CALIFORNIA BROKER

VOLUME 38, NUMBER 5 SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS FINANCIAL PLANNERS FEBRUARY 2020

THE HISTORY OF COMMISSIONS

Part II

PLUS:

- Self-Funding
- Marketing/Sales
- Benefits Trends
- Vision Insurance

...and more!

brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

A NEW WAY

TO SELL YEAR-ROUND

For nearly 40 years, we have transformed our passion for people into **easy-to-use benefit plans. Our goal** is to **make people's lives healthier, and more fulfilling**—with benefits they want, at **prices they can afford.**

We also offer a variety of Special Needs Programs to **help manage care of chronic conditions** such as Cardiovascular Disease, Diabetes, Dementia and Mental Illness for **Medicare Only** and **Medicare-Medi-Cal beneficiaries.**

Offer your clients more—with a Medicare Advantage Health Plan from Brand New Day.

CALL BROKER SUPPORT AT **1-866-255-4795 x2018**
MONDAY - FRIDAY, 8 AM - 5 PM OR VISIT OUR WEBSITE TO GET STARTED
BNDHMO.COM/BROKERS

At CHOICE Administrators, we offer flexible health care solutions. CaliforniaChoice includes 8 top California health plans and ChoiceBuilder Dental, Vision, Chiropractic, and Life. Best of all, both programs come bundled in a single package making administration simple. Empower your clients to offer simple, flexible health care with CHOICE Administrators.

CHOICE Administrators. A California Different way to do health care.

CaliforniaChoice®
Your Health. Your Choice.®

ChoiceBuilder®

Quote Different

CaliforniaChoice 800.542.4218 calchoice.com | ChoiceBuilder 866.412.9254 choicebuilder.com

CALIFORNIA BROKER

CONTENTS...

CALIFORNIA BROKER | FEBRUARY 2020 | VOL. 38 NO.5

COVERED CALIFORNIA
SMALL BUSINESS

A PARTNERSHIP THAT PAYS

Bonus Program - Coverage Effective:
February 1, 2020 - June 1, 2020

Earn even more for offering your clients California's most comprehensive access to doctors and hospitals offering:

- ✓ Full Network PPOs*
  - **Blue Shield**
  - **Health Net**
- ✓ HMO offerings from*
  - **Blue Shield**
  - **Kaiser Permanente**
  - **Sharp Health Plan**
- ✓ EPO offerings from*
  - **Oscar**
- ✓ Single bill
- ✓ No carrier participation requirements within program

Earn extra when you sell new small groups

Group Size (Enrolled Employees)	Incentive Earned
51 - 100	$ 8,000
26 - 50	$ 4,000
16 - 25	$ 2,000
6 - 15	$ 1,000

Contact your local Covered California for Small Business sales representative to learn why we're growing and how we can help build your business! An increasing number of agents and their clients are glad they did.

CoveredCA.com/ForSmallBusiness
844.332.8384

Some Key Rules:

- Applies to new Covered California for Small Business (CCSB) groups with initial effective dates of 2/1/20, 3/1/20, 4/1/20, 5/1/20, 6/1/20.
- Subscriber count (i.e. enrolled employee count) is determined at time of initial enrollment as counted in CCSB systems and is based on medical subscribers only. No retroactive additions will be eligible for incentive payment. Dependents of enrolled employees are not counted.
- Groups must satisfy standard CCSB binder payment requirements for enrolled employees to count towards incentive program payments.
- Business written through partnering General Agencies qualifies.
- CCSB intends to issue incentive payments 90 days following the effective month of a qualifying group. CCSB may modify its payment schedule at any time.

For a complete list of the program rules go to: rebrand.ly/Incentive2020

blue of california · Health Net · KAISER PERMANENTE · oscar · SHARP HEALTH PLAN

Insurance companies vary by region and are subject to change

CALIFORNIA BROKER
FEBRUARY 2020

PUBLISHER
Ric Madden
publisher@calbrokermag.com

ASSOCIATE PUBLISHER
Naama O. Pozniak
naama@calbrokermag.com

EDITOR
Victoria Alexander
editor@calbrokermag.com

ART DIRECTOR
Michael Vannatter
mike@calbrokermag.com

VP MARKETING
Devon Hunter
devon@calbrokermag.com

ACCOUNT EXECUTIVE
Gregory Allen Clauss
gregory@calbrokermag.com

ASSOCIATE EDITOR/MARKETING
Linda Lalande
linda@calbrokermag.com

ASSOCIATE EDITOR
Thora Madden
thora@calbrokermag.com

CIRCULATION
calbrokermag@calbrokermag.com

BUSINESS MANAGER
Lexena Kool
lex@calbrokermag.com

LEGAL EDITOR
Paul Glad

EDITORIAL AND PRODUCTION:
McGee Publishers, Inc.
3727 W. Magnolia Blvd.,#828
Burbank, CA 91505
Phone No.: 818-848-2957
calbrokermag@calbrokermag.com.

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

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

No responsibility will be assumed for unsolicited editorial contributions. Manuscripts or other material to be returned should be accompanied by a self-addressed stamped envelope adequate to return the material. The publishers of this magazine do not assume responsibility for statements made by their advertisers or contributors.

Printed and mailed by Southwest Offset Printing, Gardena, CA.

MORE CONTENTS...

32 VISION

Transparency in Vision Benefits: How to Overcome Four Common Pain Points
By Jesseca Oscar
Vision benefit companies are making significant strides in transparency (pun intended!) to make vision an understandable health benefit—one that encourages employee use and drives member satisfaction.

36 2020 VOLUNTARY BENEFITS SURVEY: PART 2

Compiled by Thora Madden
As part of our series of carrier surveys, Cal Broker reached out to some of the major players in voluntary benefits. They were happy to fill us in on what's happening in their worlds. In fact, we had so much info we had to break the survey responses into two parts. Last month we published part one. Here's part two. Read the complete survey and responses online at calbrokermag.com.

42 EMPLOYEE BENEFITS

Workplace Compliance Trends for 2020
By Robert C. Love
The business world is constantly evolving to accommodate the changing world in which we live. At the forefront of that evolution in the insurance segment is compliance. For better or worse, regulatory changes at the local, state, and federal levels create new compliance issues every year. 2020 is no exception.

44 INSURTECH

2020 and beyond: why it's vital that insurers embrace AI-driven CX
By Mia Papanicolaou
When it comes to insurance, the use of artificial intelligence (AI) to determine premiums, assist with fraud detection, and speed up claims processing is becoming far more commonplace. Less well regarded, but equally important, is the role AI plays in customer communication.

IN EVERY ISSUE

HIGH LIMIT DISABILITY

Individuals annually earning in excess of $500,000 need disability benefits that can keep pace with their affluent lifestyle - they need High Limit Disability. The benefits of a recently-insured surgeon, making $1,100,000 consisted of:

- **$10,000/month Group LTD**
- **$15,000/month Individual DI**
- **$32,000/month High Limit DI**

Call **(800) 345-8816**
or
visit **www.piu.org** for more information.

Occupation: **Surgeon**
Age: **51**
Income: **$1,100,000**
Total Benefit: **$57,000/month**

PETERSEN®
INTERNATIONAL UNDERWRITERS

MEDICARE NEWS

Original Medicare Preferred to Medicare Advantage and Employer Plans

By LES MASTERSON

Medicare for all is a hot topic in the 2020 presidential election, with supporters arguing that people don't like their current health plans. However, an Insurance.com survey finds that respondents overwhelmingly like both Original Medicare and private insurance plans. In fact, a recent Insurance.com survey finds that Original Medicare receives better marks from members than any other type of health insurance, including Medicare Advantage, employer-based coverage, Medicaid and individual insurance.

Original Medicare tops the list, with not one respondent giving it a low mark. Medicare Advantage and employer-based plans are tied for second.

The survey of 1,000 people reveals that 43% of beneficiaries with Original Medicare give their coverage the highest mark (a 5 on a 1-5 scale). Another 39% grade their plans a 4. That means 82% of people with Original Medicare grade their plan one of the two highest marks.

Why such a large variation for Medicaid? One possibility is that Medicaid varies by state. The federal-state program allows states to create their own plans and eligibility. Three dozen states have expanded Medicaid to lower-middle-class people, while the remaining states continue to offer the program to a smaller group of people. A state's specific Medicaid program likely impacts a person's thoughts on that health insurance.

Medicaid fared much better than individual insurance. Individual insurance, including Affordable Care Act (ACA) exchange plans, received low marks. Only 36% of people with an individual plan gave their plans a 5 or 4. The most common grade for individual plans was a 2 (28%). Forty-two percent of individual plan members ranked their plans as a 2 or 1. That was the worst rating by far in the survey.

One possible reason for the low marks may be related to costs. People who are ineligible for government subsidies pay higher health insurance costs with individual insurance than is typically the case with other types of plans.

Rating	Employer-based	Original Medicare	Medicare Advantage	Medicaid	Individual or ACA plan
1-poor	5%	0%	7%	6%	14%
2	6%	3%	6%	18%	28%
3	18%	15%	16%	16%	22%
4	33%	39%	35%	22%	22%
5-Excellent	39%	43%	37%	39%	14%

Source: Insurance.com commissioned a Google survey of nearly 1,000 people

The survey reveals that 72% of Medicare Advantage members are well satisfied with their coverage, giving their plans one of the top two marks. Employer-based plans received the same volume of combined 4 and 5 marks – 72%.

While respondents didn't give Original Medicare one low grade, 7% of Medicare Advantage members and 5% of employer-based insurance members ranked their plans at the lowest score level.

These three types of plans fared much better than Medicaid or individual insurance. The survey uncovers a wide variation between people's thoughts about Medicaid. More than half of Medicaid members give the health insurance program for low-income Americans a 4 or a 5 (61%).

However, nearly one-quarter of Medicaid members rate their plans poorly. Eighteen percent graded their Medicaid plan only a 2 and 6% ranked it as a 1.

Health insurance satisfaction survey results

How would you rate your satisfaction with your health insurance plan?

Look for debates over Medicare changes and proposals for Medicare for All to rage on in 2020. Consumer satisfaction will play a major role in all of these debates.

Les Masterson is managing editor at Insurance.com, an industry website that covers auto, home, life and health insurance. He has researched and written extensively about health insurance and health care for consumers, executives and hospital CEOs.

CIGNA GLOBAL

Individual worldwide coverage tailored to fit any customer needs.

Partner with us today.

Learn more about Cigna Global and become our partner today!

James Elbaum
Business Development Manager
James.Elbaum@cigna.com
Phone: 480.622.8625

Visit us on:
www.cignaglobal.com/brokers

Together, all the way.℠

Cigna®

Many Californians Still Don't Know Health Coverage is Now Required

As of January 1, the Individual Shared Responsibility Penalty went into effort. That means, for example, if a family of four doesn't secure health insurance coverage they could see a $2,000 penalty when they file their state taxes for 2020. (Note: the Franchise Tax Board is kind enough to supply a handy little estimator on its website at ftb.ca.gov to assist consumers in understanding what they will actually have to pay.) A new survey by Covered California however, shows that 56% of uninsured Californians still remain unaware that California requires its residents to have health care coverage in 2020 or face a penalty. See what you can do to get the word out, okay? Oh, but on the bright side, Covered Cal also says that more than 500,000 Californians have already qualified for new subsidies that help further lower the cost of coverage.

Webb, Katz Join CB Editorial Advisory Board

You simply can't get better help than this. Cal Broker is pleased to announce that insurance industry veterans Yolanda Webb and Alan Katz will be pitching in. Katz, co-founder and CEO of Take 44 – and past president of LAAHU, CAHU and NAHU – will be writing monthly on topics such as health care reform and sales/marketing.

Yolanda Webb, of Webb Insurance Solutions, is IEAHU Awards Chair, CAHU VP Corporate Affairs and on the NAHU Medicare Advisory Council.

Webb will be contributing stories as well as finetuning our carrier/GA/product surveys and our View from the Top content. We look forward to working with both of these industry superstars!

WE GOT MAIL!

Dear Cal Broker editor:

I was very excited to read Paul League's article in the December 2019 issue with the headline "Seeing Through the Smoke and Mirrors of Obamacare." The first line definitely grabbed my attention. League wrote:

"By several credible measures, the Affordable Care Act (ACA/Obamacare) has proven a colossal failure, having done little to stem the ever rising costs of healthcare."

