

CALIFORNIA BROKER

VOLUME 38, NUMBER 3

SERVING CALIFORNIA'S LIFE/HEALTH PROFESSIONALS FINANCIAL PLANNERS

DECEMBER 2019

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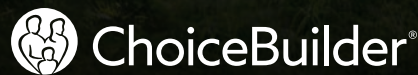
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For a complete list of the program rules go to: rebrand.ly/AgentIncentive2020

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M E D I C A R E N E W S

How to Help Clients Navigate the 2020 Benefits Tide

Hint: Let your customer be your guide

By **HOLLY ACKMAN**

Now is the time to educate your Medicare clients about the much-anticipated new benefit plans for 2020. News about this is beginning to buzz. Seniors may have seen ads on TV, received some (or a lot of) direct mail, or gotten their Annual Notice of Change from their current health plans. No matter the delivery method, the point is there's a glut of information during the annual enrollment period (AEP), and seniors are hearing about the array of "new benefits!" made possible by recent Medicare flexibility. This will be exciting news for some of your clients, but may be overwhelming for others.

As you know, there are many Medicare Advantage options in California with seemingly similar plan designs. So how can you best prepare to help your new clients find the right plan for their specific healthcare needs? How do you know when your current clients might need to evaluate their existing coverage? Our ultimate goal is for Medicare beneficiaries to find a plan that will provide real value to their health and quality of life. That's what, ultimately, leads to member satisfaction and retention for both the plan and the broker.

Know what floats your client's boat

Most Medicare Advantage members are satisfied with their current health plans, and we know that low out-of-pocket costs, preventive care and prescription drugs are top priorities. There's also interest in additional perks—such as gym memberships and allowances to spend on eyeglasses or over-the-counter items.

With the ability to now offer certain non-medical benefits, SCAN and other Medicare Advantage plans are debuting a variety of extras in 2020 that include everything from home-delivered meals to massage therapy to Fitbits. As a result, you will be able to serve your clients on a more personal level than ever before, with plans that provide products and services targeted to your clients' unique health needs and lifestyle.

Know what they've already got

To help your Medicare clients navigate their options, you'll first need a clear picture of what they're looking for. A good way to do this is to ask them how their coverage fits into their

life. When a new client comes to your office or you're making your annual follow-up calls, ask, "What do you like about the plan you have now? Is there anything you wish would be different?" Understanding what matters most to your clients will make it easier to find and recommend the plans that best match their specific needs.

First, though, don't assume your client knows everything their current plan includes. In SCAN's service areas, for example, we've found something surprising about Medicare Advantage members: Although a majority of seniors belong to plans that offer a variety of supplemental benefits, most of those members don't know they have them! But perhaps we shouldn't be that surprised. We don't typically "market" new benefits to existing members the way we do to prospects. Existing members receive their Annual Notice of Change, with format and content dictated by Medicare. It's far from an exhaustive benefit list and doesn't always highlight what's new and notable for the coming year.

That's where you can help. Your client may find that something they were hoping to get with a new plan is already being offered in their existing coverage.

Consider today and tomorrow

As you help clients weigh the value of new benefits each year, there are a few important things to consider.

What health changes has your client experienced this year? In a perfect world, seniors would review their available health plan options regularly and adjust as needed if their health status changes. The reality is, many seniors stay with their existing plan merely because it's easier than trying to compare options or find out how to change coverage. A recent poll by WellCare Health Plans shows just how much seniors dread reviewing their Medicare plan: Nearly a quarter of seniors surveyed said the task is just as unpleasant as getting a colonoscopy or going to the dentist!

Despite their hesitation, even your most anxious clients stand to benefit from a plan evaluation if they've experienced a change in their health—perhaps not to change plans, but to at least fully understand what their current plan offers that can address any new health challenges. For example, SCAN

(CONTINUED ON PAGE 27)



HIGH LIMIT DISABILITY

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SCAN Offers Immersive Experience to Put Audiences in the Shoes of Aging Adults

SCAN Health Plan® has launched Trading Ages Virtual Reality (TAVR), the evolution of the organization's successful Trading Ages senior sensitivity training program. The insurer is tapping expertise honed over more than 40 years of helping seniors and leveraging advanced virtual reality technology to bring to light the unique physical and emotional challenges of growing old. Those who experience the TAVR are immersed in a combination of visual effects, 360-degree audio and ingenuity to navigate everyday activities while physical and emotional impacts are simulated. The user is guided through a series of scenarios that mirror what it is like to live with hearing loss, macular degeneration and even what it is like to be a caregiver of a loved one with dementia. These mock encounters are incorporated into the larger educational session that is delivered in a group setting, giving participants a real sense of the physical, social and emotional aspects of aging. Built upon the success of the original version of Trading Ages, SCAN has taken the program to the next level and taps the immersive power of virtual reality so program participants may experience more realistic scenarios that replicate some of the daily obstacles associated with aging. Significantly enhancing the efficacy of the program, TAVR brings to life the challenges that older Americans face every day. This program aims to pioneer a new era of sensitivity training, offering fresh insights and perspectives to individuals, businesses, organizations and government entities—anyone who interacts with seniors regularly.

Second Chance to Catch SIIA Content

If you weren't able to attend the Self Insurance Institute of America's (SIIA) annual conference in September, here's your chance to at least see what happened. Videos of educational sessions included as part of the national conference can now be accessed on Canoe, SIIA's on-line information and educational content platform. Canoe can be found on-line at www.siiacano.org. Much of the content is restricted to SIIA members, however. If you're not a member, contact Jennifer Ivy at 800/851-7789 or jivy@sii.org for info on membership and access to the videos.

Medicare Supplement Agents: Oxford Life Eases Underwriting with InstaWrite

Oxford Life® Insurance Company's InstaWriteSM process is now available for the underwriting of Medicare supplement policies. This feature eliminates the interview step that was previously required for these sales. Oxford says InstaWrite is a better experience for agents and clients, improving upon the traditional Medicare supplement sales process by offering an almost instant health assessment. Since InstaWrite is an electronic process, agents can perform the underwriting on a laptop computer, tablet or smartphone from a client's residence without involving anyone else. Go to www.oxfordlife.com to sign in as an agent, access the "tools" tab and use the InstaWrite feature.

NextGen Leading the Way

Health and Medicare leads company NextGen Leads seems to have it figured out: the company recently announced that it has grown revenue by over 1,454% in the past three years, expanded its employee headcount to over 100, and moved its headquarters to an 8,000-square-foot contemporary office building in downtown San Diego. The company has also been recognized as number 315 on the Inc. 5000 list as a fast-growing company. The company is founded by ex-Googler, past insurance agency owner, and now CEO, Chris Kelly. NextGen Leads has developed a powerful sales lead platform aimed at enabling carriers, insurance agencies and independent agents to lower acquisition costs and grow their business. Interested in learning more about career opportunities at NextGen Leads? Visit nextgenleads.com/company/careers.

LTC Insolvency Hitting Policyholders Hard

By Bonnie Burns, California Health Advocates

In March of 2017 a long-term care insurance company was declared insolvent. The company, PennTreaty Network America (PTNA) and its subsidiary company, American Network Insurance Company (ANIC) were subsequently declared insolvent and are now administered by each state's Guaranty Association. The reserves and assets of the two companies are woefully insufficient to pay the benefits promised to their policyholders; and far too deep to fill by the imposition of any reasonable amount of premium increases.

State guaranty associations are responsible for keeping long-term care coverage in force when a company becomes insolvent. They do this by collecting premiums, and paying claims up to each state's cap on benefits. State guaranty associations also have the right to seek significant premium increases, which most states have granted. In addition, the guaranty associations can assess insurance companies doing business in a state for the cost of an insolvency; and under state law, insurance companies are allowed to pass that cost along to their policyholders.

State guaranty associations charge an assessment to the other insurance companies doing business in a state for the cost of their competitor's insolvency. This cost includes the administration of the insolvency and the difference between a company's reserves and the costs of their claims. Each company's assessment is calculated based on the amount of premium collected in a state.

PennTreaty/American Network policyholders living in California were notified of the premium increase imposed on their coverage and given options to lower that increase by reducing their benefits. The amount of benefits a policyholder can collect in California is \$554,556; certainly less than the amount of lifetime coverage some people purchased. At the same time, most other companies that sold long-term care insurance have also been notifying their policyholders of sizable premium increases and similar options to reduce coverage.

Recently CNA Insurance Company has begun notifying its policyholders that as a result of the insolvency of PTNA/ANIC, CNA was passing on the assessment imposed by the California Guaranty Association to their policyholders in the form of a surcharge. This surcharge is in addition to any prior or any future premium increase. It is unclear if this is a one-time surcharge, or one that will be imposed annually. It is likely that other

companies will follow suit and that policyholders with other insurance companies will be notified shortly of an increase in their premiums based on this assessment methodology.

In addition to some recent jaw dropping premium increases for long-term care insurance, the necessity of giving up previously purchased benefits to reduce that premium increase, having their lifetime benefits capped, and now paying a insolvency surcharge imposed by their insurer, policyholders are financing much more than the cost of the original benefits they bought to pay for their care in later life.

California policyholders with questions about their options can contact their local Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. HICAP provides free, individual and unbiased assistance and information on Medicare and other health insurance related questions such as long-term care insurance.

More Children Now Uninsured; Plus Many Americans Clueless About ACA

The number of U.S. children without insurance rose from 3.6 million in 2016 to 4.1 million in 2018, according to a new report from the Georgetown University Center for Children and Families.

Researchers say the progress made in insurance coverage for children with the advent of the Affordable Care Act is now all but reversed. The reversal is thought to have happened as a result of changes to Medicaid, delays in the funding for the Children's Health Insurance Plan and as a result of the Trump Administration's efforts to unravel the Affordable Care Act.

Speaking of the ACA, a new State of Healthcare and Politics Report from insuranceQuotes.com found that a full 34% of Americans are unaware that the ACA is still in effect.



