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OCTOBER 2020

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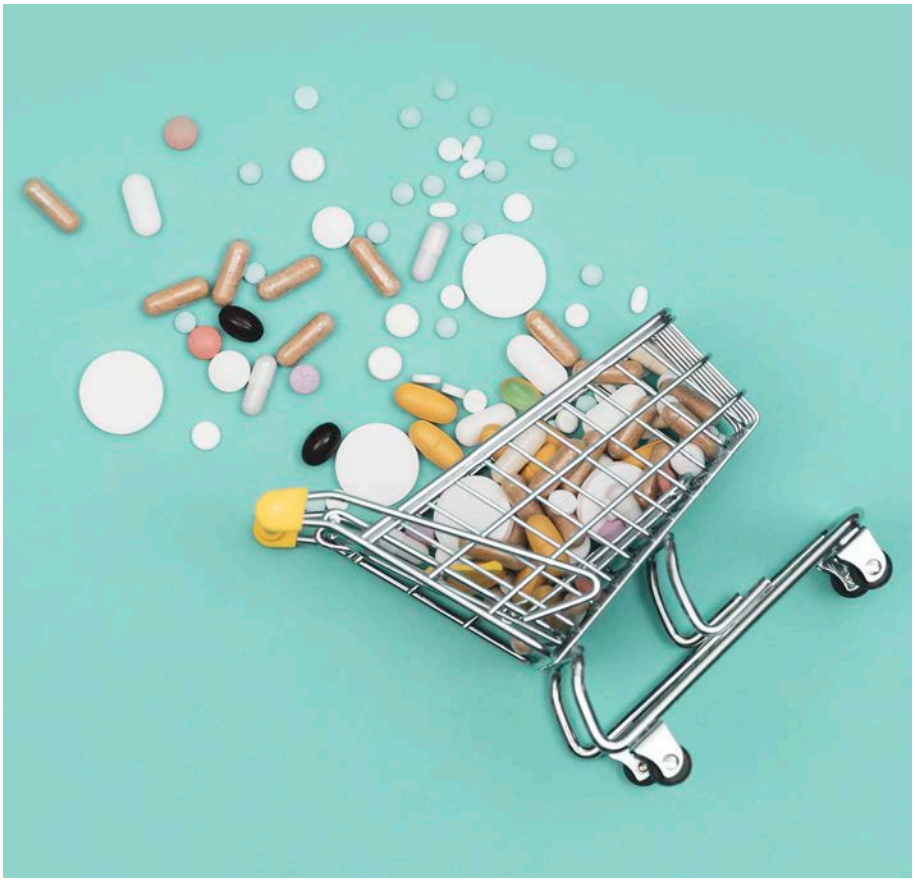

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Editor's note: a version of this article was also published by the California Association of Health Underwriters. Opinions expressed in the article are those of the author, not CAHU or California Broker magazine. Please let us know what you think! Email editor@calbrokermag.com

WILL COVID-19 LAYOFFS AND EMPLOYMENT LOSS SPARK ANOTHER SINGLE PAYER DEBATE?

BY DOROTHY COCIU

The year 2020 will be a memorable one for many reasons; most of them not positive, and for many, devastating. The COVID-19 pandemic has caused nation-wide layoffs equaling the great depression. People are struggling to pay their rent, pay their mortgages, and feed their families. As we all know, the pandemic forced the closures of hospitality businesses, hotels, restaurants, gyms, hair salons, and many other industries for weeks or months. The restaurant industry was reduced to take-out only, then allowed to reopen at 50% capacity, only to be closed again, followed by outdoor dining only. So if you're employed in one of these hardest-hit industries, you are likely just trying to barely survive. But those aren't the only businesses affected, of course. Manufacturing and production facilities that were non-essential businesses were shut down, and even after massive cleaning efforts and purchasing personal protective equipment (PPE), putting in policies and social distancing, some still have not yet returned to work. Some, however, have been offered the opportunity to return to work, yet declined to return (due in part to being paid by federal unemployment benefits through July more money than they would have been paid on the job). Many office workers have been and will continue to be working from home, when able, but this just continues to impact our economy and our well-being.

State and national unemployment numbers

California saw a record-breaking unemployment rate in April, 2020 of 16.4%, which skyrocketed from March's 5.5%, lowering slightly to 16.3% in May. In June, California improved to 14.9%. Nationally, we increased from 4.4% in March to 14.7% in April, 13.3% in May and 11.2% in June. These are not numbers we can brag about.

Is the employer-based health care system in jeopardy?

There has been a lot of press on the effectiveness of the employer-based health care system, most recently due to the pandemic layoffs. This system, which covers nearly half of the insured in our country, is something that needs to be preserved and employers should be applauded for the coverage they offer. Yet the single payer advocates are back on the forefront, slamming its effectiveness and looking to replace it with something unrealistic and costly—Single Payer. In mid-August, the anticipated report from the "Healthy California For All" committee was released, which warrants serious review. (We'll address this further later on in this article). The press is also hitting heavily on the fact that some insurers are seeing high profits during the first two quarters of the pandemic, with no discussion on the fact that they will have to pay for future claims, once pandemic-delayed services are rescheduled. And during the pandemic, we are not seeing huge increases in premium rates. In fact, just the opposite, and multiple carriers have been going out of their way to keep people enrolled, with forgiveness on premiums for small employers, extending marketplace open enrollment, and lightening their normal underwriting guidelines to help people get or stay insured. The bottom line is, there have been numerous reports with misinformation, and I'd like to attempt to set the record straight.

A look Into the reality

So is all of this true? Are so many

There have been numerous reports with misinformation, and I'd like to attempt to set the record straight.

uninsured because of the employer-sponsored health plan market? Are employers to blame? Are the insurance companies profiting while hospitals and providers are suffering? Are the uninsured numbers true and do they tell the whole story? Sadly, only part of the stories are being told. My job today is to try to point out some of the realities, and help you to understand the facts, particularly as we head into the fall election cycle, where we know all of these things and more will be battled in the press, TV advertising and debate stages.

I spoke with Mike Ferguson, CEO of the Self-Insurance Institute of America, who commented: "Yes, people have been laid off and losing coverage, because of the situation, but what's important is to gather the market segments, and how it intersects with the self-funded market. We've been having monthly calls with our Diamond sponsors, which are our big stop loss carriers, TPA firms, etc., [representing many large, self-funded employers]. At the beginning of this, since March, there was a concern the plan participant count was going to drop dramatically, but as we got into this, we're not seeing this. We're not seeing a significant erosion in plan population—meaning, people are not getting laid off, and they are getting their benefits taken care of. Now, keep in mind, in the self-funded world, mostly you're not dealing with companies with fewer than 50 employees. In the under 50 employee market, arguably, a lot of those types of companies are more susceptible to layoffs—because they are in the hospitality industries, gyms, or things with higher degree of restrictions [such as] restaurants, hotel workers, etc—they are getting laid off. Most are not part of a self-funded health plan. In our market, the self-insured market, there has not been a significant erosion in plan population..."

But the employer-based heath insurance marketplace also covers small, mid-size and large groups that may not be self-insured, so I want to also mention how important that coverage is to workers. And if they are laid off due to COVID-19 (or any other reasons), it's important to note that they do have options available to them, quite often without a lapse in coverage. They can enroll in a Marketplace plan, which the ACA set up for just these reasons… Here in California, we offer Covered California, which is the most successful ACA marketplace in the country. Covered California also, incidentally, welcomes the services of insurance agents, who can assist these individuals when they do lose coverage, and direct them to subsidized health plans or even Medi-Cal.

Press hot topics

During this time, as people fear most about getting sick, the press has been hitting heavily on the pandemic's causing massive health insurance coverage losses, and reporting the "greatest health insurance losses in American history. In this article, Families USA reported that because of job losses between February and May of this year, 5.4 million laid-off workers became uninsured, and reported that these recent increases in the number of uninsured adults are 39% higher than any annual increase ever recorded. The New York Times later picked up this story and added to it, citing that Kaiser Family Foundation has estimated that 27 million Americans have lost coverage in the pandemic, and reported that the Urban Institute and the Robert Wood Johnson Foundation projected that by the end of 2020, 10.1 million people will no longer have employer-sponsored health insurance or coverage that was tied to a job they lost because of the pandemic.

In addition, several news outlets have reported that insurance carriers in the fully insured markets are reporting huge profits due to COVID-19. In Forbes, August 6, 2020, it was reported that "In some parts of the country, hospitals are being overwhelmed by an influx of patients and many have announced staggering financial losses. Meanwhile, insurers have been able to avoid shelling out big money for surgeries and other complicated medical procedures while people have been less likely to visit their doctors over the past couple of months." Forbes went on to report that "UnitedHealth Group saw its net income double from $3.4 billion to $6.7 billion, while Anthem's grew two-fold, climbing from $1.1 billion to $2.3 billion." They also stated that CVS Health (which owns Aetna and other brands, including pharmaceutical companies) added an extra billion dollars in net income in the second quarter of this year, increasing from $1.9 billion to $3 billion. There were others, including Humana, discussed in the article.

The press makes it sound like all employers are experiencing massive layoffs. They are not. Industries like the trucking and distribution industries are booming, because they are supplying groceries and other needed items to retail markets. Grocery retailers are booming and can't find enough workers to fill of the jobs. And self-insured employers, for the most part, mostly due to their size, are not seeing massive layoffs like the smaller employers.

Continued on page 38

UnitedHealthCare and Canopy Announce Another Collab

UnitedHealthcare and Canopy Health announced the launch of the California Doctors Plan, the latest addition to the portfolio of health plans that have resulted from the collaboration between the companies. California Doctors Plan is available for people with employer-sponsored health coverage in nine Bay Area counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano and Sonoma. Canopy Health is an integrated, high-performing accountable care network of providers and health systems in the Bay Area that are committed to delivering high-quality, affordable care. UnitedHealthcare established a product partnership with Canopy Health in 2017 to give commercial members enrolled in the Signature-Value HMO plan access to the unique value proposition of the network: the flexibility of accessing care from a variety of physicians and hospitals across the Bay Area but at a lower premium than a traditional HMO plan. UnitedHealthcare and Canopy Health expanded their relationship earlier this year with the launch of the UnitedHealthcare Canopy Health Medicare Advantage plan. Now with the introduction of California Doctors Plan, the companies aim to not only offer significant cost-savings but also a more personalized, simplified and coordinated care experience, according to Steve Cain, CEO of UnitedHealthcare in Northern California. "Our relationship with Canopy Health is working so well because we share a commitment to providing consumers and employers with high-value health care." UnitedHealthcare members in Northern California enrolled in the plans have access to more than 5,000 physicians and 19 hospitals in Canopy Health's network, which includes UCSF, John Muir Health, John Muir Medical Group, Hill Physicians Medical Group, Meritage Medical Network, Santa Clara County IPA (SCCIPA) and Dignity Health Medical Network–Santa Cruz. The California Doctors Plan offers plan participants the opportunity to save up to 25% on premiums compared to a traditional PPO offering as well as $0 co-pays for primary care and urgent care, 24/7 telehealth visits, and care coordination driven by a patient's primary care physician.

Colonial Life Offers New COVID-19 Coverage

Colonial Life announced a new group critical illness plan with an optional rider that offers a lump sum benefit for hospitalization for treatment of COVID-19 and more than a dozen other infectious diseases such as antibiotic-resistant bacteria, Legionnaires' disease, meningitis, Lyme disease and sepsis. Colonial Life's new group critical illness plan has a flexible plan design with a wide range of face amounts to meet different needs. Coverage is available for up to 56 different serious conditions and treatment procedures, including heart attack, stroke, cancer, organ failure or coronary artery bypass graft surgery. Additional conditions covered for children at no additional cost include Down syndrome, cystic fibrosis, cere-

bral palsy, spina bifida and cleft lip or palate. Employees can further personalize their coverage with riders that provide additional benefits for infectious diseases, cancer, first diagnosis, heart procedures and progressive diseases such as Alzheimer's disease. Other features of Colonial Life's new group critical illness plan include:

* Spouse and child coverage—available with employee coverage
* Guaranteed issue—provides all employees, spouses and eligible dependent children access to coverage
* HSA-compatible—allows employers to provide coverage that can be used alongside employees' health savings accounts
* 100% coverage for all breast cancer—invasive or non-invasive
* Wellbeing assistance benefit—designed to pay a benefit for one of 25 different health screening tests, such as a colonoscopy, mammogram or BRCA genetic test that identifies breast cancer risk
* Additional diagnoses coverage—benefits are payable for multiple different critical illnesses as well as reoccurrence of the same illness, including cancer
* Access to Helpsy Health mobile app—easy-to-use online tool to track symptoms, treatment plans and appointments and find resources for transportation, financial assistance, and emotional support while dealing with cancer.