Unfortunately, I feel that the article simply did not deliver on its promise. We are heading into an election cycle that is likely to prove once more that those with the least knowledge are likely to express their opinions most loudly. I am sure I am not the only California broker who has listened to the political debate with a sense of foreboding. Some of the most radical voices advocating the most extreme changes have been seeing surprising success. We can certainly use solid analysis of the results of the ACA to better educate ourselves and the public.

I have been waiting with bated breath for studies to finally start crunching the data of the previous five years. The Bureau of Labor Statistics Consumer Price Index for Medical Care (Medical CPI) is one such measure I figured would figure prominently in any analysis. Other measures include the amount of bad medical debt being discharged, the rate of uninsured showing up for emergency care, the claims data available, Medical Loss Ratio, nuanced premium analysis or any number of other statistics that must be available to people in our industry or regulators. I have been scouring the pages of the Congressional Budget Office, Office of Management and Budget, Government Accounting Office, the Center for Medicare and Medicaid Services, the policy office for Health and Human Services — all without luck. The think tanks on every side of the political aisle don't seem to be doing the quantitative analysis either. Even the most likely sources of solid data analysis like AM Best and the Kaiser Family Foundation don't seem to be doing the calculations.

If we are to fight the rampant disinformation, someone has to take up this slack. We are in the business of risk which means we are in the business of numbers. Statistical analysis is the backbone of what our industry does. I find the lack of credible measures somewhat distressing. Where are the number crunchers we need so dearly? Obamacare promised transparency, as has every politician who has spoken on the subject. Policy wonks on all sides speak about the importance of quantitative analysis. Where is it?

I certainly look forward to future articles that can help clarify exactly what is going on. I see too much risk in the rampant ignorance of some members of the general public about our industry for comfort.

—Jacob Faturechi, CIC

Aflac Survey Says Majority of Consumers Want Companies to 'Take a Stand'

The majority of U.S. consumers expect companies to actively stand up for social good, according to the 2019 Aflac Survey on Corporate Social Responsibility. The findings reflect a growing sentiment among consumers and investors for corporate America to do good.

Over three-quarters (77%) of consumers say they would be motivated to purchase a company's products or services if the company shows they are committed to making the world a better place;

73% of investors (defined as adults who own individual stocks) agree that a company's efforts to help improve society and the environment contribute positively to return on stockholder's investments.

49% of respondents said that it is very important for a company to "make the world a better place," while 37% said it is very important for a business to "make money for its shareholders."

Younger (millennial) investors put significantly more effort into researching a company's role in improving society and the environment before deciding to invest – 41% compared to Gen X (27%) or boomers (16%).

Fifty-five percent of American consumers say it's important for companies to take a stand on social and political issues, 53% of consumers also say they have stopped using the products of a company because of its public position on some issue, and 48% of investors report they have decided to not invest in a company because of its position on some issue, with 38% having actually sold shares.

A surprisingly large majority of consumers (72%) report they are willing to "forgive" a company's bad behavior, either unethical or illegal. Still, many Americans have grown cynical when it comes to judging corporate social behavior, claiming "zero tolerance" when it comes to infractions of ethical corporate codes. This "one strike club" includes 25% of consumers and 22% of investors.

New Pet Insurance Law

Pet lovers will also love California's new pet insurance law. Assembly Bill 1535 now requires pet insurers to disclose the contact information for the underwriting insurer, the agent or broker and the Department of Insurance to consumers that hold pet insurance policies. The new law aims to provide consumers with greater transparency and help streamline communication between pet owners and pet insurance carriers so that owners can get their claims handled appropriately. Makes sense!

Join NAHU at CapCon!

#BrokersMakingADifference

While conventional wisdom often assumes less policymaking in an election year, we think 2020 could continue the recent streak of proving conventional wisdom wrong. Whether it's surprise billing, prescription drug pricing or the Texas v. Azar decision, or even the possibility of expanding the 21st Century Cures Act, there is a lot to talk about in D.C. this year at Capitol Conference. We expect a fierce debate over multiple healthcare issues to carry over and continue throughout 2020. Register today and join members across the country to not only learn, but to also share with the very legislators who will be voting on these and other items that affect you and your clients daily! NAHU's CapCon is Feb 24-26. Registration and info at nahu.org. *—Patricia Griffey*

Patricia Griffey, NAHU president has been a licensed agent for over 40 years with more than 20 of those years as a group benefits General Agent. Today she is the owner of Page 1 Medicare, a subsidiary of Hailey-Campbell, Inc, and currently serves as the president of the National Association of Health Underwriters. Prior to becoming NAHU's president, she held the positions of Treasurer, vice president and president-elect on NAHU's Board of Directors.

INDUSTRY EVENTS

NAIFA Los Angeles/Society of Financial Service Professionals Award & Leadership Recognition luncheon
February 20, 11 a.m. - 2 p.m, Taix French Restaurant, 1911 Sunset Blvd., Los Angeles, CA 90026,
members (includes NAIFA, FSP, WIFS, LAAHU, NAHU, CAHU, VCAHU): $50.00, More info at naifa.org.

OCAHU 8th Annual Business Development Summit
February 28, DoubleTree by Hilton-Anaheim/Orange County
Contact: Gail James Clarke (714) 441-8951, ext.3, email: orangecountyahu@yahoo.com

The 29th Annual IEAHU Symposium
March 10, Riverside Convention Center
Email Inland Empire Association of Health Underwriters for more info: ieahu.administration@gmail.com

SIIA Self-Insured Health Plan Executive Forum
March 16-18, Charleston, SC. More info at siia.org

CAHU Women's Leadership Conference
March 25-27, JW Marriott Resort & Spa, Las Vegas. More info at cahu.org.

SIIA Mentor Connection Forum (For Younger SIIA Members)
April 6-7, The Notary Hotel, Autograph Collection, Philadelphia, PA. More info at siia.org.

SIIA Washington, DC Fly-In (Meet Your Members of Congress)
April 21-22, Washington, DC

LAAHU Annual Symposium
April 22, Skirball Center, Los Angeles. More info at laahu.org

The 16th Annual BenefitsPRO Broker Expo
May 18-20 Hilton Austin in Austin, TX. More info at benefitspro.com

SIIA National Conference & Expo
October 11-13, JW Marriott Desert Ridge Resort & Spa
Phoenix, AZ. More info at siia.org

hello,

savings · choice · simplicity

harmony

It's time for a health plan that hits all the right notes.

With UnitedHealthcare SignatureValue® Harmony, you can offer your employees lower premiums and the freedom to choose from **more than 9,200 providers and 60 primary hospitals in Los Angeles, Orange, San Bernardino, Riverside and San Diego counties.** And with our new dedicated service that helps members get their care and coverage questions answered in just one call — they may be happier, too.

UnitedHealthcare SignatureValue Harmony

Get a quote today at uhc.com/svharmony and find out how your clients can save up to 25%.*

*Based on a February 2019 comparison of other UnitedHealthcare plans within the Choice Simplified portfolio.

This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your broker or UnitedHealthcare sales representative.

Savings based on lower premiums for SignatureValue Harmony compared to other similar UnitedHealthcare plans as of 1/1/2019.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UHC of California DBA UnitedHealthcare of California or other affiliates. Administrative services provided by UnitedHealthcare Services, Inc., OptumRx, OptumHealth Care Solutions, Inc., or its affiliates. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC).

UnitedHealthcare SignatureValue Harmony is available in Los Angeles, Orange, San Bernardino, Riverside and San Diego counties.

UnitedHealthcare®

Industry Gears Up for Second Annual CAHU Women's Leadership Summit

By CERRINA JENSEN

It started as a vague idea to promote female leadership in our industry, and now – 16 months later – we are making final preparations for our second CAHU Women's Leadership Summit (WLS). Pinch me! Actually, the original trigger that planted the seed took place at a birthday dinner to celebrate Past CAHU President Stephanie Berger, during NAHU's 2018 Capitol Conference. There were a number of colleagues who attended, some arriving later once their flights arrived in DC. But the first round of attendees all received a silly little party favor gift from a clever prankster at the table. These tiny plastic men in their tiny briefs all had a name on their butt. Mine was Mitch. There was also a Brad, a Chad, and some others I don't recall.

What does this have to do with anything you ask? Where is she going with this?! Let me tell you ... These little dudes took on a life of their own. We started taking pictures of them having all sorts of adventures, and a hilarious group text thread was born. They went hiking, they went out for cocktails, they went on vacation, to the pumpkin patch, and plenty of AHU conferences. And in between our photo antics with these little toys, we'd share our challenges, frustrations, business questions and achievements with each other. And, a tribe of support and camaraderie was born. That triggered an itch to pay it forward – to share and expand this sense of sisterhood.

CAHU Women's Leadership Conference will be March 25-27 at the JW Marriott Resort & Spa in Las Vegas. More info and registration at www.cahu.org.

I started thinking about how cool it would be to host retreats of some kind to get female leaders together, and right around the same time Stephanie approached me with an idea – what if we hosted a conference focused on female leadership and empowerment? I was ecstatic that I wasn't the only one dreaming up some way to bottle what we had discovered and share it beyond our small group of lady bosses. That's what we started calling ourselves, and we also adopted the group nickname sheAHU. Korey Platt even gifted us with adorable

#sheAHU water bottles at a planning lunch after VCAHU's Dream Racer 5k in January of last year.

From the beginning, we were committed to ensuring a collaborative and inclusive approach. I remember saying in a few of our early meetings that we were not in the man-bashing lane, and everyone was thankfully on the same page without hesitation. Once we established our foundational premise, everything else fell into place so smoothly, that it almost felt like a dream. It was a lot of hard work by a lot of dedicated individuals, to be sure. There was so much to coordinate – and not a whole lot of time to do it. But folks stepped up and leaned in. We even created what we now affectionately call the Mars Squad, in homage to Dr. John Gray's 1992 bestseller, Men are From Mars, Women are From Venus. Forty of the most amazing of our male colleagues readily donated $250 to join, in a statement of support for their female counterparts. We hope they'll all return in 2020, along with additional members.

We selected the JW Marriott in Las Vegas for the first summit last April and they did such an amazing job for us that we are returning there again this year. We settled on Las Vegas due to location and ease of travel, and deliberately chose a property off The Strip to encourage our attendees to stay at the summit and engage in all the programming we prepared for them. I was deeply honored to deliver one of two keynotes, and will always remember the other during which Becky Patel of LISI stepped in front of the podium and out of her smart pumps to demonstrate that she is small, yet mighty. Yay, I thought – another shorty! We enjoyed many other talks and workshops, delivered by truly incredible women. I learned so much at the summit as a participant, and am forever grateful that I was part of something so magical.

This year's summit will be even more so. Jessica Word of Word & Brown has been instrumental in helping us land a group of female powerhouses to headline the program, and we have a great lineup of additional speakers, workshops and networking opportunities. I am so excited to attend, and so is my daughter who will be joining me this time. She saw a note about it on my social media and reached out asking if she could attend. Pinch me again! No, not really – it's just an expression, ok?

In all seriousness … if you're a female leader – or aspire to be one – don't miss this summit. We limited attendance last year to 100 but this year we have more capacity, and a hotter program. And men are welcome to attend as well. But … you WILL have to participate in all the activities – maybe even get some lashes done? Hey – we don't judge at this summit. We just encourage, learn, grow, support, laugh and play. Who's in?

My heartfelt thanks to our entire planning committee and our support village, without whom this would simply not be possible. Please visit cahu.org for more information, including registration links and cool partnership opportunities.

Cerrina Jensen is an AVP benefits consultant with CoreMark Insurance and the founder of Stellar Stories, a leadership and communication consultancy. Jensen is a longtime executive board member of CAHU, and has been honored with many local, state and national awards for her leadership and consumer advocacy. She's currently serving as CAHU's VP of Professional Development, as well as Chair of NAHU's national Chapter Leadership Development Committee. In 2018, she was appointed by Insurance Commissioner Dave Jones to the CA DOI Licensing Curriculum Board. Jensen is also past president of the Sacramento Association of Health Underwriters.

THE HISTORY OF COMMISSIONS

PART II

By PHIL CALHOUN

Part Two of the History of Commissions begins with story of hard work and survival, and then moves into an introduction on how general agencies formed and the role general agencies played to facilitate connections between carriers, general agencies, brokers and clients. Part Two follows the September 2019 article which covered the history of commissions prior to 1990. We now begin in the 1990s as we see the growing role of the broker, the demise of indemnity plans and the rise of HMO plans.

Commission driven personal stories

Most brokers from the early days of the health insurance industry moved into health from life. These earliest brokers had begun selling life insurance in the 1960s and 70s but, since health insurance was not distributed on a wide scale through independent brokers, most were unable to sell health plans. This all changed once health plans were available to sell.

