

CALIFORNIA BROKER

VOLUME 34, NUMBER 2

SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

NOVEMBER 2015

**KEEPING YOUR CLIENTS' NEST EGG
FROM GETTING SCRAMBLED WITH**

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

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

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

The publishers of this magazine do not assume responsibility for statements made by their advertisers or contributors. Printed and mailed by Southwest Offset Printing, Gardena, CA.

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Be Careful

ABOUT REPLACING OBAMACARE

by **MARILYN M. SINGLETON, M.D., J.D.**



Since the day the Affordable Care Act (ACA) was enacted, we have been subjected to the repeal and replace mantra. Replacement offerings are slimmed

down versions of the ACA. A few brave souls have proposed a straightforward repeal. Of course, such bills were merely making political hay since Obama would never sign away his namesake law.

Several GOP presidential candidates have doubled down on the misguided repeal and replace promise, including the yet-to-be-elucidated Donaldcare. But the real question is whether the ACA should be replaced at all.

Any healthcare system—new or old—is subject to the long arm of the federal government. Central control does not have a good track record for creative solutions, security, fraud control, administrative efficiency, or the ability to change personal habits.

The federal government has yet to figure out a way to comply with HIPAA's 20-year-old mandate to remove Social Security numbers from health insurance cards. The mere possession of a Medicare card poses the risk of identity theft in our most vulnerable population.

And speaking of identity security, a core tool of the healthcare system is the electronic health record. Health providers who see Medicare or Medicaid patients must have meaningful use of electronic records in their offices or face monetary penalties. However, using wireless networks for sensitive information requires sophisticated security measures that most physician offices do not have. Even with the highest-level resources at its disposal, the federal government has failed to secure its own records.

The Health and Human Services (HHS) Office for Civil Rights reported 32 health data hacking incidents in 2015. Millions of people now have their medical information, Social Security numbers, and other personal identifying data compromised. According to a House Energy and Commerce Committee investigation, the HHS Inspector General reported that over the past seven years, HHS had pervasive and persistent deficiencies across its information security programs.

Fraud and administrative errors plague the Medicare program. According to the federal Office of Management and Budget, its fiscal year 2014, high-error programs produced approximately \$125 billion in improper payments, i.e., those that violated guidelines or rules in some way. Medicare fee-for-Service, alone, had \$45 billion in improper payments or 12.7% of the total. Fraud, lack of documentation, and medical necessity authentication issues are the main culprits.

Even as the Department of Justice touts its improved record of Medicare fraud convictions, the ACA's federal Health Insurance Marketplace had an epic failure on the fraud front. The Government Accountability Office performed 18 undercover tests. During these tests, the Marketplace approved subsidized ACA coverage for 11 of the 12 fictitious GAO telephone or online applicants for 2014.

The Veterans Administration clinic debacle is a prime example of federal administrative inefficiency. The Office of Inspector General concluded that enrollment program data were generally unreliable for monitoring, reporting on the status of health care enrollments, and making decisions about processing timeliness. As of September 30, 2014, the system had some 867,000 pending records, 307,000 of which were for individuals reported as deceased by the Social Security Administration.

Finally, government attempts to mandate healthy behavior don't work. For example, a 2015 scientific study analyzed the Los Angeles Fast-Food Ban, a 2008 zoning regulation restricting the opening and remodeling of standalone fast-food restaurants in South Los Angeles. Consumption of fast food and obesity increased in all geographic areas from 2007 to 2012, and the increase was significantly greater in the regulated area.

Politicians need a system to expand central control. Central control breeds mediocrity. Government programs play to the lowest common denominator. One size fits all quickly becomes one size fits none. Call me crazy, but I want the second opinion about my treatment to come from a physician, not a bureaucrat.

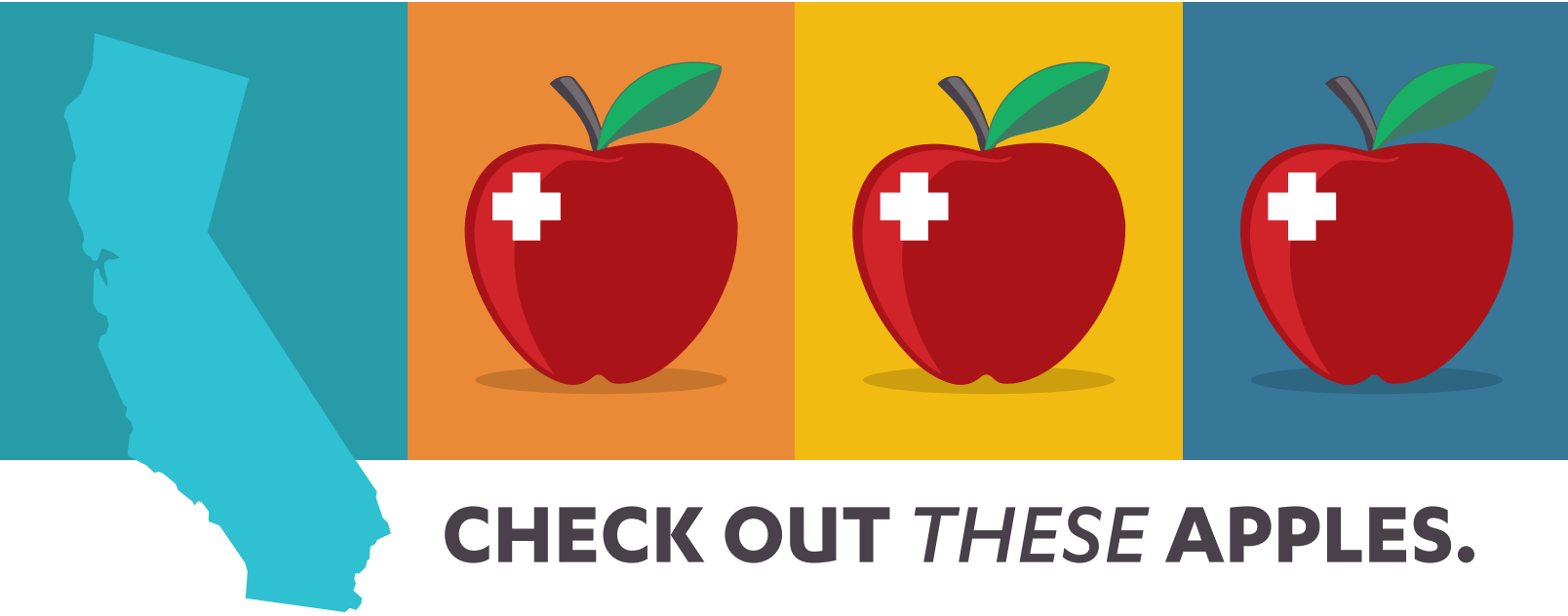
As Malcolm Gladwell of *Tipping Point* fame opined, "Rather than expanding insurance we should keep insurance in its proper role for unexpected, big-ticket things. And the bottom end of healthcare should be a market-driven cash economy."

Competition brings out the best in us. For example, Theranos, a company started by a Stanford freshman, provides 14 accurate basic kidney/liver function tests from one drop of blood for \$7.27 at Walgreens. In contrast, my insurance co-pay for lab tests is \$40.

Politicians can't fix our medical care access problems. That's up to us. As a start, consider enlisting direct pay physicians who give personal care at reasonable prices and replace the ACA with your own healthcare system. ★

Marilyn M. Singleton, MD, JD is a board-certified anesthesiologist and Board member of the Association of American Physicians and Surgeons. Dr. Singleton runs a wellness clinic in association with her county food bank and is in Oakland's Medical Reserve Corps. Along with delivering medical and educational supplies, she started two make-shift medical clinics in two rural villages in El Salvador.

COMPARING APPLES TO APPLES?



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American Equity	A-	BBB+ A-	ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.55%*	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	2.75%*	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	3.00%*	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 9/24/15. 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 Solutions MYG	S	2.20%** 2.35%** ^b	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000 (Q&NQ)	1.5% age 0-75 .75% age 76-85
*CA Rates Effective 10/12/15. First year rate includes 1.50% interest bonus. a (less than \$100K ; b (100K or more)											
American General Life Insurance Companies	A	A+	A+ American Pathway Fixed 5 Annuity	S	2.00%** 2.20%** ^b	5 yr.	None	9%, 8%, 7%, 6%, 5%, 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.00% age 0-85 1.00% age 86-90
*CA Rates Effective 10/12/15. Includes 2.00% 1st year bonus, 1.00% base rate subsequent years. a (less than \$100K) b(100K or more)											
American General Life Insurance Companies	A	A+	A+ American Pathway Fixed 7 Annuity	S	2.35%** 2.55%** ^b	5 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ)	3.00% age 0-85 1.50% age 86-90
*CA Rates Effective 8/6/15. First year rate includes 4.0% bonus 1 st year. a (less than \$100K) b(100K or more)											
American General Life Insurance Companies	A	A+	A+ American Pathway Flex Fixed 8 Annuity (Q/NQ)	F	4.15%* *(includes a 2% interest rate bonus for first year)	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 10/12/15											
Genworth Life & Annuity Insurance Co.	A	A-	A- SecureLiving Rate Saver	S	2.80%* 2.65%	7 yrs. 5 yrs.	None None	9%, 8, 7, 6, 5, 4, 3 9%, 8, 7, 6, 5, 0	Yes	\$25,000 (NQ)	Varies 0-85 *Effective 8/19/15. Based on \$250K or more.
Great American Life	A	A+	A+ SecureGain 5 (Q/NQ)	S	2.40%	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 6/8/15. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.40%. For under \$100,000 first-year rate is 2.25%. Escalating rate five-year yield 2.25%.											
Great American Life	A	A+	A+ SecureGain 7 (Q/NQ)	S	2.65%	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 6/8/15.. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.54%. For under \$100,000 first-year rate is 2.55%. Escalating rate seven-year yield 2.44%.											
Great American Life	A	A+	A+ Secure American (Q/NQ)	S	1.75%*	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 6/8/15.. Eff. yield is 2.77% based on 1.75% 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 1.75%. Surrender value interest rate 1.75%. Accepts additional purchase payments in first three contract years. COM12255											
The Lincoln Insurance Company	A+	AA	AA MYGuarantee Plus 5	S	1.75%*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	**Rates Effective 10/1/15 for premium less than \$100,000 and are subject to change
The Lincoln Insurance Company	A+	AA	AA MYGuarantee Plus 7	S	2.15%*	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	**Rates Effective 10/1/15 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 9/29/15 and is subject to change.											
Reliance Standard	A+	A+	A+ Eleos-MVA	S	3.50%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 7/28/15. 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+	A+ Apollo MVA (Q/NQ)	S	4.45%*	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 7/28/15											
Symetra Life, Inc.	A	A+	A Custom 7 (Q/NQ)	S	3.05%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 10/8/15. 2.55% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.											

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A GREAT *Smile* IS GOOD FOR BUSINESS



Brokers need to understand the different types of dental plans to determine the best option for their California small business clients. Like health insurance plans, dental plans are usually categorized as indemnity or managed care plans (Dental PPO plans fit in this latter category). The major differences concern choice of dental care providers, out-of-pocket costs, and how bills are paid. Typically, indemnity plans offer a broader selection of dental care providers than do managed care plans. Indemnity plans pay their share of the costs for covered services only after they receive a bill. Patients may have to pay up front and then get reimbursement from the insurance company.

Managed-care plans typically maintain dental provider networks. Dentists who participate in a network agree to perform services for patients at pre-negotiated rates and usually submit the claim to the dental insurance company directly. In general, patients have less paperwork and lower out-of-pocket costs with a managed-care dental plan and a broader choice of dentists with an indemnity plan.

ARGUMENTS FOR A DENTAL PLAN

Offering a dental plan makes economic sense. A quality dental plan can aid in employee recruitment and retention. Employers are finding that offering a voluntary plan allows them to retain this prized benefit amid rising costs and shrinking budgets. As a voluntary benefit, employees usually bear most, if not all, of the cost of dental insurance.

