

CALIFORNIA BROKER

VOLUME 33, NUMBER 9

SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

JUNE 2015



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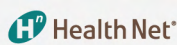
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Subscriptions and advertising rates, U.S. one year: \$42. Send change of address notification at least 20 days prior to effective date; include old/new address to: McGee Publishers, 217 E. Alameda Ave. #207, Burbank, CA 91502. To subscribe online: calbrokermag.com or call (800) 675-7563.

California Broker (ISSN #0883-6159) is published monthly. Periodicals Postage Rates Paid at Burbank, CA and additional entry offices (USPS #744-450). POSTMASTER: Send address changes to *California Broker*, 217 E. Alameda Ave. #207, Burbank, CA 91502.

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No responsibility will be assumed for unsolicited editorial contributions. Manuscripts or other material to be returned should be accompanied by a self-addressed stamped envelope adequate to return the material.

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THE NECESSARY AGE OF SMART CHOICE



by **RON GOLDSTEIN, CLU**

Freedom of choice is part of the fabric of America, so the appeal of choice for health care coverage has economic as well as cultural dimensions. But a prickly paradox to choice is this: an abundance of unstructured plan options becomes overwhelming. As the pre-eminent American psychologist Barry Swartz points out, whether one is choosing a health care plan or buying a pair of jeans, a bewildering array of choices “floods our exhausted brains,” restricting our abilities to make a selection. This is where health benefit plan advisors and providers—particularly those serving the unique needs of California’s 670,000-plus small businesses—have huge opportunities to step in and save the day.

With choice overload, decision-making freezes. A well-known Columbia Business School study demonstrated this phenomenon when it looked at participation rates for defined-contribution plans, such as 401(k)s and IRAs. Using records from nearly 800,000 eligible employees, the study showed that offering scores of investment choices with only basic descriptions and little or no professional direction de-motivated participation.

This phenomenon also holds true for health care coverage. Too many plan choices without proper professional service and provider support can cause decision paralysis for businesses and workers. That can prove disastrous if either ends up making random decisions about selecting a plan—or worse—not picking one at all. For health insurance brokers, benefit advisors, providers, and carriers, it means customers, employees and consumers who may be confused, frustrated, unhappy, and, perhaps most importantly, improperly covered for their needs.

Without a doubt, health care reform and the emergence of highly publicized, government-sponsored exchanges have accelerated consumer appetite for choosing the best coverage. But it is another thing to try making the best decision without professional counsel or a well-designed provider platform with strong broker and customer service.

A recent Penn Wharton University study reveals that only about 14% of people surveyed could answer multiple-choice questions about the four basic components of health insurance plans: deductibles, copays, coinsurance, and maximum out-of-pocket costs. Just 11% of people could navigate the features of a traditional plan to calculate the estimated cost of a four-day stay in the hospital.

State and federal governments are expecting Americans to grapple with these concepts and through employer offerings or on their own while purchasing insurance on exchanges or directly from carriers. This underscores why brokers will continue to be highly valued by employers, especially among small group employers with fewer staff and resources to research, manage, and administer plans.

There is another vital component to enabling a smart choice. While brokers and advisors serve as expert navigators, they are often only as effective as the routes available to them. Too many options, especially ones that are inadequately constructed and serviced, impede the path to choosing optimal health insurance options.

The answer is to turn to providers that offer a customizable plan choice, useful technology, and personalized service. Plan choice offers brokers an expansive choice platform for their clients while

offering employees well-defined options that facilitate decision-making rather than hinder it.

Technology is another important part of the equation because it can encourage decisiveness and foster smart choices. But, it is only effective if it’s usable. Easy-to-use online quoting and enrollment are a must for brokers and clients to compare plan costs and benefits. But tools, such as online physician and provider directories, hospital comparisons, RX searches, plan comparisons and more are just as important. People want to be sure that a plan allows them to continue seeing their doctor or specialist; the ability to do a quick look-up makes a big difference.

While technology brings computing and access to information to our fingertips, service still reigns supreme when it comes to optimizing the provider-broker-customer interplay and traversing a byzantine array of choices. A recent poll of 1,000 U.S. consumers found an overwhelming preference for personalized service and human interaction from their insurance providers. While technology has enabled the seemingly overnight proliferation of online insurance marketplaces and exchanges, providers that can deliver service support to brokers and their customers will win out in the long term.

This means much more than simply providing service to employers and their workers, although that certainly is essential. Today’s professionally licensed benefit specialists routinely serve as de facto human resources, personnel and/or payroll departments for many small businesses. In too many instances, technology and automation are attempting to substitute for dependable human support that the best carriers and exchanges provide. The best of technology and personal service are required for choice to work effectively.

So what does this all mean for brokers and benefits advisors? First, continue to do what you do best, which is to provide your clients with expert counsel, guidance and service. Doing so allows employers and workers to find the best range of options while providing manageable levels of personal autonomy and control in selecting the health plan that fits their needs. Then, be sure to work with providers that offer plan choices supported by exceptional, convenient customer service. This service should include useful technology that helps you and your small group customers find, aggregate, curate, and compare quotes and plan options simply and efficiently. And it should include high-touch assistance and support from real people who are there for you like you are for your clients.

We live in an era where choice is and should be celebrated. But the ability to maximize options makes all the difference. The right mix of health plan choices is a powerful tool for small groups (and large). The combination of savvy brokers and plan providers that offer great benefits, simple administration and top-notch customer service provide the ingredients to help deliver that choice smartly. ★

Ron Goldstein, CLU, is president and CEO of CHOICE Administrators®, which provides health insurance options and provider access to small businesses and their employees. He also created and currently manages America’s longest-standing, state-approved exchange, CaliforniaChoice. For additional information, please visit calchoice.com.

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MAY 1, 2015

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 3/3/15. 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	3.70%*	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 5/18/15. First year rate includes 1.50% 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 6/1/15. 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	5.85%*	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 5/18/15. 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	1.80%*	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 4/13/15												
Genworth Life & Annuity Insurance Co.	A	A-	A-	SecureLiving Rate Saver	S	2.45%* 2.20%	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 4/1/15. 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	1.10%*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
**Rates Effective 5/1/15 for premium less than \$100,000 and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	1.50%*	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	
**Rates Effective 5/1/15 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 4/28/15 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	2.80%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 5/15/15. 2.30% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												

WORKPLACE WELLNESS: *It Matters*

by ELIZABETH HOLMAN, MBA

Workplace wellness is everybody's business. Most employees spend more than one-third of their day at work and the majority of their waking hours. Given all of the time we spend at work, employers and employees coming together to create a healthy work environment benefits everyone.

Good health leads to good business. Good health includes good mental health, as the mind and body are connected. Keeping employees healthy, productive, and engaged is one of the most critical challenges for employers. Also providing resources that address stress, depression, poor sleeping habits, and chronic disease is of the utmost importance.

Employees with untreated mental health or substance use issues and underlying chronic disease can lead to absenteeism, limited productivity, high turnover, and more disability claims—all of which adds costs to the employer. People experiencing a personal or family crisis, chronic stress; etc., often have nowhere to turn for confidential advice other than the EAP offered through their workplace. A full-service EAP offers a variety of resources for the employer, employees and their household members, and can provide tremendous support in a confidential manner for a multitude of issues.

Counseling for:

- Drug and alcohol problems
- Marital and family conflicts
- Adolescent behavioral problems
- Stress-related problems (and more)
- Gambling addiction
- Lifestyle coping techniques (chronic disease, nutrition, etc.)

Addressing Work Performance Issues:

- Workplace violence (suicide & homicide)
- Critical incidents in the workplace
- Crisis planning
- Fatigue management

EAP and wellness programs help mitigate employer risk. Here are some facts and trends to be aware of as benchmarking for your employer clients when evaluating employee benefit offerings:

- Approximately 90% of Fortune 500 companies offer an EAP to their employees, according to Public Health Reports. Mental health issues including those relating to stress and addictive disorders cause 217 million missed workdays each year in the United States and account for 7.6 percent of health expenditures, with an indirect cost of an estimated \$105 billion, according to the National Business Group on Health (NBGH).
- Companies that provide an EAP may be viewed as more employee-supportive compared to competitors that do not provide such a program for workers. In addition, employee assistance programs have been cited as an effective element in employee retention efforts designed at reducing turnover. "We have to focus on the job and the ability to do the job. We don't want to play counselor and dive into areas we're not qualified for," one business executive told the *Pittsburgh Business Times*.

"We recognize the importance of creating a best-place-to-work environment, and we know that doing so leads to successful business outcomes," says David Kasiarz, PhD, senior vice president of Global Compensation and Benefits at American Express. Kasiarz began his professional life in the mental health field and changed careers midstream out of a desire to evolve human resource management by working to create what he describes as "enlightened policy." ★

Elizabeth Holman, MBA, is the vice president of Sales & Marketing at The Holman Group, and has worked at Holman since 1999, a global specialty behavioral health company that has been in business for over 36 years. Ms. Holman is a certified CE instructor with the DOI, has been on various boards for local Health Underwriters chapters, speaks at various associations in the community and participates in Health Forums. Her primary responsibility includes business development, underwriting, compliance and marketing.

The Holman Group is a Knox-Keene licensed company that has been in business for over 36 years. The company provides EAPs, mental health and substance use services, and integrated wellness programs to more than a million members nationwide. For more information, email TheHolmanGroup@holmangroup.com or call 800-321-2843.



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MODERN DISABILITY

Financial Planning

by W. HAROLD PETERSEN, RHU, DFP

The new century presents great opportunities for advisors to serve people with their knowledge, using the latest planning concepts. With this opportunity comes the duty to diligently and fully provide modern and unbiased financial advice. You won't find Personal Economics 101 in college course catalogues. Parents who are untrained in personal economics can't provide dependable information and guidance. Typically, their children need helpful information about their financial plans. The highly important task of providing personal economic and financial advice is the domain of financial service professionals.

Credentialed studies and a commitment to continuing education provide evidence that advisors strive to be highly professional and provide competently sculpted financial plans. Changes in 21st century perceptions and functions have created a class of professional generalist versus the professional specialists we knew last century. In the 20th century, purveyors of financial plans and products were specialized in areas, such as securities, life and health insurance, property and casualty insurance, real estate, accounting, law and banking. In the 21st century purveyors co-mingle knowledge from these various venues and become specialists in providing expertise in overall financial planning.

The change is working well except in the challenging field of disability financial planning. Industry statistics tell us that advisors are not preparing consumers for the awesome and frustrating financial contingencies that result from becoming disabled. A study by the Dept. of Labor reveals a widespread dereliction of duty among advisors. Only 27% of income earners in America have any disability insurance, and of that number the majority has inadequate amounts to meet their obligations.

DIMENSIONS OF AN ADEQUATE DISABILITY FINANCIAL PLAN

People of every income level must maintain an income cash flow level of 65% to 75% of normal or they will be forced to liquidate some of their assets, according to surveys by the *U.S. News and World Report Magazine* and separately by the Dept. of Labor.

Most Americans are supported by income earned by themselves or someone else. Curtailment of earned income creates harsh financial consequences for those who depend on it. Our state and federal governments have long recognized the vital need for people to have a continuing flow of income when they are unable to earn it. These governments have established programs to help citizens have a continuing income cash flow:

The Law	Year Enacted
Workers' compensation	1908
Unemployment compensation	1917
Social Security retirement	1935
State disability plans (five states)	1942
Social Security disability	1956
Tax advantaged retirement plans	1957

Economists and scholars of finance have long recognized the need for continuing income cash flow. Life insurance was once looked upon as a burial fund. With the 1913 book *Life Insurance* by Solomon S. Huebner, Ph.D., CLU, the definition was expanded to income replacement insurance for survivors of a deceased wage earner. Dr. Huebner said that disability income insurance clearly belongs in the life insurance group of coverages. The basic purpose of life insurance is to replace income when the earner is unable to personally produce it. Up to that time in history, disability insurance, then known as "accident and health insurance," was considered a casualty coverage, which was offered by casualty companies or by accident and health insurance specialty companies.

OIL AND WATER

Dr. Huebner also created the concept of "human-life value." He cited the need for income replacement insurance whether the loss of income stems from "dead death" or "living death." Financial advisors have encountered difficulty, disappointment, and disdain because of the many limits life insurance companies impose on the underwriting of disability income insurance. Balancing income cash flow replacement in the case of dead death has been relatively easy, but in the 127-year history of disability insurance in America, with few exceptions, adequate income replacement benefits have not been available from a single source.

CEOs of life insurance companies are frequently selected from banking, accounting, and finance. So it's natural for them to view the companies they manage as financial institutions, not as insurers. Without insurance experience, they have had little understanding for consumer's insurance needs. These executives often perceive disability insurance as working against attempts to accumulate premiums for investment purposes. Disability insurance entails a claims obligation that involves sending premium money back to policyholders during periods of disability. In addition to the actual claims costs, substantial claims reserves must be set aside quickly. Annuities and life insurance, which do not



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present such volatility, are considered by financial managers to be a safer risk to insure.

As a result of this uneasiness about disability insurance, the number of companies that underwrite disability insurance has dropped precipitously from 350 to 26 in just the past decade. With a lack of competition and with only two or three reinsurers active in the disability field, the conditions for limited and controlled benefit offerings exists.

Some financial planners have shunned disability insurance because of a lack of capacity, and others because of harsh underwriting. Both factors have contributed to disappointment and resentment among clients and prospects who don't get the coverage they need. Few life insurance companies promote disability sales, few offer sales incentives to foster sales, and most have, long ago, forgone educational endeavors in this field.

To homogenize the needs of the consumer with the now available coverages, creativity is needed to forge an adequate disability plan. All sources must be considered to deliver the required amounts. Highly compensated people cannot be adequately insured with individual disability income or group disability alone. Disability financial planning will be needed to provide an adequate disability income plan.

