

CALIFORNIA BROKER

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SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

OCTOBER 2014

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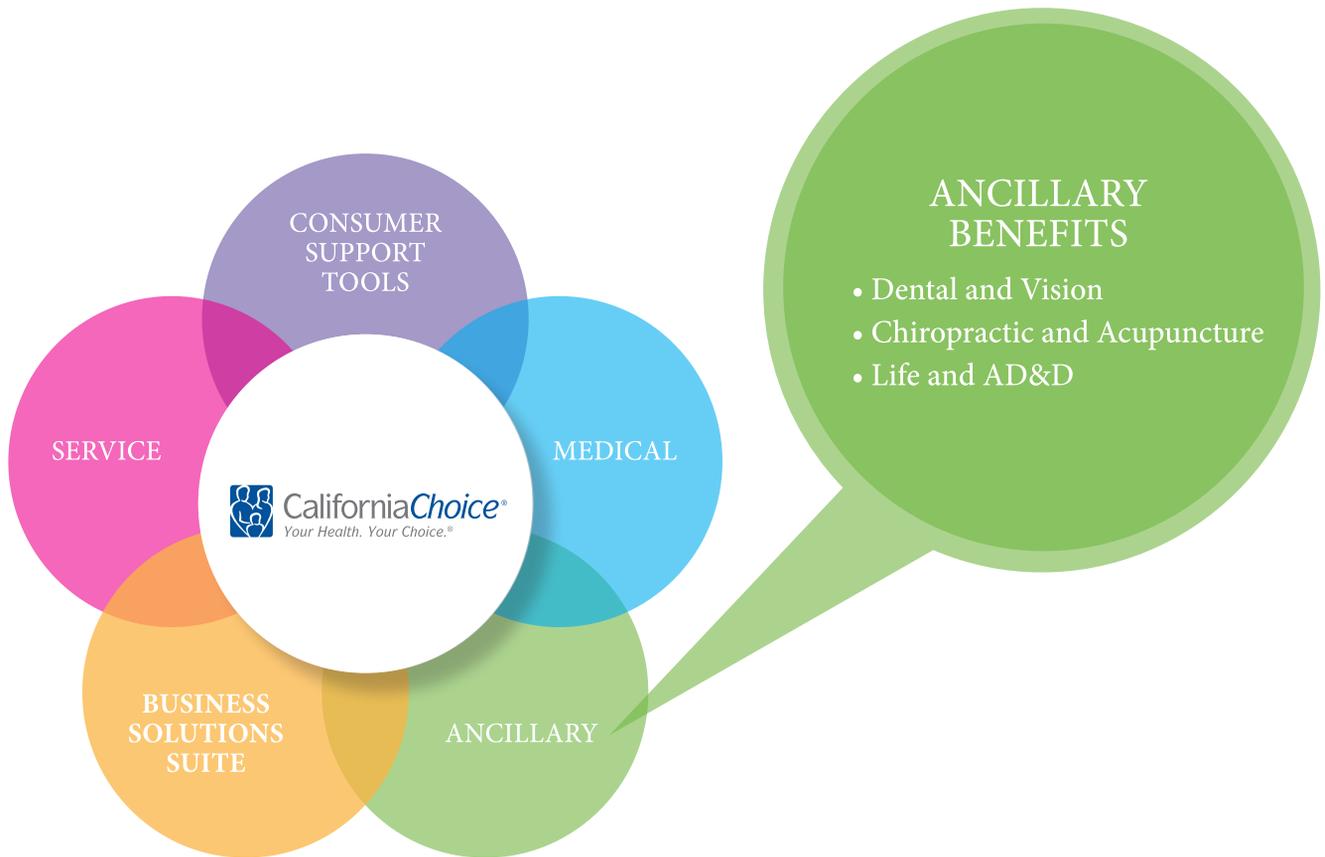
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Undoing a Sensible Approach Malpractice

On May 15, 2014, Initiative 1606 qualified for the November ballot. If it passes, all purchasers of malpractice insurance would have increased costs, which would be passed on to purchasers of health care, whether it is to the government, to employers, or to individuals or groups who purchase exchange plans. The Legislative Analyst's Office estimates that the costs to state and local governments would be "likely at least in the low tens of millions of dollars annually, potentially ranging to over one hundred million dollars annually." State and local governments have few choices to meet this increased cost: reduce expenditures in other government programs, increase taxes or shift the cost to the private sector.

The battle over Initiative 1606 will be the subject of ongoing campaigns that flood our mailboxes and dominate the media this fall. Not surprisingly, Initiative 1606 is supported by entities associated with the medical malpractice trial bar.

The essence of this proposal is to change a core decision made when California enacted the non-economic damages limit — that the cap not be increased for inflation. It has been over 35 years since California became a leader in health-care reform, addressing the malpractice insurance crisis in a measured way. In 1975, the Medical Injury Compensation Reform Act (MICRA) capped non-economic damages at \$250,000, and limited contingency fees that plaintiff's attorneys could charge injured plaintiffs according to a sliding scale. No limits were placed on the amounts that an injured plaintiff could recover for medical care, lost earnings and other economic damages. The sliding scale provides for a limit of 40% of the first \$50,000 recovered, 35% of the second \$50,000, 25% of the next \$500,000, and 15% of recoveries over \$600,000. Attorneys' fees on a \$1 million recovery may not exceed \$238,333, a decrease of \$95,000 over the usual one-third contin-

gency fee. The decrease in fees that can be charged benefits the injured plaintiff. Attempts to amend or repeal MICRA and to challenge it in the courts have occurred regularly since its enactment.

This decision was revisited several times, but was never changed because the late 1970s and early 1980s were periods of runaway inflation in the United States. The Initiative 1606 would not begin to adjust for inflation on its effective date, but would travel back in time and insert an inflation provision in MICRA as of its enactment — overruling the judgments made when it was enacted and those made by later legislatures. After the initial adjustment, the cap would be adjusted annually for inflation. This change would also apply retroactively to cases that are pending on the effective date of Initiative 1606. Because of the extraordinary inflation in the late 1970s and early 1980s, the proposed cap would increase to about \$1.1 million under the Initiative. The proposed cap would be about \$560,000 if the increase in inflation was calculated beginning in 1985 when the California Supreme Court held that MICRA was constitutional.

There have been many studies of MICRA. A Rand Corporation study from 2004 concluded that MICRA reduced the amounts awarded to the injured plaintiff in cases that were resolved by a jury verdict by 15%, but also reduced attorney's fees in those cases by 60%. Of the estimated savings from MICRA in those cases, savings from attorney's fees accounted for two-thirds of all of the savings from MICRA.

Initiative 1606 is an example of the current trend in designing initiative measures. Rather than seeking an up or down vote on the core issue, measures are designed with messages or elements expected to resonate with the public and to draw focus away from the core of the proposal. For example, while the Initiative will increase attorney's fees paid by injured

plaintiffs, it adds an unneeded reference to the existing attorneys' fee provision of MICRA. This would permit supporters to assert that the Initiative limits attorney fees when it has the opposite effect.

In addition, the increase in the amount that can be recovered for non-economic damages has been combined with a proposal to require drug testing of physicians while imposing the cost on physicians and hospitals. It would also require the use of the Controlled Substance Utilization Review and Evaluation System (CURES) prescription database before a physician can prescribe certain drugs to reduce or eliminate prescribing to patients seeking opiate prescriptions from multiple physicians. There are many undeniably tragic situations involving both of these issues and the issues are expected to resonate with the public.

But each of these issues has other solutions, such as a diversion program to avoid harm to the public and to permit recovery by the physician. Funding for these programs can also be increased with salutary results. These programs have suffered from budget cuts along with other important state funded programs in California. Similarly, the CURES database is underfunded, as a result, is not used or useful. While SB 809 has been adopted to begin to address this issue the changes will be implemented slowly.

The goal should be to protect patients from harm and compensate them when harm occurs in an efficient and fair manner. The promise of the future is to develop a system that efficiently compensates people injured during the course of medical care on a no-fault basis while taking steps to improve the system of care to reduce harm. Returning to 1975 is not the way to address either issue. □

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New Approach to Annuities

The structured note annuity (SNA) is a compelling and important offering that will profoundly affect the insurance complex. The flexibility of SNAs to match risk/return objectives opens the door to meeting a wide array of client needs that are not well met within existing annuity programs.

The launch of fixed indexed annuities (FIAs) in the 1990s was an innovation on a longstanding fixed annuity model. Owners could take a little risk on the yield in return for a higher potential payout. Using current pricing, a fixed annuity might offer a set 2% annual yield whereas an FIA would pay up to 3.5%, depending on market performance. Driven by the promise of greater upside, FIAs have grown to roughly \$40 billion in annual issuance from their inception 20 years ago.

Fifteen years after the introduction of the FIA, a new annuity category was born: the structured note annuity (SNA). For brokers and clients alike, SNAs introduce increased flexibility to match risk/return objectives with an additional tool in the annuity product line. The insurance industry is increasing the level of risk in return for higher potential returns. Thus, while FIAs are limited to fully principal protected products and relatively modest caps, SNAs offer products with a defined level of principal at risk in exchange for higher profit potential.

Risk/Reward Comparisons

SNA's fill a gap in the current annuity offering:

- Fixed annuities offer fixed returns
- Fixed indexed annuities offer higher potential but capped returns with complete protection
- Variable annuities do not have defined protection but provide conceptually unlimited upside
- SNA's provide increased upside

at the cost of increased risk

As of the end of 2013, there was approximately \$4 billion of notional invested in these products. While asset growth has been impressive, this is still an asset class in relative infancy, and we expect to see a plethora of new and hopefully innovative structured strategies to meet client retirement objectives.

Understanding Structured Notes

SNAs were born out of the existing structured note market. Dominating this \$2 trillion global asset class are large bank issuers that sell them primarily to high net worth retail clients. In the United States, annual issuance is approximately \$100 billion. Similar to an FIA, the defining characteristic of a structured note is a defined outcome to the investor. A defined outcome is a commitment by the bank or insurance company issuer to deliver a return based on a reference index. For instance, an FIA on the S&P 500 may guarantee 100% principal protection if the S&P 500 finishes down and has the same return as the S&P 500 if it finishes up. It is capped at an annualized performance of 3.5%.

Existing Annuities Comparisons

The major distinction between SNAs and FIAs is that an FIA must guarantee 100% principal protection while an SNA can guarantee less than 100% protection. So, an SNA can offer more upside potential. For example, while an FIA may offer 100% principal protection and a 3.5% maximum yield an illustra-

tive SNA may offer only 90% principal protection and have the ability to provide a higher maximum cap of 15%.

In summary, an SNA customer can take on a measured level of risk for increased return potential. The SNA innovation could widen the use of defined outcomes in the annuity space. Currently, the only defined outcome products available to annuity investors are FIAs — products that appeal to an audience that values principal protection much more than they value appreciation potential. In contrast, SNAs appeal more to appreciation-seeking investors who want a level of downside protection.

Due to the exposure of potential principal losses, SNAs are considered securities (unlike FIAs) and therefore must be registered with the SEC and advisors offering the product must be licensed with FINRA.

Fit With Issuers

The SNA product platform is compelling to issuers of FIAs and variable annuities (VAs). The product allows FIA issuers to offer similar defined outcome products with additional flexibility in risk/reward characteristics. You can offer your clients 100% principal protection with up to 3.5% annual upside and then graduated levels of risk with higher annual upside. The product allows VA issuers to offer a unique array of protection features sought by the market. Products like managed volatility have been popular over the past few years due to their reduced volatility for the client and insurer and their perceived mitigation of downside risk. While managed volatility should help dampen downside loss, there is no defined buffer or protection level associated with the strategy. SNAs would allow a VA issuer to provide a defined level of protection, which is a compelling characteristic of FIAs. Therefore, the SNA is a bridge between FIAs and VAs.

Understanding SNA Characteristics

SNA purchasers must select from the following variables, which dictate investment characteristics. These characteristics improve with the following variables:

- Duration of the product – The longer the client commits to the structure.
- Underlying index – The more volatile the underlying index is.
- Degree of principal protection – The

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A buffered cap option is the most popular product type. A buffer provides a level of protection for first losses of an index. For example, if an SNA offers a 10% buffer on the S&P 500, the customer would be protected on the first 10% drop in the index and have exposure to negative moves thereafter. For instance, if the S&P 500 was at 1,800 when the SNA was issued, the SNA would protect the client from principal losses until the S&P 500 declined below 1,620, representing a 10% drop (10% of 1,800 = 180; 1,800 - 180 = 1,620).

A cap is the maximum gain that a client can generate. Let's imagine that the cap is 5%: If the S&P 500 finishes up 3%, the client would receive a 3% gain. If the S&P 500 finishes up 10%, the client would receive a 5% gain since the 5% cap limits the upside.

As mentioned earlier, issuers can provide different upside scenarios by adjusting buffer protection and total duration. For example, while a one-year 10% buffer can provide a 5% cap for the year, a six-year

product with the same buffer can offer a total 66% cap for the six-year period. Similarly, the cap amount declines as higher buffer levels provide additional protection. For example, for a six-year duration, the carrier can offer a 66% cap with a 10% buffer and a 30% cap with a 25% buffer.

Sorting through the dizzying array of SNA permutations can be challenging for even a seasoned investor. As the SNA offering matures, new instruments will arise to help guide the consumer to the product that best matches their risk/reward profile. Also, potentially simplified products may offer similar investor freedoms with fewer options.

Many of the largest variable annuity issuers are in the process of developing an SNA program or closely watching the early SNA movers — as a testament to its potential, SNAs have garnered \$4 billion in notional value from the few current issuers available. It is a space worth watching closely as it continues to grow and evolve. □

Joseph Halpern is CEO of Exceed Investments. You can find his company online at www.exceedinvestments.com.

What's in a name?

A few names have been used to describe this annuity category:

- Indexed variable annuities — These are indexed funds in the VA space, which may cause product confusion.
- Structured note annuities / Structured Product annuities — The product is very similar to the current bank product defined as “structured notes” or “structured products.”
- Author's recommendation — If I had my druthers, FIAs would be renamed “structured fixed annuities” and SNAs would be renamed “structured variable annuities.”

The Skinny On Structured Note Annuities

Structured note annuities are performance driven by a reference index, such as the S&P 500. Investors can choose from a selection of defined protection options against market downturns (e.g., protection against the first 20% decline), in return for capped upside performance. This middle ground product provides more upside than fixed index annuities and more defined protection than variable annuities. There is a dizzying array of product choices to make without intuitive guidelines on how to make them.

