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TABLE OF CONTENTS

VISION

10 Exchanges Ushering in Vision's Age of Consumerism, But What Does It Mean for Brokers?

by Lukas Ruecker
Brokers might need to change the subtleties of their roles, but not necessarily their entire business models.

12 The Re-Envisioned Eye Care Plan: Premium Benefits with Low Out-Of-Pocket Costs

by Donna Geringer
There has been a collective push for greater price transparency in the optical industry.

DENTAL SURVEY

15 2015 Dental Survey Part 4

by Leila Morris
Our annual survey of dental insurance carriers in California

PPO SURVEY

18 2015 PPO Survey Part 1

by Leila Morris
Our annual survey of PPO carriers in California

HEALTHCARE

21 Gearing Up for Year Three of Covered California

by Jennifer Moore
There's much to celebrate about California's exchange, but also there's more work ahead.

MEDICARE

23 Five Things That Seniors Look for in a Medicare Advantage Plan

by David Milligan
Why Medicare opens a world of opportunities for brokers.



OPEN ENROLLMENT

25 Tips for a Successful Fourth Quarter

by Jessica Word
Why it's so crucial to come to the aid of group clients during the upcoming fourth quarter.

HEALTH MARKET

28 Agents Will Continue To Thrive—An Interview With Ron Goldstein

by Meg McComb
A look at opportunities in the new health-care market

MEDICAL PROVIDER GROUPS

31 What Brokers Should Look for When Evaluating Medical Groups

by Jeff Burnich, M.D. and Steve Nolte
Quality, access, price, stability, and value

DISABILITY

32 Disability Claims from There to Here

by Arthur Fries
The ins and outs of disability claim processing

LIFE INSURANCE

37 Continuing the Sale With Life Insurance

by Mickey Elting
Change is the only consistency in the insurance business. Be ready!

ANNUITIES

38 Meeting a Variety of Retirement Needs with Today's Annuities

by Doug Wolff
Combining FIAs and IOVAs can help clients reach three very different savings goals.

TECH TALK

41 Using Technology to Navigate the Medicare Advantage Plan Minefield

by Nidhi Saxena
To sell Medicare Advantage products, you really have to understand CMS regulations.

ALSO IN THIS ISSUE:

Guest Editorial.....	6	News.....	42
Annuity Sampler.....	8	Classified Advertising.....	46
Legal News.....	35	Ad Index.....	46
New Products.....	40		

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A Time of

HISTORIC OPPORTUNITY FOR AGENTS

by **KIRK WHELAN**



As Californians prepare for the next chapter of the Affordable Care Act, approximately 1 million enrolled Covered California members will be renewing coverage. And thousands throughout the state will be shopping for coverage as the third open-enrollment period begins on November 1—some for the first time in their lives. In addition, there are significant changes occurring

in the small-business marketplace. In all cases, Covered California Certified insurance agents will play a critical role in enrolling eligible Californians and businesses into the program that best meets their needs.

There are major changes ahead for small businesses, which create opportunities for enterprising agents. In the next two months, it is estimated that 70% to 80% of all currently insured small businesses will move to plans that are compliant with the Affordable Care Act. A large percentage of these groups are expected to turn to a small-business exchange when they make that move. Adding to the excitement is the small-business market expansion that will include groups with 51 to 100 eligible full-time-equivalent employees starting Jan. 1, 2016.

Our small-business program, Covered California for Small Business, is primed to provide agents with opportunities that will meet the marketplace demand in this quarter and into early next year. Our products, rates and new plan offerings from leading health insurance carriers, combined with exclusive access to federal tax credits and a true employee-only coverage option, make it a competitive, affordable solution for agents looking to provide employers with great options.

At Covered California, we have been preparing for this. Our operations for our small business program are strong, with more than 98% of new groups consistently processed within three business days. An important update is that agents can be confident that we have worked out the commission challenges and that checks are arriving on a timely basis.

We offer many ways for agents to partner with us to sell small-group policies, including support from our small-business sales team, our SHOPWorks direct mail program and our lead management program. Online enrollment is newly available for the agent community, giving agents the real-time tools they need to speed up new group processing and reduce the potential for enrollment errors.

Another big opportunity for agents is the annual open enrollment period for the individual market, which runs from November 1, 2015, to January 31, 2016. We began

preparations by negotiating an average weighted statewide rate increase of 4% and added two new health insurance companies to our roster: Oscar Health Plan of California and UnitedHealthcare Benefits Plan of California.

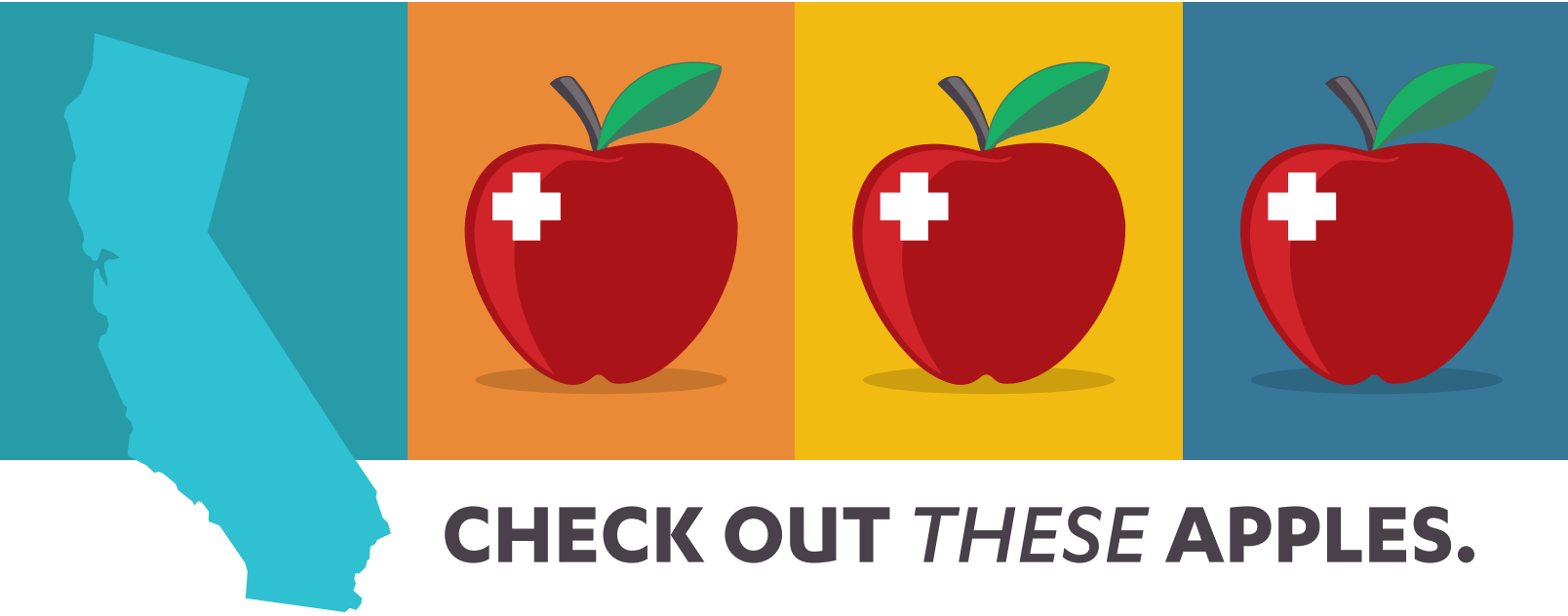
Agents can help consumers in their communities find them by using new collateral and other printable, customizable materials. We are launching innovative tools that will be shared with agents to help them reach consumers, such as our statewide heat map that estimates where subsidy-eligible consumers reside. We encourage agents to watch for an invitation to join open-enrollment kickoff and statewide marketing events and also for our returning weekly e-newsletter, which keeps agents current on the latest enrollment system information, training updates, and enrollment opportunities. Covered California is also deploying a team of field-based regional coordinators to help support agents' individual plan enrollment throughout the state.

Continuing one of the most successful changes from the previous open-enrollment period, more than 140 agents have developed Covered California storefronts since we launched the program last year. All of them can be found using our online "Find a Storefront Near You" locator. I recently spoke with a certified insurance agent who is opening his sixth Covered California storefront in Southern California and yet another who is looking to open his first in San Francisco. During last open enrollment, we routinely posted new agent storefront locations and heard about agents who received walk-in traffic the very next day. Many of these agent storefronts are now working with our sales team to add small-business coverage to their service portfolio, a recent expansion to the storefront program that provides even more opportunities to agents.

There's no question that this quarter is bringing historic activity to an already busy season, and Covered California is prepared to make it a time of incredible opportunity for agents. Since our implementation, more than 12,000 agents have become certified with Covered California, and these certified insurance agents have enrolled over 45% of all Covered California members. We recognize the value that agents bring to Californians and our program, and we credit them, among many others, with the drop in the uninsured rate in our state, which went from 22% to 11%. Together we are working to change health care in America. To that end, we are committed to supporting our agent partners with resources to ensure their success and the viability of Covered California for the health of all Californians. ★

Kirk Whelan is director of outreach and sales at Covered California

COMPARING APPLES TO APPLES?



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In a market with many small business offerings, it's tough to find one that will be the apple of everyone's eye. Small businesses want the freedom and ability to control how much to invest in their health plan. Employees want a choice of health plans to find the best option that fits their needs. Our apples make everybody happy.



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SEPTEMBER 1, 2015

Company Name	Ratings			Product (Qual./Non-Qual.)	Type SPDA FPDA	Initial Interest	Guar. Period	Bailout Rate	Surrender Charges	Mkt. Val. (y/N)	Min. Contrib.	Comm. Street (May Vary)
	Bests	Fitch	S&P									
American Equity	A-	BBB+		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.55%*	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 8/3/15. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG	S	2.15%** 2.30%** ^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 8/6/15. First year rate includes 1.50% interest bonus. a (less than \$100K ; b (100K or more)												
American General Life Insurance Companies	A	A+	A+	(*Guarantee Return of Premium) (Q/NQ) American Pathway Fixed 5 Annuity	S	1.45%** 1.65%** ^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 8/6/15. 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+	(*Guarantee Return of Premium) (Q/NQ) American Pathway Fixed 7 Annuity	S	1.90%** 2.10%** ^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 8/6/15												
Genworth Life & Annuity Insurance Co.	A	A-	A-	SecureLiving Rate Saver	S	2.50%* 2.35%*	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 9/1/15 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 9/1/15 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 8/6/15 and is subject to change.												
Reliance Standard	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+	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 8/31/15. 2.70% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												

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EXCHANGES USHERING IN VISION'S AGE OF CONSUMERISM

But What Does It Mean for Brokers?

by LUKAS RUECKER

As private exchanges become an increasingly popular topic of conversation, this much is clear: very little is clear. The industry consensus is that there is no consensus. Benefit experts can't tell us what the future of private exchanges looks like, although it's not for a lack of predicting.

Chances are that, if you have a stake in the world of benefits, you have a prediction about how private exchanges will play out: how many there will be, how many people will enroll in them, and what the format will look like. Try plotting the estimates on a graph; you'll end up with a Jackson Pollock painting.

Whether or not private exchanges increase in popularity, attract new players, or undergo format changes, one concept central to exchanges will stand the test of time: consumerism. I recently had the pleasure of speaking to the American Optometric Association on this topic. My message to them is the same I'd relay to anyone involved in benefits. We live in an age of consumerism when health decisions and transactions are scrutinized for value, convenience, and customization like other purchases. Members are enabled; competition is encouraged; new tools engaged; and the benefit decision-making process is enriched.

Here's what we're seeing in the vision benefit space of private exchanges:

- People see value in vision, and are willing to pay for it. So far this year, when Aon offered a three-tier plan on its private exchange, 52% of enrollees chose the highest tier, the Gold plan, up 2% from 2014. Thirty-one percent chose the Silver plan. Just 17% chose the Bronze plan, down 3% from 2014. We realize that this data might be contrary to what medical benefit companies are experiencing on the exchanges.

- Employees stick with what they know. We've found that when employers switch to an exchange that offers their previous vision carrier, employees will stay with that carrier more than 50% of the time. The results are even more dramatic when employers stay on an exchange. In this scenario, only 28% of enrollees changed vision carriers from the prior year on an exchange, according to a 2015 Towers Watson analysis.
- There are two types of private exchanges: employee-choice and employer-choice. Similar to the future scope of private exchanges, you'll find varying opinions about the role of brokers in private exchanges. Some doomsayers claim that exchanges will make brokers obsolete while some say that exchanges will make brokers more important than ever. Brokers are important business partners. They are vital to the success of carriers.

