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CALIFORNIA BROKER

VOLUME 40, NUMBER 3

Serving California's Life/Health Professionals & Financial Planners

November 2021

**All
eyes are
on LTC:
here's
what you
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to know**



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Cal Broker's Annual Survey

COMPILED BY THORA MADDEN

Cal Broker reached out to industry insiders for a peek at what's happening in the small group world.

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AMERICAN ACADEMY OF ACTUARIES DISPEL PLAN MYTH

The American Academy of Actuaries has published an issue brief, "The 80% Pension Funding Myth," to alert the public, pension plan participants and other stakeholders, including policymakers, that the financial health or soundness of a pension plan cannot be reduced to a single measure or benchmark at a single point in time.

"While the funded ratio of a pension plan is certainly a useful measure, its reporting of 80% funding – or any other funded ratio percentage – simply doesn't provide enough information to accurately gauge its financial health," said Academy Senior Pension Fellow Linda K. Stone. "While the funded ratio is a useful measure and important aspect of a pension plan's financial condition, it is most meaningful when viewed in the context of other relevant information. A plan that is funded at 80% at a single point in time could be anywhere in the spectrum from excellent to poor financial condition, depending on other factors."

The actuary academy says that while it is unclear when widespread use began, an 80% benchmark has appeared in research reports, legislative initiatives, and in the media as a misleading bright line between healthy or well-funded plans and unhealthy or underfunded plans. The Academy's issue brief notes:

- Using an 80% funded ratio as a benchmark for whether pension plans are healthy is inappropriate.
- No single level of funding defines a line between a "healthy" and an "unhealthy" pension plan.
- Pension plans are generally better evaluated on the strategy in place to attain a funded ratio of 100% within a reasonable period of time.
- The financial health of a pension plan depends on many factors in addition to funded status, including the size of any shortfall compared with the resources of the plan sponsor.
- Projections under a range of scenarios can be particularly useful in evaluating the plan's expected funding trajectory and assessing plan health.

Go to actuary.org to learn more!

Imperial PFS Introduces Quivit



North America's largest premium finance company Imperial PFS® announces the launch of their much-anticipated insurtech product Quivit™.

According to the company, Quivit is the first insurance-specific product to merge document signing, storage and an integrated payment processing system – allowing for both paid-in-full and financed transactions. The result is a streamlined workflow, transforming a complex, high-touch process into an efficient, digitally-driven sales closer.

InsurTech NY Launches Insurance Collaboration Index

Whoever thought of doing this should get a pay raise...

InsurTech NY, the leading resource for the InsurTech Community in the New York Metro Area, announced the launch of its Insurance Collaboration Index™. Based on input from InsurTech executives, the index scores insurance and reinsurance companies on their willingness and ability to partner with startup insurance technology companies. It provides a rigorous and objective measure of how easy it is for a carrier and a startup to work together.

If you want the big guys to work with you, just start rating them and get them competing to be numero uno. Brilliant.

Breeze Launches Online Portal to Streamline How Agents Sell Disability Insurance

Breeze, an insurtech focused on disability insurance, has launched the Breeze Agent Portal that streamlines how agents sell disability insurance and critical illness insurance to consumers.

"Today, we're excited to announce the launch of our Breeze Agent Portal, which gives insurance agents the ability to leverage our underwriting technology. This means they can not only seamlessly quote and apply for income protection policies for their clients, but sometimes even instantly bind policies pending client eligibility," said Colin Naby, CEO & co-founder of Breeze.

The company says the online agent portal advances Breeze's mission to offer smart, affordable insurance that can help financially protect individuals and families from unexpected injuries and illnesses.



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- Groups must satisfy standard CCSB binder payment requirements for enrolled employees to count towards incentive program payments.
- Business written through partnering General Agencies qualifies.
- CCSB intends to issue incentive payments 90 days following group qualification. CCSB may modify its payment schedule at any time.

For a complete list of the program rules go to:

<http://www.coveredca.com/agents/PDFs/Agent-commission-schedule.pdf>



*Insurance companies vary by region and are subject to change

Anxiety and Depression Declined in 2021

A CDC report says that national rates of anxiety and depression declined in the first half of 2021 but remain elevated compared to pre-pandemic levels. The report is based on the ongoing Household Pulse Survey, a national online survey developed by the U.S. Census Bureau and the National Center for Health Statistics.

Based on responses, CDC found average anxiety severity scores increased 13% between August and December 2020 before declining 26.8% between December 2020 and June 2021. The researchers reported a similar trend for depression rates.



Fly You to the Moon — Or Somewhere Out There?

Everyone seems to be fantasizing about space travel due to the launches of Virgin Galactic, SpaceX, and Blue Origins. We thought you might find some enjoyment in the findings of a recent space tourism survey by ValuePenguin:

- 49% of Americans want to travel to space. Men are more interested in space travel than women (56% versus 44%), while interest in space tourism decreases with age (63% of Gen Zers versus 38% for baby boomers).
- 28% of both men and Gen Zers would choose a free trip to space over being debt-free. Among all consumers, 23% opted for a trip to space rather than the ability to wipe out their debt.
- Reality check: Of those consumers who want to travel to space, just 19% would shell out \$100,000 or more to make it happen — and even that might not be enough. Seats on Virgin Galactic's SpaceShipTwo are estimated to start at a whopping \$250,000 per person.
- 60% of Americans agree that space travel should be accessible for everyone, not just those who can afford the exorbitant costs. On a similar note, 41% don't think billionaires should be spending so much money on space travel.
- About 1 in 4 (24%) don't think space tourism is ethical. For example, some scientists fear that frequent space travel could give way to climate change, harming the environment through a high rate of emissions-per-passenger, as well as soot released by the rockets.

All we have to add: there have gotta be insurance opportunities if space tourism takes off! :)

EVENTS

SIIA Crowdsourcing Forum, In-Person,
December 6 - 8, Charleston, SC. Info at siia.org.

CAHU Women's Leadership Summit,
March 14-16, Green Valley Ranch, Las Vegas. Info at CAHU.org.

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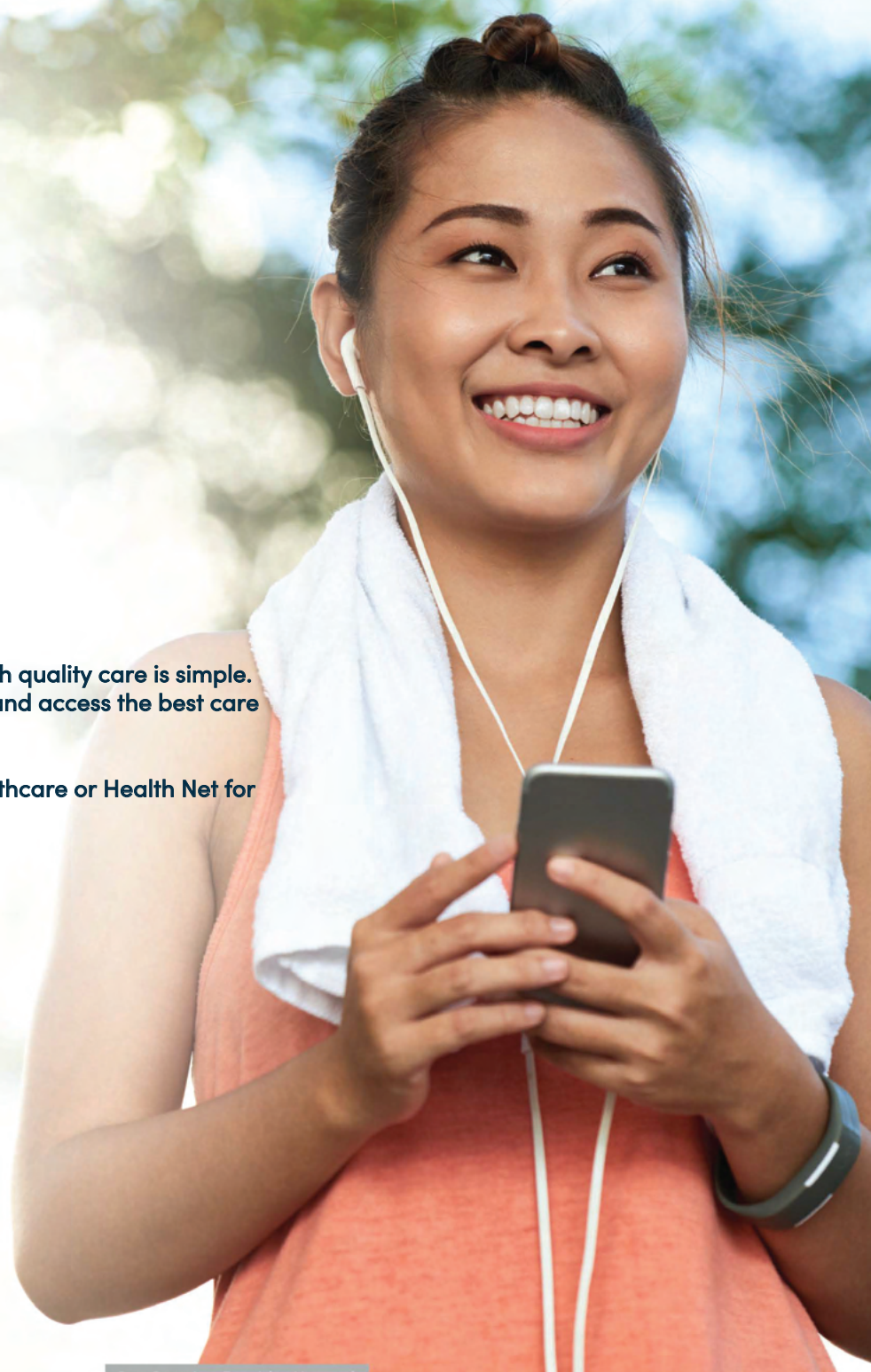


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Redesigning The Washington State CARES Act For California

There is a strong movement in California to implement a publicly funded long term care (LTC) program. The California Long Term Care Insurance Task Force has been established “to explore the feasibility of developing and implementing a culturally competent statewide insurance program for long-term care services and supports.” The task force has a committee of fifteen members, consisting mostly of California Department of Insurance employees and representatives of caregiving organizations.

BY LOUIS H. BROWNSTONE

The LTC task force has now met three times and is beginning at a very high level to undertake its exploration. It is looking at several programs, including those from one or two European countries. However, the main example it is discussing is the recently enacted Cares Act from the State of Washington. A number of other states are pursuing the same track, but California may be the most advanced thus far in its thinking and organization.

The Washington Long Term Care Trust Act will be funded beginning in January through a mandatory payroll tax of .58% on all W-2 earners in the state. This will give workers a lifetime benefit of up to \$36,500 adjusted annually by Washington's Consumer Price Indexed inflation. There is a wide range of benefits, both at home and in facilities, based on the need for assistance in three of 10 activities of daily living, including cognitive impairment. The self-employed are given an option to opt-into the program, and citizens with private long-term care insurance are given a very limited option to opt-out by November 1, 2021.

The concept here is to provide a small long-term care benefit and to encourage citizens to buy wrap-around private long-term care insurance. This would protect citizens and save the state many millions of future Medicaid dollars.

