CALIFORNIA BROKER

VOLUME 33, NUMBER 12 SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS SEPTEMBER 2015

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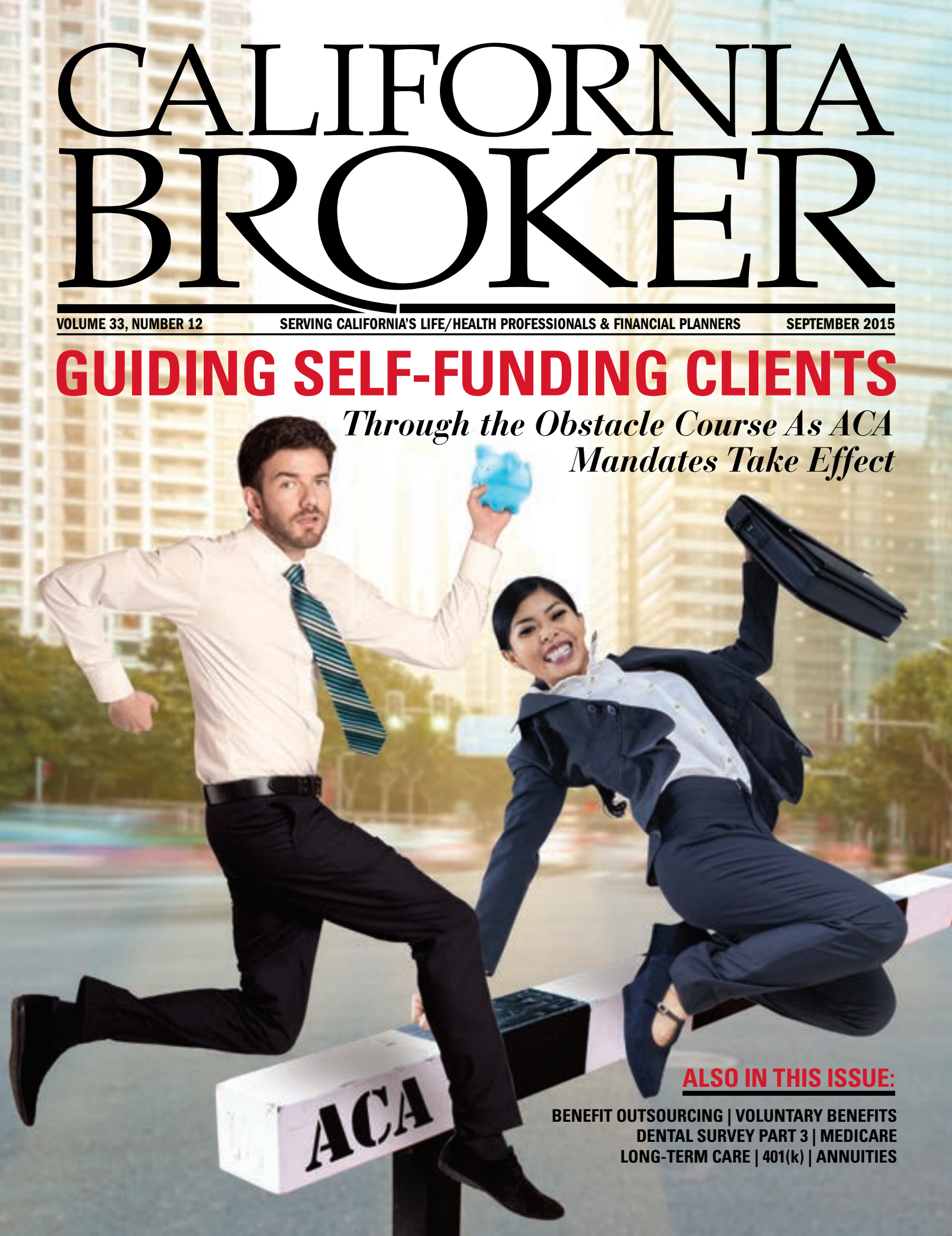

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Agents Are the Answer

What's Behind the HEALTHCARE MERGERS

by **ERIC WILSON**

The Affordable Care Act (ACA) was designed to cover more people and create more competition among insurers. But 17 major medical insurance companies have gotten out of the business, have been acquired, or have simply gone out of business. Aetna bought Humana; Anthem bought Cigna; and Centene bought Health Net. In the past year, 95 hospitals across the country have merged or consolidated. These mergers have created monopolies or at least regional monopolies that are likely to drive up consumer pricing due to lack of competition.

The Medical Loss Ratio (MLR) is one reason for this. The MLR is the percentage of revenue spent on medical claims versus administration. Before the ACA, many carriers operated at an MLR in the low to mid 70s, meaning that 70% of revenue was used on claims; the rest was on marketing, sales, salaries, and rent etc. Now the law states that on individual health they must spend 80% on claims and 85% in the group health market. This is difficult for many carriers, especially smaller carries.

Also, there is no more underwriting since all plans are guarantee issue. Many smaller companies had some tougher underwriting requirements to keep plans affordable. In June, Assurant announced that it will exit the market or be sold. The company lost $90 million in the first quarter of this year after losing $64 million in 2014. This will affect about 1,200 employees. One of Assurant's strengths was its ability to determine risks.

The larger carriers have merged for similar reasons. Companies can reduce their overhead by combining forces and gaining greater negotiating power with doctors and hospitals. Some also have special areas of interest. While Humana is in the group health and individual market, it is a large player in the Medicare Advantage market, which will enhance Aetna's presence in that area. Cigna has a strong network administration division as well as being in the other spaces, so that will add value to Anthem. Sadly, from this trend, it looks as if all of the remaining smaller carriers will eventually be eliminated.

The ACA also created consumer oriented and operated plans (co-ops). The intent of these not-for-profit taxpayer-funded companies was to get rid of the "greedy" insurance companies. But only one of 23 co-ops across the country has reported positive income. CoOportunity Health, which served Iowa and Nebraska, closed in January. In 2014, it lost $45.7 million when adverse claims or claims expenses exceeded revenue. Eleven co-ops have suffered even greater losses than CoOportunity.

Hospital systems are merging and acquiring medical groups and physician practices. Insurance carriers have cut doctor reimbursements as they narrow down networks. Hospitals are penalized for treating patients who are re-admitted for the same illness. This sometimes is of no fault of their own (The patient does not follow orders). Mergers and acquisitions can reduce the expenses of the medical group or hospital. But it's likely to increase the patient's expenses. When their doctor is no longer in practice, the patient is more likely to go to the emergency room or the urgent care facility, which costs more. Larger hospital groups have more leverage when negotiating prices with the insurance companies.

Without free market forces keeping prices in check, consumers will face higher insurance premiums and deductibles. Medicare and Medicaid recipients are likely to face higher taxes. The ACA comes with many additional taxes and expenses to medical professionals and insurance companies. Many of these are passed on to the consumer. The mergers can streamline some of these expenses. But if you have a life-threatening situation and there is no hospital within 30 or 40 miles, does it matter if you have insurance?

Eric Wilson is principal of Wilson Associates.

LETTER TO THE EDITOR

Dear Editor,

We are proud of your magazine and the good you do in helping educate and guide brokers. For that we say thank you. We do have an editorial issue to discuss with *California Broker.* On the cover of the June 2015 issue, there was highlighted, "Ancillary Benefits," one of which went on to list nine "Ancillary Benefits," one of which is disability.

We need to talk. Disability is a primary need coverage. It was brought to the attention of people nearly a century ago when the book *Life Insurance* was written by Solomon Huebner, founder of the American College of life insurance. In his book, he proclaimed disability insurance to be an income replacement coverage which paid a regular income when due to sickness or injury; if a person could not work and earn money, he/she would receive monthly benefits. He called it the "Living Death" and like life insurance, it was intended to replace lost income. He went on to say that disability income clearly belongs in the life group of companies.

My plan to you is to no longer refer to disability as an ancillary benefit. It is a primary benefit according to the sources quoted.

W. Harold Petersen
Petersen International Underwriters

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Company Name	Ratings Bests	Fitch	S&P	Product (Qual./Non-Qual.)	Type SPDA FPDA	Initial Interest	Guar. Period	Bailout Rate	Surrender Charges	Mkt. Val. (y/N)	Min. Contrib.	Comm. Street (May Vary)
American Equity	A-	BBB+		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.55%*	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	2.25%*[a] 2.40%*[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+	American Pathway Fixed 5 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.45%*[a] 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+	American Pathway Fixed 7 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.90%*[a] 2.10%*[b]	5 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	$5,000 (NQ) $2000 Q	3.00% age 0-85 1.50% age 86-90
				*CA Rates Effective 8/6/15. First year rate includes 4.0% bonus 1st 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	2.80%* 2.65%	7 yrs. 5 yrs.	None None	9%, 8, 7, 6, 5, 4, 3 9%, 8, 7, 6, 5, ,0	Yes	$25,000 (NQ)	Varies 0-85
				*Effective 8/19/15. Based on $250K or more.								
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	2.40%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 6/8/15. Includes .25% first-year bonus and is for purchase payments over $100,000. Escalating five-year yield is 2.40%. For under $100,000 first-year rate is 2.25%. Escalating rate five-year yield 2.25%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.65%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 6/8/15.. Includes 1.00% first-year bonus and is for purchase payments over $100,000. Escalating seven-year yield is 2.54%. For under $100,000 first-year rate is 2.55%. Escalating rate seven-year yield 2.44%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.75%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 6/8/15.. Eff. yield is 2.77% based on 1.75% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.75%. Surrender value interest rate 1.75%. Accepts additional purchase payments in first three contract years. COM12255												
Jackson Insurance Company.	A+	AA	AA	Bonus Max (Q/NQ)	F	3.20%*	1 yr.	None	8.25%, 7.25%, 6.50%, 5.50%, 3.75%, 2.75%, 1.75%,0.75%**	Yes	$5,000 (NQ) $5,000 (Q)	6.00% 0-80 3.00% 81-85 1.50% 86-90
				*Effective 10/6/2014. The first year interest rate includes any first year additional interest, if applicable. Interest rates in subsequent years will be less. **Each premium payment, including any subsequent premiums, is subject to the withdrawal charge scheduled as detailed.								
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.75%*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	$10,000 (Q/NQ)	
				**Rates Effective 8/1/15 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 8/1/15 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	3.20%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	$10,000	Varies
*Effective 7/22/15. 2.70% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for $250,000 and above.												

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Why Companies Are Outsourcing BENEFIT ADMINISTRATION

by **SCOTT KIRKSEY**

The insurance industry was a lot simpler 50 years ago when most benefits were as basic as two weeks of vacation and retirement pensions. Today, benefit administration includes everything involved in creating and managing employee benefits including medical coverage, dental, vision, 401(k) plans, vacation days, sick leave, paid time off, medical and maternity leave, life and disability insurance, childcare, flex time and tuition reimbursement.

The Affordable Care Act has been a primary driver in leading more companies to outsource employee health care plan administration. Daunting compliance challenges have made it harder to track the status of part-time and full-time workers. There are regulatory considerations, changing laws, and tax implications. It takes a particular expertise to master benefits, understand compliance, and avoid penalties. Even experts are still trying to navigate delayed non-discrimination testing rules. Many businesses want outside experts to evaluate, track, and manage benefit administration to avoid potential penalty costs.

To weigh the trade-offs of managing benefits in-house versus outsourcing, it's important to assess a company's benefit administration capabilities. Elements to consider include the quality of current practices, technology tools available, investments, and long-term goals. Once employers and brokers have an accurate view of those values, it's easier to compare existing practices and capabilities with the offerings and know-how of prospective vendors.

Some employers fear that outsourcing will lead to poor or impersonal service. A quality service provider is critical, which is why every business that is considering outsourcing should vet prospects thoroughly and spend time talking to references past and present.

Businesses may lean toward insourcing benefit administration to retain more control. It also provides employees a centralized place for all their needs. Having in-house administrative power may deliver a more personalized, customized service that allows employees to interact regularly with benefit administrators whom they know well. If a business keeps benefit administration in-house, the employer retains more oversight of how processes work. However, more control leads to more responsibility and more risk for things to fall through the cracks.

Complicated benefit packages and changing requirements force HR staff to become experts in many areas in very little time. Additionally, workforces can fluctuate dramatically through the year (like during enrollment), requiring a business to choose between costly staff additions or lower service levels during busy periods.

Many large companies that have abundant resources to invest in human resources choose to outsource some or all of their benefit administration, and entrust experts who focus solely on human resources rules, regulations, and issues.

In some cases, a company has recently invested significantly in enterprise resource planning systems. It may not make as much financial sense to outsource immediately. An investment in such a system also includes training to keep up with radically changing requirements. There are also employee turnover costs, and the need to recruit additional experts over the long term.