EVENTS

LAAHU Holiday Party

Dec 17. More info at laahu.org

SDAHU Expo 2020

January 16, 2020 @ 8:00 am - 2:30 pm

Town and Country Resort and Convention Center, San Diego. More info at sdahu.org.

OCAHU 8th Annual Business Development Summit

February 28, 2020, DoubleTree by Hilton-Anaheim/Orange County

Contact: Gail James Clarke (714) 441-8951, ext.3, email: orangecountyahu@yahoo.com

CAHU Women's Leadership Conference

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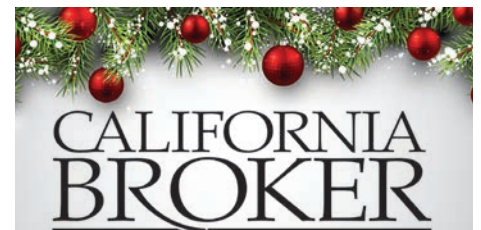
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Seeing Through the Smoke & Mirrors of Obamacare

By PAUL M. LEAGUE

Best cost reduction option for 2020 and beyond!

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

Instead, the persistent reality is that of ever increasing Healthcare Exchange costs, medical costs, rising insurance plan premiums, and a steady reduction of plan benefits. Add to this the failed attempt to help offset these costs by shifting them onto consumers.

Fleshing out ever increasing costs

I use the terminology of “smoke and mirrors” to best describe Obamacare. This legislation is anything but transparent, depending instead on its use of arguably deceptive terminology like “affordable care” when it has proven to be anything but affordable.

The legislation called for the establishment of an expensive bureaucratic infrastructure that birthed federal and state Healthcare Exchanges/Marketplaces, and the Standardized Health Plans offered thereon: Bronze 60, Silver 70, Gold 80, and Platinum 90 Metallic TIER plan designs. These plans require certain costly benefits that many do not need or want (like maternity coverage, preventive care, etc.), resulting in more, not less, overall costs for everyone.

Even projected costs for such things as computer software to run Exchanges, and their calculation of tax subsidies and

health plan benefit designs, etc. were grossly underestimated. The result—added costs to the government and consumers, to the tune of multi-billions of dollars.

All of this was done for the supposed reason of bringing about a “competitive marketplace” of benefit-standardized health plans, from multiple insurers. However, in essence this was reinventing the proverbial wheel as the ACA grossly underestimated the exorbitant cost of such an endeavor.

Well, it would have been far more efficient, and cost effective long term, to simply have insurance companies handle all of this, right down to calculating any subsidies, while using the same government Federal Poverty Level (FPL) figures as Exchanges now do, and on the same standardized plans.

Returning to our “smoke and mirrors” analogy—the application of such things as tax subsidies have, quite naturally, been interpreted by consumers as some kind of a new government entitlement program, where the connection to costs is completely lost in the smoke, with consumers seeing this as a freebie—which it is not.

Where does the money actually come from to pay for the escalating “infrastructure” costs? Not out of thin air! Rather they come from multiple consumer-foggy sources like administrative fees, penalties and taxes.

Remember, it was the Supreme Court that many years back ruled on the ACA tax legislation; hence its

passage was determined to be another, legal way, to impose more, not fewer, taxes on the American public. How to counter the tax increases and costs of Obamacare?

Since plan benefits were standardized via the passage of the ACA, the only recourse for insurance companies to address their rising claims and systems costs, is to raise health plan premiums. And for the government to reduce benefits by increasing policyholder maximum out-of-pocket liabilities by shifting the costs and risks onto the backs of consumers. This leaves licensed insurance professionals, along with their client consumers, with few practical or effective cost controlling options.

The art of risk shifting by buyers

What’s health insurance really all about? Is it about paying for every nickel and dime healthcare expense? Or, is it really more about capping risk exposure to manageable levels?

Health insurance is best structured, designed and purchased to limit overall financial liability exposure to a level a person can reasonably afford.

Cost effective liability capping options for 2020

Let’s first understand what the limits are to maximum out-of-pocket liabilities going into 2020 using one of the Obamacare standardized health plans, while noting that few persons ever hit yearly

maximum liability caps. Typically, incurred medical claims are minor and well within one's own resources to cover.

The four standardized metallic TIER health plan types are: Bronze 60; Silver 70; Gold 80; and Platinum 90 (not taking into account the "Minimum Coverage" option for certain young persons, or the three enhanced Silver TIER versions for lower income earners).

The Bronze 60 TIER offers the lowest premium, along with the exact same maximum out-of-pocket of TIERS Silver and Gold: \$7,800 Individual/\$15,600 Family. Only the highest priced plan, Platinum 90, offers a lower maximum out-of-pocket cap of \$4,500/\$9,000; however, one pays for that lower exposure via substantially higher health plan premiums—not a win-win outcome.

Since all three of these (Bronze/Silver/Gold) have the exact same maximum out-of-pocket, why would anyone ever want to pay the higher premiums for a richer benefits TIER?

Well, if you know you will be facing very high healthcare expenses (claims) in the year to come...then, and only then, might you want to purchase a Platinum 90 Plan with richer benefits and lower maximum out-of-pocket cap.

Further complicating matters here in California (and also in Vermont), is that the legislature has re-imposed the individual tax mandate penalty for not having health insurance in effect from 1/1/2020 onwards.

The mandate, which takes effect on Jan. 1, 2020, requires Californians to have qualifying health insurance coverage throughout the year. Many people already have qualifying health insurance coverage, including employer-sponsored plans, coverage purchased through Covered California or directly from insurers, Medicare, and most Medicaid plans. Under the new mandate, those who fail to maintain qualifying health insurance coverage could face a financial penalty unless they qualify for an exemption.

Generally speaking, a taxpayer who fails to secure coverage will be subject

to a penalty of \$695 when they file their 2020 state income tax return in 2021. The penalty for a dependent child is half of what it would be for an adult. The penalty is based on your income and the number of people in your household. To avoid a penalty, California residents need to have qualifying health insurance for themselves, their spouse or domestic partner and their dependents for each month beginning on Jan. 1, 2020.

A look at the numbers

Example: Single, age 40, in zip code 90210 (So. Calif.) using Anthem Blue Cross HMO, with household income as noted below. Annualized savings, plus minimum savings after six years of Obamacare, assuming no health plan premium increases, no changes in income, no maximum out-of-pocket increases for six years:

W/O Subsidy (at 50k):

Bronze 60: $\$336.00 \times 12 \text{ Months} = \$4,032 \times 6 \text{ years} = \$24,192$
 Platinum 90: $\$634.00 \times 12 \text{ Months} = \$7,608 \times 6 \text{ years} = \$45,648$
 Minimum yearly savings after 6 years: $\$3,576 \times 6 \text{ years} = \$21,456$

WITH Subsidy (at 45k):

Bronze 60: $\$324.00 \times 12 \text{ Months} = \$3,888 \times 6 \text{ years} = \$23,328$
 Platinum 90: $\$623.00 \times 12 \text{ Months} = \$7,476 \times 6 \text{ years} = \$44,856$
 Minimum yearly savings after 6 years: $\$3,588 \times 6 \text{ years} = \$21,528$

Ask yourself—why spend money on a health insurance plan unless it really benefits you?

If we agree that insurance is best used to limit maximum out-of-pocket liabilities, then why purchase any other TIER than the one that can best help in cost-effectively accomplishing that? No more overpaying, and no more over or under insuring!

Of course, you could opt to have no health insurance at all and simply pay any individual state mandated tax penalty, which is something few would advise. Or, you could do so on the basis that you are so wealthy that you can afford to pay all liabilities from your own resources; however, most understand that it's simply a cheaper proposition have an insurance company take on liabilities for what amounts, to them, as pennies on the dollar.

Wouldn't you prefer not to give up those potentially "saved" premium dol-

lars, as noted in our example, versus paying more for a richer first-dollar benefits Silver, Gold, or Platinum TIER Plan?

In some ways of thinking, this is akin to self-funding (specific self-insurance), with an overall maximum out-of-pocket aggregate insurance with an insured-cap on your outside liabilities, and at the lowest premium costs.

Also, if you never reach your maximum out-of-pocket and this goes on for several years (hopefully forever), you will in essence be self-funding your own personal financial "savings" account, on which you can also earn interest, to cover part or all of any later maximum out-of-pocket event. You can also tap into those funds for other expenses, and/or create a pre-tax Health Savings Account (HSA) from which you can reimburse yourself, tax free, on any eligible healthcare expenses for the rest of your life. Or, you can use those HSA accumulated assets to pay for your own private long term nursing/homecare insurance on a tax-favorable basis.

Some will want buy a PPO to use a doctor that is not available via any cheaper HMO plan type, or if not available on a PPO health plan can only access that "indispensable" doctor as a PPO covered out-of-network doctor. Proceed with caution here. PPO insurers will only pay such a non-network doctor at 50% of what they would pay one of their fee-discounted in-network doctors. Not very many doctors or consumers are "happy campers" when those realities hit home, under any circumstances.

The bottom line

Consider transitioning to a Bronze 60 HMO health plan during the next annual open enrollment—a move many are making to efficiently and effectively save thousands annually!

Paul M. League, qualified financial planner (QFP) is the founding principal of League Financial & Insurance Services, a privately held company established in 1984, and located in Palm Desert, Calif. Paul and his company specialize in assisting clients to create, expand & preserve assets. Contact: 800.482.5347, Info@LeagueFinancial.com or www.LeagueFinancial.com.

THE STATE OF MENTAL HEALTH IN THE WORKPLACE

By KELLY BLISS

Take a look around—at the grocery store you frequent, in the car next to you on the freeway, at your clients' offices, and, perhaps, even in the mirror—and you'll likely see individuals who are among the 300 million people afflicted with depression and other mental health conditions that are often never diagnosed. They face a daily struggle to cope with problems that interfere with and limit harmony in both work and home life.

While many of your employer groups are finding ways to address the topic of mental health in the workplace, they often struggle to start the dialog and build a strategy that works in their environment, for their population.