In my view, this noble effort, guided by actuaries from Milliman, got many things right in its design. It's a mandatory program. It is funded by a progressive tax, so that the poor pay very little and the very rich can opt-out. Its benefits are far-reaching. It has a seventy-five year vision to adjust the program to ensure its financial solvency. It will be administered in a hands-on manner by Washington State government personnel.

However, the Washington Cares Act has run into some difficulties as well. There was strong public opposition to the imposition of the tax, despite the fact that the legislature approved it. No one likes to be taxed. The regulations included the fact that citizens who moved out of state would forfeit their contributions to the Fund. In addition, citizens who lived out of state, say, in Oregon or Idaho, but worked in Washington, would have to move to Washington in order to receive their benefits.

Because of these reasons, there was a huge rush by citizens to purchase private long-term care insurance in order to opt-out of the tax. The insurance carriers suddenly got deluged with applications and could not cope with the volume. Many applications were for very small benefits and premiums. The carriers were thus concerned that applicants would cancel their policies once they could show the Washington Cares Act that those policies were in force, as there was no planned recertification that these policies remained in force. In addition, applications for small benefits are generally unprofitable, due to the costs of underwriting and administration. Consequently, the carriers ceased taking applications almost three months before the closure of the brief opt-out option.

What can the California Task Force learn from the Washington Cares Act experience?

The main take-away is that in its efforts to be all-inclusive

and ensure its solvency, the designers of the Washington Cares Act included some elements which were not well accepted by its participants and which might need some revising in the future. The problem is that many of these revisions would result in a shortfall of revenue and could necessitate an increase in the tax.

Here are some areas of concern which need further investigation.

First, and above all, there needs to be greater cooperation with the insurance industry. This would include a far longer period to be able to opt-out. There should also be minimum benefit requirements in order for a policy to qualify as an opt-out policy. The insurance industry should also be compelled to recertify opt-out policies on a regular basis in order for a policyholder to retain their opt-out status.

Second, Washington State's citizens should not be penalized if they move out of state. They should at least receive a refund of their premiums. In this method, Washington could retain any increases from inflation to cover their administrative costs.

Third, CPI inflation may become a weak method to keep up with the rise in the costs of care. In the present environment, CPI inflation is 2%, and the increase in the costs of care is about 4%. In 36 years, at these rates, CPI inflation would create a \$200/day benefit, but a four-hour home care cost of \$120 now would increase to \$480. The Cares Fund would pay for less than two hours of home health care. This gap would continue to grow over time. A new method needs to be created to keep up with the rise in the costs of care.

All of these revisions would affect the size of the tax required. I believe that there would be little objection to the increase in the tax so long as the total remained under one percent. There may be other ways to cushion the need for a tax increase, such as inserting a small elimination period in order to receive benefits.

If the California Long Term Care Insurance Task Force uses the Washington Cares Act as its model, which I believe it will, it will attempt to overcome its shortcomings. I have submitted 10 recommendations to the task force as a starting point for discussion and revision. I hope that this and input from others will guide the task force in creating a program which will benefit many Californians.

Here are my recommendations:

1. Extend the Opt-Out Provision period to at least two years to handle the crush from California, whose population is five times that of Washington's.
2. Enact minimum requirements to qualify as an Opt-Out policy. Suggestions:
 - a. Traditional LTCI: \$150 daily benefit, 730 day benefit period, 3% compound inflation.



- b. Linked life/annuity with LTC rider: \$250,000 death benefit with equal LTC rider.
- c. Life with LTC rider: \$250,000 death benefit with equal LTC rider.
- 3. Recertify Opt-Out policies at least every other year.
- 4. Promote Opt-In for self-employed and include spouses.
- 5. Include either a 30-day or 45-day elimination period to cushion the size of the tax.
- 6. Include reimbursement for members who move out of state, either with a refund of premium cost or the current value of the account.
- 7. Create a new formula to keep up with the rise in the costs of care.
- 8. Have California's senators fight for federal matching funds.
- 9. Include some of the elements of the California Partnership for Long Term Care.
- 10. Don't call it a tax, call it a premium, a payment, an assessment – anything but a tax.

Others should feel free to weigh in with their recommendations to the task force. We should all pull together to create a good program for California's citizens.



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CALIFORNIA

LONG
TERM
CARE
TODAY
IN

BY PATRICK JOHNSON

The basics of long term care (LTC) is the need for assistance or supervision with the six activities of daily living. These are eating, bathing, dressing, toileting, transferring and continence. There are many health-related issues that can play a role in the need for long term care: chronic illness, advanced age, accident, stroke, Alzheimer's disease and other cognitive impairments.

Long term care policies cover home health care, including part-time skilled nursing services, physical therapy and respite care. They also provide care at a residential care facility, nursing facility and assisted living communities. Additional services would also include hospice care, medical equipment and home modifications.

The top reason one would buy a long term care plan is to allow your loved ones to care about you instead of caring for you. Also — to remain independent, to have a choice where to receive care and to avoid burdening loved ones with caregiving roles. The cost for home care in Sacramento, Calif. is around \$28 to \$32 dollars per hour. A one bedroom assisted living community starts around \$4,500 per month.

Assisted living communities have many levels of care. Most have up to six levels, with some with up to nine levels. Each level up provides additional care and can cost \$450 per month more. Up to a level nine could offer a registered nurse around the clock.

3 Types of Plans Offered

The three most common types of long term care products are the traditional pay as you go, hybrid Life/LTC combo products and universal life with a LTC rider.

1) The traditional plan is a cash flow sale: you pay a monthly premium based on the options you choose. This could include:

- The daily benefit amount
- Inflation options — usually are 3 and 5%
- 20-year option or life time option
- Length of coverage such as 2, 3, 4, 5, 6 years or unlimited.

Also in the calculation is the elimination period for a claim to start — usually 90 days. Some plans also offer a Zero Day elimination rider for home care. The age of the client and if single or married have an impact. Some plans do offer a couples discount.

2) The hybrid Life and LTC product combines a little life insurance protection on the back end if you never file a claim and die owning the policy and not using the LTC benefits. It also offers some sort of a return of premium. This is an asset sale.

- Most clients pay a single premium to lock in the coverage for life and it's guaranteed not to change.

- Some carriers allow a 5 or 10 year pay plan as well.

- These plans work just like the traditional plans with the same features and benefits.

- 3) The last option is to purchase a larger life insurance plan and just add a LTC rider to the death benefit.
 - o These plans can be a fixed universal life plan or an indexed life insurance plan.
 - o The LTC rider could be 1, 2 or 4% of the death benefit and the coverage amount could last up to 25 months.
 - o A full 26% of all LTC cases written last year were ages 45 to 56 years old. This age group typically needs more life insurance coverage.
 - o These plans provide tax-free accumulation of cash value, tax-free distributions if needed, a tax-free death benefit if the insured dies and tax-free LTC benefits.
- New features in California in 2021 include a new version of shared care in which the carrier just provides a third pool of equal benefits that can be shared by a couple in the event they exhaust their benefits. Also, this year you can pay a traditional plan with a 10 year pay or a single pay which would be guaranteed for life. A lifetime coverage benefit is also new to traditional products.

LTC Underwriting Today

You have to qualify for long term care coverage. That entails considering your current age, health, medications and current medical treatments. Carriers have pre-submission tools that can help clients know if they should move forward with the application process.

Items that can disqualify an applicant could be height and weight, certain medications and conditions such as Alzheimer’s disease, dementia, congestive heart failure, type 1 diabetes, oxygen use and Parkinson’s to name a few. All carriers provide agents with underwriting guides that list the conditions and medications. Other items that could make a client ineligible for coverage would be that they were previously declined for

coverage, or that they currently require assistance with the activities of daily living, use a walker, wheelchair or are non-compliant with medications and treatments.

Some of today’s biggest medical concerns for the underwriters are depression, by-polar diagnosis, insulin dependence, diabetes, orthopedic problems, sleep apnea, cognitive dementia and memory loss, family history, obesity and circulatory issues and what is called co-morbid conditions – having more than one major medical issue.

Carriers offer a quick quote service where you can fill out a form or compose an email of the client's medications and what they use them for and any other pertinent information for the underwriter to consider. Usually within a 24-hour period, you can get a thumbs up to move forward with the application or a thumbs down – which means a decline – or they may come back with additional questions. Most carriers offer a couple of underwriting classifications such as preferred, select, Class 1 or Class 2.

Based on the client's age, usually a telephone appointment is all that is needed to qualify. At age 65 to 66, carriers require a live cognitive exam and will send out a registered nurse to visit with the client. Carriers usually order prescription drug checks and order medical records to complete the overall medical picture before an offer is made.

New 2021 Client Enhancements

For the first time ever, California has now approved a LTC traditional carrier with a single premium option. **A client can now do a partial or full surrender via a 1035 tax-free exchange of a non-qualified annuity into long term care. This is HUGE!**

Also, besides paper applications clients can now do an electronic application with their agent thru I-GO/E-APP and do it all online. **CB**

PRO TIP: Make sure that your will and trust are up to date and that you have current California long-term care directive, power of attorney for health care and power of attorney for finances.



PATRICK 'PJ' JOHNSON is an independent life insurance agent and also does sales and marketing for Cal Pacific South out of the Sacramento office. PJ has been a NAIFA member since 1984 and currently serves on the board of directors for the Greater East Bay Chapter. He is also a past board member of the FPA Sacramento Chapter. He has CLU and CLTC designations and can be reached at: **pj@cpssac.com or 925-200-9482.**



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NOVEMBER IS LONG-TERM CARE AWARENESS MONTH

LTC is the #1 Unplanned Health Event for Seniors

BY MARCIA ISRAEL

PLAN
preventative
community
quality
care
ort therapy
plementary



Writer's Note: *My own mother, at age 43, suffered from oxygen deprivation to the brain and required full-time care for 7 years – my dad had to pay for a number of caretakers to help our family. The unexpected can and does happen!*

This is the time of year when we analyze the best Medicare and health care plans for senior clients; as agents we also re-assess our own health care plans. That is all part of taking care of ourselves and our clients. **The fact remains that there is one facet of healthcare that is all too often delayed or passed over: Long Term Care (LTC) planning.** This is important because NOT planning for LTC can have serious financial and emotional consequences for families.

Because the need for LTC is not immediate and planning requires forward-thinking and intention, it is often never addressed by families. It is crucial for adults to plan for LTC (aka Extended Illness Care). Yet most seniors (59 and beyond) and younger seniors (ages 48-58) have not put aside funds, purchased LTC insurance, developed a LTC plan, or had family discussions about care and end-of-life wishes. Some families

are fortunate and their own parents purchased LTC insurance decades ago. Yet, those same senior-age children, who now benefit from their parent's foresight, have delayed planning for their own care needs in the future.

More often than not, when we, as advisors, ask seniors about clients' long-term care plan, the answers are, "I will think about it," or "I don't need it." As advisors, we read articles about the need, cost, and financing of long-term care, but what are the financial and human costs if planning is delayed?

Senior Care and Caregiver Concerns

The COVID-19 pandemic has taught us that life is unpredictable. Prior to the pandemic, we lived our lives with the belief that life will move forward in a fairly predictable manner.

One of the first major worries, as COVID-19 spread, was how to protect our vulnerable senior population. (Think: February 2020 – the skilled nursing facility in Kirkland, Wash. – one the first cases of COVID-19 affecting LTC facilities where approximately 27 of the 108 residents and 25 of the 180 staff had some symptoms).

