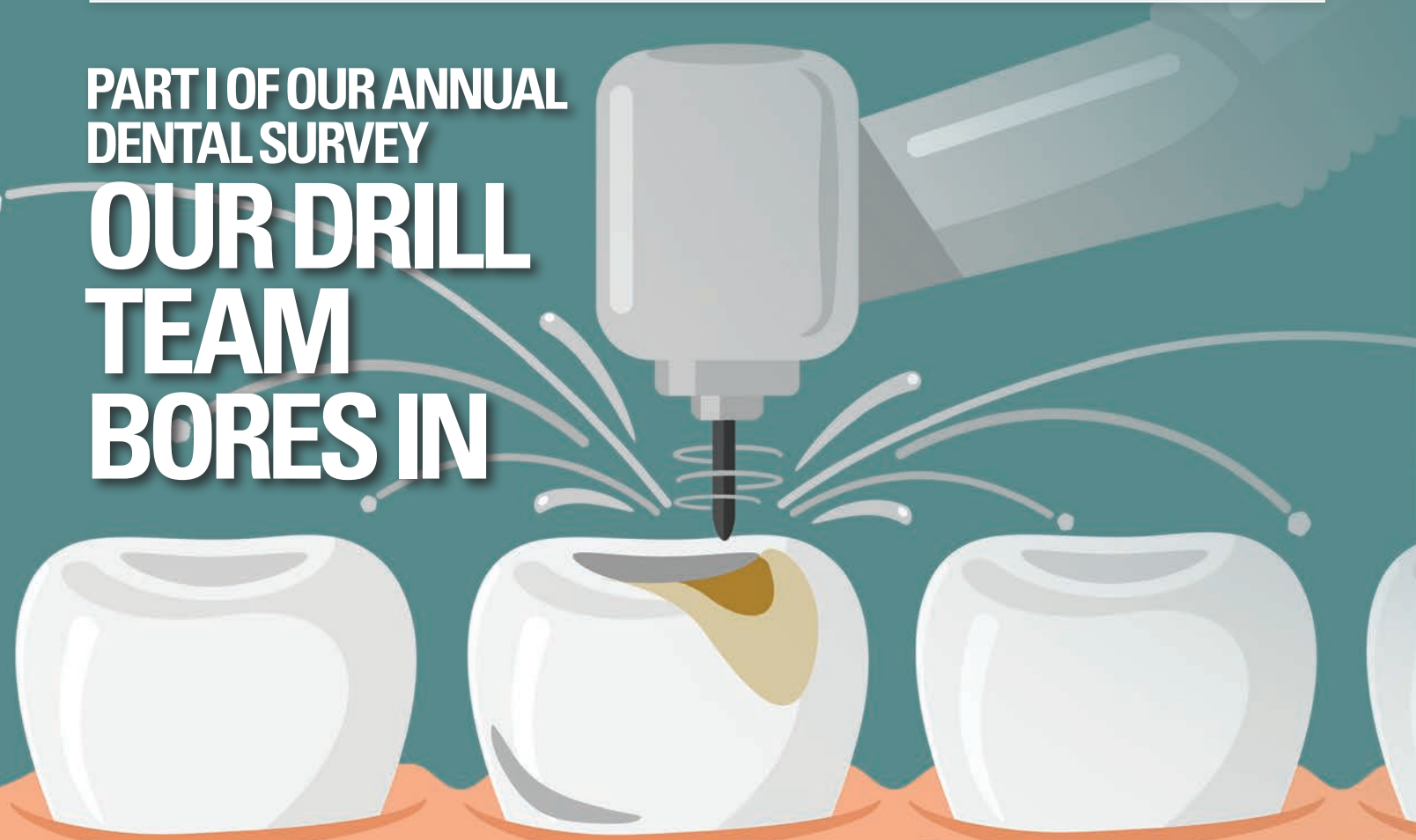
CALIFORNIA BROKER

VOLUME 36, NUMBER 10 SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS JULY 2018



PART I OF OUR ANNUAL DENTAL SURVEY

OUR DRILL TEAM BORES IN

Side-by-Side Comparisons of the State's Most Popular Plans

Also Inside:

- **Long Term Care**
- **Health Insurance**
- **Life Insurance**
- **Serving the Under 65 Market**
- **Reference Based Pricing**

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Over 2.5 million adults in California have been diagnosed with Diabetes

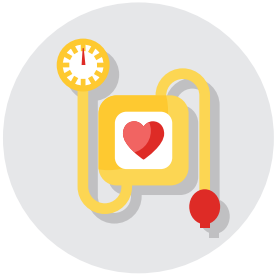
(Source: UCLA Center for Health Policy Research)

At least 1 in 3 adult Californians are living with at least one of the most common forms of cardiovascular disease

(Source: CA Dept. of Public Health)

The Alzheimers Association projects that there are 630,000 Californians age 65 and older living with Alzheimer's disease

(Source: Alzheimers Association, 2017 Facts and Figures)



1 in 4 Californians have chronic high blood pressure

(Source: UCLA Fielding School of Public Health)

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DENTAL

Check out part one of our annual dental survey. The state's top dental players answer key questions for brokers who sell their products. Next month: don't miss part two.

HEALTH INSURANCE

By David L. Fear, Sr. RHU

A recent proposal coming out of the California State legislature seems to indicate that the politicians are now turning their attention to a critical issue in America today: The very high cost of health care. While it is unlikely that a solution will be found in the immediate future, this is a good first attempt to get the issue out in front of people.

LONG-TERM CARE

By Louis H. Brownstone

The success rate in underwriting a long-term care insurance applicant has been decreasing over time. Declination rates

are now in the 30 to 40 percent range, and this is before withdrawals and not taken policies. How can agents understand the underwriting issues in today's environment and do a better job of underwriting?

New info from the American Association of Long-Term Care shows how many people are declined for LTC coverage.

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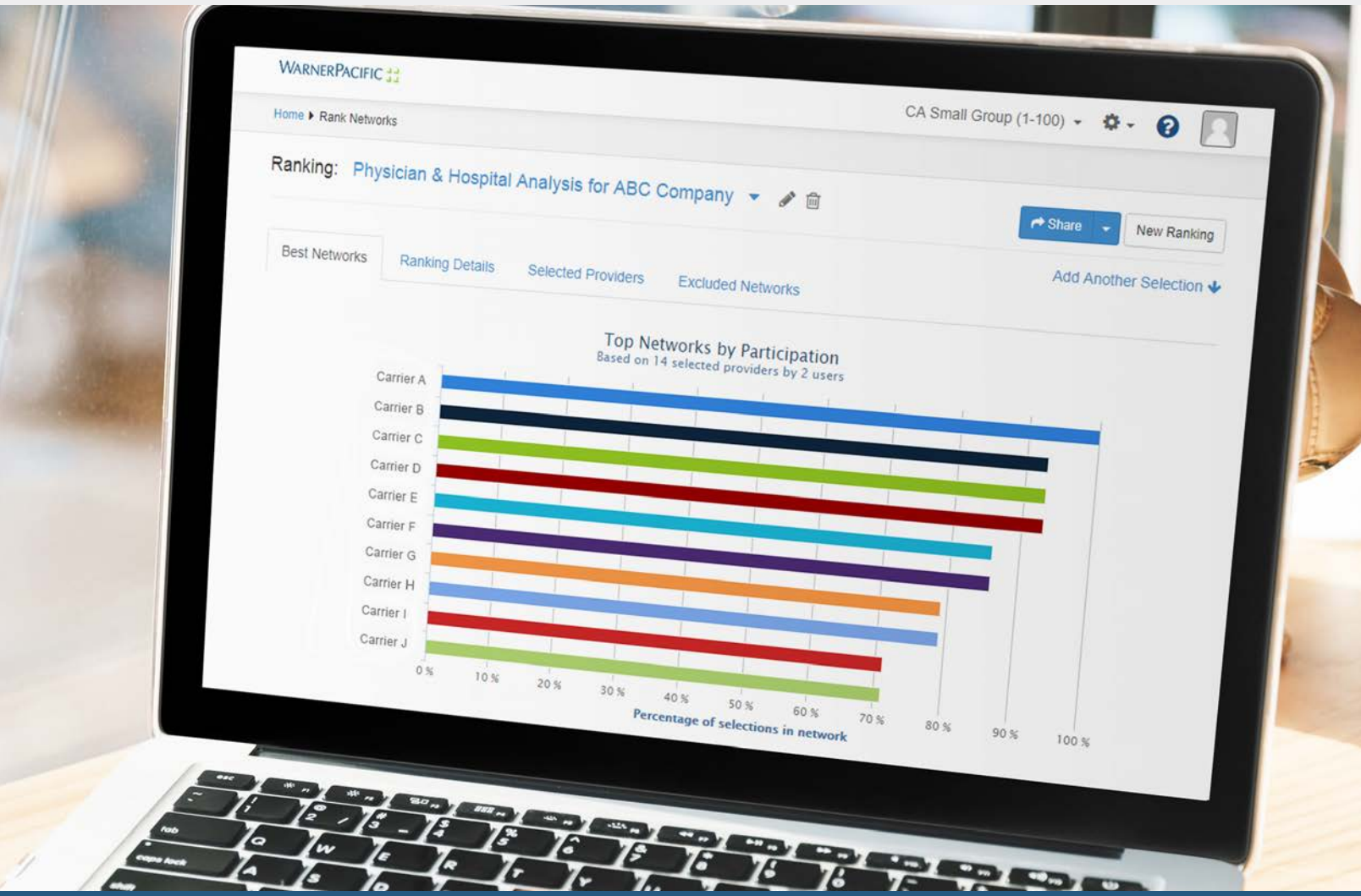

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CALIFORNIA BROKER

JULY 2018

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Subscriptions and advertising rates, U.S. one year: $42. Send change of address notification at least 20 days prior to effective date; include old/new address to: 3727 W. Magnolia Blvd.,#828, Burbank, CA 91505. To subscribe online: calbrokermag.com or call (800) 675-7563.

California Broker (ISSN #0883-6159) is published monthly. Periodicals Postage Rates Paid at Burbank, CA and additional entry offices (USPS #744-450). POSTMASTER: Send address changes to *California Broker,* 3727 W. Magnolia Blvd.,#828, Burbank, CA 91505.

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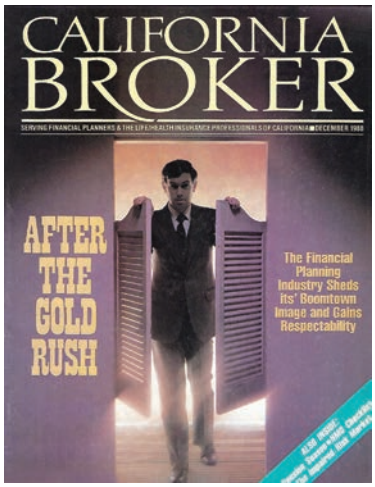
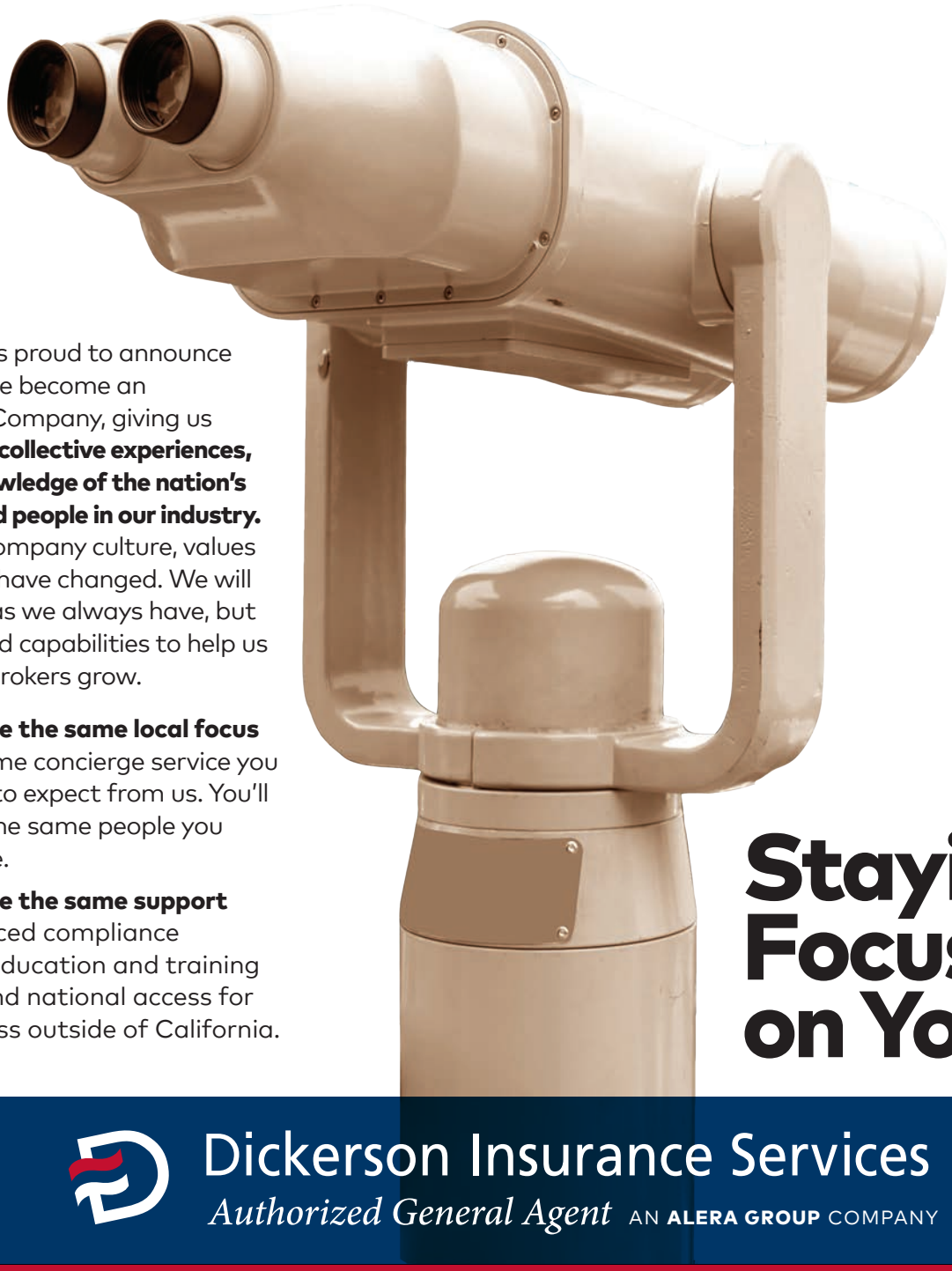


IN EVERY ISSUE...

