

# CALIFORNIA BROKER

VOLUME 33, NUMBER 7

SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

APRIL 2015

## All-Terrain Ancillary Benefits Vehicle for Off Road Commissions

Acupuncture | Long-Term Care | Identity Theft  
Vision | Disability | Chiropractic



ALSO IN THIS ISSUE:

Annuities  
Health Exchanges  
Life Insurance  
HMO Survey Part II  
Self-Funding  
Leave Management

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## APRIL 2015

### PUBLISHER

Ric Madden  
email: publisher@calbrokermag.com

### EDITOR-IN-CHIEF

Kate Kinkade, CLU, ChFC  
email: editor@calbrokermag.com

### SENIOR EDITOR

Leila Morris  
email: editor@calbrokermag.com

### ART DIRECTOR/PRODUCTION MANAGER

Loc Tran

### ADVERTISING

Scott Halversen, V.P. Mktg.  
email: scotthalversen@calbrokermag.com

### CIRCULATION

email: calbrokermag@calbrokermag.com

### BUSINESS MANAGER

Lexena Kool  
email: lex@calbrokermag.com

### LEGAL EDITOR

Paul Glad

### EDITORIAL AND PRODUCTION:

McGee Publishers  
217 E. Alameda Ave. #207,  
Burbank, CA 91502.  
Phone No.: 818-848-2957;  
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# INSURERS NEED TO FOCUS ON VALUE

by **STEVE ADAMS**

Is the high rate of people who switched health plans on Healthcare.gov for 2015 coverage a sign that consumers regard cheaper insurance plans as better? Or does it indicate that insurers need to do a better job of encouraging informed consumer buying and focus more on the value of their products?

As cited in a recent *New York Times* article, “High Rate of Shopping and Switching in Obamacare Plans Is a Good Sign,” more than half of the people who bought insurance on Healthcare.gov last year shopped around before choosing a plan for this year, according to a report by the Department of Health and Human Services. More people shopped around for a new plan (2.2 million) than those who were automatically re-enrolled (1.96 million), according to the report.

Andy Slavitt, the principal deputy administrator of the Centers for Medicare and Medicaid Services said, “The objectives of this marketplace—of any marketplace—[is] to have competition, and have issuers competing to offer better prices and better products for consumers.” Slavitt also said that if he were an insurer, “I would want to come out very price-competitive.”

While Slavitt’s suggestion that the objective of a digital marketplace is to create competition and offer better products for consumers is correct, his guidance to insurers is focused primarily on being price competitive.

A true digital marketplace offers benefits to buyers and sellers and is rarely predicated on creating a place where sellers are forced to offer the lowest priced products to be successful. Most importantly, a digital marketplace provides an opportunity for sellers to offer the most value to current and potential customers. With that in mind, insurers need to focus on what additional value they can bring to establish and promote the credibility of their brand.

The notion that the cheapest is the best may be a dangerous proposition when it comes to purchasing healthcare, and also may explain the high rate of shopping and switching. Consumers generally switch/abandon a brand because they conclude that the price they paid is not commensurate with the value they receive. The antidote to this is informed buying.

To transition consumers from shoppers/switchers to informed buyers requires insurers to provide robust and engaging education and decision support tools with content that is personally relevant, matches plans offered with individual health and financial wellness goal, and is accessible 24/7.

They should also offer a comprehensive portfolio of products to provide consumers with the most complete and cost-effective coverage. For example, a high-deductible healthcare plan with one or more critical illness, accident, or hospital indemnity plans.

Insurers also need to establish their brand and its credibility based upon value—not just lowest price.

The perspective that shopping and switching is a good sign is misguided. Product hopping is a sign of dissatisfaction. It’s what happens when a value proposition fails to deliver as promised. It’s time-consuming and disruptive for all involved. Helping consumers become informed buyers, alternatively, is a win for all.

*Steve Adams is CEO of Navera. Navera is a leading provider of a cloud-based benefit engagement. For more information, visit [navera.com](http://navera.com).*



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Company Name	Ratings			Product (Qual./Non-Qual.)	Type SPDA FPDA	Initial Interest	Guar. Period	Bailout Rate	Surrender Charges	Mkt. Val. (y/N)	Min. Contrib.	Comm. Street (May Vary)
	Bests	Fitch	S&P									
American Equity	A-	BBB+		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.25%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.45%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.70%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
*Effective 2/5/15. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A	A+	American Pathway Fixed MYG 10 Annuity (Q/NQ)	S	4.95%*	1 yr.	None	10%, 9, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$5,000 (NQ)	4.00% age 0-75 2.20% age 76-80 1.70% age 81-85
**CA Rates Effective 3/16/15. First year rate includes 3% interest bonus												
American General Life Insurance Companies	A	A	A+	American Pathway Flex Fixed 8 Annuity (Q/NQ)	F	4.00%*	1 yr.	None	8%, 8, 8, 7, 6, 5, 3, 1, 0	No	\$5,000 (NQ) \$2,000 (Q)	2.20% age 0-75 1.70% age 76-80 1.20% age 81-85
*CA Rates Effective 3/16/15. Includes 2.00% 1st year bonus, 1.00% base rate subsequent years.												
American General Life Insurance Companies	A	A	A+	American Pathway Fixed MVA 9 Plus Annuity (Q/NQ)	S	5.60%*	1 yrs.	None	9%, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$5,000 (NQ)	2.75% age 0-75 1.70% age 76-80 1.20% age 81-85
*CA Rates Effective 3/16/15. First year rate includes 4.0% bonus 1st year.												
American General Life Insurance Companies	A	A	A+	American Pathway Select MVA 10 Annuity (Q/NQ)	S	1.30%*	10 yrs.	None	10%, 9, 8, 7, 6, 5, 4, 3, 2, 1	Yes	\$5,000 (NQ) \$5,000 (Q)	1.20% age 0-80 (5 yr.) .90% age 81-85 (5 yr.) 2.50% age 0-80 (7 yr.) 1.75% age 81-85 (7 yr.) 2.00% age 0-80 (10 yr.) 1.20% age 81-85 (10 yr.)
*CA Rates Effective 2/2/15												
Genworth Life & Annuity Insurance Co.	A	A-	A-	SecureLiving Rate Saver	S	2.55%* 2.30%	7 yrs. 5 yrs.	None None	9%, 8, 7, 6, 5, 4, 3 9%, 8, 7, 6, 5, 0	Yes	\$25,000 (NQ)	Varies 0-85 *Effective 3/4/15. Based on \$250K or more.
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	1.95%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	\$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 7/30/14. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 1.95%. For under \$100,000 first-year rate is 1.85%. Escalating rate five-year yield 1.85%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.40%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	\$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 7/30/14.. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.29%. For under \$100,000 first-year rate is 2.30%. Escalating rate seven-year yield 2.19%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.40%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 7/30/14.. Eff. yield is 2.42% based on 1.40% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.40%. Surrender value interest rate 1.40%. Accepts additional purchase payments in first three contract years. COM12255												
Jackson Insurance Company.	A+	AA	AA	Bonus Max (Q/NQ)	F	3.20%*	1 yr.	None	8.25%, 7.25%, 6.50%, 5.50%, 3.75%, 2.75%, 1.75%, 0.75%**	Yes	\$5,000 (NQ) \$5,000 (Q)	6.00% 0-80 3.00% 81-85 1.50% 86-90
*Effective 10/6/2014. The first year interest rate includes any first year additional interest, if applicable. Interest rates in subsequent years will be less. **Each premium payment, including any subsequent premiums, is subject to the withdrawal charge scheduled as detailed.												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.55%*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	**Rates Effective 3/1/15 for premium less than \$100,000 and are subject to change
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	1.95%*	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	**Rates Effective 3/1/15 for premium less than \$100,000 and are subject to change.
North American Co. for Life and Health	A+	AA-	A+	Boomer Annuity (Q/NQ)	F	6.57%*	1 yr.	None	15%, 14, 13, 12, 11, 10, 8, 6, 4, 2	Yes	\$2,000 (Q) \$10,000 (NQ)	7.00% (0-75) 5.25% (76-80)
* 6.57% First Year Yield reflects a 5% Premium Bonus in years 1-5, annuitization bonus after year 10. Penalties are waived at death. This yield assumes no withdrawals. The Interest Rate is based on current rates as of 3/10/15 and is subject to change.												
Reliance Standard	A+		A+	Eleos-MVA	S	3.05%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 2/9/15. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+		A+	Apollo MVA (Q/NQ)	S	4.00%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	\$5,000	4.00% to age 75**
Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 2/9/15												
Symetra Life, Inc.	A	A+	A	Custom 7 (Q/NQ)	S	2.70%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 2/11/15. 2.20% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												

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# TOP 3

# REASONS WHY AGENTS WORK WITH US



# LEAVE MANAGEMENT: WHY CALIFORNIA EMPLOYERS *Should Consider Outsourcing*

by **ROBERT JACOB**

**C**omplying with employee leave laws isn't getting any easier for employers, especially in California. They must contend with the Family and Medical Leave Act (FMLA), the Americans with Disabilities Act (ADA) and others. Employers must deal with the administrative burden of implementing and tracking employee absences based on different and often overlapping leave statutes.

In California, the challenge is compounded as employers must also address a myriad of employment laws including last year's Healthy Workplace Family Act (effective 7/1/15), which entitles California employees to paid sick leave. All told, California has 13 separate state leave laws—the most of any state. In addition, California employers must comply with the state disability income replacement law (SDI).

It's not surprising that the state's leave and absence rates are up to 15% higher than in other states. This higher rate of incidence may be partly due to the fact that California's SDI program is difficult to manage effectively. There is a perception that the program is not consistently medically managed.

There are four important objectives your clients need to manage employee absences under these numerous leave laws:

**1. COMPLIANCE:** With all the laws' many requirements, ensuring compliance is difficult for most employers, particularly for companies with limited or no in-house legal expertise. An employer that doesn't have staff to ensure that all federal, state and company-specific leave policies are applied consistently could make decisions that lead to costly penalties. Being compliant requires employers to verify employee eligibility and approve or deny FMLA and state disability leaves. They must also track and record all reported federal, state, and company-specific protected absences, such as state-mandated sick leave.

In addition, a principal requirement of the ADA is to

interact with a disabled employee, which is usually the responsibility of the HR department. This may include offering suggestions for potential worksite or job modifications. HR managers must also handle all the transactions, conversations, and documentation required when employees go out on disability or need help to stay at work. Unfortunately, human resources departments are often stretched thin dealing with changing healthcare laws and other responsibilities, so many don't have the time or manpower to devote to employee absences.

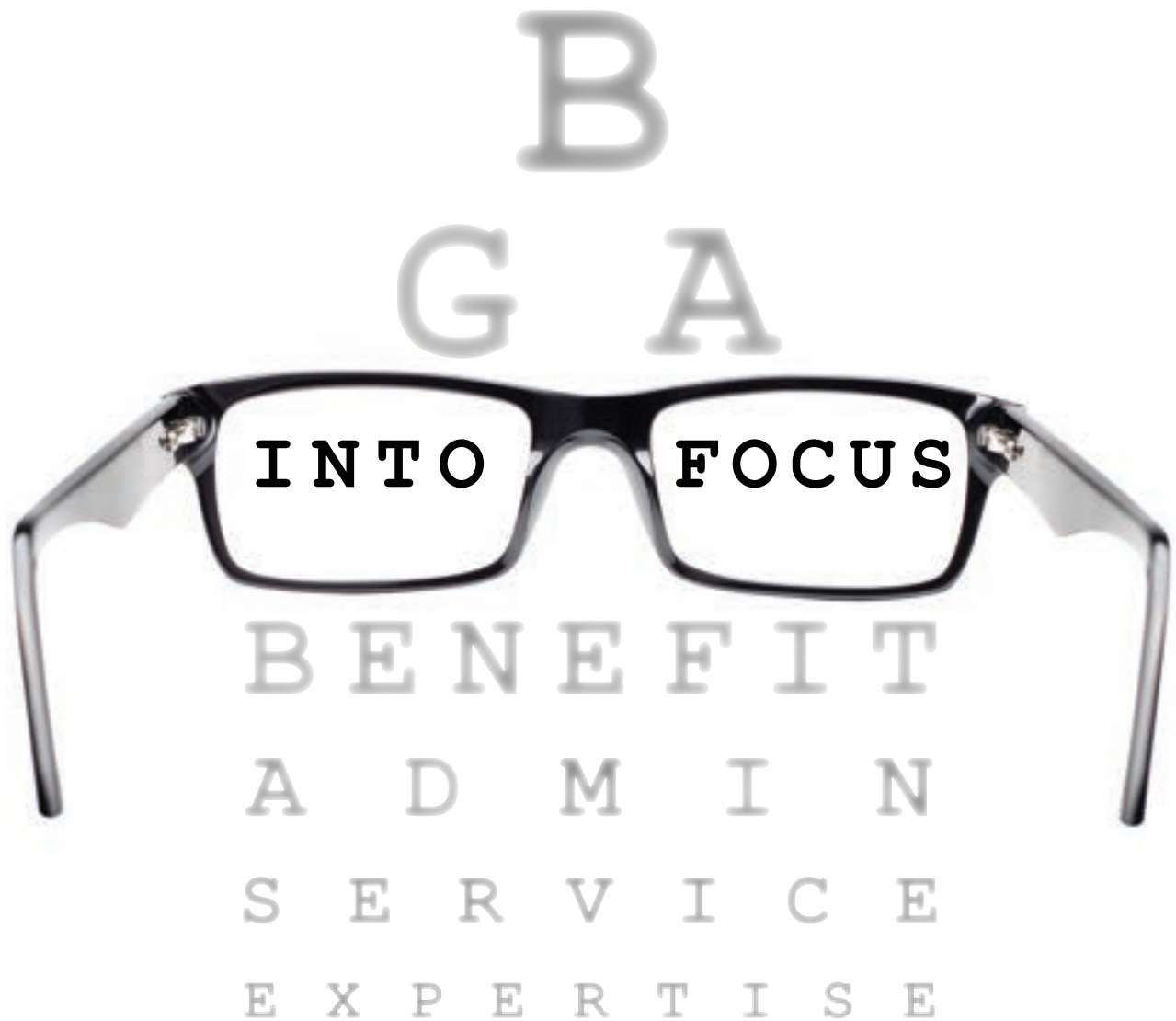
**2. COORDINATION:** While the FMLA provides 12 weeks of leave in a calendar year, employees don't have to take these leaves consecutively. Many employees who care for their aging parents while supporting their own children use FMLA for intermittent leaves to care for themselves or family members. Employees often use intermittent leave to deal with disabling conditions, which may include behavioral health issues, such as anxiety, stress, and depression. Recognizing and accommodating these increasingly prevalent conditions can be a challenge for employers seeking to comply with ADA regulations.

