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Dickerson is led by founder Carl Dickerson (center) and his sons-in-law President Michael Wolff (left) and CEO Tony Lee (right).

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Table of Contents

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Guest Editorial *by Brian Poger*

Don't be a Victim; it's Time for Brokers to Thrive

I recently asked one thousand brokers a straightforward question, "What advice would you give Congress around the ACA?" Reading the feedback, I could tell that most had been written with clenched fists and gritted teeth. The anger and frustration we feel is palpable. Across the nation, brokers feel like the rug has been pulled out from under us. Here are just a few of the main concerns that surfaced from our survey.

- We are working more for less: Regulations are more complex than ever before, yet commissions are declining. One broker stated, "If I calculated what I get paid to help a client through the exchange and what the carriers are paying I am making about $2.50 an hour."
- We feel helpless to assist our clients: In the face of spiraling rates, we become the messenger rather than the insightful advisor we want to be. Our tried-and-true strategies don't make enough of a dent in double-digit rate increases to matter to our clients, just as one broker wrote, "My clients literally get a sick feeling when they see me coming. I'm tired of being the bearer of bad news."
- Work/life balance is out the window: Due to the timelines caused by early renewals and grandmothering, 12 months of work has now been compressed into two or three. One person told me, "During the fourth quarter, I am working 12 to 16 hour days just to tread water."
- More than 80% of the brokers who responded to our survey had negative or strongly negative feelings to the Affordable Care Act. But here's some tough love: despite the new Republican Congress, the reality is that core elements of the law -- guaranteed issue, subsidies for lower income Americans -- are likely to stay intact. So the question shouldn't be, "How do I get rid of this monstrosity?" Instead, you should consider, "How can I live in this new reality?"

The Victim Psychology

As someone who holds the broker profession dear, I also feel frustrated. I'm concerned though that for too many brokers, frustration has transformed into despair. Clinical

psychologists know that people respond to traumatic events in a deeply personal manner. While some people bounce back quickly, others never truly heal from their physical and emotional scars. In short, you can be a victim. Or you can be a survivor.

Victims feel helpless and fragile. They focus on memories of the past and how things just aren't what they used to be. Many brokers have assumed a victim mentality, like this one who wrote to me, "I've been in the business for over 30 years and am seriously considering retirement. We used to have a fairly healthy industry, but now it's gone."

Survivors, in contrast, are grateful for what they have. The trauma still remains, but it is now a memory, integrated into their life story. Their day-to-day becomes focused on rebuilding and healing. Several brokers I spoke to took-on this perspective. Though they had suffered longer hours and lower pay, they viewed their struggle as a noble effort on their clients' behalf, "I have worked harder and longer in the years since Obamacare trying to help save these businesses...my clients depend on me."

While better than victimization, merely surviving stills feels like an awfully low bar. Of course, there's a third and vastly superior response – thriving. The thriver is genuinely satisfied with what they have. Thrivers feel strong, empowered, and open to new possibilities. To the thriver, the future is bright with potential. With the health insurance universe shattering all around us, how can we thrive at a time like this? In my conversations, I've found that thrivers do three things that survivors and victims do not.

Three Things Brokers can do to Thrive

First, brokers who thrive embrace new revenue models. Commissions face increasing downward pressure as insurance companies aim to cut costs. Thrivers know that management fees are the future. When brokers deliver valuable, cost-saving services to employers, fees are easily justified.

Second, brokers who thrive differentiate themselves with technology. While victims view technology with indifference or as a threat, thrivers know that technology (used correctly) can enhance their value to clients.

Third, brokers who thrive devote time and energy to understanding new benefits models. The tried-and-true group insurance model no longer makes sense for everyone. For example, companies with a high proportion of lower-income workers and with low employee participation may be better served with individual market plans than with traditional group offerings. As the client's trusted advisor, it's your imperative to provide the right recommendation for their specific business situation.

So what are you going to do? Will you be a victim, survive, or thrive? You've taken your licks, but that's the past. Personally, I think the future is bright. ❑

Brian Poger is the CEO and co-founder of Benefitter. Benefitter provides software and services to help employers make a positive, profitable and deliberate transition to the new era of health benefits; an era defined by individual empowerment. Moving from group insurance to the individual market can be a win-win for employees and employers alike. But a change of that magnitude can be intimidating; everyone has questions. Benefitter produces answers and a path to legally compliant implementation. You can see the full results of Benefitter's broker survey at www.benefitter.com/broker-survey

SHOP from Covered California helps small businesses reduce health benefit costs with a substantial tax credit for qualified groups. And new Dual Tier Choice lets employers offer plans from two adjoining metal tiers, giving employees real choice they won't find anywhere else.

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Annuity Sampler

January 1, 2014

Company Name	Ratings Bests	Fitch	S&P	Product (Qual./Non-Qual.)	Type SPDA FPDA	Initial Interest	Guar. Period	Bailout Rate	Surrender Charges	Mkt. Val. (y/N)	Min. Contrib.	Comm. Street (May Vary)
American Equity	A-	BBB+		ICC13 MYGA (Guarantee 5) (Q/NQ)	S	2.25%*	5 yr.	None	9%, 8, 7, 6, 5, 0	Yes	$10,000 (Q) & $10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				ICC13 MYGA (Guarantee 6) (Q/NQ)	S	2.45%*	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**
				ICC13 MYGA (Guarantee 7) (Q/NQ)	S	2.70*%	7 yr.	None	9%, 8, 7, 6, 5, 4, 3, 0	Yes	$10,000 (Q) & $10,000 (NQ)	3.00%, age 0-75 & 2.10%, age 76-80**
				*Effective 10/1/14. 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 Fixed MYG 10 Annuity (Q/NQ)	S	4.90%*	1 yr.	None	10%, 9, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	$5,000 (NQ)	4.00% age 0-75 2.20% age 76-80 1.70% age 81-85
				**CA Rates Effective 12/22/14. First year rate includes 3% interest bonus								
American General Life Insurance Companies	A	A	A+	American Pathway Flex Fixed 8 Annuity (Q/NQ)	F	4.05%*	1 yr.	None	8%, 8, 8, 7, 6, 5, 3, 1, 0	No	$5,000 (NQ) $2,000 (Q)	2.20% age 0-75 1.70% age 76-80 1.20% age 81-85
				*CCA Rates Effective 12/22/14. Includes 2.00% 1st year bonus, 140% base rate subsequent years.								
American General Life Insurance Companies	A	A	A+	American Pathway Fixed MVA 9 Plus Annuity (Q/NQ)	S	5.90%*	1 yrs.	None	9%, 8, 7, 6, 5, 4, 3, 2, 1, 0	Yes	$5,000 (NQ)	2.75% age 0-75 1.70% age 76-80 1.20% age 81-85
				*CA Rates Effective 12/22/14. First year rate includes 4.0% bonus 1st year.								
American General Life Insurance Companies	A	A	A+	American Pathway Select MVA 10 Annuity (Q/NQ)	S	2.15%*	10 yrs.	None	10%, 9, 8, 7, 6, 5, 4, 3, 2, 1	Yes	$5,000 (NQ) $5,000 (Q)	1.20% age 0-80 (5 yr.) .90% age 81-85 (5 yr.) 2.50% age 0-80 (7 yr.) 1.75% age 81-85 (7 yr.) 2.00% age 0-80 (10 yr.) 1.20% age 81-85 (10 yr.)
				*CA Rates Effective 10/13/14								
Genworth Life & Annuity Insurance Co.	A	A-	A-	SecureLiving Rate Saver	S	2.55%* 2.20%	7 yrs. 5 yrs.	None None	9%, 8, 7, 6, 5, 4, 3 9%, 8, 7, 6, 5, ,0	Yes	$25,000 (NQ)	Varies 0-85
				*Effective 11/26/14. Based on $250K or more.								
Great American Life	A	A+	A+	SecureGain 5 (Q/NQ)	S	1.95%	5 yrs.	N/A	9%, 8, 7, 6, 5	Yes	$10,000	2.50% 18-80 (Q), 0-80 (NQ) 1.50% 81-89 (Q&NQ)
Effective 7/30/14. Includes .25% first-year bonus and is for purchase payments over $100,000. Escalating five-year yield is 1.95%. For under $100,000 first-year rate is 1.85%. Escalating rate five-year yield 1.85%.												
Great American Life	A	A+	A+	SecureGain 7 (Q/NQ)	S	2.40%	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 7/30/14.. Includes 1.00% first-year bonus and is for purchase payments over $100,000. Escalating seven-year yield is 2.29%. For under $100,000 first-year rate is 2.30%. Escalating rate seven-year yield 2.19%.												
Great American Life	A	A+	A+	Secure American (Q/NQ)	S	1.40%*	1 yr.	N/A	9%, 8, 7, 6, 5, 4, 3	No	$10,000	5.75% 0-70 4.65% 71-80 4.40% 81-89
*Effective 7/30/14.. Eff. yield is 2.42% based on 1.40% first year rate, 1.00% available portion of 10% annuitization bonus (available starting in contract year two) and 0.02% interest on available portion of bonus at the rate of 1.40%. Surrender value interest rate 1.40%. Accepts additional purchase payments in first three contract years. COM12255												
Jackson Insurance Company.	A+	AA	AA	Bonus Max (Q/NQ)	F	3.20%*	1 yr.	None	8.25%, 7.25%, 6.50%, 5.50%, 3.75%, 2.75%, 1.75%,0.75%**	Yes	$5,000 (NQ) $5,000 (Q)	6.00% 0-80 3.00% 81-85 1.50% 86-90
				*Effective 10/6/2014. The first year interest rate includes any first year additional interest, if applicable. Interest rates in subsequent years will be less. **Each premium payment, including any subsequent premiums, is subject to the withdrawal charge scheduled as detailed.								
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 5	S	1.75*	5 yr.	None	7%, 7, 6, 5, 4, 0	Yes	$10,000 (Q/NQ)	
				**Rates Effective 1/1/15 for premium less than $100,000 and are subject to change								
The Lincoln Insurance Company	A+	AA	AA	MYGuarantee Plus 7	S	2.15*	7 yr.	None	7%, 7, 6, 5, 4, 3, 2, 0	Yes	$10,000 (Q/NQ)	
				**Rates Effective 1/1/15 for premium less than $100,000 and are subject to change.								
North American Co. for Life and Health	A+	AA-	A+	Boomer Annuity (Q/NQ)	F	6.57%*	1 yr.	None	15%,14,13,12,11,10,8,6,4,2	Yes	$2,000 (Q) $10,000 (NQ)	7.00% (0-75) 5.25% (76-80)
* 6.57% First Year Yield reflects a 5% Premium Bonus in years 1-5, annuitization bonus after year 10. Penalties are waived at death. This yield assumes no withdrawals. The Interest Rate is based on current rates as of 1/1/15 and is subject to change.												
Reliance Standard	A+		A+	Eleos-MVA	S	2.85%*	1 yr.	None	8%, 7, 6, 5, 4	Yes	$10,000	3.25%**
				*Effective 6/9/14. Includes 1.00% 1st yr. bonus. Min. guarantee is 1.00%. **Reduced 20% ages 76-80, and 40% ages 81-85								
Reliance Standard	A+		A+	Apollo MVA (Q/NQ)	S	4.30%*	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 6/17/14								
Symetra Life, Inc.	A	A+	A	Custom 7 (Q/NQ)	S	2.60%*	7 yrs.	N/A	8%, 8, 7, 7, 6, 5, 4, 0	No	$10,000	Varies
				*Effective 1/1/15. 2.10% base rate with no guaranteed return of purchase payments. Plus 0.50% bonus for $250,000 and above.								

Small Business Owners Have Been Slow to SHOP ACA Exchanges

One of the very groups that the Affordable Care Act was designed to help – small business owners with 50 or fewer employees – is not signing up for the Small Business Health Options Program (SHOP) at the rate expected, the *Washington Post* recently reported. SHOP's portion of HealthCare.gov received about 200,000 visits during the first week of this round of open enrollment (versus 1.5 million visits to the individual part of the site), and brokers say they've seen little interest from that demographic, said the report.

While SHOP hasn't gained steam as quickly as anticipated, insurance payers still need to be on alert if and when business owners start signing up in droves. It's critical that they accurately track membership profiles for reconciliation later, the moment new buyers come on board.

Brokers who are supposed to help SHOP participants choose plans are also running into problems accessing their accounts. SHOP is supposed to work by allowing small business owners to pool resources in a marketplace so payers will offer insurance at the rates of larger businesses.

While SHOP hasn't gained steam as quickly as anticipated, insurance payers still need to be on alert if and when business owners start signing up in droves. It's critical that they accurately track membership profiles for reconciliation later, the moment new buyers come on board.

Instituting automated reconciliation controls helps ensure that payers have accurate membership data during every step of enrollment. These controls let organizations easily and continually track estimated payment details and compare them with actual payments as they come in. Controls that include a dashboard give clear visibility into anticipated payment collections versus what's actually received.

Having such a thorough system of controls in place helps organizations identify and resolve any potential issues before they become a real problem. You'll know you can trust your data at every point of the membership process.

While the number of small business owners signing up for SHOP may so far be a trickle, make sure you're ready if and when the tide comes in. Controls will keep your membership data accurate as each new wave arrives. ❑

Emily Washington is director of Business Operations for Infogix. Washington, who joined Infogix in 2003, leads the product management team. She is responsible for taking Infogix products to market and creating product and solution road maps — most recently with focus on healthcare solutions addressing key ACA requirements. Before coming to Infogix, she held customer support roles for Cyborg Systems and Respond.com in Silicon Valley. She has a Bachelor of Arts in English from San Jose State Univ.

Helping Clients Make the Switch: Defined Benefit to Defined Contribution Plans

In recent years, state and local governments and some of the nation's largest companies have switched from defined-benefit plans to defined contribution plans, such as a 401(k)s, 403(b)s, or supplemental deferred-compensation 457 plans. In 1985, 90% of Fortune 500 companies offered traditional defined benefit plans compared to under 10% in 2012. At the same time, defined compensation plans have grown from under 10% in 1985 to nearly 80% in 2012, according to a Towers Perrin survey.