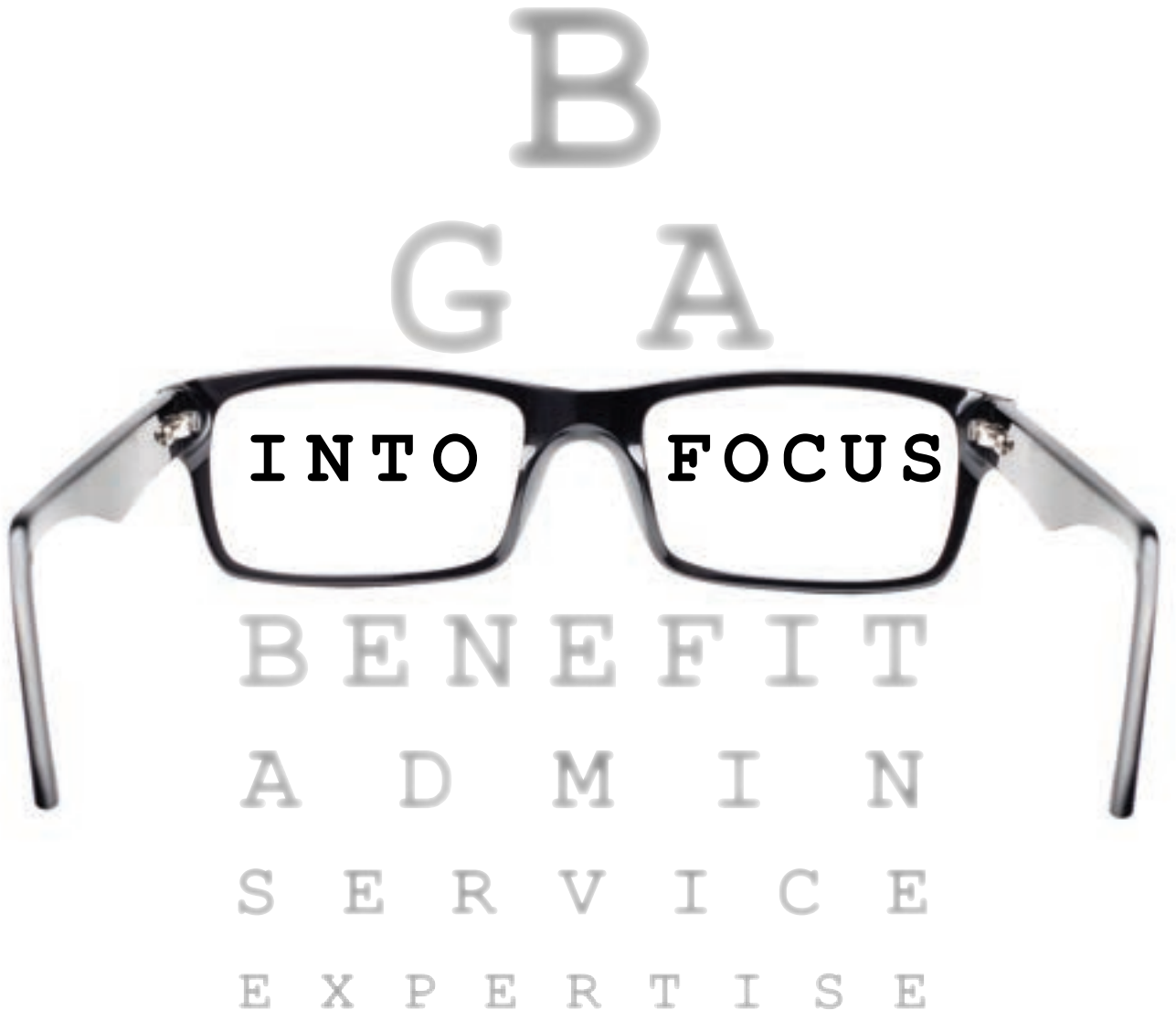
Sometimes companies assume that outsourcing certain human resource functions will cost too much or would be too cumbersome to transfer responsibilities. Although keeping benefit administration in-house can give an employer a greater sense of control over the process, companies also face the risk of lost productivity if an employee with a key administrative role becomes sick or leaves the firm.

Some companies fear that outsourcing benefits will make it harder to access vital data to make big decisions. It's true that keeping more information in-house can lead to a greater ease of information sharing, but when records are stored on-site, there is also huge potential for lost, stolen, or inappropriately handled information, exposing the company to damaging lawsuits and scarred reputations in the eyes of clients, employees, and potential job candidates. Outsourced benefit administrators have to meet strict compliance standards that keep information safe. Many companies are recognizing that records are often more secure offsite than in-house. Business administration partners know what data leadership want to have access to; they offer reporting tools to make vital information easy to find.

Because so many companies outsource complex benefit administration, there are lots of options on the market, and the cost of outsourcing is generally less than what companies may fear. Service providers are not only vetted experts in their fields, but they also offer flexible, scalable solutions that fit every business. Benefit administration specialists have proven their expertise in ensuring regulatory compliance, delivering helpful tools and information to employees, improving data accuracy, increasing data security, lowering administrative costs, and freeing internal resources to focus more on the core business and less on the headaches of benefit compliance and management. When exploring benefit administrators, look for a partner that can offer the services that your clients need the most. The partner should employ vetted specialists who understand the intricacies of your client's demands as well as the most current regulations and industry trends.

Scott Kirksey is president of BenefitMall.

BRINGING BENEFIT ADMINISTRATION SOLUTIONS



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SUN, SAND AND SICK?

Nearly half of all Americans have experienced the disruption of a trip due to an illness or injury serious enough to require medical attention, yet preparing for a health emergency isn't high on their list of concerns when planning vacation travel. Those are among the findings of a new survey conducted by Kelton Global and sponsored by Teladoc. The nationwide survey of adults, conducted last month, found that 45% of Americans report that they or their travel companions have gotten sick enough to seek professional health care while away from home on vacation. However, 53% say they don't always bring their health insurance cards when traveling; 68% don't always pack preventative care items with their belongings, and 82% don't always bring their physician's contact information on a trip.

"It's surprising that, in contrast to the time and effort that often goes into planning vacation travel logistics and activities, many people neglect to plan for a health event that has the potential to ruin an otherwise perfect trip. Remembering to take a few simple steps ahead of time, such as packing your insurance card and physician contact information and making a checklist of all your medications, can minimize the disruption if someone in your party becomes ill," said Dr. Henry DePhillips, Teladoc chief medical officer.

According to the survey, the health issues most often mentioned by vacationers are, in order, colds/flu, stomach ailments, injury, allergies, urinary tract infection, extreme sunburn, rash, bites and heatstroke, many of which can be treated through telehealth. Thirty-two percent say their family member's illness or injury resulted in the loss of at least two days of vacation time. And 26% say they've experienced health issues that led them to seek care from a hospital or urgent care center. ★

BY THE NUMBERS

132 MILLION
Americans say they or a companion got sick while traveling

OVER 50M AMERICANS SAY GETTING SICK WOULD RUIN THEIR VACATION.

Source: teladoc.com

Why Travel Insurance Is in High Demand

A new consumer report from InsureMyTrip finds that nearly 75% of all its customers choose a comprehensive travel insurance plan for domestic and international travel. This includes insurance purchases for a variety of trips including cruises, tours, and group travel as well as domestic and international trips.

Comprehensive travel insurance offers the most protection for travelers. It provides a variety of benefits including trip cancellation, trip interruption, emergency medical evacuation, emergency medical coverage, 24/7 emergency assistance, and baggage protection. For example, for a $5,000 two-week vacation to Aruba, a comprehensive travel insurance plan will cost a couple in their 50s around $200. This includes a $50,000 medical limit, $250,000 for medical evacuation, and trip cancellation coverage.

Travel medical insurance provides emergency medical coverage, 24/7 emergency assistance, and emergency medical evacuation coverage. Trip cancellation is not typically included. For the same trip to Aruba, a travel medical insurance plan will cost a couple in their 50s around $80. This includes a $50,000 medical limit with a $250 deductible and $500,000 in medical evacuation coverage.

Comprehensive and travel medical insurance plans provide a valued supplement for people who travel overseas, offsetting possible coverage gaps evident in some domestic health insurance plans including the following:

- Emergency medical care when a traveler needs a doctor or hospital visit when traveling abroad.
- Emergency evacuation when a traveler needs transportation to another medical facility or back home for further care.
- 24/7 emergency assistance when a traveler needs help with a medical-or-safety-related issue, needs to find a doctor or hospital, or needs translation services.

Some travel insurance policies also cover pre-existing medical conditions. A travel medical protection plan is the second most requested type of travel insurance. These plans provide emergency medical coverage, emergency medical evacuation, and 24/7 emergency assistance. Trip cancellation is not typically included.

In a related study, 25% of Americans don't know whether their health insurance works outside the US, according to a survey from InsureMyTrip. Medical coverage can vary widely depending on your domestic healthcare provider, specific plan, area of travel, and network coverage. Travelers should also be aware of deductibles, co-insurance, and copayments.

Medicare does not cover medical care for travelers outside the US. Supplemental plans, such as Medicare Advantage and Medigap, can provide limited additional coverage. For more details, visit Medicare.gov.

According to the State Department, very few domestic health insurance companies will pay for a medical evacuation back to the United States, which can easily cost up to $100,000 or even more, depending on the condition and location of the patient. It is important for travelers to know about any limitations of domestic health insurance policies while out of the country. In most cases, there are gaps in coverage. Some gaps are significant. Travel insurance is recommended because it can act as supplemental or primary coverage. For more information on types of plans available, visit InsureMyTrip.com or contact a licensed travel insurance agent at 1-800-590-2650. ★

2015 DENTAL SURVEY PART 3

OUR ANNUAL SURVEY OF DENTAL INSURANCE CARRIERS IN CALIFORNIA

18. DO YOU PROVIDE COVERAGE FOR ALL TYPES OF SPECIALIST REFERRALS?

Aflac: The Aflac Group Dental plan does not require referrals.

Ameritas PPO and the FDH Networks: Yes, specialty coverage can be a part of any Ameritas plan designs. Our networks comprise a full spectrum of specialists to cover the needs of our customers.

Aetna: Yes

Anthem Blue Cross: Yes, specialist care is available for both our Dental PPO and DHMO plans. No referrals are required on our Dental PPO plans, including Dental Prime and Dental Complete. On our DHMO plans, the member's general dentist can refer them to a specialist when needed.

BEN-E-LECT: Specialist referrals are not necessary. Coverage is available for all types of specialty procedures including, but not limited to, endodontic, periodontic, cosmetic, orthodontics, oral surgery and pedodontics.

BEST Life: Yes, specialists are covered at full contract benefits as described in our Indemnity and PPO plan certificates of insurance. Our orthodontic plan is available for all of our PPO and indemnity plans either at a deductible or lifetime maximum.

Blue Shield: Specialist care is available for all dental plans. Dental PPO/INO plan members may self-refer to any specialist, although INO members can only see network providers. For dental HMO plan members, the primary care dentist is responsible for referring the member to a participating specialist; however, there is no coverage for prosthodontic specialists.

Delta Dental: Fee-for-service enrollees can self-refer; referral by the general dentist isn't required. For DHMO enrollees, the primary care dentist must complete the DeltaCare USA Specialty Care Direct Referral Form when making a referral. The general dentist should refer assigned patients directly to DeltaCare USA contracted specialists when the established referral criteria is met. Referrals are subject to a patient's plan-specific benefits, limitations and exclusions.

Cigna: For the DHMO: Network general dentists initiate patient referrals for endodontic, oral surgery, and periodontal treatment. Cigna does not contract with prosthodontists. Referrals are valid for 90 days from the approval date. Specialty referrals are not required for orthodontic treatment, if covered on their plan design or for pediatric care for children up to age seven as long as individuals visit network specialists. The network dentist may submit a request for pre-authorization to Cigna Dental for oral surgery, endodontic and periodontal services. Individuals are responsible for the applicable patient charges listed on the patient charge schedule for all covered procedures. After specialty treatment is complete, the individual should return to the network general dentist for care. If it is determined that a network specialist is not available, the general dentist will refer the patient to a non-network specialist and the patient will only be responsible for charges listed on the Patient Charge Schedule.

- *For the DPPO:* There is no need for a referral by a primary care dentist to obtain services from a specialist with the Cigna Dental PPO plan. Members may choose to seek service from any in- or out-of-network specialist or general dentist at any time. Of course, network dentists have agreed to our reduced fee schedules, which lower out-of-pocket expenses.
- *For the Indemnity Plan:* Cigna traditional indemnity members are always free to seek care from any licensed dentist at any time.

Dental Health Services: Yes. Dental Health Services' plans provide specialty coverage for endodontics, periodontics, oral surgery, pedodontics, and orthodontics.

Guardian: We provide coverage for all types of dental specialists.

Health Net Dental: Health Net Dental DHMO plans cover a wide range of specialty care, including endodontics, periodontics, oral surgery, pedodontics and orthodontics. If the procedure is covered under the plan, the member must first see general dentist for a specialty care referral to a participating specialist.

HumanaDental: HumanaDental provides coverage for specialist referrals; members are encouraged to refer to their certificate of coverage to confirm the service being

sought is a covered benefit under their plan. HumanaDental encourages members to check if the specialist referred by their dental provider is in-network. Humana has a provider directory available on our website Humana.com. Members can also call the customer service number on the back of their insurance card. Members should request a pre-treatment estimate from the provider.

Principal Financial Group: Generally yes.

Securian Dental: Our plans do not require referrals. We provide coverage based on plan benefits.

United Concordia: Our PPO plans do not require specialist referrals. Our DHMO plans require referrals from the general dentist office for specialty coverage for endodontics, periodontics, pedodontics, oral surgery and orthodontics. However, the DHMO referral process is open, in that there is no requirement for United Concordia to pre-authorize the referrals. The services provided by specialists that are considered for benefit reimbursement are limited to the specifics of the dental contract for each covered member.

Western Dental: Specialty coverage is available in all of our group plans. Oral surgery, periodontics, endodontics, pedodontics, and orthodontics are covered specialties.

19. IF COVERED, EXPLAIN THE PROCESS THAT ALLOWS THE GENERAL DENTIST TO REFER TO THE SPECIALIST.

Aetna: For DMO plans, general practitioners can refer to a participating specialist directly based on published guidelines. DMO members have direct access to participating orthodontists and do not need a specialty referral. Indemnity and PPO plans have direct access for specialty services.

Aflac: The Aflac Group Dental plan does not require referrals.

Ameritas PPO and the FDH Networks: Specialist referrals are allowed at any time from our general dentists. There is no gate-keeper involved in this process.

Anthem Blue Cross: With our Dental Prime and Dental Complete plans, we do not require referrals. For the Dental Net DHMO, referrals that do not include high-risk procedures are reviewed post-treatment. Using the Direct Referral program, the participating general dentist can refer a patient to a specialist without prior authorization. Dentists' practice patterns are reviewed to help ensure that they share in our commitment to providing access to effective healthcare. For the Dental Net DHMO products, the member's assigned general dentist can call the customer service hotline in an emergency to get an immediate authorization for emergency services.