21ST CENTURY DISABILITY FINANCIAL PLANNING

Disability Insurance is not about elimination periods, benefit periods, and definitions of disability. Those are technical aspects of a given product. Disability insurance is about income—money. It is truly a vital financial product. The 20th century policy that only yields enough benefits to fund bread and water and a tent in the park is no longer sufficient. In the 21st century, attitudes of underwriting and planning have changed and will continue to change.

Losing a job is not a new century concern. In this century, people will change jobs six to eight times during a career. The measure of a career period will be replaced by a cash flow concern. The old 20th century advice of getting a job with a big company; staying out of corporate politics; and hanging on until retirement doesn't hold any believability. Product obsolescence, new technology, consumer tastes, and mergers and acquisitions create job change developments.

Insurers' issue limits, participation limits, and caps are based on old century concepts. These limits result in inadequate amounts of deserved and needed income cash flow. A new planning approach to measuring people's disability income needs will overcome these limitations. The 21st century issue limits will consider the probable asset value of the career earnings of a consumer, not just the person's past earnings.

DISABILITY FINANCIAL PLANNING FOR THE HIGH INCOME EARNER WHO IS NOT YET SUPER RICH

A highly successful entertainer, athlete, or business or professional person must set aside a portion of their earned income to create wealth and build a passive income and a retirement income to sustain a lifestyle of choice. Financial discipline and time is required to achieve this level of independence. If earned income diminishes or ceases altogether during the wealth creation period, the plan will fail.

Bankers commonly recommend that their clients buy life insurance to cover their indebtedness to the bank. In the event of disability, earned income would cease and repayment of debts would be in doubt. But bankers have glossed over disability insurance because most disability insurers do not provide sufficient coverage to fulfill the need. Modern underwriting provides for bank loans to be insured outside the insureds personal disability financial plan.

Supplemental disability insurance and softened underwriting rules have been combined to limit such problems. Bankers enthusiastically endorse the aspects of carrying bank loan indemnification insurance until the client is debt free.

DISABILITY FINANCIAL PLANNING FOR THE ALREADY RICH

Take the example of a 40-year-old CPA who inherited wealth. He earns \$250,000 per year from his accounting practice. He inherited an apartment building appraised at \$13 million, which yields net rental income of \$250,000 per year. Combined earned and unearned income total \$500,000 per year.

Without hesitation, the CPA and his financial advisor decided to buy insurance on the \$13 million building. The loss of the building would include the value of the bricks and mortar, but more importantly, the loss of an endless income stream of \$250,000 per year of passive income. Next comes the question of whether the client should insure the \$250,000 of income he earns from his practice. This income flow, when measured as an asset, achieves a comparable value of the \$13 million building when the current rate of income is calculated over a period of time (to age 65) and includes a 6% rate of growth/inflation.

ALL INSURANCE IS IMPORTANT IN PROTECTING ASSETS

This year the changes are the following:

Asset	Odds
Home	1 in 1,200 of being destroyed by fire
Auto(s)	1 in 250 of needing it
Death	1 of 150 of happening this year
Disability	1 in 30 of suffering a long term disability

Few people have net asset values that exceed the capitalized value of future earned income. Like the recognized hard assets owned by a person, the value of future earnings should be as insurable as buildings, autos, art, jewelry and collectibles. If it makes sense to insure a \$13 million building, it makes sense to insure the \$13 million asset of future earned income.

Do rich people need disability income insurance? As the bankers agreed, yes, they do. The only difference between the needs of the rich and the not so rich are the dimensions of the coverage. ★

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 Blvd, 2nd Floor, Valencia, CA 91355. Telephone: 800-345-8816. Email: whp@piu.org. Website: piu.org.



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BY THE BAY



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Making the Most of

MEDICAL & VOLUNTARY BENEFITS

by PHILIP KAUFMAN

Businesses that are looking to reduce health care costs might consider eliminating ancillary benefits, such as vision, dental, disability, and life insurance. But there are compelling reasons why employers should continue to offer or add these benefits—either paid for partly by the employer or as voluntary benefits with premiums paid by employees.

Many employees value these benefits highly, also known as “supplemental benefits.” Employers can offer these benefits with little or no additional cost. Offering these supplemental benefits along with medical coverage can also give employers additional tools and information to help provide proactive outreach to improve employees’ health and productivity while managing medical costs more effectively.

Implementing voluntary benefits can prove valuable to employers and employees with growing evidence of a link between oral and eye health to overall health and an array of chronic medical conditions.

Many health insurers now offer packages that allow employees to select from several plans, with the company paying a set amount and employees having the option to pay the difference to enhance or expand their coverage. This approach offers companies a predictable and manageable cost while allowing employees to purchase added benefits on a pre-tax basis. Benefits, such as critical illness and accident protection, can also complement high-deductible medical plans, which have become increasingly popular among many employers.

Voluntary benefits can help attract and retain employees while improving morale, according to a 2014 report from LIMRA International. These benefits can be especially attractive depending on an employee’s life stage,

such as someone with two teenagers who need braces or a middle-aged person whose vision is diminishing.

Voluntary benefits include more than dental and vision coverage. Disability, life insurance, accident protection, and long-term care can also be provided as voluntary benefits. Another example is critical-illness coverage, which pays cash benefits that can be used for living expenses and out-of-pocket medical costs if a covered employee or family member contracts an illness or condition, such as cancer, heart attack, stroke, or paralysis.

Combining medical and voluntary benefits can result in more comprehensive and coordinated care that includes wellness initiatives aimed at improving the overall health of employees.

Health plans that combine medical and voluntary benefits have shown to reduce the duration of disability claims when disability and medical programs are managed together. Upon filing a critical illness or disability claim, plan participants with a chronic condition, such as cardiovascular disease, can receive additional support and information, including a case manager and exercise and nutrition advice. These additional resources help employees get back to health—and work—more quickly.

Other integrated programs encourage preventive dental and vision care, helping to stop diseases before they start.

A 2012 UnitedHealthcare study demonstrates how eye care providers can play a key role in identifying people with various diseases. The study concludes that eye care practitioners can help detect and monitor many chronic conditions—in addition to diabetes—including several unexpected ones. Eye care providers can also help detect and monitor multiple sclerosis, tumors, Crohn’s disease,

and sickle cell anemia. For some conditions, such as sickle cell anemia, the value of eye care is in monitoring the disease. For others, such as Crohn’s disease, the impact is greatest when a comprehensive eye exam helps care providers identify the condition earlier and track ocular complications caused by medications used during treatment. Eye care providers can also help monitor disease severity and progression for many conditions, including high cholesterol, rheumatoid and juvenile rheumatoid arthritis, Graves disease, AIDS and lupus.

Many employers are starting to embrace this approach by using programs that integrate vision and medical benefits that support patients and health care professionals with information, decisions and outcomes. These programs can include a variety of features, including the following:

- Eye care practitioners can be encouraged to code claims with chronic condition categories. Those diagnoses are referred automatically to disease-management programs for follow-ups based on the patient’s needs.
- Eye care practitioners can be notified of patients with at-risk conditions during the exam authorization process, with a recommendation to include, as part of the comprehensive eye examination, a dilated fundus exam that uses eye drops to dilate the pupil to gain a better view of the eye.
- Patients with diabetes, diabetic retinopathy, hypertension, hypertensive retinopathy, vascular disease or high cholesterol can be notified with a phone call, which is more effective than a postcard



recommended care for their chronic medical condition. Among the group receiving dental care, annual average medical costs were \$2,320 lower than those not receiving dental care, with net savings of \$1,829 after accounting for the cost of the dental care.

Besides dental and vision coverage, employers may want to consider programs that help their employees address hearing loss. Hearing loss is a significant health issue for more than 48 million Americans, 60% of whom are still in the workforce or in school. A growing number of private health insurance plans, along with stand-alone programs offered by some national hearing aid companies, provide discounts for hearing aids, helping to make these devices more accessible and affordable. Hearing aids can help more than 90% of people with hearing loss; however, they can cost up to \$8,000 a pair, making them unaffordable for many people.

Helping address hearing loss can foster a healthier, more productive workforce. New research shows that hearing loss is associated with a range of physical and mental health issues, including increased risk of falls, social isolation and even dementia. People with hearing loss are more likely to be unemployed, while people with untreated hearing loss who are employed earn about 25% less on average than those without that diagnosis, according to a study published in the *Annals of Otolaryngology, Rhinology & Laryngology*. Finally, hearing loss may affect a patient's ability to fully understand recommendations provided by their health professional, affecting adherence and, in turn, their ability to manage their health.

Offering voluntary benefits as part of an employee's menu of benefits options can maximize the effectiveness of a company's health care dollars and, when offered alongside medical insurance, provide families with added peace of mind for both their health and financial protection. Employers that combine voluntary and medical benefits may be able to reduce turnover, increase productivity and build a culture of health. ★

Philip Kaufman is president of UnitedHealthcare Specialty Benefits.

reminder, about the importance of their annual eye exam.

- For patients who may have chronic conditions, referrals to primary care providers or specialists can be supported via specially designed forms available online to eye care practitioners.

Dental and medical benefits also can be integrated. UnitedHealthcare studied three years (2008 to 2011) of dental claims data associated with more than 130,000 plan participants enrolled in both employer-sponsored dental and medical plans. The study showed that improving the oral health of people with chronic medical conditions, such as diabetes, asthma and cardiovascular disease, can reduce health care costs.

The research showed that people with certain chronic conditions who received appropriate dental care, including preventive services and the treatment of gum disease, had net medical and dental claims that were on average \$1,038

lower per year than claims for chronically ill people who did not receive that type of oral care. Among diabetics, the average annual net medical and dentals claims were \$1,279 lower per person for individuals who were treated for gum disease compared to people who were not. The savings for all of those groups were achieved even after accounting for the additional cost of the dental care.

Total average medical costs were lower across all chronic conditions for people who received periodontal treatment or cleanings compared to those who did not receive such services, even after accounting for the costs of additional dental treatments.

People with chronic conditions who received regular cleanings (at least three times during the three years) had the lowest health care costs of any other dental treatment group (i.e., infrequent cleanings or no cleanings).

The savings were significant even for those who received regular dental care, but were not compliant with the

NAVIGATING COMPLICATED ESTATE PLANNING ISSUES

WITH A *Group Legal Plan*

by ANN McDONALD

We all know that we need estate planning documents to protect our assets and our families, but have you ever stopped to consider all of the things that are part of your estate? Our lives are much more complicated than they were even a decade ago. We now have complicated family relationships, virtual properties, and much more to consider when planning for the future.

Today's estate planning often requires the expert guidance of an attorney, but many people don't know where to find a good attorney, or they feel that the cost will be too high. In fact, although nearly 75% of Americans agree that planning for the future and protection of assets is important, only one-third actually have the necessary legal documents to do so, according to a study by the AARP.

With all of the complications involved in today's estate planning, having access to legal help is more important than ever. Group legal plans offered as part of a voluntary benefit package make it possible for people of all income levels to contact an attorney to navigate the complicated issues involved in estate planning.

VIRTUAL PROPERTIES

Although considering virtual properties during the estate planning process is a new issue, some law firms have already taken steps to address the issue with their clients. Trullinger & Wenk, PLLC in Goodyear, Ariz. now has standard language inserted into wills and most power of attorney documents designating that whoever is named the executor of the will has the authority to handle digital assets. This language gives the executor or agent, named in the document, the authority to shut down social media and cloud accounts for the individual.

Vanessa Heim, an attorney with Trullinger, says that it is an emerging area of interest among her clients and more people are asking about this during the estate planning process. Most of her clients are satisfied with the standard virtual properties language in the will or power of attorney and for those that question its importance, she explains that, "It's better to have language in there and not need it, than not have it in there at all and then need it."

Heim recommends that, beyond just having a will that mentions digital assets, people also make sure that whom ever they've designated as their executor in these documents has the information they need to deal with these assets properly. Heim recommends that people store sensitive information about these accounts, such as passwords

and log-ins, on a flash drive that can be stored in a safe. This will make it much easier for the executor to destroy or shut down any virtual properties.

Digital assets can include Facebook and other social media accounts, blogs and websites, bank/credit card/investment accounts, email accounts, photo or music sharing accounts, or any other number of online sites that store personal information. It's important to consider these assets because, for some people, there is a monetary value associated with them. For example, a PayPal account, eBay store, blog, or website could bring in money. It can become a difficult process to get the money from the accounts if you don't share this information with family or friends and put someone in charge of it after you pass.

An attorney is the best resource to help you figure out what should be included in your estate planning documents and discuss with you who is the best option to leave in charge of your accounts. For example, it may be better to have a younger, more tech-savvy child in charge of your digital accounts, rather than an older wife or husband. An attorney can discuss these options with you and help you make the best plan for your particular situation.

BLENDED FAMILIES



Creating a will is a simple process if you have only been married once and want to leave everything to your spouse, but things are more complicated for many people. Estate planning can be especially complicated for blended families, with multiple spouses and children to consider.

Dealing with step-children and children from another marriage can be a tricky and often sensitive situation. Meeting

with an attorney to discuss the different types of wills and trusts that will work best to cover all members of your family is essential. An attorney may recommend a non-reciprocal will, in which your will is not the exact same as your spouse's will, so you can leave a percentage or dollar amount to the surviving spouse as well as designate a percentage or dollar amount to be divided equally among your children.

Setting up a trust is another option that attorneys may also suggest in these situations. A trust can allow you to provide for your spouse during their remaining lifetime and then pass the remaining assets to children from another marriage. A group legal plan makes it possible for people of all income levels to meet with an attorney to decide what estate planning documents they need according to their particular situation.

PET TRUSTS

Without a will or trust to dictate what you'd like to happen to your pet, the responsibility will fall to your next of kin. Although this can work in some cases, it doesn't give you any real control over what happens to your pet at your passing. Your relative could give the pet away or give the pet to a shelter. It's important to not only discuss your wishes for your pet, but also to get it in writing to ensure that your family or friends know how your wishes should be carried out.