Eventually, more than 4,000 senior communities were overrun with the virus. Unprepared, families and caretakers scrambled to figure out health protocols; tough decisions had to be made all too quickly — should we keep mom and dad in a nursing home or bring them home for care? These decisions came with great consternation and a new understanding that senior care is multi-faceted and complex.

By April of 2021, with the availability of the vaccines, senior communities began to re-open and welcome back new and returning residents. However, there are still challenges with COVID-19 and health safety, and some families are sticking with home care, bearing those costs and services.

Paying for LTC

Many seniors who now wish to reside in a LTC community are finding that the facilities accept only private payment or some Medi-Cal, with very limited bed space. The fortunate are those seniors who had the foresight and financial ability to purchase LTC insurance in their 50s and 60s, about 10 to 30 years ago. These folks now make up the lion's share of assisted living communities or whose LTC insurance pays for home care. Families with no LTC insurance must scramble to find reverse mortgages, sell any life insurance (think life settlements), depend on family member contributions, or spend assets down to Medi-Cal limits. With care averaging about \$39+ per hour for home care or \$5,000+ a month for assisted living (plus costs for personal/custodial care), **shouldn't we all have these conversations with our clients? medicine**

Care facilities all say that having LTC insurance makes the care transition all that much easier. Loved ones who have LTC insurance and a Long Term Care Plan in place fare much better because financial, care, end-of-life, inheritance, and medical decisions are set so their wishes can be

met — and they can spend quality time with the family.

What about caregivers?

Most spouses and children become caregivers and do so gladly. However, with no LTC plan in place, the toll on these family heroes becomes more apparent over time. Spouses get tired or struggle with their own physical ailments as they care/lift/clean/do all household chores and shopping. As the caregiver's health suffers, some even die before the "patient" does. Other caregivers may also require LTC (with those additional costs) alongside their loved one. With family caregivers the toll is different, especially for daughters (who are relied on more often than others). They can lose time away from work (and their own family), lose income, health benefits, retirement benefits, and may also suffer health challenges.

This secondary toll of caregiving affects the whole family once more. An LTC plan and LTC insurance assists family caregivers and pays for respite care, additional caregivers, even adult day care.

Modern medicine and longevity

The "Silver Tsunami" is upon us. California will need to provide care for the increasing number of seniors who turn 65 each day. More seniors than ever are living into their mid-90s; some have become centenarians. This population will absolutely need care in their platinum years.

Our life expectancy has been extended because many diseases and chronic illnesses that resulted in death years ago are now treatable. However, the resulting chronic, lingering symptoms and conditions require not only medical care, but also non-medical care such as assistance with the ADL's. COVID-19 patients may suffer from a variety of lingering physical ailments, but not all of these may be covered by Medicare or health insurance.



Our life expectancy has been extended because many diseases and chronic illnesses that resulted in death years ago are now treatable.

LONG TERM CARE BY THE NUMBERS

Simply put, not enough seniors have the savings or the insurance to fund even 3 to 6 months of care.

What percentage of the population needs Long-term Care?

- 42%: Percentage of people older than age 85 who need long-term care services
- 47%: Estimated percentage of men 65 and older who will need long-term care during their lifetimes
- 58%: Estimated percentage of women 65 and older who will need long-term care during their lifetimes
- Just 1 in 4 Americans can afford the cost of LTC for a year
- Among people ages 70-84, about 16% will need assistance with at least one activity of daily living (ADL)
- After age 85, 45% will need assistance with at least one ADL
- About 30% (1.5 million people) have substantial LTC needs (multiple ADL limitations)
- The average yearly cost for care in California is \$138,000
- The average nursing home stay is 3 years
- 13 % of older seniors may require 5+ years of care
- Authentic Home Care in California runs \$38-\$43 per hour. Health insurance covers less than Medicare when it comes to Long Term Care.

The long-term effects from COVID-19 are yet to be revealed — the impact on the long term care community and families, as well as on the insurance industry is unknown. Stroke and Cognitive Impairments also add to the list of conditions which may persist for a longer period of time.

Dispelling Myths About Medicare, LTC and Aging in Place

“LTC” is too often referred to as “nursing home insurance.” In reality, most people who need care remain at home.

Medicare does not pay for LTC. A few Medicare managed-care plans may provide some modest long-term support and services. Medi-Cal pays for about half of all LTC costs, and is for those with low incomes or other needs. Families often pay for LTC costs themselves or provide care on their own.

Medicare services for in-home care, for an extended time or permanently, are temporary. Medicare Part A and Part B cover intermittent nursing care (part-time, skilled nursing care) for up to 21 days. Medicare does not pay for 24 hour/day home care, meal delivery, homemaker services, or help with ADL personal care: bathing, dressing or using the bathroom. **Medicare does NOT pay for LTC (custodial care) in a skilled nursing facility**, including assistance with the ADL's: continence, transferring, walking, bathing, eating, dressing.

In a skilled nursing facility in 2021, under a doctor's orders for longer than 20 days, a patient pays a \$185/day coinsurance for days 21-100 and ALL COSTS after 100 days. Medigap insurance may help fill the “gaps” (days 21-100) that Medicare won't pay — copayments, coinsurance, deductibles. If a person is expected to improve and a physician prescribes physical, occupational, or speech therapy temporarily, the patient still pays a 20% deductible — with just Part A or Part B and no additional insurance.

Aging in place (at home) is not always the best care option for seniors. The family may wish to provide the loved one a consistent support network at home. The challenge is navigating the complexities of services and health needs, including: home modifications, home care aides, transportation, medications, meal deliveries, adult day programs and coordination among many health-care providers. Many older adults benefit from community-type living and having access to increasing levels of care. For others, living independently and autonomously from their children affords them the freedom to make the final decisions about residence and care choices. However, seniors who live alone can be terribly isolated; some suffer serious health risks which have been exacerbated by the pandemic.

This California will need to provide care for the increasing number of seniors who turn 65 each day. More seniors than ever are living into their mid-90s; some have become centenarians. This population will absolutely need care in their platinum years.

How California, other states, and the federal government are addressing the impending “Silver Tsunami”

California Governor Newsom recently empowered the California Department of Insurance (CDI) to establish The California Long Term Care Insurance Task Force, charged with creating a feasibility study with the purpose of creating a statewide insurance program for LTC services/supports.

The state, NAIFA CA, CAHU, and other legal, financial, and insurance experts have monitored the roll-out of Washington state's Cares Fund, a payroll tax to fund state-provided LTC. In Washington there was a lack of clear communication about what the tax was for, how/why to purchase LTCI ahead of the tax (we received numerous calls to our agency among others), and what the “opt out” process was. Also, the benefit pool was way below the current costs for care. Other states and the federal government are also looking to offer public or private options to help fund LTC for many more people. It's a work in progress with no clear path for funding any type of LTC for all. **Refer to: Well-Being Insurance for Seniors to be at Home, or WISH Act (H.R. 4289); <https://wacaresfund.wa.gov/>.**

What's the take-away? Create a blueprint for the future

As financial advisors who work to ensure that our clients are insured and protected for many circumstances in life, we should discuss retirement and legacy options. Invite clients and their families to create a blueprint for future extended care.

Creating a blueprint:

- Gather financial, insurance, health, military, and legal documents
- Determine who will coordinate the care plan (a trustee of sorts)
- Together with the loved one, center the dialogue around care and placement options, which assets to use, residential or home care options and hospice and end-of-life wishes.
- Discuss the needs for the surviving spouse/partner as well. There is no time like the present. **CB**



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speaks passionately to senior, financial, and legal forums about the great need for families to plan ahead for a long-term health event. Her agency is active with various CAHU and NAIFA chapters. Marcia can be reached at **(818) 706-1100**.



How Self-Funded Employers Can Have It All:

Pharmacy

Cost-Savings

and Minimal Member Disruption

BY RICK SUTHERLAND

Employers are under significant pressure as they evaluate their health benefits plans for the year ahead. Recent projections by the Policy and Medicine publication show prescription drug spend growing by over \$110 billion by 2024 with faster price increases and rises in specialty drug utilization being primary factors at play. In addition, we can expect to see increased healthcare costs and higher insurance premiums for the next several decades according to a recent report by Insurance Journal. At the same time, employers are facing an incredibly competitive talent war that requires an innovative approach to acquiring and retaining their workforce, including providing a top benefits plan.

These factors have put HR leaders between a rock and a hard place. With drug spending and health insurance premiums rising rapidly, many HR leaders are seeking to control costs without negatively impacting employee health or causing any disruption to their staff. One such option being explored is whether to self-fund health benefits.

As you help your clients evaluate whether their company should choose to remain fully insured or move to a self-insured model, it's important to understand the difference between the two approaches and the questions employers should ask themselves as part of the decision-making process.

Self-Funded vs. Fully Insured – What's the difference?

Investing in health insurance is about hedging financial risks. Many employers, especially those of a smaller size, are in a traditional fully insured benefits program. In this model, they pool employees' experiences, diseases and care needs with those of many other employers. They then contract with a medical carrier that bundles together all their medical and pharmacy benefits vendors and services, and pay a health plan to assume that risk, in the form of a premium. Regardless of what transpires, the employer's costs for that year are fixed. This approach may feel comfortable, familiar and safe for the employer, but the status quo has inherent risks.

For one, **the cost of premiums for fully insured plans and their members is very high and climbing annually.** And if the employee population is healthy or doesn't utilize much healthcare or medication during the plan year, the organization will have spent a significant sum of money on premiums it can never recoup. Conversely, if the plan's costs exceed what the health plan predicted for the year, rate hikes are inevitable for the following year, making renewal negotiations tedious and exasperating both the employer and their members.

In addition to high fixed costs, **fully insured arrangements provide few, if any, options to tailor plan design, coverage, and provider networks for the employer's members.** They also limit the ability to adapt to meet new healthcare challenges as they arise, such as the rising costs of specialty medications or the impact of the COVID-19 pandemic. With this model, employers are part of a one-size-fits-all approach to

managing health benefits.

An increasing number of employers are now considering taking on that financial risk themselves in a self-insured, or self-funded, benefits model. There comes a tipping point when it makes sense for employers to stop paying a premium to have the health plan manage everything and instead design a benefit plan that is focused on what really matters to their employees — and that tipping point is lower than you might think. Evidence shows, and **most brokers agree, that it makes sense to explore self-funded benefits when the employer reaches as few as 25 employees.**

In a self-funded arrangement, the employer sets aside a monthly amount of money to cover administrative fees and employees' anticipated health and pharmacy costs. As employees seek care from physicians and hospitals and fill prescriptions at the pharmacy, the claims are paid directly from these funds. In addition, self-funded employers can purchase stop-loss insurance, which provides protection against catastrophic or unpredictable claims.

The most significant advantage of self-funding is the cost-savings potential. In this arrangement, payments and costs are reconciled at the end of the year. If claims are lower than expected, the employer receives a refund of any unused funds. If that trend continues, there may be a reduction in the necessary contributions made by both employers and workers. On the other hand, if the plan incurs above-average costs or catastrophic claims, the employer's stop-loss coverage insulates it from financial overages.

Additionally, self-funded plans are significantly more flexible and enable employers to tailor their benefits. In a self-funded arrangement, employers have full access to all claims information, giving them insight into who uses the plan and where healthcare dollars are spent. With these insights, you can help your client make educated decisions on their plan design and benefits coverage, proactively steering spending where it makes the most sense for them and their members.