To be a valued resource to your clients, benefits brokers who understand the data related to employee mental health can be even more effective in their recommendations to help employers meet the mental healthcare needs of employees. And there's a lot to know beyond the facts and figures. Behind the data are real people with real issues who struggle in their work lives as well as their day-to-day living situations.

Consider some interesting facts that were uncovered after a Teladoc Health-sponsored Ipsos MORI study focused on the mental health opinions of nearly 4,000 employees around the world. We distilled the results into four important areas that may help you understand how to grapple with a subject as intimidating as mental health.



Setting the stage so employees are free to ask for and get the care they need will help ensure that employees will use mental health benefits provided.

1. Mental health challenges in the workplace typically hit young workers hardest.

Young workers, including millennials, are changing how work gets done—seeking flexible work days and an environment that is more suitable to their style of work. This new way of working, however, comes at a cost. Workers ages 18-25 appear to face more mental health challenges than other age groups.

A large percentage of 18-25 year-olds say they feel burned out by work and deal with stress and anxiety frequently because of their mental and emotional health. In fact, 38% of respondents in this age group said they had been diagnosed with a mental health problem compared to all respondents in this study.

The most candid group in discussing their mental health—younger workers—also quickly admit that they miss work because of their mental and emotional health. Two thirds (66%) of workers aged 18-25 have missed work, compared to less than half (44%) of all age groups in the study. And, 61% of younger workers report that mental health symptoms have affected their job performance.

In this study, just 58% of respondents said they feel knowledgeable about how to improve their mental health. Given this gap, employers can help employees by offering access to more mental health help and resources to all workers. One solution that naturally resonates with younger workers is the idea of remote care and other health-related tools. A September 2019 CNBC report suggests younger workers don't hesitate to go online to seek help. Mental health providers agree that the demand for remote care has grown. One mental health therapist, Goali Saedi Bocci, Ph.D., from Portland, Oregon, says she treats 100% of her patients online and views online care as private, convenient and comfortable for both the therapist and client.

2. The stigma of needing mental health support keeps many from seeking help.

Employees from around the world indicate that stigma plays a huge role in what they don't say about their mental

health needs at work.

The study shows 82% of employees diagnosed with a mental health problem don't confide in anyone at work about their issue. And while some workers may elect to confide in a colleague, 27% of respondents said it's inappropriate to discuss mental health issues at work. Many employees also feel their capabilities at work would be questioned if they talked freely about their mental health struggles.

Most troubling, though, is that 55% of respondents said the big reason for not telling a work colleague about their mental health problem stems from fear of the information negatively impacting their job. One in 10 respondents said they felt confiding in someone at work about their mental health challenge could result in job loss.

As a trusted consultant to organizational leaders and human resource teams, brokers can cite these statistics as valid reasons to help their employer groups create a stigma-free work environment. Setting the stage so employees are free to ask for and get the care they need will help ensure that employees will use mental health benefits provided.

3: Get involved. Be visible. Talk about mental health.

It's human nature for us to avoid difficult issues. Instead of speaking up or taking action, we avoid situations that make us uncomfortable. But to be successful, senior leaders and people managers can't afford to ignore the situation. Our study shows employees will be more comfortable discussing mental health challenges when they see and hear their leaders talking about mental health in the workplace.

Without question, it's up to employers to take workplace mental health seriously. Kudos to those that have already implemented programs to help employees. But more needs to happen—57% of respondents in our study think more should be done in their workplace to improve mental health.

When leaders begin to openly discuss mental health at work, employees gain confidence in asking for the

(CONTINUED ON PAGE 20)

MONTH	FEATURE FOCUS	ALSO INSIDE	BONUS CIRCULATION
JANUARY	2020 Industry Outlook Health, Life and more	CA's Editorial Board weighs in on: Self Insurance Wellness Travel Insurance Medicare LTC & more	San Diego AHU Sales Expo
FEBRUARY	The Generations Issue Survey: GA View from the Top	Employee benefits that matter How to sell life insurance to everyone Financial wellness across the spectrum New trends in dental and vision	NAHU Capital Conference Orange County AHU Business Development Summit
MARCH	Large Group Survey: Large Group View from the Top	Closing the large group sale Consumer driven health Medicare Advantage	Inland Empire AHU Sales Symposium
APRIL	The Vision Issue	Best practices for health sales success Insurtech Life settlements Annuities	LAAHU Annual Conference
MAY	Voluntary Benefits Survey: Voluntary Benefits View from the Top	401(k) Commissions Medicare Prescription Drugs Travel Insurance	CAHU Capitol Summit & Expo
JUNE	All About Ancillary Benefits	Prepaid Legal, Vision, Disability Dental & more	NAHU Annual Convention
JULY	Survey: Dental Carriers	Annuities COBRA Life and LTC Riders	National Conference
AUGUST	Medicare Insurtech	Consumer Driven Health Prescription Drugs Travel Insurance	AHU Medicare Senior Summit Inland Empire AHU
SEPTEMBER	Life Life Settlements Survey: Life View from the Top	Self-Funding Plans Voluntary Benefits Medicare Annuities 401(k)s	NAAIA National Conference LAAHU & VCAHU Senior Summit LISI Group & Worksite Benefits Conf. PERKS LA Employee Experience Expo Healthcare Retreat
OCTOBER	Open Enrollment Survey: Large Group Roundup ANNUAL INSURANCE DIRECTORY*	Consumer Driven Health (HSAs) Medicare Supplements Vision Pet Insurance	Employer Health Care CAHU Annual Convention & Symposium
NOVEMBER	Individual and Small Group Survey: Small Group Roundup	Travel Insurance Long-Term Care Life Insurance Medicare Vision Prescription Drug Plans	Alliance of Comprehensive Planners Annual Conference *CALIFORNIA BROKER INSURANCE DIRECTORY
DECEMBER	Voluntary Benefits Survey: Voluntary Benefits Carriers	Year in Review Critical Illness Genomic Testing Life Settlements Dental	A complete sourcebook for the entire insurance industry in California, Sources for 50 products, plus profiles of Health Carriers, Dental and Vision Plans, Brokerage Agencies with websites, broker phone numbers and emails.

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When employees have access to the right tools, including remote support like virtual behavioral health, the negative impact mental health problems have in the workplace can be diminished.

help they need. Providing this sort of advice is usually outside the norm for most brokers in their relationships with business owners. Those who do attack the mental health stigma in the workplace head on may find themselves at an advantage for attempting to understand and resolve real workplace challenges.

4. Improve mental health in the workplace with access to information and support.

Remember when employers implemented mental health days into the benefits package? At the time, it may have seemed like a stretch to give workers a mental health day. Fortunately, when employees make use of this benefit it makes a huge difference in their ability to self-manage their mental health.

Of respondents in the study who experienced a mental health challenge in the past and received support, the most useful employer-provided solutions were:

- Adequate time off work (80%)
- Adjustments to work hours and setting (79%)
- A temporary reduction in workload (77%)
- Being offered specific information about their own difficulties and needs (70%)

In our study, just one-third of respondents said they believe mental health benefits at work get the same level of importance as those for physical health. And 33% said they would be more productive at work if there was better mental health support. There is indeed room for employer groups to enhance mental and emotional health resources. Access to mental health assistance using a remote solution is one offering that makes perfect sense given the use of technology in our daily lives.

It's vital for employers to offer the right resources and support. Nearly half of those who perceived mental health stigma in the workplace chose a remote form of access to information and support as a way to break through the stigma. When employees have access to the right tools, including remote support like virtual

behavioral health, the negative impact mental health problems have in the workplace can be diminished.

While we've come a long way this century, we still have a mountain to climb to meet employee mental health needs at work. Once we break the stigma associated with mental health, employers will be able to make inroads in helping employees with their challenges.

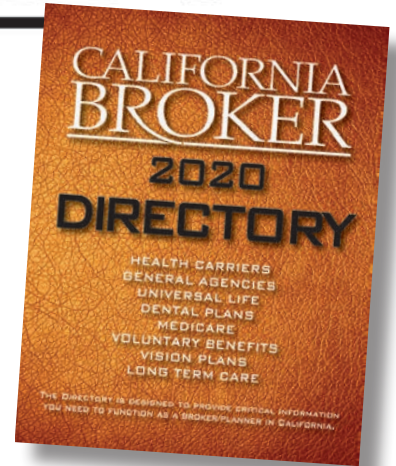
Scope and methodology

In August and September 2019, Teladoc Health partnered with Ipsos MORI, a global market and opinion research firm. Ipsos interviewed 3,894 participants online. The study was carried out across four countries with n=1,000 interviewed in the United States, n=1,000 in the United Kingdom, n=964 in Canada, and n=930 in Australia. All participants were adults who are 18-65 years in age and in full- or part-time employment. Quotas based on census data available were set for age, gender and region in order to ensure a nationally representative sample of the working population in each country was achieved. Freelancer and self-employed adults were excluded in order to focus on workplace employees. The quota limits for regions in the United States and the United Kingdom were removed in the final week of the study so the overall target of n=1,000 in these countries was met.



Kelly Bliss, chief client officer, Teladoc Health, is responsible for the global client services strategies that drive client retention, fosters advocacy, and grows partner relationships for Teladoc Health. She has strong expertise in creating cohesive client-focused organizations, having built and managed high-functioning, global teams at companies such as Best Doctors, InterSystems, and TRO-Design. At Best Doctors, she served as chief of staff, leading the organization's key strategic growth initiatives, and was integral in the integration of Best Doctors with Teladoc Health. Bliss also managed U.S. operations including human resources, IT infrastructure, real estate, and account management. She holds a bachelor's degree in industrial psychology from Nichols College.

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THE CHANGING LOOK OF LIFE INSURANCE DISTRIBUTION

By DAVE DONCHEY

How life insurance producers can ride the waves of disruption

As any good surfer knows, waves come in sets. Within each swell, energy bonds together and then travels in sets or groups of waves. In this way, they can conserve their energy as the waves travel over the vast ocean. The same could be said of trends in the insurance industry.

