

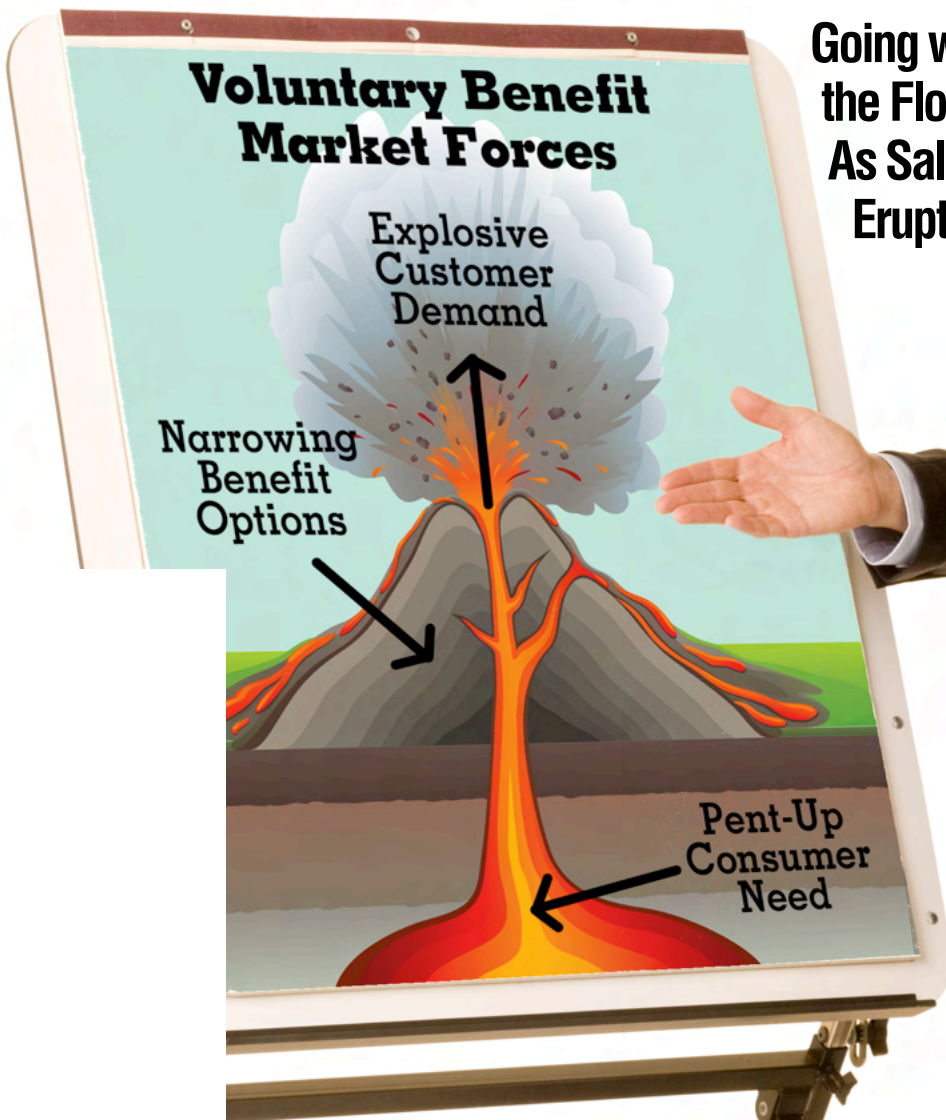
CALIFORNIA BROKER

VOL. 34, NO. 4 SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

JANUARY 2016

Volcanic Voluntary Benefits

Going with
the Flow
As Sales
Erupt



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INTRODUCING

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TABLE OF CONTENTS

9

ANNUITIES

Annuities Spark Criticism, But It Really Isn't Justified

by Scott M. Sadar, CFP
Many annuities are excellent investments, assuming that your clients truly understand what they are buying.

12

HEALTH

Open Enrollment, Brokers and Déjà Vu All Over Again

by Don Goldman
A proposed solution to reduce group congestion in the fourth quarter.



18

TRAVEL

Don't Overlook the Potential of Expatriate Health Plans

by Brendan Sharkey
Is opportunity leaving the country without you?



20

MEDICARE

Marketing Medicare Compliantly

by Colleen Gimbel
Being smart about how you market yourself and your business is the key to creating a lead pipeline and keeping it running.



22

VOLUNTARY BENEFITS

Brokers Can Discover Big Dollars in Small Businesses

by Todd Mason
Voluntary benefits offered at small businesses mean more than \$1.5 billion in annual sales.



26

Are Healthy Senses Being Ignored in Your Clients' Wellness Programs?

by Brad Volkmer
How to seamlessly integrate hearing health into a client's wellness strategy.

28

Putting Tailored Benefits into Action

by Gene Lanzoni
Get employers started on a tailored approach to support employees' changing needs.

29

HEALTH

A Re-imagined Telehealth Model

by Scott Sanford and Pat Sir
Many brokers are having tremendous success by incorporating telehealth into their plan designs.

30

WORKERS COMP

Trends in Workplace Safety

by Dinesh Govindarao, M.D.
A look at some of the top trends and recommendations in workplace safety.

32

SELF-FUNDING

Help Self-Insurers Navigate Healthcare Reforms

by Steve Kokulak
How healthcare reform affects workers' compensation with self-insured employers.

36

HEALTH

The Rise of Wholesale Healthcare Providers

by Liz Griggs
More healthcare providers are offering discounted services to the consumer.

ALSO IN THIS ISSUE:

Guest Editorial.....	6	Products.....	38
Annuity Sampler.....	8	News.....	40
Dental & Vision News.....	11	CE Credit Update.....	43
Private Exchange News.....	16	Classified Advertising.....	46
COBRA News.....	36	Ad Index.....	46

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And as 2016 ***promises*** to be just as important, we ***promise*** to keep offering you top-notch support.

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ROCK THE YEAR IN 2016

by JOE NAVARRO



It's a year of motivation for you and your clients. Here's a given: Our industry will continue to change dramatically. But unpredictability will open the door to possibilities. You will have tremendous opportunities to grow your business. The book on health insurance will continue to be re-written, and it will remain a very difficult read for most consumers and businesses (your future clients).

My prediction is that health insurance advisors and consultants like you will be more popular than Elvis in 2016 (Thank you very much).

So what do you do now? Embrace it! Start looking at creative thinking and marketing as a required skill for you and your agency rather than as something we associate with Walt Disney, Steve Jobs, or Steven Spielberg.

It requires you to invest the time and, more importantly, believe passionately in the need to ride the wave of innovation and implement new strategies for success.

The modern agent is a marketing technologist who differentiates their agency from the competition, knows that the rules have changed, and understands that consumers want something that motivates them beyond the norm.

You have a couple years of fourth-quarter insanity under your belt. Take that experience and go crazy with creativity to restructure your agency and grow your business.

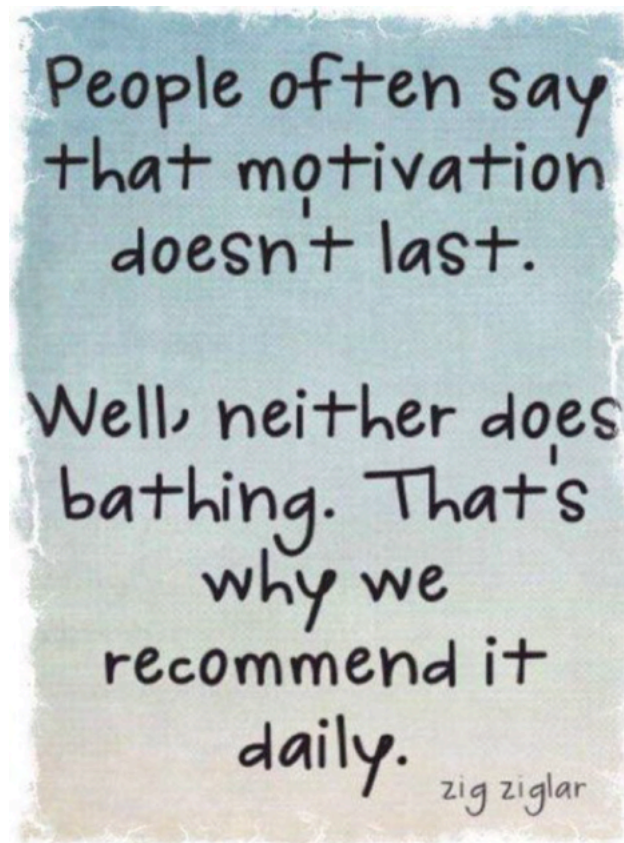
Take for example the "my tech tools are better than your tech tools" conversation going on today. Do you remember back as recently as a few years ago when this topic was a blip on the radar?

Today, it dominates the conversation, especially if you sell group products.

SO HOW DO YOU STAND OUT? DO THE FOLLOWING:

1. Communicate often (market creatively) offering as much value as possible in the shortest time with the understanding your future clients want "instant on."

2. Simplify your discussion about tech tools and reassure them that you are never far away when they need you. Personalize your message (offering more than one tool). Acknowledge the challenges and use creativity to present solutions (give them choices). Show them how you can simplify the process. Sell the support you offer. Your biggest differentiator is the fact that you service what you sell.
3. Mobile will be a key part of your marketing success including everything from smart phones, to tablets, to wearable gadgets. Can you say Inspector Gadget?

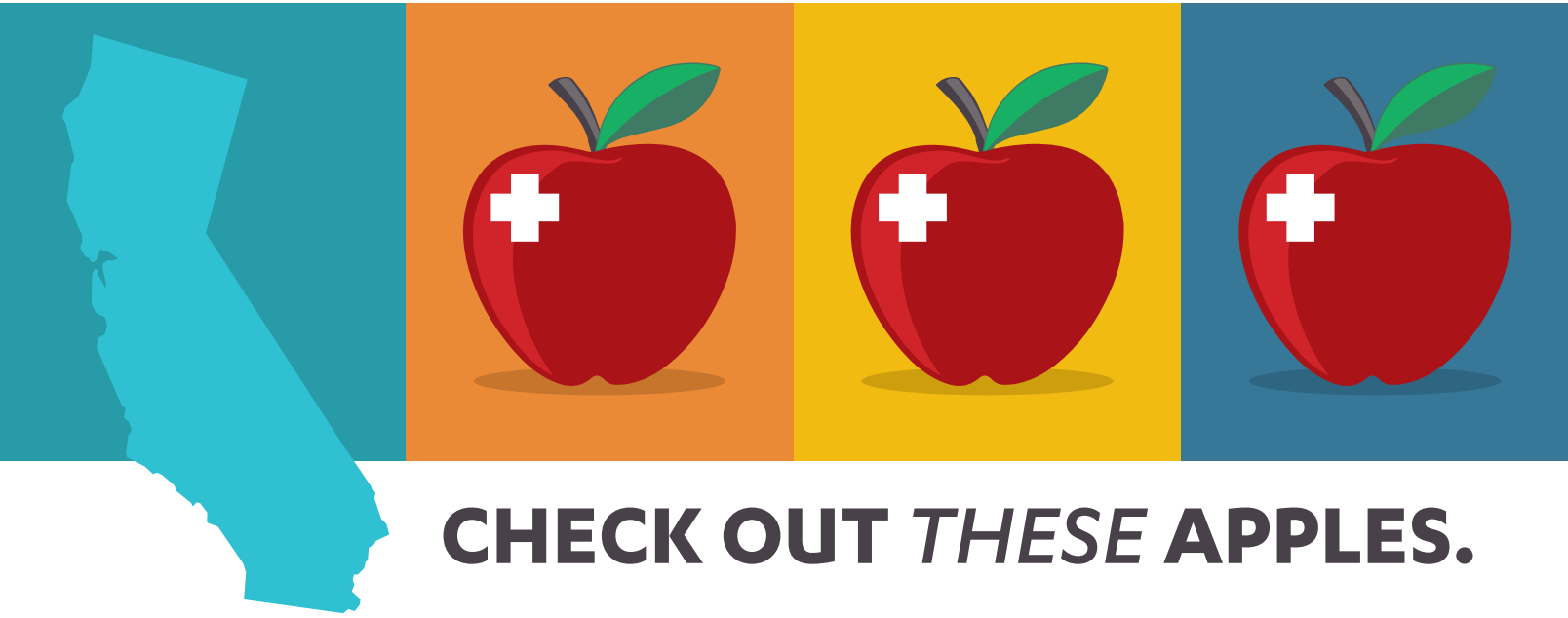


4. Data driven marketing is a smarter use of your dollars. There is gold in your data mine of existing and future clients.
5. Video is the messenger of choice among your future clients. It is content rich, and can be delivered in an entertaining way (yes, even for insurance products).
6. Go beyond health insurance. With "instant on" comes the expected responsibility of anticipating the additional needs of your future clients. It will also add to your monthly paycheck.
7. Lighten up your marketing message creatively. Your future clients are done with the doomsday communications of the ACA. Give them something to smile about. Humor lowers defenses when done the right way.

There are no rules in the land of creativity. You are a fighter; you're passionate about the services you offer; and you have definitely made a difference in the lives of your clients. Always look out for new ideas and ways to do things better. Creatively motivate your clients to take action and benefit from your many services. You have not come all this great distance and made all this great effort only to miss out on all of the opportunities. Be brilliant in 2016. I look forward to seeing you on the marketing trail. ★

Joe Navarro is marketing director for Warner Pacific Insurance Services.

COMPARING APPLES TO APPLES?



CHECK OUT *THESE* APPLES.

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



Covered California for Small Business is the health plan of choice for both small businesses and their employees, offering:

- Employer budget control through defined contribution
- Employee choice of popular health plans from leading health insurance carriers
- Small business tax credits available only through Covered California (for qualified groups)
- True employee-only coverage, helping dependents to remain eligible for individual tax credits
- Expanded PPO networks with out-of-state access
- Optional pediatric dental coverage
- No extra ACA or administrative fees
- Flexibility and competitive rates

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FOR **SMALL
BUSINESS**

DECEMBER 1, 2015

Company Name	Ratings			Product (Qual./Non-Qual.)	Type SPDA FPDA	Initial Interest	Guar. Period	Bailout Rate	Surrender Charges	Mkt. Val. (y/N)	Min. Contrib.	Comm. Street (May Vary)
	Bests	Fitch	S&P									
American Equity	A-	BBB+	A-	ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.55%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.75%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10% age 76-80**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	3.00%*	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
*Effective 9/24/15. Current interest rates are subject to change on new issues. **Commission may vary by issue age and state. See Commission Schedule for details												
American General Life Insurance Companies	A	A+	A+	American Pathway Solutions MYG	S	2.40%* ^a 2.55%* ^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 11/2/15. First year rate includes 1.50% interest bonus. a (less than \$100K ; b (100K or more)												
American General Life Insurance Companies	A	A+	A+	(*Guarantee Return of Premium) (Q/NQ) American Pathway Fixed 5 Annuity	S	1.55%* ^a 1.75%* ^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 11/2/15. Includes 2.00% 1st year bonus, 1.00% base rate subsequent years. a (less than \$100K) b(100K or more)												
American General Life Insurance Companies	A	A+	A+	(*Guarantee Return of Premium) (Q/NQ) American Pathway Fixed 7 Annuity	S	2.00%* ^a 2.20%* ^b	5 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ)	3.00% age 0-85 1.50% age 86-90
*CA Rates Effective 11/2/15. First year rate includes 4.0% bonus 1 st year. a (less than \$100K) b(100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Flex Fixed 8 Annuity (Q/NQ)	F	4.15%* *(includes a 2% interest rate bonus for first year)	1 yr.	None	8%, 8%, 8%, 7%, 6%, 5%, 3%, 1% 0%	No	\$5,000 (NQ) \$2,000 (Q)	2.20% age 0-75 1.70% age 76-80 1.20% age 81-85
*CA Rates Effective 11/2/15												
Genworth Life & Annuity Insurance Co.	A	A-	A-	SecureLiving Rate Saver	S	2.80%* 2.65%	7 yrs. 5 yrs.	None None	9%, 8, 7, 6, 5, 4, 3 9%, 8, 7, 6, 5, ,0	Yes	\$25,000 (NQ)	Varies 0-85 *Effective 8/19/15. Based on \$250K or more.
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	2.40%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	\$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 6/8/15. Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.40%. For under \$100,000 first-year rate is 2.25%. Escalating rate five-year yield 2.25%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.65%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	\$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 6/8/15. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.54%. For under \$100,000 first-year rate is 2.55%. Escalating rate seven-year yield 2.44%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.75%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	\$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 6/8/15. Eff. yield is 2.77% based on 1.75% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.75%. Surrender value interest rate 1.75%. Accepts additional purchase payments in first three contract years. COM12255												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.75%*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	**Rates Effective 11/1/15 for premium less than \$100,000 and are subject to change
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	2.15%*	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	**Rates Effective 10/1/15 for premium less than \$100,000 and are subject to change.
North American Co. for Life and Health	A+	AA-	A+	Gaurantee Choice (Q/NQ)	S	2.40%*	5 yr.	None	10, 10, 9, 9, 8	Yes	\$2,000 (Q) \$10,000 (NQ)	2.50% (0-80) 1.875% (81-85) 1.25 (86-90)
Reliance Standard	A+		A	Eleos-MVA	S	3.50%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 7/28/15. Includes 1.50% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+		A	Apollo MVA (Q/NQ)	S	4.45%*	1 yr.	None	9%, 8, 7, 6, 5, 4, 2	Yes	\$5,000	4.00% to age 75**
Includes 2.00% 1st yr. bonus. Min. guarantee 1.00% **Reduced 20%, ages 76-80, and 40% ages 81-85. Effective 7/28/15												
Symetra Life, Inc.	A	A+	A	Custom 7 (Q/NQ)	S	3.05%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 11/17/15. 2.55% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												

Annuities Spark Criticism, *But It Really Isn't Justified*

by SCOTT M. SADAR, CFP

If your sales arsenal includes annuities, you know that they can be a tough sell. While essentially self-funded pensions purchased from insurance companies, annuities tend to be complicated. So many people don't understand them. Moreover, many annuities are sold at one-size-fits-all sales presentations that dangle a free dinner and peddle only one or two annuities in a marketplace swamped with hundreds, virtually ensuring that buyers seldom get an annuity that best fits their needs.