BEN-E-LECT: Referral is not necessary for any of BEN-E-LECT's plans. The member may select a specialist and schedule an appointment upon making a phone call or personal visit.

BEST Life: No referral is necessary. Insureds can visit a specialist at any time.

Blue Shield: For DHMO plan members, the general dentist completes a specialty care referral form and provides a copy to the member, who provides the form to the participating specialist at the time of the appointment. Dental PPO plan members may self-refer to a specialist.

Cigna: For the DHMO: Network general dentists initiate patient referrals for endodontic, oral surgery, and periodontal treatment. Referrals are confirmed for 90 days from the approval date. Specialty referrals are not required for orthodontic treatment or pediatric care for children up to seven years old, as long as members visit network specialists. The network dentist may submit a request for preauthorization to Cigna for oral surgery, endodontic and periodontal services. Members are responsible for the applicable patient charges listed on the patient charge schedule (PCS) for covered procedures. After specialty treatment is finished, the member should return to the network general dentist for care. If a network specialist is not available, the general dentist will refer the member to an out-of-network specialist, and the member will only be responsible for charges listed on the PCS; however, Cigna Dental Care (DHMO) network general dentists render the range of services that are required for graduation from dental school, including diagnostic treatment, preventive treatment, operative dentistry, crown and bridge, partial and complete dentures, root canal therapy, minor oral surgery, preliminary periodontal therapy, and pediatric dentistry.

- *For the DPPO:* There is no need for a referral by a primary care dentist to obtain services from a specialist with the Cigna DPPO plan. Members may choose to seek service from any in- or out-of-network specialist or general dentist at any time. Of course, network dentists have agreed to our reduced fee schedules, which lower out-of-pocket expenses.
- *For the Indemnity plan:* Cigna Traditional indemnity members are always free to seek care from any licensed dentist at any time.

Delta Dental: Fee-for-service enrollees can self-refer; referral by the general dentist isn't required. For DHMO enrollees, the primary care dentist must complete the DeltaCare USA Specialty Care Direct Referral Form when making a referral. The general dentist should refer assigned patients directly to DeltaCare USA contracted specialists when the established referral criteria is met. Referrals are subject to a patient's plan-specific benefits, limitations and exclusions.

Dental Health Services: The general dental office sends Dental Health Services a specialist referral authorization. Upon approval, the authorization is sent back to the general dentist who informs the patient that they are now eligible to get appropriate care from a specialist.

Guardian: For the DHMO plan, any complex treatment requiring the skills of a dental specialist may be referred to a Participating Specialist Dentist. Our DHMO plans offer Direct Referral in which the member may be referred directly by their primary care dentist to a participating specialist without pre-authorization.

Health Net Dental: For DHMO plans that require pre-authorization, the contracting primary care dentist completes a specialty referral form and submits to Health Net Dental. Approvals are returned to the primary care dentist, member and specialist. Upon receiving the approval, the member contacts the specialty office to schedule an appointment for completion of treatment. For plans that have direct referral, the primary

care dentist may directly refer the member to a participating specialist by visiting our website or by contacting our customer service. Our PPO dental plans allow self-referrals to participating or non-participating specialists as needed.

HumanaDental: General dentists are encouraged to refer members to participating specialists to provide the highest level of benefit to the member. The general dentist can refer out-of-network if there are no specialists within a reasonable distance.

Principal Financial Group: Patients can choose any provider in the network; referrals are not required.

Securian Dental: No referral is required.

United Concordia: If a general dentist determines that a patient requires referral to a specialist, all care must be coordinated through the primary dental office. The primary dental office should refer the patient to a participating specialist located in our Concordia Plus Specialist Directory and also complete the Specialty Care Referral Form. The patient should be given a copy of the referral form to give to the specialist at the time of their appointment. The specialist will then be responsible to submit the claim, corresponding documentation and referral form to United Concordia for reimbursement. There is no requirement for United Concordia to pre-authorize the referral, thus providing better access to care when it is needed.

Western Dental: Once the general dentist determines that the necessary procedure is out of his or her scope of practice, the office will submit a written referral request to our plan. Western Dental's dental director then determines whether the referral is medically necessary and whether the procedure is covered under the benefit plan.

20. ARE ANY OF YOUR SPECIALISTS BOARD ELIGIBLE/CERTIFIED?

Aflac: For benefits to be payable, the specialist must be licensed by his or her state to perform the required treatment.

Ameritas PPO: Yes, all are board-eligible or certified and are monitored during the PPO credentialing process.

Anthem Blue Cross: All contracted specialists with Anthem Blue Cross must be board certified/board eligible.

BEN-E-LECT: Yes. BEN-E-LECT requires that all participating specialists be board certified.

BEST Life: All of our specialists are certified and must meet a rigorous credentialing process to be admitted into the network. DenteMax credentials its specialists using the following elements:

- License to practice
- DEA/CDS certificates
- Education/board certification
- Work history
- Malpractice claims history
- Malpractice insurance
- Application and attestation content
- Sanctions against licensure
- Medicare/Medicaid Sanctions
- Medicare opt out

Blue Shield: Yes, while this varies by specialist. Dental specialists may be certified, but it is not an industry requirement. Therefore we do not track board certification. We ensure that members receive the best possible care by credentialing and re-credentialing dentists following NCQA guidelines.

Cigna:

- *For the DHMO /DPPO:* Network dentists contracted to provide specialty care have successfully completed postgraduate dental specialty programs in their fields. Our networks include specialists in periodontics, orthodontics, endodontics, pediatric dentistry, and oral surgery. We accept dentists who are recognized specialists, including those that are board-certified or board eligible.
- *For the indemnity plan:* Network related issues are not applicable to the Cigna traditional indemnity plan. Members may choose any licensed dentist to provide care.

Delta Dental: Delta Dental requires board certification where it is required by state law. Under the fee-for-service plans, Delta Dental credentials all of its participating specialists in the same manner, whether they are board-eligible or board-certified. Under the DHMO plans, Delta Dental requires all DeltaCare USA network specialists to be board-qualified.

Dental Health Services: Yes, the majority of Dental Health Services' dental specialists are board certified.

Guardian: Many of our PPO specialists are board certified or eligible and all of the DHMO specialists are board eligible.

Health Net Dental: Yes.

HumanaDental: All participating specialists must provide copies of their specialty licenses or residency certificates.

Principal Financial Group: Yes. All specialists are required to be board eligible, board certified or be a designated specialist by the ADA.

Securian Dental: 100% of the specialists in our network are board certified or board eligible.

United Concordia: Yes, as part of our credentialing process, we verify each dentist's education, license and certifications.

Western Dental: All contracted specialists are board-eligible/certified.

21. HOW DO YOU FUND YOUR SPECIALTY CARE?

Aetna: Specialty services are paid on a fee-for-service basis.

Aflac: Aflac Dental insurance pays a set amount per procedure based on a table of allowances. Additionally, policyholders have the freedom to choose their own provider without precertification.

Ameritas PPO and the FDH Networks: Specialty care claims are paid out of the same claims reserve that is established for the group's general dentist claims. If employers are fully insured, all are funded out of the premium charged to each group. If employers are self-funded, the specialist claims would be included in the claim funding bill provided to the employer.

Anthem Blue Cross: Claims for specialty care for both Dental PPO and DHMO plans are paid according to the provider's fee schedule.

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BEST Life: Specialty care is built into the premium. Specialty care received by a network provider is reimbursed at a discounted fixed fee schedule. Specialty care received by a non-network provider is reimbursed on what is usual and customary for that area, procedure and specialty.

Blue Shield: Specialty care is paid on a discounted fee-for-service basis for dental HMO, INO and PPO plan designs. Member and plan copayments vary, depending on the plan design.

Cigna:

- *For the DHMO:* We contract with an extensive network of specialists to ensure that we provide our members with the needed services at negotiated fee levels. We pay specialists based on a reduced fee schedule. Patient charges listed on the patient charge schedule (PCS) apply at the specialist's office once we have authorized payment. We review referrals to specialists for eligibility and coverage.

- *For the DPPO:* Specialists are part of the Cigna DPPO network; members can seek care from an in-network or out-of-network specialist without a referral. Like network general dentists, we contract with network specialists on a discounted fee-for-service schedule based on average charges in a geographic area. We pay out-of-network dentists according to maximum reimbursable charge levels or fixed schedules, depending on the plan design.
- *For the Indemnity plan:* The Cigna Traditional indemnity plan is not a network-based plan.

Delta Dental: Specialty care is built into the premium. Under the fee-for-service plans, specialists are reimbursed by a combination of maximum plan allowances by procedure (contracted fees between Delta Dental and dentists) and coinsurance paid by the covered enrollee. Under the DHMO plan, network specialists are reimbursed for pre-authorized services on a per-claim basis according to contracted fee schedule and copayment paid by the enrollee.

Dental Health Services: Specialty care and treatment are paid for on a contracted basis and payment varies by procedure. These costs are built into each plan's monthly premium rate.

Guardian: Our PPO specialists are paid on a fee-for-service basis. For our DHMO plans, specialty care is funded through a portion of premium.

Health Net Dental: For both our DHMO and DPPO plans, we underwrite and rate dental plans based on an assumed specialty care claims liability and build an allowance into our dental premiums.

HumanaDental: Specialists are paid on a fee-for-service basis according to a contracted fee-schedule amount or by reimbursement limit.

Principal Financial Group: Through normal plan provisions.

Securian Dental: Network dentists (general and specialty dentists) are reimbursed on the basis of a discounted fixed fee schedule. Network dentists agree to accept the fee schedule amount as full consideration, less applicable deductibles, coinsurance and amounts exceeding the benefit maximums and will not balance bill the member.

United Concordia: Both PPO and DHMO specialists are paid on a negotiated fee-for-service basis.

Western Dental: We incorporate into our premiums what we expect specialty care claims to be. We then pay the claims based on dental necessity and plan guidelines.

22. DOES THE MEMBER HAVE TO BE REFERRED BY THE PRIMARY DENTIST TO THE ORTHODONTIST OR CAN HE OR SHE SELF-REFER?

Aetna: Member can self-refer.

Aflac: Aflac Dental insurance* pays a set amount per procedure based on a table of allowances. Additionally, policyholders have the freedom to choose their own provider without precertification.

Ameritas PPO and the FDH Networks: No, every member can self-refer.

Anthem Blue Cross: We do not require referrals in our PPO plans, including Dental Prime and Dental Complete. Members enrolled in the Anthem Blue Cross Dental Net DHMO program must be referred by their primary dentist to an orthodontist. Using our direct referral program, the participating general dentist can refer the patient directly to the specialist without prior authorization.

BEN-E-LECT: Members may self-refer to any orthodontist they prefer. In-network versus out-of-network and plan selection will determine coverage provided.

BEST Life: No referral is necessary.

Blue Shield: For dental HMO plans, the general dentist completes a specialty care referral form and provides a copy to the member, who brings this to the participating specialist at the time of the appointment. Dental PPO/INO plan members may self-refer.

Cigna: None of our plans require a referral for orthodontic care.

Delta Dental: Under the fee-for-service plans, enrollees can self-refer. For DHMO plans, the assigned network dentist refers the patient to a contracted DeltaCare USA network orthodontist by providing the patient with a copy of the referral form. Referrals are subject to a patient's plan-specific benefits, limitations and exclusions.

Dental Health Services: Yes. Members must get a referral from one of our network dentists before visiting a participating orthodontist.

Guardian: PPO members can self-refer to all types of specialty care, including orthodontia. General Dentists in our DHMO network will refer the member to a Participating Orthodontist. The referral does not require plan authorization.

Health Net Dental: Our DPPO product does not require referrals for specialty or orthodontic care, so participants may self-refer. For DHMO, there are three types of specialty referral processes based on the member's schedule of benefits. For plans that require pre-authorization, a specialty referral form must be submitted by the primary care dentist. For plans that have direct referral, the primary care dentist may directly refer the member to a participating orthodontist by visiting our website or by contacting our customer service. For plans that allow self-referral, the mem-

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ber may go directly to a contracted specialist by visiting our website or by contacting our customer service.

HumanaDental: In our PPO, the member can self-refer to an orthodontist. HumanaDental encourages members to ensure any dental provider is in-network. Humana has a provider directory available on our website Humana.com. Members can also call the customer service number on the back of their insurance card.

Principal Financial Group: A member can choose to seek services from any provider.

Securian Dental: The member can self-refer.

United Concordia: Our PPO plans allow members to self-refer. Under our DHMO plans, the primary dental office determines if a specialty referral is required, regardless of the specialty.

Western Dental: The member has to be referred by the primary dentist to the orthodontist for our IPA Dental Plan. Our Western Centers-only plan allows the member to self-refer.

23. WHAT IS THE TIME FRAME FOR PROCESSING A REFERRAL IN TERMS OF MEMBER NOTIFICATION AND PAYMENT TO THE SPECIALIST?

Aetna: DMO general practitioners usually provide a member with an immediate referral. Specialty payments are made on receipt and adjudication of the claim.

Aflac: Aflac Dental insurance pays a set amount per procedure based on a table of allowances. Additionally, policyholders have the freedom to choose their own provider without precertification.

Ameritas: Since this is a self-referring process, this question is not applicable.

BEN-E-LECT: Referral is not necessary. Members may call and schedule the appointment as desired.

BEST Life: No referrals are required. Members may self-refer to any specialist they choose.

Blue Shield: For dental HMO plans, the general dentist completes a specialty care referral form and provides a copy to the member, who brings this to the participating specialist at the time of the appointment. Our average turnaround time for claims payment to the specialist after receipt of the claim is approximately six days. Our dental PPO plans do not require referrals.