The waves of technology will continue to hit the shores of your business. The question is, will you be ready for the waves? Will you be intimidated by them? Or will you grab opportunity by the horns and ride that wave all the way into shore and beyond?

The main disruption in our industry is driven by technology, and it's impacting everyone involved: the carriers who build products and issue policies, general agencies who process them, life insurance producers who sell them and customers who buy them.

If you learn how the progression of technology's effect on carriers and General Agencies impacts you, the life insurance producer, you can learn how to ride the wave of disruption.

If you're not informed about every aspect of your business, then the internet WILL take over your company.

Carriers

Carriers have many concerns as technology is changing how consumers interact with insurance products.

Being profitable is crucial and carriers are taking advantage of technology to reduce their costs. E-applications, drop tickets, and accelerated underwriting are a few examples of processes carriers are implementing to lower their costs.

Life carriers also used to be primarily responsible for insurance producer education, as most producers were tied to a specific carrier. Carriers took that role seriously, and ensured that their agents knew the ins and outs of their products and services. Today, however, carriers have reduced or eliminated many of their training resources (and no longer offer agents an education stipend). To add fuel to the fire, more and more insurance producers are independent, and the various types of people who can sell life insurance (like investment advisors, CPAs, and health insurance agents) have further fragmented training and education.

A number of life insurance carriers are also creating direct-to-consumer platforms like Haven Life (which is owned by MassMutual), Prudential, Protective and others, because frankly, it might be a lower-cost model for certain demographic buyers. However, life insurance products are complicated and there is still an important benefit to having producers help sell larger and more technical policies. And some people need and want the skills of a good insurance producer to give them the right guidance.



Life carriers are fighting a few different forces, looking for ways to lower their costs, increase their margins, and be a sustainable leader in the business.

In summary, life carriers are fighting a few different forces, looking for ways to lower their costs, increase their margins, and be a sustainable leader in the business.

General Agencies

General Agencies have largely become responsible for producer education and training, acting as the middleman between carriers and agents.

This scenario is complicated, however, by a few factors:

- A large number of producers are autonomous and not directly tied to a carrier. Individuals who can now sell life insurance include investment advisors, property casualty agents, CPAs licensed to sell insurance, health insurance producers, and so on.

- The independent producer might be part of firm that sells many types of products, but the producer is responsible for his own training. What he or she knows about life insurance products is minimal, and in many cases, largely self-taught.

- Producers are not as well trained as they once were (by carriers) and they are generally not proactive about seeking help. They're busy trying to be successful and grow their business, but it's much more difficult to do it alone out of their home office or independent firm. Finding time to drive across town and attend a training session is a challenge. Unfortunately, many insurance producers have lost

sight of the value of education and training.

General Agencies have to be more nimble and innovative, taking advantage of technology to be able to educate producers—and do more to reach out and build connections with independent producers.

Producers

Producers have been hit hard by the incoming technology waves. Consumers are changing the way they shop for products, and life insurance is no exception. They can hop online, research, and now, even buy life insurance products from sites like Haven Life. By the time a consumer contacts an insurance agent, they've likely already done their homework.

This is an enticing process, because consumers “don't know what they don't know.” They only see a low policy premium and what appears to be a simplified process, and as a result, see little value in what an agent can provide (especially when what life insurance producers have to offer is information consumers don't think they need or already know how to search for).

So how do you counter the disruption that technology is having on the consumer's view of the value you bring to the table? If you're a well-equipped producer, and you're knowledgeable and informed, you can absolutely show consumers the story behind every spreadsheet.

General Agencies have to be more nimble and innovative, taking advantage of technology to be able to educate producers—and do more to reach out and build connections with independent producers.

Or why a particular insurance company is ideal to work with. Or why you would recommend a different product or policy.

It all comes down to maintaining a high level of training

If producers want to remain relevant and not be replaced by a computer and a website, they have to be more sophisticated. And that happens by learning the trade—well. It takes becoming an expert about products and processes, and using tools that will enhance business.

Here's where YOU can harness technology to your advantage. Instead of having to drive across town and spend an entire day at a seminar, you can participate in a short "Lunch and Learn" or watch a video or webinar—taking advantage of all possible resources to be proactive about your education and training.

Technology can also help you broaden your base of offerings, so that changes in any one segment of the industry won't hurt your business as much.

Finally, developing key relationships will boost your success (with a General Agency, for example) and provide you with a setting to have meaningful discussions and strategically talk through cases. And then, ultimately, place more cases.

Working with organizations that provide substantial training resources will help you deal with internet competition and stand out in a crowded sea of options.

According to Jim Duff, President and General Manager, Tellus Brokerage Connections, "The impact technology is having on the life insurance business is all about the experience and how everyone interacts, including the carrier, the general agency, the producer, and the client. The tradi-

tional insurance agent used to have a desk in an office. The trend now is where producers work remote, as it doesn't matter where he or she works because clients no longer expect them to have large offices. Meetings can take place anywhere. The key is to have the tools to properly manage the business and go see clients when and where needed. The consumer experience is "all in one." The consumer seeks knowledge, gets questions answered in real time, and the producer needs to learn to strike when it's hot. Instant gratification is good when it comes to the speed of getting information and consumer behavior has changed and demands this. Producers also need a general agent who can see the entire market and has strategy and tactics to find the right solutions."

The takeaway

To survive and be relevant beyond one, three or five years in the life insurance business, producers have to be engaged, recognize that the industry has changed and will continue to change, and make education and training a priority.

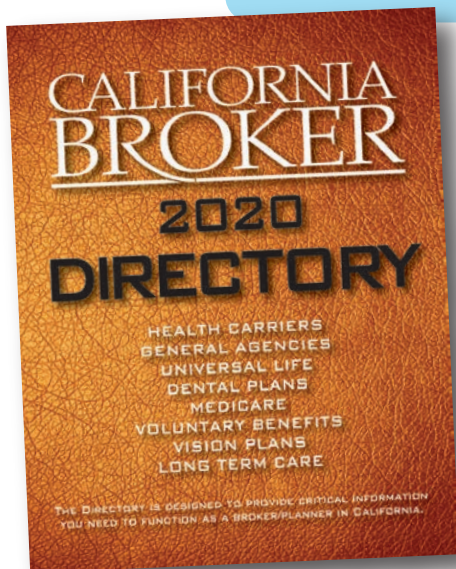
That's how you can begin to ride the wave of technology disruption in the life insurance industry.

Dude, are you ready to ride some epic waves?

Dave Donchey is president and CEO of LWT Agency. A third-generation insurance agent, Dave spent 10 years in life insurance and long-term care insurance personal production and subsequently joined LWT in 1996 as a brokerage manager. He's published numerous articles and has served as a member of several insurance industry field advisory councils. Dave handles the firm's marketing efforts and is also a Life Sales brokerage manager. You can reach him at 626-304-1300 ext 111, email him at Dave.Donchey@lwtagency.com or follow him on LinkedIn or YouTube.

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

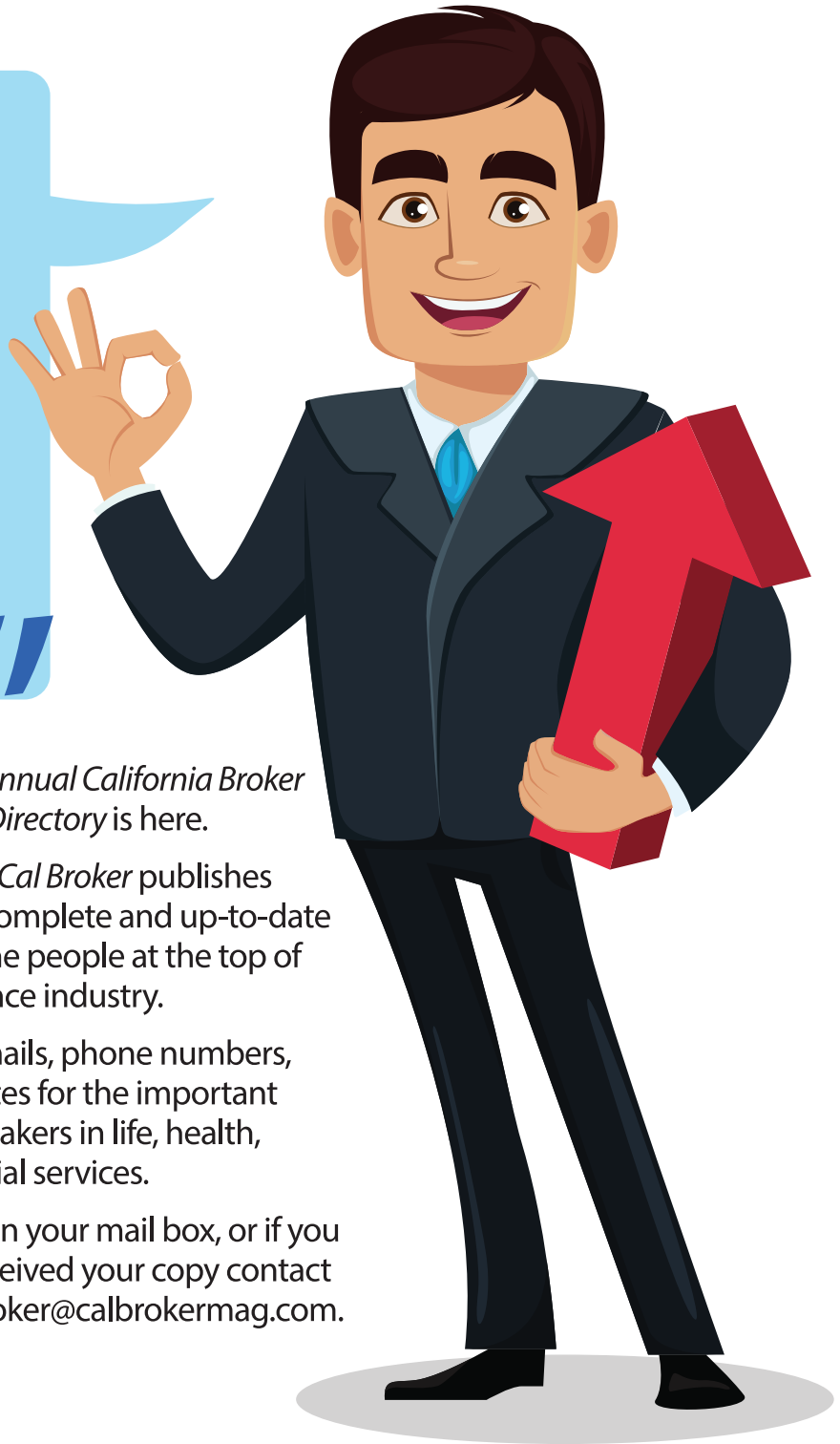


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**Doctor Engagement is the Key to Healthcare
Transformation 10, 20, and 30 Years from Today**

Although some futurists believe that concepts like Medicare for all will solve our healthcare crisis, Dr. Anil Keswani explains how building on doctor engagement, clinical integration and third-party technology disruptors will improve and transform the functionality of health care delivery.