Word eventually gets out; annuities get a bad rap; and a vicious, unvirtuous circle is enhanced. Don't buy an annuity, skeptics say, or you will get burned. One prominent critic, Ken Fisher, the chairman and CEO of San Mateo-based Fisher Investments, offers to foot annuity-surrender fees for prospective clients who invest with him, thereby happily obliterating their dalliance with annuities.

The truth is that many annuities are excellent investments, assuming that your clients truly understand what they are buying. Among the experts who say so are Wade Pfau, professor of retirement income at The American College of Financial Services and director of retirement research at McLean Asset Management in McLean, Va. "By combining an income annuity and stocks, you get the most efficient outcome," he recently told ThinkAdvisor.com. "Annuities are (better) suited (than stocks) for protecting against longevity risk and investment volatility."

Another respected annuity fan is Moshe Milevsky, associate professor of finance at York University in Toronto. Here is his message, also conveyed recently in ThinkAdvisor.com, "There is a magical, secret ingredient, a secret sauce, inside an annuity that can't be replicated by other retirement

products," Milevsky told the website.

To help you make the case to clients that annuities often make sense, here is a list of the 10 most common annuity criticisms and what is wrong, step-by-step, with this rhetoric:

1. Criticism: Variable investors can run out of money. Reality: For practical purposes, this is not true with most variable annuities because most buyers buy a rider with a lifetime income guarantee. Variable annuity returns are tied to the performance of underlying stock mutual funds, called sub-accounts. Stock market declines result in a decline in contract-cash value, but don't affect the income-withdrawal stream. This income stream, which is the primary reason people buy annuities,

is guaranteed, regardless of market performance. A weak market will hurt the cash value of the contract, but that typically affects only the amount of money a beneficiary receives.

2. Criticism: Annuity fees and commissions are very high. Reality: Higher fees pay for unique benefits, such as guaranteed-lifetime income and a death benefit. The commissions are often lower than those in a traditional managed-money account. Annual annuity fees are higher – usually 2.5% to 3.5%, but this pays the freight for the benefits cited above. The one-time sales commission on most fixed annuities is 2% to 4%; on variable annuities it is 5% to 7%. In contrast, a



fee-only financial planner charges 1% to 1.5% a year. Unlike the case with annuity-sales commissions, these fees are paid annually, not as one-time charges. Yes, annual annuity fees are higher than the fees you might charge. Aside from your annual commission, the only additional charge is usually mutual fund management fees, usually 1% to 1.5% a year. A variable annuity charges this plus an annual guaranteed income rider fee of generally 1% and mortality/expense/administration fees of generally 1.25%. On the other hand, these fees pay for a guaranteed-income stream and death benefit, as well as the mutual fund expenses. And a fixed annuity is much less expensive.

3. Criticism: Given the uncertainty of life, especially in retirement, annuity-surrender fees, which can easily peak at 10% to 12%, are a substantial negative. Reality: Most annuity holders don't pay surrender fees, partly because annuities commonly allow additional withdrawals of 10% a year without penalty. Insurance companies need to keep an annuity holder's principal to make money on that principal; hence there are surrender fees. But the 10% excess withdrawal feature, without penalty, eases potential pain. In addition, almost all insurance companies offer a variable annuity without a surrender charge. Annuity holders pay extra for this, but the charge comes solely out of the contract cash value, not from the amount of withdrawal payments.

4. Criticism: Unlike capital gains, annuity withdrawals are taxed at the higher ordinary income rate, which makes them tax-inefficient. Reality: Most retirees with annuities are in the 15% marginal tax rate, which means that they pay the same tax as the capital gains rate. A married couple filing jointly can earn \$74,900 annually after deductions and still be in the 15% marginal tax bracket. A single person can earn up to \$37,450 after deductions. Most retirees don't have more income than this, even including investment withdrawals. According to the AARP, the average annual income of a single retired

American in 2012 was \$31,742 – below the 15% threshold.

5. Criticism: Annuities pay lower rates than, say, a decade ago, making them a bad investment. Reality: You can't look at interest rates in a vacuum. All interest rates are much lower. Consider, for example, the benchmark 10-year U.S. Treasury bond. It currently yields 2.2%, which is down from 4.1% a decade ago. And once an annuity holder owns an annuity beyond its surrender period, they can withdraw the principal without penalty and invest in a higher-yielding annuity if interest rates are higher. In the interim, unlike the case with a bank CD, the annuity holder can commonly withdraw 10% from the annuity annually, and sometimes more, without penalty.

6. Criticism: Annuities offer no protection against inflation. Reality: You can buy a ladder of fixed annuities to hedge against inflation. Clients can, for example, buy a ladder of annuities expiring in three, four, five, and six years. If they think inflation will rise, but don't know when, this is a way for them to buy annuities that mature at different points, allowing them to reinvest the principal in higher-yielding annuities should interest rates rise.

7. Criticism: Annuities are bad because they are irrevocable. Reality: Most annuities are only irrevocable during the surrender period. After the end of the surrender period, it costs an annuity holder nothing to liquidate his annuity. This aside, the creation of a stable retirement investment stream often requires committing to a long-term plan. If you eschew annuities and invest solely in a balanced fund (stocks and bonds), what if there is a huge market downturn just as you are ready to begin withdrawing the money?

8. Criticism: There is too much risk putting your assets in the hands of an insurance company. Reality: Most insurance companies are rock-solid, with a long history of protecting customer funds. During the Great Depression, not one insurance company failed to pay on any of its policies, including annuities. Far fewer insurance companies

than banks failed. When one did, others stepped in and bought it to sidestep possible industrywide turmoil. Insurance companies are naturally conservative because they are run by actuaries, not investors. They invest principally in fixed-income assets. Unlike Wall Street firms, their primary goal is to protect assets and increase them conservatively, not aggressively.

9. Criticism: The government bailout of American International Group (AIG) during the Great Recession undermines the above contention. Reality: No, it does not. AIG repaid its debt, and the strength of its underlying insurance business was, in fact, the reason it received the bailout. AIG was bailed out by the U.S. government during the Great Recession, but it paid back \$205 billion on a \$182 billion loan. It ran into trouble because a London-based subsidiary got mired in the sub-prime mortgage crisis. The government bailed out the company because of the steady cash flow of its insurance business. Large insurance companies are here for the duration. A number of the top players have been around more than 100 years.

10. Criticism: Many annuity salespeople don't clearly spell out annuity fees. Reality: This is true, but fees are always clearly spelled out in the prospectus. There are mortality, expense, and administration contract charges, variable annuity subaccount fees, as well as living benefit and death benefit rider fees. Subaccount fees should be roughly 1% or less, rider fees a total of 1%, and M&E&A fees 1.25%. To make sure their fees are reasonable, annuity buyers need to comparison-shop before buying an annuity. Ask for everything in writing to ensure that you know the fees you're paying and how they could change. ★

Scott Sadar is executive vice president of Portland, OR-based Somerset Wealth Strategies and a certified financial planner. As a financial planning professional for more than 15 years, prior to Somerset he worked in annuity sales and Advanced Markets/Estate Planning at Jackson National Life and Advanced Markets Sales Consulting for MetLife.

JD POWERS RATES DENTAL AND VISION PLANS

Dental plan members rated their satisfaction with their plans at 717 points out of 1,000 in 2015 compared to 723 in 2014, according to a J.D. Power study. The report, now in its second year, measures customer satisfaction with dental plan insurance based on five factors (in order of importance): cost, coverage, communications, customer service, and reimbursement. There was a significant drop in satisfaction over plan communications at 690 in 2015 compared to 702 in 2014. Forty-two percent of dental plan members say they have not received any information about their plan from their insurer. Satisfaction among these members is 662, compared to 758 among those who did receive some type of information from their carrier.

Rick Johnson, director of the healthcare practice at J.D. Power said, "It can be challenging for dental insurance companies to communicate effectively with their members given the relationships members have with their employers who sponsor dental plans...A solid communication plan helps members better understand their dental coverage and can impact their perception

of their plan's value. The employers, dental plan carriers, and members all benefit when dental insurance companies communicate with their members on a regular basis."

Eighty-seven percent of dental plan members who rate their experience 10 (outstanding) on a 10-point scale, say they will definitely choose their current carrier in the future, compared to the report average of 43%.

Satisfaction among vision plan members was 707 in 2015 compared to 709 in 2014. Although coverage and cost remain critical to satisfaction with vision plans, Johnson added that clear, frequent communications about the plan's benefits helps members better understand how to use them and can also improve their perception of the plan's value. When satisfaction with communications among vision plan members is 800 or above, satisfaction is 873, compared to 603 when communications satisfaction is 799 or below. Eighty-eight percent of vision plan members who rate satisfaction outstanding (10 on a 10-point scale) say they will definitely choose their current carrier in the future, compared to the report average of 40%. ★

	RATINGS FACTORS – DENTAL PLANS						
	Overall Experience	Information & Communication	Dental Plan Ratings	Claims Processing	Customer Service	Cost	Coverage & Benefits
AWARD RECIPIENT: Kaiser Foundation Health Plan	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●
Aetna	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●
Anthem Blue Cross of California	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●
Blue Shield of California	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●
Cigna	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●
HealthNet	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●
UnitedHealthcare	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●

	RATINGS FACTORS – VISION PLANS					
	Overall Satisfaction	Customer Service	Vision Plan Ratings	Cost	Coverage	Reimbursement
AWARD RECIPIENT: Optum/Spectera/UnitedHealthcare	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●
Davis Vision	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●
Eyemed	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●
VSP	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●	●●●●●

	Among the Best ●●●●●	Better Than Most ●●●●●	About Average ●●●●●	The Rest ●●●●●
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Open Enrollment, Brokers and Déjà Vu All Over Again

by DON GOLDMAN



New York Yankee, great Yogi Berra said, “It’s *déjà vu* all over again” when he saw Mickey Mantle and Rodger Maris hit back-to-back home runs. Such unintended witticisms became known as “Yogisms.” The powers that be who make decisions about broker involvement in the ACA exchanges have, on occasion, remembered another Yogism, “You can observe a lot by watching.”

Pac Advantage closed its doors almost 10 years ago. It had started as a direct descendent of the California Health Insurance Purchasing Co-op (HIPC). These entities were predecessors to the exchanges under the 2010 Affordable Care Act (ACA).

At just about the same time, the nation’s first private exchange was formed. Unlike HIPC, it was dedicated exclusively to distribution through licensed brokers. Employers received monthly statements from HIPC and

other entities. The cost of commissions was featured prominently with instructions on to how to avoid paying brokers and lower their costs.

Despite the temptation to cut premiums by the usual commission percentages, a vast majority of employers continued to pay their brokers because of the important value of their services.

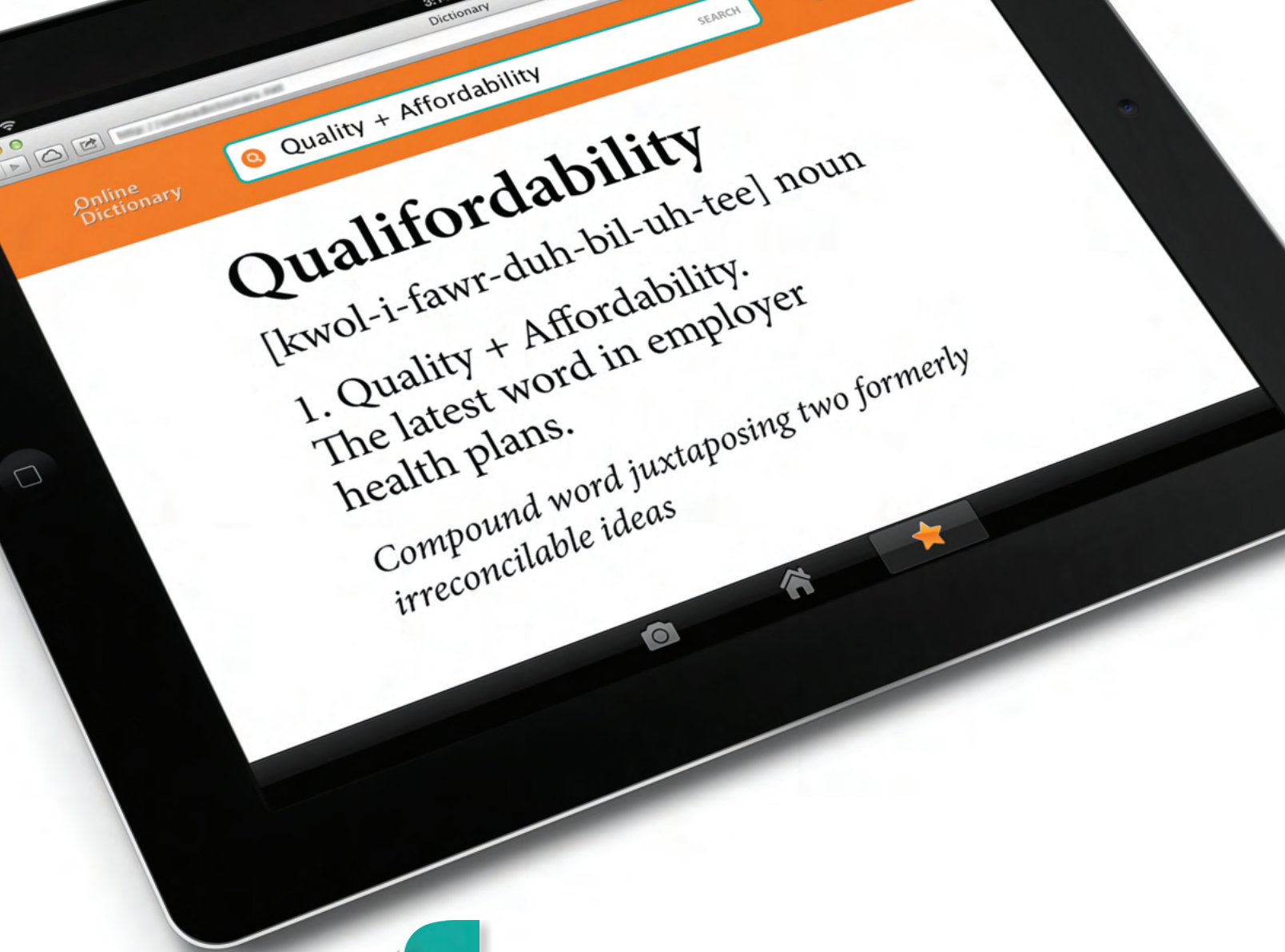
Fast forward to the ACA; original drafts of the legislation, which didn’t recognize the value of the broker, would have eliminated commissions from any exchange program. That ill-conceived idea was eliminated with leadership from organizations including the National Association of Health Underwriters (NAHU).