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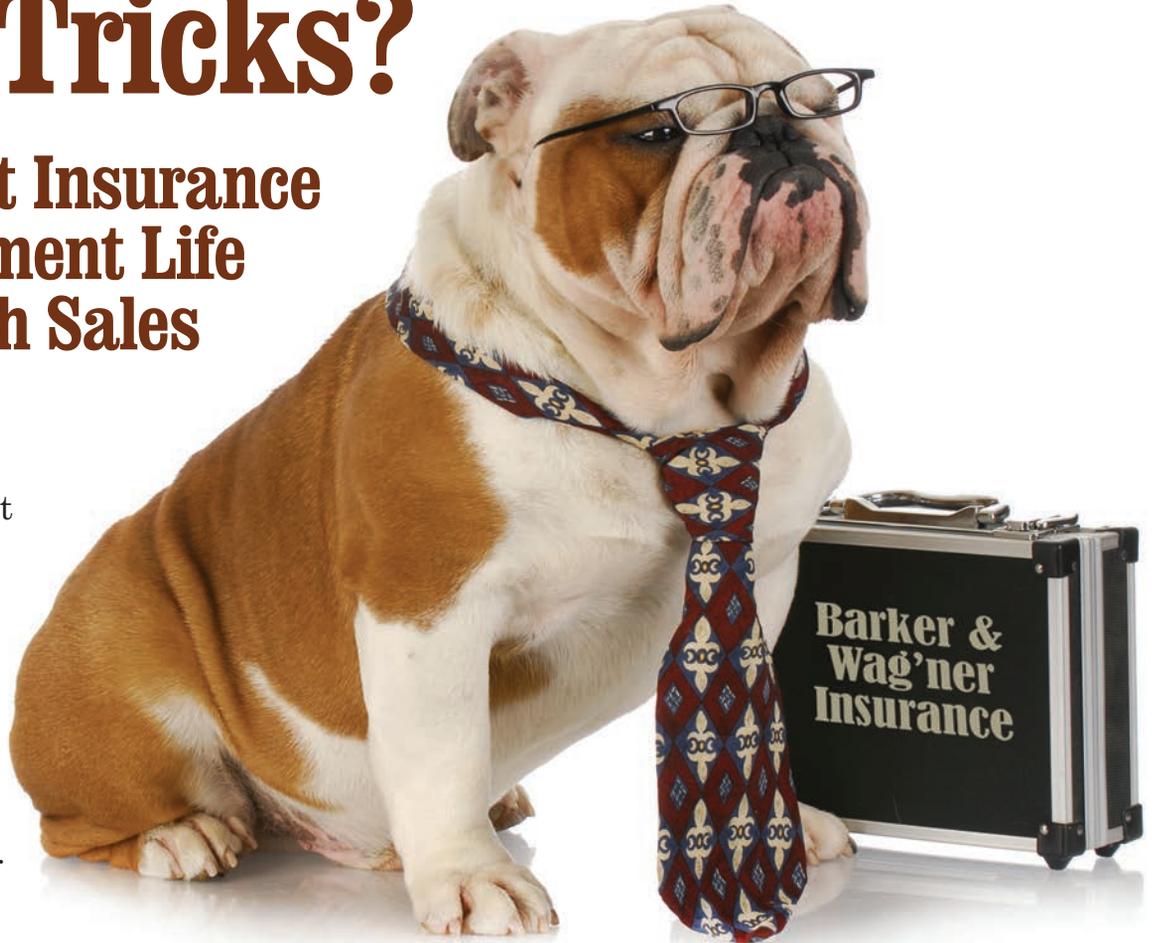
September 1, 2014

Company Name	Ratings			Product	Type SPDA FPDA	Initial Interest	Guar. Period	Bailout Rate	Surrender Charges	Mkt. Val. (y/N)	Min. Contrib.	Comm. Street (May Vary)
	Bests	Fitch	S&P									
American Equity	A-	BBB+		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.25%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.45%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.70%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
*Effective 6/30/14. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A	A+	American Pathway Fixed MYG 10 Annuity (Q/NQ)	S	4.30%*	1 yr.	None	10%, 9, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$5,000 (NQ)	4.00% age 0-75 2.20% age 76-80 1.70% age 81-85
**CA Rates Effective 9/2/14. First year rate includes 3% interest bonus												
American General Life Insurance Companies	A	A	A+	American Pathway Flex Fixed 8 Annuity (Q/NQ)	F	3.30%*	1 yr.	None	8%, 8, 8, 7, 6, 5, 3, 1, 0	No	\$5,000 (NQ) \$2,000 (Q)	2.20% age 0-75 1.70% age 76-80 1.20% age 81-85
*CCA Rates Effective 9/2/14. Includes 2.00% 1st year bonus, 140% base rate subsequent years.												
American General Life Insurance Companies	A	A	A+	American Pathway Fixed MVA 9 Plus Annuity (Q/NQ)	S	5.25%*	1 yrs.	None	9%, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$5,000 (NQ)	2.75% age 0-75 1.70% age 76-80 1.20% age 81-85
*CA Rates Effective 9/2/14 First year rate includes 4.0% bonus 1st year.												
American General Life Insurance Companies	A	A	A+	American Pathway Select MVA 10 Annuity (Q/NQ)	S	2.05%*	10 yrs.	None	10%, 9, 8, 7, 6, 5, 4, 3, 2, 1	Yes	\$5,000 (NQ) \$5,000 (Q)	1.20% age 0-80 (5 yr.) .90% age 81-85 (5 yr.) 2.50% age 0-80 (7 yr.) 1.75% age 81-85 (7 yr.) 2.00% age 0-80 (10 yr.) 1.20% age 81-85 (10 yr.)
*CA Rates Effective 9/2/14												
Genworth Life & Annuity Insurance Co.	A	A-	A-	SecureLiving Rate Saver	S	2.55%* 2.15%	7 yrs. 5 yrs.	None None	9%, 8, 7, 6, 5, 4, 3 9%, 8, 7, 6, 5, ,0	Yes	\$25,000 (NQ)	Varies 0-85 *Effective 8/20/14. Based on \$250K or more.
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	1.95%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	\$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 7/30/14. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 1.95%. For under \$100,000 first-year rate is 1.85%. Escalating rate five-year yield 1.85%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.40%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	\$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 7/30/14..Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.29%. For under \$100,000 first-year rate is 2.30%. Escalating rate seven-year yield 2.19%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.40%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 7/30/14.. Eff. yield is 2.42% based on 1.40% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.40%. Surrender value interest rate 1.40%. Accepts additional purchase payments in first three contract years. COM12255												
Jackson Insurance Company.	A+	AA	AA	Bonus Max (Q/NQ)	F	3.20%*	1 yr.	None	8.25%, 7.25%, 6.50%, 5.50%, 3.75%, 2.75%, 1.75%, 0.75%**	Yes	\$5,000 (NQ) \$5,000 (Q)	6.00% 0-80 3.00% 81-85 1.50% 86-90
*Effective 10/6/2014. The first year interest rate includes any first year additional interest, if applicable. Interest rates in subsequent years will be less. **Each premium payment, including any subsequent premiums, is subject to the withdrawal charge scheduled as detailed.												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.55%*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	**Rates Effective 9/1/14 for premium less than \$100,000 and are subject to change
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	1.90%*	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	**Rates Effective 9/1/14 for premium less than \$100,000 and are subject to change.
North American Co. for Life and Health	A+	AA-	A+	Boomer Annuity (Q/NQ)	F	6.57%*	1 yr.	None	15%, 14, 13, 12, 11, 10, 8, 6, 4, 2	Yes	\$2,000 (Q) \$10,000 (NQ)	7.00% (0-75) 5.25% (76-80)
* 6.57% First Year Yield reflects a 5% Premium Bonus in years 1-5, annuitization bonus after year 10. Penalties are waived at death. This yield assumes no withdrawals. The Interest Rate is based on current rates as of 8/26/14 and is subject to change.												
Reliance Standard	A+		A+	Eleos-MVA	S	2.85%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 6/9/14. Includes 1.00% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+		A+	Apollo MVA (Q/NQ)	S	4.30%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	\$5,000	4.00% to age 75**
Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 6/17/14												
Symetra Life, Inc.	A	A+	A	Custom 7 (Q/NQ)	S	2.70%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 6/24/14. 2.20% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												

Can You Teach an Old Dog New Tricks?

Selling Pet Insurance to Supplement Life and Health Sales

Welcome to our first ever close-up cover of pet insurance. We explain how brokers can take advantage of exciting new opportunities with pet insurance sales.



Pet Insurance – One of the Top Requested Benefits of 2014

by *Jessica Calise*

In a fluctuating economy, businesses are looking for a competitive edge by offering incentives and benefits to attract and retain the best employees. For a long time, health insurance was the carrot that many employers used but, with the advent of the Affordable Care Act, businesses are looking for new incentives. Some employers now offer a different kind of health insurance di-

rected toward a different (and for many, an equally important) family member.

Three-quarters of American households own pets including 55% of Californians, according to a 2012 report by the American Veterinary Medical Assn. Pet owners can be found in every demographic and socioeconomic class in the United States. With pet owners comprising more and more of the workforce, employers are seeking new ways

to appeal to this large subset of Americans. One of the most talked about ways is to welcome pets into the workplace. While the vast majority of office pets are dogs, other creatures have been known to visit on occasion — from cats to snakes. Advent Software in San Francisco even made sure to mention ant farms in its pet visitation policy.

Allowing pets in the workplace is a convenient perk to pet owners who

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OCTOBER 2014

are wary about leaving their animals at home all day. Pet owners who bring their dogs to work have less stress during the workday. Even co-workers who interact with the dogs report greater job satisfaction, according to a study published in the *International Journal of Workplace Health Management*. Speaking about the study to CNBC, principle investigator Randolph T. Barker, Ph.D., of Virginia Commonwealth School of Business said there is a noticeable difference in employee stress on the days dogs are in the office and days they are not. He also said that most employees who worked in an office that invited pets had a much higher job satisfaction compared to others in their industry.

In light of this national trend, a growing number of businesses in California are opening their doors to furry friends — from small, family-run businesses to large corporations like Dell Computers and Google. The website www.dogfriendly.com tracks U.S. businesses that welcome animals in the workplace.

Inviting animals into the office is not the only way that an employer can cater to employees with family pets. The majority of pet owners consider their pets to be members of the family with all the attendant emotional and financial considerations such a label can entail, according to the AVMA. It should come as no surprise that pet owners are willing to spend hundreds or even thousands of dollars a year for the care and maintenance of these furry family members. Americans spent \$14.37 billion on veterinary care in 2013. They predict that number will increase to \$15.25 billion in 2014, according to a survey of pet owners by the American Pet Products Assn. (APPA).

Families often rely on health insurance to cover the high cost of human medical bills, but they pay the full price of vet bills. Additionally, many vets require full payment at the time of treatment. A dog owner can expect to pay an average of \$231 in yearly vet visits, according to the APPA. This number nearly triples when the pet suffers a sudden medical emergency or develops a chronic condition. Some of the most common illness claims made to pet insurance companies in the United

States are allergies, feline kidney disease and cancer. The National Canine Cancer Foundation estimates that cancer treatments for a single dog can cost a family over \$6,000 in some areas of the country. Accidents and emergencies can also put a serious dent in a family's monthly budget. For instance, when the family dog swallows a foreign object, the pet owner must swallow an out-of-pocket bill to the tune of \$2,000 or more to cover the cost of x-rays, emergency surgery, and post-operative care.

Despite these high costs, only a small percentage of pet owners have taken the leap and purchased health insurance plans for their pets. However, the number of families purchasing pet insurance has increased in recent years. According to USA Today, that number is only expected to grow. As more and more pet parents go to extreme measures to keep their pets happy and healthy, they are turning to pet insurance to manage exorbitant veterinary bills. For a low monthly premium, pet insurance policies cover significant portions of annual exams, routine tests, chronic illnesses and medical emergencies. So instead of writing a check for \$2,000 the next time Fido swallows a flash drive, with pet insurance Fido's owner would be responsible for a co-pay of only a few hundred dollars.

For smart employers, offering pet insurance policies can be another tool to draw in new employees and retain their best workers. Many business owners don't realize that implementing a company-wide pet insurance program couldn't be easier. Pet insurance plans can be put in place at no cost to a business and most require very little administration on the part of the employer. In other words, a company that offers pet insurance often gains more in terms of employee satisfaction than the capital investment that's needed to make the plans available in the first place. Dozens of high-profile companies like American Express and General Motors already offer pet insurance

to their employees and more Fortune 500 companies join their ranks every year. The cost effective nature of pet insurance policies also makes them appealing to mid-size and smaller businesses as well, but most of these growing companies are not educated about the low-cost/high-reward pay-out of these plans. This little-explored corner of the insurance market is waiting to be filled by licensed P&C brokers capable of addressing this knowledge gap. □

Jessica Calise is marketing manager for PetPartners. PetPartners has offered quality plans to pet owners in all 50 states for over a decade. Employee plans include payroll deductions or direct pay from employees under employer sponsored programs, resulting in virtually zero administrative cost to business owners. PetPartners administers plans to large corporations like General Motors and is the exclusive provider of pet insurance for the American Kennel Club and the Cat Fanciers' Association. Customizable plans can be quoted online at <http://www.petpartners.com> or by calling 866-774-1113. For more information about how to become a broker/partner with PetPartners, contact Jessica Calise at jcalise@petpartners.com.



The Growing Value of Pet Health Insurance

The pet insurance industry is expected to grow 33% in 2015 according to the APPA

by Chris L. Middleton

There are several reasons why brokers should consider offering one of the fastest-growing voluntary benefits in the market – pet insurance. The pet insurance industry is expected to grow 33% in 2015, according to the American Pet Products Association (APPA). The industry is estimated to reach \$650 million this year and over \$870 million in 2015.

Pet insurance, once deemed a luxury for wealthy pet owners, is now essential to providing financial protection from escalating pet-care costs. Pets are living longer thanks to medical innovations that rival treatments for their human counterparts. But many pet owners can't afford expensive care. Pet health insurance can bridge the gap between the rising cost of pet care and the ever-tightening family budget.

Pet Insurance Is a Popular Benefit

Pet insurance is becoming a natural extension of employee health care as more and more employees view their pets as family members. Ninety-one percent of pet owners consider pets to be family members, according to 2012 Harris Poll. According to a survey by Pets Best Insurance Services, a majority of the agency's policyholders have no children living in the home. Many pet owners now view their pets as their children.

How Pet Insurance Works

Pet insurance is a low-cost, direct benefit than employers can to offer pet families. Pet insurance is a strange animal since it acts as health insurance for accidents and illnesses, but it is actu-



ally a property and casualty product. Plans vary in deductible, co-insurance, and annual or per-incident limits, but almost all pet insurance companies exclude pre-existing conditions. A number of insurers offer riders for coverage of routine care. Typically, pet owners pay veterinarians directly for treatment, and then submit claims for reimbursement. Several factors determine the total premium, such as species, age, breed, and location. Some advertised group benefits are discount or preventative care programs, which are often confused with comprehensive medical plans for pets.

Pet Insurance and Health Insurance are Great Companions

Pet health insurance is a great complement to human health insurance. Employers benefit when they can promote healthy lifestyles by keeping employees engaged with their pets. Pets not only provide love and companionship, but they also reduce stress and increase healthy activity for their owners. Pet owners are typically more active. A Pets Best customer survey reveals that 73% of the agency's policyholders walk their pets every day.

Lower stress offers a variety of health benefits, such as lower blood pressure, better cholesterol levels, and improved mental health, according to the Centers for Disease Control and Prevention. And we all know that healthy employees take fewer sick days. The presence of a pet can have a positive effect on people who are hospitalized or recovering from an illness. Pets are used in therapy for trauma victims and soldiers returning from combat.