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While options are great and choice is important, what is most critical is delivering on what we're here to do: provide trustworthy health insurance.

(MEDICARE INSIDER CONTINUED FROM PAGE 8)

was already offering Special Needs Programs for members with certain chronic conditions, but is now able to offer even more services to help members manage their conditions.

Just because it's new or different doesn't necessarily mean it's better. A plan that offers something exciting like a free Fit-bit might catch your client's eye, but is getting a non-medical item that they might be able to buy themselves (or put on a holiday wish list) worth leaving a plan they're otherwise happy with? Probably not. On the other hand, this could be a nice value-add for someone aging into Medicare. Help your clients keep things in perspective.

A plan is worth more than the length of its benefits list. It can be tempting to judge a health plan solely by how many extra benefits it offers. After all, more is better, right? While options are great and choice is important, what is most critical is delivering on what we're here to do: provide trustworthy health insurance. People depend on us to cover the care they need with no surprise costs. When you have seniors depending on you, this charge takes on extra meaning (at least, it does for me and my colleagues at SCAN).

So, one of the most important questions to ask this year is: how can you best evaluate new benefits? Your personal experience and that of your clients counts for a lot. Ask is the plan responsive? Do its representatives resolve issues and follow up in a timely manner? These are important factors to consider. More objectively, also take into account

a plan's 5-Star quality ratings, the stability of its provider network, whether a client's prescription drugs are included in the plan formulary, and if a client's doctors are in-network. These things may not be as alluring as a free fitness wearable or regular massages, but recommending a plan that cares for your customer's needs will bring more value to your client—and your reputation as a trusted advisor.

Holly Ackman has almost 30 years of experience in the Medicare Advantage industry. She is currently VP of sales operations for SCAN Health Plan, one of the nation's largest not-for-profit Medicare Advantage plans with more than 200,000 members in California. In addition to Medicare Advantage, SCAN also offers special needs plans for those with chronic conditions or who are dually eligible for Medicare and Medi-Cal. Visit scanhealthplan.com or [facebook.com/scanhealthplan](https://www.facebook.com/scanhealthplan), or follow us on twitter @scanhealthplan.



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INSIGHTS FROM LARGE GROUP EXPERTS

COMPILED BY THORA MADDEN

Cal Broker reached out to a couple of industry pros for insight on the state of large group. The message is clear: take a step back, ask the right questions, listen, then deliver creative solutions. California employers are embracing innovation and the conversation centers on transformation of the traditional access model in bold new ways. Those who can articulate the changing landscape will be of real value to their clients.

CB: What are the most important trends affecting large groups in California? For example, do you believe the Association Health Plans (AHP) rule will have an impact on the large group market, particularly in California?

**Michael Wolff, managing partner,
Dickerson Insurance Services:**

The most important trend that continues to affect large groups is the cost of healthcare products and services, particularly pharmacy. With regard to the AHP rule, I don't think this will have any impact in California because the state will not permit establishment of AHPs at this time.

**Rob Carnaroli, VP of Sales,
Health Plan Products, Sutter Health:**

California still enjoys some of the lowest average premiums in the country; however, with premium levels continuing to rise, consumer expectations for quality, value and convenience are trending high. The pressure is on carriers to deliver a greater value for the healthcare dollar, which is why we are seeing a shift to value-based care models. HMOs have never been more popular and the plans offering a seamless, integrated delivery platform are well positioned. Healthcare organizations are also ramping up investments in technology to enhance the member experience. Partnerships with innovative start-ups have the potential to completely flip the way healthcare is delivered in the near future. Additionally, we know there are many reasons why healthcare and Rx costs

keep going up. A reliance on big data is gaining momentum for carriers to more effectively manage high-cost enrollees. Health plans have been slow to tap into data analytics, and I think it's a smart way for carriers to strategically manage their resources.

Specifically, regarding the question about AHPs, currently California law does not allow large group plans to be sold to individuals or small employers through an AHP, so I don't see AHPs making an impact on the large group market anytime soon in California.

CB: We've heard from some producers that they are directly linking some groups to healthcare providers, in effect focusing on bringing healthcare to consumers rather than bringing health insurance to consumers (their words). Is this on your radar and what do you think about it?

Michael Wolff:

This has been going on for quite some time. It is just becoming more prevalent of late. Yes, we see that some direct-payment programs are beginning to take shape among very large employers. However, the very largest employers are not necessarily going to negotiate lower prices in a direct contracting arrangement because the carriers still have more purchasing clout. California carriers also have been very successful with the Accountable Care Organization (ACO) model, bringing independent entities (carriers, hospitals and medical groups) together to share data and risk in an effort to lower costs. However, we do see a trend that some employers are circumventing traditional PPO arrangements in favor of direct-contracting using a metric-based or reference-based pricing schedule.

Rob Carnaroli:

In California, we have seen some employers experimenting with direct partnerships with health systems. Although I am not sure the benefits outweigh the massive effort it takes





to implement this model of care, the concept again centers around the practice of value-based healthcare, and keeping the insurance company out of the equation. This type of partnership may allow an employer to gain more control of how their healthcare spend is allocated.

The industry is embracing integrated care. The inclusive process of sharing data and making healthcare decisions directly with healthcare providers is part of what these large employers are working to accomplish.

CB: What are the most effective ways to sell to large groups in California right now?

Michael Wolff:

Agent-client relationships that are a true business consultancy, combined with service excellence, will help gain and retain customers. Asking the right questions, knowing a client's priorities and challenges, and delivering creative solutions are all part of a successful large group sales and service model. Agents should look beyond traditional products when proposing changes in coverage. Reviews and analyses of existing plans/services is a great first step to a final proposal of a new funding arrangement or vendor partnership. If an agent is not an expert in an area of focus for the client, he or she might consider partnering with someone who is. Finally, data is king when it comes to understanding and managing a client's utilization trends and costs. If data is available to the client, it should be used to help shape benefit program designs.

Rob Carnaroli:

As we head into the fall open enrollment season, it's important for brokers to take a step back and examine the current marketplace with their clients in mind. Northern California, the center of technology and innovation, is changing the game in terms of how consumers shop for and view healthcare. The conversation with large employ-

ers is around the transformation of the traditional access model in bold new ways.

The demand for innovation is here and modern entry points are emerging—like neighborhood retail clinics, walk-in care locations and same-day pharmacy delivery. Video visits and virtual-first primary care, specifically with in-network physicians, are no longer just for early adopters. The next wave of consumer interest in virtual care is connectedness to a consumer's own medical system, and not a third-party panel of physicians. This allows for better coordination through shared electronic health records—from virtual visits to follow-up care. Finally, using artificial intelligence through virtual assistants is becoming prevalent as well. Triageing symptoms ahead of a physician's visit may help the office visit be more productive, and it reflects today's trend in performing online research as a first step in getting answers.

California employers are embracing innovation, and a distribution channel that understands and can articulate the changing landscape can demonstrate real value to their clients.

Michael Wolff is a managing partner, along with Tony Lee, of Dickerson Insurance Services, an Alera Group company. Wolff studied law in Germany, France and Russia and served in the Foreign Service in Paris, Bangladesh, San Francisco and Los Angeles. He brought his international experience to Dickerson Insurance 15 years ago, in 2004. Founded in 1965 by Carl Dickerson, the company partners with agents across the United States and internationally to offer employee benefits and property and casualty products and services to individuals and groups of all sizes. He can be reached at 800-457-6116.

Rob Carnaroli serves as VP of sales for Sutter Health Plus. Prior to joining the health plan in November 2014, Carnaroli served as Health Net's Northern California director of sales and Health Net's Western Region director of major accounts for Arizona, California, Oregon and Washington. He can be reached at carnarj@sutterhealth.org

THOUGHTS ABOUT SINGLE PAYER HEALTH CARE

By DAVID FEAR, SR.



MEDICARE
FOR ALL?

I'm writing this article in late October, a few weeks before I turn 65 and become eligible for Medicare. I'm being flooded with mail from various organizations who want me to enroll in their Medicare supplement plan. Like most baby-boomers, I can't believe the day has come that I'm now old enough for Medicare. So, like any other senior citizen, I tried to contact the local Social Security office because I had some questions.

It took me three calls to get through only to be told that they will call me back because they are so busy. I get that—it's Medicare Open Enrollment and just like our 4th quarter, a very busy time of the year for this government agency. I eventually went online and figured out the answer to my question. But now I'm asking myself a different question: Is the government ready to handle "Medicare for All"?

I think back about the botched roll-out of the Affordable Care Act in the fall of 2013. Remember that? The website blew up on the first day and was a huge disaster. Remember President Obama going on TV and trying to explain to the public why this happened? Yes, things eventually got fixed and now five years later it seems to work. However, I'm not convinced that the government can handle the "Medicare for All" proposal.

