CALIFORNIA BROKER

VOLUME 33, NUMBER 6 SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS MARCH 2015

Stop the Madness!

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CALIFORNIA BROKER
MARCH 2016

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Outlook on Patient Protection and the Affordable Care Act for 2015

Looking back on 2014, an amazing array of compliance developments took place — most of it related to implementation of the Patient Protection and Affordable Care Act (PPACA, or simply, health care reform).

Supreme Court to rule in King v. Burwell

The Supreme Court will rule on the validity of "subsidy" payments in states that have not created their own state exchange platform. Billions of dollars of federal subsidies are at stake for residents of the approximately 75% of states that have not established exchanges. Oral arguments are expected to be held in March 2015, and a decision is expected by late June or early July 2015.

Republican Congress

Although Republicans now hold the majority in both the House and the Senate, the GOP still lacks the votes needed to override a veto by President Obama. That means that even if Congress attempts to repeal or to modify provisions of the PPACA, we do not expect those efforts to be successful in repealing the measure in its entirety. However, if the Supreme Court rules that PPACA contained a "drafting error" invalidating subsidy payments in certain states, the Republicans would immediately gain huge leverage since the President would urgently need Congress to enact new legislation for the correction — and Republicans might seek PPACA modifications in exchange for their legislative cooperation.

HIPAA Privacy/Security

At the end of 2014, HHS postponed its new HIPAA-numbering mandate. We do not know when compliance will be restarted, but the postponement is likely only temporary. As federal, state, and private actions related to data privacy and security increase, complying with HIPAA is more important than ever.

Non-calendar year Mandate Compliance

For employers that satisfy the various conditions needed to start the PPACA coverage mandate on their plan anniversary date in 2015, key requirements apply. For employers who are eligible to start on their plan anniversary date, minimum value affordable coverage must be extended beginning on the plan anniversary date. Minimum Essential Coverage (MEC) alone is not an option for employers who start mandate compliance mid-year.

(Note: MEC is often associated with the "skinny" coverage concept and used to block "sledgehammer" penalties.)

Smaller, large-Sized Employers

Employers with more than 50, but fewer than 100 employees are not required to start PPACA mandate compliance until 2016. Part of the requirement to start in 2016 is the ability to satisfactorily document workforce size. ❑

Dennis G. Fiszer, JD is the chief compliance officer for HUB International Employee Benefits, Eastern Region and is a nationally recognized speaker on health care reform and the Affordable Care Act. He provides compliance and consulting services regarding health plans and other employee benefits. Dennis' areas of expertise include COBRA, Health Insurance Portability and Accountability Act of 1996 (HIPAA), wellness programs, federal and state health care reform, employment and labor issues, ERISA, and the Family and Medical Leave Act. See more at: http://www.hubinternational.com.

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Annuity Sampler

February 1, 2015

Company Name	Ratings Bests	Fitch	S&P	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)
American Equity	A-	BBB+		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.25%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	$10,000 (Q) & $10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.45%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	$10,000 (Q) & $10,000 (NQ)	3.00%, age 0-75 & 2.10%age 76-80**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.70*%	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	$10,000 (Q) & $10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				*Effective 2/5/15. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details								
American General Life Insurance Companies	A	A	A+	American Pathway Fixed MYG 10 Annuity (Q/NQ)	S	4.65%*	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 2/2/15. First year rate includes 3% interest bonus								
American General Life Insurance Companies	A	A	A+	American Pathway Flex Fixed 8 Annuity (Q/NQ)	F	3.75%*	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 2/2/15. Includes 2.00% 1st year bonus, 1.00% base rate subsequent years.								
American General Life Insurance Companies	A	A	A+	American Pathway Fixed MVA 9 Plus Annuity (Q/NQ)	S	5.60%*	1 yrs.	None	9%, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	$5,000 (NQ)	2.75% age 0-75 1.70% age 76-80 1.20% age 81-85
				*CA Rates Effective 2/2/15. 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 2/2/15								
Genworth Life & Annuity Insurance Co.	A	A-	A-	SecureLiving Rate Saver	S	2.55%* 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 11/26/14. Based on $250K or more.								
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	1.95%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 7/30/14. Includes .25% first-year bonus and is for purchase payments over $100,000. Escalating five-year yield is 1.95%. For under $100,000 first-year rate is 1.85%. Escalating rate five-year yield 1.85%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.40%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 7/30/14.. Includes 1.00% first-year bonus and is for purchase payments over $100,000. Escalating seven-year yield is 2.29%. For under $100,000 first-year rate is 2.30%. Escalating rate seven-year yield 2.19%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.40%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 7/30/14.. Eff. yield is 2.42% based on 1.40% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.40%. Surrender value interest rate 1.40%. Accepts additional purchase payments in first three contract years. COM12255												
Jackson Insurance Company.	A+	AA	AA	Bonus Max (Q/NQ)	F	3.20%*	1 yr.	None	8.25%, 7.25%, 6.50%, 5.50%, 3.75%, 2.75%, 1.75%,0.75%**	Yes	$5,000 (NQ) $5,000 (Q)	6.00% 0-80 3.00% 81-85 1.50% 86-90
				*Effective 10/6/2014. The first year interest rate includes any first year additional interest, if applicable. Interest rates in subsequent years will be less. **Each premium payment, including any subsequent premiums, is subject to the withdrawal charge scheduled as detailed.								
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.30%*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	$10,000 (Q/NQ)	
				**Rates Effective 2/1/15 for premium less than $100,000 and are subject to change								
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	1.70%*	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	$10,000 (Q/NQ)	
				**Rates Effective 2/1/15 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 2/3/15 and is subject to change.												
Reliance Standard	A+		A+	Eleos-MVA	S	3.05%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	$10,000	3.25%**
				*Effective 2/9/15. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85								
Reliance Standard	A+		A+	Apollo MVA (Q/NQ)	S	4.00%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	$5,000	4.00% to age 75**
				Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 2/9/15								
Symetra Life, Inc.	A	A+	A	Custom 7 (Q/NQ)	S	2.70%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	$10,000	Varies
				*Effective 2/11/15. 2.20% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for $250,000 and above.								

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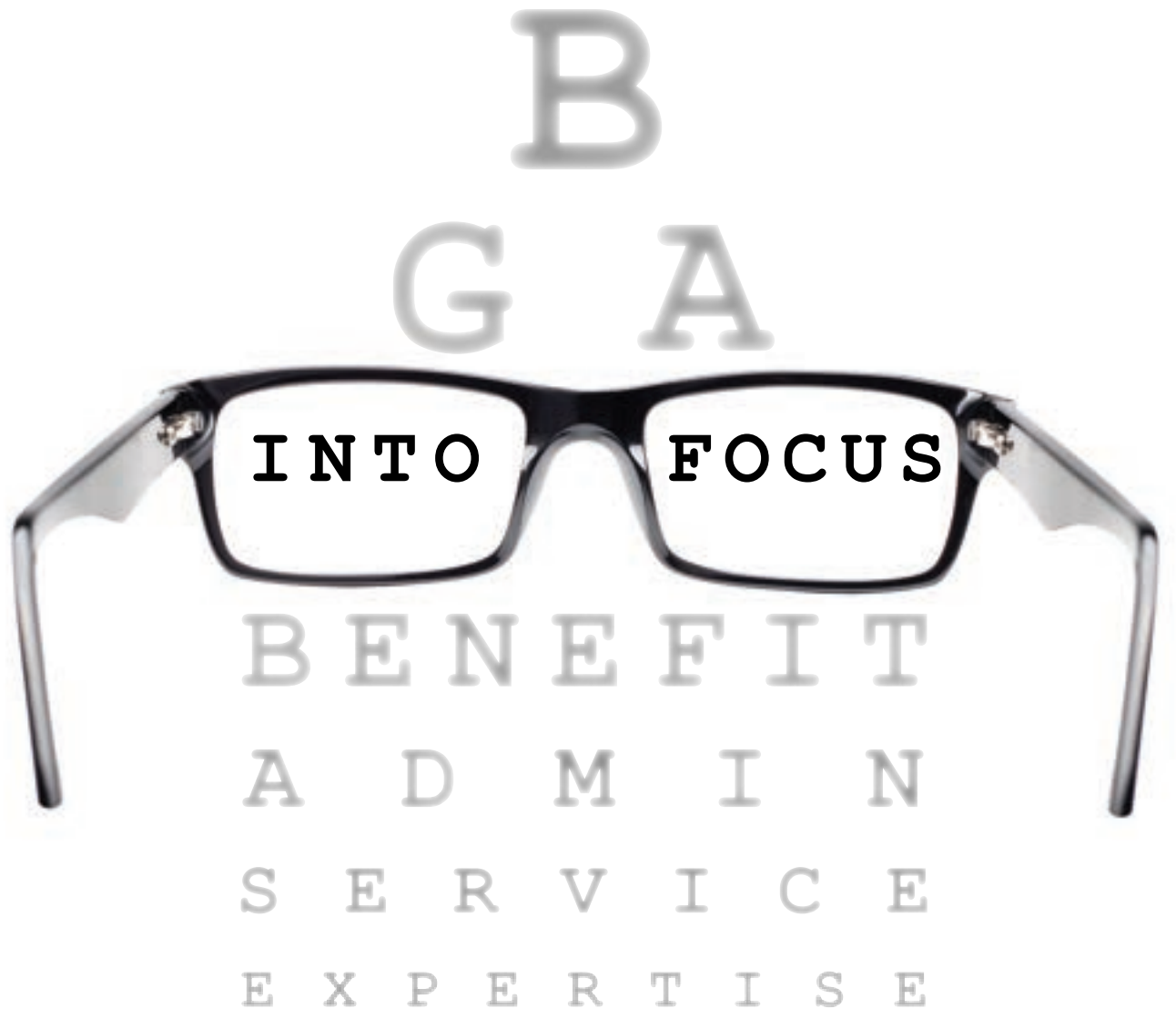

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Dental Benefits are on the Rise

In the employee benefit world, dental has been the most commonly requested product after medical. Companies – both large and small – have offered dental as part of an overall health benefit package. In many cases, it has been paid by the employer. However, the number of businesses that include employer-paid dental has been declining rapidly over the past five years.

According to Delta Dental, subtle yet important trends are reshaping dental benefit plan designs as employers continue to search for ways to keep costs in line while having a minimal effect on what they offer to their employees. Some employers are using strategies like raising deductibles, lowering plan coinsurance, adopting PPOs, and switching certain procedures from one category to another. Interestingly, though, one strategy is almost never being used — dropping dental benefits completely. Employer-sponsored dental insurance programs remain a highly sought-after benefit by employees.

Despite all the talk about a revolution in health care delivery and payment systems, changes in dental benefit programs are coming at a relatively slow pace. In part, it's because the cost increases associated with dental coverage have been minor compared to medical — usually in the 5% to 9% range. Medical costs have gone up 15% to 20% or more annually. So employers are taking bolder steps to shift those costs of medical coverage to employees. In many cases, they are leaving their dental program unchanged as a way of blunting the effect of changes in the medical plan.

At year-end 2013, about 191 million Americans – or 61% of the population – had dental benefits, according to the National Association of Dental Plans. About 99% of dental benefits are provided through an employer or other group programs like AARP. Group coverage also includes public programs like Medicaid, the federal Children's Health Insurance Program, and TriCare, which provides coverage for the military.

Delta Dental has reported these four growing trends in the dental plan industry:

1. **Higher deductibles**. Many employers continue to offer dental plans with no deductibles, but an increasing number now require a commitment from employees. Also, the level of that deductible has been rising slowly, but steadily. In the past five years, the percentage of employers offering plans with a $0 to $25 deductible has gone from 63% to 55%. That decline is expected to continue. However, most plans con-

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tinue to offer diagnostic and preventive services with no deductible.

2. **PPO plan designs**. Taking advantage of the discounts offered through PPO networks is one way that employers can continue to offer the same level of benefits without a big cost increase. The downside is that most PPO networks are relatively small, and employees may resist having to change dentists to avoid having poor out-of-network coverage levels, losing protection against balance-billing and other negatives.
3. **More self-insured groups**. An increasing number of larger groups, generally those with 100 or more employees, find that they can save money by self-insuring their group. In this arrangement, the carrier serves only as the administrator of the dental benefit program. The group picks up the tab for claim payments and pays the carrier a relatively small fixed amount per employee per month for administrative services.
4. **Lower employer contribution**. Many companies are increasing the share of costs that employees pay for dental premiums. There are still a lot of 100% employer-paid plans out there, but the trend is toward shifting at least some of the cost to employees. Many companies that introduce dental benefits for the first time are choosing voluntary plans, in which the employees pay the full cost of the premium.

Employers and other plan sponsors offer dental benefits for a variety of reasons, according to the American Dental Association. Offering a dental benefit plan makes economic sense. Dental disease is a frequently overlooked reason for employee absences or poor work performance or discomfort. As every human resources professional knows, days lost can mean money lost. Also, a quality dental benefit plan can aid in employee recruitment and retention. Dental benefits are consistently cited as one of the most sought after employee benefits.

Dental plans are typically business arrangements between an insurance company and an employer. Here are some key questions that brokers and HR execs should ask when sourcing a dental plan for employees:

- Will employees retain the freedom to choose their own dentists?
- Is the type of treatment determined by the patient and the dentist?
- Does the plan cover diagnostic, preventive and emergency services?
- Will it cover preventive services such as sealants and fluoride treatments, which may save patients money in the future? Will it provide for full-mouth x-rays?
- What type of routine dental care is covered?
- Does the plan cover crowns and bridges, braces, root canals, oral surgery and treatment of periodontal diseases?
- What major dental care is covered? Does the plan cover dentures, implants or other treatments like TMJ?
- Will the plan allow for referrals to specialists? If so, will the dentist be limited to a list of specialists from which to choose?
- How does the plan provide for emergency treatment, and what provisions are made for emergency care when you are away from home?
- If the plan requires monthly premiums, what percentage of that money goes to actual care and not to overhead or administration?

Consider what clients need; then find a product that works for them. Plus, don't get caught up in the "What's my commission?" question. Research the need and match it with the right product. Then, you won't have to worry about renewals.

But the kind of dental plan is not the only consideration of providing this benefit to employees. What about the Affordable Care Act's (ACA) implications on employee benefits? ACA mandates don't apply to health plans classified as excepted benefits. The government has established regulations in 2014 expanding the definition of excepted benefits to include self-insured dental even if that coverage is provided without employee contributions.

The dental or vision coverage will be an excepted benefit even if the waiver has no effect on employee contributions as long as the employer allows employees to waive or opt-out of dental or vision coverage. As long as dental coverage is classified as an excepted benefit, dollar limits on pediatric dental care is also permissible.

One final way that employers can help their employees keep their oral health in check is to offer a dental Health Reimbursement Account that is funded by the employer. A limited use HRA that is tied to a debit card and administered by a company that offers this plan administration is a great way to keep employees happy by providing a defined contribution each year to keep dental care a viable benefit. Employers can set aside a specific amount of money that is only used for dental procedures. Most importantly, all employer contributions to the plan are 100% tax deductible to the employer, and tax-free to the employee. Everyone wins.