National Scope. Local Service.



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HEALTH INSURANCE HAS FAILED AMERICA

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Editor's note: Views expressed in our guest editorial are those of the author, not Cal Broker magazine.

By RICH TEHRANI

Editor's note: If you have a strong opinion about this editorial or any other pertinent subject, please reach out. We welcome your comments. Please email editor@calbrokermag.com.

There are some uncomfortable truths about health insurance we need to acknowledge as the first step in finding a solution is recognizing the problem.

Readers of California Broker magazine have undoubtedly seen the article titled Why the U.S. Spends So Much More Than Other Nations on Health Care. In this piece, we are reminded that the United States spends almost twice as much on health care, as a percentage of its economy, as other advanced industrialized countries — totaling $3.3 trillion, or 17.9 percent of gross domestic product in 2016.

Part of the reason is likely because the government has been a huge proponent of providing health insurance for the masses because it was a generally accepted fact that you had to have insurance to be healthy.

This has been great news for insurance companies, but not necessarily great for their customers.

Consider: approximately 44 percent of Americans didn't visit a physician last year when they were sick or injured, according to a new West Health Institute/NORC at the University of Chicago national poll. About 40 percent say they skipped a recommended medical test or treatment in the last 12 months due to high prices. The amazing thing is most people surveyed, 86 percent, had insurance and still skipped the doctor! The cost of health insurance has risen so high that millions of insured individuals avoid the detection of a serious illness because they have no extra money to see a doctor and deal with copays and other patient responsibility.

To make matters worse, after spending most of their disposable income on health insurance, over half of Americans say they received a medical bill they thought was covered by insurance or where the amount they owed was higher than expected. Finally, more than a quarter say they received a medical bill that was turned over to a collection agency in the past 12 months.

Then there is the steady decline in the quality of medical care. Doctors say that low payments and insurance red tape are the top two reasons they provide poor service.

Not only is insurance keeping patients out of the doctor's office, if they can scrape enough money together to see the doctor, the insurance company is responsible for decreasing the quality of their care.

Free markets and transparent pricing are responsible for driving down prices on virtually everything from shirts to Lasik. In fact, Lasik is a prime example of a surgery with improved quality and plummeting cost because patients can shop, compare and get the best service they can afford.

Specifically, Lasik surgery prices decreased by 75 percent over 15 years. According to the Foundation for Economic Education while the cost of medical care services has doubled and the cost of hospitals and related services has nearly tripled.

Senator Rand Paul said in an MSNBC interview, "The one reason capitalism doesn't work in health care is the consumer is disconnected from the product."

With this in mind, what is needed to change the system to achieve better outcomes?

EDUCATION

The common belief is insurance is healthcare… We all know it isn't but our customers and politicians often do not. For example, Medicare is not health care, it is health insurance. Education is needed to let patients know the high cost of insurance could be preventing millions of individuals from catching chronic life-threatening illnesses like cancer and diabetes, early.

In addition, many do not even realize they can still see a doctor, even if they are uninsured.

This does not mean we suggest you stop selling insurance. We are just pointing out that patients need to be aware of the reality they face when choosing between high premiums and seeing the doctor who could potentially save their life.

HEALTHCARE RELATED SAVINGS ACCOUNTS

The more control patients have, the more they will look at prices when making decisions about their health. The goal is not to keep patients from getting life-saving care but instead, to allow them to receive better care for less money.

SELF-PAY PATIENT SITES

Self-pay patient sites are like Amazon for doctors and procedures. They can benefit patients who generally don't hit their deductible or who do not have insurance. Such sites work well with many of the savings accounts mentioned above.

Moreover, if patients are not likely

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*Insurance companies vary by region

to hit their deductible, they should be shopping for care inside and outside their insurance network to ensure they have the best pricing or at least as many options as possible.

This is not theory. The same price saving advantages a concierge doctor sees can be applied across hundreds or thousands of doctors to amplify the savings.

HIGH DEDUCTIBLE OR CATASTROPHIC PLANS

The government has reduced the availability of catastrophic insurance but in reality, such a plan with an HSA would benefit consumers greatly and insurance companies likely wouldn't mind much at all as they would have far less paperwork to deal with.

Free markets coupled with technology will allow for the rise of self-pay patient sites which skip insurance and connect patients to doctors, just as TripAdvisor and Expedia allow consumers to have far more choice and pay less.

In addition, as insurance regulations are rolled back, inexpensive catastrophic insurance plans will hopefully once again be available. A doctor marketplace with transparent pricing coupled with such insurance will provide patients with better outcomes at lower cost.

It is becoming apparent that as insurance rates continue to rise, that tens of millions of insurance industry customers will continue to skip going to the doctor and not catch diabetes, cancer and other diseases early. They will have shorter lives and increase the burden on the healthcare system needlessly.

The ultimate solution is a combination of the best of insurance and the best of free markets such as self-pay patient sites. ★

Rich Tehrani is COO of the self-pay patient site, UMA Health (www.umahealth.com), the first to allow patients who have no insurance, high-deductibles, or catastrophic plans to shop, pay direct and save. UMA understands the disruptive potential of the concepts outlined in this article and is actively seeking to partner with other forward-thinking companies to provide better health outcomes. Please reach out to rich@umahealth.com to discuss further.

ANNUITY SAMPLER — JUNE 1, 2018

Company Name	Ratings Bests	Fitch	S&P	Product (Qual./Non-Qual.)	Type SPDA FPDA	Initial Interest	Guar. Period	Bailout Rate	Surrender Charges	Mkt. Val. (y/N)	Min. Contrib.	Comm. Street (May Vary)
American Equity	A-		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 11/9/17. 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	3 .30%* 3.30%* *CA Rates Effective 6/2/17.	5 yr.	None	8%, 8, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	$10,000 (Q &NQ)	1.5% age 0-75 .75% age 76-85
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 5 Annuity (*Guarantee Return of Premium) (Q/NQ)	S	3.30%* 2.30%* *CA Rates Effective 6/2/17	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
American General Life Insurance Companies	A	A+	A+	American Pathway Fixed 7 Annuity	S	4.20%* 3.20% *(Guarantee return of premium (NQ) *CA Rates Effective 6/2/17.	7 yrs.	None	9%, 8%, 7%, 6%, 5%, 4%, 2%, 0%	No	$5,000 (NQ) 1.50% age 86-90	3.00% age 0-85
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	3.10%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 5/14/18. Includes .25% first-year bonus and is for purchase payments over $100,000. Escalating five-year yield is 3.10%. For under $100,000 first-year rate is 2.95%. Escalating rate five-year yield 2.95%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	3.20%	7 yrs.	N/A	9%, 8, 7, 6, 5, 4, 3	Yes	$10,000	3.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-85 (Q&NQ)
Effective 5/14/18. Includes 1.00% first-year bonus and is for purchase payments over $100,000. Escalating seven-year yield is 3.09%. For under $100,000 first-year rate is 3.10%. Escalating rate seven-year yield 2.99%.												
North American Co. for Life and Health	A+	A+	A+	Guarantee Choice II (Q/NQ)	S	2.95%*[a] 3.30%*[b] *CA rates effective 6/12/18 – a (less than $100K) b(100K or more)	5 yr.	None	8%, 7.15, 6.20, 5.25, 4.30	Yes	$2,000 (Q) $10,000 (NQ)	2.00% (0-80) 1.50% (81-85) 1.00% (86-90)
Reliance Standard	A+		A	Eleos-MVA	S	3.15%*	5 yrs.	None	8%, 7, 6, 5, 4	Yes	$10,000	2.50%**
*Effective 4/17/18. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85												
Reliance Standard	A+		A	Apollo MVA (Q/NQ)	S	4.85%*	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 4/17/18												
Symetra Life, Inc.	A	A	A	Custom 7 (Q/NQ)	S	3.65%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	$10,000	Varies
*Effective 5/3/18. 3.15% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for $250,000 and above.												

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PART I OF OUR ANNUAL DENTAL SURVEY

OUR DRILL TEAM BORES IN

LOOK FOR PART II IN OUR AUGUST ISSUE

California Broker is pleased to offer readers the next installment in our series of surveys. The Dental Survey is an opportunity to hear it straight from the carrier's mouth – so to speak. We'd also love to hear from you, though. Readers: Let us know what you find valuable – or not- in the dental survey. And if you have questions you'd like answered for the next dental survey, please let us know! Email editor@calbrokermag.com

Side-by-Side Comparisons of the State's Most Popular Plans

Question 1: What types of plans do you offer?

Anthem Blue Cross: Anthem Blue Cross, the trade name of Blue Cross of California, and Anthem Blue Cross Life and Health Insurance Company, independent licensees of the Blue Cross Association, offer a comprehensive line-up of dental plans and products that include Dental PPOs and Dental HMOs for individuals, small groups, large groups and national accounts. We offer voluntary dental plans for small, large, and national groups. We also offer our large customers the added flexibility to select custom fully-insured and/or administrative services only (ASO) plans.

Beam: Beam offers a wide range of fully customizable PPO options from preventive plans to benefits rich Ultra plans. Each plan comes with access to our nationwide network of over 290,000+ access points and includes Beam Perks, our smart electric toothbrush, paste and floss, delivered to each member's door every 6 months.

Blue Shield: We provide a wide range of affordable and comprehensive dental products to meet our clients' needs. Our Dental PPO and HMO plans offer members a wide variety of plan designs and networks that fit their budget.

• For individuals/families, we offer a unique dental PPO

plan that provides member copayments instead of the usual coinsurance percentages. Our dental HMO plan offers comprehensive benefits with pre-determined member copayments. Finally, our Duo plan offers members dental and vision coverage at a single price. Our plans can be sold with medical plans or on a standalone basis.

- For senior members, we offer two comprehensive dental PPO plans for Medicare supplement plan members. There is also a dental plus vision plan package option for Medicare supplement plan members.
- For groups, some of our dental PPO and HMO plans are available on a contributory or voluntary basis, most can be sold with or without Blue Shield medical plans and are UCR- or MAC-based.

Delta: Delta Dental offers managed fee-for service, PPO and DHMO dental plans for individuals and groups of all sizes. Our group plans are available for both employer-paid and voluntary premium contributions, and with a choice of fully-insured or ASO funding options for fee-for-service plans. We also offer ACA-compliant small group and individual DHMO and PPO plans, and provide coverage to additional groups and individuals through our partnerships with 36 health plans across the country.

Guardian: Guardian 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. Guardian specializes in customized plans based on the needs and price points of the employers and employees. We also offer dental plans for individuals/families, both on and off Covered California, the state's insurance exchange. Consumers can purchase Guardian's dental plans directly from www.mydental.guardianlife.com.

Humana: In California, Humana offers dental PPO, prepaid/DHMO, Traditional Preferred, and Preventive Plus plans. These plans are available on a voluntary or employer-sponsored basis.

National General: 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: We offer a wide selection of plans to meet the needs of employers and their employees. Dental PPO, Dental HMO, and Indemnity plans are available on an employer-sponsored or voluntary basis. Dual and triple choice, monthly switch (between a DPPO and a DHM), and Administrative Services Only plans are available as well. We specialize in customized plans for groups of all sizes based on the needs and price points of the employers and employees.

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

Anthem Blue Cross: Anthem is focused on providing high quality, affordable coverage that meets the dental benefit needs of our customers through competitive plan designs with a range of market-based premiums and deductibles, annual maximums, and optional benefits. With an array of popular benefit options, we deliver affordable, quality coverage that individual and small group customers expect and we provide our large group customers with additional flexibility to select custom fully-insured and/or administrative services only (ASO) plans.

