

CALIFORNIA BROKER

VOLUME 35, NUMBER 10

SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

JULY 2017



**2017
DENTAL
SURVEY**

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California's Single-Payer Bill Examined

By MICHAEL LUJAN, RHU, CHRS

In case you missed it, the California Senate advanced a bill to the State Assembly called The Healthy California Act (SB 562). It's another attempt to make California the first state in the country to enact a single-payer health care law. News coverage has been pretty light on this issue considering the enormity of the cost and impact to California's economy. Here's a quick recap to learn more about the single-payer bill (SP):

- SP would replace all forms of private and public health insurance in California with a state government-run health system.
- Could potentially triple our current unemployment rate because it may eliminate an estimated half million insurance, health care administration and related jobs.
- Could make California a health care destination for anyone seeking "free healthcare." Neither citizenship, nor permanent residency, would be required to use the SP system.
- Requires a massive tax increase. The additional 15 percent payroll tax would make California the highest taxed state in the country.

If enacted, SB 562 would be the largest tax increase in California's history. The entire state general fund is \$183 billion. As proposed, the bill would cost an estimated \$400 billion for the initial year and unknown costs for subsequent years. While that may seem like a deal-killer, the bill has moved forward to the State Assembly and should not be ignored.

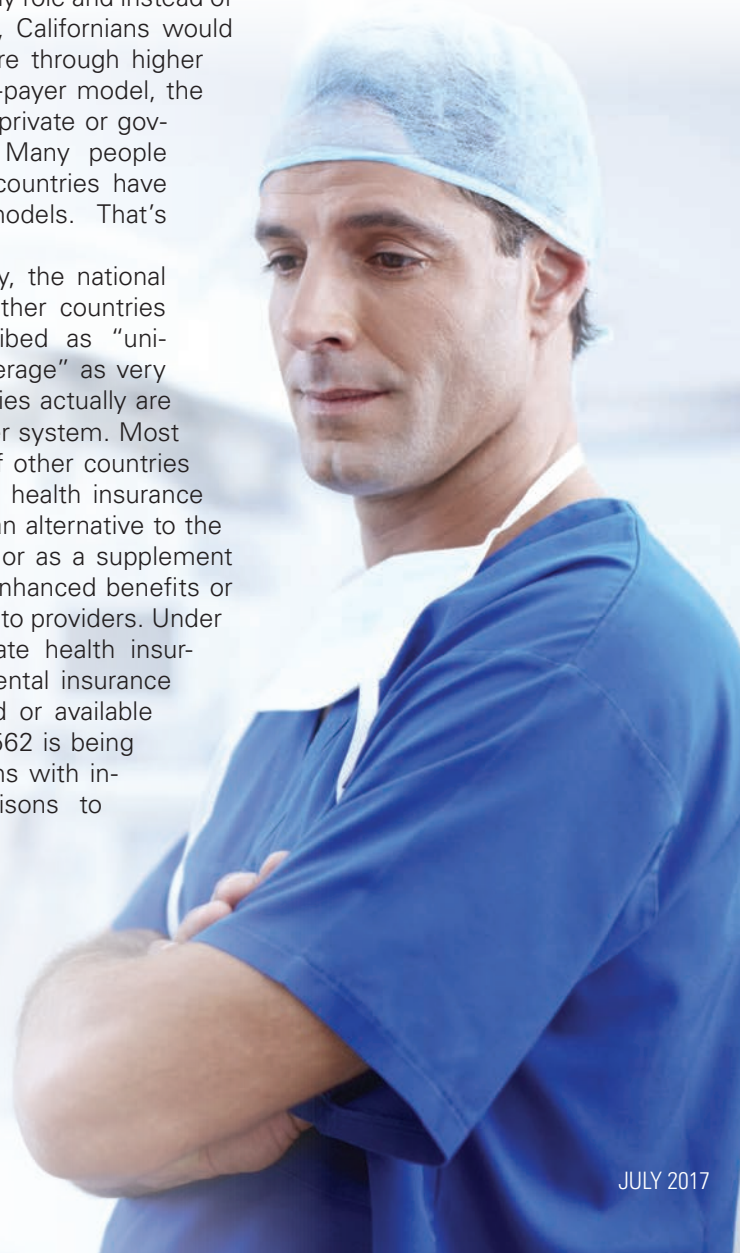
At the center of the debate is a simple but loaded question: Is health care a right or a privilege? Every other developed nation has answered the question and enacted some form of universal health coverage (UHC). Proponents of the bill often make com-

parisons to the Canadian or the UK health systems. These comparisons are inaccurate and are either deliberately misleading or simply uninformed. The term "single-payer" refers to the financial arrangement; this means one entity (the government) collects the funds (usually in the form of taxes) and this "single payer" also pays the providers. The government replaces the insurance company role and instead of paying premiums, Californians would pay for health care through higher taxes. In a single-payer model, the providers can be private or government-owned. Many people say many other countries have "single-payer" models. That's wrong.

More accurately, the national health plans of other countries should be described as "universal health coverage" as very few of the countries actually are a true single-payer system. Most of the systems of other countries also allow private health insurance to be offered as an alternative to the government plan or as a supplement to "buy-up" for enhanced benefits or expedited access to providers. Under SB 562, no private health insurance or supplemental insurance would be allowed or available in California. SB 562 is being sold to Californians with inaccurate comparisons to other systems.

HERE'S A BRIEF SUMMARY OF THE FOUR GENERAL HEALTH CARE MODELS AROUND THE WORLD:

The UK Model – In this mostly single-payer model, healthcare is provided and financed by the government through taxes. Except for small co-pays for prescriptions, there are no co-pays or deductibles as health care is



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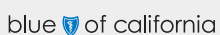


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delivered as a public service, like police and fire. With Britain's National Health Service, most doctors and hospitals are owned by the government and patient wait times can vary by region or treatment type. As the sole payer, the government controls what doctors can

"sickness funds." These private insurers negotiate prices with private hospitals and providers. Patient wait times are shorter than U.S. patients typically experience. This is the system most familiar to Americans and might be a good model to consider when devising

for still being uninsured, and a smaller percentage say they "don't need or want" coverage. If universal health care is truly the goal, it seems more logical to build upon what already works for the vast majority of Californians and figure out how to best close

"...single-payer is almost certain to return as a bill or ballot measure in 2018 or 2020. California brokers must get involved now and help their frustrated and confused clients (and legislators) understand what this means for California's health care, jobs and taxes."



do, and what they can charge. Our Veterans Administration (VA) system is a close example.

The Canadian Model – With this national health insurance model, the providers are private but the payer is a government-run insurance plan everyone pays into. Our Medicare system is a close example of this model. The private insurance plans are non-profit and manage their costs by limiting or delaying care. Canada's decentralized health system (coincidentally called "Medicare") is technically a multi-payer system with slight differences for each of their 10 provinces and three territories; some provinces/territories have co-pays at point of care and others don't.

The German Model – In this multi-payer system, providers and payers are private and largely funded through employer-based payroll deductions. Patients have co-pays at the point of care. The world's first national health system (established around 1883) offers citizens 135 private insurance plans called

our own national system.

The American Model – As noted above, we have a unique combination of the above systems. With the exception of the VA, our hospitals and doctors are private and we have a multi-payer system that includes Medicare, Medi-Cal and private insurance. We also have an out-of-pocket model, which means if you are uninsured you will pay for care on your own. This places us in rare company with some of the poorest countries in the world, like Cambodia and Nigeria, who have not yet established a universal system.

Universal health coverage can be achieved by a combination of private and public plans. The ACA was a UHC model and directly successful in getting almost everyone covered. Today, California has only 7.1 percent uninsured – the lowest rate in our history. California Healthcare Foundation data shows about one-third of California's almost 3 million uninsured are ineligible due to citizenship. Of the rest, most cite affordability as their reason

this gap.

The California budget is already bloated with unfunded commitments to transportation and water infrastructure, high-speed rail and \$1 trillion underfunded public employee pension. This is hardly the best time to attempt a massive overhaul of our healthcare. If the bill dies in the House or by the Governor's veto, single-payer is almost certain to return as a bill or ballot measure in 2018 or 2020. California brokers must get involved now and help their frustrated and confused clients (and legislators) understand what this means for California's health care, jobs and taxes. If you'd like more information and legislative updates, go to the California Association of Health Underwriters website at CAHU.org. ★

Michael Lujan is co-founder at Limelight Health and immediate past-president at CAHU. A licensed agent since 1988, former general agent, carrier executive, and founding director at Covered California, Michael is an outspoken advocate for both the uninsured and the agent distribution system.



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	Bests	Fitch	S&P									
American Equity	A-	A-		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.30%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 18-75 & 2.10%, age 76-80** 1.50% age 81-85**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.45%*	6 yr.	None	9%, 8, 7, 6, 5, 4, 0	Yes	\$10,000 (Q) & \$10,000 (NQ)	3.00%, age 0-75 & 2.10% age 76-80** 1.50% age 81-85**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.60%*	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** 1.50% age 81-85**
*Effective 6/9/17. 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 (*Guarantee Return of Premium) (Q/NQ)	S	2.25%* 2.45%* ^b	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	\$10,000 (Q&N)	1.5% age 0-75 .75% age 76-85
*CA Rates Effective 6/2/17. First year rate includes 1.50% interest bonus. a (less than \$100K) ; b (100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 5 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	1.55%* ^a 2.55%* ^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 6/2/17 Includes 1.15% 1st year bonus, 1.00% base rate subsequent years. a (less than \$100K) b (100K or more)												
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity	S	1.40%* ^a 1.60%* ^b	7 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	\$5,000 (NQ)	3.00% age 0-85 1.50% age 86-90
*(Guarantee return of premium Q/NQ) *CA Rates Effective 6/2/17. First year rate includes 4.0% bonus 1 st year. a (less than \$100K) b (100K or more)												
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	1.95%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	\$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&N)
Effective 6/19/17 Includes .25% first-year bonus and is for purchase payments over \$100,000. Escalating five-year yield is 2.20%. For under \$100,000 first-year rate is 1.90%. Escalating rate five-year yield 2.05%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	1.50%	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&N)
Effective 6/19/17. Includes 1.00% first-year bonus and is for purchase payments over \$100,000. Escalating seven-year yield is 2.39%. For under \$100,000 first-year rate is 1.40%. Escalating rate seven-year yield 2.29%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.50%*	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
1/27/17. Eff. yield is 2.67% based on 1.65% 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 1.65%. Surrender value interest rate 1.65%. Accepts additional purchase payments in first three contract years. COM12255												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5 2.05%* ^b	S	1.90%* ^a	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 6 2.25%* ^b	S	2.10%* ^a	6 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7 2.35%* ^b	S	2.20%* ^a	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 2/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 8	S	2.30%* ^a 2.45%* ^b	8 yr.	None	7%, 7, 6, 5, 4, 0	Yes	\$10,000 (Q/NQ)	
*Rates Effective 12/1/17 (a-for premiums less than \$100K, b-for premiums \$100K or more), and are subject to change												
North American Co. for Life and Health	A+	A+	A+	Guarantee Choice II (Q/NQ)	S	2.25%* ^a 2.50%* ^b	5 yr.	None	10, 10, 9, 9, 8	Yes	\$2,000 (Q) \$10,000 (NQ)	2.00% (0-80) 1.50% (81-85) 1.00% (86-90)
*CA rates effective 6/9/17 - a (less than \$200K) b(200K or more)												
Reliance Standard	A+	A		Eleos-MVA	S	3.55%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	\$10,000	3.25%**
*Effective 12/2/16. 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 12/2/16												
Symetra Life, Inc.	A	A	A	Custom 7 (Q/NQ)	S	2.70%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	\$10,000	Varies
*Effective 5/15/17. 2.20% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for \$250,000 and above.												