Defined Benefit Plans

With a defined benefit or pension plan, an employer promises to pay employees a specific benefit for life beginning at the time of retirement. This benefit is calculated, in advance, based on age, earnings, and years of service. Employers manage the plan on behalf of participants, and must ensure that adequate funding is available for these benefits. These plans provide a predictable benefit to employees and contributions are generally made by the employer.

The disadvantages include volatility and unpredictability of cash contributions and accounting expenses. There are also administrative burdens due to the complexity of applicable laws and regulations. There may also be uncertain obligations due to longevity and market risks. Pension plans have the power to lower a company's share price and undermine growth plans. A decline in market assets can lead to higher levels of underfunding, which is the chief factor affecting the management of defined benefit plans. Changes to inflation and interest rates can increase plan liabilities, and longevity can lead to higher-than-expected payout obligations.

Defined Contribution Plans

With these plans, participants make investment elections and fund contributions, along with optional employer matching contributions. These plans provide an immediate, portable benefit to a workforce that is beginning to skew younger and is far more mobile than were previous generations. Defined contribution plans offer predictable costs, eliminating unfunded liabilities. Employers can add or drop a matching contribution or adjust eligibility rules. Defined compensation plans have also reduced administrative and regulatory burdens. The investment risk shifts from the employer to the employee as participants assume responsibility for making their own investment decisions.

Some disadvantages include a higher cost to employees for funding the plan, in whole or in part, and administrative fees assumed by plan participants. These plans benefit employees who change jobs more frequently throughout their career versus public employees who have been compensated for their long service through pension benefits.

The decision to convert to a defined compensation plan should be considered thoughtfully and thoroughly. There are several factors to consider:

- Costs versus benefit of conversion
- State constitutional or statutory prohibitions against governmental plan freezes and terminations
- Budget or cost for maintain-

ing two retirement plans during the transition process
- The effect of the conversion.

Before a successful conversion can be made, consultants, brokers, and advisors must fully understand and communicate the advantages and challenges that each savings vehicle provides to their clients. Once a client has decided to convert to a defined compensation plan is made, they should understand their options. Unless a client's current defined benefit plan can be terminated, the employer will bear the cost of administering two plans for current and future employees and their beneficiaries.

At the point of conversion, plan sponsors may decide to freeze their current defined benefit plan and continue funding all benefit obligations until they are satisfied – after which the plan may be terminated.

Pension plan sponsors face two options when freezing a plan and converting to a defined compensation offering. Some may execute a soft freeze, in which new employees are not eligible for the plan, but existing plan participants may continue to accrue benefits. The second option is a hard freeze, in which current employees stop accruing additional pension benefits and new employees cannot join the plan. In the case of underfunded plans, termination cannot be made until the sufficient funds are available to pay plan participants. In this case, the plan sponsor is required to administer the plan and decide on an investment strategy that's appropriate for a frozen plan. The most critical aspect of the decision-making process is how a plan conversion will affect the participants and how the employer can create a smooth transition for employees. Here are some points to communicate to clients as they execute a seamless defined benefit to defined compensation plan conversion:

- Prepare participants for the change – It is critical to offer simple, clear, and timely communications that emphasize the positive aspects of a conversion and potential participant considerations. Communicate the conversion early, and provide a time line of deliverables to keep participants engaged in the process.
- Provide an option through the transition: Help clients structure a hybrid plan that potentially preserves participants' economic benefit for some period. A cash balance or defined benefit/defined compensation plan structure may help make the transition less challenging.
- Focus on education and resources for saving: With any transition, options may be confusing to participants, especially now that they need to manage savings and assets on their own. Provide financial education and resources including one-on-one support from a financial professional.

"Regardless of the retirement plan offering, it's important to understand the client's needs and develop a program that meets their business goals while helping participants achieve retirement readiness."

Retirement confidence increases with access to guidance from a financial professional, such as a retirement consultant, according to a Lincoln Financial Group participant satisfaction survey. Thirty-five percent of plan participants with access to a retirement consultant are confident that they will have enough money in retirement, as opposed to the 19% of plan participants without access to a retirement consultant.

Here are some helpful tips for a new defined compensation plan:

- Enroll: Encourage participants to enroll as soon as it's available. Participating in a defined compensation plan can help reduce taxable income and build savings.
- Save at least up to the company match: Many employers match contributions up to a certain percentage. Encourage participants to save at least up to the match and increase contributions rates along the way.
- Make more, save more: As participants grow in their careers and make more money, encourage them to contribute more to their plan and save any income boosts like a bonus towards retirement savings. Once savers hit the maximum contribution level, a financial professional can help them find the right place to put additional savings.
- Schedule a retirement plan check-up: Encourage participants to meet with a financial professional when they enroll and then at least once a year for a plan check-up to make sure investment and asset allocations are in line with savings goals.
- Keep saving: There may be times when participants are tempted to borrow against their plan or take out assets if unexpected expenses arise. Encourage them to resist the temptation and remain invested so they avoid missing out on potential market gains.

Regardless of the retirement plan offering, it's important to understand the client's needs and develop a program that meets their business goals while helping participants achieve retirement readiness.

John Morabito is senior vice president and head of Institutional Retirement Solutions Distribution for the Lincoln Retirement Plan Services business. Morabito leads efforts to grow Lincoln's full service Retirement Plan Services offerings for corporate and nonprofit/tax exempt plan sponsors. Morabito brings close to 30 years of experience in the retirement space. Before joining Lincoln, Morabito spent six years at Prudential Financial where he served as senior vice president of U.S. Full Service Distribution. Earlier in his career, Morabito served as national director of Retirement and Savings for MetLife's Institutional Retirement Business. Before that, he was director of Institutional Investments for New York Life Asset Management. Morabito earned a bachelor's degree in economics from the State University of New York at Oneonta. He is a Registered Principal and holds FINRA Series 6 and 63 licenses. Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

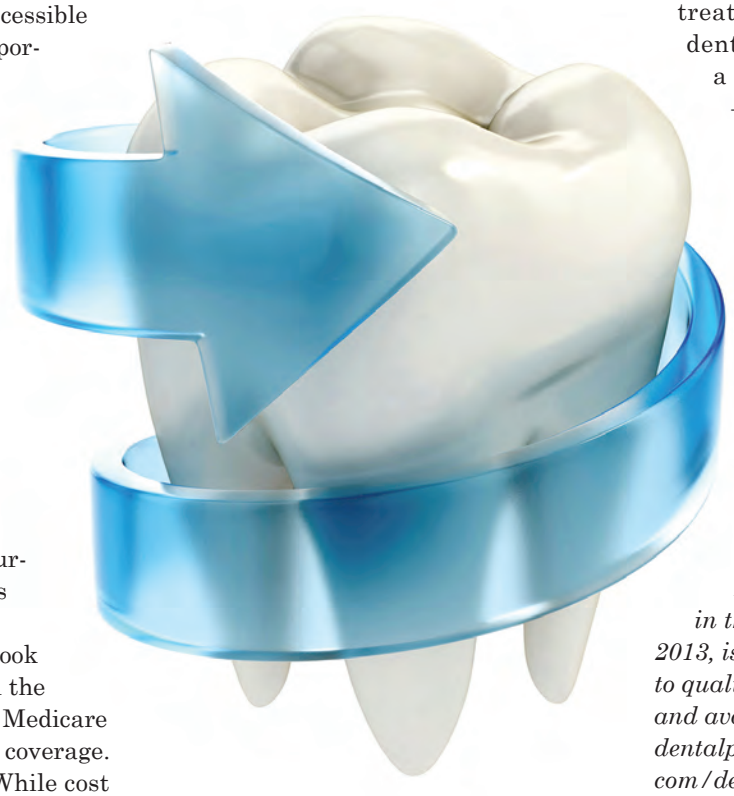
Dental Coverage: A Look Into 2015

Will Americans be smiling about our nation's dental health status by the end of 2015? All indications point to small but significant improvements in accessibility to children's dental care. But we will have to address the looming public health crisis of adult oral health. One in four Americans over 65 has lost all of their natural teeth due to decay and lack of access to affordable treatment, according to the American Dental Assn.

This situation will not improve unless we can find ways to make dental care more affordable and accessible to all Americans. As the importance of regular, preventative dental care increases, I am optimistic that providing greater affordable access to dental services will become a national priority. Perhaps this won't happen in 2015, but I do believe it will and must happen soon.

The following issues will also headline health news in 2015:

- New ways to pay: Dental savings plans, medical tourism, and health care loans and credits will be in the news this year as people look for alternative ways to fill the gaps in programs such as Medicare and traditional insurance coverage.
- Dental education loans: While cost continues to be a primary barrier to dental care for many Americans, access to dentists has also become an issue especially in rural communities. The nation could manage this growing crisis by offering funding for dental education, which could be paid back with a year or two of service in a rural area or public dental clinic.
- Dentures on demand: 3-D printing technologies, already in use to create customized medical devices such as hearing aids, will be used to print dental prosthetics. The immediate benefit will be more comfortable, better fitting dentures. Cost savings will soon follow as dentists buy 3-D printers for their offices.
- A new role for hygienists: There will be discussion around the benefits of dental hygienists performing routine procedures, such as filling cavities, freeing the dentist to focus on providing advanced treatments. This should make basic preventative care more affordable, and allow dentists to help more people with health-threatening dental issues.
- Dental spas: Why not combine dental care with other wellness treatments? Imagine following up a dental cleaning and checkup with a manicure and massage. ❑



Bill Chase is vice president of marketing for DentalPlans. DentalPlans, founded in 1999, is the largest dental savings plan marketplace in the U.S., offering consumers access to 40+ dental savings plans from trusted healthcare brands, like Aetna, Careington, Signature Wellness, and UNICARE. Plan members have access to more than 100,000 dentists nationwide. DentalPlans, which has been included in the INC. 5,000 list for 2011 to 2013, is committed to making access to quality oral healthcare affordable and available to everyone. Visit www.dentalplans.com or www.facebook.com/dentalplans. Call 804-402-5316.

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Discerning Disability Trends

Putting Your Clients on the Right Road for 2015

Experts explain why there has never been a better time to be in the disability industry.

Six Ways to Help Solve Clients' Intermittent Leave Challenges

by Lincoln Dirks

In some instances, employees can take leave under the Family and Medical Leave Act (FMLA) in separate blocks of time for a single qualifying family or medical issue. This type of leave, known as "intermittent leave," can be a challenge for your clients to manage.

It is imperative to manage intermittent leave properly to make sure that your clients provide employees the leave entitlement provided by the FMLA. It also protects against potential fines, audits, and other legal action an employer could face as a result of denying an employee's request or not administering the leave properly.

Here are six tips to help your clients administer intermittent leaves effectively:

1. Make sure that employees follow FMLA's notice requirements:

For foreseeable leaves employees must provide 30 days' notice (e.g., a scheduled surgery, medical appointments). For unforeseen leaves employees must provide documentation as soon as practical. (e.g., an emergency surgery, unexpected medical treatment due to an accident or severe illness).

2. Enforce call-in procedures for reporting an absence:

Employers can require employees to comply with their call-in procedures; this can be a great way to determine if a leave qualifies under FMLA. When employees call in, employers should request sufficient facts including, when the leave is to begin and when the employee expects to return to work. For a medical condition, questions may also include duties the employee is unable to perform and whether they have consulted with a physician for plan to.

3. Track usage carefully:

Tracking leave accurately will help make sure that employers only provide the amount of leave their employees are entitled to. Accurate tracking can also help identify patterns indicative of misuse.

4. Require medical certifications to be completed and returned:

Employers may require employees to provide a medical certification form to determine whether the medical condition qualifies for FMLA leave. Employees generally have 15 days to provide completed certifications. Once an employer gets the certification, it's a good idea to make sure that it includes the necessary information. If it's incomplete, employers must give the employee an opportunity to correct it. Employers should require employees to get the missing information or clarification to vague responses from their health care providers.

5. Ask for re-certifications:

Employers can generally request recertification. This recertification can determine whether FMLA leave should be extended or if a significant change in an employee's leave is due to a supported change in the medical condition. This can be done no more often than every 30 days. However, if the initial certification indicates that the condition will last longer, employers can request recertification after the stated duration expires or every six months (whichever comes sooner). Employers also can request recertification in less than 30 days if the employee requests an extension of their original leave), the employees circumstances have changed significantly from the original request (frequency and duration of the absences, complications, etc.), or if the employer receives information that casts doubt on the reason for the leave.

6. Consider getting a second or third opinion:

An employer can require an employee to get a second medical opinion if the validity of the certification is in question. If the first and second opinions differ, a third opinion may be required. The third provider's opinion is final and binding.

Helping clients strike a balance that allows employees to take time off in a way that adheres to the law and aligns with sensible personnel management practices is a win-win for you and your customer. You'll provide additional value, and they'll feel better equipped to tackle this challenge. ❑

Lincoln Dirks, a senior compliance analyst for absence management, has been with Standard Insurance Company since November of 2001. Lincoln received his Bachelor of Science degree in business administration from Portland State University, and his Juris Doctor degree from the University of Oregon School Of Law. He also holds the following professional designations: Certified Employee Benefit Specialist; Fellow, Life Management Institute; Fellow, Life and Health Claims. The Standard is a marketing name for StanCorp Financial Group.

A Highly Profitable Activity

Selling Disability Income Protection

by W. Harold Petersen, RHU, DFP

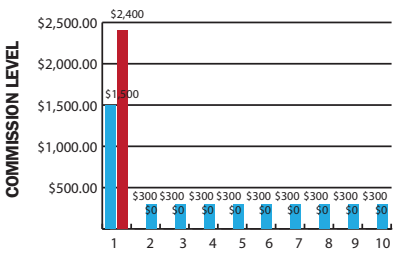
The Market: According to the last count from the U.S. Census Bureau, the population of the United States is 308,745,538 and growing. It is estimated that 188 million of those people are income earners.

Only 27% of these income earners have any form of disability income protection other than what is provided by Social Security, according to the Life Insurance Marketing Research Association (LIMRA). Additionally, based on a survey by a major insurance company, the vast majority of those with disability income protection are inadequately insured. That means 137,240,000 American income-earners have a need for more disability insurance.

These statistics are clues to how professional insurance agents and brokers can best invest their efforts. I recognized this excellent opportunity in the field of disability insurance many years ago. My passion for disability insurance comes from my father's disability story. Throughout my career, my crusade has been to suggest to all insurance professionals that delivering a disability benefit check provides great satisfaction, plus a likely plethora of referrals from a grateful client.