Further complicating leave coordination is when a short term disability leave runs concurrently or an ADA-sanctioned leave goes into effect when FMLA leave is exhausted. Throw in the fact that California also has its own disability income program, and administering employee absences in California can be time-consuming. With ADA leaves added to the mix, the challenge of coordination increases further.

**3. CONSISTENCY:** Maintaining consistency in applying leave laws can be a significant challenge since employers must ensure that all employees are treated the same no matter where they are located. The challenge is particularly great for large employers in California that have operations in multiple locations outside the state.

*(Continued on page 26)*

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# VISION NEWS



## WHAT IF YOUR VISION INSURANCE HELPED MORE PEOPLE SEE?

While 10 million American students have vision conditions that can affect learning, a simple comprehensive eye exam can help ensure that correctable visual problems don't become permanent. Now through June 30, 2015, when a VSP Direct individual vision insurance plan is purchased through [VSPDirect.com/EyeGiveBack](http://VSPDirect.com/EyeGiveBack), VSP will donate an eye exam and glasses to a child in need—up to a retail value of \$1 million. For more information, visit [VSPDirect.com/EyeGiveBack](http://VSPDirect.com/EyeGiveBack).

## CARECREDIT EXPANDS ACCESS TO VISION CARE FOR 70 MILLION VSP MEMBERS

CareCredit has an exclusive agreement to help nearly 70 million VSP members increase access to financing for eye care and optical products at thousands of participating VSP network providers. Through the agreement, the two organizations will partner together to educate VSP's nearly 70 million members and CareCredit's nine million cardholders about options for managing eyecare expenses for a range of lifestyle choices, including glasses and contacts, sunglasses, specialty sport and other customizable eyewear. They will also work to connect members and cardholders with the providers who accept CareCredit in the VSP doctor network.

Dave Fasoli, president and CEO of CareCredit said, "This agreement brings together payment options from a respected finance company and coverage benefits of a leading insurance provider to provide a complete solution for VSP customers to manage the cost of their families' vision needs." VSP will work with its network of 32,000 providers to add the CareCredit credit card as a payment option and to educate its patients about the benefits of CareCredit. For more information on CareCredit, call 800-300-3046 or visit [carecredit.com](http://carecredit.com).

## EVERY DAY EFFECTIVE DATES FOR INDIVIDUAL DENTAL AND VISION INSURANCE PRODUCTS

Security Life Insurance launched every day effective and billing dates on its individual dental and vision insurance products effective March 1, 2015. Security Life began offering every day effective dates on its shelf platform of products, PrimeStar Dental and Vision, beginning March 1 on the [SecurityLife.com](http://SecurityLife.com) online quoting and enrollment tool. In addition, several of Security Life's strategic partners who sell individual dental and vision online under unique brand names will be rolling out this capability in the next few months to further differentiate their product and further encourage online sales. To learn more call 1-855-728-7542 or visit [SecurityLife.com](http://SecurityLife.com).

## SECURITY LIFE LAUNCHES INDIVIDUAL VISION INSURANCE PRODUCT

Security Life is offering stand-alone individual vision insurance with two plan options.

The PrimeStar Choice Vision plan will use the VSP Vision Care network encompassing a strong presence of 31,000 providers in the private practice space. The PrimeStar Select Vision plan will use the prominent EyeMed Access network of 78,000 vision care providers from major retail chains. Combined, the two plans and networks cover a wide variety of consumer needs—from the big box retail optical stores to the small private shops.

The new vision plans join the suite of PrimeStar Dental insurance plans to deliver quality dental and vision solutions for individuals. PrimeStar Vision is available in 36 states, with more state approvals expected in the coming weeks. Plan benefits include immediate coverage of eye exams, lenses and frames, discounted LASIK procedure and additional savings for choosing an in-network provider. Mark Zesbaugh, CEO of Security Life said, "We have seen a strong market demand for stand-alone individual vision insurance."

Distribution partners interested in learning more about Security Life's PrimeStar Individual Insurance products are encouraged to call 1-855-728-7542 or visit [SecurityLife.com](http://SecurityLife.com).

# Making a living shouldn't be commission impossible.

**The shifting insurance landscape may change broker commissions. But at Aflac, it's for the better.**

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## THE ANATOMY OF A

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# LONG TERM DISABILITY INSURANCE CLAIM

by **ALAN E. KASSAN, ESQ.**

**D**o you ever wonder what happens when a client makes a claim on a long-term disability (LTD) policy you sold? Unless you've been through the process, the twists and turns may surprise you. This article promises to give you helpful insights so you can offer valuable information to a client, friend, or associate. The first question is whether the LTD benefits arise from an individual or a group insurance policy.

### INDIVIDUAL POLICY CLAIMS

Many disability claim concepts are the same for either type of policy, but the claim process and the remedies for a wrongful claim denial are markedly different. Claims under individual policies are more straightforward. The claim is submitted; medical evidence supporting the disability is provided by the insured or obtained by the insurer; and the claim is evaluated by the claims department. If more information is required, the insurer typically inquires of the insured or the treating physicians, and occasionally arranges to have the insured examined by a medical professional, at an independent-medical examination (IME). If denied, the insured can ask the insurer to reconsider the claim. Some policies actually require this before filing a lawsuit. If an appeal is not required, the insured can immediately file a legal action against the insurer. Such a lawsuit is governed by state law. In California, it typically includes causes of action for breach of contract and breach of the implied covenant of good faith and fair dealing, with the latter com-

monly known as a "bad faith action." Bad faith actions are not usually allowed under group policies. An insurance bad faith action focuses on the reasonableness insurer's conduct in denying benefits.

The door to damages opens up beyond just individual policy benefits when a judge or jury decides that the insurance company's conduct was unreasonable or without proper cause. When that door opens, the insured may be entitled to extra-contractual damages for things, such as emotional distress, out-of-pocket losses incurred as a result of the benefit denial, attorneys' fees, and possibly even punitive damages on top of the policy's LTD contract benefits. The bar for punitive damages is even higher since an insured has to show that the insurance company acted with malice or intent to harm or acted in reckless disregard of the insured's rights.

It's not always easy to determine whether the insurance company's conduct constitutes bad faith. Insurance disputes can be complex with evidence pointing in different directions. It is a heavy burden to prove bad faith conduct, and differing interpretations of medical evidence do not make the burden any easier. If you ask three doctors for opinions, you are likely to get three different opinions. Moreover, if the insurance company can persuade the court that there was a genuine dispute over benefit availability, bad faith damages will not likely be available.

On the other hand, for simple breach of contract (for failure to pay

a claim), the insurance company is only exposed to damages for the payment of policy benefits. And, proving contract breach does not carry the same heavy burden of proving bad faith. An insured need only prove, by a preponderance of the evidence, that they are disabled as defined in the policy.

Under either type of action, it is essential for the insured claimant to marshal all the evidence they can to support the claim, and not just rely on answering the basic questions on the claim form. This evidence includes the following:

- Medical records, and, if possible, letters from treating physicians that explain the medical records, the diagnosis, treatment, and most importantly, the functional restrictions and limitations that result from the medical condition.
- Letters or statements from co-workers, supervisors, neighbors, friends, and even family members to help establish how a claimant's condition has deteriorated or explain activities the claimant once participated in, but can no longer.
- An explanation of the adverse and often disabling side-effects of treatments and medications.

In some cases, it's appropriate to undergo additional diagnostic or functional capacity evaluations to help support particular types of limitations.

Almost every lawsuit for non-payment of individual LTD benefits

in California will include a bad faith cause of action. The possibility of being exposed to bad faith damages is a powerful motivator for insurance companies to act fairly and to pay legitimate claims. But, what happens without such motivation? What if insurance companies exposed to damages for policy benefits, even after repeatedly denying the claim to people who doggedly pursue those benefits? That takes us to disputes under group LTD policies.

### GROUP POLICY CLAIMS

Group LTD policy claims underwritten with insurance are handled much differently because group claims are governed by federal law rather than state law. In 1974, Congress passed the Employee Retirement Income Security Act (ERISA), which is designed to protect employees from unscrupulous employers and safeguard employee benefits. ERISA damages are limited to recovering policy benefits. There is no threat of bad faith or punitive damages under ERISA. ERISA does include a provision for the recovery of attorney's fees, but recovery is not automatic or guaranteed. Instead, such fees are awarded at the discretion of the trial court, and only after the insured wins the case at trial. Also, getting to trial is no easy task. An ERISA action is akin to a state law breach of contract action, but with important differences.

### THE ERISA LTD ADMINISTRATIVE APPEAL

Like individual claims, group claims are initiated with fairly simple claim forms. And like individual claims, group claims rely largely on the medical evidence supporting disability. But, this is where the processes start to diverge. Once the insurer issues a denial in a group claim, the claimant must file an administrative appeal before any lawsuit can be filed against the insurance company. During the administrative appeal phase, the insurer commonly hires peer review physicians who simply review medical records and answer very



limited questions posed by the insurance company. Occasionally, the insurance company sends a group policy insured for an IME. Insurers often hire private investigation firms to conduct surveillance on insureds. (This practice is not uncommon in individual claims as well.) Ordinarily, a claimant has little knowledge of what the insurance company is doing during the appeal administration, which can work to a claimant's extreme disadvantage. Once the appeal decision is made and delivered, the process is complete. The claimant has no further opportunity to rebut the insurance company's findings or offer evidence or explanations to counter those findings. The evidence collected or developed during the appeal is usually the only evidence the court will review. Some policies provide for a second appeal, which can afford an opportunity to supplement the evidence to support a claim. But, otherwise, the process is the same during a second appeal. Note that some group policies, such as those offered by religious organizations or governmental agencies, may be

exempt from ERISA and actions for enforcement can still proceed under state law.

One of the most important points to beware of in the group claim realm is that once the administrative appeal is closed, the claimant is likely to have no further opportunity to submit evidence supporting their claim. This underscores the importance of assembling as much documentary evidence as possible, as soon as possible, and providing it to the insurance company.

A second critical point about the appeals process is that if an appeal is not filed in a timely manner, usually within 60 to 180 days of the claim denial, the claimant is not entitled to file a lawsuit due to a failure to exhaust the administrative appeal process. This point bears repeating: Since appealing is made mandatory by ERISA LTD policies, a failure to comply is very likely to cut off the insured's right to sue.

### THE ERISA LTD LAWSUIT

If the claim denial is upheld after the administrative appeal, the next step is to file a lawsuit. These lawsuits are

typically filed in federal court. ERISA LTD lawsuits are not that common, and can be very technical. Consequently, there aren't many lawyers who can handle them capably. It is important for claimants to seek qualified counsel due to the technical nature of these lawsuits and the administrative appeals process.

For those interested in the law, ERISA LTD lawsuits usually state a claim for the recovery of policy (plan) benefits under federal statute §29 U.S.C. 1132 (a)(1)(B). In some instances, it may be appropriate to allege a claim for equitable relief under §29 U.S.C 1132 (a)(3) due to a breach of fiduciary duties. Equitable relief might involve forcing an insurer to interpret the LTD policy in a certain way, or providing for some equivalent form of damages when policy benefits are not technically available.

Over the years, ERISA LTD lawsuits have become more like administrative proceedings, and less like the types of trials you see on TV. These lawsuits almost always rely exclusively on the documents and evidence discovered or produced during the administrative appeal phase. There are rarely live witnesses or testimony. The court is not likely to consider medical evidence offered at trial if it was not produced at the time of the appeal. Why? Because, in most cases, the court only reviews how the insurance company arrived at its decision to deny the claim, and only considers the evidence the insurance company had when denying the claim. The court is not likely to overturn the denial if it finds that the insurance company acted reasonably in processing the claim, even if the court believes that the denial was not the right result. How can that be, you ask? Well, until very recently, LTD plans were allowed to have provisions that gave absolute discretion to the insurance company to interpret plan terms and make claims decisions. These discretionary clauses forced the courts to uphold insurance company deni-



als unless there was something patently unfair or unreasonable about the claims administration process. Of course, any claimant whose LTD benefits have been denied will think the denial is unfair and unreasonable. But, if the insurance company conducted a timely assessment of the claim and consulted with other medical or vocational professionals for input on the claim, courts quite often conclude that the process was reasonable enough to support a claim denial even when so much of the evidence seems to support disability.

Fortunately, a statute that California enacted, effective in 2012, has begun to stem this discretionary tide. When the insurer is not granted discretion or the discretion is nullified by law, the court looks at all of the evidence "de novo" or anew with little, if any, consideration for the insurance company's process. Even though there is hardly ever live testimony or cross-examination in these cases, the court weighs the claimant's medical evidence against the evidence produced by the insurance company, and decides whether to award disability benefits.