Dental disease or discomfort is a frequently overlooked reason for employee absences and poor performance. As every human resources professional knows, days lost can mean money lost.

At the same time, more employers are recognizing that good oral hygiene can reduce medical spending. Many illnesses manifest first in the mouth. Dentists may be the first to detect them, potentially lowering disability and medical costs. Cardiovascular disease, diabetes, and pre-term or low-weight births have been linked to chronic bacterial infections in the mouth.

The need for dental benefits is clear. According to the American Dental Assn., three economic forces have reduced dental coverage among U.S. families. Even though the unemployment rate has gone down, fewer employers are providing paid dental benefits. Employers have reduced the scope of coverage or increased the amount workers pay for third-party private benefits, according to research by the Kaiser Family Foundation.

Today, most employees share in the cost of their dental benefits, but few can choose among coverage levels. According to MetLife research, 84% of employees pay the entire cost of their coverage or share in the cost. Only 17% have a choice of plans. Sixty-seven percent of employees who have choices say they want more choices in cost and coverage. When employees understand their benefits, they are willing to pay more for more appropriate coverage.

While there is no grocery store for employee benefit plans, the concept remains the same: the most important part of the decision process is to check the label. Although the Covered California exchange may soon be an option for a few dental plans, there still needs to be more review before buying a plan.

by **MARK ROBERTS**



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But many brokers and employers are tempted to simply compare prices and do a basic review of each plan's packaging (deductible, annual maximum, coverage, and programs) without drilling down into the plan ingredients. But, when it comes to dental plans, one size does not fit all. Though it's not always obvious, these ingredients can differ dramatically from plan to plan and have a major effect on the value of the plan to employers and their employees.

Another way to help their employees manage their oral health is to offer a dental health reimbursement account (HRA) that is funded by the employer. A limited use HRA can be tied to a debit card and administered by a company that offers this plan administration. It 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 for dental procedures. Most importantly, all employer contributions to the plan are 100% tax deductible to the employer, and tax-free to the employee. The card can be tied to in-network and out-of-network benefits, and employees can see more savings by using a PPO dental network. Everyone wins.

Here are some key questions that brokers and human resource managers should consider when sourcing a dental plan for employees:

- Can employees choose their own dentists?
- 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 about orthodontia for children and adults?
- 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?
- 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?

A discount plan is the least costly way to go for extreme savings on dental expenses. It's typically 10% of the cost of traditional dental insurance. Also, there is unlimited use, no waiting, no forms to complete for reimbursement, and no claims to process. Employees go to a participating dentist and pay a significantly reduced price at the time of service.

After the pay scale, employees' next most important consideration is benefits. One great option is a discount dental plan that reduces costs significantly for the employer and employees. As a baked in benefit, the cost can be very affordable, often for just a nominal amount for the plan. Or, you can offer it to employees as a secondary or dual option along with a low cost dental insurance plan.

Although there is no coordination of benefits, employees can use a discount plan for savings on uncovered procedures, such as adult orthodontia, cosmetic work and implants, and other elective dental care. Also, after the annual maximum is reached on the insurance plan, employees can use the discount dental plan for additional dental procedures, such as extra cleanings and other special needs that develop.

A voluntary dental discount plan is not much more expensive and can often be only 10% of the cost of traditional dental insurance. The employer can get a huge savings on the cost for the plan and for the reimbursement. The employee can use a discount plan without many of the restrictions often seen in dental insurance.

Dental benefits are on the rise, and employers need help figuring out what their options are for this type of product. The open enrollment season is upon you. Hopefully, you've done your homework to consider the multiple options now available in the market place. A great smile is good for business. ★

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



THE CORPORATE HEALTH CENTER: A COST-SAVING OPTION

FOR YOUR SELF-INSURED CLIENTS

by DAVID ZANZE

I encourage you to include one more option when looking at cost-saving benefits to present to your self-insured clients: the corporate health center. The on-site or near-site corporate health center (work-site clinic) is becoming more popular, especially since the rollout of the Affordable Care Act (ACA). Employers seem to be more open to creative ways to save on health care costs. Here are three reasons why corporate health centers deserve a seat at the benefit design table:

1. A CORPORATE HEALTH CENTER IS MORE THAN AN EMPLOYEE PERK

Some client may have a preconceived notion that implementing an onsite or near-site corporate health center is only about providing convenience and enhancing fringe benefits and that it couldn't possibly make a dent in rising health care costs. There is plenty of proof to show otherwise. While the timing of results may differ from client to client, there continues to be more evidence demonstrating that corporate health centers are making a difference financially for companies of all sizes.

An August 2015 online article for Fast Company reveals that onsite corporate health centers are gaining particular traction among local governments and

school districts. The main reason is that many self-fund their health plans, so when they reduce the cost of providing health care to employees, it affects their bottom line directly.

The Hampton City School District recently implemented a near-site employee health and wellness center in 2014. School officials said their reason for implementing a corporate health center was to offer an employee benefit that provided quality and affordable health care while helping the district save money. After renovating a nearby office building for \$100,000, they opened the center to all full-time and job-share employees including dependents six years and older.

According to the Hampton Daily Press, the district staff reported to the board that the center saved the district nearly \$74,000 in the first two weeks of opening. That amount included the typical costs of visits to the emergency room and primary or urgent care centers that were avoided during a two-week period. Hampton School District officials expect the center to save the school district \$2.5 million in health care costs over the next three years.

More and more employers are taking a fresh look at implementing a corporate health center, especially when they

can see the correlation between their employees' poor health and higher health costs (see reason #3). Corporate health centers can help in today's marketplace where there is a shortage of family practice medical doctors, which is causing a lack of timely access to care. Without enough primary care providers, employees do not have a medical professional who is able to monitor their health on a regular basis, dispense proper medication, and take care of those with chronic health conditions. This all adds up to higher medical costs charged to the self-funded employer.

2. NOT YESTERDAY'S ONSITE HEALTH CLINICS

The second reason that corporate health centers are getting more attention is that they continue to evolve. They may have started out as occupational clinics that treated only workplace injuries, but today's corporate health centers offer so much more. One big difference is that, instead of treating one problem area, they play a greater role in the health of employees, and offer a variety of services. Employees can now save time completing health-related tasks, such as filling prescriptions and getting annual screenings, lab tests, and flu shots.



Many centers offer convenient hours before and after work and on Saturday mornings. Some organizations also offer personal health coaching and chronic condition education. Others offer telemedicine, and they coordinate visits from other health professionals including chiropractors, dieticians, and physical therapists.

The biggest shift from the clinics of before is the focus on health promotion, wellness, and a variety of primary care services. Provisions of the ACA have encouraged employers to offer wellness programs. By implementing an onsite or near-site center, an employer can meet the demands of having a wellness program while saving on employees' primary healthcare costs.

3. MORE INCREASED FOCUS ON EMPLOYEE WELL BEING

Improving employees' health care has several other benefits. This includes increased employee job satisfaction, retention, and higher productivity, which saves money in other areas of the budget.

The economy loses approximately \$232 billion from medical treatment and pharmacy-related costs each year, according

to a landmark study of 60,000 U.S. employers conducted by the Integrated Business Institute. In addition, employers lose \$117 billion from absences due to illness, workers compensation, and short- and long-term disability.

Another costly expense is the treatment (or lack thereof) of chronic health conditions like diabetes or obesity. Diabetes costs the U.S. economy approximately \$245 billion each year. According to the American Diabetes Assn., direct medical costs are at \$176 billion. A person with diabetes has more than double the average medical costs of someone who doesn't have it.

Employers who implement corporate health centers are better able to manage employees with chronic conditions, ensuring that they see a doctor on a regular basis. A doctor can monitor the employee medications and compliance. It can make a real difference if a corporate health center can educate and encourage employees to incorporate healthy habits. In the Surgeon General's National Prevention Strategy, it was reported that people who increased their physical activity by just two and half hours a week lost

5% to 7% of their weight. (That's less than 10 pounds for a 150-pound person). They were able to reduce their risk of type 2 diabetes by 58%.

Just think of all the ways an employee can be healthier by having easier and more affordable access to a corporate health center. The benefits include going to the emergency room less often, receiving earlier treatment for illness and injuries, and reducing the number of absences due to illness. Studies also show that employee loyalty improves for companies that offer a wellness program and/or a corporate health center, which can attract talent and increase retention. These benefits translate into real savings for your cost-conscious clients. And who isn't cost conscious these days. ★

David Zanze has over 30 years of experience as a leader and innovator in the health care industry. He is the president of Pinnacle Claims Management, Inc., an all-inclusive third party administrator (TPA) and Pinnacle Rx Solutions, a pharmacy benefit manager. Both companies offer competitive, cost-efficient benefits administration and claims processing in sync with the latest technology in the self-funded market place. Visit pinnacletpa.com or call 866-930-7264 for more information.



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PLAN SPONSORS OF EVERY SIZE

Switching to Self-Insurance

by MICHAEL JORDAN

Self-insurance is typically the go-to cost-control strategy for large plan sponsors. But it is finally making inroads with small to mid-size plan sponsors who recognize the opportunity to contain the rampant costs of health coverage.

While some business leaders still view self-insurance as a financial risk, the number of skeptics is diminishing. When implemented correctly, self-insurance can provide significant cost savings to the plan sponsor and maximum control over the plan design. Access to utilization data can provide a clear picture of a workforce's health behavior. In comparison, fully insured health plans leave plan sponsors in the dark about these issues, which prevents them from influencing healthcare costs. When combined with programs to encourage healthy behaviors, self-insurance can be a win-win for plan sponsors and members.

The value of the broker increases as the client moves from being a passive insurance purchaser to shaping a benefit program around its population. Brokers can communicate the many advantages of self-insurance, help mitigate or avoid risks, and play a role in the transition.

WHAT ARE THE ADVANTAGES OF SELF-INSURANCE?

With self-insurance, plan sponsors pay for individual health claims out of cash flow rather than as a monthly fixed premium to a health insurance carrier. Self-insurance also offers more flexibility than does commercial insurance while providing these practical and economic advantages to curb costs:

- Help plan sponsors tailor plans to the health needs of a workforce, especially if guided by the right healthcare services company.
- Generate as much as 3% in immediate savings since state premium taxes are eliminated on most self-insured plans.
- Eliminate carrier profit margins and risk charges.

Self-insured plans fall under federal ERISA law, so they are not subject to state health insurance regulations and costly benefit mandates. Self-insured plans are exempt from a significant number of health care reform provisions, most notably the health insurance provider's fee or HIT tax, which some industry observers have estimated to add 2% to 7% to the cost.

Plan sponsors can fully optimize their self-insured plans by seeking strategies that increase efficiency and improve clinical effectiveness. One innovative strategy is to use high-performance networks, also known as "narrow networks."

High-performance networks are comprised of carefully selected healthcare providers and health professional orga-

nizations that are recruited to serve a defined patient population. These networks are designed to raise the level of care and make healthcare more affordable. Despite some people referring to them as narrow, the concept should not be perceived as simply resulting in more limited choice to members. This model relies on a careful review of provider data. Only providers who deliver quality care while keeping costs down are selected for this kind of high-performance network. Any apparent limiting is very deliberate and is meant as an improvement to the network.

Support for self-insurance has grown because it can be tailored to plan sponsors. Also, it offers transparency to ensure that the plan is managed effectively. Just as important, self-insurance helps control healthcare costs, leaving more resources for investing in job creation.

STOP LOSS INSURANCE OFFERS FINANCIAL SECURITY

Adding stop-loss insurance provides an added level of financial security, which is especially important for smaller businesses. There are two types of stop-loss insurance: specific and aggregate.

Specific stop-loss protects against a catastrophic loss incurred by any individual covered by the plan, with the deductible set at a level that is appropriate for the company's size and financial strength. Under this form of stop-loss insurance, a plan sponsor pays a fixed premium each month and is liable for an individual's claim payments of up to a chosen deductible. The stop-loss carrier covers amounts in excess of that. Some stop-loss contracts don't require the plan sponsor to fund the claim and wait for reimbursement; instead, the administrator pays the claim directly from the carrier's account.