For example, the employer can choose to work with an insurance company's network so the plan and its members can benefit from its doctors, hospitals and pharmacies with contracts that outline predetermined prices — or they can allow employees to choose which doctors or specialists they prefer.

The most significant advantage of self-funding is the cost-savings potential. In this arrangement, payments and costs are reconciled at the end of the year. If claims are lower than expected, the employer receives a refund of any unused funds.

Finally, with a self-funded arrangement, employers can optimize their pharmacy benefits by carving out, or unbundling their pharmacy from their medical benefits.

How carving out can optimize pharmacy benefits

Once your client is self-funded, allowing the pharmacy benefit to remain bundled, or "carved-in," with a medical carrier severely limits the employer's options to manage rising prescription drug spending. By carving out, however, employers can optimize the value they derive from their pharmacy benefits.

To illustrate, in a self-funded administrative services only (ASO) arrangement, the employer pays for the prescription drug claims, but the medical carrier continues to process them. With this type of arrangement, the employer has more access and insight into their pharmacy claims, pricing and utilization data than they did under the fully funded benefit arrangement but will still experience many of the same frustrations they encountered. For example, the carrier remains in control of all the plan decisions, and employers can't customize their plan design or tailor their formulary based on their membership's medical needs or cost-savings goals. Ultimately, if your self-funded employer client is in a carved-in arrangement, they can't create a truly custom pharmacy-benefits experience for them and their employees.

Alternatively, **self-funded employers in a carved-out pharmacy program have full control over everything from selecting their preferred pharmacy benefits partner to their pharmacy network, stop-loss carrier and more.** When your self-funded client is in a carved-out arrangement, you can guide them in selecting a pharmacy partner that advocates for their best interests. This includes recommending strategies that align with their economic and clinical goals, helping them negotiate a competitive and transparent contract, and providing excellent member services. These are all critical aspects to look for in a pharmacy provider that will deliver sustainable prescription drug savings as well as long-term value with minimal disruption to members.

Getting started with self-funding

When working with your client to make the switch to a self-funded, carved-out plan, it's important to allow ample time to

gather the pharmacy claims file from their carrier, evaluate the data, and determine a strategy to address any clinical or financial risk areas. Additionally, by unbundling the benefit products, the employer will need to find partners to contract with for each component — i.e., medical benefits, pharmacy benefits, and a stop-loss vendor for catastrophic claims protection. This process takes time, and each of those carriers will want to see information about what the plan is currently spending. Thus, a conservative timeline calls for at least four months before the desired start date for a proper implementation process.

Some medical carriers intentionally drag their feet when providing employers with their pharmacy claims data file. However, this should not deter you and your client from pressing forward and securing whatever information is needed from the carrier. This data is key to helping you understand your client's member population and finding opportunities to reduce costs. By evaluating your client's plan performance using their claims data, you can identify potential risk areas, recommend hyper-targeted strategies to address them, and forecast the cost savings and member impact of any changes. The result is a pharmacy benefits strategy that is tailored to your client's actual clinical utilization and aligned with their plan savings and member access goals.

When developing this pharmacy analysis and action plan for your client, it's important to utilize pharmacy expertise independent of the PBM or insurance carrier. Include the best opportunities for plan design and clinical utilization management to help your client strike the right balance between providing a robust benefit, achieving cost savings, and minimizing member disruption. This will ensure they're able to make the best, data-driven decisions for their prescription drug plan and their members.


Finally, once your client decides to become self-insured, the way they communicate the change to their members is critical. Most employees feel the impact of rising healthcare and prescription drug costs each year, and will appreciate a thoughtful solution. Employers should explain to their employees how cost-control measures can positively impact their premiums, copays and deductibles. Also take the time to discuss ways that potential savings might be reinvested in

other programs that benefit employees. Communicating transparently will make employees feel valued and respected and will go a long way toward making them comfortable and empowered to make the best healthcare decisions.

Making the decision to self-fund

Ultimately, your client will need to consider their organization's tolerance for risk when determining whether a fully insured or self-insured model is the right option for them. If the company must know in advance exactly how much their employee health and pharmacy benefits will cost at the end of the year, it may be necessary to pay a predictable, monthly premium to a health plan as part of a fully insured benefits strategy, although the cost will be much more substantial than that of a self-insured plan.

Moving to a self-insured, carved-out plan can provide employers with significantly more flexibility to develop a pharmacy benefits plan that aligns with their goals, is attractive to current and future employees, optimizes member wellbeing, and reduces overall prescription drug costs.

Making changes to the pharmacy benefits plan or provider will undoubtedly cause some disruption, but if in the long run it will result in improved health, a superior service experience, and less frustration for members, all while reducing overall costs, it's worth examining. 



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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). He can be reached at rsutherland@rxbenefits.com.

2022 PREVIEW

A Continued Paradigm Shift to Personalized Benefits

BY JESSICA WORD

Of the many lessons and changes coming out of the pandemic, none has been greater than the painful reminder of the fragility of personal health. No matter the age, many across California are prioritizing their physical health and personal wellness.

To that end, employers and employees have come to appreciate health insurance benefits more than ever over the course of the last 12 months. More pointedly, employers and employees are seeing the value in personalized benefits packages and plans that meet their individual and family needs. These needs extend beyond “traditional” benefits, such as being able to continue to see a preferred doctor, copays that won’t break the bank or prescription drug benefits.

Post-pandemic employees are now more conscious of health, and they are making lifestyle changes that go beyond more frequent hand washing and healthier diets. For example, there is increasing interest in benefits that include chiropractic care, acupuncture and wellness services. Access to health programs through wearable devices (such as Apple Watches and Fitbits) have become a more common element in packages largely supported by insur-

ance carriers.

Employees have come to expect that these perks will continue to be included in benefits moving forward. It’s a trend that will extend into 2022 and beyond, especially because it leads to a healthier workforce.

Here are three other trends every broker and their clients should closely monitor:

Encourage greater integration of standalone Employee Assistance Programs (EAP).

One important health element that COVID-19 has brought to the forefront is the need for teams to have access to services that help to address the integration of work, home and relationships. Enter EAPs.

EAPs, of course, are not new, and have been used by employers for years to address work-related problems that may impact an employee’s job performance, health, or mental or emotional well-being. Still, while an EAP benefit has been offered by the vast majority of employers (often at no cost) for years, prior to the pandemic, less than 7% of North American employees took advantage of these benefits.

Today, EAP programs are specifically designed to offer high quality and personalized benefits that can range

from estate planning and identity-theft services to confidential mental health counselors. Because workplace stress and burnout accelerated in the last year, it’s important that business owners recognize (and embrace) programs where employees can regularly access mental health services to support their professional and personal lives.

In many cases, these benefits can be accessed through online apps, helplines and videoconferencing. They can provide workers with the tools to address marriage challenges, drug or alcohol abuse, adolescent behavior and emotional difficulties. The end result is helping to provide the individual with coping mechanisms and strategies that can help reduce overall absenteeism.

Brokers should regularly check-in with employer groups, especially those already using EAPs, to ensure that they find the programs helpful. And encourage them to communicate about the EAP benefit to their employees all year round, not just during open enrollment. It’s also a solid business development strategy to reach out to those clients that haven’t taken advantage of an EAP yet. Given the toll that COVID-19 has had on everyone, employers might now be more interested in giving employees the opportunity to access such a program.

Pairing employees with passes to local yoga studios, gym discounts and more are becoming a “must have” in the eyes of many employers.



Consider alternative funding.

Gone are the days of the one-size-fits-all approach to health insurance, especially related to the overall cost. Companies expect more flexibility when it comes to funding benefits for their employees.

Now, many businesses are starting to explore self-funding (or self-insuring) employees' health benefits; that's because it can offer potential savings and stabilize or reduce costs since they aren't subject to a carrier's Medical Loss Ratio (MLR) guidelines or profit goals. A majority of large employers (1,000 or more employees) are already in self-funded plans, but according to the Employee Benefits Research Institute, the number of smaller organizations moving toward self-funding is steadily rising.

Another option is a Level Funded Premium program. It offers the benefits of a self-funding solution with the predictable costs of an insured plan. This type of program is especially beneficial for employers with 25 or more healthy employees.

Clients may also consider a funding switch to save money or increase employee options. To help them with this decision, it's important that they im-

timately understand and consider how any switch will affect administration of their employee plans. For example, they might not realize that **various self-funding plans can also trigger increased compliance requirements**, including budgeting for employee benefits, employee contributions for coverage, COBRA premiums and more. Plan ahead as much as possible, especially when it comes to compliance requirements.

Introduce Wellness Passes.

In addition to carrier-sponsored health initiatives (think healthy weight and heart programs), pairing employees with passes to local yoga studios, gym discounts and more are becoming a “must have” in the eyes of many employers.

Not only do these fun benefits serve as a great stress reliever, but they also help to encourage healthy behaviors that can lead to lower elevated health risks, less chronic disease and reduced health care costs. The ultimate benefit is a healthier workplace, but don't minimize the effect that this kind of benefit can have on employee morale and hiring in a competitive talent marketplace.

Brokers who help their clients promote a healthier workplace demon-

strate their support for a culture of emphasizing employee and family health — at work and at home. Caring for the overall physical (and emotional) health is one positive byproduct of COVID-19. Ultimately, it creates more value for employers today, with the added benefit of employee appreciation and loyalty.