Chart 1

Comparison Of Commissions for Disability and Life Insurance
(A single $3,000 premium over one decade)



Today's disability market environment is strong and liberal. Insurers are making profits with their disability insurance, and they want to grow their businesses, which results in excellent products, attractive rates, and most importantly, streamlined underwriting processes. In short, there has never been a better time to be in the business of prescribing disability insurance.

The very strong renewal commissions that disability insurance yields do not take very many years to develop into a substantial cash flow for a producer. Disability insurance also provides a foundation to clients' personal or business financial plans.

Chart 1 illustrates commission yield from one $3,000 premium over a decade: Disability insurance pays a 50% first-year commission and 10% renewals while life insurance pays 80% first-year commission and no renewals. While life insurance attracts producers with high initial commission rates, disability insurance promises the longevity of renewal rates. In this example, the disability insurance commission surpasses the life insurance commission at year four and still has many years of renewals ahead.

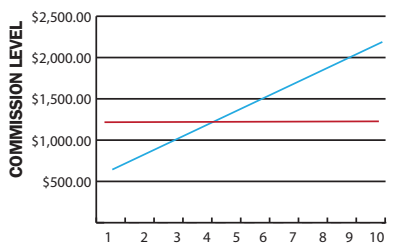
Chart 2 shows annual commissions for selling one of each policy type every week. As you can see, disability insurance surpasses life insurance by year four. While life commissions stay level, disability commissions continue to rise, resulting in a far greater income.

Largely due to the uncertainty of the new health care law, medical insurance agents are facing diminishing sales. Add to that the decreased commissions resulting from the new medical loss ratio mandate and these agents' incomes are suffering. Life insurance commissions are also shrinking while disability insurance compensation remains steady. There has never been a better time in the history of the product to be in the disability insurance industry. The demand is apparent and we are in need of more suppliers.

The recognition that people have disability needs at advanced ages has pushed expansion of the market. People are working longer because their retirement plans have fallen short of expectations. Many who have retired are re-entering the work force out of necessity. Benefit periods are now pushing retirement ages up to 67 or 70 years of age and issue ages now go to age 70 and higher.

Chart 2

Comparison of Commissions for Disability and Life Insurance
(A single $3,000 premium sold every week)



Selling only one of each respective policy type every week would translate to annual commissions as shown above. DI surpasses LI by Year 4. LI will stay level while DI will continue to rise, yielding a far greater income.

An evolution of the DI industry is dawning. It has new and enlarged capabilities due to greatly enhanced issue and participation limits, which are now capable of providing benefits in excess of $100,000 per month per person and coverage for $100 million agreements. Advancements in underwriting processes of guaranteed issue disability insurance plans for multi-life cases, online applications and electronic policy delivery all point out great reasons to make disability insurance sales part of your daily routine. ❑

W. Harold Petersen, RHU, DFP is founder of the International DI Society and chairperson of Petersen International Underwriters. He is recognized as an expert in underwriting development and policy innovation in the expanding field of disability financial planning. He can be reached at Petersen International Underwriters, 23929 Valencia Boulevard, 2nd Floor, Valencia, CA 91355. Telephone 800-345-8816. Email: whp@piu.org.

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Discerning Disability Trends

The Perfect Storm

by Chris Carlson, CLU, ChFC

We are in the midst of a perfect storm when it comes to the selling and marketing of income protection products. But instead of all the negativity of years gone by, this perfect storm is creating the most phenomenal marketing opportunity the disability insurance industry has ever seen.

I believe there has never been a better time to be selling disability insurance and I want to share with you the five factors that are causing this perfect storm.

Unlimited Prospects

The first factor contributing to this perfect storm is the fact that there are unlimited prospects for any producer. There are millions of people who need individual disability insurance. The Council for Disability Awareness has reported that there are approximately 150 million workers in the United States. Only 50 million of them are covered by some form of private disability insurance. Of that 50 million, only 10 million people have individual disability insurance. These numbers, alone, should excite agents and advisors to get serious about selling income protection products.

In addition to these raw numbers, some factors in our economy will continue to increase the prospects for individual disability insurance. Since employers are downsizing and rightsizing, many workers are out of corporate America and starting their own businesses. When they exit the corporate world, they leave their employee benefit package behind. These newer business owners have lots of insurance needs, not the least of which is disability insurance. Many of them are also great candidates for business overhead expense insurance.

A brand new class of entrepreneurs has emerged to take advantage of the incredible advances in technology. A single individual can create a huge business without brick and mortar and a ton of employees. These entrepreneurs are creating a wealth of prospects for disability insurance.

With the ever-rising cost of group medical insurance, along with the uncertainty of health care reform and legislation, employers are shifting many of the traditional responsibilities and costs of benefits to their employees. With fewer companies offering employer paid group LTD, another group of prospects for income protection has been created. All of these people we are discussing are not being talked to regarding the need to protect their income. This is creating the ultimate opportunity for you to step up as a disability insurance expert and sell a countless amount of disability insurance policies.

No Competition

The second factor contributing to this perfect storm is the fact that there is almost no competition for producers in the disability insurance market. There are fewer producers selling disability insurance than any time in the last 40 years. Let's talk about the reasons why. There are fewer career agencies in the industry. Many companies have chosen to abandon their career distribution system in favor of the PPGA or brokerage model. This switch obviously results in fewer agents being recruited into this great industry. With no career agents, you don't need managers and trainers. In years gone by, these managers and trainers were key motivators in helping agents actually talk to their clients about income protection products. So we have lost a level of coaches and cheerleaders that were critical to the success of our industry.

Agents who grew up selling disability insurance are at, or nearing, retirement. Many of these agents have watched their clientele also age, so these agents are more focused on retirement needs of their clients than they are on bringing on younger clients who need disability insurance. Combine this with the fact that we are bringing fewer agents into the business and you can see why there is no competition.

Fewer insurance companies are manufacturing their own products. As a result, fewer marketing reps are promoting disability insurance. The big three; Provident, Paul Revere, and Unum are now one company. They have dramatically decreased their emphasis on individual disability insurance products. As a result, those brokerage managers and brokerage reps are no longer on the street promoting and assisting in the sale of individual disability insurance products.

These four points combine to create an environment in which agents are shying away from disability insurance:

1. They were not trained on it when they came into the business.
2. Their company does not have a proprietary product.
3. They have no veteran agents to mentor them in this product.
4. A limited number of brokerage people are talking about the product.

Great Products

The third factor contributing to this perfect storm is that we have great products to offer our clients. There are products available from carriers that are as good, if not better, than in the glory days of disability insurance. Many veteran producers grew up in the era in which everybody was talking about non-can and own occ. It seemed that all that we used to talk about was own occ. Well, today, carriers are offering non-can and own occ policies to all kinds of occupational classes, to include those in medical specialties. So if that is what you want to sell, you can sell it. Equally exciting are the options that allow you to build a policy that is right for your client that can take the premium to a level that it eliminates the, "It costs too much" objection.

We were in a period, 10 years ago or so, in which the carriers limited the amount of individual coverage they would issue as a stand-alone basis or in combination with group LTD. Today, those issue limits are exceeding the issue limits of 20 years ago. The ability to sell additional coverage to somebody who already

believes in the need for disability insurance creates great sales opportunities.

Each disability insurance carrier has those occupational classes that they covet. For those, they have made the premiums incredibly attractive. Not only are the base rates fantastic, but there are also multi-policy discounts, multi-life discounts, and association discounts to name a few. Price should not be an obstacle to selling more disability insurance.

The disability insurance industry continues to be innovative in terms of the changing needs of your clients. We are seeing riders and products that address such needs as benefits for a catastrophic disability, benefits to fund a retirement plan and key person disability insurance.

Great Compensation

The fourth factor contributing to this perfect storm is the unbelievable compensation that is paid for selling income protection products. Not only do income protection products pay good first year commissions, but also the renewals are phenomenal. I have talked to many a veteran disability insurance producer who still marvels at the commission checks that come every month from the disability insurance carriers.

I recently had a major disability insurance carrier run a 20-year income projection assuming a producer did just one disability insurance app per week (average premium of $2,000 a year). The total income over that 20-year period was over $6 million! I challenge you to find another product in the financial services industry that can come close to those numbers. When you combine the fact that there is virtually zero service work required for a disability insurance policy, disability insurance is arguably the most profitable product you can sell.

Millennials

The fifth factor contributing to this perfect storm is the huge wave of millennials that are entering the work force. Our economy has never before seen a buying group this large. The Millennials are 100 million strong and dwarf the 80 million Baby Boomers that contributed to so much of the success the disability insurance industry had in the past. Studies have shown that the Millennials do appreciate and recognize the need to protect their incomes. Since most millennials will have several careers (not jobs, careers) in their working lifetime, a portable individual disability insurance policy will be one of the smartest financial instruments they will ever own.

If you are a young agent or advisor and are working with young people, you have a great future ahead of you. There are so many Millennials who will need help with their financial lives. Yes, they will do a lot of research online, but they will look for a professional to help them implement strategies to achieve their financial goals. Don't be fooled into thinking that Millennials will do everything on line to avoid talking to people. As I go into coffee shops, it is full of Millennials talking to people. When I go to a bar, it is full of Millennials talking to people. My point is this: Millennials still want relationships. The challenge will be how you initiate those relationships so you can have a cup of coffee or a beer with them.

I will leave you with a question. Suppose a good friend of yours, someone you trust, approached you with a business opportunity. Your friend told you that with this opportunity you will have unlimited prospects, virtually no competition, great products, phenomenal compensation, and a generation of Millennials who will want to buy this product. Would you be interested in this business opportunity? Well this business opportunity exists if you choose to make the selling of income protection products part of your practice. The perfect storm is upon us; don't let this opportunity pass you by.

Chris Carlson, CLU,ChFC, is the Founder and Creator of The Disability Insurance Coach, a revolutionary approach to the training and coaching of disability insurance producers. Chris began his insurance career as a brokerage consultant with Provident Life and Accident in 1984 and over the years has been a District Manager, Branch Manager, National Sales Manager and owner of his own independent disability insurance marketing organization. In addition to his disability insurance experience, Chris has spent the last 12 years training and coaching salespeople in the financial services industry.
As a member of the International Disability Insurance Society, Chris provides educational training to all new members. Chris can be reached at 206-419-7440 or chris@thedicoach.net. ❑

HSAs and the Decision-Support Dilemma

The year 2014 marked the 10-year anniversary of health savings accounts (HSAs). In the past couple of years, we have seen an explosion of growth in enrollment in HSAs and deposits in HSA accounts. There are about 17 million enrollees in HSA plans, according to most reports. At the same time, HSA literacy among enrollees is extremely low.

A survey by America's Health Insurance Plans reveals the following:

- 91% of health plans offer enrollees access to information on health education.
- 88% offer information about physicians' hospital affiliations.
- 75% provide access to health records online.
- 57% provide physician-specific quality data.
- 84% provide access to account balances.
- 66% gave provider cost information.

However, the availability of decision making tools that allow consumers make integrated, intelligent decisions remains remarkably low. Just do a search online for "HSA decision tools" or "HSA calculator." You'll find largely antiquated calculators that allow you to put in tax bracket, premium of current plan, and an anticipated HSA plan to get a basic cost difference.

Stride Health (www.stridehealth.com), a new online broker, has created some new integration and recommendation tools that are a bit more interesting. Taking provider data, cost data and throwing in some algorithms a user can get back an estimate of annual cost (worst case – best case –and estimate by procedure) as tied to a plan choice (not necessarily HSA related). Stride is an online, individual brokerage, and the use case is limited to that market. But the experience is nice. It offers simple, integrated, and intelligent feedback, which is closer to how it should be in our day and age.

But doing a comprehensive analysis and explaining it to a client is a lot of work. The typical HSA analysis begins with a benefit professional running insurance options in one tool or another. The information is provided in a spreadsheet. The cost difference, which may or may not take tax calculations into consideration, is displayed. Then a network or doctor impact report is done in a separate tool. Next, search for data, if available, to have a reasonable discussion with your client about the elusive cost of care to answer a question like this, "If I pay $35 now when I go to the doctor, how much will I pay if I move to this HSA?" Kaiser has an eight-page estimate of costs sheet. Nice! But how much time and business is this professional losing by having to search on multiple sites and build a library of spreadsheets to model various scenarios?

It is time for new tools that integrate by pulling in data from various sources and allow for real time modeling. ❑

Jason T. Andrew, CEO is co-founder and CEO of Limelight Health with offices in Silicon Valley and Redding, they provide innovative cloud-based products to insurance agents. Previously he was the founder of Stone Meadow Benefits & Insurance Associates. Prior to founding SMB, Jason worked as the managing producer at Lawson-Hawks Insurance Associates. Jason has advised numerous Silicon Valley startups and works closely with the Silicon Valley business community. Currently, he serves on the Board of Napa Children's Health Initiative and as an advisor to GoVoluntr, a startup that connects volunteers, non-profits and businesses. For more information, call 877-897-5005 or visit www.limelighthealth.com.

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Nine Employer Healthcare Strategies We Are Sure to See in 2015

Employers need to rethink their healthcare focus from just buying an insurance policy to having a managed, data driven healthcare strategy. As costs go up, employers shift the costs to employees or absorb the cost themselves. This strategy is used by many employers and promoted by most benefit agents and brokers as a way to give employers a financial number they can live with.

It's financially painful for both employer and employee, but easy to implement and embraced by many human resources professionals. But as premiums go up more and more, cost is shifted to employees through higher premium contributions and higher deductibles and co-pays when they use medical services.

Another issue is that employers monitor discounts (price), but not utilization. This is like monitoring how much natural gas costs to heat your house, but not how much natural gas you use. By spending a little more on insulation, you can save a lot on natural gas. Likewise, by spending a little on prevention, you could save a lot on healthcare.

Employers receive claims data reports, which is helpful. But without a plan to affect an outcome it's all just data. Unfortunately, healthcare is one of the few things in life we purchase without having a clue what it will cost, although that same quality health service can vary by hundreds and even thousands of dollars from one provider to another.

Employers also tend to focus solely on large claims, which is akin to looking in a rear-view mirror. There is no effort or strategy to keep healthy employees healthy so they can avoid some of those large claims altogether.