New Products

Offering pet insurance is a terrific way for brokers to differentiate the menu of voluntary products they offer to their corporate clients. Employers are looking for creative ways to

retain talented staff while brokers are seeking creative products to bolster retention. Employers are noticing this trend on the direct-to-consumer side. More than 1 million pets are insured in North America, according to the Pet Insurance Assn. Selling pet insurance directly to consumers is not a significant revenue stream for brokers, but offering it as an employee benefit has its advantages. Group coverage offers collective pet insurance discounts without the administrative headaches or expense. Employees typically enroll online, with no open enrollment period or minimum participation levels. Credit and debit cards are the favored payment methods over payroll deduction. The pet insurance provider handles premium collection and renewals. Once claims are submitted, review and reimbursement can take as little as two to five days. Clients can have access to powerful online tools to enroll and select coverage. Brokers can use the same technology to offer an enticing benefit to thousands of potential customers with minimal effort.

How to Offer Pet Insurance to Your Clients

Because pet insurance is an individual insurance product, it's very easy for employers to offer pet insurance as a voluntary benefit. If employees choose a direct-pay option, they can enroll at any time, and there are no minimum participation requirements. □

Chris L. Middleton is president of Pets Best Insurance Services, LLC. Pets Best, one of the largest U.S. pet insurers, has been offering pet insurance to dogs and cats since 2005. The agency offers a free and turn-key setup to add pet insurance as an employee benefit. Employees can enroll at any time and pay Pets Best directly with a credit card, direct debit or through payroll deduction. For more information about Pets Best, please visit www.petsbest.com.

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Challenging Times for the US Pet Market

The right software solutions allow brokers and policy writers to bite back

by Mark Colonnese

The pet insurance industry is facing unprecedented challenges. Some providers and brokers have expressed concern about new legislation (AB 2056), which aims to tighten up the market. It's awaiting approval in the California State Senate. The unease is understandable. But, in the long term, greater clarity can only be a good thing for the industry, brokers, and policyholders.

Often perceived as the poor relation to more traditional forms of insurance, the pet insurance market is growing and has, as yet, untapped potential. With just 1% of America's pets insured in 2012, the total bill for premiums came to \$475 million to \$500 million, according to the North American Pet Health Insurance Association (NAPHIA). Yet this pales in comparison to the estimated \$15.25 billion Americans who are set to pay for care of their pets this year. The challenge is to deliver the same high standards for pet insurance as are applied to other traditional markets, but without cutting corners or increasing policy price.

American consumers tend to assume that pet insurance would offer all the same benefits for their animals as human health insurance policies do for people and that the two are on par, but that has not been the case. As opposed to health policies for humans, pet insurance falls under property insurance as an insurable risk. Hence, everything from hidden coverage limits to unexplained exclusions for pre-existing conditions and hereditary diseases may be buried away in the small print.

With veterinary costs rising, more of us are choosing to insure our four legged friends and other pets. This has led to the pet insurance market becoming increasingly competitive, with brokers being called upon to offer a range of products and programs that mirror or are at least more in line with what is expected from human insurance plans, rather than being categorized under property insurance.

The U.S. Equine and livestock insurance markets, while significant, have considerable room for growth in their own right. The Equine market is over 30 years old, but with only 17% of six million horses insured, there remain huge growth opportunities. In 2011, livestock insurance totalled over \$1 billion — a massive number, but not when you consider U.S. farm sales of livestock totalled over \$160 billion in the same year. While not in this league, pet insurance is rapidly playing catch up. Insurers and brokers placing business across a range of markets are waking up to the fact they need to step up to the plate when it comes to delivering the same professionalism in pet insurance as in other market sectors. The potential the industry affords means pet insurance can no longer be viewed as a pet project.

California's Department of Insurance received complaints from pet parents claiming that insurers were dragging their feet in settling claims, unexpectedly denying coverage based on pre-existing medical conditions, or paying out considerably less than was seemingly due when a claim was made. Such situations tend not to be the fault of the broker or policy provider, but often stem from poor systems and a vacuum when it comes to policy and regulatory guidance. Yet all these issues can be easily and cost effectively rectified.

Capable technology platforms are essential to maintain public trust if this industry is to realize its full potential. Such systems need to address this issue and the other key challenges facing the industry as well as the approach to its customers. Inflexible systems that do not keep the customer in the loop and unclear terminology and regulation can leave customers confused, when they need to know what is involved in price and billing — in short, the kind of deal they are getting for their dollar. Any gray areas can knock public confidence in what is becoming an essential product for all pet parents, particularly as new treatments

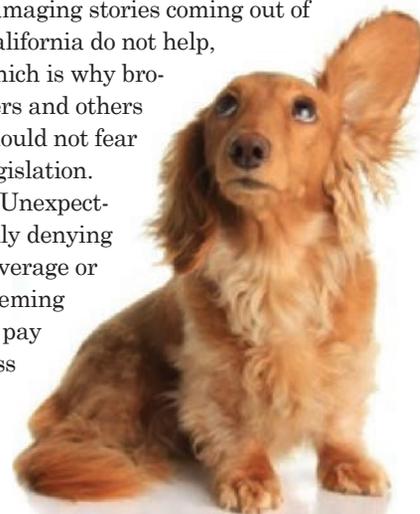
push up the cost of veterinary bills.

Not all pet insurers and brokers have the same technical requirements, but they do face many of the same operational policy and claims administration challenges. It is now perfectly possible to source systems that are customized to broker/ client requirements.

When it comes to delivering insurance products in a growing, developing market with multiple regulation and cover drivers, vendors and brokers need the means to create new products quickly, which requires a high level of flexibility. For pet insurance, there is a need to address the very different needs of various species. The data needs to facilitate more intelligent pet risk rating. This can make the crucial difference between having high claims costs and being able to deliver a profitable, yet attractive, premium to policyholders.

There is a real need to be able to work with brokers to deliver products that are attractive and meet the needs of their clients and their pets, especially using employee benefits as a key channel. Sales will stagnate if customers cannot see what they are getting for their money. They need to see they have been sold the right policy at the right price and should they need to call upon it, it will not let them down. Pet insurance is in its infancy and needs to build a strong reputation. The negative and potentially damaging stories coming out of California do not help, which is why brokers and others should not fear legislation.

Unexpectedly denying coverage or seeming to pay less



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than due helps no one. The right software can prevent this by delivering greater operational efficiency through strategies, such as electronic claims notification direct from the veterinary hospital to the insurer. All things the customer does not see, but serve to deliver them less of a sale and much more a service they can depend on.

A big worry in the U.S. and overseas concerns claims leakage; this is where effective software comes into its own. While on one side, customers need to receive what their policy entitles them to, on the other side insurers need to know that they are not paying out more on claims than is necessary. Otherwise, the spectre of premiums increasing would be a consequence.

A broker needs to be confident the system is accepting the information they need to see covered and meets any state level or other regulatory framework. And, should a claim come through, the insurer needs to know that it is paying out on the correct parameters and that the customer is aware of what these are when taking out the policy and when a claim is generated. It is in everyone's benefit to have effective underwriting and a fair claims assessment process. For this to happen, accuracy is needed across the board.

There is a real need to manage the complexity in servicing the insurance market as a result of the state filing system. The NAICs Statement of Intent document, back in 2000, outlined some important efficiency initiatives including addressing speed-to-market issues. While welcome, the right software can facilitate much of this work. Automation makes much of the essential form filing easier and significantly improves turnaround times while reducing the number of hours staff members are tied up in doing basic administration.

The pet industry is largely unregulated, but with the right systems there is little to fear from increased regulation. No one wants animal insurance to be deemed something out of the Wild West. Many providers, these days, work across states and indeed across continent, which is partly why the industry has remained broadly neutral in response to the California bill. With only 10 primary pet insurance providers, brokers will remain a big part of this process, but the number of providers will increase as pet insurance becomes more desirable. As Veterinary Pet Insurance (VPI), currently the largest US provider, has endorsed regulation, others will fall into line.

Critics have said that such regulation will give those in the industry more to do, by making specific provisions for certain states and not others but this is where a flexible business system comes into its own. Sure, requiring insurers to provide customers with a list of deductibles, exclusions, annual limits and reimbursement formulas looks onerous and a bit unnecessary. The insurance commissioner already has the power to require pet insurers to get licences and submit premiums for approval. But with flexible software, these days it's no

big deal. Critics fear that a raft of new regulation could force up premiums. But again, this would only be the case for those companies not having systems capable of handling such changes.

Successful organizations should be able to adapt to grow as business grows and contract as necessary. Regardless of any bill in any legislature, customers can vote with their feet if insurers cannot offer easy to understand policies that provide real value. To ensure that the customer is clear about their policy at every stage, insurers must have systems in place to identify areas that could lead to exclusions and then inform the customer. Clarity is key to satisfied customers; and a satisfied customer is one more likely to go for renewal when the year is up.

Each insurer has different ways of operating, and a one-size-fits-all approach simply does not live up to expectations. When it comes to identifying exclusions in policies, each insurer has different criteria, which a flexible software system can accommodate by giving greater clarity to customers and improving the customer experience. Technology platforms have been developed for every aspect of pet insurance, including that vital first step explaining the policy details exactly. By providing clear and reliable information about the policy, customers should be left in no doubt about what their insurance covers. If regulation sorts out the wheat from the chaff by eliminating bad actors and creating industry standards, it's not a bad thing. Cowboys give everyone in the industry a bad name and conditions that force them out is good news for all professional insurance providers, brokers and clients and, more important, their pets. □

Mark Colonnese is VP of Sales and Marketing for Anglo-American pet technology experts Aquarium Software Inc. Mark has extensive blue-chip experience, having previously worked for IT consultancy LogicaCMG and latterly and then as product manager at mentor Graphics, a leading US software vendor. Mark holds a Masters degree and a Diplome d'Ingenieur in engineering, speaks fluent French and lives in Oxford. For further information contact Aquarium Software Inc, on +44 (0)161 927 5620 or visit www.aquarium-software.com

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Connect Your Small-Business Clients with Carriers that Consult

It's a scenario you're likely to encounter. One of your small-business clients has an employee who is about to take a disability leave for an illness or injury. Or, perhaps, a client has an employee with a chronic condition that could escalate into a disability leave if preventive measures aren't taken. The employer has disability insurance to help employees in either of these instances, but isn't quite sure of where to start to help this employee since this type of situation doesn't arise often. So they call you for counsel.

You always recommend that your clients reach out if they need assistance. But time spent helping HR managers with the intricacies of group disability policies can keep you away from other important business-building things — namely, meeting new clients and making new sales, which is especially important during enrollment season. In this situation, you might be able to get help from a place you may not expect: your disability carrier.

Service offerings to Help Clients in Need

Many disability carriers are doing more than just offering insurance products these days. Some are providing services with their group disability offerings that can help ensure that your clients are getting the most value from their benefits. This includes providing counsel through the disability process and helping ensure your clients' workforces are healthy and productive.

Rather than have your clients rely on you to guide them through disability leave questions and nuances or help them best utilize health and wellness programs, consider the ways you can work with a carrier that offers resources in these areas. Some disability insurers offer consultants with specializations, such as helping your small business clients answer important questions and assisting with accommodations.

The key for success is educating your small-business clients about how to work with their disability carrier to help with employees' disabling conditions. It's also important to let them know about other resources carriers offer or other programs they can assist with. Not only will making this connection take work off your plate the next time a client has a claim issue but also position you as an above-and-beyond service provider.

Educate Clients on How Carriers Can Help

Disabling conditions and disability leaves might be foreign concepts to small-business clients since their staffs might not incur major illnesses or injuries at the same rate that larger organizations might. When setting up a group policy through a carrier that offers a disability consultant, a key step is to help educate clients on the types of scenarios in which a disability carrier can help. This includes return-to-work, stay-at-work, ergonomic, and mental health accommodations.

Carriers that have disability consultants (often include vocational, nurse or mental health case managers) can step in to help employees out on a disability leave. Disability consultants will work with human resources, the employee, and even the employee's medical team to find a solution — be it an ergonomic accommodation, temporary job schedule or return-to-work plan.

Medical or disability leaves aren't the only instances in which a carrier can help, though. Encourage your small-business clients to reach out to a carrier's disability consultants to help them accommodate employees who have conditions that might not be disabling or impairing yet. Back pain, musculoskeletal issues, carpal tunnel and even depression can spiral into a larger issue if left untreated.

Small businesses often can't afford to be missing key employees, as even one employee out on a disability leave can decrease profitability. Being proactive can help curb the chance that conditions could become something larger and keep employees at work and productive.

Maximize the full benefits offering

In today's wellness-minded world, small-businesses understand that they should provide additional resources to employees, such as employee assistance, wellness, and/or disease management programs in addition to their health and disability insurance benefits.

These programs exist to help mitigate the impact employee health has on an organization, and can connect employees with the resources and assistance they might need. But many may not know how and when to

properly tap, or even promote, these programs.

Encourage your small-business clients to connect with their carrier's disability consultants to help ensure they're getting the most out of their benefits programs. Disability consultants can investigate available offerings and counsel employers on how to best maximize these resources. In some instances consultants will even help make the connection with health insurance plans and benefits offered through other carriers.

Help and an Objective View

In addition to being point people for your clients, disability consultants can work directly with employees. They can help ask the tough, health-related questions an HR manager might not feel comfortable with and suggest the best resources to help with the issue at hand.

If an issue does require a claim, disability consultants can even help employees navigate the claims process. They also can work directly with an employee's medical team and help implement any restrictions or concerns into a return-to-work plan or implement reasonable accommodations.

Allowing direct access between carrier resources and clients won't just save you time, it can also help reduce instances of disability in the workplace and increase productivity and profitability. This is especially important for small businesses that can't afford to lose an employee to a disability leave.

By addressing these issues early, you can help your clients diminish the need for an employee to file a disability claim and increase your value as a resource for years to come.

Brian Kost is the program director for Standard Insurance Company's Workplace Possibilities program. He's been with The Standard since 2007 and was instrumental in creating the program that exists today. With more than 30 years of experience, Brian is a results-driven manager with a track record of innovative program design in reducing absence, improving return-to-work outcomes and helping employees become more productive. He holds a master's degree in career and guidance counseling. He also is a certified rehabilitation counselor and ergonomist.

How to Maximize Enrollment in Voluntary Benefits

Successful voluntary benefit plans offer tremendous value to employers and employees because of their affordability, ease of use and high return on investment. But these perks can't be obtained without a strong enrollment among employees. Providing education and support for employees during enrollment is key to your success with voluntary benefits.