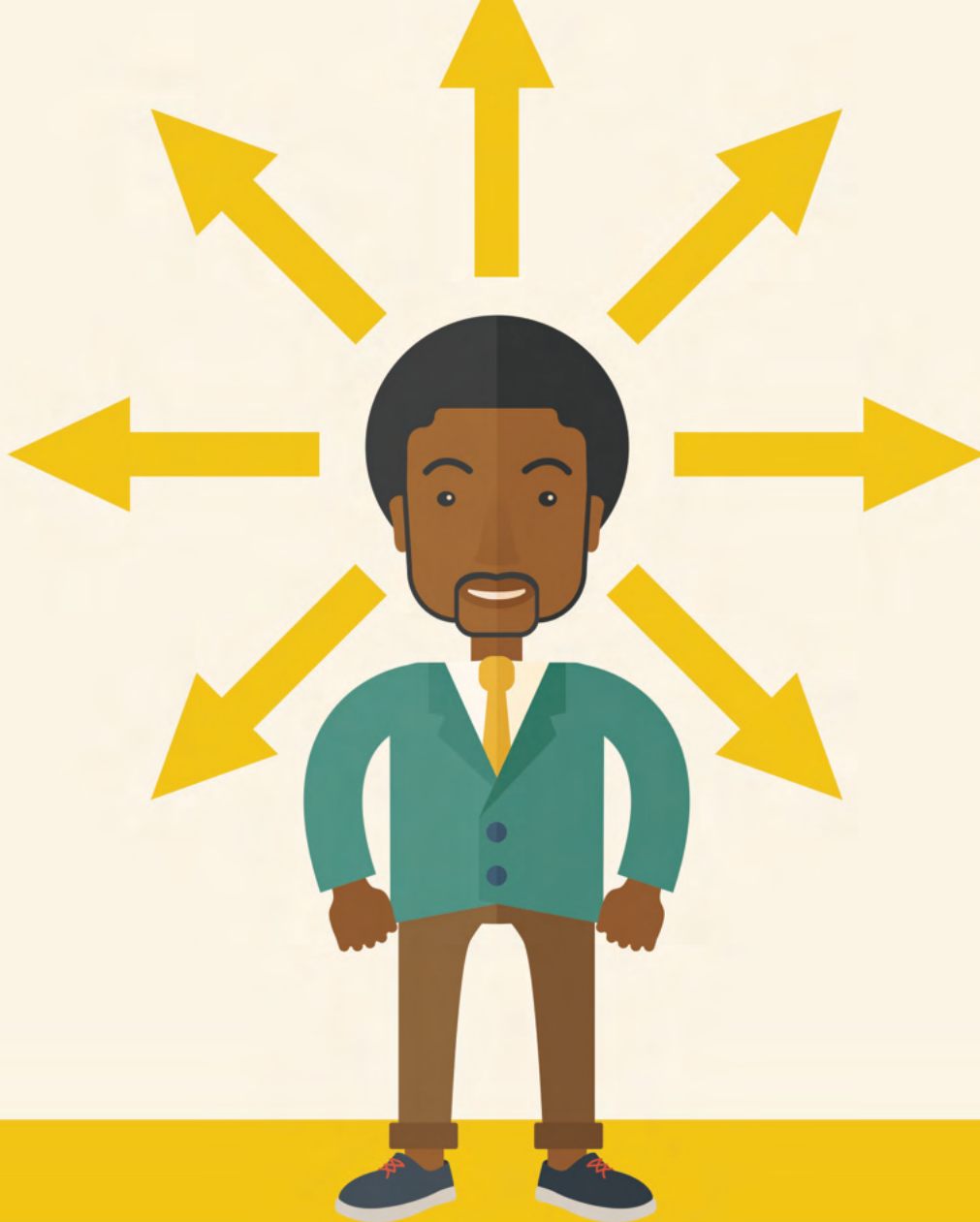
EAPs, alternative funding and wellness passes will continue to drive employer benefit plan design and decision making in the next 12 months. Benefits that pair physical and mental health for employees and their families remain highly valued. Benefits professionals who follow these trends are able to bring comprehensive solutions that extend beyond traditional medical care, and they will reap the business expansion benefits now and in the future. **CB**



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Helping Clients Navigate Self-Service Options Creates Better Health Outcomes

*Too many choices may lead to less
effective use of benefits*

BY JEREMY GALLUS

Consumers are living in a rapidly increasing digital and hybrid world, full of simplified options to complete daily tasks. I haven't stepped into a grocery store for almost six months thanks to an app; dry cleaning is picked up and delivered with the click of a button and I can have nearly anything I want delivered in less than two days. We, as a society of consumers, have become accustomed to simplified convenience. But has our healthcare industry done enough to cater to those needs?

The short answer is no. We tend to have good intentions when implementing point solutions, especially

with the exploding need for mental health support and finding answers for members that don't require a specialist. However, when you add a mental health app subscription as a part of a benefit plan and also offer access to a behavioral health specialist, EAP services, a health coach, and primary care providers, where does the member start? What questions should they be asking? Which one of these offerings is most convenient and cost-effective?

In my opinion, we don't need to offer more self-service options to members, we need to optimize and simplify how they navigate the offerings they have already access to today.

Offering more self-service options to members only stands to complicate and overwhelm their decision-making process because with too many options, members may not be sure which services stand to benefit them the most. If members are unsure which new service, out of the plethora of new services, is right for them, then they may not be able to optimize their benefits with a healthcare provider.

This detriment stands to denigrate public health and alienate members. However, if providers work to simplify how members navigate the

offerings they currently have access to, this could lead to members becoming more well-versed in their benefits.

Members becoming more familiar with the benefits already available to them also lessens the need for new self-service options, which may only stand to add further confusion for

members. Optimizing and simplifying navigation of current plan offerings is crucial for members to get the most out of their services.

At Sutter Health | Aetna, we have seen increased member engagement and access of benefits through the imple-

mentation of navigation services. For example, when we simplified navigating our behavioral health services, we saw a 30% increase within the first month in member engagement.

Part of simplifying plan navigation is about building a better-connected experience for members. We in the healthcare industry must find ways to not only connect with members but improve engagement rates around our interactions and plan offerings

Now is the time for companies to audit their benefits strategies and decide if it's important to add additional self-service options or be more intentional with the ones already available. If you are discussing new offerings for your clients, make sure you're asking the right questions.

Here are a few helpful questions to ask when determining if a new offering is a good fit for members:

What is your engagement rate with members?

How do you interact with members, and what communication modalities are available?

Push for a per engagement fee, and ensure an "engaged member" is mutually defined to avoid misaligned outcomes.

As we enter open enrollment

season still in the midst of the pandemic, the need for simplicity and is greater than ever before. Every one of us has more on our proverbial plates than usual. We can best support members by staying attuned to what is going to be efficient, streamlined, and readily accessible. Having a more personalized and connected experience must be embedded into the DNA of all healthcare providers by injecting intentionality into our offerings. **CB**

Offering more self-service options to members only stands to complicate and overwhelm their decision-making process because with too many options, members may not be sure which services stand to benefit them the most.



JEREMY GALLUS joined Sutter Health | Aetna as the head of Market Development in March 2021. In his role, he leads growth and market development efforts, ensuring Sutter Health |

Aetna's value proposition is positioned appropriately to the market to win new groups. He also leads overall sales enablement to the Aetna sales teams and has overall broker relations responsibility for national, middle-market, public & labor, small group, and student health.

Jeremy brings over ten years of sales and strategy experience from various roles within the healthcare industry where he's spent his career helping payers (employers, health plans, health systems) and consumers understand and manage the complexities of today's health care system. In his most recent role, Jeremy led commercial sales and strategy for the largest PBM transition in history, when CVS Health partnered with Anthem to build IngenioRx.

Before leading the Anthem team, Jeremy led strategic account management projects for large, regional health plans to create higher client sentiment and demonstrate the PBM's performance by reconciling difficult data that was not readily available for human consumption. Email Jeremy at: **Jeremy.Gallus@CVSHealth.com**



THE IMPORTANCE OF A “MEMBERS FIRST” MENTALITY

The top health insurance brokers don't simply convey policy terms and costs – you help your clients make major decisions about their health and well-being.

BY RICK BEAVIN

After more than a year of unprecedented challenges in healthcare, there is a demand for brokers who fully understand member needs. Just as the state of healthcare is constantly advancing, brokers, too, must be sensitive to members' needs for change and committed to improving services to ensure members remain at the center of every decision.

As we approach what is sure to be another atypical period for health insurance brokers, here are four key “members first” approaches to retain your clients and attract new prospects.

1

Provide plan options that show you understand the member's needs.

The best health insurance brokers do more than relay insurance quotes —

they are committed to aligning benefits with a member's unique medical and financial needs — as well as their personal preferences. It is important that you are familiar with new suites of products and enhancements year-over-year so you can identify what's best for each member to help them maintain their health and be happy. Some consumers may be comfortable with their current plan, but you can proactively look for new coverage offerings that may be better suited for them.

For example, if you're developing a portfolio of health insurance options for a military veteran, look for plans that were designed for former members of the armed forces. These may complement the benefits they receive from the Department of Veterans Affairs, such as the Humana Honor Medicare Advantage plan. (Medicare eligible veterans can select any Medicare Advantage plan and Humana Honor plans are available to all individuals eligible for Medicare.)

Oftentimes, moving from one plan to another will allow brokers to retain the member's business, get their residuals and most importantly, ensure the member will have the best plan for them in the coming year.

2

Present solutions that address consumer health care challenges.

As brokers help members understand healthcare benefits packages, it's important to thoughtfully identify options that address both obvious and subliminal needs, especially for seniors and those with disabilities. For example, there are a variety of added considerations to take into account when creating a portfolio for consumers who are homebound. Food insecurity became a heightened issue for millions of Americans at the start of the COVID-19 pandemic, and benefits included in some DSNP programs helped dual-eligible members gain increased access to food from the safety of their homes.

Telemedicine is also an increasingly popular benefit to help doctors and patients connect in a convenient and low-risk manner. While some members may want to return to the doctor's office for a visit, others — especially those who are immunocompromised — may have increased concerns as COVID-19 variants spike. Telemedicine is also an added convenience and safeguard for members who travel, allowing them to connect with their doctor regardless of location. These are all points a member may not realize they should take into account, but you certainly should.

3

Consider new ways to identify and connect with members where they are.

Americans quickly adapted to virtual meetings to safely connect with friends, family and colleagues during the height of the pandemic, and many members will still welcome this method

of connection come AEP season. Virtual platforms remain a convenient way to connect with others, especially health insurance brokers, who may not always need an in-person meeting to effectively discuss plan options and questions, depending on the member's preference.

To diversify your services, look for unique ways to identify and engage members, such as one-on-one virtual sessions, open forum meet-and-greets or direct mailers offering meetings by phone in areas where internet connectivity may be a challenge. I'd also encourage you to consider grassroots efforts. For example, Humana has Mobile RVs for two offices in Northern and Southern California, so beneficiaries can meet with brokers right in their community. Aim to make yourself available in members' neighborhoods to connect in a way that best suits their individual limitations or preferences.

4

Help bridge the gap between healthcare benefits and minority communities.

With diversity, equity and inclusion being a priority, it's important to carry through this element in your communication efforts. Brokers serve a critical role by connecting consumers to benefits that support their health and wellbeing and should consciously address unseen barriers that make it difficult for people to choose an ideal health plan. Using strategies that cater to diverse audiences, more Americans will be given an equal opportunity to choose optimal health plans.

Take notice of challenges your clients may face, based on where they live and what they have access to. For example:

If members express difficulty traveling to doctor's appointments, look for plan options that would meet their health needs and may also have a transportation benefit.

If food security is a concern, check to see which plans would best meet their needs and may also offer a grocery card.

Options like this show you have the member's quality of life top of mind

and will differentiate your services, ultimately casting a wider net to get beneficiaries enrolled in the plan that's best for them. If there is a language barrier between you and your clients, look for resources that can help. For example, Humana has brokers who speak many languages, including Spanish and Korean, to ensure they can cater to various cultures and answer member questions directly.

The top health insurance brokers don't simply convey policy terms and costs — you help your clients make major decisions about their health and well-being. By having a member first mentality, there's no doubt you'll expand your customer base and ensure more Americans make better, more informed health plan choices in the future. **CB**



RICK BEAVIN is Humana's Medicare President for California and Nevada. In this role, Beavin is responsible for oversight of Humana's Medicare HMO and PPO health plans,

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Baby
Boomers

Gen X

Gen Y

Gen Z

What Do Today's Employees Need Most?

A MULTIGENERATIONAL PERSPECTIVE

BY DENNIS HEALY

It's not uncommon to refer to the "workforce" collectively. But when it comes to employee benefits, it's critical to recognize that this collective comprises a diverse group of individuals, each with their own needs, challenges and expectations.

Today, employers have as many as four generations working together — from the persistent baby boomers to the often-overlooked GenXers, the heralded millennials to the Gen Z newcomers. This generational diversity — coupled with the harrowing reality of the post-pandemic "Great Resignation" — has prompted many brokers to help their clients go beyond attractive core benefit offerings and craft agile programs to serve their employees' disparate and evolving needs.