California Among States That Won't Follow New COVID-19 Testing Plan

Arizona, California, New York, Florida and Texas have said "no thanks" to the Centers for Disease Control and Prevention's (CDC) latest advice on COVID-19 testing. The CDC called to reduce COVID-19 testing, issuing guidance saying that asymptomatic people who have been exposed to COVID-19 shouldn't be tested. The CDC had previously recommended that all people in close contact with anyone with COVID-19 should be tested even if the exposed person shows no sign of illness. California and the other states say they will continue down the original course. The new CDC guidance shocked doctors and politicians and spurred accusations the guidance was politically motivated.

Stronger On The Other Side

We love the positive thinking and practical tips from the folks at Aflac. They've recently published a white paper called "Stronger on the Other Side," which examines how COVID-19 has impacted benefits and offers brokers solutions for navigating open enrollment and beyond. The white paper looks at ways to boost benefit packages that address a potentially long-term recovery and employees' emotional well-being. Find the report at Aflac.com.

Cal Broker GPS: Working From Home

Doris Ford, owner and CEO of Ford Benefits Group in Azusa, California, has the right idea. She may be a bit more confined these days, as we all are, but Ford uses her time wisely.

"I really enjoy receiving my monthly California Broker Magazine. I love the articles and I'm really enjoying the 'Women in Leadership' series," she says. This is how Ford describes her job: "I work with business owners, individuals and families, and Medicare eligible people to take the confusion out of choosing the most comprehensive insurance plan at the most affordable rate."

Thanks, Doris!

Send your photo reading Cal Broker to editor@calbrokermag.com and you could make it in the next magazine! If you have a message or words of encouragement for other agents and brokers trying to thrive in the pandemic, please also send that along.

EVENTS

CAHU Summit, Virtual, Oct 6-7- Moving Boldly Into Our Future
Keynote speaker will be Joe Buzzello, a life-long entrepreneur, author and master salesperson and organizational leader. Info at CAHU.org.

IICF Foundation Women in Insurance Regional Forums
Insurance Industry Charitable Foundation Women in Insurance Regional Forums:
Chicago: October 14
New York: October 26
Los Angeles: October 30
Dallas: November 17
Info at IICF.org

IICF Inclusion in Insurance Forum, Virtual, October 27 – 29
The Insurance Industry Charitable Foundation will convene insurance professionals, C-Suite executives, D&I leaders and other innovators for the IICF Inclusion in Insurance Forum. Gain insights and plans for acting on inclusion, diversity and innovation initiatives from respected leaders representing the industry, academia and other areas of business. Each virtual session will run approximately 2-1/2 hours, starting at 9 a.m. PST. Info at IICF.org.

CAHU Women's Leadership Summit will now be April 7-9, 2021!
The latest news from CAHU's WLS committee is that the CAHU Women's Leadership Summit will now take place April 7 –9, 2021, at Green Valley Ranch in Las Vegas. Questions should be emailed to info@cahu.org.

Appreciation for Tony Lee's 'Race & Our Profession'

"The spirit and overarching theme of [Lee's] article are very positive. I couldn't agree more. The overwhelming feeling of exasperation that marginalized people feel everyday is because the civil rights of the 1960s haven't been realized. It is my belief that the only way to achieve peace in our troubled inner cities is to make resources, opportunity and entrepreneurship available to everyone. I for one will continue to make every effort to secure this reality and encourage others to start the conversation about inclusivity and prosperity."

—Alfred Martinez

Editor's note: Lee's article was published in the September print issue and is available online at calbrokermag.com.

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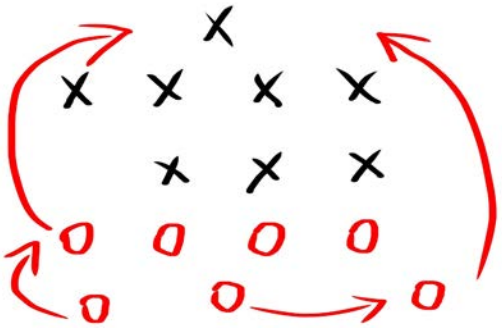


Brokers: Here's Your Game Plan for Renewal Season in the COVID-19 Era

BY JENNIFER BURNHAM-GRUBBS

It's undeniable that COVID-19 has upended a lot of norms in the benefits world. But one thing it hasn't changed: the calendar.

Pandemic or no, summer is done, which means open-enrollment/renewal season! And if you're a broker, you're probably somewhat worried about how it's going to shake out.

The coronavirus, of course, has changed how employers judge the value of their plans. It's changed the way employees evaluate their benefits options, too. Which means it should change the way brokers approach their business.

But how? How can brokers strategize for enrollment, in the face of an unpredictable public health emergency?

This article will explore some options, by examining each of the three stakeholders in the process: employers, employees, and brokers.

Here's what brokers should remember, in a renewal season dominated by COVID-19:

- The cautious employer
- The situation
- The coronavirus has American business reeling.

1. The cautious employer

Consumer spending is way, way down. Whole sectors have ground to a near halt. And even for those companies that are still making money, the macro-economic outlook seems bleak. Small wonder that most corporate leaders believe we're in for a prolonged recession.

Add to this the ambiguities surrounding healthcare utilization. Millions of Americans deferred healthcare procedures during the early phases of the pandemic. Nobody can be certain when—or if—that utilization will return. Which makes it nearly impossible to predict healthcare expenditures for the coming year.

These factors, naturally, have employers feeling cautious. They're assessing their benefits expenditures with a critical eye. If they were considering cutting spending before, you better believe they're thinking hard about it now.

In fact, according to Mercer, a full two-thirds of employers are considering major changes to their benefits plans.

These changes are likely to reflect a more conservative approach than in years past. Employers will hesitate to offer up a significant proportion of their operating budgets if they can't see a clear, measurable ROI.

They are, in other words, looking for value—ways to increase what they get from their benefits, without increasing their costs. Brokers should strive to deliver.

Take-aways for brokers:

- A majority of employers are looking for a change to their benefits
- Their approach is likely to be conservative—averse to major spending increases
- Look for ways to deliver value, without increasing spend

2. The situation: nervous employees

Stresses of the pandemic have taken their toll on the American workforce.

If the physical danger of contagion and the tedium of social distancing weren't enough, many Americans are also living in a protracted state of suspense.

Furloughs, layoffs and unemployment claims dominate the headlines. Too many Americans are wondering if their job is next.

The last thing fretting employees need is to worry about their costs for COVID care. Yet, when it comes to paying for tests and treatment, most employees have far more questions than answers.

That's a lot to deal with, right?

It's against this backdrop of stress, suspense, and confusion that employees will be making their decisions about enrollment/renewal. Brokers would do well to remember that all of this strain and worry means there is a new premium on clarity and simplicity, when it comes to benefits plans.

Employees are looking for healthcare benefits that protect them, without unnecessary complications. Just as important, they're looking for plans that communicate these benefits effectively.

Brokers can help on both fronts, by curating benefits and features that seamlessly protect employees, and by helping to design communication plans to reach them.

Take-aways for brokers:

- Employees are stressed and confused
- They want to feel protected by their benefits plans (and the feeling is likely shared by employers)
- Brokers should strive to offer benefits that protect, without frills or complications

3. The situation: the beleaguered broker

Last but not least, we should not forget about brokers ourselves. The pandemic has brought us to our own crossroads, and the professional future for many is far from certain.

Consider the simple realities of running a book in the pandemic. Working from home means that many of the broker's tried-and-true tactics are unavailable. Social distancing is safe, but it leads to lost face-time, cancelled conferences and missed opportunities for connection.

(And that's the best case scenario—things get much messier if there are kids in the picture!)

Brokers therefore have to develop the capacity to add value from afar. Tools like virtual prospecting and contactless enrollment have just moved from "ancillary" to "essential."

Nor is that all; brokers will need to stay competitive. Just as essential will be the broker's ability to curate novel, helpful solutions for clients.

However, brokers can ill-afford to squander energy on major benefits upheavals or administrative challenges. The last thing brokers want is to spend their precious hours resolving customer service issues.

So it's not enough for solutions to be new and valuable—they must also be modular and seamless. They have to integrate freely into existing benefits packages, without causing any hang-ups.

Take-aways for brokers:

- Work from home leaves brokers well outside their comfort zones
- To stay competitive, they have to differentiate themselves
- But they can't afford to waste any time

One solution: CoPatient

Finding solutions to satisfy the demands of any one of these stakeholders is a challenge. Brokers have to deliver for all three of them. That's a tall order.

But there's a solution that I believe adds value, without adding spend; that protects employees with clarity and simplicity; and that differentiates brokers, without sapping their time.

It's CoPatient. CoPatient is a full-service billing advocacy solution that brings immense value to the table. Its dedicated platform, which can be modularly added to ANY benefits design, provides billing experts who scrutinize employees' medical bills, then tirelessly advocate and negotiate for savings on their behalf—delivering an average of $500 saved per bill.

Since 80% of medical/dental/vision bills contain errors, this value service not only saves employees money; it frees employees, employers and brokers from the hassle of managing billing disputes themselves.

Even better, CoPatient is simple to sell and simple to use. It's a modular extension available on the Ease app marketplace, Employee Navigator, or through brokers directly. Employers can offer this valuable service as a benefit to their employees, at little or no cost. CoPatient is one thing that delivers tremendous value, especially now as employers and their employees do their best to navigate through the challenges of the COVID crisis—and that makes it a no-brainer addition for your clients' benefits designs.

Not only does it keep employees more productive at work (since they won't have to waste time resolving medical, dental or vision billing disputes on the clock); it keeps brokers free to focus on what we do best—growing and retaining our books in a challenging environment. Much better than getting drawn into a billing dispute, wouldn't you agree?

The CoPatient benefit can be started any time, not just at renewal. Employers who sponsor this offering set themselves up to deliver much more value to their employees, at a tiny fraction of what they pay for the medical, dental and vision benefits themselves. Their employees will feel more protected and more appreciative of their benefits because they'll actually pay out as they should whenever they use their plan.

Employers who are not ready to spend anything at all at this time can still make CoPatient available to employees as a highly affordable voluntary benefit, helping them get much more value from their existing benefits.

For brokers looking at renewal season in the time of COVID-19, it's a win-win-win on offer.

Your clients will thank you for bringing them this solution.

Jennifer Burnham-Grubbs co-founded Quantum Insurance Services in 2012 and now serves as its CFO. As a Summa Cum Laude graduate of Princeton University, Jennifer brought her work ethic and critical thinking skills to her first insurance job at a boutique brokerage firm in Beverly Hills. Her interest in people, facility with numbers and entrepreneurial spirit came together when she noticed that most insurance advisors see their work as sales, rather than consulting. To remedy this, she launched Quantum, a national commissions-agnostic insurance consulting firm. Recipient of the San Fernando Valley Business Journal Trusted Advisor Award and a top Quora writer since 2016, Jennifer continues to serve as a dynamic force within her field. Her firm regularly contributes to top financial publications such as Kiplinger and Forbes and is a valuable resource for accountants, financial advisors, business managers and clients across the country.

What It Takes to Survive Strange Days

BY ALAN KATZ

These are strange days. A pandemic. Civil unrest. A polarized and divisive election. Murder Hornets. Wildfires out of control. Hurricanes. Asteroids on the way. Heat waves. Open enrollment.

If this isn't the apocalypse, it'll do for now

Maintaining a positive attitude nowadays can be a challenge. However, challenges are a fact of life. There is always something that makes staying in bed all day seem like a viable lifestyle.

Maintaining a positive attitude is more important than ever. Positivity can be the difference between success and failure. This is one of the discoveries of the Trailblazed Sales Study. The study interviewed 200 health insurance agents in six states about their sales and businesses.

Positivity matters

Respondents were assigned to one of three groups. High-Growth Producers reported year-over-year sales growth of at least 20 percent. Low Growth Producers grew, but by less. As for No Growth Producers, well, the name says it all.

The study sought to identify what High Growth Producers do that the others do not. I grouped these success drivers into three "paths." The study's results are detailed in my book, "Trailblazed: Proven Paths to Sales Success."

One of the paths identified is a positive attitude concerning the insurance business and the role of agents. Whether positivity is the cause or the result of sales success was beyond the scope of the study. It was the correlation that caught our attention.