Sometimes, the dispute resolution process seems to get in the way of the truth, but a disabled claimant should always focus on getting the insurance company, and possibly a court, to fully understand how and why they are suffering. Whether the group policy claim is reviewed under a discretionary standard, or de novo, it's

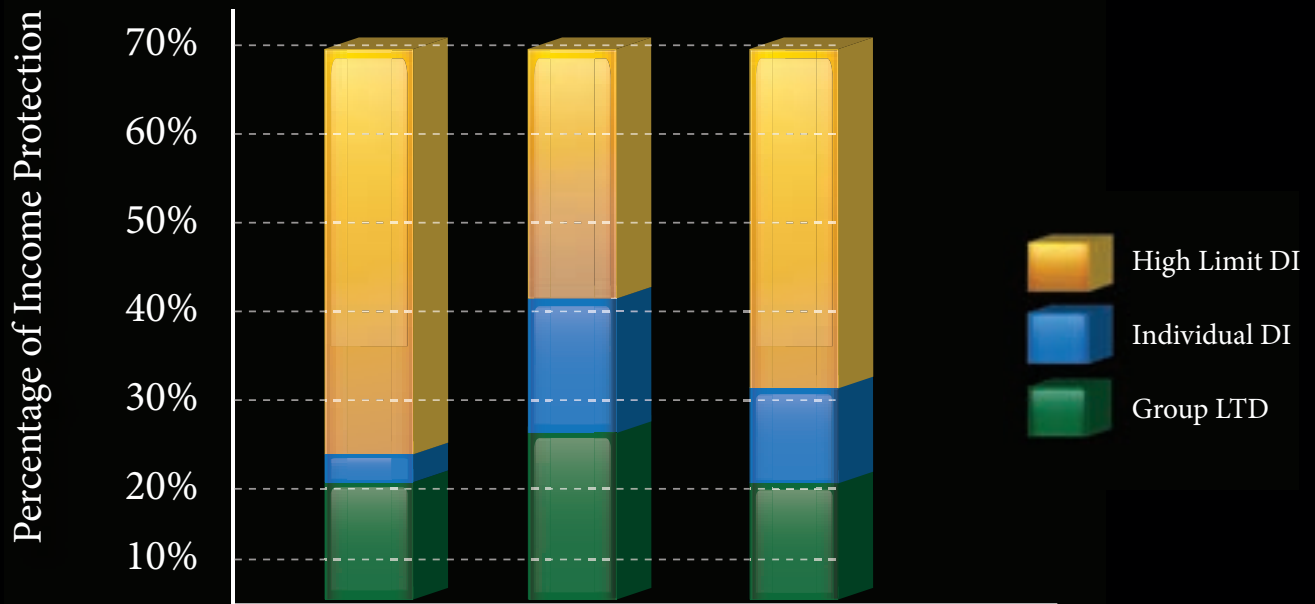
always important for an LTD claimant to gather as much evidentiary support for their disability claim as possible.

### THE BOTTOM LINE

A claimant should always read and become familiar with their LTD policy before making a claim. It is imperative to understand how disability is defined, as well as all time limits and other requirements for making and proving a claim. Beware of assuming that an LTD policy automatically provides protection in the event of an unexpected disability. As in all things, the devil is in the details. Just because the claimant or the claimant's doctors believe the facts support disability, does not mean that the insurance company will agree. Don't be constrained by what the claim forms or insurance representatives ask for. The bottom line is that the probability of a claim being approved increases in proportion to the amount of detailed, descriptive information the claimant provides to tell a compelling story of a disability.



*Alan E. Kassan, Esq. is a partner in the law firm of Kantor & Kantor, LLP in Los Angeles. The firm devotes its practice to helping insureds recover benefits under health-related insurance policies, when benefits are unclear or disputed. This includes long term disability coverage, health insurance, life insurance, and long term care insurance claims. The firm represents clients throughout California. Mr. Kassan has been practicing law for over 25 years, and is a frequent speaker and author on the subject of insurance claims. He can be reached at akassan@kantorlaw.net.*


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# FINANCIAL CONCERNS PEOPLE HAVE ABOUT DISABILITY

by **W. HAROLD PETERSEN, RHU, DFP**

**J**ust living life forces people to become consumers. Very few people could survive without the necessities and the facilities that can only be had by paying for them. Money to spend has become the staff of life, for bread alone will no longer suffice.

- **FOOD:** The human body, a magnificent machine, cannot survive without food for energy, for growth, for reproduction, for healing of wounds and for counteracting disease.
- **SHELTER:** The elements in our environment often act in a contrary way. Shelter is required or life is snuffed out.
- **CLOTHING:** Clothing has become an art form, but basically is a form of bodily protection that provides protection from the burning sun, the freezing rain and wind and a defense against exposure and disease.
- **HEALTH COSTS:** A fourth necessity has entered life's picture in these modern times, and that necessity is money for health care. The living of life in today's world takes place in areas crowded by fast-moving things that substantially increases the odds of accidental bodily injury. Our living close to others increases the transmission of disease. Physicians, hospitals, medicines, and technicians have become part of our living standard. Like the constantly moving second hand on a clock, life is being consumed. From an economic point of view, each tick of the hand on the clock represents an expenditure of money. There is no break; there is no stopping the spending.

A person can jump in bed, cover their head, grit their teeth, and vow not to spend any more money. It won't work for the belly empties and unless replenished, the person will die. The choice is to spend money or to die.

Few have been gifted or will earn enough money to buy a lifetime of needs. In the course of life, we encounter a number of income interrupters: job loss, business failure, mental or physical disability, and death. We have examined each of these in the light of experience of many. What we found is that the most devilish and potentially disastrous of all the income interrupters is disablement of the human body to the extent it cannot work and produce income.

This economic problem of becoming disabled, which is created by the very living of life, has been recognized for well over a century. This recognition has given way to the invention of certain forms of insurance that provides an income cash flow to a disabled person. The underwriting and insuring of such coverage is a matter of contending with many complex factors having to do with physiology, anatomy, law, psychology, finance, and integrity.

Unfortunately, for consumers, the complexity of underwriting the risk has discouraged insurance carriers and brokers from concentrating on this form of critical and badly needed insurance. There has been little interest in the underwriting disability insurance among the hundreds of U.S. domiciled insurance companies. With few exceptions, many carriers claim to have lost money in the underwriting of disability insurance. This can be attributed to the underwriting company's lack of knowledge

and enthusiasm. The company does not promote the coverage ardently for fear of getting too much of this business in force. They fear potentially great claims losses. But, by not promoting disability insurance, the company suffers from an anti-selection process, meaning that its unmotivated and non-encouraged sales force does not try to sell the product to all clients who could benefit, but only to those who ask for it. Experience teaches us that the consumer who asks for the coverage knows or expects that they are about to become disabled. This loads the company with poor risks without having a spread of good risks.

It is estimated that any form of disability income insurance protects fewer than 27% of American income earners. It is further estimated that fewer than 50% of all business owners have ever had the subject of disability insurance discussed with them. Life insurance agents tend to concentrate on life insurance. Health insurance agents tend to concentrate on health insurance. Casualty agents tend to concentrate on property and casualty insurance. Few brokers, though licensed to sell accident and health insurance, keep the disability plans in their daily conscious efforts.

Who will do the important job of delivering disability insurance to serve the American people? It will be a conglomeration of insurance agents and brokers from all of these fields of specialization. Once alerted to their client's true needs and educated as to how to provide a solution, insurance brokers will respond to the challenge and solve their client's problems. Clients will not be victimized by only having a cash flow outgo, but will be provided with enough of a cash flow income to match the outgo when their turn comes and disability strikes.

It is important for American consumers to be aware of how they spend their money. They must plan on having economic problems and conditions during their lives that will challenge their ability to cope and to survive.

Savings without the element of time provide no solution to most financial problems. Saving is anticipated to be a long-term process, which, if uninterrupted, will achieve a substantial end result. Of greatest concern is the interruption of the process, a shortening of the time and thereby not achieving the intended objective.

Disability income insurance is the most effective tool to provide an adequate answer to loss of income. It is available from 26 easily recognized companies. Its cash benefits can be used for any and all needs, living costs, insurance premiums on other plans, and retirement plan contributions. If the premium is paid by the insured person, the benefits are tax free! ♦

*W. Harold Petersen, RHU, DFP, has been a leader in the disability insurance industry for over 63 years and is founder and president of Petersen International Underwriters. The firm, a 30-year Lloyd's Coverholder, underwrites and administers high-limit disability, life, medical and contingency insurance products. Harold Petersen can be reached at Petersen International Underwriters, 23929 Valencia Boulevard, Second Floor, Valencia, CA 91355. Telephone: 800-345-8816. Email: whp@piu.org. Website: piu.org.*

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- 7:00 - 8:00 Registration and Continental Breakfast with Exhibitors *(Exhibitor Hall)*
- 8:00 - 8:15 Opening Remarks and Introduction of Tom Harte *(Keynote Room)*
- 8:15 - 8:45 **Tom Harte, NAHU Immediate Past President, Landmark Benefits, Inc.**
- 8:45 - 9:45 **Dan Clark, CSP, CPAE, Hall of Fame Speaker - New York Times - Best Selling Author**
- 9:45 - 10:15 Exhibitor Time *(Exhibitor Hall)*
- 10:15 - 11:15 Session 1:
- **Marketing Your Products and Services in A Changing Market Place**  
*Joe Navarro, Marketing Director, Warner Pacific*
  - **Serving the Small Group Client into 2016**  
*David Style, President, CBM - Moderating a Carrier Panel*
  - **Large Group Compliance**  
*Karen Kirkpatrick, Infinisource*
  - **All About Medicare**  
*Harry Thal, Harry P. Thal Insurance Agency*
- 11:20 - 12:20 Session 2:
- **Becoming a Trusted Advisor**  
*Ken Doyle, Executive Director of Sales and Marketing, LISI*
  - **Beyond the Medical – Expand Your Portfolio**  
*Dawn McFarland, Business Development Manager, M&M Benefit Solutions*
  - **Exchange Options 2015 – Public and Private**  
*Sima Reid, twentytwenty Insurance Services - Moderating with Covered California*
  - **Covered California and Medi-Cal**  
*Kerry Wright, Wright-Way Financial Insurance Services - Moderating with Covered California*
- 12:20 - 1:00 Lunch with Exhibitors *(Exhibitor Hall)*
- 1:00 - 3:00 Keynote and Panels *(Keynote Room)*
- 1:00 - 1:20 Legislative Update  
*Dierdre Kennedy-Simington, Genesis Financial & Insurance Services*
- 1:20 - 1:50 Phil Lebherz, Chairman, LISI
- 1:50 - 2:30 Carrier Panel *(Small Group Market Expansion Update)*
- 2:30 - 3:00 Mind Over Matter: Embracing Change  
*Dr. Nancy Irwin*



# HMO SURVEY PART 2

## 23. What is your ratio of PCPs vs. specialists?

**Blue Shield of California:** 1/2.09

**Cigna:** Data not available

**Health Net of CA:** 2013: 1 to 3.0 specialists.

**Kaiser Permanente:** The statewide ratio in California of primary care physicians to specialists is approximately 1 PCP to 1.8 specialists. Primary Care includes general practice, family medicine, general internal medicine, and general pediatrics. Specialty care includes OB/Gyn.

**United Healthcare:** As of June 30, 2011, our ratio of PCPs to specialists is 1 to 3.1.

## 24. What is your ratio of members to PCPs?

**Aetna:** 21:3

**Blue Shield of California:** 79.46/1

**Cigna:** 14/1

**Health Net of CA:** 2013: 51.0 members to 1 PCP.

**Kaiser Permanente:** We don't ordinarily release information on our member-to-doctor ratio. Physician and care provider totals are based on current and projected membership numbers. Providing members with access to physicians is essential to delivering high-quality care and to ensure it, we have developed access standards to help meet our members' needs. Monitored continuously, these standards are used to help determine the number of physicians and care providers needed as well as the location and size of our medical facilities. As dictated by membership growth and increased volume of patient visits, additional primary care physicians and specialists are added to our professional roster as needed.

**United Healthcare:** As of June 30, 2011, our ratio of members to PCPs is 131 to 1.

## 25. Does your contract include binding arbitration?

**Aetna:** Yes.

**Blue Shield of California:** No, Blue Shield members are not subject to binding arbitration and there is no arbitration provision in the Evidence of Coverage (EOC) provided to members. However, the majority of our contracts with providers include binding arbitration to resolve disputes.

**Cigna:** Yes.

**Health Net of CA:** Yes.

**Kaiser Permanente:** Yes, we use binding arbitration to resolve disputes. We find arbitration to be more attuned to the discussion of sensitive matters such as medical and more appropriate for the resolution of disputes with persons who, in many cases, continue to be health plan members. Other than small claims court cases, claims subject to a Medicare appeal procedure, or ERISA-regulated benefit claims, arbitration is used to resolve disputes such as those for

premises or professional liability matters, including claims alleging medical malpractice.

**United Healthcare:** Yes, our contract includes binding arbitration.

## 26. How often can members change their PCP at will?

**Aetna:** There is no limit.

**Blue Shield of California:** Access+ HMO members can change their personal physician without cause once a month. This change is effective the first day of the month following notice of change.

**Cigna:** We encourage our customers to stay with one primary care physician to ensure more effective care management. We also recommend that people not change their doctor while in the middle of care to the extent possible. Customers may request a PCP change once per quarter and/or if their residence or work location changes. Additionally, if a customer has a concern about care quality, he or she can change PCPs after notifying us of the concern.

**Health Net of CA:** Members may change PCPs within a physician group or from one physician group to another once per month.

**Kaiser Permanente:** Members can change their PCP at any time and as often as they like. Members can change their PCP online at kp.org, by calling the physician selection service or appointment/advice line at their local medical facility, or through the Member Services Department at their local medical facility. Studies have shown that a positive, ongoing relationship with their PCP helps to improve health outcomes and member satisfaction, so we encourage members to choose a PCP who's right for them and provide the support and systems to make it easy for them to do so.

**United Healthcare:** Members may request a change of individual provider or provider group at any time, for any reason. Requests received between the first and the 15th of a month take effect on the first day of the next month. Requests received between the 16th and the end of the month take effect on the first day of the second month. Members must select participating providers accepting new patients within 30 miles of their home or work and can identify which providers are accepting new patients by calling our customer service department, looking in our provider directory or visiting our Web site.

## 27. Do you offer a performance guaranty, such as employees will be on the computer by a certain date or have ID cards by a certain date, for example?

**Aetna:** Yes, we can offer standard performance guarantees to our clients; guarantees may also be customized on a case-by-case basis.