Based on what we've learned in recent years, this is what our valued brokers need to know about vision benefits and private exchanges:

- Due to various factors—premium amounts, retail trends, etc.—people view vision in a different light than medical and dental. Don't assume that they'll follow the same patterns as other lines of coverage offered on the exchanges.
- A lot of employers think they need to switch to a private exchange, but they don't know for sure. Exchanges are not for all employers. Even though the system is based on choice, company culture and history aren't really choices. A private exchange probably isn't the answer for a company with a large employee base with a highly

customized plan and *status quo* culture. That's why some argue that employers need trusted brokers now more than ever to help them understand the implications of moving to an exchange.

- Technology is the key in the world of private exchanges. But like any tool, it can be used improperly. Many employers misconstrue exchanges as merely new technological platforms, compliance tools, and administrative processes. They'll need educated advisors to explain the nuances.

From where we stand, brokers might need to change the subtleties of their roles, but not necessarily their entire business models. Broker-sponsored exchanges seem like a viable alternative. But we're already seeing consolidation, not expansion, in the private exchange space. Recently, Deloitte surveyed employers who were considering moving to an exchange. Forty percent said they would prefer an exchange sponsored by their insurance carrier. Just eight percent said they'd prefer one sponsored by a broker or consultant.

The way our benefits reach our members might be changing. They'll have more choice, more decisions, and more questions, but that also means that they'll need more counsel. Although employers and employees will have new technologies and platforms, it's difficult to trump the relationships and expertise brokers have developed. ★

Lukas Ruecker is the president of EyeMed Vision Care. He joined the company in November 2013 when the health benefit industry was navigating rapid change driven by federal legislation and shifting consumer expectations. Embracing the need for change, he and his team set out to reinvent vision care benefits and their delivery. This focus on the right innovation helped catapult EyeMed not only to record growth, but more importantly, to industry-leading member and client satisfaction.

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THE RE-ENVISIONED EYE CARE PLAN:



Premium Benefits With Low Out-of-Pocket Costs

by **DONNA GERINGER**

There has been a collective push for greater price transparency in the optical industry. Providers, patients, and policy makers agree that consumers need more information to understand their coverage benefits and make smart health care decisions.

Just in the past few months, the California Department of Human Resources launched a benefit calculator to help state workers compare their out-of-pocket costs for various health plans including medical, dental, and vision. The online tool will allow workers to see side-by-side comparisons of two health plans at a time and view costs for the 2015 and 2016 calendar years. It should help state workers who want a better understanding of what their care will cost. It is another indication of the demand for improved and simplified online resources to evaluate health care options.

The need for more education on cost versus value in benefits is critical for employees and employers. In fact, it's even more essential for employers as they face increasing costs and regulations.

The price of health care has been projected to increase 6.8% for employers this year, according to PricewaterhouseCoopers Health Research Institute. So, it's not surprising when we hear from our team of brokers that

they often dedicate entire conversations with HR professionals to medical coverage and benefits.

The dedicated focus on high-priced medical benefits makes sense. But it means that many brokers miss a huge opportunity to educate clients on specialty health benefits that employees want and that cost employers very little.

Vision plans offer high-value benefits at low costs. In fact, the Vision Council estimates that employers who add a vision plan to their benefit package can reap a return-on-investment of \$7 for every \$1 spent.

Beyond the financial impact, vision coverage has been shown to improve employee health and productivity. Routine eye exams can help detect chronic and costly health conditions, such as diabetes and hypertension—often at lower costs than a later diagnosis at a physician's office. Consider that one of the first symptoms of diabetes is blurred vision, even before other symptoms appear.

Early detection and treatment of eye diseases and overall health issues gives employees the chance to see better and allows for the prevention of vision loss and other serious health issues down the road. This translates to long-term cost savings for the employee and

employer and provides immediate savings in the form of productivity. An employee who can see clearly is less likely to take sick time, less likely to take frequent breaks at work to rest their eyes, and more likely to deliver better quality work. In the most recent Transitions Optical 2015 Annual Employee Perceptions of Vision Benefits survey, 90% of workers say that vision problems have affected the quality of their work.

Offering vision benefits to employees is a great way to attract and retain top-notch talent because employees see the value in vision. Nearly eight in 10 employees chose to enroll in employer-provided vision benefit plans in 2014, according to the Transitions Optical vision benefit survey. Additionally, vision care was the most popular voluntary benefit among employees, according to MetLife Inc.'s 12th annual U.S. Employee Benefit Trends Study.

STRUCTURING PLANS THROUGH OUT-OF-POCKET SAVINGS

Given the tremendous value that vision benefits provide and the growing demand for price transparency, many vision plans are focusing more on savings to the employee. This shift in strategy has uncovered an increasing desire among consumers for more information



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One Day PaySM available for most properly documented, individual claims submitted online through Aflac SmartClaim[®] by 3 PM ET. Aflac SmartClaim[®] not available on the following: Short-Term Disability (excluding Accident and Sickness Riders), Life, Vision, Dental, Medicare Supplement, Long-Term Care/Home Health Care, Aflac Plus Rider and Group policies. Processing time is based on business days after all required documentation needed to render a decision is received and no further validation and/or research is required. Individual Company Statistic, 2015. **Coverage is underwritten by American Family Life Assurance Company of Columbus. In New York, coverage is underwritten by American Family Life Assurance Company of New York.** Worldwide Headquarters | 1932 Wynnton Road | Columbus, GA 31999



about the materials (frames and lenses) side of vision benefits. Nine out of 10 workers say that it's important for their vision benefit to cover new lens technologies. More than eight out of 10 employees want their lenses to offer more light protection, according to the Transitions survey. Indoor and outdoor workers have nearly equal desire for protection from outdoor light, reinforcing the fact that employees are concerned about their vision at work and in their leisure time.

It is important for vision plans to deliver on these desires. If employees can't afford to pay for eyewear options that meet their lifestyle and vision needs, they simply won't get them. This is the reason we focus on making sure that employers know what is included and how much they are saving on their plan.

To reinforce quality, it is important to focus on emphasizing what brand names are covered, such as Transitions lenses, for example. Employees recognize this brand and understand that the lenses provide more comfortable vision by adapting to changing light conditions. It is important for employers to know whether options like these are covered in their vision plan. Employers can feature these options to show the cost-value savings that are possible with the plan. Additionally, employers can leverage these offerings to encourage more employees to participate in the employer-sponsored vision plan—leading to better vision and increased productivity.

MAKING VISION THE FOCUS OF YOUR COVERAGE CONVERSATION

The role of the broker has certainly evolved over the past few years, with education now being a top priority. Often, employers don't know the right questions to ask when they're meeting with brokers to discuss benefits for the upcoming year. Brokers can play an important role by helping HR professionals understand how offering a premium vision benefit is an easy way to enhance their benefit package, not to mention their increased return-on-investment.

One strategy that we recommend is for brokers to educate employers on key questions to consider when evaluating vision plan options. Educated employers are better equipped to ask the right questions and find a plan that offers their employees the highest value possible. Here are a few examples:

- **What does the average independent versus retail transaction cost? What is the average out-of-pocket cost employees will pay at retail chains?** Depending on your plan, pricing can vary significantly at different eye care locations. Understanding these differences helps employees make the best decisions to stay within their budget.
- **What materials coverage does the plan include?** Nearly one-third of workers are unaware whether their current vision plan offers discounts or coverage on

lens options, such as progressive lenses and impact-resistant materials, according to the Transitions survey. Educating employers so they can inform their employees on how their plans work and what's covered has a tremendous effect on the success of the vision offering.

- **How much choice in lenses and frames do employees have in this plan?** We know this is an important issue for employees. Clients appreciate having access to a large network of retail and independent providers and wholly owned labs. They also appreciate having access to a large collection of frames and brand name lenses.

Benefit brokers play an important role in recommending plans that offer the premium benefits that employees want at low costs, as well as educating employers on opportunities for out-of-pocket savings. This is the key to differentiating vision offerings and helping clients enhance employee satisfaction with an eye care plan that protects their vision and their pocketbook. ★

Donna Geringer is senior vice president, Sales and Exchange Development, at Davis Vision. She has more than 25 years of national account sales, client management and network development managed care experience. Previously, she held leadership positions at Anthem Blue Cross and Blue Shield, Aetna, and UnitedHealth.

2015 DENTAL SURVEY

PART 4

OUR ANNUAL SURVEY OF DENTAL INSURANCE CARRIERS IN CALIFORNIA

27. HOW DO YOU HANDLE THE ADDITIONAL COST OF OSHA REQUIRED INFECTION CONTROL IN YOUR PARTICIPATING OFFICES?

Aetna: These costs are a part of doing business.

Aflac: Since Aflac Dental does not have network requirements, policyholders can choose any dentist without restriction. It is the responsibility of each individual dentist to meet OSHA requirements.

Ameritas: All paid procedures are based on CDT codes. Infection control is a cost that is already anticipated in the provider's procedure fees.

BEN-E-LECT: This cost is maintained by each participating office. BEN-E-LECT is not responsible for the cost.

BEST Life: OSHA costs are the responsibility of the provider.

Blue Shield: There is no sterilization charge paid by the member on our dental PPO plans; any additional OSHA costs are incremental and included in the fees of the provider.

Cigna: Typically, dentists include these costs into their overhead, and we do not allow dentists to charge for this separately. For our DHMO plans, we pay an encounter fee to the dentist to help offset their added cost for OSHA-required infection control.

Delta Dental: The cost is included in regular dental office overhead. Network dentists are not contractually allowed to charge Delta Dental or its enrollees a sterilization/infection control fee.

Dental Health Services: The office visit copayment is designed to offset the OSHA costs for the office.

Guardian: Most dentists have incorporated the cost of Occupational Safety and Health Administration (OSHA) requirements into the fees for services and do not charge separately. If it is the office policy to charge separately for OSHA, we do not restrict or limit the fee as long as all patients, not just the PPO patients, are charged. Since there is no CDT/ADA code for OSHA, Guardian plans do not cover such charges. Also, we do not allow participating DHMO dental offices to charge additional fees for this.

Health Net Dental: OSHA-required infection control procedures are not eligible for payment. It is industry standard to implement OSHA compliant infection control stan-

dards for all equipment, facilities and staff without a stand-alone fee and/or reimbursement. For those dentists who do charge a separate fee, payment is the responsibility of the patient, although a Maximum Allowable Charge (MAC) is established.

HumanaDental: Most offices have incorporated the cost of OSHA required infection control in their overall service charges. These costs would be reflected in the data used to compile fee schedules. It's not usually a separate billable expense.

Securian Dental: The dentist must be in compliance with OSHA required standards including:

1. Meeting OSHA guidelines for hazardous material disposal including sharps.
2. Meeting all state and local requirements for safety and health. The participating office would absorb any costs associated with fulfilling this requirement.

United Concordia: Participating dental offices include sterilization costs in their service fees. In turn, United Concordia uses these fees to determine our maximum allowable charge (MAC) and fee schedules. Through a partnership with an outside vendor, we offer participating dental offices access to discounted sterilization monitoring services. All participating dental offices are required by regulations and by contract to maintain appropriate sterilization protocols.

28. DO YOU PROVIDE UTILIZATION DATA TO YOUR CLIENTS AND BROKERS?

Aetna: Yes.

Aflac: Since Aflac products are individually issued, this is not applicable.

Ameritas: Depending on the type of plan funding, size of case and the level of information, utilization data is available in conjunction with HIPAA requirements.

Anthem Blue Cross: Yes, Anthem Blue Cross provides a complete standard utilization and reporting package.

BEN-E-LECT: Yes. All data is provided at plan renewal and may be provided throughout the year by request.

Blue Shield: Yes. This is available upon request for employer groups of 300 or more employees at renewal.

BEST Life: Yes, we provide utilization information for large groups.

Cigna: Yes. We generally provide a standard package of dental information reports quarterly or annually at no charge. There is a charge for standard reports produced more frequently and for optional reports.

Delta Dental: Delta Dental provides standard utilization reports to fee-for-service clients and brokers on a monthly, quarterly or annual basis upon request. DHMO clients and brokers can receive utilization reports on an annual basis upon request.

Dental Health Services: Yes, Dental Health Services provides a wide range of utilization reporting, including treatment access, specialty claims activity, and member service call activity on client or broker request.

Guardian: Guardian provides standard utilization reports, available monthly, quarterly or annually.

Health Net Dental: Yes, we will provide utilization data upon request for large groups.

HumanaDental: Yes, on request and within the boundaries permitted by HIPAA.

Principal Financial Group: Yes, based upon the request of the client and/or broker.

Securian Dental: Yes, we can provide this information to individually rated employer groups upon request.

United Concordia: Yes, utilization reporting is available to clients and brokers for both PPO and DHMO.

Western Dental: Yes, utilization data can be provided on request to clients and brokers for large accounts.

29. COMPANY CONTACT INFORMATION

Aflac: Visit aflac.com/broker, call 1.888.861.0251, or e-mail brokerrelations@aflac.com to learn more about Aflac products and services.