Many states make broker sales extremely difficult with tiny commissions and a lack of support, but California has taken a different path. With coordination from the California Health Underwriters Assn. (CAHU), Covered

California cooperated to devise workable arrangements for the distribution of exchange-based products.

However, recent decisions about mandates to support Medi-Cal enrollment without compensation seem to fly in the face of successes between the exchange and the state’s brokers. It’s as though we’re not remembering what happened.

This step sideways in broker relations is being repeated throughout the country as navigator systems take huge financial hits. For example, a non-profit navigator, Enroll America, has cut its staff in half as funding declines. Illinois is down from 300 counselors to 150. While there is still unrest among brokers about a lot of the operational and selling decisions from the state exchange, it is clear that California has one of the best situations for brokers. For instance, Covered California has made it clear about the need for and



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In fact, agents and brokers make small group insurance shopping easier and cheaper, according to a study from the Univ. of Minnesota. This supports the value that brokers bring to consumers and to the exchanges. In counties with more brokers, small firms are 20% more likely to offer coverage; and their annual premiums are 13% less, according to economist Pinar Karaca-Mandic. Along with expanding coverage and lowering costs, consumers find brokers to be more helpful compared to other sources, such as direct sales websites or navigators. Eighty-four percent of adults buying on the exchange give brokers a very helpful or somewhat helpful rating, which is the highest rating of any sales or enrollment source.

A recent survey by the National Small Business Assn. illustrates the degree of satisfaction that small employer groups have with brokers. Eighty percent of small employers plan to purchase using their existing broker. Interestingly, only 9% plan to purchase health insurance through the Small Business Health Options Program (SHOP), a 5% decrease compared to 2014.

It should not be surprising that individuals and groups are turning to or staying with brokers. According to the Kaiser Family Foundation, 64% of people seeking help through navigator assistance programs took one-to-two hours to complete a customer service call while 18% took two to three hours. Four out of every 10 people seeking help from such assisters could not be helped at all. In addition, nine of 10 people enrolling through such programs returned with post-enrollment problems. Fortunately, the California experience has gone smoother despite some bumps. Continuing efforts by the CAHU leadership will, no doubt, improve things more over time.

However, things for brokerage operations have gotten much more difficult over the past couple of years. Open enrollment activities of the exchanges have significantly overlapped Medicare sign-up periods. Open marketplace behavior has put a huge number of group renewals into the fourth quarter. Whether intended or not, the industry appears to be quickly becoming

ing a seasonal one in many ways.

With this diminishment and, in some cases, the total elimination of money for navigator programs, brokers will be counted on to assist exchange enrollees, senior citizens, and renewing employer groups – all at the same time. If states also look to brokers for assistance in Medi-Cal, time and commissions will need to be freed up.

Splitting up the overlapping enrollment seasons for Medicare, individual exchanges, and employer groups is likely to focus on changes coming from Washington. Under the leader-



ship of NAHU's CEO Janet Trautwein, consumers got a one-month separation by backing up the end of the open enrollment date for exchanges. But the real struggle will be trying to get clear separation between Medicare and exchange periods. One month is better, but more is needed.

Exchange enrollments are most often pegged to premium tax credits, which are calendar based in January through December. So the interaction between the ACA and the tax system makes changing the exchange open enrollment period difficult, if not impossible. There is a potential for flexibility on the Medicare side if all parties are willing to work toward a system based on enrollment that's tied to a participant's birthday.

Support might evolve as carriers get hit with the intensity of fourth quarter enrollments for exchanges and groups as well as Medicare. Senior executives may find that not having to gear up as intensely for the fourth quarter is worth

making the changes needed to adjust Medicare to a birthday enrollment system. As for the pressure of fourth quarter employer enrollment, as Yogi said, we may have "déjà vu all over again." That lesson has been taught in California. Decades ago, Blue Cross of California had "focal renewal." In a very short period, practically the carrier's entire small group population had to be renewed simultaneously. The effect on brokers and the carrier was as intense as is the current ACA induced December renewal process. However, the marketplace may adjust back to renewal dates spread throughout the year as current regulations that made it desirable to move everything into the fourth quarter start to fade.

ACA rules are causing the current group congestion in the fourth quarter. As time goes on, there may be fewer regulatory reasons to stay on such a renewal date. Instead, carriers may decide to do what has already been done to break the logjam of focal renewal. To reduce their fourth quarter workloads, carriers may search for ways to get employers to accept slightly longer contracts in order to move them slowly from December to January or even February. With work at the state level, carriers may find that state insurance regulators are willing to work to allow filings that would untangle the traffic jam of December renewals.

Clearly, it would be in the interest of employers, brokers, and carriers to create a more even workflow wherein consumer matters could be handled more reasonably.

Ultimately, whether a consumer is in Medicare, on an exchange, or in an employer group, it is in their best interest to have a system in which carriers and brokers have time freed up to provide the kind of advice and problem resolution that supports the consumer's interest. Each year will be déjà vu all over again without changes in the intense fourth quarter, tri-part open enrollment process (Medicare, exchange, employer group). ★

Don Goldman is vice president of Word & Brown and is the president of the National Association of Health Underwriters (NAHU). For additional information, visit www.wordandbrown.com and www.nahu.org.



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Paychex Expands Private Exchange Offerings

Paychex is offering new resources through the Paychex Personal Marketplace. The exchange, which is in its second full year, is geared to employers who are not required to offer a group plan under the ACA. They can use the exchange to help employees gain access to coverage and avoid penalties for non-coverage under the individual man-



date. Employees can shop for and enroll in individual health insurance, including private insurance plans as well as plans that are eligible for a tax credit. Employers can manage automated employee communications.

When using the exchange, consumers get a “credit score,” providing a view of their health, income, assets, and future savings. Joe Donlan, president of ConnectedHealth said, “Last year, more than 3,000 of Paychex’s clients expressed interest in offering individual exchange options to their employees. This interest demonstrates a need in that market segment for employers to provide benefits even outside of traditional group insurance for their non-group eligible employees, such as part-time employees, contractors, seasonal, and employees who are government-tax-credit-eligible.” For more information visit www.ConnectedHealth.com.

Welltheos Expands Tools

Welltheos.com, the nation’s largest private health insurance exchange, added resources for enrolling individuals and families in ACA compliant health plans. For consumers who are qualified for subsidies, Welltheos offers access to over 28,700 individual and family health insurance plans from 239 national and regional issuers participating in the Health Insurance Marketplace. Consumers can also enroll directly in the same plans without a subsidy. All plans meet ACA requirements. This provides consumer protection against 2016 ACA tax penalties if consumers maintain their enrollment through 2016 without a gap of more than two months. Welltheos offers the following:

- A subsidy calculator
- A personalized storefront
- Instant online quotes
- An anonymous shopping tool

- Direct enrollment

For more information, visit www.welltheos.com

Mercer Grows Membership

The Mercer Marketplace private benefit exchange continues to grow. The exchange now serves more than 300 companies with 703,000 eligible employees and retirees, with an anticipated 1.5 million lives. More than 200 companies offer Mercer Marketplace to their active employees for health care and additional benefits.

For more information, visit www.mercer.com. Follow Mercer on Twitter @Mercer.

Aflac Teams with Liazon

Aflac is partnering with Liazon, operator of the private benefits exchange, Bright Choices. Brokers working with large businesses nationwide will have more options for when and how they do business with Aflac. Approved brokers will now be able to offer Aflac’s group critical illness, accident, and hospital indemnity plans through the Bright Choices exchange and other Liazon-powered exchanges, providing employers a way to offer a broader range of choices to build a personalized portfolio of benefits.

“We remain committed to finding innovative ways to support the growing broker market...Offering our products on Bright Choices will help expand our distribution model with brokers and drive broker sales,” said Aflac senior vice president of Broker Sales Drew Niziak.

Liazon’s platform offers side-by-side comparison tools, comprehensive educational materials, transparent pricing, and hands-on support.

Employers with 100 or more benefit-eligible employees will rely on brokers more than ever to help navigate these kinds of benefit options. In fact, 52% of brokers surveyed by Aflac in 2015 said that they are functioning as a producer for insurance products handled through an exchange. For more information, visit www.aflac.com/brokers. ★



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Is Opportunity Leaving the Country Without You?

Don't Overlook the Potential of Expatriate Health Plans

by BRENDAN SHARKEY

According to the Dept. of State, 8.7 million U.S. citizens live overseas. Despite the fact that these expatriates are out of the country, many are still held to the tax laws of the U.S. This means that they need to have the health insurance coverage required by the Affordable Care Act (ACA). However, these expatriates are finding that there is a considerable void in the marketplace when they shop for a health plan. They struggle to find one that offers them adequate protection and meets the mandate. They are asking a lot of straight questions that result in complicated answers. Brokers who understand the requirements of the ACA and its financial implications on expats will be able to provide solutions for their clients living and working overseas.

IS MY CLIENT EXEMPT FROM THE ACA REQUIREMENTS?

U.S. citizens are required to have minimum essential coverage (MEC) or they will be subject to the U.S. income tax liabilities. Citizens who can prove residency in another country are said to have met MEC and will not be required to purchase additional coverage. In order to prove residency, expats must meet one of the following conditions:

- They must have been living abroad for at least one year and have no immediate plans to return to the U.S.
- They must have foreign-earned income and be physically out of the U.S. for 330 days in a twelve month period.

MY CLIENT IS NOT EXEMPT FROM THE ACA REQUIREMENTS, HOW WILL THEY MEET MEC?

At this time, there are no individual expatriate plans sold to Americans that meet the definition of minimum essential coverage (MEC) and thus meet the individual mandate. A large number of expatriates living or traveling extensively outside the United States do not meet that exact 330-day threshold and are likely to be subject to a tax penalty called the "shared responsibility payment." They can purchase a domestic plan that meets the mandate, but won't necessarily meet their needs or standards for care overseas.

IS RETAINING AN ACA-COMPLIANT DOMESTIC HEALTH PLAN A VIABLE ALTERNATIVE?

Expats who choose to select an adequate international health plan ex-

pressly geared to cover them at home and abroad face the prospect of paying a penalty. This is an unintended consequence of ACA, recognizing that the intent of the law was to ensure that people maintained substantial medical coverage. Given that a lot of expatriate workers are high income wage earners, the shared responsibility payment in 2015 is likely to be 2% of income above the filing threshold (not to exceed the cost of buying a Bronze level health plan) and can best be characterized as a surcharge based on lifestyle.

To avoid the penalty, some expats have gone abroad with a domestic health plan that harshly restricts overseas coverage. This has resulted in increased financial burden and unexpected out-of-pocket expenses be-



cause of significant benefit gaps. Additionally, expats choosing this path are forced to deal with the inconvenience of managing issues with an insurer that is thousands of miles away: in a different time zone, with no understanding of the local health care or the relationships necessary to secure trusted care.

Coverage and network problems aside, most individual health insurance policies explicitly require expats to meet the ongoing eligibility criteria for the policy. Eligibility hinges upon being a resident or living in the plan service area. Definitions can vary but if an individual no longer lives or works in the service area their coverage typically terminates after 60 days or based on the last billing cycle in which their eligibility changed.

SHOULD MY CLIENT BE COVERED UNDER AN INTERNATIONAL PLAN?

The above language underscores the necessity to consider buying a comprehensive global health insurance policy that adequately protects

your client and their family when they move abroad. There are plans available that include access to quality care in the United States. If your client chooses to include U.S. home country coverage, be sure to check the policy for limitations related to length of stay; traveling for the purpose of seeking care, and any special exclusions for existing medical conditions that manifested prior to arrival back in the states.

WHAT OPPORTUNITY IS THERE FOR ME TO PROVIDE SOLUTIONS FOR MY CLIENTS?

An expatriate health plan is the perfect solution for any individual who meets the 330 day out-of-the-U.S. threshold. This ensures that they will get the level of coverage they need and the international support they'll want. Clients in this category will not be subjected to any type of tax penalty because they have met MEC.

An expatriate health plan is also a viable solution for any individual who has not met the requirements of MEC.

Though they will be subjected to the shared responsibility payment, they will not put themselves in additional financial risk by trying to use domestic coverage overseas.

WHAT'S THE BOTTOM LINE?

American expats need to carefully consider their healthcare options balancing financial and emotional risk. The expense of the shared responsibility payment is minimal when you consider the alternative of finding yourself injured or ill and uninsured overseas. Encourage your clients to make decisions that align with the regulations, the financial implications, and the level of protection they need. ★

Brendan Sharkey is the director of Individual Products for GeoBlue. From the nuts and bolts of international health insurance to the crucial themes of global health and safety, He's frequently called upon to discuss global insurance. His contributions include CNBC Squawk Box, WGN AM Talk Radio, Forbes, The Wall Street Journal, NY Times, USA Today, and LA Times, among others. To contact him e-mail bsharkey@geo-blue.com.



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Marketing Medicare Compliantly

by COLLEEN GIMBEL

Albert Einstein said, “Creativity is intelligence having fun.” As a marketing professional for over 25 years, I can say, without hesitation, that this concept is vital to creating powerful advertising. Being smart about how you market yourself and your business is the key to creating a lead pipeline and keeping it running.

Combining creativity and intelligence is hard enough without having to consider the influence of the Centers for Medicare & Medicaid Services (CMS). In the Medicare industry, CMS has many regulations on what is considered compliant when marketing Medicare products. I hear from agents all over the country that CMS regulations are the main reasons their agents shy away from marketing Medicare.

Many agents get contracted and certified to sell Medicare plans, but don’t invest any time or money letting people know that they sell Medicare. If you want to grow your Medicare business, it is imperative to tell people that you offer this service. So, how do you get the phone ringing with Medicare clients? I’m using another Albert Einstein quote to begin answering that question. He said, “You have to learn the rules of the game. And then you have to play better than anyone else.”

Let’s start with the rules. First, you have to know that CMS publishes a 116-page document with the regulations for marketing Medicare Advantage and prescription drug plans. If you’d like to read it, you can find it on Medicare.gov. Second, most carriers also have rules for marketing. At a minimum, they have to meet the CMS requirements. However, the carrier can choose to be more restrictive. Third, Medicare supplement marketing is not as highly regulated as the marketing of

Medicare Advantage and PDP plans.

I have simplified the dos and don’ts of marketing Medicare into just a few short concepts. The idea is that you get the gist of the rules. (Disclaimer: Always get your Medicare marketing reviewed by a compliance professional before you advertise. For example, we have a team of people who review agents’ proposed advertising for compliance.)

it’s CMS’ job to protect Medicare beneficiaries. And for most people, these rules make sense. Now, let’s look at what you can and should be doing to promote your Medicare business.

DO

- Do call or e-mail current clients: You can contact any current client however you want.
- Do get referrals: Referrals from cur-



DON'T

- Don’t cold call for new Medicare Advantage or prescription-drug business. You must have permission to call the prospect, from the prospect. This can be obtained in a number of ways. (See below.)
- Don’t e-mail to new Medicare prospects; agents must have permission to contact prospects via e-mail.
- Don’t go door-to-door or leave materials at a Medicare prospect’s home or on their car.
- Don’t do an appointment for Medicare at the same time as an appointment for another product, such as life insurance, final expense plans, etc.

That wasn’t so bad, was it? Basically,

rent clients are the best leads.

- Do hold community meetings: This is an excellent way to bring in new business. Most carriers provide you with all the content to host the meeting. Just make sure that you enjoy and are good at public speaking. And make sure you know the rules for holding community meetings.
- Do call leads that have established permission to call. You can obtain permission to call in the following ways:
- Prospects contact you via e-mail or phone call. The agent now has permission to call the member for 90 days. After 90 days, if you don’t sell the member a plan, you will have to ask the member for permission to

call for the next 90 days; and it must continue like that until the prospect buys a plan or refuses the extended permission to call.