**Blue Shield of California:** Yes, we offer performance guarantees for groups with a qualifying minimum subscribership.

**Cigna:** Yes, in most instances, we can work with a company to develop appropriate performance guarantees.

**Health Net of CA:** Yes, Health Net of California negotiates per-

formance guarantees with clients based on our corporate performance standards, which are derived from marketplace expectations balanced with internal administrative capabilities. An employer group must have and maintain after the plan's effective date a minimum of 1,000 subscribers in a Health Net of California plan to qualify for performance guarantee consideration. Once the client has been deemed eligible for performance guarantee consideration, Health Net is willing to discuss and negotiate the specifics of a performance guarantee package including appropriate target levels for standards of concern. Health Net of California provides customers with specific performance guarantees in the area of claims administration, including processing turnaround time (measured within 30 calendar days) and transactional accuracy (i.e. financial, payment, coding and overall). In addition to claims administration, Health Net of California offers corporate performance standards that span all aspects of our business in the areas of: implementation (i.e., identification card production, timeliness and accuracy), member services, provider network, medical management, member satisfaction, customer reporting, and HEDIS reporting. All products can potentially be covered, with the exception of our Medicare HMO due to strict guidelines already in place by the Centers for Medicare & Medicaid Services (CMS). All performance standards are evaluated on an annual basis for compliance. An annual performance standard report, including the calculation of any applicable penalties, is produced approximately 90 days after the close of the plan year.

**Kaiser Permanente:** Yes, our performance guarantees are made on a group-by-group basis. Our target is for new members to be in our data base with 24 hours of our receiving their information and to have new or replacement ID cards delivered within 7 to 10 work days 90 percent of the time.

**United Healthcare:** We may agree to performance guarantees upon approval and also if the client meets our standard requirements for enterprise-wide performance standards. However, we typically do not agree to performance guarantees for fully insured groups.

## 28. When a member moves out of state, is any transition coverage available?

**Aetna:** We have HMO plans in many states; a member might be eligible for coverage in another Aetna HMO service area. Customers may also offer out-of-area plans which provide PPO coverage if members are outside an HMO service area.

**Blue Shield of California:** Yes, if a subscriber moves out of state to an area served by another Blue Cross and/or Blue Shield plan, the subscriber's coverage can be transferred to the plan serving his new address. The new plan must offer the subscriber at least its group conversion policy.

**Cigna:** Yes, if we offer similar coverage to the account in that state.

**Health Net of CA:** Yes, through PPO, POS, and indemnity lines of business.

**Kaiser Permanente:** Yes, transition coverage is available to members moving out of state and staying in-network as well as to those moving out of network. Members receive coordinated care from providers who are linked together via Kaiser Permanente HealthConnect®, our electronic medical record system. As a fully integrated health care delivery program, we're well positioned to provide our members with seamless transitions through outpatient, inpatient, and specialty care

services from region to region. This integrated system provides physicians maximum access to members' medical information, allowing them to provide high quality health care through transitions. Members leaving our plan altogether are also provided with reasonable assistance to enable a smooth transition with no additional expenses to the former member for transition services. If a member is confined in a facility on the date coverage is terminated, benefit coverage will continue only under the conditions as per the group agreement.

**United Healthcare:** If members move out of the state permanently, they are no longer in our service area and would be terminated from the plan. Members must live within our service area to be eligible for continued enrollment in our health plan. Members traveling outside their United Healthcare service area for a limited time are covered for emergency services. This also applies to out-of-area student dependents who must also maintain a permanent residence within the service area in order to enroll in the health plan.

## 29. Describe the utilization process.

**Aetna:** Information is gathered from the physician and patient. The nurse consultant or physician reviewer and the attending physician discuss whether a test or treatment is appropriate. The physician reviewer can recommend alternative treatments and further testing. Protocol is reviewed annually. The consulting specialists, who are most familiar with procedure, review and approve any changes.

**Blue Shield of California:** Blue Shield delegates utilization management to our contracted IPAs/medical groups. We audit these processes annually to ensure compliance with our medical policy guidelines.

**Cigna:** Cigna physicians and nurses perform utilization management for inpatients in coordination with medical groups. To help ensure appropriate care and facilitate discharge planning, Cigna reviews medical records for hospitalized customers and consults with physicians via nurses located on-site at hospitals or by phone. Utilization review for most outpatient services is delegated to IPAs/medical groups. Cigna reviews inpatient procedures and hospitalizations, outpatient surgical procedures performed in a facility, transplants, and investigational therapies using Milliman Care Guidelines and Cigna Coverage Positions. Cigna utilization nurses (RNs) also conduct case management. Most outpatient referrals for specialists and procedures do not require prior authorization as long as the primary care physician requests them. However, Cigna performs utilization review of select outpatient services when there is demonstrated value.

**Health Net of CA:** Health Net provides a multi-dimensional utilization/case management (UM/CM) program to direct and monitor health care services. It involves pre-service, concurrent, and post-service evaluation of the utilization of services provided to members. The UM/CM program is structured to ensure that qualified health professionals make medical decisions using written criteria based on sound clinical evidence without undue influence of Health Net management or concerns for the plan's fiscal performance. In addition, Health Net delegates some of its Utilization Management (UM) program to our Participating Physician Groups (PPGs). The approval process for delegated Utilization Management programs and policies includes the on-site, comprehensive annual review; development of Corrective Action Plans (CAP) as required by audit results; follow-up assessments

to ensure CAP implementation; and presentation of findings to the designated committee for discussion. Health Net has a staff of Registered Nurses responsible for managing this review process for each of their assigned PPGs. PPGs with delegated responsibilities for UM are required to develop and implement a written UM Program that documents all facets of delegated authority and outlines the structure, accountability, scope, criteria, and processes of all UM services, including basic case management and care coordination. The Program must be revised, reviewed and approved by the PPGs' UM Committee and/or board of directors at least annually.

**Kaiser Permanente:** Our physicians plan member care and work collaboratively with their peers to ensure that there are appropriate treatment plans and use of resources. Utilization-Management staff are available to support doctors in the management of member's health care needs throughout our continuum of care and provide a variety of services such as discharge planning, utilization review, and care management. The majority of utilization management, including reviews, is conducted internally as part of our integrated system of health care delivery. Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and the Permanente Medical Groups work in partnership to provide and coordinate medical management and review for our health plan members.

**United Healthcare:** We use industry-leading medical management programs to ensure that each enrollee receives the appropriate care necessary and that we control unnecessary health care costs for our clients. Our medical management programs focus on reducing variation, improving the quality of care provided and ensuring cost effectiveness. We base medical decisions on scientific evidence and all of our medical management services include physician guidance and input. We developed online, science-based and objective utilization management criteria as well as technology-based clinical decision support systems related to case, utilization and disease management.

### 30. Describe the Case Management Process.

**Aetna:** The following are some ways in which cases are identified: through the PCP or pharmacy, during certification reviews, during PMG/utilization management case reviews, and through other internal reporting and sources including member services, claims, and specialty programs. The case manager coordinates services for members who have multiple and complex needs. The case manager works with the PCP and the member to develop a care plan identifying services, frequency, duration, and goals. A team approach includes the PCP, specialist, member, family, caregiver, healthcare provider community, and internal programs to coordinate care, with a focus on member education and maximizing quality outcomes.

**Blue Shield of California:** Case management focuses on early identification and management of members with potentially long-term and catastrophic healthcare needs. Using claims, authorization, and pharmacy data, we identify potential candidates for case management. The case manager helps identify appropriate cost-effective treatment options, and follows members who are receiving alternative levels of care, such as inpatient rehabilitation, skilled nursing facility care, long-term home health services, and hospice services. Members who are using an acute facility three or more times in a six-month period can also be identified for case management. Utilization management, claims, and other medical operations team members can re-

quest case management for specific situations. Family members and providers can also request case management.

**Cigna:** Customers are identified via real-time and claims-based predictive modeling tools, along with referrals from physicians and medical groups, Cigna clinical staff, and employers. Case managers collaborate with physicians, medical group case managers, customers, and employers to facilitate ongoing treatment plans and support the primary care physician. Case managers monitor short-term and long-term goals for inpatient and outpatient care. They document and evaluate the effectiveness of the services provided. In addition to traditional complex and catastrophic case management, Cigna has a number of specialty case management units. They are staffed with RNs who are dedicated to areas such as high-risk maternity, neonatal intensive care, oncology, obesity, and transplant. Cigna has an extensive suite of chronic condition management programs, including those for obesity complications and depression. Cigna also offers telephonic and online access to wellness information, care management services, and health coaching programs.

**Health Net of CA:** Health Net and its delegates provide case management/disease management programs to deliver individualized assistance to members in all lines of business who are experiencing complex, acute, or catastrophic illnesses or have exceptional needs. Health Net provides outreach to members with chronic conditions such as asthma, diabetes, COPD, heart failure, and coronary heart disease, uses population-based risk stratification and predictive modeling; and partners with physician groups to improve performance. Health Net offers disease management, ambulatory case management, complex case management, NICU and high-risk OB case management.

**Kaiser Permanente:** Members in need of case management are identified through clinical and utilization data, pharmacy records, hospital and outpatient visits, and laboratory results. Members can also self-refer to case management or be referred by a doctor or family member. Our case managers are master's-level clinicians or registered nurses who work directly with a member and their health care team to plan care and provide intensive coordination of services, including inpatient hospitalizations, transitional care, home care, skilled nursing, medications, referrals to community resources, and outpatient care. Using an interdisciplinary approach, case managers help to ensure continuity of care including utilization management, transfer coordination, discharge planning, and obtaining all authorizations or approvals as needed for outside services for members and their families. They're also responsible for identifying quality-of-care problems and monitoring utilization issues.

**United Healthcare:** We designed our case management program to identify, intervene, coordinate and monitor care plans that provide high quality and cost-effective care for covered persons with catastrophic and complex health care needs. Our case managers facilitate communication and coordination of care between all parties on the health care team. This program involves the patient and family in the decision making process to minimize fragmentation in the delivery of health care. The case manager assesses the needs of the patient and educates them and the health care delivery team about case management, community resources, insurance benefits, cost factors and issues in all related topics so that informed decisions can be made. The case manager is the link between the patient, the providers, the payer and community. ❖

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# STUDENT LOAN DEBT: A NEED-TO-KNOW ISSUE FOR DI SALES

by **MARK AMEIGH, CLU**

**P**roducers often struggle to help young professionals understand their risk of ever being unable to work for an extended period as a result of illness or injury. Youth and good health can give such clients a sense of invincibility and a belief that disabilities only happen to other people. People said their odds of winning the Mega Millions jackpot were greater than the odds of becoming disabled, according to a 2014 survey by the Council for Disability Awareness. The real odds are one in 259 million for winning the jackpot and one in four for having an income-interrupting disability.

While their mindset of invincibility hasn't changed, disability's consequences for these professionals have changed significantly. As financial professionals, we play a key role in helping them protect themselves in this altered landscape.

## HUGE DEBT IS THE NEW NORMAL

A college degree is generally acknowledged to be an excellent financial investment. An individual with a bachelor's degree can expect lifetime earnings that will be nearly 40% higher than those of a high school graduate. A graduate or professional degree widens that earnings differential significantly, according to a Pew Research Center report. In order to finance their education, bachelor's degree graduates typically start their working lives with about \$30,000 in student loan debt, according to the National Center for Education Statistics. Borrowing jumps significantly for professional school graduates, with law school graduates typically carrying \$100,000 in debt, and those pursuing medical and dental degrees borrowing \$200,000 or more.

Costs to attend medical school have risen at double the rate of inflation in recent decades, according to a September 26, 2013 *Wall Street Journal* article. Reduced federal and state funding, along with the increasing use of technology and costly equipment are among the factors driving these steep increases for medical and dental programs. In addition, with more doctors and dentists choosing to specialize, they spend longer periods in residencies and fellowships while interest on many of their loans continues to accrue.

Professional school graduates have some of the highest income potential in the national economy. They enter the workforce in their 20s and 30s, older than their predecessors,

and often having delayed major life events like household formation and home ownership while completing their education. However, their significant student loan debt often means years of \$1,000 to \$2,000 per month loan payments.

## HEIGHTENED FINANCIAL CONSEQUENCES

If one of today's young professionals were to become too ill or injured to work, they would face the same set of financial difficulties as their predecessors—how to pay for groceries, the mortgage, etc. But they would also be confronted with hefty student loan payments.

While numerous illnesses and injuries could render an individual unable to work, a significant portion would not meet the requirements for loan discharge. Under current law, federal student loans may be discharged for total and permanent disabilities. These are defined as disabilities in which a person is unable to engage in any substantial gainful activity, plus the disability is expected to last at least five years and result in death. Plus, unlike most other kinds of debt, federal student loans cannot be discharged in bankruptcy.

## FOR BREADWINNERS, IT'S ABOUT MORE THAN BREAD

An effective approach in DI sales has always been to help the client understand their risk—how a disability would affect them. This typically entails looking at routine expenses and how those would be paid without an income, thus illustrating the need for income replacement. With so many of today's families relying on two breadwinners, families may also have student loan debt from both partners. Such families would face even more acute effects of a disability than their predecessors.

Merely mention educational borrowing, and young professionals will immediately wax on about its effects on themselves and their peers. Student loan debt is front-of-mind and the burden particularly acute in early career when loan balances are at their highest and earnings yet to grow.

## ISN'T GROUP LTD ENOUGH?

Many graduates secure a position with an employer who offers group long-term disability (LTD) coverage, and assume that's all they need. Most do not understand how

*(Continued on page 33)*

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Managers in different locations may make different leave decisions or be confused about how to interpret medical information required under the ADA.

California employers have the added task of recognizing when multiple leave statutes apply as well as determining when leaves are concurrent, when they are consecutive, which leaves are paid or unpaid, and which are job protected and which are not. With employee absences based on so many different leave laws, ensuring uniform implementation can be daunting. California employers may need help in applying the laws consistently with respect to FMLA/job-protected leave eligibility and timing and related ADA regulatory considerations.