Aggregate stop-loss protects against excessive claim expenditures for the entire plan. Through actuarial studies, stop-loss underwriters can estimate smaller, predictable claims. However, since these projections are based on large, industry-wide samples, they are subject to variations and fluctuations.

With either type of stop-loss insurance, it is important to remember that risk mitigation is most effective when coordinated by an experienced health plan management firm.

HOW CAN PLAN SPONSORS MAKE THE SWITCH TO SELF-INSURANCE?

To get started, plan sponsors can enlist a healthcare services company to oversee the self-insured plan and assume responsibility for the following:

- Maintaining eligibility.
- Providing customer service.
- Adjudicating and paying claims.
- Preparing claim reports.

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- Negotiating, obtaining, and renewing stop-loss placement.
- Conducting enrollment information meetings.
- Arranging managed care services, such as access to preferred provider networks and coverage for alternative treatment programs (including acupuncture and chiropractic services); offering cost-saving prescription drug card programs; and offering utilization review.

It's important to find a healthcare services company that offers secure data analytics for remote and real-time care. The company should also provide an inexpensive vehicle for coordinating online tools that identify at-risk members as well as their patterns and treatments for various ailments—from diabetes to heart conditions. Robust data analytics allow self-insured plan sponsors to evaluate member information including age, chronic illness, risk factors, and gaps in care. They can also update medical conditions, compare previous costs to projected expenditures, and intervene with optimal prevention and programs to help members manage costly chronic health conditions.

Some plans can be designed exclusively around chronic health conditions and include educational materials, one-on-one counseling, transportation to a hospital or doctor's office, and assistance in coordinating care among providers/physicians. Health claims and other medical data are used to identify members with chronic conditions and provide the tools and support they need to manage their health.

While plan sponsors assume the direct risk of payment of claims, costs are based on actual plan member health-care use. When combined with stop-loss, self-insurance has emerged as a cost-efficient way for plan sponsors to continue offering coverage, provide greater health and well-being to members, and improve the bottom line.

Taking the advantages of self-insurance one step further, brokers can suggest that plan sponsors streamline access to care with customizable care plans based on an individual's risk profile and needs. Targeting health issues rather than simply implementing a general health and wellness program is critical for long-term sustainability.

By partnering with healthcare service companies and provider groups, plan sponsors can take advantage of deep discounts and give members greater access to coordinated care. Healthcare data analytics plays an important role in this model, providing information relevant to population health management, such as determining the chances of a relapse, the likelihood of noncompliance, and the progression of a chronic disease.

Given its many advantages over commercial insurance plans, self-insurance is a no-brainer in today's complex healthcare environment. Costs are based on actual plan member healthcare use, which makes self-insured plans more cost-efficient and effective than commercial plans. This is especially true when stop-loss coverage covers catastrophic claims. ★

Michael Jordan is president of Labor and Strategic Accounts at MagnaCare, an administrator of self-insured health plans for employers in New York and New Jersey.

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2015 PPO SURVEY

PART 2

WELCOME TO OUR 15th ANNUAL PPO SURVEY

5. DESCRIBE YOUR DRUG FORMULARY. IF IT'S A CLOSED FORMULARY, WHAT HAPPENS IF A NON-FORMULARY DRUG IS NEEDED?

Aetna: The formulary may be open or closed, depending on the benefit plan. In plans with an open formulary, both formulary and non-formulary drugs are generally covered subject to applicable limitations and conditions. With a closed formulary, formulary and non-formulary drugs are generally covered, except for drugs on the formulary exclusions list. Formulary exclusions provide less overall value than do therapeutically equivalent formulary drugs. The member's physician can request approval for coverage for a formulary exclusion.

Blue Shield: A Blue Shield formulary drug list is a list of medications that are approved by the Food and Drug Administration (FDA) and are eligible for coverage under the Blue Shield outpatient prescription drug benefit. Blue Shield has a number of different formulary drug lists, which apply to various lines of business or markets. All Blue Shield formulary drug lists are developed, maintained, and updated regularly by the Blue Shield Pharmacy and Therapeutics Committee, which meets on a quarterly basis. The committee consists of independently licensed physicians and pharmacists, who are expert consultants, not employed by Blue Shield, and include specialists in various fields. Formulary drug lists promote appropriate first-line therapy and reserve the use of certain medications with specialized uses or significant potential for misuse or overuse through the application of limits, such as prior authorization. Drugs are listed by tiers. A member's outpatient prescription drug benefit describes cost-sharing based on tiers and other conditions, and whether a formulary exception is required for coverage of drugs that are not on the drug list.

For members whose benefit requires a formulary exception to cover drugs that are not on the formulary drug list, coverage is determined based on medical necessity and use of other drugs on the formulary that are similar in safety and effectiveness. The member's evidence of coverage booklet or summary of benefits provides information about the cost-share when coverage is approved on exception.

Health Net: The Health net recommended drug list (formulary) is composed of the following:

- Tier 1: Most generics
- Tier 2: Recommended brands
- Tier 3: Non-recommended brands and some generics

The PPO formulary is not a closed formulary.

Kaiser Permanente: The PPO plan has an open formulary, which means that most FDA-approved drugs are covered for the insured, with the exception of those on the optional prescription drug exclusions and limitations list. The insured pays a copay based on whether the drug is generic or brand. Self-injectable drugs are also covered at a coinsurance.

UnitedHealthcare: We assign prescription medications a co-payment tier based on an evaluation of clinical, economic, and pharmacoeconomic evidence. Unlike our competitors, some brand drugs are placed in Tier 1 and some generic drugs are placed in Tier 2 or Tier 3 based on the overall value (for example, the lowest net cost that they offer our clients). UnitedHealth Pharmaceutical Solutions offers a three-tier plan and an open benefit design. Tier 1 drugs represent the lowest co-payment option and include many generic drugs. Tier 2 drugs represent a middle co-payment option and include many brand name drugs. Tier 3 drugs represent the most costly drugs, often with Tier 1 or Tier 2 alternatives, and have the highest co-pay option. A drug's tier placement is subject to change when its value changes as a result of a patent expiration, new product introduction, or other important clinical, safety, or economic information. When a generic drug is more costly than the brand drug, UHPS may place the generic in Tier 2 and move the generic to Tier 1 once the price decreases.

6. WHICH REQUESTED PROCEDURES ARE DENIED MOST FREQUENTLY ON THE BASIS OF "EXPERIMENTAL/INVESTIGATIVE" OR "NOT MEDICALLY NECESSARY" EXCLUSIONS?

Aetna: We seek to minimize the number of claims denied based on medical necessity through our extensive patient

management program, which includes features such as pre-certification, concurrent review, and close communication among our staff and attending physicians.

Kaiser Permanente: Requests are reviewed and approvals are given on a case-by-case basis.

UnitedHealthcare: UnitedHealthcare does not deny procedures on the basis of medical necessity, and our benefit plans do not contain medical necessity exclusions. We believe that healthcare consumers and their doctors are best qualified to make decisions about healthcare. Denials on the basis of experimental or investigative are very rare. If an individual has a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment), we may determine that an experimental, investigational, or unproven service meets the definition of a covered health service for the sickness or condition. This determination is based on whether we find the procedure or treatment to be promising and that we find that the service uses research protocol that meets standards equivalent to those defined by the National Institutes of Health.

7. WHAT HAPPENS WHEN A MEMBER PROVIDER BILLS A PARTICIPANT INAPPROPRIATELY FOR SERVICES?

Aetna: Balance billing of the patient is not permitted. The provider-relations staff monitors compliance and educates providers. A provider who is found to have inappropriate balance billing may have their contract terminated, in some cases.

Health Net: Health Net will intervene on the member's behalf by working directly with the provider's office.

Kaiser Permanente: In the unfortunate event that a provider bills an insured inappropriately, the insured should contact Kaiser Permanente Insurance Company (KPIC) customer service. If the issue requires any type of special handling, KPIC Operations staff will intervene and assist in reconciling the claim on the insured's behalf.

UnitedHealthcare: Our physician and other healthcare professional contracts preclude physicians and other healthcare professionals from balance billing enrollees. The contracts also address how physicians and other healthcare professionals must submit claims. We take appropriate action if network physicians or other healthcare professionals attempt to balance bill enrollees or to bill enrollees for covered services in breach of their contract requirements. We protect our customers from claims liability by fulfilling all state mandates concerning participating in guaranty associations, maintaining state contingency reserve requirements, or obtaining reinsurance agreements. If a network physician or other healthcare professional becomes insolvent or otherwise unable to continue to render healthcare services to individuals, we help reassign individuals enrolled in our plans to other physicians.

8. WHAT IS THE PLAN OR PPO DOING TO HAVE ONLINE SYSTEMS FOR ELIGIBILITY, ADMINISTRATIVE CHANGES, REFERRALS, ETC.?

Aetna: EZLink streamlines several benefits and HR functions. It links to our enrollment and billing systems and provides real-time eligibility; online enrollment, account maintenance, online billing, and electronic-funds transfer for payment.

Health Net: Health Net's website, www.healthnet.com, is a secure website that requires a personalized identification number (PIN). Members, employers, providers, and brokers can perform a wide range of online administrative functions. Members in an active or COBRA program can view or modify their enrollment information. Providers can verify eligibility, find specialists for referrals, and submit or check claim status. Health Net also offers online billing and payment for members, brokers, and employers, including 24-hour account access to process enrollment and maintain member eligibility. Users can view, print, and pay billing. Enhancements for our sites are ongoing.

Kaiser Permanente: Kaiser Permanente offers online billing and administration functions to its employer groups through a system called Online Account Services. Employers can pay their premiums, make administrative changes, and view their accounts.

UnitedHealthcare: Members, physicians, and employers have access to their data and the capability to communicate directly with us online. Our consumer Internet solution, myuhc.com, allows people to do the following:

- Choose a plan.
- Locate network professionals.
- Access claims history and explanations of benefits (EOBs).
- Complete a health assessment and develop an action plan.
- Order ID cards and print temporary ones.
- Communicate with a nurse.
- Compare hospitals.

Healthcare professionals can do the following:

- Verify patient eligibility, applicable co-payment amounts, and YTD and out-of-pocket accumulators.
- Search the notification database and complete multiple notifications in one session
- Submit claims.
- Receive payment statements and reimbursement.
- Perform online reconciliation and electronic funds transfer.
- Submit credentialing data online.
- Complete online CE programs.

The following features are available through Employer eServices:

- Receive Web-based eligibility management.
- Get simplified invoices, real-time calculations, and downloadable data.
- Do customer reporting
- Get claim status information.

9. WHAT IS THE RELATIONSHIP OF YOUR HMO PROVIDER NETWORK (IF YOU HAVE ONE) TO YOUR PPO PROVIDER NETWORK? DO HMO PROVIDERS HAVE TO PARTICIPATE IN THE PPO NETWORK? HOW BIG IS YOUR PPO NETWORK COMPARED TO YOUR HMO NETWORK?

Aetna: Standard provider contract provisions generally apply to all of our plans and products that the provider participates

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in. However, it is not mandatory for a provider to participate in all products.

Blue Shield: Blue Shield's HMO and PPO networks are separate. The HMO network is capitated based on medical group and IPA contracts throughout the state with some directly contracted networks in specific geographies. With the PPO, there are value-based allowances and contracts with individual physicians and medical groups. HMO providers do not have to participate in our PPO network, though many of them do. Blue Shield's PPO network has more than 58,000 physicians (defined by access points) and 380 hospitals, and our HMO network has more than 37,000 physicians (defined by access points) and 340 hospitals.

Cigna: Cigna has a comprehensive policy for ensuring the efficacy of the latest medical treatments. We have an extensive process that includes review of outside, professional literature and input from physicians to determine the safety and efficacy of procedures and interventions. We work closely with customers and physicians to help determine treatment protocols that ensure appropriate and quality care while reducing the number of denials.