At this time the majority of brokers who added health insurance to their portfolio were licensed to sell life insurance and disability. Many of these brokers had several clients, both individuals and small businesses, and when health insurance came along and carriers opened the door these brokers jumped on the opportunity to sell medical plans. Of course, brokers had clients that were a built-in prospect base to offer health insurance.

Two agents exemplified this history

Scott Dutenhoefer got his license in 1971 when hired by Fidelity Union Life insurance group where he had become a policyholder immediately upon his college graduation. Then, as Scott looked around for work, he decided to join the life insurance sales team of Fidelity, the same company where he purchased his first life policy. He worked lead lists hard and sales added up slowly as he made a good living mostly selling to college students about to graduate. Once health insurance sales opened to brokers in the 70's Scott acted quickly and got appointed with Blue Cross. Scott's timing was excellent. He continued with life sales for 10 more years and sold health policies to his life prospects. Scott built his business and was able to afford a home in Orange County, raise a family and provide for his wife and plan his future retirement. Recently Scott sold his group business and spends time on Medicare and financial planning.

Scott often led with life insurance and sold health when the prospect said no to a life policy. Most of the time Scott got two sales and made twice the commission on one client!

Don Goldmann also worked in the life industry when he first started his insurance career. Don moved into the health benefits profession after starting with life insurance. Many life agents and brokers have similar stories, centered on this opportunistic shift where carriers opened sales of health plans to the outside brokers who gave selling health insurance a try. While selling policies, Don also focused on building relationships within the health insurance industry. These relationships became a bonus for Don. About the time carriers opened the door to brokers, Don was poised to connect general agencies with carriers to access the large numbers of brokers who could sell their health plans. Initially, Don oversaw the general agency development for the MetLife medical


WORK
31

To be competitive and enroll new business efficiently, carriers decided to access independent brokers. Carriers worked through general agencies to reach large numbers of brokers. This move not only proved to be a viable method to add policy holders in the 1970's but has held true today.

HMO plans. The carriers preferred general agencies since the recruiting, contracting, training and underwriting, were outsourced. Don had great success connecting carriers with general agencies. Don knew brokers would be excited about the compensation for new and renewal commissions and foresaw this opportunity and connected several general agencies with carriers.

Don was in position to play a key role to link carriers with general agencies just as carriers began to select general agencies in the mid 1980s.

The beginning of general agencies

Many carriers entering the health plan market did not have an inside sales force capable of enrolling enough individual prospects. To be competitive and enroll new business efficiently, carriers decided to access independent brokers. Carriers worked through general agencies to reach large numbers of brokers. This move not only proved to be a viable method to add policy holders in the 1970's but has held true today. General agencies brought their values to carriers as they handled all aspects of supporting independent brokers. Carriers at this time made the move from exclusively selling through inside sales teams to working with independent brokers through general agencies. To this day the multi-level distribution channel involving carrier-general agencies-brokers remains a highly effective way to reach customers.

While other HMOs worked with brokers to sell large group plans (defined as 25 employees and up in those days), MetLife was the first to work directly with outside brokers. They paid competitive small group commissions, which gained the attention of health brokers. MetLife commissions were competitive at 20% new and 10% renewal. High commissions were needed as premiums were very low in the 1970s and 1980s and brokers needed motivation to sell. MetLife was also the first HMO to commit to distribution through the newly minted general agencies that were starting to come to market. MetLife's first three GAs included Word & Brown, Group Benefits Shoppers and AIM Marketing.

Don Goldmann helped carrier and general agencies link together to access brokers in California. His first major effort was linking MetLife with general agencies. Timing and relationships were the key for Don, along with representing the best plan available when HMOs first reached the market.

"MetLife's small group HMO plans rose to the top of the new style quoting reports that newly minted general agencies were promoting," said Goldmann. The HMO plans wanted to gain attention. So being placed on page one of the quotes, since the quotes were often organized by the size of the deductible associated with indemnity health plans, became ideal placement. Since HMOs had no deductible and were cost effective, a top placement and ranking in a general agency's quote caught everyone's attention, according to Goldmann.

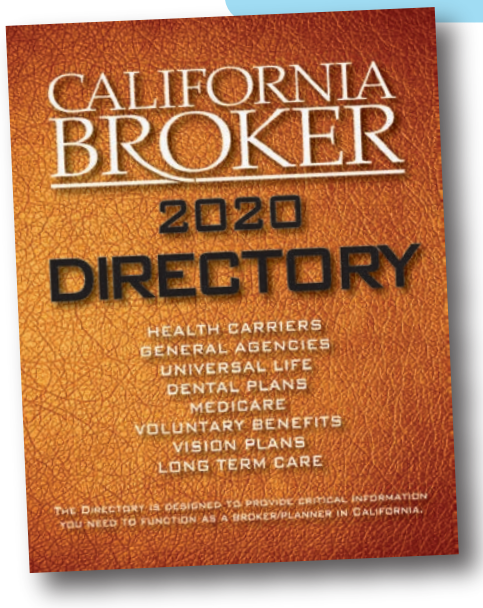
"HMOs like FHP, Kaiser, CaliforniaCare, Maxicare, General Med and eventually Health Net rose up over time to compete with MetLife. HMO plans initially had trouble competing, however, because MetLife developed significant market share and broker loyalty when they led all carriers by paying brokers healthy commissions," stated Goldmann.

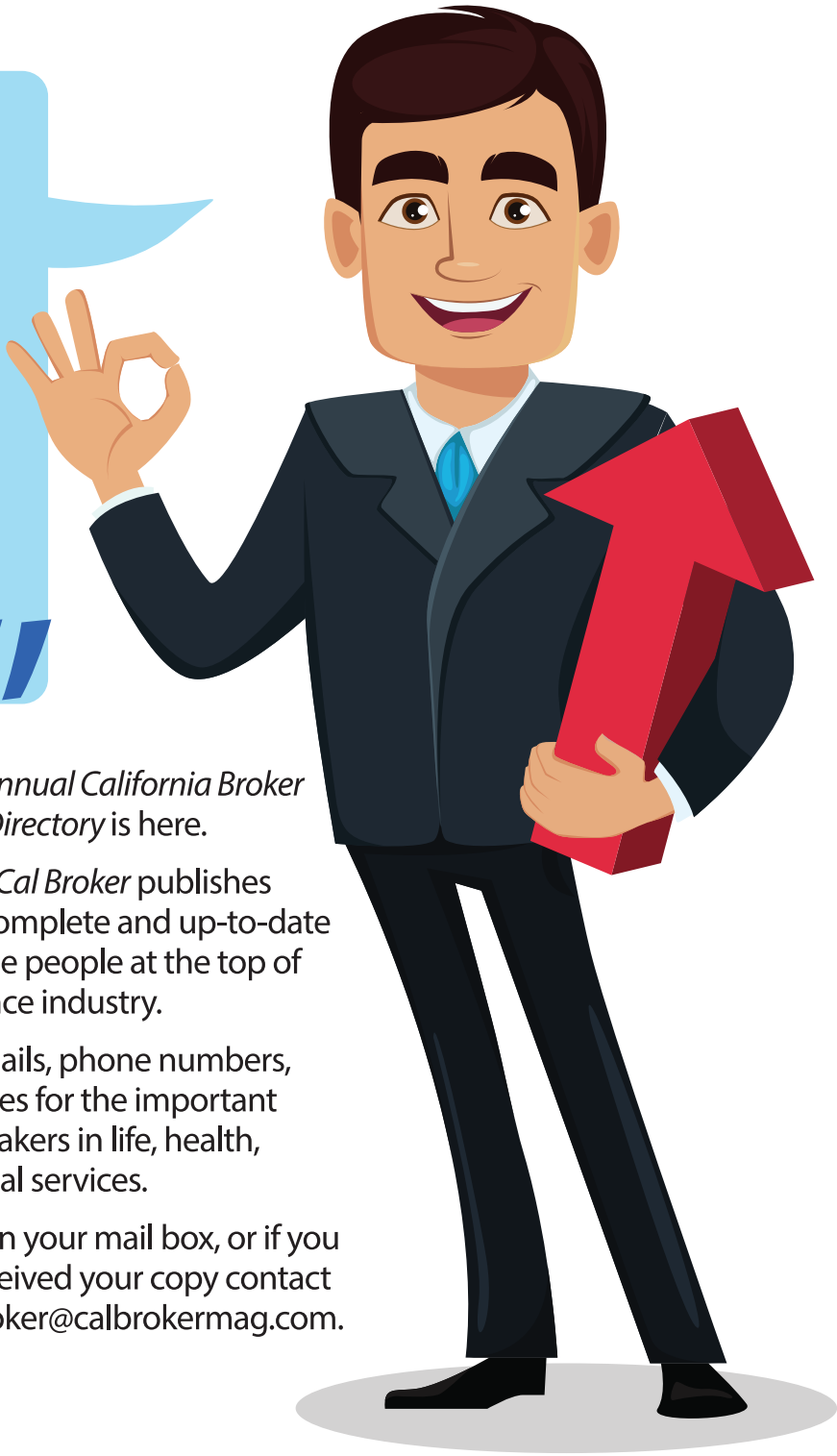
Health plan changes

During the 1990's competition on indemnity health care plans intensified when HMO plans decreased the cost of premiums. It was during this decade that indemnity premiums crossed a pricing threshold and became more expensive than almost all of the HMO plans. PPO plans came to market as a reaction to the HMO/pure indemnity pricing comparisons. PPO plans essentially gave indemnity focused carriers a new plan that was initially competitive with HMO plan premiums. During this period carriers increasingly worked with independent brokers in order to more effectively bring their plans to prospects and add market share affordably. Once again independent brokers played a key role in the marketplace as they were able to accelerate a carrier's expansion into a new market.

CALIFORNIA BROKER

"Keeping up with the industry insiders in the California insurance business can be difficult. That's why Cal Broker publishes the most complete directory of contacts for virtually everyone in life, healthcare and financial planning."





The *2020 Annual California Broker Insurance Directory* is here.

Every year *Cal Broker* publishes the most complete and up-to-date listing of the people at the top of the insurance industry.

Names, emails, phone numbers, and websites for the important decision makers in life, health, and financial services.

Look for it in your mail box, or if you haven't received your copy contact us at calbroker@calbrokermag.com.

Due to the success brokers had with sales, carriers valued both independent brokers and general agents and this distribution system became a fact of life by the late 1980s.

PPOs were popular and indemnity plans became harder to sell. As a result, PPO and HMO plans grabbed market share due to lower prices than indemnity plans which had no way to compete on cost management. Brokers helped educate consumers on why indemnity plan pricing was too high compared to other options and consumers responded with a move to more affordable PPO and HMO plans. Brokers showed decision makers why indemnity health plans were no longer competitive as they had no physician network and rich benefits and required underwriting. Brokers selling indemnity plans had to send applications in and wait for underwriting approval. Underwriting was complex and confusing, which put brokers in the position to help clients understand complex new issues like participation, preexisting conditions limitations, and coverage and charges definitions. Provider networks were not an issue with indemnity plans compared to HMO and PPO plans since indemnity plan members/policyholders could go to any doctor. Cost controls were absent as doctors were paid on a fee-for-service basis with no contracts or ceiling on how much could be billed. Eventually doctors did contract with carriers to be paid based on a "usual, customary and reasonable" standard which allowed doctors to bill, get paid a portion of their charges, and balance bill direct to the patient who was responsible to pay the remaining balance. This pricing structure did not place enough control on the cost of the care and eventually indemnity plans of this nature were priced out of the market in favor of the cost controls of PPOs and HMOs. Doctors were not pleased with the result of this change in their payment structure, but the market moved and brokers helped lead the way.

Carriers and commissions

From the beginning, Blue Cross used mostly inside sales reps when the health plans were indemnity based. The change to HMO plans moved the needle as the competition imposed by the HMO plans was the reason Blue Cross started a non-profit called Health Net as a subsidiary in 1992. This move coincided with a move by Blue Cross to "for-profit status" as Blue Cross became a public company. The public company change required Blue Cross to move its HMO business to Health Net, the new company formed for this purpose. Also at this time, Blue Cross created a new public entity called WellPoint (1992) to operate its managed care business.

Leonard Schaffer, the Blue Cross CEO during this change to a public company, was generally credited with the rapid success of WellPoint. He led the way as Blue Cross shifted sales strategies and moved to an independent broker network. During this period, carriers would often implement changes rapidly. Case in point: within a few weeks the entire Blue Cross inside sales group, which consisted of hundreds of employees, were released to sell as independent contractors. Also at this time a newly created general agency known as CIMS (California Insurance Marketing Services) became a general agency working with Blue Cross.

