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M E D I C A R E N E W S

Beneficiaries Pay a High Price for Hospice Fraud

By KAREN FLETCHER

Hospice fraud continues to be one of the top three types of Medicare fraud reported to our California Senior Medicare Patrol each month. Not only is this fraud robbing Medicare and taxpayers of hundreds of millions of dollars each year, it is hurting Medicare beneficiaries. This can happen in a number of ways, as demonstrated in the cases discussed below, and includes losing access to much-needed medication and/or treatment, losing access to one's primary physician, and in some cases, losing one's health or even one's life.

The four cases reviewed below were all reported to our California SMP and are actively being investigated.

Case #1: Beneficiary loses access to medication

In this case, an elderly Medicare beneficiary was unable to access her much needed medication due to a hold her pharmacy put on it. Not knowing why this happened and being unable to go without her prescription, this beneficiary called her daughter for help. Her daughter paid out of pocket

for the meds, and called our SMP to see what happened. In researching the complaint, our SMP learned that the pharmacy put a hold on her mother's prescription because she was enrolled in hospice.

Hospice is an important Medicare benefit for people who are terminally ill with 6 months or less to live. When in hospice, it changes one's Medicare benefits to be focused only on palliative care, not curative care. This means that when on hospice, one's Medicare will only cover meds that are palliative in nature. Any other meds will be denied. This is also true in terms of Medicare-covered services. When enrolled in hospice, Medicare will deny payment of any treatments or services intending to "cure" an illness. Therefore if a beneficiary has been fraudulently enrolled in hospice and is not terminally ill, they may start to notice Medicare denying their claims for treatments, services and doctor visits and may be forced to pay out of pocket.

In this case, the daughter had no idea her mother was enrolled in hospice, as she certainly wasn't terminally ill.

When SMP interviewed the mother, she claimed that a nurse came to her home and offered housekeeping services "covered by Medicare". This "benefit" sounded great, so she signed up. Yet the mother had no understanding that she was actually signing up for Medicare's hospice benefit.

Case #2: Medicare stops paying beneficiary's medical bills

In another case, a beneficiary became concerned when Medicare stopped paying many of his medical bills, and he called our California SMP for help. In researching his case, our SMP found out he had been enrolled in hospice. Yet, when talking to him, this beneficiary had no idea this had happened. Unlike the elderly woman in case #1, no nurse or hospice representative called or came to his door. He believes his Medicare number was stolen and used to enroll him into hospice without his consent.

Cases #3 & #4: Fraudulent hospice enrollment causes beneficiaries' health decline and death

Earlier this month, our SMP staff spoke with a son whose father died while fraudulently enrolled in hospice. He called SMP in his search to bring justice to the cause of his father's untimely death and to help prevent other beneficiaries meeting the same fate.

The son, who was his elderly father's caregiver, received a call from a nurse one day who said his father qualified for hospice because of his age. She said that Medicare's hospice benefit could provide home care services and relieve some of the burdens of his caregiving responsibilities for his dad with in home nurse visits. She promised his dad would enjoy access to even more Medicare benefits through this program. The nurse also promised the program would coordinate with his dad's primary care doctor and that he could still go to his medical check ups.

None of these promises came through. The son had his father enrolled in this hospice from May through December. During that time, his father's health declined rapidly. The hospice company changed his medications and told him not to go →

(continued on page 37)

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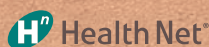
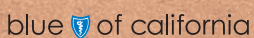


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California to Offer Health Insurance to Some Adults in U.S. Illegally

California lawmakers cinched a budget deal that would make it the first state to offer health insurance benefits to some adults living in the U.S. illegally. The benefits were included in an expansive plan for how California will spend \$213 billion of state and federal tax money over the next year, according to Associated Press reports. At presstime, the budget agreement was awaiting approval by the full state legislature.



NAHU Conference Coming to San Diego

The National Association of Health Underwriters is holding its annual convention in California this year. The event will take place June 28-July 2 at the Sheraton San Diego Hotel & Marina. There will be personal and professional growth forums. Sessions focus on practical solutions for your business, including retaining today's new workforce, buying or selling your agency, data transparency and alternative healthcare management. There's also an expanded Medicare Extreme! with proven practices and important trends on changes in Medicare, technology solutions, growing your business with group Medicare sales plus more. More info at NAHU.org. See you in San Diego!

Insurers Pay California Hospitals More Than Double Medicare

Researchers at West Health Policy Center released a study that found private insurers paid hospitals in California on average more than double what Medicare paid them for similar services in 2015 and 2016.

Analysis of financial data filed by hospitals with the California Office of Statewide Health Planning and Development (OSHPD) found substantial variation across hospitals

in the relationship of private insurance payments to Medicare. For the 10 percent of California hospitals with the highest ratio of private to Medicare payments, private insurance payments average 364 percent of Medicare and 255 percent of cost; for the 10 percent with the lowest ratio, the average is 89 percent of Medicare and 89 percent of cost. Among hospitals with more than 300 beds, the 10 hospitals with the highest ratio of private to Medicare payments include Stanford University Hospital, U.C. Davis Medical Center and Cedars-Sinai Medical Center.

So what does this mean? Researchers Richard Kronick and Sarah Hoda Neyaz offer two perspectives. The first perspective is that basically hospitals charge insurers 209 percent of Medicare on average because they can. Among the reasons: insurers need a broad network or they won't get anyone signing up for their plans. Considerable research supports this view.

In this perspective, relatively high payment rates extracted from private insurers allow hospitals to spend more money – that is, have higher costs – than they would if private payments were lower. High rates of private payments lead to higher costs, which then cause Medicare and Medi-Cal payments to be below cost. In this perspective, if private payments were lower, hospital costs would be lower, and Medicare and Medi-Cal payment-to-cost ratios (PTCRs) would be closer to 1.0.

The second perspective is that hospitals charge the high rates because it's the only way they can stay in business. Private payers account for 27.6 percent of total hospital cost. The surplus from private payers picks up the bill left from public payers and the remaining uninsured, usually resulting in a small positive margin.

Stay tuned. The researchers intend to provide more info that will be helpful in getting to the bottom of the matter.



Millennials Disrupting Healthcare?

Transamerica Center for Health Studies (TCHS) released a new report titled Millennials: An Emerging Generation Disrupting Healthcare. The research concludes that millennials are far more aware of health policy than previous generations and they access care differently. Key findings include:

Many millennials are unhappy with the quality of their healthcare and less reliant on healthcare experts. Twenty-one percent say they are “not at all” or “not very satisfied” with the quality of healthcare to which they have access—a dissatisfaction that has increased since 2016.

Millennials reported visiting their doctor’s office less often, due to the dissatisfaction, coupled with limited finances (31 percent with no visits vs. 27 percent of Gen X and 19 percent of Boomers) often than older generations from 2015-2018.

Millennials are more likely to visit a mental health professional, however. More than older generations, in the past twelve months millennials are more likely to have one or more mental health visits (20 percent vs. 11 percent of Gen X and 7 percent of Boomers).

Millennials are more likely to save for healthcare expenses and more aware of potential changes to health policy. Thirty percent say they are extremely or very aware of healthcare policy changes (20 percent of Gen X and 20 percent of Boomers), of which most (57 percent) are extremely or very concerned about these policy changes.

Advocates Want GINA to Extend to Life

Since 2012, the California Genetic Information Nondiscrimination Act—CalGINA—has prohibited genetic discrimination in employment, housing, mortgage lending, education and public accommodations. CalGINA provides broader protections for employees than does the federal Genetic Information Nondiscrimination Act (“GINA”) of 2008, which is limited to health insurance and employment discrimination coverage. Still, genetic testing advocates are pushing for discrimination protections to be extended to life and long-term care insurance. Right now there’s no law that prohibits insurers from asking potential customers about results from services such as 23andme or rating based on said results. Experts say it’s a long shot that GINA will be extended to life and LTC any time soon. Stay tuned.



Delta Survey Finds Room For Dental IQ Improvement

What? You're not versed in bruxism, prophylaxis and caries? Well, join the club. A new survey by Delta Dental found a resounding majority of adults don't know their dental terms. Unfortunately, ignorance isn't bliss. In fact, the less you know the more unease you may have in the dental chair. So, err, brush up. On your terminology, of course.



GA Warner-Pacific Unveils New Look

Westlake Village, California based Warner Pacific, a general agency that provides resources and support for health insurance brokers, unveiled a new look, complete with an updated logo. The new branding is aimed to reflect the company's continuing dedication to its clients and insurance carrier partners, while also communicating its commitment to staying at the forefront of the rapidly changing insurance marketplace, according to the company.



Health Insurance Inflation Hits High

The Consumer Price Index for health insurance in April spiked 10.7% over the previous 12 months—the largest increase since at least April 2014, according to a Modern Healthcare analysis of the U.S. Bureau of Labor Statistics' unadjusted monthly Consumer Price Index data. The likely reason for the inflation is because of growth in managed care, including Medicare Advantage, Medicaid managed care and commercial insurance, according to Paul Hughes-Cromwick, an economist at Altarum. Added administrative costs increase insurance price growth.