With dental benefits on the rise, employers need help figuring out what their options are for this type of product. A one size fits all benefit is not what brokers should offer. Consider what clients need; then find a product that works for them. Plus, don't get caught up in the "What's my commission?" question. Research the need and match it with the right product. Then, you won't have to worry about renewals. ❑

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 7 years, (www.yourbesthealthcare.blogspot.com), which is a topical weblog about various health care issues. You can reach Mark at MarkR1955@gmail.com.

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Short and Long Term Disability

With our attention drawn to ACA, it is little wonder that short- and long-term disability and other benefits have taken a back seat in this year's core enrollments.

It has been a formidable task for brokers and employers to deal with the ACA and its rules, regulations, taxes, reporting, penalties, litigation, software, tracking, working hours accounting, staffing, expanding guidelines, and compensation. They also have to contend with the creation of new products to offset the exposures of the Minimal Essential Coverage (MEC) as well as Bronze, Silver and Gold medical plans.

Many of our clients were just too busy to review new products that could be offered to their workforce this year. Getting the ACA requirements in place correctly the first time was too imperative and the penalties too severe to make an error. Often, because of our dedicated ACA focus, our employer HR departments and we have not given enough attention to other vital important benefits, such as employer-paid and voluntary short- and long-term disability programs.

As brokers, we know that offering voluntary short- and long-term disability is a great way for us to protect our client's employees and help them to maintain their financial health especially when their physical health is in trouble. Every 1.2 seconds, another person suffers a debilitating disability that can jeopardize the financial health of themselves and their family.

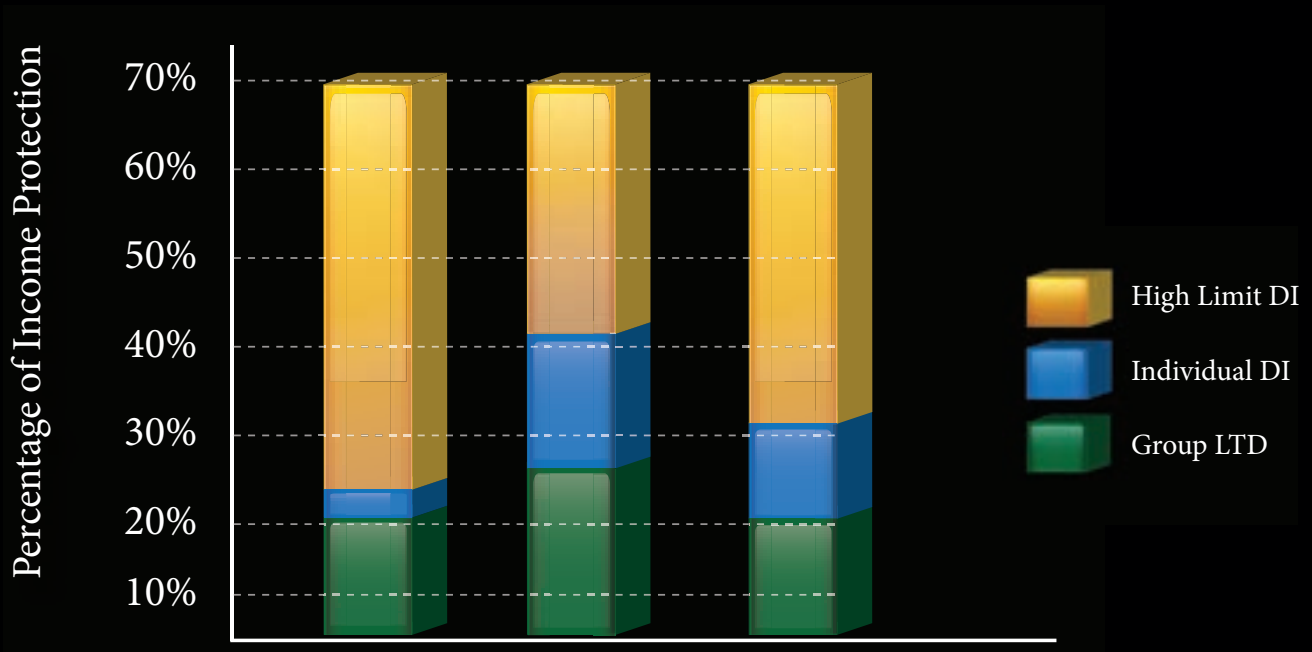
By offering a carefully designed group disability plan, we can offer employees that peace of mind of knowing that they have protected their family's paycheck and financial wellbeing.

The ability of our client's employees to earn a paycheck is their most valuable asset outside of their health. The security of their home, children's education, car payments and everyday needs and expenses are based on the employee's ability to work and continue to earn an income.

Brokers are, perhaps, the only source of cost-effective financial protection available the majority of employees in America. Very few of our clients' employees are able to purchase affordable group disability coverage outside of their employer's payroll deduction programs. As brokers, we may be offering the only safeguard to the financial security of the vast majority of Americans earning up to and around $100,000 annually. The short- and long-term disability coverage that we propose to our employer clients may be the only opportunity for the employees to protect their income and live a life that's not destined to financial ruin due to illness and injury. It is a professional opportunity and responsibility we bear as consultants and benefit counselors.

Sixty-eight of working Americans don't have Individual or group short- or long-term disability insurance protection other than what they may be provided by the state or federal government – if they qualify. As brokers, we have the ways and means to offer a much better financial outlook for our client's employees and their families.

Do You Have All Three DI Tiers?



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The vast majority of us usually offer a short-term disability coverage that wraps and matches the state's disability plan or perhaps extends coverage to an additional one or two years. These benefits are important. But do you also offer a longer term of group disability coverage for three to five years, perhaps to age 65 or to SSNRA or Social Security Normal Retirement Age (SSNRA)? If you have that's great!

If you haven't been recommending voluntary group long-term disability benefits because you think that it's too expensive, it's difficult for employees to qualify for, it's only available to large groups, or it's challenging to administer, think again.

Long-term disability carriers are providing these solutions:

- Simplify eligibility coverage and offer guaranteed issue.
- Provide benefits at cost-effective pricing.
- Provide benefits to groups with a minimum of five lives
- Deliver great administration platforms enabling them to present quantifiable benefits and ease of enrollment.

Currently, 68% of working Americans are without Individual or Group Short or Long Term Disability insurance protection other than what they may be provided by the State or Federal Government – if they qualify.

If you haven't quoted a case lately, you may be surprised that rates for longer terms of group voluntary disability may be similar to shorter durational benefits from carriers that only offer voluntary short term disability coverage.

Some carriers offer guaranteed coverage for monthly benefits up to 60% of benefit up to $4,000 per month to SSNRA. This would equate to 60% of coverage to an annual salary of $80,000 or more.

I am sure that next few years in our industry will bring very interesting times. Adjusting the ever-changing environment of our insurance world requires us to be knowledgeable and flexible enough to meet the needs of our clients and their employees. The ACA will continue to produce and require many changes. It will also present tremendous opportunities to those who are willing to look for them.

It is very important that we meet the few next years with the motivation, attention, and awareness regarding the ACA and its turbulent phases. It is vital that we not lose sight of our focus on serving the entire compliment of life and health insurance needs including group short- and long-term disability to our clients and their employees. ❑

Ken Holderbaum is VP of brokerage for Chimienti and Associates in charge of MGU Operations for Brokerage American Fidelity Assurance. Chimienti is the exclusive distribution source for AFA. For more information, visit www.chimienti.com or call 559-733-1670.

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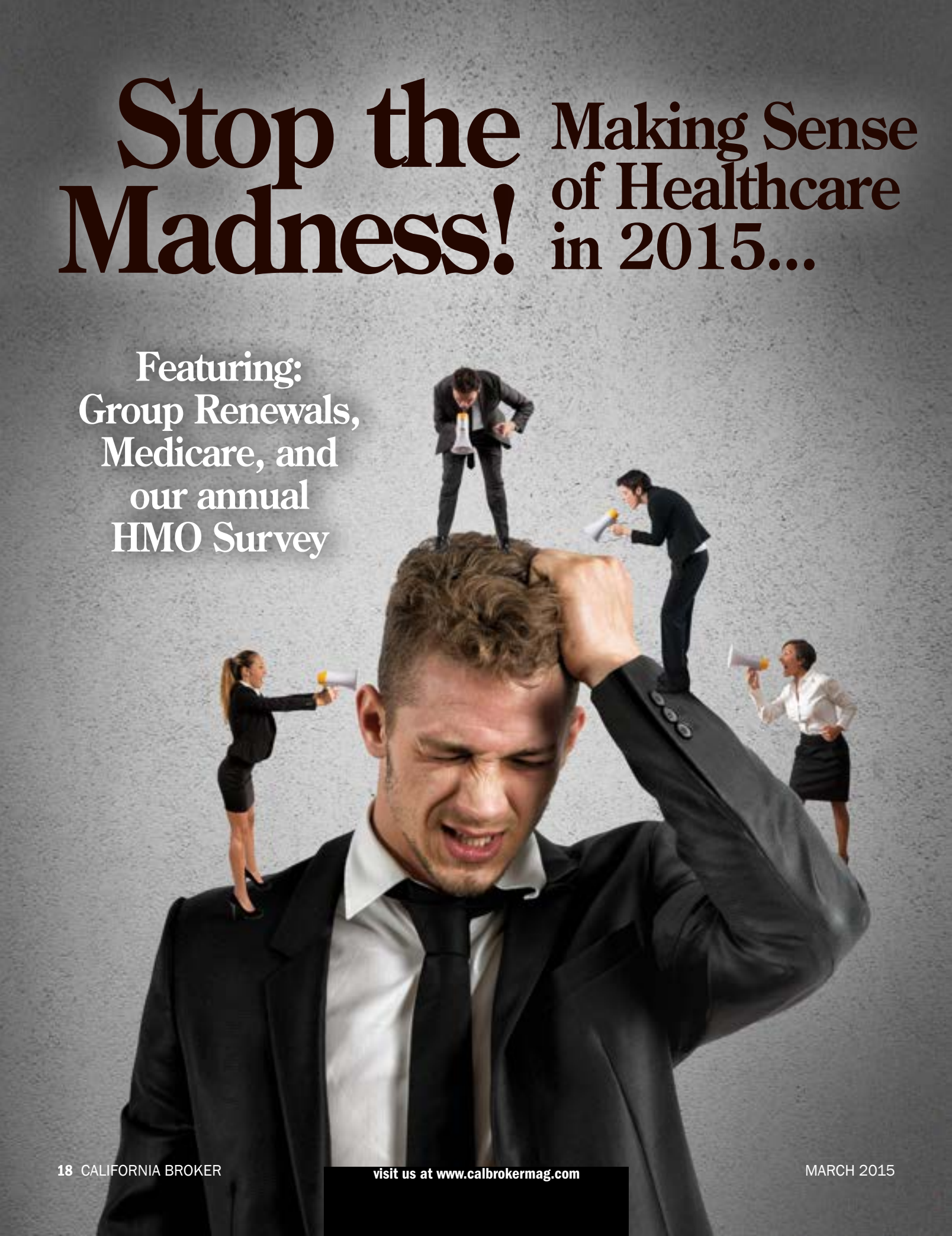

Medicare Supplements ▶ *by Amber Douglas*

Understanding Medicare

If you've listened to the news at all lately, I'm sure you've heard some talk about future changes in Medicare. There are many proposals out there that seek to help Medicare beneficiaries in keeping costs down. However, some say that there are also proposals being made that would work against these seniors.

One, in particular, would impose an extra 15% tax on those who have selected a Medicare Supplement Plan F or C. These plans cover all deductibles and copayments for doctor and hospital visits. The basis of this proposal is that people who choose these plans are not contributing towards health costs as much as those who aren't on a Plan F or C.

To me, it sounds similar to the concept of the Cadillac Tax that is scheduled to take effect in 2018 for certain plans under the Affordable Care Act. Here are two questions that should be asked: Who is working to help seniors understand these proposals and changes? Who is helping them to understand how their lives and finances may be affected by changes in the law, now and in the future? If it's not you, you're missing out on a potentially valuable area of your business.

I'm sure you know your clients' finances better than most people. Do your clients make over $85,000 (single)/$170,000 (married) per year? Did you know that if your high income earning clients are getting close to Medicare age, they could be assessed an Income Related Monthly Adjustment Amount (IRMAA) once they sign up for Medicare? This can be a shocking realization once discovered. The initial determination for an IRMAA will be based on the tax return from two year's prior (so for this year, it would be based on their 2103 tax return).

This IRMAA adds what feels like a surcharge to their Part B & Part D premiums. It's never any fun relaying this information to anyone. From the responses I have heard, people feel they have paid enough over the years and wonder why they have to pay more. I completely understand and that is a very good point. I wish there was something I could do to change it, but I can't. I have found the best approach is to be real with the client. I let them know that I would feel the same way if I were in their shoes.

If your client experienced a life-changing event such as divorce, death of spouse, work reduction or stoppage, etc., there is a form they can fill out to let Social Security know about this life-changing event (documented evidence required). Social Security will perform a review to see if their initial determination for the IRMAA needs to be adjusted. There are certain time frames this appeal must fall into and that is outlined in the initial letter they receive from Social Security.

As a broker, I am sure that Medicare clients often come to you for help when it comes to their Medicare options. Although you have a diverse background in annuities, long-term care, employer options, and other areas, you don't necessarily have the time to dedicate learning the complex world of Medicare, much less keep up with the annual certifications.

So, what can you do? The last thing you want is to send your clients to a random person who may or may not have their best interests in mind. You want to send them to a trusted source, not your competitor. You want your clients to be advised and taken care of the way you would take care of them.

Choose a partner that goes the extra mile to ensure the transition to Medicare is as smooth as possible. Although no one can foresee all obstacles, your partner should stick with your clients throughout the entire process. ❑

Amber Douglas is a manager at Morgan White Group in the Senior Services division in Jackson, Mississippi. She received her bachelor's degree from Mississippi College in Business with an emphasis in Marketing. She has four years of experience directly working in the Medicare market. She has found her passion in assisting senior clients by sorting out a system that can be quite confusing. Email us at seniordivision@morganwhite.com Register for the Medicare Supplement Quote Engine by visiting www.MedSuppBroker.com

The Grandmother Group's ACA Renewal Landscape

As the ACA's second individual open enrollment door closes, we can now take a deep breath and begin to focus on the upcoming historic fourth quarter 2015 ACA small group renewal landscape, which includes some new peaks and valleys. When S.B. 1446 was signed into law, allowing California small businesses to keep their 2013 plans, it is estimated that 80% to 90% postponed their ACA renewal (aka grandmothered renewal).

Today, the post-ACA small group market continues to evolve, and has seen its share of challenges in transitioning many employers to new plans with ACA rates, rules, and regulations. With new "consumer friendly" standardized plans, ACA rules and regs, technology, and a lot of hard work, in a mere nine months, a giant tidal wave of grand mothered small groups will crash upon our renewal landscape. Are we ready?