With one of the largest PPO networks in the state, Blue Cross' commitment to independent brokerage and general agency sales exploded opportunities for brokers. Following this lead, Blue Shield and even Kaiser embraced the value of selling through independent brokers. Again brokers benefited from carrier competition and the support of general agencies.

Carriers found independent brokers a cost effective distribution channel

Initially HMOs were sold direct to consumers through inside representatives. FHP broke the pattern in the mid-1980s and worked with independent brokers selling large group medical plans. Most HMOs followed FHP's lead. MetLife, General Med, MaxiCare and CaliforniaCare and PacificCare, along with Health Net, Blue Cross, Blue Shield and Kaiser all decided to work with independent brokers.

Due to the success brokers had with sales, carriers valued both independent brokers and general agents and this distribution system became a fact of life by the late 1980s. This system, while profitable for the brokers, was equally profitable to the carriers

Note to the wise broker: read your carrier contracts to understand the risks to commission renewals and changes in commission amounts.

as they were able to reduce selling costs. However, as could be anticipated, the growth of an ever-greater percentage of a carrier's sales through "non-employees" had a blow back effect of sorts.

Commission tension between brokers and carriers

In the late 1980s, Blue Cross was first to mandate minimum sales for brokers to keep commission renewals. Brokers with fewer sales per year than the contracted minimum required were forced to turn to the general agencies as a way to deal with this carrier pressure. This move was pursued by a few carriers as they tried to deal with ways to restrict continual commission payments to brokers and to deal with the impact of vested commissions. At this time the fear was high that other carriers would follow suit. The dynamic created by rising premiums resulted in greater payouts for brokers with commission contracts tied to a percentage of premiums. Some carriers saw the solution was to move to pay based on a per-member-per-month payment. When brokers rebelled against payment based on per member per month, the move failed.

Love and hate

While brokers enjoy bringing new plans and carriers to clients, in some cases it pays to watch out for changes. Have a Plan B to deal with those times when a carrier makes a significant change.

Brokers need to be aware and have a Plan B ready

Some painful reminders: Assurant in 2014 decided to cut commissions to 1% (from 20%/10%) after open enrollment in late 2014. Enrollment for IFP closed and when brokers received the email close to year's end they had no time to move clients.

Health Insurance Plan of California, a failed state specific choice based small group platform that began in 1994 and was conceptually similar to Cal Choice. In an effort to revive the failing program it was renamed PacAdvantage and managed by the Pacific Business Group on Health Group. It was modeled after large employer pooling concepts but allowed small employers to go direct to HIPC without a broker. If a broker was used broker fees were published. Brokers were paid less when placing business with HIPC than outside or direct to the carriers. Brokers fortunately had California Choice available with better service, support, lower premiums and fair commissions. The HIPC closed in 2006 after 13 years and who knows how much tax payer support.

One example of what can happen was PacifiCare when it pulled away from brokers. PacifiCare, not UHC, was the carrier who re-did commissions and sent brokers new contracts to modify vesting. Around 1995 PacifiCare decided to mail new broker contracts in which they could cancel vesting at any time while working to build an internal sales force.Sales from brokers dropped so fast that this move was made for one year only and then PacifiCare returned to work with brokers.

2016/2017: Individual & Family Plan compensation changes

Commission on IFP changed from 10% downward to either 1% or 2% or a flat dollar amount.

2016: Small Group compensation changes

Commissions changed from 7% to 8% downward to 5%.

Blue Cross provided notice when they pulled their individual plans out of most California markets in 2018 following UHC, Aetna and others who never entered the California market when plans turned metallic. Now in 2020, Anthem is coming back to some counties!

Note to the wise broker: read your carrier contracts to understand the risks to commission renewals and changes in commission amounts. With new carriers, check the compensation terms as vesting is often not included, giving the carrier the right to change the amount paid possibly on a retroactive basis.

Rule #1

Read your carrier agreements and understand which carriers offer options to vest and also transfer commissions. When carriers allow vesting, you generally have the option to be inactive for a period of time and

...premiums have doubled since 2013...even though commissions dropped from 7% to 5% for group, the net impact is important to consider.

still get paid.

Today commissions may or may not be comparable to the percentage of commissions in the past. This is because the guaranteed nature of the market has increased the number of possible sales and the average premium per sale has increased tremendously. One way to look at the changes in commissions over the most recent five years is to appreciate how premiums have doubled since 2013 and how, even though commissions dropped from 7% to 5% for group, the net impact is important to consider.

For group: The recent 25% drop in small group commission would be matched once three years of 8% annual premium increases happen. With the recent three year history of premium increases, we have washed out the 25% reduction.

For IFP the math is different. A drop from 10% to 1% or 2% is another story. Look for changes to this IFP commission structure as our professional associations work to build the commissions to 5%. This request, if accepted, will be due to Covered California listening to appeals and recognizing the value a broker brings to consumers.

The message to brokers is to stay involved with clients, consistently build the value of your role as a broker, and carefully pick the carriers you choose as your business partners.

Broker response

We could all write stories about how the ACA impacted us, our clients and our industry. Many brokers have shifted to sell (more) life, annuities and ancillary products since the ACA began. Medicare is a viable product line to consider as Medicare enrollments are on the increase. Since business owners, employees and friends often mirror the age of a broker, most brokers aged from 50 to 70 have added or jumped into the Medicare market with great success. With more boomers retiring, more business owners are retiring. Adding Medicare just makes sense. Commissions for MAPD have increased, which helps. Future increases will be tied to federal government increases in Medicare, which in recent years has proven to be positive. Also, Medicare supplements pay a fixed percent so brokers earn more as the policyholder gets older and premiums rise.

For the future

Current legislation in California that applies to commissions is often made available in news sources such as the John and Rusty Report or California Broker magazine. Often carriers update brokers on legal and industry changes. CAHU and NAHU, as well as your local underwriters association, provide solid commission updates pertaining to laws and bills.

The federal focus is on ACA and more changes are likely so we will see how the marketplace responds. California legislature for now is moving independent of federal efforts and sometimes in counter or opposite ways. So remember the state impact is often what broker's need to address.

Tips for all producers/brokers

John Evangelista started his own agency in 1997 and has consistently added clients over the past 22 years to reach a solid base of both group and individual clients. Often agents find that large cases can result in substantial boosts in revenue. John knows what it takes to build

The message to brokers is to stay involved with clients, consistently build the value of your role as a broker, and carefully pick the carriers you choose as your business partners.

a consistent income and commission stream. He suggests producers review their business development plans to incorporate these tips:

TIP #1

Join a professional association to learn, network and avoid repeating mistakes. Find a subset of colleagues and gather to share knowledge and connections to help one another.

TIP #2

Prioritize educating yourself on health benefits before studying the nuances of other insurances such as annuities or life.

TIP #3

Remember we are in a relationship business. Pick partners who over time can help you be more successful. Build and work on these relationships by making friends. Maximize client relationships with referrals. Lean on general agencies for technical support and choose insurance partners who can help you meet more client needs.

TIP #4

Understand the competition. Some individuals and companies are your friends; others are your competition. Screen ancillary brokers and payroll companies. Even CPAs can be licensed and take business away from you. If you refer to a professional and they do not reciprocate, they likely have a health broker referral relationship so confirm and move on.

TIP #5

Know your bread and butter. Develop and become a specialist in one health insurance product line at a time. You do not need to know Property & Casualty (P&C) if you have a trusted P&C broker relationship. The same goes for other lines of insurance.

TIP #6

Finally, follow legislation and get involved in your industry. Seeing the wave before it hits can boost you and your business. Looking back, HSAs were a boost for early adopters. Cal Choice similarly opened doors and led to an increase in business. What will be the next early adopter employee benefit plan or program that could bolster your business?

Last thought: succession

Once you build your commissions to a point, all of your work is at risk without a plan to protect your commissions. Even a younger broker needs a successor who can step in to protect their commissions in a life event, as carriers will stop paying based on loss of certification or licensure. A handshake or verbal agreement with a successor broker is not enough. A formal agreement with a broker colleague is the best practice to keep commissions coming and paid as desired. For health brokers, a written agreement often called a "commission protection plan" is best. David Ethington, 33, started 8 years ago in the health insurance industry. Today David is part of a team that works to protect commissions for brokers.

"All brokers need a successor broker to protect their commissions in a life event," states Ethington. After he helped grow agency revenues with his colleagues on a base of group, Medicare and IFP, David realized aging brokers needed help to protect their commissions to prepare for unexpected events.

"For a broker who wants to sell their commissions, our team can help them," says Ethington. "For brokers who want to stay active but have no formal commission protection, our successor program is a solid solution for active brokers to implement." His company website has information on how to protect commissions, including a growing library of videos and a handbook on the topic.

Phil Calhoun, president, Integrity Advisors is the author of The Brokers Guide: "How to Protect, Grow and Sell Health Commissions," available in early 2020. Phil can be reached at 714-612-0306 or phil@integrity-advisors.com

Special thanks to:
David Ethington, *broker advisor. David can be reached at david@integrity-advisors.com or 800-500-9799. Website: https://commission.solutions/*
Scott Dutenhoefer, *active California broker since 1970. Scott can be reached at srdclu@gmail.com.*
John Evangelista, *district general agent, Colonial Life. John can be reached at john.evangelista@coloniallifesales.com*

Employers that have complete unrestricted access to their claims data, facility/provider cost and quality information, disease management reports, pharmaceutical data, and direct-contracting capabilities will be the best equipped to make smart decisions and mitigate costs on the fly.

WHAT'S COMING IN 2020 FOR ENTERPRISE AND LARGE GROUP HEALTHCARE PURCHASING

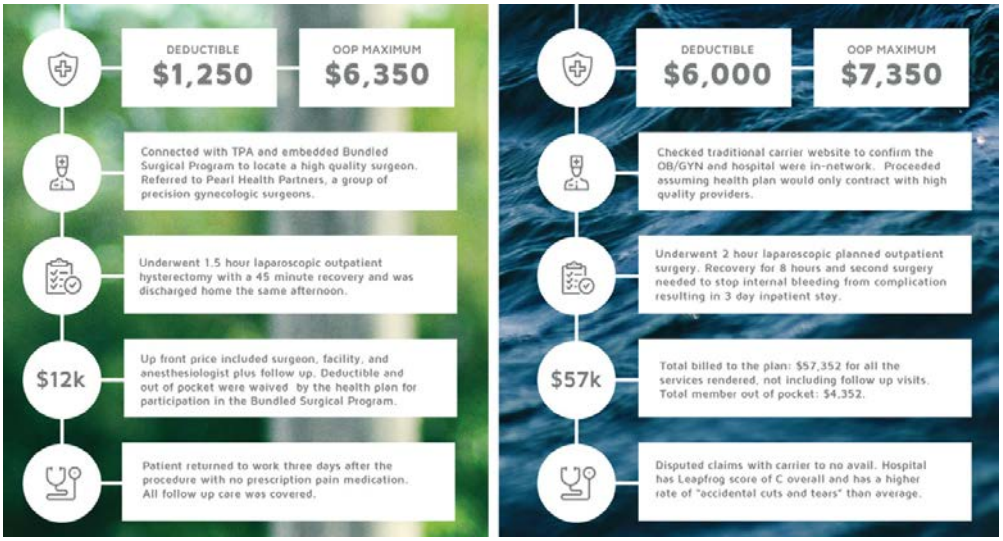
BY DANIEL CORLISS

There have been many shifts in the way mid-market to large health plans all over the country are purchasing healthcare in recent years. Change is certain to continue, even more so here in California. Employers in the state have seen very little evolution away from the traditional carrier financing model toward other financing options such as self-funding and level-funded products. But just like the San Andreas fault – that is also shifting.

Employers in California are already very heavily considering Administrative Services Only (ASO) and level-funded products as the "cutting edge" of plan design, allowing more control over increasing healthcare spend. Carriers such as Cigna and Premera who have a very strong presence in the Southern California market have already been marketing these solutions heavily, due to strong shifts in interest and demand. However, in an ASO model, a carrier is still able to dictate their network usage, along with the accompanying ambiguous discounts which still promote overspending and blindfolding. With their level-funded products, carriers are still able to retain significant premium dollars via the excess claim fund, along with the same accompanying network detriment. Employers will begin to catch on to these "smoke and mirror" tactics and naturally move even further away from carrier products. So, here are my predictions on continued health and benefits trends for enterprise and large employers as we go deeper into 2020.