BEN-E-LECT

Mailing address: P.O. Box 7809
Visalia, CA 93290

Physical Address: 5429 Avenida de los Robles, Suite A
Visalia CA 93291

www.benelect.com
(888) 886-7973, fax: (559) 733-2325

BEST Life

(800) 237-8543, fax (949) 553-0883
www.bestlife.com
email: info@bestlife.com

Blue Shield of California

Producer Services (800) 559-5905
Member Services (888) 800-2742

Delta Dental - Northern California Sales Offices

NCAsales@delta.org
100 First Street
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Phone: (415) 972-8300, fax: (415) 972-8466

11155 International Drive, M/S A2S
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Delta Dental -Southern California Sales Offices

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Long Beach, CA 90807
(562) 595-6000, fax: (562) 276-1211
Email: kheinz@dentalhealthservices.com
Website: www.dentalhealthservices.com
Plan Type: DHMO, Indemnity, PPO, EPO
Products/Services: Dental Plans
Min. Case Size: 2
Serving: CA, WA, OR

The Guardian Life Insurance Company of America

Ken Fritsch, Regional Vice President of Sales – Western Region
Kendall_H_Fritsch@glic.com
(602) 567-2602 (office)

Rick Porterfield, Regional Director
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711 High Street
Des Moines, IA 50392
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Life, Vision Products
mcconeghey.theresa@principal.com

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2015 PPO SURVEY PART 1

WELCOME TO OUR 15th ANNUAL PPO SURVEY

1. WHERE ARE DECISIONS MADE ABOUT SPECIALIST REFERRALS, TESTING, TREATMENT, SURGERY AND HOSPITALIZATION?

Aetna: Our patient-management staff members are based in geographic regions across the country.

Blue Shield: Treatment decisions, such as these, are made between the patients and their doctors. In the case of surgery, hospitalization or major diagnostic tests, Blue Shield’s prior authorization process is used to review the proposed treatment for medical necessity.

Cigna: These decisions are made by a customer’s physician in conjunction with the customer. Cigna’s clinical programs, nurse case managers, and health coaches can help individuals make decisions about their care. Cigna also offers award-winning online quality and cost information tools to help customers make informed choices. Some types of services require prior authorization by Cigna in order for the services to be covered under the individual’s plan. Customers can call Cigna Customer Service 24 hours a day, seven days a week with any questions about how their specific plan works.

Health Net: Decisions about specialty referrals for testing, treatment, surgery, or hospitalization are made with the member, the member’s physician, Health Net’s Care Management team and, if the member chooses, our external vendor AlereTM’s Nurse24 nurse line clinicians who will provide additional information to help the member through the decision-making process.

UnitedHealthcare: The treating healthcare professional and the patient make decisions about providing specialist referrals, testing, treatment, surgery and hospitalization. We determine whether such services are covered by referencing the member’s summary plan description.

2. WHICH COMPLEMENTARY MEDICAL DISCIPLINES ARE COVERED UNDER THE PPO OR WILL BE COVERED UNDER THE PPO?

Aetna: Many times, members can get special rates on visits to acupuncturists, chiropractors, massage therapists, nutritional counselors and others, which they pay directly to the participating provider.

Blue Shield: All members in our fully insured PPO groups are covered by our disease and case management programs. We offer the following:

- Transition of Care and guided imagery program.
- Our wellness assessment customizes referrals to lifestyle management programs. There are incentives to reward participation—available as a buy-up option.
- CareTips for Physicians: This clinical messaging program sends patient-specific messages highlighting gaps in care to the member’s primary care physician.
- LifeReferrals 24/7 to experts in financial planning, education, and law, along with personal consultations. It is included with all fully insured PPO plans and is available as a buy-up option for self-insured plans.
- Self-funded groups may now purchase the managed behavioral health buy-up package. This program is included with all fully insured PPO plans and is available as a buy-up option for self-insured plans.
- All members can search our health library; sign up for Blue Shield condition management and wellness programs; and subscribe to the Health Update eNewsletter. Online decision making tools allow members to compare hospitals, explore treatment options for their condition, and learn more about prescription drugs.
- Members get 25% off the usual and customary fees for acupuncture, chiropractic and massage therapy. Members can also get up to 40% off of selected vitamins and supplements, herbal supplements, homeopathic remedies, diet and sports nutrition, yoga and fitness equipment, personal body care, and health and wellness books, audio, and DVD products. (free shipping in most cases.)
- Wellness discount programs on Weight Watchers, 24-Hour Fitness, ClubSport and Renaissance ClubSport, and LASIK.
- A discount vision program.
- Chiropractic Network: Blue Shield has a directly contracted statewide network with more than 5,000 licensed chiropractors.

The plans your Small Business clients want with the online tools you need.

We're bringing it all
together for you.



We know this fourth quarter renewal period will be a busy time of year. But with Blue Shield's plans, online enrollment tools, and sales support, it can be a highly productive time as well. This year we have a paperless online renewal and enrollment process, and a host of plans to choose from—including two new PPO plans. *Look out for more from Blue Shield in the coming months. It's a big year for all of us—a year in which now, more than ever, we're committed to bringing it all together for you.*

Visit our Renewal Center at: blueshieldca.com/sbm-retention
to access the Small Group Online Renewal Tool, download rates, and get all the latest collateral.

- Blue Shield Centers of Expertise and Blue Distinction Centers: Members can find facilities and doctors that meet high-quality standards for transplant, cardiac and bariatric surgeries within California.

Cigna: This depends on the plan selected by the employer. Cigna also offers its Healthy Rewards discount program, which provides discounts for many types of complementary and alternative treatments.

Health Net: Complementary medical disciplines vary by each employer contract. If an employer chooses to offer complementary medicine, Health Net’s program offers direct referral to chiropractic and acupuncture care. All Health Net HMO and PPO members can access Health Net’s Decision Power Healthy Discounts program at healthnet.com. Health Net members get discounts when they choose selected complementary health care services from chiropractors, acupuncturists, and massage therapists participating in American Specialty Health’s ChooseHealthy networks. Members may find American Specialty Health providers listed on healthnet.com or by calling 877-335-2746. The member assumes liability for claims and is responsible to pay the provider directly on a cash-pay basis at a pre-negotiated fee schedule.

Healthy Discounts also provides Health Net members with discounts of up to 50% on a vast selection of vitamins, supplements, and other health and wellness-related products. Healthy Discounts offers discount savings on these products through American Specialty Health via ChooseHealthy.com. Members have direct access to products through the ChooseHealthy website, including vitamins and minerals, herbal supplements, yoga, relaxation products, books and videos. The website also provides educational information on a wide range of complementary health care topics.

UnitedHealthcare: American Chiropractic Network, a business segment of UnitedHealth Group, provides chiropractic benefits as well as discounts for the following complementary alternative medicine services to our enrolled individuals:

- Acupuncture
- Massage therapy
- Nutritional counseling
- Naturopathic medicine services (in states where naturopathic physicians are licensed)

UnitedHealthcare also offers employers an optional acupuncture benefit. Finally, through UnitedHealth Wellness programs, we provide discounts on products and services for nutrition, weight-management, fitness, stress management, and other wellness products and services

3. DESCRIBE YOUR COVERAGE FOR MAMMOGRAMS.

Aetna: Mammograms are included in the clinical screening annually beginning at age 40. This is only part of physical exam benefit when the customer’s benefit plan does not include a separate benefit.

Blue Shield: One annual mammography test is covered for screening and diagnostic purposes without illness or injury being present.

Health Net: Health Net’s PPO coverage for mammograms remains as follows: One baseline mammogram from 35 to 39; one mammogram every one to two calendar years for women from 40 to 49; and one mammogram every calendar year for women age 50 and older.

Cigna: Mammograms are covered annually for women age 40 and over or more frequently and at younger ages when medically indicated.

UnitedHealthcare: Options PPO provides coverage for mammograms as part of our standard outpatient surgery, diagnostic, and therapeutic services benefit. It is covered both as a preventive and diagnostic service.

4. DO YOU COVER PSA TESTS FOR NON-SYMPOMATIC MEN? IF SO, AT WHAT AGE?

Aetna: Yes. If a state has specific legislation, we will pay it in accordance with the law. There is no age limit unless it’s being paid under a specific benefit (like the Trust benefit), which has a contractual limit.

Blue Shield: Coverage includes, but is not limited to, prostate-specific antigen testing and digital rectal examinations, when medically necessary and consistent with good professional practice. There is no age limit for PSA testing when billed with a preventive-care diagnosis.

Cigna: These tests are covered based on the treating physician’s recommendations when medically indicated.

Health Net: Preventive care and diagnostic procedures for adults (age 17 and older) are covered at a physician’s direction. When medically indicated for men age 50 and above, tests and procedures, including, but not limited to, prostate-specific antigen testing (PSA) and digital rectal examinations are covered.

UnitedHealthcare: Network physicians are encouraged to follow the Guide to Clinical Preventive Services of the United States Preventive Services Task Force (USPSTF) as the basis for preventive care. We cover PSA tests regardless of age even though the USPSTF indicates this screening lacks clinical value. ★



Gearing Up for Year Three of COVERED CALIFORNIA

by JENNIFER MOORE



**COVERED
CALIFORNIA**

Ever since the nation began contemplating health insurance exchanges under the Affordable Care Act, there have been predictions that individual premiums would be so sky high that few would sign up, dooming the exchanges to failure. As we all gear up for year three of the Covered California exchange, we're hearing predictions in other states of steep spikes in 2016 individual rates (sometimes 50% or more).

Here in California, though, we are seeing far more modest premium trends, which are among the steadiest in the country. On average, California individual rates will rise just 4% in 2016, which is just under 2015's 4.2% average. These are far cries from the double-digit increases that doomsayers predicted in years past.

While there are several reasons for California's success, issues such as

the upcoming phase out of the reinsurance and risk corridor programs and the ever-increasing price for specialty drugs will require focused attention and action to help relieve the upward pressure on rates.

REASONS FOR SUCCESS

Let's face it. California did the right thing when it made the decision in late 2013 to not allow non-ACA compliant individual plans to co-exist with on- and off-exchange plans. This was a controversial call at the time, coming as it did after the President said, "If you like your current insurance, you keep that insurance."

But it was the right call. Some states skewed their risk pools when they concurrently allowed both non-compliant policies and exchange policies. That's because healthy individuals kept their non-compliant policies and sicker individuals bought coverage from their exchanges. Some of these states will see the highest 2016 rate hikes.

Another reason for California's success is the focus on cost-efficient networks of doctors and hospitals, which represents one of our best opportunities for harnessing market forces to lower health care prices, and therefore keep a grip on premiums.

According to Dan Mendelson, CEO of Avalere, a Washington, D.C.-based health care consultancy, "Given the new requirements put in place by the ACA, network design is one way (health) plans can drive value-based care and keep premiums low."

Three of the big four health plans in Covered California tailored their networks for the exchange and focused on providing value via price and quality rather than network depth. And they did so while following federal regulations that require all exchange plans to maintain a network that is sufficient in number and types of providers to ensure that all services will be accessible without unreasonable delay.

We are learning that most exchange customers are happy with their coverage. According to a Kaiser Family Foundation survey released in May 2015, 74% of Covered California enrollees say their coverage was excellent or good. And 91% said it was easy to get care from their normal source.

Further, another May 2015 study, this one by the University of California, Irvine, and the University of Wisconsin, Madison, said the average quality of hospitals available through Covered California policies does not appear lower and may actually be higher than commercial plans with wider networks.

MORE HEAVY LIFTING AHEAD

Despite the good news, now is not the time to pause and reflect. There's still some heavy lifting to be done to avoid future premium pain. That's partly because the ACA's reinsurance and risk corridor programs, which help stabilize individual premiums, go away after 2016. According to the Centers for Medicare and Medicaid Services, these two programs lowered premiums nationally by 10% to 15%. According to Covered California executive director

Peter Lee, the loss of these programs in California is expected to add 2% to individual premiums in 2017.

Of course, another persistent cloud on the horizon is high-priced drugs. According to actuaries with the U.S. Department of Health and Human Services, prescription spending in the United States leaped 12.6% from 2013 to 2014, the highest rate of growth since 2002. In a July 2015 Health Affairs report, these actuaries said the figure (which was only 3.6% the previous year) is one "result of expensive new treatments for hepatitis C," which can cost \$1,000 per pill or more.

When it released an analysis on the cost of hepatitis C drugs in June 2015, the California Association of Health Plans said, "These highly effective, but costly, treatments pose a significant threat to the stability of our health care system at a time when health care reform has expanded coverage to millions of Americans."

And it's not just hepatitis C drugs that are causing heartburn. Six-figure prices for cancer drugs are set to be-

come the new normal, and a new class of cholesterol medication, called PCSK9, could carry a national price tag of between \$50 billion and \$100 billion annually, according a Health Affairs blog post in February 2015.