- The prospect returns a business reply card requesting an agent contact them.
- The prospect attends a community event the agent advertised and provides their contact information.
- Do create (non-paid) relationships with people who will refer Medicare leads to you. CMS allows agents to pay referral fees. However, there are a lot of regulations that you must adhere to, including state department of insurance requirements, so we always recommend non-paid referral relationships. Additionally, it strengthens the relationship between you and the person who is referring the leads if they are doing it because they trust you and not because they are getting paid.
- Do send mailers to prospects (must have disclaimers). There are a few disclaimers that are required for mailing to a prospect's home. Make sure that you have the disclaimers on all generic advertising.

Now that you know the basic rules, let's discuss how you can be the better player of the game. Most importantly you have to know who you are as a business or agent. What do you offer your clients that everyone else doesn't? For example, are you a niche agency focusing on Medicare or do you want to be your clients' one-stop-shop for insurance? Are you a small shop that provides exceptional customer service or a large organization that has access to everything your client could ever need or want?

Identifying your strengths and weaknesses, as a business, is the first step in creating a successful marketing campaign. Once you have this information, you can hone in on what sets you apart from your competition. And that's the message you want to start sending out to prospects. It sounds simple enough. However, if you've never done it, you might not know exactly how to create your messaging. That's where a marketing professional can help — preferably someone who also understands compliance regulations. The larger FMO brokers should

have a marketing department you can contact for advice and assistance.

There are hundreds of ways to market yourself and your Medicare business. Here are just a few to consider:

- Your book-of-business: A book-of-business is a gold mine that many agents don't think about. Even if your clients are not Medicare eligible, they all know people who are on Medicare. Creating a marketing message to ask for referrals is simple and extremely cost effective.
- Social media: It's free to use and very effective if you have the right message.
- Networking/referral agreements: As mentioned above, referrals are the best type of leads because they come from someone who knows you, so the prospect already trusts you. You can't buy that kind of lead.
- Guerilla marketing: This is most successful when you do something unexpected that is authentic and personal to your prospect. There are hundreds of ideas you can use. Since this is an article and not a book, I'll share just one example. Put a note or flyer in a local restaurant menu that has a high number of prospects. The messaging can say something such as, "Daily special: Medicare questions answered with a side of peace-of-mind. As an experienced insurance agent, I can provide fat-free guidance and ensure that you have the insurance coverage you want." Include your contact information.

As you can see, there are many opportunities to let people know about you and your business. The most important thing you can do is to get started. Most of us have heard the quote, "The definition of insanity is doing the same thing over and over and expecting different results." (Also compliments of Albert Einstein.)

Have you been advertising the same way for years or not advertising your Medicare business at all? If you'd like to grow your business in 2016, now is the perfect time to do something different. Who knows, you might surprise yourself. □

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

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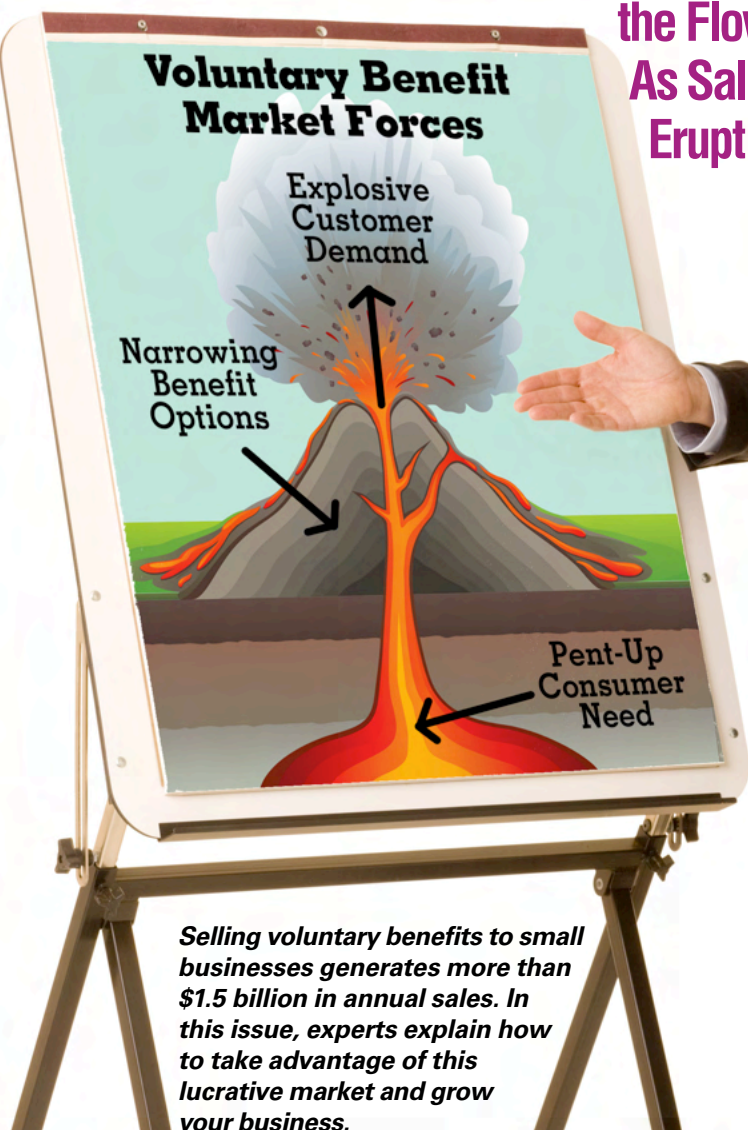
BROKERS CAN DISCOVER BIG DOLLARS IN SMALL BUSINESSES

Going with
the Flow
As Sales
Erupt

by TODD MASON

Millions of small business owners across the United States, including many in California, lack the knowledge and expertise to deliver high-quality benefits to their employees. The millions of America's workers affected by this lack of expertise can create an excellent opportunity for you to market valuable insurance products to small employers, according to a recent research report from Colonial Life. Voluntary benefits at small businesses account for more than \$1.5 billion in annual sales already, and many business owners plan to add more voluntary products to their portfolio, according to Eastbridge Consulting. Many of these business owners don't realize the value that a benefit professional can add to their business, their employees, and their bottom line, according to the report.

And there's more good news for you: Small business owners are looking for help. Millions of small business owners haven't



been approached by brokers or producers in the past year. By understanding the challenges and issues facing small business owners, and reaching out to them as consultants and partners, you can reap huge benefits in the small employer market.

SMALL BUSINESSES LOOKING TO ADD BENEFIT OPTIONS

Opportunities abound as small employers say they would be looking to add voluntary benefits in the workplace in the coming years. Up to 20% of employers with 10 to 100 employees are likely to offer a new voluntary benefit or move a current voluntary benefit, according to Eastbridge.

More importantly, small employers know that they need your help. Brokers are poised to bridge that gap and find success in helping smaller firms. Ninety-four percent of business owners with fewer than 100 employees say the need for advisors remains strong or is increasing, according to LIMRA. But only half of these firms use advisors for business or personal needs.

That presents a huge opportunity for you. In California alone, according to the U.S. Census, more than 700,000 businesses have fewer than 100 workers. Those businesses have more than 4.5 million employees. Choosing the right benefit partner is key for you to take advantage of the great opportunities for voluntary products in the small-case market.

You can better understand potential clients in the small business industry, connect in a meaningful way with them, and provide them with optimal benefits options by following three simple steps:

STEP 1: PREPARE TO WORK WITH BUSINESS OWNERS

At many small businesses, the primary decision-maker is the business owner. Benefit decisions aren't made by human resource professionals or benefit administrators. To be successful, you should tailor your approach to consider the business owner's

lack of benefit expertise and the limited amount of time they are willing or able to spend discussing benefits.

STEP 2: HAVE THE HEART OF A TEACHER

No matter who the main decision-maker is, you may find that your biggest job is to educate in the workplace. One reason that small businesses don't offer benefits is the misconception that offering benefits is costly. They assume that they don't have enough employees or that employees prefer higher take-home pay over benefits.

Voluntary benefits offered at small businesses mean more than \$1.5 billion in annual sales.

STEP 3: PICK THE RIGHT BENEFIT PARTNER

Choosing the right benefits partner is key for you to take advantage of the great opportunities for voluntary products in the small-case market. While the products and services must be right for employers and the employees, you must consider competitive compensation schedules; quality voluntary benefits that are unaffected by

the ACA; and turnkey benefit counseling and enrollment services.

Other capabilities to look for in a quality voluntary benefit partner include flexible-enrollment capabilities, maximum-revenue opportunities, and one-to-one benefit counseling support.

CONSIDER SMALL BUSINESS A BIG OPPORTUNITY

As rising health-care costs continue to put pressure on business owners to reduce benefits provided to employees, the need for voluntary benefits for employees continues to rise. This need only grows when discussing small businesses where owners are working to control costs in every way possible.

Offering voluntary benefits can be a valuable way for employers to show employees their concern and give employees the choice of benefits that they find important. There's already a large market for voluntary benefits, and it's growing. And business owners know they need help.

Finding a strong benefit partner who will provide flexible-enrollment capabilities, maximum revenues, and individual benefit counseling can remove much of the burden of selling to small businesses. At the same time, focusing some attention on smaller businesses can offer you a diversified portfolio of clients and a steady income stream. ★

Todd Mason is the territory sales manager for the Greater Los Angeles office at Colonial Life & Accident Insurance Company. Colonial Life provides financial protection benefits through the workplace, including disability, life, accident, dental, cancer, critical illness and hospital confinement insurance. The company's benefit services and education, innovative enrollment technology and personal service support more than 80,000 businesses and organizations, representing more than 3 million of America's workers and their families. The report, "The Big Opportunities for Brokers in Small Business," and other research from Colonial Life is available on Colonial's website at www.ColonialLife.com. For more information about Colonial Life's products and services, contact Mason at tvmason@colonial-life.com.



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ARE HEALTHY SENSES BEING IGNORED IN YOUR CLIENTS' WELLNESS PROGRAMS?

NEW RESEARCH SAYS PROBABLY SO!

by BRAD VOLKMER

Employers continue to look for ways to control costs and increase productivity, often turning to wellness programs as a solution. Through my 30 years in the medical and hearing health industries, I've witnessed this first hand. Nearly every major employer has some sort of wellness initiative — from motivating employees to get in shape to incentivizing them to address major medical and lifestyle issues. Today, they are spending more than ever to grow these initiatives. In 2015, employers are spending an average of \$693 per employee on wellness-based initiatives, up 17% from \$594 last year, according to a survey by The National Business Group on Health and Fidelity Investments.

With this uptick in spending, corporate wellness programs have expand-

ed to include offerings ranging from fitness memberships, to weight loss support, to assistance to quit smoking along with perks including monetary incentives and reduced health care premiums. With this broad range of elements, it may be surprising that the promotion of healthy senses, such as vision and hearing, is almost completely missing from employee-wellness programs even though they are widely accepted as fundamental to health and productivity.

EPIC Hearing Healthcare explored this topic in a survey of 518 benefit professionals in March.

FOR WHICH OF THE FOLLOWING REASONS WOULD YOU OFFER AN EMPLOYEE WELLNESS PROGRAM?

(Multiple responses allowed.)

Employer Response:	
Improved employee health	91%
Improved employee productivity	69%
Improved morale	69%
Reduced absenteeism	62%
Strong return on investment	45%

Source: EPIC Hearing Healthcare Listen Hear! Live Well 2015 employer survey

Hearing well and seeing well are fundamentally important to communication with co-workers. They affect employee health and safety as well. Yet, employers are far more likely to implement employee wellness programs that focus on overall health and fitness rather than on healthy senses. For example, only 8% of wellness programs integrate hearing.



EMPLOYER FAMILIARITY VERSUS INTEREST

Wellness programs addressing preventive health issues, such as weight control (94%), exercise (89%), smoking (88%), and diabetes management (69%) are far more common than are programs for healthy senses. There is a significant decrease in employer familiarity with vision and hearing health programs, with knowledge of vision (23%) surpassing hearing health programs (16%). This suggests that employers do not recognize the prevalence of vision and hearing loss or the risks of vision or hearing loss to employees and employers. It presents an opportunity for brokers to educate employers on how vision and hearing loss can affect their workforce. However, once educated, they are likely to express strong interest in these topics.

An alarming 30% of employees who suspect they have hearing loss have not sought treatment. Of further concern to employers is that almost all of these employees say that their hearing loss affects them on the job. This can take many forms, including pretending to hear when they cannot, feeling stressed, and having difficulty hearing on the phone. Armed with this knowledge, 86% of employers surveyed said they would integrate hearing health wellness products into wellness program offerings. Brokers should consider bringing these insights to clients and then work with them to integrate messages about hearing into their wellness initiatives. Below are several tips to integrate hearing health seamlessly into a client's wellness strategy.

INCENTIVIZE EDUCATION AND TREATMENT

Help employers find ways to reward employees for learning about their hearing health and for seeking preventive and prompt treatment.

INTEGRATE EDUCATIONAL MATERIALS INTO WELLNESS COMMUNICATIONS

Many employers have newsletters or intranet sites with health copy, or even regular health e-mails. Including hearing or vision health as a topic can really keep these health issues on the forefront. Think about ways to integrate

them creatively. For example, you can talk about the impact of diabetes on hearing health during Diabetes Awareness Month (November) or the connection between hearing and heart health during American Heart Month (February).

Provide hearing screenings as part of employee health fairs. While cholesterol and blood-sugar screenings are common in work settings, hearing and vision have not been given as much attention. Having on-site screenings sends a powerful message that this

“...the promotion of healthy senses, such as vision and hearing, is almost completely missing from employee-wellness programs even though they are widely accepted as fundamental...”

area of health care is important for employees. Reach out to a local audiologist or optometrist or find one through the employer's hearing or vision insurance provider to identify a professional who can visit your client's worksite free of charge.

RECOMMEND THE INCLUSION OF HEARING HEALTH CARE IN YOUR CLIENTS' BENEFIT PACKAGES

Many people are surprised at the high cost of hearing aids – ranging from \$1,500 to \$5,000. Even more are surprised that hearing aid costs may not be covered under major medical. Offering supplemental hearing insurance (similar to vision or dental) gives employees access to hearing professionals and discounts on hearing aids. From \$.35 to \$1.75 per-member/per-month, hearing insurance is one of the most affordable benefits for its value.

A GROWING NEED

The need to address the hearing and visual health of employees is not going away any time soon.

Over 70% of the workforce needs vision correction according to a Vision Impact Institute study. Prevent Blindness America has identified a significant increase in vision impairment among older Americans over the past decade, including an 89% spike in diabetic eye disease. With the high use of digital devices, younger employees are experiencing increasing vision problems as well. In fact, younger employees are the most likely to say that their work quality is frequently impacted by visual disturbances, like tired or dry eyes, or problems with light and glare, according to the Transitions Optical 2014 Employee Perceptions of Vision Benefits survey.

Hearing problems are also on the rise across age groups. There was a 30% increase in hearing loss in adolescents (ages 12-19) from 1988 to 2006, according to a study by Dr. Josef Sharгородsky in the *Journal of the American Medical Association in 2010*. This age group is now in the workforce. This could be one reason why younger employees are 75% more interested in hearing insurance.

Brokers can set themselves apart by integrating healthy senses into corporate wellness programs and benefit packages. They will satisfy this growing, unmet need and help employers place a higher value on these important aspects of health and wellness. ★

Brad Volkmer is the president and CEO of Ear Professionals International Corp. dba EPIC Hearing Healthcare (EPIC). One of the founding members of EPIC, he has been the driving force behind the development of the EPIC Hearing Service Plans, and the positioning of hearing and hearing benefits as a specialty care discipline. Volkmer has over 30 years of experience in health care administration. Prior to starting EPIC, he served as the executive vice president of Finance and Operations at the prestigious House Ear Institute and Clinic in Los Angeles, and chief administrative officer for the UCLA Dept. of Internal Medicine. He holds a bachelor's degree in Chinese from UCLA and a Master of Business Administration from Pepperdine University. He can be contacted at bvolkmer@epichearing.com.