Health Net: Health Net of California has taken a multi-product approach in contracting with providers, with approximately 65%

of Health Net's PPO network practitioners also participating in the HMO network. While HMO providers are not required to participate in Health Net's PPO network, approximately 88% of them do so. Health Net of California's HMO network includes more than 49,000 primary care physicians and specialists in the California 30-county HMO service area and more than 65,500 primary care physicians and specialists in the PPO network.

Kaiser Permanente: Our PPO and HMO networks are not affiliated. KPIC contracts with PHCS Network to provide access to providers and facilities nationwide for our PPO plan members. PHCS currently has more than 658,000 providers and 4,200 acute care facilities nationally and more than 68,000 providers in California. The Kaiser HMO offers more than 9,100 providers and more than 160 facilities in California.

UnitedHealthcare: UnitedHealthcare's network includes 570,000 physicians and healthcare professionals and 4,800 hospitals nationwide. In general, UnitedHealthcare's contracts apply to all of our commercial products ensuring that employees have a consistent experience throughout the country. Providers are not required to participate in all our products, but the majority of them do. The UnitedHealthcare Select or Choice HMO networks apply locally and are subject to state laws. ★

How to Achieve Personal & Professional Balance

A JOURNEY OF SEPARATION

WELLNESS ◀

by NATHAN JAMAIL

Separating personal life and work does not eliminate the personal side of business; it actually strengthens it. The greatest achievement is when a person is doing a job they love and has a family who loves them. The goal is not to sacrifice one for the other, but to be the best at both.

As technology has revolutionized the business landscape, many professionals feel that they spend all their time working regardless of their location. At the same time, many parents are using smart phones, during normal business hours, to plan kids' events and family lunch dates. As a result, many people are doing two things at once, and doing neither very well. How often have you seen a parent spend the whole time staring at their smartphone while at lunch with their child? Or perhaps that is you?

Jobs frequently require people to work late and spend days on the road. When a job needs to get done, a true professional understands that they may have to miss a child's event or be away from home at inopportune times. To be great in business, a person must make sacrifices. Most professionals work to provide for their family, and feel that their family or personal life is the most important thing to them. Moms want to be moms, dads want to be dads, and people want to be who they are other than what their business card states.

When people don't have personal and professional separation, they feel overrun and ineffective in all things. This causes employee burnout and a difficult home life. Personal issues cause employees to be withdrawn and less effective, costing the organization and affecting other employees. If a leader is having a tough time at work and brings their pain, stress, and frustration home, they might take it out on their family, which affects their home life.

When a person is at work, they need to be at work, regardless of family dynamics or problems; they must learn to leave personal issues at home. The one thing that can make any family problem even more difficult is for an employee to lose their job because personal issues affected their performance.

If employers do not deal with a struggling employee appropriately, it may result in turnover. A strong leader must sit down with the employee—and with empathy—explain the consequences of their behaviors if they don't change. They can also explore options available to the employee, if there are any. But the key is to deal with the issue directly. Some people may find this harsh, but it is the exact opposite. The leader needs to help the employee so they can get better or give them the personal time and space to go home and resolve their issues. To allow a person to suffer and ultimately destroy their career is selfish. A leader must be clear in their expectations of their team.

Here are a few ways to stay in the present:

- Never walk in the house while talking on the phone.
- When you get home, leave your phone and your uniform or suit jacket at the door. Change out of your work clothes immediately so you feel the part.
- Make eye contact with those speaking with you whether it is your co-worker, your boss, or your three-year old.
- Share the expectations with your company team and your family.
- Be aware of your state of mind and work to change it if necessary.

Employers deserve the employee's very best, and so do their families. Here is a final thought: Be happy no matter where you are in your journey. Happiness is not a destination—it is a mindset, a journey and a choice. Happy employees make great employees and happy people, make great people. ★

Nathan Jamail, president of the Jamail Development Group, and author of the best-selling Playbook Series, is a motivational speaker, entrepreneur and corporate coach. As a former Executive Director, life insurance sales professional and business owner of several small businesses, Nathan travels the country helping individuals and employers achieve maximum success. Nathan Jamail's most recent book released by Penguin Publishers is The Leadership Playbook at NathanJamail.com.

HELPING LATINO AMERICANS REACH RETIREMENT WITH CONFIDENCE

by JOHN LUVIANO

Latino Americans represent one of the fastest growing populations in the country, and are expected to comprise 19% of the U.S. labor force by 2020. Employers have the opportunity to take a holistic view of their employee base and determine ways to better connect with Latino American plan participants and encourage them to save.

Fifty-six percent of Latino Americans agree that participating in their workplace retirement plan is the only way they have to save for retirement, according to a study by Lincoln Financial Group.

Now more than ever, employers must consider the importance of offering a workplace retirement plan, and understand how this benefit can help diverse populations in their organizations, including Latino Americans, achieve retirement readiness. There are important elements that brokers and advisors should understand as they counsel clients who provide retirement plan benefits to Latino Americans and other diverse employee populations.

RETIREMENT PLANS ARE NOT ONE SIZE FITS ALL

Latino Americans represent a tremendously diverse population with variations by age, ethnicity, and birthplace. These variations can affect the retirement plan structure and implementation, including communication vehicles and plan support. To establish trust and to structure a retirement plan that resonates with participants, it is important to recognize distinct preferences, including language, as well as values, such as family, heritage, and responsibility.

For instance, since 59% of Latino-American plan participants speak Spanish on a regular basis, English-only communication materials will miss the mark for many participants. Offer Spanish-language materials as an option to Latino-American employees who have a language preference.

A MATCH CAN MOTIVATE, BUT IT IS NOT ALWAYS ENOUGH

Plan design, especially a match strategy, significantly affects deferral rates for all subgroups, particularly Latino Americans. Thirty-four percent of employees who have an employer match say they contribute up to the maximum match, but no more. This is true for 48% of Latino Americans. To encourage participants to save more, employers can consider stretching the match, for example, by matching 50% of the first 6% deferred instead of 100% of the first 3%.

While a company match can be a strong motivator to save, it may not be enough. Among Latino Americans who participate in a workplace retirement plan, four out of five households age 25-64 have less than \$10,000 in retirement savings—a number that may seem daunting as these savers look to their retirement years. To help their retirement savings compound even more over time, encourage employees to save more as they make more and set aside any extras from a bonus, raise, or other income.

CUSTOMIZED COMMUNICATIONS WORK BEST

In-person meetings with financial professionals may help this group better understand their investment options and diversify their portfolio to achieve their savings goals. Forty-seven percent of Latino American savers say that having one-on-one or group meetings with a financial professional would motivate them to take action on their retirement plan. Personalized communication should be a central aspect of any retirement plan, especially within organizations that have a strong Latino American participant base.

Half of Latino-Americans would value plan-related seminars where they could bring family members. Plan sponsors should consider how to include family

members in the retirement conversation through information sessions, take-home materials, tailored communication, and education. Digital communications also resonate among Latino Americans. Providing digital resources to plan participants is a great way to complement a strong in-person and family-centric communication program to reach the greatest number of savers.

Understanding how diverse cultures and customs can influence the retirement planning process reveals new opportunities for brokers to engage with clients and help today's sponsors structure a more holistic retirement plan offering. Connecting with Latino American savers in a more meaningful way can motivate them to take actions that can lead to better retirement outcomes. ★

John Luviano is head of Finance and Strategy, Retirement Plan Services, Lincoln Financial Group. Lincoln Financial Group is the marketing name of Lincoln National Corporation and its affiliates.



MEDICARE OPPORTUNITY IS KNOCKING

How Will You Answer?

by COLLEEN M. GIMBEL

It is 1965, the first U.S. Combat troops arrive in Vietnam; our average annual income is \$6,450; UCLA beats Michigan to claim the NCAA Basketball Championship; *My Fair Lady* wins the Oscar for Best Picture; Ed White becomes the first American to walk in space; Medicare is signed into law; and an American's average life expectancy is 67.

Fast-forward 50 years to 2015 and you don't need me to tell you how much life has changed in America. One of the most significant changes is that an American's average life expectancy is now 78.

When Medicare was signed into law, our government only had to provide medical support to seniors for an average of two years. Today, Americans are on Medicare for an average of 13 years. You can imagine how much that costs. America spends more money than does any other country on the healthcare of a 65+ year old: over \$400 billion dollars and growing.

There are 52 million Medicare beneficiaries, and about 7,000 more are turning 65 every day. That's 200,000 people per month. It's the equivalent of two sold-out Rose Bowl stadiums turning 65 every month.

If that isn't enough to blow your mind, let's look ahead five years. In 2020, more than 13,000 people a day will turn 65, and there will be over 65 million people in America on Medicare. We're talking about 400,000 people signing up for Medicare per month. And, since this is *California Broker Magazine*, you may find this statistic interesting. The state of California has more people turning 65 each year than any other state in the country.

As an insurance agent you should be asking what your role is in the Medicare arena. There is a huge gap between what consumers know about Medicare and what they need to know. Original Medicare does not provide enough coverage, and does not include any prescription drug coverage.

Americans are living longer; but we are living sicker. That's not good news. However, there is a real push from the carriers to get Medicare eligibles on Medicare Advantage, Medicare supplements, and/or prescription drug plans, so the focus can change from reactive to preventive healthcare.

The Medicare industry needs professional ethical insurance agents to do the footwork. Most Americans do not want to pick their own health insurance plan. There is too much at stake if they choose a plan that doesn't cover all their needs. Medicare eligibles want advice from someone they can trust. That's where you come on to the scene.

Medicare plans are a must-have for many reasons, including that Americans actually want to understand their health and live healthier. No one wants to live out their elder years in a hospital bed. By adding Medicare plans to your portfolio, you provide an invaluable service to your clients and open the door to bring in more clients.



There are not nearly enough insurance agents working in the Medicare space to handle the demand that will be upon us in our very near future. The beauty of Medicare plan sales is that the industry doesn't care where you come from, what your background is, or where you live. There are no barriers to success, except if you choose not to participate.

If you are not already selling Medicare plans, do any of these reasons sound familiar? You have no time; you focus on and make more commission selling other insurance products; and you're concerned about Medicare rules and regulations. If your reason isn't listed, I guarantee that we've heard it before.

We are all in sales, so you already know that by increasing your product portfolio, you increase your bottom line. What you may not know is that many Medicare plans offer lifetime renewals. Imagine how your annual income would increase if you wrote a Medicare Advantage plan for a 65-year-old client who stayed on that plan for 13 years. That's about \$3,500 you would make on one client over a 13-year period. Now, if you only have one client, that's not a lot of money. But what if you had 100 clients? That's \$350,000. Imagine what you could do with an extra \$350,000 over the next 10 years. Are you seeing the value now?

I'm a firm believer that you cannot succeed in an industry just because there is money to be made. This industry needs advocates, not order takers. We need people who genuinely care about their clients and work hard to provide quality service. Medicare is a logical step in all of our lives. If you don't have that many Medicare eligible clients today, wait a few years and you will. We all will. Do you really want some other agent to handle your clients' healthcare?

In every corner of our country, millions of Americans will turn 65 very soon; Medicare does not offer as much coverage as most seniors need; and people don't want to make these important healthcare decisions by themselves. Combine all these factors with the demand for professional and ethical agents, and you have a homerun. The Medicare opportunity is knocking. How you answer is up to you. ★

Colleen M. Gimbel is vice president of Marketing/Recruitment/Compliance for Berwick Insurance. For more information, visit berwickinsurance.com.

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WHY A HIGH DEDUCTIBLE MEDICARE SUPPLEMENT PLAN *May Be the Best Choice for Some Clients*

by MIKE SURREANO

Which plans offer the most value to your Medicare-eligible clients? There is no shortage of choices during the Medicare annual election period from October 15 to December 7. Seniors want value, not just the cheapest plan. Ask your clients probing questions to uncover their needs and expectations, such as:

- What do you like or dislike about your current coverage?
- Are you comfortable with cost-sharing?
- Do you want to stay with your current doctor?
- Do you have chronic conditions that may affect your health in five years, 10 years, or 15 years?

