurring than anticipated. One of the dirty little secrets of the insurance industry is that insurers actually rely on a certain amount of insureds to drop their policies before any benefits are paid. If it doesn't happen, they can raise rates anyway and have done so for an entire class of policyholders.

**Different Policies/ Different Underwriting**

When you stop and think about it, there are many reasons why some underwriting is more difficult than others. Let's look at a few of the differences between health insurance and long term care:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Health Insurance</th>
<th>Long Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of claim</td>
<td>Higher claim frequency due to many doctor visits and prescriptions</td>
<td>Lower utilization because claimants are reluctant to use institutional care. Home care options may change this over time.</td>
</tr>
<tr>
<td>Average claim amount</td>
<td>Claims are generally lower and fewer because most claims involve low cost doctor visits.</td>
<td>High average claim amounts because benefits are for expensive care for extended time periods</td>
</tr>
<tr>
<td>Benefit period duration</td>
<td>In most instances, benefit periods are significantly less than one year.</td>
<td>Benefits usually extend beyond one year.</td>
</tr>
<tr>
<td>Data reliability</td>
<td>Health insurance claims have a long history with very reliable data.</td>
<td>LTCI is relatively new and claims data is still being developed.</td>
</tr>
<tr>
<td>Premium payment period</td>
<td>Premiums are typically paid through group insurance plans or during the working-life of an individual.</td>
<td>Most insureds are purchasing this coverage in the 60's and 70's. Most premiums will be paid during fixed income years.</td>
</tr>
<tr>
<td>Premium ratings</td>
<td>Premiums are usually sold on an attained-age basis reflecting risk at a particular age and NO prefunding of risk for older ages.</td>
<td>Premiums are usually sold on an issue-age basis reflecting higher premiums that have already prefunded for the higher risk of claims at older ages.</td>
</tr>
</tbody>
</table>
Considering these differences, it is easy to see why underwriting changes and suitability requirements are in a constant state of flux.

**Underwriting Problems & Declines**

When evaluating a medical history of a mature client, the insurance company through its underwriting and medical departments, may determine that a rating is necessary to cover a certain risk. This may come as a surprise to a client, who has been told by his physician that he is in excellent health. It is a matter of perspective. The physician may try to be the patient’s advocate, and describe his medical condition in the best possible way. When the patient starts having physical problems, then the physician will begin treating the illness. The insurance company looks at the client’s physical condition as a potential risk, knowing that it must evaluate the medical condition in a very narrow window of time. Listed below are some of the more common impaired risks you will encounter in the mature marketplace.

**Heart Conditions**

**Heart Attack**

Heart attack is the leading cause of death in America. Approximately 500,000 individuals die from myocardial infarctions yearly. Approximately 45% of all heart attack victims are under age 65, and 5% are under age 40. Heart attacks result from blood vessel disease in the heart. Infarction occurs as the blood supply to an area becomes totally blocked, usually as a result of coronary artery disease. A clot may form on an area of partial blockage, obstructing that site or moving to a more distant, smaller area in the coronary artery, totally occluding the vessel. If the blood supply is cut off drastically or for a long time, muscle cells suffer irreversible injury and die. Disability or death can result depending on how much heart muscle is damaged. The diagnosis of myocardial infarction is usually made by the presence of severe chest pain, characteristic electrocardiographic changes, and elevated cardiac enzymes. Silent myocardial infarctions (the patient has no knowledge that an infarction occurred at some time in the past) are fairly common and may be noted on the EKG during an insurance work-up. Sometimes a coronary artery temporarily contracts or goes into spasm. When this happens the artery narrows and blood flow to part of the heart muscle decreases or even stops. What causes a spasm is unclear, but it can occur in normal blood vessels as well as vessels partially blocked by atherosclerosis. If a spasm is severe, a heart attack may result. The following factors may lead to a rating: more than one heart attack, current episodes of angina or chest pain, new EKG changes, diabetes, obesity, uncontrolled hypertension or other cardiovascular or renal disease, decreased left ventricular function, the degree of coronary artery disease, or complications such as persistent arrhythmias.

An applicant who has suffered a myocardial infarction and is under the age of fifty at the time of the application may also be assessed a temporary extra premium. Most applicants with a history of myocardial infarction can be issued an individual life insurance policy. An exercise EKG (treadmill EKG) is a valuable diagnostic and screening procedure primarily used to detect coronary artery disease. Exercise may induce ischemia (inadequate supply of blood) due to coronary artery disease that is not present at rest. In order to accurately interpret an exercise EKG, it is essential to know why it was completed. An exercise EKG is usually obtained for one of the following reasons:

- To screen for the presence of undiagnosed coronary heart disease, especially in individuals with one or more unfavorable coronary risk factors (cigarette smoking, hypertension, elevated cholesterol, family history of coronary heart disease at a young age, or diabetes), or in an individual with other known atherosclerotic impairments
- To evaluate an individual with chest pain
To clarify abnormalities found on a resting EKG
To assess the severity of known coronary heart disease

The proper interpretation of an exercise test is dependent upon the basic underlying likelihood of coronary heart disease, a detailed knowledge of any prior medical history, and additional diagnostic studies, which have been performed. In the final analysis, the likelihood that a positive (abnormal) exercise test represents ischemia will depend on other coronary risk factors including age, sex of the applicant, smoking habits, family history of heart disease, cholesterol levels, hypertension, and chest pain (angina) all modified by the results of any additional studies completed after a positive exercise test. An abnormal exercise EKG is classified as being mildly, moderately, or strongly positive. Following an abnormal exercise test it is common practice to do additional studies to confirm the finding. When these tests, such as thallium scan, exercise echocardiogram, or cardiac catheterization are completed, the rating may be modified depending upon the results of these tests.

Cholesterol and triglycerides are fatty substances (lipids) found normally in the blood. A high level of lipids in the bloodstream is called hyperlipidemia, which is a major risk factor for coronary heart disease. Hyperlipidemia can affect the heart in this way: Cholesterol and other lipids build up in the inner lining of blood vessels like rust in water pipes and, over time, close these vessels. The narrowing of blood vessels, called arteriosclerosis, keeps oxygen-carrying blood from getting to the heart muscle. The result can be severe chest pain and eventually heart attack. To determine the risk of arteriosclerosis from hyperlipidemia, one should measure total blood cholesterol, triglycerides, and lipoproteins. Lipoproteins transport cholesterol and other fats in the bloodstream. The two lipoproteins most frequently measured are low-density lipoproteins (LDLs) and high-density lipoproteins (HDLs). LDL seems to promote the deposit of cholesterol on artery walls. HDL, on the other hand, is thought to carry cholesterol away from the tissues. The CHOL/HDL ratio is the most important element in underwriting. The definition of a "high" cholesterol level varies from person to person, depending on specific lipoprotein levels. If LDL is present in the bloodstream in large quantities, the cholesterol it carries may be responsible for increasing the risk of heart disease. However, if the cholesterol in HDL accounts for a significant part of one's cholesterol count, it may help protect him from heart disease. Generally, an applicant with normal build and blood pressure, good family history, and a normal electrocardiogram will be accepted with no rating for CHOL/HDL ratios below eight if a current normal treadmill is available. Triglycerides, the other blood lipid, will generally be rated when its level exceeds 800. Non-fasting blood tests may affect lipid levels. Whenever possible, a fasting blood sample is preferred.

**Nonischemic Cardiomyopathy**
Cardiomyopathy is a disease of the heart muscle. The heart's muscle loses its ability to pump blood. In some instances, the loss of pumping power leads to irregular heartbeats (called arrhythmias). In most cases, the exact cause of the muscle damage is never found. There are two major categories of cardiomyopathy. These are ischemic and nonischemic. Ischemic cardiomyopathy typically refers to heart muscle damage that results from coronary artery disease such as a heart attack. Nonischemic cardiomyopathy includes three main types: dilated, hypertrophic and restrictive. The name of each type describes the nature of its muscle damage. Cardiomyopathy affects about 50,000 Americans, and is the leading condition for heart transplantation. Certain types of cardiomyopathies are common in young people. Cardiomyopathy can have a rapid progression into heart failure.

**Dilated (Congestive) Cardiomyopathy** ~ The most common type of nonischemic cardiomyopathy is the dilated form. This occurs when disease affected muscle fibers lead to enlargement or dilation of one or more chambers of the heart and the heart muscles are actually stretched and weakened. The dilation reduces the heart's pumping ability. The highest
incidence is in middle-aged men, but it can occur at any age including childhood. Most cases are termed idiopathic which means that a specific cause is never identified. The following factors have been linked to the disease: chronic excessive alcohol consumption, complications during childbirth, viral infections that lead to inflammation of the heart muscle (called myocarditis), toxins, and some drugs used to treat cancer. Dilated cardiomyopathy can be present for several years without symptoms. It gradually enlarges the heart and weakens it pumping power. This is called "heart failure" and is the hallmark of dilated cardiomyopathy. Heart failure symptoms include fatigue, weakness, shortness of breath that may be severe and increasing with exertion or lying down, swelling of legs and feet. In advanced stages, dilated cardiomyopathy may cause pain in chest or abdomen. Some patients develop irregular heartbeats, which can be serious and even life threatening. Once symptoms appear, a physical exam and the patient's medical history can lead to the diagnosis. A chest x-ray, an EKG, or echocardiogram, can differentiate dilated cardiomyopathy from other causes of heart failure. In some cases, more invasive tests may be indicated. These include radionuclide ventriculogram and cardiac catheterization. Radionuclide ventriculogram involves injecting low dose radioactive material into a vein, through which it flows to the heart. Pictures are taken by a camera to show how well the heart is functioning. Cardiac catheterization involves placing a thin plastic tube through a blood vessel until it reaches the heart. A dye is injected and x-rays taken to assess the heart's structure and function.

Unfortunately, by the time of diagnosis, the disease has often reached an advanced stage and heart failure has occurred. Only 50% of patients with dilated cardiomyopathy live five years once heart failure is diagnosed. About 25% live ten years after such a diagnosis. No cure exists. Four types of medications are used to manage the symptoms. Diuretics reduce excess fluid in the body. Vasodilators reduce blood pressure and reduce effort needed by heart to pump the blood through the body. Digitalis improves the pumping action of the heart and regulates heart rate. Calcium blockers or beta-blockers regulate the heart rate. Heart transplantation may be needed in which the patient's heart is replaced with a donor heart. Heart transplantation improves survival with 75% of patients living five years after transplantation. Due to a scarcity of donor hearts, only about 2,000 patients receive transplantation.

**Hypertrophic Cardiomyopathy** ~ The second most common form of heart muscle disease is hypertrophic cardiomyopathy. Physicians sometimes call it by other names: idiopathic hypertrophic subaortic stenosis (IHSS), asymmetrical septal hypertrophy (ASH), or hypertrophic obstructive cardiomyopathy (HOCM). In hypertrophic cardiomyopathy, the growth and arrangement of muscle fibers are abnormal, leading to thickened heart walls. The greatest thickening tends to occur in the left ventricle (the heart's main pumping chamber). Thickening reduces the size of the pumping chamber and obstructs blood flow. Eventually this affects the pumping action of the heart. This a rare disease found in less than 2% of the U.S. population. It can occur in people of all ages, including children, and can affect both men and women. Most cases have a genetic connection, although sometimes there is no clear cause. Many patients have no symptoms. The most common symptoms are breathlessness and chest discomfort. Other signs are fainting during physical activity, strong rapid heartbeats that feel like a pounding in the chest and fatigue with physical exertion. In some cases, the first and only symptom is sudden death, caused by a chaotic heartbeat. The first physical discovery of hypertrophic cardiomyopathy may be from a murmur heard by a health care provider. This discovery will prompt an echocardiogram. An echocardiogram is one of the best tools for diagnosing hypertrophic cardiomyopathy. It uses sound waves to detect the extent of muscle-wall thickening and to assess the status of the heart's functioning. Other tests used in the diagnosis include a chest x-ray, which determines if heart is enlarged, or an EKG, which determines if any irregular heartbeats are present. In some cases, more invasive tests may be indicated. These include radionuclide ventriculogram or cardiac catheterization. Patients with serious electrical and blood flow abnormalities of the heart must be less physically active. Various drugs are used
to treat the disease. These include diuretics, vasodilators, digitalis, calcium blockers or beta-blockers, which regulate heart rate. However, drugs do not work in all cases or may cause adverse side effects. Other treatments, such as a pacemaker or surgery, may be needed. Pacemakers change the pattern and decrease the force of the heart's contractions. The pacemaker can reduce the degree of obstruction and so relieve symptoms. Some patients who have a pacemaker inserted feel no relief and go on to have heart surgery. Surgery usually calls for removal of part of the thickened septum (the muscle wall separating the chambers) that is blocking the blood flow. Surgery to remove the thickening eases symptoms in about 70% of patients but results in death in about 1 to 3% of patients. Hypertrophic cardiomyopathy patients also are at risk of sudden death. About 2 to 3% die each year because the heart suddenly stops beating. This cardiac arrest is brought on by an abnormal heartbeat. Over ten years, the risk of sudden death can be 20% or more.

**Restrictive Cardiomyopathy** ~ This is rare in the U.S. and most other industrial nations. In this disease, the walls of the ventricles stiffen and lose their flexibility due to infiltration by abnormal tissue. As a result, the heart cannot fill adequately with blood and eventually loses its ability to pump properly. Restrictive cardiomyopathy typically results from another disease occurring elsewhere in the body. In the U.S., restrictive cardiomyopathy is most commonly related to amyloidosis, sarcoidosis and hemochromatosis. Typical signs of the condition include symptoms of congestive heart failure, which are weakness, fatigue and breathlessness. Swelling of the legs, caused by fluid retention, occurs in a significant number of patients. Other signs include nausea, bloating, and poor appetite, probably because of the retention of fluid around the liver, stomach and intestines. A physician may suspect restrictive cardiomyopathy based on a patient's symptoms and the presence of another disease. Although symptoms of congestive heart failure may predominate, the size of the heart remains relatively small, unlike other cardiomyopathies. Diagnostic information comes from an echocardiogram or other imaging studies that provide pictures of the heart. These include magnetic resonance imaging (MRI), and computed tomography (CT Scan). A definite diagnosis usually requires cardiac catheterization studies or biopsy, in which a tiny piece of tissue (including heart muscle) is removed for laboratory analysis. Restrictive cardiomyopathy has no specific treatment. The underlying disease that leads to the heart problem also may not be treatable. In general, the use of traditional heart drugs has been limited in this cardiomyopathy, although diuretics may help control fluid accumulation. In rare cases, surgery is sometime used to try to improve blood flow into the heart. The condition is similar to dilated cardiomyopathy and tends to worsen with time. Only about 30% of patients survive more than five years after diagnosis.

Clients with known cardiomyopathy face significant underwriting problems. The majority of these clients will be uninsurable for individual coverage. The following questions will help the underwriter quickly screen clients with cardiomyopathy:

- When was the client diagnosed with cardiomyopathy? As a rule, the longer the client has cardiomyopathy, the more severe the condition.
- What type of cardiomyopathy is it? Clients can contact their physician and quickly find out their type.
- What medications is the client currently taking for their cardiomyopathy? Medications such as Lasix, Lanoxin, and Cordarone suggest heart failure or arrhythmias. In either case, the client is uninsurable.
- Does the client have any symptoms of heart failure? This would include fatigue, weakness, shortness of breath (sometimes severe and increasing with exertion or lying down) or swelling of legs and feet.
- Does the client have an arrhythmia? Cardiomyopathies with an arrhythmia are very high risk and uninsurable.
**Angioplasty**

Cardiac catheterization is a procedure used to determine the extent and location of arteriosclerotic disease. This procedure involves placing a flexible tube (catheter) percutaneously (through a skin incision) into an artery (usually the femoral artery) and maneuvering the catheter transluminally (guided through the arterial system by means of x-ray) to the coronary artery. In the procedure known as PTCA, an elongated balloon-like apparatus is attached to the end of the catheter. It is advanced through the area of obstruction and filled and emptied a number of times—each time with increased pressure expanding the area of obstruction thus enabling an increased flow of blood to move through that area. This procedure was first performed in a human in 1977 and currently more than 500,000 such procedures are carried out annually in the United States. This number surpasses the number of bypass operations. The procedure actually results in little, if any, compression of the plaque—rather it tends to stretch (dilate) the wall of the vessel. During the first six months or so after such a procedure, the healing process can result in restenosis in 25-40% of patients. This is often times the result of what has become known as “creep” or the elastic recoil of the vessel wall after dilation. Blood thinners are commonly prescribed to such patients to prevent thrombosis (clotting) and enable better blood flow. As medical science has advanced, attempts have been made to use stints at the site of obstructions to prevent restenosis. Although some improvement in the restenosis rate has been noted, overall the complication rate has limited its success. Other methods of angioplasty being studied involve the use of lasers, however, this is a rather new technology. Yet another procedure is known as rotational atherectomy, which in effect cuts the plaque from the wall of the artery converting it to millions of micro particles, which are then cleared by the circulatory system. Restenosis rates for this procedure are comparable to those of PTCA. Ratings for those who have undergone PTCA depends largely on the extent of disease prior to the procedure, the success of the procedure as determined by follow-up studies, age, family history, and lipid studies. For those who have been determined to have only single vessel disease without history of myocardial infarction such as a heart attack, it may be possible to offer better rates. With multiple vessel disease, ratings will be higher depending on vessels involved and the extent to which they are diseased. As is always the case when dealing with heart disease, the ability of the heart’s left ventricular chamber to function properly is of major importance. Thus the ejection fraction (EF) as well as the general status of the cardiovascular system is all to be taken into consideration in the final determination of a rating.

**Angina**

Angina is the chest discomfort that occurs when the blood-oxygen supply to an area of the heart muscle does not meet the demand. In the majority of cases the lack of blood supply is due to a narrowing of the coronary arteries as a result of arteriosclerosis (coronary artery disease or CAD). Angina is one of many causes of chest pain, and is a result of inadequate oxygen supply to the heart muscle. Angina is usually a warning sign of the presence of significant coronary artery disease. Patients with angina are at risk of developing a heart attack (myocardial infarction). Coronary artery disease remains the number one cause of death in industrially developed countries. For approximately one quarter of the individuals who die suddenly, death is the first indication of underlying CAD. The American Heart Association estimates that more than 25% of the adult population in the United States has some form of heart disease. The most common cause is coronary artery disease. A less common cause of angina is spasm of the coronary arteries. Coronary arteries supply oxygenated blood to the heart muscle. Coronary artery disease develops as cholesterol is deposited in the artery wall, causing the formation of a hard, thick substance called cholesterol plaque. The accumulation of cholesterol plaque over time causes narrowing of the coronary arteries, a process called arteriosclerosis. When the coronary arteries are narrowed by more than 50 to 70%, they cannot meet the increased blood oxygen demand by the heart muscle during exercise or stress.
Angina is usually felt as a squeezing, pressure, heaviness, tightening, or aching across the chest, particularly behind the breastbone. Other characteristic symptoms of angina include pain that radiates to the neck, jaw, arms, back or even teeth, indigestion, heartburn, weakness, sweating, nausea, cramping and shortness of breath. Many times angina symptoms occur after a heavy meal, during exertion or severe emotional stress. Angina typically lasts one to fifteen minutes and is relieved by rest or by placing a nitroglycerin tablet under the tongue. Complete history and physical are a normal part of a chest pain workup for angina. Many times the history can strongly suggest angina. A resting EKG is usually not very helpful in angina patients, since the chest pain and lack of oxygen supply to the heart only become evident during exertion or excitement. During an exercise treadmill test, EKG recordings of the heart are performed continuously as the patient undergoes increasing levels of exercise. The occurrence of chest pain during exercise can be correlated with changes on the EKG, which demonstrate the lack of oxygen to the heart muscle. When the patient rests, the angina and the changes on the EKG, which indicate lack of oxygen to the heart, can both disappear. Accuracy of this test is between 60 to 70%. A nuclear agent (thallium) is given intravenously during an exercise treadmill test. The addition of thallium allows nuclear imaging of blood flow to different regions of the heart, using an external camera. If reduced blood flow in an area of the heart is present during exercise with normal blood flow to other parts of the heart, this signifies significant artery narrowing in that region of the heart. This test combines echocardiography (ultrasound imaging of the heart muscle) with exercise treadmill testing. Areas of blockage of the coronary arteries can be detected as abnormalities in muscle contraction of the heart. Both stress echocardiography and thallium stress tests are both about 80 to 85% accurate in detecting significant coronary artery disease.

Treatment options include rest, medications (nitroglycerin, beta-blockers, calcium channel blockers), percutaneous transluminal coronary angioplasty (PTCA), or coronary artery bypass graft surgery (CABG). Resting, sublingual (placed under the tongue) nitroglycerin tablets, and nitroglycerin sprays all relieve angina by reducing the heart muscle's demand for oxygen. Nitroglycerin also relieves spasm of the coronary arteries and can redistribute coronary artery blood flow to areas that need it most. Short-acting nitroglycerin can also be used before exertion to prevent angina. Longer-acting nitroglycerin preparations, such as Isordil tablets, Nitro-Dur transdermal systems (patch form) and Nitrol ointment are useful in preventing and reducing the frequency and intensity of episodes in patients with chronic angina. Headaches and lightheadedness due to excess lowering of blood pressure can limit the use of nitroglycerin preparations. Beta-blockers relieve angina by inhibiting the effect of adrenaline on the heart. Inhibiting adrenaline decreases the heart rate, lowers the blood pressure, and reduces the pumping force of the heart muscle, all of which reduce the heart muscle’s demand for oxygen. Examples of beta-blockers include propranolol (Inderal), metoprolol (Lopressor), and atenolol (Tenormin). Side effects include worsening of asthma, excess lowering of the heart rate and blood pressure, depression, fatigue, impotence, increased cholesterol levels, and shortness of breath due to diminished heart muscle function. Calcium channel blockers relieve angina by lowering blood pressure, and reducing the pumping force of the heart muscle, thereby reducing muscle oxygen demand. Calcium channel blockers also relieve coronary artery spasm. Examples of calcium channel blockers include nifedipine (Procardia), verapamil (Calan), and diltiazem (Cardiazem). Verapamil and diltiazem also lower the heart rate. Side effects include swelling of the legs, excess lowering of the heart rate and blood pressure, and depressing heart muscle function, thereby causing an increased shortness of breath. When patients continue to have angina despite maximally tolerated combinations of nitroglycerin medications, beta-blockers and calcium-blockers, cardiac catheterization with coronary arteriography is indicated. Depending on the location and severity of the disease in the coronary arteries, patients can be referred for balloon angioplasty (percutaneous transluminal coronary angioplasty or PTCA) or coronary artery bypass graft surgery (CABG) to increase coronary artery blood flow.
A client with a history of angina presents underwriting problems for the life insurance carrier. In many cases these clients are declined for individual coverage. However, there are clients with a history of angina who are insurable based on a “favorable” risk factor profile. The following questions will allow the agent to quickly screen any client with a history of angina:

- Does the client currently smoke? Clients who have a history of angina and continue to smoke may not be insurable for individual coverage. Smoking is a major risk factor for heart disease and one that can have a dramatic impact on outcome (i.e. life expectancy). The good news is that clients who have angina and quit smoking have better survival rates and better pricing for life insurance.
- When was the client first diagnosed with angina and have the symptoms remained stable? There are basically two kinds of angina: stable and unstable. Stable angina is usually related to physical effort such as walking up a hill or stairs, stable and managed by medications and lifestyle changes. Clients with stable angina are insurable. Unstable angina is not related to effort such as chest pain at rest, is unstable or progressively worse despite medications and usually signals the onset of a cardiac event (i.e. heart attack, coronary angioplasty, coronary bypass). Clients with unstable angina are uninsurable for individual coverage.
- What medications is the client taking? Stable angina can be managed by a variety of medications. Beta blockers, calcium channel blockers, and nitroglycerin preparations are all used to manage chest pain. Unstable angina may require more frequent use of nitroglycerin preparations (i.e. Nitrostat, Nitropaste, Minitran, etc.).
- Does the client have any history of other cardiac problems? Angina superimposed on other forms of cardiac disease almost universally renders the client uninsurable for individual coverage. Clients who have had a heart attack, coronary angioplasty, or coronary bypass surgery and go on to have angina on not insurable on an individual basis.
- Is the client currently involved in any form of cardiac rehabilitation or undergone any lifestyle changes? Lifestyle changes such as quitting smoking, exercise, diet, and stress reduction are major components to the successful management of angina. They are also major components in the final risk analysis.

### Coronary Artery Bypass

In the United States, approximately 300,000 people have coronary artery bypass surgery every year. 40% are over age sixty-five and 20% are over age seventy. There are two main types of bypasses. The *saphenous vein* can be removed from the leg, reversed in direction, and then attached into the aorta and coronary artery beyond the blockage. The second type involves freeing one end of the *internal mammary artery* from the chest wall and attaching it to the coronary artery beyond the blockage. Often when more than one vessel is being bypassed, both types of bypasses are used with the internal mammary bypassing the left anterior descending coronary artery. As many as six separate grafts may be constructed to the side of the aorta. Coronary arteries less than 1mm in diameter by angiogram measurement are not suitable for bypass grafting. Indications for CABG are: intractable angina not responding to medical therapy, left main artery disease with greater than 50% stenosis, silent ischemia noted on testing with significant three-vessel disease, three-vessel disease with impaired left ventricular function (ejection fraction less than 50%), or two or three-vessel disease if one of the vessels involved is the proximal LAD.

Studies have proven improved survival in left main disease and three-vessel disease with impaired LV function. Follow-up after CABG shows that 70% of patients have complete relief of angina, 25% have partial relief, and in 5% the surgery is unsuccessful. Stress testing done after surgery shows that 65-85% have improved exercise tolerance. Complications include arrhythmia requiring a permanent pacemaker, congestive heart failure, aortic dissection, pulmonary embolism, and depression (1st month post-op). In the typical hospital course, a
patient can be moved out of the ICU within two days and discharged within seven days. For bypass surgery patients, the thirty-day mortality rate is 6.5% and the one-year mortality rate is 12%. Graft closures remain a limiting factor to the success of CABG. Graft closures immediately after surgery are due to acute thrombosis clot formation. Closures a few months to years later are due to fibrosis or advancing atherosclerosis. The internal mammary artery graft is more likely to remain open than saphenous vein grafts.

**Intermittent Claudication**

Intermittent claudication (claudication means to limp in Latin) is a syndrome caused by arterial insufficiency (inadequate blood supply), primarily due to atherosclerosis (fatty build-up and narrowing of the arteries). Intermittent claudication is a predictable pattern of lower leg pain caused by inadequate blood flow to the exercising muscle. Intermittent claudication is also called peripheral arterial occlusive disease (arteries of the extremities of the body are blocked). 18% of persons over seventy years of age have intermittent claudication. Intermittent claudication is associated with a significant increase in mortality due to the existence of underlying cardiac disease. The most common cause is atherosclerosis. Atherosclerosis is a fatty build-up and narrowing of the arteries. This leads to limited or completely blocked blood flow through the arteries. Risk factors include smoking, family history of atherosclerosis, diabetes, high blood cholesterol, and high blood pressure. The pain of intermittent claudication has three characteristics. It is a cramping pain in the calves brought on by exertion. Rest relieves it. It is reproducible or it almost always occurs after having walked some distance. Pain brought on by walking is less serious than pains occurring during sleep or while at rest. These are indications of disease progression and warrant therapy that is more aggressive. The diagnosis of intermittent claudication begins with a through history and physical. There are three specific questions in the medical history, which is part of the assessment process:

- Do you get pain or cramping in the calf, thigh or buttock muscles when you walk?
- Does the pain or cramping go away when you rest or stop walking?
- Does the discomfort occur at approximately the same distance every time you walk

Major physical findings upon examination may include arterial bruits (abnormal blood flow sound heard by stethoscope when placed over a major artery such as abdominal aorta or femoral artery), decreased or absent leg pulses, decreased skin temperature, abnormal skin color (persistent areas of redness called dependent rubor), or shiny or hairless skin on the legs. The ankle-brachial index is an effective screening tool. It requires a blood pressure cuff and continuous wave Doppler. Blood pressure readings are compared between the upper extremities and ankle arteries. Dividing the “ankle” pressure by the “arm” pressure gives you the ankle-brachial index. An ankle-brachial index below 0.95 is considered abnormal. An ankle-brachial index between 0.8 and 0.5 is consistent with intermittent claudication. An ankle-brachial index less than 0.5 indicates severe disease. Angiography or MRI assisted angiography may be necessary to determine the extent of the disease. However, these studies are not used to make the initial diagnosis. Conservative treatment is indicated for patients who experience symptoms only upon exertion. In these cases, aggressive lifestyle modification is essential. These include stopping smoking, maintaining good diabetic control, good cholesterol levels, and normal blood pressure. In addition to lifestyle modifications, conservative treatment also includes anti-platelet medications, a walking program and medical treatment of symptoms.

There are three anti-platelet medications available for patients with intermittent claudication: aspirin, Ticlid, and Plavix. Anti-platelet medications do more than prevent complications from intermittent claudication. The Antiplatelet Trialists’ Collaboration Study demonstrated that patients with intermittent claudication who were treated with anti-platelet therapy had a 17.8% relative reduction in the incidence of heart attacks, stroke and vascular death. There are two medications approved for the treatment of the symptoms of intermittent claudication. These are
Trental and Pletal. "Surgical treatment" of intermittent claudication may be necessary with patients whose arteries are blocked in localized areas or who have narrowed lengths of clogged arteries. Surgical choices for localized blockages include "angioplasty" of the lesion or endarterectomy (replacing a blocked section of the artery). The surgical procedure for clogged, narrowed lengths of leg arteries is bypass graft surgery.

Clients with a history of intermittent claudication present underwriting concerns for life insurance companies. Most carriers operate on the theory that the younger the client the higher the rating (i.e. clients 39 and younger had double the normal underwriting rating). Complicating factors such as smoking, high cholesterol, diabetes and high blood pressure can result in higher ratings or a declination. Clients with intermittent claudication and coronary artery disease or cerebral vascular disease are in the majority of cases uninsurable for individual coverage. The following questions will help you screen clients with a history of intermittent claudication:

- Does the client currently smoke? Claudication (pain in the leg while walking that is relieved by rest) is caused by hardening of the arteries (atherosclerosis) in the legs. It is essentially the same disease as coronary artery disease (hardening of the arteries of the heart). Factors that contribute to the development of claudication are the same as those that cause coronary artery disease. These include smoking, hypertension (high blood pressure), hyperlipidemia (high cholesterol levels or high cholesterol/HDL ratios), family history of heart or vascular disease, diabetes, and obesity. Clients with intermittent claudication who continue to smoke represent poor underwriting risks. However, clients with claudication who quit smoking have better medical and underwriting outcomes. The term peripheral vascular disease refers to other vascular diseases in addition to claudication, which is a disease of the arteries of the legs. Other forms of peripheral vascular disease include carotid disease (primary blood supply to the brain), abdominal aorta disease (primary blood supply to the lower body) and renal artery disease (primary blood supply to the kidneys).

- When was the client diagnosed with claudication, and how was it treated? The goal of treatment of claudication is to improve the symptoms and stop the progression of the disease. Medications can help symptoms, but lifestyle changes can successfully treat claudication. These lifestyle changes include stopping smoking, regular exercise, losing weight and a reduction in blood cholesterol. When lifestyle alone is not enough to treat the symptoms or stop the progression, angioplasty of the affected artery or an actual bypass graft around the blocked artery is treatment options. It is important to document the original date of diagnosis and the kind of treatment the client received for their claudication.

- What medications is the client currently taking? Clients with claudication normally take an aspirin a day to reduce the chances of developing a blood clot at the blockage site. In addition, they may also take medications for high cholesterol, high blood pressure or diabetes. They may also take medications to reduce the symptoms of claudication. It is important to document ALL the medications the client is taking.

- What lifestyle changes has the client made to treat their claudication? As indicated earlier, lifestyle changes can be very effective in literally stopping the progression of peripheral vascular disease. It is important to document all the "positive" lifestyle changes the client has adopted to insure the client is given the appropriate "credit" in his or her underwriting assessment.

- Does the client have a history of coronary artery disease? Statistics reported in the New England Journal of Medicine demonstrate a high death rate from heart disease among patients with even mild peripheral vascular disease. The study demonstrated that for patients with severe claudication the ten-year mortality for cardiovascular disease was fifteen times higher than for persons who had no peripheral vascular disease. Clients who have claudication and coronary artery disease present underwriting problems that may preclude them from offers for individual coverage. It is important to ask all clients with known claudication if they have any history of any form of heart disease.
Irregular Heartbeat
The heartbeat is normally quite regular. Irregularity of the heartbeat is described as an arrhythmia. It can be felt by the individual as a palpitation or detected by checking the pulse. The irregularity may be constant or it may be intermittent or paroxysmal comes and goes. If it is constant, it can be seen in the electrocardiogram (ECG). However, a twenty-four hour Holter monitor may be necessary for further evaluation. Some of the common types of irregular heartbeats are discussed below.

Sinus arrhythmia is the variation of heart rhythm with breathing. The heart beat quickens on breathing in and slows down on breathing out. This variation may be quite pronounced in trained athletes. This is a normal response of the heart and is not rated. Premature supraventricular or atrial beats (PAC’s) arise in the upper chamber of the heart, called the atrium. These are benign and are not rated. Premature ventricular beats (PVC’s) originate in the lower, pumping chamber of the heart called the ventricle. When isolated, and in the absence of heart disease, PVC’s generally do not pose a significant risk. PVC’s of an unfavorable nature may include one or more of these features: association with any type of heart disease, origin from several different regions of the ventricle (multi-focal), increase in frequency with exercise, and runs of PVC’s such as bigeminy (every other beat is a PVC), trigeminy (every third beat is a PVC), or ventricular tachycardia (more than three PVC’s in a row). The rating will depend on the frequency and complexity of the PVC’s and the presence of other underlying heart disease. Atrial flutter or fibrillation (AF) may be paroxysmal (intermittent) or chronic (permanent). Causes of AF include: mitral valve disease, coronary heart disease, cardiomyopathy, hyperthyroidism, fever, and alcoholism. Mortality studies have shown that chronic AF, even without other significant heart disease, carries an increased mortality risk. Clients with chronic AF are at a high risk of developing blood clots, which may lead to stroke. Mitral stenosis (a narrowing of the mitral valve) associated with atrial fibrillation especially carries a high mortality.

A Pacemaker
A pacemaker is an electronic device that stimulates the heart beat. It can be programmed to begin pacing when a person’s own heart rate falls below a pre-set number. If the heart rate drops significantly, it causes symptoms such as light-headedness, dizziness, or even black-out. A slow heart rate is called bradycardia. It can occur in various types of heart blocks or arrhythmias (rhythm disturbance). The pacemaker may be needed temporarily or on a permanent basis. Sometimes myocardial infarction (heart attack) causes transient heart block requiring a temporary pacemaker. Most of the time, the need for pacing is permanent. Some of the conditions requiring a pacemaker are significant heart block and Sick Sinus Syndrome. Sometimes drugs used to control atrial fibrillation (a type of irregular heart beat) result in profound bradycardia requiring a pacemaker. There are many types of pacemakers; most are designed to pace at a preset rate. Some of the newer pacemakers can increase the pacing rate based upon needs of the body. Pacemaker batteries may last eight - twenty years. Complications of pacemakers include: infection, blood clots, malfunction, and perforation. The rating for pacemakers depends upon the underlying condition for which the pacemaker was implanted:

- Pacemaker in heart block associated with coronary artery disease (CAD); +55 in addition to CAD debits
- Congenital heart block without associated congenital heart disorder; +55
- Complete heart block or Sick Sinus Syndrome; +100
- Chronic underlying atrial flutter/fibrillation; +100 - 300

Abdominal Aortic Aneurysm (AAA)
An abdominal aortic aneurysm (AAA) involves the aorta, which is one of the largest arteries that carry blood from the heart to the rest of the body. An AAA means that the aorta is "dilated" and
at risk for rupture, hemorrhage and death. The dilatation must be permanent, localized and 1.5 times the normal diameter of the aorta to be called an AAA. 5 to 7% of people over sixty in the U.S. have an AAA. The male-female ratio over age sixty is 5:1. The incidents of AAA have increased three-fold over the past forty years. 75% of AAAs do not have symptoms (asymptomatic) and are detected during a routine exam or during some unrelated x-ray or surgical procedure. AAA is the 13th leading cause of death in the U.S. Approximately 15,000 people in the U.S. die each year of a rupture AAA. 50% of individuals with a ruptured AAA do not survive long enough to receive medical attention. Of those who make it to the hospital, 25-30% die of postoperative complications.

The most common cause is "hardening of the arteries" called arteriosclerosis. 80% of abdominal aortic aneurysms are from arteriosclerosis. Other causes include family history of AAA, male gender, smoking, vascular disease in the legs, increased age, diabetes, high blood cholesterol, high blood pressure, trauma to the aorta, inflammation of blood vessels, end-stage syphilis, and fungal infections. Many abdominal aortic aneurysms are without symptoms. They can become enlarge and rupture without warning. An AAA can also cause pain. This is generally described as a "deep pain" that is steady but may be relieved by changing positions. The physical examination is one of the most important tools for diagnosing AAA with a reported accuracy of 30 to 90%. In addition to the physical examination, other studies can be used to diagnose an AAA. These include:

- **B-Mode Ultrasound** ~ This is the screening test of choice. It is readily available, inexpensive and accurate (82 to 99%).
- **CT Scan** ~ The most accurate test for determining size and location of AAA. It is readily available, expensive and requires an injected contrast medium.
- **CT Angiogram** ~ This is a new medium that combines a CT scan with an angiogram. It eliminates the need for invasive angiography. It is expensive, requires specialized training and an injected contrast medium.
- **MRI** ~ New imaging modality for AAA. It is expensive but does not require an injected contrast medium.
- **Angiogram** ~ This is the least useful imaging modality for diagnosing AAA. It is expensive, invasive, requires an injected contrast medium and has problems with accurately delineating the aneurysm.

The treatment of an AAA depends on the size of the aneurysm. Size has been correlated with the risk of rupture. Studies have found that a diameter of six cm or greater require surgical repair due to the high risk of rupture. Patients with smaller aneurysms can be followed medically using sequential imaging studies to measure the growth of the aneurysm and to determine the appropriate time for intervention. Patients with aneurysms of 3.5 cm or less can be followed on an annual basis. Patients with aneurysms greater than 3.5 should be seen every six months. Rapid enlargement (more than 0.5 cm in six months) warrants close surveillance or intervention. Patients who undergo elective repair of an AAA have an average five-year survival of 61%. The surgical survival rate for aneurysms 6.0 cm and greater is much higher than for patients with the same size aneurysms who do not have surgery. Coronary artery disease is the leading cause of death following repair of an AAA.

A client with a history of an abdominal aortic aneurysm presents underwriting problems for the life insurance carrier. The high incidence of coronary artery disease combined with poor survival rates renders a large group of these applicants uninsurable for individual coverage. Those who are insurable need to demonstrate both successes in treating the AAA and the cause of their AAA. These are questions the underwriter needs to ask:
• When was the client diagnosed with an Abdominal Aortic Aneurysm (AAA)? Most Abdominal Aortic Aneurysms have no symptoms and are discovered during routine medical exams or as a result of other diagnostic studies. Once a suspected AAA is found, the client will have the diagnosis confirmed with imaging studies (ultrasound or CT scan). It is important to know exactly when the AAA was diagnosed. Aneurysms are dilatation (expansion) of blood vessels. Abdominal aortic aneurysms represent a segment of the abdominal aorta (the part below the kidneys) with a diameter at least 50% greater than normal.

• What kind of treatment did the client have for AAA? If the client underwent a surgical repair of their AAA, when was the operation done? Clients with AAAs can be medically managed (without surgical repair) based on the following guidelines:

  - The client is asymptomatic.
  - The AAA is less than 5cm or less than half the infra-renal aorta diameter (the aorta just below the kidneys).
  - The AAA is NOT growing more that 0.5cm per year.
  - There is NO evidence of complications from the AAA (blood clots).

  These clients are followed closely with examinations that include ultrasound or CT scan studies. Clients who fail to meet the above criteria will need to undergo surgical repair of their AAA. The "waiting period" for clients with a newly discovered AAA is generally six months to one year for individual coverage. The same applies to clients who undergo surgical repair of their AAA.

• What are the current medications that the client is taking? Hypertension is a known risk factor for AAA. It is important to identify all of the medications the client is currently being prescribed.

• Have all of the follow-up visits and studies been normal? Clients with AAA, with or without surgical repair, will have ongoing surveillance of the dilatation site. It is important to document that the client is compliant with follow-up visits and, to the best of their knowledge, the client believes all of the follow-up studies have been normal (no evidence of enlargement or return of the AAA).

Cancer

Cancer is a general term used to describe an uncontrolled cell division that results in a malignant tumor. Cancer can occur in any organ or tissue. It is a very common condition and one third of all individuals will develop some form of cancer during their lifetime. Cancer is the second leading cause of death in the United States (only death caused by cardiovascular disease being more common). Family history of a certain type of cancer may predispose an individual to that specific type of cancer, but not necessarily to other types of cancer. Many cancers are evaluated using a grading and staging system. The aggressiveness of a cancer is measured by grade, typically ranging from Grade I to Grade IV. The grading is assigned based on the cancer’s growth rate. The faster the cancer is growing, the greater the likelihood of spread to other tissues. Grade I indicates the slowest growing type of cancer with the least likely spread while Grade IV cancer generally is the most dangerous. Staging of a cancer refers to the tumor’s size and how far it has spread (if at all). Here again, the lower the number the better. Common treatments for the treatment of cancer include surgery, radiation, chemotherapy, hormone therapy, and immunotherapy. Early detection and modern treatment methods often allow for many cancers to be underwritten easier. Although preferred rates are generally not available to those who had any internal cancer at any point in their lifetime, cancer is usually underwritten by flat extras for one to five year periods if the cancer is too recent and/or high stage and grade for a standard offer. Recent high grade/stage cancers may also lead to a postponement of offers for one or more years. Simplified/Guaranteed issue products may still be
available for these individuals or other product designs, such as a survivorship product that allows for an uninsurable.

**Breast Cancer**

Breast cancer is the most common cancer in women in the United States. The National Cancer Institute estimates that the risk of a woman developing breast cancer in her lifetime is one in eight (more than half of the lifetime risk is after age 65). In three-fourths of cases, the woman presents with a palpable breast mass. Other cases are diagnosed by screening mammography (breast x-ray). The diagnosis of breast cancer is made by biopsy. In-situ breast cancers (Stage 0) have malignant cells within the mammary ducts but do not invade the surrounding breast tissue. There are two types of carcinoma in-situ. These are Ductal (DCIS) and Lobular (LCIS). In DCIS, the risk of developing recurrent breast cancer is 28% - 54% if no treatment is given beyond the excisional biopsy. Half of the recurrences will be invasive. The standard of care is a mastectomy with a subsequent recurrence rate of 1% - 2%. Another option is lumpectomy plus radiation therapy with recurrence rates of 9% - 21%. LCIS is more frequently present in multiple sites or within both breasts. The risk of invasive recurrent cancer is 17% - 37% if no treatment is given beyond the excisional biopsy. Treatment options for LCIS include careful follow-up versus bilateral simple mastectomies. For invasive breast cancer, the mortality risk varies with the stage of the cancer. Lifelong follow-up is required to detect recurrences, which can occur as late as thirty years after the initial diagnosis of cancer.

**Prostate Cancer**

Aside from skin cancer, prostate cancer is the most commonly diagnosed form of cancer among men in the United States. Only lung cancer causes more "cancer-related deaths" than prostate cancer. The American Cancer Society estimates that 198,100 new cases of prostate cancer were diagnosed in 2001. Over 31,000 men died of the disease in 2001. 80% of all men with clinically diagnosed prostate cancer are aged 65 years or older. Fewer than 10% of men with prostate cancer die of the disease within five years of the diagnosis. African American men develop prostate cancer at a higher rate than men in any other racial or ethnic group. The reasons are unknown. Many people are unclear about the location of the prostate gland. It is important to know its anatomical location to understand both detection and treatment strategies for prostate cancer. Note that an edge of the prostate gland is near the lower wall of the rectum. This is why a Digital Rectal Examination (DRE) has been used for years as a primary screening test for changes in the prostate gland. The DRE, however, has limitations. Tumors form in areas that cannot be reached by a DRE. In addition, clinicians have difficulty distinguishing between benign abnormalities and prostate cancer. PSA is an "enzyme" secreted by the prostate gland and is measured in the blood of men. An increase in PSA can be a normal part of aging or an indication of prostate cancer. At age fifty PSA levels are routinely checked in men. The normal range for PSA is: 0.0 - 4.0 ng/ml. The PSA blood test cannot distinguish prostate cancer from a benign process. In an attempt to improve the clinical usefulness of the PSA blood test, the components that make up the PSA have been measured individually. The two most important components are "Free PSA" and "Bound PSA." Together they essentially make up the PSA. When you divide the "Free PSA" by the PSA (Free plus Bound) you get a ratio or percent of which portion of the PSA is "Free."

- The percent of "Free" PSA is high in normal men (i.e. > 25%)
- The percent of "Free" PSA is low in men with prostate cancer (i.e. < 15%)
- The percent of "Free" PSA is intermediate in men with benign prostatic hypertrophy (BPH).
- A "Free" percentage of 8% or less is associated with a high probability of prostate cancer.
- A "Free" percentage of 20% or more is associated with a high probability of BPH

Knowing the "Free" PSA value can help determine who needs a prostate biopsy and does not. However, the "Free PSA" is not a diagnostic test. Only a biopsy of the prostate can diagnose...
prostate cancer. The pathology report from a prostate biopsy contains the following essential
underwriting information, which is known as the Gleason Score and Staging. The Gleason score
is a measurement of aggressiveness of the prostate cancer. When the pathologist looks at the
biopsy he or she grades the cancer (if cancer is present) by comparing the appearance of the
cancer cells to the appearance of normal prostate tissue. The grades go from Grade 1 (almost
normal) to Grade 5 (very abnormal). The pathologist adds the results from the two greatest
areas of cancer. The Gleason score is as the sum of the two areas such as 2+3). The range of
Gleason scores run from 2 to 10. The higher the Gleason score is, the more aggressive the
cancer is, and the more likely it will spread outside of the prostate gland. A Gleason score of 2
(1+1) has a good prognosis. A Gleason score of 10 (5+5) has a poor prognosis. The Staging
indicates the extent of the cancer at the time of diagnosis. Like the Gleason score, it provides
important information regarding treatment and prognosis. The actual Staging is usually not listed
in the pathology report. The Staging needs to be assessed based on what the pathology report
says about the extent of the tumor. Staging is divided into four (4) subsets: A, B, C & D or T1,
T2, T3 & T4. The higher the Staging, the more advanced the cancer. Gleason score and
Staging are the key elements in determining insurability. The lower the Gleason score and
Staging the sooner the client becomes insurable from the end of treatment. Most clients are
postponed in the first year after treatment. There are exceptions for clients with very early
tumors (Stage A) and low Gleason scores (2+3'5). Clients with large tumors (>1.5cm) or
multiple tumors are generally postponed for two years after treatment. Almost all Stage C and D
tumors (ones that spread outside of the prostate gland) are postponed for five years after
treatment. The following questions will help the underwriter screen clients with a history of
prostate cancer:

- When was the client diagnosed with prostate cancer? Prostate cancer can be insurable, in
  some cases, in less than one year following the end of treatment. The normal period of
  postponement is two years. The exact date of diagnosis is the starting point for the risk
  assessment process.
- How was the prostate cancer treated and when did treatment end? The size of the tumor,
  the tumor’s aggressiveness, the degree of tumor’s invasion and the age of the patient will
determine the kind of treatment. Small cancers that are well contained in the prostate of
older men (i.e. age 70 or older) may require only “Watchful Waiting”. Advanced cancers that
have spread outside the prostate gland may require multiple treatment modalities.

There are generally four treatments available for prostate cancer. Watchful Waiting is usually
reserved for older clients (i.e. 70 and older) who have slow growing, well contained tumors (i.e.
Stage A or B with a Gleason 5 or less). Surgery involves the complete removal of the prostate
gland (called a radical prostectomy). At the time of surgery lymph nodes that surround the
prostate gland will be removed to see if the cancer has spread outside of the prostate gland.
Radiation involves either direct beams of radiation to the cancerous areas of the prostate gland
or a newer approach that involves a radioactive seed being implanted in the cancerous areas of
the prostate. Chemotherapy involves the use of medications that will turn off the hormonal
stimulation of the tumor and hopefully slow down its spread and growth. These are used for
advanced cases of prostate cancer where surgery or radiation has failed.

The "waiting period" for clients with a history of cancer before they are insurable for individual
coverage begins from the last date of all forms of treatment. These are questions that the
underwriter needs to ask:

- What are the current medications that the client is taking? Successful treatment of prostate
cancer generally involves no on going medications. If a client is currently taking medications
for prostate cancer (Lupron, Eulexin, Zoladex, Precis, Nilandrone, or Casodex), it either
represents a primary tumor that has metastasized (spread) outside of the prostate gland or a tumor that has reoccurred following initial treatment with surgery or radiation.

- Have all of the PSA blood tests been normal since the end of treatment? The PSA blood test is used to monitor prostate cancer patients following their treatment. It should remain essentially zero or undetectable as verification that the prostate cancer is in remission. Any rise in the PSA presumes that the prostate cancer has returned. In the case of a client who has undergone the surgical removal of the prostate, a rise in the PSA blood test suggests a distant spread (called a metastasis) of the disease.

**Malignant Brain Tumors**

Malignant brain tumors contain cancer cells. They interfere with vital functions and obviously life threatening. Malignant brain tumors are likely to grow rapidly and crowd or invade the tissue around them. When an otherwise benign tumor is located in a vital area of the brain and interferes with vital functions, it may be considered malignant (even though it contains no cancer cells). Metastatic brain tumors begin as a cancer elsewhere in the body and spread, or metastasize, to the brain. Metastatic brain tumors are the most common brain tumor, with an annual incidence more than four times greater than that of primary brain tumors. 150,000 people were diagnosed with a metastatic brain tumor in 2001. 36,200 people were diagnosed with a primary brain tumor in 2001. Brain tumors are the second leading cause of cancer related deaths in males ages 20-39. About 13,000 people in the United States die of malignant brain tumors annually. More men (7,100) than women (5,900) die of malignant brain tumors annually.