Beam: We specialize in pricing for small to mid-size businesses and offer unique savings opportunities for all of our clients. Each one of our dental plans comes with Beam Perks (our smart electric toothbrush, paste and floss) included automatically. Members use our brush and app together, and then clients can save up to 15% at renewal—just for brushing their teeth.

Blue Shield: There are different underwriting considerations for each business segment. Our ability to customize offerings for groups with more than 300 employees typically results in lower rates and more choices to meet the employer's needs.

- Group PPO plans come in a wide range of deductibles and annual benefit maximums.
- Our individual, family and Medicare Supplement dental PPO plans may vary in waiting periods, deductibles, and annual benefit maximums based on the plan selection.
- All dental plans include generous benefits, competitive premiums, and strong California and national provider networks that are available to all members; we don't differentiate our provider network for small groups or individual or family markets.

Delta: We offer small businesses a very wide range of dental benefits plans, many of which are often available only to larger groups. The majority of our small business plans are offered through a special program that evaluates risk on a pooled basis, helping to keep both rates and plan designs extremely competitive when compared to large group plans. Attractive features available through our small business plans include missing tooth coverage, composite (white) fillings on posterior teeth and coverage for all three phases of orthodontics for adults and children. While large groups often have the most flexibility in customizing plan options and obtaining rates that balance their experience and cost effectiveness, the range of benefits available through our Small Business Program make our plans particularly attractive to small group purchasers.

We have both DHMO and PPO off-exchange plans for individuals and families. Rates are especially affordable for plans that emphasize preventive care, and we offer richer

plans at slightly higher price points as well. We also market plans designed to meet the needs of seniors, offering benefits most utilized by this particular population. The small business plans and individual plans that are available through the state and federal exchanges emphasize preventive care and coverage for the most commonly used services.

Guardian: Guardian offers nearly the same plan options to small group employers as to large employers, plus an array of cost-reducing options. We also offer dental benefits through the California state exchange (through Premier Access) and through our direct-to-consumer website at www.mydental.guardianlife.com.

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 networks receive deep discounts.

For individuals, Humana offers its Complete Dental plan, a comprehensive plan that offers broad preventive, basic and major services coverage. This plan works well for those who may be recently retired or are moving off of a group dental plan. Complete Dental is a PPO plan, allowing members the flexibility to have coverage with in-network and out-of-network dentists.

National General: 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.

Premier Access: Our standardized and customized plans for small group employers are the same as the ones that we offer for large group employers.

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

Anthem Blue Cross: In 2018, Anthem Blue Cross launched two new PPO products, Anthem Dental Essential and Consumer Choice PPO, that offer modernized benefit designs, lower premiums, and a broad, but competitive dentist network locally and nationally. These plans include benefit options such as dental implants and composite (tooth-colored) fillings, annual maximum carryover including a carry-in feature, an unlimited annual maximum, and cosmetic dentistry including teeth-whitening. The plans also offer additional options for out-of-network reimbursement, including the 95th percentile of FAIR Health, and benefit enhancements including accidental dental injury coverage, extension of benefits, and enhanced preventative care, including two routine and four periodontal maintenance procedures.

Each dental plan also includes access to our industry-leading clinical integration solution, Anthem Whole Health

Connection®, an innovative program that leverages Anthem's broad capabilities to provide a holistic approach to care. Through this program, our care management staff can access member medical, pharmacy, dental, vision and disability claim and clinical data, which can help them better identify and correct gaps in patient care based on a complete health profile. In addition, consumers with chronic health conditions become eligible for additional dental services including cleanings, fluoride treatments, and even sealants—all covered at 100% with no deductible, coinsurance or waiting period.

Beam: We recently launched our Ultra plans to our SmartPremiums products. Ultra plans offer 100/100/100 coinsurance levels and annual maxes up to $5000. Clients can add $0 deductibles and adult orthodontic coverage as well. This is the perfect product for companies looking to build market leading benefits programs.

Blue Shield: We are always looking to enhance our plans and provide valuable benefits to our members.

- In 2019, for Large groups, we are introducing 4 new dental PPO and 1 new DHMO plan. We are also adding 1 Diagnostic and Preventative Only and 1 Duo (dental and vision) Diagnostic and Preventative plans that will be 100% employer paid. The new Diagnostic and Preventative plans will offer a lower price alternative to our traditional dental PPO and DHMO plans. There will be no annual maximums on these plans although all standard exclusion and limitations will apply.
- For Small groups, we are introducing 11 new dental PP

plans and 1 new DHMO plan to our small group portfolio designed to fill in gaps in the benefit spectrum. We are also removing the Rollover Rewards from all plans and adding a 2- year rate guarantee.

In addition to new plan designs, all BSC plans include oral cancer screening coverage as a value-added benefit, which comes at no out-of-pocket cost to the member. We also offer enhanced dental services for pregnant women to all dental PPO plans. Pregnant women receive one additional routine adult prophylaxis, and/or one course (up to four quadrants) of periodontal scaling and root planing, and/or periodontal maintenance if warranted by a history of periodontal treatment. Treatment is payable at 100% of the allowable amount for in and out of network

Delta: Most recently, we have expanded our PPO and DHMO plan offerings to individuals and families to make them available in more areas across the country. These plans allow purchasers to choose from exceptionally affordable coverage that focuses most on preventive care and basic services, or richer plans that provide coverage for more services at a lower cost per procedure for the enrollee share.

We've also improved our dentist search capabilities to include Yelp reviews, click-to-call phone numbers, links to dentist web pages and Google Maps interface. All of these improvements place the customer first by providing them with richer information to make an informed provider choice.

Guardian: Guardian constantly develops new, innovative ideas in order to meet our customers' needs by helping keep their teeth healthy and saving them money. Guardian offers the College Tuition Benefit®, a value-added benefit that helps Guardian dental members pay for college. Employees covered by a Guardian dental plan that includes the College Tuition Benefit® earn Tuition Rewards® that can be used to pay up to one year's tuition at one of more than 375 private colleges and universities across the nation. Guardian is the only dental carrier to offer the College Tuition Benefit®. In addition, this year we introduced enhanced PPO plan designs that offer employers and employees more flexibility and control over savings.

Humana: Humana is the only specialty carrier 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.

National General: Based on valued feedback, we have provided an option to add on a $3 Network 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: Our enhanced PPO plan designs offer brokers and employers more flexibility and control over their plan design and provide 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 that allows them to switch between the DPPO and the DHMO.

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

Anthem Blue Cross: Yes, Anthem Dental Essential and Consumer Choice PPO plan members can choose their own dentist even if they are not in our network, but their out-of-pocket costs may be higher. Members who choose a provider within Anthem's Dental Prime or Dental Complete PPO network will save the most on their dental costs. Members insured by the Dental Net DHMO plans are restricted to only in-network dentists, excluding emergency care.

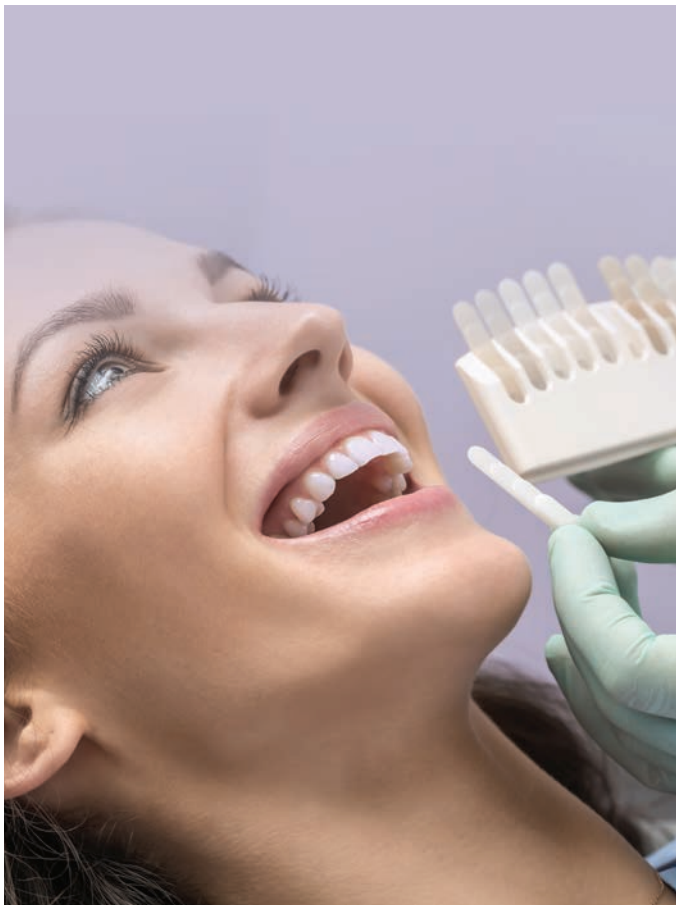
Beam: Yes, every Beam plan comes with great out-of-network coverage. Our plans come standard with 90th percentile UCR and is customizable based on the out-of-network coverage needs of an employer.

Blue Shield: Yes, both dental PPO plan members can choose to go to any dentist, although their benefits will be covered at a higher percentage when choosing a network dentist, with less out-of-pocket expense.

Delta: Yes. Delta Dental PPO and Delta Dental Premier® enrollees may visit the dentist of their choice. However, PPO enrollees will enjoy the most cost protections by visiting a PPO network dentist. Likewise, enrollees in a Premier plan can maximize their savings when visiting a Delta Dental dentist. Enrollees of these two plans can utilize any licensed dentist anywhere, and are not subject to service area restrictions.

DeltaCare® USA (DHMO) enrollees must visit their selected general dentist or approved specialist to receive benefits, with the exception of emergency out-of-area care.

Guardian: 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.



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.

National General: 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: Members covered under our PPO plans can visit any dentist they choose; however, benefits may be paid at a lower co-insurance rate for non-participating dentists. DHMO members must choose and use a participating primary care dentist.

Question 5: How many provider locations do you have?

Anthem Blue Cross: We have doubled the size of our network nationwide since 2011. Our Dental Complete PPO network includes more than 18,000 unique dentists and nearly 45,000 access points in California alone — and nearly 127,000 unique dentists and 386,000 access points nationwide. Anthem's Dental Net HMO network includes nearly 17,000 provider locations in California to choose from both general dentists as well as specialists. Additionally, all Anthem dental members have access to our international emergency dentist network, with 24/7 assistance locating an English-speaking provider for dental emergencies in approximately 100 countries worldwide. Services received through this program do not count toward the member's plan annual maximum. We also offer an expanded network of participating providers in Mexico with more than 74 dental locations, with 62 general dentists and 22 dental specialists.

Beam: 290,000+ nationwide

Blue Shield: Members have network access to over 23,900 dental HMO and 52,300 dental PPO providers in California, and more than 445,000 providers nationwide. These are two of the largest statewide provider networks in the industry.

Delta: Delta Dental PPO offers nearly 44,000 participating provider locations in California and nearly 301,000 locations nationally. Premier dentists offer nearly 53,000 locations in California and nearly 372,000 locations nationally. Currently there are nearly 6,400 participating DeltaCare USA facilities in California to choose from.

Guardian: There are over 369,602 PPO access points across the country and more than 41,924 in California. We are one of the largest PPO networks in the state based on dentists. The DentalGuard Alliance network tier, a smaller group of dentists offering greater discounts, has over 6,523 dentist access points in California. For the DHMO, there are 50,024 dentist access points across the country and 15,057 in California. Guardian's PPO network also includes dental offices in Mexico. International Assist, a value-added service available, provides dental members with access to dental care if needed while traveling outside of the U.S.

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

National General: 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: Our Dental 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 dental locations, including specialists.

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

Anthem Blue Cross: Our Dental Prime and Dental Complete PPO network model is open-access. Dental Net HMO participation status is monitored to ensure network access and adequacy, and we actively work with members and providers to ensure new enrollees have options for offices that may be closed to new enrollment.

Blue Shield: In 2017, approximately 7% of dental HMO plan network providers maintained closed practices; this represents approximately 145 offices out of 2,195 unique locations.

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Delta: Zero percent of Delta Dental PPO and Delta Dental Premier offices are closed to new enrollment. Our fee-for-service providers may close their practice, but while in operation, they must accept patients without discrimination, regardless of age, gender, ethnicity or being new to the practice.

Of our DeltaCare USA facilities, 6,382 are open to new enrollment; only 208 DeltaCare USA facilities, representing 3.26% of all DHMO facilities, are closed to new enrollment.

Guardian: In California, only 0.03% of our PPO network and 2.73% of our DHMO network are closed to new patients.

Humana: Under Humana's dental provider contracts, 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 for dental PPO plans. Approximately 95% of practices are open to new patients in the Liberty DHMO plans.

National General: 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: Less than 5% of the DHMO network is closed to new patients; this figure represents about 159 general dentist locations.

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

Anthem: Anthem Blue Cross does not require a referral for consumers enrolled in our Dental PPO products to see a dental specialist. Dental specialists submit dental claims directly to the plan and are paid in the same manner as general dentists. More than 98% are processed within 14 days. Consumers enrolled in our dental HMO products are required to get a referral to a specialist from their primary care dentist. We provide specific guidelines for the provider to follow when submitting a referral so that it is automatically approved, with payment processing closely aligned to our Dental PPO products.