Amalgamated Unveils Whole Life LP95

Amalgamated Life Insurance Company announced it will now be providing a voluntary whole life insurance solution from Security Mutual Life Insurance Company of New York (www.smlny.com). The product, Whole Life LP95, offers guaranteed coverage for those who meet the eligibility requirements as well as guaranteed premiums and strong cash values. Coverage is available for individuals and their spouses age 18 to 72. Additionally, coverage can be obtained for children and grandchildren age 14 days up to and including age 26. Individuals can purchase this insurance for their family members without having to purchase life insurance for themselves. The Whole Life LP95 insurance product allows individuals to select the death benefit and policy riders that best meet their financial goals. Competitive, affordable premium rates are based on the benefits selected and start as low as \$2.00 per week. Premiums can be paid through payroll deductions. Whole Life LP95 provides permanent insurance protection, even if the insured has a change in health, as long as premiums are paid. There is also the option to elect paid-up coverage in a reduced amount to cease ongoing premium payments provided sufficient value exists in the policy. For more information, visit: www.amalgamatedlife.com or call: 914.367.5000.

Blue Shield Of California and Landmark Partnership Helps Folks with Chronic Conditions

Blue Shield of California announced that this past year it enrolled approximately 3,500 physically vulnerable people in a program with Landmark Health to provide comprehensive, coordinated in-home care. Through the program, health care providers made 15,000 home visits. According to the companies, the program isn't a substitute for primary care physicians. It simply allows people with complex needs to get some health care assistance at home, hopefully leading to fewer expensive and unnecessary hospital visits. Blue Shield hasn't supplied data on patient outcomes or the financial impact of the effort yet.



Ease Partners with Beam Dental

Ease, a leading HR and benefits software solution for SMBs, insurance brokers, and insurance carriers, announced their partnership with Beam Dental, a leader in innovative dental benefits. With this connection, Beam will become Ease's newest EaseConnect+ partner. Like Ease, BeamDental embraces insurtech to create a better user experience with distinctive and consumer-focused product offerings.

EVENTS

NAHU Annual Convention—We'll see you here!

June 29-July 2, Sheraton San Diego Hotel & Marina
Keynote speaker is Retired Master Sergeant Cedric King. Sessions focus on practical solutions for your business, including retaining today's new workforce, buying or selling your agency, data transparency and alternative healthcare management. And there's an expanded Medicare Extreme! with proven practices and important trends on changes in Medicare, technology solutions, growing your business with group Medicare sales plus more. Plus plenty of opportunity to visit with a variety of vendors and network with colleagues More info at NAHU.org.

LAAHU and VCAHU 5th Annual Medicare Summit—We'll see you here!

August 20-21, Pickwick Gardens, Burbank
Join Los Angeles and Ventura County Health Underwriters to "Become a Medicare Icon." Speakers, breakout, CE and much more! More info at LAAHU.org.

Association of Health Underwriters Senior Summit—We'll see you here!

August 28-29, Pechanga Resort & Casino, Temecula
The Sixth Annual Senior Summit sponsored by the Inland Empire, Orange County and San Diego Associa-

tions of Health Underwriters is the largest AHU Medicare event in the country. Keynotes, breakout sessions, CE and much more. Early bird pricing in effect until Aug 1: \$79 for members, \$99 for nonmembers. More info at IEAHU.org.

NAAIA National Conference

Sept 11-13, Atlanta

Leaders from across the insurance and financial services profession will come together at this high energy industry event to further the education, advancement and uplifting of African American insurance professionals. More info soon at www.naiaa.org.

Alliance of Comprehensive Planners 2019 Annual Conference

Nov. 12-15, Hyatt Regency Mission Bay, San Diego
The Alliance of Comprehensive Planners (ACP) is a community of tax-focused financial planners who provide planning strategies for clients on a fee-only retainer basis. Conference early bird registration rates (which expire Oct. 11, 2019) are in effect now. Participation is open to all interested financial professionals. Companies interested in sponsoring the ACP Annual Conference should contact Jill Colsch at jill@acplanners.org. The agenda is available at acplanners.org.

Integrated Health Care Tips

By STEVE VALENTI

The human body functions as a holistic and well-coordinated system, yet the health insurance industry hasn't traditionally had a coordinated approach, offering products separately and thereby creating silos. With medical, vision, dental, life, disability, absence/FML and supplemental health separated from each other without effective coordination, consumers and health care providers often have a disconnected view of a person's total health and gaps in care can develop. However, a growing trend in the design of health care benefits is emerging which allows claims data and population insights to address "whole person health" through integrated health care. This puts the consumer at the center and simplifies the health care experience.

For brokers and consultants, this offers a unique opportunity to engage employers and show them how integrated health care can lower their health care costs, provide them with a simplified administration process and positively impact their employees' health outcomes while also improving workforce productivity.

Many employers already recognize the value of integrating their health benefit plans. According to a recent study conducted by Anthem, 71% of employers surveyed are either actively integrating or considering integrating their medical, vision, dental, pharmacy and/or disability benefits in the next five years – this represents an 11% increase from data collected in 2016. The study also found that among those surveyed who are actively integrating or considering integrating benefits nearly 100% of them reported integrating medical plans with pharmacy, vision, dental and/or disability benefits and the overwhelming preference is for integration with a single insurance carrier versus multiple carriers.

Additionally, the reason employers

are, or considering, integrating has shifted over the last few years from seeking cost savings to recognizing that integration leads to a healthier and happier workforce. Anthem's survey found that the 'happiness factor' is a workforce advantage with 88% of employers agreeing that integrated health care benefit programs make an organization a place where people want to work. While the cost and ease of administration remain important business imperatives to employers, there is a noticeable shift toward creating and retaining a more satisfied and healthier workforce as a driver of integration.

So, how can brokers and consultants discuss integrated health care to get a competitive edge and enhance their clients' health benefits at no additional cost? Here are three tips to consider when making a shift from the traditional, siloed benefits approach to a modern, connected employee benefits portfolio:

1. Don't wait – It's a common myth among some benefit advisors that integrated health care should only be implemented when financial return on investment (ROI) can be proved. However, in reality, the majority of employers surveyed (55%) measure success by employee engagement versus financial ROI (27%). As the insurance industry continues to evolve there will be more proof points about the value of integrated health care but the empirical evidence is clear that a shift is happening and employers want integrated benefits. Brokers and consultants should be discussing integrated plans with their clients now in order to meet both their current and near future needs.

2. Break down silos – When discussing benefit plans with clients, rather than presenting benefits in silos – 30 minutes presenting medical, 10 on dental, 10 on vision, etc. – brokers and consultants should consider a solution-centric ap-

proach that looks at the entire needs of clients. Integrating ancillary products as part of the overall story shows how a 'whole person health' approach delivers better care, simplifies the administration and consumer experience, and reduces costs.

3. Engage with carriers – If you are considering how to incorporate integrated health care in your presentation or have any questions, reach out to carriers that offer integrated benefits to learn more. Many carriers may also have a representative available who can go with you to client meetings and assist with your presentations. But be careful with this approach, while many carriers may claim to be integrated, some just have one-way data feeds that don't actually connect information in a meaningful way. Make sure you are speaking with carriers that can demonstrate real-time, auto-sharing of information that is truly integrated across the entire care experience.

The bottom line is that integrated health benefits are a topic that is top of mind with many employers and they're looking for brokers and consultants who can bring solutions to meet their needs. Brokers and consultants have the real opportunity to be leaders in this new direction, so don't risk leaving the door open to other benefit advisors who are ready to have these discussion with clients and prospective clients.



Steve Valenti is Anthem's vice president of specialty distribution responsible for further developing our integrated distribution strategy with local group and national accounts, and leading the execution of our sales and account management growth plans. Since joining Anthem in May 2014 to lead our Specialty East Region, Steve has been an instrumental part of driving Specialty's profitable sales growth and developing exciting transformation initiatives.

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2019 DENTAL SURVEY

It's that time of year again! California's top dental providers offer updated info on their plans, provider networks and more!

COMPILED BY THORA MADDEN

1. What types of plans do you offer?

Beam: Beam offers a wide range of fully customizable PPO options from preventive plans to benefits rich Ultra plans. Each plan comes with access to our nationwide network of over 335,000+ access points and includes Beam Perks, our smart electric toothbrush, paste and floss, delivered to each member's door every six months.

Blue Shield: Blue Shield provides a wide range of affordable and comprehensive dental products to meet our clients' needs. Our Dental PPO and HMO plans offer members a wide variety of plan designs and networks that fit their budget.

- For individuals/families, we offer a unique dental PPO plan that provides member copayments instead of the usual coinsurance percentages. Our dental HMO plan offers comprehensive benefits with pre-determined member copayments. Finally, our Duo plan offers members dental and vision coverage at a single price. Our plans can be sold with medical plans or on a standalone basis.

- For senior members, we offer two comprehensive

dental PPO plans for Medicare supplement plan members. There is also a dental plus vision plan package option for Medicare supplement plan members.

- For groups, some of our dental PPO and HMO plans are available on a contributory or voluntary basis, most can be sold with or without Blue Shield medical plans and are UCR- or MAC-based.

Delta Dental: Delta Dental offers managed fee-for-service, PPO and DHMO dental plans for individuals and groups of all sizes. Our group plans are available for both employer-paid and voluntary premium contributions, and with a choice of fully insured or ASO funding options for fee-for-service plans. We also offer ACA-compliant small group and individual DHMO and PPO plans, Medicare Advantage, Medicaid and provide coverage to additional groups and individuals through our partnerships with various health plans across the country.

Guardian: Guardian offers an array of plan types and options to meet the needs of employers/employees and individuals/families. Employer plans can be customized according to needs and price points. Dental PPO, Managed Dental

Rates are especially affordable for plans that emphasize preventive care...We also market plans designed to meet the needs of seniors, offering benefits most utilized by this particular population.