PUTTING TAILORED BENEFITS INTO ACTION

by GENE LANZONI

The employee benefit market has become much more complex in the past few years. The ACA has accelerated growth in voluntary benefits, alternative-funding arrangements, and technologies that simplify benefit administration and service delivery. Meanwhile, the workplace has become a more important source for insurance and retirement products to help Americans build financial security. Sixty-eight percent of employees rely on their workplace benefits for at least half of their household's financial preparedness, according to the Third Annual Guardian Workplace Benefits Study.

A majority of employees say that buying insurance and saving for retirement is easier through work than on their own. Even though Americans depend on the workplace for many financial products and services, workers remain under-insured and under-saved for retirement, with large percentages not owning life insurance, disability insurance, or a retirement plan. Employers are demonstrating a renewed focus on helping employees make better decisions. The importance of this objective is up significantly from last year. Seven in 10 employers say that it's very important to help employees make better decisions and offer benefits that meet employees' needs.

Brokers should not overlook how a tailored approach can be critical for an increasingly diverse workforce. Employees want benefits that provide appropriate protection for their life situation. They also want information that helps them choose the right level of benefits. A program that does not address the needs of employees at different work stages misses an opportunity to ensure adequate financial protection for workers and their families.

EMPLOYEES' WORK STAGES ARE VERY TELLING

The top personal and financial needs of American workers vary by their stage of career. Employees who are just beginning their careers (within the first five years of working) are focused primarily on immediate financial needs. Making ends meet is a top con-



cern for 92%. Other priorities include having job security (88%), achieving a better work/life balance (85%), and reducing debt (79%). They want more information about reducing debt, improving work-life balance, and protecting themselves from the unexpected, such as being out of work due to injury or illness, premature death, or accident. They also want to learn more about how their benefits work and how to enroll.

In contrast, near-retirees (within five years of retirement) are more focused on their future. Top priorities include having adequate health insurance

(94%), having enough retirement savings (93%), and maintaining a healthy lifestyle (90%). Near-retirees care more about managing their money in retirement and understanding health care reform as well as changes to their health insurance coverage.

The following statistics reveal that those nearing retirement are more likely to be adequately insured and saving for retirement:

- 54% of early entrants have disability insurance compared to 67% of near-retirees.
- 61% of early entrants have life insurance compared to 85% of near-retirees.
- 66% of early entrants have a 401(k) compared to 85% of near-retirees.
- Just 30% of early entrants have a pension plan.

EFFECTIVE COMMUNICATIONS

Most employees, regardless of their work stage, want more help with benefit and financial decisions. But 85% of early entrants say they need more help with decision making compared to 61% of near-retirees. Early entrants also express a strong desire for financial education and guidance on their decisions and a preference for learning about financial planning and products at work. They value the opportunity to discuss options with their employer, as well as with friends and family. Few have used the services of a financial professional. Increased access to education and advice in the workplace would help the nearly seven in 10 early entrants who say that it is very important to find a trusted source of financial advice.

Seventy-five percent of workers say it's important to receive information online. A slight majority of early entrants and near-retirees enroll in benefits online. However, two-thirds say they would prefer online enrollment. Those who are able to enroll online are more likely to say that their benefits contribute to their financial security.

EMPLOYEES SEEK IMPROVED BENEFIT COMMUNICATIONS

Tailoring communications to employee segments is a highly important goal for one in three employers. But only one in six actually does it. Companies with at least 1,000 employees and those

with a growing HR department are the most likely to say that targeted communications are highly important.

American workers, regardless of work stage, say that more can be done to educate them on financial planning and how to reach goals. Sixty percent say their meetings would be more relevant if they are targeted by age. Workers in smaller companies (those with less than 100 employees) are less likely to say that their employer provides adequate education on financial planning.

PUTTING TAILORED APPROACHES INTO ACTION

While most employers want to help employees make better decisions, some may not have considered the importance of tailoring offerings and communications. The technology, expertise, and capabilities available in today's market can make it possible for brokers to deliver more effective communication strategies than ever before.

Employers that outsource some or all of their administration tend to offer a wider range of benefits, which is a step toward helping address diverse workforce needs. They are more likely to offer core benefits like medical, dental, vision, life, short-term disability, and long-term disability. They are also more likely to offer accident and critical illness insurance.

Outsourcing enrollment activities to insurance carriers or enrollment firms can enhance enrollment and communication strategies. Nearly two in three employers outsource select enrollment services, such as enrollment materials and presentations. But only 18% say their communications are extremely effective. Enrollment activities that are outsourced don't necessarily include the communications strategy or ongoing communications. This can be an opportunity for brokers to get employers started on a tailored approach to support employees' changing needs. The Third Annual Guardian Workplace Benefit Study can be viewed here: <https://www.guardiananytime.com/2015-workplace-benefits-study>. ★

Gene Lanzoni is assistant vice president of Group Business Intelligence for the Guardian Life Insurance Company of America.

A RE-IMAGINED TELEHEALTH MODEL

by SCOTT SANFORD and PAT SIR

Many brokers are having tremendous success by incorporating telehealth into their plan designs. Telehealth involves connecting to a doctor via phone, video, or e-mail for consultation, diagnosis, and prescription medication, when applicable. It creates substantial wins for employer groups, employees, and the broker.

More than 70% of doctor visits can be handled safely and effectively over the phone, according to the Wellness Council of America. But is telehealth safe? *The Journal of the American Medical Association* found that Telehealth did not have higher rates of misdiagnosis or treatment failure. Researchers compared in-person doctor visits to telehealth consultations for minor acute issues among 8,000 patients.

A recent study by Towers Watson highlights the potential cost savings that telemedicine can deliver. Thirty-seven percent of large U.S. employers expected to give employees access to telemedicine for non-emergency health issues by 2015, and another 34% are considering offering telemedicine in 2016 or 2017.

The top nine reasons that patients visit the emergency room for non-emergency issues are almost identical to the top nine issues resolved via telehealth. So, why isn't telehealth the first discussion point in an employer-group meeting? Shouldn't it be the center of every benefit-plan design, allowing the employee to save money, time, and resources? Telehealth also leads to fewer paid-time-off days, increased productivity, reduced health plan claims and costs, and healthier employees.

The brokers who are growing their business with telehealth allow telemedicine to become the center of the discussion. No longer is major medical the lead product. Why should it be if you can resolve 70% of your healthcare needs via phone or video camera? So, by leading with telehealth, a broker can provide more flexibility in major medical plan options. Simply stated, you may not need as much medical coverage when you have telehealth. Employees don't visit the ER, urgent care, or doctor's office as often when they have access to telehealth.

To further add value, some telehealth providers include complementary products to drive down claims and costs, such as technology-based health management platforms or prescription medication pricing engines. By offering relevant health content at the time of need, the patient is educated and healthier,

which may help reduce unnecessary doctor office visits. Offering access to prescription medication pricing engines allows the patient to save on medication with cash price options. This redirects pharmacy claims out of the health plan. The pricing variance, by pharmacy location and brand, can be surprisingly large. Offering transparency allows consumers to be smart shoppers. Not only does this trifecta of telehealth, wellness, and price comparison tools save money, but it also puts employees in charge of their healthcare, giving them more choices than ever.

The key to achieving these results for your clients is to choose the right product provider. It's tempting to gravitate to the lowest cost provider. However, the low cost provider may not be the best choice since the utilization may be very low, and customer experience may be sacrificed. Then again, if the products are too expensive, the value may not match the cost.

At the end of the day, utilization and a positive consumer experience win. Clients will be more open-minded about new options when you can show that you are up-to-date on the latest plan designs and that you encourage plan members to be in charge of their destiny. Remember, you can offer the best benefit in the world, but what difference does it make if nobody uses it or if employers aren't on board? The brokers who have embraced telehealth and complementary benefits are growing their business, retaining clients, and providing the best solutions. ★

Scott Sanford is co-founder and chief growth officer at Scottsdale, Arizona-based Healthiest You, a telehealth and wellness delivery innovator founded in 2012 as a result of the merger of Healthiest You and HealthNowMD. An entrepreneur at heart, Scott started his first business creating a distribution network for a health improvement product while completing his business degree at the University of Nebraska. Sanford lives in Scottsdale with his wife Cassandra and their four children. He can be contacted at scott@healthiestyou.com.

Pat Sir is President of Healthiest You. Previously, he worked at United Health Group Ventures. Before that, he was executive vice president of Specialty Benefits Sales and Distribution at United Healthcare. He lives with his wife Shelly and four children in Mound, Minnesota. Pat can be contacted at pat@healthiestyou.com.

Trends in Workplace Safety

by DINESH GOVINDARAO, M.D.
and LAUREN MAYFIELD

The old adage, “An ounce of prevention is worth a pound of cure,” has never been more appropriate for the workers’ compensation industry. While workplace safety programs have been in place for decades, today’s successful programs are significantly different than the programs of old. In this article, we look at some of the top trends and recommendations in workplace safety. Workplace-safety programs are developed and updated regularly to reflect the best in science and other data. From ergonomics to eyestrain, workplace safety programs entail much more than how to lift heavy packages or stay out of the way of harmful chemicals. Regular data collection, analyses, and testing has resulted in comprehensive programs designed to meet the needs of particular industries. This specialization has spawned an entire industry that’s dedicated to identifying and mitigating workplace safety hazards.

A review of State Fund claims indicates that four of the top five causes of workplace injuries account for almost 50% of claims. Slips and falls cause problems for employees and for customers. As a result, employers have moved beyond proper ladder use to designing worksites and work processes to prevent slip and fall hazards in all areas of a business. Many businesses are now strict about eliminating clutter, removing rug and carpet hazards, and mandating that all employees wear proper footwear. Strain injuries are common in all businesses. Workplace safety programs now include much more than proper lifting techniques to prevent injuries to muscles, tendons, and ligaments. In addition to using ergonomics to design workstations and tools, many employers now offer onsite stretching, yoga, and other exercises to prevent strains.

“Struck by” injuries, which can be devastating, are often the focus of workplace safety programs. Employers are expanding prevention pro-



grams beyond information about moving vehicles to helping workers avoid injuries from falling items or objects kicked up by motorized equipment. Cuts and lacerations may only require onsite first aid, but they can be serious enough to require medical treatment. Some employers are working to prevent “simple” injuries with education designed to call attention to these issues.

The National Safety Council recommends aligning employer and employee goals. Employee engagement is more sustainable when you create clear goals for the management and employees, and then communicate how these goals are interdependent. Employee engagement takes many forms, including peer-to-peer leadership, use of social media, and onsite competition.

But it is becoming bigger than that. Workplace safety is gaining a regular place in employee communications and training. Wise employers are integrating workplace safety into all aspects of the employee experience. Regular, effective safety meetings and training exercises increase productivity, reduce employee turnover, strengthen morale, lower workers’-compensation injuries, and even improve a company’s image.

Safety training is increasingly being developed and conducted in the workers’ primary language. Workers who don’t speak English as a primary language may pretend to understand or bluff their way through safety training. Smart employers just don’t assume that workers who attended a safety training meeting understood the information. Many safety officers are using materials that are designed to be relevant to their audiences.

Another very important workers’ compensation trend is outcome-based medicine. It involves medical professionals who are experts in improving the outcomes of medical treatment. They regularly monitor treatment results, evaluate relevant data, and move to a new course of treatment as needed. The technology now exists to measure claims outcomes by physician, get injured workers to see these physicians quickly, and keep the care plan on track.

When organizational and employee interests are aligned, an environment is created where being safety conscious is not just a worry for employees. Instead, it’s a professional asset for everyone. ★

Dinesh Govindarao, M.D. is medical director for State Compensation Insurance Fund.

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Workers' Compensation:

HELP SELF-INSURERS NAVIGATE HEALTHCARE REFORMS

by STEVE KOKULAK

A growing number of employers are raising questions about how healthcare reform affects workers' compensation (WC). As experts in today's evolving healthcare environment, brokers can play an important role in educating and guiding clients in this area. The first step is to be prepared for client questions, and offer solutions. So what are the differences between employee health plans and WC programs? These plans vary in a number of ways.

BENEFITS

Health plans make payments for medical services while WC covers medical services and indemnity payments for lost earnings and disability. Payment depends on the employee's wages at the time of injury or illness, as well as the severity and duration of the disability.

EMPLOYEE COST SHARING

A key goal in WC is to make sure that employees who are injured or disabled on the job are not asked to cover medical bills related to their on-the-job injury. Therefore, deductibles and copayments don't apply.

PAYMENTS IN LATER YEARS

Companies that self-insure WC assume responsibility for an injury over many years even if they change to a fully insured plan down the road. With a health plan, the employer is only responsible for bills that occur in the calendar year when it was self-insured, but not for follow-up treatment provided in a calendar year covered by insurance.

CASE MANAGEMENT

WC is about helping employees return to work. In contrast, health plans focus simply on providing care, a difference that makes WC more expensive.

CARE DECISIONS

WC plans focus on identifying the cause of an injury or medical treatment, as well as the medical necessity of the treatment. Most state WC rules give employers more leeway to preauthorize or deny treatment that may not be medically necessary than is permitted with health plans – leading to higher administrative costs for WC plans.



REGULATION

Self-insured WC plans are regulated by the state. Therefore, self-insured employers must apply to the state WC board for permission to self-insure coverage. Many states have strict mandates on an employer's financial ability to self-fund and administer WC coverage. Even if self-insured status is granted, a state may require an employer to put money into escrow or have a bond issued to cover one or two years of anticipated expenses and losses. Also, the employer may be subject to state audits.

In contrast, self-insured health plans are regulated by the Employee Retirement Income Security Act of 1974

(ERISA). There are no state laws for these plans. This makes it easier to self-insure a health plan than a WC plan.

CAN SELF-FUNDED EMPLOYERS PROTECT THEMSELVES AGAINST UNEXPECTED OR CATASTROPHIC CLAIMS?

Absolutely, larger employers have the financial reserves to cover most WC claim costs. Smaller self-insured employers can protect themselves by purchasing excess or stop-loss insurance to reimburse them for claims above a specified dollar level. Stop-loss comes in two forms: specific coverage and aggregate coverage. Written together, specific and aggregate coverage can give a self-insured employer a strong financial defense against catastrophic and high frequency claims.

Specific coverage reimburses the employer when a claim is the result of one employee's illness or injury that exceeds the Self-Insured Retention (SIR) – the amount the employer is responsible for. If the SIR for one claim is \$250,000, for example, and a claim totals \$400,000, the specific coverage pays \$150,000.

Aggregate excess coverage protects against the effect of a few large claims, an excessive number of smaller claims in one year, or a combination of both. An attachment point is negotiated with the insurance company, called the "aggregate retention" or loss fund. The loss fund is the amount the employer must pay in claims before the aggregate coverage begins to pay.

HOW CAN WC COSTS BE CONTAINED?

All employers, whether self- or fully insured, must focus on cost-containment in the age of reform. Toward that end, employers must invest in promoting healthy lifestyles and safer

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workplaces to lower the number and severity of WC claims. Helping injured employees get the best possible care can help reduce the cost of medical care and get them back to work more quickly. Most employees who have a WC claim state that they seek the assistance of lawyers – a major cost-driver – because they don't fully understand their WC rights. Employers can reduce these costs by effectively communicating and expressing concern when employees are injured.

A dozen states permit certain unions to create alternative dispute resolution (ADR) programs that result in more efficient dispute resolution and more timely care with lower costs. The bottom line is that employers should ensure that they do everything legally permissible to medically manage the employee, and help them get the right care.

A key approach for employers is to partner with a third-party administrator (TPA), and participate in the decisions surrounding the hiring of vendors and case management. Employers should analyze whether the TPA is performing all services internally, such as bill review and medical case management, or if they are hiring other vendors. They should then verify that the TPA has made the right choices for the right reasons.

In addition, employers should decide whether to enter into a fully bundled contract with a TPA for all services, or if they want to enter into an unbundled contract, meaning that the TPA is only responsible for its own services. In an unbundled arrangement, the employer is required to research and possibly contract with several other entities. This is the main reason employers choose bundled services, although this isn't necessarily the most cost-effective approach in the long run.

An employer who assumes that a TPA understands how to manage claims efficiently and cost effectively, and does not question or audit the TPA, is less likely to have effective claim results.