What is a positive attitude? In the book, I define it as responsible confidence married to pragmatic persistency. For purposes of this article, however, we can equate it to optimism.

Ok, so being an optimist matters. But can you do anything about it? If you are not born an optimist, however, can you learn to be one?

Yes, you can.

Learning optimism

Martin E.P. Seligman, PhD, has spent decades researching optimism. However, he is no daytime talk show feel good pitchman. Dr. Seligman is a professor of psychology at the University of Pennsylvania and a past president of the American Psychological Association.

He has authored many books, including the seminal and, for purposes of this discussion, conveniently titled "Learned Optimism." What Dr. Seligman discovered is that the difference between optimists and pessimists is a feeling of personal control.

Personal control, according to Dr. Seligman is, "the ability to change things by one's voluntary action…" Whereas helplessness is, "the state of affairs in which nothing you choose to do affects what happens to you."

When things go wrong, pessimists assume it is their fault, that everything they do will go wrong, and that everything will continue going wrong forever. When things go well, they assume it is the result of outside forces and that it is a temporary phenomenon specific to that one event.

Optimists are the opposite. They take personal credit for what is working, and they think things are likely to work out well now and for the long term. Failure? They blame that on factors beyond their control (think incoming asteroids), assume things will change soon and that the setback is an isolated incident.

In short, pessimists wear hopeless-colored glasses; the spectacles of optimists are tinged by personal control.

The power of non-negative thinking

Overcoming pessimism and learning optimism requires more than positive thinking. Daily affirmations will not cut it. Instead, Dr. Seligman says

the way to learn optimism—and thus have a positive attitude—is to change the destructive messages we tell ourselves when experiencing setbacks to something more positive.

Negative, pessimistic thinking after a lost sale goes something like this. "She said 'no,' and so will everyone else I talk to. I'm the worst salesperson in the world. No one wants to buy from me, and no one will ever want to buy what I'm selling."

This internal dialogue no doubt arises from the frustration of the moment and the feeling of rejection all salespeople experience. Just because the feelings are universal, however, does not mean they reflect reality.

Those with a positive attitude, however, perceive a lost sale differently. "She said 'no' after I did my best to explain why it was in her interest to say 'yes.' Well, you can't win them all. There will be other prospects. And for some of them, my offering will be a better fit than it was for this one. After all, a lot of people buy—and are happy with—the products I sell. I've made the sale before and I will again."

The good news is that pessimism is a habit which can be broken. Doing so takes a conscious effort, but with time, an individual's way of viewing the world can change.

There was a fad back in the 1980s or thereabouts, when people wore rubber bands around their wrists. When they caught themselves having negative thoughts, they snapped the band to remind them to break the train of thought. The snap was a reminder to view their situation in a more optimistic way. This was straight from Dr. Seligman's school of learned optimism.

Surviving strange imes

You can see the impact of how positivity can help with sales success in how agencies responded to passage of the Affordable Care Act. Pessimists felt hopeless. This was the end of the individual market. They sold their agencies.

Optimists recognized the individual market would no longer be the revenue source it was. They acted and adapted. Some went all in on individual, streamlining their agency operations and adopting new technologies to make the lower commissions worthwhile. Others used individual sales as a bridge to senior or voluntary products.

I do not mean to minimize the ACA's impact on individual health insurance sales. For most agencies it required a major and unwelcome change to their business. This does not diminish the reality that some agencies seized opportunities and are thriving.

How one reacts to what is happening matters. Those who feel in control tend to succeed; those who feel helpless tend to fail.

In the context of the pandemic, this means that sales professionals with a positive attitude are going to adapt. If working remotely is the new norm, they will invest in tools that help them work in a new way. They will take control.

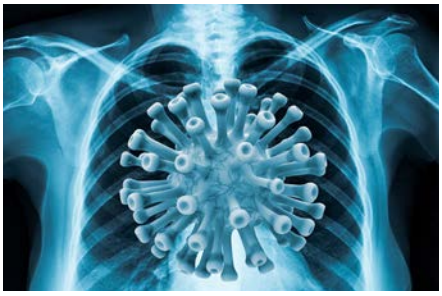
A positive attitude is not the only path to sales success. Business acumen and sales professionalism also play a critical role.

Still, it is nice to know that a positive attitude can not only help you grow your business, it can help you get through strange times as well.

Alan Katz is a co-founder of NextAgency, an agency management system with CRM, marketing, and commission tools for life and health agencies. (www.NextAgency.com.) Alan is a past president of NAHU, CAHU and LAAHU. He is a nationally known speaker on sales, marketing, business planning, and health care reform. Alan is the author of "Trailblazed: Proven Paths to Sales Success," available through Amazon. Parts of this article are taken from his book. Follow on Twitter (@AlanSKatz), (www.linkedin.com/in/alankatz44) and contact him at AlanKatz@NextAgency.com.

Editor's note: Opinions expressed are those of the author, not California Broker magazine. Please let us know what you think! Email editor@calbrokermag.com.

COVID-19 AND LONG-TERM CARE SOLUTIONS



BY LOUIS H. BROWNSTONE

The COVID-19 virus entered the United States as early as December and created consternation by mid-March. We did a poorer job by far in responding to this deadly virus than any developed country. We are still lacking robust testing and contact tracing, and many Americans refuse to wear masks. By the time you read this, over 200,000 Americans will have died due to COVID-19.

We still could face a second wave of COVID-19 during the winter. Even if a vaccine is proven to be effective, it could be many months before most Americans can be vaccinated, even if they want to be. We will defeat this virus, but it may take a while longer.

The effects of the virus on us have been huge and have caused panic and uncertainty. We have had to shelter in place. In addition, we mentally have frozen in place. In our efforts in trying to cope with the present threat of this virus, we tend not to think of our future. Most of our financial planning, including long-term care planning, has been effectively placed on hold.

Now that a few months have passed we have learned a great deal, and we still don't know a great deal. But maybe enough of the fog has cleared that we can predict the future with at least some modest degree of accuracy. This article will attempt to foresee the future of long-term care solutions as reflected in the eyes of government, insurance carriers and prospects. We will only know years from now how accurate these predictions are.

Government

Enormous deficit spending and lower tax receipts will create major challenges for local, state and federal governments. They will have to cut back and eliminate many programs that its citizens want them to provide. It is likely that we will be in a very low interest rate environment for many years. Government debt will become dangerously high. The Federal Reserve Board has reduced interest rates to almost zero in order to stimulate borrowing, and Congress has responded. The Federal Reserve Board has many levers to control the rate of inflation, and it will utilize all of them to keep interest rates low and to stimulate the economy.

An extremely important election in November will determine our future. The country is divided, but as of this writing, President Trump's reelection is in serious jeopardy. He will not have the advantage of defending economic prosperity and he has made some very bad moves recently. Many Americans are repulsed by his bad character and will make a special effort to vote against him. A lot can happen between now and November, but I am going to assume that Vice President Biden will win the election.

As President, Biden will be compelled to raise income taxes for the very rich in order to reduce deficit spending. Even so, he will initially be limited in proposing spending for social causes, just because the money isn't there. His actions may be further limited if the Republicans still control the Senate.

He will campaign on healthcare as a major issue and will advocate a government healthcare option, not Medicare for All. It's questionable whether such an option would include long-term care benefits, due to the high cost of coverage. My sense is that if long-term care benefits become a part of a government health care plan, it will either be a minimal benefit and/or it will be a rider and not be a part of the base policy.

Health care is such a complex subject that it will be fiercely debated and it could take years before a new government plan could become law. Such a law would have to overcome the objections of insurance carriers, medical providers, hospitals and the device makers. The public would have to over-

whelmingly support such a plan for it to gain traction and succeed. The Affordable Care Act took years to enact, and I foresee similar conditions now.

One major wild card here. If the Republican Party maintains control of the Senate, the Congress will continue to be deadlocked and little will get done. But if the Republican Party loses the election badly and with it control of the Senate, it will have to reinvent itself in the face of increasingly unfavorable demographics. In this process, it could reject the extreme right philosophy that it has adopted under President Trump and move toward the political center. That could dramatically alter the future and make social changes more likely.

Insurance carriers

Despite the increasing need, sales of traditional long-term care insurance policies have been declining for years, some 85% down from the early 2000's, and this product is now recognized by insurance carriers as an unprofitable loser. This is still true in spite of the fact the premiums are up to three times what they were decades ago. With one or two exceptions, the insurance carriers have lost all economies of scale, and at today's sales levels, they can't make much money if any regardless of what they charge.

In addition, with the very low interest rate environment forthcoming, their interest rate assumptions, already low, will still be higher than projected future income from safe investments. They will either have to make riskier investments or seek further rate increases, even on current products. There may also be more pressure on their reserves.

We still don't know the long-term effects from COVID-19 on people's health, especially the health of the older population. What are the implications for one's kidneys, liver, lungs and heart? Will insurance carriers have to factor in unknown potential claims resulting from the long-term effects of this disease?

These factors have led to the insurance carriers being far more comfortable selling hybrid life/long-term care and annuity/long-term care products. There has also been a large growth of life insurance policies with accelerated benefit riders, usually for chronic illness. The distinction of benefits between these chronic illness riders and traditional long-term care insurance has become very small. Now some 40% of life insurance sales include riders which cover long-term care costs.

The risks in life insurance and annuities are far better known than the risks associated with traditional long-term care products. These riders have become the main vehicle to protect people against the largest threat to their retirement.

Prospects

The initial reaction of Americans to COVID-19 was to become scared and threatened, and feel unsafe. We retreated to our homes and ceased many of our normal activities. We also had to learn to perform many routine functions differently and this required a significant mental adjustment. Now was not a time to think about the future but to worry about the present and make sure that our changed lifestyle would provide for us the best chance of surviving the pandemic.

It's obvious that the pandemic has resulted in horrible publicity for nursing homes, where many patients have become sick and died. It's even more difficult now to envision anyone interested in nursing home insurance, or even long-term care insurance with its history of caregiving in nursing homes and assisted living facilities. Almost everyone will want to be cared for at home instead. It's actually a small mental difference from "sheltering in place" to "nursing care in place." Life insurance products which cover long-term care costs provide less of this nursing home stigma and will be more readily accepted.

This nursing home stigma may require a change in long-term care product marketing to become something like "home caregiving insurance," rather than long-term care insurance, even if it includes benefits for care in nursing homes and assisted living facilities. There will have to be a large increase in both the number of caregivers and in their compensation due to the rejection of nursing homes and the rising demand of folks to stay at home.

Now that a few months have passed, and the methods to fight this virus have become better understood, we have become less fearful and are beginning to resume some of our normal activities. We can even envision a time when we will be able to adjust to whatever the new normal is and go on with our lives. This may take a few months longer, and a second wave of the pandemic could slow this adjustment, but it will happen eventually.

This could cause a long-range change in our thinking from the immediate crisis to a longer view of our needs. At that time, we will consider protection to be the basic need that it has always been. Protection can take many forms, but we will mostly want to protect our families against loss of income due to death and expense due to bad health.

Therefore, I envision a slow but steady growth of hybrid/life long-term care insurance and life insurance with long-term care riders or chronic illness riders. This could take up to 10 years to occur, but many will recognize the need for this protection and take action to protect their families.

Our current system of health care is unsustainable and we all know it. There will continue to be a great deal of talk and no action until a consensus emerges. I foresee a completely different system in place by 2030 with some sort of health care for all. It's going to be interesting to see what form it takes. Stay tuned.

Louis H. Brownstone is chairman of California Long Term Care Insurance Services, Inc., located in Burlingame, California. California Long Term Care is the largest independent specialist long term care insurance agency in California, and is broker for a group of high-producing long term care specialist agents. Brownstone is also very active in NAIFA, the National Association of Insurance and Financial Advisors.

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How to Answer the Call for Benefits that Focus on Caregivers

BY DENNIS HEALY

The protracted impact of the coronavirus pandemic continues to reverberate in workplaces across the country, especially affecting a segment of the employee population that is becoming increasingly beleaguered: those who are also serving as caregivers. There's never been a more important time to consult with your clients on which benefits and services will best assist those employees who are caring for others—and also need to take care of their own mental health.

Caught up in the perfect storm

In the U.S., more than 1 in 5 people are caregivers, according to a recent AARP study. This weary segment of the workforce already had their hands full earlier this year caring for a loved one—like an aging parent or grandparent, or perhaps a child with disabilities.

