INSIDE: INSURTECH IS FRONT AND CENTER | OUR ANNUAL DENTAL SURVEY | MEDICARE INSIDER DOUBLE HEADER

CALIFORNIA BROKER

VOLUME 39, NUMBER 10 Serving California's Life/Health Professionals & Financial Planners JULY 2021

Drugs & Money

Why the New Drug Pipeline Will Make You Rethink Your Pharmacy Benefits Management Strategies

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IN EVERY ISSUE

The secondary market for life insurance gives policyowners powerful options for managing their life insurance policies. Through transactions like a **life settlement** or a **life settlement with a retained death benefit option**, you and your clients now have the tools to tap into the market value of policies that are underperforming or are simply no longer needed. The result is **new estate planning strategies that maximize value.**

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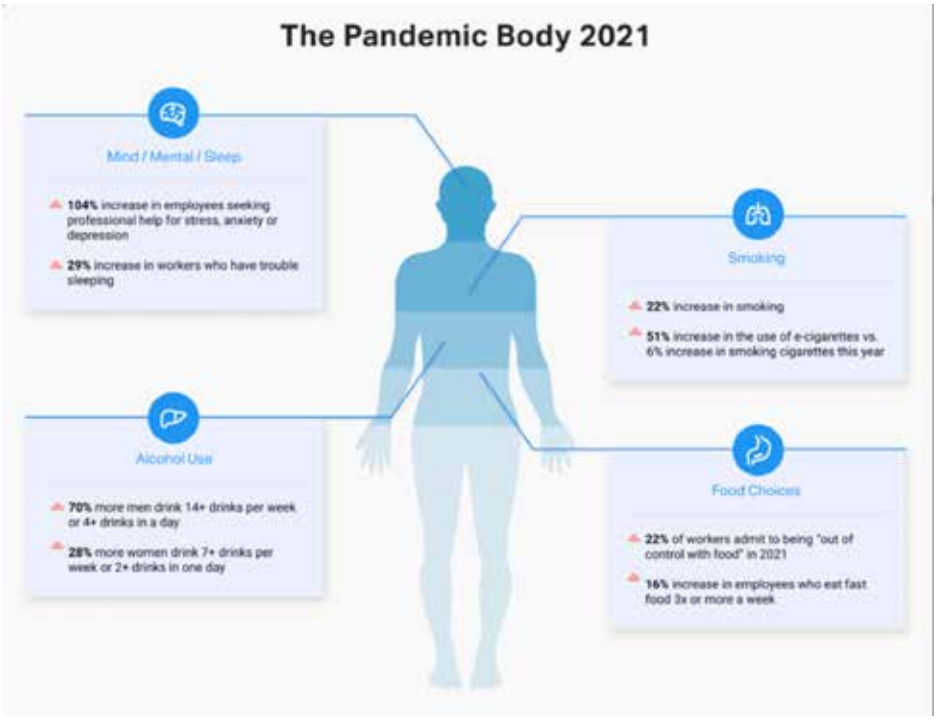


Medikeeper Quantifies The Pandemic Body

Medikeeper recently issued the results of its health risk assessment on employee health during the pandemic. Folks, the results are not pretty. All the bad stuff went up and the good stuff went down. Here's a little sample, according to results of The Pandemic Body 2021:

104%

Stress — 104% increase in employees seeking professional help for stress, anxiety, or depression

70%

70% more men drinking 14+ drinks per week. 28% more women drinking 7+ per week.

22%

Increase in cigarette use. 51% increase in e-cigarette use.

22%

22% of workers admit to being "out of control with food"

29%

29% increase in the number of employees who report difficulty sleeping.

9th Annual Senior Summit: Chart Your Course and Navigate Into the Future

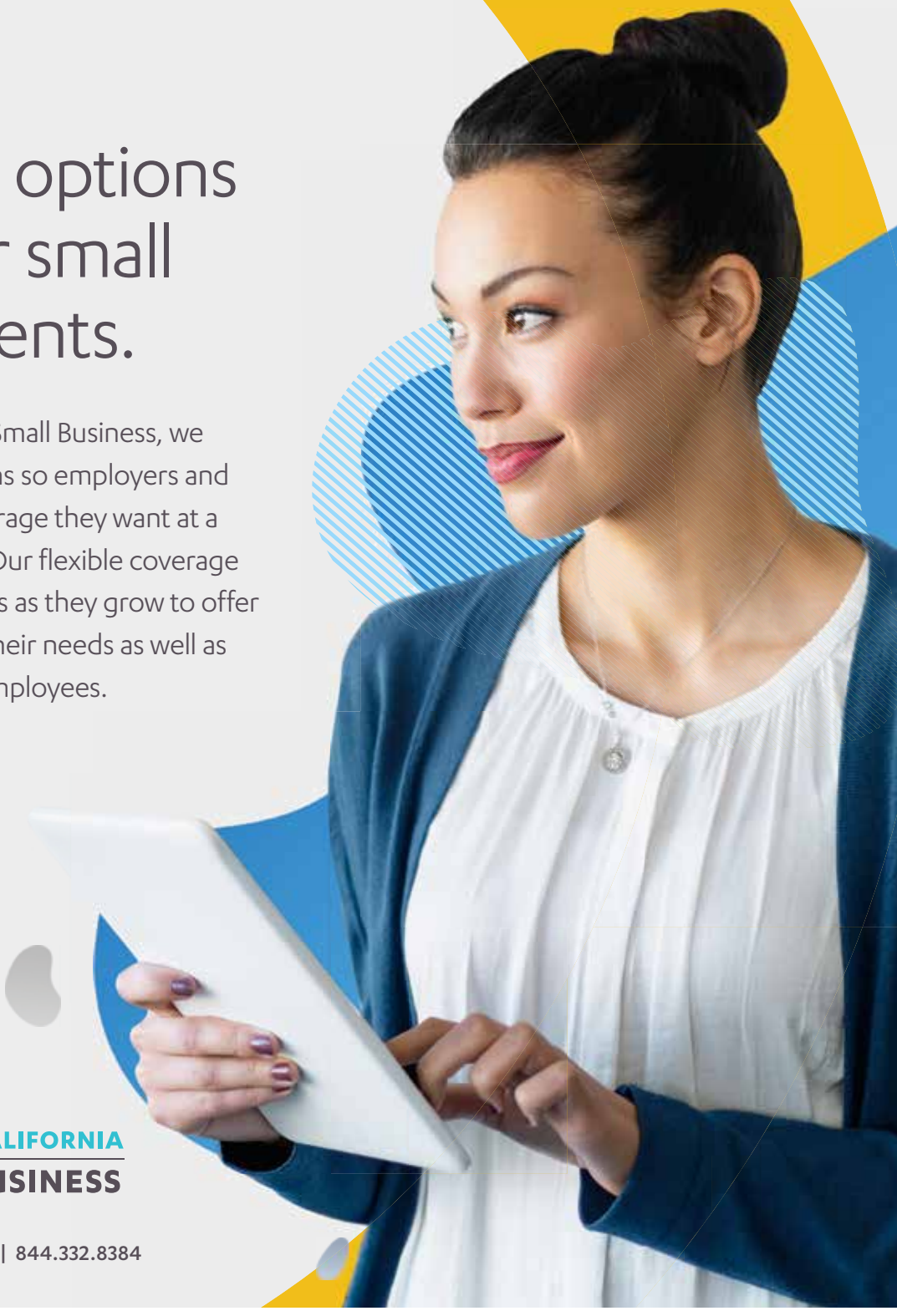
This year's Senior Summit will be IN PERSON at Pechanga Resort & Casino Aug. 31-Sept. 2. Get the latest and greatest product solutions for your agency along with industry leaders and influencers presenting programs to help you tackle today's challenges. Online registration is open through Aug. 19, 2021.

HawkSoft Partners with Duck Creek Technologies, Offering Independent Insurance Agents Direct Connections to Supported Carriers

HawkSoft recently announced its partnership with Duck Creek Technologies, a provider of SaaS insurance core systems. The partnership enables independent agencies using HawkSoft's management system to leverage policy and client data throughout the Duck Creek Platform. This integration gives mutual customers the ability to upload policy information directly to carriers using Duck Creek's Producer and AgencyPortal products.

Health plan options that fit your small business clients.

With Covered California for Small Business, we help tailor health plan options so employers and employees can get the coverage they want at a price that fits their budget. Our flexible coverage options work with businesses as they grow to offer coverage that will adapt to their needs as well as care for and retain quality employees.



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Techficient's New Analytics Platform Accelerates Decision-Making Process

Techficient announced the launch of its CORE platform, a data and analytics solution created to simplify the sale of insurance and financial products. Designed by industry veterans, the suite of applications maximizes efficiencies and should help advisors and BGAs make better decisions.

CORE is a KPI-driven, cloud-based agency management system that enables brokerage executives to gain insight into their agency. The applications take high-integrity data to create analytics that allow CORE users to understand the drivers behind case management. This approach can generate dynamic quotes, highlight top advisors, and illustrate which policy type is the most profitable. In-force policy management tools can help advisors or BGAs prevent policy lapses and can help generate new business opportunities. The software promises to help identify inefficiencies and smooth out pain points. No pain, more gain. We can get behind that.

Interest in Life Combination Products Shifts

LIMRA says the pandemic — with all the images of elderly people in nursing homes cut off from family and friends — has made a major impact in how the public thinks about life insurance coverage.

According to a recent LIMRA post: In January 2021, more than a quarter of Americans (26%) said it was very likely they would consider a life combination product (a life insurance policy with a long-term care [LTC] insurance component) if they were shopping for life insurance. This is 50% higher than in 2019. Overall 6 in 10 consumers said it is at least somewhat likely they would consider a life combination product if shopping for life insurance.

Millennials apparently expressed the most interest in combo products.

EVENTS

BENEFITSPRO BROKER EXPO

IN-PERSON in San Diego, Aug. 16-18. Save 15% with promo code RIGHTPLAN. More info at benefitspro.com

CALIFORNIA STATE MEDICARE EXPO: UNMASKING MEDICARE

Virtual, August 26-27. Details at CAHU.org

9TH ANNUAL SENIOR SUMMIT: CHART YOUR COURSE AND NAVIGATE INTO THE FUTURE

IN-PERSON at Pechanga Resort & Casino in Temecula, Aug. 31-Sept. 2. Online registration open through Aug. 19.
Register at https://guestlist.co/events/684435

AMERICAN ASSOCIATION FOR MEDICARE SUPPLEMENT INSURANCE,
NATIONAL MEDICARE SUPPLEMENT INSURANCE INDUSTRY SUMMIT

Sept. 8-10, IN PERSON at Schaumburg Convention Center, Chicago area. Info at medicaresupp.org.

SIIA 41ST ANNUAL NATIONAL EDUCATIONAL CONFERENCE & EXPO

IN-PERSON & Virtual, Oct. 3 - 5, JW Marriott, Austin, TX. Info at SIIA.org.

LOOKING AT THE COVID PRICE TAG

Researchers have been busy figuring out the impact of COVID. Case in point:

The costs of COVID-19-related care that was provided to Medicare fee-for-service patients for April-December 2020 totaled $6.3 billion, according to researchers.

Those are part of the findings that appeared recently in the Annals of Internal Medicine. That price tag probably sounds huge right? Well, the researchers actually concluded that COVID-19 did not have a major financial impact on Medicare in 2020. They found that the average cost of treatment was considerable among those who were hospitalized, but the costs for milder cases—which represented the majority—were relatively small. Interesting!

Headspace and Solera Health Team Up

Phoenix-based Solera Health, a tech company that provides a dynamic platform linking employees to evidence-based interventions to impact costly chronic conditions announced a new collaboration with Headspace, the meditation, mindfulness and mental training app. The Headspace app will now give Solera Health clients access to over 1,000 hours of mindfulness and mental wellbeing content. Besides mental health and stress, Solera also offers solutions for diabetes management, diabetes prevention, falls prevention, social isolation, tobacco cessation and weight management.