WHAT ARE THE ADVANTAGES AND DISADVANTAGES OF SELF-FUNDED WC?

Key advantages for self-funded plans

include the following:

- **Reduced costs:** Self-funded WC plans cost less because the employer retains the profits and costs built into traditional insurance premiums. Certain self-funded strategies can also be applied. For instance, plans can use managed care services, such as access to preferred provider networks; cover alternative treatment programs, including acupuncture and chiropractic services; and implement prescription drug card programs that offer utilization review. They can also partner with a healthcare services company that offers data analytics for remote and real-time care. Self-funded employers are incented to prevent claims and control costs through more proactive managed care services.
- **Employee Satisfaction:** Employees get the message that the employer is invested in their health and well-being when there are improved worker safety programs and loss controls to identify the causes of workplace injuries and illnesses. These include ergonomic issues that lead to repetitive motion injuries, slips, falls, and back injuries. This can improve employee relations and lead to fewer claims.
- **Investment income:** With a self-funded plan, the employer does not pay many of the fees and charges associated with an insured plan. Also, the employer retains control over plan reserves, which can be used to generate income that would not be available with a fully insured plan.

DISADVANTAGES OF SELF-FUNDING A WC PLAN INCLUDE THE FOLLOWING:

- **Attention diversion:** Managing a self-insured plan is much more involved than paying a premium and leaving everything in the hands of an insurer. Unless a sponsor is big enough, the management/administration of a self-insured plan may become an unnecessary diversion from business activities.
- **Administration:** It is the employer's responsibility to administer the plan and pay claims, unless a third party is hired for this purpose.
- **Risk retention:** The employer re-

tains the risk associated with claims up to the limits covered by excess insurance.

- **Bonding:** In some cases, escrow or a bond is required.
- **Regulation:** Self-insured plans are subject to state regulations.

WHAT IS THE LONG-TERM OUTLOOK FOR WC PLANS?

WC plans, just like health plans, are beginning to look for vendors to help them manage the total cost of a claim, instead of individual aspects of a claim. Maintaining a safe work environment, or healthier employees, will help curtail costs, but employers will still face challenges associated with changes in the healthcare industry. The full effect of these changes will become more measurable once we have enough data relative to employers dropping healthcare coverage and individual employees obtaining coverage. Some experts believe that medical costs will shift from the WC market to the health insurance market because a portion of the uninsured population will no longer need to use WC to get healthcare. Others believe that newly insured employees with high deductibles may still attempt to have WC cover treatment that falls within their deductible.

As access to more affordable care and health insurance lead to a healthier workforce and improved productivity, the healthcare industry is poised to move away from injury-based care management toward a more patient-centered approach that focuses on prevention and timely care. ★

Steve Kokulak is senior vice president of Casualty Services for MagnaCare. Steve joined MagnaCare in 2007 as director of Workers' Compensation and No-Fault and was promoted to senior vice president in April 2013. His primary responsibilities are new business growth, overall retention of existing business, and regulatory oversight of this line of business. He was senior trial counsel for Liberty Mutual. Steve sits on SIIA Workers' Compensation Committee, moderating lectures and contributing articles to its magazine. His chapter on workers' compensation appears in the International Foundation of Employee Benefit Plan's book, Self-Funding Health Benefit Plans, available at: <http://www.ifebp.org/bookstore/self-funding-health-benefit-plans/Pages/default.aspx>.

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COBRA AND THE ACA MARKETPLACE PLANS

There has been a lot of confusion about the interplay between COBRA rules and the new Affordable Care Act (ACA) marketplaces. Previously, people on their employer’s COBRA plan could only enroll in the marketplace during open enrollment or when their COBRA expired. But a new opportunity could help individuals and their beneficiaries enroll in plans on the marketplace that may be more affordable. As a result of the Affordable Care Act, people on COBRA can choose from a variety of plans on the health insurance marketplace. Some will even be eligible for subsidies to cover a substantial portion of their premium. They can review plans and benefit options from a variety of insurance carriers. Under the traditional and often expensive COBRA option, individuals are responsible for paying 100% of the premium for their employer-sponsored coverage plus 2% for administrative costs. A marketplace plan may end up costing significantly less than the traditional COBRA option, explains Bill Hallberg at www.ACAenroll.com.

People who are enrolled in COBRA can enroll in the health insurance marketplace from November 1, 2015 until January 31, 2016. Those who enroll by December 15, 2016 may receive a January 1, 2016 effective date. “This is important for people on COBRA since most health insurance policies reset back to zero on January 1. Typically, individuals on COBRA are experiencing claims. December 15th is a very important deadline to hit for those seeking a less expensive alternative,” he said. For more information, visit <http://www.ACAenroll.com>.

COBRA WEBSITE

Benefitexpress launched a redesigned My COBRA Express site at <http://www.myonlinecobra.com>. The site designed to allow access to help on any given page so that users can navigate more efficiently. There is a new page, Plan Highlights, which prompts users for a code to access important plan highlight documentation. This new feature provides cost savings since client documentation can be stored securely on My COBRA Express and not have to be mailed to each user. ★

THE RISE OF WHOLESALE HEALTHCARE PROVIDERS

by LIZ GRIGGS

The Affordable Care Act may have opened the doors for more access to healthcare, but many pundits say that the law has done nothing to help mitigate the high cost of health insurance. In fact, 25% of non-elderly Americans don’t have enough liquid assets to cover the deductible on their health insurance plans. Some Americans still can’t even afford to get a basic plan in the first place.



Many individuals and families end up choosing a plan with a higher deductible just to get a lower monthly premium. With today’s higher deductibles, consumers have to pay fees up front, ranging from \$3,500 to \$5,000.

On the brighter side, since so many individuals still struggle to get quality care at an affordable rate, more healthcare providers are offering services directly to the consumer at a discount or wholesale price. What’s even more promising is that wholesale and discount service options vary across the board, giving customers even more choice. For example, a number of direct-to-consumer telehealth services allow individuals to get medical advice, and/or prescriptions via an online appointment, and avoid a more costly in-office visit with a physician.

Some companies provide direct-to-consumer imaging services like MRIs, cat scans, and ultrasounds for savings up to 75%. Savings are considerable, especially since a cat scan can be up to \$1,200; an

ultrasound can range from \$300 to \$1,000; and an MRI can be up to \$2,600. Consumers use an online portal to schedule and pay for their service. The platform finds a nearby provider.

The benefits of wholesale healthcare solutions can be far reaching, including the fact that large networks of providers are available to customers. Low cost does not compromise high quality since many wholesale options provide certified practitioners and professionals to facilitate procedures.

In this new era of healthcare, there is a dire need for creative solutions that make services even more convenient and accessible. As costs continue to soar, and the need for treatment continues to rise, wholesale healthcare options could be stepping stones to what Obamacare promised to deliver in the first place – affordable healthcare services for all. ★

Liz Griggs is Founder and Director of NextImage Direct. For more information, visit <https://www.nextimagedirect.com>.

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DENTAL PLAN

Though a licensing agreement with Brighter, Cigna dental customers will have access to improved cost and quality transparency tools, including dentist profiles and verified patient reviews. Most customers will be able to see actual fees for services by dentists before making an appointment. Online appointment scheduling and electronic appointment reminders will be available at network DPPO dentists who have elected to provide these conveniences. The new tools and features will be available on myCigna.com.

ANNUITY APPLICATIONS

Genworth has launched the Annuity Smart Application Process. The free electronic platform is designed to help financial professionals improve the accuracy of annuity applications, boost productivity, and improve the customer experience. The forms used in the electronic platform are identical to the paper application process, eliminating the learning curve for financial professionals. For more information, visit genworth.com.

FIXED ANNUITIES

Genworth launched an index crediting strategy on select SecureLiving fixed index annuity products. The strategy is based on the Barclays U.S. Low Volatility II Equity ER Risk Controlled Index. The volatility control spread strategy is designed to deliver greater growth opportunity than a traditional cap strategy, with more stable spreads regardless of the interest rate environment. For more information, visit genworth.com.

INDIVIDUAL VISION PLANS

Nationwide is offering individual vision insurance plans on LiveVeryWell.com. The multi-carrier insurance exchange platform offers individual vision and dental insurance with the ability to rate and review products, allowing consumers to compare, quote, and match plans.

FRAUD PROTECTION

Aflac is expanding its offerings to deliver fraud and identity protection services for policyholders. The partnership with EZShield will provide cost-effective service to help protect an employee's personal and financial information, provide ongoing Internet monitoring, and deliver full identity restoration. For more visit aflac.com/aflacbusinesssolutions.

RETIREMENT PLANNING

Nationwide's retirement plan business now offers access to LPL Financial's Employee Advice Solution. The new tool allows Nationwide to give advisors the data they need to offer timely, personalized financial advice to plan participants. Based on information that participants provide about their financial picture, they can work with a financial advisor directly to get personalized retirement advice or manage their accounts on their own. They can also get advice all the way through retirement. For more information, visit <http://lplfinancial.lpl.com>.

FREE ACA COMPLIANCE TOOLS FOR CONSUMERS

TurboTax is offering a suite of free online tools to help tax-

payers evaluate their health insurance choices under the Affordable Care Act. For more information about open enrollment, the free TurboTax tools and additional tax tips, visit blog.turbotax.intuit.com.

PAYCHEX EXPANDS ITS PRIVATE EXCHANGE OFFERINGS

Paychex is offering new tools and resources through the Paychex Insurance Agency (PIA) Personal Marketplace. The Personal Marketplace is geared toward employers who are not required to offer a group plan under the Affordable Care Act (ACA). They can help their employees gain access to coverage, and avoid increasing penalties for non-coverage under the individual mandate. Individuals have convenient access to benefit options, decision tools, and cost estimators for private and tax credit-eligible health plans. For more information, visit ConnectedHealth.com.

INVESTMENT SOLUTIONS

Nationwide is making its Investment Solutions Builder tool more efficient. The web-based investment tool allows registered investment advisors (RIAs) to build and manage retirement plan fund lineups and asset allocation models online for plan sponsors and participants. RIAs can now manage core fund lineups and asset allocation models across all of their plans simultaneously. For more information, visit nationwide.com.

BUSINESS SOLUTIONS SUITE

Aflac introduced the Aflac Business Solution suite. The suite helps employees protect themselves and their assets against fraud and identity theft, provides small businesses with banking relationships, supports employers with ACA compliance requirements, and provides assistance to insured employees and their families with navigating benefits and online medical treatment. For more information, visit aflac.com/aflacbusinesssolutions.

ENROLLMENT ACCESS FOR SMART DEVICES

OneAmerica launched a mobile platform to give group annuity plan participants a faster, yet still secure, way to register and enroll. In just the first month, OneAmerica charted an almost 10% increase in the number of visitors who made it through enrollment. For more information, visit OneAmerica.com/companies. ★



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INIEWS

HEALTHCARE

IRS Fines Threaten HRAs

The Council for Affordable Health Coverage and 25 allied organizations urged Congress to take up the Small Business Healthcare Relief Act (H.R. 2911/S. 1697) in the remaining days of the congressional session. The bill would allow employers to offer health reimbursement arrangements (HRAs) without being subject to outrageous IRS fines. Joel White, president of the Council said, "We are in a race to the finish to save Americans' health benefits." Many small business employers have reimbursed employees for individually purchased health coverage and related medical expenses through HRAs. But since July 1, the IRS has deemed these arrangements impermissible, fining employers that provide HRAs \$100 per day, per employee. The ACA fine is 1/18th that sum for larger businesses that provide no coverage at all. White said, "With penalties that could amount to \$36,500 per employee, or \$500,000 total, employers will be forced to draw back their helping hands." For more information, visit www.cahc.net.

ACA Reporting Could Be a Security Nightmare

Under the ACA, employers must track and provide private healthcare information to the IRS, which could be a security

nightmare, according to Greatland Corp. Starting this filing season, reporting is mandatory for any company with at least 50 full-time equivalent (FTE) employees. They must provide employees' personal information from tax systems and health insurance information. This opens the door for simple errors, and could lead to misuse or abuse of personal information.

Combining this information from two very different regulated databases and importing the data into the unfamiliar 1095 form can create security issues. Employers use the 1095 form to report the offer of coverage to employees and to the IRS. The 1095 form requires data that is typically stored in the employer's payroll system as well as HIPAA-protected benefit information. It is most often included in the employer's HR software.

Employers must send 1095 forms by the end of January. Because January 31 falls on a Sunday, statements must be mailed by February 1. Employers have until the end of February to provide this information to the IRS if they are filing paper forms or until the end of March if they are filing electronically. Employers with 250 or more forms must file them electronically. While incorrect filings will not be penalized for calendar year 2015 filing (reported in 2016), employers and insurers are still required to file on time and make a good faith effort to comply.

With the increase in filing regulations this tax season, Greatland has noted an increase in businesses claiming to offer these services. Often, these opportunistic companies fail to understand the detailed documentation; they don't have the skills to navigate ongoing changes; and they don't offer the software with security measures. For tips on filing requirements, visit <http://www.greatland.com>.



Private Medicaid Expands

Last year, 66% of Medicaid beneficiaries got coverage from a private Medicaid health plan. This year, it's 70%, according to a study by PwC. California has the most Medicaid beneficiaries with 33% of the population covered. With so many people receiving Medicaid, and budgets being squeezed, states are increasingly turning to private plans to control spending. Over the past year, private plans added 7.8 million beneficiaries. The number of Medicaid beneficiaries in fee-for-service plans or public managed care programs decreased by 1.4 million. For more information, visit pwc.com.

Medicaid and CHIP Beat Private Plans in Access to Pediatric Preventive Care

Children with Medicaid or the Children's Health Insurance Program (CHIP) have greater access to preventive care than do children with private insurance, according to a survey by PolicyLab at the Children's Hospital of Philadelphia. Seventy-eight percent of caregivers of children with Medicaid and CHIP say the insurance always meets their needs compared to 73% of caregivers of children with private insurance. Eighty-eight percent of children with Medicaid or CHIP had access to preventive medical care compared to 83% of children with private insurance. Eighty percent of children with Medicaid have access to dental care com-

pared to 77% of children with CHIP and 73% of children with private insurance.

David Rubin, MD, MSCE, of PolicyLab says that private plans on the exchanges should be required to match Medicaid's mandatory benefit and cost-sharing provisions. He noted that some new insurance plans in the commercial market are tiering specialty providers as out-of-network, which blocks access for children with special healthcare needs.

Getting specialty care is a challenge for children in all coverage types, with as many as one in four having difficulty seeing a specialist. However, these challenges are greatest for children with CHIP (28%) and for privately insured children with special health care needs (29%). Seventy-seven percent of caregivers of children with private insurance have out-of-pocket costs compared to 38% of those with CHIP, and 26% of those with Medicaid. For more information, visit policylab.chop.edu.



Double Digit Cost Spikes Hit Obamacare

Obamacare insurance plans are more expensive than they were last year, on average, but fewer consumers are seeing price increases in the most popular mid-level plans. Average premiums have increased by 13% for Bronze plans, 11% for Silver plans, 15% for Gold plans, and 12% for Platinum plans. Last year, price increases were more moderate at 7% to 10% depending on the plan tier, according to the McKinsey Center for U.S. Health System Reform.

"The Affordable Care Act was intended to create competition in the health care marketplace in order to drive down costs for consumers. Instead, we are seeing more insurers leave health care exchanges and mergers of insurance gi-

ants, resulting in less competition and spikes in premiums and making health care anything but affordable. It is time that federal and state regulators...hold insurers accountable and limit unreasonable premium increases," said Stacey L. Worthy, Aimed Alliance's director of Public Policy. Aimed Alliance said that the next president and Congress will have to address the following shortcomings of the health care system:

- **Quality:** At least one quarter of Americans are underinsured and cannot access treatments prescribed to them due to insurers' profit-maximizing cost-containment measures. Instead, they are relegated to trying out and failing on inferior treatments, a policy referred to as "fail first."
 - **Efficiency:** Overly restrictive policies, such as burdensome prior authorization, claims denials, and appeals processes, waste time, are costly, and must be eliminated.
 - **Ethics:** To circumvent the ACA's prohibition on denials of care for preexisting conditions, insurers place all medications that treat certain illnesses in the most expensive specialty tier, making treatments unaffordable for people with illnesses, such as cancer, hepatitis C, HIV, and rheumatoid arthritis, thereby deterring them from joining the plan in the first place.
 - **Transparency:** Coverage rates and co-insurance for in-network and out-of-network services must be disclosed to allow for cost comparisons among insurers and providers, and to prevent surprise bills.
- For more information, visit aimedalliance.org.