LET'S WORK TOGETHER

While it was good news when Covered California announced the second straight year of modest premium increases, it is imperative that we remain vigilant and work together to address these continuing challenges. With a laser focus on the underlying factors that impact health care premiums and a sustained commitment to quality, we can continue our work providing access to affordable, quality coverage in our state.

California is a bellwether for the rest of the nation. Through dialogue and collaboration, we hope to be able to export key pieces of California's success to other parts of the nation. ★

Jennifer Moore is vice president, Individual Market and Health Care Exchanges, for Health Net.



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FIVE THINGS

THAT SENIORS LOOK FOR IN A MEDICARE ADVANTAGE PLAN

by DAVID MILLIGAN

Ten-thousand Baby Boomers become eligible for Medicare every day, which opens a world of opportunities for brokers. But it's a world of confusion for many new seniors. The Medicare Advantage marketplace is undergoing tremendous change as the Affordable Care Act pushes more consumers (commercial and Medicare alike) into managed care. Regional plans continue to emerge; existing plans get stronger through an unbridled proliferation of mergers; and competition becomes more intense than ever.

With heavy regulations and government oversight, most plans differentiate themselves through provider networks and benefit designs, creating multiple plans to appeal to market subsets. Also, special need plans address dual-eligibles (Medicare and MediCal), those with chronic conditions, and those who are nursing-home eligible, but prefer to remain at home. The result is more choices than the average consumer can digest.

Brokers can serve as a trusted resource for seniors who need to make these important decisions as the annual enrollment period is upon us. To do this most effectively brokers must understand what is most important to seniors and how seniors navigate the selection journey.

Over the past, year SCAN Health Plan asked seniors what they look for in a Medicare Advantage Plan. Here are five things that researchers found:

ONE: COST AND ACCESS ARE KEY

Seniors listed these factors as their first or second most important consideration in choosing a Medicare Advantage plan:

- 62% having low co-payments for inpatient and outpatient hospital care.
- 45% having low copayments for prescriptions.
- 54% having their doctor in the network. This factor grows in impor-

ance with age. Fifty-seven percent of seniors 71 or older ranked this factor as the first or second most important compared to only 51% of those 65 to 70.

TWO: A RICH ARRAY OF BENEFITS IS IMPORTANT

Forty percent of seniors say that their first or second most important factor in choosing a plan is having value-added benefits, such as vision benefits, dental benefits, gym membership, and transportation benefits. Even with a supplemental plan, straight Medicare offers none of these extra benefits. Before you can advocate for a Medicare Advantage plan, you need to sell the concept in earnest. Added benefits, along with care management and other quality focused programs, need to be part of that conversation. Remember, seniors aren't just choosing among Medicare Advantage plans; they are choosing between traditional Medicare and Medicare Advantage.

THREE: SENIORS ARE NOT HOMOGENEOUS

Obviously a 25-year-old's lifestyle and healthcare needs are far different than that of a 50-year-old. So it's important to recognize the differences between a 65-year-old and a 90-year-old. Younger and healthier seniors may want a health plan that is simply there when they need it. They are fine with online health information and preventative care programs that fit their busy lifestyle. But those with chronic conditions have far different needs. They are concerned about having affordable physician visits and managing complex medication regimens. They may need additional help from care managers to navigate the complex healthcare system. The frail and truly elderly are likely to need help staying in their homes and remaining independent for as long as possible. They may need in-home

assistance with daily activities, in-home doctor visits, and in-home interventions like fall prevention programs. Those approaching the end of life need respectful and dignified palliative care and help with end-of-life decisions. It is critically important for brokers to recognize these differences in order to guide clients to the right health plan and benefits.

FOUR: THE DECISION MAKING PROCESS IS NOT THE SAME FOR ALL SENIORS

Seniors who are confident and logical need little hand-holding. They want the best fit, the best cost, and the best value. Seniors who are intimidated or emotional may be afraid of making the wrong decision. They may procrastinate while the clock is ticking. Here the broker can serve the greatest value by being an informed and compassionate advisor. Brokers can provide objective counsel, help seniors sort through information, and be a reassuring voice to help them feel good about their decision.



FIVE: SENIORS TURN TO A VARIETY OF DECISION-MAKING SOURCES

When considering switching plans, more than 37% of seniors visit health plan websites while nearly 19% rely on mailings and other materials provided directly by the various plans. When choosing a plan, seniors consider the following information sources somewhat or very important: 20% their doctors; 18% recommendations from family and friends; and nearly 10% their brokers. There is an important opening for brokers to fill that gap between the information that the health plan provides and the need for an unbiased conversation. Many seniors have worked with an insurance broker for their health plan selection as well as life, home, auto, and other insurance needs. They are used to turning to a broker for objective information and help in the decision making process.

Given its enormous potential, Medicare Advantage can no longer be ignored. There are more than 54 Medicare beneficiaries in the United States. More and more seniors are choosing Medicare Advantage plans, not just for cost-savings and value-added benefits, but also because of one factor that trumps all else: coordinated care. Repeated studies have shown that seniors who are enrolled in Medicare Advantage plans experience fewer hospital admissions and readmissions, fewer emergency room visits, and lower medical costs. That's because Medicare Advantage plans help ensure appropriate utilization of services; improve the coordination of care among providers; and improve clinical outcomes. Now is the time for California's brokers to seize this opportunity, to understand the buying habits of this growing pool of potential customers, and to make Medicare Advantage a thriving part of their business portfolio. ★

David Milligan is senior vice president of sales for Long Beach-based SCAN Health Plan, one of the nation's largest not-for-profit Medicare Advantage plans serving more than 170,000 members in California and Arizona.

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⁴NAIC 2013 Medicare Supplement Insurance Experience Reports, August 2014

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TIPS

for a Successful Fourth Quarter

by JESSICA WORD

With major Affordable Care Act (ACA) changes going into effect in 2016, it is crucial for California brokers to come to the aid of their small and large group clients during the upcoming fourth quarter, so that businesses are not caught unprepared.

Many challenges will continue from 2015. Companies still have to navigate a complex marketplace to shop, compare, pick, and purchase the right plan options for their workers—all while adhering to federal mandates. In turn, eligible employees must evaluate choices, make an appropriate selection, and complete the enrollment process, which can be a complicated chore.

The coming season could be even more head-spinning. Additional hurdles could hit unprepared businesses hard during the fourth quarter, such as the end of “grandmothering,” the expansion of the small group market, and more. The overall impact could be particularly large since businesses in California employ more than 13 million people, according to data from the Census Bureau. Many of these businesses have at least two people on the payroll, and nearly 700,000 have two to 100.

Without vigilant guidance, companies can quickly find themselves forced into health plans that charge substantially more than necessary while offering employees fewer options, reduced access, or narrower benefits. Brokers can provide a steady hand to guide clients through these changes and avoid mistakes that can have catastrophic effects on employee health and fiscal well-being.

The fourth quarter is expected to be one of the busiest in our industry’s history as groups with grandfathered plans transition to ACA-compliant coverage. Many agents are taking steps now to ensure that their business groups address considerations around coverage, costs, and ACA compliance.

Doing so will help employers select the best available options to meet workers’ health plan needs while keeping tight reins on costs. Here are some key recommendations that agents should consider to guide their clients smoothly through the fourth quarter and the upcoming ACA changes:

IDENTIFY YOUR “GRANDMOTHERED” GROUPS

California is not allowing renewals of grandfathered small group plans in 2015. This means that small businesses must transition to a new health plan during the fourth quarter of 2015. As your groups prepare for their move to ACA-compliant coverage, be sure to begin shopping for options as early as possible. A previous plan may map to a new ACA-qualified plan, but it may also include significant changes. For example, coverage may be similar, but may not include certain provider networks and access to physicians and hospitals. Employees may run the risk of having significantly increased pharmacy costs, not being able to see providers with whom they have developed long-term relationships, and getting hefty fees from hospital stays or emergency room visits. Providing options early will help avoid sticker shock from higher premiums for plans that are matched automatically based on coverage rather than coverage and price.

RECOGNIZE YOUR NEW SMALL EMPLOYERS

Beginning January 1, 2016, California will join a number of other states in expanding the definition of “small employer” to mean a business that employs two to 100 people (up from two to 50). Thousands of companies throughout California will now be subject to several small-group market reforms, covering a minimum set of essential health benefits and member level rating.

Brokers play a crucial role as educators, service advocates, and expert consultants. Groups sized 51 to 100, that are facing new benefit and cost-sharing requirements, will be turning to agents to help contend with potential effects on premiums, the loss of traditional composite rating, changes in access to provider networks, and more.

ADDRESS CLIENT CASH FLOW CONCERNS

Cash flow is a major concern for all employers. For many in the small group category, their fourth quarter 2015 renewal could bring about major rate changes. One big area of change could be significant rate increases for certain plans. Helping your clients and their employees understand and prepare for these is paramount. One way is to provide rating and summary comparisons of grandfathered plans versus ACA-compliant plans. Easy to read side-by-side assessments give employers a much clearer picture of their options and the trade-offs among various plan options in terms of benefits, costs, and more.

GET EACH DEPENDENTS' DATE OF BIRTH

New ACA member level rating requires a date of birth for all health plan participants. This includes each employee and their enrolled spouse/domestic partner and dependent children. Ask your groups for this information now. This will help ensure that your clients are getting the most accurate quotes possible.

ENSURE ACCESS TO PROVIDERS

One of the biggest upsets for employers and workers is not having access to their trusted doctors, pharmacies, hospitals, dentists, optometrists, and other care specialists. This is something to monitor when shifting to a plan that meets ACA requirements. Confirming in-network participation through provider searches, upfront, is a great way to keep employees happy as well as please clients and keep them for the long term. A good carrier or general agency should offer you the tools and service support for provider search requests for medical, ancillary products, prescriptions, and much more.

GET INNOVATIVE

Brokers must turn to innovative products and technologies to meet clients' demands for traditional coverage and value while delivering better rate stability than what was seen in this year's double-digit rate increases. As the insurance industry continues to be commoditized, there is a growing need for brokers to identify packages that bridge the gaps, which have been created as carriers work to comply with medical-loss ratios and an increasingly competitive marketplace. Alternatives like PEOs allow clients to obtain a large group policy that is not subject to all of the ACA requirements. When a client's out-of-pocket maximum triples after their transition from a grandfathered plan to an ACA-compliant plan, creating a bridge plan will provide a safety net that eases the move from the traditional single co-payment to percentage-based payments.

Those who take risks may encounter unforeseen problems, but helping clients navigate the new and constantly changing insurance marketplace can change lives, and that's really what we're all in this for: to help people.



GUARANTEED ACCURACY

Business owners and their employees want and deserve to have a clear understanding about costs when it comes to health care coverage options. Be sure to seek the service and tools that enable you to deliver highly accurate quoting. This should include options, such as consolidated, multi-carrier proposals with highlighted plan differences and multi-lingual benefit spreadsheets. You also want the ability to compare current and renewal benefits and rates with the entire marketplace, so you can highlight differences in co-pays, deductibles, prescription benefits, and other features that are important to your clients.