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- **KEYNOTE (LUNCH)**
- **PANEL DISCUSSION**

Bob Tretter, NAHU Medicare Liaison
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COBRA isn't Cobra. It's C-O-B-R-A and it isn't G O N E!

By BOBBI KAELIN

I'm not sure about you, but I am tired of all of these changes we've had to implement, comply with or report on during this century. I'd like to go back to the good old days when COBRA was the trickiest acronym in our industry. Simple, plain vanilla COBRA.

"COBRA is still relevant, and if you want to be relevant to your clients you need to understand the basics. Failure to comply with COBRA can result in serious financial consequences."

A few years ago, I was told that our business was going to suffer once the exchanges opened for enrollment because subsidies would eliminate COBRA. I'll admit that I did pause for a moment, wondering or perhaps hoping this was going to be true.

Well, as of 2017 we haven't seen much of a decline in our COBRA enrollment reports. Why? I'll quickly guess that it's because individuals losing coverage due to termination of an employment were the ones who previously elected COBRA, just as they still





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do. In those cases, it's just a matter of time before they are employed again, and receive employer-sponsored benefits. Enrolling through the exchange or qualifying for a subsidy may not be of interest for the short-term coverage they need. But that's an entirely different article in itself.

What does all of the above mean? It means COBRA is still relevant, and if you want to be relevant to your clients you need to understand the basics. Failure to comply with COBRA can result in serious financial consequences.

📎 **Who must offer (Federal) COBRA:** In general, if the employer (or related employers) employed 20 or more employees during the preceding year, and offered a group health plan, the plan is subject to COBRA.

It's important that you count the total number of employees, not the number enrolled in the group health plan, and consider that there may be commonly owned or affiliated employers that will add to the total number of employees.

📎 **What exactly is a group health plan:** A group health plan is (1) a plan, fund, or program (2) established or maintained by an employer (3) for the purpose of providing health/medical care. This can include health insurance, dental and vision plans, Health FSAs, and HRAs. In addition, some wellness plans, employee discount plans, EAPs, and more may be subject to COBRA.

📎 **The DOL General Notice:** When an employee (and dependents/spouse) enrolls in the group health plan, a DOL General Notice (aka Initial Notice) is required to be provided to the covered employee/dependents and the covered spouses. The covered spouse should receive their own Initial Notice, by separate mailing.

Why? This notice provides both the rights and responsibilities of the covered employee(s) and covered spouse (if any) under COBRA. For those of you who think this is optional, think again. This is a requirement. This notice provides language indicating that if a change in status, such as a divorce or birth of a child occurs, the employee and/or qualified beneficiaries have a responsibility to notify you of this

change within a specified period of time. You don't want to have an employee divorce, yet keep the spouse on the health insurance because it's perhaps less expensive than COBRA. In fact, if the carrier becomes aware that the covered individual is no longer a spouse, they can refuse to pay claims during the time they were not eligible to be on the health plan. If you've failed to provide a General Notice, the burden could potentially fall on the plan sponsor to pay those claims. If the notice has been provided, however, the responsibility is that of the employee and/or spouse.

📎 **The Qualifying Event Letter:** When a qualifying event occurs that triggers the loss of coverage under the plan, the QE letter should be mailed out as quickly as possible. Sending it early allows you to start the 60-day COBRA election period countdown. A separate QE letter to the spouse that is losing coverage should be mailed as well. Currently, the recommended process is to send the letter to the home address on file via first class mail.

TIMELINES:

📎 **DOL General Notice** – Send within a reasonable amount of time, but the sooner the better. Within 60 days should be fine.

📎 **QE Letter** – If COBRA is administered by the plan sponsor, the QE letter should be sent out as quickly as possible, but no later than 44 days after the date of the loss of coverage. If COBRA is administered by a third party, the employer should notify the sponsor within 30 days, and the third party has 14 days in which to send the letter(s).

📎 **COBRA Election Period** – The Qualified Beneficiary(ies) have 60 days from the date coverage was lost, or the QE letter was mailed (whichever is later), in which to elect COBRA continuation.

📎 **COBRA Premium Due** – The total amount for coverage to date for the COBRA premium is due within 45 days of the election period, and thereafter the premiums are generally due the first of the month subject to a 30-day grace period.

📎 **Triggering Events & Timeframes**

Under COBRA – If one of the events below occurs, which results in a loss of coverage, the event is considered a Qualifying Event. If a loss in coverage occurs for a reason other than one of the events below, it is not a COBRA Qualifying Event. Depending upon the event that causes the loss of coverage, a maximum coverage period applies. The QEs and maximum coverage periods are:

- 18 Months – Termination of employment (voluntary or involuntary)
- 18 Months – Reduction of hours of the covered employee
- 36 Months – Divorce or legal separation
- 36 Months – Death of the covered employee
- 36 Months – Dependent child ceases to be a dependent under the plan
- 36 Months – Covered employee becomes entitled to benefits under Medicare

Other: For Retirees and their families, there are special rules if an employer's bankruptcy causes a loss of coverage under the Retiree Health Benefits.

Note that the maximum general coverage period is 18 or 36 months. However, there are certain rules that allow for an extension under Federal COBRA.

But, rather than go into those details, it's important to know that in California we have CalCOBRA. CalCOBRA basically allows for a total maximum of COBRA continuation for a period of up to 36 months. This would allow the individual who lost coverage due to a termination of employment to fully utilize 18 months of Federal COBRA, and continue coverage for an additional 18 months under CalCOBRA.

So, there you go, COBRA isn't gone, and it isn't Cobra. ★



Bobbi Kaelin, CHRS, is with PayPro Administrators. Bobbi is President Elect, Los Angeles Association of Health Underwriters and treasurer, EBPA – Los Angeles. Please visit pagroup.us for more information.



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EVOLVING EMPLOYEE ASSISTANCE PROGRAMS FOR A YOUNG WORKFORCE

Going beyond standard EAPs to offer pet insurance and much more...

by DAN POTTERTON

Every year employees seem to have unique new requests for their employers, from standing desks to nap pods at work. What's next – pet insurance? Actually, yes.

Employee Assistance Programs (EAPs) have been around in different capacities since the early-to-mid-1900s and originally tackled occupational alcoholism. EAPs now give employees access to short-term counseling and referral services to keep workplace populations happy, productive and successful.

Modern workplaces, however, have changed and evolved dramatically

since EAPs first emerged, and employee insurance plans now often fail to cover the full range of employees' needs in a way that meets their preferences. Familiarity with the resources offered by more robust, independent EAPs will help brokers connect employers to providers and keep businesses ahead of the pack, support employees with the best services available and deliver benefits in an appealing, convenient way

AN EVOLVING WORKFORCE

The rise of robust EAPs is due in part

to the presence of younger employees in the workplace. Millennials are hitting their stride and bringing a new energy and approach to work, affecting everything from workspace preferences to communication style. Combined with older employee populations, this multi-generational workforce is changing not only the way employees approach their work, but also the way employers approach insurance and benefit offerings.

With a younger workforce also come changes to EAPs. Baseline counseling services offered by employers' health insurance carriers are no longer

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enough. Today's employees are open about asking for assistance and interested in services that will help them achieve their desired work-life balance in ways they find palatable. An independent EAP familiar with the latest trends answers this need by providing childcare, housing search help and even student loan coaching through mobile technology and on-demand delivery. Brokers, too, need to be aware of evolving EAP services and workplace preferences to help companies recruit and retain dedicated, productive young employees.

NEW WAYS TO COUNSEL

EAPs have traditionally offered counseling models that use short-term telephonic assistance or face-to-face sessions to address employees' behavioral needs. With changes in technology and shifting delivery preferences, a top-of-the-line EAP provider will display service solutions that address individual requirements. Want to access services online or provide peer support after a workplace incident? A receptive EAP offers customizable, confidential resources that best meet a customer's needs.

EYE-CATCHING SERVICES

For younger workers, multifaceted programs that appeal to a variety of needs reign supreme. In fact, included in modern, stand-alone EAPs are a wide range of service areas that are more attractive to incoming workers than what is typically offered through employer health insurance plans.

WORK-LIFE BALANCE

More and more, young employees are looking to their employers to help balance their jobs with personal lives and recreation, and employers are looking to brokers to provide an EAP that fits the bill.

Recognizing emerging work-life trends such as child and eldercare services, aid with housing searches in trendy neighborhoods, and pet insurance – a relatively new but massively popular fringe benefit offered by thousands of employers – can give brokers the advantage, especially as Millennials and others continue to struggle with student loans, health care access and civil liberties.

HEALTH AND WELLNESS

Whether it's a walking meeting or lunch break spin class, the younger workforce is always on the go. EAPs with an active finger on the workplace pulse can go further than a standard, insurance-provided EAP in offering services like wellness coaching, on-site health screenings and online health guides that help employees live a more active, health-conscious lifestyle. Delivered through a mobile app? Even better.

Wellness isn't just physical, either. Millennials are, as a whole, more likely to pursue counseling for mental health issues, workplace stress or relationship challenges, leading to an increased use of EAP-provided counseling. Yet, while stigma surrounding mental health or gender issues continues to subside, shifts away from face-to-face counseling emphasize a need to ensure EAP providers offer easily obtainable information resources online.

FINANCIAL ASSISTANCE

College graduates continue entering the workforce with increasing amounts of debt, yet lack the same amount of financial education as those who came before them. EAPs that offer financial planning and consulting services are vital to fostering a dedicated, well-informed workforce for all stages of life.

Current trends show EAPs offering financial services such as budget management, student loan coaching, credit report review and tax-related education—all vital services for a generation that could use a little extra help navigating the world of loan repayments and 401(k)s.

THE INTERNET OF THINGS

Because social media is more ingrained in our lives than ever before, EAPs with a strong digital presence and internet-savviness appeal to a culture of Snaps, likes and shares. Platforms like Facebook even give users the ability to connect directly to providers and relevant information through videos, messaging and "call now" options. Brokers would do well to pay special attention to EAPs that are integrating app and SMS functions into service delivery, as well as those that prioritize positive affirmation in their messaging and communications.

GOOD FOR THE WORKER, GOOD FOR THE BOSS

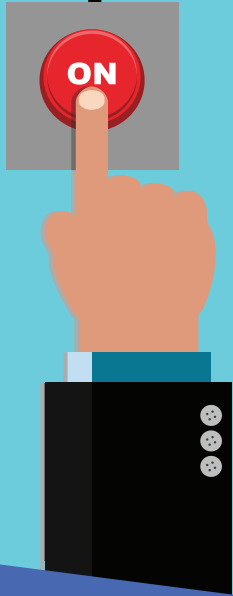
Employers are constantly looking for ways to recruit top candidates and retain them for extended periods of time—not always easy in today's high-turnover culture. Brokers who offer extensive EAP services with many of the customizable options previously described can help employers find invaluable resources guaranteed to attract new employees (and keep them in-house). An up-to-date EAP benefits the workplace by reducing absenteeism and presenteeism while increasing retention.