There are many types of Medicare Advantage plans. Some have no monthly premiums, but include high out-of-pocket costs. In some cases, those expenses are as high as \$6,700, and you have to choose a doctor and hospital in their network.

However, a traditional Medicare supplement plan requires no network participation, covers Medicare-approved out-of-pocket medical expenses, and is guaranteed renewable as long as premiums are paid on time.

Sixty-six percent of seniors who purchased a Medicare supplement plan this year selected Medicare supplement Plan F, according to CSG Actuarial, LLC. This isn't surprising since Plan F pays the following:

- Basic benefits, the coinsurance, and deductibles for Medicare Parts A and B.

- Skilled nursing coinsurance.
- A foreign travel emergency benefit, plus 100% of excess charges.

Plan F provides real value to seniors who can afford this plan and need to see a doctor regularly.

Another option is the high deductible Plan F (HDF). After the deductible, it covers the same expenses as the traditional Plan F, but at a reduced rate. Interestingly, only 1% of Medicare sup-

plement insurance policies written this year were on the high deductible plan. The HDF plan offers these advantages:

- It addresses senior's concerns over higher premiums.
- It's a great choice for seniors who are relatively healthy and can afford to pay out-of-pocket expenses.
- It offers the same great coverage as a Plan F, after the deductible.
- Customers can use the premium savings for other needs.



Most seniors who are turning 65 and just joining Medicare have been in a cost-sharing health insurance plan. A high deductible Plan F policy is a natural transition since they are used to paying their part of medical or hospital expenses.

The HDF plan was introduced in 1999 with a \$1,500 deductible. In 2015, the deductible is \$2,180, which is an average increase of \$42.50 for 16 years. Adjustments to this calendar-year deductible are subject to the Consumer Price Index, which is generally released in October of each year.

Let's compare the average costs of the traditional Plan F and the HDF plan in California for male or female non-smokers in the San Francisco Zip code 94002 and the San Bernardino County Zip code 92301. In all cases, the cost of the traditional Plan F is 3.5 times higher than the cost of the HDF plan for the same benefits (after the deductible). Over a 12-month period, your client could save more than \$1,500 in annual premiums by purchasing an HDF plan.

Would you pay \$1,514.16 per year or more in premiums to cover a possible loss of \$2,180 (HDF deductible in 2015)? What could your customer do with those savings? Depending on their insurance needs, the customer may want to consider a modest life insurance plan or cancer or critical illness coverage. Restrictions on marketing other products with Medicare supplement apply, so be sure to follow requirements for in-home life insurance sales.

How are benefits paid? HDF plan benefits begin after out-of-pocket expenses exceed the calendar year deductible. Medicare pays its portion whether or not the policyholder meets the calendar-year deductible. Let's look at how benefits are paid under an HDF plan: Mary and her husband, John both have an HDF policy in 2015. Mary has a couple of Part A claims. In January, she spends three nights in

the hospital. The bill for Part A charges is \$20,000 with no excess charges. How does the \$20,000 get paid?

- Medicare pays \$18,740 (\$20,000 minus the Part A deductible (\$1,260)).
- Mary Pays \$1,260 (This is her Part A deductible).
- The HDF plan pays \$0 (The plan pays nothing since she hasn't reached her \$2,180 deductible).

Mary goes back in the hospital three months later for two days for the same issue. Her bill for Part A charges is \$10,000 with no excess charges. How does the \$10,000 get paid?

- Medicare pays \$8,740 (\$10,000 minus the Part A deductible (\$1,260)).
- Mary pays \$920 (She is required to pay her Part A deductible again since her hospital stay is separated by 60 days).
- The high deductible plan pays \$340 (She reached her \$2,180 deductible between the two claims, so the HDF plan pays the rest of the year).

Your role as a trusted advisor is to give seniors information so they can make informed decisions about which insurance plan provides the best value to suit their needs and budget. Ask questions, listen for the answers, and may this open enrollment period be a successful one for you. ★

Mike Surrano is assistant director for sales and recruiting for United American Insurance Company. He is based in California and also serves Arizona, Nevada, Oregon, Washington, Alaska and Hawaii. He has eight years of field experience selling insurance and has helped over 1,500 agents become contracted with United American in the last three years.

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¹2015 ProCare® Plan HDF California female, age 65, nonsmoker, Area 3. Rates vary by state and area. A calendar-year deductible of \$2,180 applies before plan benefits take effect. Other plans may be more suitable for your customers' needs. ²Limited to 6th policy year on Guaranteed Issue Medicare Advantage Replacements.



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³NAIC 2013 Medicare Supplement Insurance Experience Reports, August 2014 UAI3256B2 1115

According to CSG Actuarial, LLC, of seniors who purchased a Medicare Supplement plan this year, 66% selected a Medicare Supplement Plan F to cover their health needs.

Source: CSG Actuarial, LLC. 2015. For illustrative purposes only.

CALIFORNIA HEALTH UNDERWRITERS CONFERENCE RECAP

by LEILA MORRIS

Health plan executives who spoke at the recent CAHU conference in Los Angeles said they have been gearing up for a very challenging 2016 open enrollment season. They're doing everything from bringing in temps to handle the workload to unveiling improved electronic data interchange (EDI) systems. EDI, which allows computer-to-computer exchange of business documents "will make everyone's life easier," said Brent Hitchings, vice president of Producer Sales for Blue Shield of California.

Allen Patrick, director of Sales for United Healthcare, California Small Business Unit said, "It will be a trying two weeks in the small group segment." For the upcoming open enrollment, United has looked at "how we can make it easier to do business with us." United will feature spreadsheet enrollment and sales automation.

Marshal Myers, director of Sales & Account Management for Small Business at Kaiser Permanente said his company has stepped up efforts to educate employers on health plan changes.

Kathy Dibble, vice president of Sales and Service for Aetna Small Group California said that her company has streamlined the approval and underwriting process. "We are seeing groups approved in two days." The company has sped up its processing of renewals. She added that Aetna offers each broker a dedicated account manager by phone. An account manager is available in the field for groups of 51 to 100.

Several carriers are allowing groups to change their renewal rates to November 2016 to avoid premium increases or just get more time to make plan changes.

As for early renewal, Allen Patrick of United said, "We are early renewing to avoid rate shock." Blue Shield also offers early renewal. Hitchings of Blue Shield implored brokers to submit their groups early. "Expect delays if you submit at the end of December. "If you put them in a plan, we have mapped them so you don't have to do anything. We have presumptive renewals," he added.

Blue Shield and Kaiser were the only companies to announce broker commissions at press time. Hitchings said, "We are announcing commissions early because we want you to write business early. You need to know how you would be compensated." Scott St. Clair, chief sales officer of the Small Business Group for Health Net said that paying commissions while making the company's financials work "will be tougher as we go along."

United and Aetna executives said they would not be announcing commission rates for 30 to 45 days, which works out to be November 15 at the latest. Joe Greenberg, vice president and general manager of Small Group and Key Accounts for Anthem Blue Cross said that commissions will be a little lower on small groups and higher on large groups.

Panelists also addressed wrapping, which has been a controversial subject in the health plan market. The strategy is to buy a high-deductible employee health plan and wrap the plan with gap insurance or give workers subsidies to cover the deductibles. Proponents say that wrapping helps employees reduce climbing out-of-pocket costs while opponents say that wrapping increases unnecessary utilization. Anthem still stands against wrapping. Greenberg said simply, "We don't allow it." But other carriers are taking a "don't ask; don't tell" approach including



Aetna, Blue Shield, and Health Net. Dibble cautioned brokers to remember that those groups perform differently, which may change rates.

One of the big worries of the ACA has been that small group employers would dump their plans. Carrier executives say that it just isn't happening. Patrick of United said that some groups that dumped plans have actually come back due to the tax consequences. Greenburg of Anthem said that his company is not seeing a lot of groups leave to the SHOP. Myers of Kaiser said, "We have not seen a big dumping of groups; we have seen growth." Hitchings of Blue Shield agreed, but said that more groups may dump plans when grandmothing is no longer an option. Greenburg also expects to see some dumping in the future.

A recent report from Covered California finds that nearly half of the estimated 700,000 Californians, who dropped their Obamacare policies during the past two years, have enrolled in an employer-based plan. Forty-four percent who left Covered California got employer coverage; 16% enrolled in Medi-Cal; 15% became uninsured; 13% got private coverage outside of the exchange; and 11% enrolled in health plans from other sources.

Keynote speaker Kevin Trokey of Q4i said, "The ACA has disrupted almost everything about the way our industry operates. It has disrupted the rhythm of selling and servicing our clients. It has disrupted the way in which agencies are compensated. It has disrupted the way in which the insurance products are distributed. It has disrupted the very business models of virtually every company competing in our industry. The results to which we have become accustomed are no longer as predictable as they have been in the past."

He said that firms get bogged down in the transactional side of the business. Offering unexpected value creates raving fans. "We need technology to automate so we can offer better service. We need to offer unexpected value. We need to design business around what clients value. We have to redefine the boundary of what we do," he said.

He said that it is really important to give employees feedback. Agencies often spend too much time keeping poor performers on staff. "The behavior you tolerate is the behavior you promote," he said. At the same time, he advises agencies to praise high performers.

"You need to sit down with clients to find out what they want. If you are losing business to Zenefits, you need to focus on what you are doing." Clients need to understand that a big impersonal online company can't provide the kind of service that an agency can. "You need to partner with others. I see people running away from this industry, but you need to stand and fight," he added. ★

Leila Morris is senior editor of California Broker Magazine.

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FINANCIAL SECURITY BEGINS WITH *Workplace Benefits*

by GENE LANZONI

The Affordable Care Act (ACA) is influencing how employers fund and deliver benefit programs. Most employers feel overwhelmed by the changes brought about by the ACA. They expect a large compliance and administrative burden as well as cost increases, according to the Third Annual Guardian Workplace Benefits Study. Many hope that their brokers can help them navigate ACA requirements and understand how these requirements will affect their benefit programs. Along with looking to outsourced expertise, companies are considering new options, like self-insuring and moving to exchanges to manage employee benefit challenges as a result of the ACA.

The workplace remains king when it comes to Americans seeking financial security through insurance protection. Sixty-eight percent of employees rely on their benefits for at least half of their financial preparedness. Forty-two percent of employees rely on their workplace for all or most of their preparedness. The vast majority of employees place a high value on their benefits.

Small employers, with five to 49 employees, appear to have a strong understanding of how their employees feel about their benefits. But larger employers, especially those with 5,000 or more employees, dramatically underestimate employee satisfaction with their benefits.

Given how much workers rely on their benefits for financial security, it's not surprising that nearly two in three say their employers have a responsibility to offer insurance and retirement benefits. Those who say that their employers have a responsibility to offer benefits tend to work for larger companies with 1,000 or more employees (52% vs. 42%) and earn incomes of \$50,000 or more (75% vs. 67%). Women (79%) are also more likely than men (73%) to say that it's an employer's responsibility to offer benefits. But only 16% of employers believe strongly that they have a responsibility to ensure employees' financial preparedness. Companies with at least 100 employees (46%) are more inclined to agree than are smaller firms (29%).

MANY AMERICANS ARE STILL UNDER-INSURED AND UNPREPARED

Although Americans value their employee benefits, many are still underinsured and unprepared for future financial needs and risks. Most have access to medical insurance for themselves and their families—mainly through an employer-sponsored plan. However, many do not own other forms of insurance, including disability and life insurance, or retirement savings plans if not offered through their employer. One in three workers has no disability insurance; one in four has no life insurance; and one in five has no retirement savings plan.

More than 85 million have no dental insurance. So expanding the availability of dental coverage is crucial for workers and their families. Without it, they may neglect their dental health or pay substantial fees since rates have not been negotiated on their behalf.