While employer-sponsored health fairs and wellness screens are nice events with plenty of good information, employers tell me that they get low participation and that these events do little to engage employees to change behavior. So, what is the solution?

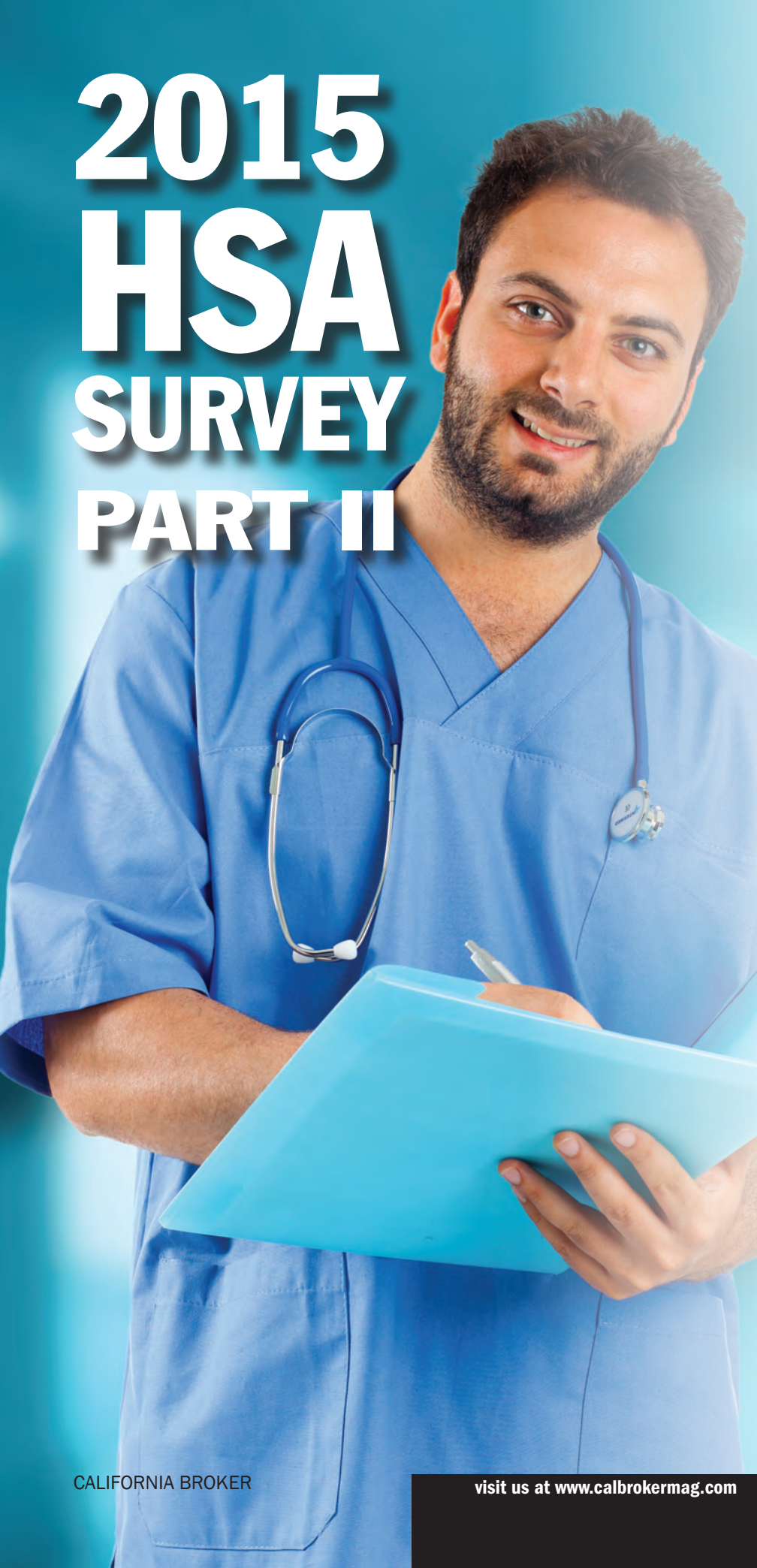
Here Are Nine Employer Strategies We Are Sure To See In 2015

1. Employers will be directly involved in helping manage the healthcare delivery system. They will educate their employees on where they can get high quality care at the best price and will reward employees that are good consumers.
2. Employers will closely monitor utilization patterns and cost of the 25% of the population driving 90% of the cost. They will use this information to steer care away from high cost emergency rooms to lower cost care options through education and plan design.
3. Employers will receive executive reports analyzing trends, demographics, actionable clinical information, chronic disease reports, and healthcare index factors, etc. This information will help employers provide benefits that are customized to provide better preventive care and lower cost.
4. Employers will focus on healthcare provider process improvement programs and know the value of specific providers. They will look for business partners who can be a resource to their employees to help them avoid health risk rather than wait for poor health and pay for it.
5. Employers will know the healthcare index of their population and focus on large claim prevention. Providing tools like health risk assessments and wellness coaches for employees to avoid health risk before it becomes disease puts up a strong defense against large claims.
6. Employers will implement chronic disease management programs, predictive analysis, nurse navigators, nurse practitioners and wellness coaches.
7. Employers will focus on managing the 80% to 90% of their health benefit costs which is claims rather than just the 10-20% that is administrative cost.
8. Employers will look to partner with advisors who can help them manage employee health and safety risk on and off the job instead of just selling them another insurance policy.
9. Employers who make effective positive changes to the way they manage their healthcare will be rewarded with healthier more productive employees and lower costs for them and their employees.

The time is right for employers to redirect their focus from the 10% to 20% administrative cost of their healthcare by just bidding and quoting their insurance to the 80% to 90% claim cost where they can not only enjoy lower cost, but also employees that are healthier, happier and more productive. ❑

Randy is a certified risk architect at Ottawa Kent in Jenison, MI. He designs, builds, and implements risk management and insurance plans for middle market companies in the areas of human resources, property/casualty & benefits. He has 35 years experience and has been at Ottawa Kent for 31 years. He is a lead instructor for the Institute of Benefit & Wellness Advisors, training agents how to bring risk management to benefits. Randy can be reached at rboss@ottawakent.com.

2015 HSA SURVEY PART II



Welcome to part II of our annual HSA Survey. We asked the top companies in the state essential questions about coverage and services that affect you, the broker. Read on to find out which plans will work best for you and your clients.

16. What service guarantees do you offer?

Aetna: We do not offer HSA service guarantees.

Blue Shield: In order to ensure that our members consistently receive excellent customer service, we have a number of service level agreements in place as part of our relationships with Wells Fargo and Health Equity (e.g., performance agreements for average speed of telephone response).

Cigna: The standard performance guarantees apply.

Kaiser Permanente: Kaiser Permanente does not offer service guarantees, but is committed to service excellence and has rigorous service level agreements in place for financial account and medical plan administration. The service level agreements cover a comprehensive scope of services including set up, call center metrics, payment timeliness and accuracy.

Sterling: We offer a full money back guarantee of up to 12 months of paid monthly maintenance fees if our account holders are unhappy with our service for any reason. Sterling was the first HSA administrator to offer such a guarantee and made this commitment when the company was founded.

UnitedHealthcare: Service guarantees will vary based on the scope of the relationship with the customer, but are typically available with respect to administrative service delivered under the plan.

17. What kinds of depositories are desired?

Aetna: Not applicable.

Blue Shield: As members may open their HSAs with the financial institution of their choice; depository guidelines will vary by financial institution.

HSA Bank: We encourage account holders to contribute as much of their allowable maximum contribution each year to maximize their tax savings (Federal and state, where applicable).

Kaiser Permanente: Kaiser Permanente does not require a minimum deposit.

Sterling: We accept cash, checks, and electronic fund transfers through our website in a secure, password protected environment. We recommend an initial deposit of $100 and require a minimum balance of $20 to keep the account

open and active.

UnitedHealthcare: No, front-end employer deposits are required for the HRA or HSA.

18. Where is your company headquartered?

Aetna: Hartford, Conn.

Blue Shield: Blue Shield is headquartered in San Francisco, Calif.

Cigna: Cigna is headquartered in Bloomfield, Conn.

HSA Bank: HSA Bank is a division of Webster Bank, N.A. headquartered in Waterbury, Conn. HSA Bank is based in Wisconsin.

Kaiser Permanente: Kaiser Permanente Foundation Health Plan is headquartered in Oakland, Calif.

Sterling: We are a California-owned company and are headquartered in Oakland, Calif. We serve clients nationwide with personal sales representatives and account managers covering all states, including Hawaii.

UnitedHealthcare: Minnetonka, Minn.

19. Please provide the phone number and e-mail that brokers can use to find out more about your plan.

Aetna: 877-249-2472, prompt 6

Blue Shield: Brokers can call their Blue Shield sales representative or call Blue Shield Producer Services at 800-559-5905 or visit Producer Connection at www.blueshieldca.com.

CIGNA: Please contact your local CIGNA HealthCare sales representative at 888-802-4462. Blue Shield: Brokers can call their Blue Shield sales representative or call Blue Shield Producer Services at 800-559-5905 or visit Producer Connection at www.blueshieldca.com

Kaiser Permanente: For questions or information about Kaiser Permanente, brokers can refer to brokernet.kp.org or contact our Client Services Unit at (866)752-4737 (8 a.m. to 5 p.m. PST).

Sterling: Brokers can contact any of our sales representatives. Their names, email addresses, phone numbers and territories are available at www.sterlingadministration.com on the Contact Us page. Brokers can also email broker.support@sterlingadministration.com or customer.service@sterlingadministration.com. Our phone number is 800-617-4729 and we're available Monday – Friday from 8 am – 6 pm Pacific. Personal service and account support is a hallmark of Sterling Administration.

UnitedHealthcare: For more information, visit www.uhc.com.

20. Which market segment (small/ mid/large) do you anticipate these plans will best accommodate? Aetna: All segments.

Aetna: Brokers and general agents, consultants, Aetna sales force.

Blue Shield: HSA-eligible plans continue to generate interest from all market segments, including individual and group markets. Therefore, Blue Shield members enrolled in HSA-eligible plans span all lines of business, from the individual and small group markets to large employers.

CIGNA: We have found that the broker/consultant channel has been the most effective.

HSA Bank: HSAs are a great way to save on healthcare costs for employers of all sizes.

Kaiser Permanente: Our HSA-qualified deductible plans are gaining popularity in all market segments, including individual and family, small, mid and large group.

Sterling: HDHP/HSAs accommodate all market segments and we serve them all today.

UnitedHealthcare: All segments.

21. What channels have been most effective in selling HSAs?

Aetna: Brokers and general agents, consultants, Aetna sales force.

Blue Shield: HSA-eligible plans appeal to all customer segments, from the individual market to small, midsize, and large groups.

Cigna: We have found that the broker/consultant channel has been the most effective.

HSA Bank: We work with brokers, general agencies, consultants, third party administrators, and carriers. However, brokers remain our most effective channel in selling HSAs to date. Results show that over half of our business comes from this channel. As such, we have a strong focus on our broker distribution channel. We offer brokers easy enrollment options to set up their groups and individuals, revenue-sharing opportunities, a dedicated call center as well as field sales support to help close deals and provide education to groups.

Kaiser Permanente: While all channels have been successful, the broker channel continues to be extremely effective for promoting these products as the marketplace shifts toward HSA-qualified plans.

Sterling: We are committed to the broker, agent and consultant channel.

UnitedHealthcare: UnitedHealthcare's HSA-qualified plans are sold primarily through brokers and consultants, or directly to individuals purchasing insurance policies on their own.

22. Which customer segments have been most receptive to HSAs?

Aetna: All customer segments.

Blue Shield: HSA-eligible plans appeal to all customer segments, from the individual market to small, midsize, and large groups.

HSA Bank: HSA Bank's internal research results indicate no statistically significant difference between HSA participants and non-HSA participants in regards to age, income, or overall health.

Cigna: We have seen receptivity in all customer segments from the smaller group segment through large national accounts.

Kaiser Permanente: We have seen strong growth in all customer segments including the individual and family, small, mid and large group segments.

Sterling: Customers who want to contain their healthcare costs and reduce increases continue moving to the HSA market. Areas with high PPO penetration move quickly as well. We believe this trend will continue due to rising health plan premium costs and taxes, as well as the advent of the Cadillac tax in 2018.

UnitedHealthcare: All segments have been receptive to the HSA product.

23. How prone are brokers to support this with reduced commissions on the high deductible health plan side of the equation?

Aetna: We have seen widespread broker support of HSA plans as a viable option for their clients.

Blue Shield: We have received positive broker feedback on our HSA eligible HDHPs, as these plans have proven to be an important option

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for brokers looking to provide plan benefit designs at more affordable price points for their IFP and group clients. In addition, HSA-eligible HDHPs are also attractive because of the possible tax and personal saving advantages.

HSA Bank: Brokers are very supportive in doing what is best for the company and employees.

Kaiser Permanente: Brokers are very supportive of these programs when they meet their customers' business needs.

Sterling: Brokers who think this is the right thing to do for their clients place them in a HDHP/HSA. Many brokers use the HSA concept as a marketing advantage to grow their book of business and sell multiple lines of coverage.

UnitedHealthcare: Brokers realize that the CDH plans are experiencing rapid adoption and they are doing their best to offer their customers the product that is right for them.

24. Will high-deductible health plans actually reduce utilization?

Aetna: We see continued positive signs of cost control and consumer engagement in studies in HSA and HRA results.

Blue Shield: While preventive care is covered on all our HSA-eligible HDHPs with low or no co-payment and all Blue Shield members can take advantage of our core wellness programs, it is yet to be determined if HSA-eligible HDHPs reduce utilization.

Cigna: During the past several years, Cigna has compiled empirical data on literally millions of individuals enrolled in our CDHP, HMO and PPO plans based on claims experience that demonstrates that our consumerism products (HRA and HSA), offered as part of a comprehensive package of communication, member education and access to reliable and actionable information, substantially reduce the overall employer medical trend. Moreover, Cigna's multi-year experience studies of CDHP plans provide evidence demonstrating that our consumer driven health plans both improve costs and health care quality.