Silver Lining: Health Plans Learn How to Increase the Love

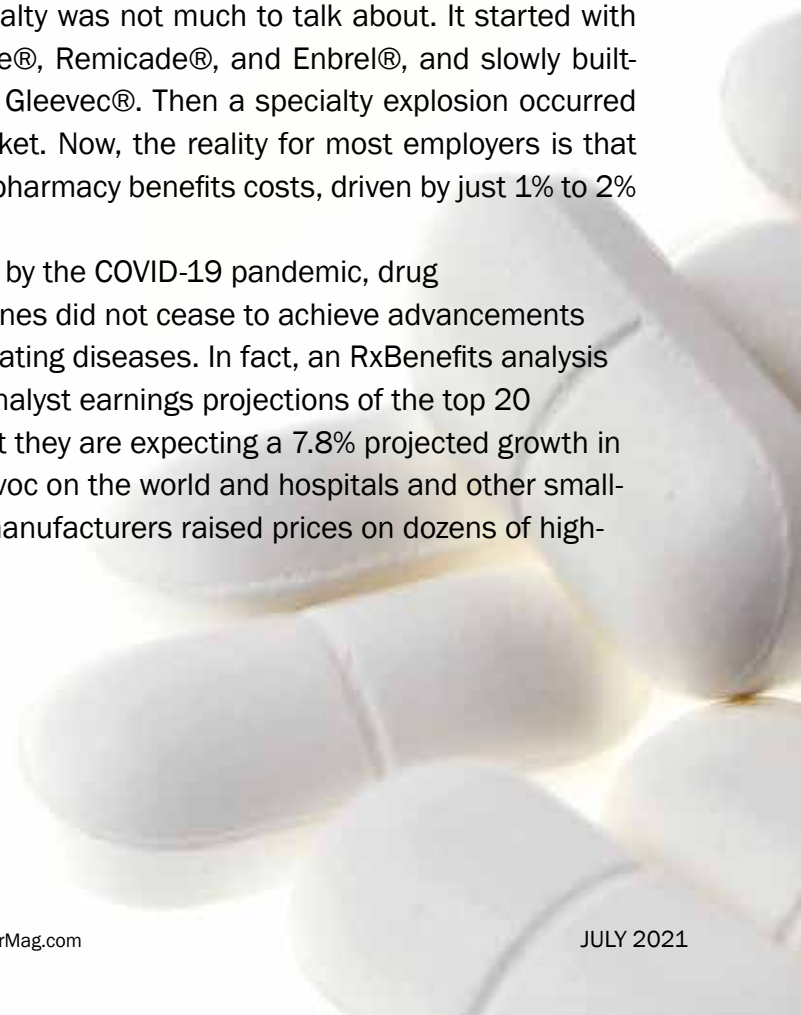
The pandemic did a lot of things, but here's something kind of interesting. Health insurers were forced to come up with tech solutions for access. This increased engagement. And guess what? People like that, according to a recent J.D. Power analysis. James Beem, managing director of global healthcare intelligence at J.D. Power, said in a statement that the events of 2020 proved that "effective use of digital channels has the power to increase customer engagement, build trust, and promote brand advocacy." He also said that while things have improved, there is much more improvement that could happen to ensure access and engagement for everyone.

Why the New Drug Pipeline Will Make You Rethink Your Pharmacy Benefits Management Strategies

BY RICK SUTHERLAND

Specialty drugs is a topic that is on the top of every broker's and employer's mind. Just 20 years ago, specialty was not much to talk about. It started with medications such as Copaxone®, Remicade®, and Enbrel®, and slowly built-up steam with the approval of Gleevec®. Then a specialty explosion occurred as Humira® came on the market. Now, the reality for most employers is that specialty drugs account for 50% to 60% of pharmacy benefits costs, driven by just 1% to 2% of their members.

Meanwhile, despite the obstacles posed by the COVID-19 pandemic, drug manufacturers' researchers behind the scenes did not cease to achieve advancements in treating some of the world's most devastating diseases. In fact, an RxBenefits analysis of the reported 2020 earnings and 2021 analyst earnings projections of the top 20 prescription drug manufacturers shows that they are expecting a 7.8% projected growth in earnings. While COVID-19 was wreaking havoc on the world and hospitals and other small- to mid-size businesses in particular, drug manufacturers raised prices on dozens of high-



cost drugs throughout 2020 and continued that trend to start 2021.

As medication utilization trends begin to normalize post-pandemic, these pricing increases are expected to begin impacting employer-sponsored plans in a bigger way. Employer plan sponsors are starting to see increasing costs within their own risk mitigation strategies as well — particularly in stop-loss insurance — because of non-intentional interventions to control utilization. In Gartner's 2021 HR trends and priorities report, more than 800 leaders across all major industries shared their plans for the year. Not surprisingly, 50% of survey respondents say they plan to optimize costs in 2021, which is up 13% from last year. Constant vigilance concerning new and expensive drugs on the horizon and having a strategy in place to address specialty, as well as non-specialty drugs, is required.

Prescription drug pipeline

Employers should be aware that the new drug pipeline focuses on manufacturer investments in developing high-cost brand, specialty and orphan drugs. With more than 8,000 drugs in development, new drug launches will reach historically high levels over the next several years. New and potentially lifesaving or life-prolonging therapies are reviewed and approved every year, but generally there are two drug pipelines to monitor: novel drugs coming to the market for the first time for any indication, and new indications for existing medications already approved by the U.S. Food and Drug Administration (FDA).

There are several specialty drug classes with notable products in the pipeline for 2021-2022: oncology, hematology, multiple sclerosis, inflammatory diseases and genetic disorders. Many of these medications are channel-agnostic and could find their way under either medical or pharmacy claims. Data analysis over the last 20+ years appears to validate that specialty drug costs are increasing at a similar rate under both the pharmacy and medical benefit, so evaluating net drugs costs within both channels is crucial for long-term sustainability. Whether the drugs are utilized in the medical or pharmacy channel, here are a few of the top drugs to look for this year:

Novel Drugs:

• **Hereditary angioedema** (HAE). Drugs such as Haegarda® and Takhyzro® are taken routinely to prevent edema attacks, while Firazyr® and Ruconest® are used for acute attacks and should be used on an as-needed basis. New to the HAE market is Orladeyo®, a lower-cost oral medication approved in late 2020 that may drive new utilization from individuals who previously exercised restraint with the mainstay injectable products.

• **Cancer treatments.** Some of the biggest cancer therapies that may make headlines this year include: **Ygalo**® (melflufen), used to treat multiple myeloma; **Fotivda**® (tivozanib), used in the treatment of advanced renal cell carcinoma; **Abecma**® (idecabtagene vicleucel), a CAR-T therapy for the treatment of relapsed or refractory multiple myeloma; **Breyanzi**® (lisocabtagene maraleucel), a CAR-T therapy for the treatment of relapsed or refractory B-cell non-Hodgkin's lymphoma; and **Tepmetko**® (tepotinib), a treatment for metastatic non-small cell lung cancer.

New Indications for Existing Drugs:

• **Rinvoq**® is FDA-approved for rheumatoid arthritis and awaiting approval for moderate-to-severe active psoriasis and atopic dermatitis, an indication that brings enormous potential for financial impact. New utilization of oral Rinvoq may occur from eligible patients who have been on the sideline due to injection aversion with Dupixent®, an injectable drug that skyrocketed to the top of many claim files in 2020. Coincidentally, Rinvoq may be accompanied by a price point higher than that of Dupixent, which may further complicate the financial outlook.

• The cancer drug category also has several therapies recently approved for new indications. Among those are Yervoy®, approved in October 2020 as a weight-based dose indication for mesothelioma, as first-line treatment in combination with Opdivo® (nivolumab); Tagrisso®, approved in December 2020 to treat lung cancer and expected to cost approximately $18,000 per month; and Iclusig®, approved in December 2020 as a treatment for leukemia and expected to cost approximately $20,000 per month.

Employer strategies to manage high Rx costs

For most employer-sponsored pharmacy benefits plans, around 90-95% of a plan's prescription claims are for generic or very low-cost brand drugs and represent about 10% of costs. The other 5-10% are the higher-cost brands, typically over $1,000, as well as specialty medications. Roughly 2% of the members will incur 50-60% of the costs of any given plan. As a result, employers find themselves in a challenging situation trying to maintain an affordable yet rich benefit for their

As we think about what we could do to help reduce costs, our emphasis is on those claims that are on the high-end of the brand category and on the specialty category. It is essential that plan sponsors have strategies in place to help steer people toward that clinically and economically valuable medication.

employees. This is especially challenging when there are multiple choices for a medication, and some have a better clinical and economic profile than others.

As we think about what we could do to help reduce costs, our emphasis is on those claims that are on the high-end of the brand category and on the specialty category. It is essential that plan sponsors have strategies in place to help steer people toward that clinically and economically valuable medication. There are several recommended strategies that are proven effective for managing high-cost specialty drugs today. It begins with first understanding the financial and member disruption (i.e., employee retention/recruitment impact) goals for each employer. Then you can focus on these four key areas to ensure a holistic solution is in place to manage costs and appropriate utilization in line with both the contract and clinical perspectives:

1. **Maximize contract value:** Obtain the deepest discounts and maximize rebate yield through an aligned formulary coupled with an unbiased analysis and independent review strategy
2. **Evaluate plan design:** Examine tiering, copay vs. coinsurance, HDHP vs non-HDHP; Deductibles/Out of Pocket Maximum changes, separate medical/pharmacy accumulators, network design, mail order, Dispense as Written penalties, etc., as well as the extent of each change under consideration (ex: 10% vs 20% coinsurance)
3. **Eliminate wasteful spending:** Remove questionable low clinical value medications from the formulary; independently review prior authorizations, suspect high-dollar claims, and drugs with the potential to be used off-label; optimize existing therapy and dosing to remedy any per-dose cost improvement opportunities; and independently verify appropriate indication and dosing for complex conditions
4. **Manufacturer assistance programs:** Leverage available manufacturer-provided member incentives on specialty medications through a PBM systems-based approach, as opposed to partial carveout solutions that require manual formulary and system manipulations that generate additional risks and inefficiencies

Focus on high-cost claims

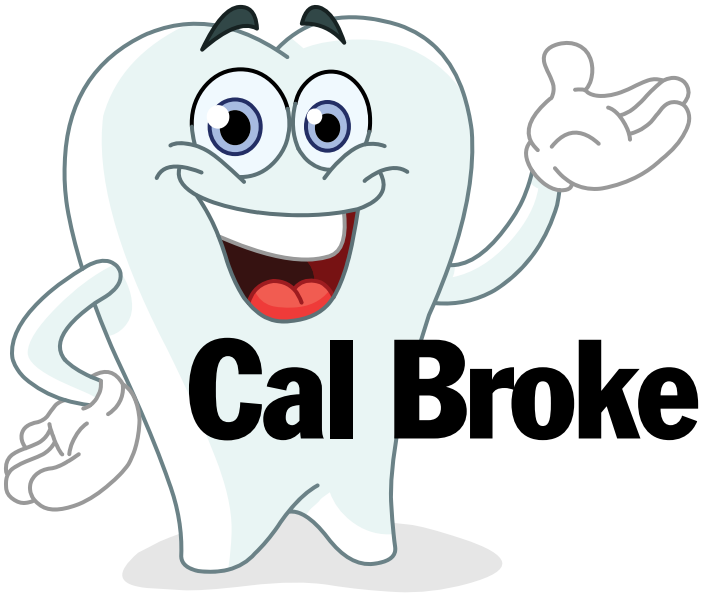
As new drugs or existing drugs with new indications enter the market this year, managing appropriate use of these high-cost medications will be essential. Employers need a tailored clinical strategy that addresses their risk areas to maintain a sustainable pharmacy benefit moving forward. For example, implementing independent prior authorizations on specialty medications can be a very valuable strategy to help your self-funded clients ensure appropriate utilization of oncology medications.

Consider these real examples where RxBenefits' enhanced oversight of complex condition medications resulted in improved clinical outcomes and significant financial savings for mid-market employers and their members:

- **Acromegaly:** Synthetic hormone Somatuline® is an orphan drug used to treat rare conditions, like acromegaly (or giantism). Our clinical team flagged a claim for this high-cost medication that was prescribed at an irregular dose of one syringe per week instead of the recommended one syringe per month. The member was injecting 4x the amount than was clinically necessary, and it was costing upwards of $300K. A clinical intervention improved the member's care and saved the plan more than $200K a year.
- **Cancer:** Chemotherapy medication Afinitor Disperz® is a parity priced medication, meaning that the drug manufacturer charges the same price for each tablet regardless of the medication strength. By optimizing dosing to account for this, employers and members can see significant savings without impacting the member's treatment. Upon making a dose adjustment, the hospital group avoided more than $220K in unnecessary expenses.
- **Cancer:** A targeted therapy treating B cell cancers, called Imbruvica® is another drug that is commonly parity priced. Oftentimes, prescribers are not aware and prescribe a smaller dose to be taken frequently when it's clinically appropriate — and more cost-effective — to take a higher dose less frequently. In some instances, there also could be an opportunity to use a capsule instead of a tablet. By optimizing the Imbruvia dose, the employer reduced its pharmacy benefits expenses without impacting the member's treatment plan.

For any other strategy under consideration, always consider the intentions of the institutions guiding the strategy options. Many times, employers unknowingly spend more than is necessary because of confirmation bias from PBMs and other entities that may benefit from excess utilization. By analyzing the plan from an unbiased viewpoint and taking a holistic approach, the employer will be positioned to experience the maximum amount of cost-savings while keeping the best interest, health, and well-being of their employees in mind. CB

RICK SUTHERLAND *works in business development for RxBenefits, the nation's first Pharmacy Benefits Optimizer. He supports brokers in the California and Hawaii regions, guiding them through the pharmacy benefit contracting process to help them evaluate their clients' prescription drug plans for optimal savings, clinical management, and service. Rick is also the current Board President for the Employee Benefit Planning Association of Southern California (EBPA). Reach him at:* **rsutherland@rxbenefits.com.**



Cal Broker's 2021 DENTAL SURVEY

Compiled by **Thora Madden**

We've been through some rough times—and we aren't yet out of the woods. But Californians are still smiling, thanks in no small part to the folks in the dental health world. We checked in with some key dental health providers to hear about their plans, how COVID-19 impacted business and more.

1. What types of plans do you offer?

Mark Zeedik, *senior manager, specialty sales, consumer, and small group, Blue Shield of CA:*

Blue Shield has provided dental coverage for more than 25 years, and our dental program is an integral part of Blue Shield's mission to provide Californians with access to high-quality health care at a reasonable price. We are committed to providing excellent dental care and member satisfaction through a spectrum of diverse dental plans. We develop and customize our plans to meet changing marketplace demands and the individual needs of our customers. Currently, more than 500,000 members are either enrolled in the Blue Shield dental program or use its networks for services.