It's important for companies to offer benefits, and provide easy-to-access professional guidance and decision-support that addresses employees' unique concerns to help them achieve financial security.

THE IMPORTANCE OF BENEFIT COMMUNICATIONS

Providing effective communications and educational support goes a long way toward ensuring that workers make the most of their benefits. Workers who get more help and communications from their employers appear to value their benefits more. They may be getting decision support tools, emails, live presentations, telephone support, videos, and online enrollment.

Group benefit meetings provide an excellent opportunity to detail the benefits that your client offers. These live presentations give employees a forum to ask questions and get professional guidance. They are particularly effective when benefit explanations are relevant to the generation or work status of diverse populations.

There are two styles in the way employees seek information about benefits: those who do it themselves and those who want others to do it for them.

	"Do It For Me" Employees	"Do-It-Myself" Employees
Take advantage of all or most of their company's benefit learning opportunities	41%	32%
Say that one-on-one in-person benefit meetings are important.	59%	49%
Say that group benefit meetings are important.	57%	46%

Fifty-five percent of do-it-for-me employees work with a financial advisor compared to 31% of all employees. Those working with an advisor place a much higher value on their benefits.

Fifty percent of workers find information about life, disability, or dental insurance through a Google search. Other popular sources of information are the insurance company website (49%), newspapers and magazines (45%), financial advisors (31%) and social media (23%). Notably, only 35% went to the HR departments for this important information.

When making benefit selections during open enrollment, 67% of workers consult with friends or relatives, and 77% rely on material distributed by their employer. Some seek help from HR while few speak with a financial professional.



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TAILOR BENEFITS AND COMMUNICATIONS BY CAREER STAGE

Employees who are beginning their careers and those transitioning into retirement have different financial, education, and enrollment preferences. Near-retirees (those within five years of retirement) value their benefits and worry about losing them in retirement while early entrants (those within the first five years of working) want more choice and education delivered via the workplace.

Even more so than last year, employers recognize the need to help employees make better benefit decisions. Two in five say it's important to increase employees' access to education and financial advice. One-third of employers say that a highly important goal is to tailor benefit communications to employee segments, though only 13% are providing a tailored approach. Companies with at least 1,000 employees and those with a growing HR/benefit department are most likely to say that targeted communications are highly important.

Market trends point toward further acceleration of consumerism in the employee-benefit industry. With advances in technology and outside expertise, plan sponsors can take a refreshed look at how they address the distinct needs of their employees at different work stages.

TOTAL COMPENSATION STATEMENTS

Workers who get total compensation statements from their employer value their benefits more and are more likely to



say that the company's benefit communications are effective. However, only 33% of all employers surveyed give employees total compensation statements compared to 44% of companies with 100 or more employees. (These employers report greater success increasing employee satisfaction, helping employees make better decisions, and improving the financial security of employees and their families.)

For most Americans, good financial health and security starts with the benefits offered at work. The more employers can do to engage workers with desired resources, the more employees will value their benefits and the happier they'll be.

The Third Annual Guardian Workplace Benefits Study can be viewed at this link: guardiananytime.com/2015-workplace-benefits-study. ★

Gene Lanzoni is assistant vice president, Market & Customer Insights at The Guardian Life Insurance Company of America.

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MARKETING IDEAS

TO INCREASE YOUR *4th Quarter Sales*

by **JOE NAVARRO**

We are smack dab in the eye of a new selling cycle. You are probably working harder than ever. You are offering a better solution to your clients or trying to save a client who has been contacted by a competitor who is “Zaying” that they can do benefits better through technology.

Your industry has been transformed. Your products have changed. Your clients are frustrated beyond belief. The constant change can be overwhelming. Sometimes, it feels that the odds are stacked against you. But great opportunities are ahead. Your role has become even more important. Believe in yourself and what you can do for your clients. Every one of you offers something unique. You may be providing the same kinds of products and services, but how you provide them differentiates you from the competition.

The best way to compete with a bigger agency is to get closer to the customer. You may say, “I offer the best plans and customer service.” Doesn’t everyone say that? Do you know who your customers are? To really know who they are, you need to go beyond the usual approach. Get the client away from the office, which is full of distractions. Coffee is always good. For a big client, consider a baseball game or even a concert for that band they have enjoyed since high school. Get to know what fourth quarter stress means to your audience. Know that Millennials demand a different experience than do Baby Boomers. They value insurance, but reject slick salespeople. One thing they all have in common is that they are stressed, and it goes beyond healthcare.

Be knowledgeable, yet kind and listen intently. When they are done,

they will speak in their words and be open, yet firm in your beliefs. They have already Googled what’s best for them, and you will want to steer them in the right direction. Tell them, up front, about the promises your competitors might make. Then demonstrate how your agency offers solutions that resonate with them. When that big company calls saying that they can do benefits better, your client will be less inclined to take the bait during the fourth quarter. According to Marketing Metrics, you have a 5% to 20% probability of selling to a new prospect and a 60% to 70% probability of selling to an existing customer.

PINPOINT YOUR UNIQUE, YOU-NEED-ME QUALITIES

It is not only important to know your clients. Do you know yourself? Figure out what makes your agency unique. Sit down with everyone in the agency once a month to list your good points. Then do the same to figure out what your competition does better. It will allow your agency to improve constantly and be more nimble for your clients. Make sure that your unique selling proposition is visible to all prospects, clients, and anyone working with you:

- How are you different upon first contact?
- What do they feel every time there is an interaction with your agency?
- What are your e-mails saying?
- How does your website communicate your brand?
- What are you doing to educate and entertain?

Commodity selling leaves them a quote, a company brochure, and a spreadsheet with your recommendations. That’s not you. You need to show your prospects and clients that you are different than the rest and that working with you is a good investment of time and money. Do the following:

- Provide a written service agreement.
- Update your website weekly with fresh content that your clients will benefit from and will motivate them to keep coming back.
- Make sure that your phones are answered by someone who is trained to offer concierge level service. This is not where you put a new hire.
- Offer extended hours Monday through Thursday during the fourth quarter because you know life moves fast and you want to be available on their terms.

PACK YOUR SALES KIT WITH SOLUTIONS

Delight clients by quickly providing a solution to their issues, then over-delivering on all requests and expectations. They are hungry and ready to embrace you as a trusted advisor. It is yours to own versus anyone else owning it. Respond to calls within the hour. When you respond quickly to prospective clients, they’ll know that good customer service is just as important to you as it is to them.

Offer clients a simplified ACA map, an easy-to-understand ACA glossary, a business resume that explains how you can help clients, a simple guide to technology tools, and a service contract that



says, “We will take care of you beyond all of your expectations.” Here’s a creative idea: Design your own health care stress card that points to you as the person who can alleviate their many concerns.

Build word-of-mouth through trust. “Without Trust there is no us.” Cascade this message down to everyone in your agency and with your clientele. Once they’re convinced, the word will spread.

And don’t forget that your prospective clients are busy; they don’t know how wonderful you are. Always be marketing the things you are doing for them. By doing this, you and your clients win. You need to be a marketing technologist to grow your agency. Technology has crept into every business crevice; you can count on it dominating your sales cycle. Today’s client is consumed by all things technology. Eighty-eight percent of consumers trust online reviews as much as they trust personal recommendations, according to iProspect. But remember, they won’t know to trust you unless you tell them by using technology. Start by providing your clients the latest tech tools that can simplify the insurance buying experience. Being a marketing technologist extends to how you communicate with your prospects and clients. With Millennials, the mobile phone is the best way to stay in touch.

HOOK UP WITH A POWER PARTNER

Content is king, and updating that website content weekly responds to their hunger for answers.

At this point, you might be saying, “I don’t have time for all of this.” That’s where I say, “au contraire.” That’s why a general agency (GA) works, behind the scenes, to partner with you, providing tools to help you stand out from the rest. Whether you bring on temporary staff, contract with a vendor, or partner with a GA, get the help you need to stay on top of your business. You can’t satisfy your clients’ business needs if you’re drowning in paperwork.

Passion for doing what is right for the consumer is a winning proposition. Make the experience all about them; be authentic and creative. Tap into your client’s emotions, overcome misperceptions, deliver an innovative experience, and communicate in the way they want to be communicated to.

Reminding yourself of your successes, instead of dwelling on the negative, will help keep your spirits and your energy high. Speaking of energy, don’t forget to take care of yourself. You will need to be in tip-top shape to stay on your toes for the next few months. This will probably be your busiest fourth quarter ever. But it can also be your best. ★

Joe Navarro, marketing director for Warner Pacific.

Understand that everyone you meet and/or you are talking to is fighting a hard battle of one sort or another. Show them you “get it” and are **passionate** about giving a solution.



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NAVIGATING LEGAL PITFALLS FOR BROKERS

by **BRANDON C. FERNALD**



California presents a myriad of legal pitfalls for every profession. So, it may come as a surprise that California law is actually quite restrictive with respect to the standard of care applicable to insurance agents and brokers.

The duty of an insurance broker in California is simply to place the insurance requested by the client. This default standard of care can only be expanded through the actions of the insurance broker. Ironically, actions intended to benefit the client, including more comprehensive client service offerings or specialization in particular types of insurance, serve to increase the liability risk for the broker by expanding the broker's duties to the client. While there are often good business reasons for engaging in these activities, insurance brokers and agents must, nonetheless, be aware of the increased liability risk that may be associated with such activities and how to mitigate it.

As the California Court of Appeals aptly put it in the seminal decision in California with respect to insurance broker standard of care (*Jones v. Grewe*), the general duty of an insurance broker is limited to the "obligation to use reasonable care, diligence, and judgment in procuring the insurance requested by an insured." More to the point, an insurance agent does not have a duty to volunteer to an insured that the latter should procure additional or different insurance coverage. This restriction provides cover for the insurance broker in the vast majority of cases in which the allegation is that the broker should have recommended a different level or type of coverage.

An insurance agent places a life insurance policy containing a two-year suicide exclusion cause. Seven weeks later, the insured commits suicide. The beneficiary sues the agent, alleging that he was negligent in placing a life insurance policy that contained a suicide exclusion.

A broker is asked to place health insurance for a couple. The policy placed contains a provision permitting the underwriter to terminate the group at any time. The policy also contained a deferral provision that permitted a new underwriter to defer coverage on group members or covered dependents who were hospitalized or totally disabled at the time coverage began. A baby is born and diagnosed as totally disabled. The then current underwriter terminates the group, and the new underwriter citing the deferred coverage provision, refused to cover the child's medical expenses. The couple sues the broker alleging that he placed inadequate coverage.

A new retail cupcake business retains an insurance broker to place necessary coverage for a retail small business in leased commercial space. Six months later an employee sues the business alleging sexual harassment. The business sues the insurance broker alleging that the broker should have recommended employment practices liability coverage (EPLI) coverage.

Each of these cases involved an insurance broker's alleged failure to recommend a particular type or amount of coverage. By default, an insurance broker has no such duty under California law. As long as the insurance broker places appropriate insurance in response to a client request, the default standard of care is satisfied. In each of the above cases, the claims failed because of the lack of evidence that the client requested the level or type of coverage at issue.

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The limited duty of an insurance broker to place insurance requested by the client is easily expanded in three primary ways: holding oneself out as an expert in a particular type of insurance; providing additional information about the insured's coverage; or offering additional services to the client.

Advertising oneself as an expert in a particular type of coverage is, perhaps, the most perilous in terms of expanding the potential duty owed to the client.

A new franchisee sued the broker alleging that she had failed to place necessary worker's compensation coverage. In response, the broker argued that her expertise and the coverage she placed pertained to the liability aspects of the business, not worker's compensation. The court disagreed, ruling that having held herself out as an expert in insuring this particular franchise, the broker had expanded her duty of care to include all types of insurance coverage necessary for the franchise, including worker's compensation.