Delta Dental: For PPO and Premier enrollees, specialty care referrals are not required, and payments to specialists are processed the same as for general dentists. For DHMO enrollees, preauthorizations for specialty care are processed within five business days.

Dental Health Services: Emergency referrals are processed immediately. In a non-emergency situation, referrals are processed within one to two weeks. Claims are paid within two to three weeks.

Guardian: Referrals are not required under our PPO plans. For our DHMO plans, payment to the specialist is within 30 days of receipt of the claim.

Health Net Dental: The average turnaround time in processing a non-emergency referral is 48 hours and then seven to 10 business days for the EOB to be received by the member. Once the claim is submitted by the specialist, our average turnaround time in processing is 10 business days of receipt and then seven to 10 business days for specialists to receive payment in the mail. If the claim was sent electronically, it will be sooner.

HumanaDental: Most HumanaDental plans do not require a referral from a general dentist to a specialist. The member gets a higher benefit when seeing a participating dentist and specialist. In 2013, 97% of claims were processed within 14 calendar days

Securian Dental: No referral is required.

United Concordia: All referrals are immediately effective. There is no requirement for specialty referrals to be pre-authorized by United Concordia. The member is instructed to provide the referral to the specialist at the time of service and the specialist files the referral with the claim. All claims, including specialist claims, mailed to United Concordia are usually processed within 14 days. Claims filed electronically are processed during the weekly cycle.

Western Dental: Emergency referrals are handled within 24-hours. The turnaround for non-emergency referrals is three business days. Specialists can expect payment in 10 business days for clean claims.

24. IF YOU LIMIT SERVICES WITH AN ANNUAL OR LIFETIME MAXIMUM, WHAT DOES THE MAXIMUM DOLLAR AMOUNT ALLOWED REFER TO?

Aetna: The maximum dollar amount refers to the total amount Aetna will pay for covered benefits.

Aflac: The annual maximum refers to the maximum amount of benefits that may be received within a policy year per covered person. Annual maximums do not apply to wellness and X-ray benefits.

Ameritas: The maximum is the total amount of dollars payable to a member under their policy during the specified plan year.

Anthem Blue Cross: Our Dental PPO plans have an annual maximum, which refers to the maximum dollar amount that will be paid by the plan in a calendar year. With Anthem Blue Cross Dental Net and Dental Select DHMO plans, there are no annual or lifetime maximums.

BEN-E-LECT: The maximum dollar and lifetime maximum refers to all services and procedures unless specified otherwise by benefit.

BEST Life: Lifetime maximum applies to orthodontia benefits. We offer multiple choices of calendar year maximums for preventive, basic and major procedures.

Blue Shield: The "maximum" is the maximum amount paid for covered benefits under the plan. The dental HMO plans have no annual maximum or lifetime maximum.Dental PPO annual plan maximums range from $1,000 to $2,000 and encompass all dental services received except orthodontics. Dental INO plans have a $2500 annual maximum. There are no lifetime maximums for dental PPO/INO plans. Orthodontia is offered to adults and children in many dental PPO plans as an additional benefit, which does not apply to the plan annual maximum. Group dental PPO/INO plans provide a generous calendar year orthodontic maximum of $1,000; there is no lifetime orthodontic maximum. Individual and family dental PPO plans offer low copayment and a two-year lifetime orthodonture benefit. Dental HMO plans have no annual maximum.

Cigna: For the DHMO, there is no annual or lifetime maximum. For the DPPO/Dental indemnity plans, the maximum dollar amount refers to the maximum amount payable by Cigna for covered services rendered.

Delta Dental: Under the fee-for-service plans, the maximum dollar amount refers to the maximum dollar amount paid by the plan. Our DHMO plans do not have annual or lifetime maximums.

Dental Health Services: The majority of our prepaid plan offerings have no annual dollar maximums, although this option is available by client request. PPO plan annual maximums range from $500 to $2,000.

Guardian: The maximum refers to the total of benefit dollars actually paid for covered services incurred within the annual period, or the member's lifetime in the case of orthodontia. With Preventive Advantage, only Basic and Major services count toward the annual maximum. We also offer an option to cover cleaning after the maximum is reached.

Health Net Dental: The maximum dollar amount is the total amount the plan will pay for covered benefits.

Humana Dental: Annual maximum refers to the maximum amount paid annually for services, excluding orthodontia. Orthodontic treatment has a lifetime maximum.

Principal Financial Group: The maximum dollar amount refers to benefits paid.

Securian Dental: The annual and lifetime maximum refer to the maximum dollar amounts we will pay for covered services in a calendar year (annual maximum) or over the coverage lifetime (lifetime maximum). Our plans generally include an annual maximum for non-orthodontic covered services and a separate lifetime maximum for orthodontia.

United Concordia: DHMO plans do not have annual or lifetime maximums. PPO plan annual and lifetime maximums vary by benefit plan and refer to the total amount paid in benefits by United Concordia annually or over the member's lifetime.

25. HOW AND WHEN DO YOU PROVIDE ELIGIBILITY INFORMATION TO YOUR DENTAL OFFICES? HOW CAN YOU ENSURE THAT YOUR OFFICES WILL PROVIDE SERVICES TO A MEMBER IF THEY ARE NOT ON THE ELIGIBILITY LISTING AND IT IS AFTER REGULAR PLAN HOURS?

Aetna: Eligibility is available to our providers 24/7 by calling our automated telephone inquiry system or by accessing the online eligibility roster. DMO providers receive eligibility rosters the first week of each month.

Aflac: Providers may verify eligibility online – aflac.com – or by calling Aflac's Customer Service Center —1.800.99. AFLAC. Aflac Dental does not require prequalification for treatment.

Ameritas: They will want to verify eligibility through our real-time system. Our plans do not require preauthorization or mandated PPO network usage.

Anthem Blue Cross: Participating providers can confirm eligibility via our secure website 24/7. Also, our customer service representatives are available toll-free Monday through Friday from 5:00 a.m. to 5:00 p.m. (PST) to help members with locating network providers, verifying provider status, member eligibility, answering claim questions, quoting plan benefits, and receiving member complaints. An interactive voice response (IVR) system is also available to answer calls and provide information 24 hours a day, seven days a week.

BEN-E-LECT: BEN-E-LECT provides electronic eligibility 24/7 through our Empowr web portal for providers and members. The Pre-Paid product will provide services upon collecting information from the member. This information will be transferred to BEN-E-LECT's system electronically.

BEST Life: Providers can use our fax back eligibility system to determine if a member is eligible, outside of normal business hours. Offices routinely check eligibility prior to appointments and have a process in place for dealing with emergency situations.

Blue Shield: Eligibility lists for dental HMO plans are distributed to the dental HMO dental center during the 1st week of each month. Providers are responsible for contacting our Customer Service Department to verify eligibility, if a member is not on their list. Our Interactive Voice Response (IVR) is available 24 hours, seven days a week and has the capability to verify eligibility and assign members.

Cigna: We offer three ways to verify eligibility: Online at the Cigna for Health Care Professionals website, through a 270/271 EDI transaction, or by phone. If an office chooses to call, we offer the option of using the automated system to hear the information or we can fax it. We also offer the option of speaking to a customer service representative. All of these verification methods are available 24-hours-a-day, 7 days a week.

Delta Dental: Dental offices can verify eligibility by contacting Delta Dental via our website, calling our automated information line or speaking with a customer service representative. Under the fee-for-service plans, a patient who is not shown as eligible may be asked to pay the entire amount of the bill up front. The dental office would be responsible for refunding the patient their overpayment after receiving Delta Dental payment. Under the DHMO plans, in addition to verifying eligibility as listed above, network dentists also receive eligibility lists at the beginning of each month. If an enrollee is not contained in Delta Dental's eligibility database and claims to be eligible for benefits, Delta Dental contacts the client or the client's benefit administrator to verify eligibility. If the eligibility verification is for an enrollee who has urgent or emergency needs, our customer service representatives will extend an urgent care authorization.

Dental Health Services: Participating dental offices receive eligibility rosters twice a month. If immediate eligibility is needed at any time, the dental office can call our 24-hour automated eligibility verification system or check eligibility online through our website.

Guardian: Dentists can use our online self-service website, GuardianAnytime.com or call our toll-free line and receive a faxed verification of benefits from 6:00 a.m. to 6:00 p.m., Monday through Friday Pacific Time. Eligibility Rosters for the DHMO plan are provided to the offices twice a month, at the first of the month and the 10th of the month. Dental Offices may also call our Member Services Department from 8:00 a.m. to 5:00 p.m. Monday through Friday.

Health Net Dental: Our DHMO dentists receive a monthly updated eligibility list that includes member name,

(Continued on page 34)

Are You and Your Clients READY FOR 2016?

by **DAVID L. FEAR, Sr.**, RHU

Now that the Supreme Court has resolved the latest challenge to the ACA, employee benefit advisors need to focus on what their clients are facing in 2016. Many clients moved their renewals to December 1 to take advantage of grandmothering provisions of the law, but now they will be forced to move them to ACA compliant plans. However, looking past December 1, there are some additional threats in store for employers.

The ACA definition of small employer is increasing from 50 to 100 employees. We've known about this for several years, and most states (including California) pushed this back to 2016. It does not appear that the current administration is likely to allow for a further extension of this provision. Most carriers are preparing their product portfolio to comply with the rules, which really only affect employer groups with 51 to 100 employees. Some will offer early renewal of their current large group product to extend through most of 2016 (another version of grandmothering only for mid-sized employer groups). It is interesting to note that, in California, the recent passage of SB-125 changed the way we calculate group size from full-time employee to full-time equivalent. In other words, California will now come into compliance with the federal law in this regard.

Simply put, if you are an employer with fewer than 101 full-time employees, but have additional part-time or seasonal employees you now count the equivalent value of those non-full-time employees. It may push you from the small employer market (two to 100 employees) into the large employer market (101 or more full-time/full-time equivalent employees).

Large employers (100 or more) will file their first Shared Responsibility Mandate report. The Employer Shared Responsibility Mandate of the ACA took effect on January 1 for employers with 100 or more employees. They will file their first report (and pay any fines/taxes for non-compliance) showing their compliance (or non-compliance) with the mandate in early 2016.

Throughout 2015, they should have been tracking employee eligibility and offering minimum-essential coverage or minimum-value coverage to those eligible employees. There is a special transition rule in 2015 that exempts the first 80 employees, but that will drop down to 30 employees in 2016. Employers with 50 to 99 employees were exempt from the requirement in 2015, but will need to become compliance on January 1, 2016 or be prepared to pay fines/taxes in 2017. Employers with fewer than 50 employees (small employers) remain exempt from this mandate.

THE ESCALATION OF SELF-FUNDED/LEVEL-FUNDED HEALTH BENEFIT PLANS

California passed SB-161 in 2013, which prohibits small employers from purchasing affordable stop-loss insurance coverage. But the trend for mid-sized employers continues to move to alternative funded arrangements. The market for level-funding has opened up substantially. Now nearly a dozen carriers offer this safe and practical product for mid-sized employers who are coming off of traditional fully insured coverage.

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- Broker Compensation
- Claims Surplus Options

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SB-161 extends the stop-loss ban for employers up to 100 in 2016, but the percentage of large employers buying stop-loss insurance and self-funding or level-funding their health benefits has increased dramatically in 2014 and 2015. Earlier in 2015, Senate Bill 701 was introduced by State Senator Tom Berryhill (R, Fresno) to modify SB-161 so that employers would again be allowed to purchase affordable aggregate stop loss insurance coverage. The measure was strongly opposed by Health Access California, but supported by small business groups including the Coalition for Business Healthcare Choices. SB-701 will be re-introduced in 2016.

HRAs ARE SPREADING LIKE WILDFIRE

With the denial of the ability to self-fund as a result of SB-161, small employers (and mid-sized employers) are turning to one of the few alternatives available—health reimbursement arrangements (HRAs). A number of small group carriers continue to forbid their products from being used within an HRA/wrapping program, but the introduction of ACA compliant plans and their higher pricing have forced some carriers to reconsider this prohibition if they are going to continue to be players in the employer sponsored health market.

Almost all large group carriers are now allowing HRA programs for employers with 51 or more employees. Under the ACA, regulations clarify that HRAs must now be integrated with a high deductible health plan. Wrapping prohibitions are in conflict with the law. Earlier in 2015, Assemblyman Travis Allen (R, Orange County) introduced Assembly Bill 1425, which would have banned the prohibition on HRA/wrapping that still exists in California. Once again, Health Access California and others opposed this measure; it was unable to pass through the Assembly Health Committee, but is expected to be re-introduced in 2016.

MINIMUM ESSENTIAL/MINIMUM VALUE COVERAGE

At the end of 2014, there was a lot of talk about MEC/MVC coverage. A number of large employers did implement low cost coverage that complied with these ACA requirements. A number of carriers and administrators now provide minimum essential coverage on a self-funded basis while almost all fully insured plans offer minimum value coverage. This is especially true for employers that are just beginning to offer coverage to avoid the employer mandate penalties. Experts believe that many MEC plans will morph into MVC plans as time goes on because employers want to comply with the A and B requirements of Section 4980h of the ACA and avoid the $2,000/$3,000 penalties.

The key is that many employers need to start tracking employee eligibility so that they are offered coverage when they achieve their eligibility. This is an issue with employers who have heavy numbers of variable-hour employees, such as those in the restaurant and agricultural industries. Payroll vendors and third-party administrators offer tools that will track employee hours, and file the compliance forms at year's end (Forms 1094/1095 B and C). Employers need to have this up and running well before 2016. Insurance professionals need to vet providers of these services in order to recommend the most efficient way for employers to come into full compliance with the ACA's employer mandate.

