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Moving the Staff from Group Health Insurance to Individual Policies: Since Obamacare became law in 2010, the growth rate in group health insurance premiums has spiked. Insurance companies must cover pre-existing conditions and they cannot directly charge the individual for a pre-existing condition. Also, policies must now cover children up to age 26 and provide more comprehensive coverage including ten "essential health benefits." Increases of 30%-40% are commonplace. Our own group policy's cost was slated to increase 23% for 2016.

With this as the background, we've decided to end the plan and help shift our covered employees to individual policies. (Employees who get their insurance through their spouses' employers will continue to do so.) We are hoping to achieve two goals in the process. First, we want to get out of the business of health insurance and the un-controllable cost increases, but second, we want to do it in a way that won't make our employees worse off. We will continue to offer a healthcare benefit (just not the insurance) and have come up with the following arrangement:

Starting in 2016, we will provide a combination of an HSA benefit plus a salary increase in the total gross amount of the combined health benefits that we offered in 2015. For 2015, we paid 67% of the high deductible insurance premiums plus $2,500 of an HSA benefit ($1,250 for singles) plus a $1,000 medical expense reimbursement allowance. Our married employees averaged $13,000 in total benefits, and our non-married employees averaged $6,500.

For 2016, we will give our married employees an HSA benefit of $6,750 (next year's maximum) plus a pay raise of $6,250. We cannot designate that this is specifically for health insurance, though they will presumably use it for that purpose. Our single employees will receive an HSA benefit of $3,350 (next year's max for singles) plus $3,250 as a pay raise.

The HSA is the only tax advantaged account that comes with a triple tax benefit - deductible contributions, tax-deferral while the money is invested, and tax-free distributions if used for health care. Because of this, the HSA should be the foundation of any new health benefit. On the other hand, the bonus compensation is deductible to the employer but incurs payroll tax. It is taxable income to the

employees and raises their pay for computing the Obamacare subsidy.

Rather than pay these benefits at the start of the year, we will pay the HSA benefit in quarterly installments and spread the pay raise over the entire year. These employees will be incentivized to purchase the less expensive high deductible insurance which is HSA compatible. If they don't have a high deductible plan they won't qualify for the HSA benefit.

The employees will move to either "on-exchange" policies offered on Healthcare.gov or "off-exchange" policies that are sold privately through agents. In general, the on-exchange plans will be more appealing to lower paid employees, and the off-exchange plans will be more appealing to higher paid employees. On-exchange plans are eligible for huge government subsidies, but will be accepted at fewer hospital networks and may provide more limited benefits. But the subsidies may be massive. A single person will qualify for a subsidy next year if his or her gross income is between $11,770 - $47,080, and a family of four will qualify with income from $24,250 up to $97,000. In 2015, 8.3 million people received subsidies, and they covered 72% of their premiums resulting in an average out-of-pocket cost of only $105/month!

Off-exchange plans are not eligible for subsidies but are considered better insurance. Think of these as being like your old group policy, with access to the same good health care, but broken into pieces and sold individually. In fact, these policies are less expensive when sold individually, because the pricing is based on a large and relatively healthy rating group versus the smaller (and likely more unhealthy) group that we had under our group policy.

Paying for the Doctors' Individual Health Insurance and HSAs: We recommend that the practice continue to pay and deduct the doctor's family's health insurance premiums. Employers have always been permitted to discriminate by offering health insurance to certain groups but not to others. Obamacare contains restrictions on such discrimination but says that those rules will be laid out in future regulations. The regulations have yet to be issued. If and when they are, they will apply for future years and will not be retroactive.

On the other hand, HSA contributions are subject to non-discrimination rules. For 2016, the maximum HSA is $6,750 for a family and $3,350 for an individual, plus $1,000 for those age 55 and over. If you want the maximum contribution but you will give your staff less than the maximum, then we recommend making the contributions individually and deducting them on your 1040 tax return, rather than through the practice.