A better understanding of each generation's distinct concerns, behaviors and preferences — as well as those they share — may help your clients stem the tide, helping them retain and recruit valued employees.

Baby Boomers

The oldest of our working generations, baby boomers (born in 1946 to 1964) have traditionally comprised a large part of the workforce. There were concerns that, as they hit retirement age, the 'gray tsunami' might negatively affect businesses. But perhaps prompted by the financial impact of the 2008-09 recession, the anti-ageism movement or simply because they wanted to, this 'live-to-work' generation has retired at a

slower rate than anticipated, enabling companies to retain and transition the institutional knowledge they feared losing.

Among the benefits that still-employed boomers value most are quality medical, dental and vision insurance. This is no surprise, since 60% of this generation is managing a chronic health condition. And not unlike other generations, baby boomers also favor allied well-being perks, like gym membership reimbursements. Giving boomers incentives to stay active as they age is important for them to maintain both their physical and mental health.

They also share with fellow employees of all ages a focus on financial wellness, but with the more immediate term need for retirement

security.

Top generation tip: Because boomers are keen on working past traditional retirement age, at least in a part-time role, the transition may make them ineligible for many benefits that are only available to full-time employees, like group health plans. Employers might consider offering individual health plans as an option to ensure continuation of medical coverage.

Generation X

Sandwiched between two much larger and high-profile generations (boomers and millennials), Gen X can be somewhat overlooked. Born between 1965 and 1980, Gen X represents about one-third of the U.S. workforce and is the second largest employment group in the country.

And their contribution is significant. They've not only become well-established in their careers and are pivotal to their employers, but they are also the working generation most likely to be caring for both their children as well as aging loved ones.

Gen Xers value customizable benefits that recognize and support work-life balance, offer caregiving options, workplace flexibility (like remote work or flex time) and paid-time off to help them effectively meet their professional and personal responsibilities.

According to PwC, more employees than ever before report that finances are the top cause of their stress. For Gen X employees, worries about their financial well-being are tied largely to student debt, a reflection of their own student loans and those for their children's education.

In addition to student loan assistance, this generation values retirement benefits and tax-advantaged programs. Health Savings Accounts (HSAs) or Dependent Care Flex Spending Accounts (DC FSA) help preserve their savings. On a similar note, at ARAG® Legal, our analysis indicates that this demographic (median age 48) is the most likely to elect legal insurance as part of their benefits packages as a means to protect themselves and their families.

Top generation tip: Convenience is essential for this stretched thin employee group. Helping employers

prioritize flexibility in their benefit offerings will go a long way in keeping Gen Xers — and their fellow employees — engaged.

Millennials

Otherwise known as Gen Y, millennials are the largest segment of the population at 87 million strong. They overtook boomers as the largest cohort in the workforce in 2016. Forecasts say that millennials will make up 40% of the global workforce by 2025. For many employers, the sheer size of this generation carries significant weight and makes meeting their needs a high priority.

Millennials are more career mobile — changing jobs more often than any generation. A LinkedIn study found that millennials will change jobs an average of four times in their first decade out of college, compared to about two job changes by Gen Xers in the same period. Because Gen Y prioritizes benefits over pay, employers are wise to provide them an ability to mix and match benefits to keep them engaged, much like their Gen X counterparts.

An unfortunate reality is that nearly 15 million millennials carry student debt, more than any other generation, making loan assistance from their employer highly valued. In addition, many millennials (born between 1981 and 1996) have started families or are planning to, so offering fertility benefits, family leave, dependent care assistance programs and workplace flexibility can be very appealing.

Top generation tip: Millennials have also adopted an “anything can happen” mindset and value benefits that bring them peace of mind — from top-ranked healthcare insurance to pet and legal insurance. Forty-one percent of millennials surveyed have purchased legal insurance to help protect them as they navigate important life decisions. And almost a third (31 percent) of millennial pet owners report having pet insurance, compared to GenXers and Boomers (15 percent and 8 percent, respectively).

Generation Z

The youngest employed generation, born between 2001 and 2020, Gen Z is just beginning to enter the workforce. While still new to the workplace, this

group appears to be ambitious and with an eye to their future. Nearly two-thirds (64%) say career growth opportunities are a top priority when looking for a job, which speaks to the need for professional development, continuous learning and mentoring.

In a recent Monster survey, 83% of Generation Z respondents said that a company's values, particularly their commitment to diversity and inclusion, was an important factor when choosing where to work.

Initially, Gen Z didn't fully appreciate workplace benefits, but since the COVID-19 pandemic, they mirror the wants and needs of millennials, their slightly older counterparts. And like Gen Y, they are likely to seek out a new job in order to find better benefits.

Gen Zers are likely to consider supplemental benefits as part of total compensation and value offerings like flexible paid time off (PTO), tuition reimbursement, pet insurance and accident insurance.

Top generation tip: Gen Z is much more open and accepting of mental health care, compared to older generations. Employers should place more emphasis on benefits that support well-being, like Employee Assistance Programs and resiliency training and stress management programs.

Across the board

As a broker, you can help your clients meet the challenges of crafting a benefits program that addresses the myriad needs of today's multigenerational workforce. Across the workforce, employees are looking for added flexibility — enabling them to match their benefit selections to their unique situation. Delivering a customizable benefits structure that can accommodate individual needs is essential in helping employees feel heard and valued, regardless of their stage in life. **CB**



DENNIS HEALY is a member of the ARAG executive team. Connect with him on LinkedIn: <https://www.linkedin.com/in/dennishealylinkedin>



Annual Enrollment Period 2021 and COVID-19 Restrictions

HOW LA COUNTY AGENTS ARE OVERCOMING **BARRIERS** TO WIN BACK THEIR BUSINESS

BY JEZABEL URBINA

In what is a familiar situation, Medicare agents currently working the once busy Annual Election Period (AEP), are encountering many closed doors. Los Angeles County, which currently enforces some of the toughest guidelines for businesses, has posed a challenge for agents trying to reach the Medicare population. Agents that once relied on conducting marketing events at clinic or provider offices during AEP are finding most clinics are not allowing this activity again this year. Some are requiring agents to be fully vaccinated and provide proof of vaccination in order to participate at their locations.

The challenge many agents are facing this year is really a matter of survival. Last year, field activity was almost non-existent for the LA market. Most agents had to rely on telephone or virtual appointments. Many agents wrote off AEP 2020 and vowed to come back strong in 2021. Then, Delta happened and we are seeing many agents having to make a tough decision: ride out another AEP, or meet vaccine requirements to conduct business in the field. For many, this has really tested their personal beliefs as there is still a big opposition to vaccine mandates.

John Gomez, an experienced agent with 12 AEP's under his belt, shared his thoughts. "I can't afford to sit out again this year," he said. "Last year, I found many seniors just wanted to stay with their current plan and not make any moves until things reopened. **The carriers have come out with some really competitive benefits this year, many with Part B rebates, but I just don't know if it's enough to get seniors to shop again this year.** I tried conducting virtual seminars, but people weren't showing up. I decided to get vaccinated, despite my initial hesitation. Now, I'm conducting seminars outdoors, I'm working with businesses who will let me set up my table, and with clinics who will allow me in with my vaccine record. At this point, I have to do what it takes to get some business in this year."

Health insurance carriers acknowledged the barriers being faced, particularly in Los Angeles County where mask mandates are in full effect regardless of vaccination status. Many carriers are improving their online enrollment platforms to assist agents in being more efficient with their enrollments.

John continued, "Telephone enrollment is something new to me. I'm a paper app guy and consider myself old school in that sense. I realize that


many seniors are old school in the sense that they prefer to meet with people face-to-face. They just don't trust people over the phone. I also work at a lot of food pantries, but most of those are drive-thru only at this point so yeah, it's definitely been hard. I'm calling all my clients and asking for referrals. I'm doing whatever I can think of."

It's really a matter of how creative agents can get this year. Many agents relied on their "pie events" in the past (conducting their formal sales events at local restaurants such as Coco's), so coming up with fresh ideas is challenging when meeting in person is not possible.

As an agency owner, I'm helping my team strategize how we can build business this year. If they need to mail out flyers to Medicare recipients in the whole city and invite them to an outdoor event where light snacks and refreshments will be served, that's what they are going to do. Cross-training is also something we are investing a lot of time in. We have our field agents, and we have our phone agents, but because of the nature of the business right now, we are making sure that our field agents are properly trained in compliance to be able to conduct business over the phone."

The County of Los Angeles issued an order requiring vaccines for many business employees beginning October 7. While the future of COVID-19 restrictions is uncertain, Open Enrollment for both Medicare and Covered California is still very much moving forward.

Many carriers have doubled down on their media advertisement in an effort to get people to call in for information or enrollment. In the Covered California Marketplace alone, Californians will have 12 carriers to choose from, many boasting competitive benefits and formularies at a lower price due to the American Rescue Plan and the increase

in subsidy assistance. In the past, a lot of agents typically turned their focus to Medicare because of the higher commission and renewals, now many are finding a new interest in selling Individual and Family Plans due to less compliance restrictions on finding new business. 



We have our field agents, and we have our phone agents, but because of the nature of the business right now, we are making sure that our field agents are properly trained in compliance to be able to conduct business over the phone."



JEZABEL URBINA, DRPH, MPH, is CEO and co-founder of Los Angeles-based Hart Sales Training Systems Inc.

LIFE INSURANCE POLICY

A. Terms used in this Policy

The following describe your rights and obligations under this Policy.
 We, us, or any of the [redacted] Life Insurance Company.
 You and your heirs, assigns, and personal representatives named in the Policy Schedule.
 Administrative rules and procedures we establish from time to time. Any change may amend or alter any guaranteed benefit provided by this Policy.
 Attained Age means the insured's Insurance Age plus the Policy Anniversary.
 Beneficiary means the person or entity entitled to receive the Designated Life Insured death benefit.
 Class means a grouping of individuals satisfying underwriting criteria, such as tobacco usage, family history and other personal history. A Life Insured is either a Smoker or a Non-Smoker, and in either a Preferred or Standard Class. We determine the Class applicable to each Life Insured and use it to establish the premium rate.



How Life Insurance Settlements Help Your Clients...and You Too! Real Life Examples

BY LISA REHBURG

Did you know that 500,000 seniors a year will walk away from their life insurance policies? Some of these seniors could be your clients — Medicare clients, business owners, life insurance clients and more. But why does this happen? The short answer is that clients no longer want the policy, need the policy or can afford the policy any longer. The reason a policy was purchased 10, 20 or even 30 years ago is no longer a concern. The house is paid off, perhaps a spouse has passed away, a business has been sold, the premiums have gotten expensive, etc.

A life insurance settlement is the ability for a client to sell their life insurance policy for cash. The investor groups who purchase these policies become the new owner, pay the premiums, and become the beneficiary. The client receives cash today, and the buyer receives an investment with a future return. All different types of policies can be sold, including term policies.