Leading Democratic candidates for president continue to promote the "Medicare for All" plan like it is the only hope for America's health care future. If we set aside the financial issues of "Medicare for All", I believe that there is no way a State or Federal agency can handle the health care needs of all citizens who are enrolled in such a program. We just don't have the bandwidth for such an undertaking in America. I think the reality of this and the high costs that would be imposed on Americans in the form of new/higher taxes has made some of the candidates turn down their rhetoric a bit. Quite frankly I think their use of the word "Medicare" is disingenuous because they are just trying to avoid using the term "Single Payer" because it produces visions of a government takeover of health care.

However, we might consider a discussion about the pros and cons of expanding the current Medicare program.

My observation over the past 40 years is that the cost of healthcare is causing serious problems in our economy. We continue to put 'band-aids' on various health care issues, but we need to seek out a longer-term solution to

One possible effect of expanding the current Medicare program is that it could lead to a reduction of health care costs by using a government negotiated fee schedule that was enacted in the Medicare Modernization Act of 2004.

stabilizing the cost of healthcare in America. I recommend you read the book by Steven Brill “Bitter Pill: Why Medical Bills Are Killing Us” or “An American Sickness” by Elisabeth Rosenthal.

One possible effect of expanding the current Medicare program is that it could lead to a reduction of health care costs by using a government negotiated fee schedule that was enacted in the Medicare Modernization Act of 2004. Prior to the act, less than 50% of providers participated in Medicare, while today over 90% participate. That’s because the government reformed the way providers are paid and has helped reduce the costs of Medicare. If those payment reforms were to apply to private coverage as well as to Medicare it would help stabilize costs for everyone in America and not just senior citizens.

Another possible result of expanding the current Medicare program is the elimination of “cost shifting” in our healthcare system. Since the enactment of Medicare in the 1960’s, health care providers have been cost shifting from government payers to private payers. Here is an example:

A 100-bed hospital needs \$100,000 a day to operate so it charges \$1,000 per day per bed to break even. However, 75 of those beds are used by Medicare patients and Medicare only pays \$750/day, resulting in a daily operational deficit of \$43,750. When you divide that among the 25 non-Medicare beds it means that non-Medicare patients are charged \$1,750/day which is 233% more than Medicare pays.

While the Medicare Modernization Act did reimburse providers more equitably, it didn’t fully stop the cost shifting that continues to affect private insurance or private payers. In my opinion, an expansion of the current Medicare fee schedule to apply to ALL payers would be a good thing. Many large employers who “self-fund” their employee health plan have been using a Medicare Price Metric (Reference Based Pricing) for several years and it has helped them stabilize their group health care costs.

Another positive I see about an expansion of the current Medicare program would be the continued use of private insurers to provide supplemental coverage to pay for the gaps that are not covered under Medicare. I’m told that more than 60% of Medicare participants have a supplement today and nearly 100% of them have a Medicare Part-D plan which is also through a private carrier.

Under “Medicare for All” proposals, private insurers and supplemental plans are completely eliminated. Having a choice of supplemental plans through private carriers is a popular feature of the current Medicare program and should be continued—certainly not eliminated.

As a former small employer, I paid a lot of money for the health insurance coverage for my employees. The cost rose each year and I was forced to make hard decisions about the level of benefits that I could afford. Under an expansion of the current Medicare system, employers could offer a group Medicare supplement that might cost less than current coverage and at the same time take advantage of stabilized premiums when a national fee schedule is applied to all U.S. providers including drug, hospital, physician and ancillary services.

I realize that my suggestions are not popular with many in my industry and certainly not popular with healthcare providers. But frankly, if we don’t do something now, the consequences for all parties will not be pretty. Look at Western Europe and you see movement away from Single Payer to combinations of public and private insurance programs that are working to contain costs, expand coverage and increase consumer choices. Even Canada is looking at major changes to their Single Payer system because it is not sustainable in its current form—they have a lot of disparity between their provinces in terms of affordability and access to health care. Why would America move in a direction that other industrialized countries are moving away from?

Americans lead the way in innovation and industry. We can build off the current public and private insurance systems and create something that is affordable, provides choice and lowers the cost of health care for all Americans. But this doesn’t require a complete overhaul of our current system. This system can and should work for the benefit of consumers, employers, and the government.



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FOUR WAYS TO HELP YOUR CLIENTS DISCOVER THE VALUE IN VOLUNTARY BENEFITS

By DENNIS HEALY

As employers breathe a collective sigh of relief after open enrollment and head towards the new year, it's time to nail down their benefit strategies for 2020. Providing voluntary benefits—those that go beyond the traditional medical, dental and life insurance—is generally agreed upon as a good thing to ramp up benefit offerings. But explaining the “how” will help your clients discover that adding the right voluntary benefits enhances an overall strategy.

Here are four ways you can show how voluntary benefits add value.

1. They serve as a multi-purpose tool to attract and retain employees.

With monthly job openings hovering around 7 million, coupled with unemployment rates that recently reached a 50-year low, it's still an employee market. Employers need innovative ways to differentiate themselves so they can attract and retain workers. This is your opportunity to offer them that direction, which can also deepen your relationships and increase your revenues.

That's where offering the right mix of voluntary benefits comes in. In fact, personnel who were given optional elec

tions were more likely to be satisfied with their jobs and less likely to be searching for a new one, according to a survey conducted by Aflac. The Aflac survey showed that 70% indicated they would sign up for extra offerings if they were presented.

Employers are starting to meet the demand for these perks. Consider this: 80% of large organizations who responded to the Willis Towers Watson's *2018 Emerging Trends: Voluntary Benefits and Services Survey* believe in the importance of voluntary benefits, with 95% saying they'll be an essential part of their total compensation package in three years. About two-thirds of the respondents use these add-ons to attract new employees and retain staff. And finally, more than 75% of the companies surveyed like voluntary benefits for their ability to provide personalized options to staff, allowing for tailoring to different generational or income brackets.

These facts all add up to compelling reasons why voluntary benefits, based on their versatility and attractive traits, can play an integral role in your clients' strategy.

2. They enhance employees' overall well-being.

On the employer side, there has been a huge national push for physical and financial wellness initiatives. Employers are recognizing the increased stress their employees deal with and are looking for solutions to not only help their workforce cope, but ultimately help them be more productive.

Voluntary benefits attractive to today's workers take a holistic approach to their overall well-being and address pertinent employee financial and personal needs. These can include:

- Financial planning
- Retirement planning
- Legal insurance plans

When these benefits offer cost savings and other attributes that employees value, like reduced stress and time savings, it could prove especially appealing to workers. Financial wellness programs are another popular benefit that can help with huge financial stressors like student loans, debt consolidation and tax issues.

Additionally, a National Law Journal survey of employees with a legal insurance plan found that they saved \$2,065 on average per legal issue. Ninety percent felt that having legal insurance reduced their stress—and saved them an average of 8.5 hours—when dealing with legal issues.

3. They meet employees where they are in life.

Voluntary benefits packages need to meet the needs of a wide range of people and continue to evolve to meet the demands of an ever-changing workforce. Everyone likes to have options, but millennials in particular want to choose from an array of products. A wide variety of options allows employees to customize their plan to their individual needs. For instance, younger employees may prefer student loan repay-

ment assistance, while workers in their 30s might want help with buying a home or starting a family. Older staff could find long-term care insurance or help with retirement planning appealing.

Legal insurance benefits plans are gaining popularity because they offer multiple services that provide value to employees at all life stages. On top of the more common legal issues one might expect from this type of plan, like trusts, wills, divorce, etc., legal insurance plans may also provide assistance with other issues such as credit monitoring and identity theft protection, financial counseling, immigration assistance, caregiving support and tax services.

4. They provide extra value—without the added cost.

Employees are faced with a multitude of benefit options, all literally competing for their "wallet share." The benefits that will win loyalty are those that present quality offerings—both in their richness and an exceptional customer experience—at a reasonable price.

It can be a tricky proposition for employers. They're now tasked with providing more choices in this "on-demand" world that so many employees (especially millennials) are used to. Employees want to have more control when it comes to deciding which options are useful. And they're asking for a benefits package that can be more personalized to them, so they feel like they are truly benefiting from what they are paying for.

Employers can help their employees determine which products are relevant to their lives and will provide a good return on investment before they spend their hard-earned dollars. This can be done by intranet and email communications. Adding in-person meetings will offer employees an opportunity to ask more in-depth questions.

Technology can be helpful here as well. For example, MyChoiceSM by Businessolver[®] is a streamlined, easy-to-use tool that provides recommendations on the benefits that are right for individuals based on their responses to a group of personalized questions. And these customizations pay off for employers. An Aflac survey found that employees who were offered voluntary benefits were 19% more likely to be satisfied with their job—and 14% less likely to be job searching.

What's this all mean for you when you meet with your clients to ring in the new benefit year? As interest in voluntary benefits increases, explaining the "how" behind the value delivered will help your clients get the most out of their voluntary benefits by zeroing in on what their employees really want. After all, offering the products that deliver the strongest price-to-value proposition and a quality customer experience is bound to give you an edge for your consulting or brokerage business.



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DEMAND FOR DENTAL AND VISION BENEFITS INCREASES

Don't overlook vision benefits

By BRIAN MUSE

In today's tight labor market, competition for talent in California is fierce. Employers are faced with recruiting and retaining skilled workers where job opportunities far outnumber job seekers, according to CNBC. The talent shortage has inspired many employers to reconsider their employee benefits package and focus on workforce demands.

Although dental and vision plans have been popular for decades, demand for this supplemental benefit continues to grow. Market research frequently ranks dental and vision plans among the most desired employee benefits, following medical and retirement plans. Year over year, annual employee surveys from LIMRA and Employee Benefit Research Institute have reported dental and vision benefits as extremely important to an employer's benefits package. With its increasing popularity, dental and vision benefits present an opportunity for benefit consultants and brokers to add value to their clients' existing coverage.

To help better identify those opportunities, here is a look at some of the

key factors impacting the market, and a few tips that may help optimize your clients' dental and vision approach.