Social Security: The last Newsletter explained why we like the idea of starting our Social Security benefits at the earliest age at which benefits will not be reduced by continuing employment. Currently that is age 66, but it could be as early as 62. But, does the fact that benefits are subject to income tax support delaying the benefits to age 70? Yes, if you assume that Congress will change the law and not tax Social Security benefits in the future. The much more realistic scenario is that Congress will change the law to tax **100%** of the benefits (up from **85%** now). The next steps will be pushing back the full retirement age and eventually reducing benefits for those who don't "need" them. All of this supports the idea to claim earlier rather than later.

If you want a bigger benefit to support your spouse after you pass away, then use your spouse's age in the break-even tables in the November 15th Newsletter to see which alternative will give your spouse the larger lifetime benefit.

A Closer Look at Your Patient Retention

By Sally McKenzie, CEO

You understand how important it is to develop a loyal patient base for your practice. After all, without patients, you have no reason to come to work every day. The truth is many practices struggle with

patient retention. I recently did a survey that covered dental practices in business for an average of 22 years. The survey revealed a patient retention ratio of 31 percent. So for every 10 new patients who visit your office, seven won't return. To break that down even further, if you have 1,000 patient records on file, you only have 300 active patients—not nearly enough for you to grow the successful, profitable practice you've always wanted.

You can't lose out the back door more than 50% of the new patients coming in the front door. If you are, I guarantee you're headed for a production plateau. But before you throw money at marketing to attract new patients, find out why current patients aren't coming back. Is there a customer service issue? Are your fees too high? And, of course, you also have to scrutinize your recall system. This is the most neglected practice system, yet it's the principal vehicle for patient retention.

This is where system accountability comes into play. You need someone who is responsible for reaching out to and scheduling past due patients. Pre-appointing and then confirming appointments isn't enough.

To ensure these phone calls lead to appointments, be prepared with all of the necessary patient information as well as a professionally written script that reinforces the need to return and the benefit to the patient. This can also include integrating a patient communication system with text, email and voicemail as well and be sure to measure its effectiveness.

Don't expect to get the results you're after if professional training has not been provided. Trust me, this makes a difference and can take a practice that's hovering at 75% patient retention to 95% patient retention, which will give you a big boost in production. If out-bound patient calls seem to not be possible with your current team, then consider hiring a part-time employee. If the employee is earning $18/hour and making five 10-minute calls per hour, they may average a scheduling rate of 35% of those calls. That translates into 1.75 appointments. So he or she is bringing in about $402.50 an hour (this is assuming a fee of $230 for an exam, prophy and four bitewings). The direct cost to you is only $10.29, or 4.5% of the fee charged to the patient.

I hope this helps you see how vital a strong recall system is to your practice's success. It's time to stop relying on the easiest, cheapest recall methods that only consist of pre-appointing and sending out generic post cards, and instead start delegating recall efforts to an "accountable" employee who is trained on how to secure patients back into your practice.

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Tax-Deductible Foreign Travel and Tax Deductible Cruise Seminars: Foreign conventions are deductible only when you can prove it was "reasonable" to hold the meeting outside of the USA. We doubt any foreign convention will qualify for deduction unless it is a foreign meeting of an international organization that moves the meeting to a different country each year. The best argument we can imagine to prove it is "reasonable" is that the nature of the organization requires that the meeting be foreign.

Meetings held in the "North American Area" are considered domestic. This includes the U.S., its possessions, U.S. Trust Territory of the Pacific, Canada, Mexico, Bermuda and certain Caribbean countries with whom the U.S. has tax treaties. These are identified in IRS Revenue Ruling 2011-26.