NEVER STOP EVOLVING

The Millennial workforce—and very soon, Generation Z—is causing major changes in the world of insurance offerings and EAPs, with more changes still to come as successive generations join the working world and tech innovations advance. It's crucial brokers keep up with EAP and other benefit trends, offering employers the resources they need to stay competitive and recruit the best of the best in a changing marketplace. Young employees are interested in services that will give them the greatest support for both mind and body in ways they're comfortable with, and brokers with a strong EAP product stand the best chance of offering current and future generations the benefits they desire most. ★



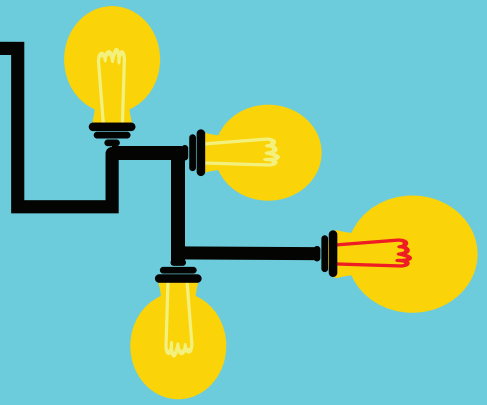
Dan Potterton, COO, has oversight for all customer facing functions of FEI Behavioral Health. He has more than 25 years' experience in the industry. Prior to this he worked as an independent healthcare business consultant to complex health care systems and venture capital firms. Prior to that he was executive vice president with CareAdvantage. Dan also served as president of Cigna Behavioral Health, and before that he served in a number of senior management positions at Value Behavioral Health (VBH) and Preferred Health Care (PHC). He was also the executive vice president for new business technology strategy for VBH and the founding chief operating officer for the behavioral healthcare division of Empire Blue Cross and Blue Shield under contract with PHC. Visit www.feinet.com for additional information.



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“The conference has been awesome! I've been to many conferences that claim to understand the power of networking, but here it's an established culture!”

Dustin Yudowitch, Director of Client and Participant Services, Creo Wellness

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1. Be a thought-leader.

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3. Develop a large database and connect with them.

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OPEN WIDE: OUR ANNUAL DENTAL PLAN CHECK-UP

2017 DENTAL SURVEY

Welcome to *California Broker's* 2017 dental plan survey. We asked insurers crucial questions about their plans so you can make educated decisions about which plans to provide for your clients.

1. What types of plans do you offer?

Delta Dental: Managed fee-for-service, PPO, and DHMO group dental plans; individual DHMO dental plans and group HMO vision plans. We also offer ACA-compliant small group and individual dental benefits in 38 state and federally administered exchanges including the District of Columbia. In 2017, we are covering over 226,000 lives in these exchanges as a stand-alone dental plan, and just over 470,000 enrollees as the dental partner for about 15 health plans around the country. This required us to design pediatric and family dental plans based on different sets of rules for the federal and state exchanges, for stand-alone versus bundled scenarios, and for differing market conditions.

Dental Health Services: Dental Health Services offers high-quality, affordable prepaid (DHMO) dental benefit solutions for large and small employer groups and individuals. Other plans are also available, including PPO, EPO, indemnity (reimbursement) products for groups of all sizes, and ASO services for self-funded groups.

Humana: In California, PPO, prepaid/DHMO, traditional preferred, and preventive plus plans. These plans are available on a voluntary or employer-sponsored basis.

Liberty Dental: PPO, DHMO, Individual DHMO, Individual and SHOP DHMO Exchange plans

LifeMap: PPO and DHMO

National General Accident & Health: We offer fixed indemnity dental plans. These plans provide a set cash reimbursement to the member for specific services rendered. An optional additional benefit is a dental/vision savings card to take those insurance dollars even further and get member pricing from retail to wholesale rates within the participating providers.

Premier Access Insurance Company: Premier offers an array of plan options to meet the needs of employers and their employees. Dental PPO, prepaid/DHMO, and indemnity plans are available on a voluntary or employer-sponsored basis. Dual and triple choice, monthly switch (between a DHMO and PPO), and administrative services only plans are also available. We specialize in customized plans for all different-sized groups based on the needs and price points of the employers and employees.

United Concordia: United Concordia offers flexible fully insured preferred provider organizations (PPOs), EPO, POS and dental health maintenance organizations (DHMOs) plans. ASO funding arrangements are available based on client size. Most plans are offered on an employer-sponsored or voluntary basis.



Dental Health Services: Dental Health Services works with its group clients on customizing dental benefit solutions that meet their needs. All individual plans offer the same high-quality benefits and services at competitive rates.

Humana: We offer flexible plan designs with a range of deductibles, co-payments, and out-of-pocket expense limits to meet the needs of small to large groups. We also offer large groups the additional flexibility to customize plan options. All our dental plans provide employees with incentives for preventive dental care, which promotes their overall health. Customers who see dentists participating in our dental PPO network receive deep discounts. Humana does not offer individual dental plans in California.

Liberty Dental: Individual products are limited to exchange and limited DHMO plans. All standard plans are available to both small or large groups markets. Pricing varies for large group which is experience rated versus small group rating done through a pool.

LifeMap: Benefit designs differ; we offer richer plans to larger groups than small group and individual.

Premier Access Insurance Company: We offer the same plan options to small group employers as to large employers.

National General Accident & Health: The rates for the dental indemnity product are comparable if not slightly lower than a traditional plan offered through a group chassis. The 'cash dental' plan- as ours is -also takes a less traditional approach but the net effect of the benefits tends to work out the same. Plans range in cost from \$15.50 to \$145.10 per month.

United Concordia: While larger clients have more flexibility in customizing benefit options than smaller clients, United Concordia offers an array of standard client products and options that provide small businesses with cost-effective, quality choices. To keep the small business client premiums comparable to those found in larger clients, slightly higher deductibles, lower coinsurance percentages and lower maximums are more commonplace within this market segment.

Western Dental: Our individual and small group rates are marginally higher for standard benefit plans. Customized benefits plans are available for large groups. However, our underwriting guidelines can be adjusted on a case by case basis to ensure that plans and rates are competitive.

Western Dental: Western Dental offers traditional DHMO plans that range from little to no copay plans to higher copay plans at a minimal monthly premium. We have a unique mixed-model provider panel comprised of (a) contracted independent, general dentist and specialists, along with (b) Western Dental employee dentist and specialists, who work in the company-owned Western Dental Centers. Western Dental currently operates general dentistry and orthodontic offices throughout CA, AZ, NV & TX.

2. How do plans you offer for the individual and/or small group compare in rates and benefits to the large-group plans?

Delta Dental: While benefits offered to smaller groups are comparable to those offered to larger groups, larger groups have more options in terms of plan designs. Rates can be slightly higher for smaller clients and individuals, but Delta Dental strives to be competitive while balancing our financial risk. With individual DHMO plan benefits, we offer three different plan options — two for individuals and families and one customized for seniors. The individual and family plans offer a wide range of covered services. The senior plan is designed to offer services most utilized by this particular population.

3. What have been the most recent changes in your plan(s)?

Delta Dental: Delta Dental enrollees benefit from cost estimating tools now available to them:

- Delta Dental's Cost Estimator tool has replaced our old Fee Finder tool. The goal of Cost Estimator is to provide more transparency about an enrollee's out-of-pocket costs, and to encourage PPO network utilization by comparing costs for PPO and Premier providers.
- Cost Estimator (enterprise developed) - Delta Dental offers an advanced version of the cost estimator tool that:
 - Provides personalized estimate (based on a 5-digit ZIP code) for an entire dental visit, not just a single procedure
 - Calculates enrollee's share based on current benefits (i.e., eligibility, deductibles, maximums), offering most accurate out-of-pocket cost estimate
 - Is visit-based, not procedure-based; most common procedures grouped into typical visits; provides a link to the standard version, which lists more options

This feature is available to at no additional cost to all fully insured groups as well as self-funded clients who elect to go paperless. All other self-funded clients can receive this feature at an added cost.

Dental Health Services: Dental Health Services now offers dental implants as a covered benefit. Specialized crowns and upgrades are also now available. The company also covers all the most recent ADA Code changes to keep the plans current to offer extensive coverage on each of its plans.

Humana: Humana is the only dental PPO plan in the market to offer a plan with an unlimited annual maximum. For the first time, employers can provide a true dental insurance plan for their employees. Plans in our new generation of products are available as voluntary plans, and to groups with as few as two employees.

All our plans offer an extended maximum benefit where members receive 30 percent coinsurance on services rendered after they reach their annual maximum (implants and orthodontia excluded). It's important to note that because benefits never reach a maximum, network providers must continue to honor the network discounts, which are among the deepest in the market. This results in members paying as little as 30 percent of retail, depending upon the area of the state where they reside.

In addition, we offer open enrollment assistance, orthodontia benefits, and no waiting periods for major services for voluntary groups with 10 or more enrolled. Additional deductible choices, implant coverage, and acrylic filling coverage are also offered. Due to the connection between oral health and overall health, we have added – at no additional cost – oral cancer screenings to all of our products, excluding DHMO/prepaid plans, as well as four periodontal cleanings per year in addition to the two regular cleanings.

Liberty Dental: Liberty has updated all plans to be CDT 2017 compliant

LifeMap: Additional flexibility

National General Accident & Health: Based on valued feedback, we have provided an option to add on a \$3 Net-

work Savings Card at point of sale. This enhancement creates the ability for a member to maximize savings by using a PPO dentist, in addition, includes access to vision benefits.

Premier Access Insurance Company: We've introduced enhanced PPO plan designs that offer brokers and employers more flexibility and control over the plan design and opportunities for savings using our unique tiered network combined with our tiered benefit design. Members also have the option to enroll in a monthly election plan allowing them to switch between DHMO and PPO.

United Concordia: In 2016 we moved space maintainers from Class II to Class I due to industry trends. We also refiled our implant rider to include repair codes and cone beams going forward. Additionally, in 2016 we launched both our Concordia EPO and Triple Access POS products in California.

Western Dental: Our Series 7 plans increases the number of covered procedures to include the availability of cosmetic alternatives and more orthodontic options for children and adults. Our dental benefit designs are an effective way to reduce the rapidly increasing cost of dental benefits while improving access to quality of care. Our approach to dental benefit design delivers affordable dental plans that can meet your client needs and their budget. Additional significant benefits and advantages selecting Western Dental Office are:

- Flexibility in allowing members to visit any Western Dental Center without the worry of being appointed to a provider
- Electronic Health Records (EHR)
- Digital Intra-Oral Cameras
- Self Service Kiosk
- Centralized Electronic Appointment System
- 3M Digital CAD CAM machines for advanced digital impressions
- iPads for customer surveys following a customer visit

4. Can an insured use their own dentist even if they are not on your participation list?

Delta Dental: Delta Dental Premier enrollees can visit any licensed dentist for care, although there are advantages to visiting one of more than 50,000 dentist locations for Delta Dental Premier dentists in California. Enrollees can go to any dentist, but they are only guaranteed to get in-network benefits and avoid balance billing when visiting a Delta Dental dentist. Delta Dental PPO enrollees also have freedom of choice, but can benefit from the protections associated with selecting one of more than 41,000 dentist locations for Delta Dental PPO dentists in California. PPO enrollees have access to Delta Dental PPO and Premier dentist networks with different levels of savings. DHMO enrollees must use a participating general dentist or approved specialist, except for emergency care. There are more than 6,000 dentist facilities for DeltaCare USA in California.

Dental Health Services: Members of the Dental Health Services' prepaid (DHMO) and EPO plans choose their den-

tist from the company's exclusive Quality Assured network. Participating dentists on all prepaid (DHMO) plan networks are subjected to credentialing, background checks and a 107-point quality checklist. They are also regularly monitored by the company's Professional Services staff, and plan benefits are only available at these Quality Assured dentists. The company's PPO and reimbursement plans allow members to receive treatment from any dentist.

Humana: PPO members can visit the dentists of their choice. Out-of-pocket savings are greater when members visit participating network dentists. DHMO members must select a participating dentist.

Liberty Dental: Dependent on the type of plan, such as a PPO, a member may seek services by a non-participating dentist but may also incur additional costs. For all DHMO plans, there is no coverage for out-of-network services, with the exception of limited dental emergency services. However, Liberty is always open to member nominations and is constantly developing and growing our network.