Primary brain tumors are tumors that begin in the brain tissue. The type of tissue in which they begin classifies primary brain tumors. As important, primary brain tumors tend to stay in the brain. The most common primary brain tumors are gliomas, which begin in the glial (supportive) tissue. High grade or malignant gliomas are the most commonly encountered primary brain tumors. They affect mostly middle-aged adults, although they can occur at any age. There are several types of gliomas including astrocytomas, brain stem gliomas, ependymomas, and oligodendrogiomas. There are other types of brain tumors that do not begin in glial tissue. Some of the most common include medulloblastomas, meningiomas, schwannomas, craniopharyngiomas, germ cell tumors and pineal region tumors. Secondary brain tumors are tumors from cancer that begins in other parts of body and spreads (called metastasis) to the brain. Cancer that spreads to the brain is the same disease and has the same name as the original (primary) cancer. Malignant brain tumors tend to grow rapidly and crowd or invade the tissue around them. Like a plant, these tumors may put out “roots” that grow into healthy brain tissue. If a malignant tumor remains compact and does not have roots, it is encapsulated. The cancers that most commonly metastasize to the brain are breast and lung cancer. The prognosis of patients with brain tumor metastasis from systemic cancer is poor, with median survivals being less than six months. The causes of brain tumors are not known. Although brain tumors can occur at any age, studies show that they are most common in two age groups. The first group is children three to twelve years old; the second is adults forty to seventy years old. Some types of brain tumors are more frequent among workers in certain industries, such as oil refining, rubber manufacturing, and drug manufacturing. Other studies have shown that chemists and embalmers have a higher incidence of brain tumors. The symptoms of brain tumors depend mainly on their size and their location in the brain. If a brain tumor grows very slowly, its symptoms may appear so gradually that they are overlooked for a long time. The most frequent symptoms of brain tumors include headaches that tend to be worse in morning and ease during the day, seizures (convulsions), nausea or vomiting, weakness or loss of feeling in the arms or legs, stumbling or lack of coordination in walking (ataxic gait), abnormal eye movements or changes in vision, drowsiness, changes in personality or memory, and changes in speech.
In addition to a complete history and physical examination, a complete neurological exam is done to check for alertness, muscle strength, coordination, reflexes, and response to pain.

Tests that are useful in diagnosing brain tumors include:

- The CT scan is a series of detailed pictures of the brain. A computer linked to an x-ray machine creates the pictures. In some cases, a special dye is injected into a vein before the scan. The dye helps to show differences in the tissues of the brain.
- A MRI (magnetic resonance imaging) gives pictures of the brain, using a powerful magnet linked to a computer. MRI is especially useful in diagnosing brain tumors because it can "see" through the bones of the skull to the tissue underneath. A special dye may be used to enhance the likelihood of detecting a brain tumor.

Other tests that may be useful to diagnose a brain tumor include:

- A skull x-ray can show changes in the bones of skull caused by a tumor. It can also show calcium deposits, which are present in some types of brain tumors.
- A brain scan reveals areas of abnormal growth in the brain and records them on special film. A small amount of radioactive material is injected into a vein. This dye is absorbed by the tumor, and the growth shows up on the film.
- An angiogram or arteriogram is a series of x-rays taken after a special dye is injected into an artery (usually in the area where the abdomen joins the top of the leg). The dye, which flows through the blood vessels of the brain, can be seen on the x-rays. These x-rays can show the tumor and blood vessels that lead to it.

All of the above tests are useful in determining if a brain tumor is present, however a surgical procedure is usually necessary to make a brain tissue diagnosis of the brain cancer. The biopsy results will determine if the tumor is malignant. Sometimes, a biopsy is done with a needle guided CT scans or a MRI to pinpoint the exact location of the tumor. This method called stereotaxis may be used for a biopsy or treatment. Treatment for a brain tumor depends on a number of factors. Among these are the type, location, and size of the tumor, as well as the patient's age and general health. Treatment methods and schedules often vary for children and adults. Malignant brain tumors are treated with surgery, radiation therapy and chemotherapy. Before treatment begins, most patients are given steroids, which are drugs that relieve swelling (edema). They may also be given anticonvulsant medication to prevent or control seizures. If hydrocephalus (excessive fluid on the brain) is present, the patient may need a shunt to drain the cerebrospinal fluid. A shunt works like a drainpipe carrying excess fluid away from the brain and into the abdomen or heart. Surgery is the usual treatment for most brain tumors. To remove a brain tumor, a neurosurgeon makes an opening in the skull (craniotomy). If possible, the surgeon removes the entire tumor. If the entire tumor cannot be removed, then as much as possible is removed. Even partial removal helps to relieve symptoms by reducing pressure on the brain and reduces the amount of tumor to be treated by radiation therapy or chemotherapy. Radiation therapy (also called radiotherapy) is the use of high-powered rays to damage cancer cells and stop them from growing. It is often used to destroy tumor tissue that cannot be removed with surgery or to kill cancer cells that may remain after surgery. Radiation therapy is also used when surgery is not possible. Radiation therapy may be given in two ways. Generally, external radiation treatments are given 5 days a week for several weeks. Treatment schedule depends on the type and size of the tumor and age of the patient. Giving the total dose of radiation over an extended period helps to protect healthy tissue in the area of the tumor while killing the tumor cells. Radiation can also come from radioactive material placed directly in the tumor (implant radiation therapy). Depending on the material used, the implant may be left in the brain for a short time or permanently. Stereotactic radiosurgery is another way to treat brain tumors. Treatment is given in just one session; high-energy rays are aimed at the tumor from
many angles. In this way, a high dose of radiation reaches the tumor without damaging other brain tissue. Chemotherapy is the use of drugs to kill cancer cells. It may be one or a combination of drugs given by mouth or by injection into a blood vessel or muscle. Chemotherapy is usually given in cycles; treatment period followed by recovery period.

Obtaining individual life insurance on individuals with a history of a malignant brain tumor that is currently in remission presents underwriting problems. If the malignant brain tumor is secondary (metastatic) to primary tumor from another organ, the minimal "postpone period" is five years from the end of treatment. This assumes that that the end of treatment produced a complete remission for both the primary and secondary tumors. Metastatic brain tumors are the most common brain tumor, with an annual incidence more than four times greater than that of primary brain tumors. If the malignant brain tumor is a primary lesion, the "best case scenario" is a postponement for three except in the most favorable cases such as a well-differentiated tumor that is less than 5cm in size. The following questions can effectively screen clients with a history of a malignant brain tumor:

- When was the malignant brain tumor diagnosed?
- Was the tumor primary or was it secondary to another cancer somewhere else in the body?
- What treatment did the client receive and when did it end?
- How long has the tumor been "officially" in remission?
- Are there follow-up studies to verify the remission?

**Diabetes**

Diabetes Mellitus is a chronic incurable disease in which the insulin produced by the pancreas is inadequate. This condition is characterized by abnormalities in the metabolism of carbohydrates, fats, and protein. Glucose (sugar) in the urine is often one of the first signs of diabetes. There are two types of diabetes. These are insulin-dependent diabetes or "juvenile onset diabetes" and non-insulin dependent diabetes or "adult onset diabetes". In young individuals, the onset of diabetes is apt to be sudden with severe symptoms of increased urination, thirst, and appetite, along with weight loss and weakness. Diabetic coma is common if the condition is not diagnosed and controlled quickly. Juvenile onset diabetes is typically manageable only with daily inceptions of insulin. It should be noted that some physicians and most underwriters refer to "juvenile onset" diabetes for any diabetes diagnosed prior to age 35 or 40 requiring the injection of insulin. More commonly, diabetes starts in adult years, after age 40. Development of the condition in adults is more gradual than in juveniles. The affected individual often does not experience any symptoms. Diagnosis is by routine urine analysis (and often insurance company lab work). Once diagnosed, non-insulin dependent diabetes may be controlled with a special diet, weight loss, and medication or a combination of the above. Sometimes injections of insulin are required for adult onset diabetics as well. Not all individuals who show sugar in the urine will be diagnosed as diabetics. Certain individuals who consistently show sugar in the urine may simply have a condition referred to as "low renal threshold". In individuals with this condition, the kidneys permit sugar to be spilled into the urine at blood sugar levels that are below normal threshold levels. If this condition is suspected, an underwriter will likely request additional clinical tests to rule out diabetes as a condition of concern. Although not all individuals who show sugar in the urine are diabetics, many of them are, and can be diagnosed as such with additional testing.

Diabetes leads to macro and micro vascular disease that affects the heart, cerebral vessels, and kidneys. A significant number of diabetics will suffer coronary artery, cerebrovascular, and peripheral vascular disease earlier in life than what is expected of the general population. As a result many die prematurely from heart disease, cerebral hemorrhages (strokes), or kidney failure. Premature mortality assumptions for diabetes depend age of onset, how long the proposed insured has had the condition, and the degree of diabetic control as indicated by
current lab findings as APS history. Although non-insulin dependent diabetics are generally offered insurance rates lower than those available to insulin dependent proposed insureds, an insulin dependent diabetic with excellent control could obtain a better offer than the non-insulin dependent diabetic under poor control. Understanding the degree of control is important to successful diabetes underwriting. Even though a diabetic may “feel in excellent shape” the lab findings as documented in an insurance company exam or APS data can sometimes indicate the condition is “out of control” and must be managed before an offer of traditionally underwritten insurance can be extended.

Additional risk factors of serious concern to an underwriter will be the use of tobacco, alcohol, and drugs. Also, substantial deviations from normal lifestyles, such as frequent foreign travel or hobbies that may complicate control/treatment of the condition should be addressed in a detailed cover letter with a formal application. Family history of diabetes will be considered for underwriting, especially for borderline diabetics (those who cannot be diagnosed as having diabetes or not having diabetes).

**Kidney Transplant**

Healthy kidneys do three things. They remove wastes from the blood, regulate levels of water and different minerals, and produce hormones that control body functions. When the kidneys no longer work well enough, dialysis treatment or a kidney transplant is required. In 2000 there were 50,305 patients “waiting” for a kidney transplant. In 2000 there were 13,372 kidney transplant operations. Of the 13,372 kidney transplant operations in 2000, 5,293 were from living donors. The approximate “preservation time” for a kidney from a live donor is up to 72 hours. 94% of kidneys transplanted from a live donor are still functioning one year after surgery. 88% of kidneys transplanted from a non-living donor are still functioning one year after surgery. There are two sources for kidney transplants. These are a "living donor" transplant and a "cadaveric" transplant. Living donor transplants are usually from a blood relative (i.e. immediate family members). The donor’s blood group and tissue type must "match" the person receiving the kidney. Cadaveric donor transplants are from a person who has recently died. This issue of "compatibility" is still key to "matching" a kidney between the deceased and a potential recipient. Following the kidney transplant, it is important to monitor both the function of the kidney and prevent "rejection" by the body. To do this requires blood tests and medications. Blood tests that are used in the post-surgical period include WBC (white blood cells), HCT (hematocrit or % of red blood cells in the blood), PLT (platelets), BUN (a waste product normally removed by the kidney), Creatinine (a waste product normally removed by the kidney), and electrolytes. Medications that are used in the post-surgical period include Cellcept which fights rejection by decreasing the number of white cells the immune system produces, Sandimmune which suppresses the immune system to ward off rejection, Prograf which suppresses the immune system to ward off rejection, Deltasone or prednisone which prevents and treats rejection, Imuran which suppresses the immune system to ward off rejection, Orthoclone which suppresses the immune system to ward off rejection, and Zenzpax which is the first genetically engineered medication used to ward off rejection.

A client with a history of a kidney transplant presents underwriting problems. Survival following a kidney transplant depends on age, what caused the kidney failure, severity of associated disorders, closeness of match, and type of donor (live or cadaver). These are the primary factors that are assessed in determining insurability. The following questions will allow the underwriter to screen clients with a history of kidney transplant:

- What was the cause of the kidney failure that led to transplantation? It is important to know what precipitated the kidney failure. Was it a disease of the kidney like glomerulonephritis, or was it secondary to another medical problem like diabetes? The cause (also called
etiology) will have a significant bearing on the both the success of the transplant and the assessment for life insurance.

- How old was the client at the time of the kidney transplant? The ideal age for a kidney transplant is between fifteen and sixty-five. Clients under fifteen years of age or over sixty-five are considered for life insurance on an "individual consideration basis."

- What was the source of the new kidney? The ideal source is a kidney from an identical twin. After that, a kidney from a live, related donor who has an identical "match" is the next best choice. This is usually from a sibling. The next best choice is from a live donor who had a good "match". Finally, there is a kidney from a cadaver. The time of postponement from the date of the kidney transplant until the client is insurable depends first and foremost on the source of the kidney like three months for an identical twin as opposed to two years with a cadaveric kidney. In addition, the cost of insurance for the client increases with a less than optimal "replacement" kidney.

- What are the current medications that the client is taking? As noted above, transplantation requires the use of medications in the post-surgical period. It is important to document all the medications the client is taking for their kidney transplant and any other medical problems such as hypertension or diabetes).

- Does the client have other medical problems? Clients with additional significant medical problems in addition to their kidney transplant will generally not be insurable for individual coverage. It is important to "discover" the full extent of their medical history in the "screening" phase of the case.

**Depression**

The underwriting of depression presents a unique challenge. Terminology is confusing, many depressed clients do not seek treatment and attending physicians can be unwilling to provide detailed psychiatric histories. Overall, depressed people experience a death rate twice that observed in the general population. There are several types of depression. *Dysthymia* is a chronic low-grade depression, which is present for at least two years. *Major depression* may be unipolar when present alone, or bipolar when associated with at least one episode of mania (a period of elevated, expansive or irritable mood). *Seasonal affective disorder* (SAD) is a type of major depression, which occurs at specific seasons of the year. Some people residing in the northern latitudes experience SAD during winter. This remits with the arrival of spring.

Treatment for a bipolar disorder is generally Lithium. Unipolar depression usually responds to antidepressant medications. If medications fail, electro convulsive therapy ECT or "Shock Treatment" is usually required. SAD responds to intense white light. 50% of people with major depression recover within the first six months. Thereafter, the rate of recovery declines markedly. Depressed clients experience increased mortality from natural as well as accidental causes. Most of the excess mortality from natural causes is due to common conditions such as heart disease, lung infections and influenza. The higher incidence of accidental deaths is probably related to greater risk taking behavior. Persons with psychiatric illnesses are more likely to be either victims or perpetrators of violence. They are more prone to abuse alcohol and drugs. The risk of death from accidental causes is greatest for those aged 35-44 and least for those over 75 years of age. The most serious complication of major depression is suicide. It has been estimated that half of all patients who commit suicide suffer from major depression. A quarter of patients with a diagnosis of major depression attempt suicide in a lifetime and 15% of patients with major depression ultimately die by suicide.

Features associated with a poor risk include: three or more episodes; lack of full maintenance dose medication; multiple drug therapy; poor compliance; need for hospitalization and co-morbidity such as substance abuse (alcohol or drugs), psychotic episodes, personality disorder and suicidal attempt.
**Alcohol Histories**

Underwriting alcohol histories is difficult due to the lack of available information on which to develop a complete picture and mortality assessment. 70 - 80% of the people in the U.S. consume alcohol with 8 - 10% of those becoming problem drinkers. Alcohol abuse ranks third as a cause of death, behind heart disease and cancer. The alcohol associated mortality risk is higher for women than men and in those younger than 40. Alcohol abuse is significantly tied to traumatic deaths and is implicated in 80% of fires, 64% of suicides, 69% of drownings, 59% of motor vehicle accidents, and 65% of homicides. The public health definition of *moderate drinking* for a male is no more than 2 drinks/day and for a female, no more than 1 drink/day. A *heavy drinker* is defined as someone who drinks alcohol nearly every day and, on occasion, 5 or more drinks in one sitting. Hazardous drinking is defined as consuming 70 - 80 grams of alcohol/day. This equals six mixed drinks or a 750 ml bottle of wine or a six-pack of beer in one day. Tools for assessing alcohol abuse includes blood profile, family history, inspection reports, driving records, history of prior treatment or alcoholic anonymous (AA) attendance, and candid information from the proposed insured. Using these tools, the underwriter works to develop as complete a picture as possible. Unfavorable features include other substance abuse, abnormal liver enzymes or positive alcohol marker, history of family/friends’ concern over drinking habits, adverse driving record, medical complications from alcohol (heart, nervous system, liver, blood, etc), and financial/marital/employment/legal problems related to alcohol. Following successful completion of a treatment program for alcoholism, only 20 - 50% will stay recovered after two years. Ongoing commitment to Alcoholics Anonymous (AA) is a very positive factor in terms of decreasing the potential for relapse.

**Underwriting Suspected Alcohol Abuse**

An applicant for life insurance can be postponed or declined for suspected alcohol abuse (SAA). The key word is "suspected." Unlike the client with a known history of alcohol abuse who underwent a treatment program and is "clean and sober", the client with SAA may or may not have a drinking problem. Just the suspicion of abuse, however, is enough for a carrier to decline coverage. Some agents believe that clients with SAA are rejected based on health concerns over existing or future liver problems. While liver disease is a concern, it is not the primary issue. The primary concern with SAA is death from driving while intoxicated. The National Highway Traffic Safety Administration (NHTSA) defines a fatal traffic crash as being alcohol-related if either a driver or a non-occupant had a blood alcohol concentration (BAC) of 0.01 grams per deciliter (g/dl) or greater in a police-reported traffic crash.

Suspected alcohol abuse (SAA) is discovered at some point in the underwriting process. Through the medical records, laboratory tests or the applicant’s driving record, evidence surfaces that give an underwriter reason to believe the applicant has SAA. SAA can be documented in the client’s medical file. A chart note where the physician advises the client to reduce their alcohol intake or simply stop drinking strongly suggests SAA. This is also true of chart notes that report the client’s desire to reduce or completely stop drinking. While the medical file is a critical underwriting document, it may not always portray an accurate picture about SAA. If the physician is opposed to all forms of alcohol consumption, the client may be unfairly labeled with a diagnosis of SAA just for social drinking. There is also the possibility of bias with third party reporting of SAA, such as a possible drinking problem reported by a spouse.

It is also important to look for a history of depression if SAA is suspected. Unfortunately, many users of alcohol are depressed to begin with, and experience a kind of "self-medication" relief while drinking. This, however, is short-lived, and always leads to even deeper depression when the user is not drinking. There are specific blood tests available from either the medical file or the blood work done for life insurance that can be very useful in determining whether someone is abusing alcohol or has liver disease. There are also special blood tests that are used to clarify...
cases of SAA. The motor vehicle report may reveal a previous history of one or more DUI (driving under the influence of alcohol) arrests. The following guidelines will help agents sort out which cases are worth pursuing and which cases are not.

Ask a SAA client to complete an alcohol questionnaire. This provides a "baseline" from the client regarding present and past alcohol consumption. Alcohol questionnaires are available from most carriers. Review the completed questionnaire with the client. Many times additional information that is beneficial to the client is obtained in the review process. Always have a copy of abnormal liver function test sent to the client's attending physician. The client's physician may want to repeat the tests or order new ones. The updated medical records can then be used to "reopen" the case or present it to a different carrier. Many times clients with SAA simply deny the facts of the case. There is little point in arguing with the client who is in denial. It is better to walk away from the case once it is apparent that the drinking history is more complicated than presented by the client. There will be clients with SAA who do not have a problem with alcohol. With careful attention to their true consumption pattern and repeated or expanded laboratory testing, agents can successfully find coverage to this group of applicants.

**Substance Abuse**

Clients with a suspected or known history of substance abuse represent a complex and very often frustrating area of substandard underwriting. The specifics of a client's actual history of misuse of a substance can be a source of conflict for the client, agent and life insurance carrier.

In working with these clients it is helpful to keep in mind certain characteristics that appear common to all of these cases. Substance abuse by definition represents a *fundamental change between the user and the substance*. This is as true for alcohol as it is for cocaine or prescription medications. This fundamental change, where the substance gains the upper hand in the relationship, also changes the user’s psychological agenda. When users slip into abuse their personalities are dominated by *personal gratification* as the primary behavior and *denial*. These changes are nearly absolute without some form of intervention such as detoxification and treatment. The user practices these changes with what can only be described as a pathological passion, because he denies substance abuse even as he is being admitted to a hospital for an overdose.

Substance abuse behavior presents in many patterns and may not be detectable by the casual observer. Many combinations of legal and illegal drugs are possible. The appearance of functionality of a suspected abuser may not relate to the degree of his substance abuse. He may work everyday. There are many industrial strength users who consume large amounts of a substance and are still able, for a period, to keep their world in tact. Eventually they all self-destruct, but until that time they appear normal. One helpful way to assess clients with suspected or known histories of substance abuse is to place them in one of four categories:

- **Admitted abuse with appropriate treatment.** Clients who have admitted to a substance abuse problem and received treatment have the best underwriting outcomes. This assumes that there has been no permanent damage to vital organs from the substance abuse such as cirrhosis of the liver from alcohol abuse. If their treatment includes after-care like AA of NA, the pricing will be even better. The usual waiting period for single substance abuse with treatment is one to two years. A history of polypharmacy, which occurs when more that one substance being abused at the time of treatment will increase the waiting period for insurability for up to five years from the end of treatment.

- **Admitted abuse with no treatment or self-treatment.** Clients who admitted to a substance abuse problem and are self-treated or untreated face a much more difficult underwriting outcome. The lack of any formal intervention combined with obvious limitations of self-treatment does not carry the same prognosis as those with treatment histories and supportive therapy. These clients are seen from an underwriting perspective as abusers...
who have simply "paused" in their abuse instead of actually undergoing a real transformation through insight into their problem.

• Refusal to admit abuse with a history of treatment. Denial is a major component of the substance abuse personality. Some clients simply insist that they were badgered into treatment from their family or their employer. They minimize or reject the notion that they had a problem. These clients face the same difficult underwriting outcome as those who are self-treated or not treated.

• Refusal to admit abuse with not treatment. Clients who have not admitted to substance abuse and remain untreated have universally poor underwriting outcomes.

**Obesity**

An estimated 97 million adults in the United States are overweight or obese. Obesity raises the risk of morbidity from high blood pressure, hyperlipidemia, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems and endometrial, breast, prostate, and colon cancers. Higher body weights are also associated with increases in all-cause mortality. Obesity is the second leading cause of preventable death in the United States. Most doctors believe obesity is a chronic disease that develops from an interaction of genetics and environment. As a rule women have more fat than men do. Doctors generally agree that men with more than 25% body fat and women with more than 30% body fat are obese. Precisely measuring a person’s body fat is not easy. The most accurate method is to weigh a person underwater, which is limited to a lab with sophisticated equipment. The other two simpler methods for estimating body fat can be inaccurate if done by someone inexperienced or if done on someone grossly obese. Both methods, measuring skinfold thickness and bioelectric impedance analysis, should be viewed skeptically. Most doctors rely on other means to diagnose obesity. Two widely used measurements are **weight-for height tables** and **body mass index (BMI)**. Most people are familiar with weight for height tables. Doctors have used these for decades. One problem with these is that doctors disagree over which table is the best to use. Some take into account the person’s gender or body frame size while others do not. At best these tables can be used for general guidelines only. Body Mass Index (BMI) is a new term to most people. However it is the measurement of choice for physicians treating and studying obesity. BMI is a tool used to diagnose the degree of obesity. It is based upon a relationship between weight and height, excluding frame size and muscle mass. Doctors are concerned with not only how much fat a person has but also where the fat is on the body. People whose fat is concentrated mostly in the abdomen are more likely to develop significant health problems associated with obesity. Doctors have a simple way to measure body fat. The measurement is called waist-to hip-ratio.

Obesity tends to run in families, suggesting that it may have a genetic cause. However, family members share not only genes but also diet and lifestyle habits that may contribute to obesity. Still growing evidence points to heredity as a strong determining factor of obesity. A person’s environment also plays a significant part. Environment includes lifestyle behaviors such as what a person eats and how active he or she is. Most Americans have high fat diets and also do not get enough exercise. Psychological factors also may influence eating habits. Many people eat in response to negative emotions such as boredom, sadness or anger. 30% of those people who seek treatment for obesity have difficulties with binge eating. Those with a binge eating disorder will need special help, such as counseling or medication to control their binge eating before they can manage their weight. Some rare illnesses can cause obesity. These include hypothyroidism, Cushing’s syndrome, depression and certain neurologic problems that can lead to overeating. Certain drugs, such as steroids and some antidepressants, may cause excessive weight gain.

Obesity is not just a cosmetic problem. It is a health hazard. Someone who is 40% overweight is twice as likely to die prematurely as an average-weight person is. Obesity has been linked to
several serious medical conditions, including diabetes, heart disease, high blood pressure and stroke. Obese men are more likely than non-obese men to die from cancer of the colon, rectum, and prostate. Obese women are more likely than non-obese women to die from cancer of the gallbladder, breast, uterus, cervix and ovaries. Other diseases and health problems linked to obesity include: gallbladder disease and gallstones, osteoarthritis, gout and pulmonary problems including sleep apnea. Doctors generally agree that the more obese a person is, the more likely she or he is to have other health problems. One of the most painful aspects of obesity is the emotional suffering it causes. American society places great emphasis on physical appearance, often equating attractiveness with being slim, especially in women. These messages tend to make overweight people feel unattractive. Many people assume obese people are gluttonous, lazy or both. However, more and more evidence contradicts this assumption. Obese people often face prejudice or discrimination at work, at school, while looking for a job, and in social situations. Feelings of rejection, shame or depression are common.

The method of treatment will depend on how obese a person is. Factors such as an individual's overall health and motivation to lose weight are also important considerations. Treatment may include a combination of diet, exercise, and behavior modification. In some cases of severe obesity, prescription medications or gastrointestinal surgery may be recommended. Successful weight reduction is predicated on a dietary deficit on 500 to 1000 calories/day. In order to lose one pound of body fat, 3500 calories must be eliminated from the diet. Generally a daily 500-calorie deficit will result in about a one pound a week reduction in weight. Reducing dietary fat, along with reducing dietary carbohydrates, usually will be needed to produce the caloric deficit needed for an acceptable weight loss. An increase in physical activity is an important component of weight loss therapy, although it will not lead to substantially greater weight loss over a short period of time. Most weight loss occurs because of decreased caloric intake. Sustained physical activity is most helpful in the prevention of weight regain. In addition, it has a benefit in reducing cardiovascular and diabetes risks beyond that produced by weight reduction alone. For most obese patients, exercise should be initiated slowly, and the intensity should be increased gradually. The patient can start by walking thirty minutes for three days per week and can build to 45 minutes of more intense walking at least five days per week. With this plan, an additional expenditure of 100 to 200 calories per day can be achieved. Weight loss drugs that have been approved by the FDA for long-term use can be useful addition to dietary therapy and physical activity for some patients. Medications are indicated only for patients with a BMI greater than thirty with no other risk factors or diseases, and for patients with a BMI greater than 27 with risk factors or other diseases present. At the present time, sibutramine is available for long-term use. It enhances weight loss modestly and can help facilitate weight loss maintenance. Potential side effects may occur including increases in blood pressure and heart rate. Weight loss surgery is an option for weight reduction in a limited number of patients with clinically severe obesity (BMI’s greater than forty or greater than thirty-five with other medical conditions). It is usually reserved for patients in which other medical therapies have failed and who are suffering from the complications of extreme obesity. Gastrointestinal surgery (gastric restriction- vertical gastric banding or gastric bypass-Roux-en Y) is an intervention weight loss option for motivated subjects with acceptable operative risks.

Clients who are overweight are generally insurable with the exception of applicants who weight is in excess of 350 lbs. The pricing of overweight clients will depend on two key items. One is the client's build or height and weight. The other key item is whether he has other medical problems such as high blood pressure or diabetes. All insurance company's underwriting manuals have "build tables." These tables define the acceptable height and weight ratio as well as the additional rating that will be assessed for clients who exceed these ratios. It is crucial to document any possible underwriting "credit that could help off set a possible rating for overweight clients. Possible areas of underwriting credits include normal blood pressure, good
cardiovascular fitness, no family history of premature (under age sixty) cardiac disease, good total cholesterol/HDL ratio, and normal pulmonary function test.

**Underwriting Declines**

Handling declines properly is another of underwriting you must master. No one likes to be rejected, especially if the rejection has negative health implications. If your client is declined support his feelings; let him know that you too would be upset. Why? Because everyone wants to have their feelings validated; they want to be told they have a right to feel a certain way. Also, as much as you want to, resist the urge to practice medicine. Don't defend or criticize the carrier's decision. Adopt a neutral stance so you can remain an effective facilitator for the client. Finally, have a clear plan on how to manage the decline, i.e., have the results reviewed by the client's physician, order some new tests, try a different carrier, etc. You may never be able to insure certain clients but your attention and compassion is definitely comforting when bad news is in the air.

**Insurers and Underwriting**

When we think about underwriting, it is most often though of a process to protect the insurer. However, insurers are not always the "victim", sometimes they ARE the problem. Early policies, for example, were sometimes approved on a post claims underwriting basis (now illegal). The company accepted applicants with little or no real health underwriting, but when individuals attempted to file claims, the company engaged in vigorous investigations of the individual's health in an attempt to demonstrate that he or she did not adequately disclose health conditions on the application. The company would then rescind the policy instead of paying the claim alleging misrepresentation of a health condition on the part of the applicant. The company used a vague or confusing health questionnaire to aid in this practice. These tactics were only used by a few less than reputable companies and are now prohibited in most states.

There have also been many publicized, criticized and possibly abusive rate increase tactics in the industry. Insurers promise they will not raise premiums due to age or health, but that does not guarantee that the premium will stay the same for the entire class. And, it happens more than you think. Lawsuits have been filed in North Dakota and Florida over long term care premiums that have increased as much as 700%, even though the products were promoted as having level premiums. Granted, this is unusual. Rate increases in the 25% to 50% range are more apt to occur. Either way, rate increases especially hurt seniors (your customers) on fixed incomes. Since it may take many years for rates to be raised, people who originally bought on non-fixed incomes typically transition to fixed incomes. They are affected too.

**Underwriting Factors You Can't Ignore**

A new effort to simplify the application and approval process is underway featuring easier-to-understand policies and applications, "bundled benefit packages" which give consumers three or four good policy choices and "express" applications where a simple application pre-qualifies the insured and third party representatives complete the application with the client over the phone.

Even when these policies become widespread you will need to face the fact that up to 30% of your clients will be rejected. Mature market underwriting is tough! But, before you start complaining, you need to understand that a consistent, fair process of evaluating potential insureds is your best guarantee that the company you represent is going to be around long enough to actually pay your client benefits. Some recent events involving a popular LTC insurer have brought underwriting to the forefront. Rampant sales and minimal underwriting practices have brought this company to the brink of liquidation. High claims have depleted company reserves to less than half required by state regulators. Lawsuits have been filed which may
involve agents. Besides the embarrassment and financial exposure of a situation like this, no agent wants to hear that a policy sold to a client at age 60 is worthless at age 80, when he really needs it.

**How can you improve the underwriting process for you and your clients?**

- Read carefully the General Underwriting Guidelines from your insurance company.
- Obtain a specimen policy and clear-up any questions you have before submitting an application.
- Spend at least 50% more time on applications than you do now. Strive for accuracy and completeness fewer rejections and quicker processing.
- Submit your applications in a timely manner. Most companies consider apps stale-dated if submitted after 30 days.
- Allow underwriting time to process applications: you’re to the only customer. Underwriters review each application individually -- if it fits the required guidelines, it will be issued. It usually takes up to 45 days to receive an insurer's decision.
- Know whether or not your state has special rates, disclosures forms, etc. Use the proper paperwork, especially if you work in more than one state.
- Provide underwriters as much information on the prospect as possible. You are legally bound to make personal observations about mobility, living conditions, attitude, etc., on a separate piece of paper. Anything less could result in an insurer claim against you for breach of duty. Anyway, why would you waste your time trying to get an obviously unqualified individual approved.
- Make sure the paramed exam has been scheduled and the confirmation number has been recorded on the application before submitting the policy for approval.
- If an Attending Physician Statement (APS) is necessary, get the name of the applicant's personal physician who has the insured's medical records. Call the physician's office and ask how much the fee for an APS is and include this information with the application. Sometimes, the physician's fee is more than the check sent by the insurance company. A delay to send more money can slow the entire process.
- Make sure all sections and questions on the application are completed.
- Don’t ask for benefits or riders that are not available for the plan selected.
- Be aware of issues limits.
- While individuals with certain controllable conditions, such as diabetes, might not qualify for the best rates at a top-tier company, an agent who knows the market may still be able to write a policy at standard rates with a top-notch company. Also, there is nothing wrong with calling underwriters and making a case for a client with a stable condition.

**What are some special tips that I can use for getting better approvals for my mature market clients?**

- Attach photographs of the insured.
- Send an accompanying letter detailing your observations of the insured.
- Type out your application.
- Make sure your submissions are so complete that there is no questions left to ask. Make sure that you let underwriters know that this is how you operate.
- Point our the strengths and weaknesses of your applicant.
- Underwriters treat agents best who respect them. Never yell or argue with an underwriter who controls your future submission.
• Give a little, get a little. Don’t make every submission the principle on which you are willing to risk your relationship.
• If possible, handle deliver some applications to get to know the underwriter personally.
• Underwriters get pushed around all day long. Act differently and they will treat you better.
• Include brochure or resumes on your office. It never hurts for the underwriter to know you work for a top-flight company.
• Attach a colored checklist of everything you send. It contributes to the completeness of your application.

**What about my real elderly clients? Is there something more I should be doing to improve their underwriting chances?**

With the life expectancies growing, there is an ever-growing stream of life insurance candidates in the 75+ year age category. With these advanced ages come risk assessment challenges that can complicate or be the basis for denial of coverage.

Most producers are familiar with normal medical problems of aging, like heart disease, cancer, stroke, etc.), a much smaller number, however, are becoming well versed in “functional issues” that have a significant impact on the primary purpose of underwriting: predicting life expectancy.

RiskTutor (www.risktutor.com) suggests the following advice in their April 2002 newsletter:

“Up to age 80, LE is based predominately on past and current medical information. While life style, habits, occupation and avocation play an important part in determining insurability, it is the client’s "medical health" (derived from their medical records, life insurance examinations and other sources) that will form the basis for how long an underwriter assess the client will live. At 80, however, LE starts to be governed by more than the static facts of medical information. How these medical facts play out in the ability of a person to live their life (called functional ability) becomes of utmost underwriting concern. As important, at 80 the "quality" of a client’s functional ability may have a greater impact on LE than the mere presence or absence of medical problems.

This is not to say that medical health and functional ability are distinct and separate entities. They are not. They are interdependent and collectively determine not only the applicant’s insurability but provide a more complete picture of their true health. It is because of this interdependency that it is important for producers not to “assume” an older client is automatically insurable or uninsurable based simply on their medical history. A complete underwriting assessment of clients in this age group includes information on functional ability. Knowledge of a client’s functional ability provides producers with information that is not always obvious in the medical file of an applicant but can make the difference between getting a policy or getting a declination.

When most producers hear the term functional ability they immediately think of Activities of Daily Living (ADLs). ADLs are divided into the "basic" and "instrumental." The basic ones cover the fundamental tasks of living (walking, eating, using the bathroom, etc.) while instrumental ones cover more advanced living skills (i.e. driving, shopping, pay bills, etc.). While functional ability does include ADLs, it encompasses a much broader perspective of how the client is adapting to their environment in the face of aging. This "enhanced" overview for clients 80 and older is essential to the underwriting process of life insurance. It is "essential" because of the simple fact that functional ability cannot be predicted based on client’s medical history.
Consider the following example:

Client A is an 80 year-old female, non-smoker, who had a heart attack (myocardial infarction) three years ago with minimal heart damage. She also has a history of well-controlled high blood pressure on medication (Tenormin) and takes an aspirin a day.

Client B is an 80 year-old female, non-smoker who reports no significant health issues on her life insurance exam. She is currently taking Synthroid and Premarin daily.

Both Client A and Client B have fully intact basic and instrumental ADLs.

Most producers would assume that Client A is a higher risk for life insurance. Most producers would assume that Client A has a shorter LE than Client B. In the absence of meaningful functional ability information, that would be a reasonable conclusion. Now, let's reconsider the LE of Client A and Client B based on more detailed functional ability information.

Client A has been a widow for over 10 years. She belongs to a senior center and attends exercise classes four times a week. She also goes on trips sponsored by the center which include hiking, sight seeing and cook outs. She volunteers at a local hospital two days a week and drives herself to these appointments. She is active in her church and attends many functions a month. She lives alone in a residence she has owned for over thirty years. She does her own shopping, cooking and manages her own finances.

Client B lost her husband less than a year ago. She still has her drives license but rarely drives herself. Her daughter, who manages her mother's finances, also provides most of the transportation for shopping and "getting out." Client B lives alone and spends the majority of her time watching television. She does not volunteer in the community and does not attend religious services. Her interaction with her friends is usually when they stop by for a visit or on the telephone.

It appears that the heart attack has not slowed down Client A. But is also appears that Client B is, from a functional perspective, slowing down in many areas of her life. It would not be unreasonable to assume with this new information that Client A not only has the same LE as Client B but that Client A may have a longer LE!

It is important to remember that the most significant information about an applicant's functional ability may not be contained in their medical file. For client's 80 and over, it is not enough to simply get the APS and hope for a good offer. Producers must be knowledgeable of the appropriate functional ability questions and how to use them in the underwriting process. Unless the producer provides this information to the underwriter, the 80 year-old and older client may wind up being assessed from a "one-dimensional" underwriting perspective.

What are the crucial functional ability questions and observations that can assist an underwriter?

1. Regular physical fitness exercise is well documented to improve survival in older adults. It is important to ask about physical fitness exercise and carefully document the exact type and frequency. Client A despite having a previous mild heart attack, exercises at a senior center on a regular basis. Client B, despite the absence of significant medical problems, has a sedentary lifestyle.
2. Advanced ADLs need to be quantified to be of any value in the underwriting process. In the case of Client A and Client B, both had valid drivers licenses and both could answer "yes" to the question "do you still drive." But this is not enough information for underwriting purposes. Knowing that Client A was still a very active driver with numerous outings each week while Client B, was slowly surrendering her driving skills is the type of information that can be used to accurately assess the applicant's true functional ability.

3. Volunteers at older ages have a lower risk of dying than non-volunteers. Client A’s volunteer activities not only demonstrated her driving abilities, it also indicated that she had a source of "productive engagement" in her life. Productive engagement, such as volunteering, has been shown to have just as much positive impact on mortality as physical fitness activities (Glass, T.A., Mendes de Leon, C., Marottoli, R.A., & Berkman, L.F. (1999). Population based study of social and productive activities as predictors of survival among elderly Americans. BMJ, 319, 478-483.). Take the time to find out if your older client is involved in these types of activities along with their frequency.

4. If the client has an active social life, don’t be afraid to be creative in reporting it. Client A has a very active social life. One way to present this type of information is to provide the underwriter with a spreadsheet of the client’s social calendar over a 30-day period. You may also consider obtaining a recent photo of the client at a charity event or social outing that offers the underwriter a chance to see the applicant successfully functioning in their social environment.

5. Be clear about who really does what in terms of financial matters. There is a big difference between the older adult who is presented “summaries” of financial issues by a son or daughter for approval and one who manages all aspects of their personal finances. Client A manages her own finances (i.e. pays bills, balances her checkbook, etc.). Client B, has her finances managed by her daughter.

6. Mobility may be the final key to insurability. This is an area that concerns underwriters when they look at an applicant 80 and older and for good cause. Poor mobility, namely problems with imbalance, muscle weakness and uneven gait, put a person a high risk for falls and their unpleasant outcomes. Providing information on the client’s mobility can be very helpful to an underwriter. It is best to describe the older client’s ability to "get around" in terms of their walking stamina (i.e. how far can she walk) and how well they negotiate stairs.

For an overview of Falls in Older Adults, see the Winter 2001 LTC Tutor Newsletter at www.longtermcaretutor.com/demo/winter_01.html

Final comments: The gathering and reporting of functional ability information by the producer may seem a bit excessive at first glance. Why bother? It seems like a lot of work and isn’t there enough information in the medical files, life insurance examination and inspection report to determine insurability for these older clients? The answer is both yes and no. Yes, there is usually enough information to underwrite the applicant without significant health problems.

No, it may not be complete or portray an accurate picture of the applicant’s true health for older persons with medical problems. With these clients one or two extra years of LE can spell the difference between insurability or rejection, between an affordable policy and one that is financially unreasonable. Those one or two years of extra LE may only be possible
with the introduction of well documented and detailed functional ability information from the producer.

It is no surprise that the number of applicants 80 and older will continue to grow over the next thirty to fifty years. It is important for producers to learn how to screen these applicants in terms of functional ability. Given that a client’s medical diagnosis cannot predict functional ability and that the medical file is of limited use in this area, it is up to the producer to assist the 80 and older applicant with a fair representation of all the factors that need to be weighed in determining insurability.

What Are Minimum Underwriting Requirements?

These will vary from company to company. However, you may see guidelines such as this:

• Applicants age 40 to 69: Applications will be verified by telephone. If high benefit limits are requested, a paramed exam may be required. After reviewing results, underwriters may decide whether an Attending Physician’s Statement (APS) will be necessary.

• Applicants Age 70-84: A paramed exam will typically be required, and at the underwriter’s discretion, an APS may also be ordered. If high benefit limits are requested, an APS will always be required. Certain coverages like unlimited or lifetime benefits may not be available at all to these individuals.

How can you know if your insurers are doing their job?

Make sure that minimum sales requirements are being met:

• Applications should contain clear, unambiguous, short questions designed to ascertain the health condition of the applicant. Questions shall be limited to yes or no answers. If a question asks for the name of a prescribed medication or prescribing physician, then any mistake or omission shall not be used as a basis for denial of a claim or rescission of a policy or certificate.

• The following warning should always be printed in a conspicuous place on the application: "Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage."

• If an insurer does not complete medical underwriting and resolve all reasonable questions arising from the information submitted with an application before issuing the policy, then the insurer may only deny coverage for a valid claim based on convincing evidence of fraud or material misrepresentation.

• A copy of the complete application should be delivered to the insured at the time of delivery of the policy or certificate.

Your state may also go beyond these requirements and need a checklist of required documents and disclosures such as outline of coverage, receipt of a shopper’s guide, a suitability worksheet, replacement policy guidelines and/or specific terminology concerning preexisting conditions, etc.

How else can you help your clients? Stay abreast of the news. Watch your company ratings and their reserves. Inform clients of any changes and discuss the need to move, if possible, and when necessary. Of course, most states have state guaranty funds that can help preserve your clients coverage. However, the guaranty systems are a last resort system with limitations. Further, most states do not permit agents to use state guaranty fund information as an incentive to any form of insurance.
INSURANCE AS INVESTMENT

The insurance and financial industries were revolutionized during the 1980s. Banks began offering discount brokerage services in addition to their traditional savings products. Stock brokerage firms began to sell insurance, bank certificates of deposits, and even residential real estate. Insurance companies began offering mutual funds, limited partnerships, and a full range of investment products through broker/dealer subsidiaries. Savings and loan institutions, which simply used to take in savings deposits to raise money for residential mortgages, began to offer checking accounts, car loans, boat loans, lines of credit, as well as many other important consumer products and services.

Nowhere has the increased offering of products been more profound than in the life insurance industry. Life insurance companies now offer consumers a dazzling array of savings and investment products tied to their life insurance policies. What was normally thought of as the "cash value" of a life insurance policy earning a very low rate of return, can now be invested in a variety of savings and investment vehicles. Such policies as whole life, universal life, variable life, universal variable life, and other generic products offer real growth possibilities compared to the four or five percent returns commonly offered just a little more than a decade ago.

It was not long ago that anyone referring to life insurance as an "investment vehicle" was laughed at or criticized. Similarly, annuity products were conceptually limited as vehicles to pay out retirement benefits from pension plans. Insurance company products were considered to be relatively staid and boring. However, times have changed. These products now have an important role in personal investment planning.

Today buyers of life insurance must be well versed in the use of life insurance annuity products as part of their investment portfolios. They must be able to evaluate potential future purchases and analyze their existing life insurance for appropriateness and for the adequacy of its investment performance in today's investment world.

The life insurance industry has been through turmoil in adjusting to today's economic environment. It must continue to evolve in order to adapt in the future. The life insurance industry is now a part of the greater financial services industry. The insurance company of the future is likely to be a broadly based financial services organization. The successful life insurance company will understand that the services it must offer to its clients are not just life insurance and annuities, but also stocks, bonds, mutual funds, other interest-sensitive products, and money management services.

LIFE INSURANCE AS INVESTMENT

The objective of understanding life insurance is to select appropriate products that will provide long-term satisfaction. Risk and return are important elements in the selection of life insurance products. It is important to understand the risks and potential returns of these products.
The process of selecting life insurance products is changing. The insurance companies which have the best due diligence, thorough examination and screening of products being offered for sale, and the best investment and product management people within its organization, will be the survivors.

**Breaking Down The Insurance Contract**

As a result of interest sensitive product development, new regulations have surfaced concerning the component parts of life policies. This means that expenses, mortality charges, investment results and the amount at risk are now exposed to the inspection of the consumer. Since these elements exist in every life insurance policy, old or new, the costs and benefits of all policies can now be compared to each other. Quantitative decision making information is now available.

The Deficit Reduction Act of 1984 (DEFRA) defines life insurance for income tax purposes in terms of requiring an "amount at risk." In other words, if the insured dies, the law stipulates that a significant amount of insurance company money must be paid. It further demands that this "life insurance" exist in a sufficient amount in order for the contract containing the net amount at risk to be deemed life insurance.

There are three basic tests of "sufficiency" of net amount at risk. They are:

1. **A Cash Value Accumulation Test.** This test states that the net cash surrender value (the policyowner's current equity in the contract) cannot exceed the discounted value of the net single premium that could compound to the face amount of the policy at age 95. The discount factor is 4 percent or the minimum rate guaranteed in the contract.

2. **Guideline Premium Requirements.** These requirements are based upon the guideline single premium or the sum of the guideline level premiums to date. The single premium portion of the test limits the amount a policyowner may invest in a policy. One cannot pay more into a life insurance policy than the net present value of the future benefits to be paid at age 95, which is the face amount, discounted at 6 percent assuming the contract's stated mortality and expenses.

The guideline level premium means the level annual amount that will fund the future benefits (face amount at age 95) payable to age 95, assuming the contract's stated mortality and expense charges and four percent interest.

3. **The percentage relationship of the policy's death benefit to the policyowner's equity is referred to as the cash value corridor requirement.** These percentage limitations are contained in Code Section 7702(d)(2) of DEFRA. The death benefit may not be less than the following percentage of the cash surrender value.

Code Section 7702 of DEFRA is a historic and important document because this is the first time that life insurance has been defined for income tax purposes. In dealing with today's life insurance, and with today's regulations, it becomes necessary to redefine life insurance, formerly defined as: insurance company money to be received by a beneficiary upon the death of the insured.

The distinction here is that only the money that is not the property of the policyowner prior to the insured's death is deemed to be life insurance. In various places, the authorities refer to this by stating that "only the excess of the amount paid by reason of the insured's death over the contract's net surrender value shall be deemed to be life insurance." This is often referred to as "net amount at risk."
Making the distinction between policyowner money (referred to as cash value, surrender value, account value, or policyowner equity) and the amount that is paid over and above that policyowner money in the event of the death of the insured (insurance company money) and referring only to the latter as life insurance will ease the understanding and evaluation of today's life insurance products.

People buy life insurance because in the event of death, the life insurance company pays the beneficiary more than what has been deposited with the company. These life insurance company dollars are deemed desirable by many. They have value, and must be paid for. If a policy should ever go below these requirements and be deemed not a valid contract of life insurance, the three primary tax advantages of life insurance would be lost, and a current tax liability would be created. The three tax benefits of a life insurance policy are:

1. The total death benefit of a life insurance contract received by the beneficiary is excluded from the beneficiary's taxable income. This benefit would be lost, and only the death benefit exceeding the net surrender value would be excludable from income tax by the beneficiary, if the contract were not deemed to be life insurance.

The account value of the policy would be subject to an ordinary income tax liability to the extent it exceeded the policyowner's basis.

2. The annual increases in cash value exceeding the annual net premium paid into the life insurance contract is tax deferred during a policyowner's lifetime and tax-free at the time of the insured's death. If the contract were deemed not to be a life insurance contract, these annual increases would be subject to current ordinary income tax.

3. The total accumulated income, exceeding the policyowner's basis in the contract, would be immediately subject to ordinary income tax at the time the product failed to meet the cash value corridor or percentage tests of Code Section 7702 of DEFRA.

It is obvious that the government makes a great distinction between the living account values of a life insurance contract and the net amount at risk. It becomes obvious that this net amount at risk is not provided by life insurance companies without charge. Every policy, new or old, that includes a net amount at risk until age 95 (i.e., life insurance), makes expense and mortality charges for the coverage. Every policy must have this net amount at risk until age 95, if it is to qualify as life insurance. These charges are taken from the policy each year. This is done either by extracting direct payment from the policyowner or by using a part of the return earned by the policyowner on the cash value to pay those expenses.

**Expenses**

Expenses in connection with interest-sensitive products exist at the investment account level, as well as at the policy level. These are the expenses incurred before the money even gets to the mutual funds or other investments. They are subaccounts or separate accounts. These are insurance company charges that cover its costs, commissions to intermediaries, company profit provisions, etc.

**Front Sales Load**

The front sales load is an expense charged against money being deposited into the policy. The insured can typically expect to pay 4 percent for this. He may find a policy that drops the charge after some stipulated sum has been paid. There are some policies that charge no front end sales load. There are others with front end loads of up to 8.5 percent.
**State Premium Taxes**

There are state premium taxes deducted from every dollar paid into a policy that go to the insured's state of residence. The table below shows the premium tax for each state:

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This table, showing the state premium taxes as charged by the individual states, should be studied. For example, an investor living in New York will find that only about nine-tenths of one percent of his investment goes to state premium tax. A $100 premium would incur only a $.92 tax. If the insurance company makes no additional charges against the investment, $99.00 would go to work in your accumulation account. In this case, this charge will probably be lower than most low load mutual funds.