HSA Bank: Our data supports evidence of lower claims, which makes sense because consumers shop differently with their own money. They adopt the usual consumer behaviors. They shop on quality and price and even start to adopt healthier behaviors. However, there is a distinction between HDHPs when paired with an HSA vs. HRA. HRAs do not lower claims because the employer, not the employee, owns the money. Without owning the money, there is a use it-or-lose-it mentality, just like with FSAs. In fact, claims for unnecessary visits and procedures can go up, not down, just to use-up the money available. In other words, the wide adoption of HRAs with HDHPs has unfortunately voided the HDHPs intended low-utilization premise and actuaries are now pricing HDHPs higher relative to traditional plans to the point that the savings spread has almost disappeared.

Kaiser Permanente: We regularly evaluate the impact on utilization. Based on some small samples assessed, we have seen some reduction in utilization with our members enrolled in HSA-qualified health plans. The lower risk factor behind this population segment may be a contributing factor. Additionally, there are also some small studies that indicate a change in behavior from these members as they become more financially engaged and responsible for their health expenses. Preliminary information shows that some members have pursued alternative options such as emailing their physicians. Kaiser Permanente encourages all members to receive preventive care services and to take advantage of our wellness and health education programs.

Sterling: Our experience suggests that our clients are carefully evaluating cost/treatment alternatives, thereby reducing unnecessary medical utilization. Trends on a national level are below that of traditional health plans.

25. How can vendors make HSAs more effective and attractive for brokers?

Aetna: Make the sales process as simple as possible and give brokers tools that allow them to present these options to employers and employees effectively.

Blue Shield: Blue Shield has relationships with HSA custodians to promote HSAs and offer consumer education to brokers and employer groups. For example, vendors can demonstrate for employers how moving from a traditional PPO or HMO product to an HSA-eligible HDHP offers more affordability, which also allows for greater employee coverage. Our website provides extensive information on this topic: http://www.healthequity.com/BSCemployeeEd.

Cigna: By providing information to help brokers understand the consumer advantages of the HSA product, providing products and processes that are easily understood by employers and supporting the customer education at enrollment and on an ongoing basis.

HSA Bank: From doing enrollments to answering difficult questions, brokers can count on outstanding customer service dedicated to them and their clients. We provide quality service.

Kaiser Permanente: Vendors can make HSAs more effective and attractive by keeping the sales process simple, supporting communications and education, supporting installations, and bringing effective online tools to the employer and members. By creating an integrated HSA pairing that includes our integrated delivery model, we can offer an effective, attractive, and competitive solution for our brokers.

Sterling: We support the broker channel with sales representatives who handle their needs personally. We also offer HSA training and education, including CE classes and webinars, analysis tools, PowerPoint presentations, and other sales material. In addition, we support the broker's employer clients in a similar fashion. This helps our broker partners better satisfy their clients' needs. We also consistently update clients on regulatory changes, important new service benefits, etc. through targeted email campaigns, our blog, Facebook, Twitter and LinkedIn.

UnitedHealthcare: Make quoting, set up, and enrollment as simple as possible for the broker. Provide as much broker training as possible. Provide simple communication materials for HR staff and the enrollees. Leverage the experience and materials of your health plan partner, who can offer communications materials and other tools to provide assistance.

26. Will consumers purchase plans for their traditional health plan features and view the HSA account as a perk to cover short-term medical expenses or will the primary purchase decision focus more on long-term financial planning to cover immediate and long term medical expenses and to reduce tax liability?

Aetna: We see both with the latter being more common.

HSA Bank: That's the beauty of an HSA—its flexibility. If a consumer needs to cover qualified medical expenses, they can do so tax-free with their HSA funds. The consumer also has the option to grow their funds through self-directed investment options with no minimum balance.

Kaiser Permanente: Consumers purchase Kaiser Permanente HSA-qualified deductible plans and open HSAs to cover both immediate and long term medical expenses, as well as to reduce tax liability and achieve long-term savings goals.

Sterling: The latter appears to be the case. This is truly a new way to finance the costs related to healthcare. In today's economic climate, the HSA is a great way to budget for medical, dental and vision expenses as well.

UnitedHealthcare: Optum Bank's analysis of saving vs. spending pat-

terns of HSA consumers reveals diverse trends in spending vs. saving behavior on the HSA account. Data from Optum Bank released in September 2013, shows HSA account holders typically can be categorized into one of three basic patterns of account usage: spenders, savers and investors. Around 45% of Optum Bank's 1,100,000 account holders are spenders (typically spend more than 50% of their annual contributions). A sizable 16% of the population saves 100% of their HSA funds while the remaining 39% spend 1% to 50%. In addition, there is a growing population that is seeking mutual fund investing, as a way to help save for future medical needs. An average Optum Bank HSA account holder carries over $2,100 in their account. Investors tend to have significant higher balances, averaging over $11,000 in their investment portfolio.

27. Do you envision interest in an HSA eligible HMO (low-cost) plan?

Aetna: Yes, since January 2006, Aetna has offered an HMO HSA in some markets.

Blue Shield: We are reviewing the HMO/HSA market trends and will be introducing new HDHPs that answer the market's needs.

HSA Bank: Yes. And, carriers should not overlook this as an option for California.

Kaiser Permanente: Absolutely. Since 2005, Kaiser Permanente HSA-qualified deductible plans have appealed to all market segments, including individual and family, small, mid and large groups.

Sterling: Several carriers already offer an HMO/HDHP plan or EPO/HDHP plan design. Sterling administers the HSA account component of these plans.

UnitedHealthcare: Yes, as long as the plan is a qualified HDHP.

28. Which geographic areas and consumer demographics are brokers seeing a demand for competitive individual and family plan HSAs?

Blue Shield: Blue Shield experience indicates that the broker interest in HSAs is statewide.

Cigna: We offer an array of individual and family plans in California, some of which are HSAs. Cigna is price competitive in this market.

Kaiser Permanente: We are seeing demand across all geographic areas and demographics.

Sterling: We know that the early Baby Boomer is very interested in choosing a HDHP/HSA product. Areas with high PPO concentration and lower pricing are high sales areas. The individual market has been a PPO market for some time and was the first to migrate to the HSA. Some individuals already have a HDHP and now have a tax-advantaged way to pay for medical expenses or save for retirement. We also see strong interest in certain geographic areas where Sterling has expanded, including key markets in the Southwest. We serve clients nationwide.

29. What problems, if any, have you encountered with HSA eligible plans?

Aetna: None

Blue Shield: We have not encountered any issues specifically pertaining to HSA-eligible plans.

Cigna: We have not encountered problems with the administration of the HSA eligible plans. One of the challenges of introducing these plans is to educate the customer on the value of the plan and the tools to become actively engaged in the management and mainte-

nance of their own health care.

Kaiser Permanente: Excellent communication among brokers, employers, the health plan and employees is key to ensuring successful implementation and administration of HSA eligible plans. Kaiser Permanente provides extensive support to all constituencies to avoid potential issues.

For our brokers and employers, we offer educational materials, marketing collateral, and training on HSA-qualified plans to ensure understanding of options and a smooth onboarding and implementation.

For employees, we provide education on how deductible plans and the HSA work together, and also phone outreach pre- and post-appointment to support awareness and education of the cost of services, point of care health plan and HSA educational materials, member financial assistance, and online tools and information that can be accessed any time.

Sterling: Pricing is imperative in an HSA plan. If the rates are not competitive, then the HDHP plan does not sell well.

UnitedHealthcare: No problems, but it is important to educate consumer on how to take financial responsibility when receiving health services. Most consumers are used to dealing with a health insurance company or their bank. The HSA product is more than the sum of its parts; it involves educating the members and encouraging them to ask financial questions when seeking and receiving health services.

30. How has your plan changed from last year?

Blue Shield: Blue Shield's significant growth in the account-based health plan market—especially with full PPO plans with built in health savings accounts—is aligned with industry trend reports demonstrating clear shifts nationally among large and mid-size employers in favor of these health plans. Since Blue Shield's ABHP plans are offered through a fully integrated platform, this gives the company an edge over some carriers. Customers (both employers and employees) favor full-integration because it promises a superior user experience. But full-integration also demands a technologically-advanced model strategically linking the systems and resources of Blue Shield and its ABHB financial trustee, HealthEquity. This model delivers enhanced claims processing capabilities along with continuously-improving member portal customization and features. Blue Shield has provided the leadership and resources necessary to ensure its edge is maintained in this increasingly important, value-driven customer option.

Cigna: We continue to enhance our online and mobile app cost and quality comparison tools, to help people make informed choices about where they seek care.

HSA Bank: While our HSA hasn't changed from last year, we are always looking for ways to enhance our product to best serve our account holders. We have added online bill pay, myHealth Portfolio – a suite of tools to help members track their expenses and pay for qualified medical expenses. We have also added a mobile application for busy members to manage their account on the go.

Kaiser Permanente: Kaiser Permanente is the only health care account based plan solution that offers a single end-to-end user experience, provides innovative auto-substantiation technologies, and automates work flow for brokers, employers, and account holders. The system is managed on one technology platform and integrated web portals.

Our partnership has allowed us to enhance our account based plan capabilities and offer a comprehensive array of integrated member and customer service features, including the following:

1. An employer portal providing a convenient, role-based online solution for managing accounts
2. Data exchange enhancements which provide an efficient tool for loading employee profile, enrollment, dependent, contribution and bank account data on a regular, automated basis
3. Employer reports and notifications accessible via email and/or the secure self-service employer portal
4. Employee online account management via single sign-on through KP.org; employees can file claims, upload and track receipts, view claims history and notifications, plus access forms
5. Mobile applications (iPhone, iPod Touch, iPad) or Android-powered devices with the option for receiving text messages to keep up to date on changes to claims and payments

Sterling: We continue to invest in our HSA offering with mobile applications and website functionality to enhance the client experience. We offer discounted set-up fees for groups adopting multiple products from Sterling (HSA with HRA, HSA with FSA, COBRA). We do not charge set up fees for HSA rollover business. We continue to offer two HSA plans – Standard and Value. Finally, we have been complimented for our outreach to the Latino community with our website, collateral and customer service representatives. ❑

Products

Financial Planning

White Paper on Same Sex Financial Planning

Prudential released an update to its white paper, "Financial Planning Considerations for Same-Sex Couples After Windsor." In a new development – the Social Security Administration now recognizes some non-marital legal relationships as well. Named for Edith Windsor, the plaintiff in the federal case United States v. Windsor, the Windsor decision refers to the overturning of Section 3 of the Defense of Marriage Act (DOMA), which limited the definition of marriage for federal benefit purposes to opposite-sex unions. As a result of the Windsor decision, same-sex marriages under state or a foreign jurisdiction are now recognized for federal law purposes.

The original paper explored how the 2013 landmark decision to overturn Section 3 of DOMA afforded legally married same-sex couples many of the employee benefits and financial planning strategies once available only to opposite-sex married couples.

The marriage equality landscape has continued to evolve since the original paper was published. "As of January 2015, 36 states plus the District of Columbia now recognize same-sex marriage," says James Mahaney, author of both papers and vice president, Strategic Initiatives, at Prudential.

Mahaney added the Social Security Administration has historically only recognized legal marital relationships among couples based on the laws of the state in which they reside, regardless of the state in which they were married. The Social Security Administration now recognizes some non-marital legal relationships as well. For more information, visitwww.news.prudential.com.

Nationwide Expands 3(38) Fiduciary Service

Nationwide has expanded the company's 3(38) investment fiduciary service from IRON Financial, LLC. The service will now include fiduciary monitoring of Nationwide's managed account service (at the plan level) for no additional cost. When a plan sponsor elects the 3(38) service, IRON Financial assumes the responsibility and legal liabilities associated with selecting, monitoring and replacing plan investments under section 3(38) of ERISA. For more information, visit www.nationwide.com ❑

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The Road Ahead for Private Exchanges

In the next decade, enrollment in health insurance marketplaces — public, private or some hybrid— is expected to grow significantly, according to Price Waterhouse Cooper's 2014 survey of 1,200 employers. The following are highlights of the report.

The Affordable Care Act's (ACA) new public exchanges have increased awareness of the exchange concept and raised the prospect of a shift in health insurance purchasing. While the ACA's public marketplaces are expected to see rapid early growth, the shift to retail-style private exchanges will be more of a steady trickle. Thirty-two percent of employers are considering moving active employees to a private exchange in the next three years.

As more consumers take control of their healthcare spending, new opportunities can arise for health advisors—much like the role of financial advisors for retirement planning. Private exchanges are already starting to support consumer decision-making, and new opportunities will arise for non-traditional healthcare companies with data and customer expertise.

Several major insurers are recasting their business models to succeed in the business-to-consumer environment. In the not too distant future, consumers will customize health plans to their own price points. Insurers and exchanges may incorporate subscription services that provide easy access to primary care and electronic health information for a small annual fee. Insurers may also start offering insurance packages that are customized to a disease or condition, such as diabetes. Abir Sen, CEO of the healthcare marketplace Gravie, said, "When you buy a health plan, you're buying the actual insurance; you're buying a plan design and networks. In the future, those things will be disaggregated. One small example is what's happening — perhaps a consumer purchases a bronze plan with a high deductible and pairs it up with a pediatric concierge service. Maybe they supplement that with a line of credit."

"Private exchanges are already starting to support consumer decision-making, and new opportunities will arise for non-traditional healthcare companies with data and customer expertise."

Many private exchanges may also expand product offerings into life, home, and pet insurance. Some exchanges already offer ancillary products, and the demand will likely grow as the retail experience improves. The $267 billion U.S. health and wellness market is poised for growth as more companies enter the sector with new products and services. Retailers could use exchanges to provide personalized recommendations for non-regulated health products, such as nutrition and fitness items. Big-box retailers could eventually become strong competitors.

Some employers will maintain the structure for active employees and move retirees to a private exchange. In fact, 43% of businesses are considering moving their pre-65 retirees to a private exchange with a subsidy in the next three years.

The Advantages of a Private Exchange

Private exchanges can offer more affordable insurance to the more than 5.6 million small and mid-sized companies in the United States. Transitioning to a retail marketplace can also alleviate administrative tasks. Private exchanges typically offer consumer decision support, integrated wellness programs, and online benefit sites that would require too much time and money for employers to implement on their own. Private exchanges can also help employees find the health plans that meet their needs. With the right guidance, employees can find high deductible plans that are manageable and cost effective.