LifeMap: Yes

National General Accident & Health: Yes. Since this is a fixed indemnity dental plan, there are no networks. However, to maximize savings during a wait period, a member might consider using an in-network provider if they selected our Network Savings Card. This provides an average savings of 43 percent on dental care — on top of the cash benefits from our plan.

Premier Access Insurance Company: Members covered under our PPO plans can visit any dentist; however, benefits may be paid at a lower coinsurance rate for non-participating dentists. DHMO members must choose a participating primary care dentist.

United Concordia: In most cases, yes. If a member has one of our PPO products, they may utilize any licensed provider. If a member is utilizing our Concordia EPO or DHMO products, they would not receive benefits for seeking treatment from an out of network provider.

Western Dental: Through the DHMO plans, the member must use a dentist who participates in our network in order to have coverage. A member can nominate a dental office by contacting our Provider Relations Department at 1-800-511-8111.

5. How many provider locations do you have?

Delta Dental: Our networks offer access to more than 50,000 dentist locations for Delta Dental Premier, more than 41,000 dentist locations for Delta Dental PPO and more than 6,000 dentist facilities for DeltaCare USA in California.

Dental Health Services: Dental Health Services' exclusive quality assured dental network consists of 950 general

practice offices with 4,500 participating dentists and an additional 2,000 specialists.

Humana: Nationally, Humana has more than 290,000 dental PPO provider locations. In California, we have approximately 30,000 dental PPO provider locations and more than 18,000 DHMO provider locations.

Liberty Dental: DHMO Select (Office Assignment required)– 1,497; DHMO Choice (No assignment required, members must seek care at a DHMO Choice contracted provider office) - 2,003; PPO Nationwide



LifeMap: The best way we can answer is to give unique provider count: 13,000

National General Accident & Health: We are a hybrid of sorts due to the platform of fixed indemnity and optional access to our Careington Maximum Care Dental Network — a national network of more than 200,000 dental practices.

Premier Access Insurance Company: Our PPO networks offer access to more than 56,000 dentist locations nationwide, with more than 12,000 in California. Our DHMO network in California has more than 3,300 dentist locations including specialists.

United Concordia: To support our diverse product portfolio consisting of fee-for-service, DHMOs and PPOs, we maintain some of the largest dentist networks in the nation. Our largest network provides access to 98,523 dentists at more than 343,842 access points. In California alone, we have 15,135 providers at 44,233 access points. Our DHMO network includes more than 2,396 primary dental offices and almost 1,667 specialists nationwide, with over 1,566 primary dental offices and 825 specialists in California. (All data is as of 12/31/16. Pulled from the *(Continued on Page 26)*)

*You might say we have a one-track mind.
We prefer to think of it as...*

LASER-FOCUSED

At Premier Access Insurance Company, we're driven by one thing: people. Over 25 years ago, our company was started by a practicing dentist who wanted to offer better care and benefits to his patients. As the company has grown to serve more than a million members, we've maintained our focus by building a team of great people who are dedicated to providing value to our customers.

What are the secrets of our success? We make our clients' and members' satisfaction our highest priority. We listen to our customers so we can learn what's important to them. We seek the latest technology that allows us to reduce costs and offer better service. And we partner with other like-minded professionals so we can take advantage of industry expertise and achieve market leading network discounts.

PREMIER ACCESS AND AVĒSIS: A COMMON BOND.

In 2014, the Guardian Life Insurance Company of America® (Guardian) purchased Premier Access and immediately saw the value in keeping Premier as its own brand. Guardian, a Fortune 250 company founded more than 150 years ago, is one of the largest dental benefits providers in the country, yet it remains focused on its time-honored values of putting people first and maintaining high standards and ethics. We're proud to share these qualities with our parent company.

As a regional provider, Premier's entrepreneurial culture allows our people to seek innovative solutions for faster response time and more personalized service. At the same time, Guardian's strength and reach in the marketplace offer Premier Access opportunities that might not be readily available to an independent insurance company. When Guardian purchased Avēsis in

2015, they recognized an ideal synergy with Premier Access.

Everyone needs dental care, but because of its cost, those without insurance coverage often don't get regular checkups. A lack of oral care can cause other health problems, which may impact a company's bottom line. Our vision is just as important; regular eye care is essential for those who spend extensive time in front of screens or outdoors.

It's no surprise that Premier Access and Avēsis found a common bond in providing market-leading benefits that help improve the lives of millions of Americans. Avēsis, a leading industry veteran with over 9.5 million members* and 9 regional offices across the country, has provided high-quality dental and vision programs for nearly 40 years. Premier's alignment with Avēsis allows us to offer a more diverse portfolio of benefits with greater value than ever before.

BENEFITS THAT BENEFIT YOUR BUSINESS.

Let's face it: the world of benefits continues to become more complicated and confusing for employers. As a broker, you do much more than simply offer quotes; you demystify the options, stay current with the latest regulations, and help your customers choose the packages that are the best fit. Your clients depend on you for timely answers and expertise, so it makes sense for you to choose benefits providers that afford the same quality service.

Employers recognize that ancillary benefits can make the difference between retaining good talent and exceptional talent. But these valuable perks can increase costs when purchased separately—and who has the time to juggle different phone numbers for questions about their dental and vision plans?

Together, Premier Access and Avēsis offer your clients greater value because of our laser focus on providing excellent benefits and customer service. We've used our collective knowledge of the industry to create The Essentials, a dental and vision benefits bundle that helps meet the needs of the modern marketplace.

We offer The Essentials at discounted rates with just one direct account contact who can quickly answer your questions and address your concerns. This allows us to be more responsive and flexible in our customer service. But most importantly, it gives you more freedom to grow and manage your own business as a broker—while keeping your clients' valuable employees happy, too.

You have a business to run. Let Premier Access and Avēsis make The Essential benefits easy for you and your clients.

THIS IS JUST THE BEGINNING.

We're excited about being on the leading edge of ancillary benefits, and we're eager to see what the future will bring. Our relationship continues to allow us to find new efficiencies and develop innovative offerings that serve the needs of our client companies and members. We recognize that the best ideas come from the people we serve, so we'll continue to listen and learn what's important to them.

Whether we're serving the State's largest employer or helping a small business owner navigate the world of dental and vision benefits, Premier Access and Avēsis are dedicated to helping working Americans get the most value for their hard-earned money.

Are you in the business of people, too? Add Premier Access and Avēsis to your portfolio and discover the difference a common bond makes.

*2017 membership count
#2017-42254.

Come to Our *Senses*

Oral and ocular health are not merely fringe benefits; they're essential to our quality of life. That's why dental and vision plans are valued by employees—and why businesses who want to attract and retain the best bundle these benefits.

Premier Access dental, now with Avēsis vision, takes a bite out of time and money, with one point of contact, one ID card, one invoice, and a discount for bundling. Contact one our many regional sales executives by phone at 888-326-3210 or by email at Sales@Premierlife.com, and come to our senses.



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(Continued from Page 23)

Network Summation reports on the Reporting SharePoint site. Utilized the Advantage Plus 2.0, Concordia Plus PDO and Concordia Plus Specialist reports.)

Western Dental: We have over 4000 provider access points across the state of CA alone. This being a combination of both IPA and Western Dental locations.



6. What percentage of your network is closed to new enrollment? How many offices does this represent?

Delta Dental: 0 percent. Under the PPO/Premier plans, enrollees are free to see any licensed dentist. Contracted dentists can close their practices to new patients but cannot close their practice exclusively to new Delta Dental patients; 2.96 percent of DHMO dental facilities are closed to new enrollment.

Dental Health Services: Although roughly 5 percent of participating dentists have been lost over the past 12 months, our overall network size has increased by 5 percent over the previous year. By focusing on seeking out only the most qualified dentists, the company improves accessibility and availability for members. The names and phone numbers of all offices are available upon request.

Humana: Under Humana’s dental provider contract, participating dentists must schedule and treat members without discrimination, including benefit or payer differentials. Because this is a fee-for-service reimbursement program, closed practices are not common. Approximately 97 percent of practices are open to new patients.

Liberty Dental: DHMO 4.74 percent for a total of 71 offices.

LifeMap: None

National General Accident & Health: None – the core plan is ‘go anywhere’. If the dental/vision savings card is selected, those providers are all available to new participants.

Premier Access Insurance Company: Less than 5 percent of the DHMO network is closed to new patients; this figure represents 159 general dentist locations.

United Concordia: Less than 1 percent, or 2,355 offices of our largest wholly owned network is closed to new enrollment. (Data pulled from the Table 898, Monthly Full Files as of 12/31/16.)

Western Dental: Turnover is about 3 percent for the past year. Yes, we will provide the names and phone numbers for 3 of these offices, if requested.

7. What is the time frame for processing a referral in terms of member notification and payment to the specialist?

Delta Dental: For PPO and Premier patients, specialty care referrals are not required, and payments to specialists are processed the same as for general dentists. For DHMO enrollees, our standard turnaround time for processing specialty care preauthorization requests is five business days.

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

Humana: Humana’s dental plans do not require a referral from a general dentist to a specialist. The member gets a higher benefit when seeing a participating dentist and specialist. In 2016, 98.3 percent of clean claims were processed within 10 business days (14 calendar days).

Liberty Dental: Plans requiring specialty referral are typically processed within 14 calendar days of receipt, unless it is flagged as urgent. Payment to the specialist is processed the same as general dentist payment, typically within 30 days of receipt of the claim.

LifeMap: No referrals needed.

National General Accident & Health: This kind of transaction would be handled in the member services area in the same manner as regular treatment. So, as long as the services are deemed necessary and covered, benefits would be available as per the contract.

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

United Concordia: All referrals are immediately effective. The member is instructed to provide the referral to the specialist at the time of service and the specialist files the re-

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ferral with the claim. All claims, including specialist claims, mailed to United Concordia are usually finalized within 14 to 30 calendar days of receipt of the paper claim. Claims filed electronically may be finalized in a shorter time frame compared to paper claims. Please also submit the referring provider information with the electronic claim. Payment for both paper claims and electronic claims is made during the weekly check writer cycle which occurs on Thursdays.

Western Dental: Dental Offices have the capabilities of emailing and emergency referrals which is handled within 24-hours. The standard turnaround time for non-emergency referral is three business days or less. Specialists can expect payment in 10 business days for clean claims.

8. How do you handle early termination of coverage when a member is still in the middle of orthodontic treatment?

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

Dental Health Services: [answer not provided.]

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

LifeMap: Coverage ends.

Liberty Dental: Payment for orthodontic treatment is prorated and paid on a monthly basis, should a member lose his/her coverage in the middle of treatment, future payments would cease and the member or the new carrier would be responsible for the remaining months of treatment.

National General Accident & Health: Not applicable to our coverage, as our plan does not provide such benefits.

Premier Access Insurance Company: If a member is undergoing orthodontic treatment and his or her Premier coverage terminates, we pro-rate the benefit to cover only the time period during which coverage was in force. We do not extend benefits. Our DHMO agreement provides for the contracted orthodontist to complete treatment at the contracted patient charge on a number of our plans.

United Concordia: The extension of orthodontic coverage for DHMO and PPO plans is 60 days if payments are being made monthly. However, if payments are being made on a quarterly basis, coverage will be extended to the end of the quarter in progress or 60 days, whichever is later.

Western Dental: Western Dental has a continuation fee which allows our members to continue their orthodontic care with the treating orthodontic office. The continuation fee is based on the completed months of treatment.

9. Does your plan have annual and lifetime maximums on dental coverage? If so, what are they?

Delta Dental: Annual maximums for our Premier and PPO plans vary and, for group plans, are determined by the group purchaser; lifetime maximums apply only to certain procedures such as orthodontia (if covered by the plan). Under our DeltaCare USA DHMO, there are no annual plan maximums; lifetime maximum applies to orthodontia.