Many small businesses that postponed their health insurance renewal may not be excited about new ACA member rating increases (including new pediatric dental mandatory rates), new provider networks (full and narrow), and new formulary lists for prescription benefits. This year's renewal process may be a wild west of a transition for brokers to navigate groups out of the grandmothered world and into the new ACA world. Since some of these changes are not easy to adjust to, there will be more friction for some employers. For other employers, it may be a welcomed renewal based on their current makeup of employees, plan design portfolio, and current contribution structures.

First, let's take a look at new ACA member rating. The grandmothered pre-ACA age ratio has been based on a 5:1 (or greater) scale. This renewal now brings a significant rate compression to the table with the new 3:1 age ratio, as members cannot exceed the ratio three times the child rate.

Here is how this plays out for different employers: Current groups with an older age population (45 to 65 years old) may appreciate their renewal and see their rates even go down. On the other hand, employers with a younger workforce and larger families will have spikes in their renewal. Not only has the rate compression made it less affordable for younger employees and their families, but also each member now gets their own rate. Under pre-ACA plans, the 35-year-old employee with a spouse and three children has had the same rate as another 35-year-old with a spouse and only one child. So, within a group's renewal there will be rate increase spikes in these scenarios. This introduces more complexities for brokers and employers to look at renewal options and be able to make a decision that is best for all employees. New member rating also introduces a learning curve for employees to understand payroll deduction amounts for each child, not to exceed three rates per family.

In addition to new member rating, employers and employees will have to make room for new mandatory pediatric dental rates. This has proven to be a rating nuisance as carriers have dealt with pediatric dental rates differently on and off-exchange. Secondly, the nuisance is greater for employers who already offer dental plans and now perceive this as another ACA tax of some sorts. Renewing medical and traditional dental plans for an employer has a new layer of quoting and communication to be covered by the broker. Finally, it's important to note that new ACA rate increases are also driven by new and additional essential health benefits and standardized metal plan designs. Bronze, silver, gold & platinum tiers are ultimately helpful at the consumer level, but don't allow for much innovation at the car-

With all hands on deck, brokers will need new technology tools to leverage efficiency in the renewal process. What makes the process more efficient is having all the data you need at your fingertips.

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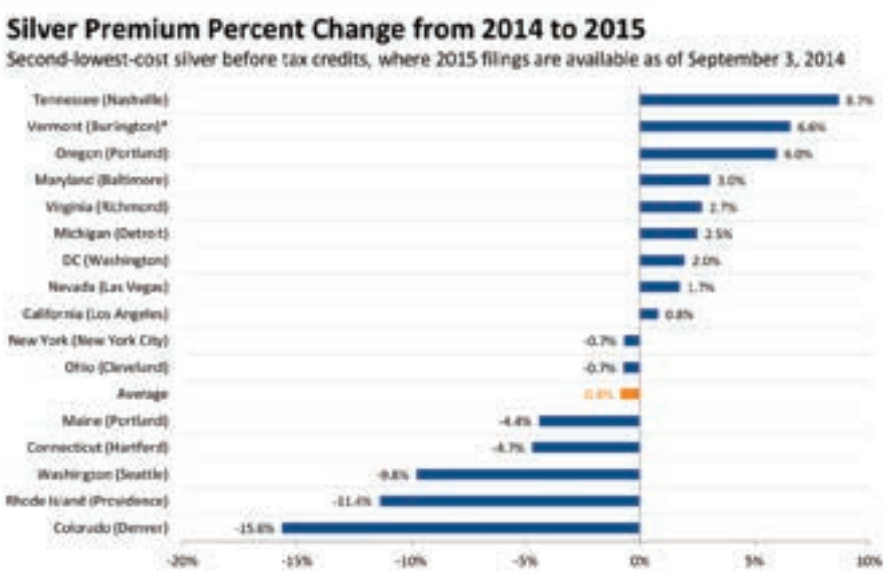
rier level. However, the fourth quarter should prove to see some creativity within the eco-system of the small group plan distribution (carriers, GAs, TPAs, private exchanges and brokers).

This renewal will include new plan options with two important areas that carriers have been adjusting to compete on price: provider networks and Rx prescription/formulary benefits.

Table 1: Monthly Silver Premiums for a 40 Year Old Non-Smoker Making $30,000 / Year

State	Rating Area (Major City)	2nd Lowest Cost Silver Before Tax Credit			2nd Lowest Cost Silver After Tax Credit		
		2014	2015	% Change from 2014	2014	2015	% Change from 2014
California	15 (Los Angeles)	$255	$257	0.8%	$209	$208	-0.8%

Another interesting topic in the small group market as it relates to new member rating looking at individual on-exchange plans with subsidies, and off-exchange plans. Small group employers who only contribute toward the employee's premium and are already targeting the lowest cost grandmothered plans, may not be able to afford new ACA renewal increases. Individual plans are an option that some employers want to know more about, and there are vast differences in how to go about this process. In most cases, the main incentive in moving to individual plan options is cost savings. Some employers might be able to save 20% to 40% from their current grandmother plan, but there will be other issues when looking at overall employee experience and satisfaction, individual rate differentials from one employee to the next, as well as provider networks and Rx prescription benefits.



Now, in some cases, you can purchase a more affordable plan though your doctor may not be in the new ACA narrow network, or your Tier 3 or Tier 4 expensive prescription may not be covered on new formulary lists.

The Pre-ACA renewal and quoting experience has largely been based on rates, benefits and full provider network options. Now, the process will evolve beyond standard spreadsheets as plan designs are standardized. Spreadsheets alone are difficult to include provider and prescription data as it pertains to different employees. The quoting experience is demanding, in many ways, to now include this data in the decision making process. In reality, incorporating this data has proven to be a more manual and time-consuming process, as it is not easily accessible beyond a static PDF from the carrier. This has created an opportunity for technology to leverage this data and make it available with easier ways of comparing renewal plan provider networks and Rx prescription benefits.

With all hands on deck, brokers will need new technology tools to leverage efficiency in the renewal process. What makes the process more efficient is having all the data you need at your fingertips. Brokers will have to cover a lot of data and information with their clients this upcoming renewal season. Data availability and transparency are now a must have, in order to guide clients in making the best decision. Showing all available ACA group plan options with multi-dimensional cost and benefit comparison points between the employer and each employee will keep us all busy this season. ❑

Data availability and transparency are now a must have, in order to guide clients in making the best decision. Showing all available ACA group plan options with multi-dimensional cost and benefit comparison points between the employer and each employee will prove to keep us all busy this season.

Garrett Viggers is co-founder and chief product officer at Limelight Health, a SaaS company passionate about simplifying the quoting process in the health insurance industry with mobile-first technology. Garrett has spent 11 years in the industry as a broker, consultant and CDH and ACA IFP subsidy expert. He helped launch CDH company Veritas Health Systems in 2002, and lead product design at Inovius in 2006, a SaaS company taking static insurance cost and benefits quoting data and making it interactive. For more information, visit www.limelighthealth.com or email garrett@limelighthealth.com.

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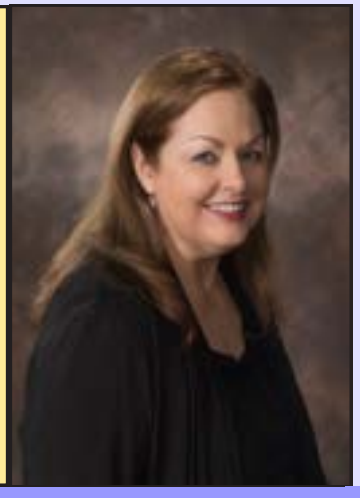

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Medicare Advantage News

CMS Finalizes Medicare Advantage Program Changes For 2016

The Centers for Medicare & Medicaid Services (CMS) issued a final rule revising regulations for the Medicare Advantage (MA) program (Part C) and prescription drug benefit program (Part D). The following are some of the key provisions:

- **Agent and Broker Training and Testing:** It removes requirement that agents and brokers be trained and tested with CMS endorsed or approved documents. It still requires that agents and brokers be trained and tested annually.
- **Medicare Coverage Gap Discount Program and Employer Group Waiver Plans (EGWP):** It requires Part D sponsors to offer waiver plans to employer groups. These plans must provide discounts to EGWP enrollees according to the Defined Standard benefit.
- **Immigration Requirements:** It establishes lawful presence or U.S. citizenship as eligibility criteria for enrollment in cost, MA, and Part D plans. It also requires disenrollment of individuals from cost, MA, or Part D plans when they lose eligibility due to unlawful presence status.
- **Part D Notice of Changes:** MA organizations and Part D sponsors must provide annual notice of changes to plan rules to CMS at least 15 days before the annual coordinated election period for changes that are effective with a new plan year.
- **Drugs Covered Under Parts A, B, and D:** Medicare Advantage Prescription Drug (MA-PD) plans must have a process to ensure timely and accurate point-of-sale (POS) transactions with network pharmacies.

In addition to describing what the rule does, CMS describes what it does not do. The rule does not finalize any of these provisions:

- Lifting the protected class designation on three drug classes – antidepressants, antipsychotics, and immune-suppressants for transplant rejection.
- Requiring Medicare Part D sponsors to include any pharmacy willing to accept the terms and conditions to participate in narrower pharmacy networks that offer preferred cost sharing to beneficiaries.
- Reducing the number of Part D plans a sponsor can offer.

The provisions in the final rule will generally be effective for Contract Year 2016 operations. The final rule is accessible at: https://www.federalregister.gov/public-inspection.

Low Income Americans Benefit from Medicare Advantage Plans

Medicare Advantage plans offers a vital source of coverage for low-income beneficiaries and racial/ethnic populations, according to study by America's Health Insurance Plans (AHIP). The survey of beneficiaries in 2012 reveals the following:

- 37% of Medicare beneficiaries with Medicare Advantage coverage had incomes of less than $20,000. About 18% had incomes of $50,000 or more. In comparison, 34% of Medicare FFS beneficiaries had incomes of less than $20,000. About 28% had incomes of more than $50,000.
- 29% of all non-institutionalized Medicare beneficiaries were enrolled in Medicare Advantage plans.

- Medicare Advantage had a higher overall share of racial/ethnic populations compared to Medicare Fee-For-Service (FFS), 30% versus 23%. Medicare Advantage also had a higher share of Hispanic beneficiaries: 15% of Medicare Advantage enrollees were Hispanic compared to only 8% for Medicare FFS beneficiaries. The proportion of African Americans - 10% - was the same for Medicare Advantage and Medicare FFS. Forty-four of Hispanic Medicare beneficiaries were enrolled in Medicare Advantage plans. Thirty percent of African-American Medicare beneficiaries were Medicare Advantage plan members.
- Medicare Advantage plans had a higher percentage of beneficiaries in the 65 to 84 age group: 77% compared to 71% for Medicare FFS.
- 55% of Medicare beneficiaries with Medicare Advantage coverage were women. In comparison, women accounted for 54% of Medicare FFS beneficiaries. As with prior reports in this series, the statistics in this report were calculated from the MCBS Access to Care files.
- 29% of all non-institutionalized Medicare beneficiaries chose Medicare Advantage plans in 2012.

Bill Would Change Open Enrollment Period

Congressman Kurt Schrader (D-OR) and Congressman Keith Rothfus (R-PA) introduced H.R. 588, the Medicare Beneficiary Preservation of Choice Act of 2015. This bipartisan legislation would restore the Medicare Advantage (MA) open enrollment period that gives seniors the chance to switch between MA plans in the first three months of each year. Until 2011, seniors were able to elect an initial Medicare Advantage plan between October 15th and December 7th each year. And, then were able to switch their plans between January 1 and March 31 if they were not satisfied, lost their doctor, or made a mistake.

The 90-day Medicare Advantage re-enrollment period was eliminated, and replaced with a forty-five-day disenrollment period that forces seniors to stay in their current MA plan or switch back to traditional Medicare.

The Medicare Beneficiary Preservation of Choice Act of 2015 will reinstate the ninety-day enrollment period and allow seniors to make one plan switch to best meet their needs.

Congressman Schrader said, "Choosing a health plan that's right for you can be a complicated process, especially for seniors who have specific medical needs...It makes sense to allow them the opportunity to find a plan that works for them, and if they need to make changes, the option is there. This bipartisan

legislation gives seniors the flexibility they need, and I'm optimistic Congress will restore this open enrollment period." Congressman Rothfus said, "In today's ever-changing health care environment, it is critical that seniors be given this ninety-day time-frame that allows them to test-drive a plan, and then make necessary changes if they are not able to keep their doctor and aren't satisfied with their coverage."

More than sixteen million seniors were enrolled in Medicare Advantage plans nationwide as of December 2014. Seniors report high levels of satisfaction with these plans, which have earned a reputation for providing better quality health care coverage. ❑

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Stop the Madness! Making Sense of Healthcare in 2015...

Monitoring HMOs

Our Annual Survey

Each year California Broker surveys health maintenance organizations (HMOs) in the state with direct questions about their plans. We then present the answers to such questions here for you – the professional agent or broker. We hope that this valuable information will help you serve your savvy healthcare clients better.

1. Do you guarantee a time limit on getting referral/treatment routine, urgent, emergency? If not, how many days does it take?

Aetna: Our internal policy is five days for routine, two days for urgent pre-certification, and no referral is required for urgent or emergency care.

Blue Shield of California: Our appointment wait time standards are as follows:

- Preventive care (annual physical, annual GYN exam): within 30 calendar days
- Non-acute and routine care with personal physician: within 7 calendar days
- Non-acute or routine care with a specialist: within 14 calendar days
- Urgent care appointment: within 24 hours
- Emergency care (acute, life-threatening): immediately.

Cigna: While we don't guarantee a time limit on getting appointments or referrals, we do have appointment accessibility standards and we monitor performance against these standards annually. Performance is monitored by analyzing several questions on the annual CAHPS (customer satisfaction) survey and reviewing customer concerns regarding appointment access.

Kaiser Permanente: For emergency medical conditions, enrollees should call 911 or go to the nearest emergency department. Emergency care is also provided 24 hours a day, seven days a week from any Kaiser Permanente Medical Center or Plan Contracted Hospital. The following standards for appointment availability were developed by the California Department of Managed Health Care (DMHC) and we're committed to offering you a timely appointment when you need care.

- Urgent Care appointments — Offer the appointment within 48 hours of enrollee's request
- Non-urgent appointments for primary care (PCP) — Offer the appointment within 10 business days of the request
- Non-urgent appointments with specialist physicians (SCP) — Offer the appointment within 15 business days of the request
- Non-urgent care appointments with a non-physician mental health care provider — Offer the appointment within 10 business days of request
- Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition) — Offer the appointment within 15 business days of the request

In some cases, the wait may be longer than the time listed if the treating practitioner decides that a later appointment won't have a

negative effect on the member's health. The standards for appointment availability do not apply to preventive care services. The standards do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists. Our telephone advice nurses are available 24 hours a day. If you have a medical concern, they can help you decide whether you need to get care.