On the other hand, a resident of the Virgin Islands has a state premium tax of 5 percent. This means that $100 going into a universal variable policy will be diminished by $5, only $95 will be invested. In either case, there are probably investments within the product which are advantageous because the tax saving involved and the tax-free interest compounding far outweigh these one-time charges.

**Back End Load, Surrender Charges and Other Fees**

The back end load is the amount of the policy account value forfeited if the policy is surrendered. It reimburses the insurance company for expenses that have not yet been recovered. The surrender charge, sometimes referred to as a deferred sales charge, is limited. Deferred sales charges are used to pay sales commissions. The insurance company advances a commission at the time of the sale and will not recover this unless the policy stays on the books long enough for the company to profit from it. If the insured plans to invest substantially above the basic premium, he must be careful to determine how such contributions will effect surrender charges. Also, if he decides that he wants to reduce his face amount while the surrender charge still is applicable, he will need to determine how much of the surrender charge will be applied as a result. Normally, no more than a pro-rata share is deducted, proportional to the amount of the policy reduction.

The back end load is an expense paid when the insured terminates his contract. It could go on forever, meaning there could always be a surrender charge, no matter how long the policy is
held. Typically, there is a contingent deferred sales charge. This is applicable if the policy is terminated or if the insured reduces his policy within a certain period of time. It is contingent upon how long the contract is owned.

Surrender charges or contingent deferred sales charges are frequently defined as a percent of the target premium. For example, consider the basic target premium for New York State licensed insurance companies. It is the premium level on which commissions are calculated on flexible premium contracts, as determined by the Commissioner of the State of New York.

Normally, the commission payable on these types of policies is about 50 percent of the target premium, plus 4 percent of payments in excess of the target premium. Renewal commissions based upon continued investment into a policy for years two through ten average approximately 4 percent of premiums paid. For the eleventh year and thereafter, it is 2 percent. This 2 percent is a transferable service fee, payable to the agent providing the policyowner with service. Currently, it is applicable only to new money being paid into the contract.

These commissions are paid out of the expenses that the insured pays to the insurance company. If what the insurance company deducts is insufficient, it advances the commissions and then amortizes those expenses from what they earn in future years. Commissions are also paid to the agent when the policyholder requests an increase in the face amount of the policy. There has been pressure in recent years to downsize sales commissions. There are those who think that a movement away from high first year and low renewal commissions toward more level commissions and charges based upon assets under management would be better for all. The theory with these policies is that the help of a knowledgeable agent to manage policy profitably can be invaluable. The insured needs long-term interest in him and his contract. The commission system of today is not conducive to that.

The target premium is determined when the policy is issued. It is based upon gender, smoking status, and the policy face amount. Generally, the target premium is approximately 75 percent of a typical annual premium. The limitations on various expenses based upon the target premium should be understood. These costs can determine how they will affect the performance of a policy.

First year administration fees are typically higher than ongoing administration fees. The higher first year fee covers the costs of setting up the policy and those costs incurred in determining if the insured is healthy. The average first year cost is between $300 and $400, with a high of approximately $600 to $700. This fee enables the insurance company to provide continuing services, such as mailing confirmation notices, generating periodic reports, providing telephone reporting, issuing annual reports, and others. It can run from $4 to $15 a month, with $5 to $7 being typical.

**INTEREST SENSITIVE LIFE**

To improve their competitive position, a number of companies have developed ordinary life products using current assumptions. These are called interest-sensitive products. In essence, current assumption whole life is a version of whole life which uses current mortality and interest earnings based on current yields, rather than overall portfolio yields. In all other respects, it is identical to conventional ordinary life.

These current assumptions are reflected in different ways. This depends on whether the company is a stock company or a mutual company. Mutual companies generally reflect their current assumptions through the dividend formula. On the other hand, stock companies typically reflect their current assumptions through the cash value formulas or through premiums.
Briefly, here are some of the significant features of this product, regardless of whether the issuing company is stock or mutual:

- Premiums are basically fixed, but may change based on company experience. A policyowner does not have control.
- Death benefits are guaranteed and do not fluctuate.
- Cash value minimums are guaranteed, although company experience may enhance the cash value.
- Policy loans are available as they are with traditional insurance.
- Withdrawals can be made from dividends without impairing the base policy. With nonparticipating policies, excess accumulation value can be withdrawn subject to any surrender charges usually without impairing the base policy.

Life insurance companies offering interest-sensitive whole life products are conveying to the buyer that at all times the policy will be current. The policyowner will be paid an interest rate on his reserve cash value that reflects what is going on currently in the economy. Perhaps the best explanation of the interest-sensitive concept comes from the following statements which have been taken verbatim from a current sales brochure put out by a life insurance company. The only change which has been made is the substitution of the generic term "interest-sensitive life" for the proprietary name of the company's product.

**The Design of The Interest-Sensitive Product**

Mortality charges are the costs imposed by the insurance company for the amount of insurance for which it is at risk. For term insurance, it is risking the entire face amount. For non-term plans, it is risking the difference between the face amount and the reserve (the cash value or the separate investment account). Mortality charges increase with age.

Current mortality charges are the charges reflected in the ledger statement, which influence the reserve value. This is shown in the following example under the heading of "Current mortality." Current charges are less than the maximum charges that can be imposed. Some ledger statements have either no current charges or very low mortality charges. Maximum mortality charges are the maximum charges that can be imposed as stated in the policy contract.

The following things should be considered when dealing with mortality charges such as those shown below:

- The mortality charge is what the insurance company is risking per $1,000 of life insurance.
- The mortality charges are for a male nonsmoker.
- Some companies have lower mortality charges for different amounts of life insurance. This is known as the band approach.
- Mortality charges are on an annual basis. The monthly charge has been multiplied by 12.
- The higher ratio of current charges to maximum charges means that current mortality charges will not increase by much, if anything, in the future.

The death benefit, unlike for example, a traditional whole life policy which uses dividends to purchase additional paid-up life insurance, does not increase unless the reserve (the cash value), which is dependent upon the actual interest credited and actual mortality charges, forces an increase in the death benefit because of the cash value accumulation and the corridor test. The death benefit must exceed the reserve by a specific percentage. The larger the reserve, the greater the death benefit.
A relatively recent feature added to many interest-sensitive products is the ability to adjust the initial premium level to tailor the policy to the needs of the client, giving the agent more marketing flexibility.

Another policy feature many insurers have added is the automatic inclusion of what is called the "living benefits" provision. Although this feature varies from policy to policy, it is basically designed to provide terminally ill policyholders with benefits which are deducted from future death benefits, subject to company guidelines.

Guaranteed surrender values are accumulated at the guaranteed interest rate, minus any company surrender charges. Current surrender values are accumulated at current rates, minus any company surrender charges. Many companies do not calculate surrender charges on a flat percentage basis. Policy specifics will detail this.

Death Benefit Options
When selecting any interest-sensitive product, the insured will be asked whether he wants Death Benefit Option I (sometimes referred to as Option A) or Death Benefit Option II (sometimes referred to as Option B). These options are defined as follows:

Option I (A): The amount of life insurance will go down as the account value goes up. The insurance company will have less net amount at risk, since it will be providing the insured with less life insurance as the policy account value increases. The bigger the account value, the smaller the net amount at risk. Each month the company calculates the number of thousands of dollars of net amount at risk and multiplies that by the cost per $1,000 of life insurance. This determines the total monthly amount to be charged against a policy account. Less life insurance results in less cost for life insurance.

If the client prefers to maintain the amount of the insurance company money at a constant level, rather than reducing its amount at risk with each dollar paid in, he may select:

Option II (B): With this option, at death the policy would pay the original face amount, plus the policy account value. It is usually recommended that an insured begin using this option during account building days. When the insured is no longer adding capital to his policy, he may then switch to Option I. The insured can ask the insurance company to reduce his face amount, being careful to avoid partial surrender charges or income taxes, in order to eliminate unneeded life insurance and mortality charges.

Whole Life Insurance
Whole life insurance evolved out of what were considered the negative aspects of yearly renewable term life insurance. The premium (annual cost) for term life insurance increases each year.

Premiums for the young are very low. Therefore, term insurance is popular with the younger age group. However, as age increases, the cost per $1,000 of insurance increases to unacceptable levels. A solution was sought to this unacceptable escalation in premium. The solution was whole life insurance, a policy on which the premium remained level for the "whole" of one's life. This was relatively easy for the actuaries to design. The whole life premium is the result of a calculation leveling the increasing annual insurance costs and spreading them over the life of the insured.

The level premiums would be more than sufficient in the early years and less than adequate in the later years. The insufficiency in the latter years would be taken from the overpayments in the early years. Alternatively, the insurance company would use the policyowner's reserve to pay a
portion of the total death benefit and reduce the net amount at risk, or life insurance, thus reducing mortality expenses.

The portion of the contract which is life insurance; that is, insurance company money, net amount at risk, decreases with age. The result is that even though the cost per $1,000 increases each year, smaller and smaller amounts are necessary, eliminating both cost and life insurance by age 100, at which time money that can be taken out while living is equal to the insured's death benefit.

Most life insurance policies in the United States dated prior to 1976 that involve savings or investment are whole life types of policies. They may be labeled a family plan, a 20-pay life plan, a life paid-up at age 65 plan, an endowment plan, or some other marketing name that refers to some of the features of the policy. The name may refer to the fact that the premium paying period has been adjusted to something less than the "whole" of the insured's life.

The shortened premium payment period is accomplished by increasing the level premium so that the required premium is collected over a shorter period of time, by age 65, rather than for the "whole of life," considered to be age 100. Excess of funds required for the current year's mortality and expenses are invested in the insurance company's general portfolio.

Previously, it was safe to say that this general portfolio was primarily comprised of long-term bonds and mortgages, as dictated by the various state insurance laws. Today, there can be a rather different risk/reward relationship in an insurance company's general portfolio management. For example, in a 1983 incident, it was found that a company was investing in the stock of its own subsidiaries.

In 1986-87, Executive Life had problems with the State of New York regarding the quality of its bond portfolio and the reinsurance arrangements it was using to eliminate liabilities from its books. In June of 1987, New York mandated that insurance companies licensed to do business in that state must not include more than 20 percent of "less than investment grade" bonds (junk bonds) in their general portfolio. At that time, it was reported that Executive Life of New York's portfolio contained some 57 percent of this type of bond. Executive Life failed and was taken over by the state insurance commissioner. Unfortunately those policyowners with the "higher than the rest, why take less?" attitude learned about risk. They learned that they could have settled for less and actually gotten more. Guarantees are only as good as the company behind them.

The quality of insurance company portfolios varies. The risk of the investments and the return on the investments from company to company will also vary. When selecting life insurance, clients are likely to consider company selection as a primary criteria. Company selection is based upon the quality and integrity of the insurance company, the availability of useful products from that company, and profitable investment management.

The investment vehicle for whole life insurance is the company's general portfolio. Since the general nature of, and the predominant influence on, investment results are the long-term bonds and mortgages typically held within this portfolio, results can be expected to parallel this type of investment. As a result of regulatory pressures, these general account portfolios have bonds of shorter maturities, few mortgages and lower returns.

A policyowner can expect inferior investment returns from the long-term bond and mortgage portfolio in an economic environment in which interest rates are increasing. These returns are the result of the relatively low yielding investments locked within the portfolios until their maturities.
Conversely, in decreasing interest rate economic environments, long-term bond and mortgages provide superior investment results, as a result of the higher interest rates that have been locked up within the portfolio. The question that must be examined when offering this type of policy is whether or not the investment results that can be expected from investments in long-term bonds and mortgages are in accordance with the client's objectives. In addition, should part of these investment results be expended to pay for the life insurance?

If the answers to these questions are yes, that the client wants bonds and mortgages and he wants a part of his return to buy life insurance, then the next evaluation should zero in on the particular company. How does the company under consideration manage its general portfolio? What have their investment results been in the past and what are the investments results that can be expected in the future? The best sources to provide this information are:

- The company's annual reports
- Best's Insurance Reports-Life/Health, which presents annual comprehensive statistical reports on the financial position, history, and operating results of life insurance companies in the United States and Canada.

From these sources one may obtain an insurance company's past track record of portfolio rates of return, the general makeup of the insurance company's portfolio, and an opinion of how a company is being managed. A part of the return earned on the insurance company portfolio is returned to the policyowner in one or two ways. The policyowner receives a return in only one way if the policy is nonparticipating. This means that the policyowner does not receive dividends. In these policies, the contract provides a guaranteed cash value only.

This amount is stipulated within the contract at issue, and providing the policyowner pays the stipulated premium, the guaranteed cash value is the only return that will be earned. If the policy happens to be profitable to the insurance company, these profits will be paid to the shareholders of the stock life insurance company, not to the policyowners.

Whole life insurance policies which have two ways of transmitting portfolio returns to policyowners are called participating policies. These policies use the first method above, providing contractually guaranteed cash values, and in addition, they provide dividends, allowing the flow-through of investment results to the policyowner. Life insurance dividends are not dividends per se. They are not like corporate dividends received from stock. Life insurance dividends are not taxable since they are considered, for tax purposes, to be a return of excess premium.

If the premiums paid to the insurance company turn out to be more than the company needs as a result of fewer insureds dying than expected, the company's expenses being lower than expected, or the company's portfolio investment return being larger than projected, the company returns some of this excess premium to the policyholder and refers to it as a dividend. It is not too difficult to predict with relative accuracy how many insureds will die each year. Further, expenses have not gone down for most insurance companies. Therefore, it can be safely assumed that a substantial part of the dividends paid by participating companies result from better investment results than originally predicted.

As far as whole life insurance is concerned (that type of insurance with its reserve or cash value investment within the general portfolio of the insurance company), dividends are the only way any variability of returns can be passed to the policyowner. Nonparticipating policies have not been able to pass favorable returns to policyowners. Therefore, the competitive position of older nonparticipating whole life policies has diminished to almost nothing.
Types of Whole Life Policies
Whole life policies can be divided into three main types: ordinary life policies, limited payment life policies, and single premium life policies. Whole life benefits can also be provided by split life insurance.

Ordinary Life Insurance
Ordinary life insurance, sometimes called straight life insurance, furnishes lifetime protection to the insured with premiums payable continuously until death. Ordinary life insurance has the lowest premium rate of any permanent life insurance policy. It is written on the level premium plan; that is, the premium payable annually remains constant throughout the life of the insured, in contrast to the continually increasing premium charged for term insurance.

Limited Payment Life Insurance
Limited payment life insurance policies also provide lifetime protection to the insured. However, the payment premiums, instead of being for life, are limited to a specific period of years, such as 10, 20, or 30 years, or until the insured reaches a certain age, for example, 60 or 65. Since the premium paying period of the limited payment life policy is less than the life of the insured, the premium rates charged must be higher than those for an ordinary life policy. This increase in premium is reflected in a higher cash value buildup. In all other respects, the limited payment life policy is similar to the ordinary life policy.

Single Premium Life Insurance
A single premium life insurance policy, as the name implies, requires the payment of the entire premium for the policy in one sum, rather than periodically throughout the lifetime of the insured.

Split Life Policies
Split life policies, like ordinary life, provide a death benefit made up of the cash value (or premiums paid, if greater) of the annuity, plus the protection element of the yearly renewable term insurance.

Uses of Whole Life Insurance
There are a great many uses for whole life insurance. It is fair to say that whole life is probably the most adaptable and versatile of all life insurance policy forms.

The most popular and widely used form of whole life insurance is the straight, or ordinary life policy. Not only does the insured get more permanent insurance per premium dollar with this type of insurance than with any other form of permanent insurance, but the savings element contained in the premium payments permits a buildup in cash values that can be applied to meet a wide variety of needs. This savings element permits the creation of so-called nonforfeiture values that are listed year by year in the policy contract. The values so listed are guaranteed to the insured.

Nonforfeiture values are usually referred to as the cash value of the policy. The insured may borrow against this cash value. In addition to having cash and loan values, nonforfeiture values can be used to keep in force a lesser amount of paid-up life insurance without the necessity of paying any further premiums. They may also be used to keep the whole amount of the policy in force on an extended term basis for a given number of years and days as stated in the policy. Also, the insured is generally permitted, either by contract provision or company practice, to convert the nonforfeiture value into a life annuity at or around the normal retirement age.

Further, if the insured is willing and able to save more, he can change ordinary life to a limited payment or endowment policy (but not a term policy) without a medical examination.
In summary, ordinary life provides a perfect hedge against the twin hazards of premature death and low income retirement and does so at the lowest possible premium cost for any form of permanent life insurance.

Because ordinary life affords the greatest permanent protection at a low initial cost, it can be recommended for the single young man who, in most instances will be married after a few years, at which time he will appreciate the protection procured at an early date. Likewise, the young married man with anticipated needs greater than his budget can stand will probably do well with this policy.

For the individual who may need greater protection for his or her family due to increased responsibilities, or for business or credit purposes, the ordinary life policy will stretch the premium dollar to fit these added needs.

**Dividend Crediting**

Participating policies have different methods of crediting dividends. The traditional way to credit dividends on participating whole life insurance policies was the portfolio method. Under this method, the total investment return on the portfolio held by the insurance company was determined. The extent to which that rate of return exceeded what had been guaranteed within the contracts, the insurance company credited to all policyowners with their proportionate share of the divisible surplus. No attempt was made to distinguish the rate of return earned on monies invested with the insurance company in previous years to the rate of return earned on those funds deposited more recently.

The portfolio method homogenized rates of return and made them more stable over time. It served to favor new policyowners in periods of decreasing interest rates. They were able to invest in a portfolio that held securities with interest rates that were higher than generally available at the time. The portfolio method was a disadvantage to new policyowners during periods of increasing interest rates. Long-term policyowners were disadvantaged under this method during decreasing interest rate environments because they had to share their higher portfolio returns with new policyowners. It assisted old policyowners during periods of increasing interest rates when the new policyowners were contributing new money that could be invested at the higher rates of return, thus improving their overall portfolio return.

Some insurance companies began to provide more equity to their policyowners by departing from the portfolio method of crediting dividends. They devised the current money method, which is also referred to as the new money method of application of dividends. The result of this procedure is that the return earned on the money invested in the insurance policy depends on when the investment is made. The rate of return is determined by the rate the insurance company is able to secure at the time the policyowner invests. This method is also sometimes referred to as the segmented or investment block method, since certain blocks of business receive different dividend amounts.

It is very difficult to determine which of these two methods of crediting dividends is the best for any one particular policy or policyowner. This depends on the market interest rates, combined with policyowner's cash flow into the policy, both of which are difficult to predict. This type of investment return is unique to whole life insurance policies that utilize the company's general portfolio.

Whole life insurance retains its viability as a way of paying for life insurance protection because of the relative stability and predictability of its portfolio rate of return. Furthermore, several aggressive strategies are being used by insurance companies to enhance the rate of return. For example, dividend addition riders are being offered by some insurance companies as a means
of getting greater amounts of cash investment into an insurance policy with lower amounts at risk attached to that investment.

The objective is to provide a greater return on that supplemental additional investment to the policyowner. This can be accomplished because less of the rate of return on the dividend addition riders must be used to cover mortality and expense charges. This allows a greater return of investment and enhances the rate of return within the policy as a whole.

Economic gravity must be factored into the study of whole life insurance. Economic gravity presumes that investments will tend to do in the future what they have done over the period of recorded history. To expect bonds to perform differently over the long-term is to expect history to change. The economic gravity theory assumes that investment returns will vary, but they tend to return to their historic norms. Based on common sense, one could assume that the investments within a whole life policy will not defy economic gravity. If they attempt to do so, the company could follow the steps of Executive Life.

Insurance companies also make special compensation contracts with sales representatives to defer the receipt of commissions in order to enhance front end investment returns in policies.

**The Whole Life Investment**

After understanding the nature of the investment within a whole life contract and the risk/reward relationships as a result of the particular company under consideration, the next consideration in understanding the whole life product is examining the mortality and expense charges required to make the investment. This is, the additional charges of a particular policy. Whole life insurance is a fixed premium product. The premium is determined by age, sex and risk information. The insurance company gives a stated level premium for the premium paying period selected. The stated premium is billed each year. It cannot be increased. The only reductions available in cash flow into the contract would be as a result of taking some of the investment results out of the contract either through dividends, if this is a participating insurance policy, or through policy loans. This fixed, sometimes called "inflexible," premium characteristic of whole life insurance is an important element in financial planning. Obligatory premium payments can be a problem during periods of unemployment, illness or high expenses.

In a whole life policy contract, the policyowner has no control over the investment vehicle. The insurance company selects the long-term bonds and mortgages and continues to invest and reinvest in the assets selected by its portfolio managers. If at any time the policyowner is disenchanted with that particular investment, one alternative is dropping the policy, therefore losing whatever life insurance is provided by the contract. If this is done, the policyowner must pay ordinary income tax on any accumulated gain, that is any amount received from the policy over what was paid into it. The net after-tax results are then available to reinvest elsewhere.

Another alternative, providing the policyowner is still insurable at acceptable rates, is to do a "1035 tax-free exchange" of the policy. The policyowner may make an absolute assignment of the contract to the same or another insurance company. He may trade it into a new contract without incurring a current tax liability. Once the absolute assignment is complete, the new insurance company will direct the old insurance company to drop the old policy and send a check for the proceeds of that policy directly to the new insurance company. The new insurance company will then manage the investment as provided for under the replacement contract applied for by the policyowner. This provides a tax-free transfer of basis from the old contract into the new one. It protects any otherwise taxable gain in the policy from current taxation.

One of the unique advantages of whole life insurance to the policyowner has been the fact that personal management of the investment vehicle is not required. The long-term bond and mortgage portfolio of the insurance company provides stable and consistent results. These
stable and consistent investment results are one of the characteristics within whole life insurance that may be used to establish a life insurance purchasing strategy.

Interest-sensitive whole life is similar to traditional whole and graded premium life and variable life in that a waiver of premium in the event of total disability waives the entire premium. Cash value accrues just as though the premium were paid. Approximately 25 percent of all universal life products now also offer a waiver of premium feature not just on mortality charges, but also on the planned premium. In the past, universal life plans only waived the mortality charges, and no new money was added to the reserve.

How can an interest-sensitive whole life policy compete with a participating policy that includes paid-up additions riders? A new approach is to attach an interest-sensitive whole life rider to the base interest-sensitive whole life policy. This is the approach taken by a fraternal society which has started using it in the five states where it operates. This new operation has met with seemingly immediate approval. In the product's first month and a half of sales, the fraternal society had already received over 60 applications.

The interest-sensitive whole life riders developed for this purpose are a low-pay and a single-pay. Both credit the same current interest rate as the base interest-sensitive whole life policy and have the same guaranteed interest rate. Neither of these has any front end loads deducted. Only the cost of insurance charges plus surrender charges are taken out if applicable.

The ten-pay rider can accomplish the same thing as a participating policy that has a paid-up additions rider because it not only increases the base coverage with permanent insurance, but it also increases the policy values through its participation credits (the excess interest and mortality gains to the policy, above the guaranteed values).

The participation credits are like dividends, only they are more flexible and up to date than dividends. That's because the fraternal society reviews them quarterly, whereas par companies usually review dividends only annually.

Another distinction of these riders is that clients can add the ten-pay rider at issue or at any time after the contract is in force, whereas buyers on par contracts typically make the decision up front about whether to add a paid-up additions rider.

Additionally, the ten-pay rider has a type of guaranteed insurability feature. It allows the client to purchase an additional low-rider at the end of each ten-year period, through age 60. The face amount of the new rider will be lower than that of the first rider because it equals the amount purchased at the attained age by the premium paid on the initial low-pay rider. The coverage is offered on a guaranteed issue basis with no new underwriting.

This gives the customer an opportunity to get a substantial amount of additional insurance. The premium for the low-pay runs higher than a typical ordinary participating policy, but that is because it is completely paid for in ten years, rather than in annual premiums for a lifetime. The contract is structured to stay within government rules regarding modified endowment contracts so that the client can use the coverage for college funding or retirement planning purposes. Zero cost policy loans against the cash value are available starting in year one, and the company permits surrenders, subject to a six-year surrender charge, which is taken against the participation credits but not against the guaranteed cash values.

The company does not expect the contract's provision permitting zero cost loans starting in year one to be overused. Most people will buy these riders to accumulate money, so few will probably want to take loans in the early years.
The contract’s earnings can also be used to pay the base plan premiums or may be used for early mortgage cancellation plans.

The low-pay rider is available on new issues with the lesser of $10,000 in face amount or $600 of annual premium. The single-pay rider must be purchased at policy issue. It is designed only for use in 1035 exchange situations. Under its terms, the cash value from the old policy (the one being exchanged) is used to purchase the rider. Minimum premium on the rider is $500, and the rider must be attached to a new interest-sensitive whole life base policy. The company does not offer the single-pay for use with other large deposits, nor can it be added to existing issues. Like the ten-pay rider, the single-pay can be used to pay base premium plans, as well as for college funding and retirement accumulation purposes. Surrender charges against the participation credits run for six years.

These riders represent a culmination of two years of market research and product development. Developing the necessary administrative system took special effort. When combined with other new products, these riders will enable agents to custom design insurance plans.

**Payment Strategies**

Short pay, quick pay, four-pay life, and seven-pay life are premium paying strategies frequently presented with a whole life insurance contract which requires premiums payable for life. These limited payment periods are accomplished by using a part of the investment return, dividends from the long-term bonds and mortgages to pay the mortality, and the expense charges on the policy for the rest of the policyholder’s life. Whether such proposals actually work depends upon whether the actual investment results are at least as good, or better, than the predicted results. In the past, these strategies have worked well to accomplish the policyowner’s objective for a relatively worry-free minimum cash outflow for long-term life insurance protection. The actual investment results of quality insurance companies have exceeded their projections. However, with the intense competition going on in the insurance industry today, there has been a tendency to stretch predicted returns, which could result in future actual results being less than predicted results. If this is the case, some policyowners may find it necessary to pay premiums into these policies for longer periods than have been predicted.

Another policyowner strategy used with whole life is minimum deposit. Under such plans, the policyowner would observe that within a participating whole life policy, the combination of the cash value increase (guaranteed within the contract) and the dividend, was more than the policyowner’s premium. The dividend is the nontaxable return of part of the policyowner’s premium, as a result of fewer death claims than anticipated, lower expenses than predicted, or better investment results than expected. Since this asset base is available to the policyowner through guaranteed policy loans offered at somewhere between 5 to 8 percent, the policyowner can instruct the insurance company to reduce the annual premium requirement by the amount of the current dividend and pay the balance of the premium due with a loan against the policy cash value. This strategy resulted in a minimum deposit into the insurance contract. As those policy loans increase in amount, interest costs would also increase.

In the past, there was little reason to be concerned about a 5 percent policy loan that was deductible. Additionally, the policy loan did not affect the policyowner’s investment results, meaning, his dividend was not any different than the dividend received by a policyowner who had not borrowed on his cash value. This procedure was particularly advantageous in the economic environment of increasing interest rates of the 1970s and early 1980s. However, it was inevitable that insurance companies would have to do something about the practice of borrowing at the low 5 percent interest rate guaranteed in their contracts in order to invest it at higher rates of return available from other financial institutions that occurred during this period. The flow of funds being loaned to policyowners at 5 percent during the period of time that the
money market mutual funds were paying rates in the high teens was devastating to insurance company portfolios. As a result, the insurance companies took the following steps:

- They increased the guaranteed interest rate on whole life policies being issued at the time to 8 percent or made the rate adjustable.
- They presented upgrade and enhancement offers to their existing policyowners, the substance of which was that the policyowner could accept the payment of current market rates of interest for any loans, in return for the insurance company promising them higher future dividends.
- They began issuing conduit types of policies, such as variable life and universal life. These are policies in which the policyowner accepts the investment risk, and the insurance company acts as the money manager. These policies segregate the funds into separate accounts from the company's general portfolio and, after charging a management fee, pass all investment returns -- both good and bad -- to the policyowner.

The economic impact to those whole life policyowners utilizing policy loans is that the cost of those loans has increased. When accepting the upgrade offer, the cost of the loan goes up by the amount of the actual new higher interest rates, less whatever increased dividend is received as a result of accepting the offer.

If a policyowner chooses not to accept the upgrade offer in order to retain his low interest charges on policy loans, the loan still increases in cost to him as a function of the lower dividend he now receives as a result of his refusal to accept the upgrade offer. Quantifying the actual amount of the increase in policy loan costs (increased interest costs or decreased dividends) to the policyowner as a result of these changes has added a degree of complexity to whole life insurance policy management. In effect, it increases the costs of management to the policyowner.

In addition to the increased costs being imposed on policy loans by the insurance companies, the Tax Reform Act of 1986 (TRA 86) attacked the deductibility of these interest charges for both the personal and corporate borrower. For the personal borrower, TRA 86 generally regards interest paid on policy loans as consumer interest and thereby limits its deductibility. There are some exceptions that will allow full deductibility of insurance policy loan interest to the individual. Loans to finance investments continue to be deductible to the extent of net investment income. Also, loans on policies held for trade or business purposes on the lives of officers, owners, or employees generate deductible loan interest for loans aggregating no more than $50,000 per officer, employee, or owner. For corporate borrowers on their life insurance policies, TRA 86 has "grandfathered" policies issued before June 21, 1986. It allows corporations to continue to deduct interest on policy loans on those policies. For policies issued after June 20, 1986, only the interest on policy loans up to the amount of $50,000 are deductible. For policy loans exceeding the $50,000 threshold, deductibility for policy loan interest is denied.

The impact of these changes, higher interest rates charged by insurance companies on policy loans, lower dividends paid on policies with outstanding loans, and the reduction or elimination of the deductibility of policy loan interest, has served to destroy the economic feasibility of the minimum deposit strategy for paying whole life insurance premiums.

Disintermediation

The concept of disintermediation, often referred to as "the movement of money," was of great concern to insurance companies several years ago when new money market interest rates were extremely high. Now it is of little concern if the current rate is not paid on borrowed money. Insurance companies no longer show concern for loans against the cash value of a policy, provided they can protect themselves. They can indeed protect themselves by not paying the
current rate on borrowed money and by having appropriate investments for their investment strategy. For example, placing maturity dates on bonds that can protect the insurance company in the event of changes in interest rates.

Unless a variable loan rate is available, the current rate will not be paid on borrowed money. This differs from the practice with traditional whole life in that, if a variable loan rate is paid equal to the dividend interest rate assumption, the dividends will not be reduced if a loan is made against the cash value.

When the investment strategy employed by the current interest rate is a new money approach, the popularity of such an approach will naturally be very high when new money rates are high. Emphasis on new money is more apparent in a modified portfolio rate. Enthusiasm for a new money rate approach, however, should be tempered with extreme discipline. The evidence is quite conclusive that in the long run, a higher rate of return is achieved in the capital market than in the money market.

Interest-sensitive whole life, or excess interest whole life, as it is also known, has become an important part of many product portfolios. Many companies have updated older products, introduced new ones or entered the market with these for the first time. Relatively high guaranteed interest rates of 4 to 6 percent and the ability to add extra amounts and vanish premiums early combine to make interest-sensitive whole life a popular product. A surrender charge transfers the lapse risk and expense from the company to the policyholder. Most of these policies have a fixed policy loan interest rate, but some rates are variable, with the minority of these tied to Moody's Corporate Bond Index. Some of the fixed rates are payable in advance.

**Universal Life Insurance**

Another type of interest-sensitive life insurance product is universal life insurance. As interest rates skyrocketed in the late 1970s and early 1980s, money market mutual funds were born. The public demanded an opportunity to participate in the higher yields of the day, and the mutual fund industry responded. As interest rates went up, the return on long-term bond and mortgage portfolios of whole life insurance contracts did not look as good. Money moved out of insurance policies into money market accounts. At this time, life insurance as an investment vehicle was often questioned. Long-term bonds in a rapidly increasing interest rate environment were not attractive.

The market demanded a response, and the appropriate vehicle was a money market mutual fund. The market driven insurance industry had no choice but to offer short-term money market investments within their insurance policies, instead of the long-term bonds and mortgages of whole life.

It is interesting to note that it took a life insurance company executive, working with the brokerage firm of E. F. Hutton, to get the universal life product into the marketplace. E. F. Hutton's success with the universal life product brought in small niche companies born in the days of very high interest rates. These new companies were not burdened by the baggage of large portfolios of old long-term bonds and mortgages. They were able to get a fast and effective start. The old line life insurance companies looked fearfully at the new universal life product as a vehicle that would create more, rather than less, disintermediation problems.

According to a 1981 Life Insurance Management Research Association (LIMRA) study, 78 percent of the annualized premiums were for traditional cash value life insurance, 19 percent were for term insurance, and only 3 percent were for the newer products. By 1986, these figures changed dramatically. Only 30 percent of the new annualized premium was going to traditional
cash value life insurance, 11 percent to term insurance, and 59 percent to investment orientated new products.

While the universal life product has a number of unique characteristics, the most notable is its basic investment vehicle, current interest rate investments. The interest rate to be earned usually is guaranteed for one year. At the end of that year, the policyowner is informed of the rate for the next twelve-month period.

Universal life brought total disclosure to the life insurance business. The specific charges, expenses, and credits are itemized and available to the policyowner. These policies were referred to as transparent policies because of the detailed information offered for the first time. This information is essential when evaluating policies.

When considering putting premiums into a universal life policy, it is important to study these expenses and credits on a monthly basis. First year expenses usually are the highest, paying to get the policy started. Other important considerations are:

- What deposits are recommended for the policy?
- How often should deposits be made?
- How long should the deposits be expected to be made using conservative interest rate assumptions?
- How much is taken out for state premium tax?
- What amounts are deducted for insurance company expenses initially, then per month?
- What is the maximum expense charge that could be made?
- What is the amount at risk, i.e., how much life insurance is being offered by the policy? Does the death benefit include the account value, or is it paid in addition to the account value?
- What is the current monthly cost and annual cost for the amount at risk (mortality charge)?
- What is the contractual maximum mortality charge that could be made?
- Are there any other additional charges being made against the policy for other policy benefits?
- What earnings are currently being credited to the policy account on a monthly and annual basis? Historically, how much has that interest dropped in the second policy year?
- Are any earnings guaranteed?
- How much remains in the policyowner's account at the end of the first month and at the end of the first year?
- If the policy is surrendered at the end of the first month, how much is available? At the end of the first year?
- For how long is the cash surrender value less than the account value, that is, how long does the back end load stay in existence?

Another characteristic of the universal life product is that the insurance company often retains the right to change the charges it makes for mortality and expenses. Charges for mortality are often based on the company's current experience. Therefore, the long-term results of a universal life policy depend upon how well the company selects new insureds. Since this is an element over which the policyowner has no control, he must do two things: He must choose a quality company with careful underwriting standards, and he must determine whether or not the maximum potential charges for mortality guaranteed within the contract are acceptable. These maximum charges by statute are contained in the "1980 Commissioners Standard Ordinary Mortality Table."

The third important characteristic of universal life insurance is the policyowner's ability to adjust the face amount and what is paid into the policy so that it fits his needs. He is able to change
the face amount or premium level to suit his own particular needs. It is not difficult to raise or lessen the amount at risk. For example, if a policy is purchased and shortly thereafter the insured elects to reduce the amount at risk, he will likely forfeit a portion of the account value in the form of a back end load. The amount of that forfeiture is disclosed in the contract.

On the other hand, if the insured directs the company to increase the amount at risk, he may be asked to provide evidence that he is still in good health. Some expenses will likely incur at the time of increase. With some policies, this is the most efficient and least costly method of increasing coverage. The fact that universal life is flexible and adaptable is a critically important factor to many people.

The universal life product is attractive for those who prefer an investment that pays current competitive market rates of interest, as opposed to the long-term bond and mortgage account returns of whole life. It also has appeal for those who may want to use its adjustment features. The market share of this product has decreased dramatically since 1986 because of competition from variable life and decreased interest rates. In fact, it has dropped from more than 50 percent in 1986 to less than 22 percent in 1990’s.

The minimum funding level of a universal life policy requires that there be enough money in the policy account to cover the mortality and expense charges for the year. Under a minimum funding arrangement, the policy account could dwindle to the amount of the remaining back end load, and the insurance company would call for more money. Unless an insured makes a premium deposit sufficient to cover the mortality and expenses, the policy could terminate. In some cases, the company will not require payment to cover the full year, but rather a shorter period, such as one quarter. If an insured decides not to make an additional premium payment, the policy will terminate, and he will pay the back end load within the policy. When using a minimum funding strategy, the insured is essentially purchasing yearly renewable term insurance. It generally is not economical to use a universal life policy as a term policy. The expenses of such a policy are typically more than a regular term policy, and there is also the issue of the back end load. Further, there usually is a target premium on these flexible premium products, the premium the company considers adequate to maintain the policy on a long-term basis.

At some point in the life of a policy, there is an amount on deposit large enough so that tax-free interest earnings are sufficient to pay for the mortality and expenses of the contract in the current year. At this point, the insured is buying term life insurance protection entirely with interest earnings that have not been diminished by income taxes. This type of funding allows the insured to pay the minimum amount possible for the protection he desires. If the insured is in the 30 percent tax bracket, he must earn $1.43 in order to pay an after-tax dollar for a term premium. However, if he earns interest inside a policy, he may use that whole dollar, undiminished by taxes, to pay the term premium within the policy. He saves $.43 for every dollar of premium paid.

**Overfunding**

What would happen if the insured decides to overfund his universal life product deposit by putting in an extra $10,000 for investment purposes? Before making this decision, he must look at whether or not the policy is a good investment alternative. What does it cost to get the money into the policy? Does the deposit increase any back end loads? How would he get the money out if needed?

In the beginning, few of the agents selling universal life understood it, and in some cases, it was improperly sold. Some policyowners who purchased contracts in 1979 have insurance company illustrations for periods of 20 to 50 years based on 12 percent or more interest rate assumptions.
for the entire period. Often those who bought these contracts did not even realize that part of that return would be used up in expenses and mortality charges. They bought universal life insurance because of its associated high gross interest rate predictions and bad publicity surrounding whole life, as interest rates rose to their 1980 levels.

Most damaging was that policyholders determined the amount of money they would put into the universal life policy based on those high interest rate assumptions. As a result, they minimized their annual deposits and underfunded their contracts. Unfortunately, as interest rates have decreased and the policy earnings on their accounts have diminished, some of these policyowners are finding that the earnings on their accounts are not sufficient to cover mortality and expense charges. A portion of the principal in the policy account is being utilized to cover these costs, and so their policy accounts are being systematically eliminated.

Also, some policyowners regard universal life insurance as they did whole life insurance, that is, they put the policies away and forget about them. They may be totally unaware of decreases in the principal amount of their account values. Unfortunately, they will be shocked when they are notified that their policy account has diminished to a level that cannot sustain the policy, and they are going to have to put in more money if they expect their policy to remain in force. These people will receive a call on their policies similar to a call on margin accounts from stockbrokers. This is why a conscious decision must be made with respect to the funding level in a universal life insurance policy. It must be monitored to make sure it is doing what it was intended for. It is easy to understand the problems policy owners may encounter if they do not actively manage their policies when the following factors are considered:

- The insurance company can, at its discretion, increase the mortality charges up to the maximum guaranteed within the contract, for example, from the lower current rates to 1980 Commissioners’ Standard Ordinary Mortality Rates.
- The insurance company can increase expense charges up to the maximum guaranteed within the contract, for example, from $4 to $8.
- Mortality charges will inevitably continue to rise, as a result of the policy owner’s advancing age.

These factors occurring together can result in the rapid decline of an account value to zero. If, as this point approaches, the insured's health has deteriorated to such an extent that he can no longer obtain life insurance, he would have no alternative other than to meet the call for more money. In a worst case scenario, if the insured's resources have also decreased, he might find it difficult, or impossible, to meet the call. He could lose his insurance coverage altogether.

Life insurance companies, insurance agents and financial planners will have a great deal of difficulty explaining this situation to these policyowners. Policyowners should be encouraged to maintain at least adequate funding levels and to overfund their contracts during good times, when they have excess resources and the policy is a reasonable investment alternative.

The risks in universal life are as follows:

- The interest earnings on the policy account will move up and down as market rates fluctuate.
- The insurance companies can and will change mortality rates.
- The insurance companies can and will change expense charges.
- The policy requires policyowner's management and continued vigilance.
- Interest rates have moved from a cyclical high in December, 1980, to a cyclical low in 1994. If the insurance company is maintaining a high interest rate and paying out more than it is earning to do so, company failure is a possibility.
If a client is not aware of the risks in a universal life product or does not intend to deal with them, he probably would be better off with retail term life insurance.

Looking at the risks associated with universal life, one might conclude that this type of policy requires an inordinate amount of confidence in a company. The account from which interest is earned is a part of the general account of the insurance company and could be frozen by the state insurance commissioner, if the company has problems. This points out the importance of dealing with an investment grade insurance company that is rated well by the various services.

**Interest Rate Advantage**

Insurance companies may be able to pay slightly higher than current market interest rates on their universal life policyowner accounts. They guarantee those rates for a 12-month period and can be fairly sure that most of the money on which they are paying will remain with the company for more than one year. If experience bears this out, the company will be able to lend out reserves of these policies for periods somewhat longer than 12 months, and as a result, earn a higher rate of return for the policyholder. Universal life is a single-pocket policy, providing no investment flexibility. A multiple-pocket policy similar to a multiple-pocket 401(k) plan allows diversification for greater safety and higher return.

**Maximum Funding Level**

If a universal life policy has proved a good place to store cash, if it has provided a competitive after-tax rate of return, the insured might consider maximal funding of the policy. The policy can accept only a limited amount of money, if it is to retain the tax advantages of a life insurance policy. The insured's agent or broker can help to find out just how much is allowed. If the insured wishes to put more money in the policy than the code permits, he may increase his death benefit. This, however, involves expenses, additional mortality costs and proof of insurability. The increased death benefit will provide an increased maximum funding level.

**Expenses**

The universal life product is relatively new, when compared to the whole life product. However, insurance companies are learning to manage these policies, and technology is improving. There is a possibility that the expenses associated with its management could go down. This will benefit policyowners, companies and intermediaries. Now clients can watch expenses. They can complain if expenses are no longer competitive. Ultimately, they can consider moving to a better contract. This, however, should be done carefully and with the help of an advisor, especially if attempting to do a 1035 tax-free exchange.

**Mortality Costs**

Due to better education, better nutrition and better health care, mortality rates have consistently improved. Will they continue to improve, or will some new illness cause rates to go up to the maximum guaranteed by the contract? The AIDS threat, for example, has made insurance companies fear the latter. The risk of reduced returns as a result of increasing mortality costs is not unique to universal life. Higher death rates affect all insurance. Term rates can go up, and whole life dividends can be diminished.

**Managing The Death Benefit**

With universal life insurance, the insured has the ability to manage the premium associated with his policy. He also has the ability to manage the amount at risk. The insured must determine whether he wants Death Benefit Option I or Option II. Option I is the conventional whole life design, whereby the death benefit stays at the face amount selected at the purchase of the policy, say $100,000, in spite of the fact that the account within the policy grows. Therefore, if the insured died and the insurance paid off the $100,000, it would be partially with the insured's
own account value money and partially with insurance company money, i.e., life insurance. In effect, every time money is put into the policy or the account value grows as a result of interest earnings, the amount of life insurance is decreased. Alternatively, the insured could request Option II, making the amount at risk a constant. That is, the insurance company promises to pay the beneficiary $100,000 of insurance company money in addition to the amount of money in the policyowner account. In most cases, when applying for one of these policies, the insured should keep the life insurance company at risk for the maximum amount, choosing Option II.

In the future, when the insured is more concerned about expenses in the policy than in the death benefit, it would be logical to switch from Option II to Option I. This would result in the total death benefit being leveled to the benefit in force at the time of change. Thereafter, further increases in the account value would diminish the insurance company's amount at risk, thereby reducing mortality charges within the policy.

The insured may come to a point where he wants to decrease the mortality charges even more. In that case, he may request that the insurance company reduce the death benefit on his policy. This should be done with caution in the early years because the insured may have to pay a partial surrender charge. Also, it might cause a payout of money from within the policy, which is likely to create an income tax liability.

The insurance company will limit any death benefit reductions that would disqualify the policy as a life insurance policy under IRC 7702. With the minimum face amount, the minimum amount of investment return from the account value is used to service mortality charges, but the policy still remains a life insurance policy. Earnings remain sheltered from income taxes, and the policy serves primarily as an investment vehicle.

Very often the reverse scenario is found when working with young policyowners. When a young couple gets married and both parties are working, they are relatively independent of each other economically. They may purchase a universal life insurance policy with a minimum face amount and adjust their premium payments to reach the desired funding level. At some future date, children may come along, and one spouse could become more economically dependent upon the other. In this case, the couple may ask that the policy death benefit be increased. In many cases, this is far less expensive than applying for and starting a new insurance policy to increase coverage. In fact, if the this couple had maximized premium payments while both were working, they might now decrease their cash flow into the contract while increasing the amount at risk.

The key to the proper analysis of a universal life product is having a monthly breakdown of state premium taxes, expenses, amounts at risk, mortality charges, account interest earnings, and potential surrender charges. The insurance company providing the policy earns a profit in a number of ways. It can profit on the expense charges by charging more than it costs to administer the policy.

There also has to be some profit margin built into the mortality charges, so the charge may be for more than the mortality being experienced at the current time. In addition, the company is paying less interest than it is earning on the policy account and is charging investment management fees against the account. A policyowner should expect these charges. He will want his policy with a profitable company, as long as the profits and charges are reasonable.

**Variable Life Insurance**
Variable life insurance was first brought to the marketplace in the United States by the Equitable Life Assurance Society in 1976. It took four years of development, negotiations with the Securities and Exchange Commission (SEC), and the approval of the various state insurance
commissioners in order to bring this revolutionary product to market. It was not until four years later that another company, John Hancock, did the same, followed shortly thereafter by Monarch Life.

Variable life insurance has been slow to develop for a number of reasons. First, a variable life insurance policy must be registered under the Securities Act of 1933 as a security. Secondly, the agent selling this policy must be registered under the Securities and Exchange Act of 1934 and must pass the National Association of Security Dealers (NASD) tests in order to obtain a license to sell it. Finally, life insurance agents generally have been uncomfortable with securities. They are used to guarantees. For example, they often perceive that whole life offers guarantees and have not taken quickly to variable life insurance.

It was in December of 1976 that the SEC came out with Rule 6E-2, providing the limited exception from sections of the Investment Company Act of 1940 that gave this product life. This rule requires that insurance companies provide an accounting to policyholders, imposes limitations on sales charges (there are no such SEC limitation in whole life or universal life), and requires that the insurer offer refunds or exchanges to variable life purchasers under certain circumstances. Further, policyowners also must be offered the option of returning to a whole life type policy.

Rule 6E-2 defines variable life insurance as a policy in which the insurance element is predominant, the cash values are funded by separate accounts of a life insurance company, and death benefits and cash values vary to reflect investment experience. The policy also has to provide a minimum death benefit guarantee and have mortality and expense risks born by the insurance company.

The basic policy structure is similar to whole life insurance in that a stated face amount at a stated age requires a specific, level, fixed premium payment. Once the policy is issued, the cash value of the contract increases or decreases daily, depending on the investment results of the underlying investment fund. There is no guaranteed minimum below which that fund can fall. Fixed premium variable life contracts guarantee that the face amount will not go below the originally issued face amount, regardless of investment experience, and that only the guaranteed level premium will be required to keep the policy in force.

If investment experience is positive, on the anniversary date of the policy, the face amount of the contract is adjusted upward, reflecting that investment experience. If investment experience is negative, the death benefit will be adjusted downward, but never below the face amount originally contracted for. The original variable life policies had only a money market account and a common stock account available for investment.

The insured may affect the investment results of a variable life insurance policy by borrowing from it. By taking a policy loan, he uses the equity as collateral from the underlying investment accounts. When this happens the insurance company moves an amount equal to what is borrowed to a loan guarantee account not subject to market risk. He earns 1 or 2 percent less interest than the insured is paying for the loan. The new equity stays in that account, securing the loan, until such time as the loan is paid off.

The principal difference between whole life and variable life is the investment factor. The variable insurance policy is preferred if the insured wants his assets invested in an assortment of mutual funds, rather than in the long-term bond and mortgage portfolios typical of a whole life policy. Variable life provides downside protection basically by guaranteeing that the face amount of the policy will never be less than the originally issued face amount, regardless of what the investment results are, as long as the scheduled premiums are paid. This guarantee is not
available in universal life insurance policies or in universal variable life insurance policies. Guaranteed death benefits require guaranteed premiums. Variable life policies provide the potential for future growth of the death benefit, if the investment experience proves to be favorable.

A LIMRA study entitled, "The Performance of Variable Life" reported that only three companies sold equity-based variable life insurance prior to 1981. Variable life insurance sales also represented only one percent of the life insurance market. By the end of 1981, there were 10 companies selling the product. Market share had increased to 2.5 percent of the ordinary life premium. Today, variable life sales can and do represent up to 10% of the market, ebbing higher during good equity markets and lower during tougher times.

The Equitable Life Assurance Society now has dozens of years of experience with this product. According to its prospectus, it has a historical net rate of return in its common stock account for that period of 14.3 percent per year. This rate exceeds the Standard and Poor's 500 average for the same time. Those figures substantially outperformed the typical rate of return in conventional whole life insurance contracts. The important news is that consumers are taking notice of these alternatives.

The key advantage of variable life insurance is that the buyer has the ability to direct his account value to the investment of his choice from among those offered. Further, a variety of new accounts are being added. Today there is not only the money market and common stock accounts that were in the early policies, but also aggressive stock accounts, balanced funds, global funds, bond funds, high yield bond funds, guaranteed interest accounts, zero coupon accounts, and even some real estate accounts.

Even though higher expenses have been associated with first generation variable life insurance policies, they have offered the highest net return available from a life insurance product from 1976 to the present, when invested in the common stock account.

These policies must be sold with a prospectus that divulges more information regarding the workings of a life insurance policy than ever before. The data has to be extracted from the prospectus to be useful. The prospectus is a great source of quality information.