Very Few Cruises Will Qualify as Deductible Seminars: To be deductible: (1) the ship must be a U.S. registered vessel, meaning that it flies the U.S. flag; (2) **all** ports of call must be in the U.S. or U.S. possessions such as Puerto Rico or the USVI. Just one stop in Canada, Mexico or the British Virgin Islands disqualifies the entire trip; and (3) special information statements about the cruise must be submitted with the tax

return. **You must perform the due diligence yourself**. The cruise company will not give a tax opinion that seminars conducted on their ships will qualify as deductible seminars.

Municipal Bond Opportunities: We continue to like tax-free municipal bonds from issuers that have monopolistic control over an essential service. These are referred to as "revenue bonds" where the bondholders are repaid from the usage of these services. The following categories represent good value: electric revenue bonds, water and sewer, and bridge and tunnel. In addition, airport revenue bonds tend to be very good investments, especially if they have monopolistic power over an important area (e.g., Dallas/Ft. Worth Intl Airport, Miami Intl Airport and Chicago O'Hare).

These bonds are generally quite safe because the issuers provide essential services and have the pricing power to raise the fees they charge. How long will your water bill go unpaid if the city shuts off your service due to nonpayment? How will you get from northern New Jersey to Manhattan without the bridges and tunnels? When you sense that you don't have any choice but to pay the fees, don't get mad, buy the bonds. Here are some recent prices, yields, and taxable equivalent yields for someone in the 39.6% federal income tax bracket. If you buy bonds from issuers in your home state, you will also get the state tax exemption:

Dallas/Ft. Worth Intl Airport (CUSIP: 235036S76): 4.125% coupon, Nov. 1, 2027, A+ rated, 3.2% Yield to Maturity, 5.3% Taxable Equivalent Yield.

Miami Intl Airport (CUSIP: 59333PNL8): Oct. 1, 2018, callable Oct. 1, 2017, 4.125%, A-rated, 1.89% Yield to Call (TEY 3.13%) and 4% YTM (6.2% TEY).

New York Triborough Bridge and Tunnel (CUSIP: 89602NWN0): Jan. 1, 2021, 5%, AA-, 1.6%, TEY 2.65% or 3.35% for New York City residents.

Springfield Illinois Electric Revenue (CUSIP: 850578RP2): March 1, 2025, 5%, AA, 1.6%, TEY 2.65%.

Issuers to Avoid -- Pension Obligation Bonds (POBs) and Hospital Bonds: POBs are issued by underfunded government pension funds. They invest the bond proceeds in shoring up their pension funds. They hope to earn returns in the stock market that will exceed their interest obligation. But, with the stock market near an all-time high, this is a risky endeavor for the issuers and the bondholders.

Hospital bonds are one category of revenue bonds that we avoid. The hospital will pay off its bondholders with income generated by providing hospital services. But if the revenue is insufficient, the hospital can't raise its prices without losing business. With water, sewer and power, there is usually only one issuer which means a monopoly. Prices can be increased without much risk of people turning off the water or power to their homes.

Floating Rate Preferreds: This is another category of income investment that we think is a relatively good deal, particularly in a tax sheltered account. A preferred stock is a hybrid of a bond and a common stock. The preferred dividend has a "preference" over the common stock's dividend, but it is made only after the bondholders get paid their interest payments. Preferred shares are interest rate sensitive, so when rates rise, the share prices will fall. To protect against the interest rate risk, consider preferred shares where the dividend rises as interest rates rise. For example, the interest rate may be the **greater** of (a) 0.75% over the short-term LIBOR rate or 3.75%. If you can buy the preferreds at a discount to their $25 par value, then the actual yield will be even higher. Here are two examples:

Goldman Sachs Series D (NYSE: GS.PRD): LIBOR + 0.67% with a floor of 4.00%, current yield of 4.95%.

HSBC USA Inc. Series F (NYSE: HUSI.PRF): LIBOR + 0.75% with a floor of 3.50%, current yield of 4.14%.

US Bancorp Series B (NYSE: USB.PRH): LIBOR + 60% with a floor of 3.50%, current yield 4.12%.