ASO and level-funded products will gain steam – but only as an evolutionary fad

These are very hot products right now in the California market – but for the same reasons I mentioned in my opening statements, these will be part of a continued evolution away from carriers and toward true self-funding with independent TPAs and transparent plan partners. If you do not have complete transparency and control over your health plan, you are not in a truly self-funded plan arrangement. Employers that have complete unrestricted access to their claims data, facility/provider cost and quality information, disease management reports, pharmaceutical data, and direct-contracting capabilities will be the best equipped to make smart decisions and mitigate costs on the fly. Cost containment requires being fast and informed. You just can't do that properly with red tape and a blindfold over the eyes.



Above are 35-year old females with 2 kids and almost identical medical history. On the left, she was participating in a self-funded employer health plan with carved out, bundled surgery at a high-quality, low-cost facility. The woman on the right is with an employer carrier network health plan.

Value/reference-based pricing is here

Reduced-network and no-network health plans that utilize claim repricing methodology have taken the country by storm over the last five years, with continued rapid growth year-over-year. Health plans that use great reference-based pricing (RBP) / value-based pricing (VBP) vendors are seeing very little pushback from facilities and providers (less than 2% of membership). That along with up to 50% savings on total health plan spend the first year of implementation, without cutting or reducing benefits. A good RBP/VBP vendor doesn't just reprice claims at a multiple of Medicare or cost, as most people think. They negotiate fair and sustainable rates with facilities and providers that both parties can agree to. Then they put direct-contracts in place that benefit the entire community. They work as advocates on behalf of the plan and plan members to make sure that balance billing and collection attempts are stifled and resolved quickly. They also work as bill-review specialists to prevent fraudulent billing, upcoding and duplicate billing. This type of arrangement works very well to contain costs and increase convenience if done properly with the right plan partners put into play. It's going to be a game changer in the California market for 2020 and beyond.

Technology will continue to evolve

HRIS systems and benefits/enrollment platforms were the last big thing to hit our industry. If you're still using paper forms to track eligibility, census data and enrollments then you are back in the Stone Age. Many employers are looking ahead by leveraging predictive population health and outcomes data to mitigate member risk and costs. This is valuable information that allows employers and plan partners to deploy internal initiatives to promote happier, healthier lifestyles. Where we are starting to see even more truly transformative leaps in technology is in fully integrated employer platforms. These blend claims, eligibility and enrollment visibility and usage, along with full vendor and plan partner marketplaces. Plan members or administrators can log in and check real-time claims data and utilization, out-of-pocket costs and deductibles, search for an EOB, or enroll a newborn child. They can also get direct access to their telehealth vendor, see a list of their network providers, and inquire about a bundled total knee arthroplasty (TKA) surgery with their contracted surgical specialists. Platforms like these provide great transparency and steerage that save both the plan and plan members time and money. They also provide immense convenience and reduced bandwidth from the HR team. We will see continued innovation and demand here in 2020.

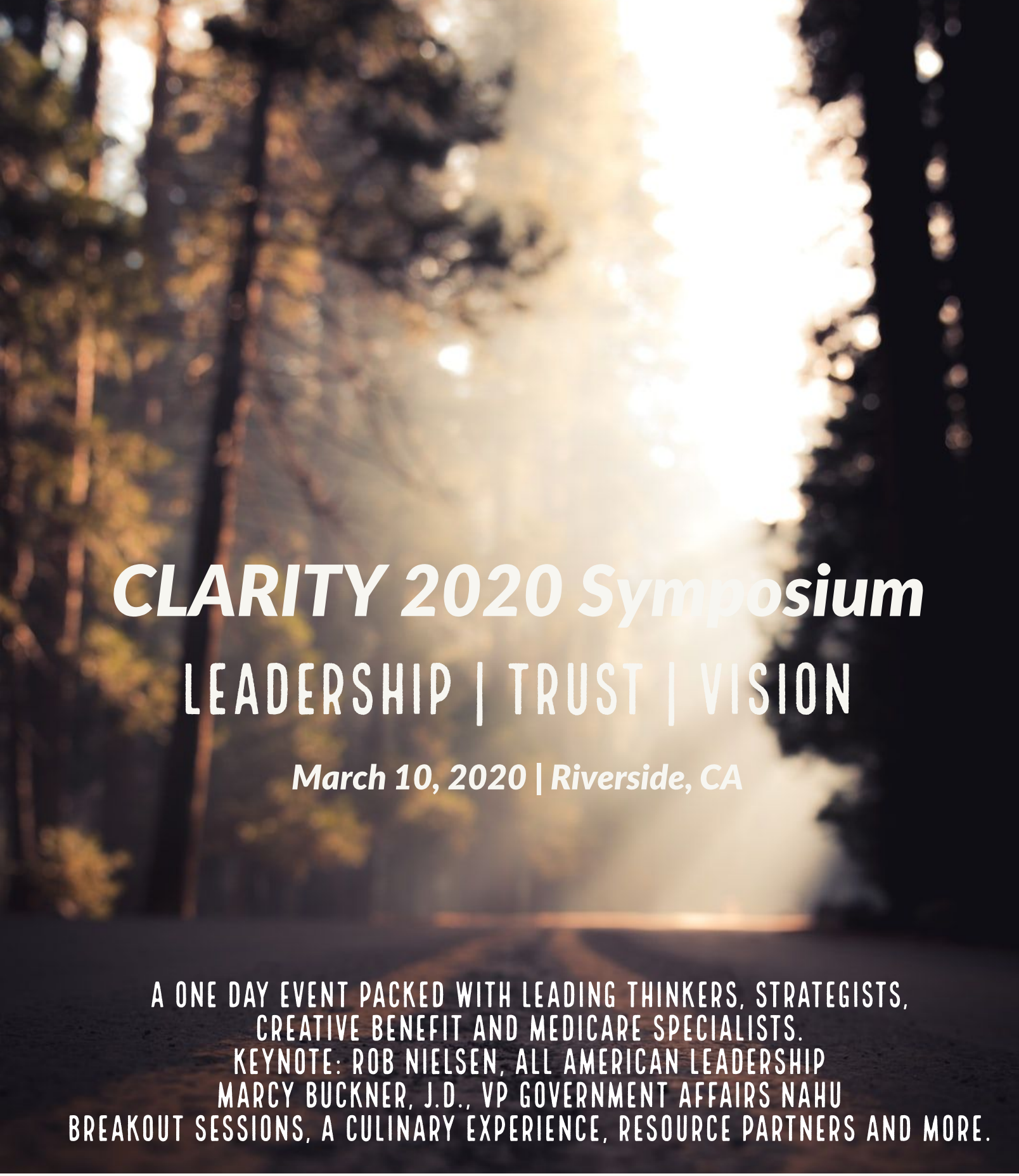
Expect to see continued expansion of bundled surgical and medical tourism

As we all know, rising healthcare costs are unsustainable for employers and plan members. Where it really hurts the most is on high dollar claims that are elective and predictable, because those are savings that should be controlled and achieved. Direct contracting with high quality facilities and providers at a relatively lower costs than average carrier reimbursements can net a plan huge savings. The chart shown above is a perfect example of a case study outlining this. Both of the examples above are 35-year old females with two kids and almost identical medical history.

This is just one of the many examples of how smart employers can provide high-quality, low-cost options for their plan members that produce better outcomes, added convenience, and incentivized cost control through waived out-of-pocket costs and covered travel expenses. Expect this trend to continue in 2020 as we continue to see more transparent cost, quality and outcomes data by physician, facility and procedure.

I think we will continue to see even more trends that are facets of the self-funding model continue to improve and grow in 2020 here in California.

Daniel Corliss is large group health and benefit plan advisor at DC Advisory LLC.



CLARITY 2020 Symposium

LEADERSHIP | TRUST | VISION

March 10, 2020 | Riverside, CA

A ONE DAY EVENT PACKED WITH LEADING THINKERS, STRATEGISTS,
CREATIVE BENEFIT AND MEDICARE SPECIALISTS.
KEYNOTE: ROB NIELSEN, ALL AMERICAN LEADERSHIP
MARCY BUCKNER, J.D., VP GOVERNMENT AFFAIRS NAHU
BREAKOUT SESSIONS, A CULINARY EXPERIENCE, RESOURCE PARTNERS AND MORE.

IEAHU
INLAND EMPIRE ASSOCIATION OF HEALTH UNDERWRITERS

NAHU
National Association of Health Underwriters

HTTPS://GUESTLIST.CO/EVENTS/630966
866.922.8387
IEAHU.NET

POWERFUL PRES
FOR YOUR AUDIENCE'S SAKE
PART I

BY ALAN KATZ

Do you give speeches? Maybe at carrier or GA product seminars? Or at association events? Do you use seminar marketing? If so, you probably use PowerPoint (or its Mac cousin, Keynote) an- This article is addressed to you.

It's written for your audience, however. Because sitting through presentations with lousy slides can be painful.

PowerPoint can turn an interesting speech into nap time. This isn't the software's fault. Like splitting the atom, presentation software can be used for good or evil. Slides can generate tremendous energy or radioactive tedium. If you use slides, for your audience's sake, please use them wisely.

It's about you

I've sat through hundreds of presentations. And I've given hundreds, too. This doesn't make me an expert on them, but it makes me experienced. Plus, I've spent time researching what makes good slides. In this article (about content) and next month's (on design), I thought I'd share some of what I've learned. Full disclosure: I may not always follow these rules myself, but I know I should.

In reading this advice, please remember that YOU are the presentation. The audience wants to hear you talk about your products and services. Otherwise they could stay home and read brochures.

Slides can help you deliver your message, but they are not the focus of your presentation. They can provide context and underscore key points. They should never distract. Slides should be something your audience glances at, quickly comprehends, and then returns their rapt attention to you.

Don't read them. Your slides are not a script. That's what notes are for. Reading your slides is a crime against humanity, at least the slice of humanity sitting in front of you. There's a place in hell reserved for slide readers, right next to those who talk during movies and recline their seats on airplanes.

Your audience can read silently faster than you can read out loud. Once an audience sees you reading slides, you've lost them. They'll read the slides for themselves. And then they'll check their email.

There is an exception to this "no reading" rule. If you're not reading every slide, when you do read one it can capture the audience's attention in a very powerful way. I make use of this exception during talks based on my book, *Trailblazed: Proven Paths to Sales Success*. During that presentation I define sales professionalism. An agent surveyed for the book did a great job of describing the term. My slide shows his entire quote and I read it. As a result, the definition stands out. Because it stands out, the definition is more memorable. Use restraint when applying this exception, however. Read more than a few slides, and it's back to the emails.

Slides aren't handouts. As noted, slides can provide context and emphasis. However, what if you want to use the slides as something your audience can take with them to keep your message fresh?

Don't. That's not what slides are for. Flyers and brochures are for handing out. Links to articles and blog posts are for sharing. Slides are for supporting your presentation. Use the right tool for the right job. This requires a bit more effort on your part, but you'll be much more effective as a result.

Sentences are unnecessary. You should talk in complete sentences. Your slides don't have to. The audience should be able to glance at the slide, glean its meaning and return their attention to you (the star of the show).

ENTATIONS

This makes complete sentences counterproductive, with a few exceptions. For example, if you're quoting someone, you want may need to provide the entire quote. Although there's a reason they invented ellipses.

At first you may find it uncomfortable to not use complete sentences on your slides. Sentences can be reassuring. They tell you what to say. But you'll also be tempted to read them. And that, as we've discussed, is unacceptable.

Phrases are friends. They too can remind you what to say. And they're easier for your audience to read. Sometimes just a word or two can be powerful. In my healthcare reform presentation, I explain why brokers should not worry too much about proposals like Medicare for All. I could write out the reasons in cogent sentences. But that would transfer attention from me to the slides.

Instead, I explain the reasons and borrow a couple of reassuring words from Douglas Adams' *The Hitchhiker's Guide to the Galaxy*. "Don't Panic." That's all the slide contains, two words: "Don't Panic." This not only underscores my message, it's somewhat comforting.

Words can be unnecessary. Sometimes you don't need any words. Instead of telling your audience something, you can show them. Discussing what's happening in Washington, D.C.? A picture of the Capitol or the White House provides context. Talking about impending danger from bad policy making? Use a picture of a tidal wave or an avalanche to underscore your message.

Pictures can also add a bit of humor to your message without distracting from what you're saying. For example, when talking about what's happening in Washington, D.C., use the avalanche picture. Your audience will get the point. They may even chuckle.