UnitedHealthcare: Optimally, the specialist referral process should take less than 30 days from referral to appointment. We monitor this standard annually using the Consumer Assessment of Health Plans Survey (CAHPS) member satisfaction survey. We adjust our goals by market depending upon past performance and national percentile benchmarks. Our standards are as follows: routine appointment less than 30 days, specialist appointment less than 30 calendar days, and urgent care less than 24 hours. We also have the Express Referrals program that streamlines the referral process. A primary care physician (PCP) in a participating Express Referrals provider group may refer a member to a specialist in one of many specialties in their group without prior authorization from the group's utilization review committee. Members pay their normal office visit co-payment for a referral to a specialist.

2. Do you have any conditions/diagnoses/ symptoms that are referred automatically?

Aetna: Yes.

Blue Shield of California: No; however, Blue Shield requires that our contracted IPAs and medical groups employ a standard referral processing guideline of 24 hours from the time the necessary information is received.

Our Access+ HMO plan has been designed to ensure members have a great deal of flexibility in accessing care inside the HMO network. Each Access+ HMO member chooses a primary care physician from an extensive network of general and family practitioners, internists, pediatricians, and OB/GYNs. We also ask our HMO physicians to refer members to specialists within their IPA or medical group; since we fully capitate all professional services, in-network referrals help control cost and utilization.

Cigna: Yes.

Health Net of CA: Health Net delegates medical management activities to participating physician groups (PPGs). Each PPG has its pre-certification requirements and systems, which may include direct access to specialty care. For members who are not delegated to a PPG for management, such as Health Net's Direct Network HMO membership or other fee-for-service membership, authorization for specialty consultations is not required. Members with a chronic condition or disease that requires continuing specialized medical care are eligible for a standing referral to a specialist. A standing referral allows extended access to a specialist for members who have life-threatening, degenerative or disabling conditions.

Kaiser Permanente: Members identified with specific chronic or high-risk conditions diagnoses, or symptoms are automatically referred for enrollment in whichever care management programs are appropriate. Participation in these programs is completely voluntary and if a member chooses not to participate, they may easily opt-out, though less than 1 percent chose to do so. Members also have direct access to all primary care services and can easily self-refer to specialty care in the Obstetrics/Gynecology, Optometry, Psychiatry, and Chemical Dependency/Addiction Medicine Departments. At some facilities, members may also self-refer for mammograms and Ophthalmology and Dermatology Department services.

UnitedHealthcare: Yes.

4. Do you have self-referral to a gynecologist for an annual well-woman exam?

Aetna: Yes

Blue Shield of California: Yes.

Cigna: Yes.

Health Net of CA: Yes.

Kaiser Permanente: Yes. To make access to Obstetrics/Gynecology services as convenient as possible, women can self-refer for Ob/Gyn appointments without the need for approval from their PCP. Routine Ob/Gyn care often includes basic health maintenance counseling and screening such as recommendations and reminders for immunizations, managing cholesterol, smoking cessation, and mammograms.
UnitedHealthcare: Yes.

5. Can a member with severe back pain get an appointment with an orthopedist immediately?

Aetna: The PCP determines this.

Blue Shield of California: Yes, Blue Shield developed Access+ Specialist for those times when HMO members want direct access to a specialist or physician other than their personal physician. For a slightly higher fixed co-payment, members can go directly to a specialist or primary care physician in the same medical group or IPA as their personal physician without a referral. To use the Access+ Specialist option, members simply call the physician they wish to see to schedule an appointment. Members can also choose to go through their personal physician to request a specialty referral and pay their usual office visit co-payment.

Cigna: Yes, customers should consult their primary care physician who can contact an orthopedist or other specialist (neurosurgeon, neurologist) to arrange for an immediate appointment. At the direction of the physician, a customer can also be enrolled in Cigna's chronic condition management program for lower back pain. A registered nurse helps coordinate timely care.

Health Net of CA: Yes, as an emergency.

Kaiser Permanente: Most back pain can be managed best by the PCP while ensuring the treatment does not impact a person's other medical conditions. When back pain does not follow the expected course, or is unusual in presentation, our orthopedists are available for consultation. UnitedHealthcare: Yes, with a PCP referral.

6. How long does it take to get an MRI or equivalent test when a lump is found in a member's breast or uterus?

Aetna: The PCP determines this.

Blue Shield of California: Authorization turnaround time for an urgent request is 72 hours. In special cases, Blue Shield attempts to process the request immediately

Cigna: The customer's physician determines the exact time frame. But, an appointment can be made immediately if medically necessary.

Health Net of CA: Health Net delegates utilization management activities to medical groups. Therefore, if the member belongs to a delegated participating physician group (PPG), the PPG has its own pre-certification requirements, and an MRI may or may not require pre-certification. If the member does not belong to a delegated PPG and Health Net is responsible for conducting utilization management, MRIs require pre-certifi-

cation requests within 72 hours of receipt of all information. Requests for elective MRIs are processed within five business days.

Kaiser Permanente: Except for very rare exceptions, the discovery of a lump in a woman's breast would not prompt the use of magnetic resonance imaging (an MRI) as a diagnostic tool but would immediately receive a mammogram to better understand the nature of the lump. Similarly, the discovery of an unusual uterine growth would be investigated with more direct methods.

UnitedHealthcare: Immediately.

7. Can the member get a second opinion outside of the IPA or the medical group?

Aetna: When medically appropriate

Blue Shield of California: Yes, per benefit mandate H&S ß1374.55, Blue Shield will provide or authorize a second opinion by an appropriately qualified health care professional when requested by an enrollee or participating health professional (PCP or specialist) who is treating the enrollee.

Cigna: Yes.

Health Net of CA: Yes, a member, his or her authorized representative or a provider may request a second opinion for medical, surgical or behavioral health conditions. If the member has an HMO or POS plan and requests a second opinion about care from a Primary Care Physician (PCP), the second opinion should be authorized by the delegated participating physician group (PPG) and provided by another qualified health care professional within the PPG. If the member requests a second opinion about care from a specialist, the member may request a second opinion from any provider of the same or equivalent specialty from within the PPG or IPA. Such specialist referrals within the PPG must be authorized by the PPG. However, if the request is for a specialist outside of the PPG, the referral must be authorized by Health Net.

Kaiser Permanente: Yes, our doctors can refer members to non plan providers for second opinions when medical expertise relevant to their condition is not available through Kaiser Permanente providers. Any non-emergent out-of-plan care must be authorized by Kaiser Permanente in order to be covered by your health plan benefits.

UnitedHealthcare: Members can get a second opinion in accordance with the specifications of the evidence of coverage (EOC) and disclosure form, as summarized below. A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified provider. This provider must be either a primary care physician or a specialist acting within his or her scope of practice, and must possess the clinical background necessary for examining the illness or condition associated with the request for a second medical opinion. Upon completing the examination, the provider's opinion is included in a consultation report. Either the patient or the treating participating provider may submit a request for a second medical opinion. For additional information, please refer to "evidence of coverage" brochure.

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

Aetna: For our delegated groups, the PCP makes decisions with their PMG/IPA. The health plan makes this determination for non-delegated groups.

Blue Shield of California: These types of decisions are made by our contracted IPA/medical groups, and involve Blue Shield if there is a question about appropriateness, or if a member is dissatisfied.

Cigna: Primary and specialty care physicians make decisions about referrals, testing, and treatment. At times, they can coordinate care with their medical groups or IPAs. Hospitalization can require authorization from Cigna.

Health Net of CA: A Health Net member's participating physician group (PPG) authorizes all treatment, including specialty referrals for testing, treatment, surgery or hospitalization. A member with a chronic condition or disease requiring continuing specialized medical care is eligible for a standing referral to a specialist. A standing referral allows extended access to a specialist for members with life-threatening, degenerative or disabling conditions. The member's PCP will refer the member to practitioners who have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen requiring ongoing monitoring

Kaiser Permanente: Typically, the member's primary care physician (PCP) makes the decisions about specialist referrals, testing, treatment, surgery, and hospitalization and do not need authorization to put these decisions into action.

UnitedHealthcare: Our contracted PCPs act as the single point of contact, resource, and consultation for all health services provided to members, including specialty referrals. We believe this approach promotes familiarity with the member's medical history and permits a single physician to monitor the member through complete episodes of care. These physicians look at the whole medical picture, as opposed to looking at symptoms from a specialist's point of view. This method reinforces a strong doctor-patient relationship, provides early detection of medical problems, and ensures that medical referrals are appropriate and necessary.

9. What criteria are used to authorize or deny specialist referrals, treatments, or tests?

Aetna: There are a variety of reference tools, including Milliman, and many that the plan has developed and copyrighted. A medical director must make all denials for medical necessity. In addition, the plan has adopted an external review process for all fully insured members.

Blue Shield of California: We use nationally recognized, evidence-based industry sources to identify services subject to precertification or prior authorization, including:

- Milliman Guidelines
- Thompson Length of Stay Criteria
- St. Anthony's Guidelines to Medicare Coverage
- Guide to Preventive Services: Report of U.S. Preventive Services Task Force
- Medicare Guidelines
- BlueCross BlueShield Association Technology Evaluation Center
- California Technology Assessment Forum
- Third party review agencies
- Blue Shield Medical Policy and Medication Policy
- Internally developed guidelines

Our Utilization Management Committee (UMC) is responsible for developing and maintaining the policies and procedures that define utilization management authority, including prior authorization. Comprised of Blue Shield senior management executives (including physician representation) and functioning as the steering committee for quality activities, the UMC is responsible for reviewing on an annual basis our prior authorization policy and, if necessary, updating our list of services requiring authorization.

For HMO plans, Blue Shield may delegate prior authorization responsibilities to a medical group contracted to Blue Shield for HMO business. Under this arrangement, the group is responsible for pro-

cessing and monitoring prior authorization requests for providers, except for experimental or investigational procedures, for which Blue Shield provides the authorization. Blue Shield monitors delegated medical groups to ensure that all utilization management activities are timely, effective, and consistent with Blue Shield's internal program.

When prior authorization is delegated, the personal physician submits a service request to the delegated IPA/medical group. The delegated IPA/medical groups will issue a determination and contact the requesting provider by telephone/fax within 24 hours of the decision to inform the physician of the status of the authorization request.

For non-delegated HMO medical groups, Blue Shield is responsible for processing and monitoring prior authorization requests, and evaluating referrals for specified services, procedures, or drugs that require authorization. Prior authorization determinations are made by licensed review nurses or pharmacists, and decisions are based on medical necessity and appropriateness, reflecting the application of Blue Shield's approved review criteria and guidelines.

Cigna: Cigna uses Milliman care guidelines. In addition, Cigna continually assesses developing technologies using evidence-based medicine and independent expert opinion to develop coverage positions, which are posted on our website. All medical decisions are based on clinical guidelines. A physician who is knowledgeable in the specialty area makes the decisions.

Health Net of CA: Health Net utilizes established written guidelines, such as InterQual Clinical criteria, along with the Health Net Medical Policy Manual, clinical practice guidelines, and the Schedule of Benefits.

Kaiser Permanente: Our doctors are not required to seek authorization for the vast majority of medical services so long as the medical specialty, treatment, or test is available within our plan.

UnitedHealthcare: We require our provider groups to demonstrate the use of appropriate medical management guidelines. We conduct annual reviews of written procedures and consider the following factors for cases that may not meet criteria: age, co-morbidities and complications, response to treatment, the psychosocial situation, and home environment. We use written criteria based on sound clinical evidence and specific procedures for applying the criteria to make utilization decisions. In addition, we apply objective and evidence based criteria and consider individual circumstances and the local delivery system. We require our delegated providers to do the same.

10. Are you monitoring the length of time for referral authorizations? What are you doing to reduce or eliminate delays?

Aetna: Yes, timeliness of decisions is part of a monthly case assessment audit. Turn-around time is monitored by annual audits and quarterly report submissions. Audits and training are used to address performance gaps

Blue Shield of California: Blue Shield's contracted IPA/medical groups are responsible for the timeliness of decisions about referral authorization. They must comply with our standard of two working days to get all necessary information for a non-urgent referral, one calendar day for urgent referral/treatment, and immediately for emergency care. Blue Shield-delegated oversight consultant nurses perform annual audits to ensure that standards for timeliness are met. An IPA/medical group that does not meet timeliness standards for utilization management must take corrective action.

Cigna: Cigna works closely with physicians and medical groups to ex-

pedite referrals and measures customer satisfaction with the referral process on a regular basis.

Health Net of CA: Yes, it is done through access audit reports, member satisfaction surveys, HEDIS indicators, physician profiles, medical group comparison reports and member complaints. Delays are remedied through corrective action.

Kaiser Permanente: Our doctors are not required to seek authorization for the vast majority of member's medical services. Practically every aspect of a member's encounter with their health care team will later go through our internal utilization review process. If there are any factors found to be slowing the processing of referrals, steps are taken to remove or change those factors.

11. What are the criteria and processes for getting a referral to a specialist outside of the MG/IPA or plan?

Aetna: Out-of-plan approval is done if one or more of these criteria are met: required services are not available in the group or network; required non-emergency service is available in the plan option, but is not accessible in reasonable timeframe; or the patient is a new member and was receiving services from an out-of-plan provider (reviewed on case-by-case basis).

Blue Shield of California: Personal physicians can refer patients out of the network with the agreement of the IPA/medical group or authorization from Blue Shield. Blue Shield is involved in referrals only when an IPA/medical group wants to refer out-of-network and not be financially responsible. The IPA/medical group would then contact Blue Shield for authorization and request that Blue Shield be financially liable.

Cigna: A primary care physician can request a referral for service outside the medical group or plan when the service is not available. Customers can also contact Cigna directly to arrange a second opinion.

Health Net of CA: Health Net's contracted participating physician groups (PPGs) are delegated to provide member care, including all specialty referrals. If the PPG does not have a particular kind of specialist with which it contracts, the PPG is still responsible to find a specialist out of its network for the member. The PPG has the financial responsibility for paying the specialist. The PPG may deny the request if it has a particular kind of specialist within its network and a member requests to see a specialist that is outside the PPG's network. The member has the option to appeal the denial with Health Net.

Kaiser Permanente: If a member needs specialty care not available within our plan, the chief of the appropriate specialty service is required to approve the referral. With a large group of our specialists practicing in more than 75 specialties and subspecialties, Kaiser Permanente is able to minimize outside referrals significantly so that our members do not need to leave the continuity of our in-plan care, which includes provider access to the member's online medical records

UnitedHealthcare: Our contracted provider network is comprehensive and provides a qualified specialist for every covered benefit. When a service is not available within a member's provider group, the member receives a referral to a qualified provider or specialist outside the member's provider group, but contracted with UnitedHealthcare. Either the provider group or we will assess the medical necessity for these requests and authorize care as necessary. Referrals to non-contracted providers rarely happen, generally only in emergencies or for specialized services not available through a contracted provider; therefore, we do not track this statistic.

12. Which complementary medical disciplines are covered or will be covered?

Aetna: Chiro rider. Acupuncture is covered when administered.