—Delta Dental

Care (Prepaid/DHMO), Indemnity, Dual and Triple Choice, Monthly Switch (between a DHMO and PPO), and Administrative Services Only Plans can be offered as voluntary, contributory, or on an employer-sponsored basis. Individuals/Families can buy direct from guardiandirect.com. Additionally, Guardian offers family and individual plans through its subsidiaries Premier Access and Access Dental on the Covered California exchange.

Humana: In California, Humana offers dental PPO, pre-paid/DHMO, Traditional Preferred (TRP), and Preventive Plus plans. These plans are available on a voluntary or employer-sponsored basis.

National General: We offer fixed indemnity dental plans. These plans provide a set cash reimbursement to the member for specific services rendered. An optional additional benefit is a dental/vision savings card to take those insurance dollars even further and get member pricing from retail to wholesale rates within the participating providers.

Premiere Access: Premier Access offers a wide selection of plans to meet the needs of employers and their employees. Dental PPO, Dental HMO, and Indemnity plans are available on an employer-sponsored or voluntary basis. Dual and triple choice, monthly switch (between a DPPO and a DHM), and Administrative Services Only plans are available as well. We specialize in customized plans for groups of all sizes based on the needs and price points of the employers and employees.

2. How do plans you offer for the individual and/or small group compare in rates and benefits to the large-group plans?

Beam: We specialize in pricing for small to mid-size businesses and offer unique savings opportunities for all of our clients. Each one of our dental plans comes with Beam Perks (our smart electric toothbrush, paste and floss) included automatically. Members use our brush and app together, and then clients can save up to 15% at renewal—just for brushing their teeth.

Blue Shield: There are different underwriting considerations for each business segment. Our ability to customize offerings for groups with more than 300 employees typically results in lower rates and more choices to meet the employer's needs.

- Group PPO plans come in a wide range of deductibles and annual benefit maximums.

- Our individual, family and Medicare Supplement dental PPO plans may vary in waiting periods, deductibles, and annual benefit maximums based on the plan selection.

- All dental plans include generous benefits, competitive premiums, and strong California and national provider networks that are available to all members; we don't differentiate our provider network for small groups or individual or family markets.

Delta Dental: We offer small businesses a wide range of dental benefits plans, many of which are often available only to larger groups. The majority of our small business plans are offered through a special program that evaluates risk on a pooled basis, helping to keep both rates and plan designs extremely competitive. Attractive features available through our small business plans include missing tooth coverage, composite (white) fillings on posterior teeth and coverage for all three phases of orthodontics for adults and children. While large groups often have the most flexibility in customizing plan options and obtaining rates that balance their experience and cost effectiveness, the range of benefits available through our Small Business Program make our plans particularly attractive to small group purchasers.

We have both DHMO and PPO off-exchange plans for individuals and families. Rates are especially affordable for plans that emphasize preventive care, and we offer more comprehensive plans that benefit major procedures as well. We also market plans designed to meet the needs of seniors, offering benefits most utilized by this particular population. The small business plans and individual plans

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All our dental plans provide employees with incentives for preventive dental care, which promotes their overall health. Members who see dentists participating in our dental networks receive deep discounts.

—Humana

that are available through the state and federal exchanges emphasize preventive care and coverage for the most commonly used services.

Guardian: Individuals and small group employers can choose from nearly similar plans as large groups with cost-reducing options. Individuals/families can buy direct from guardiandirect.com or on the exchange through Covered California.

Humana: We offer flexible plan designs with a range of deductibles, co-payments, and out-of-pocket expense limits to meet the needs of small to large groups. We also offer large groups the additional flexibility to customize plan options. All our dental plans provide employees with incentives for preventive dental care, which promotes their overall health. Members who see dentists participating in our dental networks receive deep discounts.

Typically rates for large group clients are lower than small group, as the risk is spread out among a larger membership pool.

For individuals, Humana offers our Complete Dental plan, a comprehensive plan that offers broad preventive, basic, and major services coverage. This plan works well for those who may be recently retired or are moving off of a group dental plan. Complete Dental is a PPO plan, allowing members the flexibility to have coverage with in-network and out-of-network dentists.

National General: The rates for the dental indemnity product are comparable if not slightly lower than a traditional plan offered through a group chassis. The 'cash dental' plan—as ours is—also takes a less traditional approach but the net effect of the benefits tends to work out the same. Plans range in cost from \$15.50 to \$145.10 per month.

Premiere Access: Our standardized and customized plans for small group employers are the same as the ones we offer for large group employers.

3. What have been the most recent changes in your plan(s)?

Beam: Beam is using machine learning and AI to produce quotes and process claims which will lower costs of insurance for our partners uniquely.

Blue Shield: We are always looking to enhance our plans and provide valuable benefits to our members.

- In 2020, for Large groups, we are introducing 14 new dental PPO plan to our portfolio which provide richer benefit options.
- For Small groups, we are introducing six new dental PPO plans with richer benefits to our small group portfolio designed to fill in gaps in the benefit spectrum. We are also continuing to offer a two-year rate guarantee.
- For IFP, we are offering two new DPPO plans with a \$2,000 annual maximum to our portfolio. One of these plans also offers ortho benefits up to a lifetime maximum of \$1,500.
- For Medicare Advantage we are expanding into full counties LA/OR/SB/RV. Our optional dental DHMO plan rate decreased and our optional PPO dental rate increased.
- 10/01/19 MedSupp Optional PPO 1000 plan rate decreased and we changed the waiting period from 12 months to six months for major services. For the MedSupp Specialty Duo we removed the 90-day waiting period for vision benefits.

In addition to new plan designs, all BSC plans include oral cancer screening coverage as a value-added benefit, which comes at no out-of-pocket cost to the member. We also offer enhanced dental services for pregnant women to all dental PPO plans. Pregnant women receive one additional routine adult prophylaxis, and/or one course (up to four quadrants) of periodontal scaling and root planing, and/or periodontal maintenance if warranted by a history of periodontal treatment. Treatment is payable at 100% of the allowable amount for in- and out-of-network.

Delta Dental continues to offer benefit procedures that we feel are trend setting. We have covered dental implants for many years and continually look for new technology and procedures to benefit our members.

—Delta Dental

Delta Dental: Delta Dental continues to offer benefit procedures that we feel are trend setting. We have covered dental implants for many years and continually look for new technology and procedures to benefit our members. Recently, Delta Dental selected Amplifon Hearing Health Care and QualSight to offer commercial group enrollees access to preferred pricing on hearing aid and LASIK services.

Guardian: Guardian constantly develops innovative ideas in order to meet our customers' needs. As the cost of college tuition continues to rise, Guardian helps our members and their families by offering the College Tuition Benefit®, a value-added benefit that helps them pay for college. Members enrolled in a Guardian plan, like dental, that includes the College Tuition Benefit® can earn 2,000 Tuition Reward® points annually, per product. Each tuition reward point equals \$1 in tuition reduction; accumulated points can be used to pay up to one year's tuition at one of more than 400 private colleges and universities across the nation. The benefit can be included with up to four lines of Guardian coverage with rewards increasing each year and with each line of coverage.

In addition, Guardian's Administrative Services Only (ASO) option offers the same product features, network and claims processing as fully-insured. For those hesitant to move to ASO, we offer an innovative Level-Funded option that offers fixed monthly costs starting with a 105% aggregate stop loss and if claims are lower than expected, Guardian returns the entire surplus to the employer.

Humana: Recently we enhanced and expanded the coverage of our dental PPO and TRP plans to encourage members to get the care they need whenever they need it. These updates included:

Enhanced Preventive Care: Our new benefits include a wider array of preventive benefits covered at 100 percent, including additional periodontal cleanings, space maintainers for children, and oral cancer screenings for members 40 years of age and older.

Extended Annual Maximum: Members who reach their annual maximum no longer need to put off the care they

need. As a standard benefit in all of our dental PPO and TRP plans, Humana offers an innovative plan design that provides a 30 percent coinsurance paid by Humana for preventive, basic, and/or major services after members meet their annual maximum.

Optional Unlimited Annual Maximum: Members can now receive care whenever they need it without the worry of reaching their annual maximum. With our Unlimited Annual Maximum, offered as an optional rider for an additional cost, the member's coverage continues throughout the plan year, regardless of the total accumulated amounts paid. It takes into consideration only deductibles, coinsurance amounts, and standard limitations and exclusions.

Implants: While implants themselves can become a covered benefit through Humana's dental PPO and TRP plans with an optional rider, now all implant-supported prosthodontics—such as crowns and dentures—are covered whether the group selects the implant rider or not.

National General: Our Dental plans can now easily be offered to groups through List Bill – no contribution or participation requirements.

Premiere Access: Our enhanced PPO plan designs offer brokers and employers more flexibility and control over their plan design and provide opportunities for savings using our unique tiered network combined with our tiered benefit design. Members also have the option to enroll in a monthly election plan that allows them to switch between the DPPO and the DHMO. Additionally, we have expanded our Premier Choice Network throughout the state giving more access to quality dentists at an increased discount.

4. Can an insured use their own dentist even if they are not on your participation list?

Beam: Beam plan comes with great out-of-network coverage. Our plans come standard with 90th percentile UCR and is customizable based on the out-of-network coverage needs of an employer.

Blue Shield: Yes, both dental PPO plan members can

Members covered under our PPO plans can visit any dentist they choose; however, benefits may be paid at a lower co-insurance rate for non-participating dentists. DHMO members must choose and use a participating primary care dentist.