Our dental PPO and HMO plans offer members a wide variety of plan designs and networks to fit their budget.

For individuals and families, we offer a unique dental PPO plan with member copayments instead of the usual coinsurance percentages. Our dental HMO plan offers comprehensive benefits with predetermined member copayments. Finally, our Duo plan offers members dental and vision coverage at a single price. Our plans can be sold with medical plans or on a stand-alone basis.

For senior members, we offer two comprehensive dental PPO plans for Medicare supplement plan members.

For groups, some of our dental PPO and HMO plans are available on a contributory or voluntary basis. Most can be sold with or without Blue Shield medical plans, and they are either based on Usual, Customary, and Reasonable fees or reimbursements that are capped by the Maximum Allowable Charge.

Joe Stefano, *divisional VP, Western U.S., The Guardian Life Insurance Company of America:*

Guardian offers an array of plan types and options to meet the needs

Mark Zeedik
senior manager, specialty sales, consumer, and small group, Blue Shield of CA

Joe Stefano
divisional VP, Western US, The Guardian Life Insurance Company of America

Chrissy Cabra
executive sale consultant, Premier Access

Michele Childers
executive sale consultant, Premier Access

Diana Steinhoff
SVP of Client Services, Aflac

of employers/employees and individuals/families. Employer plans can be customized according to needs and price points. Dental PPO, Managed Dental Care (Prepaid/DHMO), Indemnity, Dual and Triple Choice, Monthly Switch (between a DHMO and PPO), and Administrative Services Only Plans can be offered as voluntary, contributory, or on an employer-sponsored basis. Individuals/families can buy direct from **www.guardiandirect.com**. Additionally, Guardian offers family and individual plans through its subsidiaries Premier Access and Access Dental on the Covered California exchange.

Chrissy Cabra & Michele Childers, *executive sales consultants, Premier Access:*

We offer dental DHMO and PPO plans and vision plans.

Diana Steinhoff, *SVP of Client Services at Aflac:*

Aflac Dental Insurance is available in Maximum Allowable Charge (MAC) and Preferred Provider Organizations (PPO) plans, each with three levels of coverage and optional orthodontia benefits available. Coverage includes no waiting periods (excluding orthodontia services) and no copays required for most preventative procedures.

2. How do the offerings for individual and small group compare to large group plans?

Zeedik, Blue Shield of CA:

There are different underwriting considerations for each business segment. Our ability to customize offerings for groups with more than 101 employees typically results in lower rates and more choices to meet the employer's needs.

Group PPO plans come in a wide range of deductibles and annual benefit maximums.

Our individual, family, and Medicare Supplement dental PPO plans may vary in waiting periods, deductibles, and annual benefit maximums based on the plan selection.

Stefano, Guardian:

Individuals and small group employers can choose from nearly similar plans as large groups with cost-reducing options. Individuals/Families can also buy direct from guardiandirect.com or on the exchange through Covered California.

Cabra & Childers, Premier Access:

We don't offer individual plans at this time. Both small group and large group plans offer great flexibility in benefit options.

Steinhoff, Aflac:

Aflac's current individual dental plan is an indemnity plan that reimburses members different dollar amounts for specific procedures.

Our small-group plans, which are for two to 99 eligible employees, have three PPO plans and three MAC plans available with different coinsurance and annual max options. Orthodontia is available as an optional benefit, and all plans come standard with a deductible that decreases over time, carry-over credit and no waiting periods.

With our large-group plans, which are for 100+ eligible employees, we offer customized plan designs. Aflac has the ability to match most plan designs offered by other carriers, allowing for limited disruption for employees. Dual choice, high/low, and core/buy-up plan offerings are all available within our large-group space, in addition to the listed benefits within the small-group plan offering.

3. What changes in plans or benefits should brokers be aware of for open enrollment this year?

Zeedik, Blue Shield of CA:

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

- For members on our Blue Shield 65 Plus plan who elect to enroll in our Optional Supplemental Dental PPO plan, the waiting period for all dental procedures was removed on 1/1/2021.

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

Stefano, Guardian:

Brokers should be aware of new features introduced to

address the changing needs of members. This includes discounts on byte® at-home invisible aligner treatments to help members straighten their teeth without visiting a dental office. In addition, members now have access to Guardian Teledentistry if they are seeking easy access to urgent dental care without visiting the dentist.

One benefit that brokers should be aware of is Guardian's College Tuition Benefit®, a value-added benefit that helps families pay for college. Members enrolled in a Guardian plan, like dental, that includes the College Tuition Benefit® can earn 2,000 Tuition Reward® points annually, per product. Each tuition reward point equals $1 in tuition reduction; accumulated points can be used to pay up to one year's tuition at one of more than 400 private colleges and universities across the nation. The benefit can be included with up to four lines of Guardian coverage with rewards increasing each year and with each line of coverage.

In addition, Guardian's Administrative Services Only (ASO) option offers the same product features, network and claims processing as fully-insured. For those hesitant to move to ASO, we offer an innovative Level-Funded option that offers fixed monthly costs starting with a 105% aggregate stop loss, and if claims are lower than expected, Guardian returns the entire surplus to the employer.

Our ability to customize offerings for groups with more than 101 employees typically results in lower rates and more choices to meet the employer's needs.

—Mark Zeedik, Blue Shield of CA

Cabra & Childers, Premier Access:

We have not made changes.

Steinhoff, Aflac:

Aflac has the ability to enroll several product lines within the same third-party enrollment platform. All of our traditional supplemental insurance products, life, disability, dental and vision insurance plans can all be enrolled by our team at the same time. We can also help HR staff streamline their open enrollment process by bundling several products together.

4. Has COVID-19 changed any of your offerings or had a substantial impact on any of your plans, like a change in claims or use of benefits due to postponing care during the pandemic?

Zeedik, Blue Shield of CA:

Teledentistry has been an added option during the COVID-19 pandemic. Teledentistry codes are included in Blue Shield dental plans, and members are able to meet virtually with a dentist to discuss issues and determine whether emergency care is needed. Customer Care has been able to assist members in finding a provider who offers teledentistry if their current provider does not offer this service.

Stefano, Guardian:

In 2020, we introduced Guardian's Pandemic Support program to help employers manage costs and continue to provide affordable, uninterrupted access to dental care. Through the program we offered a one-month premium credit for fully insured dental plans or an extended rate guarantee. We also made plan changes including enhancing frequency limits on dental cleanings, exams, and fluoride treatments (if applicable) to a minimum of two per calendar year from July 1, 2020 through December 31, 2021. We also provided PPE financial relief to our network providers to help ensure the safety of their practices as well as our members.

To help address the changing needs of members, we offered in-network coverage and discounts on byte® at-home invisible aligner treatments to help members straighten their teeth without visiting a dental office, and we launched Guardian Teledentistry to provide easy access to urgent dental care without visiting the dentist.

Cabra & Childers, Premier Access:

We have not made COVID-19 related changes to plans/benefits.

Steinhoff, Aflac:

Across the industry, pandemic conditions led to a decrease in dental claims last year. This helped influence multi year rate guarantee extensions as well as more aggressive new business pricing. Persistency within the industry has been at an all-time high, and we have now seen an increase of people using their dental providers and insurance benefits as they become comfortable visiting their providers.

5. Do you reimburse for out-of-network dentists if an insured chooses to go outside of your network?

Zeedik, Blue Shield of CA:

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

For non-network claims, the reasonable and customary expense allowance is provided by FAIR Health. The FAIR Health data is updated every six months and has UCR allowances from 50% to 95% in 5% increments. The UCR percentage utilized to process claims depends on the plan's out-of-network (OON) benefit design.

Stefano, Guardian:

Members covered under our PPO plans can visit any dentist; however, benefits may be paid at a lower coinsurance rate for non-participating dentists. Managed Dental Care/DHMO members must choose a participating primary care dentist.

Cabra & Childers, Premier Access:

Yes. Members can access care from any dentist. With our PPO plans, they can use our Premier Choice Network (PCN), which is a smaller, select group of dentists that offers extreme member discounts; our Preferred Provider Network, which includes all contracted dentists with significant

discounts; or an out-of-network dentist of the member's choice.

Steinhoff, Aflac:

Our Passive PPO plans and MAC plans provide coinsurance options as well as reimbursing and paying claims directly for out-of-network providers. Our PPO plans use the 90th usual, customary and reasonable (UCR) amount within our small-group segment. Our large-group segment has the ability to customize the UCR amounts and increase or decrease it depending on the customer's needs.

6. How many provider locations do you have?

Zeedik, Blue Shield of CA:

Blue Shield's Dental HMO network includes more than 22,000 access points in California. Our Dental PPO network includes more than 45,000 provider access points in California and over 400,000 nationwide. These are two of the largest statewide provider networks in the industry.

Stefano, Guardian:

There are over 482,063 PPO access points across the country and more than 50,728 in California (Source: Network360). We are one of the largest PPO networks in the state based on dentists. The DentalGuard Alliance network tier, a smaller group of dentists offering greater discounts, has over 4,721 dentist access points in California. For the DHMO, there are 8,558 general dentists and specialist access points in California. Guardian's PPO network also includes dental offices in Mexico. International Assist, a value-added service available, provides dental members with access to dental care if needed while traveling outside of the U.S.

Cabra & Childers, Premier Access:

In California, we have 10,900 PPO locations and 1,298 DHMO locations.

Steinhoff, Aflac:

Aflac Dental Insurance offers over 303,000 access points and comprises over 75,000 unique providers in the Aflac Dental Network.

7. What percentage of your network is open to new enrollment? How many offices does this represent?

Zeedik, Blue Shield of CA:

In 2020, approximately 96% of dental HMO plan network providers maintain open practices. This represents 21,910 out of 22,834 access points. View our dental network map for an overview of county coverage.

Stefano, Guardian:

In California, only 0.003% of our PPO network and 4.5% of our DHMO network are closed to new patients.

Cabra & Childers, Premier Access:

We do not have this data at this time. Historically, the DHMO panel is at about 80 % and PPO is at about 90 %.

Steinhoff, Aflac:

In the Aflac Dental Insurance network, 99.5% of our in-network offices are accepting new members to their offices.

8. What happens if a member is still in the middle of orthodontic treatment and they lose their coverage due to a job change or other circumstance?

Zeedik, Blue Shield of CA:

Providers are typically reimbursed for orthodontia over a 24-month period. In the event of an insured's loss of coverage for any reason, if at the time of loss of coverage the insured is still receiving orthodontic treatment during the 24-month treatment period, the insured and not the dental plan administrator will be responsible for the remainder of the cost for that treatment, at the participating orthodontist's billed charges, prorated for the number of months remaining.

Stefano, Guardian:

If a member is undergoing orthodontic treatment and his or her Guardian coverage terminates, we prorate the benefit to cover only the period during which coverage was in force. We do not extend benefits.

Our DHMO agreement provides for the Contracted Orthodontist to complete treatment at the contracted patient charge on a number of our plans. As an additional contract rider, we can allow for supplemental transfer coverage for Orthodontia under our DHMO.

Cabra & Childers, Premier Access:

If the member has a PPO plan: Orthodontia is based on a percentage paid to a provider over the course of treatment. Premier Access pays the provider a portion of the maximum ortho benefit at the start of treatment and pays in increments throughout the course of treatment. If a member were to leave Premier Access mid-treatment and move to a new carrier that also had ortho, the member would provide a copy of their EOB, and the new carrier would pay the remaining portion based on the benefit level they offer. If the member has a DHMO plan: Orthodontia is based on a copayment and an agreement between the member and provider. If the member were to leave Premier Access prior to the completion of treatment, the provider would determine whether they will still accept the copayment amount.

Aflac has the ability to match most plan designs offered by other carriers, allowing for limited disruption for employees.

— Diana Steinhoff, Aflac

Steinhoff, Aflac:

If a member loses eligibility during orthodontic treatment, the reimbursement is typically prorated based on the number of months the member was eligible. However, services required beyond the eligibility period are typically not covered.

9. What are your annual and lifetime maximums if any?

Zeedik, Blue Shield of CA:

Our annual maximums vary from as little as $500 to as much as $5,000 or more, depending upon individual or group coverage and group size. Employers have a choice in annual maximums, with more flexibility for large-group customers to

customize their annual maximum to meet their needs.

For large groups, we also offer our Rollover Rewards benefit feature, allowing qualified members to boost their annual maximum.

The annual account reward will vary depending on the annual claims threshold, which is determined by the plan's chosen annual maximum. The annual network reward for members who visit a network dentist, rather than a non-network dentist, is $100.

Brokers should be aware of new features introduced to address the changing needs of members.

— Joe Stefano, Guardian

Stefano, Guardian:

For PPO, the maximum refers to the total of benefit dollars actually paid for covered services incurred within the annual period, or the member's lifetime in the case of orthodontia. Guardian has flexibility with maximums. Typically, Preventive, Basic and Major have a combined maximum. We offer both an annual single maximum option (range from $500 - $5,000) and an annual split maximum option (maximums differ for in-network and out-of-network services). With the Preventive Advantage option, only Basic and Major services count toward the annual maximum. Maximum Rollover allows a portion of unused annual maximums to carry over for future years. We also offer an option to cover cleaning after the maximum is reached. For orthodontia, the lifetime maximum options range from $500-$2,500. Our DHMO plans do not include an annual maximum.