Blue Shield: For PPO members, Specialist referrals are not required, and payments to specialists are processed the same as for general dentists. For DHMO members, preauthorizations for Specialists are normally processed within 5 business days.

Delta: For PPO and Premier, referrals and preauthorization are not required; payments to specialists are processed by the same guidelines as general dentists. Our standard turnaround for processing DeltaCare USA specialty care referrals is five days.

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

Humana: Humana's dental plans including DHMO 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 2017, 97.6% of clean claims were processed within 10 business days (14 calendar days).

National General: 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: Referrals are not required under our DPPO plans. For our DHMO plans, payment to the specialists is within 30 days of receipt of the claim.

Want more info? Contact:

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Randy Ebersberger, Director, Specialty Sales, Southern California randy.ebersberger@anthem.com

Beam
You can email Beam at info@beam.dental for more information, and one of our Broker Success Managers will be in touch with you right away!

Blue Shield
Brokers who currently work with Blue Shield of CA contact their BSC representative.
For those who do not have a direct contact, they can locate more information by logging onto our website at our Broker Connection:
https://www.blueshieldca.com/bsca/bsc/wcm/connect/broker/broker_content_en/broker/home

Delta
Readers can navigate to https://www.deltadentalins.com/about/contact/ to find the number specific to their location and area of interest.

The Guardian Life Insurance Company of America
Rick Porterfield, Regional Director
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415.490.4433 office
Richard_Porterfield@glic.com
Joe Stefano, Regional Director
SoCal Metro, San Diego, Las Vegas, & Central California Markets
949.885.1720 office
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Company Site: https://ngah-ngic.com/supplemental-insurance.php

Premier Access
www.premierlife.com
Phone: 888-326-3210
Sales Executive: Robert Semrow – robert@premierlife.com

Readers: Don't miss part II of the dental survey in Cal Broker's August issue!

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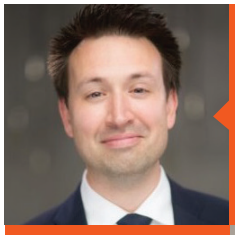

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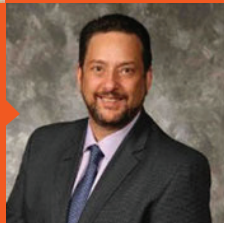

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HEALTH INSURANCE:
CONTROLLING COSTS THROUGH REFERENCE BASED PRICING

By DAVID L. FEAR, SR. RHU

A recent proposal coming out of the California State legislature seems to indicate that the politicians are now turning their attention to a critical issue in America today: The very high cost of health care. While it is unlikely that a solution will be found in the immediate future, this is a good first attempt to get the issue out in front of people.

As you know the Affordable Care Act (ACA) seemed to focus on the reform of the health insurance industry and did little to address the high cost of health care. However, a better attempt to curb health care costs may have come to us through the passage of the Medicare Modernization Act (MMA), which went into effect in 2004. Most people will tell you that the MMA just introduced a new benefit (prescription drug coverage) and the creation of health savings accounts (HSA). However, what most people don't know is that the government put into place a huge change in the way providers are paid by Medicare.

Prior to the MMA, less than 50 percent of providers were accepting Medicare patients. Today, that number is closer to 90 percent and growing. Why? Because the MMA changed the formula as to how providers are paid for their services. That formula has been fine-tuned for the last 14 years. While they may not want to admit it, providers are in fact making money when they accept Medicare patients. The formula is complicated yet works.

Since 2004 employers who are "self-funding" their group health benefits have seen the effect of the MMA and have reached out and attempted to pay providers a percentage of what Medicare pays. A whole cottage industry has developed around this strategy, which is referred to as "reference based pricing" (RBP).

While the Federal government remains the largest purchaser of health care services in America, the employer community is not far behind. And those employers are challenging providers to reduce their prices or suffer a loss of patients who will be directed by their employers to seek care from more affordable providers.

Forty years ago, employers demanded that their health insurers provide options to reduce health care premiums. Almost overnight, those employers began to change from "indemnity" insurance plans to managed care plans such as HMOs or PPOs. Yet, premium rates continue to increase each year (there was a flattening out in the mid-90's). As the cost/savings of HMO/PPO plans began to lose their luster, employers were offered "narrow network" products which did save money but also reduced the choice of health care providers.

Following full passage of the ACA, large employers began to "direct contract" with providers and offered to pay them a percentage of Medicare. Given that about 90 percent of providers are now accepting Medicare payment it seems logical that they would accept a percentage of Medicare (i.e. 125 percent or more).

So how does paying a provider 125 percent to 200 percent of Medicare save an employer money?

To answer that question, let's go back to 2014 when Time magazine devoted an entire issue on the topic of health care costs. The article was entitled: "The Bitter Pill: Why Health Care Costs Are Killing America". Author Steven Brill conducted a lengthy investigation of the health care industry and it did not paint a pretty picture. The bottom line was that providers – who now report their costs to the Federal government – are routinely marking up their costs and billing patients as much as a 1000 percent over cost. Brill calls out hospitals, medical device manufacturers and the pharmaceutical industry in this regard. He cited the use of a computer program called the "chargemaster," in which hospitals routinely bill for services that greatly exceeded their costs. He cites huge mark up on the price of many medical devices as being more than 500 percent of cost.

He then pointed out that Medicare now pays those same providers to cover their costs plus earn a modest profit. The claim that they "lose money" when they take Medicare patients is disproven when you see the amount of advertising that some hospitals now do in places like Florida where a high percentage of the population are enrolled in Medicare. Why would they be looking for new patients when they lose money on those patients who are enrolled in Medicare?

Many employers are now using the services of reference based pricing administrators who contract and negotiate prices directly with providers. Because they have the data compiled by Medicare with regard to provider costs, they can and do challenge the huge mark-ups that providers routinely bill for their services. Here is an example:

A hospital bills the patient $10,000 for a specific service rendered. The hospital participates in Medicare and reports that their actual cost for this service is about $1,500 and Medicare pays the hospital $1,950 for the service. A patient without insurance coverage will be billed $10,000 but might be given a 20 percent "discount" for cash payment. If that same patient has health insurance through a PPO provider, the carrier will pay $5,000 for the service (thus reporting that they saved the patient 50 percent off of billed charges). Yet the employer paying the bill – using the services of a reference based pricing administrator – negotiates to pay the hospital 150 percent of the Medicare allowance, which is $2,925.

At the end of the day the employer saves greatly versus the use of a traditional PPO or even cash-discounted costs. Of course not all PPOs have the same agreements with providers but in the case of employers using a reference based pricing strategy they are starting at a much lower point and end up paying no more than they would have with a PPO.

Each case varies because health care costs vary by many factors including geography and severity of the condition. Given the fact that the Federal government has compiled a huge amount of information on health care pricing and uses that to pay Medicare providers, it only makes sense for private payers – such as self-funded employers – to take advantage of this strategy.

AT THE END OF THE DAY HERE IS WHAT REFERENCE BASED PRICING ATTEMPTS TO DO:

A. Get the provider to accept a reasonable payment for their services – reasonable being more than Medicare but less that what some PPO and HMO plans are paying (and far less than "retail" price), and;
B. Agree to not "balance bill" the patient for the difference between the billed charge and the agreed-upon payment.

Again, the recent legislative proposal in California would effectively require that all providers accept a percentage of Medicare. Naturally the hospitals, doctors and other providers don't like this idea. Yet the question needs to be asked of them: Then why are 90 percent of you now accepting Medicare patients?

Reference based pricing is nothing more than using Medicare as a payment point for fee-for-services provided by health care providers. Smart employers are doing this and are seeing immediate savings which helps to control their total benefit costs provided to their employees.

While this all sounds great there are some challenges that will be encountered when RBP is first implemented. For example, some providers agree to a percentage of Medicare payment but turn around and attempt to "balance bill" the patient, threatening to take them to collections if they don't pay the balance. That frightens employees and angers employers.

Thus, when contracting with an RBP organization you need to make sure they have muscle to negotiate with providers and see that those providers agree to not balance bill the patient after a fee has been agreed upon. Most providers will do this and while it might take some time, in the end both parties can come up with a number that works.

The alternative is the provider / payer go to court or an arbitrator and the provider then risks having their "billed charges" revealed as a very high mark-up over their costs. Most RBP administrators claim that less than 1 percent of all claim payment disputes end up in court or arbitration – because in the end providers don't really want price transparency.

Slowly but surely reference based pricing is beginning to take hold and we can actually thank the MMA for helping change the way that health care providers are compensated in a fair and equitable manner and that this strategy is now helping the private sector and not just the Federal government! ★

David L. Fear, Sr. RHU is the President and CEO of Shepler & Fear General Agency of Roseville, California. The firm specializes in alternative funding arrangements for employers of all sizes. He is a past president of CAHU and NAHU and the 2015 recipient of the Harold R. Gordon Memorial Award for Health Insurance Person of the Year.

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Long-Term Care Underwriting Considerations

By LOUIS H. BROWNSTONE

The success rate in underwriting a long-term care insurance applicant has been decreasing over time. Declination rates are now in the 30 to 40 percent range, and this is before withdrawals and not taken policies. This is one of the factors which make it so difficult for an agent to be successful selling traditional individual long-term care insurance, and this can be very discouraging to all concerned. How can agents understand the underwriting issues in today's environment and do a better job of underwriting?

Has the underwriting become tighter? Many think it has, but that is not my view. If anything, there has been some loosening of underwriting restrictions around the edges. This has mainly been the result of advances in medical science which have made some diseases either controllable or curable. There has been an improvement in preventive medicine as well. I believe the increased declinations are the result of other causes.

First, let's look at underwriting from

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the agent's perspective. Many applications are now being taken remotely. This normally prevents agents from physically seeing signs of uninsurable conditions, such as unstable walking, ramps at the home, oxygen tanks in the closet, etc. Agents usually have to rely on the verbal representations of the applicant. This problem may be partially solved in the future by greater use of Skype and other visual aids in remote selling.

Second, as aging issues become better known and understood, I believe that there has been an increase in the percentage of applicants who either have bad family history or have significant medical conditions themselves. The increase in the cost of the insurance has scared off those who are not strongly motivated to be covered. The most strongly motivated are those who have concerns about their health, probably because they have health conditions. The applicant pool seems sicker to me, which of course leads to more declinations.

Third, and most disturbing, there has been an increase in people who are lying about their health. Applicants with medical conditions are trying to see if they can hide the truth and get covered. Many leaders, including President Trump, lie a great deal, and set a bad example. It's incumbent upon agents to tell applicants that insurance carriers have many access points to medical history, and that a dishonest application will likely result in a declination.

Most declinations are now due to a failure one way or another to reveal medical conditions on the application. Agents need to obtain a full medical history, preferably before presenting a long-term care solution. They also need to carefully consult underwriting guides and call an underwriting hotline if potentially declinable conditions exist.

The main motivation of the underwriters is to place policies if possible and encourage agents to send in applications, so conversations with underwriters need to be taken with a grain of salt. Therefore, if an underwriter says, "We'll consider this case," the case will in all probability be declined. If an underwriter says, "This sounds like our impaired underwriting class,"

the case will in all probability be declined.

All parties desire a high placement rate, but it's tough for the agent not to attempt to get the applicant insured, despite the declination risk. The agent doesn't get paid, the carrier fails to make a profit and the applicant's desires are not fulfilled until a policy places. On the other hand, it's a mistake to submit too many borderline cases. Frequent declinations are discouraging to the agent and may cause him or her to be turned off to selling long-term care insurance. Placement bonuses for the general agent are often gained or lost on what happens to the borderline cases, and all in the general agent's hierarchy are affected by the success or failure of the general agent.

The presence of adverse medical conditions may well lead the agent to present a hybrid product, linked product, linked annuity product, or even a critical illness product. More later on these alternatives.

Now, let's look at underwriting from the carrier's perspective. Underwriting is the carrier's main line of defense against huge losses, as much as a million dollars on a single policyholder. No wonder carriers are being so careful not to insure a bad risk. They now have the advantage of being able to rely on several reliable sources of information.

First, they are requesting a complete medical history on the application. A long-term care insurance application used to be the front and back of one piece of paper. Now it's 25 to 30 pages and more, with exhaustive medical history profiles. Some carriers are even asking about family history as well as lifestyle. The information on the application is often checked by a phone interview and where necessary a cognitive screen. In addition, a great deal of medical history is now housed in the doctor's office on a computer, increasing completeness and clarity of the history.

Second, carriers are utilizing the Medical Information Bureau and the Drug Formulary to verify the information on the application. These sources can reveal missing or intentionally omitted information. They are a relatively new and reliable line of defense for the underwriters. They can also help personal interviewers in asking questions which will result in a clearer picture of the applicant's medical condition.

Third, there is plenty of sharing of information between the carriers, both formally and informally. This has led to more homogeneous underwriting standards. It used to be that one carrier's underwriting for a specific medical condition could be quite different from another's. These variations still exist but are far less prevalent.