—Guardian

choose to go to any dentist, although their benefits will be covered at a higher percentage when choosing a network dentist, with less out-of-pocket expense.

Delta Dental: Yes. Members can receive care from a non-contacted dentist. Delta Dental offers our members the choice of two provider networks, PPO and Premier. Member dentists in each network are contracted to fee allowances that are well below retail charges and cannot balance-bill the member above the contracted fee. They are also subject to quality assurance and utilization management provisions. Enrollees of these two plans can utilize any licensed dentist anywhere and are not subject to service area restrictions.

DeltaCare® USA (DHMO) enrollees must visit their selected general dentist or approved specialist to receive benefits, with the exception of emergency out-of-area care.

Guardian: Members covered under our PPO plans can visit any dentist; however, benefits may be paid at a lower coinsurance rate for non-participating dentists. Managed Dental Care/DHMO members must choose a participating primary care dentist.

Humana: Yes, dental PPO, TRP, and Preventive Plus members can visit the dentist of their choice; however, out-of-pocket savings are greater when members visit participating network dentists. DHMO members must select a participating dentist.

National General: Yes. Since this is a fixed indemnity dental plan, there are no networks. However, to maximize savings during a wait period, a member might consider using an in-network provider if they selected our Network Savings Card. This provides an average savings of 43 percent on dental care—on top of the cash benefits from our plan.

Premiere Access: Members covered under our PPO plans can visit any dentist they choose; however, benefits may be paid at a lower co-insurance rate for non-participating dentists. DHMO members must choose and use a participating primary care dentist.

5. How many provider locations do you have?

Beam: +335,000 nationwide

Blue Shield: Members have network access to over 21,415 dental HMO and 47,563 dental PPO providers in California, and more than 406,169 providers nationwide. These are two of the largest statewide provider networks in the industry.

Delta Dental: Delta Dental PPO offers more than 47,000 participating provider locations in California and nearly 320,000 locations nationally. Premier dentists offer more than 55,900 locations in California and nearly 392,000 locations nationally. Currently there are more than 6,600 participating DeltaCare USA facilities in California to choose from.

Guardian: There are over 435,000 PPO access points across the country and more than 54,568 in California (Source: Netminder). We are one of the largest PPO networks in the state based on dentists. The DentalGuard Alliance network tier, a smaller group of dentists offering greater discounts, has 6,523 dentist access points in California. For the DHMO, there are 15,886 general dentists and specialist access points in California. Guardian's PPO network also includes dental offices in Mexico. International Assist, a value-added service available, provides dental members with access to dental care if needed while traveling outside of the U.S.

Humana: Nationally, Humana has more than 94,000 dental PPO providers with over 14,000 dental PPO providers the State of California. For DHMO, Humana has more than 63,000 DHMO provider locations in specific markets. In California, we have over than 5,600 DHMO provider locations.

National General: We are a hybrid of sorts due to the platform of fixed indemnity and optional access to our Careington Maximum Care Dental Network—a national network of more than 200,000 dental practices.

We are a hybrid of sorts due to the platform of fixed indemnity and optional access to our Careington Maximum Care Dental Network—a national network of more than 200,000 dental practices.

—National General

Premiere Access: Our Dental PPO networks offer access to more than 56,000 dentist locations nationwide, with more than 12,000 in California. Our DHMO network in California has more than 3,300 dentist dental locations, including specialists.

6. What percentage of your network is closed to new enrollment? How many offices does this represent?

Beam: N/A

Blue Shield: In 2018, approximately 7% of dental HMO plan network providers maintained closed practices; this represents approximately 148 offices out of 2,154 unique locations.

Delta Dental: All of Delta Dental PPO and Delta Dental Premier offices are open to new enrollment. Our fee-for-service providers may close their practice, but while in operation they must accept patients without discrimination, regardless of age, gender, ethnicity or being new to the practice.

Guardian: In California, only 0.03% of our PPO network and 2.73% of our DHMO network are closed to new patients.

Humana: Less than 1% of Humana's dental PPO providers are closed to new patients. Under Humana's dental provider contracts, participating dentists must schedule and treat members without discrimination, including benefit or payer differentials. Approximately 2% of practices are closed to new patients in the Liberty DHMO plans.

National General: None—the core plan is 'go anywhere'. If the dental/vision savings card is selected, those providers are all available to new participants.

Premiere Access: Less than 5% of the DHMO network

is closed to new patients; this figure represents about 159 general dentist locations.

7. What is the time frame for processing a referral in terms of member notification and payment to the specialist?

Beam: N/A

Blue Shield: For PPO members, Specialist referrals are not required, and payments to specialists are processed the same as for general dentists. For DHMO members, pre-authorizations for Specialists are normally processed within 5 business days.

Delta Dental: For PPO and Premier, referrals and pre-authorization are not required; payments to specialists are processed by the same guidelines as general dentists. Our standard turnaround for processing DeltaCare USA specialty care referrals is five days.

Guardian: Referrals are not required under our PPO plans. For our DHMO plans, payment to the specialist is within 30 days of receipt of the claim.

Humana: Humana's dental plans, including DHMO plans, do not require a referral from a general dentist to a specialist. In 2018, 96.6% of clean claims from all dentists, including specialists, were processed within 14 calendar days.

National General: This kind of transaction would be handled in the member services area in the same manner as regular treatment. So, as long as the services are deemed necessary and covered, benefits would be available as per the contract.

Premiere Access: Referrals are not required under our DPPO plans. For our DHMO plans, payment to the specialists is within 30 days of receipt of the claim.

For large groups our Rollover Rewards benefit allows qualified members to boost their annual maximum. The annual account reward will vary depending on the annual claims threshold which is determined by the plan's annual maximum chosen.

—Blue Shield

8. How do you handle early termination of coverage when a member is still in the middle of orthodontic treatment?

Beam: Beam will pick up orthodontic treatments in the middle of their period for new members. For an early termination, Beam will cease making payments on that coverage when it terminates.

Blue Shield: Orthodontic coverage/payments end at cancellation of coverage.

Delta Dental: Delta Dental's obligation to cover orthodontic treatment ceases after the date the enrollee loses eligibility or terminates coverage.

Guardian: When an orthodontic appliance is inserted prior to the PPO member's effective date, we will cover a portion of treatment. Based on the original treatment plan, we determine the portion of charges incurred by the member prior to being covered by our plan and deduct them from the total charges. Our payment is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the orthodontic treatment started. Also, we enforce the plan's orthodontic benefit maximum by reducing the total benefit that Guardian would pay by the amount paid by the prior carrier, if applicable.

If a member is undergoing orthodontic treatment and his or her Guardian coverage terminates, we pro-rate the benefit to cover only the period during which coverage was in force. We do not extend benefits.

Our DHMO agreement provides for the Contracted Orthodontist to complete treatment at the contracted patient charge on a number of our plans. As an additional contract rider, we can allow for supplemental transfer coverage for Orthodontia under our DHMO.

Humana: For orthodontic claims, Humana pays benefits monthly through the month that the member is termed.

Orthodontia is prorated over the time of treatment, depending on how long the member is in treatment.

National General: Not applicable to our coverage, as our plan does not provide such benefits.

Premiere Access: If a member is undergoing orthodontic treatment and their Premier Access coverage terminates, we will pro-rate the benefit to cover only the time period during which coverage was in force. We do not extend the benefits beyond the policy termination. Our DHMO agreement provides for the contracted orthodontist to complete treatment at the contracted patient charge on a number of our plans.

9. Does your plan have annual and lifetime maximums on dental coverage? If so, what are they?

Beam: All plans have customizable maximums. Beam's new Ultra plans can support annual maximums of \$5,000 and orthodontic maxes of \$3,000. One of our strategic advantages is flexibility; we can underwrite a wide variety of maximums based on the needs of the employer!

Blue Shield: Our annual maximums vary from as little as \$500 to as much as \$5,000 or more dependent upon individual or group coverage and group size. Employers have a choice in annual maximum with more flexibility for large group customers to customize their annual maximum to meet their needs.

For large groups, we also offer our Rollover Rewards benefit feature allowing qualified members to boost their annual maximum. The annual account reward will vary depending on the annual claims threshold which is determined by the plan's annual maximum chosen. The annual network reward for members who visit an in-network vs. a non-network dentist is \$100.

Delta Dental: Virtually none of our DeltaCare USA (DHMO) plans impose annual or lifetime maximums on dental cover-

Premier Access offers plan design flexibility to allow brokers and employers to custom design their dental benefits, including annual or lifetime benefits. The most common annual benefit maximums are \$1,000, \$1,500, and \$2,000.

—Premier Access

age. For most PPO and Premier plans, annual and lifetime maximums vary, and are determined by the group purchaser. Maximums typically range from \$1,000 to \$2,000.

Guardian: For PPO, the maximum refers to the total of benefit dollars actually paid for covered services incurred within the annual period, or the member's lifetime in the case of orthodontia. Guardian has flexibility with maximums. Typically, Preventive, Basic and Major have a combined maximum. We offer both an annual single maximum option (range from \$500 - \$5,000) and an annual split maximum option (maximums differ for in-network and out-of-network services). With the Preventive Advantage option, only Basic and Major services count toward the annual maximum. Maximum Rollover allows a portion of unused annual maximums to carry over for future years. We also offer an option to cover cleaning after the maximum is reached. For orthodontia, the lifetime maximum options range from \$500-\$2,500. Our DHMO plans do not include an annual maximum.