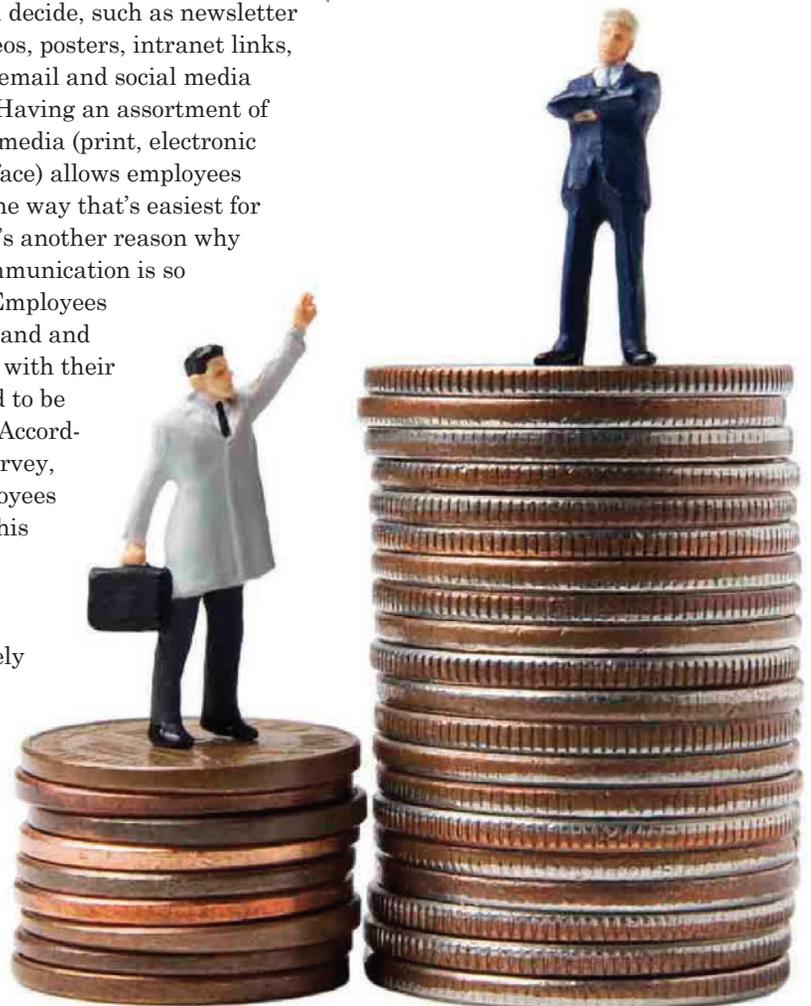
Thirty-eight percent of employees say they aren't very confident that they made the right decisions during their last annual enrollment, and 42% don't believe they use their benefits effectively, according to a 2014 survey by MetLife. The following strategies will help you maximize participation in your company's voluntary benefit plan through a simple and stress-free process.

Communication Is Key

How a company communicates to employees about benefit offerings determines how popular the benefits will be. The reason is simple: employees are more likely to enroll in voluntary benefits that they perceive to have value. Employers should select a plan provider that is committed to guiding them through employee education and enrollment. Before selecting a provider, look into their approach to account management. Having an account manager assigned to a company makes a big difference when it comes to communicating with employees and implementing and maintaining the benefit.

Often, employees aren't sure of their needs. Reputable providers offer a variety of well-crafted communication tools

to help them decide, such as newsletter articles, videos, posters, intranet links, and text for email and social media campaigns. Having an assortment of educational media (print, electronic and face-to-face) allows employees to learn in the way that's easiest for them. There's another reason why effective communication is so important. Employees who understand and are satisfied with their benefits tend to be more loyal. According to the survey, 74% of employees agree with this statement, "My benefits communication effectively educates me and I am very loyal."



Personalize Communications

One of the biggest findings from the study is that employees want benefits that are tailored to their needs. Eighty percent of employees say that having customized benefits would increase their loyalty to their employer. This desire for customized benefits is highest among younger employees. Fifty-four percent of Generation Y employees say they need more help understanding how their benefits work and how the benefits can help meet their needs.

To meet employees' needs for customized benefits, your communications should include personalized messages and materials reflecting how the benefits can help the employee. Employees are more likely to enroll in a voluntary benefit plan when they fully understand the details of the offering, such as the services they will receive, the costs, and how much time and money they will save by participating.

Know Your Employees' Communication Preferences

There are many ways to communicate your benefit offerings. It's a good idea to provide different options for your employees to access information on benefits. According to the study, 70% of employees say one-on-one meetings are most helpful. The next most popular option is sending a confirmation of benefit enrollment elections to each employee. The following are some other popular ways to communicate:

- A toll-free help line
- Group meetings
- Benefit webinars
- Online decision support tools, such as calculators and FAQs
- Mailings to home

Social media, apps, and on-line chats aren't currently the most popular ways to communicate benefits, but this is an area employers will want to keep an eye on. Generation Y favors mobile apps (50%) and social media (48%) when enrolling in benefits.

Make It Easy For Employees

Employees are more inclined to enroll in a voluntary benefit plan if their employer is behind it because they trust the employer to provide the best options. To achieve optimal enrollment, employers should offer voluntary benefits on the ballot alongside traditional benefits during annual open enrollment.

Offering the benefit plan annually gives employees the opportunity to enroll if they haven't previously. Additionally, companies can allow enrolled employees to stay in the plan without re-enrolling, which is convenient for employees and benefit staff.

It's also important for employers to distribute communications and include the materials in the company's benefit guides. Employees will read materials from the employer, especially when included with the employer's benefit workbook.

Offering voluntary benefit plans is an easy, low-cost way to improve employees' lives, but employees cannot reap the rewards without enrolling. A few, simple best practices can

make a big difference in the success of your voluntary benefit plan. Employers that apply these practices provide employees with a solid understanding of the benefit plan and its value, thereby giving them reasons to enroll.

Marcia Bowers is director of Sales and Marketing for Hyatt Legal Plans, a MetLife company. She has nearly 20 years of experience in the employee benefits business and has implemented group legal plans for hundreds of employers. She has conducted consumer research and written articles about the value of legal services for employers and employees. Bowers earned a JD from the University of Akron School of Law and belongs to the Cleveland Chapters of the American Advertising Federation and Sales and Marketing Executives. She is also on the Education Foundation board of directors for the AAF. With 1,600 sponsors, Hyatt Legal Plans is the market leader in group legal services and was recently named Customer Service Department of the Year at the American Business Awards.

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Products

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Enrollment Support Tools

Transamerica Employee Benefits is offering interactive enrollment education and decision support tools at no cost to eligible employer groups. This limited time offer will be available September 1 to January 1, 2015. The platform will include educational modules for voluntary products underwritten by Transamerica Life Insurance Company – critical illness and accident insurance – along with medical, term life, hospital indemnity, dental, and vision insurance modules. It makes it easy for producers and employers to provide a personalized enrollment experience. For more information, visit www.transamericaemployeebenefits.com.

Self-Service Enrollment

Navera is offering employers and brokers a suite of educational and decision support software for self-service enrollment in Humana's workplace voluntary benefits. Humana Inc. and Navera will include education and decision support software for other Humana benefits, including medical, dental, and vision products. For more information visit www.humana.com.

Health Exchange

Aon Hewitt is expanding coverage options under the Aon Active Health Exchange for 2015. Employers can offer a wide range of elective benefit plans during this fall's annual enrollment season. The following elective benefits that can be offered on the Aon Active Health Exchange for coverage beginning January 1, 2015:

- Critical Illness
- Hospital Indemnity
- Long-term Disability
- Legal
- Accident
- Life
- Identity Theft
- Pet Insurance

For more information, visit <http://exchangesolutions.aon.com/our-exchange-portfolio>.

Education on Fiduciary Risks

The Guardian launched The Fiduciary Awareness Quiz to help plan sponsors understand their fiduciary obligations. For more information, visit <http://exchangesolutions.aon.com/our-exchange-portfolio>.

Global Health Budget Tool

The Kaiser Family Foundation has launched an interactive tool that provides the latest data on the U.S. government's global health budget in

an easy-to-access form. The U.S. Global Health Budget Tracker lets users follow the budget from the President's budget request through the appropriations process in Congress, and see trends over time. The Foundation will host an interactive web briefing on the new tool on Thursday, September 11 at 10:00. To view the tool, visit <http://kff.org/interactive/budget-tracker/landing>. To register for the briefing, visit <https://cc.readytalk.com/cc/s/registrations/new?cid=udvgeuo8nhi>.

Financial Planning

Social Media Content For Financial Reps

Guardian Life is expanding its social media program to financial representatives and wholesalers. They now have access to articles, images and videos that they can post to their followers and prospective clients. On average, Guardian's users share eight pieces of content each month. The program was recently recognized at the LIMRA LOMA 2014 Social Media Conference for Financial Services with the Best Use of LinkedIn Award. For more information visit www.GuardianLife.com. □



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Big Data – The Cure for Quoting and Online Enrollment In an ACA World

For millions of Americans, shopping online for health insurance has leapt from market idea just a few years ago to consumer expectation today. It's a blessing and a curse for all of us in the individual insurance and employee benefits business. But one thing is clear — to compete and thrive in an era of health care reform, carriers, brokerages, agents and providers will need enterprise-level big data technology to drive online quoting and enrollment.

More than ever, individuals, families, and employers are demanding easy ways to shop for and compare health insurance plans online and get immediate quotes. Much of this recent surge has been driven by the Affordable Care Act (ACA) and the proliferation and promotion of government-run health insurance exchanges.

During the past year, alone, an estimated eight million individuals selected a health insurance plan through state-based and federally facilitated exchanges, according to Dept. of Health and Human Services. Millions more purchased coverage through private exchanges and online insurance marketplaces. Experts predict that these numbers will continue to climb sharply in the coming years.

Enabling online insurance plan shopping is a market necessity, but doing so is much easier said than done. The technology requirements and investment needed to operate and sustain an effective system on a regional or national basis are complex and immense. But, in the new world of healthcare,

it's vital for insurance providers to carve out their piece of this growing online marketplace.

The most significant hurdle may be to address the database technology and infrastructure, which is the cornerstone of any effective online system. But there is a cure, and it rests with big data platform and software solutions at the enterprise level.

What Exactly Is Big Data?

Plainly stated, the term, "big data" describes massive amounts of information that can be captured, curated, stored, searched, shared, transferred, analyzed, and visual-

ized. It's difficult or nearly impossible to process the sheer volume of complex data with commonly used software tools. Instead, specialized software systems are needed — ones that often require tens, hundreds, or even thousands of servers to operate.

Big data isn't new to many industries. Retail, banking, entertainment, and other sectors have embraced it for years to identify trends, optimize product and service offerings, create and customize promotional offers, establish online purchasing platforms, enable real-time electronic transactions, and much more.

Our health care industry is a relative newcomer. But the revolutionary shift is finally in overdrive thanks, in part, to significant advances in technical capabilities to gather, curate, and aggregate complex data from multiple sources, as well as ACA-led streamlining of information technology standards and protocols.

One of the first major industry pushes began in 2009 with the Health Information Technology for Economic and Clinical Health (HITECH) Act incentive program. It set up \$40 billion in incentive payments to drive adoption of electronic medical records. This impetus has quickened big data integration on

the clinical side ever since, like seeing what treatments are most effective for particular conditions across specific groups of people.

This technology momentum continues in earnest with health care reform serving as a major propellant. Carriers now have two markets to serve with data — one online and the other off. With this comes

a push for increased transparency in covered benefits, the introduction of multiple in-network tiers, and more complex benefit structures. All of this comes together to create ever more data

(Continued on Page 26)



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(Continued from Page 26)

points to manage, thereby boosting the need for big data and the ability to analyze large amounts of plan information.

These and other factors are game changers for all of us in the industry — carriers, brokers, general agents and online providers. And the potential financial value is exponential. Management consulting firm McKinsey & Company estimates that big data will generate some \$300 billion in annual financial value to the U.S. health care market over the next several years.

The good news is that health care stakeholders can tap this value and access what McKinsey & Company calls “promising new threads of knowledge that make up the ingredients forming big data.” Big data allows insurance providers to build their business through online and cloud-based channels. Enterprise-level technology harnesses the power of big data, creating online insurance quotation and enrollment solutions that work in today’s changed health care setting.

For online health insurance plan shopping, a high-volume information pipeline fuels online decision support tools, consumer driven shopping platforms and seamless enrollment. Effective use of big data is becoming a key way for health insurance companies to outperform their peers. With consumers primed to expect instant insurance quotes and health plan comparisons at their fingertips, big data platforms provide the requisite doorways for success.

The DaaS Solution for Big Data Needs

But how do you create and maintain complex big data systems cost effectively? One of the best answers for mid- and large-sized organizations that market and sell health insurance is to use enterprise-level technology via a Data-as-a-Service (DaaS) model. With DaaS, data is centrally hosted and licensed on a usage basis. It is sometimes referred to as “data-on-demand,” and is typically accessed by users through cloud-based systems.

Here are a few reasons why DaaS makes sense for many organizations. First and foremost, building a national database of health plan pricing and

benefits from scratch does not make sense and is simply out of reach for most organizations. It can often take more than a year to create a customized technology solution, not to mention the costs of implementing, supporting and continually updating the system.

With DaaS, instead of purchasing and implementing an expensive software solution, companies outsource their needs to an experienced provider. DaaS providers host applications on their servers, and process enrollments quickly. They also offer big data connectivity to insurance carrier databases and, in the most selective cases, even to the federal and state marketplaces.

A cloud-based DaaS insurance solution from the right partner can be a powerful, scalable, and cost efficient option for carriers, brokers and others. A group with the technological expertise and insurance company relationships (and application volume) can provide immediate access to the widest range of up-to-date rates and multi-carrier benefit information. Solutions can be plugged in quickly, offering flexibility and speed to market. And they can provide seamless integration for optimal user experience.

To Buy or Build?

There’s no getting around the fact that online health insurance shopping and enrollment is today’s reality and that big data is an integral part of this future. But does it make sense to build your own system? In the vast majority of cases, the simple answer is no. The typical technology outlay for an independent database-driven insurance quoting system is around \$300,000. But the cost of sustaining an independent system goes up even further when you factor in IT maintenance and licenses to purchase and update applications. The costs will continue to gobble up company dollars and staff resources for as long as the system is in place. But those costs are relatively small compared to the cost of maintaining a database of up-to-date and compliant health plan information. A dedicated staff must update plan data regularly and manage ongoing carrier relationships to ensure a high level of accuracy. Managing this data

on a national basis can cost upwards of several million dollars per year. Cloud-based DaaS solutions are attractive because they leverage big data systems through a single, manageable cost for a variety of services that can scale up or down as needed. More importantly, these services are fully supported and updated consistently to meet the requirements of our highly regulated health care insurance industry.

There are other major benefits to buying or renting a platform versus building one. The best models offer an integrated online enrollment solution that allows agents to maintain consistent and tailored branding while quickly converting inquiries into sales. For carriers, DaaS offers versatility, as well as immediate market deployment capabilities. It also offers controlled total cost of ownership that a custom-built, internally operated and maintained option can rarely, if ever, match.

The Next Frontier Is Here

The rise of big data is a tipping point for the next frontier of clinical care, operations, marketing, customer relationship management, and service in the health care industry. For online shopping and enrollment solutions, it is the force empowering the new business processes that are needed to address today’s changing health care environment.