In another case, an insurance broker, holding himself out as an expert in the field of group medical and life insurance for small businesses, was asked to place such insurance for a business's officers and employees. In applying for a group plan, the broker directed the client to sign a certification of non-applicability of Medicare provisions of the Tax Equity and Fiscal Responsibility Act (TEFRA). As it turned out, the business was subject to the Medicare provisions of TEFRA. The business's insurer ultimately denied coverage and sought rescission of the group health plan as a result of the inaccurate certificate. The business thereafter brought suit against the broker for negligence. The court upheld the suit, reasoning that having held itself out as an expert in business group health insurance, the broker had assumed a duty to accurately advise on the intricacies of such insurance.

Developing an expertise in insuring particular risks and advertising it is often a key to driving new business. The point of this article is not to discourage this type of activity. Rather, if one is going to develop and advertise an expertise in a particular area, the insurance broker must be aware of the expanded standard of care such activity entails. An expert can expect to be called to account for not placing appropriate levels or types of coverage within his or her area of expertise.

Turning to the second manner in which a broker's duty to the client can be expanded, insurance brokers should be ever aware of the adage, "No good deed goes unpunished." While there are good business reasons for going above and beyond for the client in terms of providing information, assisting with the tendering of a claim, etc., the broker must ensure that these additional efforts are performed correctly and comprehensively.

The following case illustrates the point. The owner of a building sought insurance coverage from a new (to the owner) insurance agent. The agent placed a standard property and casualty policy for the building. Subsequent heavy rains caused the municipal sewer system to back up, flooding two basement apartments in the building. The insurer declined coverage under an exclusion for sewer backups.

The building owner sued the insurance agent for failing to place an insurance policy that covered the loss. In deciding the case, the court first recognized that ordinarily the insurance agent would not be liable for failing to place cov-



erage without a sewer back up exclusion, absent a specific request for such coverage. However, the insurance agent in this particular case had provided a cover letter with the policy, describing it as "All Risk subject to the All Risk Property Coverage Exclusion list attached for reference." Loss resulting from sewage back up was not among the eight listed exclusions in the agent's cover letter.

According to the court, the agent's additional duty arose because he "undertook to prepare an insurance proposal for the [client] to review prior to purchasing a policy of insurance. [The agent] thus came under a duty of due care to accurately inform the [client] of the policy's provisions."

Once again, the lesson here is not to avoid going above and beyond for your client. Rather, an insurance broker who decides to go beyond what is minimally required (placing insurance specifically requested by the client) must take particular care to ensure that the additional effort is performed correctly and accurately.

Similar to offering additional information, insurance brokers and agents often get into trouble for offering additional services and then failing to follow through on the services offered.

As an example, a broker's website that offers to assist clients with their insurance claims could be utilized down the road to support allegations that the insurance broker assumed a duty to correctly handle a client's insurance claims. By default, an insurance broker has no duty to assist a client with the tendering of its insurance claims. Once such a service is offered or undertaken however, the insurance broker potentially assumes an obligation to perform the service and perform it correctly.

If additional services are offered, the insurance broker must ensure they are actually undertaken and performed in a competent and comprehensive manner.

California law is surprisingly favorable then it comes to defining the standard of care owed by insurance brokers and agents. By default, a broker's duty is limited to placing the insurance specifically requested by the client. This limited duty is often upended by business realities, which often require specialization and/or a comprehensive client service offering. These activities cannot be pursued lightly as they will inevitably expand the limited default standard of care under California law. ★

Brandon Fernald, Esq. is a named partner in Fernald Law Group LLP, a litigation boutique with offices in Los Angeles and Las Vegas. Fernald regularly handles litigation involving insurance brokers and agents.

GIVING GROUP LONG-TERM CARE INSURANCE A FIRST LOOK OR A SECOND CHANCE

by STEVE CAIN

Despite the challenging landscape for long-term care insurance (LTCI) in recent years, the corporate or worksite segment of the marketplace continues to provide a significant opportunity for benefit brokers and advisors to help clients and grow their businesses. In the recent past, group LTCI carriers were offering voluntary programs to mid-sized and larger employers, proposing guaranteed issue underwriting. Even groups with as few as three employees could qualify for some form of simplified issue underwritten policies.

However, these opportunities and offerings have changed. Low lapse rates, a challenging regulatory environment, record-low interest rates, and worse-than-expected claims experience have caused many of these programs to go away. The industry has also seen numerous in-force rate actions and fewer carriers in the marketplace. Sounds like a recipe for disaster, right? Actually what is going on is an evolving insurance market that's changing to support the growing need for this type of planning. Simply stated, the industry has gained experience over the past 10 years, and made changes (product, pricing, underwriting, underlying chassis, etc.). In fact, as a distributor, we've seen a significant increase in employer-sponsored opportunities and heightened consumer awareness around the issue of long-term care.

Most employers (HR professionals and C-suite executives) get it; they're in the age range to be thinking about retirement planning or have experienced a long-term care event with a loved one. So one of the challenges the LTCI industry is facing is overcoming broker apathy. But now that the market has stabilized, many benefit brokers are giving group LTCI a first or second look. These brokers also understand that we don't have a demand issue; what we're seeing is a supply is-

sue with a limited number of carriers offering group programs.

Having said that, group LTCI can play a role in most companies' benefit packages by doing the following:

- Helping protect a retirement plan: Well-informed and financially savvy people understand the dangers that an extended healthcare event can present to their financial portfolios.
- Giving people a choice about care: Although Medicare and Medicaid (Medi-Cal) pay for LTC costs, coverage might be limited.
- Easing the burden on family members: LTCI lets family members be involved in the caregiving process without being the primary provider.

For group LTCI, many carriers are using their individual LTC plans and offering them in the worksite with premium discounts, unisex rates, and underwriting concessions. There is one true group plan offered for employers with 500-plus eligible lives. Additionally, we have seen several group life insurance products offer qualified LTC riders or accelerated death benefit/critical illness riders.

The need for LTC planning has not changed even if the landscape for providing it has. Group LTCI continues to be a popular, in-demand product in the pre-retirement marketplace. While this article does not provide an exhaustive discussion of all the possibilities, it is important to know that group LTCI plans can include the following:

- Premium deductibility and income tax-free benefits.
- The ability to carve out specified employee groups.
- Simplified-issue coverage.
- Unisex rates.
- Corporate discounts.
- 100% portability.
- Ease of enrollment.



You've read all the studies or have already seen the stats. There is a growing recognition of the need to prepare Baby Boomers for healthcare costs in retirement, and more of them are turning to their employers for help. By understanding the issues and the evolving nature of the industry, brokers have the opportunity to present group LTCI coverage as a viable and highly desirable option for their corporate clients, and one that will resonate as a true benefit to their employees. ★

The information contained in this article is provided with the understanding that it is not to be interpreted as specific legal or tax advice. Neither LTCI Partners, LLC nor any of its employees nor representatives is authorized to give legal or tax advice. Individuals are encouraged to seek the guidance of their own personal legal or tax counsel.

Steve Cain is a principal and national sales leader at LTCI Partners, a brokerage general agency specializing in Long-Term Care Insurance solutions. Email Steve at steve.cain@ltpartners.com and visit ltpartners.com for additional information.

Long-Term Care Insurance

BETTER TO HAVE AND NOT NEED, THAN TO NEED AND NOT HAVE

by **ESZYLIE TAYLOR**

A wise man once said that it is not a matter of how much you make, but how much you keep. One key component of a solid retirement is education about long-term-care insurance (LTCI). By definition, long-term care (LTC) includes a variety of services that help meet the medical and non-medical needs of people with a chronic illness or disability. LTCI is for people who cannot care for themselves for long periods. The benefits associated with coverage come into play when someone is unable to perform acts of daily living. These include activities, such as feeding oneself, bathing, dressing, and maintaining continence.

Recently, a client shared his best friend's story with me. His friend's mother suffered a major stroke and passed away en route from her home to the hospital. His exposure to medical expenses and care were quite low. His father, on the other hand, battled chronic illnesses for nearly a decade, which drained the estate's assets. A once bountiful sum of money, which was intended to provide a legacy for their heirs, was virtually depleted. This is an LTC exposure that just cannot be ignored. Neither can the rise of health care costs, which continue to escalate at an unbelievable rate each year. A limitless financial liability such as this should not be overlooked, and measures to guard against it should be taken.

I contend that LTC should actually be called "retirement-protection insurance." It protects the savings and investments that clients have worked so hard to amass over the years, so it will not have to be used to pay for long-term care expenses. The statistics on this subject are startling to stay the least. There is a 66% chance that a senior citizen will become physically or cognitively impaired in their lifetime, and a 33% chance that they will enter a nursing home, according to the U.S. Agency for Health Care Policy and Research. While we generally associate LTC with old age, over 40% of people on claim for benefits today are 18 to 65. Younger people are far less likely to suffer from strokes, dementia, or other debilitating ailments than are elderly people, but their tolerance for risk and adventure may expose them to injuries. This can result in an inability to care for themselves, which renders the need for assistance.

The median income for men and women is roughly \$20,000 per year in the U.S. and the average cost of LTC is about \$75,000 per year. When you couple the fact that most people have inadequate savings for retirement to begin with, and people are living longer than they have in generations past, we have a recipe for disaster. If one were to project their expenses in retirement, and then add a \$6,000 to \$7,000 expense on top of those bills, how long do you think their money would last? Insurance simply represents the transfer from one source to another. In this case, the risk is being transferred from the individual to the insurance

carrier. This creates a comfort zone for the individual by eliminating the worry factor altogether.

Americans spent \$500 billion on LTC services for the elderly in the past five years. While nursing home bills account for the lion's share of LTC expenditures, there is an ever-growing trend for people to spend their money on home and community-based care. In my opinion, the risk to the everyday person is too great to ignore the need to plan for this type of contingency.

In addition to the burden an LTC need could have on one's finances, it can also have a tremendous impact on the family. Caring for someone else is a loving and selfless act, but it can have an adverse effect on a marriage, children, and careers, aside from retirement plans. Far too often, I hear people say, "My children will take care of me." Or perhaps, "I have a big family, and we would never abandon one of our own." I do not think the gravity of the actual occurrence can be appreciated until one actually has to live through it. It is not a matter of compassion and a desire to make sure loved ones are attended to.

A good friend of mine shared his LTC story. His mother and father fell victim to debilitating ailments that required the need for care. Unfortunately, they never purchased LTCI. As a result, their son had to step into the role of caregiver. His once proud parents were now forced to have their son feed them, help them around the house, and bath them because they had lost control of their bodily functions. He constantly held back tears as he witnessed the helplessness in his parent's eyes. Although he would have preferred a professional service to assume the burden, the cost was simply prohibitive.

Without LTCI, one is making the bold statement that they are willing to exhaust their savings, liquidate their investment accounts, and sell their home to pay for LTC expenses. I hardly think anyone consciously sets out to work 30 to 40 years to save enough money to retire one day, only to pay it all to caregivers. It's important to have LTCI to safeguard our retirement. We insure our homes, cars, and general overall health, but we do not think enough to guard against long-term injuries, illnesses, and/or disease. When we are young and healthy, we are ideal candidates for the richest plans with the lowest premiums. We have to educate our clients and help them put a secure financial plan in place before there is a foreseeable need. While I hope to never use my LTCI, I am glad I made the decision to purchase it. It is better to have it and not need it than to need it and not have it. ★

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LTC NEWS

HOW LTC AGENTS CAN USE SOCIAL MEDIA

Social media sites, especially Facebook, LinkedIn, and Twitter, make it easy for LTC agents to reach out to clients and prospects in a low-key way, says Denise Gott, CEO of ACSIA Partners. But long-term care insurance agents often resist reaching out to friends who could use their help. And consumer who are looking for LTC insurance information also resist reaching out to friends who may be in the business. But there's much to gain from overcoming this reluctance, Gott said.

Agents who get lots of inquiries from friends tend to post on social media regularly, maintaining an ongoing presence and dialog. Gott gives these two examples:

LTC agent Gabrielle Gelo said, "Facebook allows me to reach out to childhood acquaintances that I might not have maintained contact with otherwise, through the high school Facebook page. They need help with long-term care planning, and the trust is already there. For me, social media works. It costs nothing, and takes minimal time."