Cabra & Childers, Premier Access:

Benefit maximus are determined during the quoting process. Our maximums will only change if a request is completed during the renewal process. Annual maximums are per member and vary between $500 and $5,000.

Steinhoff, Aflac:

For our small-group segment, depending on the plan level, Aflac Dental Insurance annual maximums range from $1,000-$2,000. All plans allow insureds to carry over $250 each year toward their annual maximum, up to a total of $1,000, for use with any qualifying dental expense. Optional orthodontia benefits provide an annual maximum of $750 and a lifetime maximum of $1,500.

Our large-group plans allow for customization for both annual and lifetime maximums. Our annual maximums start at $500 and are capped at $10,000. Our lifetime maximums within our orthodontia benefit start at $500 and are capped at $5,000.

10. What is the plan deductible?

Zeedik, Blue Shield of CA:

Deductibles can vary from as little as $0 to as much as $300 or more, dependent upon group size and individual or family coverage. Employers have a choice in deductibles, with more flexibility for large-group customers to customize their annual deductible to meet their needs.

Stefano, Guardian:

Our PPO product offers many different deductible options ranging from $0-$300 and will vary by plan design with $50 historically being the most common. Deductibles are often waived for Preventive Services as Guardian's plans are designed to encourage members to get preventive care, thereby avoiding the need for more extensive dental care in the future. All our DHMO plan designs offered in California have no deductibles.

Cabra & Childers, Premier Access:

Deductibles vary between $0 and $100. The plan deductible is determined during the quoting process and will only change if a request is completed during renewal. Plan deductibles are typically for three members of family coverage; however, if the broker/group would like to see other options — such as a deductible for two or four members — they can request that during the quoting process. Deductibles are one-time occurrences during a calendar year. We can give a credit for the deductible for new business if proof the deductible was met is provided.

Steinhoff, Aflac:

In our small group segment, Aflac Dental Insurance plans provide a deductible that decreases over time. With this new-to-market benefit, insureds see a reduced deductible each year the plan is in force, with the first year at $50 per person, the second decreasing to $25 per person, and the third and subsequent years seeing no deductible.

Aflac large-group dental insurance plans can use the same deductible that decreases over time and customize their deductibles to any annual or lifetime amount.

11. What percentage does your plan cover for: preventive costs, root canals, crowns?

Zeedik, Blue Shield of CA:

Preventive costs

Preventive care is covered at 100% when using a network provider. Out-of-network coverage will vary based on the plan selected, but is typically not less than 80%. Members may also be balance billed for amounts exceeding the allowable payment to non-network providers based on their plan. For large groups, there is additional flexibility to customize the percentage of costs covered.

Root canals

For large groups, root canals can be covered under basic or major services. Typically, basic services are covered at 80% and major services are covered at 50%. Out-of-network coverage will vary based on the plan selected, but the most common percentage

is 50%. For IFP, root canals are typically covered under major services at 50%. For small groups, root canals are typically covered under basic services at 80%.

Crowns
Typically, for all lines of business, crowns are considered major services and are covered at 50%.

Stefano, Guardian:
Preventive
While we offer a variety of options, the most common for DHMO and PPO is 100%.

Root canals
For PPO, we most often cover root canals as a basic service. The basic coinsurance percent for our most common PPO plan sold is 80%. Our DHMO plans cover many root canal procedures at various copayment levels based on plan type.

Crowns
For PPO, we most often cover crowns as a major service and the major coinsurance percent for our most common PPO plan sold is 50%. Our DHMO plans offer a wide variety of different crown option procedures covered at various copayment levels based on plan type.

Cabra & Childers, Premier Access:
Percentages are determined during the quoting process and vary among our PCN network, PPO network, and out-of-network dentists. Procedures can be moved among preventive, basic, and major services. The covered benefit percentage is at the discretion of the broker and the client, with the goal of providing the most comprehensive, cost-effective plan for the members.

Steinhoff, Aflac:
For our small-group segment, all Aflac Dental Insurance plans cover 100% of costs and waive the deductible for preventative and diagnostic services. Depending on the plan level, basic services, including crown repair, are covered at 80-90% and major services, including root canals and crowns, are covered at 10-50%.

Aflac dental Insiurance plans in our large-group segment can have customized coinsurance percentages, allowing for several different coinsurance options. For preventative costs, 100% coverage is standard.

12. Do you provide dentist cost and quality transparency tools?

Zeedik, Blue Shield of CA:
Yes. Once registered on our website, members may review their claims information and locate providers. They also have access to treatment cost information through our Treatment Cost Estimator. The Treatment Cost Estimator allows members to search for common procedures, including exams, cleanings, X-rays, fillings, and root canals. This tool is quick and easy to use, enabling members to promptly receive estimated costs for procedures.

Stefano, Guardian:
We have a Dental Cost Estimator tool that provides an estimated range of allowable charges (fee schedule amounts) for the selected procedure codes in a selected region and provider contracted tier. Note that this is not the actual Guardian fee schedule amount for a provider nor the expected paid amount for a particular Guardian plan design. At this time, we do not offer provider quality ratings.

Cabra & Childers, Premier Access:
Members are encouraged to have a pre-determination completed for any services estimated at $300 or more. This will provide a detailed report with member's total out-of-pocket expense based on the services suggested by a determined provider. Members are encouraged to use our website to find an in-network—either PCN or PPO—provider to get the lowest possible out-of-pocket cost.

Steinhoff, Aflac:
Aflac launched all group dental plans nationally in January 2021, and we are still completing some of these detailed tools. We are able to provide network analysis reports, premium vs. claims, provider utilization reports and procedure utilization reports.

13. Who can readers contact for more information?

Zeedik, Blue Shield of CA:
Brokers who currently work with Blue Shield of CA should **contact their Blue Shield representative.**

Members are encouraged to have a pre-determination completed for any services estimated at $300 or more. This will provide a detailed report with member's total out-of-pocket expense based on the services suggested by a determined provider.

— Cabra & Childers, Premier Access

Stefano, Guardian:
The Guardian Life Insurance Company of America.
Joe Stefano, Divisional VP, Western U.S.
jstefano@glic.com

Cabra & Childers, Premier Access:
Readers can contact the Premier Access sales team at **sales@premierlife.com.**

Steinhoff, Aflac:
For more information, including plan highlights, provider search and member portal, get to know Aflac and our Dental Insurance at Aflac.com/NetworkDental. For other inquiries, please email **mediarelations@Aflac.com.**

Understanding California's Unique Medigap Rules and Extra Consumer Rights

BY BONNIE BURNS

It's often the case that insurers, and sometimes agents or brokers, are unaware of many Medigap guaranteed issue rights in California. As a result, applicants are sometimes erroneously refused coverage. Guaranteed issue means that an insurer cannot underwrite coverage, and must issue coverage at the best price for a particular Medigap plan in the pricing area for that plan. What follows is an overview of the guaranteed issue rights unique to California law. Some of these rights are an expansion of federal law.

Regulating Medigaps

In California, Medigaps are regulated by two state agencies. The California Department of Insurance (CDI) regulates most Medigap policies, and the Department of Managed Health Care (DMC) regulates Medigap plans sold under the trademark of Blue Cross or Blue Shield.

Statutory requirements in state and federal law are the same under both agencies; the bulk of Medigap requirements are in federal law. In 1990, the National Association of Insurance Commissioners (NAIC) was tasked with incorporating the new federal standardization requirements into the NAIC Model Law and Regulation for Medicare Supplement Insurance, including the 10 standard benefit packages which cannot be changed by state law. The NAIC updates their Model Law and Regulation whenever changes in federal law occurs; for instance, when previous Medigaps were retired and new Medigaps such as K, L, M and N were added. States can have stricter requirements and more generous rights so long as those don't change or conflict with federal requirements. Over the years, California has enacted many more generous guaranteed issue rights than exist in federal law.

The birthday rule

This right is available to anyone with a Medigap who wants to switch coverage. It's triggered on their birthday and a policyholder can choose the same lettered plan for a lower premium from a different company, or replace their current plan with another Medigap plan with the same or fewer benefits. Insurers are required to notify their policyholders of this right no more than 60 days before their birthday. The policyholder has 60 days from their birthday to switch their coverage. Insurers are not allowed to include any additional benefits they've added to a Medigap policy, such as vision or dental coverage, to determine whether a Medigap plan has more benefits than an existing Medigap. For instance, a plain Medigap plan G without additional benefits has the same benefits for the purposes of the birthday rule as a Plan G that includes additional benefits.

The legislation that created the birthday rule took effect in 1997 and didn't include Medigap plans with cost sharing that were added later. The federal Balanced Budget Act of 1997 (BBA) added high deductible options to Medigap plans F and J, but those options took effect after the birthday rule.

In 2010, another round of federal changes became effective, retiring several Medigap plans and adding new cost-sharing Medigaps. The birthday rule was amended to clarify which Medigaps issued prior to the federal changes could be replaced by Medigap's issued after that date. That left two high deductible plans, F and J, that could only be replaced with the remaining high deductible plan Medigap plan F.

It's unclear whether Medigap plans K and L or M and N can only be replaced with another plan of the same letter since there are no other Medigaps with the same benefit and cost sharing design. A high deductible plan, though, can only qualify to be replaced with another high deductible plan. Insurers can, of course, allow replacement of any Medigap plan with a plan of their own choice, but they are not required to do so by the law as it is currently written.

Medicare beneficiaries younger than 65

While federal law does not require insurers to issue Medigaps to younger beneficiaries on Medicare when they first take out Medicare Part B, California law does. Younger beneficiaries with kidney failure, also known as End State Renal Disease (ESRD), are excluded from this right. In California, younger beneficiaries without ESRD have the right to purchase Medigap plans A, B, D, and G, K or L, or M or N if an insurer sells those plans. Insurers, however, can charge higher premiums for this population, which means they can charge higher premiums for younger beneficiaries than for those 65 or older. California law does not unfortunately ensure that Medigaps are affordable,

and younger beneficiaries with ESRD continue to be excluded from these rights. Approximately 35 states now require companies to issue Medigaps to these younger beneficiaries with a disability, although each state may limit the lettered plans a person can buy or place other restrictions or limitations on that right.

Holidays for underwriting and other requirements

Insurers can always be more generous in waiving requirements in the law, as long as any waiver is not discriminatory. For instance, an insurer can waive underwriting for all applicants during a period of competition with Medicare Advantage plans, such as during the Annual Enrollment Period each fall. An insurer can also restrict an underwriting waiver to certain applicants, such as those who already have a Medigap and want to replace it. In each case, an insurer can designate the lettered Medigap that is available to all applicants during an underwriting waiver. Insurers can accept any applicant at any time for the Medigap of their choice; but they can also exclude those with certain medical conditions, those who have recently been hospitalized, or who have had a nursing home stay within the last year. An insurer cannot apply a waiting period for preexisting conditions if an applicant is switching from a previous Medigap plan.

Employer coverage

Federal law requires a guaranteed issue right to a Medigap when an individual loses coverage under an employer plan that is secondary to Medicare. California law applies a guaranteed issue right regardless of whether the employer coverage is primary or secondary to Medicare. Additionally, both federal and state law require Medigap guaranteed issue when an employer plan doesn't cover, or cuts the benefits for the Medicare Part B copayments, or doesn't pay any benefits after Medicare pays. Beneficiaries need to consider whether they are giving up any additional benefits under an employer plan if they decide to replace their employer benefits with a guaranteed issue Medigap.

Medigap and Medi-Cal

When a person has full Medi-Cal benefits, it's illegal to sell them a Medigap policy. However, when a person who has Medi-Cal is dropped from Medi-Cal or assigned a Share Of Cost (SOC), they have the right to a guaranteed issue Medigap. A SOC functions like a monthly deductible. It's an amount that must be spent for medical costs before Medi-Cal will begin paying benefits. The amount of the SOC is the difference between the income threshold for Medi-Cal and an individual's monthly income. A Medigap premium can offset part of the SOC, and having a Medigap will sometimes allow a Medi-Cal recipient to see providers that don't usually take Medi-Cal.

If a person already has a Medigap when they become eligible for Medi-Cal, they can ask the insurer to suspend their Medigap for up to 24 months in case they lose their eligibility for Medi-Cal in the future. During that 24-month period, they can reinstate their Medigap, or if it isn't available, choose another Medigap. A person who has a Medigap when they become eligible for Medi-Cal can keep it, and use it to access providers who don't ordinarily treat people with Medi-Cal.

COBRA and Medicare

While this issue was covered in a previous article, the federal American Rescue Plan includes 100% payment of COBRA premiums for six months. This may cause some former employees who are eligible for Medicare, but not enrolled, to mistakenly choose COBRA coverage over Medicare. Unfortunately, anyone eligible for Medicare is not eligible for the free COBRA benefit, and can incur federal penalties for failure to advise their employer of their Medicare eligibility. In addition, COBRA coverage can conflict with their Medicare eligibility, trigger later recovery actions of mistakenly paid primary COBRA benefits, and incur Medicare late premium penalties and delayed benefits.

It's important to understand that COBRA is secondary to Medicare, regardless of whether an individual has actually enrolled in Medicare. The only exception is when a covered individual has ESRD, is covered by Medicare, and is still in Medicare's 30-month coordination period.