Unlike individual long-term care insurance, there has been some tightening of standards in the association and employer market. Guaranteed issue is very rare, and modified guaranteed issue is also infrequent. The most frequent underwriting is simplified issue. Simplified issue sounds like liberal underwriting, but it often is not. If an applicant admits to a medical condition, the simplified underwriting actually becomes full underwriting for that condition.

Now what about hybrid products and linked products? The underwriting at this point is more liberal than for traditional long-term care insurance. Why? The medical risks are essentially the same. A diabetic who

applies for a hybrid or linked product has the same medical risk if he or she applies for traditional long-term care insurance. However, while the medical risk is the same, the financial risk is different.

Let's look at an example. In the case of traditional LTC insurance, a policyholder might pay $2,500/year for 25 years, or $ 62,500. The carrier could double that amount at 5 percent growth in those 25 years to $125,000. If there were a claim, the first $125,000 would be paid out of the policyholder's invested capital before the carrier would have to pay out of their own capital.

Now let's take that same $62,500 and invest it in the first year in a hybrid or linked product. At 5 percent growth for 25 years, that $62,500 would grow to $211,625. Now, if there were a claim, the first $211,625 would be paid out of the policyholder's invested capital. That's a $86,625 better investment for the carrier…about 70 percent more money to utilize than with a traditional long-term care insurance policy. No wonder that carriers prefer hybrid and linked products to traditional long-term care products! The financial risk is lower.

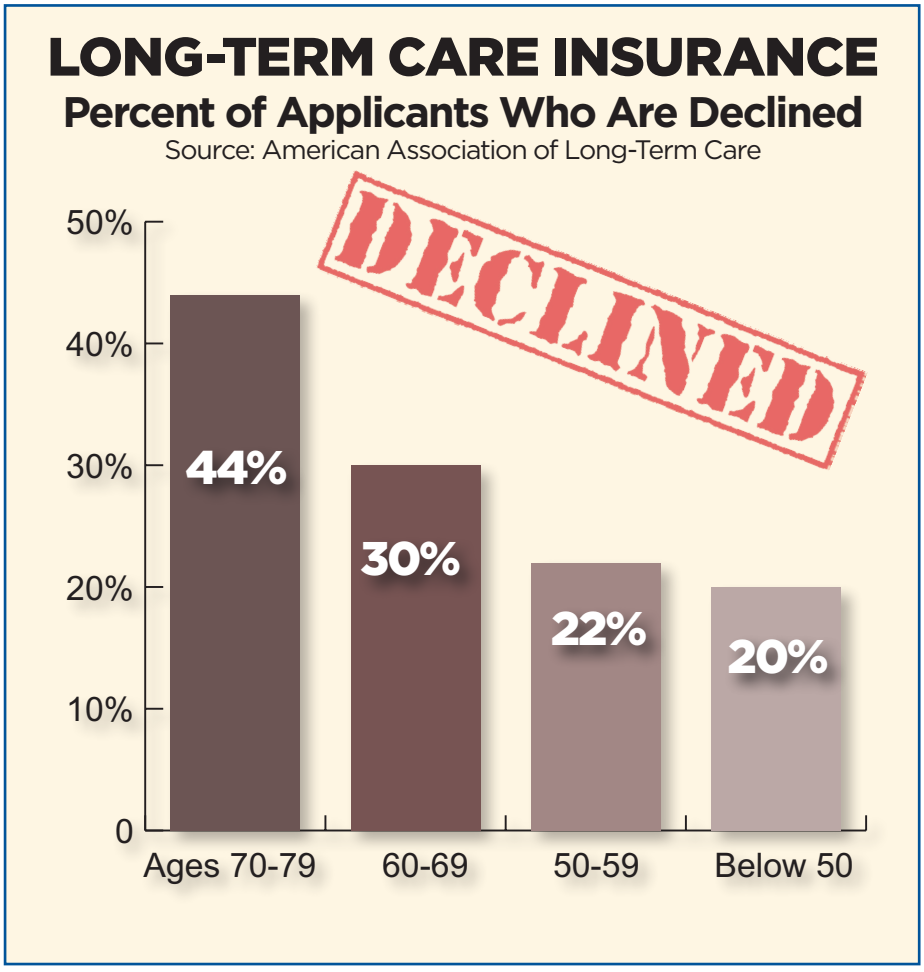
The result is that the underwriting is changed because the carrier's exposure is reduced. But that's not all. In most cases, the traditional long-term care insurance policy may contain a compound inflation rider. Even with just a 3 percent compound inflation rider, the daily or monthly benefit would double in 24 years. This is generally not the case for the hybrid and linked products. Hybrid products are generally sold without an inflation rider. Their long-term care benefit is expressed as a percentage of the death benefit, and it often is for a limited period. Linked life products generally only provide an acceleration of the death benefit, which usually does not rise over time. No wonder that carriers prefer hybrid and linked products to traditional long-term care products. They contain built-in limitations on the financial exposure of the carrier.

The same general conditions are true for hybrid and linked annuities, which usually only pay two or three times the annuity value. They also contain built-in limitations on the financial exposure of the carrier. As for critical illness insurance, this product pays a set amount for certain medical conditions.

Are hybrid and linked products the wave of the future, in part due to more liberal underwriting? They could be. However, I see some resistance to the concept of selling two benefits at the same time. The cost is higher, and the long-term care leverage is lower than with traditional long-term care insurance. Assuming rate increases on new long-term care products will be minimal, traditional long-term care insurance will be the best value in long-term care planning. Admittedly, in the end, the public will decide which products best serve their needs.

One last thought. I believe the future in long term care protection will rest in the employer market. This has not happened yet because human relations directors are so concerned about the potential increase in their medical costs. But if the costs of medical insurance stabilizes, companies will begin to consider long-term care insurance as the core benefit that it should be. If and when this occurs, underwriting considerations will be reduced by the sheer size of the cases and the fact that employees are well enough to be working. ★

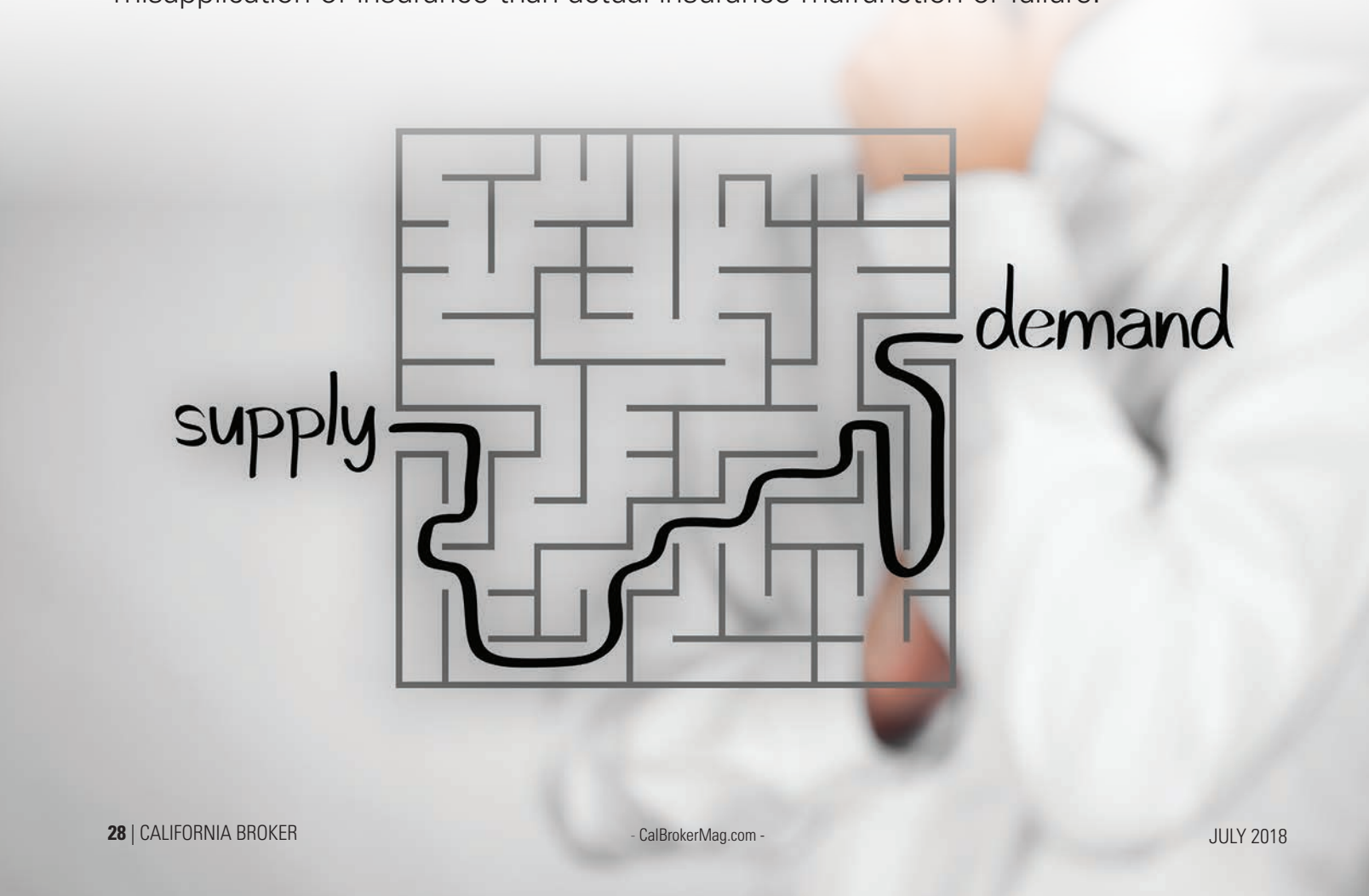
Louis H. Brownstone, a Cal Broker regular contributor who writes about long-term care, is chairman of California Long Term Care Insurance Services, Inc. located in Burlingame, California. California Long Term Care is the largest independent specialist long term care insurance agency in California, and is broker for a group of high-producing long term care specialist agents. Brownstone is also very active in NAIFA, the National Association of Insurance and Financial Advisors. One of his goals is to revive the California Partnership for Long Term Care in order to insure more Californians and save the State of California billions of dollars in future Medi-Cal expenses.



CONSUMER DEMAND TRANSFORMING THE VERY PURPOSE OF HEALTH INSURANCE

By DENNY WEINBERG

Every broker knows that today's health insurance model is broken, enduring disruption by regulators and lawmakers, often forcing non-insurable dynamics on an insurance model. In every case, the market itself re-adjusts, sometimes surprisingly. Is it possible that stability is just around the corner, driven more by these natural system dynamics and the marketplace reactions themselves? Perhaps. The erosion of health insurance effectiveness may be much more due to misapplication of insurance than actual insurance malfunction or failure.



History and science show that health insurance is most effective when designed for the highest risk – the unforeseen – especially hospitalizations and expensive therapeutic events. The price necessary to cover these kinds of expensive events alone would be quite small compared to today's prices. However, due to years of over-regulation and legislative mandates, a surprisingly high portion of today's health insurance prices relate to high frequency, low-cost routine care that could sometimes cost less by going direct. Generic prescriptions are a great illustration – many can easily be bought for less than the cost of processing a claim, especially with additional discounts offered by large retailers looking for deeper consumer relationships. That is a terrible waste of insurance premiums, and insulates consumers from natural cost–controlling behaviors.

The good news is, these increased prices are forcing more consumers and workers to choose lower priced plans with higher out-of-pocket costs. This has in turn fostered greater awareness of coverage dynamics for larger and less frequent health care risks. In fact, many studies are showing that emerging consumer engagement with lower priced insurance plans might be forming a new end game. This author believes that end game will be all about risk and consumer engagement around complex care risk and insurance versus routine care costs and increasing self -funding in new delivery models.

Consequently, two usage paths seem to emerge:

- Lower-cost routine care models, responsive to personal engagement, convenience, local access, and the ability to negotiate costs directly by prudent consumers.
- High-cost, complex care models, supported by today's unlimited insurance policies, and which offer care excellence and risk protection initiatives.

It is interesting to look back at the time when routine and complex care were financed separately (and perchance more effectively?)—see sidebar on page 30. Then we might lament the possibly unwise dynamics that resulted in merging these coverages organically in the late 1970s under a Major Medical model. It appears now that separate coverage paths might actually make sense. Back to the future?

While history demonstrates a systemic difference between routine and complex care, our insurance model is no longer structured or priced to reflect these differences very well. Routine care impacting a large percentage of the population, delivered by physicians, including drugs and diagnostics, creates substantial cost and price pressures on the insurance model. Meanwhile, consumers and workers have adopted unreasonable expectations about "coverage" for everyday routine care costs, which prior to the 1990s was largely paid out of pocket, not by health insurance. Hospital-based care for more complex or acute services, while incredibly expensive, is easily covered by insurance models, because they occur so infrequently in a normal population. As a result, the insurance plans pre-1990s were quite inexpensive as they were designed to cover only these complex care events.

"...emerging consumer engagement with lower priced insurance plans might be forming a new end game...about risk and consumer engagement around complex care risk and insurance versus routine care costs and increasing self -funding..."