Cigna: When medically necessary, some customers can access acupuncture and chiropractic services as a component of short-term rehabilitation. Other benefit plans offer homeopathic and naturopathic services as riders. In addition, Cigna's Healthy Rewards(r) program offers customers discounts on alternative/complementary medicine services and other health-related programs for acupuncture, chiropractic services, fitness club membership, hearing care/instruments, laser vision correction, massage therapy, vitamins, herbal supplements, non-prescription medications, and smoking cessation programs, among other programs. More information on the Cigna Healthy Rewards program is available to customers through their personalized online portal on mycigna.com.

Health Net of CA: Health Net offers chiropractic and acupuncture benefits as supplemental benefit riders to its traditional medical benefit plans. The riders may be purchased with the HMO and POS medical plans. They are designed to complement the benefits plans, rather than replace them. The rider is only available to groups. A variety of benefit plan designs is available, including chiropractic only, acupuncture only, and a combination of chiropractic and acupuncture.

Kaiser Permanente: KP offers supplemental benefit riders for chiropractic and acupuncture services to commercial group members. All members also have access to discounted services through American Specialty Health Plans of California, Inc. (ASHP) for acupuncture, chiropractic care, exercise centers, fitness clubs, massage therapy, and naturopathy.

13. Do you cover blood tests for prostate cancer for non-symptomatic men? If so, at what age?

Aetna: Yes, age 40+.

Blue Shield of California: Screening for prostate cancer is covered beginning at age 40, if at increased risk. Increased risk factors for prostate cancer include African-American men and men with a family history of prostate cancer.

Cigna: Yes, for men over 50 annually or more frequently when medically indicated.

Health Net of CA: Yes, beginning at age 40 as determined by the PCP.

Kaiser Permanente: Yes, prostate cancer screenings are part of our basic coverage regardless of a man's age, personal medical history, or the medical history of his family. Early detection of prostate cancer can lead to better outcomes. Members do not need a referral to make an appointment for a prostate cancer screening.

UnitedHealthcare: Yes, these blood tests are covered benefits. The member's primary care physician determines the necessity of this and all other blood tests.

14. Do you cover mammograms for women with no history of breast cancer?

Aetna: Yes, age 40+.

Blue Shield of California: Yes, upon referral by a nurse practitioner, certified nurse midwife, or physician, providing care to the patient and operating within the scope of practice provided under existing law for breast cancer screening or diagnostic purposes.

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Cigna: Yes, for women over 40 annually or more frequently as directed by their physician.

Health Net of CA: Yes, typically, every one to two years from ages 40 to 65+, but the PCP may authorize mammograms at his or her discretion.

Kaiser Permanente: Yes, mammograms are part of our basic coverage regardless of a woman's personal or family history of breast cancer. Members do not need a referral to make an appointment for a mammogram.

UnitedHealthcare: Yes, mammograms for women with no history of breast cancer are covered in accordance with U.S. Preventive Services Task Force Guidelines

15. Do you have an open drug formulary?

Aetna: Yes.

Blue Shield of California: The Blue Shield Drug Formulary is a list of preferred generic and brand name drugs that have been reviewed for safety, efficacy, and bio-equivalency, and are approved by the Federal Food and Drug Administration (FDA). This formulary is developed and maintained by the Blue Shield Pharmacy and Therapeutics (P&T) Committee, which meets on a quarterly basis. The P&T Committee consists of independently licensed physicians and pharmacists in community practice and who are not employed by Blue Shield. A drug prior authorization program is available for selected drugs on the formulary as well as for non-formulary drugs to promote appropriate first-line therapy or to reserve use of certain medications with specialized uses or significant potential for misuse or overuse.

Blue Shield offers the following types of outpatient prescription drug benefit

- A closed formulary plan provides coverage for generic drugs, formulary brand-name drugs, and specialty drugs. Non-formulary drugs and most specialty drugs are covered only when prior authorization is approved.
- An incentive formulary plan provides coverage for generic drugs, formulary brand-name drugs, and specialty drugs. Non-formulary drugs are also covered for a higher co-payment. Prior authorization may be required to cover some specialty and certain non-formulary drugs. If coverage for a non-formulary drug requiring prior authorization is approved, the member is responsible for the non-formulary co-payment.

Cigna: We typically use a closed drug formulary. However, employers can choose a three-tier or two-tier pharmacy plan if specified and agreed to in the contract.

Health Net of CA: Health Net offers a 3-tier Recommended Drug List, an open formulary that includes most generics on Tier 1, recommended brands on Tier 2 and some generics and brands on Tier 3.

Kaiser Permanente: No, our formulary is maintained and regularly updated by our doctors and pharmacists working in tandem with our Drug Information Services Team. The team independently analyzes data and reports on new drugs while doctors and pharmacists research the effectiveness and safety of each. Whenever therapeutically appropriate, we include the generic medicines in our formulary.

UnitedHealthcare: No, we use several managed formularies at different tier levels, but we do not offer an open formulary.

16. If a closed formulary, what happens if a non-formulary drug is necessary?

Aetna: Not applicable.

Blue Shield of California: For selected formulary, non-formulary and specialty drugs to promote patient safety, appropriate first-line therapy, we have drug prior authorizations for medical necessity in place to promote patient safety, appropriate first-line therapy, to manage use of specialized, high-cost or highly addictive or habit forming medications, and to help keep the cost of healthcare affordable.

The P&T Committee is responsible for establishing and overseeing drug prior authorization policies and procedures. Coverage criteria are developed under evidence-based medicine principles and current medical literature. Requests for prior authorization are considered for the following reasons:

- The requested drug, dose, and/or quantity are safe and medically necessary for the specified indication
- Formulary alternative(s) have failed or are inappropriate
- Treatment is stable and a change to an alternative may cause immediate harm
- Step therapy requirements have been met
- Relevant clinical information supports the use of the requested medication over formulary alternatives

Physicians may contact Blue Shield pharmacy services directly through a toll-free phone or fax number to request prior authorization. Some drugs may be limited to a maximum quantity and require prior authorization if a given drug's limit is exceeded. The P&T Committee may also determine that a certain quantity of a given medication may need prior authorization to review for medical appropriateness.

All prior authorization requests are reviewed by pharmacists and pharmacy technicians to determine if the criteria approved by the P&T Committee for the requested drug meets the criteria for an exception. A coverage determination can be made via telephone within minutes if all required information is provided. Urgent prior authorization requests sent via fax are reviewed within three business days, while non-urgent requests are reviewed in no more than five business days. The member's clinical information must be received by Blue Shield in order to start the review process. If the physician does not submit the required information, Blue Shield will send a follow-up request to the doctor. Delays sometimes occur if the physician does not provide the required information in a timely manner. If a non-formulary drug requiring prior authorization is approved under the closed formulary plan, the member is responsible for the applicable brand co-payment. If a non-formulary drug requiring prior authorization is approved under the incentive formulary plan, the member is responsible for the applicable non-formulary co-payment.

If a request from a physician for a drug that requires prior authorization for medical necessity is denied, a denial letter is mailed to the member. Included with the denial letter is the reason for denial, alternative covered therapy, if appropriate, and the Blue Shield Appeals and Grievance procedures. The physician also receives notification of the denial along with a list of preferred formulary alternatives.

Cigna: The customer or their physician can ask for an exception to get a non-formulary drug. Cigna's clinical staff reviews the request.

Health Net of CA: N/A

Kaiser Permanente: It is at the medical discretion of our doctors to prescribe any FDA-approved non-formulary drug if its use is in the best medical interest of the member. In these cases, the member would pay their usual cost-sharing fee as opposed to the full price they would be charged for a non-formulary medicine

UnitedHealthcare: Medically necessary non-formulary medications can be approved through our preauthorization exceptions process.

18. Which requested procedures are denied most frequently based on experimental investigative or not medically necessary exclusions?

Aetna: The most frequently denied procedures are those deemed experimental or investigational. We provide clinical policy bulletins on our website that outline what procedures are covered and what are not, and the reasoning.

Blue Shield of California: The following are the most frequently denied procedures due to the absence of medical necessity or because they are considered experimental/investigational:

- Bariatric surgery – morbid obesity surgery
- Reduction mammoplasty
- Varicose veins
- MRI of the breast
- PET Scan of the breasts

Cigna: This data is not available.

Health Net of CA: The most frequently denied requested procedures are those that are not FDA approved/accepted in the medical community as standard, safe and effective.

Kaiser Permanente: If a plan physician determines that a procedure or service is medically appropriate for a member and its omission would adversely affect the member's health, then it is considered medically necessary. As a result, we do not consider a medically necessary service or procedure to be an exclusion. Additionally, we do not deny experimental or investigative procedures if they are considered medically necessary and appropriate for the member's care. All procedures and treatments are reviewed on a case-by-case basis with the determination for care made by the doctor often in consultation with the chiefs of service for their own area of practice and other related areas of practice.

PacifiCare: This information is not available. We do not track the number of most frequently denied investigational/experimental or not medically necessary procedures. We do track appeals and grievances. If a member appealed a denial, and it was due to one of the above reasons, we may be able to provide that procedure; however, it would not apply to our book of business.

19. What is the standard hospitalization for normal and a Caesarean birth?

Aetna: The physician determines it.

Blue Shield of California: The standards are two days for a normal birth and four days for a Caesarean.

Cigna: Typical hospitalization is at least 48 hours for normal vaginal delivery and at least 96 hours for a Caesarean section. But, this can be modified based on the physician's recommendations.

Health Net of CA: Standard hospitalization for normal birth is two days and four days for Caesarean birth

Kaiser Permanente: According to our 2012 HEDIS scores, in Northern California the average length of hospital maternity stay for all types of births is 2.41 days and 2.48 days in Southern California. We no longer separately track hospitalization stays for C-section deliveries.

PacifiCare: The average length of stay is two days for a normal birth and four days for a Caesarean.

20. How many hospital days are utilized in a year for every thousand HMO members?

Blue Shield of California: Our most recently reported utilization rate for inpatient days per 1,000 was 157.79.

Cigna: Data not available

Health Net of CA: 2012: 200.9 days per 1,000 HMO members.

Kaiser Permanente: According to our 2012 HEDIS scores, in Northern California, the ratio is 3.32 hospital days per 1,000 members and 3.37 hospital days for Southern California

PacifiCare: Our total in-patient utilization in 2010 was 160.92 per 1,000 members.

21. What are your loss ratios, administration/medical?

Aetna: This information can be found in our filings with the DMHC and the CDI as well as federal regulators.

Blue Shield: Our medical loss ratio (MLR) percentages filed for 2012 are as follows:

- MLR by Lines DMHC-regulated CDI-regulated of Business Plans Plans
- Individual and Family 81.3% 78%
- Small Group 76.6% 84.2%
- Large Group 89.4% 84.8%

Cigna: This information is publicly available through reports we submit to federal and state regulators.

Health Net of CA: In 2012, the medical care ratio was 87.7% and the administrative loss ratio was 10.3%.

Kaiser Permanente: Based on our 2011 DMHC Annual Report, our administrative loss ratio plan-wide was 4.33 percent and our medical loss ratio was 94.63 percent. It should be noted that we no longer use the phrase "Medical Loss Ratio," using instead "Medical Benefit Ratio" (MBR) whenever possible. Along with many others in health care, we feel that MBR is a more accurate and descriptive means of describing this important ratio.

22. Is your plan NCQA accredited?

Aetna: Yes, Aetna Health of CA Inc is accredited and has got Quality Plus distinction in Care Management, Physician and Hospital Quality.

Blue Shield of California: Yes.

Cigna: Yes, our HMO plan has received NCQA's Health Plan Accreditation status of "Accredited." Cigna has also earned Accreditation for other NCQA evaluations that include Cigna HealthCare of California, including Full Accreditation for Managed Behavioral Healthcare Organization, Accredited with Performance Reporting for Wellness and Health Promotion, and Patient and Practitioner Oriented Accreditation for Disease Management. In addition, Cigna has earned NCQA's Physician and Hospital Quality (PHQ) Certification, which assess how well a plan provides individuals with information about physicians and hospitals in its network to help them make informed health care decisions. Cigna also holds URAC Health Utilization Management, Case Management and Pharmacy Benefit Management Accreditations.

Health Net of CA: Yes. Commercial HMO, PPO and POS lines of business have received the "Commendable" accreditation status from the National Committee for Quality Assurance (NCQA), and Health Net's Medicare HMO received the "Excellent" accreditation status.

Kaiser Permanente: Yes, we are. As of the third quarter of 2013, all of our service areas across the country have NCQA ratings of "Excellent," their highest possible rating, for our HMO and Medicare lines. ❑

2015 Brings Premium Changes to the Exchange Plans

Insurers are facing strong competitive forces in the ACA exchange plans, according to research by the Kaiser Family Foundation (KFF). That's good news for members. In fact, premiums have gone down for the second-lowest-cost plan on the ACA exchanges. (KFF looked at plans in major cities where data was available.)

Insurers have adjusted their pricing now that they've seen what their competitors are charging and how the market share is distributed. Premium changes for 2015 are quite modest among low-cost insurers in the exchanges, which is where enrollment is concentrated. At the same time, competition has increased price volatility. Premium changes for the second-lowest-cost Silver plan range from a decrease of 15.6% to an increase of 8.7%.

Eighty-five percent of people with a plan through the exchanges are receiving tax credits. Thanks to changes in tax credit calculations and poverty guidelines, a person who is eligible for a subsidy and whose income has not changed from 2014 generally paid a little less this year to enroll in the second-lowest cost Silver plan. However, subsidized enrollees who re-enrolled in a plan that is no longer a low-cost could have faced large premium increases.

Sixty-five percent of exchange enrollees chose Silver plans this year, which have an actuarial value of 70%. The second-lowest-cost Silver plan is the benchmark for tax credits for people with incomes of 100% to 400% of the federal poverty level ($23,850 to $95,400 for a family of four). Through these tax credits, eligible individuals pay 2% to 9.5% of income to enroll in the second-lowest-cost Silver plan. Out-of-pocket maximums for Silver plans resemble those of Gold or Platinum plans for lower-income people who get subsidies.

People with incomes up to 250% of the federal poverty level are also eligible for cost-sharing subsidies that lower their deductibles and copays if they enroll in a Silver plan.

In 2015, people buying coverage in exchanges gravitated toward lower premium plans.

Twenty percent of people chose Bronze plans, which typically have the highest deductibles and copays and the lowest premiums. These plans have an actuarial value of 60%, meaning they cover 60% of enrollees' health expenses on average for a typical population.

Even with standardization in essential benefits, exchange plans still vary quite a bit. Plans offered in the same state and within the same metal level may have very different cost-sharing structures. This is, in part, because there are many ways plans can set cost sharing and still achieve a given actuarial value.

For example, a Silver level plan in Pennsylvania has a $4,500 deductible, $10 copays for physician visits, and no cost-sharing after the deductible for inpatient care. Another plan in Pennsylvania has no deductible but a $50 copay for physician visits and a 50% coinsurance for inpatient care. Both plans have an actuarial value of approximately 70%, but the same person may fair very differently in one plan than the other, depending on health care needs in a given year.