Where to get help

The law regarding Medicare Supplement insurance (Medigap) open enrollment and guaranteed issue events in California is in the California Insurance Code (CIC) at 10192.11 and 10192.12. These rules are duplicated in the Health and Safety Code for those companies regulated by the DMHC. The Health Insurance Counseling and Advocacy Program (HICAP) has trained counselors who help Medicare beneficiaries and their families with questions about supplementing Medicare. There is a HICAP in every county in California and can be found here: https://cahealthadvocates.org/hicap/ or by calling 1-800-434-0222.

BONNIE BURNS *is a consultant with more than four decades of experience in Medicare, Medicare supplemental (Medigap), and long-term care insurance. She actively promotes improved consumer protection in state and federal legislative efforts affecting Medigap and long-term care products. A consultant to California Health Advocates (CHA) on long-term care insurance, she represents CHA on policy issues related to financing long term care for the middle class. She consulted for the National Council on Aging and SHIP Resource Center on Medigap and long-term care insurance issues. Burns served as an advisor on consumer interests to the 2017 California Partnership for Long-Term Care TaskForce, and during the 1992-93 formation of the program. She served as a consumer representative to NAIC since the beginning of the program in 1992, representing consumers in the development of Model Laws and Regulations used by states to regulate insurance companies and the marketing and sales of insurance products to older consumers. Burns was awarded a "Beneficiary Services Certificate of Merit" by CMS, an award from NAIC, and was honored as a Money Magazine "Hero."*

401 (K)

What a 401k Retirement Plan Committee Should Be Doing

BY ROBERT LAWTON

Most 401(k) plan sponsors worry about whether the retirement plan committee is discussing the right things at committee meetings. Is the retirement plan committee using its time wisely talking about what is important? Or do they spend way too much time reviewing investment performance?

As a 401(k) investment adviser who is also an Accredited Investment Fiduciary (AIF), I have worked with committees for decades. I believe that a retirement plan committee should focus on the following at its meetings:

1. Understanding its new cybersecurity responsibilities

On April 14, 2021, the Department of Labor (DoL) issued guidance regarding what employers and providers should do to mitigate cybersecurity risk. That guidance included:

- Best practices for retirement plan providers
- Best practices for selection and review of retirement plan providers
- Security tips for plan participants

Although not requiring employers to do anything immediately, with this guidance, the DoL has expanded the fiduciary responsibilities of employers to include mitigation of cybersecurity risks. Note that mitigation does not mean elimination of cybersecurity risk or insurance of participant balances.

It is important to note that following these tips and guidelines will help employers lay the groundwork to defend against possible future litigation claims from a data breach resulting in a cybersecurity theft.

Why did the DoL issue this guidance? Some experts feel that retirement plans are cyberthieves' numero uno target as collectively they hold more than $9 trillion in assets.

Suggestions on how to comply

- Construct a review request document that contains the tips and guidance shared by the DoL and submit it to the recordkeeper. Add the responses to a plan's file as evidence of due diligence.
- Review the contracts you have with retirement plan providers following the DoL's contractual guidelines.
- Distribute the DoL's Online Security Tips found their website for participants to all employees.
- In consultation with the information systems department, either construct a cybersecurity policy for the 401(k) plan or ask it to incorporate a plan into their existing cybersecurity policy.

2. Ensuring fiduciary compliance

Having worked with committees for more than 30 years, I can confidently state that no one who joins a retirement plan committee has an understanding of what their fiduciary responsibilities are.

As defined under ERISA and outlined by the DoL, a retirement plan fiduciary's primary responsibilities are:

- *Loyalty:* To act SOLELY in the best interests of plan participants (and their beneficiaries).
- *Prudence:* To carry out their duties prudently.
- *Diversity:* To offer a diversified menu of investment offerings in the plan.
- *Plan provisions:* To follow the terms of the plan documents.
- In addition, fiduciaries are expected to pay only reasonable plan expenses, monitor for prohibited transactions, respond to inquiries about the plan and obtain a fidelity bond for the plan.

That's it.

Make sure you spend a portion of at least one meeting each year on fiduciary responsibility education. Your investment adviser should be able to lead that discussion. Most, like me, are AIFs who spend a lot of time staying up to date on fiduciary responsibility.

3. Following a prudent decision-making process

Probably the most important fiduciary responsibility that retirement plan committee members have is making decisions that follow a prudent decision-making process.

What is a prudent process?

It is a decision-making process a fiduciary (that is you) follows that employs care, skill and diligence to arrive at a decision that SOLELY benefits plan participants.

To better understand how a prudent decision-making process works, it may help to review a few examples. First, an example of what not to do.

Example of a decision-making process that is NOT prudent

An investment advisor works for a bank and is recommending an investment fund that is managed by the bank. The advisor offers no comparison to similar funds in terms of cost and performance. The retirement plan committee likes the advisor and doesn't want to embarrass him by asking for this information or ignoring his recommendation.

The committee votes to accept the investment advisor's recommendation without any questions or discussion.

Not only did the committee not engage in an evaluation process with regard to the fund, it did not explore whether the advisor had any conflicts of interest in recommending it. In many situations like this, advisors may receive additional compensation from their employers for selling a proprietary fund. As a result, the advice shared by the advisor about the fund may be conflicted.

Example of a decision-making process that IS prudent

Your investment advisor works for a bank and is recommending an investment fund that is managed by the bank. The advisor presents a number of reports that illustrate the fund's performance, cost, risk and other factors in comparison with its peer group.

The committee tries to understand why the advisor feels the recommended fund is better than the alternatives and asks a number of questions about the fund. The committee also asks the advisor whether his compensation will be affected in any way if it votes to offer the fund in the plan.

The advisor acknowledges he is required to present investment options the bank manages any time he talks about changing the investment lineup. He discloses that his compensation will increase if the committee decides to add the fund to the lineup.

The committee has uncovered a conflict of interest and decides not to add the fund that is recommended. Instead, it asks the advisor to come to the next meeting with more information about one of the alternatives.

The committee has engaged in a prudent decision-making process and needs to only do one more thing: record the decision-making process in the meeting minutes.

4. Taking good meeting minutes

There is no way to prove that a retirement plan committee engaged in a prudent decision-making process unless that process is documented adequately in the meeting minutes.

It is tough for a lot of employers to take good minutes. Most either err on the side of taking too detailed minutes, resulting in minutes that are many pages long, or just recording the committee votes.

Here are my suggestions for taking good minutes.

Try to stick to one page

Unless the retirement plan committee meetings stretch on for days, one page should be sufficient. More (pages) are not better, in this case.

If meeting minutes end up stretching to multiple pages, the minutes are likely too detailed and might raise more questions than they answer when someone looks back at them.

Reference attachments to the minutes

All reports shared in a meeting should be attached to the minutes. Rather than describing the contents of the reports or what they represent, it is fair to say something like, "The attached reports detail the options evaluated. After a thorough discussion, the Committee voted 7-0 in favor of Option A due to superior historical performance and low cost."

Don't use a lot of words to describe discussions that don't result in decisions

This is the biggest mistake that I see minutes takers making. An investment adviser will likely spend quite a bit of time talking about recent investment performance and expected future market activity. All that needs to be said about these discussions is that they happened. For example, the following could be stated in the minutes: "As shown in the attached reports, our adviser reviewed recent market and fund performance."

The retirement plan committee agenda should be part of your minutes package. That agenda outlines the items the committee discussed. One of those items is probably a review of recent investment performance. The report the adviser shares on that subject should be attached to the minutes along with the agenda. That's good enough. It's not necessary to record whether your adviser feels the Fed will be raising interest rates soon.

If it isn't documented, it may not have occurred

Minutes should be taken at every retirement plan committee meeting and reviewed and approved at the following meeting. Although it's not required to document discussions, and I don't recommend documenting discussions the majority of the time, when the committee arrives at a decision that may not make sense without some added background, it is smart to share the reasoning.

It is also important to document

some discussions that may not result in decisions. For example, those discussions that relate to costs.

Quick, what was discussed two meetings ago? Even if the report references the meeting minutes to help with your memory, it is likely most of what was discussed won't prove to be memorable. Hence the importance of documenting decisions and rationale since they can be so easily forgotten.

Most plan sponsors try very hard to do the right thing. But without documentation indicating that they did, it can appear they were negligent.

5. Reviewing investment option costs (and performance)

This is one item that every retirement plan committee generally gets backwards. It isn't that committees don't spend time on cost, it's that most spend way too much time on performance, the markets, investment strategies and outlooks.

Keep in mind that a retirement plan committee has no control over past investment performance, future performance or the markets. But it does have control over the cost of the investment options offered.

The DoL has made it clear, and significant litigation has reinforced, that plan sponsors need to closely monitor the cost of the investment options in their menu.

Keeping an expensive fund option in a 401(k) lineup, when cheaper options are available with similar performance, exposes an employer to considerable litigation risk. Yes, the retirement plan committee should review investment performance, but it should focus intently on investment option costs.

6. Reviewing provider costs (and performance)

A primary purpose of a retirement plan committee is to monitor the cost of the entire 401(k) plan, not just investments. Although substantial litigation has focused on using the lowest cost share class of each investment fund, retirement plan committees also need to closely monitor the cost of all providers. These include the trustee, custodian, recordkeeper, investment adviser, auditor and any other consultant.

Keep in mind that a plan does not need to use the lowest cost provider for any function or the lowest cost investment fund in every asset class.

The committee can decide to pay more for a provider offering more services, or an investment fund that they believe offers better performance. They just need to demonstrate that their decision to hire a more costly provider or use a higher cost investment fund was arrived at using a prudent decision-making process.

The DoL recommends bidding out provider services (trustee, custody, recordkeeping and investment advisory) every three years. However, it is not necessary to run an RFP process every three years. This requirement can be satisfied by conducting a benchmarking review that focuses on where a plan stands relative to the marketplace on costs and services.

Make sure that any benchmarking reports and/or RFP responses find their way into the plan file, even if you don't make a change. It is important to be able to document due diligence in monitoring plan costs and provider performance.

Other key practices for the retirement plan committee

Most committee members are senior executives within their companies. As a result, members often carry their corporate mindsets into committee meetings. It is hard not to view everything through a CFO lens when those responsibilities are front of mind 24/7.

Share the following reminders with committee members. They should try to do the following when attending meetings about the plan:

- Take their corporate employee hats off when walking through the door and put on their participant hats.

- If it helps, they should visualize a non-management employee they know and like and think about what would be important to him or her. Remember, you can never discriminate in favor of highly compensated employees, but you can always discriminate in favor lower compensated employees.

- If they are doing their job as a committee member, they will have occasions when they will need to support initiatives that their boss may not agree with. This is difficult for "C"-level committee members, since they typically report to the CEO. They need to do it anyway.

One last suggestion: Encourage all to be courageous in their retirement plan committee meetings and do what they know is right for all plan participants. CB

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A New Digital Era Born from the Pandemic

BY JESSICA WORD

With the COVID-19 pandemic impacting business operations across the globe, the health insurance industry is no exception. Almost immediately, a new accelerated digital era began to reshape business as we know it — and the impact on our industry has begun to change how brokers will conduct business from here on.

To start, as companies pivoted their operations to accommodate staff working from home, both executives and employees have come to master the art of video conferencing. The health insurance industry was in a unique position because of its role in the center of a pandemic. To increase accessibility, the industry had to leverage tech tools in a way that had

never been done before.

For the first time in recent history, brokers left the paper forms of the past behind, moving instead to digital technology tools available at the click of a mouse.

In a pre-COVID-19 world, brokers preferred to meet with their employer clients in-person to discuss benefit design, costs and more. Once these meetings were concluded in advance of open enrollment, the pressure was on the benefits professional to pull together quotes, review them with the customer, choose a plan and begin filling out the paperwork as part of the process.

Not anymore. COVID-19 effectively shut the door on in-person consultation and with it, a reliance on the literal "paper trail."

The good news is that now many of the processes that took days pre-pandemic are more streamlined, creating time savings for brokers and business owners alike. Plus, video conference tools such as WebEx, Microsoft Teams, FaceTime and Zoom allow brokers to meet with clients, guide them through open enrollment and answer questions while still being face-to-face. Smartphones allow brokers to maintain their relationships, expanding their value by being available for a video conference in a pinch.

Healthcare providers have hopped on the digital technology bandwagon, too. For example, a report from the Centers for Disease Control and Prevention (CDC) found that virtual telehealth appointments experienced an uptick in the early pandemic period (January 2020 through March 2020). And, the use of this technology continued to increase throughout the year, allowing patients the option to receive quality care while also limiting exposure to COVID-19.

It's become clear that the digital shift is here to stay. In fact, many events held in-person prior to COVID-19 have gone virtual. The shift to webinars and other video-based professional development summits allow brokers to create personal virtual connections, while also remaining engaged with the newest developments in the industry, including how to digitally improve the overall customer experience.

We believe the move to a new digital paradigm has just begun. Here are just a few of the examples of technology that will affect the health insurance space in 2021:

• **App-based quoting engines:** The days of paper quotes that can take days to generate are gone – with apps now being designed for small group quoting. Now, brokers can build and revise quotes at their fingertips. That means adjustments like adding a new hire can be done in real time, decreasing the need for a broker to go back to the drawing board to build a new quote. Instead, a quoting app allows users to customize options that represent the client's brand, with custom-tailored rate and benefit details, and changes in contribution scenarios.