Pet owners can leave their pet to someone in their will and/or set up a pet trust to provide money to care for the pet after their passing. For those who are concerned about

the care their pet might receive after they're gone, just leaving the pet to someone in a will may not be enough. Your will only names someone to take the pet; it doesn't put any requirements on what they should do with the pet.

In the past decade, pet trusts have become more popular to allow pet owners to indicate what they'd like for their pets when they pass. Forty-six states now allow you to create a pet trust. With a pet trust, you can name a caregiver for your pet and/or leave money and guidelines for the pet's care. You can also state in the trust exactly how you'd like your pet to be taken care of as far as vet visits, exercise and diet needs—even what toys and activities the pet likes.

There is a lot you can do with a pet trust, so it's important to contact an attorney for assistance drafting the document. An attorney can discuss what you can and can't include in your trust as well as help you decide how much to leave for a pet's care.

In today's complicated world, you shouldn't attempt to go it alone when planning for the future. There are many complicated issues to consider for protecting your assets and your family. Having access to an attorney through a group legal plan can provide much needed legal help for complicated estate planning issues. ★

Ann McDonald is the communications manager for Hyatt Legal Plans, a MetLife company and the country's largest provider of group legal plans. Hyatt Legal Plans helps American workers address important life issues through group legal plans. The company serves three million people at more than 1,700 organizations, including over 150 Fortune 500 companies.

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CHIROPRACTIC CARE in a SELF-FUNDED ENVIRONMENT



by **C. BRET SULLIVAN, DC FACO**

Chiropractic care can be an asset to any health plan. But it can be difficult to balance having a good benefit and easy access with protecting the plan from overutilization or abuse. Chiropractic care and other ancillary professions can save health plans significant dollars, but they can be very costly when left unmanaged. Self-funded groups can see significant savings in this often ignored area.

Chiropractic care is widely used in the United States. Twenty percent of the population has sought chiropractic care at some time in their life. Utilization is from 4% to 11% annually nationally. There are 65,000 chiropractors in the U.S., of those approximately 12,000 are located in California.

Chiropractors are licensed as health care providers, by each state. Their scope of practice varies by state, but is primarily focused on the physical medicine arena as a non-surgical, non-drug approach to musculoskeletal issues. Most chiropractors treat spinal conditions, such as lower back pain, neck pain, sciatic nerve pain, and extremity issues, such as shoulder injuries. Chiropractors are involved in treating musculoskeletal conditions in facilities under the VA and the Dept. of Defense. It is increasingly common for hospitals and ACOs to have practicing chiropractors treating at their facilities.

Numerous studies of health plans demonstrate a cost savings when chi-

ropractic care is included as a benefit. Large insurers have found that chiropractors are very cost effective compared to all other practitioners who treat spine disorders even adjusted for condition. When chiropractic benefits are provided, medical spending is reduced. Chiropractic replaces services instead of adding additional costs.

A self-insured employer can realize major savings and positive outcomes by including chiropractic care as well as other ancillary care benefits in their health care strategy. By moving the member away from traditional medical care, many employers see a reduction in lost work time and cost of care for spinal and other conditions. Some technology companies incorporate chiropractic and other ancillary practitioners in their on-site medical facility.

While chiropractic care and other ancillary care benefits are assets to self-insured plans, some providers over treat. They increase the number of procedures to a level that may not be medically necessary, causing costs to skyrocket. This is why the care needs to be managed with a balance of a good benefit, fair reimbursement, and proper oversight and review.

Most ancillary care benefits don't get much attention due to the relatively low cost on a per-member, per-month basis. If the cost of chiropractic is 2%, it is believed that the

major effort in managing health care spending should be focused on other specialties with more significant cost savings potential. For example, injection therapy can represent 7% to 10% of the health care spending. So a 10% decrease in costs for that procedure would save significant dollars. With ancillary care, if it is 2% of the cost, a savings of 10% would equal .2%. This reduction is realized with significant resources. Therefore the ROI is not feasible. Because of this, the ancillary benefit expertise in large insurers is minimal.

Negative issues associated with chiropractic care are primarily due to poor benefit design and a lack of utilization review. Most large self-insured organizations choose one of the large insurers to manage the medical benefit. Traditionally, the large insurers will re-price claims with little or no oversight.

Chiropractic care gets the least amount of attention since it is a relatively low cost part of health care spending. The problem is that costs can and will sky rocket if left unmanaged. Once the crisis happens, the knee jerk reaction is to reduce or eliminate benefits, increase copays and deductibles, and decrease the number of visits.

There is a potential to eliminate the benefits of having chiropractic coverage. This common reaction results in less utilization on the chiropractic side

and increased utilization on the more expensive medical side. The expensive diagnostic tests and procedures, such as epidural injections or surgical interventions, become the norm once again. It is also common for patients to look to Workers' Compensation for their care. If a chiropractic benefit is not available, injured employees may seek Workers' Compensation benefits for a minor issue that could have been solved by a good chiropractic benefit for far less.

There are ways to manage chiropractic benefits in the self-funded environment to save on the medical side while preventing chiropractic benefits to be taken advantage of or overutilized.

Benefit design issues can keep members from seeking lower cost care. Some insurers have increased the copayment to \$40+ per visit and they reimburse the chiropractor \$45. A \$40 copayment in medical can make sense if the average medical office visit is \$100 to \$200. In chiropractic it is not uncommon for the reimbursement to be less than what the general practitioner charges with the same

copay. Dollar caps can be an issue. It is not uncommon for a plan to have a \$500 yearly maximum on chiropractic services with a \$500 deductible, which is a non-benefit for those who mostly seek chiropractic care. In some plans, the reimbursement is so low that network participation levels have been dropping. The number of yearly visits is allegedly a stop gap to prevent further care. If the utilization review is effective, they should not need a maximum number of treatments since what they are getting is medically necessary and justified.

Data management provides an overview of what the network is doing at a high level. It does help in seeing trends and looking at outlier providers. Provider report cards can help the provider see how they are doing compared to the rest of the network.

Utilization review can be an asset if executed properly. The provider should not have to submit extensive paperwork if the condition to be treated falls within guidelines. A treatment window, such as five to 10 visits per

year, should be a sufficient treatment number for most conditions. The average number of treatments per patient, per year is five to 10 visits, depending on the employer. So it would make sense to place the cap above the average number of visits. A pre-treatment document could be required after the number is met to support the need for further care.

In conclusion, chiropractic with appropriate management can work very well in a self-funded environment. With a good benefit design, high quality network and a good management strategy, members can get the care they need and the employers can have healthy happy employees. ★

C. Bret Sullivan, DC FACO is the medical director of ChiroMetrics. He has been in private practice since 1983 and has been involved with major state and national chiropractic associations since 1989. Dr. Sullivan has extensive experience in managed healthcare as a medical director of a major specialty HMO, managing chiropractic, acupuncture, and physical therapy benefits throughout the western United States.



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DENTAL IN E W S



MEDICAID'S DENTAL CUTS DRIVE EMERGENCY ROOM VISITS

As a result of budget constraints, California Medicaid eliminated its comprehensive adult dental coverage in July 2009. The policy change led to a significant and immediate increase in dental emergency room use, amounting to more than 1,800 additional dental emergency room visits per year, according to a study published in *Health Affairs*. The policy change affected young adults, members of racial/ethnic minority groups, and urban residents disproportionately. Average yearly costs associated with dental emergency room visits increased 68%. For more information, visit content.healthaffairs.org

BROWN TO PROVIDE BUDGET FOR DENTAL CARE FOR LOW-INCOME KIDS

The Helping California Smile Coalition, a new statewide group of health, education, and medical organizations is urging Governor Brown and Calif. state legislators to provide resources in this year's state budget for much-needed dental care to low-income children. Nearly two dozen groups are leading the coalition.

The coalition is asking for adjustments in provider rates to make up for years of neglect and cuts, including regular increases to keep up with inflation; improvements in state oversight, better data, and targeted strategies for addressing acute shortages; and expansion in outreach services to let eligible kids and adults know that dental care is available.

Serena Clayton of the California School-Based Health Alliance said, "California's Denti-Cal program is facing the perfect storm. Already one of the worst states in ensuring access to dental care to children in low-income families, our state is facing a flood of new enrollees that will further limit access to a dentist. Without dental care, kids experiencing tooth pain stay home from school and their academic performance plunges. We need to do all we can to make sure that doesn't happen by ensuring access to a dentist."

According to Clayton, a recent report by the California State Auditor found that nearly 60% of children enrolled in the state's health care program for low-income families were unable to get needed dental care. "That's not because there are not enough dentists. It's because there aren't enough dentists who can afford to see these patients since the reim-

bursement rate for their dental services hasn't been adjusted for inflation since 2001. In fact, it was cut in 2013 because of the state budget deficit," said Clayton. Helping California Smile coalition has launched a website www.HelpingCaliforniaSmile.com as well Twitter (@helpingCAsmile) and Facebook (Helping California Smile) to urge legislators to support its request for increased budget resources.

DENTAL DISCOUNT CLUB NOW AVAILABLE IN SAN FRANCISCO AREA

Dentegra Smile Club, a new program launched by Dentegra Insurance Company, is not insurance—instead, it connects members to discounts on dental products and services, pricing transparency and dentist reviews. Members have access to Dentegra's 5,300 dentists in California, who agree to charge Smile Club members their contracted fees. Also, club members receive a discount on the purchase of the Kolibree Connected Electric Toothbrush—the first of its kind that offers 3D sensors and real-time interactive feedback to users in an innovative way—and can earn a cleaning and exam for good brushing behavior.

Dentegra Smile Club membership is available to residents of Alameda, Contra Costa, Marin, San Francisco, San Mateo and Santa Clara counties free of charge. There are no membership dues or fees for club membership.

The Dentegra dentist network—nearly 24,000 strong across the nation and growing—will help Smile Club members get cleanings and a significant number of the most common dental care services for fees averaging as much as 50% off of the normal cost. Dentegra Smile Club is not insurance; club members simply visit a contracted Dentegra dentist and pay discounted fees for covered services. There are no claim forms, no annual deductibles, and no annual maximums.

The Kolibree Connected Electric Toothbrush, offered in addition to the monthly club membership fee, includes a free mobile app that keeps people of all ages engaged and motivated to brush better and for longer. Basically, it registers both brushstrokes and location in tooth brushing. Rewards will be based upon information automatically collected by the Kolibree toothbrush. More details about the pilot discount plan and how it works are available at dentegrasmileclub.com. For more information, visit dentegrasmileclub.com. ★

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Optimizing Choice in VISION BENEFITS

by SHANNON SCHUMACHER

We all value having choices. Just walk down the barbecue sauce aisle at the grocery store and see how many options you have. Our life is dictated by the choices we make. What to eat, what to wear, what to drive, where to live, where to work, and what time to go to bed. It's one of the best things about being an adult.

But choice can also complicate matters. Choice is an increasingly relevant in our business, which is complicated enough already. But choice can muddy the waters if it's not handled properly. That's why it's our responsibility, if not our duty, to educate employers and employees so they make the right choices for themselves, their companies, and their loved ones.

What good are options if you don't have the information necessary to evaluate the options? Having a choice without having any educational tools is a dart throw. It's a coin flip. It's like reaching in a hat and pulling out a benefits plan.

IS THE RIGHT PLAN BEHIND DOOR NUMBER ONE, TWO, OR THREE?

Luckily, since we have the tools at our disposal to educate employers and employees, they don't have to play a guessing game. Let's use vision benefits as a case study. Employers have the choice of whether to offer it. And employees have the choice of whether to enroll. Increasingly, it's a choice they want to be able to make. More often than not, they'll sign up if it's offered. Also, vision has a bit more of a consumer feel. People use the benefit for eye exams and to shop for frames and lenses. As some have noted, unless you're really into teeth cleanings, it's the only benefit that people really want to utilize.

There are a number of teachable moments and tools to provide guidance from the time an employee enrolls in a plan to the time they walk out the door with new eyewear:

- **Enrolling:** Gone are the days when a benefits administrator could pass out plan descriptions once a year and wash their hands of the enrollment education process. Most of the employer groups I work with used to view benefits education as a once-a-year event. It has now become important to keep employees educated about changes on the horizon. Employees are more interested in their benefits, which we view as a good thing. We want employees to become better consumers of their own health care. That's why we work with carriers to provide easy-to-read brochures, infographics and online tutorials that walk them through the enrollment process. It might seem passé,

but it's important not to forget about ID cards. Even in the digital age, employees want those cards to have and to hold and make them feel secure.

- **Deciding on a plan:** This used to be a no-brainer in vision. If your employer had a plan, you decided whether you wanted it. In some instances, your employer might have a high-low plan. But in recent years we've seen the advent of new multi-tier plans that offer a basic option and a premium option.
- **Finding where to go:** Provider locators are nothing new, but they are becoming more sophisticated. They are on mobile devices, and have become more easily sortable. Vision benefit holders can adjust their locator based on location, network, provider type, products, and brands. Think of it as Amazon for your vision care. Some locators are included in a mobile app that also can double as an ID card.
- **Online Shopping:** In the past, the only way to see what frames looked like was to try them on in the store. Now, various online providers allow employees to upload a photo and try on glasses virtually.

These are just some of the educational tools we should be promoting to our employers and employees. There are more online capabilities on the horizon including new discounting options, cost comparisons, and wellness initiatives.

If we're going to continue to offer more choice—and I think we can all agree that seems to be the trend in our industry—we need to guide benefit holders through the choosing process. In doing so, it's important now more than ever that we use all the tools at our disposal. These are unique times for our industry. You don't need me to tell you that. Most employers feel that healthcare is too complicated. It has caused a trickle-down effect, which has hurt employees. Employers are spending more time than ever trying to stay compliant. Often, they don't feel they have time to educate their employees in-house, so they're turning to their consultants for the tools and guidance. We have the knowledge and the tools to help, but we also have a responsibility. ★

Shannon Schumacher has been a benefit broker for more than 15 years, the last eight years at Cincinnati-based HORAN. She is a director of the Select Business Solutions Team, (fewer than 100 employees). For over 65 years, HORAN has served as a trusted advisor and thorough planner in the areas of life insurance for estate and business planning, employee benefits consulting and wealth management. HORAN serves both corporate and individual clients in 40 states. In 2014, HORAN was recognized as the United Benefits Advisors' (UBA) Partner Firm of the Year.