Dental Health Services: On prepaid (DHMO) plans there is no annual maximum. The company’s PPO/EPO plans feature annual maximums and lifetime orthodontic coverage.

Humana: We offer flexible plan designs with a range of annual maximums to meet the needs of small to large groups. We do not have lifetime maximums. We are the only dental plan in the market to offer an unlimited annual maximum.

Liberty Dental: PPO plans do include annual maximums that can vary by plan, lifetime maximums apply to orthodontic services. We do not impose any lifetime or annual maximums on our DHMO or individual plans.

LifeMap: Only annual. The maximum amount varies.

National General Accident & Health: Yes. The Basic Plan has a \$500 maximum calendar year benefit; Intermediate is \$1,000; and the Plus plan is \$1,500. However, preventive benefits do not take away from this annual benefit (adding \$150-200/annually in benefit, depending on plan level). Members can use their savings card on covered and non-covered services at any and all times of the coverage being in force.

Premier Access Insurance Company: Premier offers plan design flexibility allowing brokers and employers to custom design their dental benefits including unlimited annual or lifetime benefits. The most common annual benefit maximums are \$1,000, \$1,500, and \$2,000.

United Concordia: All United Concordia PPO/EPO/POS Plans contain an annual max; several standard options exist for groups to select from: \$500, \$750, \$1,000, \$1,250, \$1,500, \$1,750, \$2,000, \$2,500, and \$5,000. Orthodontic services are excluded from the annual maximum, but have a separate lifetime maximum. The standard amounts are: \$1,000, \$1,250, \$1,500, and \$2,000. Please note, fully credible, experience rated business does have the option of selecting non-standard amounts. DHMO plans do not contain an annual maximum standardly.

Western Dental: There are no lifetime or annual maximums on the DHMO plans. Members have a listed copayment based on the services received.

10. Does your plan have a deductible. If so, what is it?

Delta Dental: Deductibles for our Premier and PPO plans vary and, for group plans, are determined by the group purchaser.



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chaser. Deductibles do not apply under our DeltaCare USA DHMO plans.

Dental Health Services: Prepaid (DHMO) plans have no deductibles. The company's PPO/EPO plans have deductibles.

Humana: We offer flexible plan designs with a range of deductibles to meet the needs of small to large groups. The deductible is always waived for preventive care. We want to ensure there are no barriers to members receiving the necessary preventive care.



Liberty Dental: PPO plans may include a deductible per individual with a maximum of three per family on a calendar or plan year. DHMO and individual plan offerings do not impose any deductibles.

LifeMap: Yes, varies by plan. Ranging from \$0 to \$50 is standard.

National General Accident & Health: There are no deductibles.

Premier Access Insurance Company: Brokers and employers can custom design their dental benefits including plans with no deductible; the most common are \$25 and \$50.

United Concordia: The majority of our PPO/EPO/POS products do contain a deductible standardly, however \$0 is a standard option. Additional standard options include (individual/family): \$25/\$75, \$50/\$150, \$75/\$225, and \$100/\$300. Please note, DHMO products do not have a deductible.

Western Dental: As a DHMO, Western Dental does not have deductibles.

11. What percentage of preventive care costs does your plan cover?

Delta Dental: Percentages vary according to the plan.

Dental Health Services: Dental Health Services values preventive services. Most of the company's plans feature no cost for preventive services.

Humana: Preventive care is always covered at 100 percent, unless a large group designs a custom plan. We encourage all employers to cover preventive to ensure there are no barriers to members receiving the necessary preventive care.

Liberty Dental: Preventive is covered at 100 percent for most plans, however plans may vary.

LifeMap: We offer several plan designs, but usually cover preventive at 100 percent.

National General Accident & Health: The member is reimbursed a select amount toward their preventive visit based on benefit level plan selected. For example, our 'Plus' plan offers \$100 cash reimbursement toward preventive services.

Premier Access Insurance Company: Brokers and employers can set this coverage from 0 percent to 100 percent; the most common is 100 percent.

United Concordia: The vast majority of all UCD products cover preventive services at 100 percent. The exception to this would be a couple of products created to hit a low cost price point.

Western Dental Plan designs provide 100 percent on preventative care.

12. What percentage of root canal costs does your plan cover?

Delta Dental: Percentages vary according to the plan.

Dental Health Services: Dental Health Services offers many variations to plan designs and varies the cost sharing for members on procedures. The company offers plans with very low cost sharing on root canals.

Humana: We offer flexible plan designs with a range of co-insurance percentages to meet the needs of small to large groups. A group can elect to have endodontic coverage in basic or major.

Liberty Dental: We have a wide array of plan designs and member cost sharing can vary to allow employers to select an option that fits best with their needs and capacity. Our DHMO and individual plans include set member copayments ranging from a \$0 copayment to a \$530 copayment depending on the type of root canal and difficulty level (i.e. specialty required). For PPO plans root canal, therapy is typically considered a type 2 (basic) procedure but can also be considered a Type 3 (major) service. Basic services on our PPO plans are most commonly covered at 80 percent and major services are typically covered at 50 percent.

LifeMap: We offer several plan designs, we usually cover root canals at 80 percent.

National General Accident & Health: According to our cost and transparency calendar, a molar root canal – for example – may cost \$1,382. The plan cost is \$707 with a network savings of \$675 or a percentage savings of almost 50 percent.

Premier Access Insurance Company: Brokers and employers can set this coverage from 0 percent to 100 percent. The most common is either 50 percent or 80 percent.

United Concordia: Standardly this is covered between 50-80 percent, depending on the plan design.

Western Dental Plans provide coverage for root canal procedures as a listed benefit copayment. These copayments depend on the benefit plan design.

13. What percentage of crown costs does your plan cover?

Delta Dental: Percentages vary according to the plan.

Dental Health Services: We offer many variations to plan designs, which vary the cost sharing for members on procedures. The company offers plans with very low cost sharing on crowns.

Humana: We offer flexible plan designs with a range of co-insurance percentages to meet the needs of small to large groups. Crowns are typically covered as part of major services.

Liberty Dental: We have a wide array of plan designs and member cost sharing can vary to allow employers to select an option that fits best with their needs and capacity. Our DHMO and individual plans include set member copayments ranging from a \$0 copayment to a \$530 copayment depending on the crown and elective upgrades. For PPO plans root canal therapy is typically considered a type 2 (basic) procedure, but can also be considered a Type 3 (major) service. Basic services on our PPO plans are most commonly covered at 80 percent and major services are typically covered at 50 percent.

LifeMap: We offer several plan designs, we usually cover crowns at 50 percent.

National General Accident & Health: The cash benefit for a crown ranges from \$45 to \$450. However, if the Careington Network is used – for example – the cost for a Crown (porcelain fused to noble metal) may cost \$1,424. The plan cost is \$726 with a network savings of \$698 or a percentage savings of almost 50 percent.

Premier Access Insurance Company: Brokers and Employers can set this coverage from 0 percent to 100 percent.

The most common is 50 percent.

United Concordia: Most frequently covered at 50 percent; but several products cover crowns at both higher and lower amounts.

Western Dental Plans provide coverage for crown as a listed benefit copayment. These copayment depend on the benefit plan design.

14. Do you provide dentist cost and quality transparency tools?

Delta Dental: Yes. A variety of tools are available to Delta Dental enrollees. On our website at deltadentalins.com, registered enrollees can access behind login our cost estimator tool, which estimates an enrollee's approximate fee based on their eligibility, benefits, dentist and location information. At deltadental.com or via an app for Android and iOs, enrollees can access a cost estimator tool, which shows estimated costs as well as actual fees charged by a specific dentist(s).

Dental Health Services: Dental Health Services Prepaid (DHMO) plans offer a flat member copayment for all procedures. Regardless of what a dentist may charge in their practice, plan members only pay the set dollar amount listed in their schedule of covered benefits.

Humana: At this time, Humana's website does not provide cost information for our dental products.

Liberty Dental: Liberty does not provide dentist cost and quality transparency tools at this time.

LifeMap: No.

National General Accident & Health: Yes. If a member decides to use our Careington Network for specific services, they can go to: <http://www.careington.com/ngahdsavings/>. These resources provide a simplified way to determine costs of treatment.

Premier Access Insurance Company: Cost and quality tools for the website are in development. We do offer pre-determination of benefits to members who request them through our phone-based customer service representatives.

United Concordia: Yes, we offer schedules of benefits (copy schedules), certificates of coverage and online tools for both members and dentists – My Dental Benefits for members and My Patients' Benefits for dental offices. We also provide dental offices with a Dental Reference Guide and quarterly provide a newsletter, which are both available on our website.

Western Dental Plan uses Fair Health a national independent, nonprofit corporation to assist with transparency and cost. ★

EMPLOYER-SPONSORED HEALTH CARE PLANS

Dependent Verification Review Project – Who Does It Protect? By MARK HELTON



Dependent eligibility reviews are often thought of as a way to reduce employer cost for health care plans, but there are other reasons to engage in such a process. These reasons include, for example, the legal and financial issues employees may face from enrolling ineligible individuals on an employer group health care plan. You may be protecting your clients – employers and employees – from future hazards by ensuring everyone is aware of the rules. Regardless of whether there was an intent to defraud or the employee just does not fully understand the eligibility rules, the time to correct the error is not when the dependent has a major health issue and claim.

THE POTENTIAL THREATS OF INELIGIBLE EMPLOYEES

Employees sometimes misunderstand the rules of eligibility. For example, they may allow a former spouse or former stepchildren to remain on coverage following a divorce. It may be even that a court orders an employee to maintain coverage on a former spouse and/or stepchildren for a given period of time. Some employees don't understand that this order only obligates the employee to pay for coverage and is not a court order for the employer to maintain coverage for the employee's former family members. With a few exceptions (such as for fully insured plans in Massachusetts), employees can't keep former family members on

employer-sponsored healthcare plans, but if ordered by a court to supply insurance they may opt to pay the full rate for COBRA or move the former family member to a private plan on the open market.

To be clear, the true danger for an employee who enrolls former family members may not only be committing insurance fraud, but they may also be in violation of the court order that demands they maintain the coverage. The employee may be saddled with paying all health care costs for a former family member if the insurance claim is refused. Often ineligibility may go unnoticed until there is a major claim, which of course is then too late. The employer may also request repay-



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ment of previously paid claims after the date of divorce, which again could be substantial.

For larger claims where stop-loss may come into play, the claim may be denied as stop-loss carriers will often check eligibility before paying a claim. This, of course, means the employer's plan has already paid a large sum toward an ineligible claim and again may be faced with asking for a refund from the employee or writing off the claim's expenses to "lessons learned."

HOW DO CLIENTS MAINTAIN A CLEAN ENROLLMENT ELIGIBILITY ROSTER?

The most efficient way to verify clean enrollment is to review all dependents. For example:

1. Begin with a full audit of all dependents currently enrolled in the health care plans.
2. Once a full audit is complete, maintain vigilance by requiring verification documents for all dependents added at a later day.
3. Additionally, a complete review of spouses (and stepchildren associated with those spouses) should occur every few years.

Keep in mind that divorce is often a main cause of ineligible dependents remaining on the health care plans and a legitimate spouse this year may be a former spouse next year. For employers who are utilizing spousal carve outs or exclusions, checking every year to confirm continued eligibility and status in regard to the rules of the carve out may also be warranted. This check can also be built into an ongoing eligibility review.

WHEN SHOULD A DEPENDENT VERIFICATION REVIEW BE CONDUCTED?

The answer is: anytime other than during open enrollment. Complete lists of active dependents may change quite a bit during open enrollment so it's best to complete the audit prior to the open enrollment window or after enrollment is complete.