Humana: We offer flexible plan designs with a range of annual maximums to meet the needs of small to large groups. We do not have lifetime maximums. We are the only specialty carrier in the market to offer an Unlimited Annual Maximum.

National General: Yes. The Basic Plan has a \$500 maximum calendar year benefit; Intermediate is \$1,000; and the Plus plan is \$1,500. However, preventive benefits do not take away from this annual benefit (adding \$150-200/annually in benefit, depending on plan level). Members can use their savings card on covered and non-covered services at any and all times of the coverage being in force.

Premiere Access: Premier Access offers plan design flexibility to allow brokers and employers to custom design their dental benefits, including annual or lifetime benefits. The most common annual benefit maximums are \$1,000, \$1,500, and \$2,000. We do offer custom benefit plans above those amounts if the employer and broker desire that.

10. Does your plan have a deductible. If so, what is it?

Beam: Beam plans include a standard \$50 deductible (\$150 family) but is fully customizable. Our Ultra plans can go as low as a \$0 deductible!

Blue Shield: Deductibles can vary from as little as \$0 to as much as \$300 or more dependent upon group size and individual or family coverage. Employers have a choice in deductible with more flexibility for large group customers to customize their annual deductible to meet their needs.

Delta Dental: Virtually none of our DeltaCare USA (DHMO) plans require enrollees to satisfy a deductible. For most PPO and Premier plans, deductibles vary, and are determined by the group purchaser. Deductibles of \$50 per individual / \$150 per family are not uncommon.

Guardian: Our PPO product offers many different deductible options ranging from \$0-\$300 and will vary by plan design with \$50 historically being the most common. Deductibles are often waived for Preventive Services as Guardian's plans are designed to encourage members to get preventive care, thereby avoiding the need for more extensive dental care in the future. All our DHMO plan designs offered in California have no deductibles.

Humana: We offer flexible plan designs with a range of deductibles to meet the needs of small to large groups. The deductible is always waived for preventive care. We want to ensure there are no barriers to members receiving the necessary preventive care.

National General: There are no deductibles.

Premiere Access: Employers and brokers can custom design their dental benefits, including plans with no deductible, the most common designs requested are no deductible, \$25 and \$50.

Beam will cover preventive at 100% in all cases' we strongly believe in preventive care's role in the dental health equation for all members!

— Beam

11. What percentage of preventive costs does your plan cover?

Beam: Beam will cover preventive at 100% in all cases' we strongly believe in preventive care's role in the dental health equation for all members!

Blue Shield: Preventive care is standardly covered at 100% when using an in-network provider. Out-of-network coverage will vary based on plan selected but typically not less than 80 percent. Members may also be balanced billed for amounts exceeding the allowable payment to out-of-network providers based on their plan. For large groups, there is additional flexibility to customize the percentage of costs covered.

Delta Dental: Delta Dental's fee-for-service coinsurance percentages vary by plan. The majority of fee for service plan designs benefit preventive and diagnostic procedures at 100%. DHMO copays are set at a fixed schedule and vary by plan design.

Guardian: For PPO, we offer coinsurance percentages ranging from 0%-100% for preventive services. The preventive coinsurance percent for our most common PPO plan sold is 100%. Our DHMO plans offer a wide variety of covered services usually covered at 100%.

Humana: Preventive care is always covered at 100% in network, unless a large group designs a custom plan. We encourage all employers to cover preventive care at 100%. We want to ensure there are no barriers to members receiving the necessary preventive care.

National General: The member is reimbursed a select amount toward their preventive visit based on benefit level plan selected. For example, our 'Plus' plan offers \$100 cash reimbursement toward preventive services.

Premiere Access: Brokers and employers can customize

this coverage from 0% to 100%; the most common is 100% coverage for preventive costs.

12. What percentage of root canal costs does your plan cover?

Beam: We will typically cover root canals at 50%, but it is customizable based on employer preference.

Blue Shield: For Large groups, root canals can be covered under Basic or Major services. Typically, Basic services are covered at 80% and Major Services are covered at 50%. Out-of-network coverage will vary based on plan selected but the most common percentage is 50%. For Individual/Family plans, root canals are typically covered under Major services at 50%. For Small Group, root canals are typically covered under Basic services at 80%.

Delta Dental: Delta Dental's fee-for-service coinsurance percentages vary by plan. As a dental carrier, we can administer any coinsurance level that the employer or broker requests. DHMO copays are set at a fixed schedule and vary by plan design.

Guardian: For PPO, we most often cover root canals as a basic service. We offer coinsurance percentages ranging from 0%-100% for basic services. The basic coinsurance percent for our most common PPO plan sold is 80%. Our DHMO plans cover many root canal procedures at various copayment levels based on plan type.

Humana: We offer flexible plan designs with a range of co-insurance percentages from 50% to 100% to meet the needs of small to large groups. A group can elect to have endodontic coverage in basic or major.

National General: According to our cost and transparency calendar, a molar root canal – for example – may cost \$1,382. The plan cost is \$707 with a network savings of \$675 or a percentage savings of almost 50%

Delta Dental's fee-for-service coinsurance percentages vary by plan. As a dental carrier, we can administer any coinsurance level that the employer or broker requests. DHMO copays are set at a fixed schedule and vary by plan design.

—Delta Dental

Premiere Access: Brokers and employers can customize this coverage from 0 percent to 100%; the most common designs cover 80% or 50%.

13. What percentage of crown costs does your plan cover?

Beam: We will typically cover crowns at 50%, but it is customizable based on employer preference.

Blue Shield: Typically, for all lines of business, crowns are considered Major services and are covered at 50%.

Delta Dental: Delta Dental's fee-for-service coinsurance percentages vary by plan. As a dental carrier, we can administer any coinsurance level that the employer or broker requests. DHMO copays are set at a fixed schedule and vary by plan design.

Guardian: For PPO, we most often cover crowns as a major service. We offer coinsurance percentages ranging from 0%-100% for major services. The major coinsurance percent for our most common PPO plan sold is 50%. Our DHMO plans offer a wide variety of different crown option procedures covered at various copayment levels based on plan type.

Humana: We offer flexible plan designs with a range of co-insurance percentages to meet the needs of small to large groups. Crowns are typically covered as part of major services and the coinsurance ranges from 50% to 60%.

National General: The cash benefit for a Crown ranges from \$45 to \$450. However, if the Careington Network is used – for example – the cost for a Crown (porcelain fused to noble metal) may cost \$1,424. The plan cost is \$726 with a network savings of \$698 or a percentage savings of almost 50%.

Premiere Access: Brokers and employers can custom-

ize this coverage from 0% to 100%; the most common design covers it at 50%.

14. Do you provide dentist cost and quality transparency tools?

Beam: Our Lighthouse portal is for brokers and administrators and offers the ability to quickly and effectively edit account and member level details, manage everything from enrollments to COBRA, and gain unique insights into how a group is performing against plan, especially as it relates to their Beam Brush data and renewal rates.

Blue Shield: Yes. Once registered on our website, members may review their claims information and locate providers. They also have access to treatment cost information through the Treatment Cost Calculator. The Treatment Cost Calculator allows members to search for common procedures including exams, cleanings, x-rays, fillings or root canals. This tool is quick and easy to use with members being able to get an estimated cost for procedures quickly.

Delta Dental: Yes. Enrollees can use our Cost Estimator to determine costs for procedures based on dentist participation and location. Additionally, our Find a Dentist tool provides links to Yelp reviews as well as other helpful information including languages spoken, wheelchair accessibility and public transit access.

Guardian: We have a Dental Cost Estimator tool that provides an estimated range of allowable charges (fee schedule amounts) for the selected procedure codes in a selected region and provider contracted tier. Note that this is not the actual Guardian fee schedule amount for a provider nor the expected paid amount for a particular Guardian plan design. At this time, we do not offer provider quality ratings.

Humana: Humana's website does not currently provide cost information for our dental products.

Enrollees can use our Cost Estimator to determine costs for procedures...Additionally, our Find a Dentist tool provides links to Yelp reviews as well as other helpful information...

—Delta Dental

National General: Yes. If a member decides to use our Careington Network for specific services, they can go to: <http://www.careington.com/ngahdsavings/>. These resources provide a simplified way to determine costs of treatment.

Premiere Access: We are developing cost and quality tools for the website, which we believe we help consumers make better informed decisions. We also offer pre-determination of benefits to members who request them through our phone-based customer service representatives.

15. Who can readers contact for more information?

Beam: You can email Beam at intro@beam.dental for more information, and one of our Business Development Representatives will be in touch pronto!

Blue Shield of California: Brokers who currently work with Blue Shield of CA contact their BSC representative. For those who do not have a direct contact, they can locate more information by logging onto our website at our Broker Connection. The link is listed below.

https://www.blueshieldca.com/bsca/bsc/wcm/connect/broker/broker_content_en/broker/home

Delta Dental: Readers can visit <https://www.deltadentalins.com/about/contact/> to find the information specific to their location and area of interest.

Guardian: For more information, your readers can contact Guardian through our website. The Guardian Life Insurance Company of America® www.guardianlife.com

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National General: Kellie Bernell, Regional Sales Director (805) 341-7843 / email: Kellie.Bernell@NGIC.com
Company Site: <https://ngah-ngic.com/supplemental-insurance.php>

Premiere Access: www.premierlife.com
Phone: 888-326-3210
Sales Executive: Robert Semrow – robert@premierlife.com

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5 MYTHS ABOUT BENEFITS ENROLLMENT

Help your clients create a more effective enrollment by busting these benefits myths

By STEVEN JOHNSON

The saying “You don’t know what you don’t know” can apply to a lot of things in life — including employee benefits. And when both your clients and their employees fall into this trap, that can lead to a benefits program that’s not valued, utilized or cost-effective.