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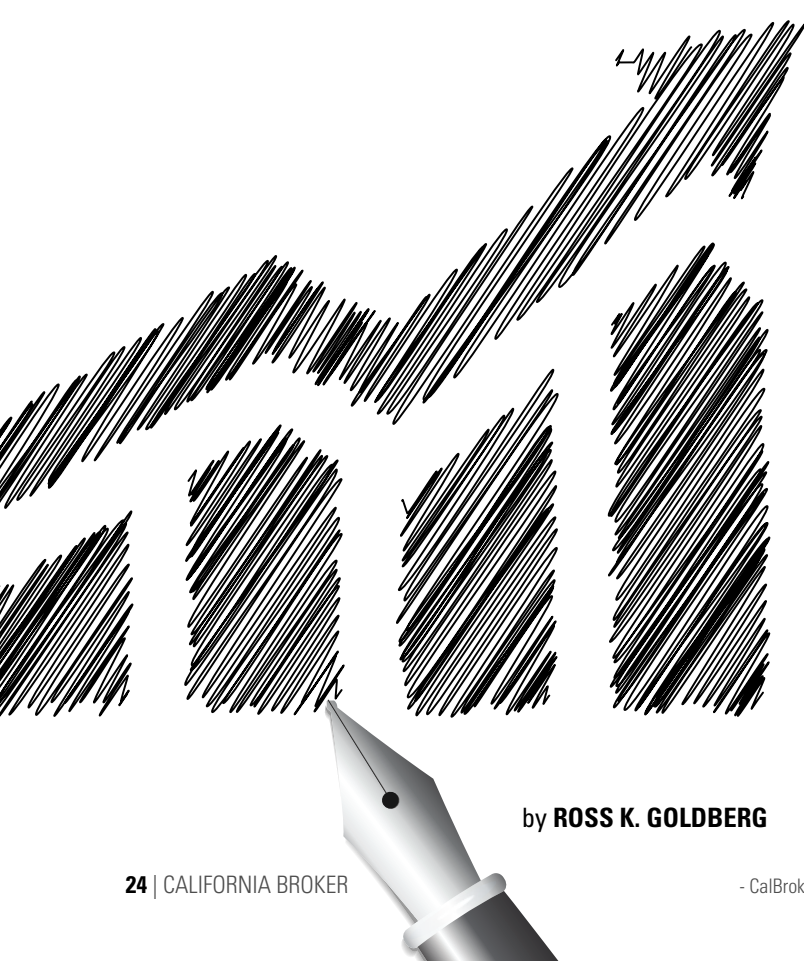
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SOLID MARKETING PLAN



by **ROSS K. GOLDBERG**

When it comes to selling insurance, your clients aren't just choosing your product, they are choosing you. Your trust. Your experience. The value you bring. Brokers live in a highly competitive world where attracting and keeping clients is more challenging than ever. In an industry engulfed in sophisticated database marketing, constant emergence of new products and frequently changing regulations, brokers need new ways to create value for their customers and distinguish themselves in the market. Key to that is a solid marketing plan that will help them grow their revenues, stand apart from the competition, and position themselves as the go-to person for individuals and/or business owners.

Large companies have amazing marketing tools at their disposal. Individual brokers do not. Still, a robust marketing approach can help you keep sight of the big picture, establish measurable goals, set the course for success and give you confidence going forward. Here are six tips to help make that happen.

REFRESH YOUR PLAN

All successful brokers have a plan for attracting and retaining profitable business. But the world changes and, along with it, so should your marketing strategies and tactics. That means it may be time to look anew not only at how you are selling, but also to whom you are selling. Everyone or anybody might be potential clients but you probably don't have the time or money to market to everyone. Who is your ideal customer and has that changed? Who does it make sense for you to spend your time and money promoting your services to? You might define your ideal customer in terms of income, age, geographic area, number of employees, revenues, industry, etc.

This is also a good time to ask if there is a market segment that is not being well served by you or the competition. This kind of niche strategy will allow you to focus your marketing efforts and dominate your market, even if you are a smaller player. Taking such an approach requires a candid assessment of your competition, which is always changing. What new competitors are on the scene? What are they offering, and how are they offering it? How do you need to reset your compass to remain competitive?

FIND A WAY TO DIFFERENTIATE

To many business owners and individuals, insurance brokers are as much a commodity as the insurance they are selling. But look at your portfolio of products—each one has found a way to differentiate itself and make it something special and relevant for the potential buyer. You need to do the same. As antiseptic or uncomfortable as it may feel, think of yourself as the product. What makes you different? What makes you special? What is your unique selling proposition? It has to be more than providing outstanding customer service because, while your delivery on that is critical to retaining existing customers, it doesn't differentiate you in attracting new business. After all, who among your competitors wouldn't claim to be delivering on that?

Finding your differentiating quality and, in essence, your own brand can be a journey of self-discovery and candid reflection. Is your depth and breadth of experience different?

Do you speak multiple languages? Do you offer a broader product portfolio? Do you offer insurance products across different spheres that are more convenient for your customers? Do you have the industry's best retention rate? Do you offer state-of-the-art online accessibility? Whatever that special something is, you need to find it, claim it, and market it in a way that is meaningful to your customers. In short, if you can turn that feature into a benefit, you will be well ahead of the competition.

LEVERAGE THE POWER OF THE INTERNET

Online communication, whether from a desktop computer or handheld mobile device, has forever changed the way business is conducted. Are you leveraging it fully?

Access to information has increased consumer involvement in all purchasing decisions. People shop online with growing frequency for everything from cars to clothes to vacation destinations. Insurance is no different, and consumers want easy 24/7 access to information that will help them make intelligent choices. To meet that demand, brokers need to have at their disposal dynamic search engines that allow them and their clients to view all of their insurance options and go through a simple needs assessment so they can find the benefit structure and price point that is right for them. Do you offer that to your clients?

Today there are many sophisticated database software programs that allow a broker to segment their target audience in a myriad of ways. Similarly, there are customer relationship management (CRM) tools that can give brokers a decided competitive advantage when it comes to retention. Make sure you are taking advantage of all that automation has to offer.

Thinking far beyond the barebones of having a friendly and easy-to-navigate website, brokers should aggressively tap into such social media platforms as LinkedIn, Facebook, Twitter, and Google Plus. They should also look for opportunities to contribute content to existing blogs or even launch their own. In an era where content is king, brokers should look at all available options to self-publish and do the things necessary to optimize their search engine optimization (SEO) results so their name appears with greater prominence to those potential customers looking for a broker.

DON'T IGNORE TRADITIONAL MEDIA

While the Internet is defining the way many people shop and get their news, the power of traditional media should not be ignored. For one thing, mass media still carries an inherent trust not found in self-publishing. That's because many people believe that news conveyed through a respected and time-proven source has undergone an editorial filter and received a third party endorsement. That makes it real and credible. Despite the bias that individual editors or outlets may possess, conventional media is still considered more objective than information an individual or organization posts online themselves.

Another value of mass media comes in the sheer number of readers or viewers it can provide. While numbers for conventional media may be dwindling, newspapers, radio, television and magazines all still deliver large numbers that

most online outlets simply cannot match. For those reasons, conventional media must not be ignored. For insurance brokers the opportunities to tap into local media are tremendous. You can write a commentary on a timely topic for the local paper. You can submit letters to the editor. You can provide advertorial content to support any local advertising you may be doing. Perhaps there is a local radio show or cable news program where you can be a guest.

BE OPPORTUNISTIC

Proper planning sets the course and outlines the tactics to get you to your ultimate goal. But in marketing your business it is critically important to remain flexible and opportunistic as market conditions change. For those brokers selling health insurance, the introduction of the Affordable Care Act (ACA) was—and still is—a perfect example. The public is looking for clarity and you can provide it. One good way is by offering yourself to local groups—chamber gathering, veteran organizations, PSTAs – as someone who is available to speak at their monthly meeting and explain what the ACA means to them. You don't need to make it a sales pitch (in fact, you will likely need to guarantee that it won't be), but your very presence there positions you as the expert. And you can provide your phone number, email address and business card for anyone who might have follow-up questions.

Being opportunistic also means taking advantage of what might be changing in your community. Has a new business moved in that is ripe for targeting? Have the demographics changed within your community or within the workforce of a current business client? Is the local population aging; and, if so, are there new products or services that you should be offering to appeal to this evolving market?

REMEMBER THE BASICS

Good promotion can sell a bad product once. Translation: Even doing all of the above won't mean a thing if you forget the basics when it comes to customer expectations. That means making sure that your product portfolio is complete and that you are offering products that match your customers' needs. It means remaining knowledgeable on industry trends and being able to discuss where the industry might be going. It means working with insurance providers who you know will deliver exceptional customer service throughout the year—as the interaction your clients have with the insurance companies themselves will have a strong influence on whether you retain that customer next year.

Remember, clients must be aware of not only your products; they must have a positive disposition toward you. They must trust that you will deliver what you say you will, or they will move on to someone else making that promise. Never lose focus, and never take your customers for granted. Putting together a fresh marketing strategy may require you to cut the umbilical cord from how you've done things in the past, and for many that can be unsettling. But doing so will very likely stoke your fire for success in ways you never imagined. ★

Ross K. Goldberg is founder and president of Kevin/Ross Public Relations in Southern California. His web site is kevinross.net.

WHY LTC INSURANCE IS THE LATEST MUST-HAVE EMPLOYEE BENEFIT

by JOHN WANE

In the face of rising healthcare costs and with the Affordable Care Act soon to change the landscape of the employer benefit arena, employees are being asked to cost-share more of their health insurance. Meanwhile, employers are trying to soften the blow by enhancing other benefit offerings. And all at the same time, Baby Boomers are wondering if they'll be financially prepared to retire.

As it turns out, these circumstances are coming together to brew the perfect storm of opportunity for brokers selling long-term care (LTC) insurance in the group market. LTC insurance and other voluntary benefits have been experiencing an uptick in sales during the past couple years. This comes as employers are beefing up their buffet of benefit options in an attempt to fill coverage gaps and maintain a benefit package that attracts and retains talented employees.

Industry experts expect this trend to continue. In fact, according to MetLife's 2013 Study of Employee Benefits Trends, 47% of employers are planning to add more voluntary benefits in the next two years. In particular, LTC insurance is well received in today's worksite environment because of the advantages it offers to both employers and employees.

SAFEGUARDS SAVINGS

LTC insurance serves as a much needed safety net to help protect employees' savings and retirement funds, given the high cost of long-term care and the high likelihood of needing it. According to the Dept. of Health and Human Services (HHS), more than 70% of Americans age 65 or better will need long-term care services at some point in their lives, and on average, care will be required for three years. HHS pegs the average cost of a private room in a nursing home at \$83,580 per year.

What's more, LTC insurance is proving to be of value for older and younger generations, alike. The Family Caregiver Alliance estimates that 40% of the 13 million people receiving long-term care are between the ages of 18 and 64.

These startling statistics are starting to resonate with consumers as they set aside their denial about the potential need for long-term care and begin to adopt a readiness to prepare for reality. Seven out of 10 working-age adults are concerned that they might need long-term care services in the future. As well, many Baby Boomers are caring for aging parents and, thus, are becoming increasingly likely to consider purchasing LTC insurance as a way to relieve their own children of bearing that same burden down the road.

PROTECTS PRODUCTIVITY

In addition to safeguarding employees' savings, LTC insurance helps protect productivity in the workplace. Employers offering this coverage to employees and their families are able to offset the potential costs that occur when employees become caregivers to a parent, spouse or other family member.

Employees who are pulling double-duty as caregivers are likely to experience stress, distraction or even a need to leave their job. For employers, this translates into decreased productivity and increased absenteeism, as well as possible retraining and replacement costs.

An LTC insurance policy pays for someone other than the employee to provide care for the insured, allowing the employee to remain at optimal performance on the job.

SIMPLIFIES UNDERWRITING REQUIREMENTS

Many group LTC insurance cases offer simplified medical underwriting. This involves an abbreviated application

with fewer health questions. In some cases, this can be a multi-life plan's biggest advantage over an individual policy considering that many people who otherwise would be declined for LTC insurance coverage are able to qualify with simplified underwriting.

FITS GROUPS OF ALL SIZES

Perhaps the biggest misconception about multi-life LTC insurance is that it is only relevant for large employer groups. The truth is that, with a minimum group size of just three, LTC insurance is a suitable benefit to present to companies of all sizes from the mom-and-pop shop down the street to your city's largest employer.

ALLOWS FOR FLEXIBLE CASE DESIGN

The versatility of LTC insurance plans for the group market gives you the options you need to structure the right plan for each of your worksite clients. Cases can be designed as employee-paid, employer-paid or a combination of the two – each structure having its own nuances in terms of the availability of underwriting concessions, as well as costs and benefits to the employer.

- **Employee-paid:** Most of the new business written in the LTC insurance group market is made up of voluntary plans, in which employees pay their own premiums. The plan is endorsed by the employer, allowing the broker to meet with employees about the coverage. Plans are offered to the employees at a group rate. Simplified underwriting can be made available to employee-paid cases when minimum enrollment requirements are met.
- **Employer-paid:** Although less common in the current economy,



some employers, such as those at the helm of a family-operated business, opt to pay LTC insurance premiums for their employees. The company may pick up the tab for the entire premium or pay a set percentage or dollar amount toward a policy with the employee expected to pay the remaining balance. Normally, employer-paid cases offer simplified underwriting.

- **Executive carve-out:** A popular type of employer-paid case is an executive carve-out plan. With this structure, companies pay for LTC insurance for the business owners and select employees only. An employer can handpick from within the business whose policies will be paid by the company because LTC insurance is a non-qualified employee benefit and, therefore, not subject to the Employee Retirement Income Security Act (ERISA) or employee discrimination rules.