The majority of Bronze plans and many Silver plans have what are called "combined" deductibles, meaning that there is a single deductible for both medical services and prescription drugs. The plan will not begin covering most medical or prescription services until the deductible has been met (though many health plans do not apply the deductible toward certain services).

Most Silver, Gold, and Platinum plans have separate medical and drug deductibles (or, in some cases, have no deductible for prescriptions). Enrollees in plans with separate deductibles will begin to receive payment toward their prescriptions once they meet their prescription deductible (or immediately if there is no deductible) even if they have not yet met their medical deductible. Conversely, if an enrollee meets their medical deductible, the plan wouldstart covering medical services even if the enrollee had not yet reached the drug deductible. In plans with separate medical deductibles, the average Bronze deductible is $5,372, and the average Platinum deductible is $418 (including many plans with $0 medical deductibles).

Fifty-four percent of Silver plans have separate drug deductibles. Sixty-one percent of Gold and Platinum plans have $0 drug deductibles. So they begin to pay toward prescriptions immediately. The average prescription drug deductible amounts range from $133 in Platinum plans to $465 in Bronze plans.

Insurers have differing expectations of the risk pool in the second year. Second-year enrollees are likely to be healthier than those who enrolled in the first year. States where enrollment was strong in the first year may tend to have risk pools that are more balanced. Conversely, states that permitted non-compliant plans to continue under a federal transition policy may have less balanced risk pools since healthier – than-average individuals probably stayed in those non-compliant plans. For more information, visit www.kff.org. ❑

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Leila Morris is senior editor of California Broker Magazine.

HEALTHCARE

How the ACA Has Affected Brokers

Benefitter recently asked 1,028 brokers how the Affordable Care Act (ACA) has affected them. Eighty percent had negative or critical feedback around the Affordable Care Act. The following are brokers' top concerns:

- 26% Rate increases
- 22% Increased complexity
- 21% Reduced role of broker
- 11% Plan quality
- 11% Other law nuances
- 5% Employer dumping
- 4% Compressed timeline

The most common complaint is that insurance premiums have increased significantly for their group clients. Many brokers are concerned that health insurance products now come with higher deductibles and narrower networks. Brokers are under increasing pressure to guide clients through a complex regulatory environment. Medical loss ratio (MLR) limits and other factors have reduced broker commissions while their workload has grown.

Several brokers have already seen many of their group clients drop health benefits and transition employees to the individual market. Many businesses now have a December renewal date due to last year's transition relief, creating an onslaught of fourth quarter work for brokers. Brokers are also facing website malfunctions at the state's exchange, Medicaid's uneven expansion, and confusion over grandmothering.

Here are some representative quotes:

"My clients saw much higher increases at renewal last year – double or triple what we normally see. The increases we've seen since the inception of the ACA have been catastrophic to some businesses."

"I'm tired of hearing advertising about a 1% state wide average rate increase. Twenty percent to 40% of employers are already purchasing the highest deductible plans to get premiums down, so there is no where to go next year."

"Brokers are spending two to three more times explaining and educating clients."

"The constant changing and postponing of the original implementation schedule makes me look like I don't know what I am talking about."

"If I calculated what I get paid to help a client through the exchange and what the carriers are paying, I am making about $2.50 an hour."

"Commissions have dropped 40%. I am working many more hours."

"We should exempt brokers from MLR. Employers are being deprived of impartial advice because brokers can't earn enough money to stay in the business."

"It's not always about the rate increases; it's also about rates staying the same and the plans turning to garbage — from a $2,500 family deductible to a $12,700 deductible."

"My county has three carriers to choose from with a limited network. Members have lost their doctors with no indicator it will change."

"About 75% of all small group renewals renew in December now. That, with open enrollment for individual plans and Medicare plans during the fourth quarter, it makes it almost impossible to service our clients. I am working 12- to 16-hour days just to tread water."

"I have spent the majority of my time rewriting the existing book of business and assisting people who lost their group coverage. These groups will be forced to shut their plans down and tell their employees they are on their own. I wouldn't be surprised to see 50% leave the employer sponsored market."

"The state exchange website is down all the time; there is no workable electronic communication system; brokers have to wait on hold for up to an hour to get information."

"All our work is jammed into this impossible time period."

"It's disheartening when you cannot help someone because their modified adjusted gross income does not reach 100% of the federal poverty level but they are not eligible for Medicaid."

For more information, visit www.benefitter.com.

Have Insurers Found a New Way to Weed Out Members?

Eliminating discrimination on the basis of preexisting conditions is one of the central features of the Affordable Care Act (ACA). But there is evidence that insurers are resorting to other tactics to dissuade high-cost patients from enrolling, according to a study by Harvard's School of Public Health. The findings suggest that many insurers may be using benefit design to dissuade sicker people from choosing their plans. A recent analysis of insurance coverage for several other high-cost chronic conditions, such as mental illness, cancer, diabetes, and rheumatoid arthritis showed similar evidence of adverse tiering, with 52% of marketplace plans requiring at least 30% coinsurance for all covered drugs in at least one class. Thus, this phenomenon is apparently not limited to just a few plans or conditions.

A formal complaint submitted to the Dept. of Health and Human Services (HHS) in May 2014 contends that Florida insurers offering plans through the new federal exchange had structured their drug formularies to discourage people with HIV from selecting their plans. These insurers categorized all HIV drugs, including generics, in the tier with the highest cost sharing.

Insurers have used tiered formularies to encourage enrollees to select generic or preferred brand-name drugs instead of higher-cost alternatives. But if plans place all HIV drugs in the highest cost-sharing tier, enrollees with HIV will incur high costs regardless of which drugs they take. This effect suggests that the goal of adverse tiering is not to influence enrollees' drug utilization, but to deter certain people from enrolling in the first place.

Researchers analyzed adverse tiering in 12 states using the federal marketplace: six states with insurers mentioned in the HHS complaint (Delaware, Florida, Louisiana, Michigan, South Carolina, and Utah) and the six most populous states without any of those insurers (Illinois, New Jersey, Ohio, Pennsylvania, Texas, and Virginia).

Researchers found adverse tiering in 12 of the 48 plans — seven of the 24 plans in the states with insurers listed in the HHS complaint and five of the 24 plans in the other six states. There were stark differences in out-of-pocket HIV drug costs between adverse-tiering plans and other plans. Adverse tiering plan enrollees had an average annual cost per drug of more than triple that of enrollees in regular tiering plans ($4,892 vs. $1,615), with a nearly $2,000 difference even for generic drugs. Fifty percent of adverse tiering plans had a drug-specific deductible, compared to only 19% of other plans.

Enrollees may select an adverse tiering plan for its lower premium, only to end up paying extremely high out-of-pocket drug costs. These costs may be difficult to anticipate, since calculating them would require knowledge of an insurer's negotiated drug prices — information that is not publicly available for most plans.

Second, these tiering practices are likely to lead to adverse selection, with sicker people clustering in plans without adverse tiering. Over time, plans offering generous prescription-drug benefits may see a large influx of sick enrollees, which would reduce profits and lead to a race to the bottom in drug-plan design. The ACA's risk-adjustment, reinsurance, and risk-corridor programs provide some financial protection to insurers

whose enrollees are sicker than average. But the existence of adverse tiering in 2014 suggests that selection opportunities remain. Furthermore, the reinsurance and risk-corridor programs will be phased out after 2016, which will only increase insurers' incentives to avoid sick enrollees.

Price transparency is one approach to address unexpectedly high out-of-pocket costs for people with chronic conditions. Insurers could be required to list on their formulary each drug's estimated price to the enrollee, based on the negotiated price and the copayment or coinsurance. However, price transparency would probably accelerate the adverse-selection process if adopted in isolation.

One would be to establish protected conditions in drug formularies. Medicare Part D has designated several protected classes of drugs, including those used for HIV, seizures, and cancer. A similar approach in the exchanges could set an upper limit on cost sharing for medications for protected conditions. Such a policy would reduce financial exposure for people with these conditions even if they chose sub-optimal plans. Other safeguards for protected conditions could also be implemented, such as limits on prior-authorization requirements.

An important additional step would be to require marketplace plans to offer drug benefits that meet a given actuarial value, meaning that the percentage of drug costs paid by the plan (rather than the consumer) would have to exceed a particular threshold. This level could be set at the actuarial value for a given plan (i.e., 70% for silver plans) or above it. In order to significantly increase cost sharing for one drug, an insurer would have to reduce cost sharing for another drug. This step is crucial because it encompasses treatment of all health conditions, not just protected conditions and addresses non–formulary-based methods of passing costs on to consumers that may induce adverse selection (e.g., drug-specific deductibles), according to the report.

Stopping adverse drug tiering will not completely eliminate discrimination in the insurance marketplace. Some insurers will think of new ways to dissuade sick enrollees from joining their plans. Eliminating premium discrimination on the basis of health status was one of the ACA's chief accomplishments in the non-group insurance market and one of the law's most popular features. Preventing other forms of financial discrimination on the basis of health status — with the attendant risks of adverse selection in the marketplace — will require ongoing oversight, according to the report. The ACA has already made major inroads in designing a more equitable health care system for people with chronic conditions, but the struggle is far from over. For more information, visit www.hsph.harvard.

Shopping for Care Can Lower Out-of-Pocket Costs

Out-of-pocket spending for common health care procedures can vary from $10 to nearly $1,000 depending on the procedure. With out-of-pocket spending rising, there are real opportunities for consumers to save on health care if they have price information to make better decisions, according to a study by the Health Care Cost Institute (HCCI).

The HCCI report is based on data from actual amounts paid for health care services. The report looks at per capita out-of-pocket spending for five common medical procedures. It looks at average differences in consumer payments nationally and in nine states: Ariz., Colo., Fla., Ga., Md., N.J., Ohio, Texas, and Wisconsin.

In 2013, consumer payments for a new doctor visit varied by $19 nationally, $10 in Arizona, $12 in Colorado, and $35 in Wisconsin. However, variations were much higher for surgical procedures. Consumer out-of-pocket payments for cataract removal varied by $444 nationally. Variations were larger within states. Consumer payments varied by $989 in Wisconsin and $490 in Georgia. The variation in consumer out-of-pocket payments for a lower leg MRI was $342 nationally. Payments varied by more than $410 in several states including Ohio, Texas, and Wisconsin.

In 2013, an adult consumer with employer-sponsored insurance paid more than 15% of their medical bills out-of-pocket for about $700 a year. That's up 6.9% from $662 in 2012.

HCCI executive director David Newman said, "The lack of transparency of medical prices is a growing problem since consumers are financing a larger and larger proportion of their care. Although the savings for a physician visit may be minimal, for other procedures like cataract removal or an MRI, the potential savings could be a substantial benefit to many households." HCCI is launching a transparency tool that will provide national, state, and local information to help consumers shop. The first version of that tool is slated to go live in early 2015. For more information, visit www.healthcostinstitute.org.

Small Businesses Must Gather Data Now for Obamacare 2016 Deadline

Companies with 50 to 99 employees will fall under the federal healthcare mandate starting January 2016, but they should prepare now. Small companies should begin tracking data to help them determine compliance and which employees are entitled to an offer of coverage in 2016. "Unfortunately, no magic bullet exists in the form of affordable software that gathers data in one tidy place; nor is the government ready with a form. The required reporting is detailed. Leaving the record keeping to the 11th hour will be too cumbersome for smaller companies... Planning facilitates developing the best ACA strategy," says Finny Varghese, an expert on the ACA.

Here's what companies need to do according to Lexus/Nexus:

- Classify workers. Coverage is required for full-time employees, those working 30 or more hours weekly, and full time equivalents. FTEs are calculated as the number of part-time workers multiplied by the number of hours worked per month divided by 120. Companies may discover their total full-time count falls below the range.
- Define standard measurement periods for determining employee classifications. There will be one look-back period for ongoing employees and measurement periods for each new hire. Tracking this year provides a beta test for 2016 data and could guide classifications.
- Detail each employee who gets coverage under current healthcare policy. This information includes the duration of any waiting period, months of eligibility and coverage, premium for the lowest cost option for employee-only coverage, and whether coverage meets the government standard.

For more information, visit www.nexusstaff.com.

FY 2016 Budget to Extend Medicare Mental Health Benefits

The fiscal year 2016 budget, released by President Barack Obama calls for elimination of a provision that limits Medicare beneficiaries to just 190 days of inpatient psychiatric hospital care during their lifetime. Mark Covall, National Association of Psychiatric Health Systems (NAPHS) president and CEO said, "Mental illnesses are the leading cause of disability and contribute to premature death. When people experiencing a mental health or addiction cri-

sis cannot access needed treatment, families and communities are at risk. The President's budget takes an important step forward to address arbitrary limits that prevent people from accessing the right treatment at the right time. There is no such lifetime limit for any other Medicare specialty inpatient hospital service."

NAPHS also called on the Administration and Congress to address another discriminatory barrier in the Medicaid program. Adults (ages 21 to 64) with Medicaid don't have coverage for short-term, acute care in psychiatric hospitals because of the "Institutions for Mental Disease (IMD)" exclusion. "The IMD exclusion is penalizing the disabled and poor. This policy adds to system inefficiencies and adds to the cost of care," Covall said. Congress has taken bipartisan action to address this issue. Rep. Tim Murphy (R-physician assistant) has developed an NAPHS-backed comprehensive mental health reform plan, the Helping Families in Mental Health Crisis Act. It would create a pathway under Medicaid for people to get access to short-term acute psychiatric care. The measure, which has had bipartisan support, is slated to be reintroduced in the 114th Congress.

The Medicaid Emergency Psychiatric Care Demonstration is also underway in 11 states and the District of Columbia to show the value of giving adult Medicaid beneficiaries this type of access. Preliminary demonstration statistics show that the length of stay in psychiatric hospitals is very short (about eight days). Readmission rates are low (with 84% not returning to the hospital). People are able to go home or to self-care with hospitals' community partners.

Medical Homes Improve Care and Reduce Costs

Primary care patient centered medical homes are delivering results, according to a report by the Patient-Centered Primary Care Collaborative. This team-based health care delivery model is led by a primary-care physician. Researchers looked at peer-reviewed studies, state government program evaluations, and industry reports. Sixty percent of the studies report cost reductions, and 92% report improvements in utilization. All seven state government reports reveal reduced costs, and six show improved utilization. Four of seven industry studies show cost reductions, and six show improvements in utilization.

Christopher Koller, president of the Milbank Memorial Fund said, "In order for the patient centered medical home to be sustainable, we need greater investment in primary care and less reliance on the fee-for-service payment system." Justine Handelman, vice president, legislative and regulatory policy at Blue Cross Blue Shield Association said, "Spending more than one in five medical claims dollars in value-based care programs located in virtually every state, the Blues are creating innovative models that align incentives, support care coordination, and put patients first." For more information, visit www.pcpcc.org/initiatives.