You can help your clients create a stronger benefits program that makes them more competitive by dispelling some common myths they might believe.

Myth #1: My employees understand the benefits available to them

Reality: Only one-third of employees understand their benefits very well, according to a recent Colonial Life survey of 1,500 full-time U.S. employees. And employees who don’t understand

their benefits don’t value them, or the significant investment their employer makes in them.

This can lead to major problems for your clients, because lack of engagement with the benefits program leads to lower morale and higher turnover, the survey showed. Employees who spend less than an hour considering their benefits at enrollment time are significantly more likely to:

- Feel dissatisfied in their jobs
- Think their employer doesn’t care about them
- Leave their current jobs within the next six months

Ask your clients what they typically spend to recruit, hire and train a new employee, and you — and they — will quickly see the impact on the bottom line when employees don’t understand their benefits.

Myth 2: My employees take the time needed to research their benefits

Reality: Unfortunately, this isn’t true, either. In fact, 69% of employees spend an hour or less considering their benefits annually, according to the survey. Even worse, a third say they spend less than 30 minutes learning about benefits their employer provides.

It’s not enough for your clients to simply offer a comprehensive, competitive benefits package. To make that investment pay off, the benefits program must be backed by an equally comprehensive education and communication program. Better education drives greater engagement — and higher participation levels that help your business succeed, too.

An effective benefits communication plan will reach employees and allow them to access information when and where they want, and may include



Look for a partner that can provide both a wide array of voluntary benefits and the experienced, licensed, knowledgeable benefits counselors to communicate and enroll them.

group and individual meetings, call centers and online chats, website or portals, and print and digital materials offered over a period of several weeks.

Myth #3: My millennial employees prefer to research their benefits online

Reality: Only 10% of millennials turn to the Internet to learn about employee benefits at enrollment time, according to the survey. That doesn't mean they don't have questions and want help figuring out their needs and benefits options — rather, it means most employees want to talk with a live human being. In fact, more than three-fourths of employees in the survey said they turn to other people, such as their HR department, coworkers, family members and friends, for advice.

Yet that strategy may not be effective. The survey showed only 40% of employees named HR professionals as their go-to source to learn about benefits — with older employees more likely to do so than younger employees. While more people turn to HR professionals than any other source, it still means the majority of employees aren't taking advantage of the most knowledgeable resource. And understaffed, overburdened HR staff may not have the time and expertise to help employees determine their individual needs and understand the types of coverage that best meet those needs. The result is an even wider gap in benefits education for millions of America's workers.

Myth #4: Individual meetings aren't necessary to communicate my benefits

Reality: Research shows one-to-one sessions are the most effective benefits education technique. According to the survey, virtually all — 93% — of employees who've participated in one-to-one benefits counseling sessions found them valuable. Yet only 15% of employees are offered this kind of personalized benefits enrollment experience.

The reason why may reveal other myths your clients believe: It's too expensive, or my company is too small to benefit from or qualify for this kind of service. The truth is this kind of personal support isn't available just to your large clients with bigger budgets. A top-tier benefits partner will communicate with employees individually in all accounts to ensure they understand all their employer's benefits — not just those the provider offers — as part of their included services at no direct charge.

Myth #5: The core benefits I offer my employees are enough

Reality: If your clients aren't offering a comprehensive benefits package that includes core benefits such as major medical as well as voluntary benefits such as dental, vision, life, disability and critical illness coverage, they're not going to be competitive when it comes to attracting and keeping top talent. A Willis Towers Watson survey showed the vast majority—79%—of employers of-

fer voluntary benefits to enrich existing core benefits and offer more personalized options.

What's not a myth

You don't have to be an expert in voluntary benefits, communication and enrollment to provide your clients with effective solutions. Take advantage of benefits partners with the expertise you need to complement your portfolio and your toolkit. Look for a partner that can provide both a wide array of voluntary benefits and the experienced, licensed, knowledgeable benefits counselors to communicate and enroll them.



Steven Johnson is vice president of enrollment solutions at Colonial Life & Accident Insurance Company. He can be reached at 803-678-6599 or sdjohnson@coloniallife.com.

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THE DISABILITY CLAIM CONSULTANT

Why the Need?

By **ARTHUR L. FRIES**

Would you go to court without an attorney? Would you file a tax return with the help of a CPA? Most of you would answer no to these questions. But, what if your client has a disability claim? Are they prepared to go up against the seasoned insurance company claim person who will handle their claim?

Enter the disability claim consultant.

Although few in numbers, they cost no more than other professionals who provide a service that your clients so readily need and deserve. Their job is to help them secure a monthly benefit and solidify their disability claim for the future. These benefits can involve a substantial amount of monies often running into millions of dollars.

How do they think their disability claim will be handled? What is the reality versus their expectations?

Following is a list of the services provided by a disability claim consultant:

1. Prepare a written audit of the

claimant's disability policy(s) on forms that have been specially designed for that purpose. Send them a copy of the audit and discuss the details with them. This will include contractual wording that considers the definition of total disability as well as partial disability. It is very important to know if they can work in another business that is not in conflict with their medical issues and also if earnings from that other business will affect the monthly benefit that is paid. Can they continue their practice or business and hire another person and still collect the full monthly benefit? Some policies will allow that and others will reduce their benefit as it relates to a total disability definition. The consultant will also discuss pertinent policy wording in other areas that will have an influence on the amount of monies that are paid.

2. Tell your client when to call an insurance company for claim forms. Calling "too early" can jeopardize their rights. When the forms are received they will be provided advice on how

to complete the claim forms, which includes not only the claimant's forms but those that must be completed by the attending physician. They will be advised on who will be the doctor to complete the form and receive advice as to exactly how that form must be completed in order to enjoy a high success rate of approval. Understand that anyone who completes the physician's form (APS), whether it be their doc or someone in their office, has never taken a course on how to complete these forms. They do not know the definition of total disability or the difference between the various disability wording as it relates to personal disability policies, group, association, workers' compensation, state disability or Social Security disability. They must be educated and the disability claim consultant can provide them with that education through the claimant, the direct communicator with the doc's office. It is important that forms be completed correctly and with credibility, and just one error by the claimant or their doc's office can prevent them from being



paid. Does the insurance company want more than one APS completed... by ALL their docs? Does the policy(ies) say anything on this point? The consultant can advise on how to respond to this issue?

3. The consultant will provide advice as to what is considered proper medical care...and when to seek same.

4. In addition to the claim forms, the consultant will prepare the claimant for the additional documents that are required that relate to tax returns, procedure codes (for professionals) and other documents that are required.

5. When approved or even before, the insurance company will want the claimant to provide "continuation forms" as well as from their attending physician with different wording that will also require advice.

6. The consultant will also provide advice related to video surveillance, a visit by a field representative to the

claimant's residence as well as advice on how to handle an I.M.E. (Independent Medical Evaluation/Exam) by a doctor assigned by the insurance company. Sometimes, an F.C.E. (Functional Capacity Evaluation) is allowed by policy language but often it is not. This is a "test," usually by a physical therapist, that can take several hours and may determine how much "beating up" parts of the claimant's body can take.

7. There are various questions that the claimant will want to ask related to their disability claim that require accurate answers and often cannot be answered by the agent, broker or association who sold the policy(ies).

8. Some companies like to offer a "buyout" of the claim after it has been approved. The consultant should be able to provide advice in this area as to what is a fair figure and what isn't.

9. What activities can the claimant participate in post disability? Do they like to golf, ski and play tennis? Will

these be in conflict with their medical issues?

10. The consultant can also help the claimant prepare additional documents that may not be asked for but help to clarify the claim as it relates to the hours worked and the medical history that prompted the claimant to seek disability benefits.

In essence, a disability claim consultant can reduce your client's/claimant's anxiety and pave the road so that they have the highest chance of success as it relates to collecting on a disability claim. It is their job to present the claimant in the best possible light so that they do not have to seek legal recourse because you or they failed to recognize the valuable services provided by a disability claim consultant.

Art Fries is a disability claim consultant providing advice on a national basis in the U.S. He is located in Nipomo, California. He can be reached at 800-567-1911 or friesart@hotmail.com.

MOVE OVER MILLENNIALS: GEN Z VISION BENEFIT ENROLLMENT, UTILIZATION IS ON THE RISE

By **MARC PANNIER**

Move over millennials—Gen Z employees are the new kids in town, and they're shaking up the benefits landscape.

As part of a generation known for spending enormous amounts of time on digital screens, Gen Z employees have unique needs when it comes to their vision benefits compared to other generations. With Gen Z taking notice of the importance of vision benefits—and as they continue to make up a larger portion of the workforce—it's time to start structuring vision benefits to meet their needs.

Gen Z Enrollment on the Rise

In 2018, only half of Gen Z employees were enrolled in a vision plan, and just 56 percent said they would be likely to visit an eyecare professional (ECP) in the next 12 months, according to the 2018 annual Transitions Optical Employee Perceptions of Vision Benefits survey. Fast forward to 2019: The number of Gen Z employees enrolled in a vision plan increased to 6 in 10, with 65 percent saying they are likely to visit an ECP in the next month.

While there is still much room for improvement, enrollment in vision benefits among this age group increased by almost 10 percent in just one year. In comparison, enrollment in dental benefits among Gen Z employees remained relatively the same from 2018.