Employer-paid policies are often used as part of an executive benefit package, as a retirement benefit or retention tool for key employees. In addition, voluntary coverage may be offered to the rank and file.

OFFERS TAX ADVANTAGES

The potential tax advantages for employers and employees who choose to invest in LTC insurance coverage are significant. Premiums for tax-qualified LTC insurance policies are eligible for federal and state tax deductions. Employees can treat premiums paid for LTC insurance for themselves, their spouse, parents, or other tax dependents as a personal medical expense.

For employers, the amount paid in tax-qualified LTC insurance premiums on behalf of their employees is tax deductible as a business expense. The tax advantages are multiplied for self-employed individuals and are the greatest for C corporations, which are entitled to deduct as a business expense 100 percent of the tax-qualified LTC insurance premiums paid on behalf of their employees, as well as their spouses and dependents. The deduction is not limited to age-based eligible premiums.

Last but not least, if an employee or other insured should need long-term care services, the LTC insurance benefits received are non-taxable.

QUALIFIES FOR HSA SPENDING

A Health Savings Account (HSA) is considered to be one of the most tax-favored savings vehicles. As an account funded with pre-tax dollars and not subject to taxes at withdrawal, an

HSA is an advantageous way to pay for qualified medical expenses, which can include LTC insurance premiums.

PROVIDES PORTABILITY

Employees appreciate that employer-sponsored LTC insurance policies are completely portable. This assures them that even after leaving the company or retiring, they can keep this valuable coverage in place by paying the premiums at the same rate.

The abundance of advantages that group LTC insurance provides to employers and employees is making it the latest must-have employee benefit. It can't be overlooked that this valuable coverage comes at little to no cost to the employer; just what your clients are seeking in the current worksite environment. The opportunity for brokers is enormous, and there is no better time than now to talk with your clients about LTC insurance. ★

John Wane is the president of American Independent Marketing (AIM). With a 35-year history of focusing on retirement protection solutions, AIM's product portfolio has grown to become one of the most complete in the industry, providing its agents access to multiple markets from a single source. In addition to carefully selecting the finest mainstream carrier solutions, AIM also has a successful track record of developing its own products designed to meet evolving consumer needs, including a critical illness linked-benefit product that covers long-term care. For more information, visit whyaim.com or call 800-672-7202.



by ELIZABETH HALKOS

Helping Clients Create A BENEFIT PACKAGE THAT ADDRESSES WORKFORCE DIVERSITY

As part of their ever-present challenge to recruit and retain the best workers, employers seek a comprehensive benefit package that is meaningful to employees. Yet today's diverse workforce has different needs and wants when it comes to benefits. So how can brokers assist their clients in providing all of those options without raising benefit costs?

Voluntary benefits are the answer in finding benefit offerings that resonate with employees. The variety of traditional and non-traditional voluntary benefits allow employees to have a choice. Today's workforce spans three generations—Millennials, Generation X and Baby Boomers—who look at work, life, money and finances in totally different ways. Likewise, they have different benefit needs and with voluntary benefits, workers can choose what suits their particular situations.

In the process of helping clients provide a more robust benefit package, brokers build stronger client relationships and also have increased product sales.

BUILDING A BETTER BENEFIT PACKAGE

There's an abundance of voluntary benefits on the market today—both traditional and non-traditional—so how do you select benefits that will resonate with your clients' employees?

Without a doubt, employers look to their advisors for recommendations on both core and voluntary benefits in order to build a more robust employee benefit program to help them recruit and retain employees. In particular, they want to structure voluntary benefits that improve employees' financial health and provide a financial safety net.

Once considered just a nice extra, voluntary benefits have become an essential element of building a comprehensive employee benefit program. Even though the employees have to pay the premium, voluntary benefits have grown in popularity because they allow employees to customize their benefit package. The key to achieving a high benefit engagement and satisfaction rate is for employers to offer options that fill in the gaps of core benefits and meet the needs of employees, in addition to supporting business objectives.

To build a benefit package that helps employees with their financial protection needs, you need to take a look at the generational differences in the workforce today. The Baby Boomers are the oldest generation in the workforce. According to AARP, they make up 38% of the workforce. And some are already contemplating retiring. The middle generation is Generation X which has a distinctly individualistic outlook. The U.S. Bureau of Labor Statistics reports that Gen Xers make up one-third of the workforce. The remainder make up the youngest generation in the workforce—the Millennials, also referred to as Generation Y. They have higher expectations when it comes to promotions.

Employees often have more financial stress and needs than employers realize. Eighty percent of employees working full-time say they have financial stress, according to a July 2014 Harris Poll on behalf of Purchasing Power. Their stress is related to long-term and short-term financial needs. Sixty-seven percent say that the stress is related to long-term financial needs (savings, retirement plan, etc.) while 60% said stress is short-term related (everyday living expenses as well as unexpected financial needs such as a car repair, appliance replacement, or emergency medical expenses).

VOLUNTARY BENEFITS BY PURPOSE

Brokers have access to more voluntary options than ever. With half of today's employees saying benefits are a key reason why they remain with their employer, the importance of making sure that your clients offer benefits that their employees actually need is getting more critical. What's available in the marketplace today? Combining traditional and non-traditional voluntary benefits yields a long menu of options.

Traditional voluntary products can fill in the gaps left by scaled-back core benefits, higher deductibles and more consumer-driven health plans. Not surprisingly, these benefits are also the most popular with employees.

The non-traditional voluntary products in the marketplace provide a wide array of benefits that employees can choose from to enhance their lifestyle, protect their well-being, and improve their financial wellness. They can generally be categorized by purpose:

- Buying and banking options that give employees alternative ways to save spend or borrow such as an employee purchase program or discount program.
- Lifestyle and convenience options that allow the employee to take advantage of cost savings through their employer that they wouldn't get otherwise.
- Personal care and improvement benefits that show employees their employer cares about the whole employee while encouraging them to be proactive about their physical, mental and financial health.
- Financial safety nets that offer protection from financial crises that can be potentially devastating for the employee.

WHAT MATTERS TO TODAY'S EMPLOYEES?

Breaking today's workforce down by generation reflects a different picture of what is important to them. Here is a closer look at each of the three generations, their attitude to their job, and their financial situation, as well as examples of non-traditional voluntary benefits that can help to address their financial situations.

Put a feather in your capital.



In the changing insurance landscape, who is your best partner for creating new opportunities?

With major medical carriers now offering voluntary benefits, there may appear to be more answers to that question than ever before. But when you take a closer look, one stands out: Aflac.

Aflac has exceptionally high brand recognition to help drive enrollment. It also has guaranteed-issue group products, so it's a great way to grow your business with clients both old and new.

While many brokers are currently working to simply maintain their margins, there are those who are open to new opportunities that will expand their businesses. You may even be one yourself. Needless to say, we're happy to help make it happen — and tip our hats to your success.

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Baby Boomers (born 1946–1964)

Baby Boomers’ work ethic is driven and committed, and they believe that rewards come after paying one’s dues and building a career. Their greatest fear is losing their pension, savings, or job and being unable to retire. Keys to job retention for Baby Boomers are salary, job security, and health benefits. They want to count on medical insurance and back-up care for their parents. Some Baby Boomers are in second careers. Some still have grown children living at home and/or are helping them out financially until they can support themselves.

For the most part, if there’s something Baby Boomers want, they are able to buy it. However, many will question if they should buy it or just save their money. Instead, they are trying to be financially responsible and scaling back from a materialistic lifestyle. Baby Boomers, even if they are high earners, worry about retirement – both having enough money for retirement and wondering when the right time is to retire.

The following non-traditional voluntary benefits may appeal to Baby Boomers:

- Discount Programs
- Financial Counseling
- Legal Assistance
- Auto Insurance
- Home Warranty Insurance
- Homeowners’ Insurance
- Long-Term Care Insurance
- Wellness Programs

Generation X (born 1965–1979)

Gen Xers’ work ethic is balanced and flexible with a work hard, play hard attitude. They believe in accumulating skills by taking on differing projects. Their greatest fear is being overshadowed by Millennials and being overlooked for promotions. Keys to job retention for Generation X are salary, autonomy, independence, and promotion, promotion, promotion! Their benefit needs include income protection, family support, customizable plans, automatic retirement management, and retirement education.

This generation’s financial stressors come from multiple angles. They are raising children, preparing for care of their aging parents, and trying to save for their own financial futures. The rapidly changing retirement, Social Security, and healthcare landscape hits them the hardest. Because of

these factors, they appear to be having the toughest time financially. They find it difficult to meet their household expenses on time each month and are the most likely to carry balances on their credit cards.

The following non-traditional voluntary benefits that may appeal to Gen Xers:

- Discount programs
- Employee purchase programs
- Flexible spending accounts
- Financial counseling
- Wellness programs
- Employee assistance programs
- Child care
- Cyber security insurance
- Homeowners’ insurance
- Identity theft protection
- Long-term care insurance

Millennials (born 1980–2000)

Millennials’ work ethic is that professional fulfillment matters more than salary. They expect rapid promotion and meaningful work or they seek other opportunities. They often juggle many jobs and move from job to job frequently. Their greatest fear is experiencing silence, unplugging, being trapped in a routine and experiencing eternal internship. Keys to job retention for Millennials are personal relationships, multiple tasks, and fast rewards. Their benefit needs include portable benefits, forced savings, financial education and concierge services.

Key values for Millennials include future financial security and better quality of life. To improve their financial situation, they need a better job or a promotion and expert advice on how to make the most of their money in addition to beginning a 401(k) or other retirement plan.

In general, Millennials are very highly educated. One-third of Millennials have four-year college degrees, but that comes with a high price tag. The average Millennial has \$29,000 in student loan debt alone. Not surprisingly, they are also more concerned about paying down existing debt or incurring additional debt than their day-to-day expenses.

The following non-traditional benefits that may appeal to Millennials:

- Employee Purchase Programs
- Discount Programs
- Tuition assistance
- Employee assistance program
- Wellness program
- Flexible spending accounts
- Financial counseling
- Identity theft protection

The more valuable the advice you are able to give your clients, the more valuable your relationship will be with your clients—and the greater your revenue stream! ★

Elizabeth Halkos is chief revenue officer at Purchasing Power, a voluntary benefit provider of an employee purchase program. She has over 15 years of experience in client relationship development, sales, marketing and product strategy.



Are You a Health Care Saver?

by **MARK ROBERTS**

When it comes to your health care, are you a saver or a spender? Health savings accounts (HSAs) are great for saving money on health related expenses, and they were originally designed by Congress as a way to help offset the rising cost of medical care by using pre-tax dollars. They also make a great savings vehicle.

According to the U.S. Treasury Dept. website, health savings accounts will change the way millions meet their health care needs because they are designed to help individuals save for qualified medical and retiree health expenses on a tax-advantaged basis. To encourage saving for health expenses after retirement, individuals age 55 and older are allowed to make additional catch-up contributions to their HSAs. Once an individual enrolls in Medicare they are no longer eligible to contribute to their HSA.

Amounts contributed to an HSA belong to the account holder and are completely portable. Funds in the account can grow tax-free through investment earnings, just like an IRA. Funds distributed from the HSA are not taxed if they are used to pay qualified medical expenses. Unlike amounts in flexible spending arrangements that are forfeited if not used by the end of the year, unused funds remain available for use in later years.

Any adult who is covered by a high-deductible health plan (and has no other first-dollar coverage) may establish an HSA. Tax-advantaged contributions can be made in three ways:

- The individual or family can make tax deductible contributions to the HSA even if they do not itemize deductions.
- The individual's employer can make contributions that are not taxed to either the employer or the employee.
- Employers sponsoring cafeteria plans can allow employees to contribute untaxed salary through salary reduction.

Here are some key findings from the 2014 *Year-End Denver HSA Research Report*:

- HSA accounts approach 14 million. HSA accounts rose to 13.8 million, holding over \$24 billion, a year over year increase of 25% for HSA assets and 29% for accounts for the period of December 31st, 2013 to December 31st, 2014.
- Health plans drive growth. During 2014, health plans were the leading driver of new account growth, accounting for 35% of new accounts.
- A continued strong market fuels HSA investment growth. HSA investment assets reached an estimated \$3.2 billion in December, up 40% year over year. The average investment account holder has a \$12,995 average total balance (deposit and investment account).
- Investors show solid returns. Investors achieved an average annualized return of 12.5% on their HSA investments over the past three years.
- HSA assets exceed \$27 billion January 2015. The 2015 January HSA Supplement Survey found that HSAs grew to over \$27 billion in assets by the end of January, 2015.

HSA owners tend to have lower medical expenses. This results in lower health insurance premiums and lower rate increases. Why is this? HSA owners are paying for their own doctor visits and prescription drugs until they meet their deductible. They are more involved in their treatment, questioning the cost and necessity for medical procedures. Also, they take better care of their health, knowing that being overweight, smoking, or not exercising is bound to be very costly to their own financial future.



HSA owners also tend to have more money in the bank. They know enough not to pass up the immediate tax deduction of HSA contributions. They certainly don't want to miss an opportunity to start a tax deferred investment account that is never taxed if the money is used to cover medical expenses. "You own and you control the money in your HSA. Decisions on how to spend the money are made by you without relying on a third party or a health insurer. You also decide what types of investments to make with the money in the account in order to make it grow," according to HSA-Manager.com.