Buying down to lesser coverage can save employers a lot by encouraging employees to comparison shop and use healthcare services more efficiently. A private exchange study by the Kaiser Family Foundation reveals that, in two out of three geographic areas, 60% of employees chose the lowest-cost plans, and 52% enrolled in a plan that would allow them to establish a health savings account. Many employers already have cost-control strategies with defined contribution and higher cost-sharing plans. Sixty seven percent of employers offer high-deductible health plans, and 47% offer plans compatible with health savings accounts that can receive employer and employee contributions.

After going with a private exchange, Walgreens found that employees had a better shopping experience with more choices and the ability to tailor products to their employees' needs. Also, the staff had reduced administrative duties. Tom Sondergeld, Senior director of Health and Well-Being for Walgreens, explained that a private exchange fit the bill because Walgreens has a mix of employees across geographic regions, which is important for stabilizing premiums. Second, having a staff with an average age in the mid-30s contributes to lower-than-average claims costs. Walgreens found it easier to educate employees on how to purchase through metal pricing tiers since the company already converted to a silver metal equivalent for its health plans. About 43% of the company's employees stayed in a silver plan while about 29% bought less expensive plans.

Not a Solution for All Employers

Companies with the most sophisticated benefit programs may not see as much value in a private exchange. Many employers have become skilled in benefit management: they can underwrite claims, administer health and wellness programs, and even contract directly with certain healthcare providers to create high performing, low-cost networks. Some employers are already keeping spending growth below average or close to zero. Safeway, with approximately 135,000 employees, has done this with its own self-insured health plan that supports over 40,000 members.

Moving to a defined contribution model could put employers at risk for penalties if they fail to meet the ACA's affordability guidelines, which require an employee's share of premiums to be less than 9.5% of adjusted gross income. Private exchanges can also open self-insured employers to the risk of relying on a third party to control healthcare costs. "While many employers are interested in private exchanges, most are waiting to see how they evolve to manage healthcare costs," said Brian Marcotte of the National Business Group on Health. Most employers rely on insurance companies to help control healthcare cost growth and manage risk. Engaging a private exchange can take the benefit selection process—and, in some instances, health and wellness management—out of the hands of the employer.

How to Determine Whether a Private Exchange is a Good fit

Benefit consultants should do the following to see if a private exchange is the right fit for the employer:

- Conduct a thorough cost-benefit analysis.
- Compare what an exchange offers with what is or can be done effectively in-house.
- Determine how a private exchange could affect employee retention as well as other indirect costs. Consider factors, such as employment region, market competitiveness, and employee demographics.
- Recognize that you're buying into a benefit delivery platform, not a product. With many exchanges still in development, pricing and features are not set and can vary widely. Employers may need to compare bids from several exchanges. Partner with exchanges to select plan designs, shape the user experience, and potentially design a defined contribution strategy.
- Have a sophisticated communications strategy. While many exchanges have good educational materials, employers should create a plan for media and internal communications before announcing a change.

"As retail becomes a prevalent model for purchasing insurance, the health sector will need to evolve as well. Insurers, providers, and pharmaceutical companies will face pressure to lower prices, improve patient outcomes and provide more transparent data."

Address employees' concerns, and make sure corporate values align. Be prepared to answer tough questions.

- Determine whether there's value in creating a company-branded, single-carrier private exchange or partnering with others. Some of the large national insurers are already working with several private exchanges. As exchanges evolve, many want to integrate strong regional insurers to increase savings for employers.
- Distinguish your brand. Insurers on the exchanges should find ways to compete outside of price, especially as new competitors enter the fray. Consider marketing to a broad, general audience and using employee outreach through on-site

representatives and marketing materials to help stay top-of-mind for consumers when they select a plan.

- Develop or enhance transparency and outreach tools for consumers. Consumers will need to understand how their coverage works as they choose lower-premium and higher cost-sharing plans. Tools can help manage member costs and expectations, such as expense tracking, provider price and quality shopping, medication and screening reminders, and interactive tools to track and improve health. Consider acquiring or partnering with companies that have already created these tools.
- Explore direct contracting arrangements. In the future, private exchanges could facilitate direct contracting between providers and employers. Seek early opportunities to build out the market.
- Prepare for growing pressure on price and transparency. Providers will face pressure to cut prices, boost quality, and transparency or risk being clipped from health plan networks. Providers, like insurers, will need to stand out among their peers.
- Expect tighter formularies. Insurers are lowering costs by adding formulary tiers, prior authorization, and step therapy requirements in addition to striking some drugs altogether. Increased cost-sharing can drive consumers to seek less expensive alternatives. Providing data to demonstrate a drug's effectiveness and value will be important as consumers become savvier.

Two essential factors will determine success of private exchanges: whether employers see sustainable cost savings and whether exchanges enhance the customer experience. As retail becomes a prevalent model for purchasing insurance, the health sector will need to evolve as well. Insurers, providers, and pharmaceutical companies will face pressure to lower prices, improve patient outcomes and provide more transparent data. To get the report, visit www.pwc.com/us. ❑

Leila Morris is senior editor of California Broker Magazine

Four Types of Private Exchanges

1. **The broker/consultant model:** This model, which is growing quickly, typically offers fixed products and integrated consulting services. These exchanges typically provide a fixed shopping storefront and are funded by fees from the employer, commissions from health insurers, or a combination of the two.
2. **In the insurer-sponsored model:** Health insurance companies run their own proprietary exchanges. These exchanges can be built on technology that is licensed from other companies. Some insurer-sponsored private exchanges participate in the small group and individual markets in select states, with plans to extend into more states and larger group markets.
3. **The technology model:** This model is considered to be the most flexible. It is geared to employers, states, insurers, and brokers/consultants. Employers that choose this route can purchase a full exchange or the technology components of benefit outsourcing. It provides cloud, software, and data analytics solutions to insurers, states, brokers/ consultants, and large employers looking for a custom exchange.
4. **The pure-play model:** This more mature model is known for its focus on consumer decision support and customer storefronts. Once rooted in the small group market, this model is now in the mid-to-large employer market as well. This model is known for decision support and technology as well as product offerings. Some pure-play exchanges offer online financial tracking tools and ancillary products, such as life and disability insurance.

by Joseph Berardo Jr.

Self-Insurance: The Strategy of Choice for Small to Mid-Size Employers

With healthcare costs continuing to grow in a stagnant economy, it's time for health insurance brokers to revisit self-insurance as a way to provide the employers value and great control over their plans.

Traditionally considered a cost-control option for larger employers, self-insurance has become an appealing alternative for small- to mid-size companies as well. The key is to effectively communicate the advantages, explain how to avoid risks, and outline how to manage the transition from simply purchasing insurance to taking control of and shaping a benefits program around the needs of the employee population.

Key Advantages of Self-Insurance

Cash Flow

With self-insurance, employers pay for individual employee health claims out of cash flow rather than as a monthly fixed premium to a health insurance carrier. Costs are based on actual plan member healthcare use, which makes self-insuring cost-efficient and more effective than commercial plans.

Flexibility

Self-insurance also offers greater flexibility than commercial insurance while providing the kind of practical and economic advantages that curb costs, such as the following:

- Helping employers tailor plans to the health needs of a workforce population, especially if guided by the right healthcare services company
- Generating as much as 3% immediate savings because state premium taxes are eliminated on most self-insured plans
- Eliminating carrier profit margins and risk charges

Exemptions

Self-insurance is exempt from many of the federal healthcare law's health insurance taxes, which will be onerous for the commercial plan market. As the majority of large businesses, labor unions, and governments self-insure, the new health insurance tax will result in smaller percentage increases in average health insurance premiums for large firms, and cause greater increases for small firms that rely on insured coverage, as well as non-group health insurance coverage. Furthermore, self-insured companies do not have to offer the government-mandated essential health benefit, which allows them to tailor benefits to the needs of a company and the demographics of its workers.

In addition, the federal healthcare law does not subject self-insured health plans to the jurisdiction of the states while insurance-based plans must comply with the varying coverage mandates, insurance statutes and regulations of the 50 states. Also, self-insured plans continue to be exempted from state mandates and regulation by virtue of ERISA's preemption of state action in connection with self-insured health and welfare benefit plans. For the most part, self-insured plans are not subject to litigation in state courts or the appeal and complaint procedures of the insurance departments of each of the states.

Other Benefits

Support for self-insurance has grown because it can be tailored to the needs of employers and offers transparency to ensure the plan is managed in an efficient and effective way. Equally important, self-insurance helps control healthcare costs, which can lead to higher wages for employees and more resources for employers to invest in job creation.

What About Risk?

The addition of stop-loss insurance provides a financial buffer for the self-insured employer if, for example, an employee is found to have cancer or needs an organ transplant. This added level of financial security is especially meaningful for smaller businesses. There are two types of stop-loss insurance: specific and aggregate.

Specific stop-loss protects against a catastrophic loss incurred by any individual covered by the plan, with the deductible set at a level appropriate for the size and financial strength of the company. Under this form of stop-loss insurance, an employer pays a fixed premium each month and is liable for the claim payments of an individual up to a chosen deductible, with amounts in excess of that covered by the stop-loss carrier. Some specific stop-loss contracts don't require the employer to fund the claim and wait for reimbursement; instead, the administrator pays the claim directly from the carrier's account.

Aggregate stop-loss protects against an excessive amount of claim expenditures for the entire plan. Through actuarial studies, stop-loss underwriters can estimate smaller, predictable claims; however, these projections are based on large, industry-wide

samples and are therefore subject to variations and fluctuations.

With either type of stop-loss insurance, it is important to remember that risk mitigation is most effective when coordinated by an experienced health plan management firm.

Finding a Healthcare Services Partner

With guidance from a healthcare services partner, health insurance brokers can develop marketing seminars to target prospects and demonstrate their ability to think outside of the box.

Also, a health plan management firm can play an important role in walking brokers through the complexities and nuances of self-insurance. Some health plan management firms have forged long-term relationships with stop-loss carriers, allowing them to provide brokers with competitive rates. Generally, healthcare services companies oversee the self-insured plan and assume responsibility for the following:

- Maintaining eligibility.
- Providing customer service.
- Adjudicating and paying claims.
- Preparing claim reports.
- Negotiating, obtaining and renewing stop-loss placement.
- Conducting enrollment information meetings.
- Arranging managed care services, such as access to preferred provider networks, coverage for alternative treatment programs including acupuncture and chiropractic services, prescription drug card programs that offer cost-saving opportunities and utilization review.

In particular, brokers should find a healthcare services company that offers secure data analytics for remote and real-time care while providing an inexpensive vehicle for coordinating online tools that identify at-risk members, their patterns and treatments for various ailments – from diabetes to heart conditions. Robust data analytics allow self-insured employers to evaluate employee information, including age, chronic illness, risk factors and gaps in care, and update medical conditions, compare previous costs to projected expenditures, and intervene with optimal prevention and wellness programs.

Optimizing Self-Insurance

Taking the advantages of self-insurance one step further, brokers can suggest that employers streamline access to care with customizable care plans based on an individual's risk profile and needs. Targeting health issues, rather than simply implementing a general health and wellness program, is critical for long-term sustainability.

By partnering with healthcare service companies and provider groups, employers can take advantage of deep discounts and give employees greater access to coordinated care. Within this model, healthcare data analytics plays an important role, providing information relevant to population health management, such as determining the chances of a relapse, the likelihood of noncompliance, and the progression of chronic disease.

Some plans are designed exclusively around chronic disease and include educational materials, one-on-one counseling, transportation to a hospital or doctor's office, and assistance in coordinating care among providers/physicians. Health claims and other medical data are used to identify members with chronic conditions and give them the tools and support they need to better manage their health.

Conclusion

Self-insurance has emerged as a key strategy for employers to remain viable while generating health and wellness for employees. That's no surprise, given its effectiveness, cost-efficiency, and advantages over commercial insurance plans in the wake of healthcare reform. Having the ability to continue offering an attractive health benefit option is critical for attracting and retaining top talent.

What's more, self-insured employers pay for individual employee health claims out of cash flow rather than as a monthly fixed premium to a health insurance carrier. While employers assume the direct risk for payment of claims, costs are based on actual plan member healthcare use, and catastrophic claims are covered by stop-loss coverage. This makes self-insuring cost-efficient and more effective than the increasingly expensive, cookie cutter design of commercial plans. ❑

Joseph Berardo Jr. is CEO of MagnaCare, an administrator of self-insured health plans for employers in New York and New Jersey.

Robert K. Shepler

Rob Shepler, one of the founders of the Shepler & Fear General Agency passed away on December 27, 2014 after a lengthy illness. Born in Newton, Kansas on May 31, 1954, he lived many years in the Wichita area before moving to Folsom, California in 1990.

Rob spent over 30 years in the employee benefits industry, working for Equicor Health Plan in Wichita, KS in 1985 and then relocated to Sacramento, CA in 1990 where he was employed by PCA Health Plan (later Qual-Med and then Health Net). In 1994, he joined Centerstone Insurance & Financial Services (later BenefitMall) and in 2004 became a part of the LISI General Agency. In 2009, he and David Fear, Sr. started the Shepler & Fear General Agency in Auburn, CA, later moving to Roseville, CA.

Within the employee benefits industry Rob was an active member of the National Association of Health Underwriters (NAHU) and in both the Sacramento (SAHU) and California (CAHU) chapters. He served as SAHU president and board member for several years as well as a member of the board of CAHU. In 2012 he received the NAHU Distinguished Service Award for his long time contribution to the association at both the local and state levels.

He was a long time member of the Optimist Club of Sacramento, having served as the organization's president and charity golf tournament chair for several years. During this time he helped to raise over $500,000 for local children charities. He was also a member of the Romulus Club of Sacramento.

One of Rob's passions in life was Kansas University basketball (Jayhawks). He was an avid fan and supporter of just about anything from the State of Kansas, but his biggest passion was his family and his devotion to his wife of 38 years, Jane and their three children (Tim, Megan and Katelin).

A memorial service was held on December 31, 2014 and a memorial fund in his honor has been established through the Sacramento Optimist Club. Contributions to that fund can be sent c/o Shepler & Fear General Agency, 2140 Professional Drive, Suite 150, Roseville, CA 95661 (1-877-361-7342).