DaaS models offer a smart response to this transitioning marketplace. They play a central role in offering a big data solution that enables health insurance and employee benefits stakeholders to meet customers’ online demands and service expectations now and in the future. □

Chad Hogan is senior vice president of Quotit Corporation, a leading Internet application service provider for the health insurance and employee benefits industry. Quotit connects insurance companies, brokers and retail consumers with insurance rates and benefits online, in real time through more than 300 insurance carriers representing over 40,000 plan designs. For additional information, please visit enterprise.quotit.com.

PPO POWER

Welcome to Our 14th Annual PPO Survey



Welcome to our 14th annual PPO survey. For this survey, seven PPOs in California diligently answered direct questions about their plans. Our readers, who are savvy health brokers, suggested many of the questions.

We hope this information will help the professional agent or broker better serve sophisticated healthcare clients.

1. Is an Approval Procedure required for Getting a Specialist Referral or a Diagnostic Test or Treatment In-Network or Out-of-Network?

Aetna: There is a high-tech radiology pre-certification requirement for some customers.

Blue Shield: No, PPO plan members can generally self-refer to any doctor for care. They can choose to use in-network or out-of-network providers with claims reimbursement based on their benefit plan. Out-of-network services are usually subject to a higher deductible and co-payment amount.

Cigna: No referrals or approvals are required since the PPO benefit plan is an open-access program. Customers are covered whether or not they get care from PPO network providers. Customers who use services from an in-network provider may have reduced co-payments and lower out-of-pocket costs.

Health Net: There are no approval procedure requirements for visits to in-network or out-of-network specialists. A prior authorization list for diagnostic tests or treatments is included in the member's Evidence of Coverage (EOC).

Kaiser Permanente: PPO members do not need a referral to obtain care from specialists. Most diagnostic tests are covered, provided they are ordered by an insured's doctor, are a covered benefit, and are deemed medically necessary. However, if a test or treatment is on the precertification list (e.g. MRIs and CT scans), precertification is required.

UnitedHealthcare: To strengthen the patient-physician relationship, primary physicians are not required to request an authorization when they refer a patient to a network specialist for an office visit. Primary physicians are very effective at ensuring that our enrolled individuals receive medically appropriate and necessary specialty care. In fact, practice pattern analysis shows that primary physician referrals to network specialists have been almost 100 percent effective and medically appropriate.

2. Are there any restrictions on getting second opinions from an in-network provider or an out-of-network provider?

Aetna: A member, who has the option of an out-of-network benefit, may arrange their own second surgical opinion with a non-participating provider.

Blue Shield: No, a member may get a second opinion from any in network or out-of-network provider. When an out-of-network provider is used, the member is responsible for any difference between Blue Shield's payment and the billed amount.

Cigna: There are no restrictions. The PPO is an open access plan, allowing customers to seek care in-network and out-of-network at any time. When accessing medical services, customers have the option to decide whether to use a network provider. By using a network provider, customers have lower out-of-pocket costs.

Kaiser Permanente: Second medical opinions are covered regardless of the provider's network affiliation. As in all cases, charges will be lower when care is received from a participating network provider. Members are encouraged to contact Member Services for a full explanation of their benefits. The physician offering the second medical opinion should not be affiliated with the physician offering the original medical opinion.

Health Net: Health Net members may see any in-network or out-of-network provider for a second opinion without obtaining a referral. Members are encouraged to call the Customer Contact Center with any questions regarding their benefits.

Kaiser Permanente: Second medical opinions are covered. Coverage is limited to charges for physician consultation and any additional X-rays, laboratory tests, and other diagnostic studies. Benefits will not be payable for X-ray laboratory tests, or diagnostic studies that are repetitive of those obtained as part of the original medical opinion and/or for which Kaiser Permanente Insurance Company (KPIC) has paid benefits. For benefits to be payable, the second medical opinion must be rendered by a physician who agrees not to treat the covered person's diagnosed condition. The physician offering the second medical opinion may not be affiliated with the

physician offering the original medical opinion.

UnitedHealthcare: A second opinion is not mandatory under our plans. Our UnitedHealthcare Options PPO product is open access. Members may seek second opinions from any participating or non-participating physician. The member's benefit level will vary depending on the physician's participation status.

3. Where are decisions made about specialist referrals, testing, treatment, surgery and hospitalization?

Aetna: Our patient-management staff is regionally located. The region is determined by the location of the customer.

Blue Shield: Treatment decisions such as these are made between the patients and their doctors. In the case of surgery, hospitalization or major diagnostic tests, Blue Shield's prior authorization process is used to review the proposed treatment for medical necessity.

Cigna: These decisions are made by a customer's physician in conjunction with the customer. Cigna's clinical programs, nurse case managers and health coaches can help individuals make decisions about their care. Cigna also offers award-winning online quality and cost information tools to help customers make informed choices. Some types of services require prior authorization by Cigna in order for the services to be covered under the individual's plan. Customers can call Cigna Customer Service 24 hours a day, seven days a week with any questions about how their specific plan works.

Health Net: Decisions regarding specialty referrals for testing, treatment, surgery, or hospitalization are made with the member, the member's physician, Health Net's Care Management team and, if the member chooses, our external vendor AlereTM's Nurse24SM nurseline clinicians, who will provide additional information to help the member through the decision-making process.

Kaiser Permanente: Decisions regarding testing, treatment, surgery, and hospitalization are made by the insured and his or her physician. Referrals are not needed to see a specialist. The insured is required to obtain precertification to ensure certain services are both medically necessary and cost effective. This includes any hospitalization and certain special procedures as defined in the insured's Certificate of Insurance.

UnitedHealthcare: The treating healthcare professional and the patient make decisions about providing specialist referrals, testing, treatment, surgery and hospitalization. We determine whether such services are covered by referencing the member's summary plan description.

4. Which complementary medical disciplines are covered under the PPO or will be covered under the PPO?

Aetna: Members can get special rates on visits to acupuncturists, chiropractors, massage therapists and nutritional counselors, which they pay directly to the participating provider. Participating providers and vendors in the alternative healthcare programs are solely responsible for their products and services. We have not credentialed or reviewed them. Members can save on over-the-counter vitamins and supplements, aromatherapy, foot care, and natural body-care products.

Blue Shield: We offer the following:

- All members in our fully insured PPO groups are covered by our disease and case management programs.
- LifeMAP and guided imagery program.
- Our wellness assessment customizes referrals to lifestyle management programs. There are cash incentives to reward participation – available as a buy-up option.



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- **CareTips for Physicians:** This clinical messaging program sends patient-specific messages highlighting gaps in care to the member's primary care physician.
- **LifeReferrals 24/7** to experts in financial planning, education, and law, along with personal consultations. It is included with all fully insured PPO plans and is available as a buy-up option for self-insured plans.
- Self-funded groups may now purchase the managed behavioral health buy-up package. This program is included with all fully insured PPO plans and is available as a buy-up option for self-insured plans.
- All members can search our health library; sign up for Blue Shield condition management and wellness programs; and subscribe to the Health Update eNewsletter. Online decision making tools allow members to compare hospitals, explore treatment options for their condition, and learn more about prescription drugs.
- Members can get 25% off or more from published fees for acupuncture, chiropractic and massage therapy. Members can also get up to 40% off of selected vitamins, herbal supplements, homeopathic remedies, diet and sports nutrition, yoga and fitness equipment, personal body care, and health and wellness books, audio, and DVD products. (free shipping in most cases.)
- Wellness discount programs on Weight Watchers, 24-Hour Fitness, Drugstore.com, and LASIK.
- A discount vision program.
- **Chiropractic Network:** Blue Shield has a directly contracted statewide network with more than 5,000 licensed chiropractors.
- **Blue Shield Centers of Expertise and Blue Distinction Centers:** Members can find facilities and doctors that meet high-quality standards for transplant, cardiac and bariatric surgeries within California.

Cigna: This depends on the plan selected by the employer. Cigna also offers its Healthy Rewards discount program, which provides discounts for many types of complementary and alternative treatments.

Health Net: Complementary medical disciplines vary by each employer contract. If an employer chooses to offer complementary medicine, Health Net's program offers direct referral to chiropractic and acupuncture care.

All Health Net members, whether HMO or PPO, can access Health Net's Decision Power Healthy Discounts program at www.healthnet.com. Health Net members receive discounts when they choose selected complementary health care services from chiropractors, acupuncturists, and massage therapists participating in American Specialty Health's ChooseHealthy networks. Through this program, members receive direct access to chiropractors, acupuncturists, and massage therapists. Members may find American Specialty Health providers listed on www.healthnet.com or by calling 877-335-2746. The member assumes liability for claims and is responsible to pay the provider directly on a cash-pay basis at a pre-negotiated fee schedule. Healthy Discounts also provides Health Net members with discounts of up to 50% on a vast selection of vitamins, supplements, and other health and wellness-related products. Healthy Discounts offers discount savings on these products through American Specialty Health via www.ChooseHealthy.com. Members have direct access to products through the ChooseHealthyTM website, including vitamins and minerals, herbal supplements, yoga, relaxation products, books and videos. The website also provides educational information on a wide range of complementary health care topics.

Kaiser Permanente: The availability of complementary medicine depends on the plan and options selected by the member's employer. All plans offer physical, speech, and occupational therapies as base benefits. Coverage for chiropractic care and acu-

puncture can be added by the employer.

UnitedHealthcare: American Chiropractic Network, a business segment of UnitedHealth Group, provides chiropractic benefits as well as discounts for the following complementary alternative medicine services to our enrolled individuals:

- Acupuncture
- Massage therapy
- Nutritional counseling
- Naturopathic medicine services
(in states where naturopathic physicians are licensed).

UnitedHealthcare also offers employers an optional acupuncture benefit. Finally, through UnitedHealth Wellness programs, we provide discounts on products and services for nutrition, weight-management, fitness, stress management, and other wellness products and services.

5. Describe your coverage for mammograms.

Aetna: Mammograms are included in the clinical screening annually beginning at age 40. This is only part of physical exam benefit when the customer's benefit plan does not include a separate benefit.

Blue Shield: One annual mammography test is covered for screening and diagnostic purposes without illness or injury being present.

Cigna: Mammograms are covered annually for women age 40 and over or more frequently and at younger ages when medically indicated.

Health Net: Health Net's PPO coverage for mammograms remains as follows: One baseline mammogram between the ages of 35 and 39; one mammogram every one to two calendar years for women between the ages of 40 and 49; and one mammogram every calendar year for women age 50 and older.

Kaiser Permanente: Mammograms are covered as part of the adult preventive screenings benefits for women beginning at age 35. Frequency increases with age or as medically necessary.

UnitedHealthcare: Options PPO provides coverage for mammograms as part of our standard outpatient surgery, diagnostic, and therapeutic services benefit. It is covered both as a preventive and diagnostic service.

6. Do you cover PSA tests for non-symptomatic men? If so, at what age?

Aetna: Yes. If a state has specific legislation, we will pay it in accordance with the law. There is no age limit unless it's being paid under a specific benefit (like the Trust benefit), which has a contractual limit.

Blue Shield: Coverage includes, but is not limited to, prostate-specific antigen testing and digital rectal examinations, when medically necessary and consistent with good professional practice. There is no age limit for PSA testing when billed with a preventive-care diagnosis.

Cigna: These tests are covered based on the treating physician's recommendations.

Health Net: Preventive care and diagnostic procedures for adults (age 17 and older) are covered at a physician's direction. When medically indicated for men age 50 and above, tests and procedures, including, but not limited to, prostate-specific antigen testing (PSA) and digital rectal examinations are covered.

Kaiser Permanente: Yes. PSA tests are covered as part of the adult preventive screenings benefits, which are available at age 18 when medically necessary and consistent with good professional practice.

UnitedHealthcare: Network physicians are encouraged to follow the Guide to Clinical Preventive Services of the United States Preventive Services Task Force (USPSTF) as the basis for preventive care. We cover PSA tests regardless of age even though the USPSTF indicates this screening lacks clinical value. □

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The people portrayed in this ad are models and not real members or patients.

How Return-to-Work Strategies Can Help your Employer Clients

Unplanned absences can take a significant toll on the finances and productivity of a company and its employees. Increasing employee productivity is a primary objective for today's employers, yet only 45% have return-to-work strategies, according to MetLife's 12th Annual Employee Benefits Trend Study.

Clearly, many employers are missing valuable opportunities that return-to-work programs can offer. The primary reason may be that they simply don't understand the benefits of return-to-work programs. Employers need to understand how return-to-work programs can increase productivity, reduce the cost of employee training, reduce overtime, reduce the need for temporary hires, and increase employee morale and engagement. In addition, providing workplace accommodations for disabled employees helps employers meet the requirements of the Americans with Disabilities Act.

A recent case study reveals how a return-to-work program can improve short-term disability incidence rates and durations. In the first 12 months, lower short-term disability rates helped the employer save more than \$1.4 million in lost work days. The employer also saw a 25% improvement in eligible claims for post illness injury management.

Collaboration to Drive Results

The key to a safe and successful return-to-work program is the partnership between the insurance provider's return-to-work coordinator and the employer's benefit team. A close collaboration drives greater understanding of the company's needs. The case study featured an enhanced reporting package that integrated worker's compensation and disability claims. The team reviewed the results to identify how the employer could benefit most from a return-to-work program based on reported claim durations and the status of employees who returned to work without restrictions. Site visits were done to review the actual case results and determine which claim scenarios could benefit from earlier or better return-to-work strategies.

A return-to-work coordinator can offer continued monitoring of the current cases at each location in order to track the status of return-to-work efforts and identify opportunities for improvement.

In this case, the partnership led to an enhanced effort to find cases that could benefit from a health intervention, highlighting health services the employee could use to increase their chances of safely returning to work sooner.

Employee Productivity, Engagement, Morale

Return-to-work programs not only benefit the employer, but they also benefit the employee by boosting employee morale and, in turn, productivity and engagement. The odds of returning to a full employment after being on disability leave drops to 50-50 after six months. Yet injured employees who participate in a return-to-work program come back to work 1.4 times sooner than do those who don't have a return-to-work program, according to a Rand study.

The Key Elements

A successful return-to-work program requires dedication from all areas of the company — from managers who develop and implement the program to employees who are committed to following all of the program guidelines. In the case study, the employer's dedication to the program carried through to all levels of the organization. The return-to-work coordinator and the employer focused on integrating and leveraging data to identify challenges and increase the utilization of return-to-work services. The employer's internal medical director and case manager helped build a stronger team and improved communication to drive awareness and utilization of the return-to-work program.

Education enabled employees to understand the importance of return-to-work programs and disability insurance in general. Commitment from the management and everyone at the company ensured participation and a strong outcome. Implementing all of these key elements can help mitigate the losses incurred when employees are out on disability, offering financial savings and increased productivity for employers and a quicker path to returning to work for employees. □

Phil Bruen is vice president of products at MetLife



KEY PERSON DI

Key person disability benefits allow for funds that may be used however the company sees fit such as to scout, hire and train a replacement employee, or simply provide much needed capital to a business in transition.

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There's An Eye Care Experience for Every Member

(And They Won't Be Happy If It's Not in Network!)