Then the pandemic hit. In the midst of this medical and economic crisis, employees are faced with a triple-edged sword: they're trying to navigate their own situation, whether it's working from home or being asked to come back in to work. They may also have kids who are learning remotely or who've been sent home because of an outbreak at school. Or they've pulled a parent or grandparent out of a care facility because of infection or social isolation concerns. For a middle-aged adult living in the sandwich generation, this makes for a full house with a lot of responsibilities to juggle.

Understanding the increased pressure on employees

One person who's seen these scenarios unfold firsthand is Jennifer Morris-Pugliese. She's a Care Support Team Manager at CareScout®, whose caregiving services we offer to employees through our ARAG legal insurance plan. Her job is to provide emotional and logistical support during a family's caregiving journey and help them make the best-informed decisions regarding care needs. In fact, last year she did that for me when a medical issue with my father arose. It was so helpful to have that type of guidance and support available, especially when you get into the nuts and bolts of addressing eldercare issues.

Morris-Pugliese notes that for people who suddenly find themselves in a caregiving role, it often feels like a whirlwind of tough decisions, difficult situations and unending obligations, especially now. "There's so much uncertainty in our lives, and when you include caring for someone on top of that, it's a lot of added stress. For example, if your loved one is admitted to the hospital or care facility, it's now stressful like never before—perhaps you can't visit them. Even getting information is challenging. It's hard to emotionally prepare for that because it's not our normal everyday situation."

In California, for example, nursing homes remain sealed off to almost all visitors. Families and watch dogs are increasing pressure on state officials to allow at least one "essential caregiver" inside to check up on loved ones. "On the other hand," she adds, "Caring for someone while working from home means even more isolation for and pressure on

the caregiver, which takes a toll on the employee."

The numbers show increased need for caregiving benefits

What does this mean for your clients? The day-to-day responsibilities and related stress that further tax employees' emotional, physical and financial health spills over into where they work. This results in more absenteeism and presenteeism, reduced employee engagement and higher health costs.

For example, more than 80% of employees say caregiving has affected their productivity at work, according to a Harvard Business Review survey. In addition, the National Family Caregiver Alliance, a caregiver resource group, reports that caregiver related absenteeism costs companies about $5.1 billion each year and can increase a company's healthcare costs.

But there is good news on the caregiving front: Employer interest in supporting employees with caregiving responsibilities is growing. According to a Business Group on Health® survey, over a third of respondents (35%) offer caregiver leave benefits now, and another 28% are considering it by 2022.

Echoing this trend, the 2019/2020 Employer Benchmarking Survey reported that 61% of respondents consider caregiving a top priority for them. And while nearly half (45%) believe they are on par with similar organizations in developing caregiver-friendly benefits, almost a quarter (22%) see themselves as below or well below average, a solid indication there is still room for improvement.

Caregiving complications caused by the pandemic

California residents have certainly been on a roller coaster ride when it comes to the setbacks and success of battling the coronavirus. It's admittedly complicated by a labyrinth of mixed messages from public health officials, various state, county and city ordinances and differing social behaviors.

Despite many cities clamping down on stay-at-home orders early in the pandemic, cases exploded in June as the state rapidly reopened the economy and people went back to summer routines such as parties and other social gatherings. State officials have been particularly concerned about workers getting sick at their jobs and then infecting others at home. This is especially concerning for caregivers who may be caring for those in high-risk groups.

Additionally, school and childcare center closures, as well as heightened concerns over the health of the elderly—have increased the burdens of caregiving endured by workers. According to data collected by Kinside, a child care benefit provider, about 20% of daycares are not expected to reopen after the pandemic. If that percentage plays out, your clients will need to recognize that for employees who are working parents, their increased caregiving responsibilities will continue. Without childcare, many will be making difficult decisions about quitting jobs or reducing work hours. Even for those who decide to stay at work, it may be that their spouse has to quit a job or change their schedule in order to take care of the kids, resulting in new financial issues and added stress.

> ***The key is to provide benefits that not only help employees care for a loved one, but solutions that also address a worker's mental health, because that's what's really at stake here.***

Morris-Pugliese states that in the cases she's managed, there are less adult daycare centers and day support available. "Even daycare centers that will open will probably have restrictions on the number of clients they can serve which will further exacerbate the strain on available supply." She adds that it's also more difficult to find home health care for her clients. "The agencies we're reaching out to, they're stretched thinner, they're more cautious, conducting more training and working to ensure they have enough personal protective equipment. As a result, they have less staff available to do the work, which means caregivers may be taking over more of the physically demanding, day-to-day care."

Look for benefits that benefit the caregiver

Time is such a valuable commodity in today's request-and-immediate-response world, so it's no surprise the most popular caregiving benefits are flexible work schedules (84%), remote work (67%) and paid time off (53%), according to the 2020 Employee Wellness Industry Trends Report. The pandemic has forced many employers to offer all three of these benefits, at least in the short-term.

As you search for ways to offer benefits that are becoming increasingly relevant and truly speak to the needs of those playing a dual role of employee and caregiver keep these three tactics in mind.

1) Find flexible solutions and hidden gems that benefit caregivers. Sit down with your clients for a benefit review to uncover any gaps in their program that may not be adequately addressing caregivers' needs. Also, look for features and services within a current benefit they may not be fully promoting. This could include a telehealth option in their medical coverage, financial education opportunities through a retirement plan or a caregiving referral service offered through a legal insurance plan.

2) Stay on top of current laws and trends. In response to the pandemic, California has taken several proactive steps to help its residents, including executive orders signed by Gov. Gavin Newsom that addresses worker comp protection, eviction moratoriums, sick leave provisions and protections for essential workers.

Also be familiar with the Families First Coronavirus Response Act (FFCRA) and how it impacts employers and employees. FFCRA requires certain employers to provide workers with paid sick leave or expanded family and medical leave for specified reasons related to the coronavirus. The Act also outlines which employees are eligible and the qualifying reasons and duration allowed for a leave.

Understanding which employers are covered and how the paid sick leave provision works will help you consult with clients who may need to beef up their paid leave program to either coincide with FFCRA or be more inclusive for employees. As a barometer, a 2019 WorldatWork survey found that 20% of companies offered paid caregiver leave last year.

3) Take advantage of technology. Employees have become well-acclimated to interacting digitally, whether it's through online messaging or video calls. So think outside the standard benefit box to offer services ranging from online wellness seminars and EAP sessions to video yoga sessions or lunch dates—it's an easy and effective way to help employees feel connected—especially those immersed and possibly more isolated in a caregiving situation.

The key is to provide benefits that not only help employees care for a loved one, but solutions that also address a worker's mental health, because that's what's really at stake here. As Morris-Pugliese puts it, "We need to help caregivers take care of themselves. We ask them to remember the standard airline 'oxygen mask' directions provided before each flight: put your own mask on first before you can take care of others." This is your opportunity to provide that direction—and relief—for those employees.

Dennis Healy is a member of the ARAG® executive team. Dennis is a passionate advocate for legal insurance because he has seen firsthand how it helps people receive the protection and legal help they need. He has nearly 30 years of insurance industry experience, with a primary focus on the sale of group voluntary benefit products to employer groups of all sizes through the broker and consultant community.

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FEBRUARY	The Millennial Issue Survey: GA View from the Top	Wellness Part II Consumer Driven Health (HSAs) Life Settlements & IUL	Orange County AHU Business Development Summit
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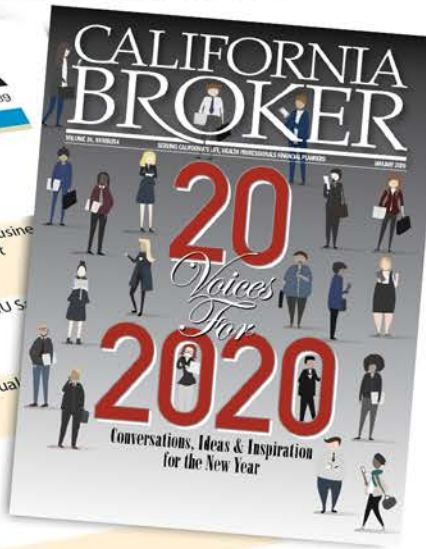

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CALIFORNIA BROKER'S ANNUAL LIFE SURVEY

Check out what some great life insurance minds have to say about the present and future of this product

COMPILED BY THORA MADDEN

1. Given all the dramatic forces at play in the world right now, do you see growth in particular niche markets in response?

Bob Ruff, SVP, Growth Solutions, Aflac:

The pandemic has been a difficult time for all of America—whether emotionally, financially or physically for those who get the coronavirus. Aflac examined this larger topic in our white paper "Stronger on the Other Side," where we discuss the increased interest in supplemental insurance and value-added services as a result of these uncertain times.

While not new, supplemental products warrant a second look because they can offer employers and employees added peace of mind. These plans serve a dual role: In addition to helping with expenses health insurance doesn't cover, they also serve as a financial safety net if covered illnesses arise as complications of the coronavirus. According to the 2020-2021 Aflac WorkForces Report, more than 80% of employers have expressed interest in offering supplemental insurance plans that cover costs associated with the coronavirus or a future pandemic. It is worth noting that many carriers are actively developing new plans and enhancing existing plans that pay benefits for prevention, diagnosis and treatment of a variety of virus strains.

Telemedicine is increasingly popular because it provides access to remote consultation and care. While it will not replace regular, physical examinations, telemedicine provides a solution when in-person care is not feasible, realistic or required. Employers can incorporate telemedicine into their benefits strategies to increase employee access to care. Supplemental insurers may include these services as part of a partnership or can help make these services available at low or no direct cost to employers. It's a simple step that can pay big dividends in employee health and well-being.

In addition, emotional well-being during the pandemic and beyond is an important issue for businesses looking for ways to help take care of employees. Stress-management programs and resources are important to fostering mental and emotional well-being that can fuel workforce productivity. Examples of these programs, often referred to as value-added services, include disruptive-event-management programs, employee assistance programs (EAP), health advocacy services, wellness programs and financial support services. Administration and funding of value-added

> ***... in our white paper "Stronger on the Other Side," ... we discuss the increased interest in supplemental insurance and value-added services as a result of these uncertain times.***
> ***—Bob Ruff, SVP, Growth Solutions, Aflac***

services may be difficult for some businesses. Many supplemental insurers recognize these barriers and respond by providing services at no or a reduced cost when benefits counselors are given opportunities to meet with employees during enrollment events. Others may embed services into plan designs or make them available to employers at reduced rates negotiated with the service providers.

Pam Jenkins, AVP, Product and Market Development, Colonial Life:

Life insurance is needed across all markets as America's workers in general are uninsured or underinsured. LIMRA's 2020 Insurance Barometer Study shows that nearly half of us don't have coverage. Certainly if a primary wage-earner died, this would cause tremendous hardship for surviving family members. The pandemic has heightened our sensitivity to the very real chance of unexpected serious illness or death.

Matthew Purington, AVP, Product and Market Development, Unum:

Frankly, not so much growth in niche markets, but rather an increasing awareness of the need for life insurance in general; the direct and indirect impact of the pandemic as well as continued social unrest have brought the need for protection into sharper perspective.

2. Has there been a significant change in product mix for life insurance over the past 12 months in terms of guarantees, variable or term?

Ruff, Aflac:

Our group whole and term life insurance plans continue to show sizable growth. Among other things, COVID-19 has been a staunch reminder of how suddenly things can change in the world. As customers continue to make flexibility in insurance decisions a priority, these plans remain popular for many. Aflac has expanded our guarantee-issue options to help make coverage accessible and as affordable as possible.

Jenkins, Colonial Life:

According to the 2019 Eastbridge Worksite/Voluntary Sales Report, life sales again captured the largest share (28%) of total voluntary sales by line of business. We continue to see a major focus on the term life market. Sales increased 8% in 2019, primarily from group term life provided by the employer with buy-up for the employee. Cash value life sales increased by 3% over the previous year.

3. What is happening with your distribution systems? If you have an agency force, is it growing? Are you hiring? Is there more attrition than usual?

Ruff, Aflac:

Independent agents licensed to sell Aflac insurance and brokers are invaluable in helping us connect with individuals and businesses in the United States, Guam and Puerto Rico. Their feedback helps provide us with new ideas and innovations on the distribution side in the hopes of further expansion and efficiency. This is why we have taken action during the pandemic such as providing no-interest loans, in accordance with IRS guidelines, for Aflac independent agents.