Greater dental and vision health awareness

According to the National Institute of Dental and Craniofacial Research, over the last 50 years, medical professionals have gained a greater understanding of the critical role that oral health plays in an individual's overall health and wellbeing.

Recent medical research and studies by the Mayo Clinic and the Centers for Disease Control and Prevention (CDC) show the link between dental and vision health and certain diseases. We now know that regular dental and vision exams can reveal signs of certain types of cancer, heart disease, diabetes, eye conditions and other serious medical conditions—usually leading to more effective treatments.

The general public has also become more aware of how dental and vision health affects overall health, thanks to public health programs and the medical community.

In spite of these gains in public aware-

ness, some workers take their dental and vision health for granted, ignoring signs and symptoms to their detriment.

One explanation for this could be that many medical plans do not offer dental or vision coverage, which can leave employees with high out-of-pocket expenses, or worse, avoiding essential dental and vision care altogether.

In the 2015 survey "Oral Health and Well-Being in the United States," the ADA Health Policy Institute found that 95% of respondents believed that regular dental appointments were essential to their health, but only 37% actually visited a dentist within the last 12 months. Moreover, more than half of the respondents who reported visiting a dentist within the last year had private dental benefits. Another report by the National Association of Dental Plans (NADP) found that Americans with dental benefits were more likely to receive dental care and experience greater overall health, compared to those without benefits.

Marketing Tip: Show benefit value

Benefits consultants and brokers have the opportunity to show employ-



Client relationships mean everything in this industry, but it's easy to have a strong client relationship and still lose sight of your client's changing business priorities and goals.

ees the coverage gap and demonstrate the value of dental and vision plans. Communication materials should help educate employees on the importance of preventive health, while providing examples of how the plans can help make that care more affordable.

Reinforce these messages during client and enrollment meetings. Work with carriers who can provide customizable employee communications and help during enrollment meetings, allowing you to provide this level of service to all of your clients.

Select the right plan for maximum impact

While employee benefits may play a small part in an overall business strategy, it's important to note the wrong benefits mix will exacerbate business challenges. In fact, there is enough evidence to present a strong case for employers to be concerned with both the health and the financial wellbeing of their employees.

According to a 2017 Willis Towers Watson study, poor health and financial worries have a strong correlation to employee productivity. The University of Alabama at Birmingham School of Optometry reported in a computer vision study that even minor vision problems can decrease an employee's productivity level. These studies make it easier to understand why some employees would consider changing jobs for better medical, dental and vision benefits. Yet, many employers don't offer dental and vision benefits alongside medical plans.

Only 68% of employee respondents said their employers offered dental benefits, and only 64% said their employers offered vision benefits, according to a 2018 workplace benefits survey by

Employee Benefit Research Institute and Greenwald & Associates. There are various reasons employers decide not to offer dental or vision plans, including these common explanations:

- Misconception that their company is too small
- Previous plan offerings were unsuccessful
- Employees would not be able to pay the monthly premiums or see the value of the plans

Another common rationale is that employers may find selecting dental and vision plans a bit intimidating with too many plan options, including the different types of dental plans like MAC, Passive PPO, Active PPO and DHMO. They may also be confused by how dental and vision insurance products work. In an industry full of acronyms, it sometimes takes a little time and a good tutor to become familiar with the alphabet soup of dental and vision insurance.

The truth is that employers need benefits consultants and brokers to guide them through the process. They look to you to deliver the right plans that meet their specific business goals, benefits needs and their budget—no matter how large or small the company. Benefit consultants and brokers must go beyond shopping for the lowest price by advising their clients to select dental and vision benefits that appeal to both current and future employees.

Marketing Tip: Really know your clients

Seasoned brokers and advisors know that delivering a higher level of service means getting to know each of your

clients' needs, beyond client data, industry codes and prior enrollment history. Know what each client values most, their unique challenges and their top talent competitors. This is essential to helping your clients develop a solid benefits strategy with streamlined solutions that align with their priorities.

Client relationships mean everything in this industry, but it's easy to have a strong client relationship and still lose sight of your client's changing business priorities and goals. And for the employer, it's easy to slip into a routine of offering the same benefits plan year after year, and miss the signals that it's time to update the dental or vision plans.

As benefits professionals, you are in a perfect position to assist your clients in identifying these signals and providing guidance on whether it's time to update their dental and vision plans—or maybe even add another dental plan option to their benefit package. Monitoring employee demographics and annual plan utilization reports are great ways to spot some early signs that your clients may need adjustments to their dental and vision benefits. Through this consulting process, your clients will be better equipped to help employees maintain their health and productivity levels. And happy, healthy employees also help your clients win in today's competitive labor market.

Brian Muse is VP of Dental and Vision Market Development at Unum, primarily focused on supporting business development and client satisfaction of dental and vision products. He has 29 years of comprehensive sales, account management and business development experience, including more than 14 years of experience in the employee benefits industry.



TOP TRAVEL INSURANCE TRENDS FOR 2020

By RAJEEV SHRIVASTAVA

The travel insurance market is booming. A recent report by the United States Travel Insurance Association (USTiA) revealed that while Americans are now spending almost \$4 billion annually on travel insurance, only 6% of that figure is for travel medical insurance. This represents a huge opportunity for life and health brokerages.

Grandparents, gamblers, getaways and the rise of “bleisure” family travel

- The newly-released USTiA study demonstrates that Americans lack sufficient education concerning the risk they take when venturing outside of the U.S. without sufficient travel medical insurance coverage.
- Three countries have taken a step toward mandatory travel insurance requirements for entering their countries—look for more of this in 2020.
- A new travel demographic has emerged—split generational travel—where grandparents and grandchildren ditch the middle and travel sans mom and dad.
- The rise of the “micro-cation” may drive the rise of annual policies for the travel medical insurance industry.
- 64% of travelers are taking or are considering taking their families on business trips, opening the door for multi-trip and multi-individual policies.

The travel insurance industry is obligated to educate U.S. travelers

The fact that only 6% of U.S. travelers secure travel medical insurance—which differs from trip insurance—illustrates

the gamble Americans take when venturing overseas without travel medical insurance. There is a perception with the American traveler that their U.S.-based medical coverage will cover them while out-of-country and that the cancellation and delay coverage they purchase when completing their airfare purchase will cover them for everything else.

Nothing could be further from the truth.

Just as uninsured Americans can lose their home or find themselves declaring bankruptcy from lack of sufficient medical coverage in the states, Americans who travel overseas and sustain serious injury or illness are gambling with their financial security at home when venturing abroad without sufficient travel medical coverage. It is the responsibility of the travel insurance industry to educate and warn their customers that the level of risk is high when they travel abroad without an adequate travel medical insurance plan.

Multiple countries will make travel medical insurance coverage a condition for border entry in 2020

As global travel continues to rise, universal health care systems are threatened with insolvency from bearing the burden of emergency medical treatment incurred for foreign visitors. This year, three countries began the process of requiring all non-nationals to secure travel medical insurance before entering their country.

Thailand’s new retirement visa requirement

Thailand instituted requirements for travel medical insurance for all travelers over 50 coming to their country on what

Any family travel should be insured for special benefits including emergency reunion coverage, which allows for bedside visits from parents back home, and return of minor children...

is known as the country's 'retirement visa.' This age demarcation is when pre-existing conditions become more common. The Ministry of Public Health approved the measure and created three policy options that foreign visitors can purchase online from the Office of Tourism.

Travelers who do not secure a visa must purchase a plan at the airport at their time of arrival or they will be denied entry. The policy maximum requirement is 2 million Baht (THB), the equivalent of approximately \$65,000 (USD), more than double the Schengen area visa requirement for travel to 26 of its European area countries.

Japan pushes travel insurance coverage as the 2020 Olympics near

Japan found that nearly 30% of international tourists come to their country without travel medical insurance and that one-fifth of hospitals in Japan have been hit with unpaid medical bills incurred by foreign travelers. This according to Japan's Health, Labor and Welfare Ministry. This prompted a huge PR push by the Japanese tourism industry to distribute flyers at tourist information centers in airports and hotels, and to distribute cards listing the most expensive hospital treatments.

Private travel insurers noticed an uptick in sales from foreigners following the initiative. Prefectures such as Okinawa have pushed tourists to purchase travel medical insurance onsite at convenient locations while enjoying their popular beaches and warm weather.

Look for the implementation of mandatory travel medical coverage in Japan as the country prepares to host the 2020 Summer Olympics in Tokyo.

A tiny country with a very busy port

The tiny island country of New Caledonia, a French Pacific Island territory, welcomes more than 1 million cruise passengers each year. The country found itself treating uninsured and ailing holiday travelers and cruise ships passengers this year and implemented a potential entry ban for travelers who cannot prove that they have sufficient travel medical insurance.

Several cruise lines that make over 500 stops each year to their port are ramping up awareness outreach to passengers regarding New Caledonia's recent requirement to carry adequate medical insurance and repatriation coverage. Those

who disembark without travel medical insurance will be required to state in writing that they will pay for any medical expenses they incur while on the island.

Look for more countries to initiate mandatory travel medical insurance requirements in 2020.

Watch for the rise of split-generational travel

Travel insurance providers have seen the rise of multi-generational travel for the last two decades, especially in the cruise industry where specialty policies have begun to surface. Now on the horizon comes 'split generational' travel where the kids get to leave mom and dad at home and travel with grandparents or other older relatives.

Children are more prone to illness and injury while traveling. Travelers aged 55+ are more likely to have diabetes, hypertension or heart conditions, all of which are considered pre-

57% of Americans took vacations lasting fewer than five days in 2018
25% of Americans took three "micro-cations" in 2018
28% of Americans did not take a leisure trip in 2018

Source: Ipsos poll, 2018

existing conditions. Comprehensive coverage for acute onset of pre-existing conditions is imperative for this age group.