Finding the right picture is easy. Free images can be found on the web and stock photos are available for very little cost. It's worth taking some time to search for the right "thousand words" picture.

Graphs can be effective, too. Just make sure you attribute them and that they can be read in the back of the room. If you have to apologize for how small the graph is, don't use it.

Title and closing slide tips. You're most likely being introduced before you approach the podium. A title slide with your topic and your name is good to have on the screen during this time. If it also includes your company's name and logo, even better (more on logos next month).

And there's no need for a slide at the end that reads "Questions?" You'll tell your audience when it's time for questions. Instead, your last slide should be a near duplicate of the title slide. This end slide, however, should include your contact information. After all, they came to hear you. Use this slide to help them follow-up with you.

Your slides need to have the right context. They also need to be legible. That's where good design can help. And that's next month's topic.

Alan Katz is one of Cal Broker's 2020 editorial advisors. He'll be writing monthly about marketing and sales growth as well as health care reform. Katz is a co-founder of Take 44, Inc., the company behind NextAgency, an agency management system for life and health agencies. He is a past president of NAHU, was an SVP at WellPoint and general manager of the general agency Centerstone. Katz also served as chief of staff to California's Lieutenant Governor and on the Santa Monica City Council. You can follow him on Twitter (@AlanSKatz) and contact him at Alan@Take44.com.

BOOSTING EMPLOYEE BENEFITS WITH LEGAL AND IDENTITY THEFT PLANS

BY EMILY B. ROSE

In the last decade, the competitiveness of the job market has increased with recent college graduates entering the workforce and tenured employees pushing back retirement. This trend has employers searching for unique ways to attract and retain talent. In addition to health benefits, employers seek to provide emotional and financial support benefits. This, coupled with employee's desire for additional financial wellness benefits, causes benefit managers to focus on the addition of voluntary benefits, such as legal and identity theft protection plans, in their employee benefit packages.

A robust plan and affordable price are critical components to a voluntary benefit package that is valuable to both employees and employers. Employees have become more knowledgeable about what constitutes a "good" benefits package and as a result, are demanding comprehensive benefit packages, especially those that contain financial wellness benefits. It is not surprising then that employees are raising their hand for legal and identity theft protection plans and with more frequency, employers are implementing these plans in direct response to employee feedback.

As an industry leader and pioneer in the legal and identity theft plan space, I believe we can do more as a benefit partner to boost benefit offerings and make them valuable to all employees, not just those enrolling during a defined open enrollment period. Technological advancements – from benefit portals to mobile apps – have changed the service delivery model of benefits. Due to these advancements, we can now deliver a robust value-add benefit to employees who elect coverage while still providing employees considering their benefit options a way to "kick the tires" to ensure they are making an informed decision.

Providing additional tools as part of the benefit adds value in surprising way to an employer's benefits package. By offering "freemium" features and leveraging the "try before you buy" concept, employees can access select plan benefits without enrolling. For example, with our LegalShield plan we provide access to free legal forms. By using our Artificial Intelligence chat bot "Ask Erin," employees receive answers to common legal questions. These specific benefits provide support regardless of whether the employee enrolls in the full benefit and increases long-term engagement and overall enrollment. LegalShield's cutting-edge technology is another way employers can lean on their benefit partners to encourage employees to obtain the help they need while reducing presenteeism (working while sick) and increasing employee satisfaction.

In an article published last year, I touched on financial burdens faced by today's workforce, especially residents of Los Angeles and the San Francisco Bay area.

Renters in these locales spend more than 30% of their income on rent. As one might imagine, this financial burden may lead to credit card debt, bad credit and even bankruptcy. By providing direct and quick access to an attorney who can navigate the steps of the debt collection process, a sound legal protection plan can help mitigate or even avoid

Working with a benefit partner that provides the necessary tools to educate a multi-generational workforce while simultaneously providing a benefit that will promote user engagement is a win-win for employers and employees.

the catastrophic outcome of a bankruptcy. At the touch of a button via our mobile app or our chat bot "Erin," employees now have quick and convenient access to legal services like never before.

With housing prices and rent rising and debt such as student loans becoming a common burden for many employees, financial stability is a must across all generations. Legal and identity theft plans work in concert to assist employees with achieving financial freedom. For example, when buying a home, it is imperative to maximize one's credit score. With IDShield, our identity theft plan, participants can track their monthly credit score and obtain helpful tips to improve this critical number. These tools provide employees a valuable way to evaluate credit health and proactively manage financial planning. If a credit matter evolves into a debt collection issue or even a simple negotiation with a creditor, convenient access to our attorneys through our mobile app helps minimize stress and leads to a faster resolution. A legal plan can provide further financial stability by helping participants with purchase and sales agreements as well as real estate closings. Beyond real estate, participants can ensure continued financial security through estate planning and continued monitoring of financial accounts. By utilizing our mobile apps, participants can start preparing their estate plan with a convenient will questionnaire. They also have quick access to financial account monitoring updates.

However, just adding a legal or identity theft protection plan to a benefits package is not enough. Reinforcing the value of the benefits offered throughout the year while providing engaging content is critical to a successful enrollment and on-going participant satisfaction. Working with a benefit partner that provides the necessary tools to educate a multi-generational workforce while simultaneously providing a benefit that will promote user engagement is a win-win for employers and employees.

Not so long ago, benefits were only accessible via a member portal. But in today's era of instant gratification, benefits need to be delivered in new and innovative ways. Benefit plans that can be accessed by mobile apps typically experience an overall increase in user engagement and positive affirmation with the benefit and the employer. With this in mind, we have created intuitive, user-friendly and content rich mobile apps that expand the employee's experience beyond the traditional "only when you need it" approach. Nearly 1.5 million people have downloaded our mobile apps with tremendous satisfaction and consistently high ratings. From quick speeding ticket resolution to identity theft restoration, we engage with employees and enrich the user experience on a more fundamental basis than a traditional mobile app would allow. We are committed to engaging employees by the use of cutting-edge technology to ensure a value-rich mobile app experience.

Thanks to mobile apps, legal and identity theft protection plans are more impactful because of direct integration into our daily lives. They can be a huge resource because life happens and things get complicated from time to time. But most importantly, they protect employees and their respective financial wellness. These benefits cross the generational divide, truly bridge the financial gap and serve the needs of employers and employees. Voluntary benefits not only help protect participants' legal rights and personal identity, but also improve financial health and boost an employer's suite of benefits. Yes, the financial savings are great, but the peace of mind is unrivaled.

Emily B. Rose is the SVP of sales for LegalShield's Business Solutions Division. Rose has more than 15 years of experience in the voluntary benefits space, including group legal plans, identity theft protection plans, supplemental health and property and casualty. Prior to joining the LegalShield team, she specialized in national account sales in MetLife's Voluntary Benefit Sales Division.

TRANSPARENCY IN HOW TO OVERCOME FOUR COMMON PAIN POINTS

BY JESSECA OSCAR

As head of Human Resources for an organization that is in the business of healthcare benefits, I see every day how important healthcare transparency is for employees. I expect it will become an even bigger topic since President Trump signed an executive order in June 2019, directing hospitals to tell patients upfront what they can expect to pay for treatment.

That's a major move in transparency. Healthcare and insurance companies have a lot of work ahead to implement this mandate. In the meantime, I think we can expect even more discussions on what transparency means for employers offering group benefits, and the employees with those benefits.

Fortunately, one of those discussions should be simple. Vision benefit companies are making significant strides in transparency (pun intended!) to make vision an understandable health benefit – one that encourages employee use and drives member satisfaction.

That's certainly good news, but you may be wondering what transparency in vision benefits looks like – and why it matters.

Why health benefit transparency matters

The key to using benefits is understanding them. And understanding benefits starts with clear, concise communication. But, research shows that doesn't happen as often as it should. Approximately one half of all employees don't understand their benefit materials, and only 4% of Americans can define basic benefit terms like "copay," "deductibles" and "coinsurance."

As Hub International's Employee Benefits Barometer 2018 report points out, employers' number two benefit priority after managing costs is helping "employees make more informed decisions when it comes to choosing and using their benefits."

With an ancillary benefit like vision, understanding and transparency may matter even more because most employees are making a conscious choice to add vision to their benefit package, often paying the entire cost of the benefit.

Using vision benefits can result in significant savings compared to retail prices on eye exams, eyewear, lenses and more, but those vision purchases generally have out-of-pocket

VISION BENEFITS

costs for the employee. Employees need to understand how this works, and the key to driving employee understanding and benefit use is driving employer understanding. Brokers can have a vital role to play in that process.

Embracing transparency: the gains and pains

When vision benefits are transparent, the resulting gains can be impressive. In addition to higher enrollment in a cost-effective preventive benefit and healthier employees, there's the potential for improved productivity thanks to vision care. Slight vision issues can decrease productivity by 20% without the employee even being aware of the problem.

Another plus is potentially smoother discussions come renewal time. No broker wants to spend precious time with a client discussing pains caused by a vision plan.

Because EyeMed has spent years fine-tuning an easy and transparent benefits experience, we've learned how to help employees understand their benefit. We've also identified a few pain points along the way that your benefit vendors can help you address for clients and members. Here are four of those pain points and solutions to look for.

Pain point #1: Complex benefits and limitations

Confusion with vision benefits can occur around what's included, at what frequency, and how benefits and discounts are applied. Employees want to focus on what they can do to improve their vision, not on navigating rules and limitations that might prevent them from getting the care and eyewear they want and need. These may even reduce their satisfaction with the benefit.

For example, rather than complex formularies and restricted product selection, EyeMed takes a simple approach to vision benefits, providing a "free-to-choose" model for the member on products, as well as retail-based pricing on all products and services. It's a consumer-friendly approach that's easy for members to understand, letting them better anticipate their out-of-pocket costs and leading to a positive and confident eyewear shopping experience.

Look for carriers truly focused on transparency to kick off strong member engagement with a variety of educational materials and toolkits to help employees understand the benefit at all stages, from decision-making to benefit use.

Pain point #2: Lack of engagement during enrollment

Look for carriers truly focused on transparency to kick off strong member engagement with a variety of educational materials and toolkits to help employees understand the benefit at all stages, from decision-making to benefit use. This increases engagement – and not coincidentally, can increase enrollment as well – a good outcome.

Some carriers will even send experts to qualifying benefits events to help walk employees through decision-making tools, explain how the benefit works, review local in-network options and more.

Pain point #3: Uncertainty on how to use and maximize the benefit

Once the excitement of enrollment has settled, members will use their vision benefits after they become effective, which could be many months later. Here the real test begins. You want members to experience benefits that are simple to use, with easily accessible resources in multiple formats across multiple delivery channels.

It's particularly crucial that those resources be accessible across many platforms. In EyeMed's case, we offer:

- Welcome packets mailed to newly enrolled subscribers including ID cards
- A customer care center that's open for calls 7 days a week, with extended hours
- Online access to an advanced provider search tool, interactive education tools and special offers that can help members maximize their benefit further
- A members' mobile app to get benefit information on the go
- Ongoing education in a variety of formats – including opt-in text alerts, e-newsletters and more

You'll know the resources and communications have been successful when utilization is up and members are using in-network providers. These can be key indicators that members understand their benefits and the value they deliver.

Pain point #4: Surprise costs with benefit use

The last thing anyone wants is to get a bill with additional "surprise" costs – which takes me back to where I started. EyeMed believes that in vision benefits, "no surprises" means fixed pricing on options, with benefits spelled out upfront (both in-network and out-of-network). A cost estimator tool for members can also be hugely helpful in avoiding surprises.

Thanks to the Affordable Care Act (ACA), cost estimators are becoming more prevalent. Forty-five states have included such a tool in their ACA implementation.

I'm excited about EyeMed's online cost estimator tool called "Know Before You Go" now available to nearly all clients. It lets members view ahead of time an online menu of available eye care services and products, and then see the anticipated out-of-pocket cost. In my world as an HR leader looking for ways to provide a great benefits experience to employees, I'm thrilled that we can help other HR teams and make a difference in benefits transparency.

Expect vision to lead the way in transparency and engagement

I anticipate ancillary benefits carriers and medical insurers will pioneer and perfect more transparency initiatives that improve the member experience. But for now, I encourage you to demand and expect maximum transparency from your ancillary carriers—including your vision carrier—so employees can see all things clearly when enrolling and using their benefits.

I invite you to visit eyemed.com and select "Broker Resources" to learn more about EyeMed vision benefits.