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Five Life Insurance Game-Changers & Cautions in 2015

Many consumers shy away from purchasing or modifying a life insurance policy due to high premiums and a glut of red tape. However, over recent years and even months, the life insurance industry has made great strides and is now more consumer-oriented than ever before. Common barriers and challenges that once blocked shoppers from securing great coverage with ease and at affordable prices are a thing of the past. Indeed, amid a handful of game-changing industry innovations, the time to consider life insurance coverage is now. Here's why.

1 No Medical Exam Necessary

Medical exams have always been a major pain point in the life insurance process. Increasingly, companies are offering policies for lower benefit amounts (like $400,000 and under) without the need for a medical exam. However, insurance companies do check pharmacy records to see all medications prescribed in the past five years. While underwriting times for these policies average about three weeks, some companies do offer coverage in just 24 to 48 hours and you can even find instant issue term life insurance.

Cautionary note: With new "no medical exam" processes leading to quicker issue policy options, be careful to research an insurance company before submitting an application, even when the process is entirely online. When an insurance company declines an applicant, that status is stored in the Medical Information Bureau (MIB) database, which is a service that gives all of the major insurance companies access to shared data. The MIB services alert underwriters to errors, omissions, or misrepresentations made on insurance applications in an effort to mitigate their risk exposure and, in doing so, allow them to pass cost-savings to consumers. This declined status will tarnish your client's record and can make it difficult for them to secure insurance from another provider.

2 Technology-Driven Price Drops

Today's life insurance rates are down as much as 70% from their highs in the mid 1990s. This is largely due to the Internet, which has fostered aggressive competition among insurance companies. New technologies have made it possible for companies to cut administrative costs, and those savings are passed on to the marketplace. If your client has an older life insurance policy, there's a good chance that they can get a better deal on an updated policy. As with refinancing a home mortgage to take advantage of better rates, it's a good idea to revisit the current policy to see what's available in terms of lower costs and higher benefits.

While consumers can get insurance quotes online, many of the rate comparisons on the Internet will just quote based on the lowest premiums for the healthiest of applicants. One attractive rate may be advertised but, after the underwriting and health questionnaire process, many individuals find they actually qualify for more expensive policy rates. In addition, many rate comparisons found online require the customer to enter in their name, phone, and email address to run a quote. This can be problematic for consumers since this personal information is often sold to agents as leads, which can result in the consumer receiving sales calls from up to eight agents that bought the lead. Unfortunately, these calls can continue for years, and email can be spammed for years. Companies that sell your information as such are required by law to disclose that they will use automated dialers or provide your information to third parties.

3 Ageism is Extinct

Don't make the mistake of thinking that once your client is past a certain age,

they can no longer get affordable life insurance. Regulators have revised life-expectancy projections -- known as mortality tables -- for the first time since 1980. A man who is 40 years old today can expect to live to be 78, not 73, as was the expectation 25 years ago. Because of this, an 80-year-old male can get a 10-year term policy and an 85-year-old can still get a fully underwritten whole life policy.

As we get older we experience more medical issues. Anyone who is over 50 or has known medical issues is best off contacting an experienced agent to handle their life insurance needs, as this agent will contact underwriters of multiple insurance companies to discuss the nuances of their application before applying in order to avoid the client being declined or adversely rated in the MIB. This agent-driven process also allows for insurance companies to compete to provide the best rate. More inexperienced agents can submit an application without reviewing multiple options and/or are captive and can only sell/submit to one specific insurance company. An independent agent or brokerage is best to ensure flexibility and customized service.

4 New Living Benefits

New living benefit riders enable your client to use their life insurance policies while they are alive. For example, the accelerated death benefit rider allows your client to use up to 75% of the coverage amount if they have a terminal illness. The chronic illness rider allows your client to use up to 90% of the policy's death benefit if they are unable to perform two of the six daily living requirements of bathing, continence, dressing, eating, toileting, and transferring. This is very similar to a long term care policy. Companies leading the way for living benefits riders are Transamerica and Protective Life Insurance. There is also a critical illness rider, which allows your client to use up to 90% of the death benefit of their policy if they suffered a critical health condition such as cancer, heart attack, stroke, a major organ transplant, end stage renal failure, ALS, blindness, or paralysis of two or more limbs. Life insurance companies realize that people are living longer. This is good news for everyone. No longer are great benefits only for the young or for those willing to pay high premiums and jump through multiple hoops. The insurance industry has listened and has responded to the needs of the consumer in order to streamline the application process and deliver benefits that make sense. Now not only can your client get life insurance at any age, but they can also enjoy those benefits during your lifetime. It doesn't get much better than that.

While some of these new benefits are wonderful, they are still very new. State regulators are still reviewing some of these benefits and some of them may even be required for free in some states, like California. For example, waiver-of-premiums due to disability has been under scrutiny in various regions. So, it's important to capitalize on these benefits while they are in play. Gaining access to insurance benefits while the insured is living stops unscrupulous businesses from buying insurance policies from sick people for pennies on the dollar. Using life insurance to fund long-term care is a great idea for some, though an estate planner can advise regarding the best solution based on personalized needs. Accelerated death benefits, chronic illness riders, and critical illness riders are outstanding considerations and should be discussed.

5 Painless Policy Procurement

Traditionally, to buy life insurance, a consumer had to have an in-person meeting with an insurance agent. In fact, most insurance companies required their agents to be present in order to witness the application. This practice has gone the way of the dinosaur. Fifty percent of consumers prefer buying life insurance without a face-to-face meeting, according to a 2013 study by LIMRA and The Life Foundation. The industry apparently heard this collective marketplace voice and, today, there is no need to meet with the insurance agent in person. Applications can filled out over the phone or on the Internet, the entire process is quicker and easier than ever. To that end, insurance carriers are offering express or rapid applications that include time-saving features, such as digital applications, the acceptance of digital and voice signatures, and the ability to scan or fax the applications, thus avoiding snail mail altogether. In addition to making the application process simpler and faster, insurance companies are making it easier and more convenient for consumers to comparison shop and find the policy that best fits their budget. You can research all the insurance carrier's rates online; some brokers even allow consumers to run rate comparisons online without requiring them to enter their contact information as part of the process. This model is a bona fide hit, with 80% of the marketplace now researching and running rate comparisons online before purchasing a policy.

While new insurance policy shifts are positive for consumers and allow them to make more informed decisions and offer more convenience, be mindful of potential security and identity theft issues. First, ensure you are dealing with an A-rated insurance carrier, which you can easily confirm by utilizing online resources like www.ambest.com. This online resource allows consumers to search any insurance company's financial ratings. Because insurance applications contain social security numbers and much other personal information, don't send your application to more than one person and, before hitting "send," confirm the recipient's email address is correct. Second, because you have an application in digital format, be sure your own computer or device is secure, which may require firewall, virus and malware cleaning software.

For those who put off getting life insurance because of the medical exams, paperwork, price, or pushy salesmen, the good news is that modern industry enhancements have largely alleviated those concerns. But, keep in mind that just a few minutes of due diligence can make a huge difference in the outcome of the life insurance endeavor. ❑

Brian Greenberg is founder and executive of multiple online businesses, including serving as president of True Blue Life Insurance. He can be reached online at www.TrueBlueLifeInsurance.com.

Healthcare

Employers Are Missing the Boat on Alternative Provider Models

Many employers don't understand alternative provider delivery models and payment reform. As a result, they may miss a significant opportunity to improve health and financial results for their workforce and business, according to a study by Aon and Catalyst for Payment Reform. Despite their lack of understanding of the models, 60% are providing or are considering providing a financial incentive for employees and dependents to use these new models through plan design changes, narrow network options, HRA/HSA contributions, or cash.

The study reveals the following:

- 75% don't understand payment transformation models.
- 51% don't understand the cost and quality data provided by their carriers related to new models like Accountable Care Organizations (ACOs).
- 71% are unaware or need to learn more about the attribution process and how they are directly contributing to the payment of these new provider delivery models.

"Employers have the potential to be one of the strongest voices in driving systematic change, but if they don't understand it, they won't make it a priority or demand validation for the improvement that is needed," said Mike Taylor, senior vice president of Delivery System Transformation at Aon Hewitt. According to a separate Aon Hewitt 2014 Health Care survey of more than 1,200 employers, 65% of said that provider payment models that promote cost-effective, high quality health care outcomes will be a part of their strategy. Of those, 12% say it will be one of their three highest priorities. Taylor said, "Employers are increasingly making innovative provider network structures an important part of their strategy, which will help to improve health care purchasing and shift the payment focus towards value based reimbursement and support providers who produce higher quality outcomes."

While few employers have adopted provider network structures, that number is expected to increase in three-to-five years:

- 24% of plan sponsors steer participants to high quality hospitals or physicians for specific procedures or conditions through plan design or lower cost. Another 56% are considering doing so in the next three-to-five years.
- 18% use integrated delivery models, such as patient-centered medical homes, to improve primary care effectiveness, and another 56% plan to do so in the next three to five years.
- 11% contract with hospitals or other health providers directly in specific locations, and another 28% plan to so.
- 10% have adopted reference-based pricing, and another 58% plan to do so.

For more information, visit www.aonhewitt.com.

Millions Would Drop Coverage If Subsidies Were Eliminated

Eliminating government subsidies for low- and moderate-income people through federally run health insurance marketplaces would reduce enrollment in the individual market by more than 9.6 million, according to a new RAND study. If the Republican controlled Congress strikes down the subsidies, enrollment in the ACA-compliant individual market would drop to 4.1 million in 34 states. Individual market enrollment would drop 70% among people buying policies that comply with the Affordable Care Act. Christine Eibner, the study's senior author and a senior economist at RAND said, "The disruption would cause significant instability and threaten the viability of the individual health insurance market in the states involved. Our analysis confirms just how much the subsidies are an essential component to the functioning of the ACA-compliant individual market."

Premium costs for a 40-year-old nonsmoker purchasing a silver plan would rise from $3,450 annually to $5,060. In addition, unsubsidized individual market premiums would rise 47% in those states. The hike would correspond to a $1,610 annual increase for a 40-year-old nonsmoker with a silver-level plan.

The Supreme Court has agreed to hear a court case (King v. Burwell) that challenges the use of government subsidies to help low- and moderate-income people buy health insurance in marketplaces operated by the federal government. Ending federal subsidies would have a bigger effect in states with federally run marketplaces than in states that run their own marketplaces. States with federally run marketplaces generally have more low-income participants who are more likely to drop insurance without subsidies. Those states also had higher uninsurance rates prior to adoption of the Affordable Care Act. For more information, visit www.rand.org.

How Health Payers Will Engage Consumers in 2015

In 2015, U.S. payers will adopt a multiple-channel model to engage consumers, according to a paper by IDC Health Insights. The paper also finds the following:

- Payers will form more partnerships with providers that support value-based reimbursement, global payments, and pay-for-performance reimbursement.
- More payers will implement private cloud solutions, including those featuring software-as-a-service (SAAS) to manage data collection, aggregation, and analytics.
- More payers and other healthcare organizations will face cyber attacks, requiring a multi-pronged security strategy and investments in IT.
- Challenged by the increasing magnitude of clinical, analytical, and financial data, more payers in 2015 will need to look at investing in data management and warehousing.
- More payers, particularly larger organizations, will consider it solutions provided through outsourced services, including business process outsourcing.
- More payers will participate in the government-funded lines of business including Medicare advantage, Medicaid, and dual eligibles, resulting in more demand for specialized it solutions and support services.
- Payers will continue to adopt more of a population health management approach to care and disease management.
- More payers will develop non-insurance lines of business, including innovative health IT solutions that address consumer communications and support private health insurance exchanges.
- Payers will increasingly assess and develop private health insurance exchange solutions.

For more information, visit www.idc.com.

Unions Strike Against Kaiser Over Mental Health

The National Union of Healthcare Workers went on strike to protest what it says are Kaiser's chronic mental healthcare failures. More than 12,000 people emailed Kaiser executives by signing onto a new petition to reduce wait times for those seeking critical treatment.

Kaiser Permanente is already paying a near record-breaking fine of $4 million for not providing timely care, forcing patients with serious mental health illnesses to wait weeks or even months for urgent care. The union says that Kaiser has refused to staff its mental health departments with enough clinicians to handle the ever-rising caseload. Dr. Paul Song,

executive chairman of Courage Campaign and practicing oncologist said, "Plain and simple, health insurance giants like Kaiser are responsible for decreasing services and jacking up premiums, and people all over the state are waking up to it. Kaiser needs to come back to the table and join commonsense proposals like clinician management committees to work together with mental health workers to determine facility staffing needs and provide all Californians with the coverage they deserve and pay for." To view the petition, visit:http://act.couragecampaign.org/sign/KaiserStrike_NUHW.

John Nelson, vice president of Government Relations, Kaiser Permanente responded, "NUHW is a small California union representing fewer than 5,000 of Kaiser Permanente¹s 175,000 employees. Since its creation in 2009, it has never negotiated a contract with Kaiser Permanente. In fact, NUHW stands alone as the only union that has been unwilling or unable to reach a fair agreement concerning a contract covering our employees during that time." Kaiser Permanente is committed to finding a solution that benefits our employees, and NUHW must have the same commitment. We are committed to continuing to bargain whenever and wherever possible to avoid a strike, and we are urging our employees to resist the call to leave members and their patients for the weeklong strike called by NUHW. NUHW has spent the last several years publicly attacking our mental health services while at the same time resisting important steps we are taking to enhance mental health care for our patients. Although NUHW has been using intimidation and obstructionism to try to achieve its goals, we will not let that stop us from continuing to make progress on addressing the national challenge facing all mental health care providers. We remain fully committed to meeting that challenge.Our mental health employees are critical to our efforts to continue improving mental health care for our patients. We believe that by working together, we can better address these issues and make progress on behalf of our patients, and the industry as a whole, continuing our focus on what really matters providing our members with the best health care possible."