When these policies work efficiently, the investment in the contract provides the insured with life insurance protection, a family of mutual funds for investments, professional management, and the ability to redirect investments. All this can be accomplished without incurring income tax liability, as assets are moved within the contract. The shelter of the contract protects interest, dividends, and capital gains from current income taxation. In addition, the sale of one fund and purchase of another within the contract is not a taxable event.

A disadvantage of the fixed premium variable life insurance product is that once it is purchased, the amount paid into it cannot be increased or decreased. It is designed to be a level premium contract, and terms cannot be dictated. However, this might also be considered an advantage, since the insured is required to keep up his investments in the contract. For some insureds, this may be just the incentive they need to continue investing. Unfortunately, many people interpret the flexibility of the investment feature in the universal life insurance product as an excuse to not invest. Instead, they often choose to spend, which is often detrimental to economic well-being.

The amount of life insurance is fixed at its minimum level upon the date of purchase. The face amount varies thereafter only as a result of positive and negative investment account results above the initial face amount. This policy does offer a unique advantage in that even if investment results are disastrously poor, the insured will never be called upon to pay a larger premium than contracted for originally, nor can the face amount of the policy decrease below
that at which it was originally purchased. This is unique to fixed premium variable life insurance; it is not available with any other type of policy.

While early variable life insurance policies have had positive investment results, the product has been slow to catch on with the public, the insurance sales force, and the financial planning and investment communities. Many times life insurance agents drag their feet because of their relatively conservative backgrounds and training, as well as the additional licensing and educational requirements for selling this product. Investment advisors have been reluctant to recommend it, in spite of its long history of credible results, because many planners have their minds set against mixing insurance and investments. The financial planning community will have to become more aware as more clients ask about it.

Variable life insurance does require a level premium which is substantially higher than that required by a yearly renewable and convertible term insurance policy, so the decision to invest that additional capital is an important one. Any insured should inquire about expenses, management fees, and other factors when deciding to make an investment within a mutual fund and should also make similar inquiries when investing in variable life.

Fixed premium variable life lacks the flexibility of premium and face amount. Universal variable life, introduced in 1985, brings both flexibility of premium and death benefits to the variable life policy.

Universal variable life insurance is discussed in more detail below. It bears reminding when moving from a fixed premium variable life contract to a universal variable life contract, there is exposure to an additional downside risk. With a universal variable product, if expenses and mortality costs increase to the maximum contractually allowable level and investment results are negative, the contract could require a premium higher than the guaranteed level premium in a variable life policy in order to keep it in force.

**Universal Variable Life**

Universal variable life insurance has been called "the financial product of the century," since, for the vast majority of people, it is a convenient and economical way to invest. It is a product that is capable of helping nearly everyone. It is a very efficient life insurance and investment product for the consumer. It is efficient in that costs are competitive, and investments are tax sheltered, diversified and productive.

In order to determine the efficiency of a universal variable life product for a particular investor, certain questions must be asked:

- Are the term life insurance costs (mortality costs) of the product competitive and acceptable?
- Are the expenses associated with the contract acceptable, and are they expected to be offset by the income tax savings on the investment capital and the income tax and transaction cost savings resulting from moving money among the various mutual funds within the contract?
- Is this a profitable product to the company issuing it?
- Is the mutual fund family within the contract broad enough and performing well enough that it is likely to provide good investment opportunities for the rest of the investor's life?
- Is the investor expected to fund the policy to the maximum as soon as possible and as often as practical? The cost benefit ratio of these products works best when the policy is funded to the maximum.
The universal variable life product was created from a combination of universal life, which provides the flexibility of face amount and premium payments, and variable life, which provides flexibility of investment. This combined flexibility makes the product unique.

Whole life insurance, on the other hand, dictates the investment vehicle, premium amount and face amount. It leaves little room for change. In 1976, when variable life was introduced, it allowed the policyowner to dictate the investment vehicle, but it continued to feature a level face amount and a level premium payment throughout the policy lifetime.

In 1979, the universal life product gave the public the investment vehicle it seemed to want at that time -- money market types of accounts. The universal life product allowed the policyowner to decide on the amount of the premium, within certain parameters, and the size of the policy face amount. It permitted change of these decisions to suit personal objectives over time.

Since 1981, the consumer has seen the rate of return diminish on interest-sensitive accounts, and he is becoming increasingly disenchanted with interest only contracts. Universal life had 8 percent of the market in 1985, 35 percent of the market in 1986, and was dropping below 22 percent in 1993. The market share lost is being gained by the universal variable product, the product with three-way flexibility that first came to the market in late 1985.

The universal variable product generates new enthusiasm because it is not only a second generation variable life policy, but also a second generation universal life policy. An insured can go to a universal variable policy and have its performance emulate that of the old universal life policy. This is done by using the guaranteed interest account available within the contract as the only investment. In fact, the expenses and back end loads are lower in universal variable product than in the universal life product.

Therefore, a universal variable policy may make a more cost effective universal life policy (just using the guaranteed interest account) than a regular universal life policy. The universal variable policy is a security, and its expense loading is limited by the Securities Act of 1940.

With the universal variable product, the three strings of insurance company control -- investment vehicle, face amount and premium payment -- have all been cut. In a universal variable policy, the policyowner now controls his face amount, premium allocation, and investment. He may direct the insurance company to bill him a certain amount at specific times in order to increase or decrease his face amount. He may change the allocation of incoming deposits in the various investment accounts and move existing investments from one policy account to another. Further, he may make withdrawals or borrow, using his policy as collateral. In some policies, the insured may even be able to dictate the account charged for the expenses and mortality costs.

Pruco Life, a subsidiary of Prudential Life, was the first to market a universal variable life product in 1985, closely followed by Equitable Life in 1986. By 1993, the product was well accepted. There were many more of these products available to the consumer, and more respected companies were offering it.

There are now information services which provide up to date information on both the companies providing these products and the performance of the underlying investment accounts.

A universal variable product will give the insured the right to move his existing investments among the mutual funds within his policy. However, it may limit the number of moves he may make or charge per year for the moves. The objective is to have the freedom to move as often as possible at the least amount of cost. Most companies make no charges for four moves per year and reserve the right to charge up to $25 per move thereafter.
Evaluation Of The Universal Variable Life Product

The financial evaluation of a universal variable life policy is very similar to the process followed for universal life. It requires a monthly illustration over a number of years, based on an agreed upon premium and a specified assumed rate of return. It requires a year-by-year illustration to age 95, based on the assumed premium input requested.

The latter shows when back end loads are no longer a factor. It also shows the possible failure of the policy if the illustrated premium results in a policy that is underfunded. The guaranteed illustration will show the downside risk if the insurance company increases its expense loading or mortality costs to the maximum allowable under the contract. The rate of return illustrated on the account values within the contract should always reflect the rate which is considered to be conservatively sustainable in the future.

As with universal life, the universal variable product makes an inefficient term insurance contract, since underfunded policies are not economical. The additional expenses incurred in setting up these contracts are higher than the initial set up costs for a term policy. There is the potential for ordinary income tax liability when the policy is terminated in some way other than by dying.

To the extent that the contract has been successful and the policy account values exceed any total premium contributions, the amount of gain is subject to ordinary income tax in the year of surrender. If the insured intends to hold the policy at least beyond the period in which a back end load is charged, this is preferable to a front end load in most circumstances. Front loads reduce the investment.

Expenses

The universal variable life product is most likely the most profitable life insurance one can buy today. However, the financial reporters bring up an important point for study. The variable universal life policy, like any insurance product, must be examined in order to know whether the expenses are competitive and acceptable.

Naturally, the three key elements of investment type life insurance -- expense, mortality cost and use as an investment vehicle -- will vary in their degrees of importance. The investment element is the part of the policy that impacts the insured's economic well-being the most. Consequently, it can make a relatively expensive policy, such as the first generation of the variable life product in 1976, outperform its less expensive competitors by a substantial margin. Those 1976 variable life products were invested in the stock mutual funds and were quite successful, when compared to all whole life and universal life policies issued at that time.

Of course, expenses are important, but many people become paralyzed by what they perceive as low load or no load products improperly applied to their situations. Unfortunately, at this point, many people lose the most, while thinking they are actually saving.

Guaranteed Interest Account

Any charges against a guaranteed interest account are taken prior to the company's quote of the guaranteed interest rate. The company quotes the net interest rate. This account is part of the general account and is not subject to the Securities Act of 1933 or the Investment Company Act of 1940. These expenses are not considered as the company determines the gross expected rate of return on the insured's money within the guaranteed interest division. With a universal variable life product, the insured should know whether the guaranteed interest account is guaranteed for both principal and interest, how the current interest is credited, and for how long a period the interest is guaranteed.
Expenses at the Mutual Fund Level
The expenses at the investment account level are charged against the investment accounts. They reduce the return of these accounts. The mutual fund investment return does not include these charges.

There is a common tendency for most people to look only at the net rate of return, whether it be from the guaranteed interest account or from the various separate accounts offered. If they find it competitive, they decide not to worry about what the insurance company deducts for itself. The problem here is that, over the long-term, high expenses at the investment account level will affect returns. In order to get the most from a universal variable life product, insureds should make sure that what they are paying is competitive with the other universal variable life products available.

Mortality And Expense Charges
The insurance company provides a number of guarantees within a policy and charges for them. These guarantees provided are:

- Continuing lifetime service
- Maximum monthly administrative charges
- Maximum monthly cost life insurance charges
- Guaranteed annuity factors within the contract

Investment Management and Fee Advisory
This is the fee charged for the overall management of the underlying mutual funds. It is what the insured pays for the professional management of his investment. It is taken daily from the underlying mutual funds' daily net assets. It may go down, as the size of the funds under management grows; for example, .50 percent on the first $350 million to .45 percent on amounts over $750 million. This fee also varies with the different mutual funds in the family of funds within the policy, based upon the differing management required for a money market fund, which is 40 percent, as opposed to a global or asset allocation account, which is 55 percent.

An important policy investment objective should be to earn sufficient return each year on the capital invested in order to pay for the expenses and term insurance costs for that particular year. If this is accomplished, the insured will have paid for his life insurance costs with the pre-tax earnings on his investments. This is the least expensive way to cover these costs. This means that a specific amount of capital within the policy is used to meet an important near-term objective, i.e., to pay the costs charged against the policy each month.

Ideally, there should be a sufficient amount of capital to generate the monthly earnings to cover these costs in a relatively conservative account that has a high likelihood of generating the required income. The accounts most certain to accomplish this objective may be those accounts that guarantee both principal and interest or those that can be depended upon to generate income. One strategy would be to put enough into that account to generate the income required to cover all mortality and expense charges. For example, if the policy expenses were $100 per month and the guaranteed interest account was earning 5 percent, there should be $24,000 ($1,200 + 5 percent) in that account.

Funding For Other Objectives
Additional capital placed in a universal variable contract can be used to accomplish other investment objectives. This offers the advantage of no current income taxes being assessed against investment earnings, in addition to changes of investment allocation within the family of funds offered under the insurance contract being made without creating income tax liabilities or transaction costs.
Additionally, there often are beneficial purchases. There are riders such as disability premium waiver, accidental death benefit, children’s term insurance, other insured and spouse term insurance, guaranteed insurability riders, cost of living increase options, automatic increase options, and survivor insurability provisions. The desirability of any of these is unique to each policyowner. The advantage of purchasing these riders within the policy is the ability to do so with pre-tax dollars.

**Exchange Privilege**
The exchange privilege allows the change of insureds. The policyowner may take a policy on his life. When he no longer needs it, he may insure the life of another individual who may need it at that time. In family situations and those involving key employee life insurance, this privilege can be very valuable because one policy can provide for a succession of insureds. Naturally, policy charges are adjusted based upon the new insured’s age, sex and insurability status; however, start up charges are eliminated. This is an important feature in the universal variable product. Since first generation universal variable policies often were more favorable to the consumer than the new products, when a policyowner no longer wants or needs his policy, he has the option of finding someone who does.

With this product, the policyowner has the ability to manage flexible premium variable life insurance and adapt it to his changing needs and economic situations. This is its main advantage. Conversely, its disadvantage is the same; one must actively manage it. The help and advice received from the agents or intermediaries often will increase profits. They must know what the insured is trying to accomplish. They work with these policies every day, and they have learned from policyowners and through their continuing education how to make them perform best.

**Policy Loans And Withdrawals**
The provisions relating to policy loans and withdrawals are important to examine. They tell what it takes to get money out of the policy without terminating it. These provisions determine the liquidity of the universal variable life investment. When discussing loans and withdrawals, the insurance company speaks in terms of cash surrender value. The cash surrender value is represented this way:

- Policy account value (gross value of money in the policy)
- Surrender charge
- Cash Surrender Value

Typically, the insured is able to borrow 90 percent of the cash surrender value. He can expect to be charged $25 to process a withdrawal.

The subject of policy loans can be confusing. People often believe they are taking money out of their policies, but in fact they are not. They are actually borrowing from the insurance company, using their policies as perfect collateral. If the loan is not paid off, the insurance company will take the money from the policy or from the death benefit. The company takes an amount equal to what has been borrowed and moves it into a loan guarantee fund. This fund then earns interest for the insured. So, the insured is paying interest to the company for money he borrowed, and the company is paying interest on the amount in the loan guarantee fund. The difference between the two is called the spread. Typically, you will find the insurance company credits 2 percent less than the interest the insured is paying for the loan. The spread at best could be zero, whereby the insured and the company would be paying each other the same interest.
Withdrawals can create ordinary income tax liabilities within the first 15 years of the policy's life. In some cases, there may be a minimum, such as $500, and fees may be assessed for making such withdrawals. These are typically $25 for each withdrawal.

**Economic Gravity**

The crux of all interest-sensitive products is economic uncertainty. One might assume that investments will tend to track past norms in the future. On the other hand, one might say that because history has changed, the investment results likewise will change. Generally, those in the industry say that various investment classes will perform in a similar manner as they have in the past, simply because there is no other criteria.

These are the effects of economic gravity. The obvious inference here is that we should not invest in only one asset, class or anything that inflexibly dictates and provides only one class for long-term investment. Interest-sensitive life insurance products are rate of return driven. Expenses and mortality charges are most significant in policies that cannot generate investment returns significant enough to pay those costs.

**Guarantees**

Because of the fact that life is uncertain, we look to guarantees. What we often fail to do is to examine the guarantor, or the strength behind the guarantee and what is being guaranteed. If one is going to put any stock at all in guarantees, he or she must shop for the company with the best guarantee, the highest guaranteed cash value, and the highest guaranteed interest rate. However, acting on that alone, investors may well find themselves buying from a company doomed to disappear. If general interest rates drop below the company's guaranteed rate and the company's general account becomes unable to earn what its guarantee promises to pay, the company's surplus will be diminished as it delivers its promise. It continues to pay more than it is earning.

Today's regulatory environment requires companies to own quality and lower yielding investments in their general accounts. It also dictates that state insurance commissioners take over companies whose surpluses fall below certain levels. In this environment, companies that could have survived economic aberrations in the past find it more difficult to do so in the future. A word of caution to any investor is that when minimum interest guarantees become all important, the guarantor may be heading for trouble. The security being sought within the guarantee is weak. Flexibility, asset allocations and maximum investing are more important than guarantees.

The absolute best way to buy an interest-sensitive product is buy those promising to pay a contractually fixed premium. Guaranteed cash value occurs only when the policyowner provides the fixed premium payments required by the contract. Simply, when he violates the pay in provisions, he loses his guarantee.

Guaranteed death benefits are purchased the same way. One must agree to invest some minimum amount. If this is not done, the guarantee is lost. Some will argue that there is no guaranteed cash value and often no guaranteed death benefit, and if invested unwisely, a policy could self-destruct. Certainly, we must acknowledge that a universal variable product could fail. However, this does not necessarily make this product more risky than a policy with guarantees. The risk of failure also exists within a policy with the guarantees (if the company mismanages it), or with a universal variable contract (if the policyowner mismanages it). The risk can be controlled with a universal variable life product. The policyowner cannot control the risks in a policy with guarantees.
**Mismanaging A Universal Variable Product**

There are two primary ways in which a universal variable product can be mismanaged. One is by investing too little in the policy and by not using common sense and diversification in investing the capital within that policy. Funding a universal variable policy with the same level of investment required of a comparable whole life policy and using reasonable care and diversification within the policy investments greatly contribute to the opportunity of the policy to become a successful investment vehicle.

The best approach to a universal variable life product is to invest as much in the policy as possible and as much as the law allows, while still retaining all of the income tax benefits unique to the life insurance policy investment. The concepts of whole life “paid-up at age ___,” short pay, vanishing premium, or whatever other label implies that the pay-in is no longer necessary seems to be nearing obsolescence. This became evident when the investment returns available within the contract were able to compete favorably with the taxable investment portfolio, and when the variable universal life product became available. In order to enjoy maximum investment results and maximum income tax benefits within the universal variable product, the investment must be maximized.

**Funding Levels**

Once the decision has been made to buy life insurance with pre-tax dollars earned on an investment account, the policyowner still must decide how much to invest and where to invest. Whether the policyowner has decided on a conventional whole life product and its long-term bonds and mortgages or the interest-sensitive variety and its short-term money market types of investments, he must decide on both the amount to invest and where to invest.

The insurance company tells the investor how much to pay based upon the face amount of the contract and the type of policy. There is little flexibility of premium payment after that. Similarly, with variable whole life, the policyowner agrees at contract inception to set a premium and face amount. He retains management control and flexibility over where the money is to be invested in the contract. On the other hand, if he has purchased a universal life contract, the level of funding is important not only on the day the specific face amount of life insurance was determined and the policy was put in force, but this is important throughout the life of the contract. The ability to vary payments offers important investment opportunities. To take advantage of these, it may help to think of the funding strategy as one of the following: tax-free funding, adequate funding, underfunding, minimum funding, investment funding, or maximum funding.

**Tax-free Funding**

The primary objective of any life insurance policy is to provide life insurance protection in the amount considered necessary. This may be done with income tax-free earnings on an investment account. The tax-free funding point is reached when the amount of capital invested inside the policy will earn enough nontaxable return in the year in question to pay all of the mortality and expense charges within the policy that year. This strategy assures that the life insurance will be paid with the pre-tax earnings on the after-tax capital invested. As long as the mortality and expense charges are fair and competitive, this objective is accomplished.

To determine the tax-free cost funding level, the amount of the expenses and mortality charges within the policy for the year must be known. This may be done with income tax-free earnings on an investment account. The tax-free funding point is reached when the amount of capital invested inside the policy will earn enough nontaxable return in the year in question to pay all of the mortality and expense charges within the policy that year. This strategy assures that the life insurance will be paid with the pre-tax earnings on the after-tax capital invested. As long as the mortality and expense charges are fair and competitive, this objective is accomplished.
$8,000 earning 5 percent interest will generate $400 of pre-tax interest, which is sufficient to cover $400 in expenses and mortality charges.

Suppose a 45-year-old person is buying a $250,000 straight term insurance policy with an annual premium of $430 in the first year. To generate the $430 after taxes, he would have to earn $614 ($430 divided by (1 minus a marginal tax bracket) $430/.70). Alternatively, he could have elected to pay $571 inside a universal variable policy. He would have the option of investing enough after-tax capital in the policy so that the untaxed earnings are sufficient to pay the $571. He would save $43 ($614 - $571) in the year in question if the tax-free return on $11,420 of capital ($571 divided by 5 percent) in the policy is competitive with alternative investment opportunities.

On the other hand, if the same $11,420 were invested elsewhere, it would have to earn 5.4 percent to guarantee the $614 of taxable earnings required to service a $430 straight term premium. If the policyowner can obtain either a 5 percent tax-free return or a near 5.4 percent taxable return outside the policy, the choice between buying straight term or paying for term insurance inside a universal or universal variable product becomes a toss up. The returns offered within variable universal policies typically are very competitive, provide for diversification, and offer generally lower risks. Also, future term rates are often lower than those available elsewhere. This is aside from the fact that they also provide an opportunity for greater investment.

The next decision to be made concerns where to invest the capital, given the choices offered within the policy. The first investment objective will be to service the policy's expense and mortality charges. The need is for monthly income to cover monthly costs, so the policyowner should look at the guaranteed interest account, a money market account, a bond account, or some other account that generates dependable monthly income.

**Adequate Funding**

Tax-free funding has been described as a strategy whereby investment proceeds in the policy generate enough investment return to pay all mortality and expense charges incurred in the policy in the year in question. Adequate funding is a strategy to be used if the investor does not have, or does not wish to invest, sufficient capital within a policy to reach the tax-free funding level immediately. It provides for a level of payments that allows for the arrival at tax-free funding at some future date.

At least yearly, the policy should be checked to see how it is progressing. The funding level may need adjusting to a more current situation or investment objectives.

**Underfunding**

If the mortality and expense charges exceed the combined total of the investment earnings in the policy and the current year's payment into the policy, the universal variable policy is underfunded and in trouble. For example, one might look at the annual report on the universal variable life policy and find that the expenses for the year were $500. Upon further examination, it is learned that the policy interest earnings amounted to only $100 and that the investor has paid only $100 into the policy during the year. The contribution and the interest earnings totaled $200, whereas expenses totaled $500. To cover the $500 due in expenses, a $300 bite is taken from the principal, the capital previously accumulated in the policy. At the end of the year, there will be $300 less capital in the policy than when the year began. If one ignores this process, there will be less capital in the coming year to earn interest. If the contributions are not increased, there will be, at the end of that year, another decrease in capital exceeding that of the previous year.
The situation gets worse as the mortality charges in the policy increase. The expense charges also may be increased to some contractual maximum, and the interest earnings in the policy could be decreased because of changes in the prevailing level of interest rates. If all four events occur simultaneously (capital down, interest rates down, expenses up, mortality costs up), the policy costs will consume the principal at a rapid pace. As the capital base in the policy approaches depletion, the insurance company will warn that the contract will terminate unless payments are made into that contract. Underfunded policies eat up principal at an ever-increasing rate.

When universal life products first appeared in 1979 and 1980, interest rates were high. Funding levels were chosen assuming that those inordinately high rates were going to stay there. Many of these policies are under-funded today. Many of them have actually been involuntarily terminated. Angry policyowners do not understand this, which has resulted in consumer complaints to state insurance commissioners.

In many cases, even insurance sales people who were selling these policies were not sure what they were selling. In competitive situations, an agent could sell the same amount of coverage at a lesser rate. This smaller premium represented a lower investment and lower investment returns. Lower investment returns meant lower tax-free interest, thus a less efficient policy. Underfunding is the poorest of strategies with a universal or universal variable life policy. It is wiser to buy a yearly renewable and convertible term policy with after-tax dollars. Minimum funding should be the lowest funding level considered.

**Minimum Funding**

The minimum funding level for these types of policies should be the level at which the policy interest earnings and contributions are no less than the amount of the mortality and expense charges in that particular year. This will assure that the capital accumulated within the contract stays at a constant level for the year and is not depleted by policy costs. What is put back into the policy can be adjusted to that of a straight term policy during times when there is no extra money to invest.

This feature can be a great benefit and comfort if suddenly the investor finds himself out of work. His life insurance continues uninterrupted at minimal outlay.

**Investment Funding**

If the investor has reached the tax-free funding level and policy earnings are sufficient to cover all policy expenses, why would he choose to invest even more capital? Let's assume that the investor has purchased a universal variable life policy and has started out with a strategy of adequate funding. This strategy, though interspersed in times of stress with years of minimum funding, has helped attain efficient funding, the point at which expenses and mortality charges are entirely covered by policy earnings. The investor has been utilizing the guaranteed principal, and guaranteed interest account to hold the monies that represent the tax-free funding level. Further, he still has the family of mutual funds available for use. These funds differ from commercially available funds because the earnings, capital gains, dividends, and interest earnings within them create no current income tax liability. There is the tax-free compounding in IRAs and qualified retirement plans. Now this is available within life insurance products, as well.

The funds in a universal variable life product are treated generously. The gains do not have to be shared with the government. The gains may be reinvested intact within the funds in the policy, and taxation will be either deferred until some future time, or eliminated entirely if the policy pays off as a death benefit. If one owns a universal variable life product, taxable mutual funds are a poor investment until the policy has reached its maximum funding level.
**Maximum Funding**
The maximum funding level is based upon the policy death benefit. The death benefit dictates the point at which no additional funds can be added to the policy, based upon the controlling income tax provisions in Internal Revenue Code Section 7702. According to the tax code, a policy funded above this level ceases to be a life insurance policy, resulting in immediate taxation of all deferred earnings. The insurance company should not, and in all likelihood will not, accept money that would cause a policy to go above maximum funding. To determine if a maximum funding strategy would be advantageous, an investor must determine exactly what additional expenses, if any, will be incurred when applying additional investment dollars. One consideration is that these dollars will be diminished by state premium taxes. These taxes are charged by the state of residence on every premium paid into a life insurance policy. There may also be a front end sales load, which averages about 4 percent.

**Asset Allocation**
When assessing the available investment options within a universal variable life product, this process is known as the asset allocation decision. That is, the policyowner must select the kinds of investment accounts to be used. He must determine the percentage of money to be allocated to each. A simple asset allocation model called the Portfolio Allocation Scoring System (PASS), developed by Professor William G. Droms of Georgetown University, serves as a tool to assist in this process.

The PASS system has been extensively tested and implemented by major insurance companies and used successfully to plan investment portfolios for thousands of clients. This system has also been used by a number of banks and CPA firms, has been published in the Journal of Accountancy, and is included in the American Institute of Certified Public Accountants' Personal Financial Planning Practice Management Handbook.

The system is easy to use and is based on unique risk/reward preferences. Successful implementation requires that the policyowner understand the asset allocation process, the risk constraints which should be imposed on the portfolio, and the return opportunities available from the various investment alternatives offered.

Asset allocation is a process of distributing portfolio investments among the various available categories of investment assets, such as money market instruments, bonds, and stocks. Selection of the asset mix is the single most important determinant of long-term investment performance. In a widely diversified portfolio, for example, the selection of specific stocks to hold within the equity portion of the portfolio normally has much less impact on total portfolio performance than does the determination of the percentage of the total portfolio that will be allocated to equity investments.

Asset allocation is the key strategic decision to be made in planning an investment portfolio. Once the strategic decision of how much of each asset category to hold is made, tactical decisions can be made to implement the overall investment strategy. Tactical decisions involve selections made from the mutual funds available within the policy.

Making strategic asset allocation decisions requires consideration of return objectives, as well as the constraints on these objectives. Constraints would include such factors as the degree and types of risk to which the insured will submit his portfolio, along with liquidity requirements, income needs, long-term growth expectations, tax situation, and investment time issues. For most people, return objectives and planning constraints tend to be extremely broad and highly qualitative in nature, making the asset allocation problem more difficult. Over the long-term, portfolio performance is not affected very much by how hot a stock picker the policyowner might be or how great a market timer he might be.
Risk
Money market instruments, such as Treasury bills, short-term bank certificates of deposit, bankers' acceptances, and bond repurchase agreements, are generally purchased by individuals in the form of money market mutual funds or through bank money market deposit accounts. Such investments offer a high degree of safety of principal, immediate liquidity and a rate of return commensurate with inflation.

Fixed income mutual funds such as corporate or government bond funds and mortgage backed funds generally offer a high degree of current yield, moderate liquidity (from virtually instantaneous marketability for bonds to lesser degrees of liquidity for mortgages), and if of high quality, excellent protection of principal. Additionally, high quality, long-term bonds offer an excellent hedge against deflation. In times of falling prices and interest rates, bonds are excellent investments because they increase in principal value as interest rates fall. In increasing interest rate environments, the opposite is true. Bond values typically decrease as interest rates go up.

Equity investments, such as common stock mutual funds, offer the best opportunity for long-term capital appreciation, however, they do have the potential for loss and fluctuation in principal values. Common stock/equity investments are the classic hedges against inflation because they generally increase in value over long periods of time as the economy expands. It is not too much of an exaggeration to note that in planning individual investment portfolios, many people know that what they want in an investment that will increase greatly in a short period of time with no risk. It is critical that the individual's attitude toward risk be assessed before designating any objectives for return.

It is important to understand that there is no such thing as a risk-free investment. One cannot avoid risk with investment capital. The choice of doing nothing or leaving the capital in the bank is extremely important in terms of the impact on wealth. Risk is commonly measured quantitatively in terms of standard deviation about the mean total annual return. This measure of total risk can be applied to virtually any investment. Standard deviation measures dispersion about the mean of the distribution of total annual returns, that is, the higher the standard deviation of return relative to the mean level of return, the greater the risk.

Individual investors are concerned with other aspects of risk that may not be captured by the standard deviation of total return. Liquidity risk, the inability to liquidate promptly without loss of principal and the risk of incurring a loss within a particular investment holding period are chief among these risk factors. The latter risk is especially important to investors in the stock market because, while historical experience shows that stocks provide higher returns in the long run than do fixed income instruments, they do so at the price of incurring losses during some years. Modern portfolio theory provides the formal theoretical framework for most quantitatively based asset allocation models used by institutional portfolios, such as pension funds and endowment funds. Portfolio theory assumes that investors base their portfolio decision on only two considerations: the expected return from an investment and its riskiness as measured by standard deviation of expected return. Investors are assumed to attempt investment in efficient portfolios, defined as those portfolios that provide the greatest return at a given risk level or, alternatively and equivalently, the least risk for a given return objective.

ANNUITIES
The term annuity literally means “A series of payments made at regular intervals such as monthly, quarterly or annually over a definite period of time. (e.g. number of years, life etc.) Keep in mind that a decision regarding any payout option does not have to be made until later on, not at all or could request an immediate payout through immediate annuitization.
While annuities are regulated by State Insurance Departments, an annuity is not life insurance. There is no question, however, that an annuity is a product of a life insurance company.

Annuities have been categorized as the “upside down” insurance product because they act differently than does life insurance. Life insurance distributes a death benefit at the death of the insured while annuities provide distributions when the annuitant is alive. Typically, annuity payouts stop when the annuitant dies.

**Annuity Types**
The investor buys an annuity by making a payment to the insurance company. The purchase can be made by a single premium, a series of pre-established fixed payments or even a flexible number of payments, which require no specific amount of deposit. How the annuity is categorized is determined by how the deposits are made. Here are some types of annuities you should know:

**Immediate Annuities**
This type of annuity provides for a single-sum payment, or premium to be made to the insurance company. In return, the insurance company agrees to make to the annuitant a periodic series of payments beginning in thirty (30) days. Because the immediate annuity starts right away it is impossible to put in additional payments on a deferred basis.

**Deferred Annuities**
The deferred annuity requires the contribution of single premium, fixed or flexible deposits. You should first determine your client’s financial goals and objectives before making a decision as to which purchase method is better.

**Deferred Annuity (Accumulation Period)**
The amount of contributions that are made during the accumulation period will depend on the choice of deferred annuity chosen by the annuitant. Once again, these choices include:

- Single premium
- Fixed payments
- Flexible payments

The dollar amount of the payments will vary depending on the annuitant’s financial goals and the insurance company rules.

**Single Premium Annuity**
The single premium annuity during the accumulation period requires the payment of one (1) payment only. (e.g. $100,000). These types of annuities will not allow any additional contributions at a later time. If your client wishes to add deposits, he/she must purchase a new annuity at the then current interest rates.

The insurance company credits the annuitant with the contribution. The account will earn the guaranteed rate of return chosen by the investor. Once the insurance company deducts any costs, they will then place the remainder in the insurance company’s General Account and invest in such conservative securities such as investment grade bonds, treasuries etc.

Some examples of fixed rates of returns include the following:

- One Year Guarantee - 5.8%
- Three Year Guarantee - 6.2%
- Five Year Guarantee - 7.0%
Of course, the number of years and rate of return will vary from insurance company to insurance company. It will also depend on how the insurance company has invested its dollars from the general account.

As a side note, most insurance companies are very concerned as to how they now invest their dollars because of all the bad press and current investor concerns. For the first time in history, many investors are not accepting insurance company rates of returns without first asking how and what the insurance company is investing in. This has been brought on most recently by defaulting companies and those that are close to defaulting.

After the initial guarantee rate of return ends the annuity will be subject to the insurance company’s renewal rates. It is very important that before purchasing an annuity for your client you check the company’s history of renewal rates. Some insurance companies will pay initial bonus rates to get new money in but their renewal rates may be below current market rates. I would advise you to call insurance companies and have them send you a copy of their renewal interest rate history.

Most companies base their renewal rates on their investment portfolio. If the company had purchased long term bonds, as an example, and current interest rates are lower, your annuity may still be renewed at higher than current rates, due to the fact that the investment portfolio is still able to generate bond coupon rates that were locked in at the time of their purchase.

As an example, if the insurance company had purchased long term investment bonds two years ago that were yielding 9.0% the company will be able to pay a higher rate of return for both new annuities and those annuities subject to annual renewal rates even if the current market rates were yielding 8%.

Knowing this, it would be prudent on your part to investigate current interest rates, renewal rates and details about the insurance company investment portfolio prior to making any final recommendations to your clients.

**Flexible Payment Annuity**

The flexible pay annuity allows investors to place additional deposits into their annuity accounts on a regular or irregular basis. (e.g. $100 per month) This would be in contrast to the single premium annuity, which was already discussed. The accumulation period rules still apply as well as interest rate guarantees. You would have to check with each insurance company to see how they apply their rates of return.

Some insurance companies will apply the then current rate of return to all deposits as they are contributed into the annuity. Others will allow the original rate of return to apply to all new deposits contributed during the first calendar year. There is no set pattern or absolute rule, so check with the insurance company and make sure your client completely understands.

Minimum deposits may be required by the insurance company. As an example, some companies require a minimum deposit of $100, after the initial contribution. There also may be some limitation as to the number of contributions allowed during a specific time period. An example would be six contributions with a minimum of $50 each during each new calendar year.

All other rules regarding the accumulation period would also apply to the flexible annuity contract.

**Annuity Contracts**

As with all life insurance a contract is formed between the insurance company, known as the insurer, and the annuitant (the contract holder)
Legal Parts of an Annuity

- Offer
- Acceptance
- Consideration
- Capacity of the parties
- Must be for a legal purpose

Offer
The insurance company, through its agents, will attempt to solicit invitations for offers from prospective clients. This is usually done through advertisements, telephone solicitations and personal contacts. Once a prospect becomes interested in a particular annuity he/she will fill out an application (annuitant is now making the offer), submit the required deposit, (depends on the type of initial premium selected such as a single premium, flexible or fixed) and await for the insurance company to accept the offer by the issuance of the annuity contract.

Keep in mind that it is the prospect that makes the offer, not the insurance company. The insurance company, as stated before, only invites offers through its agents, advertisements etc.

Acceptance
After the annuitant submits both the application and the initial deposit to the insurance company, then the insurance company alone will decide whether it will or will not accept the client’s offer. Once the insurance company accepts the offer it will issue the annuity contract. The insurance producer must then deliver the contract to the annuitant. As with traditional life insurance, the policy should be delivered in person. The annuity could be mailed to the client but this would not be the favored delivery method for a number of valid reasons. After all, the client could decide to purchase an annuity from another insurance company or could have a change of heart. With a twenty (20) day “free look” period, the chance of a cancellation increases.

Consideration
As with any contract, there must be consideration from all the parties. The annuitant fills out and submits the application along with the initial deposit. This action on the part of the annuitant represents his/her needed consideration. The insurance company promises to pay a stated rate of return while the investor actively participates in the purchased annuity. This promise represents consideration on the part of the insurance company.

The type of contract formed is known as a unilateral contract. It is comprised of an act (premium payment by the annuitant) and a promise by the insurance company to pay the annuitant in the future. (annuity payout option for the annuitant)

Capacity of Parties
It is important to note that all the parties to the contract must be capable under the law to make and form a legal contract. This means that if the party was a juvenile, considered mentally incompetent or otherwise unfit, the contract may become null and void.

Purpose of the Contract
The purpose of any contract must be for a legal purpose. If not, the contract will also be null and void.

Annuities and Financial Planning
Purchasing annuities can provide investors with the following financial planning benefits:

- Asset consolidation
- Simple “one vehicle” approach
- Tax deferred growth
- Diversification among fixed and variable contracts
- Selection of payout options
- Tax free income (exclusion ratio)

**Annuities and College Education Planning**
Consider a parent who has a college bound high school student who is in need of financial help for attending college. Generally, during the student’s junior year in high school, the parents will apply to a college or university to see if they qualify for any grants, work-study programs or loans. The parents must list their assets and liabilities and then apply the results to a government formula for final determination as to whether the parents will qualify to get help in funding the college education.

In many cases life insurance and/or annuities may not count as includable assets. So why not roll some of the investor’s current funds being set aside for college into an annuity. Then, within one year of purchase annuitize the contract over a five-year period¹ certain which may avoid penalties and company surrender charges while picking up an approximate 85% tax exclusion ratio. In other words, why not let Uncle Sam help pay for the education of an investor’s children and/or grandchildren!

**Comparing the Purchase of Bonds to Annuities**
A great question to ask is as follows: “Would you rather have your earnings at risk or your principal”? Take a look at the chart on the next page to answer this question.

<table>
<thead>
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<th>BOND</th>
<th>VS</th>
<th>ANNUITY</th>
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<tbody>
<tr>
<td>Coupon rate guaranteed</td>
<td></td>
<td>Earnings Fluctuate</td>
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<tr>
<td>Interest rate the same until</td>
<td></td>
<td>Interest rate changes</td>
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<tr>
<td>the bond matures</td>
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<td>at the end of the guarantee</td>
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<td>Locked into a rate that may</td>
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<td>Renewal rates will stay</td>
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<td>may be lower then the current</td>
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<td>interest rates</td>
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<tr>
<td>Principal guaranteed at</td>
<td></td>
<td>Principal always guaranteed</td>
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<td>maturity but not if sells the</td>
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<td>bond earlier</td>
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**Market Risk?**
Can I sell the bond without losing principal at any time, even when interest rates go up? NO!

**Inflation?**
With inflation increasing can investors stay ahead with the purchase of bonds? NO!

**Credit Risk?**
Will the corporation be able to pay the interest due and the principal at maturity? MAYBE!

**Are Taxes Reportable?**
Do current taxes have to be paid on the income received? YES!

¹ Check with your tax advisor before recommending the five-year program because of possible IRS penalty rules!
Probate?
Can probate be avoided? NO!

Wash Sale Rules?
Can a bond be sold, bought back in less than 30 days and still take a tax deduction on the loss? NO!

Are Bonds Callable?
If interest rates decrease can the corporation call my higher interest rate bond without my approval? YOU BETCHA!

Annuities vs. Trusts

A Case Study:
Let's suppose that a five-year child by the name of Peggy Sue has grandparents that were thinking of establishing an irrevocable trust providing that when Peggy Sue becomes an adult, the trust would provide her with lifetime income.

Unfortunately the expenses seemed high and their investment flexibility was limited once the trust was established. They realized that the trust would have to pay taxes on the growth until the proceeds would be paid to Peggy Sue.

Solution: An annuity was purchased under the UGMA Act. Peggy Sue’s grandmother was custodian and elected a payout date to begin before she reaches age 18. The grandparents elected a life income with a twenty (20) year period certain payout option which would provide income to Peggy Sue that she could never outlive.

During the upcoming years as custodian, they would have complete flexibility as to the selection of investments and payout options. Since the payout election would begin before Peggy Sue reached majority, her income option could never be changed.

While the investment is accumulating earnings there are no current taxes paid, unlike the trust income which would have typically, been taxed.

Investors Who Buy Annuities

Usually age 45 or older
Annuities provide a way for investors to save dollars, just like a savings account and a money market. As investors get older, this type of savings vehicle will become more popular as retirement nears. The compounding, tax deferral and safety features are very attractive to this age group.

CD Investors Who Don’t Like To Pay Taxes
The number one complaint about certificate of deposits is typically the fact that taxes are due on a yearly basis. The annuity not only provides tax-deferred savings but also allows the savings to compound at a greater rate because taxes are not paid at year-end and of equal importance, no 1099 form is received.

Investors Looking For Safety
Annuities are guaranteed by an insurance company that writes the contract. Investors will look for the higher rated annuities with ratings such as A++, A+ or A. Standard & Poor also rates annuities with the highest rating that is AAA. Some states, like Illinois, have an Insurance Guarantee Fund as well as requiring insurance companies to hold extra dollars in reserves to protect the investor.
Immediate Annuity Purchasers
Usually immediate annuity purchasers are in the 65-90 years of age range. These investors usually require some sort of income arrangement, such as income for life.

Pension, Thrift and Profit Sharing Plans
Annuities purchased in these types of plans are called Guaranteed Investment Contracts also known as GIC’s. These special types of annuities were developed for pension plans and are somewhat more flexible than regular annuities. If purchased correctly, they will also supply extra liquidity, which is needed for those employees who leave the company who start to collect their pensions.

Tax Sheltered Annuities (TSA)
The TSA represents a provision of Section 403(b) of the Internal Revenue Code that allows employees of non-profit institutions to exclude a portion of their salary from current taxation. This represents a specialized market and various insurance companies specialize in products that provide special tax advantages for these types of employees and employee plans.

Individual Retirement Accounts (IRA)
As in any IRA account, the maximum yearly contribution is $2,000. Monies can be transferred directly from other custodians to purchase annuities within the IRA. Also, distributions may be made from other qualified plans and then placed into an IRA account where annuities may be purchased.

Some investors will say that putting an annuity into an IRA account or any other qualified plan doesn’t make sense because the product already provides a tax-deferred benefit. Keep in mind, however, while this is true, the annuity provides a degree of safety and a guaranteed rate of return for an agreed number of years. Typically, an annuity will provide a rate of return that will be at least 1/2 point higher than a certificate of deposit. There are certainly advantages for placing an annuity in a qualified account.

Lottery Sponsored Annuities
Nearly all state lotteries pay out lottery winnings over an extended time period of approximately 20 years. In order to do this, the lottery commission sets up an annuity for the specific period and the amount of each payment to the winner is calculated to exhaust the lottery winnings over that period of time. Lottery pay-offs are an example of a temporary fixed period liquidation method, with the total amount dependent upon the amount of the winning ticket.

Customer Acceptance
Annuity customers have learned to appreciate the various annuity benefits that are now available. These benefits include;

- Competitive rates
- Guarantees of principal and interest rate
- Tax deferred compounding
- No front-end costs
- Retirement planning flexibility

Contract Flexibility
The following items help contribute towards the flexibility of annuities;

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1. As of January 1997 a non-working spouse can open an IRA for $2,000 which allows for a total of $4,000 for both spouses. (Old law only allowed $250 for non-working spouses)
• Short and long guarantee periods available
• Bailout/window rates (surrender contract without any company surrender charges)
• Indexed rates (e.g. 1 year Treasuries)

**1035 Exchange**
If an individual has an annuity and doesn’t want to renew it at the new interest rate, a 1035 exchange may make sense. Forgetting about any remaining surrender charges, the 1035 exchange allows the individual to cash in the current annuity and have the proceeds transferred directly to a new annuity contract without experiencing any IRS penalties.

This strategy is especially helpful when an investor has held the annuity for a period of time and the current renewal rates offered by the insurance company doesn’t make any financial sense or the surrender period is now expired and the new renewal rates are not competitive.

The 1035 procedure requires annuitants to sign a special form required by the state for the specific purpose of advising them that the move may not be financially advantageous due to potential losses and penalties. This signed form is then sent to the new insurance company which is required to forward it on to the current insurance company in order for the transfer to take place.

**Fixed Annuities**
One of the major benefits of a fixed annuity is that the insurance company guarantees the principal deposited by the investor. Keep in mind that this guarantee is not insurance related and also cannot be compared to Federal insurance at a bank. However, the insurance company, through it’s assets and reserves, promises to repay the client all deposits placed into the account plus accrued interest. All of this may be subject to Federal Excise Tax penalties and surrender charges, if surrendered early.

**Insurance Company Ratings**
This would be a good place to discuss insurance company financial ratings as they have a direct bearing on the capability of an insurance company to guarantee their annuities.

A.M. Best Ratings: The rating refers to the insurance company’s claims paying abilities. The A.M. Best Company rates insurance companies as to their ability to discharge their responsibilities to annuity.

Obviously, as the ratings get lower, the ability of the insurance company, in the opinion of A.M. Best, will decrease. It is most important that your client understands the importance of the ratings. In fact, in today’s world, the client will probably ask you what the rating of the insurance company is.

Standard & Poor and Moodys also rate insurance companies giving A.M. Best some competition. The highest rating is similar to that given out when bonds are rated (AAA - Aaa). Even some of the insurance companies that have been rated A++ by A.M. Best have not been given the Standard & Poor and Moody’s rating of AAA - Aaa. You should also be aware that there are a number of other rating services also available but they are not followed as closely as A.M. Best, Standard & Poor and Moodys.

**Guaranteed Rate of Return**
Insurance companies will offer various rates of returns, which will be based on the number of guaranteed years asked for by the investor. Rates, such as the following can be locked in for a designated period of time;
• 6.5% - One Year Rate Guarantee
• 6.8% - Three Year Rate Guarantee
• 7.2% - Five Year Rate Guarantee

The number of years chosen for interest rate guarantees has nothing to do with surrender or withdrawal charges, which will be discussed later. At the end of the initial rate guarantee period, the insurance company will then apply their current renewal rate to the remainder of the next time period (usually for one more year).

**CD Annuities**

Over the last couple of years the CD annuity has become quite popular for those investors who have traditionally invested in Certificates of Deposit at their local banks and who want a guarantee of their invested dollars and a higher rate of return that CDs are paying.

Unlike traditional annuities with surrender charges ranging from five to ten years, the CD annuity allows the investor to surrender the annuity after the initial one year time period without any surrender charges being applied.

Investors will usually be able to lock in a higher interest rate then CDs but a lower rate that a longer term annuity would provide.

**Tax Deferred Growth**

The accumulated interest in an annuity will grow on a tax deferred basis. This of course means that investors will have more accumulated dollars compounding faster because taxes are not being paid as they would in a non-tax deferred investment such as a Certificate of Deposit (CD).

<table>
<thead>
<tr>
<th>Year</th>
<th>Taxable</th>
<th>Tax-Deferred</th>
<th>Taxable</th>
<th>Tax-Deferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$105,400</td>
<td>$107,500</td>
<td>$106,120</td>
<td>$108,500</td>
</tr>
<tr>
<td>5</td>
<td>$130,080</td>
<td>$143,560</td>
<td>$134,580</td>
<td>$150,370</td>
</tr>
<tr>
<td>10</td>
<td>$169,200</td>
<td>$206,100</td>
<td>$181,120</td>
<td>$226,100</td>
</tr>
<tr>
<td>20</td>
<td>$286,290</td>
<td>$424,785</td>
<td>$328,050</td>
<td>$511,200</td>
</tr>
</tbody>
</table>

**TAXABLE vs. TAX DEFERRED SAVINGS**

$100,000 Deposit

**Break Even Tax Brackets**

Following is a hypothetical illustration showing the degree to which an individual’s tax bracket would have to increase during the year of surrender in order for their earnings to break-even with the earnings of a currently taxable plan. The following illustration assumes a $100,000 initial deposit, an 8.5% annual interest rate and a contract that would not be surrendered prior to the age of 59 1/2 years of age.

---

3 Taxable rate based on a 28% tax bracket.
4 Surrenders of annuity contracts prior to age 59 1/2 will usually be subject to a federal excise tax penalty of 10% and will become taxable income unless there is a 1035 exchange.
<table>
<thead>
<tr>
<th>Year</th>
<th>Tax Deferred Growth</th>
<th>Taxable Growth</th>
<th>B/E Bracket</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$108,500</td>
<td>$106,120</td>
<td>28.00%</td>
</tr>
<tr>
<td>5</td>
<td>$150,370</td>
<td>$134,590</td>
<td>31.34%</td>
</tr>
<tr>
<td>10</td>
<td>$226,100</td>
<td>$181,120</td>
<td>35.67%</td>
</tr>
<tr>
<td>20</td>
<td>$511,200</td>
<td>$328,050</td>
<td>44.54%</td>
</tr>
</tbody>
</table>

**Front End Load Fees**
There are some insurance companies which will charge the customer up-front sales charges which would be taken out of the investor’s initial deposit. Most insurance companies selling fixed annuities do not have front end sales charges.

**Contingent Withdrawal or Surrender Charges**
As most life insurance companies do not charge a front end sales load, they have to make sure that they have sufficient earnings to pay the expenses and commissions to the sales force. So most, if not all, insurance companies will have a surrender charge policy.

The typical surrender charge schedule is for a total of seven years and could look like this; 7, 6, 5, 4, 3, 2, 1, 0%. The surrender charges can apply to just the accrued interest or to the entire annuity value.

**Sample Surrender Charges**

- Five year plan - 5, 4, 3, 2, 1, 0%
- Nine Year Plan - 9, 9, 9, 8, 8, 7, 7, 7, 0%

Whenever annuity business is solicited make sure you are familiar with the surrender charge rules so clients don’t get upset down the road with any “surprises”.

Also, your clients may be subject to Federal Excise Taxes if they make partial or total withdrawals and are under the age of 59 1/2 years of age. There are certain exceptions that can apply such as contract annuitization and disability, which will be discussed later.

**Annual Contract Fees**
Some insurance companies will charge an annual contract fee when purchasing annuities. This fee can be as little as $25.00 or higher depending on the company. Some insurance companies may even charge a percentage of the value of the annuity.

For your client’s benefit it is necessary that you learn about any of these charges prior to your discussion with your client. It can be most embarrassing if your client asks you if there are any charges to purchase an annuity and you respond in the negative when in fact there is an annual contract fee.

**Annual Administrative Charges**
Similar in nature to annual contract fees the insurance company may impose annual administrative charges against the value of the annuity. After all, there certainly is a cost of doing business such as clerical, mailing statements, administration and other expenses. *It is your responsibility to research these charges and make sure your client is well informed.*

**State Premium Taxes**
A state premium tax may be imposed by certain states which is based on the premiums of all policies sold. Simply stated, some states raise revenue by taxing annuities. The state premium taxes are a sales tax on annuities. Some examples of annuity premium tax states are as follows:
• California – 2.35%
• District of Columbia – 2.25%
• Kentucky – 2.00%
• Maine – 2.00%
• Nevada – 3.50%
• South Dakota – 1.25%
• Texas - .04%
• West Virginia – 1.00%
• Wyoming – 1.00%

Potential Risks of Purchasing a Fixed Annuity
Even though a fixed annuity offers a guarantee of principal and a guaranteed rate of return, there are still risks for those who purchase this type of product. Remember, there is no such thing as the perfect investment or one without any type of investment risk.