**4. TRACKING AND REPORTING:** Tracking and monitoring so many different types of employee absences, including overlapping leaves, can place a major burden on benefit departments. In fact, disability and leave management are so labor intensive that it now requires one full-time person for every 5,000 employees to manage FMLA and an additional half person for every 5,000 employees to manage disability absences.

For California businesses with smaller HR staffs or those whose benefit managers are otherwise engaged, it can be time consuming and confusing to track these various leaves, as well as any new leaves or changes in leave dates and expected return-to-work dates. Benefit managers must not only provide reports on case status and continually update employees' leave status, but they must also identify patterns and trends in employee absences.

Looking at the reasons why employees are going out on leave can be crucial in helping businesses understand how these absences affect costs and productivity. Tracking is critical for some industries, such as healthcare, retail and manufacturing since even short absences can have a major impact. When an employee in these industries is out on leave, employers may need to hire a temporary replacement or authorize overtime for other employees, increasing costs. Tracking is also important in benchmarking how a company compares to other businesses and other industries when it comes to absences.

If your clients are having difficulty meeting their objectives for leave management, you might want to suggest outsourcing. Here are some things your clients should consider as they decide whether to use a third-party:

- What are your leave metrics?
- How does your company benchmark against peer employer/industries?
- Are you compliant?
- Do you have the resources to remain compliant with all the statutes?
- What would be your return on investment to outsource?

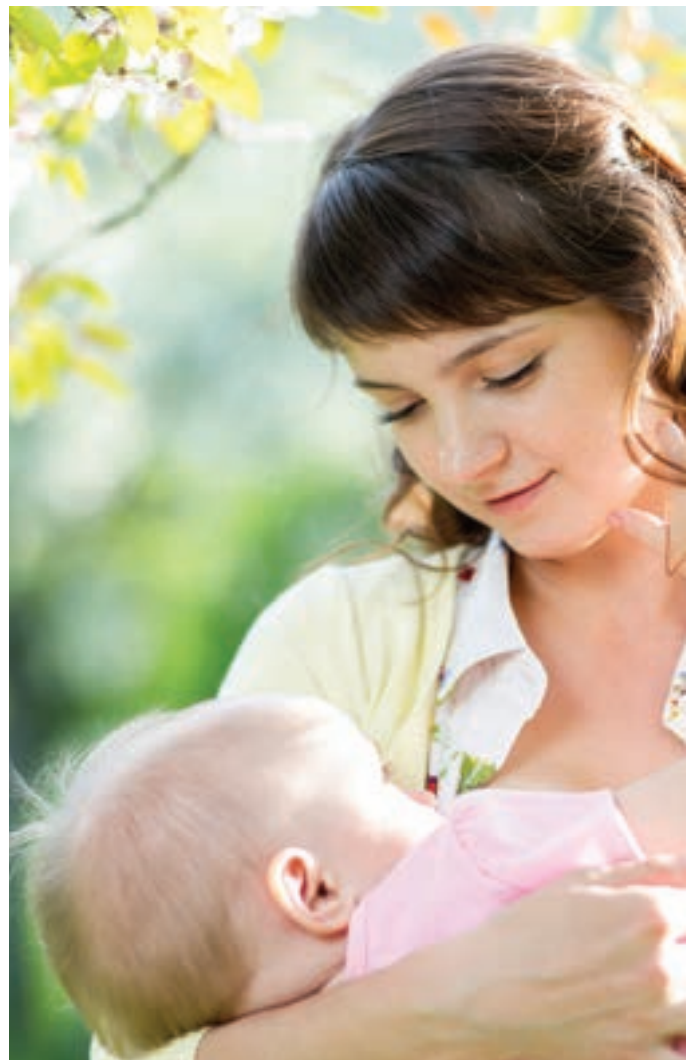
With employers continuing to be concerned about employee productivity, outsourcing leave management can

help make certain that productivity isn't affected more than it has to be. Using an outside firm can also relieve benefit managers of the chore of dealing with leave tracking and absence management, resulting in better use of their time. In addition, a specialty vendor may be able to suggest ways for disabled employees to stay at work or return to work, allowing them to remain productive during this time.

Finally, outsourcing can also help meet an employer's need for a simple, more cost-effective absence management solution by providing access to a cadre of expert resources that may include medical and legal experts, virtually eliminating the need to have these employees on staff.

By turning over the details of leave management and tracking for FMLA, ADA, state leave laws and other disability absences to a third party, California employers can reduce absence, increase productivity, and gain valuable time for their strategic initiatives and feel comfortable they have minimized their liability for non-compliance. ♦

*Robert Jacob is director of Health & Productivity Development for Unum U.S., National Client Group.*





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# HOW TO TARGET GENERATION X WITH *Fixed Annuities*

by **RICH LANE**

**B**aby Boomers have been great clients for insurance professionals over the years. But now may be a good time to shift some of your focus to Generation X as its oldest members approach their mid-50s. The majority of this demographic are heading into what likely is the last decade of their working years, and many have retirement on their minds.

As survivors of the dot-com bubble burst in 2001 and the Great Recession of 2008, Generation X often possesses a distrust of the market. In fact, this group is more pessimistic than millennials and Baby Boomers that they'll have enough money for retirement.

However, the fixed annuity purchase, which was previously thought of as an investment strategy for retirees, is gaining traction within this financially conservative group of investors who are looking to protect and grow assets. I suggest that all financial professionals take the time to learn more about the purchasing and saving habits of generations following Baby Boomers to sell effectively.

## WHY A FIXED ANNUITY WORKS FOR GENERATION X

Generation X is looking for a reliable, low-risk way to invest. That's why fixed annuities provide a practical option for these conservative investors. These deferred annuities, which track the performance of a specific index tied to the stock market, earn interest based on the performance of the selected index for a predetermined time span. This time span may be as short as a month or as long as a number of years. The beauty of this type of a fixed annuity is that the client does not lose money if the index remains flat or has a negative return. In other words, a fixed annuity provides great upside potential and very little downside risk. At any time, before or after retirement, the deferred annuity can be turned on to create a guaranteed income stream if needed.

## A SECURE COMPLEMENT TO A PORTFOLIO

As always, when positioning an annuity, it's important to understand your client's needs. Many workers who are preparing for or nearing retirement are at a life stage in which risk tolerance is low. A fixed annuity can be a practical investment for those who don't want to gamble with money they've worked hard to accumulate for retirement. This is especially pertinent for those whose investment portfolios may have taken a hit in the recent recession.

Savvy brokers can recommend an annuity as part of a larger portfolio. When connecting with potential clients in this age group, make sure they understand why fixed annuities can offer a perfect addition to any retirement plan. Emphasize that fixed annuities can provide a pre-

dictable future with flexible payout options that offer a guaranteed income stream, and those earnings aren't taxed until the funds are used. As a result, more of your clients' money continues working for them—instead of Uncle Sam.

## GET STARTED COMPOUNDING GROWTH

Even with today's low interest rates, a fixed annuity's compound growth rate and tax-deferred status can grow purchasers' savings faster than they might think. For example, placing \$50,000 into a five-year guaranteed annuity paying 2% interest would guarantee \$55,204 at the end of five years without early withdrawals. No matter how financially conservative your client may be, it's important to stress that waiting to invest isn't a sound strategy. Some investors may opt to let time go by and wait until interest rates rise before purchasing. But there is a cost to waiting.

Consider that a \$50,000 annuity purchased one year from now would need to earn 2.51% in interest annually for four years to match the original \$55,204. Waiting two years bumps the needed interest earnings to 3.36% for three years to achieve the same earnings that would have been guaranteed by purchasing an annuity at a lower interest rate today.

## SECURING A HAPPY CLIENT BASE

For most of us, risk tolerance goes down as we near retirement age. Because of this low risk tolerance, the annuity marketplace is seeing strong growth in fixed annuity sales. Brokers can sell a fixed annuity by concentrating on protecting the purchaser's money and funding the purchaser for the rest of their retirement years. Recommending a fixed annuity purchase to clients interested in low-risk investments is a smart move.

Annuities provide a guaranteed income stream that a client can count on after leaving the workforce. For the broker, selling annuities not only provides more options for you to help prepare your clients for retirement, but it also will keep sales in-house instead of with a competitor. ❖

*Rich Lane is the director of individual annuity sales and marketing for Standard Insurance Company. He has been in the fixed annuities industry for more than 17 years, with an emphasis on product and distribution development for brokerages, banks and broker/dealers.*

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# WHY

# *Reference-Based Pricing*

## IS GETTING POPULAR AGAIN

by DAVID ZANZE

**A**s the saying goes, “Everything old is new again.” More self-insured employers are looking for additional ways to keep health care costs down, and more are considering one of the latest trends—reference-based pricing. The reality is that this pricing trend and versions of it have been around for decades. When used properly, it can offer substantial savings for employers while ensuring quality care for employees. In this article, I will explain the background of this pricing strategy, explain why it’s trending today, and share some tips on how to boost its success should you have clients who plan to adopt this pricing structure into their self-insured plans.

### THE HISTORY OF REFERENCE-BASED PRICING

In basic terms, reference-based pricing is when an employer decides on a maximum amount (reference price) that the health plan will pay for a specific health-related service – anything from a hip replacement to a lab service to a pharmaceutical drug. It involves cost-sharing with employees. If a provider charges more than the employer’s set amount for a health service or drug, the employee will need to pay the difference or find another provider who accepts that amount.

The concept of reference-based pricing actually dates back to the 1950s when relative value scales were developed to determine a value of one procedure over another. The California Medical Association was the first to use them in 1956, and it was known as the California Relative Value Scale. In the 1970s, Yale Uni-

versity developed Diagnostic Related Groups that gave descriptions and a numeric value to all types of patient care in an acute care hospital. They included all of the Medicare population and newborn, pediatric, and adult populations and were used to determine the payment level a hospital would receive for reimbursement.

Then in 1983, the entity now called the “Centers for Medicare and Medicaid Services” (CMS) implemented diagnostic related groups for the prospective payment system in which services were classified for reimbursement on a pre-determined fixed amount. The prospective payment system with the diagnostic related groups helped motivate providers to reduce unnecessary treatment and deliver patient care in the most efficient and effective way.

In 1985, Harvard conducted a national research study at the request of the CMS and came up with the Resource Based Relative Value Scale. Through its research, Harvard documented what physicians typically charged for several routine services and gave a resource-based value for each one. Each value was based on three factors: physician work, practice expense and professional liability insurance as well as geographical differences. All of these earlier versions of reference-based pricing came together in 1992, when Medicare dramatically changed its reimbursement process. CMS moved from paying physicians based on physician charges to using the Resource Based Relative Value Scale system, which based payments on the resource costs needed to provide health care services.

### WHY REFERENCE-BASED PRICING IS TRENDING NOW

Now that you know that reference-based pricing is not new to the health care scene, you are probably wondering why it’s recently gaining momentum as a pricing option for health care plans. First off, because the Affordable Care Act mandates large employers (50+ employees) to provide health care coverage or face penalties, employers are embracing new pricing methods to save on costs while ensuring quality care for their employees. Self-insurance is on the rise for larger employers (250 or more). Reference-based pricing can work well for self-insured employers since they have the flexibility to design their own plans.

Reference-based pricing appeals to self-insured employers for two main reasons. First, they like its transparency since employees can see the range of prices that providers and hospitals are charging for their procedures and services. Previously with other pricing structures, employees only paid co-payments or co-insurance amounts and were not exposed to the true cost of health care services. Once their financial obligation was met, the rest was covered by the company.

Second, with reference-based pricing, employees get a set amount of health care dollars to spend, which encourages them to do pricing comparisons and become more engaged in their health plan. Suppose that an employee wants to go to a provider who charges more than the reference price for a procedure. The employee can pay a little more out-of-pocket or find a provider that delivers the same service, but is priced at a level that is

*(Continued on page 38)*



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## *The New Eco-System of* PRIVATE EXCHANGES

by **JASON T. ANDREW, CEO**

**T**he private exchange concept is not new. In fact, private exchanges have been around for decades. There are dozens, if not hundreds of exchanges or pools in California and throughout the country. The Affordable Care Act has only accelerated the conversation about private exchanges. The conversation is now about changing the distribution of packaged employee benefits and health insurance products. We have public exchanges, state and federal exchanges, and a whole slew of private exchanges coming on the market.

In a post ACA world, agents, brokers, carriers, and consumers are looking for smarter, more innovative, and cost efficient ways of understanding plan options. All are seeking creative ways to grow enrollment and broaden the distribution of health insurance products to more people.

What we are creating in this historical period of transition is a private exchange ecosystem, which brings together players from all ends of the spectrum. Start-ups are clamoring for the best new customer experience. Technology data companies are obsessed with providing the most complete analytics to give us decision support tools, scaling from consumer to company.

Employee health benefit companies are re-inventing how they do business via greater transparency and seamless integration of their products and technology tools. They are working to provide a complete end-to-end process with which customers can understand and interact.

The ultimate winners will be those who figure out how to connect the pain points that still need a solution. You may be, asking “How do I help someone understand which health insurance products are best for them at point-of-sale?” “How do I painlessly enroll them in in-

urance coverage offering up the Amazon consumer experience that consumers expect as status-quo today?” “Once the consumer is enrolled, how can I maximize efforts and efficiencies in follow-up and plan renewal?” Companies that operate seamlessly across at least these areas, and more, will win in the new marketplace.

At this early stage, it remains to be seen which platforms will be most valuable in evolving insurance from fragmented, paper based process and toward an integrated, beautifully designed end-to-end experience.