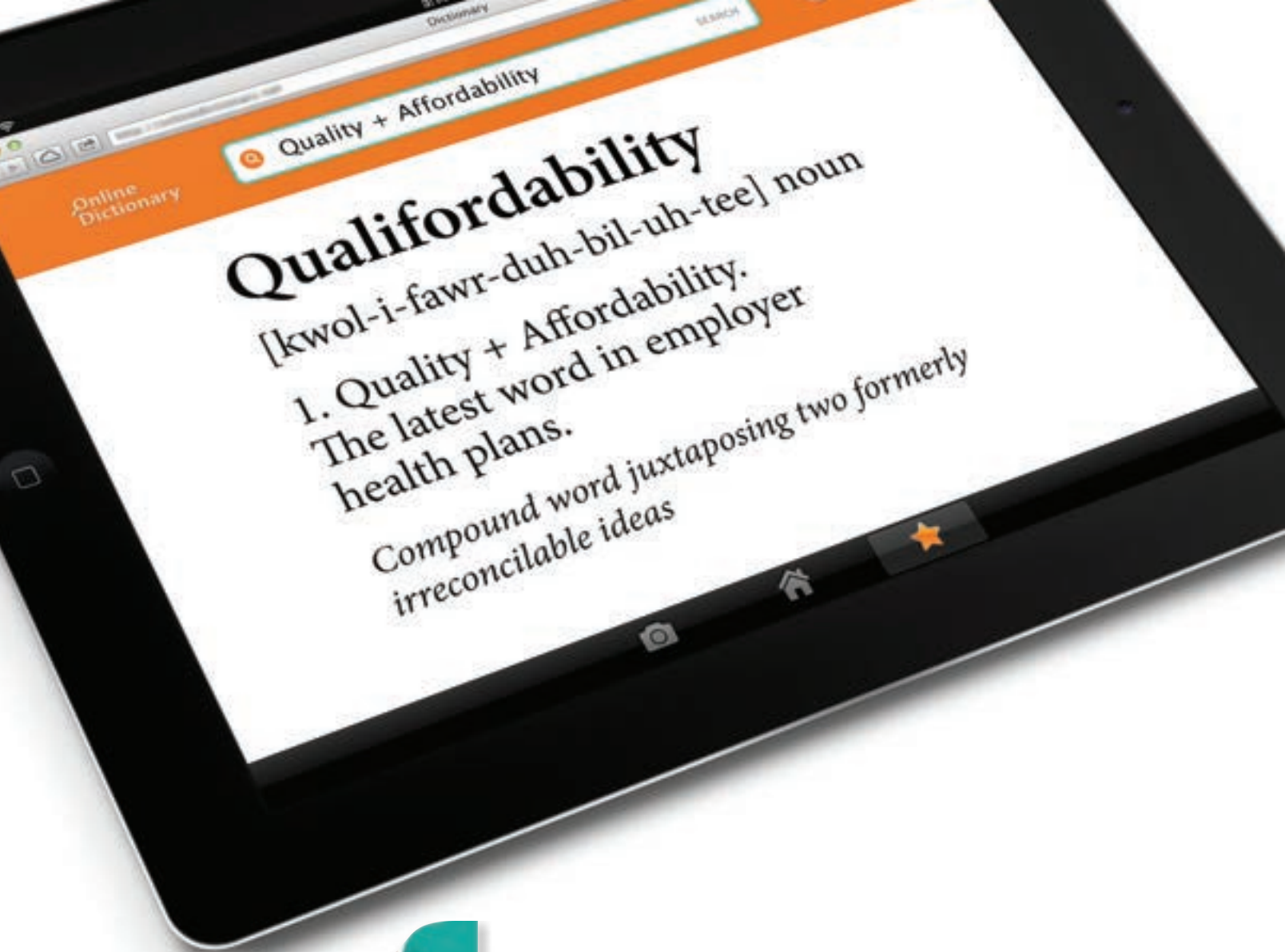
OFFER ONLINE ENROLLMENT BACKED BY PERSONAL SUPPORT

Customers demand real-time, simple-to-use online tools not only to shop and compare health plans, but also to enroll. Employees want and expect the ability to go online and create an account; compare coverage and plan options; complete and submit an application; have access to physician, pharmacy, and other provider directories; and more. Using the right system with the latest technological innovations allows brokers to better serve clients, and manage new and existing business throughout the entire enrollment process—whether they use online enrollment or paper applications.

Technology, alone, is not enough. It must be supported by personal service. That means having the support of experts who can be tapped, at a moment's notice, for professional advice, assistance, and troubleshooting.

As groups renew benefits for 2016, businesses that are unprepared are going to find themselves facing a difficult time or worse. The broker community needs to get out in front of the season as early as possible and serve, serve, serve. Understand the federal and state mandates and how they affect your customers. Connect to and provide the technology and tools needed for quotes, comparisons, and enrollment. Do as much upfront legwork as possible. And be sure to be there for expert counsel and support before, during, and after the fourth quarter. The earlier that agents recognize the season's potential difficulties, the better they will be able to strategize ways to best serve their clients' needs. ★

President of The Word & Brown General Agency, Jessica Word, is a recognized leader in developing and distributing comprehensive health benefit plan models and insurance solutions through licensed brokers. For additional information, visit wordandbrown.com.



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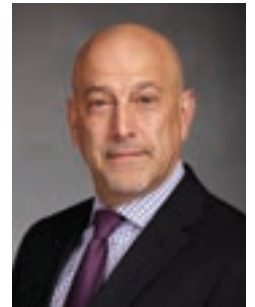
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AGENTS WILL CONTINUE TO

AN INTERVIEW WITH RON GOLDSTEIN

Thrive



Ron Goldstein, CLU, is president and CEO of CHOICE Administrators. He also created and manages America's longest-standing, state-approved exchange, *CaliforniaChoice*.

by **MEG McCOMB**
CAHU VP of Communications

With grandmothering going away this year, and small group defined as up to 100 lives in 2016, will the California marketplace implode?

No, the California marketplace will not implode because of the loss of grandmothering and the new small group definition. Agents can help employers, especially those now classified as small group, to understand the changes and chart a course to identify the best options for their employees. Agents provide much needed guidance to small businesses that are putting together or updating their benefits packages.

What are the biggest challenges that agents will experience in the next five years?

The biggest challenges that agents will experience in the next five years include working with small businesses to maneuver narrow physician networks, technology-driven products (e.g. online enrollment, determination of group size, physician directories, Rx search), and more.

How important is technology to agents' success?

Technology is critical to their success. It gives agents opportunities to increase their role as valuable experts and resources for employers and employees. Agents need to embrace technology, which can include online quoting engines, provider directories, and additional technology-driven products. These tools allow agents to simplify processes for employers and employees, resulting in better overall service.

Will private exchanges be a major factor in the California marketplace in the next 24 months? How about the next five years?

First, we need to define a private exchange. Private exchanges come in different shapes and sizes. Most private exchanges feature a single carrier and technology that aggregates information and services. Once a business is enrolled, the carrier facilitates the claims and day-to-day services. The other

model is a multi-carrier exchange. The goal of the multi-carrier exchange is to offer their groups and their employees a range of carriers and plans.

Recent studies from groups, such as Accenture, point to the increasing dominance of private exchanges. We expect these exchanges to remain a major factor in the California marketplace throughout the next 12 to 24 months.

Will carriers be forced to provide full networks in the individual marketplace over time?

Based on the regulatory and legislative environment, carriers will continue to work within that framework and offer better network options to individuals and employees in California.

What is the biggest threat to California agents—federal or state mandates?

They are both equal threats; many agents have already seen their books of business decline due to the regulatory environment.



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Will agents be forced to charge a fee for their services to sustain their income? If so, how soon?

Most large brokerage firms have been charging consulting fees for years. As commissions decline, agents will have to come up with solutions to keep their income steady. Part of the solution might include charging fees.

Do you expect all medical insurance enrollments to be online in 24 months? What about the next five years?

Online enrollment is already extremely prevalent in the large group market today. I foresee the online enrollment process becoming more accepted in the small group market in the next five years.

Will health care reform compliance become the biggest reason employer groups dissolve medical insurance programs in the next five years?

Our feeling is that the health care reform will not result in a massive exodus in the group market. We're seeing micro groups (one to four lives) dissolving their health insurance programs and sending their employees to the state exchanges to purchase their benefits.

Will the small group market remain viable in California in the next five years?

Yes

Do you expect Congress to pass legislation to remove agent compensation from the medical loss ratio?

It would be great if Congress is able to pass legislation to remove agent compensation from the medical loss ratio.

What do you think the biggest change in health care delivery will be in the next five years?

The biggest changes that the health care delivery system will experience in the next five years will include a greater number of network changes and accountable care organizations gaining traction in the marketplace. This will include telemedicine, along with the ability for consumers to monitor and manage their health through online services where they can schedule their appointments, view test results,



x-rays, and more. Technology will be at the forefront in how patient care is administered.

What would you say to a young person who is considering a career as an insurance agent?

I would advise a young person considering a career as an insurance agent to identify why they want to be in the market. Then I would ask them to really think about what aspects of insurance interest them—health insurance, life insurance, etc. I would tell them to have a good understanding of newer technologies and their benefits, so that they can provide added value and greater service to their clients.

What role has CAHU played in preserving the role of the agent in California?

CAHU has played a vital role in preserving the role of the agent in California. CAHU emphasizes the value and service that agents bring to employers in an era of increasing choices, to address the needs of a changing workforce.

What if you had one piece of advice to give agents, what would it be?

Embrace technology and provide quality service—it remains king! ★

CHOICE Administrators provides health insurance options and provider access to small businesses and their employees. For additional information, please visit calchoice.com

WHAT BROKERS SHOULD LOOK FOR

When Evaluating Medical Groups

by **JEFF BURNICH, M.D.** and **STEVE NOLTE**

Brokers must navigate waters that are always changing course. To make one aspect of brokers' lives easier, here are some quick reference points for brokers to consider when assessing medical groups on behalf of their clients.

QUALITY

One thing is more important than anything else to today's healthcare consumers—and that's a great doctor. High-quality care is the cornerstone of any reputable medical group. Only consider medical groups that rank consistently among the top performers in providing quality patient care both in California and nationally. Look for medical groups that sustain long histories of improvements and advancements in healthcare excellence.

ACCESS

Savvy consumers want convenient ways to access their healthcare. It's important to consider how medical groups innovate to address evolving community needs. Can patients connect to their medical group through a secure online portal, mobile app, or mobile clinic? Can they substitute an office visit with a video visit? Does the medical group offer after hours or weekend care in their own offices, in an urgent care clinic, or in an affiliated clinic that's part of a major retail outlet? Does the medical group use an electronic health record system that shares pertinent patient information easily and securely through a health information exchange if necessary? Does the medical group use dedicated navigators to help patients find physician specialists? Does it have dedicated clinical navigators to guide patients with certain health conditions through their treatment plans? Greater options often translate into greater convenience, which consumers value very much.

Because of the Affordable Care Act, the past couple years have been all about change and relearning. The great thing that's come out of this is a new attention to customer service. Brokers should look for great health plans that use innovative technology to improve access and move information through the system more effectively and efficiently. This means less work and headaches for the broker.

PRICE

It's no secret that consumers choose healthcare providers based on cost. Cost transparency helps patients and payers make more informed choices. Accountable care organizations (ACOs) focus on managing the total cost of care, improving efficiency and enhancing quality, especially for the

chronically ill. The goal of these arrangements between medical groups and insurers is to help patients receive the right care at the right time without medical errors and unnecessarily duplicating services. When an ACO succeeds in delivering high-quality care and spending healthcare dollars wisely, it shares in the savings it achieves for the Medicare program. It's worth examining which medical groups tap into these partnerships. Improved care coordination and standardized processes also help keep costs low and quality high.

STABILITY

Brokers and consumers should always look for a health plan that's highly stable. Too many moving parts and changes can be complicated and unpredictable. When brokers present an annual renewal, they should be sure they're pitching a stable, predictable, high-quality, well-branded healthcare option.

VALUE

The bottom line is that choosing a health plan is all about value, and value appears at the intersection of quality, access, price, and stability. When brokers look for these key attributes in a health plan, they drive high customer satisfaction and pave the path to their own success. ★

Jeff Burnich, M.D. is Senior Vice President, Medical & Market Networks, Sutter Health. Steve Nolte is Sutter Health Plus CEO.



DISABILITY CLAIMS

FROM

THERE

TO

HERE

Disability claim departments have made great inroads in processing disability claims over the past 25 years. The disability claim process used to be simple. There was a simple form for the claimant to complete along with the attending physician statement. Tax returns were not requested and there was very little support from physicians, CPAs, or in-house other consultants or from independent consultants.

It was common for larger cities to have local claim managers and a staff of local claim adjusters. Many claims were decided on a local basis with little interference from the home office. But if a claim involved a significant dollar value, home office approval was usually required. Local brokers often had relationships with the local claim managers. A broker with a large book of business might have some influence in the decision process. I can even recall a claim in which the client just purchased a disability policy and then went on claim several months later. The claim sounded fishy to me, and I communicated such to the local claim manager who was appreciative of my feedback. After an investigation, the claim was denied appropriately.

Sometimes a call to a vice president at the insurance company might have been warranted on behalf of a claimant who appeared to have a legitimate claim. In those days, relationships mattered, and there was a degree of trust between producers and insurance company claim departments. As a member of a group of heavy hitters who sold a substantial number of disability policies, mostly to professionals, I enjoyed the quarterly meeting of some eight to 10 of us who were privy to changes that would soon occur in the industry before that information was available to the general producer audience. Having a local marketing manager or local claim manager talk to our group was indeed a pleasure and most informative. Although there was healthy competition among the carriers and brokers, camaraderie enabled us to strive to be the most informed and the best at our craft. Those days are long gone. It's often almost impossible to determine who the claim manager is for a particular insurance company.

In spite of the many improvements in the claim process among claim departments and third-party administrators, there is a huge lack of conformity in the wording of claim forms—many of which have archaic and confusing wording. Some questions are there just to confuse the claimant as well as the attending physician, and are ambiguous at best. The result is confusion on the part of the claimant and the attending physician. In turn, a confusing question receives a confusing answer (garbage in; garbage out). Some questions are repeated over and over on the forms, in hopes that the respondent will be inconsistent in the answers. Some questions require the claimant to rephrase the question in order to give an intelligible answer.