Possible Risk to Principal
While insurance companies do guarantee the investor’s principal when purchasing an annuity the guarantee is only as good as the insurance company. There are some states that require additional reserves for all annuities sold to help reduce the risk by the insurance company.

Interest Rate
Interest rate risk occurs when an interest rate is locked in for a period of time and the general interest rates rise higher over that same period of time. As an example, let’s suppose that a fixed annuity is issued with a guaranteed five year rate of 7.0%. The purchaser will be locked in to this rate for the duration of the annuity or face possible surrender charges and penalties for early withdrawal. Because of the locked in rate the investor cannot take advantage if interest rates start to rise.

Liquidity Problems
After an annuity is purchased the purchaser is “locked” into the annuity for the duration assuming that surrender charges and IRS penalties are not a reasonable alternative. Lack of liquidity means that the investor cannot get out of the annuity without experiencing some financial loss.

Purchasing Power Risk (Inflation Risk)
This type of risk almost goes hand in hand with interest rate risk. In essence, the value of your annuity increases each year by a fixed amount while the cost of living may go beyond that and increase even more then the rate of return. A variable annuity may help to eliminate this risk and will be discussed in the next chapter. The chart on the next page clearly displays the effect of inflation on fixed dollars.

The story here is rather clear. If good and services were purchased at the beginning of 1988 for $100,000, those same goods and services, if purchased at the end of December 1997 would cost $140,342. This represents an average annual inflation rate of 3.45% over the 10 year period.

Knowing that the “spending dollar value” of the annuity is really decreasing, in terms of inflation, a viable alternative would be the deferred variable annuity, which, because of its many investment choices, can possibly offer a solution to this problem.
Consumer Price Index

**Single Lump Sum Investment**
Initial Investment - $100,000 - January 1, 1988

<table>
<thead>
<tr>
<th>Year Ending Date</th>
<th>Inflation %</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/31/88</td>
<td>4.39%</td>
<td>$104,390</td>
</tr>
<tr>
<td>12/31/89</td>
<td>4.65%</td>
<td>$109,242</td>
</tr>
<tr>
<td>12/31/90</td>
<td>6.11%</td>
<td>$115,912</td>
</tr>
<tr>
<td>12/31/91</td>
<td>3.06%</td>
<td>$119,463</td>
</tr>
<tr>
<td>12/31/92</td>
<td>2.87%</td>
<td>$122,893</td>
</tr>
<tr>
<td>12/31/93</td>
<td>2.78%</td>
<td>$126,307</td>
</tr>
<tr>
<td>12/31/94</td>
<td>2.68%</td>
<td>$129,687</td>
</tr>
<tr>
<td>12/31/95</td>
<td>2.47%</td>
<td>$132,888</td>
</tr>
<tr>
<td>12/31/96</td>
<td>3.39%</td>
<td>$137,397</td>
</tr>
<tr>
<td>12/31/97</td>
<td>2.14%</td>
<td>$140,342</td>
</tr>
<tr>
<td>12/31/98</td>
<td>1.6%</td>
<td></td>
</tr>
<tr>
<td>12/31/99</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>12/31/00</td>
<td>3.4%</td>
<td></td>
</tr>
<tr>
<td>12/31/01</td>
<td>2.8%</td>
<td></td>
</tr>
</tbody>
</table>

The Consumer Price Index chart makes a strong argument as to the reasons why the purchase of fixed annuities should be made for those persons who understand the risks discussed. A possible solution to this inflation problem is to purchase a variable product, which will be discussed later.

**Disposition of Proceeds**
At some point in time your client may want to stop contributing to a flexible deferred annuity or want to receive the proceeds from an already established single premium deferred annuity.

This process is called annuitizing the annuity contract. In reality, the entire principal amount is turned over to the insurance company for their control in return for receiving agreed upon benefits. Once your client makes this decision, it is irrevocable, your client loses total control of the principal and now the insurance company owns the funds.

The following payout options will be available to your client. It is important that you review all of these, understand the pros and cons and discuss these in great detail with your clients in order to meet your client’s immediate and long range financial objectives.

**Life Annuity**
This annuity is also called the straight life annuity and will usually pay the client the largest income amount per month. As this is a basic selection, it doesn’t contain any of the “bells and whistles” associated with other payout option choices. It offers the annuitant income that cannot be outlived by providing a monthly check for life.

As for the downside, this option doesn’t provide for any minimum number of guaranteed payments and has no refund provisions once it is chosen. Because of this, many people have felt they would be cheated if they were to die after payments have begun.

As an example, assume your client has chosen the life annuity after accumulating $100,000 in a flexible payment annuity. The insurance company and your client agree that he/she will receive monthly payments of $750. After the fourth payment your client dies. The remainder of the
$100,000 remains the property of the insurance company and none of it will pass on to your client’s estate or to any beneficiaries.

The insurance company will tell you that the unused principal of annuitants who die before they reach their life expectancy is used to provide lifetime incomes for those people who live beyond their life expectancy. This certainly doesn’t make your client feel any better about this payout option.

**Annuity With A Period Certain**

This annuity payout is also known as the guaranteed minimum annuity because it provides a certain number of payments or a certain amount of money without regard to whether or not the annuitant is still alive. This payout option helps overcome objections of clients regarding the straight life annuity already discussed.

There are a number of reasons as to why a client would choose this payout option. An example would include the wish to have the remainder of the annuity value pass on to their beneficiaries because financial assistance is still needed by the client’s family. Reasons for financial assistance may include children’s education, daily maintenance or other similar needs.

The annuitant is still guaranteed a life income. If your client dies within the guaranteed period, payments are continued to his/her designated beneficiary until the guarantee period expires. Annuity contracts may be written, as an example, as life income for a period certain of five years, ten years or any other number of years as long as the insurance company agrees.

**Cash Refund Annuity**

This payout option makes a settlement in cash upon the death of the annuitant paying the difference between what the annuitant received in annuity payments prior to his/her death and the actual cost of the annuity.

**Installment Refund Annuity**

The installment refund annuity pays the annuitant agreed upon payments for life. However, if the annuitant dies prior to receiving an amount at least equal to the original annuity amount, payments will continue to the annuitant’s chosen beneficiary until the entire amount of the premiums have been paid out by the insurance company.

**Uses and Benefits of Fixed Annuities**

The following chart provides some of the objections given by potential investors for not showing an interest in purchasing annuities as well as some responses used in overcoming these objections.

<table>
<thead>
<tr>
<th>OBJECTIONS</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of money (can’t afford</td>
<td>Flexible Annuity</td>
</tr>
<tr>
<td>a lump sum investment)</td>
<td>using small deposits</td>
</tr>
<tr>
<td>Low rate of return</td>
<td>Historical returns typically</td>
</tr>
<tr>
<td>are higher than CDs</td>
<td></td>
</tr>
<tr>
<td>Ties up money too long</td>
<td>Use the 1035 exchange</td>
</tr>
<tr>
<td>Try the split annuity</td>
<td></td>
</tr>
<tr>
<td>Lack of information available</td>
<td>Brochures and seminars</td>
</tr>
<tr>
<td>are always available</td>
<td></td>
</tr>
<tr>
<td>No tax benefit</td>
<td>Tax deferred growth</td>
</tr>
<tr>
<td>No need or interest</td>
<td>Retirement? College Savings? Save Taxes?</td>
</tr>
<tr>
<td>Too old for annuities</td>
<td>High age limits</td>
</tr>
</tbody>
</table>
Too Risky--------------------------------------------------------------- Principal guarantee
(Fixed Annuities)

**Split Annuity**
A split annuity will allow an investor to split an initial deposit between a fixed deferred annuity and an immediate annuity that is meant to provide monthly income. This strategy provides the investor with the best of two worlds. First, he/she will receive tax favored monthly income with a guarantee of their principal and end up with more money in their pockets when compared to receiving income only from a traditional certificate of deposit.

<table>
<thead>
<tr>
<th>IMMEDIATE ANNUITY</th>
<th>DEFERRED ANNUITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100,000</td>
<td>$69,500</td>
</tr>
<tr>
<td>PTS Insurance Co.</td>
<td>PTS Insurance Co.</td>
</tr>
<tr>
<td>Five years of monthly income</td>
<td>Interest Rate Guarantee</td>
</tr>
<tr>
<td>Guaranteed monthly income $583</td>
<td>Guaranteed Term: 5 Yrs</td>
</tr>
<tr>
<td>Total per year: $6,993</td>
<td>Value at end of 5 years: $100,000</td>
</tr>
<tr>
<td>Total over 5 years: $34,965</td>
<td>At the end of this initial</td>
</tr>
<tr>
<td>Of this amount, 87.2% is excluded</td>
<td>period this amount can be:</td>
</tr>
<tr>
<td>from taxation.</td>
<td>1) continued at the current</td>
</tr>
<tr>
<td>Thus:</td>
<td>interest rate or:</td>
</tr>
<tr>
<td>Yearly Income: $6,993</td>
<td>2) used to fund a guaran-</td>
</tr>
<tr>
<td>Excluded $6,098</td>
<td>teed monthly retirement</td>
</tr>
<tr>
<td>Taxable: 895</td>
<td>income</td>
</tr>
<tr>
<td>Taxes @ 28%: 251</td>
<td></td>
</tr>
<tr>
<td>Yearly after taxes: $6,742</td>
<td></td>
</tr>
</tbody>
</table>

**Monthly after taxes: $562**
**Annuity beats CD by $142**

**Laddering Fixed Annuities**
One of the objections made when selling annuities is that investors don’t want to be locked an interest rate for a large number of years while current interest rates rise. This type of risk is known as interest rate risk.

This potential problem can be remedied by purchasing a series of annuities with interest rate guarantees spread out over a number of years, just like bonds are for bond investors.

With the large number of years to maturity available through a number of insurance companies, the flexibility is there to offer maturities typically for a minimum of one year to a maximum of five to seven years. This is known as Laddering annuities and it helps provide relative interest rate protection for investors. The following example shows five annuities purchased with different interest rates so as to provide the benefit of the renewal of the then current interest rates on an annual basis.
Variable Annuities
Variable annuities were created because there are a number of risks associated with fixed annuities, which are not acceptable. These risks include;

Purchasing Power Risk (Inflation Risk)
As you may remember, a fixed annuity provides the annuitant with a fixed rate of return. When you’re done applying the annual inflation rate, the final real return has not improved the client’s position to any great degree. Bottom line, there are less dollars left to make purchases because inflation has eaten away your client’s savings.

Interest Rate Risk
With a locked in interest rate the client will not be able to take advantage of any increases in the interest rate market.

Variable Annuity Theory
It has been established that the market value of securities will generally move in the direction of the cost of living and will usually provide results that will stay ahead of it.

One must be careful however, and understand that the stock market will have short-term declines from time to time. No-one can predict these on a regular basis and so the annuitant must realize that the value of his account may in fact decrease during these down periods.

This of course is one of the major risks associated with variable annuities. It is especially tougher when the annuitant is already on a payout program and received $500, as an example, last month and now the stock market has a correction and the next monthly check is only $400. This must be carefully analyzed before recommending this type of an annuity to your clients.

Are There Any Guarantees for Variable Annuities?

Principal Guaranteed?
No! Because the investment choices are now in the hands of the annuitant and the insurance company will not assume the risk to the principal and the risk will pass to the annuitant. This remains true during both the accumulation and payout stages.

Guaranteed Rate of Return?
No! Because the variable product has variable returns there is no way to guarantee a fixed rate of return like the fixed annuity. Once again, the risk of the investment and return will fall on the annuitant, not the insurance company.
Tax Deferred Earnings?
Yes! Just like fixed annuities, all earnings will grow on a tax deferred basis. This means you do not have any current taxes to pay as long as the earnings stay within the protection of the annuity. But be aware that if an early distribution is made prior to the age of 59 1/2 and the available exceptions are not the reason, the IRS will impose a 10% excise tax penalty.

In addition, with qualified plan annuities, when the annuitant reaches the age of 70 1/2, just like an IRA, he/she will have to start taking distributions from the account. The IRS has a schedule based on actuary tables to determine specific dollar amounts, which need to be withdrawn. If the required amount is not taken out of the annuity, the IRS will impose a 50% penalty on the amount that should have been distributed.

Accumulation Units
As the annuitant deposits money into the annuity, the money is invested into the accounts (mutual funds) as chosen by the annuitant such as a stock fund, balanced fund, bond fund and/or guarantee fund. As the deposit is made, the portfolio is evaluated and a certain number of accumulation units will be purchased.

As an example, if a unit is valued at $25.00, a contribution of $1,000, after deducting expenses, will purchase about 40 units for the following year. If the value of the unit changes because of changes in the valuation of the portfolio then the $1,000 may purchase more or less than 40 units. The next step will involve the client with the process of annuitization. At this point in time the accumulation units are converted into Annuity or Retirement Units.

Annuity or Retirement Units
The current market value of an annuity unit is used as a reference to obtain the payments that will be made under a straight life annuity payout option.

Assumed Interest Rate (A.I.R.)
All variable annuity contracts will be assigned an assumed interest rate, which represents an expected rate of return for the annuity contract. The expected return is based on anticipated returns of the underlying investments.

For this example we will be using an AIR of 5% for a variable annuity contract which has been purchased with a life income payout option.

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment</td>
<td>$400</td>
<td>$450</td>
<td>$500</td>
<td>$450</td>
</tr>
<tr>
<td>Return %</td>
<td>5%</td>
<td>6%</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Change</td>
<td>None</td>
<td>More</td>
<td>More</td>
<td>Less</td>
</tr>
</tbody>
</table>

There are a number of rules that you will need to remember with variable annuities and the assumed interest rate.

1. An assumed interest rate is always assigned to all variable annuity contracts.
2. AIR is directly related to the actual performance of the investment portfolio chosen by the annuitant.
3. The main principal is that when the portfolio performs better than AIR, the annuitant’s monthly income will increase. If on the other hand the portfolio results with a return, which is less than AIR, the monthly check will decrease. If the investment results in a return equal to AIR, the next monthly check will be the same as the prior month.
Types of Variable Annuities

Single Premium Immediate Variable Annuity
This is probably the simplest of all types of variable annuities. It provides a monthly income for life, which is based on the current value of annuity units. After the first few payments, the amount of the payments will vary according to the performance of the investment fund.

Single Premium Deferred Variable Annuity
This type of annuity provides lifetime benefits after a specific accumulation period. After expenses are deducted, the net premium is placed into the investment fund(s) which will grow or decline depending on the investment portfolio’s performance. At the end of the accumulation period the account value is applied to purchase annuity units.

Periodic Payment Variable Annuity
This annuity is really a series of single premium deferred plans. Each payment contributes to an accumulating account by buying accumulation units which will vary in value.

Variable Investment Common Sense Rules

- Stock market goes up - Stock funds go up
- Stock market goes down - Stock funds go down
- Bond market goes up - Bond funds go up
- Bond market goes down - Bond funds go down

Remember, variable annuity results are directly tied into one or a combination of different accounts including stock and bond portfolios.

Minimum Death Benefit
While there are none of the usual guarantees that you would find in a fixed annuity such as a guarantee of principal and a guaranteed rate of return, the variable annuity will still provide a guaranteed minimum death benefit.

Let’s suppose that a client purchases a variable annuity contract with $100,000 and places all of the monies, after expenses are deducted, in an aggressive stock fund. Unfortunately for him it was October 19, 1987 and the stock market lost approximately 30% of its value. The very next day the client’s portfolio was worth only $70,000. This shocked the annuitant so badly that he had a heart attack and died. Even though his account was only valued at $70,000, his beneficiary will receive the full $100,000 because of the guaranteed minimum death benefit.

The rule is very simple; the beneficiary will receive either the original amount that purchased the annuity or the value of the portfolio, whichever is higher.

Equity Index Annuities
The equity index annuity is basically a new product in the United States and actually originated outside the United States. In England and France there have been approximately 30% of all equity annuity products sold.

During 1995 and 1996 there were about 35 insurance carriers entering this market. Premiums totaling over $2 Billion during this time period were experienced with anticipated premiums of over $6 Billion by the end of 1997.

There are estimates of over $10 Billion by the end of 1998 with over 50 companies marketing this product. It is also estimated that the equity index annuity will ultimately account for 40% of the total US fixed annuity premiums sold.
A General Explanation of a Equity Index Annuity

In a general sort of way, the equity index annuity combines the traditional features of a fixed annuity which include:

- Guarantee of principal
- Tax deferral
- Free withdrawals
- Surrender charges when applicable with;
- Current rates credited which are linked to the equity markets.

This type of annuity provides a rate of return that is determined as a defined share in the anticipated appreciation of a major stock index. The annuity will provide a guaranteed minimum return as do regular fixed annuities.

One of the major keys to the equity annuity is to allow the investor to participate in interest rates that are linked to the equity markets but avoiding the possibility of downside market risk.

So, a Equity Indexed Annuity (EIA) is a fixed annuity with traditional guaranteed minimum interest rates, with an excess interest feature that is linked to an equity index such as the S&P 500. (Explanation in Section 6.4, below)

The contractual features of the annuity fit within the general definition of a non-security that mark it as an insurance product not requiring a securities license.

What is probably more important are the differences between the various Equity Index Annuities and how the index calculation is made. There are also substantial variation between company designs, and quite frankly, no two products are alike.

Is the Equity Index Annuity a Security?

Variable annuities must be registered as they are also securities products. To sell a variable annuity you need an insurance producers license as well as a NASD Series 6 or NASD Series 7 securities license.

While equity index annuities have been linked to the equities markets, registering as a NASD securities representative wasn’t necessary. The reason for this is that the rates of return for the annuity while are linked to the equity market, the performance of the contract does not vary directly with the underlying assets and the insurance carrier bears the investment risk, not the holder of the annuity. This is not true with variable annuities in which the annuitant has the risk of investment loss.

There’s another important difference between the equity index annuity and a variable annuity. This difference involves minimum guaranteed values. While variable annuities do not offer the holder minimum guaranteed values, the new equity index annuities do. If an insurer decides to register their equity index annuity as a security product then this product, just like a variable annuity, will also require the delivery of a prospectus and only sold by NASD registered representatives holding either a NASD Series 6 or NASD Series 7 registration.

It also appears that those equity index annuities that have been registered have provisions called “market value adjustments” which may invade the principal of the annuity. These adjustments effect the surrender values of the policy either up or down which reflect current market conditions. Because of this, the investment risk shifts from the insurer to the holder.
In addition to these equity market value adjustments there are also market value adjustments that do not invade the annuity’s principal and therefore would not require registration as a security. The key point to remember is that it is the investment risk shifting element that causes registration of the product, not the equity index element.

Comparison of Fixed Annuities, Variable Annuities & Equity Index Annuities

<table>
<thead>
<tr>
<th></th>
<th>Fixed Annuities</th>
<th>Variable Annuities</th>
<th>Equity Index Annuities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Deferred</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Withdrawal Penalty</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Registered Security</td>
<td>No</td>
<td>Yes</td>
<td>Yes and No</td>
</tr>
<tr>
<td>Death Benefit Free of Probate</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Asset Mgt Fees</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Principal and Prior Credited Earnings Protected From Market Declines</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Earnings Tied to Equity Market Performance</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Comparing Equity Index Annuities to Fixed Annuities
The structure of a fixed annuity is not fundamentally altered. A premium enters the contract, the company pays expenses and commissions, sets up a reverse liability, sequesters appropriate capital and surplus for the policy and backs these policies by investing cash from bonds and fixed income assets. Interest is credited to these accounts, generally based upon the investments the company makes, less a required spread to recoup expenses and return required profits. There is rarely a front-end load on this account but rather a back-end surrender charge.

The equity-linked annuity operates similarly, except that the insurance company invests additionally in a call option on an index of equities (S&P 500) and the management declared interest rate is transformed into a credit of a management declared percentage of the index performance generated by the option.

Understanding the Indexing Process
This section will explore several topics relevant to indexing. First, we will consider the S&P 500 Index itself, what it is, what it represents and why it is used with Equity Index Annuities (EIA). We will also discuss index investing ("indexing") as an investment strategy. Actually, index investing is not directly applicable to Equity Index Annuities. It is a strategy used widely with mutual funds (and EIAs are not index mutual funds). However, it is important to understand the
concepts of indexing in order to fully grasp the importance of the S&P 500 Index and consequently, its use with EIAs. Finally, as registered EIAs which can be marketed solely on their merit as an investment become more widely available, a greater focus on the indexing component of EIA will emerge and will require a thorough understanding by marketing professionals.

As already discussed, the Equity Index Annuity offers current earnings that are linked to an equity index. There are a number of indices available but today most equity-linked products in the US use the S&P 500 Composite Stock Price Index".

**Why Use the Standard & Poor’s 500 Index?**

- It is a viable hedging instrument because there is a large, active, highly liquid market in S&P 500 Index related futures and options ("derivatives").
- It is widely regarded as the benchmark of broad US stock market performance. Most equity money manager's performance is gauged against the S&P 500 Index.
- The Index has been a US Department of Commerce leading economic indicator since 1968.
- The S&P 500 Index represents over 70% of the total domestic US equity market's capitalization.
- The Index does not represent the 50 largest companies but it does include such giants as Mattel, McDonald's, Ford, Quaker Oats and Kodak just to name a few. There are also relatively small companies in the Index but they are leaders within their industry group.
- There are four major industry sectors within the US economy - industrials, utilities, financial and transportation. The Index allocates a representative sample of stocks within each group so the Index is "market-weighted" - each stock impacts the Index in proportion to that stock's importance in the market.
- The S&P 500 Index includes a representative sample of common stocks on the New York Stock Exchange, the American Stock Exchange, and NASDAQ National Market System.
- The S&P 500 Index is widely used in "passive investing" strategies.
- The S&P 500 Index is a price index and therefore does not include dividends.
- Today, some equity index annuities are linked to other indices or multiple indices. The "diversified" EIA links its return proportionately to two or more indices. Nor are all indices based on the US economy. International indices include:

  * The **DAX**, an index of 30 stocks on the German (Deutsche) stock exchange; The **FTSE** (Financial Times Stock Exchange), an index of 100 stocks on the London stock exchange; The **Nikkei**, an index of 225 stocks on the Tokyo Stock Exchange.

**The Process of Indexing Explained**

"Indexing" is an investment strategy that seeks to match the performance of a defined group of securities. This group of securities forms a recognized market measurement called an "index." An index is a benchmark or relative measurement of performance. One example is the Consumer Price Index that tracks the changes in prices of consumer goods from year to year.

Indexing seeks to match overall performance of the index, so the particular securities held and the quantity of each is pre-determined by the composition of the index. Investment managers for a S&P 500 Index fund will purchase each of the 500 stocks in proportions that match the index in order to replicate the performance of the index itself. Indexing is often called "passive investing" because the type and amount of each stock is decided by the index composition. This is in contrast to "actively managed" investing where a professional money manager devises unique strategies and investment philosophies in order to select individual securities. Indexing emphasizes diversification and by definition results in reduced trading activity.
Indexing arose from the "efficient market" theory of the 1960s, so it is not a new concept. If, as efficient market theory suggests, markets naturally tend toward optimum efficiency, it is questionable as to whether any strategy or philosophy can consistently outperform the market (at least do so by a significant margin.) If efficient market theory holds true, then simply "buying the market" (or, indexing) will be the least risky and most effective investment strategy.

The historical performance of the stock market is clear - over the long term it has simply gone up. However, while the trend has been decidedly upward, there has been significant volatility with some extreme highs and lows over short-term periods. This daily volatility means that investors may experience significant increases or decreases to their principal within the course of a few days.

Indexing is a "buy and hold" investment strategy. "Buy and hold" (in the context of the S&P 500 tends to outperform an "active trading" strategy for the average investor. We know that the average investor over time has exhibited a "buy high, sell low" behavior that is detrimental to long term investment returns.

The advantages of indexing can be evaluated by considering the indexed mutual fund, one of the most popular investment vehicles of the '90's.

**Index Mutual Fund Points**

- Indexing only seeks to match the performance of the index so investment objectives and investment policies are well defined. "Actively managed" investment funds, which attempt to outperform the market may have complex strategies as their money managers actively trade in attempts to take advantage of market movements and economic conditions.
- Diversification minimizes the volatility of owning high concentrations of any stock within a given industry or market sector. Index funds will own many or all of the stocks which make up the index. An S&P 500 Index fund usually owns all 500 stocks that make up the Index.
- Professional investment managers actively attempt to outperform the market through the use of sophisticated skills, technology and research data. Actively managed funds historically do not outperform indexed funds. For the 10-year period ending December 31, 1994, the total return of the S&P 500 Index (including dividends) was 14% Vs. the average general equity fund that returned 12%. In fact, the S&P 500 Index outpaced 78% of all equity funds for the same 10-year period. 5
- According to Lipper Analytical Services, Inc., the average general equity fund has an annual expense ratio of 1.38% while indexed fund's expenses are much lower. This is largely due to the fact that passive investing does not require the high level of trade activity found in actively managed funds. The resulting low trading costs helps reduce the indexed funds total costs.
- Rarely does any actively managed fund consistently outperform the market over the long run. According to Lipper Analytical Services, Inc., the S&P 500 Index surpassed more than half of all general equity funds since 1984 and at its worst, outperformed four of ten funds.
- While it's impossible to accurately predict the performance of the market, an index fund will perform consistently with the performance of its index. When the index is up, the fund will increase proportionately Actively managed funds are much less predictable because the managers use specific stocks and market segments that may out-perform or under-perform the index within a given period.
- A mutual fund distributes interest, dividends and capital gains annually. Taxes are due on distributions (that occur outside qualified retirement plans). Since indexed funds use a "buy

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5 Vanguard Marketing Corporation - 1996
and hold" strategy, there is less turnover (and fewer distributions) in the portfolio and therefore, indexed funds are considered more "tax efficient."

- Index investing can be suitable for most portfolios. In its simplest form, all money could be allocated to various indexed vehicles. Indexing can also be the core investment in a diversified program or used to add diversification to an existing investment strategy.
- Again, indexing is not new. Institutional pension plan managers, who enjoyed the broad diversification and low costs associated with indexing have used the strategy since the 1970s. A significant portion of today's pension funds are held in indexed accounts.
- The advantages of indexing are clear but there are some disadvantages. It should be pointed out that generally, the S&P 500 Index mutual funds outperform managed funds in up markets while managed funds tend to do better in down markets. The reason for this is simple. During bear markets, active managers can sell stocks and buy fixed interest rate investments while by definition index funds must remain fully invested in the stocks that make up the Index. By definition, the indexed fund will move up and down with its index.
- This apparent down market weakness of S&P 500 Index mutual funds does not have as great an impact on EIAs since they protect principal and previously credited interest from downside market movement. Indexed mutual funds bear full downside market risk.

Comparing Indexed Mutual Funds to an Equity Indexed Annuity
We have considered the features of indexed mutual funds to help explain the concept of index investing. Remember, an EIA is not an indexed mutual fund and the following comparison clarifies their differences. It also illustrates how the EIA with equity-linked participation can be suitable for the risk averse investor - who can now participate in equity-linked returns without exposing principal and previously credited index interest credits to downside market risk.

Dividends are a topic of great confusion and discussion when comparing EIAs to other financial vehicles. It is important to know that:

The S&P 500 Composite Stock Price Index' (the "S&P 500 Index") is a price Index and by definition, does not include dividends.

The S&P 500 Index value is listed in the Wall Street Journal and is announced on TV. Again, this number is just an index value, it is not quoted as a percentage and it does not reflect return or dividends. However, the performance of the S&P 500 Index is often discussed in terms of "total return." Total return is the appreciation or depreciation of an investment over a given time period and includes reinvested dividends and capital gains. It is typically stated as a percentage. This figure would reflect not just the movement (changes) in the S&P 500 Index but also the dividends that are paid by the stocks underlying the Index.

When discussing S&P 500 Index total return performance, dividends can account for a significant part of the yield. The performance of index mutual funds reflects dividends because index mutual funds own the very stocks which make up the Index in the same proportions as the Index. And they receive the dividends paid by these stocks which are then included in the total return.

This fact is often cited as a disadvantage to EIAs when the two products are compared. EIAs participate in the growth of the S&P 500 Index, not the total return. However, EIAs participate only in the upside potential of the S&P 500 Index - they enjoy 100% downside protection from market declines. Index funds that are based on total return do not enjoy downside protection and values will vary up and down with market movement.
**Equity Interest Rate Issues**

Equity Index Annuities usually have most of the same product features found in traditional fixed annuities:

- Minimum guaranteed cash values (called the contract value),
- Free withdrawals,
- Selection of retirement income options,
- Surrender charges and
- Probate-free death benefits.

Like traditional fixed annuities, both single and flexible premium EIAs are available and may be sold in qualified and non-qualified markets. The main difference between a traditional fixed annuity and an EIA is the method of determining the current credited interest rate. Regardless of the product design variations, all EIAs have the following features:

- Earnings are credited at contractually defined points in time.
- The earnings are linked to growth in the Index that occurs between contractually defined points in time and which may be referred to a "measuring period" or an "Index Interval."
- The method of measuring the growth in the Index is contractually defined. It may simply be the actual increase in the Index from one date to another or it may measure growth from a starting date to some averaged end value (such as the average of all S&P 500 Index values over the last 90 days of the measuring period).
- The consumer participates in a percentage of the growth in the Index. A participation rate (the percentage of the index growth in which the client will share) is applied to the index growth to find the resulting index interest credit.
- The index interest credit may be limited by a cap rate in some designs. Other designs may use other limiting features such as the explicit deduction of an annual fee.
- If the Index declines or remains flat, there is no decline in the annuity accumulation value. The principal and previously credited index interest credits are locked in and are guaranteed never to decline due to market drops. (There are a few products which "accrue" index earnings for annual statement reporting. These earnings are not actually credited, earned or "locked in" to the client's values until the end of the term. These designs may be confusing since the client's values will appear to fluctuate up and down. However, once "locked in" principal and earnings will never decrease due to market declines.)
- There is an underlying guaranteed minimum contract value.

**Comparing Interest Rates Between Traditional Annuities & The EIA**

Simply put, the EIA owner trades a fixed, company declared current interest rate for potential equity index participation:

<table>
<thead>
<tr>
<th>Interest Based Annuity</th>
<th>Equity Index Annuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Base Rate</td>
<td>Current Participation Rates &amp; Cap Rates</td>
</tr>
<tr>
<td></td>
<td>Trades for</td>
</tr>
<tr>
<td>Renewal Rates</td>
<td>Renewal Participation &amp; Cap Rates</td>
</tr>
<tr>
<td></td>
<td>Trades for</td>
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</tbody>
</table>

**Following is the comparison chart between Traditional Fixed Annuities and Equity Index !**
<table>
<thead>
<tr>
<th><strong>Traditional Fixed Annuity</strong> (Interest-Based)</th>
<th><strong>Equity Index Annuity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed declared current interest rate</td>
<td>Participation in S&amp;P 500 Index</td>
</tr>
<tr>
<td>Current interest rate guaranteed for first year (with or without bonus)</td>
<td>Participation rate, cap and floor guaranteed for first year (or term)</td>
</tr>
<tr>
<td>Interest credited daily</td>
<td>Interest credited at contractually defined points in time which may be from one to ten years</td>
</tr>
<tr>
<td>Minimum guaranteed interest rate, cap and floor as well as Minimum contract value</td>
<td>Minimum guaranteed participation</td>
</tr>
<tr>
<td>Carrier generally matches investments to length of surrender charge period</td>
<td>Carrier generally matches investments to length of surrender charge period</td>
</tr>
<tr>
<td>Carrier attempts to maintain base Interest rate during surrender charge Period, economic conditions permitting</td>
<td>Carrier attempts to maintain participation rate, cap and floor during surrender charge period, Economic conditions permitting</td>
</tr>
</tbody>
</table>

**Equity Index Annuity Investments**

The EIA is a fixed annuity and the lion’s share of EIA premium dollars are invested in the same types of fixed-rate investments that insurance companies use to support their traditional fixed interest annuities. In a traditional fixed annuity, current (or excess) interest is paid in the form of a declared current crediting rate. In an EIA, current (or excess) interest is paid in the form of participation in the equity index.

Again, the major part of the investments cover the underlying minimum contract value guarantee. The carrier deducts a percentage of their investment earnings (called a "spread") to pay for expenses and their profit margin. The balance is used to purchase future participation in the equity index growth. The company can hedge future index growth by buying call options. They may buy them directly on the exchange floor or from a third party like a bank.

It may seem counterintuitive but the level of the S&P 500 Index or the current direction of the stock market is not the significant factor in setting participation rates. In fact, it is the level of current interest rates that actually determines the amount of stock market participation the company can offer. The higher current market rates, the more investment earnings are available with which to purchase call options which then allows a higher participation and cap rate. The cap permits the company to offer a higher participation rate by setting an upside limit on the index growth. If the Index increases over the cap, the carrier does not keep the difference because they only hedged up to the limit of the cap.
Buying call options that are not used to actually hedge a liability is considered speculative and would be considered a high-risk transaction.

All things being equal, the higher the participation rate, the lower the cap and vice versa. Unfortunately or fortunately, depending on the understanding of the insurance producer, various combinations of the participation rate and cap rates are available even possibly in the same annuity product.

**Understanding any Downside Protection**

In the midst of evaluating and comparing Equity Index Annuity products and their most visible product features, it is easy to lose sight of what is perhaps the most compelling benefit offered by Equity Index Annuities - downside protection. It is difficult to overstate the advantage to the consumer of being able to participate in market linked returns while enjoying the peace of mind that comes with knowing their nest egg is not at risk.

In the short time span in which EIAs have been widely available, acceptance by the industry has been overwhelming and the rapid growth of premium revenues has been unprecedented. The opportunity to earn equity index-linked returns with no downside market risk has clearly appealed to a core consumer need amongst both novice and experienced investors.

When the second wave of new products first hit the market, there was some inappropriate positioning of EIA. The unprecedented performance of the S&P 500 Index over the past two years tempted many producers to fall into the "performance mania" trap. Undue emphasis was placed on participation rate percentages and promotion of the potential for 20% and 30% returns. As a result, some popular investment periodicals discounted the value of EIAs when compared to long-term "buy and hold" equity investment strategies which produce superior returns utilizing any number of strategies that combine the direct purchase of stocks, mutual funds, call options and futures. Fortunately, this trend seems to have subsided as carriers and producers more clearly define the competitive positioning of EIA.

EIAs are not competition for direct equity investment in any form. They are designed to provide relief to consumers that suffer from a common and potentially dangerous condition - "risk aversion."

*It is found that EIA buyers fall into two categories. First, many consumers are so risk averse that they are incapable of making an equity investment, even though they know on a rational level that their long-term financial outlook could be greatly improved by doing so. They continue to earn low fixed rate returns because they must have protection of principal. The second group actually wants to increase their equity exposure without incurring additional market risk. EIAs allow the first group to finally move toward equity-linked returns but with full downside market protection. The second group will sacrifice some yield on some of their portfolio in order to protect principal and prior earnings from market declines. The key to the success of EIAs with the buying public is "downside protection."*

**Downside Protection Charts**

The following chart plots a hypothetical seven-year movement of the S&P 500 Index. Its sole intention is to demonstrate how the accumulated value of an EIA is calculated. Hypothetical values of the S&P 500 Index are plotted on the left vertical axis and the resulting hypothetical EIA accumulated value on the right axis. Downside protection is at work in years two and five when the index declines yet the accumulated value stays level.
The next example clearly illustrates the powerful force of downside protection. The "square" legend simply reflects movement of the S&P 500 Index (as a percent annual change). The "diamond" legend reflects a hypothetical account value that has downside protection and a 14% cap.

Hypothetical EIA Accumulated Value assumes a participation rate of 80% and 12% cap.
Notice that even though the 100% S&P movement account grows by some extraordinary percentages, the hypothetical EIA account is capped, avoiding the down years, and the need to recover from previous losses, allowing the hypothetical account to perform almost as well as the pure S&P movement account ... and it's hard to measure the effect on the investor's peace of mind that comes from removing the market volatility.

What this means in everyday laymen's language is that when the stock market goes down and sustains losses, the EIAs have protection built in so the worst case scenario will be that the EIAs remain flat without downside loss. During the down markets the EIAs will tend to remain flat without any upside momentum until the market starts to move up again and the EIAs will follow.

When an investor is invested in the stock market and the market drops 10% a major hurdle is that the investor not only needs to recover the 10% loss to get back to what he/she had before the decline and then have the market go up even further to sustain any net gains. This scenario can make it very difficult for the average investor to recover from any losses.

Regardless of how you "spin" index annuities with Indexing methods, rates, caps and marketing hype, remember, the key feature that consumers value is the psychological safety net that comes with downside protection.

**Minimum Contract Value**

One of the EIA features that is most commonly misunderstood is the minimum contract value. This value is an underlying secondary guarantee or "safety net" that ensures a guaranteed minimum cash value is available to the consumer.

The minimum contract value is guaranteed regardless of how the index performs. (Index performance is reflected through index increase credits to the current accumulation value.) So if the index stays flat or declines over the entire term of the contract (so that effectively, no index increases are earned) this minimum contract value comes into play. Of course, the likelihood that the Index will remain perfectly flat or consistently decline over a long period of time is statistically small. However, this guarantee exists to accommodate that scenario.

When calculating "cash value" benefits, such as a surrender value, death benefit, annuitization value or withdrawal the buyer always receives the greater of the current accumulation value or the minimum contract value guarantee. In non-registered products, this value must comply with minimum Non-Forfeiture Regulations, which for single premium contracts equals 90% of the premium at 3% interest compounded annually. (The regulation for flexible premium contracts is 65% at 3% interest compounded annually.) Today, the most common minimum contract value provision is 90% at 3% interest, which, for example, would equal 110% of principal at the end of a seven-year term. However, there are contracts that now guarantee 100% of premium at 3% interest and some flexible premium contracts guarantee less than 90% of premium at 3% interest.

Some contracts "top up" the minimum contract value at the end of a term to equal the current accumulation value as of the just ended term. This effectively increases the minimum contract value guarantee to reflect previously earned index credits.

In and of itself, the minimum contract value is not a particularly meaningful feature with which to compare the competitiveness of a product. In reality, this value will only be meaningful:
• Upon early surrender.
• If the index is flat or declines over the entire term.

Evaluating Benefits and Designs
As there is no such thing as a perfect investment, you will find that features, benefits and commissions of the Equity Index Annuity are “trade-offs”.

While minimum cash surrender values, known as “Non-Forfeiture Values”, are defined by state insurance regulations, the minimum value for a single premium fixed annuity must equal at least 90% of the single premium compounded at 3% interest. Also, the carrier must allocate a major portion of the single premium to be invested in fixed assets such as corporate bonds, mortgages and more to support this guaranteed value.

Marketing expenses vary from company to company but generally range from 6% to 10% of the single premium. Of course, the company must also meet its profit objective, pay taxes, administrative expenses and cover overhead.

After the above items are accounted for, one final expense remains – the cost of crediting interest that is tied to the growth in the S&P 500 Index and guaranteeing no down side risk. Companies are able to cover this expense through the purchase of S&P 500 Index hedges – and this is where the trade-offs in EIA product design really begin.

There are many combinations of product features possible including indexing methods, participation rates, cap rates, using averages to measure the index growth, stated surrender charges, vesting schedules and “non-traditional” surrender charges. These are just considered to be mechanics. All of these features work together to produce the calculation that determines the share of the S&P 500 Index gain that will flow to your client’s bottom line. In comparing all these different product features, we use the mechanics to get at the real question:

“What share of the S&P 500 Index gain will be credited to the customer’s account and how frequently are credits made?”

Let’s refer to this bottom line as the “Index Benefit.” Generally, there is a trade off between:

• Index Benefit
• Guarantees
• Liquidity

For instance, the greater the real Index Benefit and the longer it is guaranteed, the less liquidity. The converse is also true.

A key point to remember is that there are no secrets about where and how insurance companies buy their index hedges. Option trading is a huge international business, it is highly competitive and is getting more so every day Remember the limits described above ... the result being that each company has about the same amount of money “left over” to cover the hedging cost. Does it stand to reason, all other things being equal, that different hedging strategies (i.e. Point-to-Point, High-water Mark, averaging, etc.) that cost about the same amount to hedge will produce vastly different returns or results? Of course not ... looking at these various designs is just looking at the other side of the same coin. In fact, the large banks and investment firms that sell the hedges are indifferent to the design used since they can price almost any equivalent strategy conceivable.
The final point to remember is that the trade off between the carrier, consumer and insurance producer just may not be as obvious as with the products you are more familiar with such as Universal Life Insurance. If you sell a UL policy just try and remember what the big difference is between the “plain vanilla product” and the “most competitive” version. One of them is probably your commission.

Another comparison can be made with high commission fixed annuity products. Typically the higher commission products will also have longer and higher surrender charges required.

As an experienced insurance producer it is important that you identify the trade-offs of the equity index annuity even though it may be more difficult to find them. With trade-offs not being so obvious as with some products you are more familiar with it is important to understand how the EIA works.

**Long-term Guarantees**

Another trade-off to consider is the long-term guarantee of the participation and cap rates. As a reminder, a **cap rate** is the explicit maximum account value percentage increase allowed. The cap for an annual reset product is the maximum account value percentage increase allowed for a given policy year. A cap serves to set an upward limit on the client’s Index Benefit. Cap rates are clear state limits on the index growth.

**Participation rates** represent the percentage of the increase in the index that will be credited to the accumulation value, which may be subject to the cap in some of the contracts. To add to some of the confusion already created, a contract with a 100% Participation Rate does not necessarily produce a greater Index Benefit than a contract with an 85% Participation Rate.

If guaranteed for the term, an 85% participation and 14% cap would become 65% and 12% respectively. Realize, you have a design similar to a traditional interest based annuity and a long term guarantee of these participation and cap rates would create significant surplus strain (just like it does for an interest based fixed annuity. Ever notice that traditional interest based annuities’ long term rate guarantees are lower than the current, year to year guarantees?) Similar to "company practice" with interest based annuities, it is the company’s intention to maintain the participation and cap rates for the length of the term. The bottom line ... if you deal with a reputable carrier with a reputation for fair and honest renewal rates, the annual reset design will provide the intended benefits and results.

**High-Water Mark Designs**

It measures the S&P 500 Index from the start of the term to the highest anniversary value over the term. Generally participation rates are guaranteed for the term. This design protects the client from market declines at the end of the term that could result in low or no Index increases. A second advantage is its enhanced liquidity that permits access to Index increase subject to an increasing vesting schedule.

The High-water Mark design may be offered with or without a cap. If a cap is used, it is usually a cap on the growth over the term (not on a given year’s Index growth). The term cap structure is advantageous because a client may participate in extraordinary Index growth.

**The Death Benefit Trade-Off**

The death benefits of an EIA can vary as widely as their accumulation values. Death benefits are extremely important to your client. One of the major advantages of the death benefit is to avoid probate, publicity and delays.
While there are a number of different types of death benefit methods applied to EIAs, the important question to ask is, "does the death benefit include additional index interest earnings and if so, as of what date?"

♦ Most of the products provide some additional index interest credits earned to the date of death. Methods such as the S&P 500 Index value on the date of death and/or index credits as of the last policy anniversary are the most advantageous treatment for the consumer.
♦ The death benefit not so favorable for the customer is where the death benefit will not include index interest earnings since the date of purchase or the end of the last term. Because of this, there can be steep effective surrender charges.

Do not make any assumptions regarding the death benefit rules. Always ask before you write an application.

Marketing Equity Index Annuities

Who are your Prospects?

You will find that there are many prospects for EIAs - they do not fit into a simple age and household income profile. Anyone who wants better than fixed rate returns coupled with guarantees of principal and a lock in of prior earnings is an EIA prospect.⁶

EIA buyers can typically be any of the following:

• “Index-oriented” investors who embrace the concept of “passive investing” yet want guarantee of principal, prior earnings and no downside market risk
• Fixed annuity owners, especially long-term owners experiencing low renewal rates.
• Bond fund owners that fear loss of principal.
• Consumers that are already "in the market" and are seeking to "lock in" market gains.
• Consumers that are already "in the market" and looking for "Correction Protection."
• Qualified Plan participants (i.e. 401a) who never benefit from a market loss.
• No load mutual fund investors.
• Retired and seeking alternatives to fixed income rates in order to beat inflation while protecting principal.
• Asset allocation investors interested in bond alternatives.
• Looking for a SPDA or CD exchange due to current low rates.
• "Inflation conscious" and "equity reluctant."

Questions to Ask Prospects to Test their “Mental Attention”

• Are you happy with your returns?
• Do you have funds in the stock market?
• Do you have funds invested elsewhere that earn less than equities?
• If you could allocate more funds to equities without incurring additional downside risk, would you do it?
• Given that your principal is 100% safe from market risk, what would you take given the following choices?
• Guaranteed gain of 4% to 6% (CD type choice)
• A chance for a gain of up to 14% and a guarantee that you lose nothing (EIA choice)
• Do you want equity participation with or without downside protection?

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⁶ Financial Distributors Inc.
The market is toppy and we know that a bear market is inevitable. Would you be interested in locking in the market gains you’ve made over the past two years?
What if I show you how to stay in the market without risking principal or prior earnings?
We know that market timing doesn’t work. Staying the course is sound advice. If I can show you how to stay in the market without downside risk would be interested?

**General Rules Regarding EIA Compliance**

- Only use insurance approved consumer brochures
- Pick your target audience carefully and use specific advertising
- Use the carrier provided disclosure forms
- Comply with your contract with the insurance carrier
- When prospecting use the full name of your insurance carrier
- Explain carefully that the EIA is a fixed, deferred, single or flexible premium annuity policy
- Do not imply that the EIA is a retirement program, private pension plan of savings plan
- Use only company approved hypotheticals
- Don’t compare EIAs as being similar to investments such as mutual funds or like savings accounts
- Avoid the following words:
  - Absolutes such as never, always, all, none, only
  - Unlimited, safest, highest, lowest
  - Free, no cost, no extra cost unless absolutely true
  - Investment profit sharing, deposit, savings as you must always disclose that this product is a deferred annuity policy

**Disclosure**
You must not forget that disclosure is required for all of your insurance prospecting and selling. Of utmost importance is learning all there is about EIAs. If you don’t understand all about EIAs you won’t be able to disclose the important issues to your clients and prospects.

**Other Compliance Issues**
Know your client! Suitability is key in compliance. Before recommending any investment, including the EIA you must make sure that the investment of choice is suitable for your client as based on financial goals, information obtained, risk tolerance, liquidity needs etc.

Risk averse customers expect a 100% guarantee of principal. If your customer is not in equity markets today, even in light of the market’s recent performance, it’s safe to assume that preservation of capital is a primary concern. It’s important to avoid “performance mania” products and hype. If you sell performance, what will you do when the next and inevitable correction come? Avoid using S&P performance yields that are at best, unusual and at worst, improbable. Be especially cautious of average index method products that show 25% to 35% performance examples.

**INSURANCE & PENSIONS**
Life Insurance for employees in a qualified plan can often be provided favorably by having the insurance purchased and owned by the plan. We’ll discuss issues such as the advantages, disadvantages and when this benefit can be utilized.
Advantages
There are certain advantages of funding qualified plans with life insurance. Let's review these advantages!

Life insurance provides one of the safest investments for a qualified plan, the tax treatment of life insurance in qualified plans, while having been reduced, have not totally been eliminated, life insurance costs are typically less than those found outside a qualified plan in individual life policies, because the pure insurance benefit portion of life insurance is not subject to regular income tax or to the 15% tax on excess accumulations. Therefore, dollar for dollar, life insurance may provide an effective means of transferring wealth than any other kind of plan asset.

In addition the use of life insurance helps provide predictable plan costs for the employer and fully insured plans can be exempt from minimum funding standards, can reduce administrative costs and can allow higher initial levels of deductible plan contributions.

It should be noted that a fully insured plan is one that is funded exclusively by life insurance or annuity contracts. One of the advantages of a fully insured plan is that changes in pension laws have made many noninsured plans overfunded, which can lead to statutory problems. Life insurance companies will usually provide low installation and administrative costs for these services if the plan uses their investment products.

In comparison to group term life insurance costs, life insurance within a qualified plan may be less expensive to the employee. Greater amounts of life insurance can be provided to owner-employees through certain pension formulas than through group term plans. Substandard rates are not taxed to the insured employee. The employer ends up paying for any rating adjustments. Life insurance in the plan transfers the death benefit risk to the insurer. This way the employer can walk away from any “moral obligations” toward the family of the insured. If the employee terminates or upon retirement, an employee can generally obtain an individual life insurance policy at original rates.

Disadvantages
Two of the disadvantages of using life insurance is that the rates of return on life insurance products may be low when compared to investment returns of other types of investment products and policy expenses and even commissions on life insurance products may be higher than traditional investment products placed into retirement plans.

When Should Life Insurance Be Used?
It is important to know when life insurance should be used in a qualified plan. You should use it when members of a qualified plan have a need for additional life insurance protection either for family protection or estate liquidity also when employers want a secure funding vehicle, when life insurance can be offered as an additional option, when a qualified plan is overfunded or close to full funding limitations and when highly compensated plan participants can reduce exposure to excess accumulation taxes as pure insurance is not subject to this tax.

Defined Contribution Plans Use of Life Insurance
Let's talk about the use of life insurance in defined contribution plans. A part of each participant’s account can be used to purchase insurance on the participant’s life. It should be noted that the amount of insurance must be kept within the incidental limits.

The IRS considers any non-retirement benefit in a qualified plan to be incidental so long as the cost of that benefit is less than 25% of the total cost of the plan.
The two tests used for evaluating incidental insurance benefits are as follows;

- The premiums paid over the entire life of the plan for a participant’s insured death benefit are less than the following percentages of the plan cost for the participants.
  - Ordinary life insurance - 50%
  - Term insurance - 25%
  - Universal life insurance - 25%
- The plan participant’s insured death benefit must be no more than 100 times the expected monthly benefit

Plans can use either of the above two choices. It is becoming more common for defined plans to use the percentage limits since the necessary calculations are easily computerized.