Given all this we should not be surprised that today's health insurance policies are not very effective because their provisions like deductibles, coinsurance and out-of-pocket limits relate well to complex care, but poorly to routine care. But, because of the years of increasing requirements for insurance plans to cover a vast array of otherwise uninsurable routine care services, the price of health insurance has become essentially unaffordable. Again, misapplication of insurance is the culprit.

Currently, new approaches to routine care, diagnostics and therapies at home, in retail settings, by mail and Internet are continuing to expand the nature of routine care. These developments only reinforce the argument that this category of care is unique and different.

Is this affecting the market? Yes. Consider the explosion of voluntary plans sold to employers along-side lower priced high deductible plans. Or the increased use of HSA and HRA accounts alongside high deductible health insurance. These are simply mechanisms to focus insurance on complex care, and secondary mechanisms for routine care, that will be managed by the consumer/worker as a more engaged player. Hixme is responding with the Hixme Health Bundle™ of coverages and others are already packaging supplemental coverages with core health insurance in order to create value from this distinction.

Now what does all this mean? Lets face it. Today's emerging role of health insurance will cause most routine care to be essentially self-insured, with mechanisms to stimulate consumer engagement. This is the silver lining. Consumers (willing or not) are becoming more discriminating and exhibiting smarter consumer decision-making. This allows consumers to focus on qualitative questions including: How long is the drive? How easy is it to navigate the front office? What is the cash price for services? Can terms of payment be negotiated? (Hixme does this type of fee negotiation routinely for its members' balances.) If self-insuring, are consumers more likely to even change doctors to lower costs? People are already doing that today more than ever before.

On the other hand, if diagnosed with a significant medical issue, or an acute medical need occurs, consumers are far less concerned by convenience or

even out-of pocket costs, because consumers view serious medical needs in a completely different light. And in that case, even a significant deducible is not a barrier to care. This is especially true because catastrophic care costs beyond consumer share are so substantial today. Once you reach your deductible and out-of-pocket maximum, 100 percent unlimited coverage is itself the value. (Once triggered after maximums, today's plans are required to cover unlimited costs annually and over a lifetime.)

HOW MIGHT THIS AFFECT HEALTH PLANS IN THE FUTURE? MORE DIRECT ROUTINE CARE.

With patients increasingly accessing routine care they pay for out-of-pocket, I predict physician networks will decline. This may happen to the point where we may see networks actually disappear for routine care. If I'm paying so much of it anyway, what do I care if it's in or out of network – unless there's a significant price difference that I can actually compare? And can I leverage that comparison with my provider to negotiate the fee I pay?

Watch for routine care coverage to slowly diminish and disappear entirely from health plans due to cost sharing mechanisms. Many savvy patients will tell physicians and pharmacies that they are not insured in order to get access to cash prices and other incentives. On the complex care side, watch for the evolution of systems and specialized Centers of Excellence around certain kinds of health care needs, with a much more highly elevated role for these care centers. This could increase effectiveness and reduce costs. (For more info: https://www.callisonrtkl.com/news/the-consumerization-of-healthcare/).

Critically, empowered consumer negotiation is fundamental to this transformation. Negotiating fees for care is the crucial "consumerization" piece. (For more info: https://www.jpmorgan.com/global/cb/consumerization-of-healthcare.)

On the complex care side, virtually all health plans can get you to the right place for care for the right reasons when something serious happens. And as noted earlier, now plans

Here's the backdrop:

MEDICARE:

- Coverages have always been separately structured and separately accessed: Part A (complex hospital-based care), Part B (routine physician care) coverages and Part D (prescriptions that cross between routine and complex at the point of dispensing).

BLUE CROSS (created by hospitals) and BLUE SHIELD (created by physicians):

- Initially were created as separately financed structures; one generally focused on routine care (physician), the other on complex (hospital based). Today, years later, virtually all are merged. Has this been good or bad? Out-of-control inflation seems to have been triggered at right about the same time. Is this a consequence?

COMMERCIAL HEALTH INSURANCE:

- Private health insurance emerged prior to World War I. However, it was not until well after the stagflation of the 1970s that hundreds of commercial insurance companies entered this new market. Their initial offerings focused on "hospitalization coverage" and were common in government and commercial markets. While almost all of these companies are gone today due to mergers, those that remained created the Major Medical movement-- comprehensive coverage that blurred the differences between routine and complex care.

- State regulations increasingly reinforced comprehensive care insurance requirements, with broader definitions of "care" for today's policies, despite the inflation cycle that it may well be feeding.

- All insurers, public and commercial, forced to respond to this inflation cycle and price/cost pressures from buyers and users, have increased deductibles and out-of-pocket maximums so significantly that much routine care today is never "funded" even though much is "covered."

- While costs have soared, and legislation has attempted solutions, the structure of the health care system remains largely (and mostly unresponsively) the same. Most hospital systems and physician systems still operate independently. However, hospitals have consolidated into regional or national systems. Independent or small practices of physicians affiliated with larger groups are emerging as increasingly powerful organizations.

- Most recently, Accountable Care Organizations (ACO) created under the Affordable Care Act (ACA) were supposed to accelerate the interconnection between these large systems. But the whole ACO movement just hasn't evolved the way it was anticipated, partially because of the challenges integrating professional physician systems and corporate hospital systems. Reference: http://whartonmagazine.com/blogs/clarifying-the-blurred-lines-in-health-care/#sthash.o3S12buP.dpbs.

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are required to cover unlimited costs annually and over a lifetime, once triggered after deductibles and maximums are met.

The fact is, under today's insurance guidelines, all insurance policies have to cover all 10 Essential Health Benefits. But look for that to change. While there is an effort to allow states again to redefine essential benefits as they choose, new gaps that emerge there will easily be addressed by the new generation of voluntary and supplement coverages that kick in when certain medical events occur. Watch for those to be more integrated into health plans, like Hixme's Health Bundle™. (For more info: https://hixme.com)

"I believe our end game will be all about aligning risk with consumer engagement. And I predict that this evolution to more purposeful insurance will be a welcome change…"

WHERE TO FROM HERE? A SUMMARY

The two paths (routine and complex) that we have come to know as a single system for nearly 20 years, spurred by the Major Medical coverage model, may now re-emerge. As explored, complex care, often involving hospital or institutional systems, is highly insurable because such major high dollar expenses occur so infrequently. Routine care is not insurable in the same way for three reasons.

- First, high frequency claims are, by their very nature, uninsurable.
- Second, some routine services can cost more in additional premiums or co-payments than the cost to access and pay directly, if the patient engages pro-actively with the practitioner to negotiate.
- Finally, most routine care today will never get past a health insurance plan deductible or out-of-pocket maximum on its own.

"…now plans are required to cover unlimited costs annually and over a lifetime, once triggered after deductibles and maximums are met."

Therefore these two paths are emerging very organically by virtue of high deductibles and high copayments in today's health insurance plans. That will continue. Perhaps we find ourselves back to where we began, albeit within a regulatory arena that is much more complex. In any case, routine care and complex care will likely be what separates the type of coverage designed and offered in future models.

We already see this in the marketplace with more tailored coverage packages like the bundled coverages offered by Hixme and others that can help control costs by recognizing the difference in coverage approaches for routine and complex care.

As I said, I believe our end game will be all about aligning risk with consumer engagement. And I predict that this evolution to more purposeful insurance will be a welcome change for the entire marketplace. ★

Hixme CEO Denny Weinberg is a 25-year veteran executive in health care financing and operations. His broad background includes a 20-year tenure as co-founder and EVP of WellPoint, during a financial turn-around and nine major acquisitions. Denny also served as CEO of a number of WellPoint's largest and most unique operating companies. He holds multiple U.S. patents and manages a portfolio of early stage companies in the health and medical arena as well as other industries. Denny gives back to his community as a board member, advisor and consultant to both private equity-backed and publicly traded Blue Chip companies. About Hixme: Hixme is a radical alternative to traditional group coverage. Hixme's benefit model for employers with several hundred workers is primarily direct to market. Brokers who serve employers with more than 500 workers are an important part of Hixme's future. For more information go to: https://hixme.com.

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Candid Life Conversations with Clients

Life insurance sales is largely a conceptual process made complicated by the fact that most clients would rather not think or talk about the matter at hand. Agents and brokers are challenged to overcome this attitude to influence their clients to consider and prepare for the inevitable. It's important to help clients understand the long-term financial implications associated with selecting the correct life insurance policy.

By GUY BAKER PhD

Typically, clients act on impulse and present-day cost without a true comprehension of how the product functions and how policies are funded. A candid conversation can facilitate an educational conversation and address client objections as they come to understand the sensitive topic.

PROSPECT SMARTER, NOT HARDER

Focus prospecting efforts on people who are predisposed to buy life insurance or core products as opposed to potential clients who refuse to meet for a preliminary, frank discussion about life insurance. This method will save time through every stage of the prospecting process and ultimately results in a higher commitment to a policy. Whatever your prospecting methods entail, clients must be willing to have these conversations.

One common objection brokers face in their careers and preliminary meetings is a client's misconception that it's best to purchase a term life insurance policy instead of a permanent policy and invest the cost difference. It is vital to interpret the underlying logic behind this objection and respond accordingly. Explore the client's possible motivations to further understand their thought process.

They may not want to spend a lot of money on life insurance, or they believe other investments would yield better returns than an insurance company. At this point, compare the alternate investment option with the insurance product itself. The client may feel safer with an expected return of 10-12 percent in real estate, their business or even the stock market. At a first glance, this may seem like a smart choice when contrasted against an insurance policy where the underwriter typically earns a higher return than what is paid out to the client. But don't mix apples and oranges. Your job is to help them understand the benefits of a well-planned life insurance policy and avoid a misalignment of

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OPEN WITH CANDID CONVERSATIONS

During the first meeting with a client, ensure they understand life insurance. Regardless of whether clients feel they understand the basic principles of life insurance, an introductory conversation will typically reveal they have some underlying doubts or questions. When you discuss the product in-depth for the first time, it is important to present the full picture, so clients can make an informed decision.

Help them understand that all life insurance essentially is term insurance. Insurance providers base all policies – both term and permanent – on the same set of probabilities and mathematics. All policies operate on the same mathematical, scientific principle based on the predictable probability of death. Illustrate how a mortality curve is created and used to price insurance. To determine how much life insurance will cost, you need to know your client's life expectancy. If you add up the cost of insurance at life expectancy, the cost equals 74 percent of the face amount of the policy. The underwriting company must collect 74 percent of the death benefit to be actuarially sound.

Clients who purchase term insurance effectively agree to pay the mortality curve. The initial premium is low the first year for term insurance. It is based on the probability of death that first year. But, by the time they reach life expectancy, the premium will have increased exponentially as it reflects the higher cost of dying as fewer in the insured group survive.

EMPHASIZE IMPORTANCE OF COMPOUND INTEREST

The next step is to ensure your prospective client understands the power of tax-free compound interest and how it can reduce their share of the mortality cost during their lifetime. By over-contributing to the policy, a higher premium builds a reserve that is invested to pay the higher mortality costs in the later years. Explain that this additional amount of premium is stored in a "box," the cash values of a permanent policy. Everyone who buys insurance has a choice. They can either pay the curve or fill the "box." The fundamental difference is whether the mortality costs are going to be paid with their money or the money from growth in policy.

If enough funds are contributed to "the box" over the client's lifetime, the compound growth on the policy's cash value should cover the curve. Clients can fund "the box" with this sum in a number of ways – 1) an upfront lump sum, 2) periodic payments over a lifetime or 3) a short-pay period of 10 to 15 years. As long as "the box" is sufficiently funded, the earnings are designed to track the policy curve. All insureds have to make the same choice – either pay the life insurance mortality curve with their own money or fund the mortality costs by filling "the box" with enough premium to keep the policy for life.

"After clients understand the difference between term and permanent policies, they rarely will want term insurance, but it may be all they can afford. If that is the case, help they buy as much term coverage as they need."

Of course, a permanent policy's earning on the curve depends upon the underlying investments. If "the box" earns more than was projected, clients won't need to put as much in "the box." If it earns less than projected, they will need to increase their funding, or "the box" will run out of money. If it is properly funded, a permanent policy will pay the curve for a client's lifetime. This is true whether they buy universal life, variable life, whole life or indexed UL. If a policy is overfunded, the insured can borrow or withdraw the excess as income during retirement – a common use of insurance that is not available with a term policy.

LIFE INSURANCE AS AN ASSET CLASS

Think of life insurance as an asset class and a tool designed to protect wealth and the family against premature death. Realizing no one knows when they are going to die, term insurance may sound like a good idea at the outset, but it is not the best solution to guarantee coverage when clients outlive their ability to pay the rising mortality costs. Only the most aggressive investor would put 100 percent of their assets at risk with one product or solution that may fail down the line. When you compare the internal rate of return of a life insurance policy, after you subtract the mortality costs, it fares very well to tax-free equivalent investments and other like kind asset classes. There is always room for a solid life insurance contract in a well-diversified investment portfolio.