The IRS has announced that HSA contribution limits and high-deductible health plan out-of-pocket maximums rose slightly for this year. HSAs are tax-exempt accounts that help people save money for eligible medical expenses. To qualify for an HSA, the policyholder must be enrolled in an HSA-qualified high-deductible health plan, must not be covered by other non-HDHP insurance or Medicare, and cannot be claimed as a dependent on a tax return. Here are the allowable contribution limits for this year, and would have been established by account holders before the end of 2014:

HSA 2015 Contribution Limit

- Individual (self-only coverage)—\$3,350 (\$50 increase from 2014)
- Family coverage—\$6,650 (\$100 increase from 2014)

HDHP 2015 Minimum Required Deductibles

- \$1,300 for self-only coverage (\$50 increase from 2014)
- \$2,600 for family coverage (\$100 increase from 2014)

Out-of-Pocket 2015 Maximum (expenses include deductibles, co-pays, and other amounts, but not premiums)

- \$6,450 for self-only coverage (\$100 increase from 2014)
- \$12,900 for family coverage (\$200 increase from 2014)

Fox Business News reported in 2014 that the Affordable Care Act placed new restrictions on HSAs. These include prohibiting the use of HSA funds to buy over-the-counter drugs without a prescription and subjecting non-medical withdrawals to an increased tax penalty of 20%, up from 10%. Consumers who already have a health savings account and are looking at their options on the exchanges may wonder what will happen to their current HSA. If you choose one of the marketplace's more conventional health plans with a smaller deductible, no additional contributions can be made to the existing HSA, but the funds in the account may still be used for qualifying health expenses.

If you switch to a new bronze or silver high-deductible health plan, there are a few options to consider. That plan could have an arrangement with its own HSA and you might want to combine HSAs, or you might want contributions going into one, but you keep the other. HSAs are useful tools for consumers because they are able to avoid going through insurers to pay for medical expenses and can enjoy tax benefits as a result.

It saves money, particularly for people who have ongoing medical expenses. They may have a continuing problem like diabetes or high blood pressure. It's really a triple play in terms of benefits for employees. HSA contributions can lower your taxable income, earn interest, and be used tax-free to pay for health care expenses.

National carriers and economists confirm that HSAs are the product to watch in 2015. Growth in private exchanges, based on employer defined contributions, should accelerate HSA growth. According to Sterling HSA, cost is not the only growth factor. The basic tenants of an HDHP/HSA lead people to become savvy healthcare consumers. This has been reported for the 10 years that HSAs have been available (since 2004). People make more thoughtful decisions on their healthcare spending. ★



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This does not mean that people do not get necessary care. Quite the contrary; people ask for generic medication; use emergency rooms for true emergencies; and use preventive care services at a much higher rate than do their counterparts in other products. Some people with an HSA never make withdrawals to cover medical expenses. These people, Baby Boomers for the most part, consider their HSA a retirement account. Other people use the money each year to pay for their deductible expenses. That's the beauty of a HSA. They are extremely flexible, triple tax advantaged accounts.

The investment opportunity with a HSA is only limited by IRS regulations. The instrument must be liquid (stocks, bonds, mutual funds). The ability to invest is very flexible but determined by your HSA administrator. Year-over-year growth of balances in these accounts proves that people really will walk into Medicare with a nest egg.

John Young, CEO of Consumerdriven LLC, and industry expert, reported in a 2014 study his findings that show the growth of HSAs within the private exchange market. Although the public exchanges also allow for high deductible plans that also include the option to purchase an HSA on individual insurance sales, the actual purchase rate has not been that intense. However, the private exchange market is a different story.

The private exchange market has been experiencing solid incremental growth over the past five years. Although most employers are still taking a wait and see attitude toward private exchanges, several large national companies have moved their workforce toward a private exchange platform. Darden Restaurants, Sears Holding, Walgreens, Home Depot, and other large employers have already made the shift, including part time workers. As well, Time Warner, IBM, and GlaxoSmithKline in 2013 began shifting their retirees to the private exchange universe.

While a number of companies signed up for private exchanges last fall, just 3% plan to use private exchanges for

active employees next year, although 35% are considering doing so in 2016 or later, according to a National Business Group on Health survey of 136 large U.S. employers. Four percent of the large employers and 6% of midsize companies moved to private exchanges in 2015, according to a survey of large and midsize companies conducted by Benfield Research last year.

According to the Kaiser Foundation, given the growth of transparency organizations like Castlight Health, the easiest way for employers to make a move from a defined benefits model to a defined contribution model will be through private exchanges. It not only eliminates a substantial administrative burden, but it also allows for integration of consumer-focused tools (like physician finders, HSA-management software, cost-transparency tools etc.) that typically might only be available to bigger companies).

Still, these private exchanges make up just a small slice of the employer-sponsored health insurance market, which covers an estimated 150 million plus Americans. But Accenture projects that, in just a few years, up to 40 million Americans will receive workplace health insurance this way as employers look to limit their health-care costs. HSAs are going to be a big factor in this overall new health care paradigm.

So, what does this discussion indicate? The HSA product is a hot commodity. Brokers who wish to help increase tools in their bag of tricks would do well to include this type of plan design. Employers want it. Employees want it. Health plans need it. Administrators love it. As a matter of fact, plan administrators such as Fidelity Investments, HSA Bank, and UMB HealthCare Services among others have reported huge increases in funds under management.

CAN YOU SAY BILLIONS?

The only immediate downside is that communication and education are suffering. In spite of all the media attention and marketing efforts by organizations promoting them, HSAs are not yet getting the traction they deserve. You'd think more employees would be moving toward purchasing an HSA product with all the exposure over the past five years since the Affordable Care Act went into effect. Brokers can and should get the word out.

As the health care industry and the insurance market are still searching a level set (always challenging in an ever changing governmental shift), HSAs have yet to make a serious dent in health care savings for employers and employees. Some few millions have had a light bulb moment, and they get it. Early adopters have been saving money. The rest of the crowd has yet to have an epiphany. Brokers can play a major role in waking up their clients. And HSAs are a great product for all stakeholders. ★

Mark Roberts' professional sales background includes over 30 years of sales and marketing in the tax, insurance and investment markets. Mark is a licensed life, health and accident insurance agent in all 50 states and DC, for insurance products and discount health plans. Mark has also been writing a health care blog for the past 8 years, (www.yourbesthealthcare.blogspot.com), which is a topical weblog about various health care issues. You can reach Mark at MarkR1955@gmail.com.

SOMETIMES THE UNIVERSE JUST FALLS INTO PLACE.

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**LIFE
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Life Insurance should be one of the unquestioned cornerstones of any financial plan. It is as vital to the financial wellbeing of a family as is any investment decision. While those of us in the financial profession will proudly proclaim its importance in a peer-to-peer setting, the majority of us are less outspoken in front of our clients. The fear of coming across as a salesman rather than an advisor deters us from beginning the life insurance conversation. If we can find a way to communicate the importance of life insurance, we will lend credibility to the label and the role of the advisor that each of us holds dear.

SHARE A REAL LIFE STORY

Helping your client understand the importance of life insurance in a financial plan is the first step toward having a productive conversation. I usually incorporate a recent client story (without getting too specific) in which the value of life insurance was realized. One that often comes to mind is the story of "Sarah." Sarah was a housewife to a successful (or so she thought) businessman. Her husband handled everything money related in the household. Her husband died suddenly at age of 55. Upon his death, it came to light that his business had not been successful for a number of years and was now heavily in debt. The assets that they had accumulated were now potentially under siege from creditors. Luckily, as their investment advisor, I had continually pushed her husband to buy as much life insurance as he possibly could qualify for. In fact, he often wondered why he had so much and whether he was throwing his money away. In the end, Sarah was able to pay off the debts and still retain enough of the insurance proceeds to live comfortably for the rest of her life. The moral of the story is that the power of life insurance can turn a crisis into a manageable situation. Each of you has a story to tell; don't be afraid to tell it.

CONNECT ON A PERSONAL LEVEL

I will also identify aspects of the client's life that they care about most to help educate them about life insurance and tug at the heartstrings a bit. A bit of introspection on the client's part never hurts in helping them understand the importance of buying life insurance. The conversation should be an easy one if the client has young children or even young grandchildren since these needs practically identify themselves. You don't have to go overboard and paint a picture of despair if they don't purchase the coverage; just simply accentuate the comfort of knowing that financial issues will be softened considerably through the benefit of life insurance. The pride in leaving a legacy is often enough to sway the client and shines a positive light on life insurance.

IDENTIFY THE ADVANTAGES

Don't forget to lay out the advantages that life insurance holds over other types of investments. The savvy prospect might find the inclusion of an ROI on death benefit as a way to quantify the opportunity you are presenting them. While I don't advocate getting overly technical with a potential client, there is a time and place to flex your intellectual and technical muscle. Don't be afraid to accelerate the conversation into technical terms if it seems that the client

by **JASON DUDUM**



is fit and prepared to have a high level conversation. An accountant might be blown away by the idea that they can accumulate an account balance tax-deferred in a life insurance policy and then potentially take tax-free loans in retirement. The unique features of life insurance can aid you in your sales process with different client personalities.

ADJUST THE CONVERSATION

Once the need and value have been identified, you must adjust the conversation to the appropriate level. If the client seems most interested in addressing the need in the most cost effective way, focus on term insurance. If the client doesn't want to throw money away and would like a return on their investment, universal life might be of interest. From here, it really depends on your level of comfort explaining how much insurance is needed. With most sales involving income replacement, I always use the simple adage that a client can expect their beneficiaries to live comfortably on a 5% income of the death benefit. This usually underscores the importance of buying a policy with a seven-figure death benefit. Never be deterred when a seemingly large sale turns into something much smaller. Many of my largest clients have come about from starting off with a term policy. Once your level of expertise and attention to detail becomes evident with your small term clients, the level of trust in you increases and their willingness to place more (and larger) business with you will increase dramatically.

MANAGE EXPECTATIONS

Getting your client to buy into the idea of life insurance and the amount to purchase is really just the beginning.

You must manage the client's expectations, and continue the conversation if you are to place the policy. Explain that you have a team of professionals to help them through the process. They must understand that not all communication about the policy will come directly from you as the advisor; this will save you a tremendous amount of time in your workday. You must also explain that the process will not be like making an investment; there is an approval process that goes along with buying life insurance. Make sure that your client doesn't get surprised by the amount of detail that goes into the process.

Putting a policy in force may seem like the end product, but you would be foolish to rest on your laurels. As I hinted above, once the prospect becomes a client it is your golden opportunity to display your expertise. Securing meetings to review their policy should be an easy task, and the meeting should always include additional ideas on how you can help them with other aspects of their financial plan. There will be plenty of instances where the client passes on the idea of buying additional coverages. I would argue that many clients will want to learn more about the ideas you are introducing. Now the education process begins again. Sharpen your skills and start the life insurance conversation. Your business can flourish by taking these simple approaches. ★

Jason J. Dudum, LUTCF is chief Executive officer of Dudum Financial. He has more than 15 years of experience in advanced estate planning and asset management. He is a 10-year member of the Million Dollar Round Table (MDRT), and a former chairman of the distinguished Top of the Table. He is also a member of NAILBA and frequent speaker at local NAIFA meetings and carrier conferences.

OPENING THE DOOR TO BUSINESS OWNER



by CHASE BRAKKE, DIA, DIF

Most advisors want to break into the business owner market, but don't have the confidence or fear they lack the knowledge to have a meaningful conversation with a business owner. Part of the problem is that, when we aren't in our comfort zone, we tend to revert back to when we first entered the business when we felt the need to tell someone everything we know with hopes they'll listen to us and take action.

A good salesperson understands that the sale is more likely to happen when we ask good questions that help lead the client to understanding and acceptance. As Nelson Mandela said, "It is wise to persuade people to do things and make them think it was their own idea."

Even if you don't know everything there is to know about disability insurance and how business owners can benefit from what you offer, there are some questions and general ideas you can present to help get the business owner in the proper frame of mind. Again, the goal isn't to impress them with how much you know; it is to help them understand where some of the gaps may be so they can decide for themselves that protecting the risk of a disability is worthwhile.

HOW DO I GET THE CONVERSATION STARTED?

Most of us tend to focus on the individual side of things when talking with clients because it's what we know and what we've been asked to help them with in many cases. Transitioning from personal to business can be a delicate process since owners are often protective of their business. You first need to identify what type of business owner they are. Is the business owner active in the productivity of the company? Is their presence vital to production, revenue generation, and customer relationships? Is the business completely dependent on their ability to show up every day and perform? Businesses with this characteristic are usually in the service industry, including chiropractors, dentists, attorneys, consultants, and even insurance and financial advisors.

There are typically two or three things these individuals should have concerns about related to a disabling event. When presenting to this group, try asking these questions to open the door:

- **What happens to your personal income if you got hurt or sick and can't show up to work for the next six months?** This question gets them thinking about losing their personal income so you can open the discussion for individual disability insurance.

- **What would happen to your business and your customers if you got hurt or sick and couldn't show up to work for the next six months?** This question helps them think about what their business will look like without them and whether it could survive. This will open the discussion for business overhead and loan protection insurance.
- **What would happen to your business if you could never return to work?** Is there anyone you intend to transfer the business to? This helps them identify with the fact that their business has value and might be worth something to someone else. This will also help with the need for business overhead expense or key person insurance for solo owners or for disability buy-out if there is more than one owner.

After you get the answers to these questions, hopefully they've given you some idea as to how their business operates. At this point you can transition into the game plan. A great way to get this started is by saying, "So from what I'm hearing, it sounds like we need to accomplish a few things."

- **Step One:** Protect your income so that your lifestyle, family, and future won't be affected.
- **Step Two:** Protect the business from a short-term mishap so you have something to return to.
- **Step Three:** Create a disaster recovery plan for your business if your return is questionable.

Many of the products you sell can fit into one or more categories in the above three steps. The key is to avoid product discussions and focus on the problems and the solutions (the three steps). Once you've explained the game plan, ask them if they have any questions and to affirm that they are on board with the direction you plan to take. From there you can consult with your wholesaler or local expert and identify the solutions that fit best.

WHAT IF THE BUSINESS COULD SURVIVE WITHOUT THEM?

You'll need to ask a few extra questions if the business is not solely dependent on the owner or there are multiple owners. These types of businesses will take a little more skill and practice, but you can still open the door to conversation by asking a couple of simple questions to get them

thinking about the consequences of a disabling event. All of the questions should still be asked so you can get an idea as to how their business operates. Hopefully, this will allow you to identify other key people within the business.