Despite all the cool innovations and buzz happening in this new world, the focus of these new technologies, tools and services should center on delivering a better value—a personalized consumer experience, a more transparent cost management structure, and the most efficient means of delivering on the product. Exciting times! ❖

*Jason Andrew is co-founder and CEO of Limelight Health. Limelight Health, with offices in Silicon Valley and Redding, provides innovative cloud-based products to insurance agents. Previously, Jason was the Founder of Stone Meadow Benefits & Insurance Associates, a Silicon Valley-based insurance brokerage. He has advised numerous Silicon Valley startups and works closely with the Silicon Valley business community. Currently, he serves on the Board of Napa Children’s Health Initiative, a non-profit whose mission is to enroll all children in subsidized health insurance. He also serves as an advisor to GoVoluntr, a startup that connects volunteers, non-profits and businesses together.*

*Previously he was on the Silicon Valley Association of Health Underwriters (SVAHU) Board of Directors. He led a committee for CAHU, which was designed as a collaborative discussion between CAHU and HHS Region IX Director, Herb Schultz. He also served for seven years as a minister for the International Churches of Christ and holds a degree in communications from Lewis and Clark College.*

(STUDENT LOAN DEBT – Continued from page 24)

group LTD would work in their circumstances. Benefit caps, restrictive definitions of disability, lack of portability, and taxation of benefits are all facets of group LTD that may affect higher-earning professionals. These are among the many good reasons to consider the purchase of supplemental individual disability insurance (DI). Choice of definitions of disability, benefits for partial disability, cost of living adjustments, and guaranteed options to increase coverage are just some of the many advantages of individual DI.

### DI PROTECTION FOR STUDENT LOANS

One top-rated DI carrier introduced a new rider directed at protecting a person's ability to continue repaying student loans during a period of total disability. It reimburses monthly student loan payments, and is available with a term of 10 or 15 years. An added plus is that this coverage amount may be issued in excess of regular policy issue and participation limits.

Relative to base policy cost, the price tag per hundred dollars of coverage is low. For those who generally carry the largest amount of student loan debt—physicians and dentists—the student loan protection rider offers the chance to secure separate, additional coverage for student loans.

Another nationally recognized carrier offers a unique disability product that will pay a lump-sum benefit of up

to \$100,000 in the event of a total and permanent disability. It is generally less expensive than more comprehensive individual DI products, and is built around a simplified underwriting process. There is a trade-off however; the definition of disability is more stringent than that in most other individual IDI contracts.

### STUDENT LOAN DEBT AS CONVERSATION STARTER

Product solutions aside, burgeoning student loan debt presents a significant new opportunity for producers to get the income protection discussion started. In addition, this issue can open doors with DI prospects beyond the medical and dental professionals who've been the focus of the IDI market for many years.

Today's young professional school graduates have made significant financial investments in their future earnings potential. Producers need to help them protect not only their earnings but also their ability to repay their educational obligations. ❖

*Mark Ameigh, CLU, is senior analyst for DI Competitive Intelligence in the DI Product Strategy Division of The Guardian Life Insurance Company of America. He has over 30 years of disability insurance sales and product experience, and is a regular contributor to industry publications.*



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# WHY YOUR CLIENTS NEED



by **DIA LAUTENSCHLAGER**

Identity theft is not new; it's been the FTC's number one consumer complaint for 14 years running, but it is of particular relevance to health insurance professionals right now. The Anthem data breach, while not the largest in recent memory, has the potential to create the most problems, and biggest opportunity for agents. As Anthem announced that customer data in the breach dates back to 2004, agents can expect some calls from distressed clients. If properly educated on what identity theft really is, and the types of coverage they can offer their clients, brokers stand to profit.

But first, make sure your house is in order—if your customers, vendors or employees are victims of identity

theft because of a data breach at your business, you could be held liable. There's an alphabet soup of Federal regulations and laws requiring businesses to protect Non Public Information (NPI)—HIPAA, FACTA, FCRA, and Gramm-Leach Bliley, to name a few. Add in all the states' laws and they are too numerous to mention.

Big companies like Anthem, Target, and Neiman Marcus are the ones that make headlines, and they also have the resources to survive such a storm. Could yours? According to a 2013 report by the California attorney general, 50% of all data breaches happen at small or medium sized businesses.

Penalties for not complying range from class action lawsuits, to fines, and even to jail time for top officers. Just one provision of one law, the Disposal Rule of FACTA imposes penalties for non-compliance that include a \$1,000 state fine and a \$2,500 federal fine per infraction—meaning per individual victim. That means a single small data breach of 100 individuals' data could cost \$350,000 just in FACTA fines. Even without these penalties, the damage to your customer relations and brand image that such a PR nightmare would bring could be devastating.

While the AG's report focuses on protecting data from cyber thieves it also recommends tightening security around personal information in general, "including training employees and contractors." It's humans who push the buttons on the systems, and if those humans aren't trained properly then all the cyber security in the world won't help. Even the good intentions of an employee, such as someone taking files home to work on over the weekend, can inadvertently lead to identity theft if those files fall into the wrong hands.

What's a small business owner to do? Luckily, most agencies just want to see that reasonable care has been taken to protect consumers' information. Be sure to consult with your business attorney to make sure you're in compliance, but taking reasonable care can be done in a few simple steps:

1. Appoint a security officer,
2. Adopt a written security policy,
3. Train all employees on that policy, and
4. Document all of the above.

In addition, most insurance agencies offer cyber security insurance nowadays, so consult with your P&C agent as well as your attorney. A great place to start is the guide the California AG has released for California's small business owners. That can be found at [oag.ca.gov/news/press-releases/attorney-general-kamala-d-harris-releases-report-data-breaches-25-million](http://oag.ca.gov/news/press-releases/attorney-general-kamala-d-harris-releases-report-data-breaches-25-million).

This is all fine and good, but even businesses that don't experience a data breach can still suffer significant losses. What happens in the more likely event their employees are hit by identity theft originating from outside the company? If your clients haven't called you with this question, they are probably thinking about it right now.

Estimates vary on how much time on average a victim spends resolving ID theft issues, but there is some good news: the amount of time victims spend cleaning up the mess has trended downward since the beginning of the epidemic (probably due to more people monitoring their credit and catching the crime early). Nonetheless, the Bureau of Justice Statistics reported that the median victim spends 9 hours resolving the problem, but 295 spent a month or more resolving the problems. The most severe cases can take years to resolve.

The long and short of it is that employees who have been hit by identity theft will inevitably need to take time off work given most of the institutions they need to deal with are open 9:00 to 5:00. The stress of the situation is likely to cause them to be distracted while at work. So the employer faces an increase in absenteeism and presenteeism, not to mention the potential increase in medical claims due to stress. Up to 90% of the doctor visits in the United States may be triggered by stress-related issues, according to the Centers for Disease Control and Prevention.

So why not educate yourself on the options and offer your clients a solution?

There are several types of coverage available to the consumer, and most do very little, if anything, to keep employees on the job when they become a victim of identity theft.

Monitoring is important as an early detection system, but alone does little to help clean up the mess. Therefore most credit monitoring services have added some type of resolution services, which helps. The victim is mailed a kit and trained customer service reps answer all their questions about all the work they will have to do to resolve their problems.

Reimbursement policies do just that—reimburse a victim for lost wages, attorney costs, postage, child/elder care, and sometimes even for funds stolen from bank accounts. This of course is after the fact and does nothing to keep the employee on the job.

Restoration services are designed to take over and clean up the mess for the victim. True restoration services should be done by an experienced licensed investigator because they have the ability to research and uncover fraud that may not be showing up on a credit report. Only 17% of all identity theft is financial and credit related. The other types of identity theft—tax, medical, driver's license and criminal—can be much more serious and difficult to fix. (Even the company Anthem hired to help the people whose information was lost specifies they help with credit and financial fraud only.)

The only way to know if a company offers true restoration is if the victim signs a limited power of attorney. If a LPOA is not in place, then the investigators cannot legally do the work on the victim's behalf.

Legal services should also be part of the solution. What if your employee gets pulled over for a routine traffic stop and finds out they have a warrant (or several) out for their arrest? If the employee doesn't have 24/7 emergency access to an attorney, they most likely won't show up for work the next day because they had to spend the night in jail. More than half of all identity theft victims end up with some type of legal problem. Trying to find and pay an attorney means additional stress and time off the clock, so access to legal services are important.

David Bruerd of the identity theft Awareness Group states, "The bottom line is that business owners should assume that it is not a matter of whether customer information will be lost or stolen. It is a matter of when. It is, therefore, imperative that every business develop affirmative defense strategies before a breach of security takes place so that, if a breach occurs, the plan can be implemented in an orderly and efficient manner."

With 16.6 million hit by identity theft just last year alone, as an insurance professional dedicated to protecting clients against risk, it's time to start offering a solution to your clients. ❖

*Dia Lautenschlager is a certified identity theft Risk Management Specialist—CITRMS—and a representative of LegalShield Employee Benefits.*

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## ADD VALUE, BUILD RELATIONSHIPS: HELPING YOUR CLIENTS

# FILL THE LONG-TERM CARE GAP

by **CHRISTINE MCCULLUGH**

**O**urs is a business of relationships. When you help your clients meet their goals by bringing them something they didn't know they needed, you add value for them and help cement the relationship you have established. A frequent topic of discussion today is employee retirement readiness. Your employer group clients understand that the responsibility for paying for retirement now rests primarily on the shoulders of employees, and they are doing more than ever to help employees figure out how to meet the need.

But there is a significant gap in this education. What if the money disappears due to a need for long-term care? By educating your employer clients, you can add value, for them and for their employees. And by doing so, you can firm up your working relationships.

### **WILL THEY NEED TO DIVERT RETIREMENT MONEY?**

A retiring employee may walk away with a significant lump sum of cash that they have worked hard to save. Ideally, the employee has done some planning, perhaps seeking advice from an investment professional to determine how much money they need each year to maintain their lifestyle.

If an accident or an illness occurs, though, it may become necessary to divert that money toward long-term care. How likely is someone to need long-term care? According to the federal government's long-term care website ([www.longtermcare.gov](http://www.longtermcare.gov)), nearly 70% of people turning 65 will need long-term care at some point in their lives. This is not medical care, which is paid by health insurance, but rather assistance with the activities of daily living (ADL). ADLs

include bathing, dressing, toileting, transferring, eating and incontinence care.

Sometimes, an event triggers the need for long-term care. This can apply to anyone at any age. In fact, a study from the Georgetown University Long-Term Care Financing Project found that 37% of people using long-term care services in 2000 were 18 to 64. That leaves the majority of people who use long-term care services in the 65 plus age bracket.

For them, the need for long-term care often arises gradually. In the early stages, it may mean family members managing medicines, bringing in part-time household help, or providing rides to doctor's appointments. Later, more help may be needed, and moving to an assisted living facility could be an option. A person who has needs that are outside the scope of care in an assisted living facility may need care in a nursing home.

The cost of care is significant. In 2012, the average hourly cost for a home health aide was \$21, or \$30,576 per year, according to a MetLife study. Assisted living facilities averaged \$42,600 per year, and care in a private room in a nursing home averaged \$90,520 annually. It is easy to see how quickly the average 401(k) balance of \$91,300 could evaporate.

### **MEDICAID, SAVINGS, OR INSURANCE: THREE WAYS TO PAY**

Your employer clients and their employees probably don't realize that their hard-earned retirement savings are at risk. They may believe that their health insurance, disability insurance, or Medicare

will pay for long-term care. Not so; health and disability insurance only pays for those specific issues. And Medicare will pay for a maximum of 100 days of skilled nursing or rehabilitative care if that care is provided immediately after a stay in the hospital. It does not pay for assistance with ADLs.

Medicaid (MediCal in California) is the government's long-term care safety net. It will pay for long-term care for those who have spent their assets, minus the family home, down to the poverty level.

But financial pressures on the Medicaid system have risen significantly in recent years. The system now pays for 40% of long-term care spending in the United States, and spending has increased from \$75 billion 20 years ago to more than \$400 billion today. All of this has the government tightening the controls: qualifying for benefits is more difficult. They have the right to review an applicant's financial records for the five prior years to ensure they haven't transferred assets to someone else. What's more, as a condition of continued federal funding to the state Medicaid system, the federal government is now requiring states to seek recovery of amounts spent on an individual's care. In effect, the program agrees to pay for the individual's care, with the understanding that the estate will be billed for the money spent on care once the person has died. For many families, this means selling the family home.

By presenting your clients with effective education about long-term care, you can help them help their employees. With enough information, employees can then decide



whether to purchase coverage, save the additional money they may need, or spend down and let MediCal take care of it. Or, they may choose to simply roll the dice and hope they will be among the roughly 30% of people who won't need long-term care.

### PRICE INCREASES MEAN STABILITY AMONG CARRIERS

You may hesitate to present long-term care coverage to your clients because you've heard that it has increased in price in recent years or that insurance companies are no longer offering the product. A few companies no longer offer long-term care coverage, and the prices have increased. In order to educate your clients about long-term care coverage, you need to understand how these things came about.

With any insurance product, actuaries determine rates based on educated assumptions and expectations in the economy, utilization, plan design, and a variety of other factors. When long-term care insurance was introduced in the 1970s, those factors determined the pricing. Since then, plan designs changed; utilization and lapse rates were different than expected; the economy entered a period of extraordinarily low interest rates; and the population aged significantly.

Now, some 40 years later, the industry recognized the need to adjust the pricing of long-term care products. Beginning in 2010, companies increased premium costs an average of 25% to 75%. Interestingly, from 1999 to 2014, employee out-of-pocket costs for health insurance rose 212%, according to the Kaiser Family Foundation. All of us have come to expect price increases each year in the health insurance market. But long-term care coverage has seen an increase just once in many years.

In part, this is because each state regulates the coverage on its own; the insurance commissioners must be approached individually about any increase and grant permission for that state. Because this is such an arduous process, long-term care carriers try to set accurate pricing that will cover their risk for many years. I expect prices to increase more often than they have in the past, but in my opinion the increases might be in the neighborhood of 5% to 15% every five to 10 years.

Long-term care insurers have responded to the changing demands of the marketplace in the design of their LTC products. With about 8,000 people turning 65 each day in the United States, according to AARP, many of us have been forced to deal with the realities of care needs by our loved

ones. The most expensive care option is a nursing home setting. But that is generally a last resort when there are other options. Policies now cover care provided at home and in assisted living facilities, allowing policyholders to access their preferred mode of care.