Broader Prescription Drug Coverage Improves Health Outcomes

Enhanced prescription drug insurance can improve patient health outcomes and reduce the use of costly health care services, according to a study by Brigham and Women's Hospital and CVS Health. When drug insurance programs are enhanced or expanded, more patients can afford important medications enabling them to adhere to prescription medicines for chronic conditions. As a result, they face fewer costly complications and lower health care use, including hospitalizations from unmanaged or under-managed conditions. In contrast, several studies also reveal that patient health outcomes decline when insurers place burdensome caps on drug benefits.

Troyen A. Brennan, M.D., Chief Medical Officer, CVS Health and a study author said, "Our analysis indicates that, while expanding insurance benefits may lead to initial cost increases, these costs should be offset by future reductions in spending associated with preventable patient morbidity and mortality." She added, "Many public and private insurers are taking steps to control rising health care costs. For example, some state Medicaid programs…have placed…limits on the number of prescriptions a patient can fill each month… Restricting the availability of prescription drugs or prohibiting access could have negative effects on patients' health and may not produce the expected cost-savings." For more information, visit www.cvshealth.com.

EMPLOYEE BENEFITS

The Top Voluntary Products

Short-term disability was the most frequently offered voluntary product in 2014 followed by term life, critical illness, and accident among the carriers participating in a survey by Eastbridge Consulting. The percentage of carriers offering long-term disability and AD&D increased while those offering universal/whole life, dental and long-term care remained about the same compared to a similar study conducted in 2012. Fewer carriers have been offering hospital indemnity, limited benefit, and supplemental medical plans, most likely due to how healthcare reform has affected these plans.

Slightly over one-third of the carriers offer or plan to offer non-insurance or discount products in addition to their traditional voluntary offering. These include health discount cards, hybrid dental insurance and discount products, financial/legal discount cards, beneficiary support services, health advocacy/nurse advisors, and/or other value-added services such as EAP, ID theft recovery, travel assistance or leave management. Most carriers classify their voluntary products as having average profitability. The products rated most often as very profitable include accident, hospital indemnity, and vision. Products receiving lower profitability ratings include cancer, critical illness, dental, and universal/whole life. For more information, visit www.eastbridge.com.

Consumers Want Wellness Rewards

Seventy-five percent of consumers with company-sponsored health plans say that incentives would motivate them to meet health goals, according to a survey by HealthMine. Also, Seventy one percent want access to programs and guidelines for health management; 67% say that employees who are in a healthy weight range should get a discount on their health insurance; and 52% say that employees should be rewarded for adhering to medication for a chronic disease. They also say that co-workers who engage in unhealthy behaviors or don't manage their health should be penalized. For example, 63% say that employees who smoke tobacco should pay more for their healthcare. For more information, visit www.healthmine.com.

Addressing Vision Problems in the Workplace

Nine out of 10 employees say that the quality of their work has been affected by problems with their vision – and, more alarming, half admit that this is a regular occurrence, according to the 2015 annual Employee Perceptions of Vision Benefits survey, supported by Transitions Optical. The survey explored top visual complaints in the workplace. Both indoor and outdoor light are largely to blame

News

– with six out of 10 employees say they are bothered by light at work.

Nine out of 10 employees say that visual disturbances are affecting their quality of work.

These findings build on results from Transitions Optical's 2014 survey, which found that visual disturbances at work – ranging from tired or dry eyes, to light and vision-related headaches – affect nearly all employees, leading them to take multiple breaks throughout the day to rest their eyes. In line with the 2014 results, the most common vision problems reported by employees in the 2015 survey included tired eyes (40%), dry eyes (31%), headaches (27%), and blurry vision (21%). Light was the top complaint – with employees saying they are bothered by a wide range of disturbances including bright, glaring light and light reflected off of a computer screen, personal device, or other surfaces. In total, 56% of employees said that light bothers them at work – with the majority of employees saying they are affected primarily by light outdoors, or a combination of light indoors and outdoors.

The survey also explored the demographics of those affected the most by visual disturbances while on the job. Overall, parents (73% vs. 52%), those between the ages of 18 to 44 (71%), and those who work outdoors or a combination of indoors and outdoors (79% outdoor workers, 76% indoor/outdoor workers, 57% indoor workers) were more likely to say that the quality of their work frequently suffers as a result of vision problems. These groups were also significantly more likely to say that light, specifically affects the quality of their work – with Hispanic Americans significantly more likely than Non-Hispanic Whites to say this (78% vs. 54%).

While vision problems affect nearly all employees, just 13% of employees say they have addressed these issues with their employers – and just half say they discussed workplace vision problems during their last eye exam. Less than one-third said that they specifically talked about light-related vision problems with their eyecare professional.

"This is unfortunate, considering vision problems caused by light and glare are among the easiest to address – since eyewear options, like Transitions lenses and anti-reflective coatings, can help to enhance visual comfort and reduce glare," said Jonathan Ormsby, strategic account manager,

For more information, visit www.HealthySightWorkingforYou.org. ❑

Products

Affordable Care Act Tool. EBenefits Solutions is introducing ACA tools. The ACA Navigator guides employers through each aspect of the ACA's employer coverage mandate. The ACA Compliance Module provides eligibility tracking for all employees, sends monthly notifications to employees and human resources staff, and monitors the latest changes to the ACA. For more information, visit http://www.ebenefits.com

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Tax Credit Services. State and Federal programs offer $2,400 to $9,000 in tax credits for each eligible new hire. The Tax Credit Professionals have been assisting businesses nationwide with the extensive process of claiming these credits and refunds. TC Services USA offers three partnership options: 1) Integration Partnerships 2) Referral Partnerships, and 3) Private Label Partnerships. With either option, TC Services USA can integrate their Tax Credit Services with your own software or client portal. For more information, visit http://www.TCservicesUSA.com.

Prescription Discount Card. The free Watertree Health Prescription Discount Card helps people afford their medications. It complements plans obtained through the ACA as well as those provided by employers. For more information, visit www.watertreehealth.com.

Quoting App. Limelight Health launched the QuotePad app, available now at the Apple iTunes Store. QuotePad provides a simple, interactive platform for health insurance professionals to quote and compare employee health benefit information. For more information, visit www.limelighthealth.com or call 1-877-897-5005.

Affordable Care Act Advisor Module. HotSchedules released a module to help employers manage schedules and preserve employee hours while controlling labor costs under the Affordable Care Act's Employer Mandate. For more information, visit http://www.hotschedules.com/acadvisor.

Wellness. Health and wellness company Nudge, is offering apps that track physical activity, calorie intake, sleep, hydration levels, and indulgence. Additional features, such as visual feedback systems and graphs, help users create a plan to change bad habits and improve wellness. You can download the Nudge app at the Google Play Store. For more information, visit http://www.nudgeyourself.com.

Guide on Matching Voluntary Benefits to Demographics. Purchasing Power is offering an interactive guide to matching voluntary benefits to the three generations in the workforce. It can be viewed on phones and tablets in addition to computers. The guide discusses the three generations, their financial stressors, and their varying benefit needs. It presents a menu of traditional and non-traditional voluntary benefits available in today's marketplace. For more information, visit www.PurchasingPower.com. ❑

Positioning Life Insurance as the Attractive Asset Class

Astute advisors always keep in mind that prospective clients have a variety of investment opportunities other than life insurance, particularly those that appear more attractive and lucrative. But it may be the intangible quality of life insurance that raises doubts with even the best prospects. Talk about having peace of mind and preparing for "when you're no longer" can seem less than compelling reasons to buy life insurance.

It's not surprising that many consumers view life insurance as an optional or even luxury purchase. One way to help clients see it as a responsible and safe investment is by using the internal rates of return (IRR) report that's available on all permanent life insurance products.

As we all know, premiums are paid to the insurance company in exchange for a promise to pay a certain amount of money at death. An appropriate IRR can be determined, each year, by comparing the likely death benefit with the total premiums paid by the end of that year.

When the IRR drops to 0%, if the client were to die, the death benefit would equal the amount of premiums paid. In other words, there was no gain from having paid all those premiums for all those years, which is a major issue with clients when considering the purchase of a life insurance policy.

This is a legitimate concern to say the least. There's no need to attempt to sidestep it because there's much more to the story. It's important for consumers to understand how life insurance, particularly permanent products, can bolster the IRR and give them peace of mind based on knowing that they have made a prudent investment.

First, a unique feature of a permanent life product is the guarantee. You will find guaranteed universal life polices, along with the less common guaranteed indexed universal life policies on the IRR. These guarantees separate a permanent life policy from other asset classes so that they become uncorrelated. Now, before you try to explain uncorrelated assets to clients and lose them for sure, just make it simple and say, "Unlike other asset classes such as securities, real estate, or even education, a guaranteed universal life policy will not waiver. The numbers you see in the guaranteed columns of the insurance illustration are nearly infallible, putting them in the same category as bonds, but with potentially much higher yields, and that other thing that keeps coming up because it's so important to all of us, peace of mind. When other asset classes rise and fall with the tide of the market, guaranteed universal life policies stay the course.

The second feature that allows guaranteed universal life products to standout from other asset classes is the tax benefit. Unlike gains in securities, bonds, or almost any other asset class, the death benefit [and, potentially, dividends while still alive (FiFo)] is tax-free.

So, while an IRR of, say, 3.5% at age 90 (a very reasonable mortality age) doesn't make the impression of a projected 9% by that age for a mutual fund, the post-tax gains suddenly become comparable. Here's the important message for clients: one is a solid guarantee while the other is unpredictable.

There are many seemly more appealing asset classes vying for your clients' attention than permanent life insurance, so use the IRR report to move life insurance to the top spot in their thinking.

Because IRR reports can be applied to any asset class, it's a convenient, straightforward way to explain to your client why the purchase of a guaranteed universal life policy is the wise choice to meet their needs.

If peace of mind is not a client's top priority, that's okay, then there are guaranteed indexed universal life policies out there that never dip below 0% so that even in a bad year, they maintain the potential for relatively lucrative gains.

No other asset out there can offer the combination of tax exemptions, guarantees, and the ability to ensure that if one were to have an untimely death, their loved ones will be accounted for. For there are only three guarantees in this world: death, taxes, and guaranteed universal life insurance policies. There's an IRR report to prove it. ❑

Peter Sullivan, an illustration specialist, is a member of the Internal Sales Group at First American Insurance Underwriters, Inc., an insurance brokerage that specializes in supporting agents in all 50 states with life insurance, long-term-care, and annuity products from more than 30 insurance companies. Sullivan can be reached at psullivan@faiu.com or 800-444-8715.

Become a Brand Behemoth in Your Market by Seizing the Digital Moment

Would you shop in a store that only carried one brand of television? Of course not. Likewise, today's policyholders no longer accept a single company quote. It's hard to satisfy this consumer demand if you're an agent who can only offer one product. It's why the era of the captive agent is coming to an end. Only independent agencies who meet their customers online by leveraging their customers' desire for information and choice will succeed.

The rise of digital media — the web, social media, the smartphone and other mobile devices — has leveled the playing field and even tilted it toward independents. Independent agents can now compete against the industry's brand behemoths by making their brand even more powerful in their area. They can become local brand behemoths. Digital tools enable you to provide a better service experience to your clients. Online lead generation allows you to find new clients more efficiently.

Improving Customer Experience

In a commoditized industry like insurance, the only way you can differentiate yourself is to provide excellent customer service. In the digital age that means giving your customers the opportunity to interact with your agency whenever and however they want. From policy changes to evidence of insurance, customers would rather do things themselves online than wait to call your office when it's open. Surveys show that companies of all types, including insurers, consistently get better service scores when they let consumers manage their account themselves. Does your website allow customers to make policy changes, track their claims, get quotes, or review their policy limits? Consumer tastes also require your website to be mobile-compatible. The smartphone has replaced the computer as the device of choice for consumers. A mobile-compatible site must be clean because smartphone screens are small. Users must be able to navigate and read your site quickly on a smartphone. Your website can't be static and one-dimensional. People don't want to read gobs of copy online. Your site should give visitors interactive experiences. For instance, display the icons of the companies you represent instead of listing them.

Attracting New Customers

Use online resources to expand your marketing efforts. LinkedIn provides a great example. Start by identifying people on LinkedIn whom you are connected to indirectly (i.e. through an existing contact but not directly) or are members of the same business group as you. These are your LinkedIn prospects. Next, go through your business network and identify a service provider like an accountant, photographer, or other small-business owner. Ask them if they would be willing to provide a discount to customers you refer to them. If they agree, send an email to your prospects identified from LinkedIn letting them know they can receive a discount. This creates a win-win for both of you.

Digital Giveaways

No one gets excited about a birthday card from their agent. Instead, how about giving away a mobile app so your business can stay top of mind? An app that gets your name on their phone is a proactive way to stay in touch and provide something of real value.

Facebook, Twitter, Tumblr, and More

You need to be on social media. Although engaging with social media takes time, what you learn online provides you gain valuable customer insights, which gives you a real advantage. It's like getting the questions to a test in advance. Social media isn't just about following people. Post or tweet information about how to prepare for open enrollment, for example. The more you engage digitally, the more relevant you become online. You're probably thinking: I don't have time for this! You're right! Find someone who uses these tools every day – a student or a young person in your office and put them in charge. All the pieces have fallen in place for independent agents. Seize the digital moment now and prosper! ❑

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Our Minds Can Play Dirty Tricks On Us

"Digital disruption makes a nice headline," said an insurance executive, responding to a news report that insurance agents are being "squeezed" by the Internet. "The realities of the insurance business are a bit more complex than that," he said, assuring insurance agents that digital is no threat to their business.

We like to think that what we do is impervious to disruptive forces. But the tipping points come and the longstanding pillars begin to crumble. Some try to hold on for dear life. Somehow or other, we believe we can beat the odds, that the storm will miss us, it's others who will be affected, but we'll be safe. Here are seven dirty tricks our minds play on us, and what we can do about them:

1. **Customers for life:** This is one of most seductive ideas in business — and for good reason: we want to believe it. But no matter what we do, how hard we try, or how much we focus on meeting customer expectations, customers aren't forever, they have a life expectancy. For one reason or another, they leave and there's no way to avoid it, no matter what we do. With changing needs and situations, it's unrealistic to think that we can keep customers indefinitely. But what's even worse, the idea of customers for life dulls to the task of prospecting, or more properly, an active replacement program.
2. **Some things just aren't that important:** At least that's what we think. It's easy to remember all the good things we do for customers, helping them out when they're in a jam, taking more time with them than necessary. And we expect them to appreciate our efforts. Not necessarily. Customers never forget small things. When a sign for a drycleaner was going up on a store, a woman rushed up to company president. "I'll never go there," she yelled. "Ten years ago, you people lost my favorite blouse." It's a story she has undoubtedly repeated many times. Negative experiences are indelibly imprinted on customers' minds, unless we're sensitive enough to stop and address the complaint quickly to their satisfaction.
3. **Falling in love with what we do:** Aren't we supposed to love what we do? At least that's what the gurus tell us. "Be passionate," they say. Perhaps, but former IBM and Apple head, Louis V. Gerstner, offers caution. "Organizations tend to fall in love with their existing products and processes," he says. "People get caught up in the status quo. When someone says, we may have to change, there is real resistance."