And apps with integrated tools such as provider searches allow brokers to ensure that employers and employees alike can continue to see their preferred doctors or visit a hospital close to home in an emergency.

• **Online business management tools:** Managing a book of clients can be hard enough for even the most seasoned brokers. The good news is that the piles of paper that used to dominate a professional's desk are now stored in online platforms.

Instead of having to physically call someone to check the status of underwriting, these web-based and mobile app tools can provide real-time updates on case status and much more. Plus, these platforms can help brokers keep their clients (and groups) organized by building in quick group name searches, along with coverage information, policy numbers and even payment information. Even when life returns to some sense of "normal," the ability to access a book of business on-the-go allows brokers to provide better customer service to existing and new clients.

• **Smartphone-accessible health insurance cards:** Another aspect of the digitization of the health insurance industry is the slow phasing out of physical health insurance cards. An increasing number of general agencies are now providing their brokers with the ability to equip employers and their workforce with a digital health insurance card. This helps to alleviate client "what if" worries, such as what happens if the card is lost in the mail, what if care is needed before the card arrives in the mail, what if the card is forgotten before an appointment and more.

Access to medical records via a smartphone is now becoming a must-have with consumers — it's only natural that the health insurance industry is adapting as well. Plus, delivery of a card directly to a mobile device provides another value-add brokers can leverage with the clients.

A final thought on **digital security.** The move to the digital space must keep security top of mind. Security features should be built into these apps and tools in order to keep clients' personal information confidential. At the most basic level, two-factor authentication is one security feature offered on most platforms that everyone should be using. To ensure that information is kept secure, simply turn the two-factor authentication settings on and list a backup phone number or email to verify identify whenever a login attempt is made.

The successful rollout of vaccines will help businesses return to a pre-pandemic normal, but the implementation of digital tech tools is here to stay. In-person meetings with clients will undoubtedly be welcomed, but the improved efficiency and accessibility that comes from online and app-based technology will be the new industry standard. It's important that brokers continue to educate (and use) digital tools to increase their productivity and provide quick, seamless delivery of information vital to employer and employees' health. CB

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Are You Using the Medicare Tools Available to You?

BY MAGGIE STEDT

Many agents, whether just starting out or experienced in the Medicare focused market, rely on the company trainings and certifications offered American Health Insurance Plans (AHIP), Gorman, NAHU or other companies. While certainly they are important components and a necessity, there is so much more that the Medicare focused agent needs to know to be able to assist their Medicare beneficiary clients.

The **www.medicare.gov** website provides most of the information and the materials that the informed agent needs to access. The site contains a wealth of information and resources. The three most important materials or textbooks as I call them are:

1. 2021 The Medicare and You
2. 2021 Choosing a Medigap Policy
3. Your Guide to Who Pays First

These three publications are key to your understanding of Medicare and other health benefits and should be read cover to cover and referred to as needed.

The Medicare and You Handbook

This handbook changes yearly and covers information from signing up for Medicare, understanding Original Medicare, Medicare Advantage Plans, Medicare Supplement Plans and Prescription Drug Plans. It outlines what services, tests and items are covered and not covered under Part A and Part B of Original Medicare. It covers the enrollment periods and the optional coverage and types of plans. It also provides resources for other Medicare Information. There is information regarding Medicaid, extra help, the appeals process, protection from fraud plus definitions of terms and much more.

2021 Choosing a Medigap Policy

This booklet is required to be provided to the Medicare beneficiary at the time you are presenting a Medicare Supplement (Medigap) plan. It is the guide to what Medicare Supplement plans cover, a beneficiary's rights to buy a Medigap policy and how to buy a Medigap policy. It is a helpful tool in addition to the actual company's Medicare Supplement Enrollment kit. I find the sections on "What is Medicare," "Your Medicare Options," and the chart showing the plans and the benefits of the various Medigap options are especially helpful. Clients are able to take notes and highlight what is important to them during their appointment.

Your Guide to Who Pays First

This booklet helps you to understand how Medicare works with other types of coverage such as Small Group, Large Group, Retiree, Veteran's benefits, TRICARE, Workers Compensation, No Fault and Liability Insurance, the Federal Black Lung Benefits Program, ESRD and COBRA. It is a resource for when the beneficiary has a question on the coordination of benefits. This guide is a must for you in working with clients with other coverages and will help those agents who work with employer groups.

While these booklets are great guides, bear in mind that changes may occur after their printing so it is important to visit **www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227)** for the most up-to date information.

Make time to review the **www.medicare.gov** website in depth as it offers far more than the plan and prescription drug finder. Through this site you have access to how to apply to Medicare, understanding Medicare costs, addressing Medicare card issues and a review of the mail that is sent to a beneficiary. There is also so much other information such as:

- Understanding the Order of the Medicare Part A and Part B Enrollment Periods
- Income Related Monthly Adjustment Amount (IRMAA)
- Part D Penalty Amount for Current and Past Years
- Claims & Appeals
- Manage Your Health
- Forms, Help, & Resources
- Where can I get covered medical items?
- Get Medicare Forms
- Publications
- Information in other languages

Through the Publications section there are other booklets that you can order and provide to your clients. Some of these include: "A Quick Look at Medicare," "Enrolling in Medicare Part A & B," "Medicare and Home Health Care," "Medicare Coverage of Durable Medical Equipment and Other Devices" and many many more. Topics include addressing skilled nursing, hospital care, enrolling in Part B when outside

This chart shows basic information about the different benefits that Medigap plans cover. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you must pay the rest. If a box is blank, the plan doesn't cover that benefit.

	Medicare Supplement Insurance (Medigap) Plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100% ***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
							Out-of-pocket limit in 2021**			
							$6,220	$3,110		

* Plans F and G also offer a high-deductible plan in some states (Plan F isn't available to people new to Medicare on or after January 1, 2020.) If you get the high-deductible option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of $2,370 in 2021 before your policy pays anything, and you must also pay a separate deductible ($250 per year) for foreign travel emergency services.

**Plans K and L show how much they'll pay for approved services before you meet your out-of-pocket yearly limit and your Part B deductible ($203 in 2021). After you meet these amounts, the plan will pay 100% of your costs for approved services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

the country and so on. There are also ebooks you can download as well.

If you are on Medicare yourself, you should create a **www.mymedicare.gov** account as it not only provides information for you personally but can help you to learn just what information is also available to your clients. They may wish to share their information with you in order for you to assist them since you are a "trusted advisor." Remember, always be mindful of HIPAA compliance when assisting your clients on this site.

Also, sign up for the email updates from Medicare in the Publications section of the site to keep you up to date on Medicare information and programs! The site also provides Helpful Links and links to CMS and HHS websites.

There is so much to learn and to be aware of that we could fill up this entire magazine! I recommend that you take some time to go to **www.medicare.gov** and begin your in-depth learning process. As a Medicare knowledgeable agent you will be far better prepared to assist your clients and grow your business! CB

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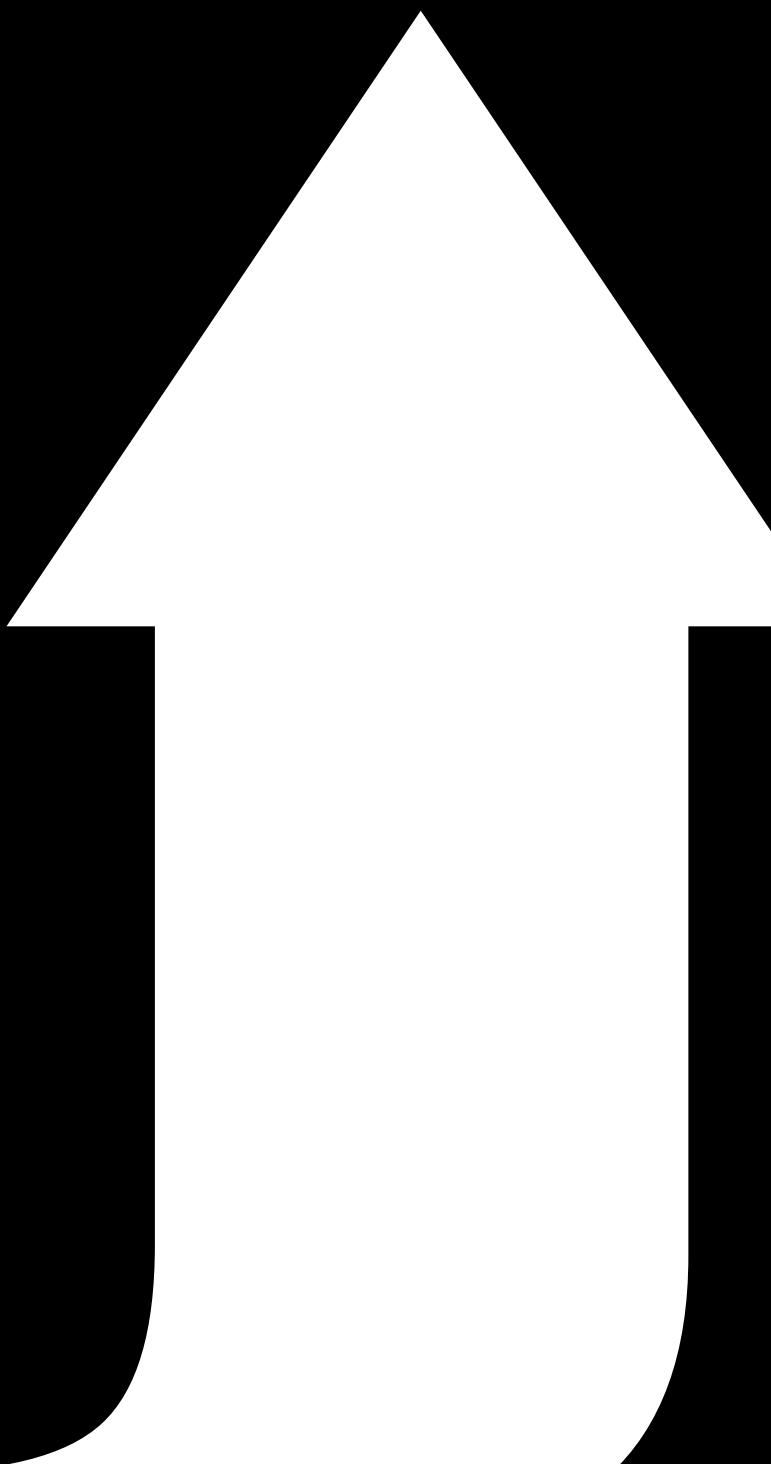
How Digital Health Platforms are Addressing the Spike in America's Mental Health Needs

BY MARY LANGOWSKI



The healthcare sector is only beginning to grasp the toll that pressures during the pandemic are taking on Americans' mental and physical health. Some 84% of respondents surveyed by the American Psychological Association in January 2021 reported symptoms of prolonged stress, while 67% of respondents said they felt overwhelmed by the number of issues America is facing. Even before the pandemic, more than half of adults (55%) in a Gallup poll reported feeling stressed "a lot of the day."

The $1.9 trillion American Rescue Plan that President Biden signed into law in March earmarks approximately $4 billion for programs that support the prevention and treatment of substance abuse and mental health conditions. Vast amounts of investment dollars are also driving a new assortment of digital and community-based providers that can help individuals manage their stress, sleep, social isolation, tobacco cessation, weight gain and other common conditions.

However, despite new options for addressing our mental health needs, the system can be difficult for individuals to navigate to find the best provider for their needs. The number of point-solution providers (or those treating a single need rather than a range of conditions) makes it difficult for large payers to identify those offering truly evidence-based services. Vetting, contracting and managing those relationships requires substantial resources for payers. A payer could easily invest hundreds of hours to select focus areas and providers, audit those providers and integrate each one into its offerings — not to mention the staff hours required for monthly monitoring and performance reviews of each provider.

The health sector needs ways to streamline the process of finding and providing consumers with increased and easy access to relevant digital and community-based providers who meet their needs. Tailored solutions targeted to individual needs are beneficial to payers, providers, and most importantly, help address the specific mental health needs of a person and their family.

Platform solutions

Technology solutions are helping consumers find and access healthcare that fits their specific needs, while enabling payers to work with a curated roster of providers through a single vendor that functions as a gateway to multiple providers. These platforms can be integrated into a payer's own provider selection infrastructure to create a seamless experience for the consumer.

Advanced digital health platforms can give the individual employee, plan member, or patient a single touchpoint for streamlined engagement and management of chronic conditions. Based on submitted profile info, a platform can match consumers with their best-fit digital and health-community-based solutions. Whether it be connecting users with companions to combat loneliness or providing digital and coached tools to positively impact low- to medium-acuity mental health needs, these customized plans allow members to craft their own experience.

The payer benefits by working with a digital platform of point-solution providers by increasing customer engagement with little additional administrative costs, since the platform can handle outreach on the payer's behalf and can deploy best-in-class engagement techniques. With the ability to offer personalized health benefits plans that organize lifestyle, behavioral and chronic disease benefits for the member, employers and payers make it easier to choose solutions that address the user's needs with less confusion. The platform operator can ensure the payer can offer the most in-demand treatments and services and can manage performance to ensure high-quality health care.

Other savings occur over the long term as treatment of stress, depression and other mental health issues helps to avoid costly medical care for conditions that could have deteriorated into more severe mental or physical conditions. By the same token, when consumers use the platform's providers to stop smoking, lose excess weight, overcome substance abuse or make other changes that help them avoid chronic illness and live healthier lives. Both plan members and payers benefit from the reduced need for expensive medical treatments down the road.