Vision benefits are getting a second look. There is renewed interest in this affordable, value-added ancillary benefit thanks to the Affordable Care Act (ACA), an aging workforce, more time spent working on computer screens, tablets and smart phones, and the eyewear industry's success in blending medical utility with fashion.

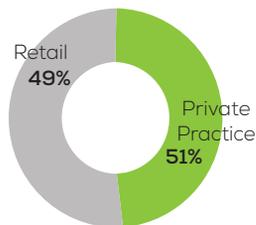
What people want

Consumers choose to get exams at...



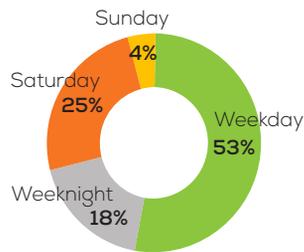
Source: The Vision Council Vision Watch Eye Exam Standard, June 2014

...but choose to buy their frames at...



Source: Vision Watch – The Vision Council Member Benefit Report – March 2014

...and they get them when they want to.



Source: EMI Online Research Solutions, Consumer Study Commissioned by EyeMed 2010

A strong network is at the core of any solid managed care benefit; and vision is no different. When evaluating a vision network, it's important to focus on what really matters to members and understand the full range of what is available in this dynamic area of healthcare. Most brokers prefer a vision network that can satisfy members across a diverse book of business. The following are some areas that deserve your focus when selecting a go-to vision plan:

The main purpose of eyewear is to meet a clinical need, but glasses are

worn on our faces. Eyewear used to be just a medical device that people wore reluctantly. Now prescription eyewear is becoming such a desirable fashion accessory that many members purchase more than one pair. Still, there are also many employees and dependents who are cost-conscious and prioritize practical purchases.

Choice in a vision network is closely correlated to member satisfaction. Look for vision networks that provide access to quality customer experiences at every price point. It usually takes

Six questions to ask when evaluating vision networks

Brokers don't have the bandwidth for vision that they do for medical or dental, but you can't afford not to make a solid recommendation. Ask the following questions to gauge how well a vision network would satisfy members across your book of business:

1. Does the network offer a large selection of private practitioners and retail options?
2. Does the network offer choices for different consumers? Consider the members who prioritize designer frames and selection as well as the economy shoppers. Don't forget those who want to have their exam in one location, but shop for frames and lenses somewhere else.
3. Are there in-network options within 10 to 20 miles of most residences in your territory?
4. Does the network offer ample locations open during evenings and weekends?
5. Does the network offer broad access to the latest technology in eye exams, fittings and lenses?
6. Does the provider locator give members the full picture about nearby network providers through a robust online tool? Can they access the provider information they want through a convenient app? □



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a mix of independent providers and retail optical locations to drive healthy enrollment across clients with diverse workforces.

Those of us in the vision benefit industry sometimes oversimplify network options by sorting all providers as independent or retail. But independently owned and operated practices run the gamut from tony eyewear boutiques in high-end shopping districts to neighborhood practices serving generations of the same family. And not all retail is created equal. National retailers offer a wide selection of designer frames along with the latest technology; some retailers are suited to young families; some focus on the economy buyer; and several regional chains have built strong brand identities and loyal customers through service and selection.

A Strong Network Offers Access to Innovation and Technology

A wave of innovation is just beginning with digital eye exams, ultra precise eyeglass fitting devices, frame try-on booths and virtual shopping apps. This wave of innovation will redefine what patients expect from their annual eye exams and eyewear selection. Watch for more providers and dispensaries using tablets to explain vision health, lens options and insurance coverage to their patients. Many members are satisfied and well served by a basic eye exam once a year in a very traditional practice, but many others appreciate having access to the latest advances. These members often associate technology with quality of care. Be sure to ask how many in-network locations offer access to technology that improves the clinical and dispensary experience.

Employees Want Vision Care That Fits Their Schedules

Nearly half of employees prefer evening and weekend vision appointments, according to a 2010

6?'s to ask when evaluating vision networks

Recommend the network that delivers the most satisfaction across your client base.

1 First, look for a mix of independent and retail providers.



Does the network offer a large selection of private practitioners as well as retail options?

2 Then look beyond independent vs retail for a range of distinct consumer experiences.

Satisfy a diverse base of end-users with real network choice. Consider the members who prioritize designer frames and selection as well as the economy shoppers. Don't lose sight of the many who opt for an exam in one location, but shop for frames and lenses somewhere else.



3 Ensure nearby in-network options.



Are there in-network options within 10 to 20 miles of most residences in your territory?

4 Ask if the network offers convenient operating hours.

Does the network offer ample locations open during evenings & weekends?



5 Explore the network's ability to bring the latest technology to members.



Does the network offer broad access to the latest technology in eye exams, fittings and lenses?

6 Put network information at the member's fingertips.

Does the provider locator give members the full picture about nearby network providers through a robust online tool? Can they access the provider information they want through a convenient app?



study from EMI Online Research Solutions, commissioned by EyeMed Vision Care. Members who want extended hours might want different vision care and eyewear shopping experiences. Many employees will not find their needs met by networks that only offer a few retail options for the economy shopper or networks with weekend and evening hours that are skewed toward higher-end providers. The optimal networks offer extended hours at a variety of locations.

Not Every Vision Plan Member Wants One-Stop Shopping

You might be surprised to learn that 69% of vision plan members prefer to get their exam at one location and then get their prescription glasses or contact lenses at another in-network location, according to The Vision Council. So, having a network with a variety of eyewear shopping experiences can be as important as a network with the most access points.

Many members have a long relationship with an independent vision provider, but prefer the selection of designer frames at a national retail chain. Some members want to complete exams for the whole family on one day at one network location, but choose different dispensaries for various family members. As ordering prescription eye glasses over the Internet becomes more common, I expect more vision benefits to include in-network online options.

Disruption Can Be a Good Thing In Vision Networks! Expect and Embrace It

Most brokers who deal with medical and dental benefits know that disruption is often a deterrent to employers considering a move to a new carrier or plan. In vision, disruption can be a good thing. When you give people more choice, they often exercise it. If an employer's plan does not offer enough choice to meet the demands of a diverse workforce, switching to a plan

with a more diverse network will often boost enrollment. Employees who are enrolled in the former plan are encouraged to shop around for an in-network option that better fits their priorities and preferences. Of course, employees are likely to be dissatisfied if you try to move them from a vision network with ample choice to a network with fewer locations with extended hours and less access to the latest technology. If you must choose a smaller network to contain costs, I recommend looking into network options that still offer a wide variety of choices even if there are fewer in-network locations.

The Best Networks Make It Easy For Members to Find Their Vision Care Match

Employees are accustomed to using online or interactive tools when searching for consumer services, so why wouldn't they want the same tools for selecting an in-network provider or dispensary? It just isn't enough any more to offer an online directory that lists the names of participating network providers that can be searched by zip code. More search tools are widely available from vision benefit companies, showcasing the best that every network provider can offer, including hours of operation, available frames, and break-through technology for exams or eyewear selection. Members especially appreciate turn-by-turn directions to provider offices, as well as online scheduling. □

Jason Rome is a vice president of EyeMed Vision Care. He is passionate about creating new ways that vision benefits can help brokers and EyeMed clients achieve their HR and business goals. Before joining EyeMed, Jason was Vice President of Sales Operations for Staples, Inc., leading its \$7 billion Contract B2B Division. With more than 36 million members, EyeMed Vision Care is the nation's second largest vision benefits company and the fastest growing. EyeMed contracts with more providers and provider locations than any other vision benefits company in the U.S., offering members a robust selection of independent providers as well as access to several top national optical brands, including LensCrafters, Pearle Vision, Target Optical, Sears Optical and JC Penney Optical.

Voluntary Benefits ▶ by Jeff Caldwell

Producers Can Change the Game with Voluntary Benefits

The onset of fall only means one thing for many sports fans: football season is here. Players have spent countless hours preparing for the upcoming season studying film, doing conditioning, and going to practice.

Now it's time to make their mark where it matters most – on the field. By recognizing their opponent's pattern of play, a player can become a game-changer with one play and provide a victory for the team.

The employee benefit season is also here, and it is time for producers to make their mark. Producers can change the employee benefit game by integrating voluntary life and supplemental health products into the overall strategy. They can implement benefits that are easy to understand, simple to enroll, are supported by payroll deduction, and are available at no cost to the employer. Customized products and packaged solutions can help employees reduce their out-of-pocket exposure to rising health plan deductibles. Employers can even improve productivity while attracting and retaining top talent – all because they provide options that offer that help with the financial protection that employees need.

Producers have many challenges to overcome, such as health care reform, employee exposure to increased deductibles, rising major medical premiums, the need to educate employees on benefits, a decline in agency revenue and insurance exchanges. Plus, employers and employees face conflicting interests when it comes to health insurance coverage. Employers prioritize lower cost over higher quality while employees prefer higher quality over lower cost. Sixty-two percent of workers prefer to pay more for

a higher quality health coverage option, compared to only 38% who would prefer to reduce insurance costs even if it means lower quality, according to a Transamerica Center for Health Studies survey.

What Employees Are Saying about Voluntary Benefits

Voluntary products have expanded over the past several years. Employees are increasingly making their financial protection decisions at the workplace. These products offer more financial protection than ever for employees, and they can improve employee engagement and retention. Well-rounded benefit programs are a major influence in job satisfaction among potential and current employees. On behalf of Transamerica, Harris Interactive did a nationwide survey of 2,028 U.S. adults employed full-time by companies. The following results show respondents' interest in voluntary benefits and their desire to purchase them:

- 65% said that it is very or somewhat important for their employer to offer voluntary benefits.
- 64% said their knowledge about voluntary benefits is about the same as it was three years ago.
- 62% are likely to purchase voluntary products if faced with less comprehensive benefits due to health care reform.
- 47% had not been offered additional voluntary benefits by their employer since health care reform legislation was signed into law in 2010.



- 46% said it is likely or very likely that they would remain at their current employer primarily due to the voluntary benefit package offered.
- Employees consider price, need and fear of inadequate coverage as most important when purchasing voluntary products.
- When asked how they would like to receive information about their benefits from their employer, the top three responses were e-mail (54%), employer internet/intranet site (29%) and one-on-one meetings (27%).

Voluntary Benefits Get Popular

Voluntary benefits, such as critical illness, accident, short-term disability and cancer policies, are becoming increasingly important due to health care reform. Critical illness insurance provides a lump-sum to help pay for expenses including deductibles, co-pays, child care, credit card bills and travel for medical treatment. Accident insurance helps employees pay for the medical bills and other out-of-pocket expenses that often arise after an unexpected injury. Many employees ignore short-term disability, mistakenly assuming that their savings will cover costs until their long-term disability and/or long-term care kicks in. Cancer insurance helps provide financial protection for the treatment and non-medical expenses associated with the rising cost of cancer care.

Two additional products are gaining momentum – supplemental medical expense and hospital indemnity insurance. Supplemental medical expense plans pay a benefit for deductibles, co-insurance and copayments for expenses associated with the employer's basic, major medical

or comprehensive medical plan. Hospital indemnity insurance pays a specified amount for each day an employee is confined to the hospital. It can provide benefits for a range of other medical situations through a series of optional riders. Employers can customize plans to include hospitalization benefits only or include diagnostic procedures, outpatient surgery, intensive care and other benefits. Although health care reform doesn't affect life insurance, employers can add it to enhance a benefit package, especially the options of accelerated death benefits for living care and critical illness.

Voluntary Benefits Help Employers Meet HR Objectives

Paying for and maintaining a comprehensive benefit package is tough for most employers, particularly with the onset of health care reform. Controlling costs is the top benefit issue for employers, with more than 80% ranking it among their top three challenges, followed by dealing with the implications of health care reform and keeping employees healthy, according to a 2013 survey by Gallagher Benefit Services. Employers want solutions to drive down utilization, reduce physician office visits, and protect employees' out-of-pocket exposure to increased co-payments, co-insurance amounts, and deductibles. Even under health care reform, high deductibles and rising premiums will continue. But with the right strategy, voluntary products can help provide rate stabilization while giving employees resources to defray these out-of-pocket expenses.

About 21% of employers view voluntary benefits as important, and 83% plan to

take advantage of voluntary benefits to enrich the core benefit plan, according to a 2013 Towers Watson survey. By offering customized product designs and packaged solutions, employers can use voluntary benefits to supplement their major medical plan, reduce the out-of-pocket exposure to increasing deductibles and provide choices to help protect employees financially.

A company that offers comprehensive voluntary benefits protects its business by safeguarding the financial wellness of its employees, resulting in a more loyal and productive workforce. As a new employee benefit paradigm continues to emerge, more employers will evaluate the perceived and real value of adding new voluntary benefits.

The Opportunity for Producers

Now is the time to sell voluntary benefits as the economic recovery and health care reform reshape the benefit landscape. Voluntary benefits will play an even greater role in companies of all sizes and industries. With the right educational and enrollment tools, you can take your business to the next level. Producers with insight, vision and an ability to execute will be in the best position to take advantage of these marketplace opportunities. Changing the game means adding voluntary benefits to your portfolio and developing the skills to market and enroll these programs for current and prospective clients. The game is not over; there's still an opportunity for producers to bring something new and bold to their clients. □

Jeff Caldwell is marketing director of Transamerica Employee Benefits.

Presenting Vision So It Doesn't Get Missed

The rise of consumerism has transformed how employers and employees see their insurance benefits. Many employees have been accustomed to choosing among similar plans at similar price points from year to year. But drastic changes have forced them to look at their options more carefully. Employees are more receptive to learning about their benefit choices, which can produce a healthier workforce.

But, with so many changes and choices, it can be hard to maintain a focus on voluntary benefits during enrollment conversations. Overlooking high-value plans, like vision, can create big problems. Vision coverage ties closely to employee satisfaction. Also, the better you can see, the more efficient you are at work. Almost 80% of employees encounter at least one visual disturbance at work, and more than half take daily breaks to compensate, according to the Transitions Employee Perceptions of Vision Benefits survey. Visual discomfort can also affect the quality of their work. Catching vision problems early is more likely to happen when employees get regular eye exams. This enables employees to take preventive measures before health issues lead to absenteeism and reduced productivity.

Vision is also tied to health concerns that can impede productivity and increase employer costs. For example, diabetes is the number-one cost driver for three out of the four employers I advise. Having a quality vision offering that covers dilation during the exam can aid in the early detection of health issues like diabetes and hypertension.

When healthcare reform was first being implemented, some speculated that medical carriers would offer more vision coverage. But many still don't cover exams with dilation. The upside to having

a separate vision carrier is that employees get more coverage options as well as regular dilated eye exams. Eyewear technology has come a long way, and consumers want more choices than a standard lens and basic frame. As a result, many employees choose a high-quality vision plan over a basic plan. They get a lot more bang for their buck since the cost difference is not usually significant on a per-paycheck basis. Having access to vision-correction options also increases productivity. Many of the most common vision-related complaints can be alleviated by wearing the right eyewear including an updated prescription and lens enhancements, like antireflective coatings and photochromic lenses to increase comfort and reduce visual disturbances.

We've launched quite a few vision products in the past couple of years, and found that employers can be hesitant before they understand the value of these benefits. But it's often surprising to employers how many employees purchase the benefit.