Any family travel should be insured for special benefits including emergency reunion coverage, which allows for bedside visits from parents back home, and return of minor children for situations where the grandparents of a traveling child may become unable to care for them. Emergency medical evacuation is another critical benefit that families need to include with their policy which allows for air evacuation from land or sea should a critical injury or illness occur with one or more of the traveling party.

The rise of the "micro-cation" in vacation-starved America

Americans take less vacation time than any other developed nation in the world. This holds especially true for millennials and Gen Z now entering the workforce. Both demographics are typically strapped with student loan debt but rank global, experiential travel as one of their top expenditures over buying a home or having a car.

Many of these young workers have a fear of taking too much time off work at once, hence the emergence of "micro-

Many popular credit cards may provide adequate coverage for trip delays or cancellations, but all U.S. travelers venturing out of the country need travel medical insurance coverage.

cations.” These allow employees to carve out long weekends over national holidays or simply use smaller chunks of their paid time off more frequently to allow them to take three- to five-day vacations wrapped around a weekend.

Destinations such as Iceland or Costa Rica offer cheap airfare and enough of an escape from the ordinary to provide desperately needed life-work balance. Enduring red-eye and other sleepless flights in foreign time zones is seen as a minimal sacrifice to escape the pressures of work. This demographic segment is poised to take over the travel market after baby boomers and Gen X.

But, this does not mean that “micro-cation” travelers are

Cancel for work reasons vs. cancel for any reason

Business travelers who rely on the travel insurance policy provided by their employer are familiar with the benefit of “cancel for work reasons,” which allows them to cancel travel for valid work reasons and recoup a portion of prepaid expenses. However, if an employee is putting family and leisure travel into the mix, they would need separate coverage for both themselves and their family to cancel a trip due to a natural disaster, political unrest, or for any other reason.

For the bleisure traveler who wants the ability to recoup up to 70% of prepaid expenses should an incident occur up to 48 hours prior to departure, they would need to purchase “can-

75% of business travelers extend their trips for leisure purposes, many do so multiple times per year

72% of business travelers are joined by another person, typically their spouse

Business travelers who have family or friends joining them is on the rise, now at 56%

The opportunity for quarterly and yearly travel insurance policy sales to cover visiting spouses or family is a great opportunity for life and health brokerages that sell travel medical insurance

Source: Hotel Business, March 2019

less at risk than those of Americans venturing out on longer vacations. Regardless of the length of a trip, comprehensive travel medical insurance and trip insurance coverage are critical for the traveler to secure.

Many popular credit cards may provide adequate coverage for trip delays or cancellations, but all U.S. travelers venturing out of the country need travel medical insurance coverage. This is especially true for those engaging in hazardous or adventure sports which require specialized policy riders. These can add between 4 to 10% in additional cost to a policy depending on age and the length of travel.

More business travelers want to take their families with them

Thomas Cook released its yearly travel trends report in September which showed that 64% of travelers are taking or are considering taking their families on business trips, opening the door to sales of multi-trip and multi-individual policies.

The business travel insurance market has seen the rise of bleisure travel for the last two decades—travel that wraps leisure time around a business trip—but more and more business travelers want to bring their families, especially with the continued rise of working mothers occupying more senior and executive positions that require travel.

cel for any reason” (CFAR) policy coverage. This pricey policy option is growing in popularity as travelers fear unforeseen events or weather impacting their travel.

2020 will be a benchmark year for travel insurance

2019 ends with at least three countries requiring travel medical insurance, including Japan, the country hosting the 2020 Summer Olympics in Tokyo. The uncertainty surrounding Brexit is foreshadowing the upcoming European Travel Information and Authorization System (ETIAS) visa which will be required for Americans who travel to Europe beginning in 2021.

The upcoming ETIAS visa requirement in 2021 offers yet another opportunity for travel insurance providers to offer protection for border entry denial in their policies. This is just one of the many sales opportunities on the horizon for 2020 as global travel becomes more regulated due to strained national health care systems and the implementation of new visa requirements.

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WHAT CARRIERS WANT BROKERS TO KNOW ABOUT VOLUNTARY BENEFITS

A Q&A with John Thornton, Amalgamated Life Insurance Company, Executive Vice President, Sales and Marketing

Q: There continues to be a lot of hype around voluntary benefits. Is there really that a great demand for them?

JT: Yes. Industry data from multiple sources continues to project increasing demand for voluntary benefits, both on the part of employers and their employees. Earlier this year, DirectPath and Gartner released the findings of their study, 2019 Medical Trends and Observations Report. In it, they reported that 66% of employers now offer long-term disability voluntary benefits and 50% offer short-term disability. Further, the report indicated that 75% of employers offer supplemental life—up from 45% in 2018; 60% offer AD&D up from 27% in 2018, and most other voluntary benefits such as identity protection and legal services are also showing upward trends.

Q. What's the main reason more employers and plan sponsors are offering various voluntary benefits? Is it largely to shift the costs of benefits to their employees?

JT: The primary reason which is to retain and attract employees. Of course, cost-shifting is a factor and an incentive for employers to offer voluntary benefits.



According to unemployment data released by the U.S. Bureau of Labor Statistics, unemployment has held at 3.7% for consecutive months; the lowest rate since 1969. The candidate market is tight, especially in certain white collar and professional roles including those in the Science, Technology, Engineering and Mathematics (STEM) fields. Today's workers are very savvy and many place a high premium on financial security and quality of life. They recognize that having access to high quality voluntary benefits will ultimately accrue long-term life benefits and financial wellness for themselves and their families. As a result, they are seeking out employers who realize the importance workers place on these benefits. This is not lost on businesses.

Q: So, I guess you're saying there is a huge opportunity for brokers relative to their selling voluntary benefits?

JT: Yes, without question. We're seeing it in our own product sales. Our voluntary product sales have continued to climb, which is why we have been actively expanding our voluntary portfolio for the past several years. In June, for example, we announced that we are now offering a voluntary Portable Term Life product. Last year, we added an identity protection and credit monitoring voluntary benefit and are continually looking for other solutions that serve America's workforce.

Q: Do you think brokers are missing out on the voluntary boom?

JT: No. I do believe many are capitalizing on it and bringing these solutions to their clients. Where there may be a gap is that many are marketing voluntary benefits just as they would group benefits. They do require a different approach. It's not enough to have a great working relationship with the client, the employer/plan sponsor. Marketing voluntary benefits requires a new process that takes into account that the employees are the ultimate customer for voluntary benefits. Therefore, brokers must take the time to understand their clients' workforce demographics, and do the research to understand what voluntary benefits resonate most with the different generations. In this way, the sales emphasis can be on those products that best reflect the needs of the client's employee composition.

It's also important to know what percentage of their group health plan premium employees are paying for. This will be a factor in how much they might be able to afford in other voluntary benefits. Clearly, there will be some accounts where all voluntary benefits will not make sense based on their workforce demographics; that is whether workers are largely highly-compensated employees or in lower paying jobs, and how much of their health benefit cost they are assuming.

Being financially secure is top of mind for millennials...Brokers marketing...to millennials should educate them about the role voluntary benefits have in supporting financial security.

Q: How important is the enrollment process and how can broker optimize enrollment periods to market voluntary benefits?

JT: Of course, enrollment periods are when a broker has both the employer’s and employees’ attention. It’s when the focus on benefits is highest, perhaps with the exception of life events such as marriage, birth of a child and the onset of a major illness occurs—all of which can trigger an interest in various insurance products. To capitalize on this heightened share of mind, brokers should do all they can to educate and motivate both parties.

Employers and plan sponsors need to understand the value proposition voluntary benefits offer them, especially when paired with their company’s high deductible plans. Together, the combination is an extremely cost-effective way for employers to help their employees gain the added protection they want and need, without incurring extra costs which, over the long run, could jeopardize the company’s financial stability.

Brokers should arm employers with consumer-friendly, jargon-free information about the various voluntary benefits and let them know there will knowledgeable product specialists on hand during enrollment sessions to explain the benefits to their employees and answer their questions. Additionally, it’s important that brokers remind employers that voluntary benefits can be offered to all employees, including part-timers who, like full-time employees, benefit from not having to conduct all the research on their own.

As for employees, in addition to providing product information that is easily understood by the average worker, and when necessary, provided in a second or third language, brokers need to let employees know that product information is readily accessible online. Brokers should inform employees that information on the carrier or company behind the voluntary benefits is also available online. This provides employees with added confidence that they will be purchasing products from organizations that the broker has carefully vetted.

Q: You’ve spoken about employees as a whole, but isn’t it true that marketing voluntary benefits to millennials may require brokers to be even more tuned in to their priorities?

JT: To the extent that millennials have surpassed Gen-

eration X as the largest number of workers in the American workforce, yes. Based on this Pew Research data and other research, millennials have priorities that, in many ways, differ from Generation X and the baby boomers. Whereas the boomers’ focus is on retirement and Generation X members’ are focusing on retirement and paying down their debt, millennials—ages 23 to 38 in 2019—have placed a higher premium on making enough money primarily so they can enjoy their lives and feel financially secure. Many millennials witnessed their parents and grandparents lose a lot of money in their retirement plans during the Great Recession; some even lost their jobs. Being financially secure is particularly top of mind for them. Brokers marketing voluntary benefits to millennials should educate millennials about the role voluntary benefits have in supporting financial security.

Millennials, the first generation who grew up using digital communications, also have an expectation that you’ll communicate with them as they communicate—largely through their mobile devices with a high emphasis on text messaging. They also appreciate, as do the other generations, a personalized approach that lets them know you understand them, took the time to educate them regarding the risks various voluntary benefits address, different levels of coverage and related cost factors.

Q: Any last words of advice to brokers selling voluntary benefits?

JT: Yes. Voluntary benefits were made for cross-selling. They are an ideal way for brokers to build higher revenues from an existing client, while also strengthening that client relationship and reducing the potential for another broker selling voluntary benefits to breach that relationship. There is every reason for brokers to be marketing voluntary benefits to their existing clients and using them as a hook to build new client relationships.



John Thornton is EVP of sales and marketing for Amalgamated Life Insurance Company.

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