As much of the U.S. workforce has been operating remotely, the need for our distribution partners to have access to digital tools is more crucial than ever before. This includes continual benefits communication and education through the use of emails, microsites, videos, brochures and more. The enrollment environment looks different, as well, with virtual meetings being the norm to consult with a benefits advisor and apply for coverage. That said, Aflac values a high-touch, high-tech experience where human interaction

Life insurance is needed across all markets as America's workers in general are uninsured or underinsured.
—Pam Jenkins, AVP, Product and Market Development, Colonial Life

and technology are balanced to help ensure a satisfactory customer experience.

Jenkins, Colonial Life:

At Colonial Life, our strong agency distribution has kept us among the leaders of the voluntary industry. There is tremendous opportunity in the worksite industry for people who genuinely care about protecting America's workers. Colonial Life provides the chance to be in business for yourself but not by yourself, and control your own schedule and income. Our agency sales organization members build their business by working both directly with employers as well as partnering with brokers.

4. In terms of life insurance customers, are there certain niches or age groups that brokers should place more of a focus on?

Ruff, Aflac:

Everyone is a potential candidate for coverage. There are far too many Americans without sufficient life insurance, and our hope is to educate all of them on the importance of obtaining such coverage. According to Life Happens and LIMRA's 2020 Insurance Barometer study, 46% of U.S. adults did not have life insurance prior to the pandemic. Considering the financial hardships many may face because of the coronavirus, that number could be even higher now. Additionally, millennials may be a strong demographic to hone in on, because rates tend to be less expensive when you obtain coverage earlier in life. In fact, 40% of people who own life insurance wish they had purchased policies at a younger age, according to the LIMRA study. Whether they are single or have a family, life insurance can have value, in particular if they are a caregiver for an older family member or their parents co-signed loans with them. It is important to consider life insurance to help those who may be financially impacted if you were to pass.

Jenkins, Colonial Life:

The days of a personal life insurance agent who visited your home are long gone. Many people don't know where to turn to even ask about life insurance. This highlights a huge opportunity for brokers to work with clients to offer life insurance in the workplace.

Young people—Gen Y and Gen Z employees between ages 18 and 37—are less likely to report life insurance as an option at their employer. Just 40% of young employees say life insurance is available, while nearly 60% of older employees—Gen X and Baby Boomers between 38 and 70—report the same. This indicates there may be an opportunity for better benefits education and communication to younger employees who may be considering life events that increase the need for life insurance (marriage, children, buying homes).

Purington, UNUM:

Not so much more focus, but continued focus; for individual policies with "issue age" rates, purchasing at a younger age can provide a lifetime of protection at the most economical rate for the consumer; for group policies with "guaranteed issue" purchasing and maintaining sufficient coverage to replace the income of an insured should they die is a key financial strategy for those who have loved one who rely on the insured's income for their sustenance.

5. What kind of growth do you see in life insurance sales as an employee-paid or employer-paid benefit?

Ruff, Aflac:

Demand continues to grow for more valuable and accessible life insurance packages. Our response has been to bolster our guarantee-issue options, helping employers

> ***... the direct and indirect impact of the pandemic as well as continued social unrest have brought the need for protection into sharper perspective***
>
> ***—Matthew Purington, AVP, Product and Market Development, Unum***

maximize their benefits spending with a variety of coverage options. We have significantly increased the amount of guaranteed-issue coverage offered and lowered the requisite participation levels enough to allow for more employees than ever before to have access to quality coverage through their worksite.

One trend we see is the rise of rates and benefits tying into wellness initiatives. Companies are more often rewarding healthier behavior with higher face amounts or better premium offers. Since better eating and exercise habits tend to lead to a healthy lifestyle, it can be a win-win for both parties: Insureds have incentive to better their health, while companies can reward those who commit themselves to a positive lifestyle.

Jenkins, Colonial Life:

Making sure customers understand the options for life insurance is key. Many don't know when they leave an employer they may not get to keep—or even think to keep—their group term life insurance. Term insurance growth is stimulated by employer-paid benefits, which does create additional growth as employees "buy-up" for more coverage. For cash value plans that are intended to cover a person for their lifetime, employee-paid and owned coverage is the best solution. The main thing is to have life insurance!

Purington, UNUM:

Growth continues modestly, as would be expected for a highly penetrated insurance product.

6. What, if any, state or federal legislative issues are you concerned about?

Ruff, Aflac:

Since Aflac supplemental insurance plans are not major medical health insurance, healthcare legislation has not directly impacted our business. Because of the uncertainty surrounding the healthcare industry, we continue to educate consumers about their healthcare offerings and the benefits of supplemental coverage. We believe that regardless of how an individual or family acquires their health insurance, no system will cover everything. There is always a tremendous need for our products to help with the expenses health insurance doesn't cover. Many employees are shouldering the burden of higher costs because many companies are offering high-deductible plans due to rising healthcare costs. Unforeseeable out-of-pocket healthcare expenses along with the added costs associated with injuries and illnesses, including child care expenses, travel costs and taking time off of work, can be overwhelming to Americans. Aflac coverage pays cash benefits that can help with those costs and help provide financial stability.

Jenkins, Colonial Life:

Low interest rates are the single greatest challenge facing the industry. These low rates will continue to put pressure on financial services companies and the interest-sensitive financial products they issue, including life insurance. All life insurance products are affected to varying degrees, but long-term contracts that rely heavily on earned interest, such as whole life and universal life, are especially impacted. All life insurers will be challenged to make product adjustments in order to manage lower investment income and profitability in the current environment, as exhibited by the latest mandated change to the non-forfeiture and valuation interest rates.

Purington, UNUM:

Not so much specific issues as it is continued divergence among states which have their own specific insurance regulations; while it is understood that state's first priority is to protect their citizens, significant variance in state requirements force insurers to have different products in different states which is expensive, inefficient, and leads to confusion in the marketplace.

Face-to-face benefits counseling wasn't an option when the country was quarantined. With our technology, we were able to quickly pivot and implement virtual solutions where none may have previously existed.
—Pam Jenkins, AVP, Product and Market Development, Colonial Life

7. What are some of the common characteristics of your most successful life insurance producers?

Ruff, Aflac:

Top life insurance producers are true benefits counselors, asking every account and employee they meet with about that individual's circumstances to better understand their needs. Rather than trying to make a sale, they help clients and employees understand the importance of life insurance and discuss how Aflac coverage can help serve as a valuable part of their overall benefits plan. These producers understand that supplemental coverage is increasingly becoming a need in the workplace and that workers are feeling the effects of higher health costs and need options to help offset expenses.

Effective producers can help educate insureds on the ever-changing need to evaluate their coverage. Life changes daily, and our producers help insureds understand how to adapt to ensure they have adequate protection in all stages of life. We believe employees are less likely to seek individual coverage through other vendors when they have a better insurance offering through their workplace.

Jenkins, Colonial Life:

Our most successful life insurance producers balance the preferences of both clients and brokers, while striving for the great opportunity to educate employees on their full benefits portfolio. We believe in the value of one-to-one, personal benefits counseling sessions. Being flexible with enrollment options is also important in today's virtual world. Helping employees understand their needs and options means they can create an effective financial safety net for themselves and their families. So our most successful life insurance producers are those who are not only experts in product knowledge but who also excel at this customized counseling approach. They create trust and credibility, as well as long-term relationships. We've developed a certification process so brokers, employers and employees can be assured they're working with the best in the business when it comes to individual benefits counseling.

8. How has the pandemic impacted your company or life insurance in general?

Ruff, Aflac:

We are learning more about how the pandemic is impacting our business and are quickly pivoting to better balance face-to-face and virtual sales practices. On a positive note, we continue to invest in virtual tools and technology to help us reach American workers operating remotely while maintaining the appropriate human touch. As we look ahead, we are very excited about our pending acquisition of Zurich Group Benefits and their integration into the Aflac family, which we announced earlier in 2020, as well as our build-out of U.S. network dental and vision products through our acquisition of Argus. These position Aflac well to help employers offer a competitive benefits package and for workers to have access to a full suite of product offerings.

Jenkins, Colonial Life:

Face-to-face benefits counseling wasn't an option when the country was quarantined. With our technology, we were able to quickly pivot and implement virtual solutions where none may have previously existed. Many of our sales teams already used call center enrollment options, and this was a significant advantage to continue our benefits counseling. Certainly we had reduced or no access to some businesses, but we looked for alternative solutions.

The pandemic has reminded people that we are all mortal, and illness and death are realities of life. Often in unexpected ways and times.

HELPING EMPLOYERS UNDERSTAND THE IMPACT OF CMS PART D PROPOSAL ON SPECIALTY DRUG COSTS

BY DEA BELAZI

The Centers for Medicare & Medicaid Services (CMS) recently proposed a new payment rule for Medicare Advantage (MA) and Part D plans designed to generate competition and more rebates for specialty drugs. For commercial plans, it's important to understand the proposed rule because, typically, federal trends influence commercial stakeholders.

The high cost of specialty drugs is a challenge that is being effectively addressed by Specialty Pharmacy Benefit Managers™ (SPBMs). SPBMs are innovative, pharmacy benefit managers that offer high quality prescription drug management services specifically for those with chronic diseases that require specialty drugs. Along with customizable services, they offer carved-out specialty pharmacy services and cost-savings programs that extend discounts on prescription medications. They also adhere to transparency and initiate innovative treatment programs that leverage their existing tools to negotiate favorable rebates, as well as take advantage of the new rule to advocate for patients and reduce costs.

On the commercial side, savings can be measured in several ways. Consider the example of a program for hemophilia patients that saw a savings on drug costs of 10-40%, in addition to significant reduction in hospitalizations, improved patient education and awareness, as well as elevated understanding of pharmacy options to support coordinated care. Programs like this could continue to produce more savings if the CMS rule allows for more competition and opportunity for PBMs to negotiate in a way that impacts the larger commercial marketplace.

For brokers advising employers, the costs of managing chronic disease, such as hemophilia, is an important discussion to have, including the impact of legislation on commercial plans and their bottom lines. For instance, while hemophilia is a rare disease, affecting approximately 13 out of every 100,000 lives, it is still common enough that most employer groups will eventually deal with the challenges of providing care to hemophilia patients in their workforce.

A look at the proposed CMS rule

The proposed CMS rule would create a new preferred tier for Part D plans for specialty drugs in a bid to eventually lead to lower prices for seniors, giving plans more flexibility and two potential tiers if it is deemed that a specialty drug will drive more competition and rebates.

Currently, Part D plans put all specialty drugs, which often

The concept of the proposed rule is to give Part D sponsors "maximum flexibility" to get a brand-name drug that could cost less after a rebate than a generic or biosimilar.

have the highest cost, into their own tier that has the same level of cost-sharing. The proposed second "preferred" tier would allow for a lower percentage of beneficiary cost-sharing for such specialty drugs. CMS is proposing that the maximum amount of cost-sharing for either specialty tier is 25% or 33%, depending upon whether the plan has a deductible.

Manufacturers would prefer a lower cost-sharing percentage for their drug in order to enable greater access, but they could be more willing to offer plans a higher rebate in order to get lower cost-sharing. The concept of the proposed rule is to give Part D sponsors "maximum flexibility" to get a brand-name drug that could cost less after a rebate than a generic or biosimilar.

Another provision of the rule that could help Part D plans and PBMs save money is a requirement for plans to disclose pharmacy performance measurements, such as generic drug utilization.

In the absence of a core set of performance metrics across plans, a pharmacy could face a separate set of metrics from one plan to the other. Ultimately, stakeholders should agree on one set of metrics that would make it cheaper to administer.

Understanding the high cost of specialty drugs for commercial payers

As commercial payers often follow the lead of Medicare, it will be helpful to view the costs of specialty drugs through the lens of hemophilia. Brokers and employers have only to look at the numbers to see the potentially crippling costs, with many self-insured employers spending up to $1 million a year on patient care.

For a patient with hemophilia A, the annual cost of treatment ranges from $59,101 for those with mild disease to $301,392 for patients with severe disease receiving prophylaxis. For a patient with hemophilia B, the cost of treatment ranges from $85,852 to $263,253. Furthermore, factor replacement products represent up to 94% of total costs for patients with severe disease.

One SPBMTM program for hemophilia patients enabled one hospital to reduce its specialty spend by 30% in the first year.

With the development of new technology and tools for addressing high-cost diseases, employers can adopt a comprehensive chronic disease management program designed to provide an unprecedented level of control, transparency and accountability, not only for payers but also physicians, specialty pharmacists and patients alike. For self-insured employers, this approach enables them to contain prescription costs, ensure appropriate medication utilization and monitor physician and pharmacy performance in real-time.