GET READY FOR THE CADILLAC TAX

Another controversial part of the ACA involves the implementation of a federal excise tax that will go into effect in 2018. It's called "the Cadillac Tax" because proponents stated that it would be a tax on the most expensive benefit plans–those costing more than $10,200/$27,500 (single/family) per year (adjusted annually based on inflation). The tax will be 40% of the cost of benefits that exceed these predetermined thresholds. Obviously, back in 2010 when the ACA became law, no one seemed to worry about something that would happen eight years later and then only to really expensive plans. But here we are with a little more than two years to go and many benefit plans are now looking at rates/costs that will meet or exceed these thresholds. These cost levels include employer contributions to HRA and HSA plans. Benefit advisors need to begin having plan design conversations now with their clients about how to position their fully insured or self-funded plans to avoid the Cadillac tax through benefit design changes that will reduce costs or minimize tax liability. That process may take more than the two years remaining before the tax goes into effect.

In conclusion, there is much more to come with the Affordable Care Act. Benefit advisors need to examine each client's needs to determine how they will comply with the law. Many general agencies now offer consultative services for ACA compliance for licensed insurance agents and brokers in order to help them assist their clients through these challenging times. ★

David L. Fear, Sr. RHU is the managing partner of Shepler & Fear General Agency located in Roseville, California. He is a 35 year veteran of the employee benefits business and is the 2015 recipient of the Harold R. Gordon Memorial Award of the National Association of Health Underwriters.

Grow Your Business with Self-Funding
FOR GOVERNMENT CONTRACTORS

by **KC CANNON**, Jr.

California is a growth market for self-funded plans. Clients are asking brokers about self-funding as the latest Affordable Care Act (ACA) employer mandates take effect. Historically, self-funding carriers wouldn't consider a group with fewer than 250 participants. But, in recent years, groups with as few as 25 have been successful with self-insured plans.

While self-insuring can be a good cost containment tactic, it's not for everyone. Smaller uninsured groups have a tough time moving to a self-insured plan because actuaries want historical claims/experience data for underwriting the stop-loss insurance. Employers need to have a good handle on their claims history and adequate cash flow to fund claims.

The employer mandate took effect January 1, 2015 for applicable large employers with 100 or more full-time employees. The mandate becomes effective January 1, 2016 for most employers with 50 to 99 full-time employees.

It can be extremely complex to determine the number of full-time equivalent employees. It involves measurement periods, administrative periods, and possibly stability periods. For example, in the construction industry, workers have wildly fluctuating hours from week to week. The ACA considers a full-time employee to be anyone who is employed an average of 30 hours per week or more or 130 hours per month or more. For hourly employees, the employer must use actual hours of service and hours for which payment is made or due including paid time off.

Under the ACA, a worker is considered a variable-hour employee when the employer cannot reasonably determine, when hiring, if the worker will work an average of 30 hours per week or more.

THE FRINGE

Government contractors have added complexity. Suppose a contractor bids on projects under the Davis-Bacon Act, Service Contract Act, state prevailing wage laws, and living and responsible wage ordinances. They get a list of wage determinations for each job classification in the contract. They have a required amount of money to spend on employee benefits, called "the fringe." It includes a base wage and a fringe amount to provide bona fide benefits, such as health insurance for workers.

Employers can pay cash to employees *in lieu* of fringe benefits. Many government contractors believe that paying cash is the easiest way to meet the obligation. Or they offer health insurance, but fail to take proper credit against the fringe, effectively paying twice for the same benefit.

But contractors can save hundreds of thousands of dollars over the life of a contract when they offer benefits instead of cash. They can also get into compliance quickly with ACA mandates. When government contractors use the fringe to provide benefits

(medical, retirement, dental, vision plans, and life insurance), the dollars are exempt from payroll burdens, such as FICA, FUTA, SUTA as well as workers compensation insurance in California and many other states. In some cases, fringe dollars are exempt from general liability premiums. These taxes and assessments can easily add 25 cents on each dollar in wages.

Some business owners have faced negative reactions from employees when removing the fringe from the paychecks and putting it toward benefits. They can now point to the ACA individual and employer mandates as the reason the fringe is going toward benefits.

Using fringe dollars to pay for bona fide benefits also improves a contractor's chances of winning government contracts.

Since fringe dollars cannot remain in the company's general assets, they are generally held in a single employer trust account until they are needed to fund a claim. These funds are irrevocable. After claims are funded, anything left in the trust can be used to reduce the amount that the employer uses to fund the plan in the following year, or it can be maintained as a reserve for future claims.

With a traditional self-funded plan, claims are generally funded as they occur. Under prevailing wage contracts, fringe dollars are contributed to the plan whether a claim has occurred or not, building up a reserve.

The government contractor market offers tremendous potential to expand your business. When approaching this market, brokers should look for a partner with a deep level of support and unique product offerings. Working with a partner that understands the market as well as prevailing wage benefit plans can make this a turnkey opportunity. Employers will want to consider every type of plan including fully insured, multiple carriers, level-funded, and self-funded options. Contractors can choose other self-funding options before diving in, depending on their risk tolerance. Level-funded plans, high-deductible plans, and HRAs can contain the employer's health insurance costs.

Prevailing wage contractors will find it much easier to partner with a benefit provider who provides hour banking, which breaks the insurance cost into an hourly rate. It makes it much easier take proper credit for using fringe dollars to provide benefits. The hourly rate can include multiple lines of coverage, such as a single rate that takes into account major medical, dental, vision, and life insurance plans. ★

KC Cannon, Jr. is a regional vice president of Fringe Benefit Group, which has been helping the construction industry design and administer fringe benefit programs since 1983. For more information on its prevailing wage benefit plan, The Contractors Plan, contact KC at info@contractorsplan.com or 866-670-7442.

BEST PRACTICES FOR Open Enrollment

The following is a summary of a white paper reprinted with permission, from BenefitFocus

Employers can deliver accurate and consistent messaging before, during, and after open enrollment, keeping employees aware of the value of their benefits year-round. A software system that allows online enrollment with decision support tools can reduce the stress of open enrollment by delivering a seamless experience.

The goal of your client's communication strategy should be to give employees frequent opportunities for outreach as well as the resources to become knowledgeable in the open enrollment process. A detailed timeline and decision support can prepare employees well in advance of open enrollment.

An important step in planning for open enrollment is understanding employees' concerns and expectations. You can use e-mail or a free tool like SurveyMonkey to survey employees about their open enrollment concerns and what kind of benefits they prefer.

There are several convenient ways to prepare employers for an upcoming open enrollment. Besides the traditional mailings and face-to-face meetings, HR administrators can launch a coordinated campaign using blogs, social media, SMS text, message boards, FAQs, and video. Knowing your workforce is essential to choosing the appropriate way to reach them.

There can rarely be too much communication about something as complex and important as open enrollment. Offering explanations and constant communications is vital to remind employees of the significance of open enrollment.

Blogs offer a great way to help employees understand complex topics like healthcare and benefits. HR administrators can make regular blog posts to disseminate information in a friendly and informal way. Blogs can also allow employee comments and posts. One example would be an employee writing about how they chose the best coverage option during a previous open enrollment.

The message board or Wiki is a relatively older, but still useful outlet. Unlike many other digital communications, message boards can be used easily for targeted communications. Message boards are easily searchable. They allow employees to ask questions and await responses from other users or search previously posted questions to find answers. Not only does a message board allow for effective and efficient communication, but it also fosters a sense of community in the company.

Since smartphones are abundant in the workforce, social media sites like Facebook and Twitter are ideal for sending out quick bursts of information. Employers can post quick reminders and advice about benefits leading up to open enrollment so that employees are ready to participate. To make sure that employees are ready for open enrollment, IKEA sends out tweets, such as, "If I don't enroll in benefits now, can I do it later? Go here b4 it's too late." IKEA was able to communicate to mobile savvy employees about their benefits in less than 140 characters. Text messaging can also be useful for communicating with employees.

A video allows for more customization and consistency in messaging. A recent Forbes survey reveals that executives are 60% more likely to watch a video than they are to read text on the same web page. Instead of reading an impersonal memo, employees can watch a video of a senior manager explaining why a major plan change was made and how it affects them. Videos also offer a convenient means to share benefit information with a spouse or dependents.

Data analytics software can take the guesswork out of deciding which plans to offer by integrating various sources of health-related data. A company can analyze claims data and use predictive modeling to create hypothetical scenarios and forecast costs. They can use the information to design plans that accommodate their budget and meet employees' needs.

In addition, employers should explore different funding options, such as a defined contribution model. Introducing a defined contribution model will offer employees a set amount to spend on several plan options, providing more choice and personalization in their benefit packages. Defined contribution plans used with a private exchange allow employers to create a consumer-centric shopping experience during open enrollment. Similar to popular online retail sites, employees use a virtual shopping cart to see what the company will contribute to their benefits and track how they will spend the defined contribution. Private exchanges can provide payment options for employees who want to purchase additional coverage.

A survey can be used at the beginning of the online enrollment process to narrow down options so that employees see plans that match their needs and preferences. Decision support tools can provide a side-by-side comparison of plans based on key attributes, such as premium amounts and coverage details. This can help employees understand the relationship between their healthcare use and out-of-pocket costs. These tools can include historical claims data as well as national benchmark data, adding more personalization for employees to identify the plans that are right for them. Every employer's health playbook should include a way to educate employees about the financial risks of poor health and how healthy lifestyle choices not only improve personal wellness, but also lower premiums.

A few simple resources and incentives can make significant inroads in increasing employees' awareness of their health status and reducing health risks. For example, employers can offer an online library of health and wellness topics or prizes for completing a health assessment. The Affordable Care Act allows employers to vary premiums up to 30% based on participation in a wellness program and up to 50% based on tobacco use. This gives employees added incentives to stay healthy, thereby saving your client more money.

Integrating these tools gives employees an interactive shopping experience that promotes self-service while providing accurate, useful resources for employees to become more informed healthcare consumers. ★

For more information, visit benefitfocus.com.

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MEDICARE Update

FEWER COUNTIES HAVE ZERO-PREMIUM MEDICARE ADVANTAGE PLANS IN 2015

Most Medicare beneficiaries in 2015 have access to Medicare Advantage plans with $0 premiums. However, HealthPocket found that the number of Medicare Advantage plans with a $0 premium dropped from 813 in 2014 to 726 in 2015, with 113 fewer counties having access to these plans.

Fifteen states, including California, lost $0 premium Medicare Advantage plans: California, Hawaii, Idaho, Iowa, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Utah, Vermont, Washington, and Wyoming. Nebraska had the most counties in 2015 that lost $0 premium Medicare Advantage plans (36), followed by Montana (25), Idaho (23), California (12), and Vermont (8). Delaware and Alaska were the only states with no $0 Medicare Advantage plans in 2014 and 2015. Sixteen counties had no $0 premium Medicare Advantage plans in 2014, but gained access to these plans in 2015. These counties were in California, Maryland, New Hampshire, New Jersey, Oregon, and Washington.

Star ratings were higher (3.83 stars) for Medicare Advantage plans with $0 premiums in 2015, but not in 2014. Similarly the average rating for Medicare Advantage plans that had $0 premiums in 2015 and 2014 was 3.84 stars. For more information, visit HealthPocket.com.

HOUSE PASSES MEDICARE ADVANTAGE BILL

On June 17th, the House of Representatives passed The Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015 (H.R. 2570). The bill would establish a demonstration project allowing Medicare Advantage plans to use value-based insurance design (V-BID). The concept comes from Univ. of Michigan research. Researchers found that reducing out-of-pocket costs for some high-value medical services for certain patients can improve health outcomes and reduce disparities. It may also slow the growth of health care costs. If the bill becomes law, it would allow Medicare Advantage plans to lower co-payments and coinsurance for beneficiaries, encouraging the use of high-value, evidence-based medical services to manage chronic conditions. It prevents plans from increasing beneficiary cost sharing on any service.

The bipartisan companion bill, the Value-Based Insurance Design Seniors Copayment Reduction Act of 2015 (S.1396), was introduced to the Senate on May 20th. V-BID was also included in a recent Centers for Medicare and Medicaid Services (CMS) request for information to innovate Medicare. Numerous private and public payers have implemented V-BID programs. For more information, visit ihpi.umich.edu.

CMS CHANGES CHRONIC CARE MANAGEMENT

The Centers for Medicare and Medicaid Services (CMS) is trying out remote doctor visits for patients with two or more chronic conditions, according to an analysis by Frost & Sullivan. Medical practitioners can now bill non-face-to-face communications with Medicare beneficiaries. This promising revenue-generating system involves a minimum of 20 minutes of non-face-to-face service. This service can only be billed by one practice per month. The practice will assume full care-coordination responsibility including the use of certified electronic health records needed when communication is necessary among medical experts. If this model lives up to its potential, private payers and benefit plan managers may establish similar coverage. For more information, visit connectedhealth.frost.com.

BILL WOULD EXPAND ACCESS TO HOME HEALTHCARE SERVICES

The Partnership for Quality Home Healthcare is urging Congress to advance the Home Health Care Planning Improvement Act (S.578). Under the bill, nurse practitioners could certify home health services for Medicare beneficiaries without getting physician approval. Nurse practitioners are already certified to perform such evaluations for hospice services. Eric Berger, CEO of the Partnership said, "Allowing nurse practitioners to certify patients for Medicare's home health services would remove barriers to care that restrict access to patient-preferred healthcare for homebound beneficiaries. The Partnership commends Senator Susan Collins and her colleagues in the U.S. Senate for sponsoring this legislation, which would improve access to skilled home healthcare for Medicare's most vulnerable patient population, particularly those patients living in underserved and rural parts of the country." For more information, visit homehealth4america.org.