Here are some ways to ensure that vision coverage stays in sight during enrollment:

- Use real life scenarios: Many of our manufacturing clients have employees who really depend on their eyesight to do their jobs. But there aren't many professions that do not rely on clear vision. A good way to start

the conversation is to explain how vision is important in the workplace.

- Crunch the numbers: I encourage employers, if possible, to sponsor the vision benefits instead of making them voluntary because it provides such an essential value to employees. The average employer will see a return of \$7 for every \$1 invested in vision benefits, according to the Vision Council. Employees place a high value on vision benefits. A vision plan can be an inexpensive, yet valuable addition to the healthcare plan. Employees are usually willing to spend \$5 to \$10 a month for a single vision plan, and \$15 to \$19 a month for a family vision plan, according to employee research by USI Insurance Services, LLC.

- Underscore education: An important first step is to select a plan that provides broad materials coverage, a large list of providers and competitive discounts. Making sure that employees know what's included and how their plan works affects the success of a vision offering, but this step is often overlooked.
- Emphasize extras: Patients have become more active consumers. They're familiar with brand-name health products, and they weigh price against value. In addition, 86% of employees and their dependents wear eyeglasses and/or contacts, meaning that they probably have some familiarity with vision products, according to the USI survey. Employees want to know whether the plan covers high-profile brands like Transitions lenses. Brand-loyal employees may even base their decisions about plans on which brands are covered.
- Align with leaders: Not all plans are designed with current trends in mind. For example, many patients want to be able to purchase eyeglasses and contacts in the same year, have more choices in designer frames, or have multiple pairs of glasses to meet different needs. Employees feel more in control when they have access to different plan and reimbursement levels.
- Demonstrate the need: If one of our clients is open to exploring vision benefits, we survey employees to let their voices be heard during enrollment and renewals. Employers are

often surprised at how strongly their employees want a vision plan. Many employers assume that vision discount programs through dental or medical plans will meet their employees' needs. But we often find that employees would much rather have a full vision offering through their employer than a discount through another benefit plan. Fifty-eight percent of employees prefer a full vision plan over only having a discount, according to USI the survey.

- Call on experts: We have a staff wellness consultant who visits clients once a year to explore health concerns and explain how their insurance benefits can address these issues. When discussing vision benefits, an expert can help give credence to the correlation between eye health and overall health, and how hot-button issues like diabetic health come into play.
- Provide information that employees can refer back to: We typically start with an onsite review of benefits and follow up with a pre-recorded presentation that employees can watch at their convenience. During the presentation, we demonstrate the value of the benefit by explaining covered materials, buy-ups and purchasing scenarios. We also include information about how the plan is designed. Employers can refer back to this information when employees have questions later in the year.

A vision plan used to be an afterthought to medical benefits. But vision coverage is moving off the back burner to become more of a core benefit. Employers who want to take a more innovative approach to employee wellness should look at vision coverage with fresh eyes during this year's enrollment season.

Sara Niemeyer is a consultant for USI Insurance Services, LLC in Cincinnati. With more than 4,000 employees in more than 140 offices nationwide, USI is among the top 10 largest insurance brokers in the U.S. Sara was named Transitions Vision Benefits Broker of the Year for 2013 for her work encouraging healthy sight through education and superior vision care benefit offerings through vision benefits partner, EyeMed Vision Care.

Using Medicaid Expansion to Comply With the Employer Mandate

by Ben Geyerhahn

Employers face some tough health insurance choices in 2014 and 2015, but there is an easy way to mitigate their insurance costs with generous Medicaid offerings. The Affordable Care Act mandates that employers with more than 100 workers offer health insurance to all employees, and requires that those with more than 200 auto-enroll their employees into health insurance. Like employers, employees are mandated to have insurance or face a fine, so many will enroll in any company policy that's available. This is guaranteed to squeeze already narrow profit margins. How are employers dealing with this cost? Some are throwing up their hands and daring the government to fine them \$2,000 per employee for failing to offer insurance. The fine is based on the total number of people employed. Unfortunately, this will also lead to an IRS audit. Other employers have chosen to offer a minimum essential coverage plan, which is inexpensive because it covers the bare essentials and protects the company from being fined for not offering coverage. However, each employee who purchases health insurance in a state exchange to make-up for not having coverage through the employer plan triggers a \$3,000 fine for the company. Some employers are offering a bare-bones ACA compliant plan for a few hundred dollars

per month per employee, while hoping for low participation rates. The one underutilized strategy is Medicaid migration, which is available only in states that have accepted Medicaid expansion. For example, Medicaid expansion is a boon to restaurants because it increases the salary levels at which families qualify for Medicaid. That translates to millions of workers with higher concentrations in several major industries including restaurants, construction, building maintenance and home health care, among others. What many people don't know is that an individual who is enrolled in Medicaid can simply decline insurance offered by the employer, saving them thousands of dollars per employee. The tricky issue is identifying and enrolling employees in Medicaid. Although expansion states have made Medicaid a viable cost saving measure, Medicaid enrollment is

difficult because it requires adherence to a raft of regulations. Using a professional enroller who works exclusively in the workplace setting is critical. Brokers have begun including this service in their offering because it is essential to their clients and comes with a commission.

Ben Geyerhahn is the CEO of BeneStream, a company that handles the screening and enrollment of qualifying employees in Medicaid, and is a member of New York Governor Cuomo's Health Benefit Exchange Regional Advisory Committee.



How FATCA Will Affect Brokers Dealing with Foreign Insurers and Agents

Congress passed the Foreign Account Tax Compliance Act (FATCA) in 2010 following the revelation that one of the world's largest and most well-respected financial institutions, the United Bank of Switzerland (UBS), aided and abetted U.S. taxpayers in evading income taxes through unreported foreign financial accounts.

FATCA was the product of the revelation to U.S. law enforcement and Congress that the scope and prevalence of overseas tax evasion was far more serious than previously thought. Given the broad reach of FACTA, some would argue that Congress overreacted. However, the UBS case and others revealed that overseas tax evasion was not limited to small, outlaw banks operating in the shadows, but was part of regular business operations of some of the largest and most reputable financial institutions in the world. FATCA, therefore, has an exceedingly broad reach, extending into areas not traditionally thought to pose a risk of overseas tax evasion. Unfortunately for insurance professionals, one such area is the purchase and sale of insurance products.

In attempting to comply with FATCA's requirements, it is helpful to understand what FATCA was meant to combat: U.S. taxpayers holding assets overseas in order to evade paying their U.S. taxes. Pure insurance protection products present little or no risk of being used for tax evasion, whereas products with an investment

component, such as a cash-value insurance or annuity contracts, present greater risks. Dealing with reputable and well-known non-U.S. brokers or insurers is far less risky than dealing with smaller or new ones. Until the IRS provides guidance or instructions on the obligations of withholding agents, brokers simply need to be aware of the risks that their clients, insurers and products could present.

FATCA imposes obligations on non-U.S. financial institutions to identify foreign financial accounts as assets that U.S. taxpayers own or control. The extremely broad definition of a foreign-financial institution can include non-U.S. insurance companies. The complication for insurance brokers is that FATCA imposes a corresponding obligation on payers to foreign-financial institutions to ensure that the foreign-financial institution is complying with FATCA or is exempt from FATCA regulation. FACTA imposes a 30% withholding penalty if the foreign-financial institution is not in compliance, which the payer is obligated to withhold for the IRS. For insurance

brokers, the 30% penalty could represent 30% of an insurance premium payment to a foreign insurer. There may be draconian penalties for withholding agents who fail to withhold, such as the amount of tax not withheld.

FATCA reporting for withholding agents imposes two basic requirements on insurance brokers. First, insurance brokers must verify the foreign insurer recipient's FATCA status. Second, insurance brokers must report payments, such as premiums paid to the foreign insurer.

The IRS has provided forms to meet both requirements. The broker uses IRS form W-8BEN-E for the first requirement — identifying the foreign insurer's FATCA status. The broker must collect the Form W-8BEN-E from the foreign carrier verifying that the foreign recipient of the premium payment is FATCA compliant or is exempt from FATCA's requirements.

The most common way a foreign carrier will be FACTA compliant is by agreeing with the IRS to comply with its obligations under FATCA, a so-called "participating foreign-financial

FATCA has an exceedingly broad reach. Unfortunately for insurance professionals, one such area is the purchase and sale of insurance products.

institution." The IRS maintains a list of participating foreign-financial institutions accessible through its website.

The insurance broker must conduct some due diligence to ensure that the Form W-8BEN-E has been completed accurately. The IRS recently published regulations providing general guidance for withhold-

ing agents, such as brokers, and for foreign recipients to complete the Form W-8BEN-E, but how these due diligence regulations will be applied will develop over time.

Suppose that a foreign insurance carrier didn't provide the Form W-8BEN-E, claimed to be a participating foreign-financial institution, but didn't appear on the IRS database or was otherwise not exempt. The broker would have to withhold 30% of the premium, in which case there will be no coverage for the insured, or simply not do business with the foreign insurer. The broker has a continuing obligation to collect and retain Form W-8BEN-ES; the forms are only valid for three years.

A U.S. broker, such as a foreign insurance broker, must verify the FATCA status of each foreign intermediary that is used as well as the ultimate foreign insurer recipient. The foreign broker attests to its FATCA status on an IRS Form W-8IMY. The Form W-8IMY is transaction specific. The obligation can be bothersome for a chain of foreign intermediaries; the broker would have to collect Form W-8IMYs from each foreign intermediary and Form W-8BEN-E from the ultimate insurer recipient.

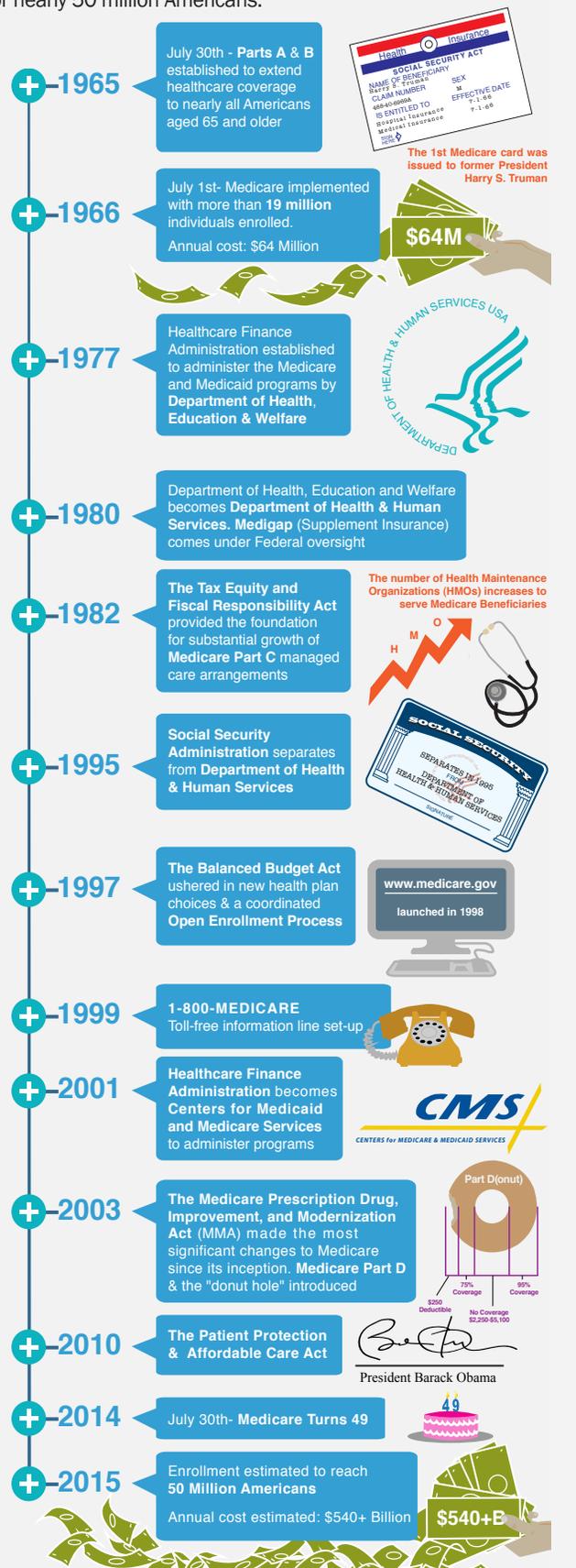
The broker would use IRS Form 1042-S to meet the second requirement — reporting amounts paid to foreign insurers. Brokers only have to report to the IRS the previous year's premium payments for U.S. risks made to non-U.S. insurer carriers. While the IRS has published instructions for the form, specific issues for insurance brokers await further clarification, such as whether to report premium payments if the broker doesn't have complete information on whether the risk insured is a U.S. risk.

While it all seems quite burdensome, FATCA was designed to be overly broad because Congress and the American public learned from the UBS case that overseas tax evasion by American taxpayers was far more pervasive and involved far more active participation by the world's largest financial institutions than previously thought. Unfortunately for insurance brokers, it means that FATCA imposes reporting burdens on industries that have not been traditionally associated with tax evasion, such as insurance. FATCA shifts the burdens to foreign financial institutions and those who deal with them to help the IRS identify tax scofflaws and collect U.S. taxes. In a world of increasing globalization, who knows where FATCA's reach will end. □

Dean Paik, an attorney with nearly 30 years of experience, recently served as a top advisor to the Assistant Attorney General of the Tax Division, Dept. of Justice (DOJ) from 2010 to 2013. He advised on a variety of civil and criminal matters including the DOJ's overseas bank account initiatives. He helped devise strategies and policies on the enforcement against banks, bankers, and account holders of the laws requiring the disclosure of foreign bank accounts, including intergovernmental negotiations to resolve conflicts in bank secrecy laws so as to allow for the implementation of FATCA. He began his career as a trial attorney at the DOJ through the Attorney General's Honors Program prosecuting tax crimes and then served as an Assistant U.S. Attorney. Today, he is in private practice with the law firm Rogers Joseph O'Donnell in San Francisco and can be reached at 415-956-2828 or dpaik@rjo.com.

THE HISTORY OF MEDICARE

As Medicare enters its 50th year serving older Americans, let's take a look at the milestones that mark the evolution of this program, which has become the largest health care provider in our nation and supports longer, healthier lives and economic security for nearly 50 million Americans.



HEALTHCARE

Top Trends in Medicare Part D

Now in its ninth year of operation, the Medicare Part D program has had consistently high levels of plan participation, offering dozens of plan choices for beneficiaries in each region and broad access to generic and brand name drugs. But there are some sobering trends beneath the surface, according to a report by the Kaiser Family Foundation. Cost and access trends could pose challenges for Part D enrollees. Although premiums have been flat for several years, average premiums have increased nearly 50% from 2006 to 2014. Median cost sharing for brand-name drugs has also increased. Finally, many low-income beneficiaries are paying steadily higher premiums for coverage when they could be enrolled in premium-free plans.