### EDUCATION IS KEY

Your corporate clients can show their interest in helping employees reach a comfortable retirement by providing an opportunity for them to purchase long-term care coverage. They spend time and resources educating employees about how to save money and even how to invest it. They may not ask you about long-term care insurance because neither they nor their employees understand the risk that they will need it. This is your opportunity to help them fill the coverage gap—one they don't know they have. ♦

*Christine McCullugh is a nationally known expert in long-term care, and the president of LTC Solutions (ltc-solutions.com). A speaker, consultant, and member of AHIP's Long-Term Care Curriculum Review Committee, McCullugh provides insights to employers, carriers, and industry associations in an effort to guide and develop the future of LTC insurance. She is pleased to provide expertise and partnership opportunities to colleagues desiring a deeper understanding of this unique market, and help presenting it to their employer clients.*

covered by their employer. By being more involved and aware of health care costs, employees soon find out that the more expensive providers and hospitals aren't necessarily the ones delivering the highest quality of care.

Also with reference-based pricing, an employer doesn't have to pay network fees or provide a narrow network. Employees can use their employer health care dollars for health care from any provider or hospital as long as they pay the difference.

Although savings can be substantial for an employer, some may be concerned that this type of pricing does not meet the requirements of the Affordable Care Act, viewing it as too heavily benefitting employers instead of employees which may incur employer penalties. Federal regulators continue to monitor this pricing strategy. However, a May 2014 Associated Press article reveals that the Health and Human Services and Labor Departments stated that the use of reference-based pricing as a cost-control strategy would not violate the ACA's cap on patients' annual out of pocket costs. They also said that it can be a good option for non-emergency, frequently performed tests and procedures. However, the agencies advised that employers must provide a reasonable method to make sure that employees have adequate access to quality providers.

### ENSURING THE SUCCESS OF REFERENCE-BASED PRICING

Here are five strategies to ensure that adopting reference-based pricing into your clients' self-insured health plans will reduce health care costs while making employees better shoppers of health care services today and in the future:

1. **Provide a well thought-out employee educational campaign.** Employees need to fully understand how reference-based pricing works, the benefit design, reference prices, and the anticipated costs for certain procedures/providers.

*(REFERENCE-BASED PRICING — Continued from page 30)*



*When used properly, it can offer substantial savings for employers while ensuring quality care for employees.*

2. **Provide the right reference price for each service:** Pricing services too low can create a very narrow network of providers while pricing services too high can result in a smaller percentage of annual savings.
3. Provide easy access to health care information including mobile applications and online tools.
4. Whenever possible, communicate and demonstrate to employees how this type of pricing structure fits into corporate values and direction so they understand how it benefits them as part of the fiscal strength of the company.
5. Factor in geographical considerations when formulating your reference-based pricing plan.

Keep in mind that reference-based pricing isn't for everyone. It's important to look for a good TPA that can help you set a reasonable reimbursement method and help employees navigate potential out-of-pocket expenses and negotiate with providers on their behalf, if needed. ❖

*David Zanze has over 30 years of experience as a leader and innovator in the health care industry. He is the president of Pinnacle Claims Management Inc., an all-inclusive third party administrator (TPA), and Pinnacle Rx Solutions, a pharmacy benefit manager. Both companies offer competitive, cost efficient benefits administration and claims processing in tandem with the latest technology in the self-funded marketplace. Pinnacle also provides administrative support for Covered California's Small Business Health Options Program (SHOP) and assistance for the Covered California Certified Insurance Agent community. For more information call 866-930-7264 or visit [pinnacletpa.com](http://pinnacletpa.com) to learn more.*

# LIFE INSURANCE TRENDS

*An interview with  
Kevin Kimbrough*

In this article, we interview a life insurance executive who gives his take on the most important trends in the life-insurance market.

by **LEILA MORRIS**

## **How are non-traditional producers now selling life insurance?**

One of the big trends is the growing prevalence of non-traditional life insurance distribution. For example, health insurance agents, financial planners, and property & casualty agents are cross selling life insurance. In many cases, they partner with a life insurance expert. This allows them to focus on their primary business while addressing a client's life insurance needs and gaining additional revenue. These non-traditional life insurance producers find that offering life insurance increases client retention and satisfaction.

## **Which products are the most popular?**

Indexed life insurance offerings will continue to be the fastest growing and one of the most popular products out there. Other products we see growing in popularity have a simplified and/or automating underwriting. Many advisors look for products with a quick and simple application process. This trend will continue to grow as carriers big data more effectively for underwriting, which mitigates the need for exams and medical records.

## **How has the use of innovative technologies affected life insurance sales?**

With technology enhancements it has gotten easier to fill out electronic life insurance applications. Many carriers are developing automated underwriting using tele-

phone interviews, motor vehicle records, and medical information and/or prescription databases to significantly cut down the time, complexity and cost of traditional underwriting. This improves the experience for the agent/advisor and the customer.

Agents and advisors are using online platforms that guide the product suitability and sales conversation. They can do a needs analysis or a product presentation to clients using a tablet or mobile device. It allows advisors to demonstrate policy returns and other assumptions at the point-of-sale, which makes the sales process more effective. Clients can see variations from product to product (with different riders or premium levels, for example). Also, during the sales conversation, clients can see what types of returns and benefits that a policy design would create for them.

Advisors are also using social media tools, such as LinkedIn, Facebook, Twitter and others to connect with clients and get their message out about life insurance.

## **Are consumers using life insurance in new and different ways? How so?**

In the past few years, we have seen consumers using life insurance to address multiple needs, most commonly for long-term care benefits. We are also seeing growth in accumulation sales. Consumers are buying life insurance to generate retirement savings because of its unique tax-favored status.

We are also starting to see that beneficiaries are using different ways to receive death benefit payouts. Traditionally, a



death benefit was distributed in a one-time lump sum. In some cases, clients are looking to set up policies with an annuitized income payment for their spouse/heir or one that is tied to certain life events of their heirs, such as college funding for children or grandchildren.

**What are some of the combination life insurance products on the market today? How are they different from the ones available five years ago?**

We continue to see the growing trend of life insurance products addressing multiple needs beyond a traditional death benefit with riders that address long-term care, critical care, and chronic illness. Everyday carriers are introducing new iterations of these types of riders.

We continue to see popularity of indexed universal life products. These indexed products, which are used as accumulation vehicles, are often used as alternative retirement savings vehicles.

We have seen a strong proliferation of life and long-term care combination products over the past five years, certainly due to the great wave of Baby Boomers preparing for and entering retirement. Many combination products offer different levels of coverage ranging from tax-qualified long term care benefits to chronic illness benefits that are included in gross income. The options also vary by the qualifying conditions that will allow the client to access the policies' benefits. Generally, chronic illness riders require that a doctor certify that the client's condition will last for the rest of their life. However, products with LTC riders can be used for a recoverable condition.

Another key difference in combination products is the movement from guaranteed universal life insurance

with living benefits to accumulation products with living benefits. Nearly all companies have tried to shift their permanent insurance business to less capital-intensive products. This shift has also aligned with a more optimistic client perspective. Consumers today are significantly more interested in cash value growth compared to years ago when security and guarantees were resonating.

**With the new types of life insurance products on the market, what trends are you seeing with policy review and/or purchases of new policies?**

As far as policy review, I see an opportunity for people who can still qualify, from an underwriting standpoint, to upgrade to the new types of life insurance policies. Newer policies offer more innovative riders. These policies have lower mortality costs and may offer riders and benefits that were not available when the client bought a policy 10 years ago, 15 years ago, or more. By using a 1035 exchange, policyholders can transition to a newer policy with these benefits. In many cases, policy holders can also look at options that may increase death benefit or lower premiums. In some cases, they can improve cash accumulation prospects inside the policy.

We are also seeing the trend of more people qualifying for life insurance at older ages as life spans and general health improve. People who are willing to do a policy review can pick up these new benefits on a new policy. This will continue to be a major trend moving forward. ❖

*Kevin Kimbrough is principal of National Sales for Saybrus Partners. Leila Morris is senior editor of California Broker Magazine*



## CALIFORNIA INSURERS ARE ON THE BRINK OF CHANGE

California's insurance market is set to undergo enormous changes as health reform takes full effect and millions become eligible for public insurance or private subsidies, according to a report by the California HealthCare Foundation. The report provides a snapshot of the insurance market in California at the end of 2013, just before the major provisions of the Affordable Care Act (ACA) took effect. It also includes some initial figures from 2014 that point to large shifts in Medi-Cal and individual coverage levels. Researchers looked at data from the Department of Managed Health Care (DMHC), the California Department of Insurance (CDI), and other sources to examine market share, enrollment, financial performance, premiums, public coverage, and consumer satisfaction. The following are Key findings:

- Health insurance was a \$123-billion business in California in 2013, with six carriers accounting for more than three-fourths of all revenues and most insurers operating in the black.
- In 2013, enrollment shifts were small, except in the pre-ACA individual market.
- State and federal policy actions brought significant growth to Medi-Cal managed care—about 2.8 million enrollees, a 58% increase in the 18 months ending in June 2014.
- Covered California enrolled 1.4 million individuals in health insurance plans through 11 carriers in the first enrollment period ending March 31, 2014.
- Product choice differed by market, with only 20% of individuals enrolled in HMOs and 79% of large group enrollees in HMOs in 2013. This could change in 2014 as the ACA implements sliding-scale premium subsidies and mandates freedom for individual enrollees to choose their product and insurer.

To get the complete report, visit [chcf.org/publications/2015/02/california-health-plans-insurers#ixzz3TOKuvlCd](http://chcf.org/publications/2015/02/california-health-plans-insurers#ixzz3TOKuvlCd).

## EMPLOYERS EXPECT CHANGES TO EMPLOYEE HEALTH BENEFITS

Eighty-four percent of employers expect to make changes to their full-time employee health benefit programs over the next three years, despite cost increases remaining at historically low levels, according to new research from Towers Watson. In addition to aggressive cost management, employers are evaluating the implications of the changing provider landscape, embracing new ways to deliver care through innovative network arrangements, focusing on increasing employee engagement and exploring new options for delivering benefits. This includes assessment of active employee private exchanges and a rapid migration of Medicare retirees to private exchanges.

Employers are using and actively considering various options to manage cost, change employee behaviors and optimize program performance.

Employers project health care costs to increase 4% in 2015 after plan changes, compared to the 4.5% employers predicted for 2014. Without plan changes, projections are for an increase of 5.2%. These modest increases are still more than double the rate of inflation and are a primary factor driving employers' affordability concerns as the 2018 excise tax in the Affordable Care Act approaches. Two in five employers that have done extensive modeling of their plans say they will trigger the excise tax in 2018. Two-thirds say the tax will have an impact on their health program strategies.

Randall Abbott, a senior consulting leader at Towers Watson said, "Employers have strived to keep their cost increases at the market average, but increasingly this just isn't enough. The new focus is on reducing cost trends to the CPI or below. This means driving cost growth to roughly 2% or less, which requires an acute focus on all aspects of health plan performance. In addition to solving the rate of cost trend, employers must pay attention to the base cost. We are seeing a wide variation across and within industries even after adjusting for unique group characteristics. High-performance health care has become the new mantra emphasizing not just reducing costs but improving workforce health, better engaging employees and leveraging new health technologies."

Among the actions gaining traction are changes to benefits for spouses and dependents. For example, the percentage of employers using spousal surcharges (when coverage is available elsewhere) is expected to nearly double, from 32% now to 61% in three years. Fifty-three percent of respondents plan to significantly reduce subsidies for spouses and dependents by 2018. In addition, 41% say they may adopt a defined contribution arrangement (capping employer contributions at a flat dollar amount) by 2018.

Employers reported greater resolve to improve health outcomes per dollar spent, with two-thirds planning to use data extensively to evaluate plan performance and employee behavior changes in lifestyle and health management. In addition, the use of centers of excellence (within health plans or via a separate network) and narrow networks are expected to triple over the next three years. The use of telemedicine services in place of in-person physician visits, when appropriate, will con-

tinue to be rapidly adopted, already expanding by 35% in 2015 over 2014. Over 80% of employers say they could be offering telemedicine services by 2018.

Over the next few years, more than 80% of employers will carefully evaluate specialty pharmacy programs and benefits embedded in their medical plans. Sixty-one percent of employers report including coverage and utilization restrictions in their specialty pharmacy strategy.

Employers recognize the business value of a healthy workforce and are encouraging employees to take control of their health. Two of the top five areas employers say will be the focus of their health care activities in 2016 link to employee engagement and accountability: developing or enhancing a workplace culture where employees are responsible for their health (66%), and adopting or expanding the use of financial incentives to encourage healthy behaviors (51%).

The following are the most popular tactics for boosting employee engagement in health care:

- 48% will place more emphasis on educating employees about how to select providers based on quality and cost information over the next two years. In 2016, 43% of employers will provide price and quality transparency tools to help employees make better consumer choices.
- 60% of employers deliver health and wellness messages through mobile apps and portals. That percentage will increase to 95% by 2018.
- 17% of employers offer full-replacement high-deductible plans tied to tax-advantaged health savings accounts. The percentage may increase to nearly 50% by 2018.
- Employer confidence in private exchanges is increasing: 17% view private exchanges as a viable alternative for active full-time workers in 2016. Confidence more than doubles to 37% by 2018.

Twenty-six percent of employers have analyzed private exchanges extensively, and 20% say they are more interested in adopting a private exchange than they were a year ago. Companies that have completed extensive analysis of private exchanges are twice as likely to find private exchanges a viable alternative in 2016.

Employers report that cost savings and administrative simplicity are key factors in prompting use of private exchanges. Finance will play a role in shifting to a private exchange model. Fifty-three percent report that finance will influence the decision to move to a private exchange or continue to maintain traditional employer-managed health plans. For more information, visit [towerswatson.com](http://towerswatson.com).

### THE ACA COULD RAISE PREMIUMS FOR SMALL GROUPS

The Affordable Care Act (ACA) expands the definition of small employer to include those with up to 100 employees for plan years beginning in 2016. Many employees in groups 51 to 100 could be facing changes to their benefits. The expansion could also mean increased premiums for those in groups of one to 50, according to a report by the American Academy of Actuaries.

The scheduled expansion of how small employers are defined could result in changes to health care premiums and coverage for significant numbers of employees of small businesses.