Treatment of some mental health issues, as well as prevention of chronic physical ailments such as diabetes and heart disease, often respond best to high-touch, low-cost programs that help individuals adhere to lifestyle changes for healthier living. Many digital and community-based providers deliver excellent results in the treatment of these and other conditions, which, if addressed early, may render more costly or invasive procedures unnecessary.

With the platforms available today, payers now have an efficient and effective means to tap various digital and point-solutions in the market. As mental health, stress, and substance abuse become larger issues that demand attention and more access to qualified providers and solutions, payers and employers can now offer their members tailored, digital resources to live healthier, fuller lives. CB

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Is a Beneficiary Designation a Good Option to Protect Your Commissions?

Explore your options before faced with a crisis

BY PHIL CALHOUN AND DAVID ETHINGTON

Passing along wealth to survivors is often a complex process. Beneficiary designations may fit for some planning situations and not for others. The question leads to a deeper look into the planning process brokers have available. This process is similar to the process a business owner would use. The common planning terminology used in business exit planning or succession planning applies to brokers and their commissions. The common goal for this type of planning is to sort through and select the better exit or succession plan, one that includes all of the owner's assets — the value of their business as well as their personal assets.

From our work with brokers it is clear there is confusion about how carrier beneficiary agreements work. A deeper understanding is important since commissions are the product of a broker's life work. Protecting and passing this value to loved ones is important. The key message is that commissions are of great value to the broker while alive as well as for loved ones when they pass. Brokers are no different from any other business owner that builds their business value over time. Brokers create significant value in their commissions. This article explains the beneficiary designation option and contrasts this approach with a written Commission Protection Plan as part of a comprehensive planning approach.

Shortfalls of carrier beneficiary agreements

The "beneficiary agreement" offered by a few carriers has several key shortfalls. The main difference is how the options impact loved ones financially and impact their client's health plan changes and service needs.

To begin with, most CPAs and estate planners suggest a comprehensive planning process as a best practice when planning time is available. The beneficiary designation can be a fit for the smaller books of business as it only addresses death of the broker and is only offered for certain types of policies and by only a few carriers. Comprehensive planning covers all types of health commissions from all carriers and in all life events.

We can stop there, as planning which addresses a broker's individual needs while alive and after they pass away, and further addresses all of their book of business, is clearly a better planning solution than a plan that has a limited focus — only on a broker's death. The details outlined here provide the opportunity to see how a comprehensive plan works.

Benefits of comprehensive planning

Since only a few carriers offer a beneficiary designation option to protect a broker's hard-earned commissions, this option would only fit with a couple of carriers. As a result this is not considered a best practice solution if the goal is to retain and pass on maximum value. Beneficiary designations apply only when a broker dies, and only covers DOI policies such as Individual & Family Plans (IFP) and Medicare Supplement lines of business. Other lines of health insurance are not eligible for this designation.

The value of the designation is restricted to the designated person only. The broker files for a carrier's beneficiary designation. The surviving family member is not allowed to sell these commissions.

With most commission protection plans, a family member may sell the commissions, often through a pre-arranged agreement with a pre-selected successor broker. The steps to accomplish this type of plan are included in most succession planning processes and in written documents. This planned sale would likely yield a higher payout.

Best practice is a properly written commission protection plan designed while the broker is alive and in consideration of their family and/or loved ones, leaving questions answered. We can stop with these limitations on beneficiary designations and just advise brokers to complete a comprehensive commission protection plan that will address all of their lines of health insurance business.

For brokers who would like to consider designating their commissions as a viable solution, there are two main concerns brokers may have in regard to planning.

First, the sale of commissions takes full advantage of the "selling at the peak concept." Commissions always drop when a broker slows down. Since most planning takes place when a broker is semi-retired, the more lightly-aligned clients are now susceptible to be lured to a new broker who may offer more service or new plans to consider.

Brokers know that every year many of their Medicare Supplement clients look to move to a less expensive plan, sometimes an MAPD. In all of these situations, brokers can work with clients and provide shopping advice leading to retention. If you think about a client currently paying high premiums, they are in need of an active broker's help to shop and compare. A Medicare Supplement client moving to an MAPD is not paid out under the beneficiary designation option.

We suggest commission agreements include payment of both plan and carrier changes during the payout period which increases the total commission payout to retired brokers and their loved ones.

Second, retention is critical and becomes a challenge under a beneficiary designation because loved ones count on the carrier to retain clients. Moving to a commission protection plan addresses the trends common with aging brokers. Many commission protection agreements include methods to assist brokers with the service their clients need. This addresses the risk that some clients may look to find another broker's help when relying on the carrier for this valued client service role.

Without a plan, upon the broker's death, the commissions drop in value. Without a licensed and certified successor ready to pursue a pre-planned client retention effort, history shows client retention will drop and lead to reduced payouts. This shows how commission retention is important and why a beneficiary (often a non-licensed friend or family member) is unable to do the job necessary to help retain clients. They rely 100% on the insurance carriers to do this service work, which is a recipe for retention failure.

When using a family member or friend as the unlicensed beneficiary, the assumption is commission retention will work without great effort. However, the carrier in these situations is now 100% responsible for all service and support for clients. Since the carrier is now responsible for all client retention, including during open enrollment, clients seeking information and making plan changes to find a better plan will have an impact on retention. The eventual result is rapidly declining commissions.

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Comprehensive planning covers all types of health commissions from all carriers and in all life events.

Overall, the beneficiary designation places clients at risk for three key reasons:

1. Open enrollment requires personalized assistance. Clients need help to shop for the best coverage, compare options, and enjoy personalized attention to address their needs. Carriers will never provide options offered by competitive carriers. Even when contacted, most carriers will not be easily accessible compared to an active broker. And finally, the carriers are unable to act as advocates for clients and as a result fall far short of the support a broker provides their clients. Relying on a carrier for client and commission retention will quickly lead to lost clients in situations where clients must rely on an impersonal 800 number for all servicing, combined with an inability to compare or enroll in plans with other carriers.

This approach to succession planning effectively eliminates retention management and will lead to a shorter than desired payout period, leaving a survivor's unlicensed beneficiaries with a shorter than expected payout period. According to agency experts, on average 70% of clients will move to another carrier or broker within three years. IFP and Medicare Supplement clients do shop plans often and are heavily marketed directly.

2. Logistics are complex. When working with any carrier that offers a beneficiary designation option, the broker must place the request while alive and use the carrier's formal process. Any request must be approved ahead of a life event so when the timing is last minute, which is often the case, mistakes can be made due to urgent time-sensitive decisions. Carriers can have completion timelines that if missed the option for the designation will close. Staying current with carrier agreements is important as well since carriers can change the terms of the agreement over time. A review of carrier agreements shows carriers have the right to change their broker agreement to modify commission amounts and conditions of payment at any time. History shows carriers do make these decisions. Also accounting for which clients are included and then monitoring that the carrier payment made when due can take time and some expertise. In a traditional commission transfer between a seller and buyer the carriers rarely get the commission transfer correct 100% of the time. This requires proactive review of statements and active management each month.

While the beneficiary option is better than nothing, the best practice is a comprehensive plan for 100% commission protection to gain the highest possible retention.

3. **Final thoughts on Beneficiary Designation Agreements.** A key goal in commission protection is to pay loved ones out when retiring or after death. This is due to the fact that commission protection planning uses a best practice approach that will create a much better solution. A $200,000 book of business could sell for two or three times, yielding $400,000 to $600,000 with a viable successor. This result is compared to a beneficiary arrangement where a slow financial draw down happens as clients change plans and move to brokers who can help them. While the payout may last a year or two, the business will quickly vanish as clients experience impersonal service and go through open enrollment with limited rather than objective assistance.

Ask yourself if the majority of your clients will stay with the same carrier and same plan for the next several years. If the answer is a yes for 80% of clients, the beneficiary designation could fit your needs for your IFP and Medicare Supplement policies.

Before you make a final decision on your planning, consider talking with a broker centered commission protection planning professional. CB

PHIL CALHOUN *and* **DAVID ETHINGTON** *operate a health insurance education program designed to assist brokers to learn how to protect, grow and sell their commissions. Both are active members of the Orange County Health Underwriters (OCAHU).*

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"The Health Insurance Broker's Guide: How to Protect, Grow & Sell Your Commissions" is available at **www.healthbrokersguide.com**

Sleep For Your Health

BY JEN PALMER

Sleeping only four hours a night may be misperceived as a 'badge of honor' by overachievers, but sleeping that few hours on average is no reason to brag or gloat, especially in the pursuit of overall health and wellness. Sleep is vital to our health, happiness and longevity, and if those are included in your personal goals, it's time to make sleep a top priority. The CDC recommends that adults get 7-9 hours of sleep per night, and teens need even more! Yet at least 20 million adult Americans experience occasional sleeping problems. According to a Gallup poll, 40% of Americans get less than seven hours of sleep per night on a regular basis. Clearly, America has a sleep problem.

What happens as we sleep?

We may not notice anything happening while we sleep, except perhaps a few dreams, but really there is a lot going on behind the scenes. During a normal sleep cycle, we pass through four phases: stages 1, 2, 3, and the fourth is known as REM (rapid eye movement) sleep. After we progress in a cycle of the non-REM stages 1-3 and then to REM sleep, the cycle repeats over again throughout the night. Each cycle lasts between 90-120 minutes.

Sleep is important not simply to prevent nodding off during the day. Stage 3 is considered the deepest level of restorative sleep which offers critical health benefits. Some of the amazing things happening while we slumber include:

- **Nervous system restoration**
- **Immune system activity**
- **Weight maintenance**
- **Risk reduction for diabetes and heart disease**
- **Lowered risk of mortality in diabetes and heart disease**
- **Mental health boost**

Clinical research shows us how getting proper rest can help us live longer, even with medical conditions such as high blood pressure or diabetes. Penn State College of Medicine conducted a large clinical trial which was published in the Journal of the American Heart Association. Half the participants had high blood pressure and the other half had type 2 diabetes accompanied by heart disease or history of stroke (which combined represents about 45% of the adult American population!). The study participants were tracked for up to 25 years, and during that time, 512 out of 1,600 participants passed away. The researchers determined that the amount of sleep they got correlated with their mortality risk. Regardless of having high blood pressure or diabetes, they had double the risk of dying from a stroke or heart disease if they slept less than 6 hours per night, as compared to those who slept more. For those who had heart disease or stroke, if they slept less than 6 hours nightly they had triple the risk of dying from cancer. Likewise, those with high blood pressure or diabetes who slept more than 6 hours nightly did not have increased risk of death despite having similar medical conditions. These results demonstrate the profound protective effect of sleep for Americans with commonplace ailments.

According to the CDC, inadequate sleep can contribute to the beginning stages of type 2 diabetes, and is linked to weight gain and increased obesity rates. Recent research shows that optimizing the number of hours slept and the quality of those hours has a positive effect on managing blood sugar control, and can alter markers such as hemoglobin A1c.

What's at the root cause of sleep deprivation?

There are many factors that interfere with sleep, which makes it tricky to research. Sleep apnea is a serious medical condition which includes frequent interrupted breathing during sleep. It is usually associated with loud snoring but not necessarily. In order to prevent the development of consequential medical conditions, it's important to rule out sleep apnea as the cause of disrupted sleep.

Then there is stress and anxiety; these are some of the more common causes for difficulty sleeping. When a person is under pressure or in stressful situations, the body releases cortisol, a hormone that triggers the fight-or-flight response. Cortisol can give the body a burst of energy that's useful when it's needed, but too much cortisol over the long term can have a negative effect on sleep cycles.

Another factor that can contribute to sleeplessness, and one that is often overlooked, is inconsistent sleeping and waking times. Keeping the circadian rhythm consistent helps us fall asleep when we need to.

It's important to pay attention to what we eat and drink if we are having sleep problems. Coffee, caffeinated soda, and even medications such as decongestants, have the ability to cause insomnia. Even drinking alcohol can interrupt sleep; it may help us fall asleep, but it hinders the deeper, restorative stages of sleep.

Lifestyle recommendations for better sleep:

- **Work with your physician to rule out sleep apnea**
- **Limit caffeine consumption in the afternoon or evening, and use alcohol sparingly**
- **Maintain a regular sleep schedule**
- **Reduce stress with meditation, exercise, yoga or your favorite relaxing activity**

CBD might help support healthy sleep cycles

CBD stands for cannabidiol. It is the second most prevalent of the active ingredients of cannabis (marijuana). CBD is not a sedative. it doesn't make you drowsy if you take it during the day, in contrast to sedating prescription sleep medications. But CBD may help you relax so you can nod off when it's time to go to sleep. While researchers are not all in agreement that CBD is linked to better sleep, there are many reasons why CBD might help.

One of the mechanisms by which CBD seems to help with sleep is by helping reduce stress and anxiety — the most common reasons for sleep interruption. Research has shown that

Recent research shows that optimizing the number of hours slept and the quality of those hours has a positive effect on managing blood sugar control, and can alter markers such as hemoglobin A1c.

CBD can improve a sense of calm and create the right mindset or frame of mind to help you fall asleep. This seems to be how it worked in a 2019 study published in The Permanente Journal. Study participants experiencing anxiety and sleep disorders took CBD capsules, ranging from 25-175 mg CBD daily, for up to three months. Most of the participants reported improvements in anxiety and many reported improvements in sleep.