Commissioner Issues Emergency Regulation Over Networks

California's Insurance Commissioner, Dave Jones, issued an emergency regulation to ensure that health insurers have enough medical providers in their networks to provide timely access to medical care. The emergency regulation will require insurers to do the following:

- Include enough primary care physicians who accept new patients to accommodate enrollment growth.
- Include enough primary care providers and specialists who have admitting and practice privileges at network hospitals.
- Consider the frequency and type of treatment that's needed to provide mental health and substance use disorder care when creating the provider network.
- Adhere to and monitor new appointment wait time standards.
- Report to the Department of Insurance about their networks and changes to their networks to the on an ongoing basis.
- Provide accurate provider network directories to the Department as well as policyholders and the public.
- When there aren't enough in-network providers, make arrangements to provide out-of-network care at in-network prices.
- Require network facilities to inform patients, ahead of time, when an out-of-network medical provider would be providing a non-emergency procedure or care.

The emergency regulation addresses problems with access to doctors, hospitals, and other medical providers in 2014 when many health insurers reduced their medical provider networks and/or shifted to offering exclusive provider organization (EPO) health insurance products with no out-of-network benefits. Consumers have complained about having trouble getting appointments with doctors, traveling long distances to get in-network medical care, and finding that the health insurer's provider directory listed doctors that were not in the network. Jones said, "Consumers have been forced to pay huge out-of-network charges when their health insurer fails to provide adequate medical providers in their network or when care is provided by out-of-network providers without even informing or asking the consent of the patient."

More and More Employers Are Offering EAPs

Over the past 20 years, the number of businesses with employee assistance programs (EAPs) has more than doubled, according to a report from the Society for Human Resource Management (SHRM). Seventy-four percent of businesses offer EAP services. Many have rapidly adopted EAP services to help lower costs. Employees with untreated mental health issues and substance abuse problems can lead to absenteeism, limited productivity, high turnover, and more disability claims — all of which adds costs to employers.

There is a $3 and $10 return on every dollar spent on EAPs, according to data from Employee Assistance Trade Association (EASNA). IBIS World Industry Analyst Sarah Turk said, "As healthcare reform has required many businesses to offer employer-mandated health insurance, many businesses have looked toward cost effective employee benefits, including industry services, thus causing revenue for the Employee Assistance Program Services industry to rise 9.5% in 2014." During the five years to 2014, industry revenue is expected to rise 5.6% a year to $4.5 billion. "Over the next five years, many EAP providers will focus on bolstering employee utilization rates," says Turk. A study by Towers Watson reveals that while 85% of employers offer stress management services, only 5% of employees use these services. As a result, EAPS will focus on communicating the availability of services and overcoming employees' reluctance to seek help for mental health disorders. For more information, visit http://www.facebook.com/pages/IBISWorld/121347533189

Dental Access is Getting Worse For Adults

Although the Affordable Care Act (ACA) has improved children's access to dental services, the situation for adults is getting worse, according to a study by the American Dental Assn. The top reasons why adults don't intend to visit a dentist in the next 12 months are an inability to pay for care and a lack of perceived need. Other important reasons include lack of time, transportation problems, anxiety, and difficulty finding a dental practice that accepts Medicaid.

The study, which focused on Maryland's dental Medicaid program, found that since 2012, per-capita outpatient dental emergency department visits for dental problems have decreased in the state, especially among children and adults ages 21 to 40. The decrease in outpatient ER visits for dental pain among children is likely attributable to reforms. For more information, visit www.ada.org/en/science-research/health-policy-institute.

ACA to Bring Profound Changes in 2015

The Affordable Care Act (ACA) will bring profound changes to health benefits in 2015,

according to a statement by Ben Geyerhahn, CEO and Founder of BeneStream. Coverages mandated by the ACA go into effect on January 1. There is also the requirement that companies with 100 or more employees must offer health benefits to all full-time staff under the employer mandate.

The employer mandate will affect the working poor the most. This year the working poor are being offered a range of options by employers, which means that many will have health insurance for the first time in 2015. However, any additional cost to the monthly budget is more than many can afford. That's why 29 states passed Medicaid expansion. Because of the expansion, Medicaid now covers up to 138% of the poverty rate, which is $32,900 in income per year for a family of four.

With the exchanges, access to health insurance means more preventative care versus emergency care. More people have health insurance upon arrival to the emergency room, which lowers costs. With the employer mandate taking effect, these factors will continue to improve.

However, full-time employees who have been getting health insurance are likely to have fewer plan options than in previous years, and those options will come with narrower networks. Many employees will see higher monthly premiums with higher deductibles along with a smaller range of in-network doctors. And some plans no longer cover out of network doctors. Also, family coverage will evaporate for many this year. Families can go to the exchange to get the remaining members covered while some may qualify for the Children's Health Insurance Program (CHIP).

Health Care Predictions for 2015 and Beyond

The ACA brings increased cost responsibility on consumers, smarter technology, and more choices for 2015 and beyond. Vitals CEO Mitch Rothschild outlines five key changes to expect in the coming year:

1. Diagnosis Outside The Doctor's Office: There are several reasons why your next diagnosis may happen outside of a doctor's office in 2015. Retail clinics and urgent care centers are often more convenient. Over-the-counter home kits are can now diagnose more conditions, such as Hepatitis C, HIV, and prostate cancer. New technologies scan for everything from fevers to Parkinson's disease. People will be seeing the doctor less often, but for more serious problems. Wearable technology provides data that patients can discuss with their doctors, allowing for more accurate diagnosis and care. For 2020, there will be a huge appetite for self-diagnostics, which could reduce the cost and resources it takes to provide routine care. A wave of simple diagnostic tools and tests will become the norm in a few years,

2. Provider Price Wars: The health care marketplace will get a boost from more options for medical care and diagnosis and more transparency. Companies and health plans are pairing quality and cost data on hospitals and doctors, allowing consumers to shop for care. Competition, cost and choice will fuel price wars among health care providers. Besides retail clinics like CVS and Walgreens, hospitals and medical centers will also compete on price. Places like the Surgery Center of Oklahoma guarantee the price for procedures, including doctor fees, initial consults, and uncomplicated follow-up care. The center has attracted patients from across the country. The cost is cheaper than local hospitals; and employers are willing to foot the bill — flights, travel and lodging included. Couponing, incentives and other retail-model discounts will become part of the shopping experience for patients. In 2020, hospitals will invest in certain diseases and disorders while outsourcing general surgeries and procedures to more efficient and price-competitive surgery centers. This will lead to better, more efficient care.

3. Emphasis On Behavioral Data: Personal data and incentives can help people take manage their financial and physical well-being. In 2020, new tools and services will be needed to connect and analyze a wider range of data sources and deliver deeper meaning as we move from historical tracking to predictive modeling.

4. Care Designed For One: The personalized care movement will come from the convergence of data and technology. Doctors will go beyond the medical history form and inflexible guidelines to consider their patients' genetics and behaviors. In 2020, there will be DNA-designed pharmaceuticals. As personalized health evolves next to genetic mapping, we will soon see medications and treatments designed for your physiology.

5. Cost Increases Spur Consumer Shopping: There is no end to the movement toward high deductible health plans (HDHPs). Large deductibles highter out-of-pocket costs. As a result, thoughtful consumer purchasing will become the norm. The result will lead us towards a less wasteful, more efficient health care system. In 2020, expect to see more benefit trimming. Pharmaceutical benefits will be redesigned. Expensive specialty drugs will force employers to increase cost sharing for brand-name medications.

For more information, visit www.vitals.com.

Key Health Care Trends in 2015

Next year, the healthcare system will be front and center as the Supreme Court rules on the constitutionality of health insurance exchange subsidies and changes to the Affordable Care Act (ACA) continue. It will be a pivotal year for the healthcare industry with the ongoing rise of healthcare costs, acceleration of consolidation among providers and payers, and looming 2016 elections, according to a report by the Navigant Center for Healthcare Research and Policy Analysis. Here are six key areas to watch in 2015:

1. Significant uncertainty continues over the ACA: Administrative actions and amendments have brought 38 changes to the law, and more will follow. Gaining attention will be the expansion of Medicaid and an expansion of health exchange enrollment expansion among individuals and small businesses. There may be a change in the excise taxes on devices, drugs, and health plans. The industry will also be monitoring demonstrations and pilots like accountable care organizations (ACO). The ACA's Physician Payment Sunshine Act will bring more transparency of business relationships along with intensified efforts to reduce the costs of unnecessary care and fraud. Congress will weigh in on the law's implementation and funding, with repeal unlikely.

2. CMS expects healthcare costs to increase 6% a year for the next decade: More employers will drop insurance coverage for employees; those keeping coverage will use higher deductible products to shift financial risk to their employees. Health insurers and employers will press for bigger discounts and shift risk to providers. Bad debt will increase for providers and margins will shrink. Demand for services resulting from the newly insured and growing Medicare enrollment will exacerbate issues of access and workforce effectiveness. Sticker shock for hospital prices and specialty drugs will continue to be big issues as employers and consumers seek more transparency.

3. Providers will consolidate into regional health systems. Many will sponsor their own health insurance plans: Alternative medicine and technological advances will drive services from beds, to clinics, to homes, and to self-monitoring capabilities. Integrating these capabilities with physicians and business partners will mean the following for hospitals: heightened risk, diversification of businesses and competencies, centralization of back office functions and supply chain relationships, increased access to capital, and a stronger fo-

cus on complying with state and federal regulations. Maintaining the status quo is not an option for most hospitals.

4. Adherence to evidence-based care will be the industry's biggest challenge: Thirty percent of health spending goes for tests, procedures, and diagnostics that have no scientific evidence of appropriateness. The Office of the Inspector General will penalize providers that do more than what's necessary for purposes of financial gain. Also, social media fuels the public's appetite to know what works best, who does it well, and at what cost.

- Medicare, Medicaid, health insurers, and employers believe that shifting risks to providers is the key to reducing costs while enhancing safety and quality: Replacing fee-for-service incentives with results means using bundled payments, value-based purchasing, penalties for avoidable re-admissions and unnecessary care, and other programs. The shift is already underway. Employers, plans, and the government are driving these changes. Clearly incentives are changing. Payers find this to their advantage, but providers are threatened. Engaging physicians, allied health professionals, and post-acute providers in the transition is cumbersome, complicated, politically risky, and expensive.
- The Informed Patient: The market for healthcare is composed of household that spend $16,000 a year for healthcare. It's second only to their housing costs, and is increasing faster than their wages. Retail clinics are experiencing exponential growth as are alternative therapies, like yoga for pain management.

For more information, visit www.navigant.com.

Doctors Warn that ACA Pain Has Just Begun

The President's unilateral delay of the employer mandate is about over. Businesses with 50 or more full-time employees will have to start filing detailed reports with the IRS in January 2015, according to a statement by the Association of American Physicians and Surgeons (AAPS). "Full time" means 30 hours or more. Congressman Michael Burgess (R-Tex.) called attention to this during a conference call co-sponsored by the Galen Institute, "Penalties don't kick in until next year, but the data collection requirements are huge and complex. Burgess said that professional assistance is likely needed."

Employers must report the number of hours worked, as well as health insurance coverage for each worker. AAPS executive director Jane M. Orient, M.D said, "The pain from the Affordable Care Act has only just begun. Higher insurance premiums, penalties for not satisfying ObamaCare mandates, and data collection expenses are unaffordable for many businesses. Costs are passed along to workers, who may lose their job altogether or be forced to work at two part-time jobs, as well as to customers. Many businesses will decide not to expand, or could fold." The Congressional Budget Office doesn't count such costs to Americans, she noted.

In the King v. Burwell case, the Supreme Court could rule that ACA means what it says about subsidies only flowing through state-established exchanges. That is the source of much uncertainty. If that is the decision, States that declined to set up an exchange could be under a lot of pressure. Orient said, "People need to remember that those subsidies are the trigger for the employer mandate's penalties. There is no free money. Some get other taxpayers to help pay their premiums; others may lose their job." For more information, visit www.aapsonline.org.

Delivery and Payment Reform May Stall without Direct Employer Action

While employers find alternative provider delivery models and payment reform attractive, most don't understand them or the value they provide, according to a survey by Aon Hewitt. As a result, they may miss a significant opportunity to lead and improve the health and financial outlook for their workforce and business. The following are highlights of a survey of more than 220 companies:

- 75% don't understand payment transformation models
- 51% don't understand the cost and quality data provided by their carriers related to new models like Accountable Care Organizations (ACOs)
- 71% are unaware or need to learn more about the attribution process and how they contribute to the payment of these new provider delivery models
- 60% are providing or are considering providing a financial incentive for employees and dependents to use these new models through plan design changes, narrow network options, HRA/HSA contributions or cash.
- 24% steer participants (through plan design or lower cost) to high quality hospitals or physicians for specific procedures or conditions, and another 56% are considering doing so in the next three-to-five years.
- 18% use integrated delivery models, such as patient-centered medical homes, to improve primary care effectiveness, and another 56% plan to do so in the next 3-5 years.
- 11% contract directly with hospitals or other health providers in specific locations, and another 28% plan to do so.
- 10% have adopted reference-based pricing, and another 58% plan to do so.

"Employers are increasingly making innovative provider network structures an important part of their strategy, which will help to improve health care purchasing and shift the payment focus towards value based reimbursement and support providers who produce higher quality outcomes," said Mike Taylor, senior vice president of Delivery System Transformation at Aon Hewitt. For more information, visit www.aonhewitt.com.

Health Care Spending Accelerates

Spending on health care services grew 5.4% in the third quarter of 2014 (July to September) compared to the same quarter in 2013. This is substantially higher than the 3.7% rate in the second quarter and the 3.9% rate in all of 2013, according to a report by the Quarterly Services Survey. Prescription drug prices rose 4.1%, up from 3.8% in September 2014. Year-over-year hospital prices grew 1.1% in October, which is the lowest reading since September 1998. Charles Roehrig, director of Altarum's Center for Sustainable Health Spending said, "While it is too early for definitive conclusions, this may well represent the predicted ramping up in spending by the estimated 10 million people gaining coverage in early 2014 under the Affordable Care Act." For more information, visit www.altarum.org/HealthIndicators.

Municipalities See Greater Need for Benefit Consultants

The Cadillac tax on richer health plans could be a major burden to municipalities beginning in 2018. However, municipalities plan to adjust health plans, making the excise tax irrelevant. They plan on using ACA benefit consultants extensively to adjust their benefit plans, according to a survey of the 50 largest U.S. cities and counties rated by Fitch Ratings. Widespread changes to health plan expected as are negotiations with labor. For more information, visit www.fitchratings.com.

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