After clients understand the difference between term and permanent policies, they rarely will want term insurance, but it may be all they can afford. If that is the case, help them buy as much term coverage as they need. The number one goal for every life insurance professional is to help their clients provide adequate coverage in the event of death. You can always return at a later date to remind them that they will not be able to pay the curve over their entire life. They may be better able to afford a more permanent solution. The curve is a great way to build clients who will eventually need additional services in the years ahead. A knowledgeable client is a great client, and you want to empower them with the proper lifeinsurance knowledge. ★

Guy E. Baker, Ph.D., MSFS, CLU, is a 48-year MDRT member with 39 Top of the Table qualifications. He qualified for Top of the Table at age 32. Baker served as MDRT President in 2010-11. He has been a registered investment adviser since 1993, working to solve clients' retirement issues. An author of many books as well as an internationally known speaker, Baker completed his Ph.D. in retirement planning and investments through the American College.

WHY I CONTINUE SERVICING AND SELLING TO THE UNDER-65 MARKET

By NAAMA POZNIAK

If you decided to not serve the individual market, you have many great reasons, and I respect it. In the face of a lot of skepticism about the individual market, I personally decided to continue selling and servicing these policies.

As I'm sure we are all aware, every year the individual open enrollment falls during Medicare enrollment and small and large group renewals in Q4. And every year, I think to myself, "What did I do wrong in my life that I need to go through this process?"

It is actually getting worse instead of better as there is a higher volume of clients

to serve and the actual individual enrollment period is getting shorter and shorter. The deadlines are the most painful; we always try to work hard to bring clients to the finish line and not leave anyone behind. The team is tired and the long stressful hours combined with the frustration of so many people who are struggling to find affordable access to care is beyond unbearable. Despite all this hardship, I must share with you all that I never felt as fulfilled as I feel lately.

For me, it's the challenge that charges new and bigger goals; if it wasn't for the challenges, I wouldn't feel as passionate as I do. I feel that our individual clients need us now more than ever. I feel that the support my team and I gave the individual market is priceless. I'm proud of my ability to view, evaluate and help clients make smart decisions and how crucial it is for their finances and health. While health care may keep changing and may even be killing the American dream, people need us more than ever!

A good portion of my book we have been servicing for over 20 years, and I feel gratitude for the ever-growing families and seeing them through the phases of their lives. Speaking of which, another large portion of my book is the children of these long-time clients and other young adults aging off a parent's plan. Each of them need their own coverage and guidance, and to understand the importance of the financial protection despite the perceived invincibility of their youth.

The knowledge, the time, and the conviction that my team and I have, the connection with the providers, the ability to turn complicated situations into a solution, and our collective dedication to these clients over time are an investment… not just a financial investment, but also an emotional one. I couldn't turn down clients that needed help through navigating the Covered California or Medi-Cal enrollment. Yes, we are not getting paid much proportionally for Covered California enrollments with all the time spent fixing them, and yes, my office enrolled about 2,500 clients over the last few years into the Med-Cal system for which we didn't see a dime.....

But have you ever asked yourself, "What is my true purpose in life?" Is it really our purpose to just make money? If that's true, then you may be in the wrong field. Pick a different industry besides anything healthcare-related.

Healthcare should be generated on the true core value of best access for each and every client. Our ability to evaluate and remain neutral to the end result allows myself and my team to find the best access for each and every client. Whether it's Medi-Cal, on-exchange with a subsidy, off-exchange direct policies, small group, or transition to Medicare, I feel I can't let these people wander without a guide after all these years.

"While it may not seem like the most economical decision for agents and brokers to sell IFP, these people need help. What will happen when agents and brokers stop servicing these clients? What will happen then?"

While it may not seem like the most economical decision for agents and brokers to sell IFP, these people need help. What will happen when agents and brokers stop servicing these clients? What will happen then?

If you really would like to service your clients in the best possible way, you should be able to provide access to various benefits that are available in our current market. As change is the only constant way of dealing with any industry, we should learn to service our clients and find ways to sustain our business.

In dealing with so many moving parts, writing so many individual policies that make up a book, I bow to the thousands of agents that enter the individual market and continue to go above and beyond and thrive. And while some of these products are difficult or frustrating or time-consuming to sell, a millennial buying a policy today will become a small business owner tomorrow. Your neighbor who had a policy with you for 20 years is now turning 65. Your friend who has a family policy just decided to get life insurance.

My practice is a perfect example for sharing how can you actually expand and survive in the IFP market. Our agency has been offering, sharing, educating and teaching agents and brokers for years how to implement various other lines of coverage, like international travel or short term options. It is kind of fascinating to watch how agents previously refused to offer these products because of the very low non-contingency compensation, but that is changing too as we become a more global economy and the products grow and change to reflect that. Above all else, we do what's right for our clients and the universe provides.

As we don't have a crystal ball, we don't know what tomorrow holds for the individual sector. However, I was just in Washington, D.C. on my annual trip with NAHU in February (which I highly recommend each agent to join), and I've never seen such bipartisan cooperation to fix our current system. It may not be perfect, but it's what we've got for now. And change is coming, however large or small, however fast or slow I do believe that we will be able to charge a fee for our service in the very near future.

I can't promise my clients that I will forever offer individual coverage through our agency, but I can say I was there when they needed me most. We were there long enough to try, unlike many other agencies. I am not judging anyone nor trying to make any one wrong; we are always each doing the best we can with what we have in front of us. I am just sharing my heart: the love and compassion that I feel to this incredible industry that we've been servicing for so many years is beyond any possible words. ★

Naama O. Pozniak, 2016 and 2017 EBA Most Influential Women in Employee Benefits, specializes in Medicare, health, life and LTC. Pozniak is CEO of Valley Village-based Paz Holding, Inc. (A+ Insurance Services). She's a mother, speaker and yoga/meditation practitioner. Pozniak is a graduate of California State University-Los Angeles and has nearly 30 years of professional experience in the wellness and health insurance industry. She can be reached at naama@rightplan.com.

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Friday, August 17th: Main Event - 8:30 am - 3:00 pm
Location: Double Tree Pleasanton, CA - 7050 Johnson Dr. Pleasanton, CA 94588
Early Bird Registration Ends August 1, 2018
Register Online www.ggahu.org

Reflections of a Cal Broker Veteran

By SCOTT HALVERSEN

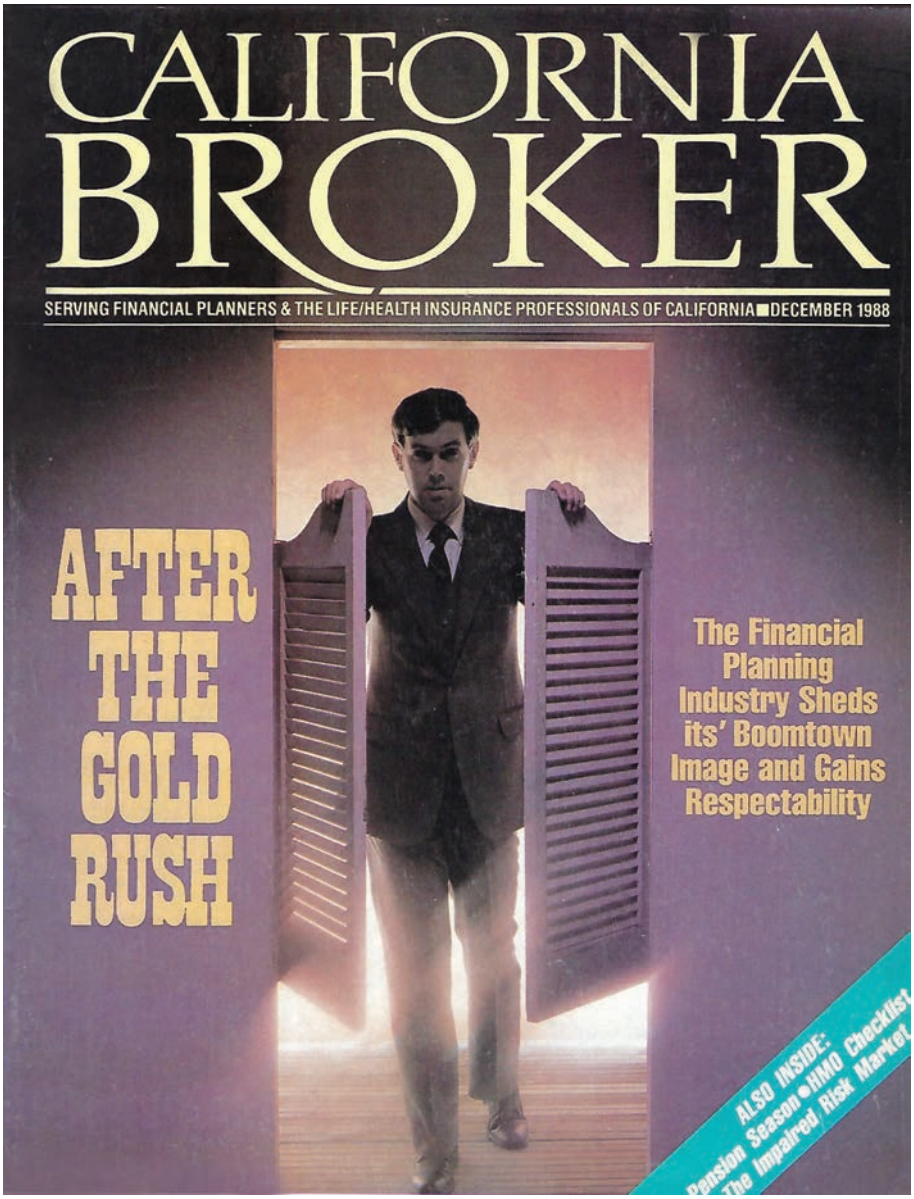
Editor's note: Cal Broker's advertising director Scott Halversen retired this month after working for the magazine for more than 30 years. Scott, unerringly good natured, assisted so many people in the industry by helping provide a space for their voices here in the magazine. Now we've asked Scott to share his recollections. Here are a few of Scott's words on how he found his way into the insurance industry and how he became such a beloved part of this publication. Scott will be missed dearly!

A 43 Year Rut. Anyone looking at my resume would think I had no imagination, or at least I've been in a deep rut. For the last 43 years, I've been trying to communicate with brokers in one way or another.

After finishing college in Utah, I began a job search which eventually led me to southern California in 1974. I knew nothing about insurance, but I applied for a job in the advertising department of Occidental Life Insurance. Despite my lack of expertise, when the ad director asked me to develop an ad for adjustable term life over night, I was able to produce some copy he liked.

THE PUZZLE PALACE

It was good thing I was not superstitious. I spent 13 years on the 13th floor in the advertising department. Occidental was a great place to learn about the brokerage market. They were the pioneers in term insurance and also the maverick carrier on the life side in working with brokers. I used to write the trade ads for the broker magazines and write local ads for brokers. Some in the broker community referred to the home office as the puzzle palace. I also learned that some brokers make more money than company CEOs because they've mastered the very difficult life insurance sell. You are asking someone to make a long term financial sacrifice for a benefit they will not be around to enjoy. Life insurance is a love product.



Cal Broker ad salesman as cover model. Scott Halversen poses for a magazine cover early in his tenure with the magazine.

DOWN IN THE DUMPS

This will sound odd, but the thing that brought me the most applause was a trip to the county dump. Occidental had a consumer ad campaign going with the theme "Exercise Your Right to Live," which tied into the fitness craze. People could write in and get a

free booklet which gave them illustrations of exercises they could do. We had boxes and boxes of letters from people who had requested booklets. One night the cleaning crew came in and tossed every last one of them. It was panic. Someone estimated we would have to spend $2 million in advertising asking people to write in again for their booklet since we had lost the letters. It was a PR disaster.

In a panicked search for the letters we went through all the trash from a three building office complex with 4,000 people. I can't even talk about all the things we discovered in polite company. We came up empty. That meant the letters had been taken to the L.A. county dump east of downtown. We made some calls and made arrangements to go out to the county dump well before daybreak. The people with the bulldozers gave us 20 minutes to search out the letters in literally acres of trash. A worker said, "I'm sorry, but we can't wait any longer." Just then I glanced to the right, and saw a letter with a stamp cut out of the envelope. I rushed over to it because I remembered our PR guy loved stamps. Sure enough, that was one of our letters and we recovered the rest of them. Truly some answered prayers.

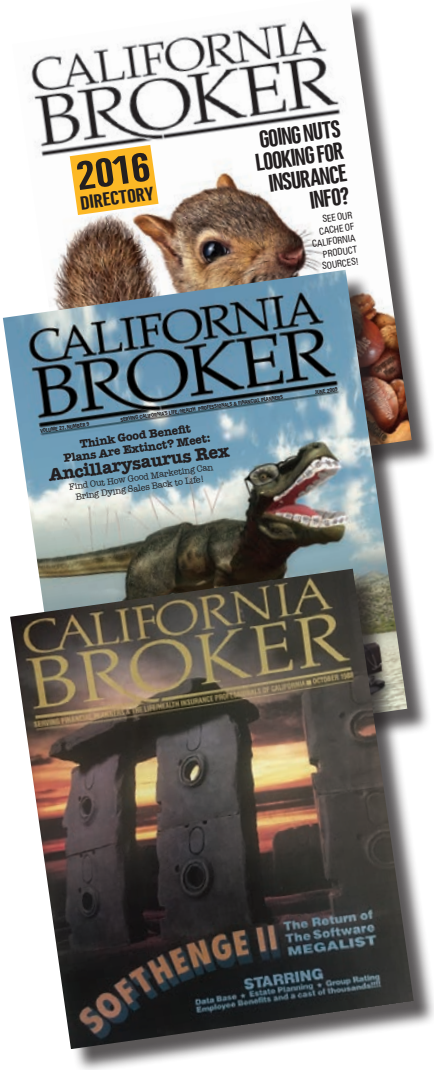
THE OWNER'S DOG

While I was the ad director at Occidental Life, California Broker had been calling on me about advertising. I got to know the Maddens (owners of McGee Publishers, the publisher of Cal Broker magazine) and I liked California Broker. So when an opportunity came to come on board, I took it.