Another agent, Kim Beckham said, "Last year, about three fourths of my business was Facebook-related. And it was mostly with friends and family and referrals from friends and family."

Beckham, like Gelo, stresses the importance of keeping things low-key and friendly. For example, "On Facebook I don't use a business page. I just use my personal page, because I feel I am my brand, and people are looking to me as a person, not an agent."

Gott said, "Our people avoid the hard sell. Mostly, they just make clear that they're in the business. And they post useful information that friends appreciate. For example, a reminder of LTC deductions available at tax time, or facts on who needs protection, or available policy types,"

"If you're an agent, you may recoil at the idea of selling to your friends. And if you're on the buying end, you may feel you're imposing if you approach a friend in the business. But you really should connect. In our experience, agents and buyers who are friends are getting together with good results on both sides." Gott said. For more information, visit acsiapartners.com.

WHY PEOPLE LAPSE THEIR LONG-TERM CARE INSURANCE

More than one third of people with long-term care insurance at age 65 will lapse their policies before death, according to a study by the Center for Retirement Research at Boston College. Men, this age, have a 32% chance of lapsing before death while women have 38% chance. Low-wealth and low-income people are more likely to lapse their insurance policies.

There is no evidence that people are lapsing because they believe they have a low probability of needing care. Lapses are common among the cognitively impaired, perhaps reflecting poor financial decision-making. Those who lapse are more likely to use long-term care. Many lapsed, not only forfeit policy benefits, but may also adopt an aggressive path

for drawing down their wealth in retirement based on the false premise that they will retain coverage.

One way of eliminating lapses would be to pay premiums in a lump sum. Most likely candidates for long-term care insurance have accumulated significant financial wealth by retirement. From the insurance company's perspective, the problem with this approach is that, in contrast to policies with monthly premiums, it would be difficult to increase premiums should claims be higher than expected. For more information, visit crr.bc.edu.

CAREGIVERS FACE A CAREER CRISIS

Providing care for loved ones has taken a toll on the careers of half of caregivers with 11% losing their jobs and another 10% having to change careers. That's in addition to the other financial, physical, and emotional effects of caregiving according to a Genworth study.

Fifty-one percent of caregivers say that that caregiving responsibilities impeded their ability to perform their jobs. The survey also reveals the following:

- 77% missed some work during the past year, up 19% in 2010.
- Caregivers missed an average of seven hours of work per week.
- 19% missed 10 or more hours of work per week.

As a result of their caregiving responsibilities:

- 11% lost their jobs.
- 10% had to change careers.
- 12% had to change positions.

Approximately one-third of caregivers provided 30 hours or more of care a week. On average, caregivers lost one-third of their income. The study also highlights several factors that contribute to respondents' reluctance to plan early. Thirty percent didn't want to admit that long-term care may be needed and 25% didn't want to talk about the issue.

Caregivers who had long term care insurance were reimbursed for 23% of their qualified out-of-pocket expenses. Forty-eight percent of care recipients had considered the possibility needing long-term care, but only 26% made a plan to cover their potential needs. Even planners felt they could have been better prepared; 63% said they should have taken steps sooner, which would have led to reduced stress. For more information, visit genworth.com.





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BENEFIT EXCHANGE

MassMutual is launching “BeneClick!” The integrated benefit exchange features a guidance tool that helps employees prioritize retirement savings, healthcare, and insurance protection benefits based on their life stages. BeneClick! is being introduced through MassMutual’s distribution partners on a limited basis and will be available more broadly starting in mid-2016. Initially, through BeneClick!, MassMutual will offer access to retirement plan enrollment features and life insurance products, and expects to add insurance products in 2016, such as critical illness and accident protection. For more information, visit massmutual.com.

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Nationwide launched Nationwide Destination Freedom, an investment-focused variable annuity for clients looking for a low-cost solution with the flexibility to choose from more than 130 funds. Higher annuity fees can drag down the potential performance of investments. Freedom+ offers a 1% base cost, helping to reduce the fee-drag on a portfolio’s performance. Freedom+ provides a tax-deferred investment option, potentially helping clients create more retirement income. It also offers more four-star and five-star Morningstar rated funds than does the leading competitor. For more information, visit nationwidefinancial.com/freedom or call 800-321-6064 for more information about Freedom+.

THE ULTIMATE OBAMACARE HANDBOOK

In The Ultimate Obamacare Handbook (2015—2016 edition) (Skyhorse Publishing, September 2015) you’ll find:

- A guide to buying low-cost health insurance.
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For more information, visit amazon.com.

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ONLINE PAYROLL SOLUTION

BenefitMall is offering an online payroll and HR solution for small and mid-size businesses. PayFocus + HR is an enhanced version of BenefitMall’s PayFocus product that rolled out in early 2015. It allows employers to hire new employees, import time and labor data to avoid multiple entries, calculate gross-to-net payroll in real time, and review all standard reports in one streamlined location, all with just a few clicks. For more information, visit benefitmall.com.

LIFE INSURANCE

Life Insurers Want to Make It Harder to Collect on Policies

Life insurance companies and other corporate interests are pushing for a change to the Uniform Unclaimed Property Act that would make it harder for people to collect on life insurance policies as well as forgotten bank accounts, unused gift cards, and other unclaimed property, according to a report from Allied Progress. Among those leading the charge for changes are the U.S. Chamber of Commerce and the American Council of Life Insurers.

They are pushing to allow corporations to limit the time in which property must be claimed. They also want to make it harder for states to use non-governmental professional auditors to enforce existing unclaimed property laws and ensure such property is reported by large multi-state corporations.

The report details how a longtime ULC commissioner responsible for co-chairing the drafting committee has worked to undermine state unclaimed property laws and is a partner in a law firm whose clients would benefit greatly if the Act were gutted.

Allied Progress executive director Karl Frisch said, “You’re talking about people who don’t even know they are entitled to a life insurance claim. To make it easier for a corporation to hold onto these benefits and keep them from the rightful owners... is unconscionable. Members of the Uniform Law Commission need to stand strong in the face of these powerful corporate interests.” For more information, visit alliedprogress.org.

HEALTHCARE

The Medicare Advantage Market in 2016

A total of 2,174 Medicare Advantage (MA) plans are in the market lineup for 2016, an increase of 90 plans over 2015, according to a report by Mark Farrah Associates. Researchers looked at data from Centers for Medicare & Medicaid Services (CMS). The Medicare market continues to be a key target for health insurance business with more than 17.6 million beneficiaries enrolled in a Medicare Advantage plan and another 37 million eligible.

Many Medicare Advantage plans are designed to be marketed in targeted regions while others are approved to be offered nationwide. For 2016, HMOs continue to be the dominant plan type; comprising 67% of plan offerings. The number of distinct HMO plans will increase to 1,463 for 2016.

2016 Medicare Advantage Preview

MA Plan Type	2015 Plan Count	2016 Plan Count	2016 %
HMO	1,358	1463	67%
Local PPO	521	516	24%
Cost	86	81	4%
PFFS	69	63	3%
Regional PPO	43	47	2%
MSA	7	4	0%
Total	2,084	2,174	100%

Source: Mark Farrah Associates

Open enrollment will begin on October 15, 2015, and competitors are gearing up to promote 2016 benefit plans. As Medicare companies finalize sales and marketing strategies, they look forward to the release of the Medicare Plan Finder data on or around October 1. The Plan Finder is an online tool that helps seniors shop select new Medi-

care plans. It is also a rich market analysis resource for the industry. Analysts within Medicare plans use the detailed benefit attributes including benefit copays and cost sharing, plan by plan, to assess competition and opportunity, county by county. For more information, visit medicare.gov, markfarrah.com, or call 724.338.4100 for more information.

Medicare Advantage and Part D Market to Remain Stable in 2016

The market for Medicare Advantage and Medicare prescription drug plans will remain stable in 2016, according to the Medicare Rights Center. Next year, consumers will continue to see a stable Part D plan market with average premiums at \$32.50 per month. The coverage of generic drugs increases to 42% of the cost of the drug in the doughnut hole. Coverage of brand name drugs will remain at 55%. Millions of older adults and people with disabilities will see affordable premiums and similar access to plans as they have in years past. As the Affordable Care Act (ACA) strengthens Medicare Advantage and prescription drug plans, beneficiaries are protected from significant increases in plan costs, benefits remain stable, and access to higher-quality plans is strong.

Enrollment in Medicare Advantage is at an all-time high. Next year the average premium will be \$32.60, down from \$32.91 in 2015. Additionally, 99% of people with Medicare will have access to a plan in 2016. There are now more four to five star plans than ever based on Medicare's Star Quality Rating. For more information, visit medicarerights.org.

How the FDA Is Driving Drug Price Hikes

The FDA's backlog of 4,000 generic drug applications is hindering competitors who could hold prices down, according to a study by the National Center for Policy Analysis (NCPA). Also, older generic drugs are often made on aging production lines, which are sometimes shut down for maintenance. Lines can be stopped after the manufacturer is warned by the FDA that the facility is out of compliance with good manufacturing practices. The resulting shortage often drives prices higher.

Thousands of drugs predate the FDA's approval process required under the 1938 Food Author and Drug & Cosmetics Act; many were grandfathered, but never officially approved. NCPA senior fellow Devon Herrick says, "The FDA wants these cheap drugs off the market and replaced with more costly approved versions from any drug makers willing to conduct clinical studies on them."

In the face of rising drug prices, many states have passed laws that worsen the situation, such as banning efficient pharmacy networks, restricting mail-order pharmacies, and restricting maximum allowable cost lists.

The NCPA study highlights ways to lower drug costs:

- Clear the FDA's backlog of applications to manufacture generic drugs.
- Resist passing perverse regulations designed to protect local business.
- Promote competition in the production of generic medications.

For more information, visit ncpa.org.

IN CALIFORNIA

Governor Signs Agent Friendly Bill

California is the first state to require health insurers to give advance notice to licensed health insurance agents before making major changes to their agent contracts. AB 1163 (Rodriguez D-Pomona) was sponsored by CAHU, the Independent Insurance Agents and Brokers of California, and NAIFA California. The law takes effect January 1. AB 1163 will require health insurers and HMOs to give appointed agents 45-days' notice of certain changes to their agency agreement.

CAHU President Michael Lujan said, "AB 1163 levels the playing field and provides for a fair and reasonable notice to licensed agents when their contract is materially changed. Most independent insurance agents are main street small business owners in nearly every community in California. This change is critical in light of the ACA compressed open enrollment period each year."

Governor Signs Disability Policy Bill



Kevin McCarty

Governor Brown signed Assembly Bill 387 into law. It will improve the department's ability to review and approve disability policy filings more effectively and completely in the specified time-frame. The law extends the period from 30 to 120 calendar days for the department to review and approve policy forms and any associated risks and premium rates. The bill was authored by Assembly Member Kevin McCarty and co-sponsored by Insurance Commissioner Dave Jones.

The new law authorizes the Commissioner to develop and publish new guidelines on the department's public website to expedite the department's file review process for life and disability insurance forms. It will provide clear guidelines for insurers to follow when submitting policies for approval. AB 387 reflects an agreement between the California Department of Insurance and the Association of California Life and Health Insurance Companies.

Seniors Gain Greater Consumer LTCI Protections



Carol Liu

Governor Brown signed Senate Bill 575 into law. It requires long-term care insurers to provide annual notifications of the availability of non-forfeiture benefits and contingent benefits to the insured and the insured's designated backup contact. The bill was authored by Senator Carol Liu and sponsored by Insurance Commissioner Dave Jones. "Without notification, individuals and their families can easily lose track of...benefits and may end up paying for care or missing out on benefits that are available to them," Jones said. Consumers may stop making premium payments because they can no longer afford them. Although the long-term care benefits may still be available to the consumer even after they stop making payments, the benefits may not be utilized by the consumer until years after the policy has lapsed, which is why consumers may forget the benefits are available. ★

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