Sixty-two percent of Part D enrollees are in PDPs, but enrollment in MA-PD plans is growing faster, representing half of the net increase in enrollment from 2013 to 2014. About 6.5 million Medicare beneficiaries with drug coverage from their former employers now get that coverage through a Part D plan designed for that firm's retirees. Enrollment in employer plans has quadrupled since 2006, partly due to changes in law that took effect in 2013.

In 2014, three Part D sponsors account for half of all Part D PDP and MA-PD enrollees. UnitedHealthCare, Humana, and CVS Caremark have enrolled half of all participants in Part D, which is relatively unchanged from 2006. UnitedHealthCare and Humana have held the highest shares of enrollment since the program began, while enrollment in CVS Caremark has grown through the acquisition of other plan sponsors. UnitedHealthCare has maintained the top position for all nine years of the program, and provides coverage to more than one in five PDP and MA-PD enrollees in 2014.

Average monthly PDP premiums have been flat since 2010; premiums for some of the most popular plans increased for 2014; and premiums for other popular plans fell. On average, PDP enrollees pay premiums of \$37.75 per month in 2014. However, PDP premiums vary widely even for plans with equivalent benefits. Premiums range from \$12.80 to \$111.40 a month for plans offering the basic Part D benefit. UnitedHealthCare's AARP MedicareRx Saver Plus PDP, which was new in 2013, raised its premiums by 54% in 2014 (an average increase of about \$8 per month). In contrast, WellCare's Classic PDP lowered its premium by 38% (an average decrease of about \$13 per month) in 2014.

Part D enrollees in MA-PD plans pay lower premiums on average (\$14.70) than those in PDPs. Cost sharing for brand-name drugs has been relatively stable in recent years, but has risen substantially since the start of Part D. MA-PD plan enrollees generally have somewhat higher cost sharing than do PDP enrollees. Cost sharing for brands increased by about 50% from 2006 to 2014 for beneficiaries in PDPs and about 70% for those in MA-PD plans.

Median cost sharing in a MA-PD is \$45 for preferred brands and \$95 for non-preferred brands plans. Median cost sharing in a PDP is \$40 for preferred brands and \$85 for non-preferred brands. Seventy-six percent of PDPs and 75% of MA-PDs use five cost-sharing tiers including preferred and non-preferred tiers for generic drugs, preferred and non-preferred tiers for brand drugs, and a tier for specialty drugs. Four-tier arrangements were most common until 2012 when plans began shifting toward the five-tier cost-sharing design.

Part D plans typically use specialty tiers for high-cost drugs and charge coinsurance of from 25% to 33% during the benefit's initial coverage period, as in previous years. These initial high out-of-pocket costs may create a financial barrier to starting use of specialty drugs, which are expected to be a significant cost driver for Medicare. Users are likely to reach the benefit's catastrophic threshold in a short period, and see their coinsurance reduced to 5%.

The number of Part D stand-alone drug plans with a preferred pharmacy network grew from 7% in 2011 to 72% in 2014. Enrollees have lower cost sharing with preferred pharmacies. However, in some plans, there is no preferred pharmacy within a reasonable travel distance, which could make it hard for enrollees to take advantage of the lower cost sharing.

Only 5% of PDP enrollees are in plans with the highest star ratings (four stars or more out of five). More than half are in plans with 3.5 stars. Nearly one-fourth are in plans with fewer than three stars; plans at this level for three years in a row can be removed from the program. For more information, visit www.kff.org.

HIV Medical Organizations Challenge Insurer Restrictions

The American Academy of HIV Medicine (AA-HIVM) and the HIV Medicine Assn. (HIVMA) are challenging new health plan policies that bar many HIV care providers from prescribing certain medications to treat hepatitis C (HCV). "Thanks to the treatments available today, most of our patients with HIV do not die from AIDS-related illness, but from other conditions including liver disease. Many people co-infected with HIV and HCV have been waiting a

long time for more effective and tolerable HCV treatment. Now that a cure is available, it is unconscionable to deny them access to medical providers who are well qualified to administer and manage this treatment," said Joel Gallant, MD, MPH, FIDSA, chair of HIVMA. A new drug approved for the treatment of HCV earlier this year offers a significantly improved cure rate over older treatments.

For more information, visit www.aahivm.org.

Experts Predict A Big Boost in Access to Mental Health Drugs

Doctors and managed care organizations anticipate increased demand for drugs that treat major depression, bipolar disorder and schizophrenia, according to a survey by Decision Resources Group. The demand for these drugs will rise thanks to Medicaid expansion in 24 states and affordable coverage through the exchanges. Doctors expect to see 30% more patients with these conditions. Managed care organizations say that drug formularies in the exchanges are the same or compare favorably to those of traditional group health plans. While there are many generic drugs to treat these behavioral health conditions, managed-care organizations offer favorable tier placement to brands they believe offer superior efficacy, safety and tolerability.

Branded behavioral drugs, such as Brintellix, Saphris, and Fanapt are excluded less often from exchange plans than from commercial group plans. Abilify will launch generically in 2015, which is expected to increase utilization, especially in Medicaid plans and in managed-care plans that offer higher payments for physicians with high generic prescribing rates.

Narrow provider networks in the exchanges are expected to drive many patients to visit primary care doctors for behavioral conditions. Compared to psychiatrists, these generalists are not as familiar with the newer branded drugs, and they welcome information about pharmaceutical companies' patient assist programs. Doctors overwhelmingly support patient assist programs. They say that patients will still need drug coupons when they face high deductibles or formulary exclusions through an exchange plan. For more information visit www.DecisionResourcesGroup.com.

Employer-Sponsored Family Health Premiums Rise a Modest 4%

by Leila Morris

Annual premiums for employer-sponsored family health coverage reached \$16,351 in 2013, up 4% from in 2012, with workers paying an average of \$4,565 toward the cost of their coverage, according to a report by the Kaiser

Family Foundation/Health Research & Educational Trust. The rise in premiums is moderate by historical standards. Since 2003, premiums have increased 80%, nearly three times as fast as wages and inflation.

“We are in a prolonged period of moderation in premiums, which should create some breathing room for the private sector to try to reduce costs without cutting back benefits for workers,” said Kaiser President and CEO Drew Altman, Ph.D. Firms with many lower-wage workers (at least 35% earning \$23,000 or less annually) required workers to pay \$1,363 more toward family premiums than did companies with fewer lower-wage workers (\$5,818 versus \$4,455 annually). The lower-wage firms offered less costly coverage too, creating a big disparity in the share of the premium that their workers pay (39% versus 29%).

In 2013, 78% of all covered workers had an annual deductible, up from 72% in 2012. Typically, workers pay this deductible before most services are covered by their health plan. The average deductible for worker-only coverage was \$1,135 in 2013, similar to the \$1,097 average deductible in 2012.

In 2013, 38% of all workers had a deductible of at least \$1,000 or more compared to 58% of workers at small firms. In fact, 31% of workers at small firms had a deductible of at least \$2,000 in 2013, up from 12% in 2008.

In 2013, 35% of employers said that wellness plans are very effective in controlling costs compared to 22% who cited disease management, 20% who cited consumer-driven health plans, and 17% who cited higher cost sharing.

Nearly all large employers (at least 200 workers) offered at least one wellness program. Thirty-six percent of large employers that offered wellness programs provided financial incentives for participation, such as lower premiums or deductibles, a larger contribution to a tax-preferred savings account, gift cards, cash, or other direct financial incentives. Fifty-five percent of large firms that offered health benefits also offered biometric screenings, and 11% rewarded or penalized workers financially based on whether they achieve biometric outcomes.

The Affordable Care Act (ACA) includes provisions that allow broader use of financial incentives to encourage workers to improve their health status and outcomes. “This will be an important issue to watch next year, as employers will have more flexibility and could ask workers to pay more because of their lifestyles and health conditions,” said KFF vice president Gary Claxton.

Thirty-six percent of covered workers were in grandfathered plans, down from 48% in 2012.

The slow growth in premiums also means that fewer employer plans will be subject to the ACA's high-cost plan tax that takes effect in 2018. The Congressional Budget Office recently reduced its estimate of the number of plans that would trigger the tax, and a continued low growth rate could further reduce the effect of this provision.

In 2013, 29% of employers with at least 5,000 workers were considering offering benefits through a private exchange. These jumbo firms employ almost 40% of all covered workers, so their interest could indicate a significant shift in the way many people get their health insurance.

Fifty-seven percent of firms offered health benefits in 2013, which is statistically unchanged from 2012 and 2011. Nearly all firms with at least 200 workers offered health benefits to at least some of their workers.

Forty-three percent of the smallest firms (three to nine workers) offered health benefits in 2013 compared to 50% in 2012. Also, 23% of firms with a lot of low-wage workers offered health insurance compared to 60% of firms with few low-wage workers. For more information, visit <http://kff.org/EHBS>.

In related news, the economic downturn can take the credit for about 70% of the recent decline in health care spending growth from 2009 to 2011, according to a study published in the August issue of Health Affairs. Insured people living in the hardest hit areas experienced the smallest increases in health spending. Thus, the authors concluded that 70% of the decline in health care spending growth was the result of the stagnant economy. For more information, visit <http://www.healthcostinstitute.org/-and-future-research-projects@healthcostinst>.

Higher Ed Employees Face More Cost Sharing

Colleges and universities are passing more healthcare costs to their employees, according to a report by the College and University Assn. for Human Resources. Forty one percent have increased the employee share of premiums since the ACA went into effect. Additionally, 26% have increased in-network deductibles; 27% have increased out-of-pocket limits; 20% have increased the employee share of prescription drug costs; and 24% have increased the employee share of dependent coverage costs. Thirty-six percent of colleges and universities have adopted or expanded a wellness program; and 21% have adopted or expanded financial incentives to encourage healthy behaviors. The survey also reveals the following about colleges and universities:

- 50% of part-time staff and 80% of part-time

faculty work less than 30 hours a week.

- The average annual premium was \$6,501 for employee-only coverage and \$17,484 for the employee plus family coverage for all four plan types (PPOs, HMO, POS plans, and HDHPs).
- 82% offer PPO plans; and 44% offer HDHPs — up from 17% in 2009.
- 60% offer healthcare benefits to same sex domestic partners or spouses (up from 46% five years ago).
- 42% offer healthcare benefits to part-time staff and 36% offer healthcare benefits to faculty. Most of those also pay part of the premium.
- Colleges and universities that don't offer healthcare benefits for part-time employees are not providing financial support for enrollment in a public exchange, and only 2% are considering doing so next year.
- Almost all colleges and universities provide basic life insurance, long-term disability, paid time-off, tuition assistance and retirement benefits. But only 64% offer short-term disability coverage.

For more information visit www.cupahr.org/surveys/benefits.aspx.

EMPLOYEE BENEFITS

What Consumers Want in a Critical Illness Product

Patients are getting medical diagnoses at earlier stages than ever due to medical advances, better treatment, and the fact that more people understand the importance of preventive care and early detection. However, critical illness contracts don't typically pay a benefit for earlier diagnoses, so those claims are not triggering a benefit and policyholders are not getting paid when they think they should, according to a study by Trustmark.

Carriers have added conditions to the list of what they cover, but it's not as helpful as it sounds. Less than 12% of people are ever paid a benefit for these conditions while the added coverage increases the cost of their policy. Consumers say they want the following in a critical illness policy:

- A benefit for an early-stage diagnosis.
- Access to a medical expert or doctor for advice.
- A policy that lasts throughout their lifetime with multiple benefits, regardless of whether they get sick. They don't want something that only centers on them being ill.
- Less confusion on what qualifies for a benefit and whether enough time has passed to pay a benefit
- A benefit even if they were previously diag-

nosed for a condition

- A commitment that their premiums will not change over the life of the policy.

For more information, visit www.trustmark-solutions.com.

IN CALIFORNIA

Court Clarifies Definition of Independent Contractor

The Ninth Circuit Court of Appeals ruled that 2,300 people working for FedEx Ground were misclassified as independent contractors instead of employees. As a result, FedEx may owe its workforce of drivers hundreds of millions of dollars for illegally shifting to them the costs of such things as the FedEx branded trucks, FedEx branded uniforms, and FedEx scanners, and missed meal and rest period pay, overtime compensation, and penalties. The case, known as "Alexander v. FedEx Ground," covers employees in California from 2000 to 2007. The ruling can be found on the Leonard Carder website at leonardcarder.com.

The court's findings could influence the outcome in over two dozen cases nationwide

in which FedEx Ground drivers are challenging the legality of their independent contractor classification. FedEx requires its so-called contractors in California to hire a secondary workforce of FedEx drivers, who do the same work as the plaintiffs under the same contract. The Alexander decision calls into question FedEx's strategy of making plaintiffs the middlemen between the secondary workforce of drivers and FedEx.

The drivers' attorney Beth Ross added, nationally, thousands of FedEx Ground drivers must pay for the privilege of working for FedEx 55 hours a week, 52 weeks a year. These workers were granted rights and benefits entitled to employees under California law. To be clear, the Ninth Circuit exposed FedEx Ground's independent contractor model as unlawful. For more information, visit <http://www.leonardcarder.com/>

FINANCIAL PLANNING

Making Financial Plans for Pet Care

Forty-four percent of pet owners surveyed by Securian Financial have made plans for their

pets' future care. For one-fifth of those owners, those plans are financial. Michelle Hall, manager of Market Research for Securian Financial Group said, "Pets may provide opportunities for financial advisors whose clients consider their pets to be members of the family and spend large sums on their care. Sixteen percent of pet owners say they would spend \$10,000 or more to save a pet's life while 29% would spend \$2,000 to \$5,000. Nearly 60% now spend up to \$1,000 a year on food, grooming, toys, etc.; three-fourths spend up to \$1,000 a year on veterinary bills; and 18% say their largest single pet-related expense was \$2,000 or more. These costs add up to many thousands of dollars over the years, especially for long-lived pets. If the owner dies suddenly or becomes disabled, the person who inherits the pet may not be financially prepared for ongoing care or life-saving procedures. Thirty-eight percent added the pet's future caregiver as a beneficiary to a life insurance policy; 35% added more coverage to their life policies; and 13% purchased annuities naming the pet's caregiver as the beneficiary. For more information, visit www.securian.com. □

Check Us Out Online

The screenshot shows the homepage of the California Broker website. At the top left is the logo for "CALIFORNIA BROKER" with the tagline "CALIFORNIA'S LIFE & HEALTH PROFESSIONALS". To the right of the logo is the website URL "www.calbrokermag.com". Below the logo and URL is a navigation menu with links for Home, Advertise, Back Issues, Classifieds, Contact Us, Privacy, Subscribe, and Write for Us. There is also a search bar. Below the navigation menu is a green banner with links for "2014 CA Broker Directory", "In The News", "Industry Updates", "Insurance Insider News", "Legislative Analysis", and "Surveys". The main content area features a "featured news" section with a headline "Insurance Insider News: Public Support for Rate Regulation Decreases" by Leila Morris. To the right of this article is a "DOWNLOAD THIS ISSUE" section with a cover image for the October 2014 issue, titled "CALIFORNIA BROKER" and "Gearing Up for Hybrid LTC". The cover image shows two hands holding gears labeled "LIFE" and "LTC".

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