Although I had never sold ads, I had been contacted by many ad reps over the years so it was pretty natural. I have since come to appreciate that virtually everything we encounter during the day was sold by someone to a skeptical client.

It was so refreshing to work for a small family-owned magazine. If there was something that seemed like a good idea, you could just go for it. You didn't need to have everything approved by the lawyers, the actuaries, the executives and the product people. I learned the company was actually named after the owner's pet Doberman, McGee. The company began as an advertising agency and I think that accounted for some of the flair over the years.

It has been a great 30 years. It seems funny to realize that my work output for three decades can be stuffed into four small boxes, which I turned over recently to the new ad director.



A small sampling of some of Scott's favorite magazine cover creations of the past three decades.

THE WORLD TURNED UPSIDE DOWN

The Affordable Care Act dramatically scrambled everything for anyone connected to the health and benefits world. It was tragic it was put together in a convoluted way along party lines with no opportunity to make necessary changes and very little done to control costs.

I truly came to appreciate all that the agents went through to service their clients even after the commission carnage they endured. The ACA would have crashed big time in California without the brokers. The carriers were also scrambling because of the medical-loss ratio.

The agents remain the group that helps civilians deal with the maze of regulations and piles of paperwork. The hours they put in during the enrollment window would crush most people.

LOSING OUR DOUBLE AGENT

We've been a close-knit family at the magazine. Many of us have worked together for 25 years. The saddest day was when we lost Dave Leveque from unexpected surgical complications. He was both an agent for the magazine as well as for his insurance clients.

I have also come to appreciate the great sacrifices in time and treasure put forth by association leaders as they struggle to maintain the broker community and look out for the interests of their clients.

The most fun part of the magazine was working on the magazine cover with Steve Zdroik, our production manager/graphic designer. I usually worked on the headlines and Steve did his graphics magic at amazing speed. I actually appeared on two of the covers when we did photo shoots. We've included some of my favorite covers in this piece.

I felt developing the annual directory was my greatest accomplishment. It's a huge chore, but it is so valuable for brokers.

SHOW TIME

I'm into triple digits on trade shows by now. The were always one of the best parts of the job. It was great catching up with people at the shows. Over time, it was fascinating to observe how frequently the folks manning the booths moved around. If I owned a Fitbit, it would've clocked a lot of miles as I made the rounds talking with all those fascinating people.

MOVING ON

It's been great getting to know so many folks in the industry. You render an incredibly valuable service against great odds. Thanks for all your support over the years! ★

Scott Halversen is now a full-time doting husband, father and grandfather.

Guardians of the Smile!

The Guardian Teams Up with HF to Promote Dental Health

The Guardian Life Insurance Company of America and the Children's Health Fund have teamed up to launch Guardians of the Smile, a program to ensure children do not fall behind in school because of dental health. Children's Health Fund published a review of literature which found that the effects of poor oral hygiene have a negative impact on a child's education leading to increased school absence and lower standardized test scores. Guardian committed $1 million to provide quality dental care to children in underserved communities across the country. The insurer is the lead sponsor of Children's Health Fund's dental program and the donation will fund screenings, clinics and mobile dental services for children in need over the next two years. To make Guardians of the Smile even more special, actress China Anne McClain pitched in to launch the program.

CAHU Health Care Summit

August 7-9, San Diego Hilton, Bayfront

This year's theme is "New Hope for the Modern Agent." There will be multiple continuing ed tracks on Medicare, IFP and group benefits, biz development & more. Two NAHU certification courses offered on August 7. Register for the summit and a certification course for a $50 discount. More info at cahu.org.

Too Many Americans Not Accessing Dental Care

According to a recent national survey from Delta Dental, many adults don't seek out proactive dental care and confess to visiting the dentist less often than they should. As a result, many adults suffer from oral health emergencies. The study reveals that more than half of Americans (57 percent) have made an unplanned visit to the dentist, with pain in mouth (33 percent) being cited as the leading cause. According to the Adult's Oral Health & Well-Being Survey, a chipped or cracked tooth (26 percent) or a cavity (20 percent) also ranked as top reasons for Americans to suddenly find themselves in a dental chair. A lost crown or filling tied at 14 percent. Capping off the key reasons is bleeding gums (8 percent). The Delta Dental survey indicates that more than two in five (42 percent) Americans admit they typically visit a dentist less than once a year. Want more dental info? Check out the first installment of our annual dental survey on page 12.

CAHU Masquerade Gala

Please join CAHU for a Masquerade Gala to revitalize the CAHU Foundation, a 501(c)3 nonprofit that is both a charitable and education foundation. The industry landscape has seen tremendous change over the past few years, and the education and growth of the insurance community has never been more critical. As we watch the policies and politics around health insurance shift, the CAHU Foundation is a vehicle that can be used to develop and educate agents, brokers and the general public in a nonpartisan way. Festivities for the Gala begin at 5:30pm at the famous Fairmont Grand Del Mar. Formal attire is requested. Gala tickets and hotel reservations plus more info is available at cahufoundation.org. Or call (800) 322-5934.

Employee Benefits

Hodges-Mace's Ben Makes Some New Friends

Ben, the Hodges-Mace avatar, is now being joined by some new friends. The company announced that namesake Ben, used to provide clients with a personalized communication experience, is being joined by a team of new avatars that provide diversity and a more relatable experience to users. Meet Liz, Tom, Ann, Jay and Sam. Now, clients can select which avatars are available to their employees, providing an even more personal experience. Employees will also be able to choose which avatar they have set to their default, controlling who speaks to them while they're on the SmartBen Essentials system. More info at hodgesmace.com

What Do New Agents Earn?

Do you know someone who just graduated from college? Maybe you should tell them this: With just three to five years of experience, insurance agency managers/owners are paid more than $90,000 on average, while sales producers earn close to $70,000. More than 40 percent of all insurance agents under age 40 earn above $75,000. This is according to Insurance Journal's annual Insurance Agency Salary Survey, which collects data on agency compensation for all positions and years of service, and its Young Agents Survey, which asks agents under the age of 40 for their opinions on the industry, the agencies where they work and their careers as independent agents. Like younger workers in other industries, though, insurance agents are impatient with some aspects. They want faster and better technology in their agencies and in the insurance companies they represent. They also want and need more diversity in the industry. But get this: Eighty-seven percent are optimistic about their careers. And almost 80 percent would recommend their career to others.

LIFE – LIMRA: U.S. Individual Life Insurance Sales Decline in First Quarter 2018

Individual life insurance new annualized premium fell 2 percent in first quarter 2018, compared to first quarter 2017, according to the recently released LIMRA First Quarter 2018 U.S. Individual Life Insurance Sales Survey. This is the third consecutive quarter of declines.

MassMutual Introduces New Target Date Fund Family

It makes perfect sense: the MassMutual Retirement Savings Risk Study found that nine in 10 retirees (94 percent) and pre-retirees (92 percent) "strongly agree" or "somewhat agree" that it is important to take steps to avoid major stock market losses right before retirement. And one in two pre-retirees (49 percent) and one in three retirees (32 percent) are apprehensive about taking too much investment risk. Now, responding to the research, MassMutual announced it's introducing a new target date fund family subadvised by a Legg Mason-affiliated manager, QS Investors, LLC, that aims to help reduce market volatility for retirement plan savers at this most vulnerable point. The Legg Mason Total Advantage Funds, a series of bank-maintained collective investment funds sponsored by Wilmington Trust, N.A. and available through MassMutual 401(k)s and other defined contribution retirement plans, offers retirement savers a combination of upside return potential with the goal of reduced volatility. The Funds incorporate both active and passive investment management strategies by investing in underlying funds that are managed by 16 different managers. A stable value investment component is a key part of the strategy to help retirement savers manage market volatility. The Legg Mason Total Advantage Funds' architecture gives investors access to not only Legg Mason managers but also to an array of external managers. More info at www.massmutual.com

Copay Accumulator: An Emerging Drug Copay Problem

The AIDS Institute joined with 60 HIV organizations that sent letters to state attorneys general and insurance commissioners nationwide asking them to investigate copay accumulators, a new drug copay practice that's emerged in employer and marketplace plans. It's something that's not just impacting the HIV population, either. In fact, any patient taking an expensive drug that's partially funded through a drug company's copay assistance program should beware. At issue is a change that means insurers may no longer count copay assistance payments toward a patient's annual pharmacy deductible. To add to the drama, many patients only find out about the change when they get a huge bill midway through the plan year, reports Kaiser Health News.

UNUM Delves Into Disability Causes

The newest research by UNUM, a 10-year review of disability claims, shows the effects of an aging workforce, medical advances and the power of early intervention.

Key findings include:

- Short and long term disability claims for joint disorders and musculoskeletal issues have increased significantly.
- Cancer has stayed the No. 1 reason for long term disability claims, representing 17 percent of claims.
- Pregnancy continues to top the list of short term disability claims, at 28 percent.
- Long term disability claims for complicated pregnancies, however, have decreased 47 percent.
- The percentage of Unum's short term disability behavioral health claims that transition to long term is down 15 percent, the result of a dedicated behavioral health program.

SF City Attny Scrutinizes Uber, Lyft Employee Benefits

City Attorney Dennis Herrera issued subpoenas to Uber and Lyft to turn over records on whether they classify drivers as employees or private contractors, as well as records on driver pay and benefits. The subpoenas follow the California Supreme Court's recent ruling on the definition of an employee versus an independent contractor. These subpoenas are the latest component of Herrera's investigation into whether ride-hailing companies comply with San Francisco ordinances. In light of the California Supreme Court's decision that companies must affirmatively prove a worker is an "independent contractor" before denying that person the wages and benefits guaranteed to California employees, Herrera seeks proof that Uber and Lyft have lawfully classified drivers as independent contractors or provide their drivers with minimum wage, sick leave, health care contributions and paid parental leave.

Covered Cal Reminds College Graduates About Special Enrollment

Somebody is on the ball at Covered California. Their latest effort to enroll more eligible Californians is nothing short of impressive. Covered California has reached out to commencement speakers from across the state to encourage them to weave the importance of health insurance into their remarks. Among those who have agreed to participate are commencement speakers at California State University - Los Angeles, the University of California at Irvine and the University of California at Merced. In addition, Cástulo de la Rocha, president and CEO of AltaMed Health Services, and Dr. Kenneth Kizer, director of the Institute for Population Health Improvement at the University of California, Davis and the former director California's Department of Health Services, co-authored an op-ed urging students who may find themselves without coverage after graduation to seek solutions. The op-ed was sent to 96 college newspapers throughout the state. Californians may enroll during Covered California's special-enrollment period if they have a qualifying life event, like losing their coverage. For example, students who had their health care needs provided by their school and are losing that coverage upon graduation, or who will lose coverage through their parents' plan when they turn 26, are eligible to sign up for a new plan through Covered California.

HEALTH CARE SUMMIT 2018

CAHU

California Association of Health Underwriters

August
7th - 9th, 2018

Hilton San Diego Bayfront
One Park Boulevard
San Diego, CA 92101

Join us in beautiful San Diego for an event that will provide NAHU Certification courses in Medicare and in Self Funding (separate registration coming soon), Continuing Education credits on topics that will help you develop as a professional and grow your business, and an opportunity to have fun and network with your peers!

For more information or to register please visit **www.cahu.org/health-care-summit**

MORE EVENTS

2018 DMEC Annual Conference, August 6-9, Hilton Austin, Austin, TX

More than 700 disability and absence management, HR and legal professionals will discuss paid leave, mental health, disability and more at the 2018 DMEC Annual Conference. Workshops and panel discussions include:

- The Business Impact of Paid Leave
- Mental Health in the Workplace
- FMLA/ADA Lessons Learned
- Reasonable Accommodation
- ADA Leave Cases Post-Severson
- Minimizing the Impact of Musculoskeletal Disorders in the Workplace
- State by State: Paid Family and Medical Leave Legislation
- Disability and Fitness for Duty in Transgender Employees
- Get Explicit About Implicit Bias

More info at DMEC.org

Golden Gate Assoc. of Health Underwriters 4th Annual NORCAL Medicare Summit: Aug.16-17

DoubleTree Hotel, Pleasanton, More info at ggahu.org.

NAILBA 37: November 1-3

Gaylord Palms Resort and Convention Center, Orlando, Florida
Contact etoups@nailba.org for more info.

AD INDEX

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