If the review is completed before the enrollment period, a clean-up audit or ongoing audit would also be recommended post-enrollment to maintain a clean and accurate account of who



should remain on coverage. Ongoing reviews may consist of weekly, monthly or quarterly reviews on any new dependent added to the roster via new hire or qualified life event.

Adding an audit during open enrollment would be taxing on the already stressed HR team at this time of year and the completion dates may not track with open enrollment and could become confusing to the employees.

HOW MUCH TIME SHOULD AN EMPLOYER ALLOW FOR A DEPENDENT VERIFICATION REVIEW?

Employers should allow enough time to complete the process, but not so much so that the employee does not see an end date coming soon. A best practice we have found is to allow six weeks for the review with an unannounced four-week grace period (aka "appeals phase") to follow. Human nature for many employees is to wait until the last minute to submit what is needed and the grace period helps those employees who do not get it right the first time. The grace period is a second opportunity for an employee to keep their eligible dependents on the plan. No respectable review process wants to remove dependents just for the sake of removing as many as possible. Reviews should not come across as hoops to jump through – it should be easy to complete, given enough time to do so and offer assistance to employees who have ques-

tions or concerns. Accuracy of the final results is key to saving money, protecting your clients from possible legal and financial issues and maintaining employee morale.

VALUE ADDED FROM DEPENDENT ELIGIBILITY REVIEWS

The end result of a dependent verification project can be positive for both the employer and the employees. Communicating to employees the importance of monitoring accurate enrollment on the health care plans is a great pre-review step. Making certain employees are aware such a review is beneficial to them and to help slow increasing health care costs will aid them in understanding the purpose of such a review. Allowing anyone to be on the plan may mean higher employee costs down the road. Having ineligible dependents on a plan may also land an employee in a great deal of trouble. ★



Mark Helton is responsible for dependent verification strategic initiatives for Hodges-Mace clients and brokers. He has a vast 25-year background in HR management, including eight years specializing in dependent audit process design, implementation and management.

For more about Hodges-Mace, please visit www.hodgesmace.com.

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THREE THINGS BROKERS CAN DO TO REMAIN RELEVANT DIGITAL ENVIRONMENT PRESENTS CHALLENGES

By ROB CARNAROLI

There's no doubt the broker arena is changing. As one generation readies for retirement, another is coming into its own—bringing a different style and brand of engagement to the market. At the same time, technology creates opportunities for savvy brokers to stand out from the competition.

To remain relevant in a digital environment, we encourage brokers to continue focusing on three areas: building relationships, demonstrating expertise and embracing technology.

BUILDING RELATIONSHIPS

For years, brokers earned business based on their expertise and the relationships they built. That hasn't changed.

Relationship building continues to set brokers apart from each other and from online tools that some view as a threat to their business. For some time—as long as many in our business can remember—relationships were formed more on the golf course than in the office. Lately the focus is less on golf and more on charitable or community events, such as 5K races, youth sporting events or non-profit fundraisers. These activities offer great opportunities to bolster professional relationships with prospects and clients while promoting worthy causes rooted in the community.

DEMONSTRATING EXPERTISE

Brokers need to leverage what sets them apart—expertise is front and center. Brokers should take an active role in educating clients. It's important to keep up with legislative changes and other market trends, and understand how they will affect employer groups.

To remain relevant, brokers must continually be part of the message. Rather than simply sharing an article



link—something that a search engine or news feed can do—brokers can add value by creating original content that delivers insight to their clients.

In today's marketplace, it's important to recognize that the ability to provide information and expertise are two completely different things. Thanks to the internet, information abounds. The ability to weed through and analyze this information in the context of market trends and customer needs is where expertise comes into play.

Brokers should showcase their expertise by sharing relevant information as a blog post, on LinkedIn and Twitter, or directly to prospects and clients. This brings a unique perspective readers may not get from a national publication. The result can be powerful in attracting prospects and retaining customers.

EMBRACING TECHNOLOGY

To outrun competition, brokers need to leverage available tools to improve engagement and customer experience. Blogging can help illustrate broker expertise, attract prospects and deliver added value to existing customers.

Brokers should engage on social media by sharing community information, recognizing customer achievements, responding to LinkedIn questions and retweeting posts from prospects, customers and business partners.

Taking the concept of original content a step further, brokers may consider creating and developing their own webinars on relevant topics. Or try creating short educational videos and posting them on YouTube and other social media sites. Google owns YouTube, so a strong YouTube presence can also improve Google search positioning for the broker's website.

Yes, today's consumers expect a digital experience. But it's the brokers who build relationships and demonstrate their expertise – along with embracing technology – who will stand out and remain relevant in today's marketplace. ★



Rob Carnaroli serves as vice president of sales for Sutter Health Plus. For more information on Sutter, visit <http://www.sutterhealthplus.org/>.

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INSURERS AND BROKERS MAY FACE UCL LIABILITY FOR VIOLATIONS OF INSURANCE STATUTES

By DAWN WILLIAMS

In the case *Walker v. Life Ins. Co. of the SW*, The Ninth Circuit recently ruled that an alleged violation of California's illustration statutes could serve as a predicate for liability under the California Unfair Competition Law ("UCL"). The ruling reversed in part a decision by the United States District Court for the Central District of California in a certified class action of indexed universal life policyholders residing in California. The state's illustration statutes, Cal. Ins. Code § 10509.950 et seq., are substantially similar to NAIC Model 582, and apply to all individual life insurance policies sold in California, with a few exceptions. The statutes mandate the inclusion of certain information, and prohibit various practices, including a requirement that insurers and producers may not "represent the policy as anything other than a life insurance policy [or] use or describe nonguaranteed elements in a manner that is misleading or has the capacity or tendency to mislead," among other things.

The plaintiff alleged that the insurer violated California's statutes because it touted the policies as retirement or investment vehicles, "misrepresent[ed]" the costs, risks, safety and security of the policies, treated policy lapse "in a misleading matter," "deceptively present[ed] the guarantee values, fail[ed] to define key terms, and impl[ie]d that nonguaranteed elements are annual guarantees." The district court dismissed those claims early in the case. Subsequently, the California Supreme Court issued two opinions seemingly giving the UCL's unlawful prong a broader interpretation. *Rose v. Bank of Am.*, 57 Cal. 4th 390 (2013);

Zhang v. Cal. Capital Ins. Co., 57 Cal. 4th 364 (2013). However, the district court denied reconsideration of its earlier orders.

In 2014, after the statewide class was certified, the case ultimately went to trial, resulting in a jury verdict for the insurer on the fraudulent concealment

"...ensure that you give the potential customer full information and document the reason for purchase. This can help negate the element of causation: even if there is some technical violation, the purchaser cannot complain that they were damaged by that infraction."

claim. The district court, nearly a year later, found for the insurer on the remaining UCL claims, which required resolution by a judge. The opinion was a beacon of hope for insurers and brokers doing business in California who often face disappointing early rulings and frequently settle. This insurer's tenacity in the face of negative early rulings and class certification paid off. Some of the highlights of the Court's order include holdings that:

- The sales process was not uniform because each agent remained free to decide how to sell the products;

- The insurer had no duty to disclose that returns projected on an illustration might be more or less volatile, where the illustrations complied with state regulation;
- Plaintiffs were not likely to be misled where there were significant disclosures on the illustrations regarding the numerical examples;
- Plaintiffs suffered no actionable injury for a failure to receive returns above the guaranteed values; and
- Plaintiffs could have avoided injury by reading their policies and returning them within the free look period.

On appeal the California Department of Insurance filed a brief supporting the plaintiff's position, and the appellate judges devoted a fair amount of time at the oral argument questioning all counsel about the statutory issue. The Ninth Circuit ultimately affirmed the district court in all respects, except for the narrow issue of whether UCL liability could be predicated on a violation of the illustration statutes. With respect to that issue, the Ninth Circuit found that even though the illustration statutes lack an express private cause of action, "private UCL claims are barred only when the underlying statute either actually bars private rights of action or provides a 'safe harbor' that renders the alleged conduct lawful."

What that means now for the *Walker* case is unclear: the Ninth Circuit specifically affirmed the district court's finding "that the illustrations of the policy charges and interest rates were not unfair or deceptive." Assuming there were technical violations of the statute, rendering the insurer's con-



duct “unlawful,” California courts take varying positions as to whether a mere violation is sufficient to pass muster under the UCL, or whether the plaintiff must prove that the violations caused her and the class damage. Compare *Davis v. Riversource Life Ins. Co.* (dismissing solely unlawful prong UCL violations because plaintiff failed “to allege that his economic injuries were the ‘result of’ Defendants’ alleged violations of” the statute), with *Goertzen v. Great Am. Live Ins.* (denying summary judgment for insurer in involving allegations nearly identical to *Davis* because “a plaintiff need not prove reliance in order to establish a claim for violation of the UCL’s unlawful prong if the predicate legal violation does not involve fraud or deception”).

The ruling suggests, though, that insurers and producers selling individual life insurance policies in California may expect to see more lawsuits – individual and putative class actions – alleging violations of technical insurance statutes. For example, there has already been at least one complaint filed after the *Walker* opinion claiming that the insurer committed a UCL violation when it failed to strictly comply with the California statutes governing the information that must be included in grace and

“...insurers and producers selling individual life insurance policies in California may expect to see more lawsuits – individual and putative class actions – alleging violations of technical insurance statutes.”

lapse notices. And, as the *Goertzen* case illustrates, a mere violation may be enough to get in front of a jury.

How can an insurer or producer seek to avoid such liability? First and foremost, ensure that you are in compliance with state and federal statutes and regulations. Statutes and regulations are often changing, so conducting a thorough and periodic audit of your materials and forms to ensure compliance is critical, as is keeping abreast of proposed revisions. Second, ensure that you give the potential customer full information and document the reason for purchase. This can help negate the element of causation: even if there is some technical violation, the purchaser cannot com-

plain that they were damaged by that infraction. Finally, though litigation is sometimes an inevitable cost of doing business (especially in California), the *Walker* case is a reminder that perseverance sometimes pays off. ★

More details on the cases mentioned in this article...

Walker v. Life Ins. Co. of the SW, No. 15-55809, 2017 WL 836592 (9th Cir. Mar. 3, 2017).

Rose v. Bank of Am., 57 Cal. 4th 390 (2013); *Zhang v. Cal. Capital Ins. Co.*, 57 Cal. 4th 364 (2013).