In the case of hemophilia, payers face key management challenges, including:

- Fragmentation of care and lack of uniformity due to no standardized guidelines or care models for treating hemophilia
- Need for reinsurance programs for high-cost members
- High pharmacy and medical benefit utilization
- Potential stockpiling and product waste
- Limited payer insight into clinical data beyond factor product cost
- Limited provider insight into product utilization, dispensed amounts and total healthcare resource utilization
- Lack of individualized treatment
- Robust and complex product selection

In today's value-based climate, and for future legislation changes, data collection and analysis will be essential to determine benchmarks and measure relevant outcomes. Equally important, collaborating with local centers of excellence under pre-agreed upon standards of care and data sharing arrangements can help to prevent the need for prior authorization. Also, holistic care and coordination of care designed to consider the whole patient—and not simply the disease—will be of utmost importance.

Finding the right SPBM

An effective all-encompassing SPBM should be designed

With the development of new technology and tools for addressing high-cost diseases, employers can adopt a comprehensive chronic disease management program designed to provide an unprecedented level of control, transparency and accountability ...

to provide optimal levels of control, transparency and accountability for all stakeholders, including payer, physician, specialty pharmacy and patient.

Look for a program that offers 100% control of the prescription through its network of reliable and transparent specialty pharmacies. It should offer prior authorization control and real-time benefits verification, prescription fill dates, refill alerts, pharmacy fulfillment accuracy and quick turnaround time.

The program should also offer unprecedented access to physician, specialty pharmacy and patient data and visibility into how prescribers are writing scripts. Also, it should provide dose optimization, identify prescribers according to the label and provide insight into which prescribers are driving the best outcomes.

For specialty pharmacy, the management program should compare all network pharmacies in real-time on a leaderboard, provide visibility into factor units prescribed vs. units dispensed, drop shipment/over shipment prevention and ensure appropriate shipment of on-demand and bleed doses.

For patients with hemophilia, there should be real-time visibility into medication adherence, infusion adherence reporting, including prophylactic vs. bleed/on-demand doses, in-home patient inventory, medication hoarding prevention, outlier infusions (with or without bleeds) based on prescription and visibility into frequency of patient dosing. It should also ensure compliance with label and clinical trial literature.

Snapshot of best-in-class SPBM management program

The most effective management programs offer specialty networks that cover most limited distribution drugs (LDD) products.

In terms of cost savings, look for a management program that is flexible and sustainable, with a guaranteed pharmacy performance product and treatment cost containment, customized pharmacy network therapy management in real-time data and outcomes reporting. Overall, it's important to find a program with a patient-centric approach that supports hemophiliac treatment center alignment.

Keep in mind that a value-based program allows for greater transparency and accountability for patient and pharmacy activity. It will also be more likely to provide utilization management and clinical interventions based on active patient management that leads to contained costs and predictability on usage and costs. In this way, an appropriate utilization management and pharmacy network design can contain costs by as much as 10 to 42%.

The best-in-class programs are being designed to align with specialty pharmacy partners with innovative programs around a customized specialty pharmacy network. These networks are focused on calculated cost savings with customized clinical management and innovative technology —which aligns well with the intention of the latest proposed CMS rule.

Remember that employers are very concerned about how to finance the high cost of new million-dollar drug therapies, some of which can cost more than what an employee would earn in a lifetime. Specialty disease management programs that combine a trusted and transparent network of specialty pharmacies with the most up-to-date technology can allow them to contain prescription costs, ensure appropriate medication utilization and monitor physician and pharmacy performance in real-time.

Dea Belazi, PharmD, MPH, president and CEO, AscellaHealth, has more than 20 years of experience in the healthcare industry, mostly developing and managing pharmacy benefit management companies. He is president and CEO of AscellaHealth, a national PBM with almost 2 million lives under management. He was part of the development of PerformRx as well as Future Scripts. Dea holds a PharmD from the University of RI and completed his dissertation work at Brown University and later completed an MPH from Johns Hopkins University and a postdoc health outcomes research fellowship at Thomas Jefferson University.

Big Picture Thinking and Lifelong Learning Lead to Long Term Success

BY CERRINA JENSEN WITH AMY EVANS AND LISA HUTCHERSON

This is the fourth installment of a multi-part series which features a question based on the book "How Women Rise," by Marshall Goldsmith and Sally Helgesen, and responses from some of the speakers slated to present at the 2nd CAHU Women's Leadership Summit, now back on the calendar for April 7-9, 2021 at the Green Valley Ranch Resort just outside Las Vegas.

To recap what we shared in our previous installments, while this series focuses on female leadership and the 12 habits covered in the book that can hamper success, it's meant to shed light on these issues for not just women but the men we work, live and play alongside.

This month's question, compliments of Amy Evans, is, "Women often focus on doing their current job well, which can generate recognition and rewards. But they have a habit of keeping their focus on the job in front of them, rather than looking ahead and taking the steps needed to get to the next level. This can result in slower (or even non-existent) career advancement in comparison to male peers. Have you put your job before your career? Was there a point at which you deliberately decided to be more strategic about your career development? If so, what steps did you take?"

Special thanks to Lisa Hutcherson for taking this one on with a thoughtful and eye-opening response, as follows.

"The answer would be yes and yes. Earlier in my career I would say that my focus was about proving my worth and value by simply focusing on the job I was hired to do. Making sure that I outshined, outworked and outlasted my peers. In many ways it was about surviving the day-to-day grind of the 'job', short term thinking.

"However, the point I became more strategic about my career or I like to call it my 'purpose' is when I began to think about my career as a long-term investment in myself and the company that I was representing. I started taking into account the tapestry of my work experiences and moved them to the next level. Doing this had a profound impact on me professionally and for those that I had the amazing opportunity to lead. Below are the specific turn of events that took place, when I became more intentional about my own development. Here are some of my 'Aha!' moments:

"I wanted the company to succeed and play a part in that development. I began thinking about how I could impact the company's growth, even in my off time.

"Professional growth and personal growth takes time. I began my journey and love for becoming a student of business (SOB). There is always room to learn something new and I intentionally looked for ways to stay relevant in my career, particularly as a woman. The markets and the tides in business are constantly changing. COVID-19 has taught me this in a real, tangible way.

"I found that being in an organization that I love and respect is important. Additionally, that same love and respect needed to be reciprocated. This is where I spent time and energy building my reputation, making connections, while working my way up the ladder.

"The biggest turn of events was when I began to lead others in their career journeys. Many of the people I have had the honor to lead desired to grow, just like I wanted to. So it became a personal and professional mission to teach and lead those through their own individual career journeys. I think long and hard about how I lead others and do my very best to equip them to stay the course and have big picture thinking and activities that will sustain them long term."

The tactical steps I took:

The first thing I did was find my own unique flavor and style in the art of leadership and mentorship. Creating a routine of learning and skill set sharpening paid off.

I set weekly, monthly and annual goals

- Study and observe others who are doing what I aspire to. Internalize the skills and practice them over and over again.
- Attend online courses on leadership, relationship building and valuing others.
- Read one to two books a month on relevant topics that will help me move ahead in relationships and also in my career.
- Annually attend a national or statewide conference to engage others in my field that know more than me and learn something new that's bigger than my local marketplace.

When the rubber really meets the road, I know without a doubt that if you have a career that you love, it's a long term, enjoyable journey that can change your life.

Cerrina's comments: Like Lisa, I encountered a series of events that helped me grow and evolve by presenting challenges, breakthroughs, and even breaking points. These, in turn, became making points. She's also spot on with the absolute game changing commitment to lifelong learning. Bar none, I've observed that the leaders I most admire, both male and female, are also lifelong learners. Never satisfied that they know it all, they also seem to be those most willing to share wisdom, insights and lessons learned with others.

Stay tuned next month, when we'll tackle another question!

Cerrina Jensen recently joined the team at Verus Insurance as a benefits consultant and team leader, and is the founder of Stellar Stories, a communications and leadership development firm. She consults nationwide with both small and large employers seeking real solutions.

Amy Evans is the president of Colibri Insurance Services, a boutique insurance agency that simplifies employee benefits for employers in Southern California. She's also the founder of AlignWomen, a leadership and networking organization for professional women.

Lisa Hutcherson is the West Territory enrollment manager for Aflac and the founder of Darlis LLC, a company specializing in training leaders in both business and ministry. She is also a certified John Maxwell trainer, business coach, public speaker, poet and author.

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I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

COVID-19 DEBATE—Cociu
CONTINUED FROM PAGE 9

What seems to be most common is layoffs in the under 50 employee market; small employers are definitely the hardest hit.

As discussed, the insured market has seen less layoffs than the fully insured and smaller group market. What seems to be most common is layoffs in the under 50 employee market; small employers are definitely the hardest hit. Of all of my own self-funded clients, only one had layoffs, which resulted in a loss of about 30 to 40 people; so not significant numbers.

Next, let's talk about the hospitals suffering and the insurance carriers profiting during these times. I find it quite interesting that none of the articles I read mentioned anything about the fact that just because people may be putting off services/surgeries and other medical procedures now temporarily, does not mean that they won't happen. Insurance companies need to be prepared for when they do—I read no mentions of reserves for such times. So let's discuss that.

It's true that many hospitals are hurting and have a shortage of beds, PPE, and medical providers. Our health care heroes continue to be just that—our heroes—graciously and unselfishly serving the needs of their patients, often at the expense of their families. Many are sleeping in garages, cars or hotels during this time to keep their families safe. No one is arguing that, and I, as well as all of CAHU, thank them for their never-ending love, support and care of our friends and families in the hospital and medical facilities. In my opinion, they should all be given "combat pay" and should be compensated for their actions accordingly. More importantly, they should be given ample support for their families, their children in day-care, and for all of their personal suffering. However, hospitals and other medical providers are not making the extra income they normally do for elective surgeries and other more profitable services, leaving them in a financial bind. This of course sometimes leads to price increases and gouging on other services, but that is a topic for another day; another article. At this point, I want to focus on the goodness of the healthcare workers and all of the other essential workers in the medical facilities, from cafeteria workers to maintenance and cleaning staff, and everyone else who are there every day during this pandemic crisis. In addition, I also want to mention that many health insurance companies have been doing everything they can to get and keep people enrolled throughout this pandemic.

Insurance carriers and reserves

Insurance companies have been made out to be the bad guys in the news. Although there are times when I'm not happy with them, I must point out the obvious to anyone who works in the health insurance industry. To us, this may seem obvious, but to the general public, they often only know what they read in the press, even if it's far from reality. I'm speaking not only as a health benefits broker and consultant, but also as a former TPA executive.

Yes, it's true many insurance companies may be reporting higher than normal profits, but they should be reserving much of those profits for future claims. Just because people are not scheduling surgeries and other procedures now, or haven't since March, when the pandemic shut us down, doesn't mean that they won't have them. Even now in October, people are starting to schedule their procedures. They may not be until the fourth quarter, and some may even be put off until after the first of the year, but they likely will happen. So the carriers need to have funds set aside for the future claims. And if a plan is self-insured, they, too will need to set aside reserves for these future claims expenses. And, the reality is, here in California, we have medical loss ratio (MLR) requirements for fully insured carriers, which simply stated, requires that carriers spend 80-85% on direct patient care, leaving only the remaining 15-20% for administration and profit. Why isn't that in the media? Existing California law requires health plans to annually submit to the federal Department of Health & Human Services (DHHS) ratios of incurred losses to earned premiums or MLRs, and requires beginning in 2012, health plans and health insurers offering group or individual coverage to provide an annual rebate to enrollees if an MLR is less than 85% for its large group business, or 80% for its small group or individual business.

To reinforce the reality, I asked some industry experts for their opinions on this. "The health insurance companies are inevitably experiencing a very short term jump in profitability simply due to the fact that their expenses have been lowered due to the current pandemic," stated Brad Davis, VP, Legislation, for the California Association of Health Underwriters (CAHU). "Those 'profits' will soon be used to pay the claims that have been pent up due to the stoppage of non-essential procedures and visits.

A word to the wise ... don't assume large profits for insurance companies are long-term.

Any wise observer should look at this situation with the long view and not make sweeping generalizations based on 1 or 2 sets of quarterly earnings reports. Assuming no major change in historical average consumer demand for services, we fully expect to see these profits returned to the consumer quite literally as rebate checks in the Spring and/or a flattening of the premium increase curve."