Because tests are computed in the aggregate, it is possible to purchase a considerable amount of life insurance in later years. Profit sharing plans may allow larger insurance purchases when any employer contribution that has been in the profit sharing plan for at least two years be used up to 100% for insurance purchases of any type as long as the plan specifies that the insurance will be purchased only with such funds.

**Tax Implications Of Life Insurance In Pensions**

It is important to understand all of the tax implications of the use of life insurance with pension plans. Employer contributions to the plan are deductible if the amount of life insurance is within the incidental limits as discussed earlier.

The economic value of pure life insurance coverage on a participant’s life is taxed annually to the participant at the lower of the IRS “P.S. 58” table or the life insurance company’s actual term rates for standard risks. It is important to note that the participant’s contributions to the plan are subtracted from the above amount. Also, there is usually an economic advantage to insurance in the plan when compared to the tax treatment of life insurance provided by an employer outside the plan.

Finally, qualified plan death benefits are usually included in a decedent’s estate for federal estate tax purposes.

**Other Insurance & Pension Issues**

Life insurance can be used in Keogh (HR 10) plan. The insurance can be used to provide a death benefit for regular employees covered under the plan as well as for an owner or partners. While rules are somewhat less favorable than other types of plans it will still work.

Third party insurance strategies such as purchasing life insurance by one plan participant for another plan participant are primarily used in qualified profit sharing or stock bonus plans. Universal life and other similar products may be used to provide an insured death benefit under a qualified plan. Insurance coverage can continue after a plan participant has retired or all retirement benefits have been received. This can be done by placing the policy on a reduced, paid up basis, sold to the participant for its cash surrender value, have the participant continue to pay the premiums or have the plan trustee continue to pay premiums out of fund earnings while the participant continue to pay the P.S. 58 Table costs.

**INSURANCE TAXATION**

A financial professional does not give legal advice, he or she should also refrain from giving estate tax advice. This is best left to a trained professional. However, a financial professional
dealing in estate planning matters should be conversant in general tax regulations in order to identify and convey a potential estate tax problem. The information in this unit will deal with this and other issues.

**Tax Guidelines Involving Life Insurance**

Generally speaking, the proceeds of life insurance are not subject to federal taxation. However-and there is always a however when dealing with taxes--the life insurance in question must meet Congress established guidelines as to just what life insurance IS in order to qualify for tax-favored status. These guidelines present the following tests for all life insurance policies issued after December 31, 1984:

1. Must meet definition of life insurance as established by applicable domestic or foreign law.
2. Must pass either the cash value accumulation test OR a guideline premium cash value corridor test.
3. And, for contracts formed on or after October 21, 1988, must conform to an amended requirement that the mortality charges upon which the policy is based are reasonable. *Reasonable* means that the mortality charges are not materially different from the charges the company will indeed impose. Mortality charges may legitimately consider the insured's medical history and current physical condition.

Before going on, let us briefly review the CASH VALUE ACCUMULATION TEST and the GUIDELINE PREMIUM-CASH VALUE CORRIDOR TEST.

The cash value accumulation test requires that the cash surrender value of a life insurance policy not exceed, at any point in time, the net single premium then required to fund a policy's future benefits. The test defines a policy’s cash surrender value without regard to policy loans, surrender charges, any terminal dividend, or any dividends accumulating at interest. The test requires the net single premium be determined at either 4 percent interest OR the rate guaranteed in the policy nonforfeiture values, whichever is higher. Mortality charges are also calculated for the net single premium: they must not be more than the standard mortality tables specified by the Commissioner of Insurance in the applicable jurisdiction. Interest rate in determining mortality charges for the net single premium is either 6 percent, OR the contract's guaranteed interest rate, whichever is higher. The future benefits of the policy are of course the death or endowment benefits ONLY. Benefits attached to the policy by riders--accidental death, guaranteed insurability, etc.--are not included in future benefits when determining if a policy meets the cash value accumulation test.

The guideline premium-cash value corridor test has two parts, both of which a policy must meet. First, the aggregate premiums paid to date under the contract are never more than the greater of either the GUIDELINE SINGLE PREMIUM or the SUM OF THE GUIDELINE LEVEL PREMIUMS. The guideline single premium is the one-time premium necessary to fund contract benefits--in other words, the amount of a one-pay life contract premium. The guideline level premium represents an ANNUAL level premium paid over a period extending to, at minimum, the insured's 95th birthday, which would fund the policy's benefit.

Life insurance contracts which are investment-oriented may qualify for some tax-favored status. Single premium contracts must pass the tests just described in order to be accorded tax-favored status. Other policies may fall into a category known as "modified endowment contracts." Such contracts are defined in the Technical and Miscellaneous Revenue Act of 1988 as any contract formed on or after June 21, 1988, which meets the definition of life insurance under applicable domestic or foreign laws, passes the cash value accumulation test, or guideline premium cash value corridor test, but DOES NOT meet the 7-pay test.
The 7-PAY TEST requires that the accumulated sum paid under the contract at any time during its first seven contract years not exceed the sum of the net of seven level premiums needed to provide paid-up future benefits IF the policy had been constructed to be paid up at the end of seven years.

In other words, this test takes a specific policy, determines the amount of benefits payable after the policy has been in force seven years, determines the total amount of premium paid under the policy in that time period, determines a level annual premium that would furnish the same paid-up benefits after seven years, and then, if the ACTUAL premium in this SPECIFIC policy does not exceed the premium in the TEST policy, the policy passes the 7-pay test.

Because the nature of life insurance contracts has changed so dramatically in the last quarter century, it is wise to review EVERY policy owned by a client, and to ACCURATELY determine whether or not the policy is entitled to tax-favored status. If some policies are not so entitled, then they should be examined to see how best to use the resources/assets they represent for maintenance and conversion of the client's estate.

**Taxation of Annuities**

A deferred annuity has two phases, the accumulation phase and the distribution phase. During the accumulation phase, the annuity grows untaxed through the years as the investment compounds. In the distribution phase, the annuity is paid out. The payment may be made as a lump sum or as a series of scheduled payouts over a specific period or a lifetime (annuitization). Regardless of the payment method, some income taxes will by due on every annuity payment the annuitant receives. If the payment is made as a lump sum, then income taxes will be due on the difference between the amount paid into that annuity and its value when it is paid back.

If you annuitize a client, part of each payment is considered as a return of previously taxed principal (i.e., investment) and part as earnings. (Think of it as the reverse of paying a mortgage, where part is principal and part is an interest payment.) He will owe income taxes on the part of the payment that's considered earnings. The amount of each payment that won't be taxed is computed by establishing an "exclusion ratio" that's determined by dividing the investment in the contract by the total amount he expects to receive during the payout period.

Taxes on a variable annuity work a little differently. In a variable annuity, you don't actually know how much the annuity payment will be each month because the market value of your investment will change based upon what stage of its manic depression the market is in. Accordingly, the excludable amount of each annuity payment is determined by dividing your investment by the period over which you expect to receive the annuity. In the preceding example, the annuity would make a payment for 270 months (12 X 22.5). Therefore, if the investment was in a variable annuity, the amount to be excluded from every monthly payment would be $370 ($100,000/270). The remainder of each payment would be declared and taxed as income for that year.

A withdrawal is any amount distributed from the annuity that is not part of the annuitization process. Those payments are taxed based on when the annuity was purchased. Investments made after August 13, 1982, are taxed on a last-in, first-out basis. That means for income tax purposes the first money out of the annuity will be considered as earnings, not principal, and will be taxed as ordinary income when withdrawn from the contract. Additionally, just like a traditional IRA, withdrawals made prior to the annuitant's age 59 1/2 are subject to a 10% early withdrawal penalty.
INSURANCE AND ESTATE PLANNING

As we have already discussed in this course, insurance plays a valuable role in planning one’s estate. For clients of any age, it is an easy, cost effective means to create or protect an estate to allow surviving family to meet their financial obligations and needs. Also, through insurance product investing, the wealth of an estate can be enhanced. Mature clients certainly have a need to protect and enhance their estates, as we have addressed in the last two sections.

Now, we turn our discussion to insurance matters involving the final stages of a mature client’s financial planning: settlement of the estate. Here, insurance can provide necessary liquidity for survivors; including cash to continue a family business or pay personal / business obligations, and / or pay estate or income taxes due at death.

ESTATE PLANNING BASICS

An estate plan is an arrangement for the transfer of one’s assets. Estate planning is the process for the creation of this arrangement. The term has a range that encompasses the small estate handled perhaps by a simple will, as well as the large, complex and intricate estate with its army of estate transfer vehicles.

Cautions Regarding Estate Planning

Three warnings are important at this point. Estate planning and tax planning are not the same term. The latter is only a facet of the former. Its function is to minimize the tax burden involved in the disposition of the estate. Too often, the estate owner seems motivated more by hate than by love. His or her hatred for taxes outstrips his or her love for his or her family. He or she may permit tax considerations to dictate the disposition of his or her estate. To elevate tax saving: "My money won't do my family much good when I die, but look how little tax I'll have to pay."

The second caution is to criticize the term "estate planning." There are too many implications in it of a single devotion to a plan for the estate when the owner dies. The estate planner is concerned usually with the wisest and most prudent use of his or her client's assets during his or her lifetime, as well as after his or her death. Estate planning is a two-phase undertaking. It seeks to maximize, for the estate owner and his or her family, the security and enjoyment flowing from property ownership, both during lifetime and after death.

The third alert is the widespread belief that estate planning is the special privilege of the large estates. Both in lifetime and in testamentary (Last Will) planning, many common problems are found in both the large and small estate. Frequently, the differences are only in degree and not in kind. It is the small estate owner who can least afford to neglect estate planning or make an estate planning mistake. The failure or waste of a single asset in his or her estate could bring hardship both to him or her and his or her family.
Estate Plan Impairments

Today, there are many forces of impairment which tend to shrink estates, decrease their efficiency, and frustrate estate owners' objectives. First, there are the costs associated with death itself, such as last illness and funeral expenses. Then there are the current unpaid bills and the more substantial, longer range debts, such as the mortgage, installment contracts and business obligations with claims against personal assets.

Probably, there will be unpaid income and property taxes. There are the costs of estate transfer, which include the administration expenses, state inheritance taxes, U.S. estate tax, and, in Canada, Canadian succession duties. However, there are more subtle elements of estate impairment. Our economic climate influences estates in a most profound and pervasive manner. Because of inflation, the value of the dollar erodes, which compels constant reappraisal and rearrangement of the family estate plan. To ignore the direction of economic change is to impose a continual levy on one's capital. The failure of one's assets to provide persistent and expected income can destroy the most praiseworthy estate plan. Instability of values can be another thief of estate assets. It might occur through improper management of a business asset, the impact of changes in consumer preferences or obsolescence, or improper management of the general estate assets after death.

An important force of impairment is lack of liquidity to pay the financial costs associated with death and to honor cash bequests. These may compel sacrifice of assets that have substantial income-producing power for the family.

Sometimes, the improper use of vehicles of transfer can impair an estate. Lawyers and other estate planning advisers occasionally find that estate assets, under the legal documents in force, will pass to unintended beneficiaries. This may be accounted for by an old will that was not kept current with family change.

It is not unusual to find life insurance improperly arranged. A major function of life insurance in the estate is to bridge the gap between the income potential of the other estate assets and the needs of the beneficiaries. The life insurance may have been programmed with little or no consideration of the adequacy of the other sources of estate income. The lack of coordination between the attorney planning the general estate and the life underwriter planning the life insurance estate is all too frequent, and may have disastrous results.

Sometimes, the most ambitious and airtight estate plan is destroyed by prolonged and expensive disabilities. Not only is a person faced with a loss of income, but his or her problem is compounded by the financial involvements of the illness itself. Health insurance can assist in the completion of estate plans in the same manner as life insurance. This is by no means to complete the full array of forces of estate impairment, but merely to offer one more illustration—the legal documents associated with the estate plan may have considerable impact. They may have a rigidity that materially penalizes the objects of the estate owner's bounty. Management "from the grave" has led to tragic consequences.

Evaluating Estate Impairment Items

Once the facts have been amassed and arranged, the forces of estate impairment can be analyzed and estimated dollar-wise. What guess can be made as to last illness and burial expenses? What measure can be placed on the debt structure of the decedent? What are the probable transfer costs, such as executor's commissions, attorney's fees, miscellaneous probate fees, state inheritance taxes and federal estate taxes? What unpaid real estate and personal property taxes will there be? What unpaid federal income tax will remain at time of death? One might include in this estimate possible income tax deficiencies for prior years. Can the surviving spouse's and children's allowances be roughly computed? Aside from the
information furnished by the estate owner, the planner will be aided by his or her experience and the various insurance and tax "services" in making rough "guesstimates" of these costs. These estimates will furnish the cash requirements needed at the time of death and will create additional background material for the preparation of the estate plan.

**LIFE INSURANCE**

Another important vehicle of transfer is life insurance. It is the only practical plan that can guarantee that cash will be available at death to meet the financial costs of death. The use of life insurance to meet estate liabilities may prevent the forced sale of prime assets. This, in turn, will reduce the ultimate shrinkage in estate values and perhaps keep alive a source of income for the beneficiaries of the decedent. The presence of life insurance with a named beneficiary will in some states bring savings in state taxes. Probate and administration costs also will be saved. For these reasons, many planners point out that a dollar of insurance is far more valuable at death than a dollar in a bank. It is difficult to conceive of an estate plan today that does not employ life insurance as a significant catalyst to its accomplishment. In the final analysis, insurance in the estate plan will be determined by the needs for liquidity, flexibility, tax minimization, investment and the requirements of family income.

Trusts, both *inter vivos* and testamentary, are used as vehicles of transfer. Sometimes, when there is the possibility of heavy cash requirements at death, or perhaps a need for broad discretion over income and principal, an *inter vivos* life insurance trust may be created.

When there is both an *inter vivos* trust and a testamentary trust, the planner may suggest that both be combined and administered as one. One way to do this is through a "pour-over" trust. Both trusts may well have the same distributive provisions, the same beneficiaries and the same trustee(s). The trustee of the testamentary trust will be authorized to turn over the assets, when received from the executor, to the trustee of the *inter vivos* trust. Local law governs the availability of this technique, and its use has increased substantially during the past few years. There are a number of distinct advantages to the establishment of a living trust and the use of a pour-over device. A single living trust permits a consolidation of family assets. In turn, this should produce savings in administrative expenses, plus an opportunity for the trustee to invest a substantial portion and obtain the benefit of diversification of trust investments. A related advantage of the pour-over is the more simplified and convenient administration of assets under a single trust instrument. A third advantage is in the area of reduced estate administration expenses. Some expenses, such as executive commissions and attorney fees, are generally based on the value of the probate estate. The greater the value of the probate estate, the more these expenses will be. In addition, there are a lot of court costs during the estate administration process. Revocable lifetime transfers represent nonprobate property, and as such will not give rise to estate administration expenses. If life insurance is payable to the trustee of a revocable living trust, the proceeds may be available for the payment of death cost, without increasing estate administration expenses. A fundamental advantage of the revocable living trust is that its terms and the identity of the beneficiaries may be kept secret. The provisions of a testamentary trust are matters of public record—available for all to see.

In a similar vein, there is as a general rule, continued judicial supervision and accounting of the testamentary trustee. Most states that permit the use of a pour-over impose no such requirement on the trustee of a living trust. There is a choice of law because the trust may be established wherever the local law is most favorable to the grantor's purposes. The living trust even gives lifetime benefits. It furnishes the grantor with a "dry run" test of the trust's provisions and the trustee. The grantor can change either prior to death if actual operation does not live up to his or her expectations. Valuable custodianship may be provided when the grantor is too
busy, traveling, ill or mentally incompetent, without the need and the risks of powers of attorney or the necessity of appointing a conservator.

Other examples of tools utilized in estate planning are sprinkling trusts, private annuities, powers of appointment and charitable foundations.

THE ESTATE PLANNING TEAM

The field of estate planning has led such a dynamic life during the past 25 years that it has engendered at least one major status conflict. This revolves about the question: Who should do estate planning? Some five groups claim this privilege, but fortunately, not to the exclusion of each other. These are the lawyers, the life agent, the trust officers, the accountants and the investment counselors.

The lawyer may claim that the estate plan is essentially a legal transaction and therefore falls essentially within his or her jurisdiction. The life agent may contend that life insurance today is so vital a part of the estate plan that without his or her active participation, estate planning has little meaning for the typical estate owner. The trust officer may state that his or her vast practical experience in such matters qualifies him or her as the person best fitted to serve the estate owner. The accountant may point to his or her intimate knowledge of his or her client's affairs and to his or her exhaustive experience and know-how in the field of taxation. The investment adviser offers his or her knowledge of investment media as a badge entitling him or her to participate in the estate planning process.

Estate planning today is so complex and subtle a process that it calls for teamwork. Each of these professional groups can play a role in the accomplishment of the estate owner's objectives without any necessary conflict. The life agent is frequently the initiator of the idea because, unlike the lawyer and accountant, his or hers is a license to solicit business. He or she can supply a vehicle of transfer through life insurance. He or she is in a position to recommend the most effective settlement options. The lawyer will draft the legal instruments that will furnish the power for the execution of the estate plan.

The accountant can be of help in supplying the intimate financial data necessary to the formulation of the estate plan. He or she is also the appropriate person to resolve the vital question of value for the closely held business interest. The trust officer can lend advice on the practicalities of the estate plan and can play a major role in the estate administration. If the estate is large enough, the investment adviser can be a vital person on the team.

In 1988, an article was published under the sponsorship of the National Conference of Lawyers and Life Insurance Companies, entitled "Some Guideposts for Cooperation Between Lawyers and Life Insurance Representatives." Its membership comprised the membership of the Joint Committee on Practice of Law of the American Life Convention and the Life Insurance Association of America, along with the American Bar Association's Standing Committee on Unauthorized Practice of the Law. The article, which was circulated widely, attempted to outline areas of activity in which lawyers, life agents and the home office counsel could cooperate in the complexity of estate planning.

In the "Guideposts" article, it was agreed that the life agent may prepare a thorough analysis of the client's life insurance estate. He or she may advise on beneficiary changes, the use of optional modes of settlement, whether policies should be converted or paid up, the appropriate plan under which new insurance should be written and the use of supplementary features, such as disability riders, accidental death benefits, term riders and the like. Forms dealing with the disposition of insurance proceeds by the company, approved by home office counsel, may be provided by the life agent.
THE ROLE OF THE LIFE INSURANCE AGENT

A life agent may, in discussing an insurance program with a prospect, refer to general subjects that would be pertinent for the prospect's lawyer to consider in his or her advice to his or her client. Further, the life agent may develop for his or her prospect an overall estate plan, solely for the purpose of demonstrating the compelling necessity of putting his or her affairs in order and inducing the client to consult his or her lawyer.

The "Guideposts" article was most helpful in clarifying the role of the life agent in the estate planning process. It did not alter certain propositions found in the 1978 "National Statement of Principles of Cooperation Between Life Agents and Lawyers." In substance, the unaltered principles are that a life agent may not:

- Practice law, give legal advice and prepare legal documents, such as wills, trust agreements and business insurance agreements.
- Dissuade a client from seeking the advice of legal counsel or attempt to divert legal business from one attorney to another.
- Act as intermediary and furnish attorneys who will give cost-free advice to the agent's clients or prospects.
- Share the attorney's fee or pay any part of his or her life insurance commission to an attorney or other person not a life agent.
- Obtain legal opinions from an attorney and circulate them as selling documents.
- Estate planning is a flourishing area of service to the American public. If reasonable freedom in the acquisition, conservation and distribution of property can be maintained, then estate planning should always be a great challenge to superior minds engaged in the professions concerned.

PROGRAMMING LIFE INSURANCE

Programming is to life and health insurance what diagnosis and prescription are to the field of medicine. In other words, it is the vehicle for carrying the product to the client. Just as a good doctor would not blindly prescribe a medicine or surgical procedure, a good agent would not recommend a life or health insurance contract unsuited to his or her client's particular needs.

Programming is the process used by a life and health agent to assist a client in measuring his or her desired financial goals and aspirations against his or her present assets, including life insurance, health insurance and other investments.

As a normal result, through life and health insurance, the agent is able to assist his or her client in solving financial problems and in reaching his or her financial goals.

Essentially, there are three basic programming problems facing every person and his or her family. All three problems involve loss of funds and/or income that must be replaced in the event of the three forms of economic death, that is, premature death, disability or retirement. In addition, the living values of life insurance and other investments are brought into the picture. Through the professional application of good programming techniques, the agent evaluates each of the above hazards with the client and together they work out the solutions. The greater the client's understanding of his or her problems, the more eager he or she will be to solve them.

Hence, the rule in programming is to have the program developed based on the client's ideas and not those of the agent. This is achieved through proper fact finding. Here, the questions asked cause the client to think about the problem before the solution is recommended.
The approach is very much like that of an architect. He or she asks his or her client what he or she wants in the way of a house. He or she then draws up a working plan based on the client's ideas. The client and the architect discuss the plan, work out reasonable alternatives and then decide on the final home to be built. The same concept is employed in professional programming.

So, regardless of the details of a specific company's programming technique, the concepts of fixing the problem, analyzing the problem, planning the solution and recommending the solution are the same.

The question of the relationship of programming to estate planning is only a matter of degree. For our purpose, it will be assumed that programming involves the measuring of financial goals, comparing them to a client's assets and uncovering needs for new life insurance, health insurance or other investments.

Estate planning includes in its application all the elements of programming, and it adds estate conservation and distribution. Estate planning also includes the disposition of business interests and the use of pension and profit sharing plans and other devices for individuals to help them establish larger estates with tax-deferred dollars.

The purpose of this section is to analyze the financial problems of the client who is not primarily concerned with federal estate taxes and who will not have a need for trust agreements, business purchase agreements or unusually complicated wills. It is significant to note that these persons make up the great majority of the insuring public. A recent study indicated that surviving spouses received, on the average, only $20,000 in lump-sum payments from all sources, including life insurance, settlements under employee retirement plans, Veterans Administration and social security funeral benefits, gifts from friends and co-workers, and the sale of possessions or business interests. Life insurance accounted for 69 percent of the lump sum received. When personal and group insurance lump-sum and income payments are taken into account, it is likely that as much as 80 percent of the typical person's estate consists of life insurance. For such a person, the organization of assets equal to as much as 80 percent of his or her estate is significant, and it matters little whether the process is called "programming" or "estate planning."

**Human Life Value Approach to Programming**

The human life value concept has had a very significant influence on the theory of programming. Briefly, the human life value concept assumes that every person who performs a valuable economic service has a very real financial value, and that this value should be replaced by life insurance in the event of premature death. Thus, the person who insures a piece of property for its value in the event of loss should apply the same concept to his or her own economic value. If a person dies prematurely, his or her family will suffer a real economic loss, which can be compensated for in some measure by the presence of life insurance.

The human life value of an individual may be determined by calculating the present value for that portion of his or her estimated future earned income that would be devoted to his or her family.

**Estate Creation, Conservation and Distribution**

Programming can be related to three principal functions. For most persons, the major function is estate creation. Most individuals are insured for only a relatively small part of their human life value. Consequently, the premature death of a husband typically results in serious financial problems for his or her surviving spouse and children. The functions of estate conservation and estate distribution may become equally important.
Estate distribution is important, even though the individual's estate may be relatively small. In fact, from the standpoint of having a margin for error, the smaller the estate, the more important it is to make certain that the insurance proceeds and other assets go to the intended parties, and in the appropriate manner.

**Programming Process**

It is often helpful to consider programming as a process. When viewed in this way, programming becomes a series of related steps, all of which are designed to accomplish a given goal or goals of individuals, which will vary widely and change with the passing of time. Consequently, a reasonable degree of flexibility should be maintained in carrying out each step in the process. If some major step is omitted or carried out in an inadequate manner without complete information, the final program will not be realistic.

Most life insurance companies have developed a standardized programming process their agents may follow in serving their clients. By introducing the new agent to a "programming process," rather than vague guidelines, he or she has definite procedures to follow and knows what to do and how to do it.

The following list of processes is by no means uniform. In fact, it seems reasonable to assume that no two companies suggest precisely the same processes or procedures to their agents. However, the following list is reasonably typical:

- Analyze all relevant factors.
- Determine the goals of the client.
- Compare present resources with those required to meet the client's goals.
- Prepare a specific plan to meet the goals.
- Provide for the creation, conservation and distribution of the estate.

**Analyze Relevant Factors**

Since a worthwhile program can only be based on the information supplied by the client, the agent should seek to obtain all relevant information. This includes a detailed analysis of the client's present assets and liabilities, his or her family relationships, and his or her goals and aspirations.

It is important for the agent to have some type of checklist to make certain that all assets and liabilities are taken into account. Most companies have prepared a confidential information form of some type. Typically, this will begin with questions to identify the client and his or her dependents, and give biographical data regarding each person. The length of the "confidential" varies from company to company. It may be a brief form, or it may be highly detailed.

**Determine the Goals of the Client**

To a certain extent, the goals of the client are closely related to his or her needs. However, there is a tendency to think of his or her "goals" as what he or she would like to achieve financially for him/herself and his or her family, whereas "needs" are often considered the absolute necessities that must be provided for.

Goals of the client were partly analyzed when the "confidential" was completed. At this point, a closer look is taken of those goals. For example, has he or she set definite goals in all the areas in which they should be set? Are his or her goals realistic in the light of his or her present and probable future situation? Has he or she set conflicting goals for him/herself without realizing it? The client may have previously given considerable thought to his or her goals, or this may be the first time that he or she actually has ever established clear-cut goals. The amount of discussion involved regarding each of the client's goals will depend upon how much previous thought he or she has given to them. The statement is sometimes made that the most important
aspect of goals is that they should be realistic. Naturally, what is realistic for one individual may not be realistic for another. In many instances, the client actually wants the agent to guide him or her in determining what is a realistic goal.

If the agent accepts the goals of the client without question, it can be argued that the resulting program may not be realistic and will not meet the needs of the individual and his or her dependents. On the other hand, if the agent exerts too much influence, then the final program may represent the agent's goals instead of those of his or her client. Perhaps the most common practice is for the life underwriter to help the person question whether or not his or her goals are realistic. Such questioning may motivate him or her to adopt more suitable goals; on the other hand, the individual may continue to insist that his or her goals are realistic. In either case, the life underwriter generally prepares a program on whatever basis the client decides. From a psychological, as well as practical standpoint, it is imperative that the program represent the client's goals, and not just the goals that the agent considers important.

**Prepare a Specific Plan to Meet the Client's Goal**

Programming typically involves a minimum of two interviews with the client. During the first interview, the agent usually explains the type of service he or she renders and, assuming the client is sufficiently interested, completes the confidential information form. The information that the agent obtains in the process of taking the confidential information is used to prepare a program. The program is a specific plan, designed to enable the client to meet the goals that he or she wishes to achieve.

In preparing a specific plan, two of the most important decisions are the amount and type of life insurance to recommend. In determining the amount of life insurance, the agent will often use a computer. It enables him or her to determine the amounts of life insurance needed to provide the various monthly income requirements through the use of settlement options. The computer has been programmed to handle the calculations and the presentation material that goes back to the client. The agent obtains the necessary information on the client's objectives and assets. This is transferred to an input form for the insurance company's computer and sent to the home office. The home office computer then works up the plan for the client. The advantages to this method are speed and accuracy of calculation and a uniform method of approach to solving the problems. This works best if computers are available in an agency. The type and degree of sophistication in computerized programming vary widely. They range from simply supplementing Social Security to planning complex estate situations.

**Program the Life Insurance**

In the case of "income needs," the benefits provided by policies of different companies and different policies issued by the same company are not necessarily identical; there may be substantial differences because the settlement options of some contracts are more liberal than others.

**Provide for the Creation, Conservation and Distribution of the Estate**

The major problem for the average client is estate creation. However, conservation and distribution should be considered, regardless of the size of the estate. If the estate is very large, this may create a need for tax planning, trusts and the other more advanced forms of estate planning. For the person of limited or average means, two key steps are (1) having his or her attorney prepare a will for both husband and wife, and (2) having his or her agent arrange for the proper naming of beneficiaries and selection of settlement options in the life insurance policies.
ANALYSIS OF NEEDS

The basic financial needs of a mature market are often divided into two types of needs: cash needs and income needs. Money for "cash" needs is not necessarily paid in a lump sum, but may be held by the insurance company at interest until needed for any subsequent emergency, education of children, and the like.

Cash Needs & Final Expenses

A final expense fund is needed to meet obligations outstanding at the time of death, or which are caused by death itself.

Examples are medical expenses, burial expenses, outstanding installment debts, taxes and the cost of estate settlement. The amount needed to pay final expenses will vary considerably, but most authorities feel that $5,000 to $10,000 represents an absolute minimum. Of course, in the larger estates, liquid funds needed for estate or inheritance taxes would materially increase these figures.

Emergency Fund

The emergency fund is to provide for unexpected financial needs. While it is possible to estimate anticipated future expenses with some degree of accuracy, even the most careful planning may be jeopardized by one or two unforeseen expenses.

Many financial experts recommend that the emergency fund be approximately 25 percent of the family's annual earned income. Thus, if the client's annual earned income is $20,000, an emergency fund of $5,000 would be suggested.

Mortgage Fund

The purpose of the mortgage fund is to provide the money needed for the surviving spouse to pay off the remaining balance of the mortgage on the family home.

In the absence of a mortgage fund, the amount of the monthly mortgage payments must be included in the income needs of the surviving spouse until such time as the mortgage payments have been completed.

Education Fund

The dramatic increase in the cost of securing a college education is common knowledge. The result is that funds must be available when needed or else a college education may be out of reach for one's children.

The fact that these costs are increasing means that it is probably unrealistic to consider any figure less than $10,000 per year. If a high-tuition school is selected, then the annual cost can easily jump to $25,000 per year or more.

Income Needs

Readjustment Income

The purpose of readjustment income is to provide temporarily the same income to the surviving spouse as was available before the other spouse died. This is usually provided for one or two years.

The value of this arrangement is that it permits the surviving spouse to recover his or her emotional equilibrium, and to make plans for the future without having to cope with financial worries at the same time.
The amount of the readjustment income, for any given program, will be larger than the amount the surviving spouse receives during the dependency period.

Thus, a given program might provide $2,000 a month readjustment income for two years, and then decrease to $1,700 a month for the dependency period.

**Dependency Period Income**
The income during the dependency period is expected to provide the surviving spouse with a fixed income until the children reach a specified age. Most programs provide dependency incomes until the youngest child reaches age 18. If plans have been made for the children to attend college, then the education fund would provide for their needs until they complete college.

Most programs provide dependency incomes until the youngest child reaches age 18. If plans have been made for the children to attend college, then the education fund would provide for their needs until they complete college. An alternative method is to provide dependency income until the youngest child reaches age 21 or 22, and reduce or eliminate the education fund.

**Life Income for Surviving Spouse**
The life income for the surviving spouse starts at the end of the dependency period and continues for his or her lifetime. Typically, the amount of the life income will be considerably less than the income when the youngest child reaches age 18. If the children plan to attend college, then hopefully this has been provided for by means of an education fund. Since most children will receive some education beyond the high school level, some life underwriters continue the dependency period income until the youngest child reaches age 21 or 22. In the event that no education fund has been provided, this may enable the surviving spouse to pay for part of the cost of education beyond the high school level.

**Retirement Income**
Retirement income will begin when the husband or wife reach their designated retirement age, typically age 65. The amount of the retirement income is often expressed as a specific monthly income while both the husband and wife are alive, with a different figure being payable upon the death of either. Typically, the monthly income paid to the survivors is two-thirds of the amount paid to both. While specific retirement income policies are issued by most companies, the usual practice is to convert the cash values of permanent life insurance policies into an annuity by utilizing the life income option at the time of retirement. If the client feels that a certain amount of protection should be kept in force, then the reduced paid-up nonforfeiture option can be elected for one or more policies.

**Need for Program Review**
From the client's point of view, an annual or at least a biennial review of his or her program is essential. Not only do his or her needs change, but his or her income tends to increase, and his or her Social Security and employee benefits change. Each change should be analyzed to determine if it requires a revision of the program, and hence there are endless opportunities for sales and service for existing clientele.

**SETTLEMENT OPTIONS**
Most people think of life insurance in terms of a lump sum of money. In fact, it is probably not unusual for a client to ask an agent, "It's true that you've prepared a very logical plan, but what guarantee do I have that the plan actually will be put into effect after my death?" The answer is that the client may elect a combination of settlement options at the time the plan is put into
effect that provides for the proceeds to be paid to his or her spouse and children in the way he or she prefers.

**Need for Flexibility**

In the plan designed through programming, it is important that flexibility be allowed in the final setup of the plan. The well-intentioned fixed settlements of life insurance contracts through unchangeable settlement options can be outdated if the plan is not reviewed annually. In addition, future changes in circumstances, such as remarriage of the surviving spouse, or his or her death, can change needs. A good rule is to provide for the needs through life and health insurance, but give essential freedom in the manner of ultimate distribution.

**OWNERSHIP & BENEFICIARY DESIGNATIONS**

A life insurance contract consists of a bundle of many rights, and the person who can exercise those rights during the lifetime of the insured is the owner of the policy. Some of the most common rights are the right to designate the beneficiary who is to receive the death proceeds and to select settlement options for the proceeds, the right to make an absolute assignment or name another owner, the right to make policy loans or to assign the policy for collateral purposes, the right to surrender a policy and receive the cash surrender value, the right to receive proceeds at maturity of an endowment, the right to elect dividend options and receive dividends and the right to select the nonforfeiture provisions to be operative upon nonpayment of premiums.

**Ownership**

The insured is the owner of this policy unless otherwise provided in the application or by later transfer. Subject to the rights of any prior assignee, and unless the owner and the Company shall agree otherwise, all rights that are available while the insured is living are vested in the owner and may be exercised by the owner without the consent of anyone else. Proceeds payable at the insured's death are payable to the beneficiary and not to the owner, unless the owner is also named as the beneficiary.

If ownership is transferred after the policy is issued, and if company practice prescribes use of an ownership clause instead of an absolute assignment form, appropriate language is embodied in the policy or in the instrument of transfer. When an individual person is named as owner, an ownership clause offers more potential flexibility than the conventional form of assignment. Where company practice permits, it is useful when it is desired to name successive owners if the first owner dies before the insured. It is also useful to name an owner for a limited period of time, or until a specified date or the occurrence of a specified event, with provisions for automatic transfer of ownership thereafter. However, company practices differ; many policies do not provide for an automatic change of ownership for any event other than the death of the owner. Some policies may require physical endorsement of a transfer of ownership, while other policies may be transferred without an actual endorsement.

Naming of a contingent or successive owner is advantageous in some cases. Although it does not avoid death taxes in the state of the owner, it enables the owner to avoid having the policy pass through his or her probate estate. In addition, it is vital to the insurance company to know with whom it can deal after the death of the original owner.

In considering the transfer of ownership by a third party owner, the problem that comes most immediately to mind is the common law requirement that one having an interest in a life insurance policy on another must have an insurable interest in the insured's life. The law of insurable interest as it relates to the naming of a beneficiary is fairly well settled. An assignee or
a transferee of ownership is not required to have an insurable interest if the assignment or transfer is made in good faith.

**Life Insurance Ownership and Estate Planning**

Today, more and more people are concerned with the problems surrounding their estates. Life insurance ownership by the insured, especially with a large death benefit, may cause unnecessary tax problems upon death for that person’s estate.

As long as the insured retains the incidents of ownership, the proceeds at death will be included in the deceased estate and will be taxed by both the federal and state governments. This of course, will help deplete the value of any estate.

Incidents of ownership include:

- Ability to change the beneficiary (Revocable beneficiary). An irrevocable beneficiary cannot be removed by an owner.
- Ability to assign the policy
- Ability to use the policy as collateral
- Ability to surrender the policy for its cash value

In order to prevent this situation it will be necessary to give up the incidents of ownership and transfer them to another. That someone else, of course, must have an insurable interest in the insured to comply with insurance laws and the insurable interest must be in effect at the time of assignment, just not at the time of death.

The previous benchmark number was $600,000. Any estate, after deductions and reductions, that was more than $600,000 was subject to estate taxation. However, the Economic Growth and Tax Relief Reconciliation Act of 2001 raised the bar. The exemption amount raises to $700,000 in 2002, $850,000 in 2004 and a $1,000,000 in 2006. In 2010, the Act completely repeals estate tax. However, estate professionals advise clients to still plan as though there will always be an estate tax because Congress could easily reinstate them starting in 2011. Also, bear in mind, there are, of course, many different items that will effect the final estate value, which will determine the estate’s tax liability.

**Transfer of Ownership May Not Affect Death Benefits**

It is important that the ownership clause of the policy be examined carefully to determine the contractual effect of a transfer. The owner may merely "stand in the shoes" of the insured. His or her rights may be limited to the rights the insured him/herself might have exercised during his or her lifetime, and those rights may expire with the death of the insured. Since the insured him/herself could not have received the death benefit, the third party owner likewise may not be automatically entitled to receive that death benefit.

Accordingly, whenever ownership of a policy is transferred to someone other than the insured, it should also be determined whether a change of beneficiary to the owner should be made. When someone other than the insured owns a policy and a third party is named as the beneficiary (e.g., where one spouse transfers ownership in policies on his or her life to the other spouse who, in turn, names their children as beneficiary), at first spouse’s death it may be that the surviving spouse has made a taxable gift of the proceeds of the policy to the children. This is because the surviving spouse, as owner, had the right to name him/herself as beneficiary and did not do so; therefore, the surviving spouse may be considered to have made a gift to the children.
**Beneficiary Designations**

There are many options that can be used to designate beneficiaries on life insurance policies, annuities and IRAs, Keoghs, SEPs, etc. Some can involve complicated legal issues or may affect estate tax for heirs. For instance, if a mature client wanted all of his retirement accounts divided equally among his living children, he might write "all my children equally" as beneficiary. However, if a child predeceases the parent, the child’s estate or family won’t receive any of the proceeds. A “per stirpes” designation (discussed below), however, would allow distribution to the first decedents of the child. Likewise, a lot of matures believe that their will makes it clear as to who will get what. As an agent, you know that beneficiary designations bypass probate and go directly to the beneficiaries unless the client lists his beneficiary as his “state”.

Life insurance policies issued today uniformly contain provisions permitting the designation of a beneficiary to receive the proceeds payable at the insured's death. There are additional provisions permitting the beneficiary to be changed and successively changed. All of these provisions will usually be found under a heading such as "Beneficiary" or "Change of Beneficiary." Too frequently, just one beneficiary is named when a policy is issued, and the designation is not reviewed again for many years. This discussion will assume that the insured is the owner, except where the context clearly indicates otherwise.

**Revocable and Irrevocable Beneficiaries**

An insured normally reserves the right, on his or her sole signature, to designate and change the beneficiary. Such a beneficiary is said to be designated "revocable," and the modern rule prevailing in all but a few states is that such a beneficiary's interest is a mere expectancy. This being the case, the insured is allowed to exercise every right under the policy, without the beneficiary's consent.

Where the right to change the beneficiary is not reserved, the designation of beneficiary is said to be "irrevocable." Here, the beneficiary acquires a vested interest that the insured cannot change or defeat, except with the beneficiary's consent.

There may be uncertainty as to the effect of an irrevocable beneficiary designation, in that, at one extreme, such beneficiary's interest may be limited merely to a requirement that his or her consent be obtained to effect a change of beneficiary, but is not needed in order to exercise the other incidents of ownership. At the other extreme, the beneficiary may be regarded as actually possessing incidents of ownership jointly with the insured so as to require the beneficiary's consent before the insured may exercise any rights under the policy.

This uncertainty may arise either because of the failure of a company to specify the rights that flow from an irrevocable beneficiary designation or because of different interpretations made by the courts. As a protection to the company, as well as to the other parties in interest, many companies specify the precise rights created by an irrevocable designation. Such a beneficiary clause may read as follows:

"The insured hereunder having so requested, it is agreed and understood that the insured may not revoke and change the beneficiary designated under this policy during the beneficiary's lifetime. The insured, without the written consent of such beneficiary, may not make loans on this policy, except for the sole purpose of paying a premium or premiums on this policy, or interest on any indebtedness on this policy, or both. In addition, the insured may not exercise, without the written consent of such beneficiary, any other option, right, or privilege provided therein, including but not limited to the right to elect any of the nonforfeiture provisions thereof, or the right to assign this policy."
The insured and not the said beneficiary shall have the right to receive all amounts payable hereunder if this policy matures as an endowment."

Today, the irrevocable beneficiary designation is in limited use. It is seen most frequently in agreements relating to separation and divorce, where provision for the maintenance of an insurance policy is included in the agreement, and where it is desired specifically to restrain the insured in the exercise of the various policy rights without actually transferring ownership to the beneficiary. Under the quoted form, if the irrevocable beneficiary predeceases the insured, the insured regains full control over the policy.

**Primary and Contingent Beneficiaries**

Consider this beneficiary designation: "Mary Doe, wife of the insured, if living at the death of the insured, otherwise to such of the lawful children of the insured as may be living at the death of the insured." Mary Doe is known as the "primary beneficiary"; the children, as "contingent beneficiaries." Two or more primary beneficiaries may be named to share the proceeds—for example, equally or all to the survivor—and contingent beneficiaries may be designated in the event that none of the primary beneficiaries survives the insured. Normally, it is considered good practice to designate a contingent beneficiary. Most policies currently being issued provide that if all named beneficiaries die before the insured, the proceeds of the policy, at the insured's death, will then be paid to the insured's estate. Where the owner of the policy is someone other than the insured, however, it is usual to provide that if all named beneficiaries predecease the insured, the policy proceeds at the insured's death will be paid to the owner or the owner's estate.

**Insurable Interest**

The presence of insurable interest is required only at the inception of the policy and not upon a subsequent transfer of the policy or at maturity of the policy as a death claim. For many years, there was doubt whether a policy, valid at its inception, could be payable to a beneficiary or an assignee who, at the death of the insured, had no "insurable interest" in the life of the insured. Broadly speaking, "insurable interest" arises either out of close family relationships or from substantial economic interest in the continued life of the person insured. In other words, there must be a reasonable ground to expect some benefit or advantage from the continuance of the insured's life. In more recent years, either by judicial decision or by statute, a person has been regarded as having an insurable interest in his or her own life. He or she may legally contract for insurance of which he or she is the owner and may generally name a beneficiary of his or her own choosing, even if the beneficiary has no insurable interest in the insured's life. However, if the policy is applied for and owned by someone other than the insured, the applicant owner must have an insurable interest in the life of the insured.

**Identity of the Beneficiary**

The following are several of the more popular types of beneficiary designations:

**The Insured’s Estate**

The proceeds may be made payable to the executors or administrators of the insured and thereby added to the other probate assets of the estate. This arrangement is useful if the proceeds are intended to cover debts, funeral expenses, taxes and expenses of administering the estate. However, such a designation may subject the proceeds to state inheritance taxes and increase the administration expenses of the estate. In addition, such designation will subject the proceeds to claims of creditors of the estate. These results may be avoided in whole or in part by designating a named beneficiary, such as the insured's spouse, to receive the proceeds.
Specifically Named Person
The most commonly used designation names the spouse of the insured as primary beneficiary, with the children as contingent beneficiaries. The designation may read: “Mary Doe, wife of the insured, if living at the death of the insured, otherwise to such of John Doe and Susan Doe, children of the insured, equally, or to the survivor of them, at the death of the insured.” It is customary to describe the beneficiary by reference to his or her relationship to the insured.

Class Designations
It is sometimes desired to designate a group of persons without identifying the individual members of the group. This is known as a class designation. The designation of "lawful children of the insured" is a common example of such a class designation. The beneficiaries actually entitled to receive the proceeds at the death of the insured will be determined by the members of the class who may be born after the date of the beneficiary designation and before the insured's death. Companies tend to limit the designation of this type of beneficiary to classes of people closely related to the insured, where the members of the class are easily identified. When it is desired to name children as beneficiaries, the simplest and usually the safest way is to designate "children of the insured" as a class. If the children are designated by name as "John Doe and Susan Doe, children of the insured," then unnamed children or children born after the date of the beneficiary designation will be excluded. If this result is not desired, "children of the insured " or "children of the insured, including John Doe and Susan Doe," should be designated.

One word concerning adopted children: Adoption proceedings may require months or even years in some states. Until the proceedings are completed, such children would not be included in a class designation such as "children of the insured." To share in the proceeds before adoption proceedings have been completed, their names would have to be included specifically in the beneficiary designation.

In any class designation, the company will usually require an exculpatory clause in the designation which permits the company, in determining the identity and the existence of the persons in the class, to rely upon an affidavit or other evidence satisfactory to it. For example, if "children" as a class are designated, the company may not know the names and addresses of all of the children. Such a clause may read as follows:

"The Company, in determining the existence, identity, ages or any other facts relating to any persons designated as beneficiary herein, either as a class or otherwise, may rely solely upon any affidavit or other evidence deemed satisfactory by the Company, and each and every payment made by the Company in reliance thereon shall, to the extent of such payment, be a valid discharge of the Company’s obligation under this policy."

Per Stirpes or Per Capita?
*Per stirpes* and *per capita* are legal terms that describe alternative methods of distributing property to one's descendants. Which method of distribution was intended by a decedent is not always an easy question to answer. To illustrate the problem, let us assume that an insured has in mind that the proceeds of his or her policy shall be paid to his or her children, John, William and Mary, or to the survivor or surviving children of a deceased child. Suppose John and Mary die before the insured. John leaves four children surviving him or her. Mary has no children. How shall the proceeds of the policy be distributed at the insured’s intent when he or she spelled out the beneficiary designation?

*Per stirpes* means by branches of the family. A *per stirpes* distribution gives the share of the deceased child to his or her children. Accordingly, under a *per stirpes* distribution, William would
take one half of the proceeds, and John's surviving children would divide the other half among themselves.

*Per capita*, on the other hand, means "by heads." A *per capita* distribution will give one share of the proceeds to each beneficiary. On a *per capita* basis, William and each of John's four children would receive one-fifth of the proceeds.

*Per stirpes* distributions are more popular. In any case, it is most important that the request for a beneficiary designation reflect the distribution desired by the insured, and that such distribution be clearly set forth in the actual beneficiary designation.

**Business Organizations**

An insured may name a corporation or a partnership a beneficiary in the same manner as he or she would an individual. The problems here are essentially the same as with the individually designated beneficiary. Where it is intended that the proceeds of a life insurance policy be received by a partnership, it is advisable to designate the partnership itself as a beneficiary to receive the proceeds, rather than designate the individual partners by name to receive the proceeds on behalf of the partnership. Where the partnership itself is designated as beneficiary, additions or withdrawals of partners will present no problem as to the proper payee of the proceeds at the death of the insured. Such a designation might read: "Brown and Company, a partnership or its assigns."

As for naming a corporation, the customary form is: "The XYZ Company, a Pennsylvania corporation, its successors or assigns." The use of the phrase "its successors or assigns" will cover a possible change in the corporate structure, such as a merger or consolidation occurring after the date of the beneficiary designation and before the death of the insured. When naming a corporation as beneficiary, it is wise to check the exact corporate title. A corporation may be popularly known by one name, but its correct corporate title may be quite different. Moreover, several corporations may have similar names. This is particularly true in the case of charitable organizations, such as hospitals, churches or homes for the ill or aged.

**Trustees**

The insured may wish to have the death proceeds paid to a trustee who will administer the fund for the beneficiaries of a trust. On policies for larger amounts, the use of trustees for lump sum settlements has been greatly on the increase with an arrangement for life companies to retain the proceeds under settlement options. The trust may be established by the insured either by agreement during his or her lifetime or at death under the terms of his or her will.

Where the life insurance trust agreement created during lifetime is used, a typical trustee beneficiary designation would read: "Henry Clack and the XYZ Trust Company, as trustees, their successor or successors in trust, under trust agreement dated _____________ ..." The insured's spouse is often named as an individual co-trustee. Additional language is frequently included in the beneficiary designation by the life insurance company, the effect of which is to relieve the life insurance company of any responsibility for the proper administration of the insurance proceeds once they are paid over to the trust.

The trust arrangement should be carefully studied to be sure whether the trustees are merely to be named beneficiaries or whether, as is often the case with an irrevocable trust, ownership of the policy should be transferred to the trustees. The designation of trustees under the insured's will as beneficiary introduces complications, which are avoided by a signed agreement executed during the lifetime of the insured. A trust created under a will can take no effect if the will fails to qualify for probate or if it should be declared invalid for any reason. There may be a question of
the validity of such an arrangement under some state laws. There is a danger that the insured may change his or her will and forget to change the beneficiary designation that ties into the will. A new will may have no trustee. Even if one is named, the insured may no longer desire the proceeds of the particular life insurance policy to be payable to the trustees under the will.

The will may create two or more trusts with different trustees, and a problem would be presented as to which trustee should receive the proceeds. Despite these potential complications, the practice of the designation of testamentary trustees as beneficiaries has increased during recent years. Several states have passed laws that encourage the practice by specifically providing that proceeds payable to a testamentary trustee will not attract state inheritance taxes and will not be subject to the claims of creditors. An example of this type of law may be found in Section 13-3.3 of the New York Estates Powers and Trusts Law. Prior to these special laws, it was felt that proceeds payable to a testamentary trustee would be subject to claims of creditors and to state inheritance tax in the same manner as if the proceeds were payable to the insured's estate. The designation of trustees under the insured's will as beneficiaries should not be attempted without the advice of the insured's lawyer. The following is an example of one format for designation of a testamentary trustee:

The proceeds shall be paid to the trustees designated under the insured's will or their successor or successors in trust, but if the company receives written evidence satisfactory to it that:

- The trustee, for any reason, fails to serve, and no successor trustee was appointed.
- A will of the insured, which was admitted to probate, made no provision for trustees.
- A personal representative of the insured has been appointed in intestacy.

Then, in any such event, the proceeds shall be paid to the executors or administrators of the insured; provided, however, that the company shall be fully discharged for any payment made to guide trustees before receipt of written evidence satisfactory to it that said trustees are not entitled to payment under the provisions of this designation; provided further, however, that if there is more than one trust established under the probated will of the insured, and the Company shall be fully discharged in making payment to such trustee or trustees in the proportions so designated.