   We want to keep on doing things our way. Because it seems safer, we reject anything and anyone who challenges it. We never seem to learn that it's the curious who thrive.
4. **Understanding customers:** "We know what our customers want. Many of them have been around for years." Such responses are often rather smug and off-putting, as if you've crossed the line, going where you're not welcome. It's an attitude in businesses that have been around for years and view themselves as well-oiled machines. Joseph Jaffe of OnlineSpin notes that these companies and brands have stopped asking questions, including questioning themselves. He suggests that start-ups have the advantage because they're more curious and test new ideas, which keeps the focus on the customer. When we think we know our customers, this may be a sign that our minds are playing a dirty trick on us.
5. **Thinking positively:** Optimism is the quality that gets universal applause in business. A "we can do anything" attitude is revered and rewarded. It rouses us to action and drives away doubts. Some researchers say that a positive attitude helps reduce stress, enhances coping skills, and lengthens lifespan.

   So, what's not to like about positive thinking. Just this. "Positive thinking fools our minds into perceiving that we've already attained our goal, slackening our readiness to pursue it," says Gabriele Oettingen, Ph.D., a New York University psychology professor. When it comes to reaching a goal, a better approach combines a positive attitude with recognizing the obstacles that stand in the way of getting there. Too often, those in marketing and sales fail because they see only the upside.
6. **Doing enough for customers:** Our minds seem well-trained to put the brakes on us. "That's far enough," they tell us, which is often evident when it comes to customer care. "How much more can we do? They're pushing us now," say owners and managers.

   While the mind may say, "Slow down," the customers want faster. Overnight delivery doesn't cut it; free shipping is nearly the norm. The commercial says the quirky ducks pays claims in four days. That wasn't good enough for the AFLAC CEO, who announced one-day payment for qualifying claims. Coffee runs are over, at least at Starbucks.
7. **Missed opportunities:** Missing the target can be fatal in business. Yet, it happens far too often. It happened to Burger King with its ill-fated "Satisfries." Amazon dialed the wrong number with Fire Phone. And, evidently, there was no target for Google Glass, least when it came to market.

It happens all the time. A recent study by Epsilon and The Luxury Institutes found that luxury brands lose 50% of their top customers each year by failing to identify their demographic and economic profile and not creating a personalized experience.

Hard to believe? Our minds tell us we're on the right track, that we've got a winner, and that we've hit a home run. Unfortunately, we don't even know we've been tricked. And it all results in costly and embarrassing missed opportunities. To avoid the dangers of our minds playing dirty tricks on us, it's better to ask one question before leaping into action: "What could possibly go wrong and what don't I know for sure?"

John Graham of GrahamComm is a marketing and sales strategist-consultant and business writer. He publishes a free monthly eBulletin, "No Nonsense Marketing & Sales." Contact him at jgraham@grahamcomm.com, 617-774-9759 or johnrgraham.com.

5 Musts for a Successful Insurance Web Site

It's an amazing feeling when someone contacts your business through the company Web site and is completely sold during the telephone follow up. Unfortunately, countless insurance professionals end up losing business because their Web site is poorly designed and does not use an efficient process for generating and capturing leads.

I have made a living selling life insurance through my own Web site and have also worked as an Internet marketer building and optimizing hundreds of Web sites for other business owners.

Over time, I've keyed in on a few specific factors that set a successful insurance Web site apart from one that does not serve a company well or at all. The following are five of the most important elements to include on your Web site to build a business and a favorable online reputation in kind.

1 Professional Design

As a business professional, you must always put your best foot forward not only to attract clients, but also to inspire confidence and trust. A Web site is a business card, a Yellow Pages advertisement, a brochure, a sales kit, a lead engine and so much more. For many, professional Web design is simply a re-allocation of marketing dollars, and the money spent on your site will likely result in a better ROI than any other type of advertising or communication strategy.

How much should you invest in professional Web development? That depends. The cost of developing a Web site can range from a few hundred dollars to over $30,000, and that can be for a simple 10 to 20 page site. While you certainly don't need to spend tens of thousands of dollars, be prepared to budget between $1,500 to $5,000 for a professional Web site in the financial field. While it might be tempting to save money by outsourcing the project overseas, keep in mind Web development is one area where you absolutely get what you pay for.

For the majority of financial professionals, I always recommend Wordpress Web sites. Wordpress is a content management system (CMS), which basically means it utilizes a comprehensive template to use for your Web site. Wordpress is the most common CMS solution available so finding designers and developers at a low cost is easy. When it comes to hiring a Web designer, it helps to choose a designer who has a portfolio of sites that resonates with you.

If you tend to be a do-it-yourselfer, this is not the time to dive into Web design and development. Your time is much better spent focusing on other aspects of Internet marketing and Search Engine Optimization (SEO) to drive prospects to your Web site. Just a few years ago the Internet was flooded with Web sites just clamoring to rank for certain keywords in Google. If you plan on trying some type of marketing plan to trick Google into ranking your Web site, I have bad news for you: it doesn't work anymore. The way to be found on the Internet and distinguish your site from spammers is to simply be transparent. Let customers know that you are a real business with real people. One of the best ways to do that is through your "About Us" company page.

2 About Us Page with Executive Headshots

The About Us page is one of the most important pages on your Web site, especially for those who are considering doing business with you. Don't be afraid to use at least 500 words on your about page to convey something personal about you and your business. How did you get started? What do you specialize in? What do you believe in? It doesn't take much, but not having an About Us page is a sure-fire way to lose a potential customer.

Also, make sure to include professional headshots on your about page. Executive headshots of you and your staff let visitors know you are a real company with real people. This small thing can put you above many other financial Web sites that don't include such information. People are very wary of things they find on the Internet so the more legitimate you are perceived the better. Executive headshots typically cost between $100 and $250, and can be professionally edited in Photoshop as needed.

3 Display Trust Signals

The e-commerce industry knows better than anyone that trust is a huge issue on the Internet. Utilizing Trust Seal graphics serve as a risk reliever that can increase conversions by up to 10%. In fact, surveys of online shoppers show that one of the most stated reasons for leaving a Web site is the absence of trust seals. There are specific trust seals you should be displaying on your financial Web site including those from the Better Business Bureau, an SSL certificate, a malware scan seal, Chamber of Commerce member-

ship, NAIFA, Trusted Choice, and even a custom guarantee seal. Trust seals can be expensive as you will be required to become a member of these organizations, however, they provide ancillary member benefits beyond the ability to display the digital seals on your Web site. You don't need to display every trust seal, though having none at all will certainly not help you build a strong online reputation.

4 Testimonials and Reviews

I love testimonials and reviews. So do prospects. Customers want to know you're competent, and one of the best ways to convey this is to let your current or past customers and business partners do it for you. The easiest way to start off is by getting testimonials, including permission to publish them. While there are no shortage of methods used to procure feedback from customers, I've found that the best way is to simply call them. Make it easy and have them give you a testimonial right there on the phone. Take notes during the call and have your customer sign off on what you have transcribed. It's best to have them send a follow up note indicating their explicit approval that you can keep on file.

Displaying reviews is a bit trickier. There are several new review plugins you can use on your Web site, although most if not all require monthly fees. The most valuable social proof is from third party review platforms such as Google, Yelp, BBB, and Yellow Pages. They provide the most benefit because they are not under your control. A great strategy for leveraging these platforms is to ask customers that you already know love your service to post a review for you on one or more of these sites. Just be careful that you do, in fact, offer a great service because negative reviews on some of these sites can be devastating to your online reputation.

5 Contact Information

I have been an editor in charge of the life insurance category, the industry in which I work, at dmoz.org – Google's online directory – for many years, so I see just about every insurance Web site submitted for inclusion. It's astounding how many of these financial professionals build a Web site and then neglect to put a physical address anywhere on it. I know many financial professionals work from home these days but there is nothing wrong with listing your home address on your site. Even worse are the sites that do not even provide an email address. Instead, the only way to contact the agent is through a contact form. I understand people are attempting to avoid getting spammed and that people want their privacy, but the whole point of your business site is to have people contact you. I have had my email address displayed on my site for years and I do get my fair share of spam, but this is handled exceptionally well by the spam and junk filter that comes with my email system. Your Web site is a tool to allow your potential customers to get to know you and your business. Appearances and authenticity goes a long way on the Internet so don't hide.

Today's consumers expect financial professionals to have a strong online presence and the quality of a Web site can either bring in more business or drive customers away. It's as simple as that. I have personally built my business around consumers shopping online for life insurance, so I urge you to learn from my mistakes and wins and duly capitalize from my experience. Your Web site is a direct reflection of you and your business so spend the time and resources to ensure it's something that will meet, and optimally exceed, its goals and objectives. ❑

Brian Greenberg is a multi-faceted entrepreneur currently serving as a founder and executive of multiple online businesses, including serving as President of True Blue Life Insurance. Recognized as one of the most creative people in the insurance industry, Greenberg is in the world's top one percent of life insurance and financial services professionals. He may be reached online at www.TrueBlueLifeInsurance.com.

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by Al Dal Porto

Did Your Client Receive An Unexpected Mutual Fund Tax Bill?

No client likes paying taxes, especially unexpected taxes. Unfortunately, that's the situation many financial advisors and their clients are finding themselves in these days. For advisors who have clients invested in mutual funds, it's likely that clients owe—or will soon owe—capital gains taxes on their investments, even if they haven't sold a single share. To add insult to injury, clients are receiving tax bills even as the vast majority of mutual funds have underperformed in the past year.

Fortunately, there are ways that advisors can help minimize a client's future tax bills. Tax-deferred solutions, such as investment-oriented variable annuities, may lessen a client's tax burden and allow investment gains to potentially generate a larger retirement nest egg.

Unexpected Tax Liabilities

Mutual funds haven't been a source of good news for most investors lately. In 2014, 79% of U.S. stock funds failed to beat their market benchmarks for the year, compared with the average of 59% over the past 25 years. Despite that underperformance, many mutual funds made distributions to shareholders last year. In fact, mutual funds distributed $239 billion in 2013—more than any year since 2008—with more than one-third ($83 billion) of those distributions occurring in taxable household accounts.

Many of those distributions were the result of funds selling their holdings. When mutual funds sell their holdings, they're required, by tax law, to pay out any profits realized. These are distributed to shareowners as capital gains, and investors are typically liable for taxes on these gains—even if they never sold a share of the fund.

Funds may sell holdings for a variety of reasons, including the following:

- When a fund changes strategy or portfolio managers, forcing the sale of many of its holdings.
- When a fund owns the stock of a company that is taken over in a merger or acquisition.
- When a stock gets too big for a fund's investing style.
- When securities need to be liquidated in order to cash out investors who are leaving the fund.

Before 2014, gains incurred due to the sale of holdings didn't trigger tax bills for many investors because mutual funds were able to offset those gains with losses. After the economic downturn and corresponding market drop in 2008, many funds accumulated several years' worth of severe losses to help minimize or eliminate capital gains for shareholders. However, after six years of a bull market, most funds have no major losses left.

To make matters worse, stocks have been on a good run lately. This has triggered a mass exodus of investors from many funds, forcing fund managers to sell more holdings at a gain.

For those higher-earning clients, advisors may want to consider alternate tax-deferral solutions, like variable annuities, that may help clients avoid current taxes on mutual fund gains and keep more of their investment returns.

Help Your Clients Control Taxes

While 2014 distributions have already hit clients in the pocketbook, the uncertainty around 2015 means advisors need to explore ways to help clients regain control of their taxes moving forward. Qualified accounts, such as 401(k)s and IRAs, provide more control over the timing of taxation than taxable accounts. However, it's likely that advisors have a number of clients who fund their qualified accounts annually to the maximum allowed levels. As a result, they are forced to hold mutual funds in taxable accounts. It's these clients who likely felt the biggest tax bite from fund distributions in 2014.

For those higher-earning clients, advisors may want to consider alternate tax-deferral solutions, like variable annuities, that may help clients avoid current taxes on mutual fund gains and keep more of their investment returns.

Placing assets that are likely to generate significant distributions in future years into a tax-deferred account means those distributions can grow in the account until the time of withdrawal. With tax-deferral, instead of taking an unexpected tax hit at a potentially inopportune time, clients will be able to continuously reinvest the amounts they would have used to pay taxes, allowing for compound growth over time that can help create optimal retirement outcomes for clients.

The Power of Tax-Deferral

Investment-oriented variable annuities (IOVAs) are next-generation variable annuities that provide advisors with a powerful investment vehicle well suited for today's increased tax environment. IOVAs typically have lower basic annuity expenses, no surrender fees and more investment options.

Clients can invest in hundreds of underlying funds through these IOVAs, including domestic and international equities, a variety of traditionally tax-inefficient fixed income categories and alternative asset classes. Additionally, exchanges among subaccounts are low cost or free, making broad diversification and tactical trading possible, all without triggering current tax obligations, as long as the original investment and any gains remain in the annuity.

Advisors who help clients manage the timing of their taxes, may be able to help give their clients a greater chance of achieving the retirement of their dreams. ❑

Al Dal Porto is vice president of Product Development and Market Research with Security Benefit Corporation (Security Benefit). Mr. Dal Porto is responsible for the design of annuity and mutual fund-based products distributed through independent channels including Education Market, Retirement Plans and Financial Institutions. He is also responsible for the firm's primary and secondary market research departments. Mr. Dal Porto earned his bachelor's degree in Actuarial Science from the University of Illinois at Urbana-Champaign, where he graduated with honors. He is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. He holds a FINRA Series 6 and a Series 26 license.

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AGA	www.appliedga.com/ (213) 353-4742	25
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CALIFORNIA*CHOICE*	www.calchoice.com 800-542-4218	3
CALIFORNIA DENTAL	https://www.caldental.net (949) 830-1600	11
CALLAHAN & BLAINE	www.callahan-law.com 714-241-4444	29
COVERED CALIFORNIA	www.CoveredCA.com 877-453-9198	7
DI&LTC	diandltc.com/ diandltc.com/	16
DICKERSON EMPLOYEE BENEFITS	www.TheBrokersGA.com 800-457-6116	21
HEALTHCARE REFORM CERTIFICATION	www.healthcarereformcertification.com 561-790-1176	31
INLAND EMPIRE ASSOC. of HEALTH UNDERWRITERS	https://guestlistapp.com/events/306534	23
LAAHU UNIVERSITY DAYS	https://www.laahu.org/ 1-800-676-1628	17
PETERSEN INTERNATIONAL UNDERWRITERS	www.piu.org 800-345-8816 818-788-1904	15
ROGERS BENEFIT GROUP	www.rogersbenefit.com 877-724-4671 (San Jose) 916-960-0400 (Sacramento) 800-872-0459 (San Diego) 877-654-3050 (Los Angeles)	47
UNITEDHEALTHCARE	uhctogether.com/casb (714) 226-7798	2
WARNER PACIFIC	www.warnerpacific.com 800-801-2300	5
WORD & BROWN	www.wordandbrown.com 800-255-9673 (Northern CA) 800-560-5614 (Los Angeles) 877-225-0988 (Inland Empire) 800-869-6989 (Orange) 800-397-3381 (San Diego)	48

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