In the self-insured marketplace, which I literally grew up in, having run a self-funded TPA for many years, and continuing to support self-funding in the marketplace, I currently have a good percentage of self-funded large groups in my book of business. Most have seen a serious reduction in claims expenses during the second and third quarters of 2020. However, we have advised them not to spend the money they are saving… They should be reserving it for the claims that they will likely see as the pandemic gets more under control and people feel safer and are more willing to see their doctors and schedule their procedures. Mike Ferguson, CEO of the Self-Insurance Institute of America, stated: " There is a bit of apprehension, but so far so good, claims are down now, but are in the 4th quarter [or later] are we going to have a tsunami of health care claims?" That's what we're planning for.

So a word to the wise… don't assume large profits for insurance companies are long-term. It is likely that, as Brad said, we should be a wise observer and not make sweeping generalizations based on press comments.

Attack on the employer-based healthcare system

The most effective, most well-liked system we have is the employer-based health care system. It works. Employers like to offer health benefits, because it helps to attract and retain employees, and prospective employees analyze health plans and other employee benefits almost as much as salaries. And yet, with current economic and unemployment statistics, it's being attacked from all sides.

"The employer-based health insurance system in the U.S. is robust and responsible for almost 50% of all insured in America," stated Brad Davis. "The other half is a mix of public programs like Medicare, Medicaid, and government workers. Private employers offer health insurance to recruit, retain, and boost the productivity of its workers. Hospitals and physician groups are also reliant on a good mix of privately insured to subsidize their publicly insured patients."

It's important to note that laid off employees do have options, and the market has responded positively, which the press is not reporting. "Even during the biggest health crisis in a century, the insurance market responded quickly to sustain coverage for consumers throughout California. Our members reported that most, if not all, of the insurance companies, have relaxed the rules to keep as many people covered as possible," stated Maggie Stedt, President of the California Association of Health Underwriters (CAHU).

The current employer-based health care system is strong and offers a variety of coverage options. Employers are perfectly positioned to determine what their employees want and need.

Options available to laid off workers

It's important to note that here in California, Covered California has reported low premium increases for upcoming renewals, which is welcome to hear. "Despite the volatility of the current economy," stated Maggie Stedt, "Covered California reported that all 11 carriers will return to the individual market with some plans even expanding into new regions. Even during a pandemic, the average premium increase statewide will be less than one percent. Further, consumers that use the professional services of an agent to shop within their current metal tier, can save an average of 7%." So why isn't this being reported in the media?

It's true that some employees have been laid off and may have lost their group health insurance, but the reality is, they really don't have to be uninsured!

Of course, the employer (if over 20 employees) offers COBRA (and Cal-COBRA in California for smaller groups), but the cost of often rich employer-provided benefits may not be affordable for a laid off employee. But that's one of the reasons we have the Affordable Care Act (ACA), isn't it? If someone has lost coverage due to a layoff, that is a qualifying event to enroll in their state's Marketplace, which is Covered California here in this state, they can choose from many plans and premium op-

An informed agent should be able to walk any person through options, including state-assisted programs like Medi-Cal or Covered California, COBRA, or plans directly from competitive carriers that cannot deny coverage.

tions, and quite often qualify for either a subsidized plan or no-cost Medi-Cal. The reality is that all you have to do is apply! Many employees that are offered coverage, which has been deemed "affordable" by the ACA, simply choose not to enroll. CAHU understands that what the ACA deems as "affordable" may not be affordable to all employees, and we understand that the high cost of health insurance is due to the high cost of medical care. That's why agents are here to help guide those individuals into coverage they can afford.

"There are so many safeguards in place to ensure universal access to health insurance that a true loss of insurance is rare and unlikely," said Brad Davis. "An experienced and/or informed agent should be able to successfully walk any person or family through a litany of options, including state-assisted programs like Medi-Cal or Covered California, as well as private options like COBRA, or plans directly from a host of competitive carriers that cannot deny coverage."

Most fully insured carriers in California (as well as other states) have relaxed their enrollment/underwriting rules, so that more people could enroll during the COVID-19 crisis, so individuals have had MANY opportunities to enroll.

"The exchange issued and extended numerous special enrollment periods and agents worked around the clock to ensure that millions of Californians were able to maintain coverage in existing or new channels to meet their needs," stated Maggie Stedt. "Our members also worked with regulators to ensure that consumers were not being balanced billed for COVID treatments and services."

"Healthy California for All" committee report

In a newly released report from the "Healthy California for All" committee, which was created by California Governor Gavin Newsom in 2019, with its purpose to "develop a plan for advancing progress toward achieving a health care delivery system for California that provides coverage and access through a unified financing system, including but not limited to a single payer financing system," the committee is (in my personal opinion, and not necessarily that of the California Association of Health Underwriters) openly and purposefully attacking the employer-based health care system, as well as the successful government programs of Medicare and Medicaid (Medi-Cal in California) and wants to replace it with a "unified financing system" (which many of us define as a single payer option), or something similar.

Governor Newsom stated, "As our march toward universal coverage continues I am calling on the brightest minds- from public and private sectors- to serve in the Healthy California for All Commission to improve the health of our state." We will discuss later in this article what "universal coverage" means. But I think I should point out that our governor may not be 100% familiar with health insurance terminology. He seems to mix his terms frequently. The governor and Newsom Administration recently called Covered California a public option, in his Proposed Budget Summary, which it is not. "This year, the Budget proposes additional investments to continue this momentum on affordability and coverage in California's health care system. Specifically, the budget includes bold plans to address health care cost trends, strengthen California's public option [referring to Covered CA], lower prescription drug prices for all Californians, and continue progress towards universal health care. These efforts will focus on returning cost savings to consumers and employers and will align with the efforts of the Healthy California for All Commission, which is charged with exploring policy solutions that drive toward a unified health care system that is universal, affordable, high-quality, and equitable for all."

In addition, Governor Newsom has referred to Medicare as a "single payer" model (which it is not): "However, to address this ongoing cost crisis in health care in the most effective way, we must have the federal tools to support California's ability to provide quality healthcare for everyone, financed through a single-payer model like Medicare. We must have the tolls to innovate and expand the Affordable Care Act, even as we build towards a more comprehensive, universal system that works for patients, providers, and taxpayers alike."

Yes, terminology is used incorrectly in both of these statements, but they may give us a more realistic idea of what 'Universal Healthcare' may look like for the Newsom Administration.

According to the Healthy California for all report, 46% of people in California are covered under employer-sponsored

California consumers have trouble evaluating health coverage options and making well-informed choices when their coverage source shifts or they move from one plan to another.

health insurance, 40% are covered by Public Medicare or Medi-Cal programs in California, 5% are covered by the individual market, and 9% are uninsured. Let's talk for a moment about the 9% uninsured that the report cited. That's 3.5 million people that are uninsured. Of that 3.5 million, 550,000 are actually ELIGIBLE for employer-sponsored coverage, but chose not to enroll, 370,000 are eligible for Covered California, over 400% of the FPL (meaning not eligible for premium subsidies), 610,000 are eligible for Covered California under the 400% FPL (eligible for a premium subsidy), 660,000 are eligible for Medi-Cal (i.e. no-cost health care coverage) and 1.3 million are undocumented. I'd like to point out an error in the above report. Premium assistance through Covered California is now available for incomes up to 600% of the federal poverty level, not 400%. Subsidies reduce consumer health plan premiums considerably, so you or your clients may be eligible for no-cost Medi-Cal. So the reality is, most of that 3.5 million number are eligible for some form of existing coverage. The 1.3 million undocumented are the largest portion of the remaining uninsured population. However, it should be noted that many receive services for births and hospitalizations through restricted scope Medi-Cal. There are also county services that are also available to undocumented residents, which does not count towards the fully insured numbers for purposes of the report. Those eligible for subsidized coverage may be surprised at how little they would have to pay, if they'd only go online to find out, or talk to a qualified health agent (preferably).

In the report, the committee recognizes the employer-based health care system, but quickly negates its effectiveness, due to insureds having to pay co-payments and deductibles, and calls pre-tax contributions a means to the loss of tax revenue. "Employer-sponsored insurance is paid for through the employer and worker premium contributions using pre-tax dollars, which means that federal and state governments essentially subsidize employer-sponsored insurance via foregone tax revenue. In addition, most plans require that workers or their family members make payments when they access care, typically via co-payments or deductibles."

The report also discusses how, "consumers struggle with health insurance literacy." The committee does recognize that here in California, "individual market consumers… face fewer challenges navigating the purchase of health insurance compared to consumers in most other states." However, they do not say why that is. We all know that is because Covered California welcomed agents, and quickly discovered that their largest population of enrollment came from independent agents who enrolled their clients in Covered California. "Nevertheless," the report continues, "California consumers have trouble evaluating health coverage options and making well-informed choices when their coverage source shifts or they move from one plan to another. Less educated Californians, those with limited English proficiency, and those with low levels of health literacy face particular obstacles related to the complexity of health insurance information." The California Association of Health Underwriters (CAHU) has been involved with the creation of many educational materials for all of these Californians, and such materials are available on the CAHU website at cahu.org, through our Public Affairs committee, as well as through the CAHU Foundation. We look at this entire section of the report as an opportunity to promote the use of agents when consumers are making health care decisions.

In a section of the report entitled "How Will a Pandemic Affect California Health Care?," the committee discusses "shortcomings" of our current system, but it fails to mention the obvious parts which I mentioned above….like premium subsidies available. Most Californians who lose job-based coverage have an option to maintain that coverage under the federal COBRA or state Cal-COBRA laws. If individuals find COBRA prohibitively expensive, they may elect to enroll in Medi-Cal or purchase insurance through Covered California in just a few short minutes with the help of an agent.

Committee report proposes to "work around" ERISA and eliminate self-funded health plans

The most important provisions in the report, I feel, are the Committee's attack not only on the employer-based health care system, but on ERISA. The Employment Retirement Security Act (ERISA) is federal law that has been

Because Californians are situated so differently today, moving to unified financing will involve change and disruption, particularly in the short run.

around since 1974, and protects the rights of employees enrolled in health and welfare (health insurance) plans as well as retirement plans. Understand that the Committee Report proposes to use a somewhat crazy and awkward solution to basically just work around ERISA!

Let me first provide some background. Further into the Pandemic section of the report, they talk about how a "unified financing approach would allow the state to move toward a more accountable and equitable system. However, because Californians are situated so differently today, moving to unified financing will involve change and disruption, particularly in the short run. To achieve a universal health care system that assures access, affordability, high qualify, and equity will require purposeful design decisions and transition planning." Let's think about this… Change and disruption doesn't make things easier… it often makes things much harder! Yes, you have to elect to participate in things like Medi-Cal (or Medicaid in other states), but it works. So now let me discuss how they anticipate changing our industry and the health insurance market, beginning with ERISA.

ERISA includes provisions that apply to many populations. First and foremost, self-funded health plans, but also to fully insured groups (those with over 100 employees must file 5500 forms and comply with other ERISA provisions, but ERISA also applies to smaller groups as far as requirements to have plan documents, summary plan descriptions, and other disclosure requirements), and union plans. I have to admit, I take this section very personally, as I've spent my entire career working with ERISA plans and self-funded plans. In addition, I personally have written many ERISA wrap-around plan documents for my full-insured groups, to assure that they comply with the federal law (as Certificates of Coverage generally do not meet ERISA requirements). So, some would call me very much an expert in this area. Given that this is my expertise, I will defend this area to the best of my ability. Please accept my apologies in advance if my emotions on this issue affect my words in this article.

It's obvious that the report is designed to present a positive case for "unified financing" (single payer), as that is what it was tasked to do. However, the reckless attack on federal law is more than irritating. In my world, it's almost criminal. I know that sounds harsh, so let me explain my views. (I suppose at this point, I should re-state that the views and opinions of the author are not necessarily those of the California Association of Health Underwriters, so CAHU, that's my disclaimer!)

I'd like to preface this section with some quotes from the pre-ERISA attack portion of the report, which of course leads up to the (in my opinion) most important and egregious sections.

The report then goes into steps to prepare to transition to Unified Financing (i.e. single payer), then goes into to revisiting employer contributions and obligations. In this section, the blatant attack on ERISA and self-funding begins.

"In developing a united financing policy, the State will need to address potential conflicts with the federal Employee Retirement Income Security Act (ERISA) in relationship to self-funded plans. Self-funded plans are those in which the employer assumes the financial risk of employees' health care cost and pays for their health care expenses directly rather by purchasing insurance and having the risk shifted to a third party. Very large employers are most likely to self-fund because their size better positions them to forecast and spread risk, and because it allows them to offer uniform benefits to their employees nationwide, avoiding both state benefit mandates and state-imposed insurance taxes. At least 5.5 million Californians are covered through self-funded employer arrangements."