Davis v. Riversource Life Ins. Co., No. 16-2801, slip op. at *8 (N.D. Cal. Feb. 21, 2017)

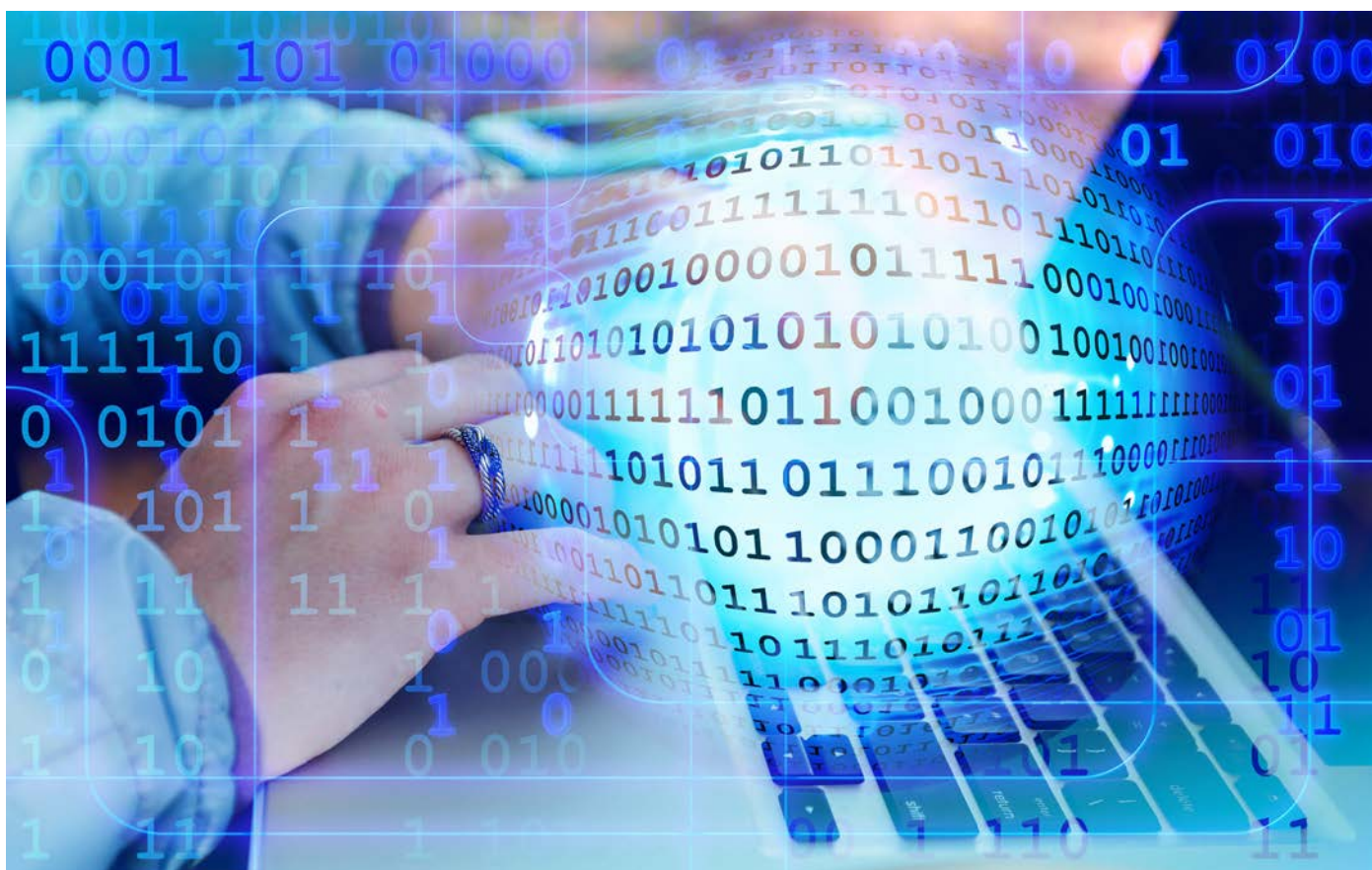
Goertzen v. Great Am. Live Ins. Co., 2017 WL 2378047, at *4 (N.D. Cal. June 1, 2017)

Dawn Williams is a shareholder in the Washington, D.C., office of Carlton Fields, where she represents a variety of clients, including insurance companies, in class action and other complex commercial litigation disputes as well as regulatory enforcement proceedings. For info, contact Dawn Williams at dwilliams@carltonfields.com.



BIG DATA ON LIFE: UNDERWRITING ACCELERATION TAKES HOLD IN THE LIFE INSURANCE INDUSTRY

By MARIANNE PURUSHOTHAM



While data science and the application of underwriting algorithms to property casualty lines of insurance has been prevalent since the 1990s, insurers have only recently taken a serious interest in these techniques to accelerate underwriting of life insurance products.

The interest may be recent, but is growing quickly. So quickly that, according to a 2016 LIMRA study of 60 life insurance companies in the U.S.

and Canada, nearly 9 in 10 companies use or are exploring the use of big data and predictive analytics to streamline and accelerate the underwriting process.

THE TYPICAL PROCESS

For life insurance applications, more traditional sources of data such as MIB checks, pharmaceutical database checks and motor vehicle records are being combined with newer data

sources including electronic health record (EHR) databases, credit data, and other consumer lifestyle/behavior information to develop less costly, less time-consuming, and less invasive approaches to assessing mortality risk. Credit and lifestyle/behavior data is obtained from data aggregators, but some insurers are also exploring more unstructured sources of data such as social media feeds.

This consumer behavior data is used

to develop predictive models that ultimately determine an “insurance risk score” for each applicant. This risk score is then used to identify those customers who can be issued a fully underwritten policy without traditional paramedical underwriting or fluid collection. The data elements and modeling process used by an insurer to arrive at the risk score is highly proprietary given the competitive advantage that could accrue for early adopters. Insurers that can successfully assess risk at a lower cost and at a fully underwritten premium level could benefit both in increased sales and improved financials.

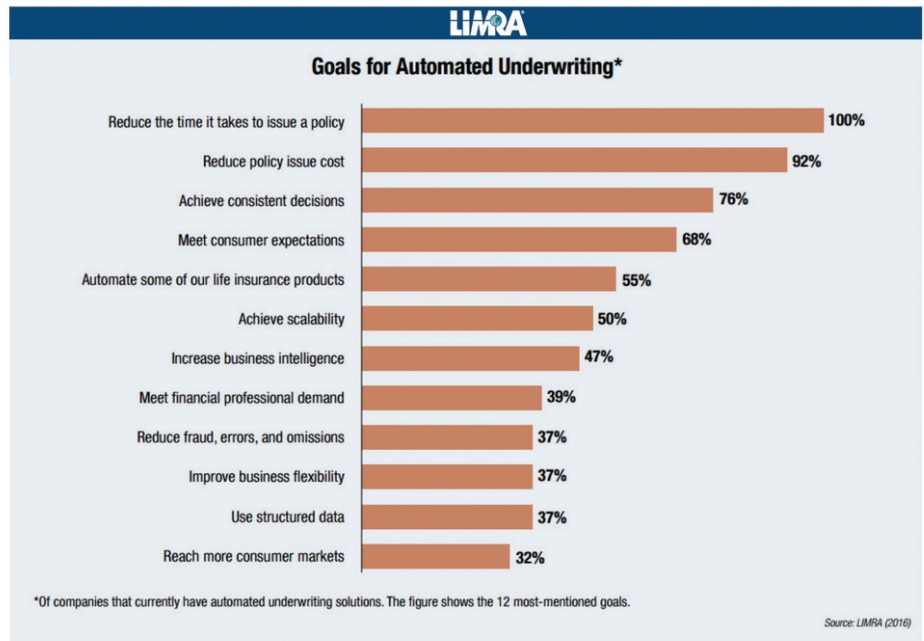
Most life insurers pursuing an accelerated underwriting strategy begin with offering a pilot program that focuses on specific products (per the

“...any particular underwriting model has a limited lifespan and potential new factors tracked and analyzed over long periods of time will need to be considered.”

LIMRA study mentioned above, whole life and term are the most common) and specific age/benefit amount levels (for example preferred or super preferred applicants that are under age 60 and looking for coverage under \$500,000). Some companies with pilots in place report promising results as they compare outcomes based on the insurance risk score produced by new accelerated underwriting algorithms with outcomes of traditional underwriting methods by running the two processes in parallel. In some cases, up to 50 percent or more of policies can be issued under these programs with reduced underwriting time from weeks to days.

THE OBSTACLES

Life insurers have been slower to adopt automated underwriting strategies at least in part because of data and



modeling obstacles that do not apply to property-casualty insurers, retail, or other industries that have relied heavily on data analytics for many years.

- Fewer “incidents” of a claim are available for analysis:

Algorithms supporting an accelerated underwriting process become more robust with a greater number of variables available for the underlying customer population (ex. demographics, buying behavior, credit data) as well as a greater number of “incidents” of a claim (ex. deaths, car accidents, etc.) to include in the analysis. For instance, property-casualty insurers will have a greater number of “incident/claim” events to study than life insurers given the relative number of car or homeowner claims versus life insurance death claims.

- The importance of specific factors in predicting outcomes changes over time:

Life insurance policies can cover periods of over 30 years and the factors correlated with mortality results (and therefore claim incidence) can shift in significance over time. This means that any particular underwriting model has a limited lifespan and potential new factors tracked and analyzed over long periods of time will need to be considered.

Huge potential benefits to accelerating the underwriting process.

Despite obstacles that life insurers

face, the potential benefits of efficiently applying big data and analytics to improve business processes (and underwriting methods in particular) are very much in line with the industry’s push to be more innovative and customer-centric. Specific benefits include:

- Modernizing the methods for selling life insurance products—with the ultimate benefit of reducing the time and complexity of the buying process for our customers.
- Reducing the cost of underwriting new business for insurers, thereby reducing the amount of surplus strain on sale of a policy.
- Building a better understanding of a company’s customer base for both new and inforce business in order to increase sales and retention with the company.

If history has proven anything, it’s that life insurers can no longer sit back as new techniques and processes change the way business is done. The landscape of the life insurance industry continues to evolve and more change is coming quickly. The innovations developed using new data sources combined with improved technology in order to streamline underwriting processes for both consumers and companies will eventually become table stakes just to operate in the business. ★

Marianne Purushotham is corporate vice president, LIMRA Research Shared Services.



Helping Clients Navigate the Absence Management Process

By SCOTT LARSEN

Absence management was once viewed as a concern only for large companies, but it is increasingly becoming a higher priority for small and medium-sized businesses. Employee absences can lead to a decrease in workplace productivity and can have a significant impact

on a company's bottom line.

Employers are required to maintain compliance with existing laws and corporate policies and to keep up with the latest provisions of the Affordable Care Act (ACA), federal and state Family and Medical Leave Act (FMLA) and Americans with Disabilities Act (ADA), and

statutory disability and workers' compensation laws. California is one of only three states that offer 12 weeks of unpaid leave as long as employees meet eligibility requirements such as being in the job for at least 12 months, working a minimum number of hours and having at least 50 employees at the firm.

The complex interaction of government requirements and corporate policies are increasingly becoming a burden on employers, many of whom are seeking ways to help ensure the compliance of their plans and to integrate their programs in a more efficient manner. Brokers can play an integral role in helping their clients mitigate the impact of absences while dealing with the growing challenges of interpreting and complying with these leave laws.

The Guardian Life Insurance Company of America just released the results of its 2017 Guardian Absence Management Activity Index SM and Study. This national survey of 1,000 benefits professionals working for employers ranging in size from 50 to over 5,000 employees measures the scope and effectiveness of absence management activities of both small and large employers. It was created to provide a better understanding of successful absence management programs and to clearly identify the most effective absence management activities employers can implement to achieve future success.

The research confirms that U.S. employers appear to be making leave administration a higher priority — and it shows. Notably, changes were most pronounced among firms with 250 to 1,000 employees as they begin to catch up with larger firms in recognizing the importance of a sound, well-executed absence management strategy.

Guardian's study highlights an encouraging improvement in key absence management metrics, with more companies reporting positive outcomes such as enhanced productivity (+21 percent), reduced lost time (+22 percent), and reduced costs (+50 percent). Nearly one-third of companies indicate that they are making a major effort to improve their absence management practices, up from 22 percent two years ago. As a result, the average Index score — a measure of the degree to which an employer is implementing absence management activities on a scale of 1 to 10 — improved to 4.4, compared with 3.7 in 2014 (a 19 percent increase).

Brokers can use this research to help their corporate clients analyze their own absence and health data.

They can then develop more effective strategies together to address long-term workforce wellness and productivity. In particular, brokers can work with employers on the five best practices of successful absence management programs:

1. RETURN-TO-WORK (RTW) PROGRAM

According to the research, employers recognize that a return-to-work program is no longer an option. Ongoing clarification of the ADA and growing scrutiny from the Equal Employment



Opportunity Commission (EEOC) and the Department of Labor (DOL) signal that employer processes must be buttoned up. In fact, 71 percent of employers (vs. 62 percent in 2014) are actively seeking ways to return employees to work.