**Minor Beneficiaries**

Under the common law, a minor under the age of 21 cannot give a valid release for receipt of life insurance proceeds. Many states have lowered the age at which a minor, or in some cases a married minor, attains majority. In many states, there are statutes applying to the minor's rights to receive benefits that permit payment of a modest amount, such as $5,000 or $10,000, directly to a minor who has attained a specified age (such as 16 or 18) or to the probate judge or other official for the benefit of the minor. If one of these special statutes does not apply, it is necessary to have a guardian appointed to receive payment on behalf of the minor, with the attendant formality, expense, legal steps and numerous restrictions as to who may be guardian and what he or she may do with and without specific court approval.

The problem is simplified by permitting the proceeds to be retained at interest by the company with the full right reserved for the minor's benefit to withdraw or to elect any other settlement option in the policy. The minor is named as beneficiary, but it is provided that if he or she is still a minor at the time for payment to him or her, a trustee, rather than a guardian, will receive the payments on behalf of the minor and may exercise the specified withdrawal privileges. The trustee is also empowered to select one or more of the installment options in the policy in lieu of the interest option. The trustee may be appointed under a separate formal trust agreement or, under the practice followed by some companies, may be named in the settlement agreement or beneficiary clause. There also may be provisions for a successor trustee if the one first named
fails to serve or ceases to serve. When there is no separate trust agreement, the settlement agreement itself may contain simple trust provisions to the effect that the trustee shall hold and expend the monies received from the life insurance company for the benefit of the minor until the age of majority and shall then pay him or her any unexpended funds. The extent to which these various procedures may be utilized will depend on company practice in each case.

How to Designate and Change Beneficiaries
The first beneficiaries designation usually appears in the application for the policy. Requirements for subsequent change are given in the policy, with which compliance ordinarily is easy. Typically, the policy provides that the request for change shall be made in writing on a form satisfactory to the company, and each company supplies forms for this purpose. Most of the older policies require endorsement of the policy to effect a change of beneficiary, but the modern trend is to make the change without physically endorsing the policy.

There are instances where an insured desires to change the beneficiary but for some reason is unable to comply with all of the prescribed formalities. For example, the policy may require its submission for endorsement of the change, but the present beneficiary may be wrongfully withholding possession from the insured. As another example, the insured may execute the forms, mail them to the insurance company and then die before the company has completed its formalities. The majority rule applicable in such cases is that if the insured does all that he or she reasonably could be expected to do in order to indicate his or her intention to make the change, the change will be deemed to have been accomplished. Generally, a beneficiary change cannot be made by a will or a codicil to a will.

Ordinarily, a change in the relationship of the parties will not of itself affect an existing beneficiary designation. Suppose "Jane Doe, wife of the insured," is designated as beneficiary under her husband's policy, and that Jane and her husband are divorced. Further, suppose that the husband does not change the beneficiary. Unless the divorce decree in that particular state terminates a divorced spouse's interest in the policy, Jane would be entitled to receive the proceeds upon the death of the divorced husband.

Simultaneous Death Clauses
An insured and his or her spouse rarely die simultaneously, whether in a common accident or otherwise. However, the contingency should be considered. As mentioned previously, a popular beneficiary arrangement may provide, in substance: "Jane Smith, wife of the insured, if living at the death of the insured, otherwise equally to such of the children of the insured as may be living at the death of the insured." Under such a designation, if the spouse survives the insured for only a few moments, his or her estate will be entitled to payment of the proceeds.

Accordingly, the proceeds will be exposed to probate expenses in his or her estate and possible claims of his or her creditors. In addition, the proceeds will pass in accordance with the terms of his or her will, or if no will was left, to the next of kin under the intestate laws of the state having jurisdiction. This result can be avoided by making all or a portion of the proceeds payable to the spouse under the interest option subject to his or her full right of withdrawal, and naming children of other persons as contingent beneficiaries to receive any proceeds remaining with the company whether the spouse dies before or after the insured. If the spouse dies shortly after the insured, he or she presumably will not have expressed the right of withdrawal.

Another variation is to require that the spouse survive the insured for a specified period, not to exceed six months. If the spouse survives the specified period and then dies, the proceeds will become part of his or her estate, as in the case of the designation first described in the preceding paragraph. The spouse is not protected against possible claims of his or her creditors, as he or she would be under the standard clauses incorporated in agreements using
the interest option or other settlement options. Further, this second procedure may have disadvantageous estate tax results; in larger estates where qualification for the marital deduction will minimize federal estate taxes, the deduction is lost if a common disaster actually occurs, and if the spouse dies after the insured's death and within the period specified.

It has been suggested that when proceeds are payable in one sum, the Uniform Simultaneous Death Act, which is in force in practically all states, takes care of the contingency of a common accident or common disaster. This is not the case. That act merely provides that if it cannot be determined whether the insured or the beneficiary died first, the insured will be presumed to have survived. Where the spouse survived the insured by as little as a few minutes, the Uniform Simultaneous Death Act obviously does not apply. Also, provisions and concepts predicated on parties dying "as a result of a common disaster" are basically ambiguous and indefinite in meaning and effect, since one party may live for days, months or even years and still die as a result of a common disaster.

If from an overall estate planning viewpoint it is vital that the proceeds qualify for marital deduction purposes in the event of death in a common disaster, the settlement agreement may incorporate a "reverse common disaster presumption." This expression refers to a provision that if the insured and his or her spouse, the primary beneficiary under the policy, die in such circumstances that it cannot be determined who died first, it will be presumed that the beneficiary survived the insured. The presumption created by this clause will be recognized for marital deduction purposes under the Internal Revenue Code.

**State Creditor Exemption Statutes and Their Effect**
Practically all states, by statute, place life insurance beyond the reach of creditors of the insured, to some degree, and under some circumstances. These statutes are known as "exemption statutes," and their provisions vary greatly. Under the most common type of statute, the exemption applies if premiums are not paid in fraud of creditors and the policies are payable to or for the benefit of the spouse, children or other relatives dependent on the insured, even though the insured retains the right to change the beneficiary. Some statutes apply the exemption if the policy is payable to any beneficiary other than the insured's estate. In a few states, the exemption is limited to some stated amount of annual premium.

**Spendthrift Clauses and Their Use**
Spendthrift clauses are concerned with creditors of the beneficiary, not creditors of the insured. There are a few states whose statutes automatically provide certain exemptions for life insurance proceeds from claims of the beneficiary's creditors. In a substantial number of states, though, by statute or by court decisions, the policyowner may use a so-called "spendthrift clause" if settlement options are specified for the beneficiary. Life insurance companies customarily include spendthrift clauses in agreements by which optional modes of settlement are elected. A typical clause reads as follows:

"Unless otherwise provided in this settlement option agreement, no beneficiary may commute, anticipate, encumber, alienate, withdraw or assign any portion of his or her share of the proceeds. To the extent permitted by law, no payments to a beneficiary will be subject to his or her debts, contracts or engagements, nor may they be levied upon or attached."

In a very few states, such spendthrift clauses apparently are considered to be against the public policy of the state and will not be upheld.

**Federal Tax Liens**
State exemption statutes do not give full protection against creditors if the creditor is the United States government under a federal tax lien against the insured. In such instances, the government may reach the lifetime values, even though the taxpayer-insured may have
designated his or her spouse, child or dependent relative as beneficiary. If a lien arises against the insured during his or her lifetime, and the insured then dies, the government can reach the proceeds to the extent of the cash value just prior to the day of death. If the beneficiary owes taxes, the government, after the insured's death, could reach the proceeds payable to the beneficiary under a lien arising against the beneficiary.

**Keeping Current**

Many problems have been discussed in this section to indicate the need for careful study of all the facts when an insured considers the designation of a beneficiary or the transfer of ownership or the making of an assignment of his or her policy. Beneficiary designations become outmoded with the passage of time. Countless beneficiary designations and assignments now in existence may one day pose problems ranging from delay in payment of proceeds to exclusion of those whom the insured had intended should share as beneficiaries. Lawyers, life agents, trust officers, accountants and people in home offices and field offices of life insurance companies can render a significant service by being on the alert to discover these problem areas and then calling them to the insured's attention either for correction of an existing transaction or, if the transaction is not yet concluded, so that the necessary steps may be taken to avoid the problem.

**ESTATE TAXATION OF INSURANCE**

Since life insurance proceeds are normally paid to a beneficiary other than the named insured, they are excluded from the insured's estate, and thus are not subject to federal estate taxes. However, there are situations in which life insurance proceeds may be included, either partially or totally, in the insured's estate. We will look at these situations now.

First of all, unless the contract meets the definition of life insurance just presented, its proceeds most definitely WILL be included in the insured's estate.

And, of course, any proceeds which are paid to the insured's estate, or for the benefit of the insured's estate, are included in that estate.

For example: Luther's Aunt Mary purchased a life insurance contract on Luther's life. Aunt Mary paid all the premiums, and she retained all incidents of ownership. She designated the policy proceeds to pay off the mortgage on Luther's house, leaving it free and clear for his wife and family. However, because these proceeds paid off an obligation of Luther's estate, they would be included in his gross estate. Note that if Luther's house is considered community property, only HIS HALF of the mortgage is considered a debt of his estate. If the proceeds pay off the entire mortgage, then such payment may constitute a gift to his surviving wife. It pays to look into all such complications BEFORE they create problems when death occurs.

When the insured retains INCIDENTS OF OWNERSHIP in the policy, proceeds will be included in his or her estate. Moreover, an insured does not have to retain ALL incidents of ownership. Retention of only one is sufficient for the proceeds to be considered part of his or her estate. As you know, incidents of ownership include a right to the economic benefits of the policy; a right to determine the beneficiary(ies) of the policy; a right to an interest in the policy more than 5% of the policy's value as determined immediately prior to the insured's death.

If either the policy itself or incidents of ownership in the policy are transferred by the insured owner within three years of his or her death, policy proceeds are included in the estate.

In community property states, life insurance policies qualifying as community property will have only one-half of their proceeds included in the insured's gross estate at his/her death. This
occurs whether proceeds are paid to the estate, or the insured merely retains incidents of ownership.

Life insurance proceeds are calculated by the date-of-death value: this amount is the total after any unpaid policy loans are deducted, and paid-up additions, dividends or interest due paid, as of the date of the insured's death.

A life insurance policy is property. Therefore, its proceeds may qualify for the marital deduction. Certain settlement options affect whether or not the proceeds, either partially or totally, qualify for the marital deduction. For example, if one spouse owes the other spouse a debt that is secured with a life insurance policy, and if the debtor spouse dies before the debt is paid in full, only those policy proceeds that remain after the debt has been satisfied qualify for the marital deduction. Note: It has been held that assets designated to satisfy a particular obligation may not qualify for the marital deduction. In such cases, expert advice may be required. Proceeds paid to a surviving spouse under a settlement option which allows him/her to choose the terms of payment are still eligible for the marital deduction so long as the surviving spouse MAY CHOOSE lump sum payment of the proceeds.

The fair market value of a policy is included in the policy owner's estate even if someone else is the named insured. For example, suppose that Aunt Mary (in the previous example) died before Luther, the named insured in the policy she both owned and paid for. The fair market value of policy AS OF AUNT MARY'S DATE OF DEATH would be included in her gross estate for tax purposes.

Settlement options can affect the tax exposure of life insurance proceeds. Generally speaking, proceeds paid in installments do not enjoy tax-favored status: the commuted value of these installments is included in the insured-deceased's estate.

**Gift Tax on Life Insurance**

Life insurance gifts are valued, for tax purposes, by their fair market value at the date of the gift. Note that only in the case of single premium or paid-up policies is there a one time gift tax exposure. In the case of an annual premium policy, the amount paid each year is a gift. Fair market value, rather than the loan or cash surrender value, is the determinant of the policy's gift tax exposure. Note that policies which have only FUTURE INTEREST value DO NOT QUALIFY for the annual gift tax exclusion. For example, Max gives his son a term policy on Max's life. This policy has no loan value, and no cash surrender value. Its benefits can only be enjoyed in the future, upon Max's death. Thus, premiums paid on this policy cannot be considered as part of the annual $10,000 exclusion.

When one spouse gives a life insurance policy to the other spouse, the unlimited gift-tax marital deduction may apply: this deduction covers gifts of interminable interests. The entire value of the gift is deductible even when the interest the donor spouse gives to the donee spouse is terminable under certain conditions. First, the gift is a "qualifying income interest for life," which gives the donee spouse ALL income from the policy, either annually or at stated intervals; the donee spouse has complete control of the property; the donor deducts the property on the federal gift tax return. Second, the donee spouse is named in a charitable remainder trust as a beneficiary: this interest need not be for a lifetime in order for a terminable interest to come under the gift-tax marital deduction.

Some clients for estate planning might wish to make a gift of life insurance to a charity: there are tax ramifications in such situations, and a careful study of applicable regulations should be made. The advice of a qualified tax consultant is recommended.
Taxes on Annuity Income

Annuities are contracts which pay out the principal sum over a period of time, distributing both principal and interest until the principal is completely depleted. Annuities may be for a fixed sum, a fixed period, or a combination of both. Since most annuities are purchased in order to provide income during the life of the annuitant, federal estate tax laws apply only in certain circumstances. Straight life annuities are never subject to federal estate tax, since their benefits end with the death of the annuitant. Some annuities continue to pay after the death of the annuitant; in such cases, the balance still to be paid may be included in the gross estate. For example, a refund may be owed; the annuity may provide for benefits to continue to a survivor/beneficiary; or there may be a death benefit provision. In cases where the annuitant paid only a portion of the cost of the annuity, the amount of benefits proportionate to that are included in the gross estate.

When an annuity is purchased as a gift for someone else, it comes under federal gift taxation regulations. Note that if a donor makes a gift of an annuity within three years before his/her death, the annuity's value will be included in his/her gross estate. And if any incidents of ownership or a life interest had been retained by the donor, the annuity would again be included in the donor's gross estate. The rule of a 5% reversionary interest also applies to annuities: should the donor have such an interest in the annuity greater than 5% of its value immediately prior to the donor's death, the ENTIRE annuity would be included in his/her estate UNLESS a general power to eliminate that reversion belonged to the donee.

Annuities may qualify for the estate-tax marital deduction under QTIP rules.

Private annuities, while not that common, serve the same purpose as more usual kinds. A private annuity is a contract between two parties, the annuitant, who transfers cash or other property, and the payer, who makes a promise—which is usually unsecured—to pay the annuitant a lifetime income. Federal income tax regulations apply to private annuities, as do federal estate tax rules. For estate tax purposes, private annuities' value is determined by discounting future payments.

Taxation of Qualified Pension and Profit-Sharing Plans

Qualified pension plans offer tax savings from the time of their inception all the way to the death of participants and the transference of benefits to their survivors/beneficiaries. For our purposes, the tax savings we are most interested in are the income tax-free death benefits funded by life insurance to the extent of the "pure insurance" factor--i.e., proceeds minus the cash surrender value; the $5,000 income tax-free death benefit; federal gift tax not applied to an irrevocable transfer of the right to receive death benefits provided by employer contributions.

Tax exposures for a decedent's beneficiary under a qualified plan are as follows:

When accumulated cash benefits are paid, they are taxable: how they are taxed depends upon how they are paid. If paid in a lump sum, the first $5,000 is tax-exempt, except in the case of certain nonforfeitable rights. If they are paid as an annuity, annuity tax rules apply.

Payments made to a beneficiary as part of a joint and survivor annuity contract are treated specifically: any estate tax due to the inclusion of the contract in the decedent's estate will be deducted pro rata over the period of the beneficiary's life expectancy. The $5,000 death benefit exclusion does not apply to joint and survivor annuities made prior to the death. When a beneficiary receives benefits as a life annuity, that annuity must be paid in the form of a qualified joint and survivor annuity, which would result in a lifetime, not a fixed-period, annuity.
In terms of Individual Retirement Accounts, the value of the IRA is part of the owner's gross estate. If a participant in a 401(k) plan dies while benefits remain in the account, those benefits go to his/her beneficiaries, either in a lump sum or as an annuity. Lump-sum distributions are now determined with five-year averaging.

Tax-deferred annuities or tax-sheltered annuities are used by 501(c)(3) organizations and public school boards as means to defer compensation to their employees. Death benefits under such contracts are included in the annuitant's gross estate. If an employee of a 501(c)(3) organization makes an irrevocable choice of a beneficiary or survivorship annuitant, no gift tax is due on amounts contributed by the employer. The employee may make a revocable choice that becomes irrevocable--again, this does not constitute a taxable gift. But under other tax-deferred plans, such an irrevocable choice does make the whole of the transferred interest a taxable gift. The above applies only to employer contributions. The employee's contributions are ALWAYS considered a taxable gift, when the right to benefits is irrevocably transferred to a beneficiary or survivor annuitant.

Unlike pension and profit-sharing plans that meet the requirements of Code 401, or annuity plans that meet the requirements of Code 403, unqualified deferred compensation plans are not eligible for the tax benefits qualified plans receive. Unqualified plans may select which employees participate: in qualified plans, ALL employees are eligible, though they have the choice of not participating if they wish. Many unqualified plans still must meet ERISA regulations.

Deferred compensation plans' benefits do constitute an asset which may be included in the participant decedent's estate. Payments made to the estate itself will be subject to federal estate taxation; payments made to a surviving spouse or other beneficiary will be taxed as income. The $5,000 death benefit exclusion will apply except in cases where the employee had a nonforfeitable right to receive the amounts concerned while living. When the deferred compensation plan pays a death.

Note: In community property states, contributory pension and/or deferred compensation plans belong equally to two spouses. Thus only 50% of taxable benefits are included in the decedent spouse's estate. In cases where a plan began prior to marriage, that portion earned before the marriage would be the separate property of the participant spouse; only the portion earned after the marriage would be community property.

Employee death benefits refer to those paid by an employer to an employee's surviving spouse/beneficiary, either by contract or voluntarily. Such benefits are not included in the employee's gross estate for estate tax purposes if three conditions are met:

1. The employee had no interest in the benefits;
2. Neither the employee nor his/her estate receives any portion of the benefits;
3. The employee had no control over the agreement defining the benefits, or choice of beneficiary.

**Federal Estate Taxes**

One of the more difficult aspects of estate planning, in many instances, is the reluctance clients have to consider their "estate" as separate from themselves. And yet, unless they can clearly grasp this concept, your ability to help them maintain and conserve their estate is handicapped. Perhaps a copy of an estate's federal income tax form, filed after the death of the person to whom the estate once belonged, will convince clients that an estate is a legal entity with a life of its own, and must be so regarded.
Estate earnings. They incur debts. They receive interest and dividends. They can buy and sell. All, of course, at the hands of their administrators. All too often, estate executors and administrators are chosen for reasons of sentiment—"I don't want my son to think I don't trust his judgement"—than for reasons of business. Convincing clients to take an interest in the fate of their estates—these legal entities that will carry on their businesses as well as their dreams—will make your job a great deal easier, and a great deal more pleasant.

First of all, let's review what constitutes the gross estate. Essentially, the gross estate includes any and all property in which the decedent had an interest, whether partial or total, at the time of death. This means real estate; cash and other negotiable assets; personal property; life insurance proceeds except under special conditions; joint and survivor annuity contracts for which the decedent paid in full; jointly owned and community property; property which the decedent legally controlled. The most significant point to look at when deciding whether or not a particular property will be included in the gross estate is whether or not two conditions are met: first, the decedent possessed the property or an interest in it at the time of death; second, that property or interest was transferred at the time of death.

As we have noted, gifts and other transfers of property which occur within three years before the date of death are usually included in the gross estate. Other units have dealt with identifying an estate's assets and liabilities, and determining which available instruments can best serve to maintain and conserve the estate. Note that credit is given for gift taxes paid on post-1976 gifts, and that a further reduction is possible under the Unified Estate Tax Credit.

Under this rule, each taxpayer has a lifetime unified estate and gift tax credit. It reduces the taxpayer's tax on a dollar-for-dollar basis. The unification is accomplished by bringing adjusted taxable gifts into the estate tax base. Note that the tax credit the unification process yields cannot be more than the amount of tax due. For transfers over $10 million, a phase-out of the unified credit begins, with 5% of the tentative tax added on to the tax due until the benefit of unification is recaptured.

Except in certain instances, the federal estate tax must be paid in full when the tax return From 706 is due—nine months after the date of death. Extensions may be granted; extensions of up to ten years can be given if the estate executor can show reasonable cause to the IRS. In certain cases, such as when a farm or closely held business interest is part of the estate, the estate tax which can be apportioned to that interest may be paid by installments. This is available only if such interest is more than 35% of the value of the adjusted gross estate. Two or more interests can be combined to make up the 35% so long as at least 20% of the value of each part of the gross estate. Also, the executor must elect to take the installment payment option.

Two points of note about the federal gift tax have been brought up again in this section: the $10,000 exclusion and the Unified Estate and Gift Tax Credit. Normally, the $10,000 exclusion is applied to gifts for current use. Thus, most transfers to minors do not come under this exclusion, with the exception of a 2503(c) trust. Such a trust provides that both property and income must be available to be spent either by the donee or for his/her benefit by age 21. At age 21, control over the distribution passes to the donee.

The Unified Estate and Gift Tax Credit gives lifetime shelter to gifts up to $700,000 (MOVING TO $1,000,000 IN 2006). All adjusted taxable gifts are added back to a decedent's estate, which enlarges it when federal estate tax is computed. The appropriate unified credit is then subtracted for the tax. Note that the present interest rule, the terminable interest rule, and the partial interest rule, are not applicable to the unified credit.
SPECIAL ISSUES OF THE MATURE MARKET

As a practicing professional, it is beneficial that you have an understanding of certain mature market issues outside the realm of insurance, such as social security, private pensions, advanced planning, inheritance, probate, wills, trusts and using the family home as a resource. Knowledge in these areas will help you better “program” insurance protection and investing.

SOCIAL SECURITY

Social Security is available to almost anyone who is employed. The major exceptions include most Federal Government employees hired before to 1984 and almost 20% of state and local government employees. The reasons why some state and local government employees are excluded are because state and local government units with a pension plan decides for itself whether to join social security.

It should be noted that after July 1, 1991, all state and local government employees who are not covered by a retirement plan of their employer are covered by Social Security. Railroad workers are covered under the separate, federally administered Railroad Retirement System.

Specific persons covered include disabled insured workers under age 65, retired insured workers at age 62 or over and spouses of retired or disabled workers entitled to benefits who; (1) is age 62 or over, or (2) has in his/her care a child under the age of 16 or over age 16 and disabled, who is entitled to benefits on the worker’s social security record. Additional covered persons include the surviving spouse of a deceased insured worker if the widow(er) is over age 60.

In addition to monthly survivor benefits there is a lump-sum death benefit payment of $255 payable upon the death of an insured worker.

Checking On Social Security Earnings

By filling out Form SSA-7004-SM (Request for Earnings and Benefit Estimate Statement). The form is available at any Social Security office or by calling the Social Security Administration’s toll free number, 1-800-772-1213.

A statement of total wages and self-employment income credited to the earnings record and an estimate of current Social Security disability and survivor benefits and future Social Security retirement benefits will be mailed to the individual. If all earnings have not been credited, the
individual should contact a Social Security office and ask how to go about correcting the records.

Starting not later than September 30, 1995, these statements must be automatically provided to all such individuals who are not yet receiving benefits and who are then age 60 or over and also to those who attain age 60 in subsequent 12-month periods until October 1999 and for whom the Social Security Administration can determine a current address.

Hold on! According to the USA Today on Friday September 5, 1997, the Social Security Administration, once again, will provide access to Social Security Accounts on the Internet. However, if you go on the Internet today you will find a form to fill out to request a written benefits report, but you will not be able to receive the information on-line.

**Monthly Benefit Checks**
Social Security checks are usually dated and delivered on the third day of the month following the month for which the payment is due. For example, checks for January are delivered on February 3rd.

**Social Security Benefits and Taxes**
Up to one-half of the Social Security benefits received by taxpayers whose incomes exceed certain base amounts is subject to income taxation. The base amounts are $25,000 for a single taxpayer, $32,000 for married taxpayers filing jointly, and zero for married taxpayers filing separately who did not live apart for the entire taxable year.

Beginning in 1994, an additional tier of taxation is accomplished by establishing a base amount of $44,000 for married taxpayers filing jointly, $34,000 for unmarried taxpayers, and zero for married taxpayers filing separately who did not live apart for the entire taxable year. This means that up to 85% of benefits are taxable at the high levels of income.

**Insured Status & Coverage**
A person becomes insured by acquiring a certain number of quarters of coverage. A calendar quarter means a period of three calendar months ending March 31, June 30, September 30, or December 31 or any year. An employee receives one quarter of coverage for each $630 of earnings up to a maximum of four.

**Example:**
Mrs. Vanation works for two months during the year and earns $1,500. She is credited with two quarters of coverage for the year because she receives one quarter of coverage for each $630 of earnings, up to a maximum of four. In order to receive four quarters of coverage during a year, Mrs. Vanation would have needed earnings totaling $2,520 ($630 x 4 = $2,520).

**Fully Insured**
A person is fully insured if he has 40 quarters of coverage. Once a person has acquired 40 quarters of coverage he is fully insured for life, even if he spends no further time in covered employment or covered self-employment.

**Currently Insured**
To be currently insured a person needs at least six quarters of coverage during the full 13 quarter period ending with the calendar quarter in which he: (1) died, or (2) most recently became entitled to disability benefits, or (3) became entitled to retirement benefits.
Retirement Benefits
In general, an individual is entitled to a retirement benefit if he or she: (1) is fully insured, 2) is at least age 62 throughout the first month of entitlement, and (3) has filed application for retirement benefits.

Age 62 is the earliest age that a retired worker who is fully insured can start to receive retirement benefits. The retirement age when unreduced benefits are available (presently age 65) will increase by two months a year for workers reaching age 62 in 2000-2005; will be age 66 for workers reaching age 62 in 2006-2016; will increase by two months a year for workers reaching age 62 in 2017-2022; and will be age 67 for workers reaching age 62 after 2022 (i.e. reaching age 67 in 2027).

Amount of a Retirement Benefit
A retirement benefit that starts at Normal Retirement Age equals the worker’s PIA (primary insurance amount). But a worker who elects to have benefits start before Normal Retirement Age will receive a monthly benefit to only a percentage of the PIA. As a general rule, a person taking reduced retirement benefits before Normal Retirement Age will continue to receive a reduced rate after Normal Retirement Age.

You should also note that a person is entitled to retirement benefits regardless of how wealthy he is. Also, the amount of retirement income a person receives (e.g. dividends, interest, rents, etc.) is immaterial. A person is subject to loss of benefits only because of excess earnings arising from his personal services.

Survivor’s Benefits
Benefits payable to the survivors of a deceased insured worker include mother’s or father’s benefits with children, surviving spouse of an insured worker, child of a deceased worker, widow(er)’s benefits and a lump sum death benefit of $255.

Social Security Cutbacks
Social Security and Medicare is paid on a “pay as you go basis”. Unfortunately, the ratio of the working age population (ages 20-64) to the retired age population (ages 65 and over) will decline from the current level of 4.7 workers per retiree to 2.8 workers per retiree by the year 2030, when most of the baby boomers will have retired. To finance the same retirement benefits on a pay as you go basis, active participants would have to pay about 67% more in Social Security taxes in 2030.

The baby boomers probably will feel a large crunch from the reduction in Social Security and Medicare benefits. Take for example, a person who is now age 45, earning $61,200 annually, and wishing to retire at age 67. To cover a 10% reduction in Social Security benefits will require an additional $63,000 at retirement.

Generation X is likely to feel the full brunt of Social Security and Medicare cutbacks. Take, for example, a person who is now age 29, earning $40,000, and hoping to retire at age 70. To make up for a 10% reduction in Social Security benefits will require an additional $123,000 at retirement. These reductions appear even more striking when compared with the benefits offered to current retirees. The Generation X'er retiring at age 65 (in the year 2031) will need an additional $420,000 to cover reduced Social Security benefits.
PRIVATE PENSIONS
To retire someday at 100 percent of someone’s standard of living, he or she will have to take advantage of Social Security, his or her employer's qualified retirement plans and save 20 percent of his or her gross income each and every year. There is no better way to begin this personal accumulation pattern than by participating at the maximum level possible in the employer-provided plan that allows one to invest with pretax dollars.

A pension plan provides the simplest, most readily available method for deferring taxation on investment earnings. Pension plans are probably the largest category of deferred tax plans offered by private corporations and public organizations.

Employee pension funds in American industry date back to the Civil War, if not earlier. Starting in the mid-1930s, pension commitments made by employers to employees became increasingly significant in business and industry. By 1950, there were some 2,000 funds in operation. It is not uncommon for an individual's largest single asset to be the vested interest in a pension or retirement plan. On average, retirees can expect their retirement income to be from 55 to 70 percent of their employment income, with after-tax dollars, derived from personal savings, pension plan(s) and Social Security.

Social Security was established as a pension plan but has never functioned as such. Instead, it has been a program of transfer payments. In 1937, the Social Security Board printed posters that read, "There is no guarantee that the funds thus collected will ever be returned to you. What happens to the money is up to each Congress."

In today's pension plans, what happens to the money is up to the employee, the employer, the pension fund manager or trustee, or a combination of these. A pension plan itself isn't an investment. It is a legal arrangement for holding investments that provides certain tax advantages.

Pension plans have five things in common:

1) Subject to certain qualifications and legal limits, money put into the plan can be deducted from the taxable income of the person putting it in—whether an employer, employee or both. Nondeductible contributions may be permitted in some cases, but not in unlimited amounts.
2) The plan pays no taxes. Interest, dividends and capital gains accumulate and compound tax-free as long as they stay in the plan.
3) Money coming out of the plan is taxed—except for the return of contributions to the plan that weren't tax-deductible when they were made.
4) There is a penalty for withdrawing money from the plan "prematurely," which generally means withdrawing money before a participant reaches age 59 1/2.
5) There must be a formal, written document covering the plan, and it must satisfy the requirements of the applicable Internal Revenue Code.

Defined-Benefit Plans
Defined-benefit plans commit employers to pay a certain benefit amount when an employee retires. The benefits are based upon employee’s age, years of service, income during employment as well as other factors. The amount is predetermined and guaranteed.

The annual pension cost is based upon a formula that consists of a percentage rate times the number of years of service, multiplied by the income at the year of retirement, or an average of several years' income. The expense of a plan for the employer is based on the estimates of the benefits to be paid. Employer and employee contributions to the plan and accumulated earnings
from plan investments are estimated to pay the benefits as provided in the plan. These plans have fallen out of favor because they require employers to pay out a certain amount upon retirement, regardless of how the investments did during working life. If the investments fail, the employer has to make up the difference. Defined-benefit plans are federally insured.

**Defined- Contribution Plans**

Defined-contribution plans have been growing in popularity. These plans commit the employer to contributing a certain amount each year, (either a percentage of the company's income or a percentage of the employee's income). Once the defined contribution is made, the employer has no other pension liabilities.

The pension expense for the year is the amount of the contribution, which is made to a third-party trustee. Because the contributions, as they accumulate, belong to the employee, the employee assumes the risk of poor investment performance. However, they also share in the profit gained from wise investment management, through an increase in future pension benefits. Employees may be responsible for choosing what they want their contributions invested in. Options can range from company stock to fixed-income securities.

The only definite figure in this sort of plan is the amount of money invested, not the amount of money that will be received. The benefits are based upon the level of the defined contributions and the earnings of the plan's investment portfolio.

Types include:

- **Stock-option plans**, which either give employees stock in the company or give them opportunities to purchase shares.
- 401(k) Plans.
- **Individual Retirement Accounts**, which are the most common form of personal retirement planning. IRAs allow an individual to contribute a maximum amount to a tax-deferred account. Contributions are permitted under two circumstances. First, if an individual or married couple has an adjusted gross income below a specified phase-out level, contributions can be made. Second, if neither a single individual nor either party in a marriage is an active participant in an employer-maintained retirement plan for any part of the plan year ending with or within the individual's taxable year, contributions can be made. The money contributed annually can be deducted from taxable gross income either entirely or partially, depending upon income. IRAs also can be sponsored by an employer.
- **Keogh plans**, which are similar to IRAs, are tax-sheltered pension plans for self-employed individuals or partnerships. Keogh plans escaped virtually unscathed from the federal tax code overhaul in 1986. There are two types: profit-sharing or money-purchase. Annual contributions to a Keogh plan are basically limited to 25 percent of self-employment earnings or $30,000, whichever is less. The IRS has different guidelines for self-employed people, employees and business owners. Keoghs have one big advantage over IRAs: When money is withdrawn from them (after age 59 1/2), forward averaging can be used to ease the tax bite.
- **Profit-sharing plans** allow the company's profits to help finance individual employees retirement benefits. A designated percentage of company profits is added to employee contributions, which then go into a trust fund that will finance retirement benefits. The portion of the employer's contribution to the plan that goes into an individual employee's account is usually tied to wages. A profit-sharing plan need not provide retirement benefits. The following provides a comparison between profit-sharing and pension plans.
- Choosing Between Pension and Profit Sharing Plans
Other Types of Plans

A **Qualified Plan** gives the employer certain tax benefits. The benefit to the plan participant is a deferral of taxes on the benefits until they are received in retirement. The employer's contribution to the plan can be deducted when made to the fund. Earnings of the fund are not taxed until they are distributed to beneficiaries years into the future.

A **Funded Plan’s** assets have been transferred to a trustee. If the total amount recognized as an expense has been given to the trustee, the plan is fully funded. If only a part of the expense has been recognized, the plan is a partially funded one.

An **Insured Plan** transfers the risk of future commitments to an insurance company. The employer funds the plan by purchasing an annuity contract from an insurance company, with the insurance company contracting to pay the defined benefits as they come due. The company agrees to contractual premium payments.

An **Unfunded Plan** does not require the company to transfer funds to a third-party trustee. Such plans can be thought of as pay-as-you-go plans. There is a significant accounting aspect to these plans; for example, funding takes place when the benefit is paid to the retiree, so no pension expense is recognized during the years of the employee's employment.

**How Is It Done? Who Can Set Up a Plan? Who Is Covered?**

In most cases setting up a pension plan is easy. Almost any bank, savings and loan association, mutual fund, stockbroker or insurance company will sponsor or provide various ready-made plans. Usually, a plan sponsored by a financial institution allows one to invest only in the investments the sponsor handles.

It is possible for individuals to be eligible for more than one type of pension plan, as long as their annual contributions, taken together, do not exceed the legal limits. Plans can be kept at different institutions.

Companies may have more than one plan. Actuarial methods may differ, but accounting for each plan should follow the stated standards. It is not possible to set up a pension plan outside the United States. Once an employer sets up a pension plan, all employees must be allowed to participate in it. Under most circumstances, any employee over the age of 21 who has worked at the company for one year is eligible. (To get credit for a year of service, an employee must have worked at least 1,000 hours in the previous 12 months.)

There are exceptions. An employer can require employees to be with the company for two or three years before granting eligibility for participation in the plan, if, when they join the plan, their right to their benefits becomes 100 percent vested immediately. Another exception applies to tax-exempt educational institutions, which can require employees to be at least 26 years old to participate.

Pension plans may not exclude an employee solely on the basis of part-time or seasonal employment if the employee has a year of service, (as defined above). Plans of the maritime industry may designate 125 days as constituting a year of service. In the case of a seasonal industry where the customary period of employment is less than 1,000 hours during the year, a year of service is to be defined by regulation.

Participation cannot be denied to an employee because he or she begins employment late in life, if the plan provides defined contributions such as profit sharing, stock bonus or money purchase plans. Plans defining benefits are permitted to exclude an employee who begins employment within five years of the plan's normal retirement age. However, for plan years
starting on or after Jan. 1, 1988, employees no longer will be able to exclude from plan participation any employees who start work within five years of a plan's normal retirement age.

A "floating" normal retirement age that could be no later than the fifth anniversary of the employee's participation in the plan could be established.

**Planning Process**

A qualified plan is one that obtains advantageous tax treatment by meeting the requirements of the code and the regulations and rulings issued by the IRS.

Receiving pension benefits seems straightforward. Once people turn 59 1/2 years old, they receive the money in their pension plans. If they want their money before reaching age 59 1/2, they face a 10 percent penalty. There are several exceptions in which the penalty is waived, including:

- If a person becomes disabled and thus is unable to work.
- If the person is at least 55 and retires or otherwise leaves the company. This is called "separation of service" by the IRS.
- If a person quits, retires or otherwise leaves the company, and receives the pension payout in a series of scheduled payments over his or her life expectancy (or the joint expectancy of the person and his or her designated survivor). The amount of payments can be determined by checking a life expectancy table, such as the IRS table in Publication 575. These payments must be roughly equal and must be paid at least annually. Payments must be received for at least five years. If the schedule is changed so it doesn't qualify for the exception or is switched to get a lump sum distribution, a "recapture tax" must be paid.

**Plan Funding**

Funding a plan means building up actuarially adequate reserves, based on actuarial assumptions on life expectancy of participants, on interest rates and on future pension levels. Plans generally are funded by employee contributions, employer contributions and earnings from investments, which can range from company stock to mutual funds to fixed-income securities. These investments may be chosen by either a plan trustee, a manager or by the participants themselves. Contributions vary; they may be a percentage of the company's income or a percentage of the employee's income.

Participants of certain pension plans are protected by federal law from financing that is inadequate to pay the promised benefits.

For defined-benefit pension plans, ERISA requires employers to annually fund the normal cost; that is, the pension benefits earned that year by the employees. Formulas are established for amortizing the past service liabilities and the cost of retroactively raising the level of benefits by plan amendment and for making up experience losses and changes in actuarial assumptions. In order to make underfunding as unprofitable as possible, ERISA provides severe sanctions. Unless a waiver is obtained, any failure by the employer to comply with the minimum funding requirements will result in an excise tax on the amount of the accumulated funding deficit. This tax is imposed whether the underfunding was accidental or intentional. The tax, which is not deductible, is imposed for each plan year in which the deficiency has not been corrected. These funding rules do not cover profit sharing and stock bonus plans. They apply to money purchase plans only to the extent of requiring that the employer contribute the amount specified by the plan formula. Pension plans funded exclusively by the purchase of certain insurance contracts, which satisfy certain conditions, are exempt from the funding requirements.
Taxes and Benefits of Qualified Plans

Over the years, the types of fringe benefits offered employees have evolved as methods of helping employees avoid or delay the impact of individual income taxes. At the same time, the government has effectively paid about half of the costs, because for every corporate deductible expense-dollar, there is the corresponding maximum federal tax saving of 46 percent, plus any state tax savings.

A pension plan provides:

- Tax deductions for some or all of the money contributed to the plan.
- Tax-free accumulation of everything the plan's investments earn.

The employer gets a current deduction for amounts contributed to the plan, within specified limits, although no benefits may have actually been distributed to the participating employees that year. This allows an employer to accumulate a trust fund for his or her employees with 100-cent before-tax dollars, which, in effect represent 54-cent after-tax dollars to the employer in the 46 percent tax surtax bracket. The employer expense for the contribution to a qualified plan may be accrued at year-end, but it must be paid no later than the legal time of filing the return (including extension).

The tax to the employee is deferred until the benefits under the plan are actually distributed or made available to him or her. If the employee receives a lump-sum distribution, a portion of it may be capital gains (based on years of participation prior to 1974), and the remaining taxable portion is subject to ordinary income rates. There is a special 10-year averaging option available.

Pension payout recipients are liable for a 15 percent excise tax if the combined payout of all their retirement plans, including qualified pension plans, profit-sharing plans, IRAs and Keoghs, is more than $250,000 annually, or a one-time lump sum distribution of more than $750,000 from retirement plans is received. The 15 percent tax is applied to the total amount over the limit. But there is a loophole: According to federal law, if at least $562,000 in retirement benefits was accumulated before August 1986, the funds can be grandfathered, allowing receipt of a lump sum payment that won't be subject to the excise tax. This election already should have been made on the recipient's 1988 income tax return, (Form 5329).

A lump sum distribution can be rolled into an IRA, if the money represents at least 50 percent of total pension benefits, all of the distribution is received in a single tax year and the distribution is being paid because the pension holder retired, quit, became disabled or died. If the recipient needs the money immediately and cannot roll it into an IRA, five-year forward averaging may be useful. Forward averaging allows the pension holder to act as if the distribution is the only income received for the year, and was spread over a five-year period. The entire tax is paid on the sum in one year, but the tax is at a lower rate than if it were taxed as regular income. This technique can be used if:

- The pension holder has been a participant of the pension plan for at least five years.
- The lump-sum distribution received is from a qualified retirement plan—pension, profit sharing or stock bonus—and represents 100 percent of the money in the plan.
- The money will be paid within a single tax year.
- The pension holder is 59 1/2 years old or older. There is an exception to this rule for people who were 50 or older on Jan. 1, 1986. Individuals born before 1932 can use five-year forward averaging with no penalty. Those born between 1932 and 1935 can use forward averaging, but must pay a 10 percent penalty on the total.
The income and gains on the sale of trust property of the trust fund are exempt from tax until distribution. Funds, which are compounded tax free under a qualified plan, increase at a much greater rate than if such funds were currently distributed to employees and personally invested by them. In the latter case, the amount received by the employee is subject to two tax bites—when he or she receives the benefits and again on the investment income earned on what is left.

FASB Statement of Financial Accounting Standards No. 35 "Accounting and Reporting by Defined Benefit Pension Plans" sets forth the standards for pension fund accounting. It applies to all defined benefit plans, except terminated plans. FASB No. 35's primary objective is to provide all the information necessary to determine the soundness of the plan, that is, the resources necessary to meet the future obligations of the plan. The requirements are as follows:

- Accounting principles not included in the statement do apply.
- Information about the assets available to pay benefits, the participants' accumulated benefits, the plan's investment performance and all other factors that may affect the plan's ability to pay accumulated benefits is disclosed.
- Statement of net assets available for benefits is disclosed.
- Information giving the present value of accumulated benefits and concerning significant changes in them is disclosed.
- The accrual basis of accounting is disclosed.
- 6) Fund investments are disclosed at their current value.
- Operating assets, if any, are disclosed at their cost less accumulated depreciation.
- Changes in the current value of investments since the last reporting period are disclosed.
- Investment income is reported.
- Contributions from employers and employees is disclosed.
- Benefits paid since the last statement date are disclosed.
- Administrative expenses are reported.
- Actuarial present value of accumulated plan benefits attributable to employee service prior to the benefit valuation date is disclosed.
- The measurement rules for accumulated benefits and the basis for the calculations should be explained.
- Cost-of-living adjustments included in the plan should be disclosed.
- FASB No. 35 and FASB No. 36, "Disclosure of Pension Information," both contain a number of actuarial and present value computations related to various aspects of a plan, including probability of payment, withdrawals, disability, rates of return, discounting future cash flow, vested benefits, nonvested benefits and current investment values.

An important tax factor that must be considered by the employer and the statement-preparer is the timing of actual payments into the pension or profit-sharing fund. All claimed expenses must have been actually disbursed (not merely accrued) by the legally required tax-return filing date, including all permissible extensions. A late filing of an 1120, without extension, would bring about disallowance of the claimed expense contribution to a pension plan, if the payment had not actually been made by March 15 (calendar year taxpayer). Preparers of financial statements should be aware of the possibility of a "subsequent event" disclosure.

ESOPs
Employee Stock Ownership Plans (ESOPs) are classified as pension plans under the Employee Retirement Income Security Act (ERISA). The primary difference between ESOPs and most pension plans is that the assets of the plans generally consist of employer stock. ERISA authorized the creation of ESOPs as one method of encouraging employee participation in
corporate ownership. The value of a benefit in an ESOP is directly related to the value of the stock of the employer.

**ERISA**

The Employee Retirement Income Security Act of 1974, better known as ERISA, requires those who establish pension plans to meet certain standards. Its main objective is to protect workers' pension rights, specifically the rights associated with funding, participation and vesting. Its passage also changed the tax and information forms that employees must file with the IRS (and in some cases with the Department of Labor).

ERISA was amended in 1984 by the Retirement Equity Act (REA) and in 1986 by the Tax Reform Act (TRA). REA provides additional protections for spouses of participants and liberalizes ERISA rules on participation and vesting. The rules are further liberalized by TRA.

Title I of ERISA describes participants' rights. Exempt from Title I are governmental plans, certain church plans, plans maintained solely to comply with workers' compensation, unemployment compensation or disability insurance laws, plans maintained outside the United States primarily for nonresident aliens and excess benefit plans that are unfunded.

ERISA requirements affect employers' costs in the following ways:

- Annual funding is no longer discretionary. A plan must be funded based upon an actuarial cost that over time will be sufficient to pay all future pension obligations.
- Tax deductions for the employer are not allowed, and fines are imposed by the government if plans are not funded in compliance with ERISA requirements.
- Comprehensive terms of a pension plan and detailed annual reports and schedules must be published.
- All reports, schedules, statements and other required information are subject to audit by independent Certified Public Accountants.

**IRAs, Simplified Employee Pensions (SEPs), Annuities**

IRAs that qualify for an income tax deduction are qualified plans as are simplified employee pension plans (SEPs), tax-sheltered or tax-deferred annuities (TSAs), 401(k) plans, profit-sharing plans and pension plans. Besides enjoying the tax deferral on the earnings within these plans, the employee as well as his or her employer may also make capital investments into these plans without having to pay taxes on the amount of investment in the year of contribution. Because a person has not paid taxes on the amount contributed into the plan, he or she does not establish a cost basis.

These qualified plans are usually among the best investment opportunities available. Even with marginal tax brackets, the tax advantages of these plans are difficult to beat. An employer may encourage an employee to invest in these plans by offering to match, for example 50 percent, of the employee's contribution. A strong net worth statement allows someone more opportunities to pursue than a weak one will. If someone would like to retire someday at 100 percent of his or her standard of living, he or she will have to take advantage of Social Security, his or her employer's qualified retirement plans and save 20 percent of his or her gross income each year. That task may seem formidable, but there is no better way than by participating at the maximum level possible in the employer-provided plan that allows employees to invest with pretax dollars. One unique feature of qualified plans is that a person is required to begin payouts from these plans, or the annuities which hold the cash in these qualified plans, in the year in which he or she turns age 70 1/2. With nonqualified annuities, the basic objective is to continue deferral of
annuitization as long as possible in order to maintain flexibility and to continue to compound the earnings within the contract without current taxation.

The present Internal Revenue Service regulations requiring someone to start making withdrawals from all of his or her qualified plans at age 70 1/2 do not change this basic strategy. In order to comply, it is not necessary to annuitize one's contract.

The case is even better for those with qualified plans who elect to make withdrawals from their plans on a joint and last survivor basis because the table for this type of distribution requires an even smaller amount to be distributed. For example, if a man is age 70 1/2 and his spouse is age 68, only 4.65 percent of his account must be withdrawn. In the following year, it would be approximately 4.83 percent and at age 75, the required distribution amount would be about 5.8 percent. Not until the man is age 85 would the amount required for distribution exceed 10 percent. Failure to make the required withdrawals will expose someone to substantial penalties from the IRS, so make sure to check with a tax advisor.

The deferral to April 15 is available only for the first-year distributions. In all succeeding years, distribution must be made within the calendar year. Be cautious in minimum distribution planning—to take less than the minimum exposes one to a 50 percent penalty on the amount that should have been withdrawn but was not.

Annuities are policy contracts that agree to pay the insured a regular income over a specified period of years. When an individual purchases an annuity policy, he or she agrees to pay the insurance company a certain amount of money in exchange for this income. The time period over which the insurance company promises to provide income varies. The contract may specify an exact number of years or the individual's lifetime—an unspecified number. The term annuity usually refers to the contract made between an individual and an insurance company; it is also used to describe the income that the individual receives under the contract. Annuities today can be an extremely efficient asset accumulation vehicle for retirement. Taxes on the interest earned on annuity contracts are deferred and are paid when distribution of the funds takes place. Therefore, this type of investment is often referred to as a tax-deferred annuity. However, some investment counselors suggest that one should avoid annuitization until such time as it is the only remaining viable economic solution. If one decides to consider annuities, be sure to carefully examine the expenses in the contract, its limitations, the variety of accounts, the service, reporting, management and the company's reputation.

A Rollover IRA Retirement Strategy

The rollover IRA is gaining popularity as an option for the disposition of retirement plan funds because it puts the retiree in control of the funds instead of the former employer. It also avoids current income taxation and provides for continuation of tax-deferred earnings.

These funds have been accumulated over a lifetime of work and are considered core assets that should be managed more carefully. If someone lives on only the income from the capital he or she has in his or her rollover IRA and never invades principal, that person will be better off than if he or she had annuitized. If one is able to live on less than the income generated within the IRA, that person will see his or her capital increase. This is highly satisfactory, not only because one is better off each year but also since one's capital base is increasing each year which will result in more capital available to generate income. Someone may be looking for a way to make reinvested earnings work as hard as they can in order to offset inflation risks.

One way to do this is to dollar-cost average the excess earnings from a guaranteed principal and guaranteed interest account holding a person's core assets into one of the common stock accounts in the family of funds available within his or her rollover IRA contract. This provides for
some diversification, and with time and patience, often positive investment results. When these earnings become significant, they may be swept back to the safe haven account in which is held one's core assets. This builds up a person's "safe" account which then generates more interest that can be used to increase the amounts being dollar-cost averaged into the stock account. The more earnings someone receives, the more earnings he or she generates.

Many conservative investors find this a very comfortable method of managing their rollover funds. It enables them to enter the stock market when they would not have been able to do so otherwise and thereby earn greater returns than they could with compound interest. It also increases diversification and allows the retiree to maintain control.

**ADVANCED PLANNING**

In his arsenal, the estate planner relies on many protection tools: insurance, trusts, wills, strategic titling of property and much more. These are discussed throughout this book. Underscoring everything, however, is the need for **advanced planning**.

For example, when the time arrives that a person has slipped into unconsciousness by the grip of a terminal disease or gradually deteriorated to advanced stages of Alzheimer's, it will be too late to make personal choices as to who will be in charge of medical decisions, finances and other moral issues. A conservatorship may be the only option.