IN CALIFORNIA

Prudential Provides Life Insurance to People with HIV

California Insurance Commissioner Dave Jones commended Prudential for being the first major insurer to offer individual life insurance to people with HIV. Jones said, "Acknowledging that HIV is a chronic, but manageable condition is the right thing to do...Prudential and its partner, Aequalis, are to be commended."

Premium Growth Slows in California's Individual Market

Premium rate growth for health plans sold in California's individual market has slowed since the Affordable Care Act (ACA) and Covered California, according to a report by the California HealthCare Foundation (CHCF). The report is based on a review of insurers' rate renewal filings from 2011 to 2016. With CHCF's new interactive tool, users can see how premium rate increases in the individual market have changed over time. The following are key findings:

- The median rate increase was 6% in 2015 and 3.8% in 2016, lower than the median increases of 8.2% to 10% from 2011 to 2013.
 - Three-quarters of enrollees in 2015 and 2016 were in plans that filed increases of 6% or less compared to 9% or less in 2012 and 19.4% or less in 2013.
- For more information, visit chfc.org.

Consumer Reports Praises Covered California

Consumer Reports says that Covered California earned its way on the nice column of its annual Naughty & Nice list because its standardized benefits eliminate much of the

confusion for consumers who are buying health insurance. Unlike most other states, which offer an unlimited number of designs, Covered California requires insurance companies to compete for consumers based on the same basic benefits and co-pays, which makes it easier for consumers to compare their option from plan to plan. Others listed on the Nice list are Home Depot, Chipotle, Panera Bread, CVS, Dish Network, Dr. Martens for Life, JetBlue, Norobo, Proctor and Gamble, Price Waterhouse Coopers, Southwest Airlines, and Target. Included on the Naughty list are Citibank, Citizens Bank, Costco, FedEx, UPS, LifeLock, Sprint, Verizon, Tom's of Maine, Turing Pharmaceuticals, Volkswagen, and Whole Foods. For more information, visit consumer-reports.org/consumer-protection/naughty-and-nice-2015.

LIFE INSURANCE AND ANNUITIES

Life and Annuity Insurers Are Positioned To Address Shifting Tides

U.S. life and annuity insurers will enter 2016 in relatively good financial shape. Global economic conditions, regulatory and monetary policies, and the political landscape are still concerns for the industry. "After years of bolstering their balance sheets, life-annuity firms are in a strong



position to invest in the innovations and technologies needed to fuel growth," said Doug French, of Ernst & Young. According to the report, life-annuity insurers should focus on areas in 2016:

- Increase innovation: Insurers should drive innovation through cross-functional teams, and share information openly across departments.
- Reinvent products and services for the digital customer: Insurers will have a hard time attracting and retaining customers if they don't respond to demands for greater digital access. In 2016, they should focus on offering multi-device access, providing clearer information on products and pricing, delivering more flexible solutions, and moving from focusing on products to serving as a trusted advisor. Life and annuity insurers may lose market share if they fail to adapt to a multi-channel world. Insurers should adapt services for new distribution models and explore the use of robo-advisors.
- Insurers need to prepare for new fiduciary standards since the Dept. of Labor's proposed fiduciary rule could upset existing distribution models in 2016.
- Drive efficiency and market growth: Insurers should determine whether they are ready for rapid market change. The assembly-line approach to policy quoting, issuance, and administration can slow application turnaround and detract from the customer and distributor experience.

Companies should also make sure that their systems meet new regulatory standards. They should invest in the latest processes and analytics, revamp their IT systems, and consider partnerships to facilitate technological transformation.

- Hire the right talent: Insurers need to attract a young, diverse workforce to match emerging customer demographics and help drive innovation. Priorities for 2016 should include competing for talent, offering more flexibility in work locations, finding creative ways to motivate and reward employees, and increasing diversity.
- Place cybersecurity high on the corporate agenda: Social media, the cloud, and other digital technologies will expose life and annuity insurers to cyber risks in 2016. Also, insurers should establish processes to monitor changing data regulations around the world since their data could reside in multiple jurisdictions and be subject to a variety of laws.

For more information, visit <http://www.ey.com>.

EMPLOYEE BENEFITS

Critical Illness Market Shows Continued Growth

The critical-illness market seems to finally be taking off. In 2014, the market saw a nearly \$381 million increase in reported new business premium and \$1 billion increase in-force premium on more than 3 million insured lives, according to a survey by Gen Re. A record 59 carriers, representing 95% of the market, participated in this year's survey. Of those, 41 were marketing 73 different critical-illness products. The remaining participants are exploring the market or are gearing up to enter it.

Fifty-nine percent of carriers in the market plan to increase their focus on critical-illness sales; 41% plan to maintain their current focus; and none plan to decrease their focus on critical illness products. While all market segments are expecting strong growth, the group and worksite segments are especially optimistic. They expect annual growth rates of 22% (issue age) and 30% (attained age) over the next three years. The critical-illness industry seems to be moving in the direction of more benefit eligibility triggers with the average number increasing from 13 last year to 19 this year. Cancer remains the number one cause of claims. For more information, visit www.genre.com.



From the California Department of Insurance:

MAKING IT EASIER TO TRACK YOUR CE HOURS, RENEW YOUR LICENSE, AND OTHER LICENSING REQUIREMENTS

In an effort to make it easier for you to track your continuing education (CE) hours, to renew your license and to be aware of other licensing requirements, the California Department of Insurance (CDI) is providing the CE: Find Out Where You Stand, New Continuing Education and Licensing Requirements, and a Review of the Producer Licensing Online Programs.

CE: Find Out Where You Stand – CDI Provides This Information On the Internet, By Telephone or Email

First, CDI encourages you to complete your CE hours at least 60 to 90 days before the expiration of your license. The early completion of CE hours assists in streamlining your license renewal.

1) On the Internet

CDI's web site at www.insurance.ca.gov provides several methods for you to automatically check your license status and your CE status by visiting the "Check License Status" link (<http://insurance.ca.gov/license-status/>), which is available in the popular links drop-down menu. On this page you may access your license record by inserting your name or your license number and pressing Submit Query. Review your licensee record as you scroll down the web page. At the bottom of the web page select "Continuing Education" to access your CE summary page to begin your CE review. Specifically, this first page provides you with the "Total Continuing Education for this renewal period" and it details your license type, your license status, the CE hours applied, hours required, and hours needed for this license renewal term.

The CE summary page also provides the "Additional Education and Training," if required to sell specific products or for license type" information that lists the completed annuity, long-term care, homeowners' insurance and other additional required courses that you completed during the current license term. Each section listed under the "Additional Education" heading informs you if these requirements were met.

For more details on the CE you completed, select the View CE Details link, which is located next to the "Total Continuing Education" at title. The View CE Details breaks down the courses you completed by the specific course number, course type, course name, completed date, course hours, and credited hours. Most importantly, this web page provides the specific courses that were completed and the number of hours completed for each course for this renewal period.

For your convenience, CDI also has available on its web site the Education Provider and Course Search at <http://interactive.web.insurance.ca.gov/providercourselookup/index.jsp> or visit CDI's web site at www.insurance.ca.gov, type Provider and Course Search in the search box on the Main Page. This service provides you with the list of CDI approved CE courses by course type to allow you to quickly and easily locate the CE course (s) you need to complete, to comply, with your CE requirements. Specifically, after opening Education Provider and Course Search web page, use the drop down menu to select your license type, your education type (continuing education, precursing), the instruction method (contact for classroom and non-contact for internet or self-study) and the course type (listed below).

To ensure that you are completing the courses that are required, we encourage you to use the Education Provider and Course Search service.

Following is a list of the CE category types and the license types that may complete these courses for CE credit

- AH – Accident and Health Agent courses
- AJ – Independent Insurance Adjuster courses
- ANUB – Annuity eight-hour courses for Life-Only Agents, Life, Accident and Health Agents, Life Limited to the Payment of Funeral and Burial Expenses that meet the specific eight-hour annuity training requirements stated in Section 1749.8 of the California Insurance Code (CIC).
- ANU4 – Annuity four-hour courses for Life-Only Agents, Life, Accident and Health Agents, Life Limited to the Payment of Funeral and Burial Expenses that meet the specific four-hour annuity training requirements stated in Section 1749.8 of the CIC.
- AP – Independent and Public Insurance Adjuster courses.
- AU – Limited Lines Automobile Insurance Agent, Personal Lines Broker-Agent, Property Broker-Agent and Casualty Broker-Agents courses.
- BL – Bail Agent courses.
- BM – Business Management courses for Property Broker-Agents Casualty Broker-Agents, Personal Lines Broker-Agents, Limited Lines Automobile Agents, Life-Only Agents, or Accident and Health Agents.
- CA – Casualty Broker-Agents Courses. *
- ET – Ethics courses for Property Broker-Agent, Casualty Broker-Agents, Personal Lines

Broker-Agents, Limited Lines Automobile Agent, Accident and Health Agents and/or Life-Only Agents, Independent and Public Insurance Adjusters, specific to ethics CE requirement of Sections 1749.3-1749.33 of the CIC.

- FLD – Flood courses for Property Broker-Agents, Casualty Broker-Agents or Personal Lines Broker-Agents.
- HO – Homeowners' Insurance Valuation courses for Property Broker-Agents, Casualty Broker-Agents and Personal Lines Broker-Agents.
- LO – Life-Only Agent courses.
- LX – Life courses for Life-Only Agents and Life, Accident and Health Agents.
- PC – Property and Casualty courses for Property Broker-Agents, Casualty Broker-Agents or Personal Lines Broker-Agents.
- PL – Personal Lines Broker-Agent courses for Property Broker-Agents, Casualty Broker-Agents* or Personal Lines Broker-Agents.
- PJ – Public Insurance Adjuster courses.
- PROP – Property Broker-Agents Courses.
- WC – 24-Hour Workers' Compensation courses for Accident and Health Agents.
- LTC8 – Eight-Hour Mandatory Long-Term Care courses for Accident and Health Agents that meet the specific long-term care training requirements stated in Section 10234.93(a)(4)(A) of the CIC. LTC – In addition, Life-Only Agents that sell long term care as a rider to a life policy are to complete this requirement.

Essentially, CDI's Check License Status web page CE link provides you with a summary of the CE courses and course hours you completed and the number of CE hours that are required to renew your license. In addition, the Education Provider and Course Search web page provides you with the CDI approved courses to take to meet your license renewal requirements.

2) By Telephone Interactive Voice Response System

The Toll Free 1-800-967-9331 automated Interactive Voice Response (IVR) telephone system is available 24-hours a day, seven days a week. Specific license information is available, including expiration date and company appointments. Licensees can also check their CE record by selecting Option #2 from the Main Menu, then selecting Option #3 from the education menu. The licensee may receive a fax-back of their CE record by selecting Sub-Option #2. In addition, license specific information and CE records are available on the CDI's web site. Licensees should keep in mind that it may take up to 60 days from when a course is completed before it is reflected on their CE record.

Producer Licensing Bureau Call Center

You may also call the toll free (800) 967-9331 and say or press "0" to speak with a Call Center Technician.

3) Email and Mail Inquiries

Your inquiries may be sent via email to the Producer Licensing Email service (<https://interactive.web.insurance.ca.gov/pli/servlet/InformationRequest>) which is available on CDI's web site at www.insurance.ca.gov/. Select Contact Us in the popular links drop-down menu, then e-mail inquiry under Licensing HotLine. When submitting an inquiry, please provide as much detail as possible and include your telephone number to enable CDI to better serve you.

In addition you may submit inquiries to the following mailing address:

California Department of Insurance
Attention: Producer Licensing Bureau
P.O. Box 1139
Sacramento, CA 95812-1139

Other Information

Please note that Section 2188.6(g) of the California Code of Regulations (CCR) states, in part, that licensees cannot receive CE credit for the same course taken more than one time within a two-year license period. In addition, CCR Section 2188.8 (a) (7) states, in part, that licensees are required to retain their CE course certificates of completion for five (5) years. Therefore, you need to review your certificates of completion to avoid the completion of the same course during a two-year license term. If courses are taken again, during a two-year term, only the first course completed will be eligible for CE credit.

In addition, you may carry-forward CE hours. However, only the additional CE credit hours completed in the second year of a two-year license term may be carried forward and applied to the next license CE requirement.

For non-contact courses (including self-directed, web, correspondence, and computer), you need to fully understand the education provider's method for calculating course completion dates. If you wait until the end of your license term to complete a non-contact course to meet your CE requirement, you may find that the education provider submitted the date that the examination is graded or the date stamped for the education provider's time zone as the completion date. The date the education provider submits could result in your CE being out of compliance. At that time you would need to submit a 50 percent penalty fee to reactivate your license. As stated earlier, CDI strongly recommends that you complete your CE courses 60 to 90 days before your license expiration dates.

Producer Licensing Online Services

Section 1655 of the CIC states, in part, that no application for a license shall be deemed filed unless that document was submitted and the proper filing fee were paid using electronic service. However, an applicant, for a good cause shown, may request an exemption to the electronic filing requirement. To assist you with the online filing requirements, listed below are some of CDI's online services that are available on CDI's web site at www.insurance.ca.gov for both resident and nonresident applicants and licensees.

Examination First Requirement

The California Department of Insurance (CDI) requires California resident applicants to first pass the qualifying license examination prior to submitting their license application. PSI Services, LLC, a California-based company providing state-based regulatory licensure services, handles the scheduling of examinations for individuals licensed by the California Department of Insurance's (CDI) Producer Licensing Bureau. Instructions for scheduling examinations are posted on PSI's Examination Scheduling Service (<https://candidate.psiexams.com/index.jsp>). Individuals may schedule their examinations with PSI either online or by telephone.

Fast Licensing Application Service is Here (FLASH)

FLASH online application is available on CDI's web site at www.insurance.ca.gov. FLASH allows both resident and nonresident license applicants to apply for a Property Broker-Agent, Casualty Broker-Agent, Life-Only Agent, Accident and Health Agent, Personal Lines Broker-Agent, Limited Lines Automobile Insurance Agent, Surplus Line Brokers, Special Lines' Surplus Line Broker, Motor Club Agent, and a Title Marketing Representative Certificate online. This service requires the applicant to pay their license fees with a credit card (American Express, VISA, or MasterCard) or a debit card (with the VISA or MasterCard logo) examination. On CDI's main page, use the Quick Links for Agents and Brokers drop down menu to select "Apply for a License" to link to the FLASH online application.

Online Address Change Service

Sections 1658, 1728, and 1729 of the CIC to state, in part, that every licensee and every applicant for a licensee shall immediately notify the commissioner using an electronic service of any change in his or her email or mailing address. You are to change your new address information by using CDI's online Free Address Change Service that is available on CDI's main page, using the Agents and Brokers drop down menu and select Updating License Info, to Report Change of Address, Change Your Address Online (<http://insurance.ca.gov/0200-industry/0080-make-changes/0100-change-address/index.cfm>). CDI tracks the licensee's mailing, residence, and business addresses. It is the licensee's responsibility to keep a current mailing and email address on record with CDI.

Education Provider and Course Search Program

CDI offers an Education Provider and Course Search feature on the CDI web site. This feature allows licensees to easily and quickly locate CE courses needed for you to comply with CE requirements. As stated in the On the Internet section, you can use a selection of criteria to customize the search to locate a course to meet your needs. Please visit CDI website at www.insurance.ca.gov, type Provider and Course Search in the search box on the Main Page or use the following link: <http://interactive.web.insurance.ca.gov/providercourselookup/index.jsp> to select the criteria for your course search.

Prelicensing Education

A. All applicants for the Property Broker-Agent (PR) and Casualty Broker-Agent license (CA) – Previously known as a Fire and Casualty Broker-Agent (FX) license must:

1. Complete an approved 20-hour property broker-agent prelicensing course and a 20-hour casualty broker-agent prelicensing course or complete a combined 40 hours of property and casualty broker agent prelicensing course for the property broker-agent and the casualty broker agent examination.
2. Complete an approved 12-hour course on ethics and the California Insurance Code.