Some questionnaires sent to chiropractor claimants have nothing to do with a chiropractor's duties or a similar form is sent to the claimant's attending physician. What a shock for me recently to see that one insurance company actually designed a chiropractor questionnaire as a supplemental form with questions that were probably created with the help of a chiropractor. Who better to understand what a chiropractor does? Certainly not a claim person or attorney.

by **ARTHUR FRIES**



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It is a waste of time and money and an additional hassle to require the claimant to complete a monthly progress report (or claimant's continuation statement) for claims that appear to be solidified and of a long-term nature. For my own clients, I can provide guidance on how to submit forms less frequently. But, they should not have to ask me for this type of advice. Sometimes common sense seems to be lacking on the part of the claim person. It is typical to see a change in claim personnel handling a claim over a period of years. Most of the time, they do not have the time to read the claimant's file from the beginning, so they merely glance at it. They lean on the claimant with requests for more frequent forms or exams and field investigations when a proper reading of the file would have shown that they were just spinning wheels with no opportunity to terminate a solid claim.

Sometimes I see independent medical evaluation reports that smell of boilerplate crappola with very little effort put forth by the physician who is hired to be independent, but is often influenced by the insurance carrier.

I'll close by mentioning probably the most abusing independent medical evaluation that I have ever encountered. My client, an orthopedic surgeon with cervical issues, ar-

rives for his independent medical evaluation exam, which was requested by the insurance carrier. He notices that all of the office personnel are male with piercings on various parts of their bodies (face, tongue, ears, etc.). The examiner (an orthopedic doc) calls him into his office, locks the door, and puts a latex glove on his right hand. My client was smart enough to ask the appropriate question, "What do you plan to do?" The examiner replied, "I'm going to do a rectal exam." My client replied, "What's that got to do with my cervical issue?" The examiner said, "We do this exam for all patients who come into our office." My client insisted that he would not be having this rectal exam since it was invasive, not permitted, and improper, to which the examiner replied, "That's okay it's voluntary on your part; you don't have to do it." As shocking as this story is, it never fails to amaze me that life presents a number of shocking stories and we just hope that they don't involve us. ★

Art Fries, RHU LIC #0450274, is a disability claim consultant providing advice on a national basis in the U.S. He is located in Nipomo, California. He can be reached at 800-567-1911 or e-mail friesart@hotmail.com. For more information, visit afries.com.



THE MOST UTILIZED LEGAL SERVICES

Hyatt Legal's most utilized legal services for 2014 were power of attorney, real estate matters, and wills, according to a recent study. Overall plan member use increased 6.7% year-over-year as plan members sought out attorneys for a wide range of legal matters. The following are the top five most utilized legal services for 2014:

1. 18% Power of attorney
2. 12% Real estate matters
3. 12% Wills
4. 11% Document preparation/review
5. 10% Living wills

IDENTITY THEFT BENEFITS

Hyatt Legal Plans is partnering with IDT911, a provider of identity and data risk management service. The partnership will allow Hyatt to offer IDT911 LifeStages Identity Management Services. With this new partnership, Hyatt Legal plan members will have access to fraud specialists who can assist with a wide range of identity theft issues. The new identity theft services will include document replacement services, resolution services if someone becomes a victim of identity theft. The plan also offers assistance for a number of growing identity theft scams, such as tax fraud, estate identity theft, military identity theft, and break-in recovery. Fraud specialists will be available 24 hours a day and will stay on the case until the issue is resolved. All new plans effective January 1, 2016 will have access to IDT911 LifeStages Identity Management Services as part of the legal plan.

According to a report released last year by Javelin Research, an identity is stolen every two seconds. Identity theft affects people at all stages of life—from childhood to college through getting married, buying a home, and retiring. Thieves only need a name, birth date, and Social Security number to steal an identity. Their methods to get this information can range from stealing a wallet or mail to hacking into computers or your phone. Last year, fraudsters stole \$16 billion from 12.7 million U.S. consumers. For more information, visit legalplans-idtheft.com.

LEGALSHIELD AND KROLL LAUNCH IDENTITY THEFT PROTECTION SERVICE

Responding to recent national data breaches, LegalShield and Kroll have launched IDShield, the only service that provides direct access to Kroll's team of licensed private investigators. The launch of IDShield takes the current LegalShield identity theft protection product to a new level with pre-emptive monitoring, a \$5 million service guarantee, and 24/7 emergency access to Kroll investigators. Consumers can download an IDShield mobile app, providing one-click access to a U.S.-based advisor for assistance in handling emergency and non-emergency issues.

Jeff Bell, CEO of LegalShield said, "More and more people know that ID theft is a real threat, but what many don't understand is that the most popular offerings provide a false sense of security. We built IDShield to pre-emptively monitor the identity theft indicators."

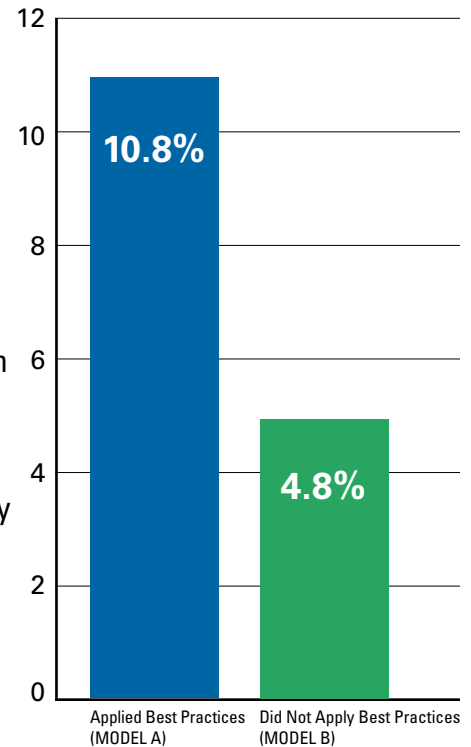
Credit card fraud is the most costly result of personal data being misused, but other types of ID theft can be harder to find and fix. Bell said, "Identity theft can compromise a lot more than your money. We've seen how stolen personal information like a driver's license number, medical and insurance identification numbers, and Social Security numbers have led to devastating events, such as false arrests, tax fraud, and insurance fraud. Even your child's personal information is at risk."

IDShield monitors an enrolled consumer's identity from multiple angles, including Social Security number, credit cards, bank accounts, name, address, date of birth, drivers' license, passport numbers, email addresses, phone numbers, and medical ID numbers. The member gets an email update if a change in their status occurs. A member who spots suspicious activity can contact a private investigator immediately and begin restoring their identity. IDShield's mobile app allows a member to contact an identity-theft expert with the push of a button. Daily updates to online dashboard monitoring enable members to see, right away, if there are changes that could indicate a potential ID theft. IDShield offers an individual plan to cover one person for \$9.95/month and a family plan that can cover up to 10 family members/dependents for \$19.95/month. For more information, visit LegalShield.com or call 800-654-7757.

5 BEST PRACTICES FOR ENROLLMENT

- 1 COMPANY CONDUCTS ENROLLMENT**
Employees enroll for all voluntary benefits at the same time so there is no need to go anywhere else to enroll in the legal plan.
- 2 OFFER THE PLAN ANNUALLY**
The legal plan should be offered alongside core benefits during regularly scheduled enrollment periods.
- 3 COMMUNICATIONS ARE DISTRIBUTED BY THE COMPANY**
Employees will read materials from the employer, especially when included with the employer's benefits workbook.
- 4 PERSONALIZE COMMUNICATION MATERIALS**
It's important to offer materials that let employees know specifically how certain benefits can meet their needs at different life stages.
- 5 COMPANY SUPPORTS THE LEGAL PLAN**
When the company recognizes the value of the legal plan, so do employees.

Source: Hyatt Legal Plans, a MetLife Company



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CONTINUING THE SALE WITH *Life Insurance*

by **MICKEY ELTING**

After 20 years of working for a large insurance company, I went out on my own as an independent broker. It took a lot of time, patience, and retraining to start thinking outside the one-company mindset.

Fortunately, the relationships that I worked very hard to develop were still strong. Many established clients asked me to help them even more than before. This goes to show that our business is all about managing relationships and making meaningful and trustworthy impressions.

This leads to the importance of what do we do after we write a policy. It is extremely important to continue the conversation and remind your clients of other services you can provide, such as life insurance. It's the worst feeling in the world when you find out that your client bought other policies from someone else just because you failed to offer them yourself. When I first started out, I was afraid to ask for business. I worried that people would think I was too pushy. As time went by, I found it easier to listen, and avoided trying to sell myself. Today, I get calls constantly, asking if I can help with a particular issue or situation. I have become an advisor as opposed to a salesperson. You must always let a potential client know what you can do for them because, if you don't, someone else will. That is a lesson I learned the hard way.

Change is the only consistency in the insurance business. You must be ready with answers to questions that you might not feel able to answer. No one knows everything. People will respect you for referring these topics to experts, therefore building the trusted relationships we all seek.

Taking the time to listen to your clients' wants and needs will help you develop meaningful and long-lasting relationships. When I train my own agents, this is one of the first things we go over. I tell new agents to ask a couple of questions and really listen to the answers. You will always know how well a conversation is going by whether the client is still talking and asking you questions. That is a good sign. Also, I tell new agents to take it easy. Don't be too serious on a first meeting or interview with a client or prospect. Your conversation will bring out a need sooner or later. The key is having patience and paying attention to details. ★

Mickey Elting is an insurance product expert for Agent Review. Agent Review is the "Yelp for insurance," letting consumers find and rate local agents, and find unbiased education about different types of insurance. Agent Review offers third party verification of an agent's profile and their reviews, which helps to guide consumers to a trustworthy partner, along with useful and objective insights on types of insurance, key term, and more.

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PS Form 3526, July 2014 (Page 1 of 4) (see instructions page 4) PSN: 7530-01-000-9931 PRIVACY NOTICE: See our privacy policy on www.usps.com					
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15. Extent and Nature of Circulation		Average No. Copies Each Issue During Preceding 12 Months		No. Copies of Single Issue Published Nearest to Filing Date	
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		25400		25650	
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(1) Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)		19333		19323	
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c. Total Paid Distribution (Sum of 15b (1), (2), (3), and (4))		24999		24999	
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* If you are claiming electronic copies, go to line 16 on page 3. If you are not claiming electronic copies, skip to line 17 on page 3.

16. Electronic Copy Circulation		Average No. Copies Each Issue During Preceding 12 Months		No. Copies of Single Issue Published Nearest to Filing Date	
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Meeting a Variety of Retirement Needs WITH TODAY'S ANNUITIES

by DOUG WOLFF

Retirement planning would be a lot easier if clients only needed to plan for one outcome like maintaining a steady income, being prepared for unexpected expenses, or having legacy planning. But advisors need to plan for all three. In the past, advisors solved this retirement planning puzzle using a hodgepodge of strategies and products, sometimes including an annuity. However, recent changes to the annuity marketplace have made it possible to help solve for all three types of retirement obligations by employing a combination of annuities.

Significant changes in the annuity marketplace have repositioned fixed index annuities (FIAs) and variable annuities as retirement planning vehicles suitable for clients with a variety of in-

come levels, not just those in the top income bracket.

The complex variable annuities of the 2000s were full of complicated guaranteed living and death benefit options combined with asset allocation investment overlays. They have given way to a new breed of investment-oriented variable annuities (IOVAs). IOVAs typically have lower basic annuity expenses, no surrender charges, and more investment options, with some offering hundreds of subaccounts. Advisors are increasingly using IOVAs to create additional tax-deferred savings opportunities for clients who have maximized other tax-deferred vehicles.

FIA products have been re-engineered to provide guaranteed future payouts over time, liquidity, and upside opportunity. Increases in account

values are achieved via crediting options linked to the performance of a financial index. This way, in most cases, the investor has no downside risk in the event of negative market movements. With these and other developments, advisors can use a combination of IOVAs and FIAs to help meet their clients' the retirement needs.

MEETING REGULAR OBLIGATIONS

One of the most important things an advisor can do is to help ensure that a client has the funds to make all regular, reoccurring payments throughout retirement, like insurance premiums, transportation costs, and groceries, among others. Covering living essentials is paramount, and requires clients to have access to a regular stream of income.

An FIA with a guaranteed lifetime withdrawal benefit (GLWB) may be an appealing solution. FIA contracts grow through crediting options linked to the performance of an index, usually a stock or bond market index. They can be capped or uncapped or may have a spread. The indexed interest is locked in and credited to the contract holder's index account when the chosen index has positive performance from one contract anniversary to the next. The indexed interest is subject to a cap or spread. Most index accounts have single-year terms, but some have multi-year terms. A negative annual return in the index will result in no indexed interest for the year, but the annuity's value will not decline.