The American Sleep Association says: "Although more studies need to be performed, some research supports the theory that CBD and cannabinoids may improve sleep."

How much CBD should you try?

If you're considering CBD, I recommend choosing a full-spectrum hemp extract; it offers more than just CBD with additional phytocannabinoids such as CBD, CBN, and CBG, as well as beneficial compounds like terpenes, fatty acids, flavonoids and phytosterols — each with their own health benefits. This medley of plant compounds works together to support the actions of CBD, creating a synergistic phenomenon known as the entourage effect.

Everyone's CBD experience is unique. Some people notice a benefit from the very first time they try it, and for some, it takes consistent daily use for several weeks. I always recommend that a new CBD user have patience and take time to figure out what works best for them. Start with a low amount, perhaps 10 mg CBD per day, and increase slowly. Finding your unique serving size, or "sweet spot" can best be achieved by keeping a journal and tracking how you feel daily. This serves as a reminder to show how you felt in the beginning, and what has changed over time. Once you achieve the sweet spot where you are getting desired benefits, stick to that amount.

What products should you take for sleep?

During the day, anxiety and stress can be detrimental to sleep and can interfere with our ability to concentrate and feel grounded. Full-spectrum hemp extract can be beneficial for supporting a sense of calm and focus, and to support regular sleep cycles. CB

JEN PALMER, *ND is the director of education for Charlotte's Web, hemp-derived CBD industry pioneers. Dr. Jen is a naturopathic doctor with 20 years' experience in the dietary supplement industry and integrative medicine profession. As a graduate of Bastyr University, she is passionate about sharing her knowledge about natural medicine through writing and speaking to consumers, retailers, and physicians. She recently created a one-year herbal certification CME program for physicians and authored "Berberine: Everything You Didn't Know" by Woodland Publishing, among other writings. Her dedication to educating on the health benefits of hemp-derived CBD started when she used hemp extract to successfully support her dog's health. Find out more at* **charlottesweb.com.**

CBD & ANXIETY

If you have occasional anxiety, you may want to consider CBD. It was demonstrated to offer relief to teenagers who frequently experienced anxiety in social situations, as published in a 2019 study in Frontiers in Psychology. Another study published in Neuropsychopharmacology in 2011 showed that taking CBD prior to a public speaking event helped support a sense of calm for the speakers, and supported normal heart rate and blood pressure during the activity as compared to the participants who took a placebo.

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3 Ways Employers can Support Mental Health

BY TERRI L. RHODES

Economic and food insecurity, family obligations, home schooling and the ongoing pandemic have sent stress, anxiety and depression to an all-time high. Calls to help centers and suicide assistance lines are up. So are alcohol and cannabis sales, and opioid deaths are accelerating. More than 40 states have reported increased deaths from opioids since the coronavirus epidemic began.

Then there are residual symptoms from COVID-19 itself. According to a recent report in Lancet Psychiatry, nearly one person in five with COVID-19 is diagnosed with a psychiatric disorder like anxiety, depression or insomnia within three months. People recovering from COVID-19 were about twice as likely to be diagnosed with a mental health disorder as compared with someone who had the flu.

Of course, depression and other mental health disorders were widespread even before the disruption of normal social interaction. According to the Centers for Disease Control (CDC), 8.1% of Americans 20 years of age and older have depression in any two-week period. It is also closely related to alcohol and other drug abuse, overeating and other behavioral health issues.

Most employers offer resources to address mental and behavioral health. But with many employees working from home, these resources can be out of sight, and most likely, also out of mind.

3 Ways Employers Can Support Employees

There are some clear ways that employers can support their workers. Here are three suggestions:

1. CLEAR AND CONSISTENT MESSAGING

One of the more difficult aspects of mental and behavioral health issues is that many, if not most, try to self-manage. There are many reasons for this, not the least of which is stigma. Employees fear they will be judged and treated differently if their employer knows they have a mental health condition. While workplace stigma has declined, we still have a ways to go before mental illness is treated like any other illness.

But this is a unique time. The workplace, routines and expectations have changed. People have become more willing to talk about declining mental health during the pandemic. And as many fear this decline will continue in some form for months, if not years, this willingness is even more important.

This means employees are more likely to be open to consistent messaging about resources available to them to help with mental, family and financial issues. Now more than ever, employers should use clear and consistent messaging to let employees know they're not on their own. Companies need to ensure intranets/portals include a centralized repository for benefits and resources and a place to view personal stories — especially for remote workers. Email and other reminders should be sent regularly. Insurance and other providers should be brought into the effort too. A consolidated effort should be sought with vendor partners to address the whole person, mental and physical.

2. EMPLOYEE ASSISTANCE PROGRAMS (EAPS)

A high percentage of employers have an employee assistance program (EAP). While use is up now, employers should be thinking of ways to continue this trend. In the past, use of EAPs has been low, and we need to ensure they don't return to pre-pandemic levels.

Some of the responsibility for low utilization lies with employers. Employers do not communicate about EAPs as effectively as they could. This is a loss to employees — and employers. Although detailed EAP performance statistics are limited, documented studies suggest employer sponsored EAPs can reduce company absence, medical, pharmacy and worker's compensation costs.

The current situation lends itself to EAP use. Since so many EAP programs are already conducted online or on the phone, remote employees can more easily integrate them into the rest of their lives. Calling into an EAP from home increases the feeling of confidentiality and privacy. In addition, there are many apps now available that include stress reduction, and mindfulness and telemedicine have more broad acceptance. Employers should double down on promoting EAPs and communicating to employees that using them has no impact on any workplace assessment or opportunity.

3. COMPANY PRACTICES

Employers have revised and created new policies for time off related to the COVID-19 pandemic — like expanded sick leave and PTO — and loosening some protocols around performance reviews and bonuses. Many remote employees are working longer hours at home than they would in the office. And while this might be great for productivity, it can interfere with household and family obligations. This, in turn, can increase stress and trigger other mental health conditions.

Even before COVID-19, employees felt anxious trying to manage their families and be productive. Employers should encourage employees to maintain work-life balance and consider revised policies, and even benefits, to help employees feel they can achieve it.

The pandemic has forced massive change over a short period of time, and even with vaccines, it's not over yet. The unavoidable result is stress, anxiety, depression and other mental and behavioral health challenges. It is more important now than ever before for employers to communicate resources and benefits available to employees so that when we do get beyond the pandemic, we have a viable and mentally healthy workforce. CB

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Technology Brings Solutions in the Insurance Industry

BY PAUL FORD

If the past year has taught us anything, it is that most people are resilient and able to adapt to new situations and challenges. All across the world people are talking about a new normal and trying to find ways that the changes of the past year can be adapted for good. Technology has started to play an even more major role in almost every aspect of life. We are just now determining which technologies we want to keep and which ones it would be better to delete. In the insurance industry, the past year has shown us how neglecting beneficial technology and upgrades can lead to issues and obsolesce. The industry needs to change and adapt, like the American workforce has been able to.

According to the Pew Research Center, at the beginning of 2020 approximately 20% of Americans worked from home at least one day a week. By the middle of the year, more than half were working from home and now, more than a year later, 70% of Americans are still working from home. As an end result, businesses are now reconsidering ways of operating as many employees report that they are more productive while working from home and reluctant to return to a long daily commute to a crowded office space.

Every facet of life has changed. Take entertainment for example. People binge watch television shows, options for streaming services have increased, virtual concerts and virtual visits to museums are common now, as are holding Zoom parties with family and friends. All this translates into families and friends — society as a whole — having new ways to communicate and connect.

The coronavirus pandemic has forced us to change the way we live, work, shop, interact and play. From remote learning to attending events online, telemedicine to video conferencing, many experts say the digital adoption we've experienced since March 2020 is equal to five years of digital gains. And while it would be wonderful to interact in person, attend a live concert and meet colleagues at conferences, now is the time to take stock of the digital gains we've made over the past year. We are moving toward the dire necessity to improve and incorporate these digital gains into our lives, which allow us more freedom over our daily schedules, more profit in our pockets and more time to spend with our loved ones. Nowhere is the need to catch up with the digital age more apparent than in the insurance industry.

For decades, the legacy insurance companies have not had much competition, which created a culture of non-innovation. Most of them operated with a "if it's not broken, why fix it?" mentality. Not only has this resulted in outdated and unneeded products, and an alienation and bad loyalty scores from the majority of the population, but it also meant that, for many companies, business came to a screeching halt in March 2020. The shutdowns had many negative consequences for consumers and agents — some immediate and some forthcoming.

When life locked down and medical establishments that were open were filled to maximum capacity, people who wanted life insurance policies could not go to the doctor's office to get the required medical exams. They could not go to the lab to get the tests they needed nor did the lab have time to process previously existing tests. This resulted in a backlog of people waiting to get insurance — in some cases, in excess of three months just to get information about which policy they qualified for.

Since people put off preventative care and elective surgery during the height of the pandemic, once people felt more comfortable going out into the public, inexorably it led to a resurgence of office visits and outpatient surgery. This caused a flood of claims to come in at the same time, with many companies lacking the technology to process them quickly.

The coronavirus pandemic will have lasting consequences in the insurance industry. In the future, unknown factors in mortuary tables will result in more policies and products that do not fit

consumers' lifestyles or needs.

Agents also suffered during the lockdown as they started to lose their means of support. Agents who relied on face-to-face selling suddenly found themselves stuck at home with no clear way to communicate with their clients and no plan forthcoming from their companies. This caused a negative effect on their earnings and livelihood and resulted in lower profits for the industry overall. The domino ›effect was in full swing at these legacy insurance companies.

The current insurance industry system is not sustainable

Consumers want and expect digital ease in their daily lives when researching and purchasing products — especially from the comfort of their own homes. According to a Rock Health and Stanford Center for Digital Health report, over the past year, the rate of consumer adoption for live video telemedicine, wearable ownership and digital health metric tracking grew by more than 10 percentage points. Consumers now expect technology to be an integral part of their healthcare experience. A PwC survey found that 41% of respondents said they were likely to switch insurance providers due to that company's lack of digital capabilities and 53% said they were likely to use digital channels to contact their insurers in the next 90 days. According to a Munich RE report, 50% of consumers are more likely to purchase an offer that appears quickly. The message is clear: Adopt and incorporate digital technology into the insurance buying and selling model or face obsolescence.

Using technology to make purchasing and researching a product easier doesn't just make sense but in the case of insurance policies, technology can also be used to create better, more relevant products as well as ones to reach substantially larger new markets.

With the right technology, potential policyholders don't have to spend hours answering questions and visiting doctor's offices and then weeks, or months, waiting to find out what they qualify for. Insurtech uses deeper levels of data and can calculate more than 4,000 data points in minutes to calculate risk and create technology-enabled products that protect consumers and insurers.

New Spectrum Life Insurance is an example of a digitally improved insurance offering — one that uses advanced technology to create a product that is more accessible to consumers and increases agents' selling potential. Typically, life insurance companies use seven categories to determine what type of life insurance a person qualifies for. If you have a pre-existing condition such as diabetes or high blood pressure, you might be disqualified or only qualify for a very expensive, very limited policy. Insurtech can help insurers and reinsurers develop, design and distribute bespoke insurance products that match client's needs, increase a company's bottom line and give agents policies that personally match a client's lifestyle, increasing their potential selling power.

As with any new innovation, there are challenges. Innovations in the industry have been sporadic up to this point and brokers have struggled to discern where the value is and what they can gain from adopting new technologies. Data can and should be used to help processes and product offerings become smarter. Agents and consumers may be reluctant and unwilling to embrace new technology but if we provide consistent messaging and education and clear concise instruction, they will learn quickly and realize the benefit.

By adopting insurance technology into their daily work routine, insurance brokers and financial planners will be able to save themselves and their clients valuable hours in the day. For example, the interview to start the process to qualify for life insurance can take several hours to complete with consumers becoming frustrated as they have to answer the same questions over and over. But digital offerings use technology to reduce the application process from hours to an average of 20 minutes. At the end of the process, the consumer receives information about a wide variety of policies that are customized to fit his or her life and situation. Not only does this benefit the consumers, but agents are able to be more responsive, have a wider breadth of products to offer their clients and have the ability to earn more money while providing stellar customer service. It is a continual beneficial circle that can reap rewards for all involved.

Agents will also benefit because they have a whole new potential audience of clients to reach out to. When policies and products are based on real data and digitally analyzed information, we are able to create products to reach groups that have never been served before — younger and older age groups, those with pre-existing conditions — people who have shied away from the industry because they did not think it had anything to offer them or even wanted to help them.

With the use of insurtech, we can now serve more than 60% of the American population that has never had the chance to consider life insurance before.

The digital revolution has happened. People are ready for a change and it is up to us to lead the way with innovative solutions and products. If you don't, consumers will find someone who will.

PAUL FORD *is co-founder and CEO of Traffk, an innovative insurance underwriting and distribution platform designed to build and launch modern insurance products and brands that scale. Ford has used his expertise in insurance and AI to create solutions to the problems of inefficient, assumption-based underwriting and slow processing in the insurance industry.*

Traffk works with agents as partners, providing them with the digital tools to work with an efficient sales process and engage consumers with a fast, accurate process for insurance policies. More info here: **https://www.traffk.com**

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