B. All applicants for a Life, Accident and Health Agent license (LO and AH) – Previously known as a Full Life Agent (LX) applicants must:

1. Complete an approved 20-hour life-only agent prelicensing course and a 20-hour accident and health agent prelicensing course or a combined 40 hours of life-only and accident and health agent prelicensing course for the life, accident and health agent examination.

2. Complete an approved 12-hour course on ethics and the California Insurance Code.

C. All applicants for the Accident and Health Agent (AH) licenses must:

1. Complete an approved 20-hour accident and health agent prelicensing course for the accident and health agent examination.
2. Complete an approved 12-hour course on ethics and the California Insurance Code.

D. All applicants for the Life-Only Agent (LO) licenses must:

1. Complete an approved 20-hour life-only agent prelicensing course for the life-only agent examination.
2. Complete an approved 12-hour course on ethics and the California Insurance Code.

E. All applicants for the Limited Lines Automobile Insurance Agent (AU) licenses must:

1. Complete an approved 20-hour limited lines automobile insurance agent prelicensing course for the limited lines automobile insurance agent examination.
2. Complete an approved 12-hour course on ethics and the California Insurance Code.

F. All applicants for the Personal Lines Broker-Agent (PL) licenses must:

1. Complete an approved 20-hour personal lines prelicensing course for the personal lines broker-agent examination.
2. Complete an approved 12-hour course on ethics and the California Insurance Code.

G. All applicants that would like to upgrade from a Personal Lines Broker-Agent (PL) license to a Property Broker-Agent and Casualty Broker-Agent licenses must:

1. Complete an approved 20-hour commercial insurance prelicensing course for the commercial insurance examination. After passing the commercial insurance examination, your personal lines broker-agent license will be upgraded to a property broker-agent and casualty broker-agent licenses.

H. Exemptions from the 20-Hour and 40-Hour General Insurance Courses

1. A new California resident applicant who holds a current California non-resident license and holds a license in another state is no longer required to complete the prelicensing education; or;
2. As stated in Section 1749.44 of the California Insurance Code, an applicant for a license holding one or more of the following designations:
 - AAI (Accredited Advisor in Insurance), (property broker-agent or casualty broker-agent)
 - ARM (Associate in Risk Management), (property broker-agent or casualty broker-agent)
 - CEBS (Certified Employee Benefit Specialists), (life-only or accident and health)
 - ChFC (Chartered Financial Consultant), (life-only)
 - CIC (Certified Insurance Counselor), (property broker-agent or casualty broker-agent, and life-only, or accident and health)
 - CFP (Certified Financial Planner), (life only)
 - CPCU (Chartered Property Casualty Underwriter), (property broker-agent or casualty broker-agent)
 - CLU (Chartered Life Underwriter), (life-only and accident and health)
 - FLMI (Fellow, Life Management Institute), (life-only and accident and health)
 - HIA (Health Insurance Associate), (accident and health)
 - LUTCF (Life Underwriter Training Council Fellow), (life-only and accident and health)
 - REBC (Registered Employee Benefits Consultant), (accident and health)
 - RHU (Registered Health Underwriter), (accident and health)

If seeking the same type of license, the applicant needs to complete an approved 12-hour course on ethics and the California Insurance Code (CIC) before taking the examination.

I. Examinations

To obtain a license, you must meet the prelicensing education requirements outlined above, and pass the license type examination, which are based on the educational objectives and the ethics and California Insurance Code established by the Curriculum Board.

Before scheduling your license examination, CDI encourages you to review CDI's Candidate Information Bulletin (CIB) (<http://www.insurance.ca.gov/0200-industry/0020-apply-license/0100-indiv-resident/CandidateInformation.cfm>) that is located on CDI's web site at www.insurance.ca.gov. To locate the CIB, on CDI's main page in the Search box type Candidate Information Bulletin (CIB) and press "Enter" to retrieve the CIB link to review the material. The CIB provides detailed information on how to prepare for your license examination, prelicensing education requirements, examination site procedures, sample examination questions, test taking strategies, and driving directions to CDI's examination sites and to 21 of CDI's new examination vendor's, PSI, test centers that are located throughout California. Please note that page 8 of the CIB provides a link to the license examination's educational objectives. Review the educational objectives for the license type you are seeking. The examination you are taking is based on the educational objectives or the study material that is provided on the link.

The following chart lists the examination types that are required by the CIC and administered at CDI's examination sites and PSI's test centers, the number of hours allotted for each examination and the number of questions on each examination.

Examination Type	Time Allotted	Number of Questions
Accident and Health	1.5 hours	75
Bail Agent	2 hours	75
Casualty Broker-Agent	1.5 hours	75
Commercial Insurance	1.5 hours	60
Life, Accident and Health	3 hours	150
Life and Disability Analyst	3.5 hours	125
Life-Limited to the Payment of Funeral and Burial Expenses	2 hours	90
Life-Only Agent	1.5 hours	75
Property Broker-Agent and Casualty Broker-Agent	3 hours	150
Independent Insurance Adjuster	2.5 hours	100
Limited Lines Automobile Insurance Agent	1.5 hours	60
Personal Lines Broker-Agent	2 hours	90
Property Broker-Agent	1.5 hours	75
Public Insurance Adjuster	2.5 hours	100

After reviewing the CIB section that is specific to the license the applicant is seeking, the applicant must submit a license application using CDI's FLASH online application that is referenced in the Producer Online Services of this article.

There are two methods to schedule your license examination date. The first method is to schedule your license examination using CDI's examination vendor, PSIs at www.psiexam.com.

The second method is to call PSI at (877) 392-6422 to speak with a Consumer Service Representative Monday through Friday between 4:30 a.m. and 7:00 p.m. and Saturday between 8:00 a.m. and 2:00 p.m. Using either of these two methods will allow you to schedule an examination at a date, time and location that is convenient for you.

Continuing Education (CE) Program Requirements

A. For Property Broker-Agent and/or Casualty Broker-Agents (PC)

1. Hours required

- Complete 24 approved credit hours for the license type during each two-year license term.
- Complete a minimum of three hours of ethics CE that is a part of and not in addition to the 24 hours of CE that must be completed in the license term.

B. For Life, and Accident and/or Health Agents (LO and AH) – Previously known as a Full Life Agent (LX)

1. Hours required

- Complete a minimum of 24 approved credit hours for these combined license types during each two-year license term.
 - Complete a minimum of three hours of ethics CE that is a part of and not in addition to the 24 hours of CE that must be completed in the license term.
- Life-Only agents. Prior to soliciting annuity products, the licensee must complete an initial eight hours of CDI approved annuity training (Annuity Eight-Hour Training, ANU8) prior to soliciting individual consumers. Thereafter, the licensee shall complete at least four hours of a CDI approved annuity training course (Annuity Four-Hour Training, ANU4) every two years prior to license renewal (Section 1749.8 of the California Insurance Code).
 - Prior to soliciting individuals for the sale of LTC insurance, the licensee must complete a CDI approved eight hours of long-term care training (Long-Term Care Training LTC 8) in each of the first four 12-month periods beginning from the date the license was issued and, thereafter, complete eight hours of CDI approved long-term care training each two-year license renewal. (section – 10234.93(a)(4) of the CIC)

C. For Property Broker-Agent, Casualty Broker-Agents, Life-Only Agent and/or Accident and Health Agents (PR, CA, LO and AH)

- If the licensee has an active PR, CA, LO, and AH license they must complete a minimum of 24 approved credit hours for these combined license types during each two-year license term. Please note that the CE requirement is credited to the individual and not to each license type held.
- Complete a minimum of three hours of ethics CE that is a part of and not in addition to the 24- hour CE requirement that must be completed in the license term.
- Life-only agents – Prior to selling annuity products, the licensee must complete an initial eight hours of CDI approved annuity training (Annuity Eight-Hour Training, ANU8) prior to soliciting individual consumers. Thereafter, the licensee shall complete at least four hours of a CDI approved annuity training course (Annuity Four-Hour Training, ANU4) every two years prior to license renewal (Section 1749.8 of the CIC).
- If the licensee solicits individuals for the sale of LTC insurance, then the licensee must complete eight hours of CDI approved long-term care training (Long Term Care Training LTC8) in each of the first four 12-month periods beginning from the date the license was issued and, thereafter, complete eight hours of CDI approved long-term care training each two-year license renewal.

D. Personal Lines Broker-Agents (PL)

- Complete a minimum of 24 approved credit hours for that license type during each two-year license term.
- Complete a minimum of three hours of ethics CE that is a part of and not in addition to the 24 hours of CE that must be completed in the license term.

E. California Resident Continuing Education Requirements for Property Broker-Agent and Casualty Broker-Agents, Accident and Health Agents and/or Life Only Agents, and Personal Lines Broker-Agents

Sections 1749.3–1749.33 of the CIC requires Property Broker-Agents and Casualty Broker Agents, Accident and Health Agents and/or Life-Only Agents, Personal Lines Broker-Agents and Limited Lines Automobile Insurance Agents to complete three hours of ethics CE during their two-year license term. The ethics CE is a part of and not in addition to the required CE hours for each license type.

In addition, Section 218.65 of the CCR took effect on June 27, 2011. This section requires property broker-agents, casualty broker-agents, and personal lines broker agents, who have not previously completed the CDI approved homeowners' insurance valuation training, to do so. This is a one-time three-hour homeowners' Insurance valuation course requirement that must be complete prior to the agent-broker estimating the replacement value of structures or explaining the various levels of coverage under a homeowners' insurance policy. The training requirement is part of, and not in addition to, the agents and brokers' continuing education requirements.

Similarly, Section 1749.8 of the CIC states, in part, that prior to selling annuity products, the California resident life-only agent or life, accident and health agent must complete an initial eight-hour CDI annuity approved training course (Annuity Eight-Hour Training, ANU 8). Thereafter, the agent must complete a four-hour annuity training course (Annuity Four Hour Training, ANU4) each license renewal.

Furthermore, Section 10234.93(a)(4) of the CIC states, in part, that California resident Accident and health Agents or Life, Accident and Health Agents must complete eight hours of CDI approved long term care training (Long Term Care Training, LTC8) in each of the first four 12-month periods beginning from the date the license was issued. Thereafter the agent must complete eight hours of care CDI approved long-term care training each two-year license. In addition, Life-Only Agents that sell long term care as a rider to a life policy are to complete this requirement.

Please note Section 1749.6 of the CIC states that any person failing to meet the CE requirement on or before their license renewal date shall have his or her license inactivated. The process to reactivate an inactive license is costly and time-consuming. In order to reactivate a terminated license, the licensee must pay a 50 percent penalty fee, complete the required CE, and satisfy any other outstanding requirements (i.e. ethics CE) within one year of the expiration of the license. Additionally, the appointments and endorsements affiliated with license are terminated. The licensee must have their company and/or organizational endorsements using these online services that are available on CDI's website for each company that the licensee intends to transact.

F. California Nonresident License Holders

A California nonresident license can be issued and existing licenses will be renewed if the nonresident applicant holds a current license for the same license type in good standing in their home state.

In addition, Section 1749.2 of the CIC, California nonresidents are exempt from having to complete the California resident licensee's CE requirement. However, although California nonresident licensees are exempt from the CE requirement, nonresident licensees must complete the required annuity and long-term care training if they are authorized to sell these products. Specifically, if a California nonresident Accident and Health Agent or the Life, and Accident and Health Agents solicit individuals for the sale of LTC insurance in California, the California specific long-term care (Long-Term Care Training, LTC8) requirement that is stated above in the California resident section must also be completed. Similarly, the annuity training (Annuity Eight-Hour Training, ANU 8 and the Annuity Four-Hour Training, ANU 4) requirements that are stated above in the California resident section must also be completed if the California nonresident Life-Only Agents or the Life, Accident and Health Agents sell annuity products.

CE Exemptions

Section 1749.3 (c) of the CIC states, in part, that any person meeting the following requirements will be exempt from completing CE to renew his or her license:

- 70 years of age or older; and
 - 30 continuous years as a licensee in good standing in California
- Any licensee who maintains 30 continuous years without any disciplinary action is considered to be in good standing. The licensee must submit a written request for the CDI to review the licensee's record to approve the request. The CDI will respond to this request in writing. If the request is not approved, the licensee may contact the Producer Licensing Bureau to request another review of the license record.

However, please note that this exemption shall not apply to those individuals licensed for the first time on or after January 1, 2010. ★

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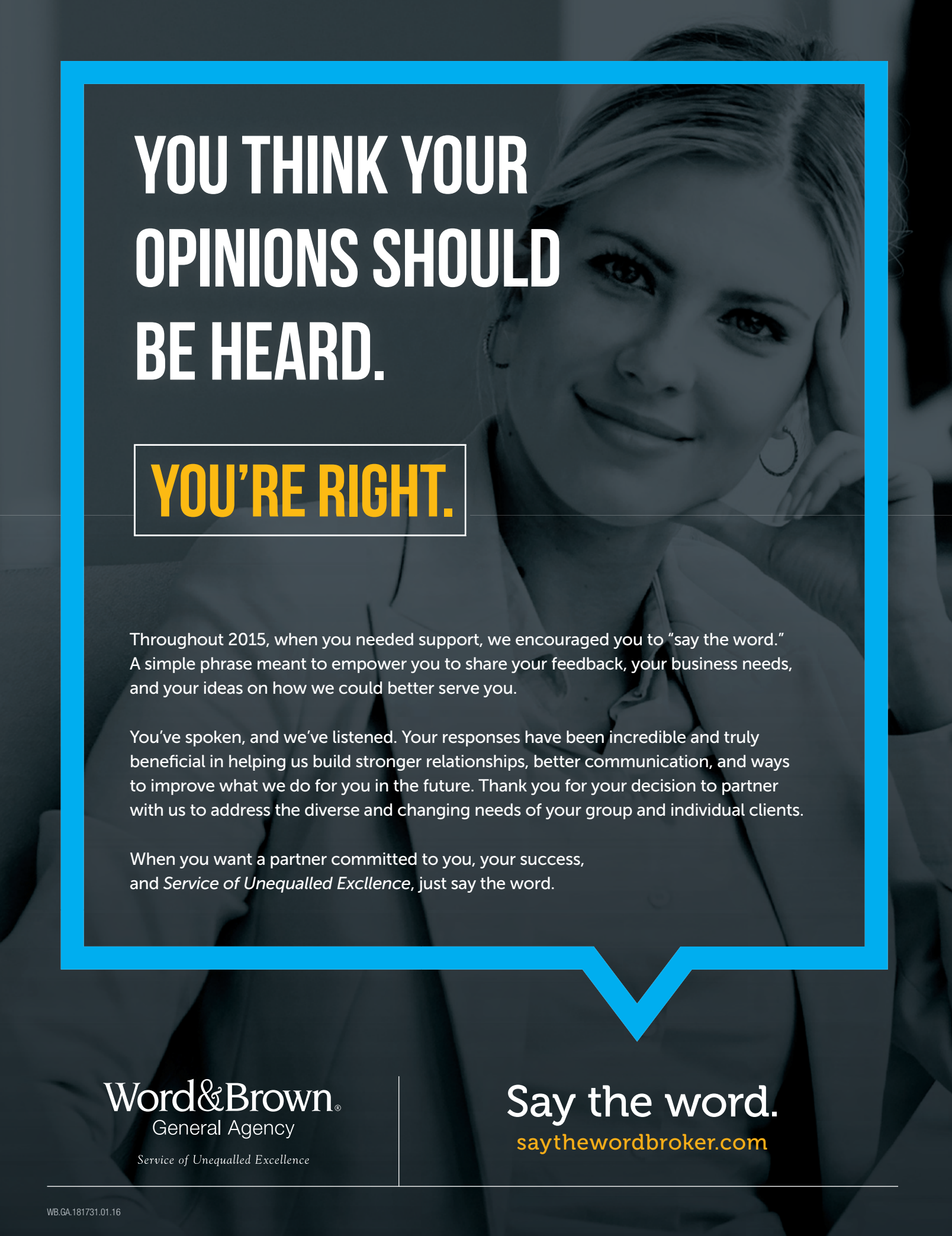
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