By adding an optional GLWB rider, clients can lock in a stream of lifetime income. These regular payments can be used to meet clients' reoccurring withdrawal needs, and eliminate concerns about running out of retirement funds. With GLWBs, the rider's benefit base receives a guaranteed annual increase each year that a policyholder waits to draw income from the FIA (up to a certain age or number of years). The increase of the benefit base is used to determine the income payment once withdrawals begin. It can be separate from any interest additions to the contract value, or it can be stacked on top of interest credits.

Generally, the longer a policyholder postpones taking income, the larger the base amount and income become. However, most contracts set a maximum age or a maximum number of years the benefit base can grow. This strategy may particularly help clients who have additional retirement savings, like a 401(k) or IRA, that are subject to required minimum distributions that need to be taken in the early years of retirement.

FUNDING EMERGENCY NEEDS

Advisors also need to structure client portfolios to allow for unexpected expenses. With retirees living longer, having unexpected health issues or caring for a child or grandchild are just two examples of unexpected events that may cause a retiree to take an unplanned withdrawal.

An FIA with a GLWB or another source of tax-deferred retirement savings can provide a consistent stream of funds to meet reoccurring income needs. But clients still need some growth during retirement to cover unexpected financial obligations. Since the account value of an FIA is linked to the performance of an underlying index, FIAs can fund the kind of emergencies that would throw a well-planned retirement into chaos. An FIA with or without a GLWB can offer market-related upside potential that presents no market downside risk, unlike taxable stock and bond investments.

However, advisors need to remember that withdrawals of the account value can reduce the GLWB's retirement income. Because of this, advisors need to explain how a withdrawal could affect retirement income. Any withdrawals should be for true needs, not temporary wants.

Advisors can place a portion of a client's assets that are not earmarked for reoccurring retirement income needs into an FIA with or without a GLWB. This will help clients continue to grow part of their savings while eliminating the possibility that an ill-timed loss throws a well-planned retirement into chaos.

LEAVING A LEGACY

Legacy planning is the third piece of the retirement puzzle. Clients may have investable assets that they are unlikely to need during their retirement years, such as proceeds from a small-business sale, an unexpected inheritance, or some other windfall. Those assets can be passed on to loved ones or charitable causes. The primary objective for these assets is to capture growth and minimize tax exposure. IOVAs offer advisors a powerful investment vehicle that's well suited to today's increased tax environment. Clients can invest in hundreds of underlying funds through these IOVAs including domestic and international equities, a variety of traditionally tax-inefficient fixed income categories, and alternative asset classes. Additionally, exchanges among subaccounts are low cost or free, making it possible to have broad diversification and tactical trading. No current tax obligations are triggered

as long as the original investment and any gains remain in the annuity. So the client's legacy funding continues to grow within a tax-deferred vehicle instead of being subjected to taxes on mutual fund distributions or capital gains.

RIGHT TIME, RIGHT OPTION

The combination of FIAs and IOVAs can help clients reach three very different savings goals: reoccurring withdrawals to meet monthly expenses, unforeseeable expenses, and growth. The annuity market is now better positioned than ever to be a key component of successful retirement planning for a wide variety of advisors' pre- and post-retirement clients. ★

Douglas Wolff is president of Security Benefit Life Insurance Company (SBL), Topeka, Kansas, and First Security Benefit Life Insurance and Annuity Company of New York (FSBL), Rye Brook, NY. Email him at doug.wolff@securitybenefit.com. For more information, call 800-888-2461.


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DENTAL PPO PLANS

Concordia Dental now offers a low-cost, customizable product in 21 states and has expanded the availability of two popular PPO products. The new product, Smile for Health—Basics Plans, is available in Alaska, Arkansas, Arizona, California, Colorado, Iowa, Idaho, Kansas, Kentucky, Massachusetts, Missouri, Montana, New Jersey, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Wisconsin and Wyoming. It includes two plans with customizable deductibles and maximums to meet varying employer needs. The plan covers preventive, restorative, and major dental services. It offers optional coverage, such as vision and orthodontics. The plans also include enhanced dental benefits for people with gum disease and certain chronic conditions, such as diabetes, heart disease, and stroke. For more information, visit UnitedConcordia.com.

WHOLE LIFE

The Guardian introduced the index participation feature (IPF) to whole life insurance. This patent-pending feature allows whole life policyholders to link a portion of their cash value to the performance of the S&P 500 Price Return Index, subject to a cap and floor. No other whole life insurance carrier offers this feature. With the IPF, policyholders can allocate a portion of their paid-up additions' cash value, choosing an allocation from zero to 100%. When a policyholder allocates money to the IPF, dividends on these paid-up additions are adjusted based on the performance of the S&P 500 Index, subject to a 12.5% cap and a 4% guaranteed floor – ensuring that the policy's downside exposure is limited. Policyholders can change their IPF allocation for future index periods, providing flexibility over time. For more information, visit NextGenWholeLife.com.

VIDEO EXPLAINS WHOLE LIFE LIVING BENEFITS

The Guardian has a video explaining the living benefits of whole life insurance. In this three-minute video, Brad Hoffner, a Guardian client, believes he no longer needs whole life insurance policy after he loses his partner and his

mother in a short space of time. With no immediate beneficiaries, Brad questions the need for continuing this coverage. His financial representative explains how the cash value of his policy can be used as an important financial resource. By staying the course, Brad has funds for a down payment on a house as a new chapter in his life begins. To see the video, visit youtube.com/watch?v=QjFdhlosDE.

STREAMLINED ENROLLMENT

CHOICE Administrators introduced its suite of smart decision technology tools. The tools help brokers enroll groups more quickly and enable employers and their employees to make more informed decisions. The resources include Online Provider Search, Online Rx Search for prescription drugs, a new Automated Choice Profiler, and new Online Enrollment for groups taking part in the CaliforniaChoice small group multi-carrier health insurance exchange, which has been operating since 1996. The Automated Choice Profiler allows employees to evaluate premiums, deductibles, and additional out-of-pocket costs, such as copays and co-insurance, to get a better estimate of their cost of health coverage. Employees can look at plans side-by-side based on doctor availability, cost, risk, and quality. They can also identify coverage that meets their ongoing, potential, or planned health conditions like asthma, diabetes, a pregnancy, or even upcoming surgery.

Online enrollment helps brokers enroll cases more efficiently and lets employers and employees go paperless if they choose. It allows employers to track enrollment and identify which employees still need to complete an application. It helps groups eliminate incomplete applications and expedites processing, so cases are issued faster. The CaliforniaChoice Online Provider Search allows employers and employees to search for a health care provider or specialist based on location, provider gender, or health plan affiliation. Online Rx Search allows employees to compare health plans based on prescription drug coverage. CaliforniaChoice also offers a wide range of discounted and no-cost products and services to employers

through its Business Solutions Suite. For more information, visit calchoice.com or choiceadmin.com.

ACCIDENT COVERAGE

Aflac introduced Aflac Accident Advantage. The new supplemental accident insurance policy offers more flexibility for individual policyholders to choose different levels of coverage and several industry-leading and enhanced benefits to help further protect consumers from high out-of-pocket costs related to accidents and injuries.

Never before offered benefits under the new policy include the following:

- A benefit designed to cover injuries sustained while participating in an organized sporting activity.
- A home modification benefit, waiver of premium benefit and family support benefit.
- A prosthesis repair and replacement benefit.
- Speech and occupational therapy are now covered in addition to physical therapy under the Therapy Benefit.

Upgrades to benefits offered in previous Aflac accident policies include the following:

- More flexibility, with four options of coverage for injuries such as fractures, dislocations, lacerations, concussions, burns, emergency dental work, eye injuries and surgical procedures.
- No waiting period for the wellness benefit, which pays policyholders for routine medical exams and immunizations. The wellness benefit is now payable every calendar year.
- An enhanced accident treatment benefit that includes different levels of benefits according to whether X-rays are ordered during an emergency room visit or at another location such as a doctor's office. Plus, coverage for care has expanded to include physician's assistants or nurse practitioners.

For more information, visit aflac.com/accident. ★



Using Technology to Navigate THE MEDICARE ADVANTAGE PLAN MINEFIELD

by NIDHI SAXENA

Despite strong political adversaries, it is clear that Medicare Advantage (MA) plans are here to stay. For insurance agencies, these relatively new plans present a tremendous opportunity for growth. Hugely increased participation and a growing enrollment base are anticipated. There is also the prospect of developing countless innovative product lines to appeal to different target audiences that have specialized needs or requirements.

THE CMS CHALLENGE

Anyone who wants to sell MA products has to become very conversant with regulations from the Centers for Medicare and Medicaid Services (CMS). CMS compliance for Medicare Advantage affects the way companies market, promote, or structure customer service. But it has an even greater effect on managing their data. CMS mandates intake of enrollments and updates based on its own coding of transactions, appropriate tagging of statuses and eligibility criteria, and the correct use of data in adhering to marketing and compensation guidelines. Those who have taken time to familiarize themselves with CMS's agent and broker training and testing guidelines will understand the stringency of their requirements.

There are strict guidelines on agent training, how the plans are marketed, which provider referrals are permitted, and how agents get compensated for the sale of a policy. Moreover, these guidelines are updated annually, so the goal posts are constantly being moved.

There's great potential to fall afoul of the regulators. The regulations are implemented to make sure that enrollees get the level of services promised. When government subsidies are involved, the fear is that free money becomes a temptation for fraud. So there's a cap on the profit agencies can make on these MA policies.

With the Affordable Care Act's Medical Loss Ratio (MLR) requirements, there are strict government guidelines as to how commissions are calculated and paid, which means that there isn't a huge profit margin. Multiple types of policies have their own compensation levels, which add complexity. With greater complexity come additional compliance challenges.

Small agencies that want to sell Medicare Advantage products need to ensure they

comply with all the guidelines including calculations of payouts to the agents, the kinds of plans they can offer, the margins they can put on these plans, and the administrative costs they have on top of the plans. For example, in order to sell certain products, they need to prove that certain certifications are in place, and that program training has been completed.

All agents and brokers who sell Medicare products are trained and tested annually on Medicare rules and regulations, and the details of the products they are selling. This includes employees, subcontractors, downstream entities, and/or delegated entities.

The training and testing procedures are in place to ensure that each person takes the test independently, which maintains the integrity of the training and testing program.

That information on training and testing programs can be provided to CMS upon request. CMS may request information that includes, but is not limited to, training tools, training exams, policies and procedures, and documentation demonstrating evidence of completion.

Their guidelines also include a sample test of 19 suggested questions for determining agent compliance, covering the following:

- Medicare basics
- Enrollment and disenrollment
- Beneficiary protections
- Marketing regulations and materials for sales by agents/brokers
- Agent/broker compensation
- Medicare marketing activities.

Looking at the following agent/broker compensation sample question, we can see the complexity and potential confusion:

A beneficiary enrolled into Acme Health Plan in 2012 as an initial enrollment and has remained in the plan since. How much should Acme pay in CY2015 to the agent who facilitated the enrollment?

- A. 50% of CY2012 fair market value
- B. 60% of CY2012 fair market value
- C. Up to 50% of CY2015 fair market value
- D. Up to 60% of CY2015 fair market value

With this level of complexity built in at the regulatory level, it's little wonder that agencies and carriers have trouble clarifying

their position with regard to staying on the right side of the law. To add insult to injury, the fines for noncompliance are hefty—even if it's because of benign neglect, without any criminal intent whatsoever. Is there anything that can be done to help make the situation better?

TECHNOLOGY: HELP OR HINDRANCE?

With manual processes still the norm in most smaller agencies, it is very easy for a carrier or an agency to make mistakes. Take compensation. You have a matrix of policies paying commissions at different rates. It's not unknown for carriers to underpay their agents for months until they uncover the error. Even the five leading MA agencies have had challenges with this, so you can only imagine what the smaller agencies have to deal with when they rely on manual processes to track compensation and compliance.

The big five providers in the Medicare Advantage (MA) market have embraced technology that supports their compliance with CMS rules and guidelines. But many of the smaller plans distributing products through a small sales force (200 to 1,000 agents) juggle the tradeoffs of revenue, the demands of CMS marketing guidelines, limited bandwidth of critical resources, and costs.

Keep in mind when introducing a technology solution that it's as much about re-engineering processes as it is about software to automation brings transparency into compensation for carriers and agencies, and shows they're being correctly compensated for making sales.

For agencies and carriers alike, if both sides are equipped with the right resources, processes and systems, these kinds of issues can be drastically reduced.

Agencies and carriers should get smart now about automation, and invest in just the level of technology they need to keep swimming in the fast-moving waters of Medicare Advantage and the constantly changing regulations that go along with it. ★

Nidhi Saxena is an insurance subject matter expert and practice leader at VUE Software. She specializes in regulatory compliance requirements for insurers and their agencies. She can be reached at nidhi@ecssi.com.