A **conservatorship** is a legal arrangement whereby another person is authorized by the courts to oversee the personal care and property of an adult considered incapable of managing alone.

Conservators can be limited to specific tasks like health care only, finances only etc.

Instead of drastic measures like conservatorship, It would be preferable for a person to make his or her own choices for an overseer. That is why “advanced thinking” legal and financial planning professionals recommend everyone draft a durable health care power and durable financial power.

The **durable health care power** authorizes another person to make medical decisions for a person who is unable to do so. Typically, these document "spring" into action when a person becomes incapacitated. Some people prepare these documents to prevent artificial means from keeping them alive when their wishes are otherwise. These documents can help greatly in situations where family members may disagree on "pulling the plug".

A **living will** is somewhat similar with the exception that a persons wishes are directed to medical personnel, whoever they may be. However, living wills only take effect when a person has an incurable and irreversible condition diagnosed by two or more physicians and has no effect if the patient is pregnant.

Similar to the health care power, a durable power of attorney for finances can "spring" into action when a person is considered incapable of managing on his or her own. The person given the authority to act on behalf of another is called an "attorney-in-fact". Typically, they would handle property and finance decisions like paying bills, making deposits, collecting insurance, etc.

Advanced planning logically extends to the preparation of wills, trusts and, of course insurance.
ASSET PROTECTION

An increasing emphasis by estate planners involves the tools and concepts surrounding asset protection. The idea of using legal vehicles to head-off economic catastrophes has more chance to grow than ever before. Face it, despite an insurance agent’s best efforts to provide safe, appropriate levels of coverage, our country’s expanding liability policy guarantees that something will be missed along the way. Just think about the thousands of legal decisions made each year based on precedents. Each legal precedent sets the stage for the next step of expansion. This, coupled with the willingness of judges and juries to allow this expansion established uncertainty and a whole new round of claims we could only imagine.

Current asset protection planning is designed to “plug the holes” insurance fails to cover. Gaps such as punitive damages or gross negligence, exposure beyond policy limits, new and exotic environmental liabilities and even a client’s inability or forgetfulness to pay premiums. Some think of it as “doomsday planning” but every asset protection attorney has an arsenal or horror stories about smart and financially secure people who purchased insurance yet lost everything over a technicality or an unforeseen claim beyond the scope of the policy.

Their solution is a combination of sophisticated “titling” strategies like Nevada corporations with matching “lines of credit”, family limited partnerships, off-shore trusts, etc, designed to make a potential creditor or plaintiff stop and think . . . perhaps opening the door to a more reasonable settlement of the differences at hand.

The essence of this legal tinkering is the assumption that “the whole is worth more than the sum of its parts”. Therefore, an estate that is divided into many small parts is less attractive to pursue than a nice, fat estate with commonly titled assets.

Good attorneys will be the first to admit that these measures may provide mere “roadblocks” in front of potential creditors . . . nothing is foolproof. These measures are reinforced, however, when asset protection is treated like a vaccine, not a cure. And like most vaccines, for best results it should be started early, before the illness (lawsuit / claim) strikes while the legal waters are calm. Critics also point to volumes of law known as fraudulent conveyance which can void a transfer of property if it is done without adequate consideration and with intent to avoid creditors.

INHERITANCE

A person has a choice in determining who can inherit his or her property. Without clear, written instructions, state law determines how property will be distributed.

When one thinks of inheritance documents, wills and trusts immediately come to mind. There are, however, other ways to directly pass property to loved ones, including joint tenancy titling, beneficiary CD’s, beneficiary type vehicles and trusts.

PROBATE

The Superior Courts are typically given jurisdiction by the state constitution over all matters of probate and administration of estates.

The "probate court" is no more than a department of the Superior Court. Probate proceedings may be either domiciliary or ancillary. If a person dies and leaves property in more than one state, administration proceedings may be necessary in each state. The original proceedings are typically brought in the state where the deceased person lived, and accordingly are know as
domiciliary proceedings. The proceedings in other states where property is found are known as ancillary proceedings.

Despite best intentions of writing wills and using probate-avoidance devices like living trusts, most estates still require a probate since there always seem to be property to distribute that has been contested or left out of specific instructions.

As a matter of fact, property left through a will cannot be transferred to beneficiaries without passing through probate.

Probate is very costly and time consuming --about seven months (longer for complicated estates) and about 5 percent or more of the value of the estate.

Ways to avoid or minimize probate include the use of living trusts, holding title in joint tenancy, designating a beneficiary on all bank accounts (“in trust for . . .”), life insurance and annuity proceeds and other beneficiary type funds like IRA’s, Keogh’s, etc,

A major probate is also avoided for all property that is left, without restriction, to a surviving spouse. All that is necessary is for the surviving spouse to submit an affidavit for community property real estate (40 days after death) and a Spousal Property Order. If no one objects, the court approves an official transfer of ownership to the surviving spouse. This process takes about one month.

WILLS

A valid will can be made by anyone who is 18 years or older. The best method is to type, date and sign in front of a witness. A will designates what should be done with property and who will do it at the death of its author. A will can also designate a guardian to care for minor children left behind.

The person designated by will to be in charge of the estate is called the executor. The executor is charged with the following duties: acquiring certified death certificate copies, inventory the deceased assets, find beneficiaries, notify benefit agencies (social security / medicaid/medi-cal), collect insurance proceeds, file tax returns, pay debts, transfer properties and handle probate.

One issue that surfaces at death, even where a will is involved, is marriage property rights. In community property states, each spouse legally owns half of the marriage property acquired during marriage and is free to leave it to whomever he or she pleases without claim by the remaining spouse. Separate property may also be left to a beneficiary other than the spouse.

What happens in a common law state or when a spouse is inadvertently omitted from a will because a person forgot to change his will after marriage? To protect the surviving spouse, the law allows what is called a statutory share or an elective share right. In essence, this permits the surviving spouse to claim the deceased spouse’s share of separate property. If the deceased intentionally indicated a wish to disinherit a marriage partner by saying so in a will, the "statutory share" claim could be blocked.

Minor children may inherit up to $5,000 worth of property without any special arrangements. Over this amount, however, a guardian must be appointed. If this is not specified in the will, the court will appoint one. Ways to avoid a court-appointed guardian include the following:

- Designate an adult in the will
- Designate a guardian for the children and a custodian for the money
Create a child's trust and designate an adult to run it

**Death Without A Will**

If there is no will and no executor designated, the court will appoint an **administrator** who has the same duties as an executor. Typically, the surviving spouse is the first choice, then the children. Without a will (intestate), property of a deceased is usually distributed as follows:

The **surviving spouse, if any, inherits all community property and 1/3 of the separate property** if there are surviving children and other close relatives. The remaining 2/3 of separate property goes to these children and relatives. If only a spouse and children survive, the separate property is divided equally. For unmarried people, surviving children inherit all: If none, the relatives.

To inherit property from a deceased person who has no will, the person who is in line to inherit must survive the deceased for at least 120 hours.

**TRUSTS**

A trust, also known as trust corpus, trust assets, trust res, trust fund, trust estate or trust principal, is the voluntary transfer of real or personal property by a person—the creator or settlor of the trust—to another party, known as the trustee. The trustee may also be referred to as grantor or donor. Aside from a written plan itself, trusts are possibly the most useful personal financial planning tool.

In simple terms, a trust can best be described as a "fiduciary relationship" that exists when one party (the trustor) transfers in trust to a second party (the trustee) title to or legal possession of certain property to be held for the benefit and use of a third party or parties (known as the beneficiary or beneficiaries). A trust can hold property set aside under the management of a competent trustee for the benefit of other persons, present and future, and often avoid some taxes that otherwise would have to be paid.

Thus, there legally exist two types of ownership in the entrusted property, namely (1) legal title held by the trustee and (2) an equitable title held by the beneficiary. And, of course, the equitable title held by the beneficiary has no real value until the death of the trustor or trustors. The trustee is obligated to manage and invest the trust principal and to pay the trust income—and sometimes the trust principal, where trust income is insufficient—to or for the benefit of the beneficiaries of the trust, usually free of court intervention. For these reasons, the one named as trustee should be a person who will be able to adequately and reliably manage the trust.

A trust may be used to provide financial security for one's family, to avoid the time-consuming and expensive probate process after one's death and, in some cases, to minimize taxes. A trust can be particularly useful in providing for minor children, handicapped relatives and any loved ones who may have special needs.

Estate planning poses particularly delicate problems for blended families, since a parent may want to protect his or her biological offspring without neglecting or offending the new spouse and stepchildren. A trust can be set up early on that will calm these fears.

The four basic elements necessary to establish a valid trust are:

1) There must be an actual and constructive expression either by words or by conduct that the trustor intends to establish a trust in respect to some particular property.
2) There must be an identifiable designation of the trust property.
3) There must be an actual designation of the parties to the trust.
4) There must be a valid trust purpose. For example, creating a trust to provide, promote and secure the welfare of one's children is a valid trust purpose. However, setting up a trust in order to defraud or hinder a creditor is an invalid trust purpose.

There is an additional element that must be present in order for the trust to come into being: "...there must be effective, immediate and present transfer of property to the trustee." In other words, a mere promise to transfer property in trust at some future date will not create or establish a trust. An effective transfer means a legally valid transfer or constructive delivery of property to the trustee.

There are many kinds of trusts. If the trust is created while the donor is living, it is called a living trust, or *inter vivos* trust. This type of trust is created during the lifetime of the grantor and is common, for instance, between parent and child.

A trust created by a will is called a testamentary trust. It goes into effect when the person who established the trust dies. The trustee is usually charged with investing trust property productively and, unless specifically limited, can sell, mortgage or lease the property as he or she deems warranted. There are many types of testamentary trusts, but in general they are used in connection with mutual fund shares by leaving the shares to a bank or other trustee to be held in trust for one's children with the income to go to one's spouse for life.

To save arguments, one should have a lawyer spell out that the capital gains distributions are to be considered as income and are not to be reinvested in the fund. Or, one can let the income be a withdrawal plan, and set the withdrawal rate oneself. Emergency use of the basic shares may also be arranged.

One way to keep the legacy intact is to direct a lawyer to draft a trust naming one's children as beneficiaries. Upon the death of the person, the designated assets will fund the trust, which will be managed by a trustee of the person's choice. The money can then be parcelled out in lump sums when the children reach the ages specified in the trust.

**The A-B Living Trust Solution**

An individual and his or her spouse can set up one common living trust of which each person owns half. When one person dies, this trust will automatically split into two separate trusts. This is referred to as the "A-B living trust" because the two separate trusts are typically trust A for the surviving spouse and trust B for the deceased. To help keep these straight, think of trust A as the one above the ground for the living person, and trust B as below the ground for the deceased.

If the value of the common trust is no more than $2 million, half of the value of the assets are placed in trust A and half in trust B. Each trust will be entitled to a $1,000,000 exemption—trust B uses the deceased's exemption and trust A will use the surviving spouse's exemption later when he/she dies and the assets in both trusts are distributed to the beneficiaries. So, assuming trust A does not grow to more than $1,000,000 by that time, the entire estate will be exempt from estate taxes.

If the trust is more than $2 million, usually only $1,000,000 of the deceased's half is placed in trust B, since this is the amount of the estate tax exemption. The rest is added to trust A (the surviving spouse's trust). There are no estate taxes on trust B because it does not exceed the $1,000,000 exemption. And there are none due now on the rest of the deceased's estate because it is transferred to trust A using the marital deduction. Later, when the surviving spouse dies, his/her exemption is used—so another $1,000,000 is exempt from estate taxes.
By using an A-B living trust, an individual and his or her spouse can leave up to $2 million estate tax-free to their beneficiaries—and with no probate costs. By using a simple will (as many couples do) or having no estate plan, and relying on just the marital deduction for tax planning, one would only be able to use one $1,000,000 exemption.

This is not a tax shelter or some tricky way to avoid paying taxes. The estate is being taxed when both spouses die—they are both simply using the exemptions to which they are entitled.

One Common Trust Vs. Separate Trusts
An individual and his or her spouse could have the same thing as the A-B trust with separate living trusts and have separate estates while they are both alive.

But most married couples have built their estates together over the years and are used to owning their property together, and usually prefer to have one common living trust. It is much simpler because there is only one document to deal with and the assets do not have to be divided until one spouse dies. If one also has some separately owned assets, they can usually be handled in the one common trust document.

However, it is not unusual to have three living trusts in one family—separate ones for property acquired before the marriage or for inheritances, and a common trust for jointly owned property or property acquired during the marriage.

Other Advantages of an A-B Living Trust
With an A-B provision in a living trust, one wouldn't have to worry that after death the surviving spouse might change the beneficiaries. This couldn't happen with an A-B living trust. After the first spouse dies and the common trust divides, trust B (the deceased's trust) cannot be changed by anyone, not even the surviving spouse.

There is also added protection in the event of a catastrophic illness. With an A-B living trust in the case of one having a modest estate without the consideration of tax planning, if the individual or his or her spouse were to suffer a major illness or injury, the medical expenses would be substantial. To qualify for valuable government benefits, it is often necessary to spend down the assets in the estate. However, with an A-B living trust, part of the estate can be protected after one spouse has died. The trust document can give the trustee discretion over whether or not to distribute income and principal from trust B to the surviving spouse.

Then, if the surviving spouse becomes seriously ill or injured and needs to qualify for government assistance, the trustee can decide not to provide any income or principal to the spouse. This prevents the assets in trust B from being considered available to pay the surviving spouse's expenses. So, only trust A (the surviving spouse's trust) would have to be spent down in order to qualify for benefits. Trust B would be preserved for the beneficiaries.

Establishing and Maintaining The Living Trust
There are certain steps that must be taken to legally establish and maintain the living trust. These steps necessarily include (1) selecting the forms, (2) preparing the forms and (3) filing, noticing or recording the forms. One can choose to consult a professional, such as a lawyer or insurance company, or one can purchase a book that is in the form of a living trust kit with all the forms needed to file. It is called the Nonlawyer's Living Trust Kit.
**Planning Beyond a Living Trust**

One may need additional tax planning beyond an A-B or A-B-C living trust. The following suggestions of additional planning tools involve both irrevocable and revocable trusts. Whether irrevocable or revocable, when deciding to use any of the following, one must be sure to read the document carefully and completely understand it before signing anything. The documents should be prepared by an estate planning attorney who has experience in this area.

**The Irrevocable Life Insurance Trust**

Most people own some amount of life insurance, and there are good reasons for doing so at all ages. However, many people do not realize that these life insurance proceeds, while not subject to probate proceedings (unless, for some reason, the estate is named as the beneficiary), are included in the estate when determining estate taxes. Depending on the amount of insurance one has, this can dramatically increase the value of the estate—and the amount of estate taxes that must be paid.

An ideal way to structure these types of irrevocable life insurance trusts enables one to apply the annual gift tax exclusion to cover contributions of money made each year to the trust for paying premiums. The trust can therefore be used as a powerful way to leverage the annual exclusion to get insurance proceeds to one's heirs without income, gift or estate tax.

With this type of trust, life insurance proceeds go into the trust instead of into the taxable estate, which reduces the amount of potential estate tax. An irrevocable life insurance trust lets the beneficiaries benefit from the insurance proceeds and keeps the value of the insurance out of the taxable estate, potentially saving the family thousands of dollars in estate taxes. It does so by owning the life insurance policy for the individual. And since the individual does not own the insurance, it will not be included in the taxable estate at death. The concept is basically the same as a living trust and how it avoids probate.

For a single person whose estate, including life insurance, is more than $70,000, or for a married person whose total estate is over $1.4million, an irrevocable life insurance trust is something that should seriously be considered. If one's estate is less than this, it is exempt from estate taxes, so it does not matter who is the owner of the policies. The living trust just needs to be named as the beneficiary of the insurance.

An irrevocable life insurance trust can be set up at any time, but because the trust must be irrevocable, some people wait until their 50s or 60s. By that time, family relationships have pretty much settled—and individuals know who they want to include (and exclude) as a beneficiary. One must be careful not too wait to long, however, as this could make one become uninsurable.

**Irrevocable Trusts**

Irrevocable trusts are most often used for reducing death tax (through gifts or as a way to own life insurance) or setting up an education fund. An irrevocable trust cannot be changed or terminated by the one who created it without the agreement of the beneficiary. This type of trust is usually created to remove property and its future income and appreciation from one's estate. One might also use an irrevocable trust if one wants to make a gift to someone but also wants to prevent that person from spending the assets too quickly. Another purpose for an irrevocable trust is to prevent a beneficiary's creditors—or even a child's spouse in a divorce action—from reaching the property. An irrevocable trust is a distinct legal entity from its creator, unlike the living trust, which is usually operated at the discretion of the creator until his or her death. The present interest and Crummey trusts are irrevocable trusts.
The trustee of the irrevocable trust must file income tax returns for the trust when it receives income above the statutory amount. The trustee's responsibilities also include distributing income or paying expenses, such as educational expenses, according to the terms of the trust. However, this trust permanently transfers assets from the estate during the grantor's lifetime and therefore escapes estate taxes.

Property placed in an irrevocable trust will not be removed from the estate if one retains certain interests or powers in the trust, such as a life income interest or the power to determine which beneficiaries will receive distributions. Furthermore, any transfer to an irrevocable trust will be subject to gift tax if one relinquishes all control over the property. If someone else will receive the income from the trust currently, or if it is a present interest trust, the $10,000 annual gift tax exclusion can shield at least part of the transfer from gift tax.

Besides saving estate tax, irrevocable trusts created for one's children may provide a limited income tax benefit. The amount of this benefit depends on how much other income the children already receive. In addition, strict rules minimize the type of control an individual and his or her spouse may keep over the trust without causing the income to be taxed. Finally, the income will be taxed if it is used to pay for an item that one is legally obligated to provide as support for the beneficiary.

An irrevocable trust can become a revocable trust after a specified period of time, usually over ten years or upon the death of the grantor. When this is specified, the change is called a revisionary trust.

An irrevocable trust can also become a charitable remainder trust. This happens when an irrevocable trust pays income to one or more individuals until the grantor's death, at which time the balance, which is tax-free, passes to a designated charity. It is a popular tax-saving alternative for individuals without children or who want to benefit children and charity.

The charitable remainder trust is the reverse of a charitable lead trust, whereby a charity receives income during the grantor's life and the remainder passes to designated family members upon the grantor's death. This type of trust reduces estate taxes while enabling the family to retain control of the assets.

**Revocable Trust**

Advantages of revocable trusts:

- Avoiding probate.
- Avoiding legal guardianship.
- Relief from financial responsibility.

A revocable trust (also known as a living trust) is created during one's lifetime and may be amended or revoked at any time. The trust instrument directs how the assets held by it are to be managed during one's lifetime. It can also act like a will by instructing how its assets should be distributed after one's death.

A revocable living trust is a legal entity set up and operated by the creator of the trust during his or her lifetime, for the benefit of those named in the trust. A revocable living trust is mainly used to avoid probate. It does not minimize estate taxes after one's death, nor does it change or lower one's income tax obligations during life. The property placed in the trust can also be levied upon by creditors during one's life.
What distinguishes a revocable trust from other kinds of trust arrangements is that the individual keeps the power to reclaim the trust assets. One can amend the terms of the trust or even terminate it altogether at any time. This means that by setting up a revocable trust, the individual really hasn't committed him/herself to anything—at least until he or she dies and the trust becomes irrevocable. For all practical purposes, one continues to own the trust property beneficially; the trust merely gets bare legal title.

For an example of a revocable trust, it is probable that the individual would buy all of the shares with him/herself as trustee holding mutual fund shares in trust for his or her spouse. Should the individual die, the shares are still in his or her estate for tax purposes, but they do not come under probate. This saves about three to five percent. After death the certificates are simply rewritten in the spouse’s name. Should the spouse die first or should the individual change his or her mind, a letter to the custodian bank (properly notarized) will dissolve the trust.

A revocable trust contains provisions which may be altered as many times as the grantor desires, or the entire trust agreement can be canceled, unlike irrevocable trusts. The revocable trust is an agreement whereby income-producing property is deeded to heirs. The grantor receives income from the assets, but the property passes directly to the beneficiaries at the grantor’s death, without having to go through probate court proceedings.

The creator of a revocable living trust places property, either real or personal, into the trust by way of executing a legal document.

The trust document names:

- The trustee, who is the person who will manage the property. This person is usually the creator of the trust.
- The person who will carry out the terms of the trust at the death of the trustee, known as the successful trustee.
- The beneficiaries—the persons designated to receive the property after the trustee's death.

The document also lists the property subject to the trust and, unlike an irrevocable trust, states that the creator can amend or revoke the trust at any time. This provision enables the individual to control the trust during his or her lifetime, as desired.

After death, however, the trust can no longer be amended or revoked. The person named as successor trustee is obligated to transfer all property in the trust to the named beneficiaries. Because the trust property does not pass by will, but goes directly to the named beneficiaries of the trust, there is no court involvement.

Therefore, it is crucial to choose someone who will carry out the individual's wishes to act as successor trustee. After all of the property in the trust is transferred to the named beneficiaries, the trust ceases to exist.

**Marital Living Trust**

Since many married couples own property jointly, in addition to paying separate living trusts set up for their own property, they can have shared property. Each spouse designates beneficiaries for his or her share of the property.

Upon one spouse's death, the property is divided, and the deceased spouse's share of the property is transferred to his or her beneficiaries, which can include the surviving spouse. The surviving spouse's revocable living trust continues to exist until his or her death.
Marital Deduction Trusts

For larger estates and estates containing closely held businesses, a marital deduction trust can often serve to provide one with more control over assets while still qualifying for the marital deduction.

This trust generally includes all property intended to qualify for the marital deduction, other than outright bequests and property interests passing by operation of law. One form of marital trust gives the survivor an income interest for life in the trust property and a general power of appointment exercisable during life or by will. This power enables the survivor to leave the trust property to anyone, including his or her own estate.

Bypass Trust

A bypass trust is often used by a person who remarries and wants to make sure that his or her children from a previous marriage are provided for after he or she has died. If the individual wants his or her new spouse to enjoy the benefits of the wealth while he or she is still living, he or she can draft a bypass trust. After the individual's death, the spouse can get income thrown off by the legacy and, with the trustee's approval, withdraw part of the principal if he or she needs it to pay for important expenses such as medical bills. When the spouse dies, the assets will then flow directly to his or her children.

A bypass trust is also called a credit shelter, unified credit trust, A/B trust or nonmarital trust, and is typically utilized in conjunction with a marital deduction trust. The bypass trust receives just enough assets to absorb the unified credit remaining at the decedent's death—a maximum of $70,000.

A bypass trust is the most important trust in estate planning. Couples use reciprocal bypass trusts in order to leave $2 million to their heirs free of estate tax—double the standard exclusion. In other words, a bypass trust can raise the amount that the heirs will receive.

Although the survivor will generally have an income interest in this trust and can receive trust principal if needed, he or she will have no power over the final disposition of the assets of the trust. It is called a bypass trust because the property, along with any appreciation and income accumulation, will bypass taxation in the surviving spouse's estate.

Medicaid Trust

Neither Medicare nor Medigap covers the cost of nonmedical care in a nursing home or at home. Yearly costs for such services can easily top $30,000, potentially impoverishing a spouse or wiping out an inheritance.

Medicaid, the government health insurance program for the indigent, pays for long-term care only for individuals whose income and assets put them at poverty levels. As a result, many older people wonder whether they should try to head off this catastrophic expense in one of two ways: either shelters their wealth in Medicaid trusts to impoverish themselves, at least on paper, or buying insurance against the cost of long-term care.

There are stringent rules under which people who transfer their assets to others can receive Medicaid. Currently, such transfers must take place at least 36 months before Medicaid qualification begins, and the money in a trust must be so out of reach that its sponsor is legally impoverished.
Rainy Day Trust
A person may feel that his or her parents will always have enough to live on. Since we never know for sure, an individual may want to plan for them in his or her will or living trust with a rainy day trust that only comes into play after the individual passes away. A rainy day trust says that a portion of the individual's assets could only be used after his or her parent's assets were exhausted or unavailable.

Children's Trust
If a named beneficiary is a minor at the time of the individual's death, an adult guardian must manage the property for his or her benefit until the age designated in the trust document. This differs from the will scenario, in which the adult guardian is obligated to transfer bequeathed property to the minor beneficiary as soon as he or she reaches the legal age of majority—usually 18.

If the individual is concerned about the maturity and ability of his or her beneficiaries to manage property at the age of 18, he or she should consider transferring property to them by way of a children's trust, which can be part of the living trust.

Upon the individual's death, if the child has reached the age designated in the trust, the trust property will be transferred directly to him or her. If the individual dies before the child reaches the designated age, however, the children's trust become irrevocable and is managed by the successor trustee of the living trust until the child reaches the designated age.

Uniform Gift to Minors Act (UGMA) or 2503(c) Trust
One can retain control of the assets until the child is 28 (or 21 in some states), by investing in his or her name in a custodial account or 2503(c) trust. But after that point, the money in the child's name is the child's, not the individual's. There's no way to control how that money is spent, either. In short, the minor tax advantage of putting college savings in a child's name is almost certainly not worth the disadvantages.

Totten Trust
An "in trust for" account or so-called "Totten trust" is created when a donor deposits his or her own money into a bank account for the benefit of a minor, then names him/herself as trustee. This is an informal and revocable arrangement under certain state's laws.

Upon the donor-trustee's death, the funds avoid probate and pass directly to the minor. However, the trust is not considered a separate entity for tax purposes because the donor retains complete control over any property in the trust. Accordingly, the donor will be taxed on the income as if the trust were not in existence. Also, assets in the trust account will be includable in the donor's estate.

Crummey Trust
A Crummey trust is a different type of trust, one to which an individual can transfer property and have the gift qualify for the annual gift tax exclusion. The distinguishing characteristic of a Crummey trust is that it gives the beneficiary the right to demand annual distributions to the trust during the year or a specified amount (e.g. $5,000 or 5 percent of the trust's value). The beneficiary (or legal guardian) must be notified of the power to withdraw the trust corpus, although the power is permitted to lapse or terminate after a short period of time (such as 30 days). If, following notification that a contribution has been made, the beneficiary fails to make a demand during the window period, the right lapses for that year's contributions. To the extent that the beneficiary (or guardian) has the right to demand distribution of the year's contributions, that contribution is a present interest and therefore qualifies for the annual gift tax.
exclusion. In practice, the child beneficiary almost never exercises the power, not wishing to bite the hand that feeds him or her, and perhaps causing the gifts to stop. This unspoken threat is the reason that these types of trusts are sometimes called "broken-arm trusts."

In all other respects, the Crummey trust is very flexible. Once the withdrawal period has lapsed, the trustee can be required to accumulate income until the child reaches a specified age. The trustee can be restricted to using trust assets and income for specific purposes (e.g. college expenses). The trust is also useful as a vehicle for permanently removing assets from the parent's gross estates.

Furthermore, for income tax purposes, the Crummey trust's income is taxed to the beneficiary or beneficiaries who allowed their withdrawal right to lapse. Therefore, once the beneficiaries are over 13 years old, the income will be taxed at their rates, which will avoid the punitive tax rates applied to trusts.

**Q-Tip Trust**

A married couple whose combined net estate is more than $1.2 million should know about the "A-B-C" living trust. The "C" part is called a Q-tip trust, which stands for "qualified terminable interest property." The fact that the surviving spouse must receive the income from trust C and may have access to the principal under certain conditions is his or her qualified interest in the property. It is terminable because this interest ends when the surviving spouse dies.

This trust is a qualified terminable interest property trust, which allows for assets to be transferred between spouses. The grantor of a Q-tip trust directs income from the assets to his or her spouse for life but has the power to distribute the assets upon the death of the spouse. Such trusts qualify the grantor for the unlimited marital deduction if the spouse should die first. A Q-tip trust is often used to provide for the welfare of a spouse while keeping the assets out of the estate of another (such as a future marriage partner) if the grantor dies first.

The advantage is that this leaves the estate intact. Since the estate has not been reduced by any estate taxes, a larger amount is available to invest and provide income to the surviving spouse. In addition, one is keeping more money available in case the spouse needs it. And, if the spouse does need part of the principal from trust C, the estate may be worth less by the time the spouse dies—so one could end up paying less in estate taxes.

The A-B-C living trust will also let the individual keep control over who will receive more of the estate than an A-B living trust would.

An individual uses an A-B living trust and dies first will probably end up controlling who will receive only $600,000 of the estate. Since that's the amount of the estate tax exemption, usually that's all that is placed in trust B—the rest usually goes to the surviving spouse's trust through the marital deduction to avoid paying any estate taxes at that time.

An individual who uses an A-B-C living trust can make sure that each spouse keeps control of half of the estate—even if he or she dies first. If, for example, upon one's death the estate was worth $1.5 million, the estate would be divided up equally so that $750,000 goes into trust A and $750,000 goes into trust B, but the remainder of $150,000 after the $600,000 exemption in trust B would go into trust C. This $150,000 would not be taxed until later when the surviving spouse dies and the assets in all three trusts are distributed to the beneficiaries.

In the event of a catastrophic illness or injury of the surviving spouse, the trust can be written to protect the assets in trust B and trust C—so only the assets in trust A will need to be spent down to qualify for valuable government assistance. However, the income from trust C will be included in the spouse's assets when application for benefits is made.
**QDOT Trust**
QDOT stands for "qualified domestic trust" and it is a special trust that allows a noncitizen surviving spouse to delay paying death tax upon the first spouse's death. The death tax, however, may be paid during the survivor's lifetime or at the survivor's death, depending upon the assets in the trust and the timing of distributions from the trust.
The unlimited deduction is restored, but there may be no distribution of assets to that noncitizen spouse without incurring estate tax. On the other hand, he or she may draw all the income from the trust free of estate tax.

**The Charitable Remainder Trust**
This trust is also referred to as a living or testamentary irrevocable income tax cutter than can also provide income for life. There are many advantages to doing charitable planning now—one can secure a lifetime income, save on income and estate taxes, enjoy the satisfaction of making the gift and, if one wishes, receive public recognition. And because the organization knows it will receive the gift at some point in the future, it can plan future projects and programs now—and benefit even before it receives the gift.

One of the most commonly used forms of charitable tax planning is called the charitable remainder trust. It is a way to convert a highly appreciated asset, such as real estate or stocks, into a lifetime income without having to pay capital gains taxes on the sale or estate taxes upon one's death. At the same time, one can benefit one or more charities or organizations. If an individual starts a charitable remainder unitrust while he or she is still alive, he or she will probably get an income tax deduction in the first year equal to the value of the remainder interest, an amount that a lawyer or accountant can calculate using special IRS guidelines. Despite the irrevocability of the trust, one can drop the charity originally named as beneficiary and name another one later. Most charitable remainder trusts require at least $50,000.

Generally, if one is age 50 or older, owns a highly appreciated asset, is in a high income bracket, would like to enjoy profits now but wants to avoid capital gains and estate taxes, and finds charitable giving appealing, he or she can probably benefit from a charitable remainder trust.

The individual places the highly appreciated asset into an irrevocable trust, naming one or more qualified charities as beneficiary. The trustee then sells the asset at full market value, paying no taxes on the capital gain, and reinvests the proceeds in income-producing assets, which will grow tax-free. For the rest of the individual's life, the trust will pay the individual an income. At the individual's death, the remainder of the trust assets (the principal) will go to the charity. Of course, the individual could just sell the property him/herself and reinvest the proceeds, but would pay more in income and estate taxes and have less left for beneficiaries.

A charitable remainder trust eliminates the income taxes on the capital gains and estate taxes. Plus, in the year the property is placed into the trust, the individual can take an immediate charitable income tax deduction, reducing current income taxes. The trustee sells the property for the full market value and, because there are no capital gains taxes on the sale, reinvests the full $500,000 in a balanced portfolio (like stocks and bonds) to provide the individual with a lifetime taxable income.

How much money one receives from the trust is flexible and will depend upon how much income is needed, the value of the property, age, life expectancy, etc. The trust is revalued each year to determine the dollar amount of income one will receive, so as the trust grows income will too.
The trust can include a "make-up" provision, so that if the trust doesn't earn enough to pay the percentage set for the year, it will make up the difference in a better year. Since the individual has elected to receive a percentage of the value of the trust assets, this would be called a "charitable remainder unitrust."

One can elect instead to receive a fixed amount of income each year. In this case, the trust would be called a "charitable remainder annuity trust." This means the amount of income received is guaranteed—it will not go down if the trust has an "off" investment year, but it also will not increase if the trust does well. Because they want protection against inflation, many people prefer to receive a percentage of the trust assets as income (the unitrust).

The charitable income tax deduction is based on the amount of income received, the size of the gift and one's age. It is limited to either 30 percent or 50 percent of one's adjusted gross income. If the individual does not use the entire deduction the first year, he or she can carry it forward for up to five additional years. Or, the income can be deferred until later. One can set up the trust, taking the income tax deduction in that year, and the trustee will invest the trust assets. By the time the individual is ready to receive an income, the trust—with good management—will be substantially greater in value, resulting in a higher income.

Who Can Receive Income From the Trust?

For a married person, the trust can pay an income for as long as either one lives. The trust could also be set up to last for the combined lives of one's children. For that matter, the person who receives the income doesn't even have to be related—or even be a person. And instead of lasting for someone's lifetime, the trust can be set up to last for a set number of years—up to 20.

**Charitable Remainder Trust Combined With Life Insurance Trust**

If the asset being put into a charitable remainder trust is a good portion of one's estate, the individual may want to replace the property in order that (the children, for example) do not lose out on such a large inheritance.

By using the income tax savings and part of the income received from the charitable remainder trust, one can fund an irrevocable life insurance trust. Each year one can "gift" money to the life insurance trust, and the trustee can then purchase enough life insurance to replace the value of the property. At the individual's death, children will receive the full proceeds from the insurance trust without probate, and free from income and estate taxes.

Life insurance is the fastest and most inexpensive way to replace the property. But for one who is uninsurable, the trustee can buy other appreciating assets—such as zero coupon bonds, stocks or real estate—to replace the value of the property transferred to the trust.

This combination of the charitable remainder trust and irrevocable life insurance trust is a "win-win" situation for everyone:

- One can take an immediate charitable income tax deduction and remove a highly appreciated asset from the estate—saving income and estate taxes.
- One receives a guaranteed lifetime income without the headaches or uncertainty of having to manage the investment.
- At one's death, children (or other beneficiaries) receive cash from the life insurance trust, replacing the value of the asset—income tax, estate tax and probate free.
- And, one is able to make a substantial gift to one or several charities.
The Charitable Lead Trust
The charitable lead trust is also a living or testamentary, irrevocable income tax cutter that preserves assets for one's heirs. This variation on a charitable remainder unitrust assumes a level of affluence beyond most middle-class people. Basically, a charitable lead trust is the opposite of a charitable remainder trust. With a charitable lead trust, the charity receives the income from the trust now, and the beneficiaries will eventually receive the principal.

A charitable lead trust can also reduce income taxes, reduce or eliminate estate taxes, and allow an individual to make a contribution to one or more qualified charities. Unlike a remainder trust, however, an individual would be interested in a lead trust if he or she currently does not need the income and wants a beneficiary other than the charity (usually spouse and/or children) to eventually receive the trust assets.

If the annual income paid to the charity is a percentage, and the amount fluctuates depending on investment performance, it is called a charitable lead unitrust. If the income is a fixed amount (the same dollar amount paid every year), it is called a charitable lead annuity trust.

Charitable Remainder Annuity Trust
This is also a living or testamentary, irrevocable income tax cutter that provides income. This works much like a charitable remainder unitrust, but the charity pays the donor a fixed amount each year, usually 7 to 9 percent of the principal.

Appreciated property producing little or on income makes the best gift for this type of trust. The reason: If the property was sold and reinvested the proceeds for higher income, a taxable capital gain would be incurred.

If a charitable trust sells the property and then replaces it with an annuity, no capital-gains tax is due, however.

Gift Annuity
With a gift annuity, the individual (or whoever is named as the beneficiary) will receive a guaranteed income for life in exchange for making a direct gift to a charity (in cash, real estate or another asset). The income will be paid in the form of an annuity, which means each payment received by the individual will be for the same dollar amount. Part of each payment is a return to the individual of his or her gift (the principal), so only a portion is taxable as ordinary income.

The individual can begin receiving the income immediately when the gift is made or the income can be delayed until a later date (usually at retirement, when one's income—and tax bracket—is lower).

If the income is delayed, this is called a deferred gift annuity. Under this option, the income will be higher because the original investment will have time to grow. Regardless of when the income begins, one can take a charitable income tax deduction in the year one makes the gift. Upon one's death (or the death of the last beneficiary), the charity will keep the remaining principal and any undistributed income.

Life Estate
This is an arrangement through which one can give a portion or all of one's home, vacation home or farm to the charity of one's choice while still alive. Until the individual's death, he or she continues to enjoy the property as if he or she still owns it—he or she can live on it, take care of it and keep any income it may generate.
An individual would consider this option if he or she was planning to give the property to the charity after death but wanted to take the charitable income tax deduction while still alive. The individual will also save on estate taxes by removing the property from the value of the estate.

One can give a charity the right to use a piece of property for a certain number of years as a public park, a wildlife refuge, an historic landmark, etc...Or one could give away just the mineral rights to a piece of real estate and keep the land in the family. The tax advantages of this type of gift are generally less than others previously mentioned.

**Personal Property**
An individual may have certain investments or valuables (for example, art, musical instruments, books, etc.) that he or she wants to give to a charity—not to have them sold and the proceeds reinvested, but rather to have them be enjoyed as he or she has enjoyed them.

For an individual to receive a charitable income tax deduction, the gift must be related to the charity's tax-exempt purpose—for example, giving artwork, antiques or jewelry to a museum, books to a university or library, musical instruments to a symphony, etc..

**Insurance**
This is an often overlooked gift. An individual can give an old policy to a charity, making it both the owner and the beneficiary. Or he or she can work with a charity and have it purchase a new policy on his or her life (the charity should be the applicant, owner and beneficiary). In either case, the individual can receive a charitable income tax deduction.

**Grantor Retained Income Trust (GRIT)**
This is also a living, irrevocable estate tax cutter that lets a person transfer property to his or her heirs. Many wealthy people use GRITS to avoid estate taxes on significant assets such as houses, artworks or antiques.

There are also advantages to transferring (gifting) assets to one's children now while still living, instead of waiting until after death—especially if the assets will continue to appreciate in value. Removing the assets from one's taxable estate now, while the value is much lower than it will be at one's death, can potentially save the estate thousands of dollars in estate taxes. And the individual will have the satisfaction of seeing his or her children enjoy the gift.

By using a Grantor Retained Income Trust (GRIT), one can transfer these assets to his or her children without paying any estate or gift taxes, and one can leverage the current value of the gift into a much larger one. With a GRIT, the children receive the asset as a gift instead of as an inheritance, and only a portion of the gift receives a stepped-up basis—the rest retains the original cost basis (what was paid for it). One can give an appreciating asset to his or her children completely free of gift and estate taxes.

If the asset is one that the children will probably not sell—such as stock in a family business or the family farm—then a GRIT may be an especially attractive option since there will not be any income taxes to worry about. By removing the asset from one's taxable estate now and delaying the gift for up to ten years, it can grow tax-free over the term of the trust—so the individual is able to leverage his or her current gift into a much larger one.

With a GRIT, a person transfers one or more appreciating assets into an irrevocable trust for up to ten years. During this time (the term of the trust), the individual will receive income from the trust. (That's where the trust gets its name—the grantor retains the income from the trust). At the end of the trust term, the trust principal is distributed to the beneficiaries.
As long as the individual survives the term of the trust, the assets are removed from the taxable estate so estate taxes are eliminated. And because the gift is delayed, the gift tax liability is based on an amount less than the actual gift the person is making. However, the individual probably won’t actually pay any gift taxes. During the term of the trust, the trust assets grow tax-free and, with good management, by the end of the trust term the original gift will have grown significantly in value. Therefore, the children will receive an appreciated asset free from both estate taxes and gift taxes.

**Grantor Retained Unitrust (GRUT)**

This is a living, irrevocable estate tax cutter than lets a person transfer property to his or her heirs. Though it is also a GRIT, the difference is that the grantor must get a fixed payment from the trustee, even if the trust does not generate enough income. In such a case, and similar to the GRAT in this instance, the trustee can either sell trust assets to cover the shortfall or borrow the funds. Generation Skipping Transfer (GST Tax)

An additional tax may apply to gifts or bequests that skip a generation. If one is planning on leaving assets to his or her grandchildren, he or she should be aware of the Generation Skipping Transfer (GST) tax. This tax applies if the inheritance skips a generation, for example, if a person omits his or her children as beneficiaries and leaves the inheritance directly to grandchildren and younger generations.

The bad news is that this GST tax is a very expensive tax—a flat rate of 55 percent. Bear in mind that this is in addition to estate taxes, which can also be as high as 55 percent. The generation-skipping transfer tax is a very significant, if not confiscatory tax. Fortunately, most people will escape it. First, outright gifts to grandchildren that qualify for the $10,000 annual gift exclusion aren’t subject to the generation-skipping transfer tax. Similarly, payments of tuition and medical expenses that avoid gift tax also avoid this tax.

The good news is that everyone has a $1 million exemption from this tax. So, an individual and his or her spouse could leave up to $2 million to their grandchildren and future generations free of this generation skipping tax. And any subsequent appreciation on the transferred property will escape generation-skipping tax.

**Spendthrift Trust**

A spendthrift trust is usually set up on behalf of a beneficiary who the creator believes cannot properly manage money—the spendthrift. The beneficiary of a spendthrift trust receives the trust income from the trustee on a regular basis, but is unable to touch the trust principal. The creator can designate an age when the trust will end, at which time the trustee must transfer all of the property from the trust to the beneficiary.

**Clifford Trust**

This trust is a short-term irrevocable trust and must be set up for at least ten years and a day and for $10,000 or more; this makes it possible to turn over title to income-producing assets, then to reclaim the assets when the trust expires. For the term, the person must specify that a certain percentage be used for a particular purpose, such as providing income for a person not his or her social responsibility, or to be used for items for his or her child that are not his or her legal responsibility.

Prior to the Tax Reform Act of 1986, such trusts were popular ways of shifting income-producing assets from parents to children, whose income was taxed at lower rates. The 1986 Tax Act makes monies put in Clifford Trusts after March 1, 1986, subject to taxation at the grantor’s tax rate, thus defeating their purpose.
For trusts established before that date, taxes on earnings over $1000 will be paid at the
grantor's rate, but only if the child is under the age of 14.

THE FAMILY HOME AS A RESOURCE

Few mature Americans consider their home a resource, but it can be a very important part of
their retirement or cash needs. Most seniors and many boomers maintain a large equity interest
in their homes, especially if they are free and clear. This equity can be tapped for special
needs, by either selling the home or loaning against the equity using a line of credit or reverse
mortgage.

A family home can also be a familiar and comfortable refuge for seniors needing home health
care or a younger family member who is forced to return home after a divorce. Therefore, it is
sometimes the best to simply prepare the house for senior access and stay long-term.

Specific advice exactly what to do can only be given on a case-by-case basis. To aid, however,
here are some facts you should know:

**Equity Lines / Reverse Mortgages**

It can be said that most matures are equity rich and cash poor. That is why they might consider
a line of credit or reverse mortgage to tap their home’s equity. The proceeds can be used for
any purpose, including long term care expenses and they are tax free to the homeowner.

If your clients is still working or just before he retires, it may be a good idea to convince him to
secure an **equity line of credit** for times when he will really need it. Of course, he does not
have to use this credit now, he can wait until he gets sick or needs some reserve cash.
Typically, no interest is charged until the credit is obtained. One disadvantage might be that a
line of credit may be considered a potential debt that could effect your client’s credit.

A **reverse mortgage** is another means of tapping home equity. In the typical reverse
mortgage transaction, a lender agrees to pay the homeowner a specified payment each month.
The balance owed the lender grows as more monies are disbursed to the homeowner. The
total accumulated balance is considered a loan against the homeowner’s equity but no
repayment is required until the borrower dies, moves or sells the home. If there are two
spouses who own the house, there is no repayment due until the last surviving borrower dies or
sells or moves from the home.

Most lenders who participate in reverse mortgage plans require the homeowner to be 62 years
of age or older. Homes must be single family (not condominiums unless they are FHA-
approved). There are no income qualifications and little, if any, credit requirements because the
owner is not going to make any payments. The maximum loan amount varies per locality, from
$67,500 in low-cost rural areas to $151,725 in costlier housing markets. The amount also
varies on the client’s age. Payments are based on actuarial tables. In addition to the full loan
amount, the borrower is liable for fees, points, closing costs, insurance premiums, plus all
interest. Interest and closing rates are generally higher than those in conventional mortgages.
Liability to homeowners is limited to the value of his home, i.e., they can’t be made to pay from
other assets. Some reverse mortgage financing programs are FHA-insured, however, many
lenders require no insurance -- they are simply banking on the owner’s large “pot of equity” to
secure the deal.
Selling or Transferring The Family Home

Before the days of estate taxes, children simply moved into the family home and took over the master bedroom after their parents died. Unfortunately, it's not that easy anymore. There are nearly half a dozen ways to handle a home transfer or give it to a child. And a couple are tax-free. But, in order for the transaction to work properly, people must plan ahead. Here is a rundown of the options.

Selling Now
For access to a large pot of money without major tax consequences, the owner of a home can sell the home outright. Section 1034 of the Tax Code provides that up to $250,000 of gain ($500,000 if married and filing joint return) from the sale can be excluded from tax as long as he or she used the property as his or her principal residence for two or more years during the five-year period prior to the sale. A taxpayer who fails to meet these requirements is able to exclude the portion of the $250,000 limit equal to the fraction of the two years he lived there.

After 2009, heirs will get the decedent's basis on the property. There would be a temptation by people to sell mom's house right before she dies because she could exclude the gain whereas a sale by the heirs would result in taxable capital gain. The new law thus makes the gain on the sale of the principal residence available to the heirs just as it would have been to the decedent to keep people from feeling like they have to sell mom's house the week before she passes away.

Selling Down The Road
If a client plans to live in his home until he dies, and his estate is below the estate tax exemption (unified credit equivalent) of $1 million (2002), when he dies, his home's tax basis will be stepped up to fair market value. Thus, he and his heirs will escape capital gains tax on the home's appreciation. And, because the value of his estate is below the estate tax exemption, his heirs will owe no estate tax. They are free to move into the house, or sell it and keep the cash tax-free. If they do move into the house, their tax basis for calculating the gain or loss on subsequent sales will be the home's fair market value at the time of the client's death.

This could be a much better strategy than gifting the house to heirs while the client continues living there. Why? Even if he pays a market-rate rent to his child, the IRS will probably argue the home's full date-of-death value still belongs in the taxable estate. The only sure way around this problem is with a qualified personal residence trust, which is explained later.

Gifting The House
If a client is moving out of his home, he can give the property to his children now. However, he will probably have to dip his $1 million (2002) tax exemption. Here's how it works.

The gift of the home is first offset by the $10,000 annual gift-tax exclusion. Remember it's $10,000 per gift. So if the client and the client's spouse each make a gift to their child and the child's spouse, this offsets $40,000 of the home's value. Then, as long as the net figure is less than $1 million (2002), he won't owe any current gift tax.

There drawbacks to this strategy is that the child's tax basis on the home will be the presumably low cost the client paid for the property, which increases what the child will owe Uncle Sam on a later sale. Also, the client's estate-tax exemption has been reduced. On the plus side, any future appreciation in the home's value is out of the taxable estate. This could be a big advantage, given the rapid price appreciation that many areas are now experiencing.
Also, the estate tax exemption will gradually be restored (at least partially). It increases by $500,000 in 2004, $500,000 in 2006, and $1.5 million in 2009.

**Selling For Less**
If one sells a home to a perfect stranger for less than fair market value (FMV), it is simply a bad deal. The IRS doesn’t care. However, when a home is sold to a relative, it’s a different story. It is treated as making a gift equal to the difference between FMV and the sale price. A house worth $400,000 sold to a child for $250,000, is the same as making a gift of $150,000. Of course, the annual gift exclusion reduces this by at least $10,000 or more. However, this may still be ok if the house is expected to go up in price. The sale successfully removes all that future appreciation from the taxable estate.

**Seller Financing**
Instead of making a bargain sale, consider making an installment sale for full market value instead. This can still meet the primary objective of transferring the home to a child in a way he or she can afford—probably with better tax consequences. Say the house is sold for $400,000, with $40,000 down. The client takes back a note form his child for $360,000. It is important that the note be in writing and that it charges a reasonable rate of interest. The child can deduct the interest. The client can even gift back some of the payments to help the child’s budget. NOTE: Gifts must be made separately to be valid, i.e, write a separate check; don’t just forgive payments.

Income tax wise, there is a sale for $400,000. The client can use his $250,000 / $500,000 exclusion to dodge any federal tax and the child’s tax basis for the home is the full $400,000 purchase price. However, the interest earned form the child’s note will be taxable income tax on your interest income from the note. But remember, the child will get an equal mortgage interest deduction.

Estate tax wise, the sale removes from the taxable estate any future appreciation in the value of the home. A few years after the sale, the child may be able to refinance and pay off the note. If so, there is no further tax implications.

**Staying In The Home Long Term**
If a client wants to transfer ownership to a child but stay in the home long term, it would be best to structure a fair market sale as opposed to any gift or bargain sale arrangement. The client could pay some market-level rent. This would remove the home’s future appreciation from the taxable estate and the client could shelter the gain with the $250,000 (for singles) or $500,000 (for married couples) home sale exclusion. Rental payments to a child could, in effect, finance at least part of the cost of buying the home. The payments would be nondeductible to the and taxable income to your child. But he or she could claim rental property depreciation writeoffs, opening up the possibility of noncash deductible losses each year. If a less-than fair-market-value or below-market rents are used the value of the home could still be considered part of the estate because the owner never really gave up his possession of the property.

**A Personal Residence Trust**
Another way to make a gift of a home while still living there is with a qualified personal residence trust (or QPRT). The residence is out of the taxable estate without moving out—even though a full FMV sale has not been made to the child.

But there are heavy risks involved because a QPRT requires that the home is put into an irrevocable trust while the client still resides there. Let’s say it is set up for 7 years. If the client dies before the seven years, the house is still included in his taxable estate.
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