Many employers and employees will be affected by the change in the small group definition. Such a change could affect over 150,000 establishments with more than 3 million workers. Groups sized 51 to 100 will face more restrictive rating rules, which will increase relative premiums for some groups, such as those with younger and healthier populations, and reduce them for other groups, such as those with older and sicker populations.

Groups sized 51 to 100 will face additional benefit and cost-sharing requirements, which could reduce benefit flexibility and increase premiums. The more restrictive rating and benefit requirements could cause more groups sized 51 to 100 to self-insure, especially among those whose premiums would increase under the new rules. To get the issue brief, click on Health under the Public Policy tab at [actuary.org](http://actuary.org).

### MEDICARE ADVANTAGE—A GROWTH VEHICLE FOR HEALTH PLANS

Health plan executives may be missing an opportunity to capitalize on the growing demand for Medicare Advantage (MA) plans, according to a survey by KPMG. Consumer adoption of these plans is expected to grow as more Baby Boomers enter retirement years. Despite interest and growing membership in MA, the number of health plans viewing the category as a major part of their market offerings decreased to 24% in 2014 from 35% in 2011. Only 29% of health plan executives see MA as a source of market segment growth in 2015, putting that category behind individual insurance and small and large group plans.

“Health plans have been going through unprecedented transformation as a result of the Affordable Care Act...Individual insurance is expected to be a major part of health plan offerings, but there is an overlooked opportunity to engage aging Baby Boomers, who may see this as an option instead of traditional Medicare as they enter their retirement years,” said Ashraf Shehata, U.S. advisory leader for Health Plans.

Congressional Budget Office projections see MA enrollment growing to 19 million by 2017, an increase from the 16 million in these plans. Two in three people older than 64, who are open to joining MA plans, are likely to do so this year. Renewal among members is at 85%, and one in three traditional Medicare plan beneficiaries are open to changing to MA.

According to the KPMG survey, nearly half of the people covered by Medicare would be willing to absorb a premium increase of \$100 per month while 38% would switch to narrower provider networks and 14% would seek plans with higher deductibles. If the monthly premium for traditional Medicare increases by \$200, only 19% would be willing to absorb the premium increase. Narrower networks would be the most attractive option to Medicare beneficiaries under that scenario over higher deductibles (54% versus 27%).

Most people pay \$104.90 for Medicare Part B, which covers durable medical equipment, medically necessary services and preventive care, according to CMS. Two-thirds of MA enrollees have at least one serious chronic illness, compared to 34% of enrollees in traditional Medicare. This disparity is likely to con-

tinue. More than half of those who said they were likely to enroll in MA in 2015 have a chronic condition. Seventy-seven percent of MA enrollees with chronic conditions are satisfied with their health plan, versus 66% of those with no chronic condition.

Shehata said, “Seniors are leaning toward MA plans as a better alternative to Medicare gap coverage, and people with chronic conditions tend to be sensitive to out-of-pocket medical costs. Our survey also found that seniors might be inclined to switch to MA plans if vision care were covered, if their primary doctor was coordinating care or if incentives were available for managing their blood sugar and blood pressure. There are some very interesting opportunities for health plans to profitably gain new customers while delivering value to seniors.” For more information, visit [kpmg.com](http://kpmg.com).

### HHS URGED TO PREPARE FOR POSSIBLE ELIMINATION OF ACA SUBSIDIES

The American Academy of Actuaries called on HHS to address the possible elimination of Affordable Care Act (ACA) premium subsidies. If the U.S. Supreme Court decides in favor of the petitioners in *King v. Burwell*, there could be a significant drop in health plan enrollment and an increase in the risk profile of remaining enrollees. This would drive up average health costs for health plans. Insurers are limited in their ability to change premiums for 2015 and 2016. As a result, premiums for 2015 and 2016 are likely to be inadequate to cover claims. These premiums need to be submitted before the court’s ruling.

The Academy said that HHS and state authorities should consider allowing contingent premium rate submissions and/or revised submissions to help mitigate the potential for inadequate 2016 premiums in FFM states. These changes could include the following:

- Allowing insurers to submit two sets of contingent premium rates. One set would reflect pricing assumptions that would be appropriate if premium tax credits continue to be available; the other set would reflect pricing assumptions that would be appropriate if premium tax credits are no longer allowed.
- Allowing premium rate revisions after the May 15 submission deadline.

For more information, visit [actuary.org](http://actuary.org).

### WHEN TO CONSIDER TERM HEALTH INSURANCE

Term health insurance premiums average 66% lower than unsubsidized premiums for Obamacare bronze plans, according to a study by AgileHealthInsurance. The reasons behind the premium differences include the broader mandatory benefits of Obamacare plans and the lack of coverage for pre-existing conditions for term health insurance. “Consumers who don’t qualify for significant Obamacare subsidies or can’t get insurance outside the enrollment period should definitely investigate term health insurance. For millions of people, term health insurance can represent a more affordable option than Obamacare or a bridge to next year’s Obamacare enrollment period,” said Bruce Telkamp, CEO of AgileHealthInsurance. The following are ideal profiles for people who purchase term health insurance:

1. People under 65 in good health.
2. People who need health insurance for a specific period (e.g. an interval in between jobs)
3. A young adult who can no longer be insured through their parents’ health plan.
4. People who need health insurance outside of the Affordable Care Act’s enrollment period, but who don’t qualify for a special enrollment period.
5. Retirees in good health who no longer have employer-provided health insurance but are too young to enroll in the Medicare program.
6. Term health insurance cannot be longer than 364 days in any state. In some states, policies are limited to a maximum term of six months.

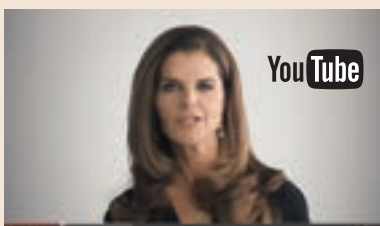
The study compared the average premiums among term health insurance and unsubsidized entry-level Obamacare health plans. When comparing premiums for nonsmoking men and women ages 30, 40, and 50, all ages saw major pricing advantages in term health insurance. Thirty-year-old applicants had premium quotes over 70% lower while 50-year-old applicants had premium quotes over 50% lower.

The dramatic savings in premiums should be viewed in light of three considerations: Obamacare premiums can be significantly reduced for those who qualify for subsidies; term health insurance premium savings should be adjusted down for the cost of the fine for not having health insurance compliant with Obamacare standards; and people with poor health can be rejected for term health insurance coverage.

People with certain chronic conditions or poor health would not be served well by a term health insurance product. Additionally, people who have had a significant health event or medical condition in the past two years also are advised to seek other forms of health insurance because pre-existing medical conditions are not covered by term health insurance.

When the coverage period for a term health insurance policy ends, an enrollee may be eligible to apply for a new term health insurance plan or seek other health insurance coverage, such as coverage provided by an employer or coverage provided by an Affordable Care Act health plan. Negative changes in health status can result in the application being rejected. But they can still purchase Affordable Care Act coverage.

Affordable Care Act plans typically have broader benefits. All health plans that comply with the Affordable Care Act must have “10 Essential Health Benefits.” Term health insurance plans don’t have a standardized set of benefits and typically offer what would be described as “major medical coverage,” which covers health-care costs in the event of serious medical issues, though normal doctor visits for routine illnesses and injuries are typically covered. Affordable Care Act plans don’t deny care for pre-existing conditions nor do they reject insurance applicants based on health problems. For more information, visit [AgileHealthInsurance.com](http://AgileHealthInsurance.com). ❖



### PLATFORM TO OPTIMIZE BENEFIT ADMINISTRATION & ENROLLMENT

Benefitfocus is offering BENEFITFOCUS Marketplace, an updated a private exchange platform. It now does the following:

- Compiles healthcare data from multiple sources and translates it into information that can help employers identify healthcare cost drivers and design plans.
- Synchronizes enrollment and billing information to streamline the monthly billing process, automate adjustments and increase accuracy of payments.
- Provides a personalized dashboard that makes it easier for consumers to find important information quickly. It also gives benefit administrators the ability to customize content and push HR notifications to users based on demographics, life-event changes and other factors.
- Allows employers to incorporate health assessments and reward programs into the benefit enrollment experience.
- Offers employers, insurance carriers and brokers a curated selection of voluntary insurance products, including: critical illness, hospital indemnity, accident, legal, permanent life, pet, auto, home and more. Offers 23 private exchanges for individuals, small employers, large employers, and retirees.

For more information, visit [benefitfocus.com](http://benefitfocus.com).

### MEDICAL CARDS TO REWARD CLIENTS ICE MEDICAL CARDS

Agents can now offer branded Medical cards as a reward to clients. The system includes a key tag and a Medical Card that fits conveniently in front of a driver's license. Members create and update their information via a secure online portal. In the event of an accident or emergency, first responders can quickly access this portal with the information printed on the back of the card, provided there is Internet or mobile phone access. For more information, visit [ICEMedicalCard.com](http://ICEMedicalCard.com).

### SPANISH BENEFITS LEARNING CENTER

Colonial Life has launched a Spanish-language version of its popular Benefits Learning Center website to better serve the country's fastest-growing demographic group. The free site is open to the public and isn't limited to Colonial Life customers. For more information, visit [benefitslearningcenter.com/coloniallife/En%20espanol.aspx](http://benefitslearningcenter.com/coloniallife/En%20espanol.aspx).

### ACA COMPLIANCE

Minnesota-based Health E(fx) released its "Compliance Connect," an Affordable Care Act (ACA) management solution. It's designed for third-party providers, including benefits administration, payroll, private exchange, and outsourced HR-managed services. For more information, visit [healthefx.us](http://healthefx.us).

### LTC EDUCATIONAL VIDEO

Genworth Financial has unveiled an educational video, "Let's Talk Now," featuring actors and media personalities Angela Bassett, Jim Nantz, Maggie Gyllenhaal, and Zachary Quinto in addition to Maria Shriver and Rob Lowe. To view the video, visit [multivu.com/players/English/7436251-genworth-let-talk-now-video-launch](http://multivu.com/players/English/7436251-genworth-let-talk-now-video-launch).



# ALTERNATIVE MEDICINE NEWS



## THE COST-EFFECTIVENESS OF CHIROPRACTIC CARE

Patients who get spinal manipulation within the first 10 days of a spinal episode face lower treatment costs as well as lower use of imaging, injections, prescription medications, and surgery, according to a study by Optum. Costs per episode are 40% lower when chiropractic care precedes medical or surgical intervention. Also, chiropractic care is associated with favorable clinical outcomes and high patient satisfaction.

According to research published in *Spine*, low back pain patients who first visited a DC versus a surgeon were about 40% less likely to have surgery. Musculoskeletal conditions are amongst the costliest health care condition for patients and payers, alike, according to Gerard Clum, DC, a spokesperson for the Foundation for Chiropractic Progress. Clum adds, "The Optum data further validates the value of chiropractic care and acceptance of the rising trend: chiropractic first, medicine second and surgery last." For more information, visit [yes2chiropractic.com](http://yes2chiropractic.com) or call 866-901-F4CP (3427).

## HEALTH PLAN MEMBERSHIP DRIVES UTILIZATION

Some chiropractic practitioners wonder whether they would be better off moving to a cash-only practice, but an analysis by Landmark reveals why withdrawing from insurance plans may not be the best move. Patients who pay completely out-of-pocket make fewer visits per chiropractic episode and pay less per visit. Some patients are simply unwilling or unable to pay for additional care. Expenditures are 91% higher for those with private insurance, 61% higher for those with Medicare, and 117% higher for other third party payers (after controlling for socio-economic, geographic, and health status.)

Patients had an average of 5.8 visits per episode of care with an average payment of \$69 per visit. This averages out to \$424 expenditure per episode of care. Nearly 30% of all chiropractic episodes are paid entirely by the patient.

Previous studies have shown that chiropractic services are very sensitive to patient cost sharing. Limiting coverage of chiropractic services could steer patients toward riskier and more costly treatments, such as opioid use, interventional pain management, and surgery, according to researchers.

Landmark looked at chiropractic services in the United States from 1997 to 2006. In 2006, 12.6 million adults made 109 million chiropractic visits with \$5.91 billion in expenditures. In another recent report, future chiropractic expenditures were projected to reach more than \$12.5 billion by 2015. That's a 68% increase in patients, a 70% increase in visits, and a 55% increase in total expenditures from 1997. Those who say that their mental health is poor or fair make fewer chiropractic visits than those who say that their mental health is good or excellent. Those without high blood pressure have shorter episode durations (45.1 versus 59.1 days) and fewer days between visits (6.6 versus 8.9 days) compared to those with high blood pressure. For more information, visit [lhp-ca.com](http://lhp-ca.com).

## CHIROPRACTIC CARE PROVES USEFUL FOR PTSD

A novel brain and vestibular rehabilitation treatment has proven to be effective in post-traumatic stress disorder (PTSD) patients who suffered combat-related traumatic brain injuries. Specialty providers in the chiropractic profession use these methods in the treatment of the brain, spine, and nervous system as a whole. The study was published in *Frontiers in Public Health*. For more information, visit [yes2chiropractic.com](http://yes2chiropractic.com) or call 866-901-F4CP (3427).

A mix of fast and slow eye movement exercises can also generate positive clinical outcomes for people who have experienced PTSD brought on by a combat-related blast, a sports-related concussion, or a stroke, according to supplementary reports.

## PSYCHOLOGICAL FACTORS PLAY A PART IN ACUPUNCTURE

People with back pain who have low expectations of acupuncture will gain less benefit from the treatment than those who believe it will work, according to new research from the University of Southampton. The University of Southampton's Dr Felicity Bishop said, "Psychological factors were consistently associated with back-related disability. People who started out with very low expectations of acupuncture were more likely to report less benefit as treatment went on...Patients experienced less disability over the course of treatment when they came to see their back pain as more controllable, when they felt they had better understanding of their back pain, when they felt better able to cope with it, were less emotional about it, and when they felt their back pain was going to have less of an impact on their lives." For more information, visit [southampton.ac.uk](http://southampton.ac.uk).

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