IF THERE ARE MULTIPLE OWNERS

Is there a formal agreement in place that requires your business to buy-out your share of ownership in the event of death or disability? This can come in many forms, but the most common is a buy/sell agreement. The goal here is only to find out if they've taken steps to prepare for transfer. If they haven't, encourage your client to do so. That will make the next question irrelevant and untimely.

IF AN AGREEMENT IS IN PLACE

How long must you wait before your company has to buy you out after you become disabled; who determines if you are disabled; and where will the money come from to pay you? Instead of talking about the owners in general, speak specifically to your client and how it will affect them. This will help them internalize the situation. Your client may or may not know the answers to these questions so feel free to ask for a copy of their buy/sell agreement.

IF THE BUSINESS COULD SURVIVE WITHOUT THEM

Who would you consider to be key employees? These are the people who make your business run even when you aren't there. Identifying key people will help you understand how the others in the company could affect your client's business. They could be employees or owners, potential buyers for the business, or those who may cost the company a lot of money to replace if something happened to them.

STICK TO THE GAME PLAN

The last three questions can take you in a lot of directions. Again, stay away from product discussions and stick to a game plan that can address their concerns. Reaffirm what you've heard them say and create a game plan that solves the problems they have. Here are a few examples of what you might say, "So from what I'm hearing it sounds like we need to accomplish a few things."

- **Step Four:** Have an attorney draft a formal agreement to ensure the structured transfer of ownership in the event of a major life event, such as a death or disability.
- **Step Five:** Identify the source of funding for a structured buy-out in the event of a premature death or disability so that the business won't be affected financially and ensure the business is capable of paying you the fair market value of your shares.
- **Step Six:** Evaluate how losing a key person would affect the business and the costs associated with that loss.

HOW DO I TRANSITION TO THE SALE?

Again, stay away from product speak as much as possible. As soon as you tell them there are five different policies that can help them solve their problems, they will do nothing or they will cherry pick the products they feel are most

important. Stick to one solution (disability insurance) or two if you are also selling life insurance. Help them understand that disability insurance can help solve a lot of their problems. The miracle of disability insurance can do the following:

- Protect your personal income along with your retirement savings contributions.
- Keep the doors open and the bills paid while you are gone so you have a business to return to when you recover. It can even pay for a temporary replacement, if necessary.
- Buys you time if you know you won't return by keeping your bills paid and customers happy, protecting your leverage while you try to sell your business.
- Decides whether or not you are disabled so the partners in your business don't have to.
- Funds a buy-out so the business doesn't starve from a loss of cash flow and ensures you get paid.
- Infuses cash into the business that can be used to replace a key employee, fund production, pay for a PR campaign, or even just supplement revenues.

Working with business owners can be intimidating, but don't let that stop you from having the conversation about helping their business. Your client relies on their business to keep their personal financial house in order, so it only seems necessary that you do everything you can to protect the source of funding for your client's future. ★

Chase Brakke, DIA, DIF is the National Disability Insurance Consultant for North Star Resource Group in Minneapolis, MN. Chase is a Board Member of the St. Paul chapter of NAIFA MN and a Board Member of the International DI Society. Questions can be directed to chase.brakke@northstarfinancial.com.



DIVIDE & CONQUER: THE CAREER STAGE-DRIVEN APPROACH TO RETIREMENT ADVISING

by KEVIN WATT, AIF

Retirement savings needs vary dramatically according to the career stage. Different participants may need different levels of advice, and some may not need advice beyond, “Continue to save.” A career stage-based approach helps put the best interests of the participants first, though it seems to run counter to an advisor’s training.

When you spend equal time at every career stage, some participants get more information than they need while others don’t get enough. Getting the planning mix right is crucial to help ensure optimal retirement outcomes, especially in California. California is one of the three lowest scoring states on the financial security scorecard from National Institute on Retirement Security. It’s also one of the most expensive states for retirees, with high health care and housing costs. The state also has very low retirement plan participation and account balances.

Advisors should determine which of the following career groups each participant falls into:

EARLY CAREER

Employees who are 25 to 35 typically have not amassed enough assets to need retirement planning. They may not think they need an advisor at all at this point. Any comprehensive retirement plans that are created now will likely need to be reworked frequently in the years to come, due to life changes. Instead, advisors should focus on providing solutions to meet their most pressing need: accumulating as much as possible to start their retirement savings off on the right foot. Younger employees will be set up for retirement failure if they do not begin to save as much as possible early in their career. The best thing advisors can do is to encourage this behavior and offer a range of solutions to help move the accumulation process forward.

MID-CAREER

Employees who are 36 to 50 are encountering financial milestones like buying a home and starting a family. These life milestones offer the opportunity to begin building client relationships and trust. They continue to build 401(k) balances and gather additional assets like IRAs or taxable stock portfolios. Advisors can help clients in the lower age range to evaluate options for purchasing their first home or establish a college savings fund. It’s critical to counsel them to continue amassing retirement savings, no matter what life milestone may occur.

Advisors can help clients in the upper age range to select the asset allocation for their age and risk appetite and create plans for adjusting it as retirement draws closer. It may be appropriate to begin initial long-range retirement discussions with some mid-career participants. Talking about retirement income goals and savings can help keep clients motivated to save despite other financial demands. For those approaching their 50s, it’s also a good time to begin outlining an income strategy for retirement and the steps to implement it.

Scaling back on retirement savings or losing a significant portion of assets during the mid-career years could halt the positive momentum from early career savings. Growth and preservation are the keywords for mid-career employees. Advisors who can provide high-level guidance on how to balance retirement savings growth with financial demands will reap the rewards when these employees transition into their final employment stage.

LATE CAREER

These employees typically have accumulated sizable assets and will rely on the guidance of financial professionals to determine what comes next. Advisors are key to helping near-retirees

develop an income strategy for their post-work years. Participants need to know how they’ll distribute their assets. Advisors can help position assets to help ensure participants have the steady income stream they’ll need. Late career employees often have questions about Social Security, legacy planning and more.

Diligent and prolonged retirement savings can be undone with a poor distribution strategy. Running out of money is a real fear for many older Americans. Advisors can help ensure that older employees won’t be forced to restart their careers in their 80s, when the retirement accounts have run dry.

Late career participants are more likely to have a higher net worth. They’re more likely to be looking for advisor assistance with rollovers and other needs. They also tend to have larger personal networks, which can increase the potential for referral business.

A WIN-WIN SCENARIO

This career-state approach helps participants focus retirement efforts on solutions that will have the most impact during each career stage. For advisors, this approach is likely to help increase the odds of successful retirement for participants while creating additional time for advisors to spend on business building activities. ★

Kevin Watt, AIF®, vice president at Security Benefit affiliated companies, has more than 20 years of experience in business development, product design, marketing and sales of 401(k) plans. In California, Security Benefit and its subsidiaries work only through local, independent advisors. Security Benefit, through its subsidiaries, partners with local TPAs that help connect providers and advisors and offers flexibility to accommodate advisors who are seeking either a commission- or fee-based compensation model. The information contained herein is not intended as and should not be construed as tax advice.

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Retirement savers can now tap into their account information any time day or night by pressing the new MassMutual RetireSmart mobile app on their Apple and Android smartphones. For more information, visit massmutual.com.

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Greatland is developing comprehensive Affordable Care Act (ACA) reporting capabilities with tools to assist businesses with the law's mandatory requirements. Greatland is able to assist businesses and insurance companies file Form 1095-B and Form 1095-C along with required 1094 transmittal forms, required for ACA reporting to the IRS and will provide copies to employees, with three filing options: paper forms, online filing or desktop software. For more information, visit greatland.com.

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Allstate, Capital One, LegalZoom, Microsoft, Office Depot, Inc. and Web.com have joined forces to create SmallBusinessConnection.com. The free online resource hub is designed to help small business owners address critical business issues. It features information on the following:

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- Insurance and Allstate Benefits
- Cash flow management and financial education resources provided by Capital One
- Legal solutions provided by LegalZoom
- Technology solutions provided by Microsoft

For more information, smallbusinessconnection.com.

SIMPLIFIED HEALTH INSURANCE PURCHASING

AgileHealthInsurance.com was launched to make it easy for consumers to purchase low-cost alternatives and supplements to Obamacare health plans. The website offers an intuitive online experience and a streamlined application process. Health insurance alternatives to Obamacare are especially important now that the Obamacare Special Enrollment Period for Tax Season ended on April 30th. Obamacare plans will not be available again, without a qualifying life event, until the 2016 open enrollment period begins on November 15th and the earliest that coverage can start for those plans is January 1, 2016. Unfortunately, many consumers are unaware of the Obamacare lockout situation.

GRADED BENEFIT DISABILITY PROGRAM

Petersen International Underwriters launched its graded benefit disability insurance plan, designed for clients with less-than-perfect health histories. Prospects who are traditionally declined or limited by disability insurance carriers can now be covered without harsh medical exclusions at graded benefit levels predetermined by the client at the time of application. For more information, call 345-8816 or email piu@piu.org.

MOBILE DISABILITY INSURANCE QUOTE TOOL

Guardian Life introduced "Guardian DI QUICKQuote." It allows financial professionals to access product information and pricing to provide on-the-spot quotes for individual disability insurance. Users can plug in their age and expected income needed to retain their lifestyle and get a quote instantly. Brokers can generate a quote on a smart phone and e-mail it directly to a client. For more information, visit GuardianLife.com.



IN NEWS

HOW TO IMPROVE YOUR EMPLOYEE BENEFIT PLAN

Just three factors are integral a successful employee benefit plan, according to a study by Navera and Met Life. They are: having the right mix of benefits, having more choice within a broader range of benefits, and having effective enrollment education and selection confidence. The study reveals the following:

- Employees who have five or fewer benefits are less loyal and less likely to recommend the company as a great place to work.
- Employees who have 11 or more benefits are more loyal and more likely to recommend the company as a great place to work.
- The two main drivers of employee confidence in their benefit selection are having easy-to-understand benefit information and effective benefit communications.
- Less than half of employees agree strongly that their company's benefit communications educated them on benefits and helped them understand how much they would pay for services.

Navera CEO Steve Adams said, "It's now time to take technology-enabled self-service benefit enrollment from theory to reality... Technology-enabled platforms deliver information in a way that is easy to navigate and available anytime... A portfolio approach to benefit selection replaces the traditional serial process of selecting benefits. In the serial approach, employees make their medical selections first, then dental, and then vision, then disability, then group life, and so on. Employees are required to make an independent purchase decision about each of these benefits. Alternatively, a portfolio approach enables employees and their families to see how the benefits they select work together to provide them with the most complete and cost-effective coverage." For more information, visit navera.com.

WHY EMPLOYEES DON'T STICK WITH WELLNESS INITIATIVES

While most employees like wellness programs and feel they help them manage their health, many don't stay engaged in their programs throughout the year, according to a survey of 1,929 employees by HealthMine. Less than half of employees stay engaged in their wellness program throughout the entire year.

Employees lack critical information about their personal health. Less than one-third know at least one of their key health metrics, which can indicate risk for chronic illness. For example, only 32% of people know their blood pressure. A majority of employees have difficulty interpreting their health information or understanding how to maintain or improve their health. Eighty-five percent want better information about their risk of chronic disease. Plus, the majority want to know which cancer screenings they need, and the actions they need to maintain or improve their health.

Eighty percent want incentives for wellness. More than half want help from their plan sponsors in setting personal health goals. Even though 30% have been diagnosed with a chronic condition in the last year, most are not getting help with disease management or medication adherence through their wellness programs.

While 70% say their wellness plan helps them manage their health, just 38% say it helps them manage healthcare costs. Even though most consumers agree it's a good idea to shop for the best deal on medical services before taking action on their health, most never do. For more information, visit healthmine.com.

EMPLOYEE WELLNESS PROGRAMS SKIP HEARING HEALTH

A survey by EPIC Hearing HealthCare reveals that 70% of employers offer a wellness program, but only 8% of these programs integrate hearing health. Employers are far more familiar with wellness programs addressing preventive health issues such as weight control (94%), exercise (89%), smoking (88%), and diabetes management (69%) than programs promoting healthy senses.

Twenty-three percent of employers are familiar with vision programs while only 16% are familiar with hearing health programs. This could be because employers assume that only the retired population is at risk. The truth is that about 30% of employees suspect they have hearing loss, but have not sought treatment; this is consistent among age groups. Employers have a definite change of heart when educated on how untreated hearing loss can affect productivity. Eighty-six percent of employers said they would integrate a hearing health wellness product into their wellness program if they knew that almost all employees with untreated hearing loss say it affects them on the job. For more information, visit epichearing.com/listenhear.

A STRONG MARKET FOR VOLUNTARY PERSONAL INJURY ACCIDENT PLANS

Accident products consistently represent around 12% to 14% of voluntary sales in 2014. With health care reform, these benefits are expected to maintain or even increase

this share in the coming years, according to a report by Eastbridge. Sales for personal injury accident products totaled \$886.7 million, representing about 13% of voluntary sales. That's also an increase of 14% over accident sales in 2013. The majority of accident products on the market have been introduced in the past few years.

Only six of the 19 participating carriers offer an individual product, but all of those also offer a group accident product. Carriers believe that flexibility and the specific benefits provided are key market differentiators for accident products today and in the future. For more information, visit eastbridge.com.

FINANCIAL PLANNING

How A Whole Life Policy Can Strengthen Retirement Planning

A white paper by Wade Pfau, Ph.D., CFA argues for integrated retirement planning. Using investments, income annuities, and whole life insurance may yield higher income and greater legacy wealth than would an investment-only strategy, according to the paper, which was distributed by OneAmerica at its annual Economic Summit.

"For years, Americans have focused on building a nest egg for retirement. This research suggests that using income annuities and whole life insurance combined with investments can create a more efficient retirement strategy. The markets have to perform extremely well to beat this integrated approach," said Dr. Pfau, who is a professor of retirement income at The American College for Financial Services.