MEDICARE SUPPLEMENT INSURANCE ASSOCIATION ANNOUNCES CONFERENCE

The Medicare Supplement Insurance Industry Summit will be held April 25 to 27 in Kansas City, MO. As the only forum exclusively focused on the growing Medigap market, this conference brings together hundreds of industry leaders and experts. For more information, call 818-597-3205 or visit medicaresupp.org. ★

The Long Slow Death of NURSING HOME INSURANCE

by **TOM ORR**

A quarter century ago, insurance executives fought vigorously to keep home care services out of LTC Insurance policies. They knew that the ultimate gatekeeper was the policyholder's fear of entering a nursing home. Providing care in one's own home would create a tsunami of claims that would gobble up reserves faster than any actuary's calculator.

Their resistance wouldn't last long as rapid evolution in the delivery of long-term services and supports (LTSS) demanded benefits in the home, community, and a wide range of facilities that offered alternatives to nursing homes. Today, 95% of traditional (non-hybrid) policies sold are comprehensive policies providing benefits in all of these settings. Nursing home-only policies account for only 1% of policies sold; and home and community care-only plans account for only 4% of policies sold.

LET'S STAY HOME

Medi-Cal, the leading payor for LTSS, encourages elderly Californians to stay home as well. Facing costs of nearly $90,000 per year for a semi-private room in a nursing home, the state desperately needs people to stay home and receive home care for $23 per hour, utilize adult day care services for $77 per day, or move to an assisted living facility or residential care facility for $3,750 per month.

Medicare simply does not pay for LTC. This has been clear for nearly 50 years, but Medicare payments for short-term restorative care and short-term pre-death care in nursing homes confuses consumers, agents, and others in the industry.

A recent study prepared for the Alzheimer's Association reveals that Medicare's cost for Alzheimer's would increase from 2% to 24% of its budget in the next few decades. These costs surely will not be paid by Medicare without massive changes to the program's requirements.

The biggest push for staying home comes from our families. A recent study estimates that the national costs of informal care (unpaid care provided by family and friends in the home) are at $475 billion annually. If the informal care network were a business, it would rank a close second to Walmart at $477 billion in sales.

THE DREADED NURSING HOME

While it appears everyone involved in the LTC industry (the elderly, our families, Medicaid, insurance companies, regulators, and even the White House Council on Aging) wants people to receive LTC in their home, the industry remains tethered to its origins–the dreaded nursing home. Based on data by the California partnership for Long Term Care, only 8% of all claims are paid for care in nursing homes. Genworth reports a dramatic decline in nursing home claims and a rapid rise in home and community care claims.

HOW DO YOU SELL?

Far too many agents sell the way they have always sold. They use the dreaded nursing home event to instill fear in prospective clients, saying something like, "Mr. and Mrs. Prospect, you have a 70% chance of needing long-term care at some point in your life (pause) and you could stay in a nursing home for five years or more."

Both statements have some basis in fact. Seven in 10 people 65 or older will need long-term care at some point. In addition, some people could stay in nursing homes for five years or more. But it is quite manipulative to suggest that seven in 10 people will stay in a nursing home for five years or more. Certainly no reader of this esteemed publication would allow their prospective clients to make such a connection. How ever you have positioned the risk; your prospect is now dealing with the fear of going into a nursing home for a long, long time. You have reached them emotionally, now you need to help them find a path to transfer that risk.

LONG AND FAT

How does this sales approach affect the premium you are about to quote? Let's examine duration and dollars (daily benefit amounts) and how they affect the premium. You have sold your prospects on the high costs of a lengthy stay in a nursing home. In the old days, that translated to unlimited lifetime benefits. In recent years, insurance companies have had enough of that risk and typically limit benefit durations to five or perhaps six years, with an average of 4.8 years in 2010. You have also sold your prospects on the high costs of care in a nursing home. A quick glance at the costs of care tells you that they will need $260 per day for a semi-private room in California.

You immediately recognize the meaty nursing home benefits, so you know you will need to adjust the ALF/RCF and home/community care benefits in accordance with the regulations (70% of the nursing home benefit for ALF/RCF at $180 and 50% of the home and community care benefit at $130). That should help reduce the premium. But it doesn't because your policy is still long and fat and your prospect can't or won't pay those premiums.

SHORT AND FAT OR LONG AND THIN?

If you are really, really good, you may still be in the conversation with your prospects. You may be backpedaling faster that Tom Brady can let the air out of a football, but at least they haven't shown you to the door (yet). It's decision time. Do you adjust duration or dollars? Should you go short and stay fat, reducing the duration and holding the line on daily benefits? Should you stay long and go thin, holding the line on duration and walking down the ladder of daily benefits until they find a premium they can afford?

After all, something is better than nothing, right? Wrong. According to LifePlans' 2011 study, the average duration has dropped from 5.6 years to 4.8 years, but that is hardly short. The average daily benefit is $153 for nursing home care and $152 for home care, which remains quite thin compared to costs.

Did your prospects buy your new plan design? Far too often, the answer is no based on declining sales of LTC insurance policies over the past decade. For most prospects, their agent could not explain how a lengthy stay and high costs in a nursing home coupled with short and fat or long and thin LTC Insurance benefits made sense in transferring their LTC risks.

IT'S TIME FOR SHORT AND FIT

With a partnership plan, you can immediately look at shorter durations. Two to three years of coverage will provide adequate non-exempt asset protection for most Californians. Next, you need to take a new look at dollars. Before you do, remember that nursing home claims are now less than 10% of all LTC Insurance claims. So we will design a plan that provides full protection for 90% of the risk and provides partial protection for the remaining 10%. Yes, it is time to start looking at the nursing home benefit with a co-payment mentality. Let's calculate 70% of the nursing home cost of $260 per day. It's about $180 per day. Now use that dollar amount as the daily benefit amount for all care settings including nursing home, RCF/ALF and home/community. With this plan design, we can provide the following:

- Benefits for eight hours of home care per day at $23 per hour, more than covering adult day care costs of $77 per day.
- Benefits for RCF/ALF care of $5,400 per month, more than covering the average costs of $3,750 per month plus essential ancillary services that are not included in the basic room and board fees.
- Benefits for approximately 70% of the nursing home costs of $260 per day. Yes, you are going to discuss with your client that they will have a co-payment of approximately $80 per day. If they are among the less than 10% who need nursing home care.

This short and fit approach (two to three years at $180/$180/$180) will clearly lead you to more affordable premiums while providing the right coverage for your new clients.

ELIMINATION PERIODS

Eighty-two percent of all policies sold have 90-day or greater elimination periods. It may be because many agents confuse LTC care provided for 90 days or more with the 90-day elimination period. There is no connection between the two. The elimination period is simply the deductible that the client is willing and able to pay before they receive benefits. Let's look at two examples using a 90-day elimination period:

- Your client needs home care three days per week for four hours per day. Their costs, in current dollars, are less than $100 per day. Their deductible, paid over a 30-week period before they receive benefits, is $9,000 in current dollars. If they think they will need long-term care, they may be motivated by the lower deductible/elimination period.
- On the other extreme, if your client enters a nursing home at $260 per day, in three months, they will pay $23,400. Of course, that cost is in current dollars. In future dollars, 20 years or more from now, your client's out-of-pocket costs could double or more. If they think they will not need long-term care, they may be motivated by the higher deductible/elimination period.

Longer elimination periods do result in lower premiums, and shorter elimination periods do result in higher premiums, of course. Make sure you describe the elimination period accurately for your clients and help them understand the implications of the premium and deductible.

THE PROBLEM WITH INFLATION

The inflation option is a challenge. California partnership plans mandate 5% compound inflation at most ages. The impact on premium and affordability can be significant. While we're confident that the partnership will soon approve less costly inflation options, you may need to recommend a non-partnership plan for the time being. If you do, make sure you write your business with a carrier that offers partnership plans in California. That will make it much easier to convert your clients to a partnership plan when the state adjusts the mandate. In the meantime, a 3% compound inflation benefit will protect your client into the future.

ASSET PROTECTION

With partnership policies, a very important consideration in plan design is the amount of non-exempt assets your client needs to protect. For example, if you design a three-year plan (1,095 days at $180 per day), you help your client protect nearly $200,000 in non-exempt assets in today's dollars. If they have more or less non-exempt assets to protect, you can adjust the duration and/or daily benefit accordingly.

HELP MORE PEOPLE

Is LTC insurance bought or sold? If you look at sales results since the turn of the century, the answer is clearly not enough of either. The key to selling more LTC Insurance is to help more of your clients buy properly designed plans. It's time to untether all of us from the nursing home and start having conversations with our prospective clients that protect them from their real risks of needing long-term care. If you can untether your LTC insurance plan design from the nursing home, we may all finally be able to experience the real death of nursing home insurance. ★

Tom Orr is president of Senior Insurance Training Services, the nation's leading provider of LTC Insurance Continuing Education and Sales Training. He is the co-founder of THE LTC EXPERTS and author of Secrets of LTC Insurance Plan Design: How to Help People Buy LTC Insurance. *Learn more at ltcinsurancece.com.*

(DENTAL SURVEY - Continued from page 21)

member status (active, dropped, suspended or transferred), member ID number, dependent names and eligibility status, fee schedule code, group number and capitation amount, if applicable. DPPO dentists do not receive an eligibility roster as members are not required to select a primary care general dentist. Members would simply choose any network dentist (or non-participating dentist, if they desire) and schedule an appointment. DPPO and DHMO dentists can verify eligibility information via our interactive voice response system and Web site, which are both accessible 24-hours a day, seven days a week. Because the IVR and Web site are available 24/7, eligibility can be verified anytime of the day regardless of whether the need occurs during business hours.

HumanaDental: Participating offices are encouraged to check eligibility before providing treatment. They can verify members and benefits by calling our toll-free customer service line or through our automated information line to get 24 hour-a-day, seven-day-a week eligibility verification. There are no eligibility rosters for PPO business.

Securian Dental: Dental offices can use a toll free number to call customer service to verify eligibility and benefits. Dental offices can also access securiandental.com to verify eligibility.

Western Dental: Western Dental provides eligibility listings to our Staff Model Offices electronically and printed eligibility listings to our IPA Providers. This information is updated on the 1st and 15th of each month. For members who are not on the eligibility listing, we offer guaranteed capitation to our network of providers.

26. HOW DO YOU HANDLE EARLY TERMINATION OF COVERAGE WHEN A MEMBER IS STILL IN THE MIDDLE OF ORTHODONTIC TREATMENT?

Aetna: We stop issuing our quarterly payments when the member is no longer covered.

Aflac: Benefits will cease upon termination of coverage.

Ameritas PPO: PPO provider discounts are determined using the treatment start date. Our PPO providers are contractually obligated to honor those discounts for any ongoing covered treatment under their plan.

BEN-E-LECT: Payment for benefits will cease at the end of the month for which the termination became effective.

BEST Life: Coverage terminates at the end of the month in which a member is no longer eligible.

Blue Shield: Once the member's coverage is terminated, the cost of treatment is the responsibility of the member.

Cigna: Coverage for a dental procedure that was started before disenrollment from the plan (crowns, root canal treatment, bridges, dentures, and partials if the teeth were fully prepared or the final impressions) will be extended for 90 days after disenrollment unless it was due to nonpayment of premiums. Coverage for orthodontic treatment which was started before disenrollment from the dental plan will be extended to the end of the quarter or for 60 days after disenrollment, unless it was due to nonpayment of premiums. Our standard DPPO/Indemnity extension of coverage is 90 days; however, other arrangements can be made.

Delta Dental: Delta Dental's obligation to pay toward orthodontic treatment terminates following the date the enrollee loses eligibility or upon termination of the client's contract.

Dental Health Services: If a member's coverage is terminated in the middle of orthodontic treatment, we encourage the member to participate in a COBRA individual plan that will allow the member to retain orthodontic benefits. If the member chooses not to maintain their coverage, the dental office can prorate any additional treatment fees. The member would then only be responsible for the prorated amount of the full treatment cost.

Guardian: When an orthodontic appliance is inserted prior to the PPO member's effective date, we will cover a portion of treatment. Based on the original treatment plan, we determine the portion of charges incurred by the member prior to being covered by our plan and deduct them from the total charges. Our payment is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the orthodontic treatment started. Also, we enforce the plan's orthodontic benefit maximum by reducing the total benefit that Guardian would pay by the amount paid by the prior carrier, if applicable. If a member is undergoing orthodontic treatment and his or her Guardian coverage terminates, we pro-rate the benefit to cover only the time period during which coverage was in force. We do not extend benefits. Our DHMO agreement provides for the Contracted Orthodontist to complete treatment at the contracted patient charge on a number of our plans. As an additional contract rider we can allow for supplemental transfer coverage for Orthodontia under our DHMO.

Health Net Dental: Upon termination of coverage, we will pay for orthodontic cases in progress on a prorated basis up to the last effective date of coverage. Benefits are no longer payable after the member terminates and are the responsibility of the member and/or the new dental carrier.