IN NEWS



IN CALIFORNIA

Consumers Face Obstacles in Understanding Prescription Coverage

Consumers find it frustrating and time consuming to get information about their prescription drug benefits, according to a report by the California HealthCare Foundation (CHFC). CHFC surveyed consumers as well as agents and enrollment counselors. Publicly posted formularies are hard to navigate. They often feature arcane terminology, provide incomplete and inaccurate information, and are not available in languages other than English.

Many consumers don't think of checking whether their medications are covered before selecting a health plan. But those who seek this information have a hard time finding it. Participants say that prescription benefit information is not prominent on plan websites or on the Covered California website. Many participants say that it took multiple clicks to locate a company's formulary, if they were able to find it. Most were unable to find all the information they wanted, and resorted to calling each plan under consideration to check whether their drugs were covered and get details on their financial responsibility.

In general, consumers are not familiar with many of the terms used routinely in prescription benefit information, such as "formulary," "prescription drug tier," "co-insurance," and "preferred drug" versus "non-preferred" drug. Consumers want materials that are written in more common, accessible language. The following are more key findings:

- Consumers have little awareness of how to request medications that are not on a plan's formulary.
- When shopping for health insurance, drug benefits take a backseat. Consumers base their health plan choices on monthly premiums, physician access, and out-of-pocket costs, such as deductibles and copays for physician office visits.
- Consumers have often assumed that their drugs would be covered so they didn't double-check their availability or potential cost.

- Neither agents nor counselors routinely help clients conduct drug benefit searches. Agents in the study say that it is too time-consuming to be profitable while counselors say they have limited familiarity with the process.

Study participants reviewed online formulary search tools. The Colorado Health Plan Finder tool is well-received among consumers and agents because it offers filters to refine plan options. Shoppers can view only plans that cover their drugs. It also displays the copays. Participants said that it allowed them to figure out what they would be spending monthly on prescriptions.

Information throughout the Covered California website was consolidated into a table to clarify relationships among prescription coverage and metal tier options. Agents say that having the information presented this way is useful when explaining drug costs to clients. Consumers are split on whether they could understand all elements of the table.

Respondents offered the following suggestions:

- Have an online tool with drug cost and coverage information, by plan. An interactive Internet formulary search tool would allow consumers to input drug names. Results would include details, such as cost and tier placement for each plan.
- Health plan websites should consolidate drug benefit information under a clearly labeled tab that's easy to find with a minimum number of clicks.
- A formulary should specify whether it is for individual or group plans or those included or excluded from Covered California.
- Consumer education should address the differences among formulary designs. There should be particular attention to educating consumers on how to appeal medication denials and seek redress of other prescription drug coverage issues. Enrollment counselors want additional education on prescription benefits.
- Use the term "prescription drug list" instead of "formulary."
- Drug categories should include understandable terms like "high blood pressure" instead of "hypertension." Other suggestions are to standardize formulary terms and abbreviations to make comparisons less confusing.
- Display copay information with tier placement, the cost of monthly prescriptions, the difference between branded drugs and generics, information on step therapy, the appeals process, and a list of pharmacies.

To get the full report, visit chcf.org.

CDI Makes It Easier for Providers to Submit CE Courses

Continuing education (CE) providers can now submit course applications, course renewals, and course completions online to the California Department of Insurance (CDI). Vertafore's Compliance Express service offers a faster online option for submitting courses and course renewals to the CDI. The cost is \$10 per course application and \$5 per course renewal. For course completions, the cost is 50 cents per student



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HEALTHCARE

CMS Steps Up Support for Agents during Open Enrollment

The National Association of Health Underwriters (NAHU) applauds the Centers for Medicare and Medicaid Services (CMS) on committing to providing more dedicated customer support for agents and brokers to help individuals, families, and small businesses sign up for health insurance in the federally facilitated marketplaces. Janet Trautwein, CEO of NAHU said, "This increase in support, through the existing call center, will enable agents and brokers to provide the best service possible to consumers seeking health insurance. NAHU is pleased our discussions with CMS have resulted in positive steps toward making healthcare more efficient and accessible."

NAHU Supports Small-Group Market Legislation

The National Association of Health Underwriters (NAHU) is urging Congress to support the Protecting Affordable Coverage for Employees Act (H.R. 1624), which would give states more flexibility in determining their small group market instead of relying on a single national standard.

Beginning January 1, 2016, the definition of small employers will change from groups of up to 50 employees to groups of up to 100. This change is mandated as part of the Affordable Care Act (ACA). Janet Trautwein, CEO of NAHU said, "This small-group expansion will prevent mid-size employers from keeping the plans they have; they will have to select a new plan offered in the small-group market. These employers will now have to comply with the actuarial value, cost-sharing, and essential health benefit requirements, which could add a 3% to 5% increase in premiums. Mid-size employers are...stuck between a rock and a hard place. The ACA is hurting the very group it was initially trying to help by taking states' ability to set their own group sizes and rushing the transition of a small group from 50 employees to 100 employees. We look forward to working with members of Congress and the Administration on this critical issue and other needed improvements to protect insurance consumers." For more information, visit nahu.org.

Efforts to Repeal the Cadillac Pick Up Steam

Unions, local governments, and representatives on both sides of the aisle are supporting a repeal of the Cadillac tax. A bipartisan majority of the House of Representatives has co-sponsored legislation to repeal the 40% Cadillac Tax on health plans. Two separate measures to repeal the 40%

tax, authored by Rep. Frank Guinta (R-NH) (H.R. 879) and Rep. Joe Courtney (D-CT) (H.R. 2050), have attracted 224 House cosponsors. The Cadillac tax is a 40% non-deductible tax on the cost of employer-sponsored health coverage that exceeds certain thresholds.

Rep. Joe Courtney said, "Actuaries and health care experts agree that the 40% excise tax will unfairly impact a broad swath of American workers and their families, degrading the quality of health insurance coverage, and increasing out-of-pocket costs. The tax undercuts the goals of affordable and accessible health care. It is already affecting workers and employers as they plan for the next several years. With a bipartisan majority in the House already backing repeal of this tax—no small feat in Washington—and business and labor united to fight it, I am optimistic that this important fix is gaining momentum."

Rep. Frank Guinta said, "I introduced H.R. 879—Ax the Tax on Middle Class Americans' Health Plans Act—to repeal a harmful provision of the president's healthcare law that will inflict a 40% tax on middle class Americans' health plans. I've heard from many municipalities in my district that this tax hike will cost in the hundreds of thousands of dollars. In the case of our state's largest city, Manchester, it will cost \$6 million alone."

Tom Flynn, political and legislative director for the United Brotherhood of Carpenters and Joiners of America said, "We commend Reps. Courtney and Guinta for their work to protect the employer-sponsored health plans of over 150 million Americans. We urge House leadership to move a stand-alone Cadillac Tax repeal bill as quickly as possible."

Sallie Clark, president of the National Assn. of Counties Representatives said Courtney and Guinta have shown tremendous leadership in the bipartisan effort to protect employer-sponsored health plans. "Not only would the excise tax hinder our efforts to attract and retain quality employees, but it would also have significant impacts on county budgets and place additional burdens on taxpayers," she added.

The 40% tax applies to plans sponsored by private sector and public sector employers, non-profit organizations, and even self-employed individuals. The tax penalizes employers that have employees with greater health care needs, workforces with higher numbers of older workers and employers based in higher cost areas, according to the Alliance to Fight the 40. For more information, visit fightthe40.com.

Online Refills Help Patients Adhere to Meds

Patients from all racial and ethnic minority groups who got prescription refills through an online patient portal had better medication adherences, according to a study in the Journal of the American Medical Informatics Association. "Our findings are consistent with other studies that suggest providing tools for health care management, such as online refills, can help improve health behavior such as medication adherence," said lead author Courtney Lyles, PhD, affiliate investigator at the Kaiser Permanente Division of Research and assistant professor at the University of California, San Francisco.

According to a recent report by the National Institutes of Health, Americans with chronic conditions only take their



medications as prescribed about 50% to 60% of the time. Poor adherence costs the health care system \$100 billion to \$300 billion each year, and results in about 125,000 deaths.

This study examined patients with diabetes from Kaiser Permanente Northern California who had been using My Health Manager. Patients who began consistently refilling their statin prescriptions online showed a 4% improvement in adherence. Those who used online refilling tended to be younger and were taking more recurring medications than those not refilling online. Also, they used the patient portal more frequently at the onset of the study. African-American portal users were less likely to use the online tool to refill their prescriptions, and all racial and ethnic minority groups had lower statin adherence compared to white patients at baseline. For more information, visit ucsf.edu or dor.kaiser.org.

MERGERS AND ACQUISITIONS

Sun Life Acquires Assurant's Employee Benefit Business

Sun Life Financial is acquiring Assurant's employee benefit business for \$975 million. The transaction will create the sixth largest group benefit business in the U.S. The combined business will have one of the broadest product portfolios in the industry. The transaction is expected to close by the end of the first quarter of 2016. Dean Connor, president and CEO of Sun Life said, "The transaction will add significant new capabilities to the Sun Life U.S." It will boost the company's group benefit business including a

strong dental business with the second largest proprietary provider network in the U.S. The transaction also includes a successful group life and disability business, and adds strong voluntary products and capabilities, vision products, and client technology. Also included is the disability RMS business, which is the leader in partnering with other insurers to offer disability products."

The transaction will grow Sun Life's in-force business by more than 50% to about \$4 billion, strengthening the company's partnerships with brokers and private exchanges and supporting investments in technology and distribution. Dan Fishbein, MD, president of Sun Life Financial U.S. said, "This combination will enable us to offer one of the broadest arrays of employee benefit products in the market... Our portfolio will include leading capabilities in the group life and disability, dental and vision, stop loss and voluntary categories. Our increased size will also support future investments as we continue to grow our U.S. business."

Upon closing, Sun Life Financial U.S. will provide protection through about 64,000 employers in small, medium, and large workplaces. The combined U.S. group benefit business will operate in multiple sites, including Sun Life Financial's U.S. headquarters in Wellesley, Massachusetts and Assurant Employee Benefits' main office in Kansas City, Missouri. For more information, visit sunlife.com.

EMPLOYEE BENEFITS

Employees Need Customized Benefit Communications

A survey by The Guardian reveals that employees prefer benefit communications that are customized to their needs. Early entrants to the workforce (those within the first five years of working) want more choice and education in the workplace. Near-retirees (those within five years of retirement) value their benefits and worry about losing them in retirement.

Early entrants have a strong desire for financial education and guidance to help them focus on their immediate financial needs, such as paying bills, job security, work/life balance, and reducing debt. Nearly two-thirds of these younger workers say that buying insurance and saving for retirement through their employer is easier than doing it on their own, and 56% prefer learning about financial planning and products at work compared to 44% of those near retirement.

Near-retirees are most concerned about maintaining adequate health insurance, having a comfortable retirement, staying healthy, and having enough savings. While 93% of respondents in this age group say that it's important to have retirement savings that last as long as needed, only 62% say they have achieved this goal.

Sixty percent of all employees say that their benefit meetings would be more relevant if they were targeted by age. Those within the first five years of working need more personal advice during enrollment. If employers increase access to education and advice, it can benefit the nearly 70% of early entrants who say that it is very important to find a trusted source of financial advice. Unfortunately, only 33% of employers place high importance on tailored communications, and only 13% have implemented such an approach. For more information, visit guardiananytime.com. ★

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aaltci.org
aacii.org
- 13 **Aflac**
aflac.com/broker
800-99-AFLAC
- 19 **Blue Shield of California**
blueshieldca.com/smb-retention
- 2 **CaliforniaChoice**
calchoice.com
- 3 **CaliforniaChoice**
simple.calchoice.com
800-542-4218
- 36 **Callahan & Blaine**
callahan-law.com
714-241-4444
- 22 **Cigna**
Cigna.com/builtforyou
- 7 **Covered California**
CoveredCA.com/forsmall-business
844-332-8384

- 5 **Dickerson Employee Benefits**
sales@dickerson-group.com
800-457-6116
- 11 **EyeMed Vision Care**
starthere.eyemed.com/
- 43 **Healthcare Reform Center & Policy Institute**
561-790-1176
HealthcareReformCertification.org
- 9 **Landmark Healthplan**
800-298-4875, option 5
sales@LHP-CA.com
- 33 **Petersen International Underwriters**
piu.org
800-345-8816
- 47 **Rogers Benefit Group**
rogersbenefit.com
877-724-4671 (San Jose)
866-405-2790 (Sacramento)
800-872-0459 (San Diego)
877-654-3050 (Los Angeles)
- 27 **Sutter Health Plus**
855-325-5200
sutterhealthplus.org

- 24 **United American Insurance Company**
855-312-1679
uagacareers.com/calbroker
 - 17 **United Concordia**
ucci.com
UCMissingPiece.com
 - 29 **UnitedHealthcare**
uhctogether.com/casb
 - 48 **Word & Brown**
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