2. REPORTING CAPABILITY

Comprehensive claims/absence data reporting has become a requirement for a well-run program. It's encouraging that more than half of employers surveyed indicate they can produce a broad range of reports that include usage patterns, claims status and costs.

3. HEALTH MANAGEMENT REFERRALS

Well-run programs include giving employees referrals to health management programs. As employers strive to improve communication across their various benefits programs, the level of health management referrals is increasing (54 percent in 2016 vs. 44 percent in 2014).

4. CENTRALIZED INTAKE

Some employers have expanded their use of a centralized portal (phone or online) beyond short-term disability (STD) and FMLA leaves to include ADA leave, workers' compensation, or other leave types.

5. SAME RESOURCE FOR STD AND FMLA LEAVES

Doing so makes for a better and more efficient overall experience — for the employee and employer. Four in 10 employers are now using the same department or vendor to administer both STD and FMLA leaves (up from 28 percent in 2014).

Securing the buy-in of senior management is one of the most critical first steps and the number one key to launching a successful program. Brokers can demonstrate to management how well-managed programs will lower costs, tighten compliance and improve the employee experience. At the same time, establishing baseline metrics and following an established communication plan are important to an employer's success.

Brokers should remind clients that absence management is not just about regulations and compliance. For many companies, it is about attracting and retaining a productive workforce that actively contributes to the mission of the organization in a manner that is safe and healthy for all parties involved. Beyond benefit plans, leave policies, and return-to-work efforts, health management initiatives, such as employee assistance programs (EAPs), wellness programs, disease management, and others, also work toward this goal. ★



Scott Larsen is vice president, The Guardian Life Insurance Company of America®. The 2017 Guardian Absence Management Activity Index and Study can be downloaded at:

<https://www.guardiananytime.com/gafd/wps/portal/fdhome/insights-perspectives/emerging-trends/absence-management-study-2017>. The Guardian Absence Management Scorecard can be found at: <https://www.guardiananytime.com/gafd/wps/portal/fdhome/insights-perspectives/emerging-trends/absence-management-scorecard>.

NAFA Annuity Distribution Summit in October

National Association of Fixed Annuities will host its ninth annual summit October 11-13 at Sheraton San Diego Hotel & Marina. The Distribution Summit is the largest gathering of IMO, carrier, bank and broker-dealer principals and executives in the industry, with a focus on the issues facing distribution within these channels. Attendees will have the opportunity to learn, share and enhance relationships with one another. Hear from keynote speakers, panelists and others engaged in fixed annuity issues. Go to <http://www.nafameetings.com/> for more information.

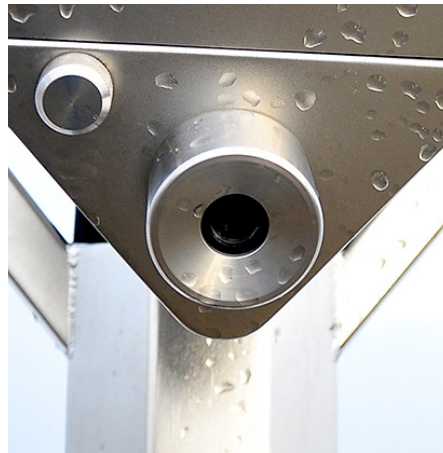
Early Bird Registration for CAHU September Retreat Still Open

CAHU's Health Care Retreat, the industry's largest conference for health insurance agents, will be September 11-13 at Pala Casino Spa Resort in Sacramento. Don't miss the fantastic break out tracks, important updates on current federal and local legislative issues as well as CAHU's annual awards ceremony. Visit www.cahu.org for info and discounted early bird registration

A.M. Best: U.S. Life/Health Insurers' Operating Income Grows Significantly in 1Q 2017

The U.S. life/health industry's pretax net operating income in first-quarter 2017 jumped 130 percent over the same period a year ago, to \$14.5 billion from \$6.3 billion, and was the highest first-quarter total since 2013. These preliminary financial results are detailed in a new Best's Special Report, titled, "A.M. Best First Look—1Qtr 2017 U.S. Life/Health Financial Results," and the data is derived from companies' three-month 2017 interim statutory statements that were received by May 22, 2017, representing an estimated 84 percent of total industry premiums and annuity considerations. According to the report, the life/health industry posted an increase in realized capital losses of \$3.1 billion compared with first-quarter 2016, which was primarily driven by a \$1.8 billion year-over-year difference at Transamerica Life Insurance Company. This moderated net income growth to \$7.7 billion, a 73.5 percent increase over first-quarter 2016. To

access a copy of this report, please visit http://www3.ambest.com/bestweek/purchase.asp?record_code=261927.



J.D. Power Study Tells Health Insurers Where to Focus

J.D. Power's recently published 2017 Member Health Plan Study found that integration and coordination of care is the most important factor influencing member satisfaction with their plan. In other words, health insurers should focus on giving consumers clear, easy access to doctors and other providers, and integration of care.

Key findings from this year's study:

- Close coordination is lacking among health plans and providers: The single most effective lever of health plan member satisfaction is helpful coordination of care among doctors and other healthcare providers. The ability to help members successfully navigate among providers is associated with a 136-index point (on a 1,000-point scale) increase in overall customer satisfaction. Yet, just 25 percent of health plan members report receiving this service from their health plan.
- Integrated delivery systems dominate rankings: Health plans that utilize an integrated delivery system (IDS)—a network of healthcare and health insurance organizations presented to members as a single delivery organization—outperform traditional health plans on every factor measured in the study.
- Presenting low-cost narrow network options improves satisfaction: Although having access to a limited network of care providers can potentially become a friction point for members, health plans that have a narrow or

tiered network also have the potential to reduce costs for commercial health plan members. Regardless of product choice, members who were presented with lower-cost narrow network options were significantly more satisfied with their health plan versus those who were not offered such an option or did not know whether it was offered. However, just 33 percent of respondents say they were offered a narrow network option.

- The effect of payer-provider alliances is mixed: Aetna, Cigna, Anthem, and many other providers have begun to offer commercial products in collaboration with specific providers in the past few years. Partnerships vary from less integrated contractual agreements to highly integrated health system purchases. J.D. Power found mixed results when it examined member satisfaction with the plans in instances when members are being served by providers that are a part of a collaborative care model. Expected improvements in satisfaction related to relationship with the physician were seen in some areas but not in others. Regardless of the satisfaction associated with the plans/products at a high level, there is significant opportunity to improve member understanding of how a plan works and what is covered in advance of enrollment.

Satisfaction is highest among health plan members in the five regions: Maryland (723); East South Central (722); California (716); Michigan (716); and Ohio (714). Satisfaction is lowest among members in the Colorado (676) and Northeast (682) regions. More information can be found at <http://www.jdpower.com/press-releases/jd-power-2017-member-health-plan-study>.

Financial Advisors Make Clients Feel Prepared

New findings from Northwestern Mutual's Planning & Progress Study revealed that Americans who receive guidance from financial advisors feel markedly more prepared for retirement. According to the data:

- 7 in 10 Americans with advisors said their retirement plan is designed to withstand market cycles compared to 30 percent of those who do not use an advisor

- Nearly all those with an advisor (92 percent) have discussed retirement with someone relative to just half (51 percent) of those without an advisor
- People without financial advisors are twice as likely (53 percent) as those with advisors (27 percent) to view lack of savings as an obstacle to financial security in retirement
- 49 percent of people without an advisor have taken no steps to address the possibility of outliving their savings – three times as many as those with an advisor (15 percent)

"As people live longer, the economy continues to fluctuate, and healthcare and other costs increase, navigating retirement planning becomes more complex and overwhelming," said Rebekah Barsch, vice president planning, Northwestern Mutual. "Working with an advisor is like having an experienced guide map out an itinerary for your retirement journey that's tailored to your unique lifestyle goals and circumstances." These findings are part of Northwestern Mutual's 2017 Planning & Progress Study, an annual research project exploring Americans' attitudes and behaviors toward finances and planning. Released in multiple waves throughout the year, the study launched in April with data on debt and the current state of financial optimism, respectively. More information can be found at <https://www.northwesternmutual.com/about-us/studies/planning-and-progress-study-2017>.

MetLife & U.S. Chamber Say Small Biz Owners Optimistic

The inaugural MetLife & U.S. Chamber of Commerce Small Business Index recently found that nearly two-thirds of small business owners are expecting revenue growth and looking to hire despite harboring concerns about the health of the national economy. Based on telephone interviews with 1,000 small business owners and operators, the survey found that nearly a third plan to hire more employees and 60 percent expect revenue to increase in the year ahead. Comparatively, only 6 percent plan to reduce their staff size and 9 percent are forecasting a decrease in revenue. "Our Index revealed that there is a huge potential for growth on Main Streets across

the country. Not only are small businesses looking to add employees, but they're optimistic about growing their revenue and investing back in their companies," said Suzanne Clark, senior executive vice president at the U.S. Chamber of Commerce. "Strong economic growth is the key to unlocking the potential of America's entrepreneurs. Now more than ever, it's important for us to understand their perspectives so we can help them succeed and grow. The majority of respondents (61 percent) rated the health of their small business as good or very good, with confidence increasing with the size of the company. More than 40 percent graded their local economy positively. But only 33 percent believe the U.S. economy is in somewhat or very good health, with one quarter (25 percent) saying that the economy is in poor or somewhat poor health. "Small businesses strengthen the fabric of our communities and are the backbone of the American economy, accounting for more than half of the nation's economic output today," added James W. Reid, executive vice president for regional and small business solutions at MetLife. "Our Index can elevate the voice of the small business owner, and, quarter after quarter, their voice will help everyone to work towards solutions that translate into small business success." This first edition of the Index produced an overall score of 60.6 (on a scale of 0 to 100), which indicates that 60.6 percent of small business owners currently have a positive outlook for their company and the environment in which they operate. The score takes into account small business owners' responses to 10 questions spanning three topics: the current health of their business; their views on the economy and other external forces that impact their company; and their plans and expectations for the near future. More information can be found at <https://www.uschamber.com/sbindex/>

Blue Cross Blue Shield Team with Lyft

In an effort to address the community effects of social determinants of health, the Blue Cross Blue Shield Association announced a first nationwide partnership with Lyft to ensure Americans are not missing vital health care appointments simply because they lack reliable trans-

portation. "Blue Cross and Blue Shield companies have always been committed to local communities – and to solving the most pressing health care challenges facing our country," said Dr. Trent Haywood, BCBSA chief medical officer and president of the BCBS Institute. "A strategic alliance with Lyft will allow us to positively impact and improve Americans' health nationwide." Over the next several months, BCBS will incorporate Lyft services into an innovative service delivery model for select Blue Cross and Blue Shield companies – at no cost to members. The model couples BCBS technology with Lyft's convenient ride-share services to reduce the number of missed appointments for non-emergency medical care in areas without optimal transportation alternatives servicing



health care facilities. "Many Americans live in areas where medical care is beyond the reach of walking, biking or public transportation. As a result, they struggle to access critical health care services, even when they have health insurance," said Dr. Haywood. "We are committed to addressing issues like transportation that are inextricably linked to health outcomes, yet can't be tackled through health care resources alone." Eighty percent of health outcomes are driven by social determinants of health including lifestyle behaviors and environmental factors. Transportation barriers alone result in missed or delayed medical appointments for an estimated 3.6 million Americans. While assistance is available for many who receive Medicaid coverage, millions of Americans are still unable to regularly access care because they lack reliable transportation options. For more info go to <http://3blmedia.com/News/Blue-Cross-and-Blue-Shield-and-Lyft-Join-Forces-Increase-Access-Health-Care-Communities#sthash.gT2z4fWf.dpuf>★

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