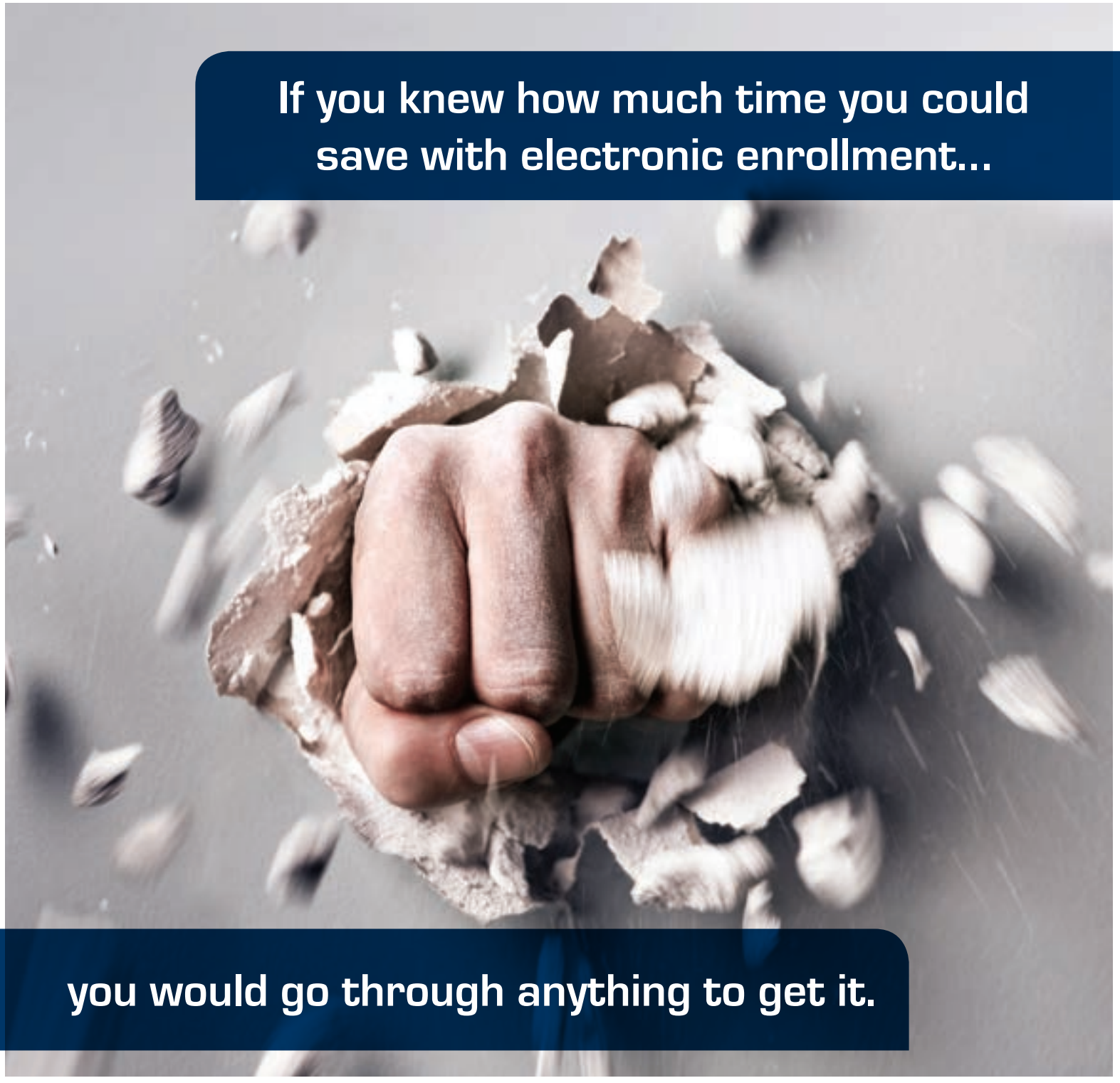
HumanaDental: HumanaDental will prorate to provide the appropriate amount given during the time the member was in the plan.

Principal Financial Group: On individual terminations, most of our plans allow for extended benefits that provide one month of additional coverage.

Securian Dental: Benefits are paid based on the services received while the member was covered by Securian Dental.

United Concordia: PPO dentists can verify eligibility at any time via our Dental Customer Service toll free number, or by using our online system, My Patients' Benefits. Primary dental offices can verify DHMO members' eligibility and benefit information 24 hours a day, 7 days a week through My Patients' Benefits available online at UnitedConcordia.com or by using United Concordia's IVR system, which can be accessed by dialing our toll free Dental Customer Service phone number at (866) 357-3304.

Western Dental: Western Dental has designed a termination clause to protect the member. The member does not incur any additional fees for the early termination of a provider. ★



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EDUCATION IS THE KEY TO IMPROVING Retirement Outcomes

by **DOUGLAS DUBITSKY**

Plan participant education can lead to higher contribution rates and more successful retirement outcomes. This is one of the key findings a recent study of 2,000 active 401(k) plan participants conducted by Guardian Retirement Solutions late last year. While 92% of plan participants surveyed were very or somewhat satisfied with their 401(k) plan, they remain stuck in an accumulation mindset. Fifty-four percent say they pay a great deal of attention to their account balances while only 29% give the same attention to the income that their account might generate in retirement.

In addition, the average 401(k) participant under 50 contributes $8,700 per year to their account; for those 50 or over the average is $9,100. In both cases this equates to a median deferral rate of 9% of personal income, which is certainly less than most financial professionals recommend to build a secure retirement income base. More than half of participants expect personal savings outside their defined contribution plan to contribute to their retirement income.

Financial professionals have an opportunity to help plan participants make the connection between saving and creating retirement income. Fortunately, there are several effective ways to educate their clients to help bridge this gap.

EDUCATION CAN BOOST CONTRIBUTION RATES

The study provides powerful evidence that plan participants who are properly informed are highly motivated to increase their plan contributions. For instance, 79% say they would be likely to increase their 401(k) contribution if they had a better sense of how much retirement income their contributions would create. Encouragingly, 74% say they would be likely to increase their 401(k) contributions if a financial professional showed them how to invest the assets in their plan.

Forty-one percent would increase their current contribution rate if they knew that it would only replace 50% of their income in retirement while 55% would leave it the same. Twenty-five percent would still increase their contribution rate if they thought they were on track to replace 100% of their income.

Some basic 401(k) terms still don't have much of a footprint among the survey participants. Most have heard of contribution rates or vesting, but only half or fewer have heard of target-date funds, dollar-cost averaging, or target-risk funds. This is unsettling since these participants are targeting high rates of return.

With the right tools and information, plan participants are more likely to fully engage in the benefits offered by their workplace retirement plans. On average, survey participants are targeting a 95% income replacement rate; they will need this support to help get them there.

SMALL PLAN PARTICIPANTS ARE MISSING OUT

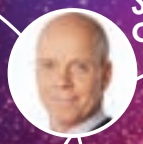
Participants in the small plan market with 25 or fewer participants are less likely to have access to plan features that participants at larger companies take for granted. Features, such as employer matching contributions, wide and varied investment options, planning and analysis tools, knowledgeable telephone and service representatives, and managed account programs are all under-represented by smaller plans.

SOMETIMES THE UNIVERSE JUST FALLS INTO PLACE.

KEYNOTE SPEAKER

DR. JIM LOEHR
J&J Human Performance Institute

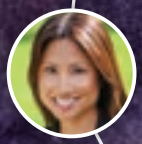
KEYNOTE SPEAKER



SCOTT HAMILTON
Olympic Gold Medalist

KEYNOTE SPEAKER

DAVID MEERMAN SCOTT
International Best-selling Author



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Small market participants may be less knowledgeable and less engaged in their plans than their larger company counterparts. There are opportunities for financial professionals to help enhance plan design and investment features for small plan participants through added features or investment options. Service providers who cater to the small plan market can help level the playing field by bringing large-plan features to the small-plan world.

POTENTIAL FOR FINANCIAL PROFESSIONALS TO ADD VALUE

A third key take away from the study was that plan participant satisfaction is higher when an advisor is involved. Participant involvement increases; asset allocation decisions improve; and there is a better probability of adequate retirement income.

Over 60% of plan participants don't have a relationship with a financial professional, a figure that does not vary much by size of the workplace. Almost 70% have no formal financial plan. Retirement planning confidence is 25 to nearly 30 points higher among the nearly four in 10 participants who do have a financial professional relationship.

Participants who work with a financial professional are much more positive about their 401(k) experience. Thirty percent are very satisfied with the information they get about their 401(k) plan. That figure jumps to 41% for those working with a financial professional.

By developing visibility with participants, there's an opportunity to build relationships through enrollment meetings or periodic investment updates. In fact, many financial professionals use enrollment meetings to further prospect and cross sell with their clients. Many financial professionals with a wealth management background take a big interest in the rollover opportunity when participants retire or move on. Sixty-nine percent of participants say they would be very or somewhat comfortable paying for personal financial advice from the financial professional who has worked with their qualified plan. To capitalize on cross-sell opportunities, financial professionals should not act in an ERISA fiduciary capacity to the plan or its participants.

From those individual financial planning conversations come the potential for increased revenue through cross-selling products, such as life insurance and disability insurance. In addition to the 401(k) commission, which is based on plan assets and compounded over time, cross-sell opportunities can also provide opportunities outside of the qualified plan sale down the road. ★

Douglas Dubitsky is responsible for directing Guardian's retirement product and service offerings. Under his leadership, Guardian is ushering in a new generation of retirement products designed to meet the evolving needs of what the small to mid-size business owner is looking for in 401(k) and other qualified plan solutions and individuals who are looking for guaranteed retirement income. Dubitsky brings more than 15 years of cross-functional experience and a proven track record in retail and wholesale distribution in the insurance and financial services industry to his role at Guardian.

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EMPLOYEE BENEFITS

10-Year Term High-Limit DI Policy Now Available

Petersen International Underwriters of Valencia, Calif. has received the exclusive rights to offer the only 10-year policy term product in the excess/supplemental disability insurance market. Working with a highly-rated European insurance company, Petersen International has developed a personal income-protection disability product that is guaranteed and non-cancellable for 10 years, which is double the maximum five-year term length found in the rest of the market.

According to Thomas Petersen, vice president of Petersen International, "This new 10-year term offering will prove to be revolutionary to the high-limit disability industry, locking in rates and commissions for a longer period than ever before. We have designed a…tool and asset for every life and health insurance advisor to provide to their clientele. The new own occupation disability product guarantees premium rates, benefit schedules and policy definitions for 10 years at a time." For more information, call 800-345-8816 or at piu@piu.org.

Claims App

Unum is offering an app to help customers manage disability claims or leave events. The new mobile app—now available in Apple, Android and Windows app stores—will help customers monitor family and medical leave and manage disability claim details. For more information, visit unum.com.

Online Eye Exams

Opternative, the world's first online eye exam service, is now available to provide convenient and affordable physician-issued prescriptions for glasses or contacts. By using a computer and smartphone, consumers can take a 25-minute or less eye exam from home and get a prescription within 24 hours to use at any online or neighborhood optical retailer. Opternative exams cost $40 for a prescription for glasses or contacts. Prescriptions are issued and signed by an ophthalmologist licensed in the patient's state. There are no additional fees. For more information, visit Opternative.com.

Workforce Management

The new Kronos Workforce Ready suite delivers enterprise-class workforce management solutions in the cloud to small and midsize businesses. Benefit plan visibility and auto-population features simplify managing an employer's Affordable Care Act strategy. For more information, visit kronos.com.

ANNUITES

Deferred Income Annuity

MetLife's Guaranteed Income Builder deferred income annuity is now available as a qualifying longevity annuity contract (QLAC) for individual clients. Guaranteed Income Builder provides a pension-like stream of income for life, helping to address a top concern of today's retirees: running out of money in retirement. By using Guaranteed Income Builder as a QLAC, clients can defer a portion of their required minimum distributions from their qualified IRA to a later date. For more information, visit metlife.com/income.

Flexible Premium Annuity

Voya Financial added a flexible premium deferred variable annuity to its suite of retail retirement solutions. Voya Preferred Advantage offers a lower-cost product with tax-deferred growth potential and the freedom to choose from a number of diverse investment options tailored to consumers' needs. For more information, visit voya.com.

LONG TERM CARE

Long-term Care Plan

Nationwide enhanced its "YourLife CareMatters" linked benefit long-term care (LTC) product, featuring an increase in the LTC benefit pool for most new policies. For the most commonly selected six-year benefit scenario, the LTC benefit will increase up to 21% for single-pay cases and up to 15% on 10-pay cases. Other benefit periods will see an increase or stay the same depending on age, gender, payment plan and benefit option. "Since CareMatters' launch, we've heard from advisors and clients that cash indemnity benefits are a game-changer because they allow for more choices in care than other long-term care products," said Eric Henderson of Nationwide. For more information, visit nationwide.com.

FINANCIAL PLANNING

Retirement Designation Course

LOMA launched an online course, "Successful Retirement Outcomes" (SRI 210). It is offered in a self-paced online format featuring video scenarios and highly interactive learning features. For more information, visit limra.com/sri.

Retirement Plan Design Book

MassMutual published the book, "Precisely," to promote its PlanALYTICS program. The program recommends improving employer-sponsored retirement savings plans through things like automatic enrollment. The book will be available to plan sponsors and financial advisors to encourage improved outcomes for retirement plans and their participants. The book is also available at massmutual.com/planalytics.

Bond Fund

Prudential Investments has launched the Prudential Unconstrained Bond Fund, which allows people to invest across a wide range of fixed income sectors and securities. This fund expands the company's suite of multi-sector bond products and provides an attractive alternative to traditional bond funds. For more information, visit prudentialfixedincome.com.

(Continued on page 44)

NEWS

ACTUARIES DETAIL THE DRIVERS OF HEALTH INSURANCE PREMIUM CHANGES FOR 2016

According to a brief by the American Academy of Actuaries the following factors will affect health insurance premium changes for 2016:

- Underlying growth in health care costs, including increased spending for medical services and prescription drugs, especially as more high-cost specialty prescription drugs come to market.
- The scheduled reduction in the ACA's temporary reinsurance program, which means less of an offset to insurers' costs of higher-cost enrollees.
- The incorporation of insurer experience regarding their 2014 and 2015 enrollee risk profiles into 2016 assumptions.
- The ACA provision expanding the small group market to include employers with 51 to 100 employees.

For more information, visit actuary.org.

PROPOSED OBAMACARE RATES 12% HIGHER FOR 2016

Proposed Affordable Care Act premiums for 2016 increased an average of 12% over 2015. HealthPocket analyzed rate proposals for 3,771 plans for 40-year-old non-smokers in the largest city in each state. The Silver plan accounted for 67% of marketplace plan selections. Premiums would grow 14% for Silver plans, 16% for Gold plans, 9% for Bronze plans, and 6% for Platinum plans.

Rates vary significantly depending on the type of health plan. For example, proposed premiums for HMO and EPO bronze plans are 20% higher while PPOs are only 4% higher.