Let me just stop there to make some important points. First, an employer does not have to be "very large" to self-fund. Although some are smaller, most are 100 or more employees. The 100 to 500 market also does very well self-funding in many instances. And I will defend the ERISA rule that allows employers to have one set of plan rules, regardless of employee locations across state lines. That is one of the best advantages to self-funding. For employers who operate in multiple states, this drastically reduces administrative and human resources costs.

The report goes on to state: "ERISA sets federal standards that apply to private sector employers that establish employee benefit plans. Intended to assure that multi-state employers can provide consistent benefit programs across multiple states, ERISA preempts 'any and all State laws insofar as they may now or hereafter relate to any employee benefit plan' covered

> ***[ERISA] could make it illegal for providers to accept payment from other sources or plans other than the unified system (single payer).***

by ERISA. ERISA does not prevent states from directly regulating health insurance carriers and the products they sell to employee benefit plans but does exempt self-funded ERISA plans from state health insurance regulation. ERISA would preempt a prohibition on self-funded employer sponsored plans in the state." This is all true, and they do have it footnoted with code sections. What they fail to state is how successful these provisions have been to keep the costs down for self-funded employers. Self-funded plans generally see 10 to 30% savings over fully insured plans of equal benefit value, and some plans, including reference-based pricing self-funded plans, can see even greater savings. And the convenience of having one set of plan rules for all participants is not only easier to administer, but generally less expensive for employers. As they said, 5.5 Californians are covered by self-funded plans. Nationally, that number increases drastically.

The report continues: "How ERISA's complex provisions may apply within the context of a specific state policy construct would be subject to court interpretation. State single payer proposals offer a range of plans that include employer contributions, such as broad-based payroll taxes. Another approach could be to place restrictions on providers, for example prohibiting providers from accepting payment from any source other than the unified system or at any different rates. These strategies would allow employers to continue to offer a self-funded plan if they chose to do so. Employers' decisions would depend on the perceived value to employees of the self-funded plan when compared to services available under unified financing at little or no additional cost. While strong legal arguments can be made for these approaches, given the high financial stakes, litigation is likely."

Let me make this clear, in case you didn't quite understand what was said here. What they are saying is that they could make it illegal for providers to accept payment from other sources or plans other than the unified system (single payer). In other words, they could defy federal laws, defy the right for an employer to self-fund their plans, which have proven to be cost-effective and successful over the long term, and they would put the burden on the providers to not accept their payments. So, the Committee's conclusion is that they should choke off the private sector, self-insured market supply to the providers. In essence, they would try to ELIMINATE self-funded plans in California. (In the rest of the report, you will see that their intent is to eliminate all types of plans—all lines of group and individual coverages, as well as Medicare and Med-Cal). And, as they said, they would be willing to spend taxpayer dollars on a very expensive legal fight, and trust me, it would definitely result in a huge legal battle.

I discussed these ERISA provisions with my own legal counsel on ERISA. "Legal challenges are a certainty," stated Marilyn Monahan of Monahan Law Office, and author of the "Legal Briefs" in the STATEMent, "with numerous stakeholders—including issuers, providers, employers, and plans, weighing in. Prolonged legal challenges will cause delays and confusion." Not to mention plenty of expense.

"The ideas under consideration to avoid ERISA preemption—a payroll tax on employers, or restricting providers from taking reimbursements from plans—would strongly discourage an employer that wanted to maintain its own self-funded plan," Marilyn continued. "A state-by-state approach to restructuring healthcare will create numerous legal and administrative challenges. ERISA was intended to create a uniform system of regulations across the country, so that employers were not subjected to piecemeal regulations. The benefits of a uniform approach are particularly important to multistate employers, including employers that hire remote workers who may live anywhere in the country."

The truth is on our side. Self-funding works. It's plain and simple. And our group, individual and Medicare markets work. We just have to get that message out.

The political environment

I think I should start this section with a reminder that California entered 2020 with a budget surplus, but is now in a serious budget deficit position. To pass such a state solution, you need federal dollars. The federal government can deficit-spend. The state cannot.

In the current political environment, we know there will be a lot of talk about changing the health care system. Understand that the Democratic supermajority in California will have a HUGE part in what happens here. California's legislature has more than a 2/3 democratic

> ***"During a global pandemic and economic crisis, it is easy to pound the drum to demolish the current employer sponsored health care system in support of single payer."***
> ***—Maggie Stedt, CAHU president***

majority, and 2/3 also happens to be the vote requirement to pass taxes. Further, the Democratic platform supports single payer. In our California primary in March, neither Presidential Democratic nominee Biden nor Kamala Harris won California. Bernie Sanders did, and he is all about single-payer. In 2017, SB 562 passed in the California Senate, but the Assembly opposed it due to no identified funding source; the Healthy California Committee Report paves the way for a funding source!

"During a global health pandemic and economic crisis, it is easy to pound the drum to demolish the current employer sponsored health care system in support of single payer," stated Maggie Stedt, CAHU president. "However, the reality is far more complicated than proponents are willing to acknowledge, especially when such a feat is considered at the state level. The state government is unable to deficit spend like the federal government can. Which means that in a year like 2020 when California is projecting a $54 billion deficit, healthcare services, or other vital public services would most likely be on the chopping block. Subsequently you could also see tax increases imposed on many Californians at a time they could least afford it."

So, I ask, is now the time to take on the single payer fight? Can California, with its huge deficit, afford to take on a $400 billion single-payer plan, plus a legal federal battle over ERISA and the right to self-fund? You and I may think not, but legislators in Sacramento, and possibly the federal government, should the Biden/Harris ticket win in November, may see it as a longer-term possibility.

It's an election year. The fight will be vocalized in the media. I asked Mike Ferguson of SIIA what his thoughts were on this, and what we should expect. "The components of a robust government participation in the healthcare system are becoming more sophisticated in their arguments, and I think what is most effective and what you're going to see, is that instead of simply saying we need more government control in contrast with the private market, they're going to start pointing out problems with the existing private marketplace. The goal is to create a narrative by which the private market looks as bad as possible." He continued, "They want to muddy up the waters, and say, yes, there are some problems, there are some issues with a government run health care system; we'll figure those out of course, but it's not like we're comparing to a system that runs well. Really, it's trading a smaller set of problems for a larger set of problems that we already know are happening in the private marketplace. The critics of government-controlled system are theorizing or projecting potential issues, where in the private marketplace, there are issues that are tangible right now. You're going to see more and more thinktanks and thought-leaders on that side of the political spectrum that are going to be poking holes in the private healthcare system. There are more opportunities to poke holes in the existing private marketplace. You can certainly critique fully insured carriers over their profit margins, and other business practices… it's harder to critique the self-funded marketplace, but I'm sure you can find a situation where some plan participant had a bad outcome. Maybe a claim was denied, or something went wrong in the process. You can pick your scenario. Given the law of large numbers, you can find something that is not working well, on a case-by-case basis in our marketplace, so we need to be prepared for that."

I'd like to conclude this article with some reader take-aways, or a summary message to our readers.

The main messages and takeaways for our readers

I'd like to try to summarize and give our readers some key takeaways and messages as we go forward.

1) Know how to respond to attacks on the employer-based health care system: The employer-based health care system has been working well for many years. It currently covers nearly half of the insureds in our country. The employer-based marketplace has been stable over a long period of time and allows employers to offer robust healthcare plans at affordable rates. Instead of blasting single payer, perhaps a more politically correct response should be to point out the good in the employer-based healthcare marketplace;

A) The employer-based healthcare system is the one segment of the market that has worked very well over a long period of time. It's the most stable part of our health insurance market.

B) Employers use health benefits as a good recruiting and retention tool.

C) Employees like receiving employer-

CAHU and NAHU want Universal Access to healthcare and promote it ... We want to do it with a combination of private and public financing... The ACA has made many strides that are working.

based health coverage. It's affordable and it's easy.

2) The ACA created exchange Marketplaces to assist small employers and individuals in getting affordable coverage. Our Covered California is the most successful Marketplace in the country, and it provides subsidies for individuals up to 600% over the Federal Poverty Line, and easily allows people to qualify for Medi-Cal. In addition, the use of agents is a no-cost and easy solution for individuals and small employers to get the help they need to understand how to enroll and see what is offered to them.

3) Understand the message: The Healthy California For All Committee's intention is to get rid of the current combination of private sector (employer-based system) healthcare system and public system (Medicare and Medi-Cal) and replace it with unified financing system. Understand what that means. Governor Newsom proposes a unified financing system, including but not limited to a single payer financing system. Keep in mind that our governor also has mis-stated important terminology. Many of us believe that the Healthy California For All Committee report this is a road map to single payer. After all, that's what the committee was tasked to do—find financing to pay for single payer.

4) Understand the difference between Universal Healthcare and Universal Access to Healthcare. CAHU and NAHU want Universal Access to Healthcare and promote it. That's what we want. We want to do it with a combination of private and public financing. The ACA has made many strides that are working. It includes no pre-existing condition exclusions, no plan maximums, the ability to go to the marketplaces and get coverage with possible subsidies or no-cost Medi-Cal (or Medicaid) coverage for the lowest income families.

It has become obvious that those speaking about single-payer, universal healthcare and "Medicare for All" are using those terms interchangeably. These terms are not interchangeable and already have a set definition of what they are and what they are not. For example, universal access to healthcare is a broad term for a program that makes some level of basic coverage available to all (likely through a government program), but also allows for private insurance as choice to the consumer. Universal access to healthcare which includes a private insurance option would allow consumers and employers to continue their current types of health plans, assuming those plans offer at least the basic coverage required. Some examples include Canada, United Kingdom, Germany and Japan.

MEDICARE FOR ALL is one type of universal health care plan where basic coverage is provided through an expansion of the federal Medicare program. This type of plan would still allow for the purchase of private insurance, as it does currently, administered by an insurance company, not by the State. This is not what the Healthy California Act (SB 562) proposes. The Healthy California Act proposes a single payer plan.

Single-payer is a system in which all residents pay the State—via taxes in amounts determined by the state—to cover all healthcare costs for all residents. This would end all individual options to buy or not buy health coverage from private insurers based on their specific needs and ability to pay. Both the Healthy California Act and the New York Health Act are true single-payer plans, which would eliminate all private and public insurance programs, including Medicare, Medi-Cal and Veteran's healtcare, among others. The actual funding of a "single-payer" system comes from all or a portion of the covered population via new taxes.

For more information, to go www.cahu.org or email info@cahu.org.

5) Learn your "elevator speech" in response to single payer. The expense to take on such a system will exceed, according to the State of California during the SB 562 fight, over $400 Billion. That is DOUBLE the existing budget for the entire state. Remember that you'd lose your ability to choose your plan and doctors. Understand that single payer results in shortages and long wait times. Understand that single payer would likely result in many doctors leaving the profession. Understand that it costs a lot of money: higher taxes per family and per employer. Is this what we want?

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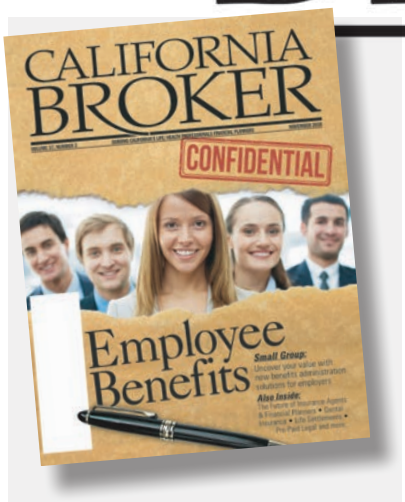

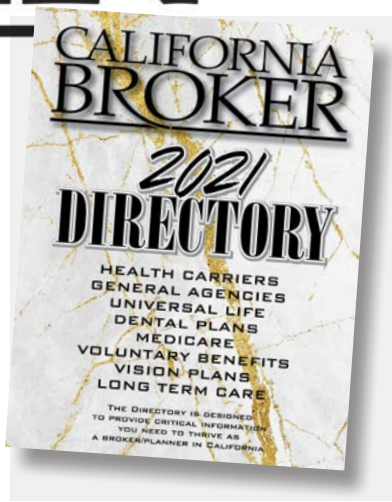

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Jan-20	14,237	48,618	542,292	427,325
Feb-20	16,619	41,848	267,662	404,542
Mar-20	10,337	41,739	173,003	266,483
Apr-20	10,337	40,455	192,206	287,909
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