This trend reinforces the fact that this cohort is starting to understand the true value of vision benefits.

A similar trend was found regarding benefits utilization. More Gen Z employees say they are likely to visit an ECP, while the likeliness to visit a dentist or a primary care physician remained relatively the same year-over-year. As Gen Z demonstrates a stronger interest in enrolling in and using vision benefits, it's imperative to stay ahead of the curve in structuring plan recommendations. Not only is Gen Z enrollment in vision benefits rising, but the survey also found that their willingness to accept a job is heavily influenced by an employer's vision benefit offering. In fact, half of Gen Z employees consider vision benefits, specifically, when deciding whether to accept a job. Overall, simply offering a vision benefit can help employers recruit Gen Z employees in today's nearly full-employment economy.

Aside from recruiting and retaining top talent, vision benefits are typically an easy choice for employers. They are relatively low cost and have a high return-on-investment by keeping employees happy and healthy. Annual eye exams—covered by many vision benefits plans—help ensure that employees have an up-to-date prescription. But beyond vision correction, eye exams also help maintain both eye and overall health.

According to The Vision Council, more than 10 million Americans have undiagnosed eye conditions or problems that can ultimately lead to visual impairment, vision loss and/or increased medical costs. Additionally, many of the most common eye conditions or diseases—like glaucoma and age-related macular degeneration—have little or no early warning signs. For this reason, annual, comprehensive eye exams can act as a preventive measure for detecting many common eye conditions.

Beyond identifying and treating many vision problems, comprehensive eye exams can also help to diagnose many overall health conditions—such as diabetes and hypertension (high blood pressure).

What Gen Z Employees Want

Although vision benefit enrollment and utilization is growing among Gen Z employees, their participation lags significantly behind millennials (74 percent), Gen X (81 percent) and boomers (81 percent). This begs the question: What does Gen Z want in a vision benefit?

Full coverage of a yearly comprehensive eye exam is clearly one highly valued benefit. And, with employees spending more time in front of screens, premium lens options that help combat light sensitivity and digital eyestrain also need to be part of the vision benefits conversation. According to Transi-



tions' 2019 survey, nine in 10 Gen Z employees experience light sensitivity at work—more than any other generation. More alarming is that nine in 10 also say that light sensitivity negatively affects their ability to do their job.

Employees should be encouraged to ask their eyecare professional about eyewear options that can help alleviate the symptoms of light sensitivity, such as headaches and eye fatigue. Lenses that have blue light filters—or photochromic lenses, like Transitions® lenses, that adapt to changing light conditions and also help filter blue light—can help with sensitivity to light for employees who work in both indoor and outdoor settings.

Offering full coverage of premium lens options, like anti-reflective treatments, photochromic lenses, or blue light filtering lenses, can help to increase employee enrollment in vision benefits. That's particularly important considering that half of Gen Z employees said they would be more likely to enroll in a plan that offered full coverage of premium lens options. Additionally, eight in 10 said they would pay more for a vision plan that offers premium lens coverage. Lens options that help protect against digital eyestrain and light sensitivity will only become more popular as Gen Z and millennials become a larger part of the U.S. workplace.

Gen Z is more likely than ever to enroll in a vision benefits plan. Tapping

into this increased desire for a vision benefit—as well as the need for eyewear that helps with light sensitivity and digital eyestrain—is critical for recruiting and retaining Gen Z employees. It's important to note that the need for premium eyewear is not isolated to Gen Z. Every generation is now spending more time in front of screens and can benefit from premium eyewear options. If these options aren't on your list to discuss with customers, now may just be the time to revamp your strategy.



Marc Pannier is a principal with Marsh & McLennan Agency (MMA) and leads the Employee Health and Benefits Division in the firm's Orange County office. Marc is a third generation native of Orange County and earned his Masters of Business Administration degree from the University of California at Irvine and his bachelor's degree from Tufts University.



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BROKERS' ROLE IN HELPING EMPLOYEES ACHIEVE THE NEW AMERICAN DREAM



Financial flexibility is the ability to manage expenses and make everyday life affordable. It is the financial stage beyond living paycheck-to-paycheck.

By ELIZABETH HALKOS

The new American dream might not be what you think it is. We used to consider the American Dream as the ‘really good life’—the beautiful home with the white picket fence, the 2.5 kids, the golden retriever, the awesome SUV in the driveway, a swimming pool in the backyard and no real money worries. But those days are long gone.

Today’s employees crave a new type of American dream. Rather than it being the ‘really good life,’ it’s simply being able to achieve financial flexibility by finding ways to make the money they do have go further. Employers are in a critical position to help employees realize this new dream, and at the same time, increase both loyalty and productivity. Brokers have a key role in this mission as well.

What is Financial Flexibility?

There’s financial stress, financial wellness, financial literacy, financial education, financial planning...so what in the world is financial flexibility?

Financial flexibility is the ability to manage expenses and make everyday life affordable. It is the financial stage beyond living paycheck-to-paycheck. It means being smart about how we use our monthly income and finding ways to make our money do more so that

we are able to pay bills on time, take a vacation, have an emergency fund for unexpected expenses and perhaps splurge on something small occasionally. Financial flexibility is the stage between living paycheck-to-paycheck and financial security (a level relatively few employees ever achieve).

Why Do Most Employees Need Financial Flexibility?

In spite of the fact that Americans recovered from the Great Recession a decade ago, that our economy is thriving, and the unemployment rate is the lowest it has been in many years, most employees are still living paycheck-to-paycheck today. That’s because employees are essentially making the same amount of money they did during the pre-recession ‘good days’ many years ago.

It’s important to think about what living paycheck-to-paycheck really means. It is struggling to make minimum monthly payments on mortgage and rent payments; on car payments; on credit cards and loans; on student loans...or other financial matters. It’s not having enough emergency savings for unexpected expenses that come up – like medical expenses, a car needing repair, a refrigerator that needs replacing. And it’s the financial stress that em-

ployees experience every day because, basically, they are ‘just getting by.’

But the problem is bigger than that, because employees bring that financial stress to work with them. Employees are spending time at work on financial issues rather than doing the job their employers are paying them to do. When employees bring their financial stress to work, it results in low productivity, absenteeism and, in many cases, higher healthcare costs.

Nearly half (47%) of employees report that they are stressed dealing with their financial situation, and 41% say that their stress level related to financial issues has increased over the last 12 months, according to PwC’s 2018 Employee Financial Wellness Survey.

Why? Because nearly 80% of American workers report that they’re living paycheck-to-paycheck. And here’s a shocker-- it’s not merely those earning low wages who are struggling. Nearly 10% of Americans with salaries of \$100,000 or more live paycheck-to-paycheck as well.

The problem is that employees’ money just doesn’t do as much as it used to. The typical American worker today earns \$44,500 a year, not much more than what the typical worker earned 40 years ago, adjusted for inflation.

So, what are employees doing when

...43% of those who are distracted by their finances at work say that they spend three hours or more at work each week thinking about or dealing with issues related to their personal finances.

they can't cover their expenses with their paychecks? They are using a number of methods that cost them more than the actual money value. They are using their credit cards and building mounting debt because they can't afford to pay it down. Many employees are withdrawing from their retirement savings plans to pay expenses and, unfortunately, these funds usually don't get replaced. They are also using high risk credit options that often come with hidden costs and associated fees that take a financially fragile situation and make it worse, such as rent-to-own contracts and payday/title loans.

Aiming for more financial flexibility can help employees get on sounder financial footing. By following a monthly budget, being wise shoppers and taking advantage of employer-offered financial wellness tools and voluntary benefits available through their employer, they can begin to achieve financial flexibility.

Financial Stress and the Employer

Personal finance issues are a distraction at work for 25% of employees. And 43% of those who are distracted by their finances at work say that they spend three hours or more at work each week thinking about or dealing with issues related to their personal finances.

Add that up. That's 150 hours per year of lost productivity per employee for almost 11% of a company's workforce who are sidetracked from doing their work because they focus instead on their finances.

Employees' financial stress im-

pacts their employers several ways, including:

- Increased absenteeism

Financial stresses have resulted in a 34% increase in absenteeism and tardiness. Additionally, stressed employees miss almost twice as many days (3.5) each year compared to their unstressed counterparts.

- Lower productivity

Even when some employees are present, they aren't working at full capacity. With financially-stressed employees spending time at work dealing with their finances, productivity suffers and that affects the employers' bottom line.

- Higher health care costs

Playing a significant role in heart disease, migraines, obesity and accelerated aging, stress can also manifest itself physically. Unfortunately, 1 in 5 people put off or consider skipping health care visits due to the cost. This can result in higher health care costs for employers later if employees don't schedule preventive care or, worse yet, ignore symptoms of conditions that become serious over time.

Brokers' Role in Employee Financial Stress

There's a role for employers in helping their workers do more with their money and achieve financial flexibility. Here's where the brokers come in. Financial education benefits are great to help employees with budgeting and debt reduction needs, but employers also need to adopt voluntary benefits that provide employees

the opportunity to have some financial flexibility.

Brokers should bring this type of voluntary benefits to the attention of their clients. Voluntary benefits that help get employees on the road to financial flexibility include:

- Low interest installment loans and credit;
- Student loan repayment benefit programs.
- Automated savings programs that encourage employees to save money each month from their paycheck;
- Bill payment programs that empower employees with debt paydown strategies and the ability to make recurring bill payments on-time each month through payroll deduction; and
- Employee purchase programs that allow workers to purchase consumer products and services through payroll deduction when they are unable or prefer not to use cash or credit.