The white paper compares three retirement scenarios for 35-year-old and 50-year-old couples. The research assumes that the 35-year-old couple has \$65,000 in a retirement account and \$15,000 available per year to invest for retirement. The integrated option provides 40% more income at age 65 and 228% more legacy wealth at age 100 than does the investment-only option. For more information, visit OneAmerica.com.

HEALTHCARE

Patients Are Less Satisfied With Health Care

Patient satisfaction continues to fall in the health care and social assistance categories, according to the American Customer Satisfaction Index (ACSI). Patient satisfaction is down 3.2% to an ACSI score of 75.1, the lowest level in nearly a decade. Patients say that visits to doctors, dentists, and optometrists (76) are better than hospital services (74), but the quality of care is lower than it was a year ago.

The demand for health care services is rising, with preliminary figures on household health care spending up nearly 6% in 2014—the largest increase since before the recession. This is probably because more Americans have health insurance.

The rate of growth in the health care workforce slowed, which likely contributed to less efficient access to care. However, since the middle of 2014, the health care sector has been adding workers at a significantly faster pace, which may lead to higher patient satisfaction in the near future.

ACSI managing director David VanAmburg said, "The influx of the newly insured is putting pressure on a system that is still playing catch up. Rising demand that is outpacing supply, coupled with increasing healthcare costs, is a formula for lower satisfaction."

Satisfaction with outpatient hospital care improved 5% to a score of 80 compared to considerably lower satisfaction with inpatient services and emergency room service (-10% to 64). For more information, visit theacsi.org.

Consumers See Massive Increase in Health Care Costs

While the U.S. government has become an even more dominant force in the nation's health care system, individuals are taking on a greater share of the costs, according to the latest index by U.S. News & World Report. Though data from the Affordable Care Act are not measured in the first iteration of the index, the federal government's expanded role is already apparent. Government-sponsored health care, including Medicare and Medicaid, have grown at a faster rate than private health insurance. The percentage of people under 65 with public health insurance coverage increased from 12.9% in 2000 to 23.8% in 2013. Private health insurance coverage decreased from 71.8% to 61% during the same period.

Americans have taken on a higher burden of health care costs, spending 1.7 times more out-of-pocket on health care by 2013. The average cost of deductibles more than doubled over a decade. The percentage of premiums paid by employees increased 4% for single and family plans. Meanwhile, there has been a 55% growth in consumers' prescription drug prices.

In 2012, the U.S. spent 17.9% of its GDP on health care, more than any other developed nation. For more information, visit usnews.com.

Insurers to Take Advantage of Wearable Devices

Nearly two-thirds of insurers expect wearable technologies to have a significant effect on their industry, according to a survey of more than 200 insurance executives by Accenture. Insurers have traditionally based their underwriting and pricing processes on a limited view of certain customer variables. But emerging technologies, such as wearables and other connected devices, can help insurers provide outcome-based services for their customers, according to the report.

Seventy-three percent of insurers say that providing a personalized customer experience is one of their top three priorities, and 50% have already seen a positive return from their investment in personalized technologies.

John Hancock recently announced that it will give new policyholders a free fitness band to track their health progress—and then reward their healthy living with a reduction in life insurance premiums.

However, most insurers struggle to fully use their existing data. Fifty-six percent say that managing data is very challenging. At the same time, 86% expect software intelligence to be integral to simplifying their IT functions. Sixty-six percent of insurers experiment with intelligence technology, and 76% believe that successful businesses will soon manage employees alongside intelligent machines.

The majority of insurers are taking part in open innovation initiatives. Seventy-five percent say that the next generation of platforms will be led by insurance players, not technology companies. Fifty-one percent plan to partner with major digital technology and cloud platform leaders; 64%

plan to team up with new digital partners in the insurance industry, and 45% plan to find partners outside the industry. For more information, visit accenture.com.

Bills Would Repeal the Cadillac Tax

The National Association of Professional Insurance Agents (PIA) has endorsed two bills that would repeal the ACA's excise tax on certain employer-sponsored health plans. The 40% excise tax on so-called "overly generous" employer plans is set to take effect in 2018. Commonly referred to as the "Cadillac Tax," it will have a much broader effect than Congress intended and is likely to affect certain groups more severely, according to the PIA.

PIA National executive vice president & CEO Mike Becker said, "The Cadillac Tax is a ticking bomb that is set to explode in 2018 and deny health coverage to millions of middle-class Americans. It has the potential to create more market disruption than we've seen since the inception of the ACA, all to benefit government programs."

PIA has endorsed two similar pieces of legislation: the "Ax the Tax on Middle Class Americans' Health Plans Act" (H.R. 879), introduced by Congressman Frank Guinta (R-NH), and H.R. 2050, a bill to repeal the excise tax introduced by Rep. Joe Courtney (D-CT).

PIA national director of Federal Affairs Jon Gentile said, "PIA strongly supports repeal of the Cadillac Tax because it will impact not just high-benefit plans, but moderate-benefit plans, and it could have an unequal impact based on the age, gender, family-size, and the geographic location of an employer's workforce. This tax has the added consequence of punishing people enrolled in private sector health plans by hitting them with a 40% surtax, simply because they have good coverage. That's inherently unfair."

"The tax is intended to target only high cost employer-sponsored health plans, not moderate benefit plans. However, a Mercer survey recently estimated that it would impact 31% of employers in 2018 and 51% of employers by 2022, indicating that the excise tax will have a much broader effect than Congress intended," said PIA national counsel & director of Regulatory Affairs, Jennifer Webb, in comments to the IRS. PIA's web address is pianet.com.

Med Supp Plans Continue to Grow

Membership in Medicare supplement plans continued to increase in 2014, according to a report by Mark Farrah Associates. Medicare supplement plans covered approximately 11.2 million seniors as of December 31, 2014, a 5.2% increase from 2013. From 2013 to 2014, enrollment in Medicare supplement plans increased by 551,135 covered lives. Though UnitedHealth was the growth leader, many other insurers experienced growth in Med Supp business.

Plan F, the most popular design, enrolled more than 6 million members and accounted for 54% of the market. Membership in Plan F increased by 494,599 enrollees from 2013 to 2014. Enrollment growth was also significant in standardized plan types G and N, with increases of 141,024 and 188,256 members.

The Affordable Care Act has had little effect on Medicare Supplement business. Reforms have not imposed major plan design changes or minimum loss ratio requirements

for these plans. Many carriers have sustained a significant presence in the market by selling products at competitive rates while maintaining favorable loss ratios. For more information, visit markfarrah.com.

Senate Bill Would Expand Access to Pharmacies

The National Community Pharmacists Association (NCPA) strongly endorses The Ensuring Seniors Access to Local Pharmacies Act, S. 1190. The legislation would expand the number of pharmacies that can offer discounted copays for Medicare Part D prescription drugs. It was introduced by Senators Shelly Moore Capito (R-W.Va.), Joe Manchin (D-W.Va.), Tom Cotton (R-Ark.) and Sherrod Brown (D-Ohio).

Medicare beneficiaries in medically under-served areas would be able to access lower copays at any pharmacy that agrees to accept a drug plan's preferred pharmacy terms and conditions. S. 1190 is a companion bill to H.R. 793, The Ensuring Seniors Access to Local Pharmacies Act, which has been introduced by Reps. Morgan Griffin (R-Va.) and Peter Welch (D-Vt.). NCPA CEO Douglas Hoey, RPh, MBA said, "Medicare beneficiaries should not be confronted with the Hobson's choice of continuing to patronize their pharmacy at a higher cost or making a long trip to another pharmacy."

The bill has been endorsed by the Alliance for Retired Americans, the Center for Medicare Advocacy, Families USA, Justice in Aging, the Medicare Rights Center, the National Consumers League, the National Rural Health Association, and the U.S. Pain Foundation. "Today many Medicare beneficiaries are effectively told by drug plan middlemen which pharmacy to use based on exclusionary arrangements among the pharmacy benefit manager (PBM) middlemen and, in most instances, large publicly traded chain pharmacies," Hoey added. According to a recent Medicare study, in urban areas 54% of preferred pharmacy drug plans failed to meet the government's threshold for reasonable access to pharmacies. In rural America the closest preferred pharmacy can be 20 miles away or more. For more information, visit ncpanet.org.

How a Network Can Improve the Health of Medicare Beneficiaries

Medicare beneficiaries with diabetes, high blood pressure, or high cholesterol may achieve better health outcomes when using pharmacies that are part of performance-based networks, according to a study by SCAN Health Plan and Express Scripts. Phase I results demonstrated that, when compared to a national sample of retail pharmacies, the pharmacies in the Quality Network achieved 60% higher performance scores for reducing the use of high-risk medications among SCAN members, and 23% higher scores for improving compliance with diabetes treatment guidelines among SCAN members. When compared to a sample of non-SCAN members using the same Quality Network pharmacies, the Quality Network achieved 34% higher scores for high-risk medications and 8% higher scores for diabetes treatment among SCAN members. For more information, visit express-scripts.com.

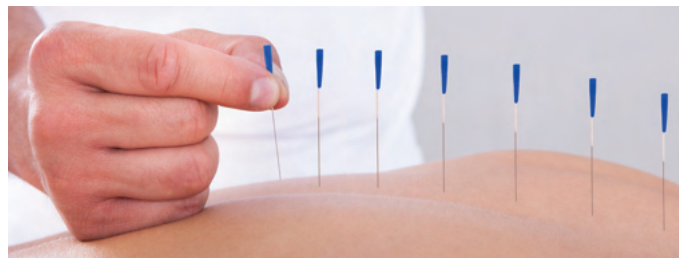
Five Things to Know About the CMS Part D Data Release by Allyson Funk of the Pharmaceutical Research and Manufacturers of America

Following the release of Center for Medicaid and Medicare services data on Medicare Part D, here are five things you need to know:

- Part D's competitive, market-based structure is unique among government programs. Part D is different than other parts of Medicare and other government programs because it relies on competition among private plans that submit bids to offer prescription drug benefits to enrollees. Competition and rebates have been significant in keeping Part D costs \$349 billion lower than initial ten-year projections and keeping costs and premiums low for beneficiaries.
- The release does not reflect actual government spending on the Part D program in 2013. According to the Congressional Budget Office (CBO), actual Part D mandatory outlays were \$62 billion in 2013, which was only about 10.6% of total Medicare spending that year.
- Significant rebates are negotiated in Part D making the actual cost of drugs lower than reported in the data. The data does not reflect the significant rebates and discounts Part D plans negotiate with pharmaceutical companies. The Medicare Trustees report reveals that many brand-name prescription drugs carry substantial rebates, often as much as 20% to 30%. On average, across all program spending, rebate levels have increased in each year of the program. In fact, actual rebates are above projected levels for each year of the program. The drug that CMS lists as number one of the 10 most expensive drugs in 2013 is actually one of the most highly rebated drugs, with rebates reportedly in excess of 60%.
- The list is already outdated and ignores generic competition. CMS' list of top-10 drugs, by cost, does not reflect the fact that competition and incentives to control costs have led to high generic utilization in Part D. More than half of the medicines on the list are off-patent or are expected to lose patent protection by 2016. Innovator companies invest in pioneering research to bring new treatments to patients, and over time those medicines become available as lower-cost generic copies. Since Part D's inception, generic utilization among seniors has increased from about 54% in 2005 to 84% in 2013.
- Use of medicines reduces other medical spending. In 2012, CBO announced a change to its cost-estimating methodology to reflect the fact that increases in prescription drug use could reduce spending for medical services. Enrollment in Part D has improved access to medications recommended to treat congestive heart failure for beneficiaries with limited or no prior drug coverage. An increase in drug adherence for Part D enrollees with congestive heart failure led to over \$2.3 billion in annual savings to Medicare, driven by reductions in Parts A and B expenditures. Over the next 10 years, further improvement in adherence among Part D enrollees with CHF could yield an additional \$22.4 billion in federal savings.

For more information, visit phrma.org.

The Benefits of Acupuncture and Other Integrative Medicine



Integrative medicine interventions lead to significant reduction in chronic pain, depression, and stress, according to a report by The Bravewell Collaborative. The findings are based on data collected by the Patients Receiving Integrative Medicine Interventions Effectiveness Registry (PRIMIEM), the first-ever patient registry on integrative medicine. It helps evaluate patient-reported outcomes over time for patients who supplement conventional medical care with other therapies such as acupuncture, yoga, chiropractic, and biofeedback.

Using data from PRIMIER, researchers found that the use of integrative medicine yielded an increase in the Patient Activation Measure (PAM), which assesses to what degree patients believe they have the knowledge, skill, and confidence to take action to improve their health, and whether they are likely to maintain positive self-care actions over time. Over six months, the percentage of patients with low levels of patient activation decreased from 29% to 17%, while those with higher levels of activation increased from 71% to 83%. Previous research has found that higher scores on the PAM are strongly related to improvements in clinical outcomes such as less pain, an increase in utilization of prevention screenings, and a reduction in emergency room visits.

After reviewing the prospective data from 369 patients over six months, researchers also found significant reductions in patients' perception of depression and stress. In 179 of these patients who were being treated for chronic pain, researchers also found statistically significant decreases in pain severity and a 28% decrease in the degree to which pain interfered with quality of life.

In related news, a different study from the University of Pennsylvania offers hope for breast cancer survivors struggling with cancer-related pain. Researchers found that electro-acupuncture reduce joint pain by as much as 40% in women with breast cancer, whether the patient expected it to work or not. The study also found that "sham" acupuncture—which involves non-penetrative needles and no electrical stimulation—provided pain reduction as high as 80% if patients had a high degree of expectation that it would work. The study results provide important implications for future treatment of breast cancer patients with joint pain.

"Our study is the first to provide evidence that expectancy has no effect on whether real acupuncture works or not, but that high expectancy does appear to have a positive effect on patients who receive sham acupuncture," said the study's senior author Jun J. Mao, MD MSCE.

"These findings certainly challenge the notion held by some that acupuncture is 'all placebo,'" said the study's lead author Joshua Bauml, MD. ★

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