The amount a policy could be worth is very specific to each client, but policies can be worth tens of thousands or hundreds of thousands of dollars — all from an asset a client was going to walk away from. Here are some real-life stories of clients, and their agents, whose lives were enhanced through a life insurance settlement:

- A 66-year-old woman with multiple sclerosis had a \$150,000 term life insurance policy. Her beneficiary was her ex-husband. There were no children, and there was no one

a

s an insurance agent, you do not need to be a life insurance expert, or even the writing agent on the life insurance policy to help your client. This can also be a good way to attract new clients, as many people have no idea they can sell their policy. If you meet with your clients for an annual review, asking them about their life insurance policy can be a good place to start. Or, adding an article in your monthly newsletter or an educational email to your clients can also help raise awareness of the benefits of life insurance settlements.

she wanted to leave the money to. Since she didn't need it anymore, she decided selling the policy made sense, in order to give her money for the care needs she knew she would need in the future. The policy was marketed and she sold it for \$25,000, giving her the financial cushion, she wanted. The referring insurance agent made \$3,500 in commission.

- A 78-year-old man with cancer had a \$250,000 term policy. He purchased the policy for his wife, so she would be protected and could pay off the house, if something should happen to him. The house had long been paid off, and his wife passed away 4 years ago. His daughters were the beneficiaries. They had successful careers and their families did not need the money. He decided that he wanted to sell the policy to make his life more comfortable while he was still here. The opening offer on his policy was \$15,000. By using a good life settlements broker who marketed the policy, he eventually sold it for \$128,500. That will go a long way to helping him stay comfortable for the rest of his life. The client was thrilled, and the referring life insurance agent earned \$14,000 in commission.

- A 58-year-old man with significant heart issues had a \$1.6 million universal life policy. He was a successful businessman, and his family was well cared for. He had a dream of living on a ranch for the rest of his life. So, he sold his business, sold his house, and sold his policy for \$350,000 (the opening offer was \$125,000). Now, he has the resources to live the rest of his life the way he wants. The insurance agent received \$25,000 in commission.

- A 66-year-old man with liver issues had a term life insurance policy that was reaching the end of its term. He purchased it for his wife to pay off the house, if something happened to him. The house is paid off, and he was not going to continue the policy. He sold the policy for \$75,000. This was great for him, as he was going to walk away from the policy with nothing, and helped make his life more comfortable. His insurance agent for his Medicare policies referred him, and collected \$12,500 in commission.

These are just some examples of clients who were able to repurpose an asset they didn't know they had, into cash to

use however they wanted. The clients are thrilled, receiving "found money" from an asset they did not know they had. And, the referring insurance agents helped their clients, but also helped their businesses as well, receiving an additional revenue source. Besides commission from the life insurance settlement itself, your client may need additional products or services from you, once they receive their money. Perhaps an annuity or additional insurance products are needed.

As an insurance agent, you do not need to be a life insurance expert, or even the writing agent on the life insurance policy to help your client. This can also be a good way to attract new clients, as many people have no idea they can sell their policy. If you meet with your clients for an annual review, asking them about their life insurance policy can be a good place to start. Or, adding an article in your monthly newsletter or an educational email to your clients can also help raise awareness of the benefits of life insurance settlements.

On average, a life insurance settlement generates 3 to 5 times cash surrender value. So, if your client is thinking about lapsing, surrendering, or walking away from their policy, considering a life insurance settlement can be an important option for them — and for you too. **CB**



LISA REHBURT is president of Rehburt Life Settlements, a life insurance settlements broker. Rehburt is energized by helping brokers and their clients benefit from unwanted or unneeded life insurance policies. By having access to many investor groups, Rehburt Life Insurance Settlements can place more policies and realize a better return for clients. Rehburt has been working with brokers in the health and life insurance industries for over 30 years.

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TRAVEL INSURANCE: When Health Insurance Won't Cover It

BY JEFF PAPENFUS

In recent months, travel has been on the back burner for many. Business trips were replaced by Zoom meetings and vacations were canceled in favor of seeing the world via television screens from the safety and comfort of the couch. But now, many people are beginning to hop back into cars, boats and planes to reach destinations across the world.

For most of us — as we eagerly map out an itinerary of fun excursions for our family trip or scramble to put together a last-minute presentation for an important international business convention — the idea of how we'll get medical care when we travel isn't top of mind. But now more than ever, as the pandemic continues and people get back to traveling, it is important to be prepared for the unexpected.

Travel insurance can protect your clients from steep out-of-pocket expenses in the event of illness, injury or other

medical concerns during their trip. But, as with most insurance, choosing the right policy can be tricky. As a broker, there are a few key steps you can take to ensure you're ready to help your clients get the coverage they need.

Understand various types of travel insurance

Travel insurance is available to both groups and individuals. If an employer-sponsored insurance plan doesn't provide sufficient coverage, an individual can get a separate, additional policy through the same carrier, or a different carrier.

Different types of travel insurance are available for various circumstances, such as leisure (for short-term trips), student, expatriate, missionary or group/business travel. This makes sense, when you consider that different types of medical needs are more likely to arise in various circumstances.

On an action-packed tropical vacation where you're hiking up waterfalls and swimming with sharks, you're more likely to wind up with an injury than you would be on the average business trip. And if you're spending months or years away from home as a student or expatriate, you're more likely to need coverage for basic preventive care than someone who is only planning on spending a few days away from home. Also, in order to get a visa for international travel, you may need a certain minimum amount of coverage for medical evacuation and/or repatriation of remains.

Understanding the differences between each kind of travel insurance will help you guide your clients to the carriers and policies that make the most sense for them. Every client is different, and it is important to strike the right balance to ensure adequate coverage while keeping budgetary considerations in mind.

Choose the right carrier partners

Before you can sell travel insurance to your clients, you'll need to become appointed with carriers (e.g., GeoBlue, UnitedHealthCare Global, Cigna Global, Aetna International, etc.).

As you decide which carriers to partner with, be sure to consider the types of plans and coverage offered. For example, some may focus more on medical coverage, while others may focus more on trip protection. Some may be better suited for domestic travel, and others may be better for international trips. Select the carriers that will best align with your clients' anticipated needs.

In addition, consider the reputation of the carrier. Keep in mind that some offshore carriers may not be bound by the same laws that apply in the United States. You'll want to make sure you are working with reliable carriers that your clients can count on.

Finally, take into account factors like practicality and convenience. How complicated is the claim submission process? Does the carrier offer user-friendly online tools or apps?

Help your clients find the right policy

In many cases, your clients may assume that because they have health insurance, they will have the coverage

they need when they travel. But that is not always the case — and you can save them a ton of headaches (literally and figuratively) by helping them understand what additional coverage they may need. You don't have to wait for them to ask about it either. By proactively educating your clients, you'll establish yourself as a helpful resource, and you might even end up with a sale out of it.

How do you know which policy is right for your client?

If your client has a PPO plan and is traveling domestically, there is a good chance they will have the coverage they need, should any medical concerns arise during their trip. However, if they have an HMO plan and are traveling domestically, depending on where they go, they may have difficulty finding in-network providers.

For international travel, most health insurance policies will only cover life-threatening emergencies, and it is up to the carrier to determine what counts as "life threatening." This means that care for common medical concerns — such as a broken arm, rash or earache — may not be covered without additional insurance. Global travelers may also find themselves in a location where they can't access quality medical care, and they will need to be evacuated to a different area for treatment. This is typically not covered by domestic health insurance, but the appropriate travel insurance policy can provide the necessary protection.

Nobody plans to need a doctor while traveling, but anything from forgetting a prescription medication at home to eating something that doesn't agree with you can leave you in an expensive bind if you don't have the right insurance. Travel insurance helps your clients relax and get the most out of their trip without having to worry about unanticipated medical costs — even if they don't use the insurance, they'll benefit from increased peace of mind.

In addition to concerns about unexpected illness during travel, your clients may want to ensure they are covered if they get sick before their trip and need to cancel it altogether. In many cases, travel insurance plans provide both trip protection (cancellation) coverage and emergency medical coverage. However, particularly if a client is traveling internationally, they may still

wish to have additional coverage beyond what a typical trip protection plan will cover.

In today's tech-driven world, another key consideration is access to telemedicine. Global telemedicine is increasingly available, and it is important to be able to answer your clients' questions about virtual care. Are there likely to be providers that offer telemedicine where your client is traveling? What coverage does the client's policy offer for telemedicine? If your client is overseas and wants to contact their doctor back in the United States via telemedicine, can they do so?

Stay up to date on changes

As you know, the world of health insurance is always changing — and as health insurance changes, the ways travel insurance and traditional health insurance complement each other is likely to adapt and evolve as well.

With this in mind, it is a good idea to communicate regularly with carriers to stay informed of any changes to their policies that may affect the recommendations you give to your clients. General agencies are another great resource for information on industry trends that may impact health insurance and travel insurance decisions.

If there's one thing we've learned in the past couple of years, it's to expect the unexpected — a lesson that's especially true when traveling during a pandemic. By helping your clients understand the discrepancies between their existing health coverage and the coverage they will need when they travel, you can help them stay healthy and avoid coming home with massive medical bills as a souvenir. **CB**



JEFF PAPENFUS

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for business growth. Find out more at www.warnerpacific.com



How Small Businesses Can Win the Talent War

Voluntary benefits and flexible schedules attract and keep loyal employees

BY ZARIFA REYNOLDS

Small businesses have always played a central role in driving the growth of the U.S. economy, as well as bringing innovation and jobs to local communities. However, nothing could have prepared small businesses for the impact COVID-19 has had on their businesses. Prior to the pandemic, small businesses provided nearly half of the country's private sector jobs, but they also accounted for 54% of the jobs most likely to be lost as a result of COVID-19.

In addition to the pressures of sustaining a business during the pandemic, small business employers had to react to a changing workplace. Many small and large companies went 100% remote, forcing many to upgrade their technology at record speed and bring in collaborative tools for their employees to use. Employers who historically relied on an onsite workforce were faced with having to manage the health and safety of its employees and deal with staff shortages due to COVID-19. In retrospect, it's understandable that in early 2020, small businesses were simply trying to survive.

The impact of COVID-19 has provided an inflection point for many small business employers.

Small business employers today must examine how the pandemic has changed employee expectations and focus on tangible and intangible benefits, whether it's enhancing an employee benefits package with voluntary benefits or a hybrid, flexible work model.



It created disruptions that deeply impacted productivity and morale. How employers responded to these challenges determined whether they were viewed positively or negatively by their employees. One notable finding from our Guardian Workplace Benefits Study is that employee loyalty is strongly tied to how they believe their companies handled COVID-19.

Handling COVID-19 well includes measures such as employer flexibility, strength of employee communications, and support provided to employees. Among employees who agree their company handled COVID-19 well, nearly half (49%) say they would like to stay at their company for more than a decade compared to just 28% of those who say their companies handled it poorly. This reveals important insights into employee expectations moving forward and what small business employers should be thinking about given the talent shortage and need to attract and retain talent.

With the Great Resignation a reality, companies right now — no matter whether they are large or small — are in a talent war to fill jobs needed to keep their businesses operating seamlessly.

This is where employee benefits brokers can be instrumental to small businesses. As the employee benefits industry continues to evolve, there are now more solutions available that can help small businesses create efficiencies, contain costs and attract and retain employees. For example, our latest Workplace Benefits Study shows there has been an upward trend for small businesses with under 100 employees to offer a better benefits package than competitors in their industry — with 69% aiming to do so in 2021.