Financial security isn't the American dream for employees because having a bottomless bank account just isn't going to happen. Financial flexibility is the new normal. It's the new version of the traditional American dream. Brokers and employers alike have a role in helping today's workforce achieve this type of financial flexibility.



Elizabeth Halkos is chief operating officer at Purchasing Power.

Our California Senior Medicare Patrol (SMP) is working hard to stop...fraud. One way you can help is to educate yourself, your clients and your loved ones about hospice fraud...

(continued from page 8)

to his doctor or emergency room.

As the son watched his father's health decline, he wasn't sure what to do. When his father was no longer eating or able to use the bathroom, the son took him to the emergency room. Weeks later, his father died. The son regrets ever agreeing to put his father in this hospice program. He truly thought he was helping his father and now, in hindsight, he sees the horrendous fraud that happened. And he sees how this fraud caused his father's early death.

Another case (case #4) also recently came in that is just as severe as the previous case #3, yet has a shorter timeline. A daughter called our SMP to report this case of hospice enrollment fraud that resulted in her father's untimely and unnecessary death. In this case, her father was hospitalized with pneumonia. While the family was visiting him on a Friday in December, a hospice company approached them to enroll him into their program. The family declined, stating he was "not there yet".

The father was 85 years old and had been living independently before contracting pneumonia

due to irritation from three months of wildfire smoke the previous summer and fall. The family was confident that once the pneumonia healed, he'd be back to living his healthy, independent life.

Before the family left from their visit, the father's doctor came and told them that their father would stay in the hospital at least one more night. This would make sure they could give him his necessary medications to control the fluid in his lungs as the pneumonia healed.

Yet, after the family left, the hospice company did not heed the family's wishes, enrolled their father into their program and changed his medications. They discharged him from the hospital and transferred him late Friday afternoon to a care home facility where the hospice company administered non-consented opioids and narcotics. The family strongly believes that their neglect of not giving him the necessary medications to manage the fluid in his lungs is what led up to his premature death. All this happened less than 48 hours after the hospice company had him leave the hospital.

Both cases #3 and 4 are egregious examples of

hospice fraud that not only caused declined health but also premature death. While two such cases are already two too many, how many more people is this happening to? Through fraudulent hospice enrollments bringing about detrimental changes of medications, causing beneficiaries not to be able to see their doctors, etc. how many other people have experienced their health decline, and/or even worse had their life shortened because of fraudsters making money at the cost of their demise? All these cases strongly demonstrate that questionable hospice enrollment comes at an incredibly high price for beneficiaries.

Our California Senior Medicare Patrol (SMP) is working hard to stop such fraud. One way you can help is to educate yourself, your clients and your loved ones about hospice fraud, what to look for and how to avoid it. Here are some good tips to start with and share:

- Beware of hospice companies enrolling patients who do not have a terminal illness with six months or less to live. Medicare's hospice benefit

is only for those who are terminally ill.

- Don't get tricked by hospice companies offering free services such as housekeeping and cooking. Medicare does not pay for this!

- Beware of calls or unannounced visits by hospice companies offering additional benefits such as help with cooking and cleaning.

If you or someone you know comes across such scams, please report any suspected hospice or other Medicare fraud to our California SMP at 1-855-613-7080.



Karen Joy Fletcher, MPH has over 20 years of experience in Medicare training, education and advocacy and has served as CHA's Publications Consultant since 2004. She is the primary researcher, writer and editor of CHA's website content, including CHA's newsletter and blog. She also develops and revises key educational materials, spearheads CHA's social media and chairs the Senior Medicare Patrol Media Team and SMP superheroes skit team.

SIMPLIFYING THE RETIREMENT STORY

By JAMES LAKE

With an ever-changing retirement landscape, preparing for your clients' retirement reality has never been more important than it is today.

Clients of all ages are seeking a personalized approach to their retirement, as well as information to help ease their retirement fears. Whether it's outliving one's savings, rising health care costs or maintaining a desired lifestyle, retirement worries are top of mind, but a path to a confident retirement is possible with the right information and discussions. In fact, a study from Guardian reveals 87% of millennials say knowing more about financial services and products would help improve their confidence in reaching their financial goals. Thus, it's time we take a step back and simplify the retirement story by starting with tools, content and conversations that can benefit a client.

As a financial professional, it's critical to be able to speak to all the different aspects of a client's retirement. It requires taking a 360-degree view, including matters related to health, home, lifestyle, relationships and money. Use these areas to start meaningful discussions around retirement and build an understanding of your client's mindset. By connecting with clients to discuss their custom preferences and needs for retirement, advisors position themselves beyond simply offering products – ultimately, they can uncover a client's changing needs, forge meaningful connections to build deeper relationships and deliver valuable resources.

Active Engagement Comes First

Retirement means something different to everyone and these days it requires more planning than ever before—it's a personal process and can invoke lots of questions and emotions as it relates to an individual's retirement reality. The retirement marketplace is full of products, data, and technical jargon that can overwhelm clients. To aid clients of all ages, it's important to provide tools to help do some discovery in a product agnostic and educational manner. Doing so helps clients understand their income and lifestyle priorities and will help them identify clearer retirement objectives and can lead to more meaningful conversations between them and their financial professional. This type of simplified engage-

ment can educate clients in a personal and conversational manner. When our financial professionals provide tools like this, it helps the client feel like they have a true advocate supporting them.

As an example, Guardian released two digital online tools – one to help clients quickly discover their income and lifestyle priorities, the other to help elevate their understanding of guaranteed and non-guaranteed sources of income in retirement. These interactive tools are starting points to better enable a more meaningful and productive interaction with their financial professional. The tools also provide the client with the opportunity to drive the conversation around what matters most to them.

It's about guarantees

Once adequate resources, conversations, and tools are provided to help clients understand their retirement objectives, they see opportunity to reduce risks and ensure more guarantees later in life. Then products that could benefit them based on their individual scenarios take on a more important and meaningful role. It's best to ease into product conversations that provide guaranteed income in retirement, such as whole life insurance and annuities. While the primary purpose of life insurance is the death benefit protection, it is important to understand the advantages that cash value accumulation can provide to clients, including supplemental income during retirement. Helping clients understand if there are income gaps in their plan for retirement as well as prepare for unexpected costs is where the financial professional can also add value. It's important for the client to know how these products help them meet their goals and align with their objectives.

With 76% of Boomers concerned they won't have enough money to last them through retirement, a guaranteed stream of income for a set period can help make them more financially confident. An annuity can be a valuable product solution for creating guaranteed income in retirement, but there's confusion in the marketplace about their flexibility. Some consumers may dismiss them because they don't know enough about how annuities work and the difference between one annuity or another. The financial professional can



help minimize confusion around annuities, especially since they are a way to safeguard against running out of money in retirement – one of consumers’ biggest fears. Plain and simple, an annuity can provide lifetime guaranteed income every month regardless of market results to be used for monthly living essentials, unexpected health care needs or anything the client wishes to use it for. Creating guaranteed income in retirement, specifically through annuities, can be a critical component to one’s retirement plan.

Annuities can also provide tax advantages in retirement, which can be attractive to many clients. The money that is contributed to an annuity is tax-deferred, meaning taxes are paid out once the money is taken out of the account. Not only would the client be receiving guaranteed monthly income, but there is also the potential for annuity payments to include interest earned on the client’s contribution, which grew tax-deferred until payout. This is especially true with fixed deferred annuities as you’re guaranteed to earn a minimum amount of interest on the contribution and while interest rates tend to be lower, they provide a predictable stream of income one can count on. Another advantage might be that when annuity payments are made and taxes are due, the client will likely be in a lower tax-bracket because they are retired and thus incur a lower tax bill.

It’s important to ensure clients understand how annuities can work to provide income in retirement. This level of flexibility can support many clients’ retirement objectives and can keep cash flows from running dry. For example, some questions to ask may include: How soon would they need the money? Do they want payments for life or for a certain period of time? Do they wish to have their money tied to the market or would they rather a fixed amount? Do they want access to their money? Do they wish to leave money to loved ones when they’re gone?

It’s well-known that the cost of living during retirement often increases for many—due largely from rising health care costs, overall inflation and housing costs, and even paying off debt. These are some of the most essential retirement risks to take off the table when planning for retirement. Whether a financial professional is taking a holistic

approach to planning with their clients or not, annuities and/or products that can provide guaranteed monthly income is critical to the conversation.

Educate and be transparent

First, make sure the client understands what type of annuity you’re recommending and why it best suits their financial goals. Like all retirement plans, using a fixed, variable or indexed annuity all depends on the client’s goals and how risk averse they are—everything should be tailored specifically to an individual client’s preferences.

Be transparent about the costs and schedules involved with specific annuity benefits. Some annuities will have penalties for accessing money early. Clients may also be subject to a federal tax penalty of 10% if they make a withdrawal before they’re 59 and a half. Be clear in outlining both the benefits of the annuity as well as the considerations – taxation, qualified or non-qualified, age considerations, optional benefits, etc. This will only help build trust with clients and strengthen your credibility and relationship.

As a financial professional, remember your first step is to understand the clients’ retirement and financial goals. Let them discuss their needs and concerns and give them time to explore available tools and content to paint a stronger picture of their retirement story. Then help them outline the gaps. At that point, it’s appropriate to discuss what products can benefit them. Building a holistic retirement plan and simplifying the process through engaging self-reflective resources and tools helps simplify the conversation and allows clients to better understand what they want and the types of products that can lead them to a confident retirement reality.

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