Jesseca Oscar is the head of human resources for EyeMed Vision Care. As a 16-year veteran in the profession, Jesseca has broad experience and a passion for all things HR, from strategy and planning to recruiting, talent management and benefits, and employee and labor relations. Prior to EyeMed, Jessica was director of HR client services at Cincinnati Bell. She earned her B.S.B.A. with a focus on marketing from the Fisher College of Business at The Ohio State University.

OCAHU BUSINESS DEVELOPMENT SUMMIT

TODAY'S VISION:
TOMORROW'S REALITY
2020

FRI FEB 28
7:30AM - 3:30PM

DOUBLETREE BY
HILTON HOTEL ANAHEIM
100 THE CITY DRIVE
ORANGE CA 92868

MEMBER-$40
NON-MEMBER: $50

CE'S • KEYNOTE SPEAKER • EXHIBITS • BREAKFAST & LUNCH • HAPPY HOUR • PRIZES

ORANGECOUNTYAHU@YAHOO.COM
PHONE: (714) 441.8951 EXT. 3
WEB: OCAHU.ORG

OCAHU
Orange County Association of Health Underwriters

2020 VOLUNTARY BENEFITS SURVEY

PART 2

COMPILED BY THORA MADDEN

As part of our series of carrier surveys, Cal Broker reached out to some of the major players in voluntary benefits. They were happy to fill us in on what's happening in their worlds. In fact, we had so much info we had to break the survey responses into two parts. Last month we published part one. Here's part two. Read the complete survey and responses online at calbrokermag.com.

14. How do you track the quality of the customer service you provide to employers? For example, do you set annual service goals and measure and report results?

Rich Williams, Aflac:

Aflac constantly measures our customer satisfaction level with policyholders and business accounts in a variety of ways, such as surveys and audits, to ensure we are meeting our established customer service goals and standards. We monitor satisfaction with the total Aflac experience as well as satisfaction with enrollment, claims and billing. Aflac's customer service quality program is administered by our Quality Assurance department. Each major business function is sampled monthly. Additionally, for quality scoring, a minimum of five audits per month for each customer service center representative are guaranteed. All scoring and error trending are reported weekly, monthly and quarterly to management. Aflac's Internal Audit department also conducts audits by line of business in addition to their annual assessment of internal claims controls.

Michael Payton, California Choice:

Yes, we measure and track both production and call metrics on a daily, monthly, and quarterly basis, to ensure we are delivering quality, timely service to our broker, employer, and member customers.

Steven Johnson, Colonial Life:

Colonial Life provides superior customer service to all of its customer groups: brokers, employers and policyholders. The company sets internal annual customer service goals and results are measured quarterly. Colonial Life also works with independent research firms to conduct ongoing surveys of plan administrators and policyholders and reports those results externally through news releases. In addition, all employees who have an interaction with a Colonial Life benefits counselor are asked to rate their one-to-one benefit counseling experience following their enrollment. Every account participating in the post-enrollment survey receives a report card with the survey results. Our benefits counselors are highly rated by employees. 97% who have had a counseling session with a Colonial Life counselor say their understanding about their benefits with their employer have increased.

Brian Sullivan, Humana:

Yes, to ensure consistent, quality customer service for our clients, Humana sets annual service goals for our Customer Care department. Performance goals are achieved by leveraging Customer Care teams and their skill-based training across all accounts. Humana utilizes Customer Care specialists dedicated to providing quality, timely service to all callers.

Humana's mission is to foster a culture of customer service that is empathetic, proactive, conclusive, and encourages every one of our associates to seek ways to improve our service.

Our Customer Care team's structure is designed to optimize supervisor/specialist interaction and includes a Resource team, which handles call escalation, monitors quality control and escalation analysis, and serves as an information source for Customer Care associates. In addition, the dedicated Training and Communications team oversees all training and promotes proactive communication efforts to Customer Care associates.

Humana's mission is to foster a culture of customer service that is empathetic, proactive, conclusive, and encourages every one of our associates to seek ways to improve our service. With this mission in mind, we monitor customer satisfaction in a number of ways.

Humana implemented the Voice of the Customer (VOC) program, which is a client-focused tool that provides a random, outbound, automated phone survey to our members. VOC surveys are conducted daily and give us an opportunity to listen to members and gauge their experience with Humana. Through VOC, randomly selected members are asked questions about their experience after their call with one of our Customer Care specialists. A group's members can voluntarily elect to take the survey. VOC provides detailed survey results, which are calculated with representative-level, team-level, service center-level, and corporate-level reporting. We use these results to coach our associates, provide feedback to our Customer Care teams, and to conduct direct member outreach to ensure satisfaction as necessary.

Humana also administers a customer satisfaction survey by email to a group's members. Those surveyed include all group members, excluding those with contract-mandated "do not contact" blocks or those who have not provided email addresses. Each member is invited once annually to participate. The survey addresses member satisfaction and overall Humana performance on a five-point scale.

In addition, we are willing to perform a group-specific member satisfaction survey funded by the group. Pricing is discussed at the time of the request based on the scope of the survey. We utilize a third party vendor to conduct the survey, collect the data, and run the analysis. Our research consultant monitors and guides the process along.

Mike Schell, MESVision:

MESVision performs member and provider surveys on a quarterly basis and reports to our brokers and employer groups our survey results.

Tim Jander, Metlife:

We have always viewed the delivery of high quality customer service as a key element in our partnership with our customers. Our Voice of the Customer Satisfaction Survey program ensures that we solicit input from our customers and their employees and implement changes to improve the process when and where necessary.

Research firm, Radius Global, conducts annual Client Service and Implementation surveys on our behalf for our group customers. The surveys are conducted to measure satisfaction with various aspects of our service and to evaluate the overall relationship between customers and their Client Service Team and to help assess our performance during the implementation process within 60 days of the effective date.

Upon request, we can provide utilization reporting to group customers. Each voluntary product has a set of service goals and performance standards. Whether we provide performance guarantees with a percentage of premium at risk depends on the customer-specifics and which products are sold.

Scott Boore, MORE Health:

We send surveys to all members that have activated service. Feedback is analyzed for improvement areas. Goals are monitored and tracked.

Steve Stigliano, Nippon Life Benefits:

Yes, we monitor.

John Stanley, TransAmerica:

We perform customer service surveys to evaluate the level of service we offer and we continually work to optimize those results. We also have mechanisms and procedures in place, including reviews of customer phone calls, to ensure that established levels of quality are being met.

15. Do you have an established local sales and service team that can provide critical service in the same cities that the broker's clients are in?

Williams, Aflac:

Yes. We have a local account management structure to provide localized support for brokers and their clients. In addition, Aflac has a team of independent sales agents licensed

Sales professionals work with brokers and their clients to help develop voluntary benefit strategies that will help clients solve their benefit challenges. Account coordinators help manage the enrollment logistics and report.
Steven Johnson, Colonial Life

to sell Aflac products throughout the United States. Aflac's certified enrollers are available to service multi-location accounts, and we have a national sales coordinator team to manage these relationships. The company also offers a team of dedicated broker sales professionals in every major metropolitan area to support and service Aflac's brokers and their clients. Aflac's agent distribution model and broker channel can help you manage your clients' open enrollment needs no matter the size or location.

Payton, California Choice:
Yes, we have representatives statewide who are able to assist brokers with clients, regardless of location.

Johnson, Colonial Life:
Colonial Life has more than 45 territory offices across the country and a national team of 10,000 sales professionals who provide local enrollment support and service for its broker partners' clients. Many of the company's accounts have thousands of employees in dozens or even hundreds of different locations across the country. Colonial Life's sales representatives provide employers with valuable services at no direct cost, such as free dependent verification, discount program for health items, wellness benefits communication and more. Colonial Life benefits counselors can meet with employees at each location and conduct individual counseling sessions with them. Because the benefits counselors are local, they can be on hand to help out with next year's enrollment and any ongoing service needs. The goal is for the company's benefits counselors to build strong relationships with employees in the account.

Sullivan, Humana:
As outlined in Question 12, we have sales and service associates located in key markets throughout California, as well as a telesales team. Our people are equipped to serve agents in all markets in California.

Schell, MESVision:
Yes, we have.

Jander, Metlife:
Yes. We have representatives who specialize in voluntary benefits located throughout the U.S.

Boore, MORE Health:
Yes, MORE Health has a sales team in various states and metropolitan areas that can provide support.

Stigliano, Nippon Life Benefits:
Yes.

Stanley, TransAmerica:
We have successfully built an internal virtual team consisting of sales professionals who can partner with brokers to answer any questions that arise during the sales process. We also have a stellar account team readily available by phone to take care of any business needs the employer has. Our virtual teams are incredibly responsive and have the knowledge and decision-making authority to ensure that clients' needs are met.

16. Do you have a sales rep and a service rep?
A sales representative helps the broker market and position products, manage blocks of business, and develop target markets. A service representative helps implement and fulfill account enrollments.

Williams, Aflac:
Yes. We have a local account management structure to provide localized support for brokers and their clients. In addition, Aflac has W-2 broker sales professionals and designated service teams that support our broker channel. The service teams will lead the broker and client throughout the implementation and ongoing administrative process.

Payton, California Choice:
Yes, we have a team dedicated to assisting brokers and their clients, including an outside field representative and inside sales representative, as well as enrollment and renewal support.

Johnson, Colonial Life:
Yes. Colonial Life's national team of sales professionals has specialized roles they perform during the enrollment process. Sales professionals work with brokers and their clients to help develop voluntary benefit strategies that will help clients solve their benefit challenges. Account coordinators help manage the enrollment logistics and report. And benefits

> ***The sales rep/account executive develops benefit solutions specifically for a customer by using his or her detailed knowledge of our product offering and a comprehensive understanding of the customer's benefit goals.***
> **Tim Jander, Metlife**

counselors meet individually with all employees to educate them on their benefits, help uncover any unmet needs and select insurance plans to meet those needs.

Sullivan, Humana:

Yes, Humana's sales representatives are available to perform the tasks noted above and our client service representatives are available to handle groups after the final sale.

In addition, to ensure account service satisfaction throughout implementation, we assign an installation administration professional, trained in the specific sold product, to serve as a single point of contact, providing service on a group's plan to the benefits administrators, designated HR representatives, and agents, brokers, or consultants. The assigned installation administration professional serves as the day-to-day contact for any service-related issues or concerns, assisting on items such as enrollment/eligibility submission or premium payment discussions, and they can engage other areas within Humana on a client's behalf, as necessary.

Schell, MESVision:

Yes.

Jander, Metlife:

Yes. Our sales and service teams work together to meet the needs of brokers and their customers. The core members of the service team are the Account Executive (sales rep) and the Client Service Consultant (service rep.)

Account Executive (AE): The sales rep/AE develops benefit solutions specifically for a customer by using his or her detailed knowledge of our product offering and a comprehensive understanding of the customer's benefit goals. The AE answers the employer's or broker's questions related to the MetLife quote and our product solutions.

Client Service Consultant (CSC): The service rep/CSC is the customer's MetLife contact for day-to-day administrative needs and claims escalation. The CSC facilitates resolutions for billing inquiries, provides reporting, escalates claim inquiries, and coordinates plan changes.

After notice of a sale, each customer is assigned an Implementation Leader (IL) who will coordinate and manage the implementation. The IL designs a project plan and timeline for onboarding or transitioning the benefits to MetLife. The IL and the Implementation Team establish connections for billing, enrollment and any other systems to ensure the account is claim-ready on Day One.

Boore, MORE Health:

Yes, we have sales reps and account management that provides service support.

Stigliano, Nippon Life Benefits:

Yes.

Stanley, TransAmerica:

Yes. We have regional vice presidents who consult with brokers on the solutions available for clients and to help grow their business and we have dedicated account managers to assist brokers and employers with onboarding and implementation, general account management and to ensure that enrollment is successful.