The 2016 rate filings represent the first time insurers have had a full year of medical claims data to determine rates for new enrollee pools enabled by the law.

Consumers won't necessarily pay the proposed health insurance premiums in the rate filings. Insurance regulators must review and approve the rates in each state, which may result in lowering some rates. Also, some consumers will get subsidies. For more information, visit HealthPocket.com.

THE PROBLEM OF INACCURATE PROVIDER DIRECTORIES

Health plans have been creating contracted network offerings at an unprecedented rate since the implementation of the Affordable Care Act (ACA). But some consumers are complaining that the provider network information from their health plan is misleading and inaccurate, according to a report by Berkeley Research Group. The repercussions of inaccurate provider directories can be significant, posing risks to consumers and health plans. New federal and state regulations require health insurers to give consumers an accurate listing of providers, facilities, and physicians participating in their networks.

Inaccurate directory information may prevent a consumer from verifying whether a preferred doctor is in-network. The consumer would also be in the dark about how many and what types of providers they would have to access under a particular product offering. Additionally, consumers may be charged higher out-of-network rates when providers are erroneously listed as being in-network. These inaccuracies also put health plans at greater risk of litigation, government penalties, and the significant administrative costs of correcting inaccurate directories.

Consumers typically use provider directories to make decisions in real time. However, there is significant variation in how often health plans update their provider directories. Many states only require an annual update. It is up to the states to decide whether to impose penalties on health plans when directories have errors, particularly when patients incur out-of-network costs because of it. Regulators may require health plans to allow consumers to re-enroll in a new health plan if their provider has been misrepresented in a provider directory.

HMOs are the most regulated when it comes to network adequacy, followed by PPOs and EPOs. In a study published by JAMA Dermatology, researchers at the University of California, San Francisco, tried contacting 4,754 dermatologists listed in the three largest Medicare Advantage plans in 12 metro areas. Nearly half of the names were duplicates, and only about half the remaining—26% of the total—were at the listed address, accepted the plan, and offered appointments. The California Department of Managed Health Care (DMHC) found that 18% of the physicians in the Blue Shield of California directory were not at the location listed, and 9% were not accepting patients enrolled

in the plan's Covered California products, despite being listed on the website as doing so.

Anthem customers filed 176 complaints on network issues from January 1 to August 31, 2014, and Blue Shield saw 130 complaints. The Department of Health and Human Services' Office of Inspector General found some glaring results. Forty-three percent of providers were not participating in the Medicaid managed care plan at the listed location and could not offer appointments. Some of these providers had participated in the plan in the past while others had never participated.

Health plans are trying to lower costs by creating narrow networks. Forty-four percent of ultra-narrow, silver-tier products sold on the ACA exchanges exclude at least one hospital from every single participating health system. These are the results of a 2014 McKinsey study. Another 31% exclude at least one hospital from at least one health system. Costs for these ultra-narrow networks are 13% lower. But it's harder to capture the relevant information in a health plan's provider system and make sure that provider directories are accurate. Also, a provider who practices multiple specialties or works at multiple locations may only be participating with a health plan for one specialty or at one location. When one piece of information for a provider changes, the entire directory becomes inaccurate until it is updated. It takes substantial resources for a health plan to maintain accurate participating provider information. All of this must be performed with resources that are limited and subject to medical loss ratio (MLR) requirements.

WELLNESS PROGRAMS EFFECTIVE IN UNCOVERING CHRONIC DISEASES

Twenty-eight percent of 750 participants in sponsored wellness programs have been diagnosed with a chronic condition in the past two years. And 46% of them discovered their chronic illness through a wellness program, according to a HealthMine survey. Seventy-four percent of employees surveyed say wellness programs should include genetic testing to identify risks for chronic conditions. Some large insurers have already started incorporating genetic testing in their wellness programs, even as program sponsors await pending regulation over privacy and other protections. Most consumers want plan sponsors to offer health screenings. In fact, 74% want vision screenings; 73% want blood pressure screenings; and 69% want cholesterol screenings. For more information, visit healthmine.com.

IN CALIFORNIA

CAHU Summit in Los Angeles Next Month

CAHU's Health Care Summit will be held September 29 in Universal City. This year's summit, Modern Agent, is focused on modernizing with technology and automation, and will feature cutting edge sales-driven sessions, and tech vendors. For more information, visit cahu.org.

New Law Increases Financial Protections for Seniors Investing in Annuities

New consumer protections were ushered in when Governor Brown signed Senate Bill 426 (Leyva) into law. Under the new law, the death benefit for fixed deferred annuities must be at least equal to the annuity amount or the accumulation value for annuities issued to consumers 65 or older. The law also prohibits companies from charging a surrender penalty on the death benefit payment. Commissioner Dave Jones said, "While many companies do not pay out a death benefit that is less than the premium paid, some insurers do apply surrender penalties reducing the death benefit below the total premiums, which is the reason for this important legislation. I thank Senator Leyva for partnering with me on this change in law." Taking effect on January 1, 2016, SB 426 earned strong bipartisan support and was supported by the California Advocates for Nursing Home Reform, California Health Advocates, Congress of California Seniors, and the Elder Financial Protection Network. Commissioner Jones encourages seniors to learn more about their options by visiting the Senior Information Center on the California Department of insurance web site at insurance.ca.gov.

Settlement in Executive Life Insurance Case Ends 16 Years of Litigation

California Insurance Commissioner Dave Jones announced a settlement with the last remaining defendant in a 16-year-old lawsuit brought by the California Department of Insurance. The case arose out of the 1991 liquidation of Executive Life Insurance Company. The French company Artemis S.A. agreed to pay $200 million in addition to $110 million it has already paid. The National Organization of Life and

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California Insurance Commissioner Dave Jones
Source: insurance.ca.gov

Health Guaranty Associations and the California Life and Health Insurance Guarantee Association also joined in the settlement. This settlement agreement closes the last chapter in the long dispute between the Department of Insurance and Artemis S.A., one of the purchasers of the Executive Life Insurance Company. Total recovery in the Executive Life Insurance litigation against all defendants is over $930 million.

California-based Executive Life insurance company became insolvent in 1991. The California insurance commissioner at the time, John Garamendi, solicited bidders to buy its assets, including its multi-billion dollar portfolio of junk bonds as well as life insurance policies and annuities. In a competitive bidding process, the commissioner selected a joint bid from a consortium of French companies that included Altus S.A. The subsidiary of Credit Lyonnais was owned by the French government. Altus bought Executive Life's junk bonds. Its consortium partners set up a California insurance company that took over Executive Life's policies. However, California law prohibits a foreign government from owning a California insurance company, which means that Altus could not legally own the company. The conspirators concealed Altus' ownership and lied to the California Department of Insurance and the Federal Reserve Bank of New York. Artemis joined the conspiracy later.

The California Department of Insurance discovered the conspiracy and sued all conspirators, which touched off a lengthy legal fight. The lawsuit asserted that if the conspiracy had been disclosed, the former insurance commissioner would not have selected the Altus consortium bid. Instead, he would have selected a bid that, over time, would have returned more money to Executive Life's policyholders. On the eve of trial in 2005, Commissioner Garamendi settled with Credit Lyonnais, Altus, and related parties for $516.5 million and with the new insurance company for $78.75 million. Artemis paid $110 million to the Executive Life estate as a part of a settlement of a separate case brought by the U.S. Attorney. Other defendants paid over $25.5 million to the Executive Life insurance company estate. Under the commissioner's supervision, the litigation recoveries were distributed to policyholders. Because Artemis did not join the earlier settlements, the department's case against Artemis went to trial in 2005. At trial, the federal court barred the commissioner from presenting evidence about the damage that the conspiracy caused to Executive Life's policyholders. Instead, the court ordered Artemis to pay $131 million in its profits to the policyholders.

In 2008, the U.S. Court of Appeals sent the case back for another trial in which the commissioner was to be allowed to present his case for damages. The retrial occurred in the fall of 2012. During the trial, the commissioner contended that a new trial judge incorrectly instructed the jury. Both sides appealed the judgment in the retrial. That appeal was pending when this settlement was reached.

EVENTS

National Long Term Care Insurance Sales Summit

The National Long Term Care Solutions Sales Summit will be held October 27, 2015 in Washington, D.C. For members of the American Association for Long Term Care Insurance, there is no cost to attend the conference or to watch the live stream online. For more information, visit aaltci.org/2015summit. ★

(NEW PRODUCTS - Continued from page 40)

Agent's Resources:

Online Health Data Security Education

SecurityMetrics has developed an educational learning center for compliance with the Payment Card Industry Data Security Standard, Health Insurance Portability and Accountability Act (HIPAA), and other information security topics. The SecurityMetrics Learning Center features videos, webinars, infographics, articles, blog posts, ebooks, and white papers. For more information, visit securitymetrics.com.

Document Security

Pitney Bowes launched the Relay multi-channel communications suite for small and medium businesses. It enhances transactional communications (bills and statements) while keeping client data private and meeting regulatory requirements. A cloud-based digital document hub helps businesses deliver communications through physical or digital channels, including email, post to web, and digital archiving. The Relay communications hub also offers off-site production options in the event of a business disruption or to alleviate capacity overflows. Pitney Bowes says that it is the only cloud-based document production software that offers document enhancement, multi-channel output, and dynamic off-site print routing capabilities. For more information, visit pitneybowes.com/us/relay. ★

Why Too Many Agents Overlook ATTRACTIVE PRODUCT OFFERINGS

by **JEREMY BOWLER**

Financial advisors have largely embraced variable annuities. But, so far, variable or indexed annuities are only being sold by about half of the life agents licensed to sell them. Given the increasing appetite for better returns, insurers need to do more to educate agents about these attractive product offerings. Carriers need to focus on the features, benefits, and appropriate cases for each product. But most critically, they must focus on how to balance the interest rate upside with the volatility concerns that agents have and the perceived risk that clients fear. Carriers that can overcome these inhibitors stand to gain the most from the growth in this sector.

In a recent study of 556 life insurance agents, Market Strategies International set out to determine how well products meet the needs of producers and their clients. They also looked at what is most important in driving business. As you might expect, term and whole life products are mainstays for life agents. More than 90% of agents surveyed have sold life policies in the past 12 months, generating an average of 63% of sales revenue. More than four out of five agents manage fixed annuities for existing clients, and almost two thirds have sold them in the past year.

Two-thirds of agents hold contracts for fixed indexed annuities (FIAs), and 43% are selling new FIA contracts. But, just four in 10 manage variable annuity (VA) contracts or have sold new VAs over the past year. Policy counts don't tell the whole story. Variable annuities accounted for 17% of total sales among life agents last year, and 6% of all managed assets, which is slightly ahead of those invested in fixed annuities.

	TYPES OF CONTRACTS		VALUE OF CONTRACTS	
	Managed	Sold last year	Managed	Sold last year
Life insurance	93%	90%	89%	63%
Property/casualty insurance	23%	21%	<1%	<1%
Fixed annuities	81%	64%	5%	14%
Fixed indexed annuities	66%	43%	<1%	6%
Variable annuities	42%	37%	6%	17%

Source: Market Strategies International Fixed Annuity Brandscape™ Cogent Report, September, 2014

The growth of new indexed or variable products has changed what agents look for from carriers. Agents spend an average of one day a week managing client accounts, trying to find better returns. Volatility has become the hardest element to manage. Investment risk is the biggest concern among their clients.

The majority of life agents are generally pleased with today's insurance and investment products. Seventy-two percent are pleased with life products at their disposal while 63% are pleased with investment products. Those who are pleased with the insurance solutions mention the broad range of products and carriers, the quality of the products and services, and how much the products are tailored to meet clients' needs.

On the other hand, almost 10% of agents rate the investment products as a five or less on a scale of one to 10. They cite concerns about excess volatility with insufficient interest rate upside to offset the risk. This may be one reason that fewer agents have been selling variable or indexed annuities in the past 12 months. However, as many as 70% of all financial advisors say they have sold variable annuities in the past year, accounting for 87% of total sales revenue in the same period from insurance products.

Agents say that retaining clients is their most important goal, followed closely by gaining clients. Next come concerns over book profitability, technology integration in their agency, and long-term succession planning.

Agents say that it's important to look for the best products to meet their clients' needs and stay educated on these products. The emphasis on education and training is most pronounced among newer agents. Even so, 66% of agents with 20 years or more in the business say ongoing product education is extremely important. Clearly then, carriers need to invest in training and support for these products as they become more important for agents.

Healthcare and retirement issues are agents' most desired training topics, deemed more than twice as important as risk management training. Many agents also say that tax/estate planning and insurance planning will be important training areas over the next two years. Fewer agents are interested in training for investment strategies or portfolio management. However, these subjects are more valuable among agents who sell variable and indexed annuities.

Financial stability is the price of entry when life agents choose a carrier. In fact, financial stability was ranked highest by four out of every 10 agents in the study. Agents also rate other criteria as important including the ease of doing business, the application/underwriting process, fees/expenses, and brand reputation. Carriers are spending significant sums on advertising directly to the marketplace. A carrier's brand reputation will have increasing importance during a client meeting at the agency office.

The product choices for life agents are growing as multiline carriers embrace the increasing revenues and attractive margins of the life and annuity markets. Agents are still the dominant distribution channel for life insurance products. So it's critical for carriers to help them meet their clients' rapidly changing needs and support the growth and prosperity of their agencies. ★

Jeremy Bowler is SVP, Research and Consulting at Market Strategies International. He has more than 25 years of experience in marketing and market research, the majority being in the financial services and insurance sectors internationally. Over the years, Jeremy has helped many companies gain a rich understanding of what drives customer expectations and behavior to prioritize business decisions accordingly. His philosophy is to help clients become more outwardly focused on the marketplace.

AD INDEX

Hmmm…maybe we should define “partner.”

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