Brokers who are counseling small business employers should consider the following solutions:

- **Individual Health Reimbursement Arrangements (IHRAs):** Health insurance is expensive, but there are ways to manage those costs, while still providing an affordable option to employees. For example, IHRAs allow small business employers to contribute to an account based on their budget, and which in turn, employees can then use to purchase primary medical insurance on their own. The cost of traditional primary medical insurance has historically been cost

prohibitive for many small employers and prevented them from offering benefits programs to their employees. The ICHRA program that now exists changes this. The U.S. Departments of Health and Human Services, Labor, and the Treasury projects that 800,000 businesses will offer ICHRAs by 2024, covering approximately 11 million employees.

- **Voluntary Benefits:** The pandemic has made employees more aware of the financial gaps that exist, and the growing need to better protect their families should a crisis occur. This has made voluntary benefits attractive to employers who want to diversify their employee benefit options, while at the same time, help increase the overall financial well-being of their workforce. Our study revealed that 52% of employees who work for a company with less than 50 employees said “money/finances is a major cause for stress in my life.”

For many small employers, voluntary benefits, like critical illness, hospital indemnity insurance and accident insurance, are financial tools that help to protect their employees if there is an unexpected event, like an accident, injury, or illness. Voluntary benefits are also surprisingly accessible and affordable for the small business employer. Depending on the carrier, there are three payment options to consider: paid by employer, shared contribution, or paid by employee.

For a small business employer seeking to control costs, voluntary benefits can be a win-win because it enables them to offer much-needed benefits for their workforce and either share the cost or pass it on to the employee. For employees, voluntary benefits help pay for medical expenses and out-of-pocket expenses that their primary health insurance may not cover if the employee or one of its family members experience an illness or accident.

- **Benefits Technology:** COVID-19 accelerated the adoption of technology, prompting employers, big and small, to re-evaluate their technology needs. In general, we have seen substantial growth in the availability of benefits administration platforms for small employers, with the capabilities to service organizations with as few as 20 employees. With cloud-based, API-integrated benefit platforms, small businesses are now able to create efficiencies in their benefits administration process, while at the same time, improve the overall employee experience. We all know that Open Enrollment can be overwhelming for employees who are trying to make important decisions about their benefits. And oftentimes, small businesses do not have a fully resourced Human Resources Department that can help provide adequate benefits education.

Today's technology can support small business employees during the benefits enrollment process. With AI technology, new platforms, like Nayya, are helping guide employees through the benefits enrollment process with personalized, data-driven recommendations. And the great news is that platforms can service small businesses with as few as 26-28 employees.

Finally, as a result of the pandemic, we saw a lot of gains in the adoption of technology among small businesses, particularly those with under 100 employees. Our latest research showed that 79% of small firms said the pandemic impacted their tech adoption with 57% adopting collaboration software, 52% adopting customer service tech and 41% adopting benefits administration technology. We anticipate this trend will continue. We encourage all brokers to work with their small

business clients to do a technology assessment and help them navigate this arena.

- **Employee Well-Being:** The pandemic has shed a spotlight for employers to do more around employee well-being and mental health resources. Employees have made it clear they'd like their employer to offer resources to help them navigate the burnout, stress and/or anxiety that the pandemic has brought on to themselves and their families. Our research showed that 60% of employers with fewer than 50 employees say they prioritize the use of wellness, preventative and health initiatives compared to three quarters (75%) of companies with 100-999 employees. This tells us there is room to improve in this area.

At Guardian, **we saw an increase in interest and usage for the Employee Assistance Program (EAPs) as well as employers moving to permanent work/flex schedules and offering paid leave.** We are also seeing new mental health benefit start-ups emerge, like Spring Health, which offer carriers the opportunity to develop and evolve their offerings. Given the mental health needs revealed, brokers and carriers have increased their discussions about mental health benefits that are available for small business employers since mental health benefits are no longer limited to large corporations.

The pandemic has changed the workplace as we know it. **In order for small businesses to attract and retain talent, they will need to address employee expectations.** What we are seeing is that it's not only about the insurance benefits but rather what employers can do to support their workforce moving forward. Small business employers today must examine how the pandemic has changed employee expectations and focus on tangible and intangible benefits, whether it's enhancing an employee benefits package with voluntary benefits or a hybrid, flexible work model. What's encouraging to see is that with the right strategy and solutions, small businesses can build a winning business model that sets them up to succeed.

Note: For more information, look up Guardian's 10th Annual Workplace Benefits Study Inflection Point and Guardian's 11th Annual Workplace Benefits Study. 



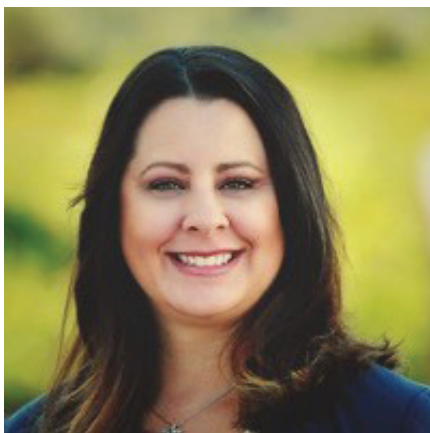
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What's in Store for Small Group?

Three industry experts their share perspective

BY THORA MADDEN



AIMEE CASTILLO

Director of Sales
Amwins Connect Insurance
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STEVE CRANE, SR.

Sales Consultant
Dickerson Insurance Services –
An Alera Group Company



MARC MCGINNIS

Sr. Vice President,
Sales & Strategic Client Management
Word & Brown General Agent

How has small group been impacted by the pandemic and/or increased access to ACA subsidies?

Aimee Castillo, Director of Sales, Amwins Connect Insurance Services, LLC:

I don't know that increased access to subsidies has made any impact, but I can say with absolute certainty that the pandemic has. More and more employees are acutely aware of the importance of access to care and that has definitely changed the landscape of how employers perceive benefits. Having a benefits package that provides employees with reasonably priced access to care has always been a factor in recruitment and retention of employees, but now it is almost a necessity that is valued pretty close

to traditional compensation. I talk to brokers and group administrators all the time who are dealing with situations where they are losing employees to competitors, or they can't hire quality candidates because they don't have a strong enough benefits package. Because of this, I am starting to see employers making larger contributions towards their employee premiums, and in some cases, even making contributions towards dependent premiums. I've also noticed that benefits packages are being crafted to include plan offerings that will provide their employees with more choices about what benefits they enroll in.

With that said, the changes are not limited to the consumer. Because of the way utilization of benefits have changed, the carriers are adapting their plan designs to accommodate for a

shift in how their claims reserves are being accessed. In an effort to keep their monthly premiums stable, I have noticed that many carriers have opted to adjust the cost sharing provisions in their plans (Co-Payments, Co-Insurance, Deductibles, inc.) and how those are applied to coverage. This can be good news for employees when it comes to their fixed monthly premiums, but if they aren't enrolled in the right plan, it can be costly when they seek services.

Now more than ever, having a knowledgeable and trusted benefits advisor is crucial.

Steve Crane, Sr. Sales Consultant, Dickerson Insurance Services – An Alera Group Company:

We thought we would definitely see shrink due to ACA subsidies and it would

cause groups to cancel their small group coverage, but neither happened. As far as the pandemic, again, we thought we would see groups fall off the map but it did not happen. Right now, we are seeing virgin groups — groups that would never have offered benefits before — wanting to offer benefits. Because there is a labor shortage, they are finding it hard to attract and retain talent without offering decent benefits.

Marc McGinnis, Sr. Vice President, Sales & Strategic Client Management, Word & Brown General Agency:

The pandemic has created a heightened awareness of, and need for, quality health care for citizens across the country. As reported by the Kaiser Family Foundation, 49.6% of Americans receive health insurance through an employer. Those Americans looked to their employers for health coverage, and utilized it during the ongoing pandemic. The global health challenge has reinforced the true value of employee benefits for workers: having quality employer-sponsored coverage available, and in place for many, is vital for employees and dependents.

The pandemic prompted many to understand the true necessity of health insurance. Federal legislators and the Internal Revenue Service responded by extending relief to citizens during the ongoing pandemic, allowing many to upgrade their health plans (or downgrade them to save money) — or allowing others to enroll in coverage midyear, outside of Open Enrollment.

The pandemic encouraged citizens to have discussions about health care, and motivated many to consider enrollment options through all available access points — via employers, the individual market, Medicaid, Medicare, and COBRA continuation options — as the nation dealt with the effects of the global pandemic.

What are the keys to being a successful broker to small groups right now?

Aimee Castillo, Amwins:

The key to being a successful broker is being present and accessible to your clients via all sources of technology, ie: phone, email and zoom, if in-person meetings are not permitted. We hear this

from brokers who were awarded broker of record (BOR) because the employer's current incumbent broker was never available or didn't understand the new landscape of technology. Brokers who are constantly educating themselves on new products or services that are emerging are also very successful, because it gives their clients or prospect clients a piece of mind that they know.

Steve Crane, Dickerson:

Pandemic or no pandemic, the tools to be successful have not changed. In depth product knowledge is critical (so the broker can better strategize a client's needs and/or beat out another broker's proposal). Offering superior customer service, continually prospecting for new business and staying ahead of technology tools are equally important. What we have seen is that some brokers "took a break" during the pandemic and other brokers hustle. Those that hustled captured some of the business from those that took a break. A pandemic is no reason to take a break. You may need to "reinvent" yourself by using technology tools such as Ease and Zoom for online enrollment and presentation. More groups are enrolling online than ever before and most open enrollment meetings are taking place over Zoom.

Marc McGinnis, Word & Brown:

Brokers need to continue finding creative ways to serve their clients using technology tools and online platforms. The new HR administrators have arrived — and they are expecting digital efficiencies and platforms that allow them to communicate to employees more dynamically. In addition, brokers need to continue to find a balance of leveraging online tools to better service their customers — while not losing the personal servicing touch that so many small groups still require in the current market.

What does the future look like for small group health?

Aimee Castillo, Amwins:

At this point, the disruption to the system has been in place long enough to where certain elements of it will be permanent and it is pretty safe to say that we are never going back to the way things were before. Employees will

continue to become more educated about what they need and what they don't and will continue to look for more cost effective ways to access their medical providers. Employers will face increased pressure to offer affordable benefits packages to both their current workers and their prospective candidates. For the past 18 months, rates have been relatively stable, and because of this, people have become acutely more aware of the elements that go into selecting a medical plan beyond just the monthly premium. It's created a much more sophisticated buyer who is aware of things like deductibles, co-insurance, and out-of-pocket maximums. The lowest monthly premium is not always going to be the deciding factor going forward as people will look more towards the overall value of the plan as a whole. So the conversations surrounding which way to go will continue to become much more technical and detailed.

Steve Crane, Dickerson:

Maybe it took a pandemic, but employers realize the importance of offering health insurance like never before. And the same with employees. We are incredibly optimistic about small group, we are seeing lots of requests for quotes and ultimately groups that would never have thought about offering coverage before are doing so.

Marc McGinnis, Word & Brown:

A recent Forbes article survey found that 55% of small business owners say the cost of providing health insurance to their employees is the biggest challenge they face. With health care costs increasing, employers are looking for creative ways to save money on employee benefits. This could mean reduced contributions or lower cost plans accompanied by account-based plans like HSAs and HRAs. The same article goes on to suggest that 66% of small businesses in our country currently are not offering a group health plan at all. The most successful brokers are finding alternative methods to help employers save — while also introducing new benefit strategies to employers who historically have not offered small group health insurance to employees. **CB**

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