17. Do you specialize in voluntary benefits?

Williams, Aflac:

Yes. Aflac is a leader in individual supplemental insurance products at the worksite in the U.S. Aflac offers individual and group products as well as a portfolio of value-added services. Aflac is a leader in providing policies that pay cash benefits directly to insureds, unless assigned. With our broad portfolio of offerings, Aflac's solutions suit virtually every business size and type. From three employees to more than 300,000, Aflac can fit easily within almost any benefits package. Many times in the supplemental insurance business, companies tend to use the same approach to market similar benefits. Aflac is different. We back our plans up with the following:

Innovative marketing campaigns
Strong financial stability
Brand recognition
A solid company reputation
Responsive claims and customer service

*One Day Pay℠ is available for certain individual claims submitted online through the Aflac SmartClaim® process. Claims may be eligible for One Day Pay processing if submitted online through Aflac SmartClaim®, including all required

> ***Our ancillary benefits exchange was developed specifically to help employers expand their benefit offerings to employees, while still controlling their costs. We offer both employer-sponsored and voluntary benefits options.***
>
> **Michael Payton, California Choice**

documentation, by 3 p.m. ET. Documentation requirements vary by type of claim; please review requirements for your claim(s) carefully. Aflac SmartClaim® is available for claims on most individual Accident, Cancer, Hospital, Specified Health, and Intensive Care policies. Processing time is based on business days after all required documentation needed to render a decision is received and no further validation and/or research is required. Individual Company Statistic, 2019.

Payton, California Choice:

Yes, our ancillary benefits exchange was developed specifically to help employers expand their benefit offerings to employees, while still controlling their costs. We offer both employer-sponsored and voluntary benefits options.

Johnson, Colonial Life:

Yes. When Colonial Life was founded in 1939, it sold accidental death coverage to individuals. In fact, the company pioneered the concept of offering voluntary benefits at the worksite in the 1950s. Colonial Life has always marketed only voluntary benefits, and during the 80 years it has been in business, the company has developed strong expertise and experience in the voluntary benefits industry.

We serve more than 95,000 companies and organizations to protect more than 4 million U.S. workers and their families.

Sullivan, Humana:

Yes, Humana has provided voluntary dental benefits since 1978 and our voluntary vision benefits have been offered since the early 2000's. We do not currently offer traditional workplace voluntary benefits such as Hospital Indemnity, Cancer, Heart and Stroke, etc.

Schell, MESVision:

MESVision has numerous plan designs for both voluntary and employer paid plans. We specialize in vision care plans only and we do work with carrier partners that can provide bundled plans as well for other health benefits.

Jander, Metlife:

Yes. Our leading market positions, innovative product offerings and 100+ years of group benefits' experience contribute to long-standing and productive relationships with our customers. We help our customers deliver information effectively and improve employee engagement and satisfaction. For more information, please visit www.metlife.com.

Per LIMRA's first-quarter 2019 U.S. Workplace Voluntary Sales Report, our market rankings based on new sales are as follows:

First in total voluntary health sales
First in the critical illness insurance market
Second in the accident insurance market
Second in the hospital indemnity insurance market
Second in the cancer insurance market

MetLife is the largest Group Auto and Home benefits provider in the country, with approximately 44.9% market share. MetLaw is the nation's leading provider of employer-sponsored legal plans.

Boore, MORE Health:

The vast majority of MORE Health's business is employer or broker paid. Voluntary benefits is a minority of the overall business.

The voluntary is a smaller portion due to the value offered compared to the premium base.

Stigliano, Nippon Life Benefits:

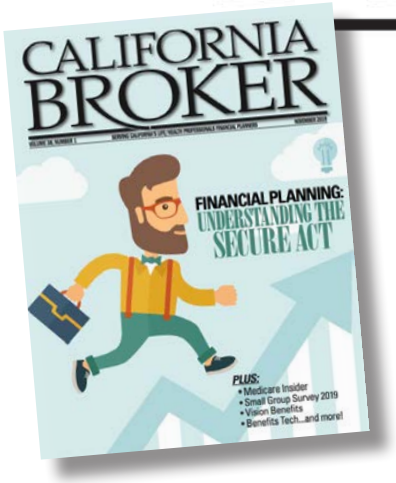
No.

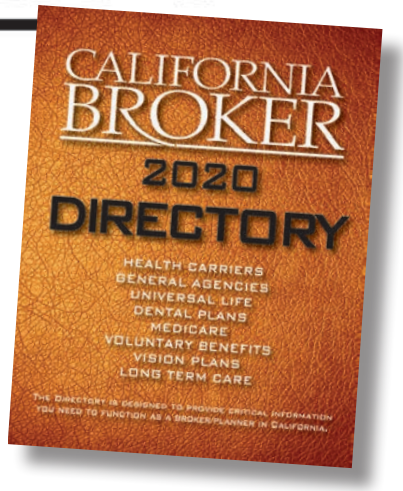
Stanley, TransAmerica:

Absolutely.Tr ansamerica has been providing voluntary benefits for nearly 90 years and we are committed to protecting the wealth + health of employees. We work with brokers and employers to ensure that our solutions are easy to understand, flexible regardless of internal processes or platforms, simple to implement, and ultimately allow for a seamless enrollment and claims experience for employees. Transamerica's voluntary benefit solutions help employees live their best lives.

Thank you to our contributors!

CALIFORNIA BROKER





You're Just One Click Away

Over 10,000 Unique Visitors Every Month*

Month	Unique visitors	Number of visits	Pages	Hits	Bandwidth
Jan 2019	14,200	34,899	569,278	695,242	10.95 GB
Feb 2019	9,086	23,422	223,634	358,682	8.74 GB
Mar 2019	10,018	28,258	302,828	395,226	8.63 GB
Apr 2019	11,211	31,849	561,050	654,941	9.48 GB
May 2019	9,719	31,755	487,291	580,316	9.91 GB
Jun 2019	8,906	39,230	651,072	735,170	10.05 GB
Jul 2019	9,211	33,257	514,002	606,593	10.18 GB
Aug 2019	8,007	29,582	626,948	737,202	12.28 GB
Sep 2019	9,760	45,229	512,593	621,563	10.01 GB
Oct 2019	11,963	58,261	444,365	552,341	10.74 GB
Nov 2019	8,482	44,912	232,020	308,322	7.11 GB
Dec 2019	0	0	0	0	0
Total	110,563	400,654	5,125,081	6,245,598	108.08 GB

calbrokermag.com

For Advertising Opportunities contact:
devon@calbrokermag.com

* Average

WORKPLACE COMPLIANCE TRENDS FOR 2020

BY ROBERT C. LOVE

The business world is never static, is it? It is constantly evolving to accommodate the changing world in which we live. At the forefront of that evolution in the insurance segment is compliance. For better or worse, regulatory changes at the local, state, and federal levels create new compliance issues every year. Staying up to date is a full-time endeavor all by itself. Below are some of the top workplace compliance trends for 2020.

Changes to overtime hours

The much-anticipated overtime rule has finally been released. It went into effect on January 1, 2020. The hallmark of the new rule is a higher salary threshold for exempt employees as outlined in the Fair Labor Standards Act. The threshold will increase to $648 weekly or $35,568 annually. The rules for determining who qualifies as exempt have also been altered slightly.

This indicates that there will be some changes to overtime hours in 2020. Some employers are likely to implement tight restrictions on overtime hours. Others may shift work from some employees to others, guaranteeing that overtime hours are kept at a minimum.

Sexual harassment training

The number of states requiring sexual harassment training of both private and public sector employees is on the rise. California has perhaps the most comprehensive sexual harassment training requirements. Those requirements will become even more comprehensive as of January 1, 2020. It is quite possible that other states will follow California's lead. If so, we may see more states mandating at least several hours of sexual harassment training for management and lesser training for non-management employees. We might also see companies in states where this training is not mandatory move forward to offer it anyway.

Paid leave laws

Next year will be a banner year for those states implementing or expanding paid leave laws. Arizona, California, New Jersey and a handful of others have had paid leave laws in place for several years. However, California recently expanded its law with new changes set to take effect in 2020. New York's law gradually expands every year for the next several years.

Paid leave also kicks in next year in Nevada and Washington state. Meanwhile, representatives in Washington are seriously considering national paid leave legislation. It appears as though it is just a matter of time before mandated paid leave is the norm.

Companies doing business in states with laws already in place should check for changes in the coming year. As previously mentioned, several states are expanding their programs in 2020.

Employee cannabis use

One of the stickiest compliance issues of all relates to cannabis use among employees. Federal law still considers cannabis a controlled substance, though enforcement has been lax in recent years. That has empowered a number of states to implement both medical and recreational cannabis laws in recent years.

In states that allow recreational use of cannabis, employers must make a clear distinction between what is considered medical and recreational use for establishing their own policies. This is necessary to avoid running afoul of laws that allow possession of medically necessary cannabis in the workplace.

Compliance is always a priority as we begin a new calendar year. Companies should know and understand all the laws that apply to them. Strategies for complying should also be implemented well in advance. Companies do not need to be caught off guard now that the calendar has turned to 2020.

Robert C. Love is president of the benefits division at BenefitMall.

2020 AND BEYOND: WHY IT'S VITAL THAT INSURERS EMBRACE AI-DRIVEN CX

BY MIA PAPANICOLAOU

When it comes to insurance, the use of artificial intelligence (AI) to determine premiums, assist with fraud detection, and speed up claims processing is becoming far more commonplace. Less well regarded, but equally important, is the role AI plays in customer communication.

The communication sent to customers by insurers is often the only interaction with them beyond the policy or bill. These can be greatly enhanced using AI, which can result in far more loyal customers.

Considering insurers are traditionally slow to adopt new technologies when it comes to the customer experience and are increasingly susceptible to disruption by a wave of tech-savvy startups, it's vital that they embrace AI as a customer communication tool in 2020.

The need for AI

One of the major failings of the insurance industry is that it simply doesn't talk to its customers. In fact, some estimates show that more than 90% of insurers worldwide do not communicate with their customers even once a year.

That not only fosters the feeling among customers that they don't really know their insurer, but that their insurer doesn't know or care about them.

Moreover, thanks to their experiences with other industries, such as banking and retail, today's customer demands highly-personalized products and services, supported by relevant, easy to understand and contextual

information – instantly on hand, via any channel they choose.

Insurers sit on mountains of data that would allow them to send out valuable, hyper-personalized communication. More than most industries, they're in an ideal position to embrace the opportunities presented by AI.

In the insurance space particularly, AI can help insurers go from taking a reactive approach to customer communication to being able to take a predictive approach that anticipates the wants and needs of their customers.

That encompasses everything from ensuring that customers receive personalized offers that are relevant to them, to improving service and communicating with them on their preferred channel without it having to be stated first.

The business imperative

Research has found that "insurers who reinvent the customer experience and drive human-machine collaboration are achieving returns in excess of 10 times their investment and could increase industry-wide profitability by between US$10.4-billion and US$20.8-billion."

But, as more and more insurers embrace AI, merely adopting it will no longer be sufficient. As far back as 2017, the insurance industry was, on average, spending nearly twice as much on AI as other verticals.

Insurers that don't have an AI communication strategy risk falling further behind and having to spend more money to catch up. Those that have, meanwhile, have to keep working to stay ahead of, or alongside, the competition.

But what might that look like in 2020 and beyond?

Using AI tools in digital communication will help transform the customer relationship. For example, using predictive tools to provide content that is not only relevant to the customer but also increases their spend will become commonplace. Couple that with the extension of chatbots in emails sent, providing another service option for customers while reducing call center volumes, makes AI the tool that will move the needle on customer experience.

To varying degrees, these changes are already sweeping through the insurance industry. In 2020 and beyond, they will continue to do so and at an accelerated pace.

Whatever new technologies emerge, however, it's vital that the customer remains at the heart of all communication strategies and that they be implemented in as human-centered and authentic a way as possible.

Mia Papanicolaou heads up the North, Central and South American operations, providing strategy and direction for both internal teams and clients alike, at Striata. Papanicolaou is a regular speaker on digital customer communication and improving the customer experience. She started her career in South Africa in the media sector, before moving to the electronic messaging space, where she served as business director for email marketing eMessageX. She joined Striata in 2006 as head of email marketing. Striata provides strategy, software and professional services that enable digital communication across multiple channels and devices. More info at striata.com.

AD INDEX

CLASSIFIEDS

CALIFORNIA BROKER

SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS & FINANCIAL PLANNERS

ANNOUNCING

2020 EDITORIAL CALENDAR

MONTHLY FEATURES:

- MEDICARE INSIDER
- INDUSTRY NEWS

And Much More...

Your ad in Cal Broker reaches over 25,000 industry professionals every month...

To receive a Media Kit with the 2020 Editorial Calendar email: devon@calbrokermag.com

McGee Publishers • 3727 W. Magnolia Blvd.,#828, Burbank, CA 91505 • (800) 675-7563 • Fax (818) 843-3489

Do you have a daughter named Erisa?

We do.

That's just how committed we are.

wordandbrown.com

Word&Brown.

Northern California 800.255.9673 | Inland Empire 877.225.0988 | Los Angeles 800.560.5614 | Orange 800.869.6989 | San Diego 800.397.3381